

GOVERNOR BREDESEN: I'm pleased to introduce our next speaker, Gerry Hinkley. Gerry is a partner with the National Health Law Firm of Davis Wright Tremaine in San Francisco, where he co-chair the firm's Health Information Technology Practice Group.

This practice is focused on community network development, finance, network user participation, system procurement, regulatory compliance, and privacy.

Mr. Hinkley has been involved with governance and network user and privacy projects for the California Healthcare Foundation, Connecting For

Health, and the California Endowment, as well as state legislative and regulatory projects and the E-Health Initiative.

Gerry, we look forward to hearing from you about state legislative activities in e-health. If we could plan on this being about, in total, a half hour, which trims it just slightly, we can get back - - I'm trying to organize lunch to happen at the right time.

(Laughter.)

GOVERNOR BREDESEN: I know everybody's very concerned about that.

MR. HINKLEY: I share that desire.

GOVERNOR BREDESEN: Please.

MR. HINKLEY: It's a pleasure to be here before this distinguished panel, and it's even more of a pleasure to start talking with you, without having to take an oath.

(Laughter.)

(Slides.)

MR. HINKLEY: But I'll be as truthful as I

possibly can be. Really, the purpose of this

presentation, is to give you a snapshot of what's happening from a legislative perspective at the state level, so I'm preaching to the choir, I think, in some respects, but I think it will be interesting to the panel to hear what's going on thematically.

Because of the length of time that I've been given for this, I'm not going to drill down potentially to the detail that you might want on this, and I'll refer you and your staff to the places where you can get that level of detail.

But I'm trying to give you some broad waves that are traversing the country, and, hopefully, at the end, give you some specific thoughts about things that you can do collectively, which will advance the cause of implementation of HIT across the country.

Generally speaking, half of the states are in the middle of attempting to implement plans for developing HIT for their states. And this is the legacy of federalism, and each of the states is taking its prerogative in that way.

I have a personal theory that many of the

East Coast states are drawing on their experiences as being founding colonies of the nation, with a history of working together for social causes, and taking these kinds of issues seriously and working in a community context, as opposed to some states, particularly out West, that may have been formed by, you know, latitude and longitude that may not necessarily have the same focus on the communities that are making this work, and I think the issue here really is community.

What we're really seeing is that IT is not a separate concept as something that needs to be infused into the health delivery systems of our nation for its own sake, but, really, as a means to an end of achieving quality, goals towards to patient safety, and also curbing healthcare costs.

You have heard and you will hear from others, about that tie, and that's not really why I'm here. In at least 20 states, the Governors have taken the initiative by executive order, to get the ball rolling.

And this isn't, in most cases, only the

Governor, but it is a demonstration that the administrative side of state government, coupled with the legislative side of state government, as we'll learn, are teaming together to solve something that is viewed as a community, nonpartisan problem.

What I'd like to direct your attention to when you have time, is a database that Jason Callan, who is the librarian of our San Francisco office, maintains, tracking all pending state legislation.

It's a terrific tool that is sponsored by the E-Health Initiative. You go through their website and you get a map of the United States and you click on a state and as of last Wednesday, we were up to date with all pending legislation in the nation, with links through to the actual bill text.

So it's a very rich resource for those of you who want to see what the words are, what's really happening in legislative activity.

So, what have we been seeing? There's been a flurry of activity in 2005 and 2006, and lots of bills have been enacted, and many, many more have

been introduced, but we've seen in the last two

legislative sessions, 37 bills being passed in 24 states.

And in 2007, thus far, 68 bills have introduced in 30 states, so you can see that the activity is rising. So what are the themes that these legislative initiatives are addressing?

One is somebody to take a look at the situation. You know, that's always the old adage, it's like the first thing is, we better find out what the problem is.

And so you're seeing the creation of commissions or directions to state enterprises that are preexisting, to take charge of the issue and make it something that is going to be solved within the state.

We also see the theme of developing, you know, the desire for implementation of quality goals. Dr. Tuckson made that comment and I think this is something that all of us at CCHIT and in the state initiatives, are focused on, which is how do we get our arms around quality, and that is a conundrum at

the state level, as you know, and something that is

sought to be addressed through these processes.

And then, lastly, and importantly for those of us in the trenches who are trying to get things up and running, many of the states are shouldering substantial financial participation in providing seed funding for initiatives at the real level, or focused on specific types of care settings that are perceived to require additional state source funding to get them off the ground.

So, let's take a quick look at kind of the commissions. In the last couple of years, 53 bills were introduced in 25 states, creating bodies to look at this type of activity and 19 of these bills were created.

We've heard already from the State of Florida in questions for the preceding panel, that they have taken a very serious hard look at how to pull together a statewide health information network focused on major metropolitan and community areas, and how to bring those together.

That has been mirrored in Idaho, in

Illinois, in Indiana, where varieties of

organizations are being commissioned to identify the problems, refine the identification of goals that can be achieved through the adoption of IT, and then developing plans, not only for operations, but also for financing and sustainability.

In this current year, there are 25 bills currently pending, that are focused on this initiative. One I want to call out particularly, is in Iowa, where their collaborative is focused particularly on the safety net.

If you think about health IT as a social good, most -- you know, at least in my view, it is most beneficial for those who get their care regularly in emergency departments, not only for them to have access to a consistent medical record that might be assemble-able, if that's a word, from the various places where they achieve care or get their care, but also it helps the emergency room providers to find out the patterns of care delivery for individuals who routinely visit emergency rooms.

And the safety net providers, are probably

the least able, at least in many states, to shoulder

this burden, but this is really where the burden is.

So, states, Iowa, in particular, I think, needs to be commended for focusing on the safety net, and hopefully that legislation will see the light of day.

I want to call attention also the State of Oklahoma. This bill is probably the most comprehensive statement, and, I think, complete and simplest statement of what a healthcare information technology task force can achieve, not only focusing on strategies, but also looking at standards for interoperability, which you've just been talking about, is really the name of the game in health IT, focusing on how RHIOs can get up and running.

You know, certainly Oklahoma is not alone in directing this, but, you know, if you believe that RHIOs are going to be the building blocks of IT, creating some consistency statewide about how RHIOs will be organized, is really kind of a key consideration.

And right now, in states where I'm active,

you know, that is not generally the case. This is

very grass roots. The various stakeholders in each community drive, you know, kind of the tone of these initiatives.

Sometimes there's a payor bent and there may be some others, you know, an employer bent, but kind of the core of this is what a RHIO is in our state, and hopefully, in our multi-state region, is not really coming through, and so I really was delighted to see this in this particular piece of legislation, that there is a goal to create the template for RHIOs.

Then, lastly, there is a recognition that funding for these organizations is key to success and looking at ways that not only can they be funded from a seed standpoint, but also how they're going to be funded ultimately as sustaining organizations, and how, you know, society will start to view IT as a cost of healthcare, like the cost of doing business.

So, hopefully, initiatives like the one that we're seeing in this bill, will result in those.

Let's see, as I mentioned before, the

state legislatures are very focused on quality. That

is an issue, certainly, in this current election cycle, that quality of care is going to be, you know, a big topic, and so the legislatures, of course, are focusing on that, because their constituents are very concerned about that.

And in 2005 and 2006, 12 of the HIT-related bills that were passed into laws -- I mean, were introduced -- had to do with specific quality initiatives to be implemented through HIT, and six of those bills passed in five states.

In 2007, we've seen an uptick in this. There are five bills that are focused on this particular aspect of healthcare. In California, Idaho, and New Mexico, they are specifically called out in the bills that are pending, that quality is essentially job one for the implementation of health IT.

About funding: The sustainability of health information exchange, from a financial standpoint, is a significant topic and is being addressed in a number of states. Many states have

put substantial dollars behind funding regional

efforts, and in the last two years, eight bills have been passed into law in seven states, and here's sample here to give you a sense of kind of the range of legislative activity.

In particular, Maine has authorized the issuance of bonds for HIE, which is one potential for creating a pool of funds for this, but presumes, when you issue bonds, that there's going to be revenue generated to pay them back.

And so that also shows an optimism, that there may be a way, ultimately, to pay for these. I think that those of us who are working out in RHIOs across the country, are, you know, entirely dependent now on grant funding, which, you know, many would say is not a positive fact, but it is a fact.

In some respects the payor-provider-consumer community is waiting for somebody to blink, to take responsibility for paying for something which David Brailer, the original coordinator for HIT in the Office of the ONC, said needs to just be standard operating procedure in the country, and that hasn't

been uniformly adopted, but is something that we're

hoping to see.

So, in 2007, there are already 12 bills that have been introduced in eight states. For example, in Arizona -- and this is an example of a trend -- there's a focus on telehealth, and that's something that has not -- I mean, with the President's suggestion that we all have electronic health records, many of us have focused on the development of that technology that comes under that name.

But for states of the Union that are predominantly rural, the communication, delivery of care through telehealth, is being perceived as an important element of the development and maintenance of electronic health records. I think, through funding mechanisms, through the FCC and through other initiatives, what we're seeing is a coming together of the telehealth movement, with the electronic health record movement, as really being components of a larger solution.

And so we've seen a fair amount of

activity in states looking at telehealth and trying

to make sense of how it fits in with an overall plan for IT development for the state.

So, for example, Arizona has allocated \$850,000 for telehealth, which I think is terrific, and, also, the State of New York has authorized \$6 million for telehealth development.

I apologize for the typographical error in the first slide, but it proves my humanity.

(Laughter.)

MR. HINKLEY: Another theme that we're seeing in this legislation, is an effort to create uniformity among state programs. State governments are huge purchasers of technology, and various agencies of the state, because of the nature of their responsibilities, deal with the same people in different situations, and so you have the prison system, the healthcare system, the social welfare system, you know, other systems that deal with individuals, who all, because of the history and the way the IT business has developed, have created and adopted, you know, information systems that don't

necessarily talk to each other.

In fact, it's probably fairer to say that these systems don't talk to each other. And so there has been movement to create some uniformity in a variety of states, and there were laws enacted in 2005 and 2006, pushing toward that.

For example, Connecticut has passed legislation that there will be a uniform statewide EHR format by 2010. The State of Florida has enacted statewide electronic organ and tissue donor registry, which has been a little controversial. Hawaii has been a leader in a variety of areas here, and they have taken the step to say, we're going to have a single patient identifier in the State of Hawaii, which, we know is a topic of some interest.

Many states, also in the past couple of years, have really looked at kind of the basis for implementing IT from the standpoint of provider usability. For example, the State of Connecticut, you know -- and this is not unique to Connecticut, but I just cite it as an example -- had to authorize the use of electronic prescribing and the use of

electronic health records, because the laws mandated

the use of tangible paper records.

The State of Georgia authorized electronic records, and specifically dispensed with the requirement that medical records be maintained in a tangible form. Indiana has authorized the use of electronic signatures in any record involving individually-identifiable patient records.

I want to spend a minute more on telehealth. You know, I've touched on it, so I'll do this one quickly, but the issues in telehealth kind of reflect the essence of a state-by-state regulation of healthcare providers.

And for telehealth to work, in the view of many, state-by-state barriers need to be addressed to allow practitioners in another state to provide consultative care to residents of your state. And that is not foregone, and in many situations where organizations are providing electronic healthcare services, where physicians or nurses are actually providing direct patient consultation, they find that their practitioners need to be separately licensed in

every state where their service can be electronically

accessed.

And that is obviously a burden to entry. The State of New Mexico has pending legislation this year that would create a comprehensive telehealth network requirement for the state, which would be a first, I believe, in terms of creating standards the way we talked about creating standards for RHIOs, creating standards for the delivery of telehealth within the state.

E-prescribing is something that has been on the radar screen for quite awhile and is recognized generally as something that will lead to good things. And in 2007, there is legislation that has been introduced in Maine and West Virginia, really focused on e-prescribing, and the Maine legislation, interestingly enough, describes the creation of a system that will maintain a complete record of the prescribed substance, the patient, and the pharmacist and the prescribing physician, as a permanent record that would be maintained with respect to that particular episode of care.

The State of West Virginia has a pending

bill that will protect the integrity of electronic prescribing records, by providing that those records are not alterable, once created.

There's a lot of conversation now about personal health records. And those are being viewed as the an essential component in many situations, to the realization of what an electronic health record can really mean for patients.

And there is legislation pending in California for the Department to manage healthcare, which is a component of their insurance administrative structure, to develop a plan for the development of a personal health record for every resident of the state.

And in the State of Iowa, there is legislation pending to develop PHR for children in foster care, which addresses a particular need for children who may move from one protective situation to another, so that their health records can be protected.

And then here's just a smattering of some

specific topics that are being addressed around the

country: Behavioral health is a particularly daunting issue with respect to electronic health records, because many states protect the privacy and security of behavioral health records to a degree that is higher than is afforded other types of records.

And the integration of behavioral health information into electronic health records, you know, has been viewed as being subject to barriers, and the State Texas has legislation pending that would develop recommendations for how to incorporate behavioral health information into EHR initiatives, while still maintaining the protections that we believe, as a society, need to be afforded to that type of information, to promote that -- you know, the delivery of care in that regard.

Texas -- and this on point from a question that was asked earlier -- has permitted state agencies now to make a condition of procurement, that the technology that's acquired, is certified by the CCHIT.

You know, that creates some issues, and

Mark spoke about that earlier. There is a lot of technology that is not certifiable, not because it doesn't qualify, but because standards for that particular technology don't exist. This particularly exists in the area of subspecialty care, where there are no standards currently in place to test, you know, for, you know, particular types of ambulatory care applications.

But, you know, this demonstrates that in cases where certification would be possible, that the state would provide leadership with respect to saying we're going to require our vendors to show that they are certified.

Colorado has legislation pending that will create an ED linking system. Many of the state-level initiatives have focused on ED linking, and, as I mentioned before, the emergency departments are the place where lots of people get care without adequate documentation, and the State of Colorado program, if adopted, would create statewide emergency continuing care record capability.

The State of Maine has focused on, for

their Medicaid program, developing a comprehensive, statewide database that would focus on their beneficiaries that are diagnosed with multiple morbidities called chronic care conditions.

And lastly, one I wanted to call to your attention, is that the State of Connecticut has legislation pending, again, reflecting the recognition that telehealth and electronic health records really go hand-in-hand, that makes patient consent, privacy, and access that would apply to EHRs, equally applicable to telemedicine.

So, to wrap up and to get back to the question that was asked in the last panel, what can the states do together to help move forward with respect to the adoption of HIT. I'm sure all of you are familiar with the National Conference of Commissioners on Uniform State Laws, that are the source of, you know, such uniformly-adopted rules as the Uniform Commercial Code, rules with respect to estates, et cetera, that benefit from the uniformity of laws from state to state, in order to ensure and

enhance the free flow of commerce.

A request has been made by the Governors Committee in Florida, to this Commission, to initiate a study and a drafting project with respect to state laws on a variety of topics, and I have them listed here.

These are generally recognized as the types of topics that ought -- that would benefit greatly from being dealt with in a uniform way. Now, the process of uniform laws, is cumbersome, but what we're learning, is that none of this happens overnight.

So, not starting, because it's going to take too long, is probably not an approach, and certainly there are some states that provide leadership in this area. It's a joint activity through the National Conference, and would be beneficial.

The topics that have been identified are just the basics about what is a medical record, who owns the medical record, rules regarding unauthorized practice of law, that, as I mentioned before, there

is ambiguities from state to state in tort law.

In situations where we're involved, I have to tell you that a fair amount of time is spent in multi-state settings, looking at, you know, if a network is going to cross state lines, what that really means to them, and it is a mind-boggling project.

I had a conversation earlier this week with representatives of the National Conference, and they asked me specifically to ask you to give them some direction in this regard, of what the states would like them to work on, because they are ready.

They have agreed to study the project, but they are very interested in direction from this group, in particular, about the types of topics that could be the subject to uniform laws.

And, with that, I will conclude. Thank you.

GOVERNOR DOUGLAS: Thank you very much. We have a couple to three minutes for questions here, before we move on. Are there some questions around the table?

(No response.)

GOVERNOR DOUGLAS: I might interject one quickly, then. As we look toward the establishment of model legislation or trying to find ways to converge what states are doing, is there some state of a couple of states we should look at as the ones who are doing it right? Are there some leaders and outliers among the states?

MR. HINKLEY: Well, I think the next person who answers that, is going to be in trouble.

(Laughter.)

MR. HINKLEY: All the states are taking this -- many -- well, most states are taking this seriously. I would call out, I think, the State of Florida, for example, that I'm familiar with, which has shown great leadership in that regard.

You know, I think what would benefit or inform this group, is pulling from various -- if you list the topics that you would like to have addressed, kind of looking at the various states, the State of Oklahoma and the charter for their Commission is probably one of the best I've seen.

And we could certainly, you know, off

record, provide that information to the group, if you'd like to see that.

GOVERNOR DOUGLAS: Dr. Tuckson, I think you had something.

MR. TUCKSON: On your Slide 54, you made the comment about state leadership in uniformity and integration of state programs. I'm trying to understand there, are you seeing any movement of apropos -- Representative Harrell's point earlier -- movement of states using national standards and sort of saying that if you're going to do business in our state, our programs need to be incorporating these sort of national standards, given that they are -- you know, thereby sort of offloading the development costs, all that work, all that R&D work to get done, and sort of say, okay, let's use the national standards and we'll just require uniformity, you know, and compliance with the national stuff, as opposed to doing it at the state level.

MR. HINKLEY: Well, there's the potential for that. I think the legislation that I'm familiar

with, leads toward a planning process to implement

that type of an integrated program, and, certainly, looking to national standards, as they evolve, would be a logical place to go. I haven't seen any barriers to that.

GOVERNOR BREDESEN: Thank you, Mr. Hinkley.

MR. HINKLEY: Okay, my pleasure.

GOVERNOR DOUGLAS: It's now my pleasure to welcome representatives of our two active Task Forces, the one on Health Information Protection, and the other on Healthcare Practice.

We're going to hear some updates from, first, the Co-Chairs of the Health Information Protection Task Force, Sallie Hunt and Dr. Bill Hacker, and the from Dr. Holly Miller and Howard Burde, who are members of the Healthcare Practice Task Force. Thank you all for being with us today.

I'll introduce Sallie first. In addition to co-chairing the Health Information Protection Task Force, she's the Chief Privacy Officer of the West Virginia Healthcare Authority. She leads the State's

privacy program; she has responsibility for

facilitating the Executive Branch's implementation and compliance with privacy principles and 20 federal and state privacy laws.

Dr. Hacker is the other Co-Chair. He's the Commissioner of Kentucky's Department of Public Health, and coordinates a diverse group of programs impacting the health of all the people of the Commonwealth, including public health emergency preparedness, maternal and child health, chronic disease, nutrition and wellness, environmental health, epidemiology, state and public health laboratories, and he works with the state's network of local health departments, as well.

Sallie and Bill, thank you very much for your leadership of the Task Forces and thanks for being with us this morning.

MS. HUNT: Thank you.

DR. HACKER: Thank you, Governors. Dave, it's good to see you again.

Our Task Force is composed of 14 members -
- I'm looking for my slides here, real quick --

(Pause.)

(Slides.)

DR. HACKER: -- who compose, with the list on our Slide No. 2, different focus expertise -- public health, Medicaid, HIV/AIDS and so forth. We've identified the need to add some additional folks, and down at the bottom, we're talking about adding another physician provider, clinical research, a vendor on electronic health records.

It's been a very, I think, well structured group. I'm certainly proud to be a member, and very pleased to be working with Sallie in this.

Our charge, as you set forth, we adopted completely, and we are trying to deal with -- come back with recommendations on how we deal with protection issues for the information that we have electronically stored around the country.

We had a fairly robust discussion on something we mentioned earlier, which is who owns the record? Who owns the information?

And we found that it is easier talking about having access to it, rather than ownership of

it, and that helped, we believe, in having a dialogue

to move forward with getting to the privacy and security issues.

Obviously, technology and policy development have to go hand-in-hand, and states do need some sort of framework in which to assess the laws and the regulations, and that is, again, something we're doing a lot of work with, and you'll be hearing more as we report back.

We're looking at, of course, the principals. We're using some of the group's work on privacy and security on what are the core foundations that you can build upon as we move forward?

We did take the work product that you drafted for us, and made two minor changes that I hope you will find acceptable. For the words "pro" and -- "discuss the pros and cons," we inserted, "discuss the applicability of various kinds of protections."

And the original referred to a patient, and we had a lot of discussion about the fact that "patient" implies a clinical situation, and, in fact,

for example, in public health, I may encourage you to

do physical activity to be physically fit, and it's really not a patient issue; that's a health issue, and it's really personal individual health, and it also is consistent with the personal health record that was also discussed.

So, with only those two minor changes, this is what we're really trying to drive for on our work going forward.

(Slides.)

MS. HUNT: The next several slides take you through the work product as we see it.

This is really the slide that talks about our pre-work.

As we looked at what you asked us to do at the charge and at the work product, we identified a number of activities that need to take place first:

We needed to figure out, first, what are the categories of the major state health privacy laws?

What principles should we use as a metric?

We needed some standard to bounce the laws

against, and we needed to figure out which states we

would pick in terms of their laws.

Do we want to base them on geographic representation?

Do we want to base them on the highest level of protections? We needed to develop a framework around which we would proceed.

(Slide.)

MS. HUNT: The first phase of our work product is focusing on the rationale behind each of the laws. It may be that at the time that these laws were enacted -- if you look in your state -- these laws were enacted 20 to 30 years ago, in large part. We may not have the same rationale today. Health care may have changed. We have an electronic environment. It's a different world today. We need to understand and get behind why were these laws enacted in the first place.

(Slide.)

MS. HUNT: Phase 2 involved the applicability to today. Do we still need that kind of protection? Is it still valid? Is it valuable to the consumers, the patients, the individuals, the clients we serve or is it not? It's in this phase that we'll bounce the laws against the privacy principles and against other factors as well.

(Slide.)

MS. HUNT: This slide goes into a little

more depth in terms of addressing the applicability.

We have heard from a number of individuals already around privacy principles. As Bill told you, we've heard about the market principles. We've heard about the principles Florida is using. We've heard about set of consumer principles. We need to get our arms around these principles and make a decision which set we believe is the correct one for states to use. I believe that this set of principles itself will end up being a tool for states to use to examine their own laws to figure out what is still relevant today.

When we looked at these laws at our April meeting in terms of principles, we also thought it was also important to categorize the laws by themes. For example, you might look at what laws require written consent, what laws can require verbal consent, your highest levels of protection. But we thought that we should aggregate them by subject matter and by theme as opposed to by states so that we could have a whole and candid discussion. When we product a work product for you, we won't be saying West Virginia has this law. Ohio has this high-level

protection or low-level protection. We'll be saying

states generally deal with mental health in the following five ways. Here's a high-level protection, medium and low. That's the way we anticipate proceeding.

(Slide.)

MS. HUNT: In the end, we will have recommendations for you. I'll get into that a little bit further down the road in these slides, but we anticipate having real tool kits to give the states. We want take-aways the states can use to facilitate health information exchange in a real way and build trust with their own consumer base.

(Slide.)

MS. HUNT: Here are some of the tool kits or resources we've talked about. One of the challenges we identified in our very first meeting is that a lot of these laws are complex. Will an average person understand what they mean. We thought it might be helpful to develop some common language or vignettes that states could then use for conversation with their consumers, with their

legislators, with their other policymakers to help

get some meaning around these technical legal requirements. We may end up with model laws where we reach consensus that really we believe states should be approaching things in the same way and at the least we'll have tool kits.

(Slide.)

MS. HUNT: This slide represents our current picture, a snapshot of where we are today. It's a preliminary list of categories that we intend to focus on. When you look at this slide, those areas that are bolded and italicized are where we intend to focus first. We felt that it was most important to start with the kinds of laws that have the highest levels of protections. That box is at the very top of the slide. These are the areas that we identified first -- mental health, HIV, genetic and disability.

Also, given your charge to us to make this work patient-centric and given our desire to focus on the individual, we decided to focus on treatment as well as individual and provider access to data. When

we talk about providers, that could be doctor-to-

doctor, doctor-to-hospital, that sort of thing.

(Slide.)

MS. HUNT: So in addition to the privacy principles -- and you should have those in your packet -- when you think about privacy principles, those are things such as who gets access to information? Do you share only the minimum necessary? Is there an enforcement mechanism? There are themes that experts believe should be in place in any program. On this slide we identified a number of additional questions that we want to answer about each type of state law that's out there.

So for example, HIV, we want to run it through all of these different questions to see is it still relevant today? Does it make sense today? And if it does, is there some sort of very easy technological solution that we can apply to it and then tell other state about when they run into this issue? But if it is not valid today, if there's nothing that provides benefit to consumers today with that law, what do we recommend? How do we get around

changing the law. What are some models? If we

recommend new laws, what should they look like? What sort of tool kits can we give states to help them through their own individual analyses of their laws?

(Slide.)

DR. HACKER: From our dialogue, we fleshed out other issues that do need to be addressed. For example, provider liability as was discussed earlier this morning, access to information. Does a physician have increased risk of exposure. If not, what's going on. So it does get very complicated. Enforcement really deals with the issue that the public won't buy into this if their confident that they've been notified if there is a breach of their information. Some inappropriate, unauthorized access did occur. And secondly, that there's a mechanism in place by which their concerns can be addressed and the enforcement piece is going to be, I think, very important for the adoption.

Choice of law also deals with the issue of which jurisdiction has the control. The data is in one state. The patient is in another state. The

provider is in a third state. This parking lot list,

I'm sure, will be fleshed out more. With only two meetings, we've identified these. Others will be added I'm sure as we go through.

(Slide.)

MS. HUNT: This is a list of some of the possible outcomes you might see from us. When you think about your state's privacy laws, they're based upon your own state's culture, values, the way people think in your state. If laws are passed today, it's probably very much impacted by the level of education that consumers and legislators have about health information technology. So we see differences across the country, but what we want to do to promote health information exchange is to look to see where we can harmonize best practices. Whose laws are working well, where are they still relevant, what can we do to advance health information exchange while maximizing privacy and security and really enhancing that consumer trust and building it along the way? Can we look to other work for the other working groups we've heard about this morning and really

learn a lot of the wisdom from the collaborative that

Jodi Daniels mentioned -- the 34-state participation looking at our own barriers on privacy and security and looking at some of the conclusions and recommendations those states have drawn about what we need to do as a whole. Where should we focus our efforts to become more uniform and consistent? I believe there's a lot of wisdom to be gained. We'll be meeting with those folks in June.

(Slide.)

MS. HUNT: So some milestones. We are in the middle of our pre-work now and starting to focus on some of the work from May. May will be the first phase of our work product to you where we will identify the rationale behind the major categories of law. In June, we will have work product focusing on which of those laws are still relevant today.

(Slide.)

MS. HUNT: Here's our contact information and I'll move on to the last slide. I believe the last slide is now in your packet. It's the list of all 34 states that are participating in the health

information, security and privacy collaborative.

Thank you.

GOVERNOR DOUGLAS: Thank you both Sally and Bill for leadership and your presentation today, for your update. Our plans for members of the Alliance is to have some discussion about the scope and direction of both of our taskforces to consider the proposed changes in the work product that Bill mentioned and described just a few minutes ago to make sure that we're comfortable with them and approve them if we are.

I thought it would be helpful to have Howard and Holly give a presentation first on their taskforce, then we can begin to talk about both of them. But if there's any burning question to Sally or Bill right now, I don't want to ignore it.

Commissioner?

COMMISSIONER PRAEGER: I just have one question.

When you're going through this next phase, I think what would help states -- I think we all agree that getting to the uniformity in health

information is an important goal. If the states can

understand how some of these state laws would really inhibit that, that's going to make it easier for them to address that. Is that going to be part of the discussion?

MS. HUNT: I think we'll hear that and I think we'll also get a lot of that information from the HITSP Project, too. These states that participated should have already identified the variations and barriers and have solutions and an implementation plan moving forward. So we'll hear from that along with hearing from experts at our next meeting about the barriers and need for change.

COMMISSIONER PRAEGER: I think some of our state laws were put in place when we were very suspicious of any information going through the Internet. We've come a long, I think, in our understanding and acceptance. I think we're ripe for repelling some of those laws or modifying them.

MS. HUNT: We should address that in our second work product to you.

GOVERNOR DOUGLAS: Good point,

Commissioner. Times change. Laws don't always. We

want to make sure it's dynamic as the taskforce continues its deliberations.

Let me introduce Holly Miller and Howard Burde, who are members of our Health Care Practice Taskforce. Holly is the Chief Medical Information Officer for the University Hospitals in Cleveland. She oversees implementation of the EHR system there. She has been a physician administrator for two decades and for the last couple of years has been managing director of the Cleveland Clinic. She has implemented and disseminated the clinic Internet system across the main campus, family health centers and the Florida facility. She joined the facility in 1999 as director of the Clinic Internet Systems.

Howard Burde is a partner at Blank Rome. He represents health information technology companies, health plans, federal, state and local governments. He routinely counsels in a number of areas, including health IT, insurance-managed care law, licensure and certification and accreditation matters. We met Howard at our last meeting as I'm

sure you'll recall and we really appreciate his

taking the time to be with us today and also serving on the taskforce.

So Howard, Holly, welcome. Thank you for your hard work.

MR. BURDE: Thank you very much Governor Douglas, Governor Bredesen and members of the Alliance.

(Slide.)

MR. BURDE: We appreciate the opportunity to give you an update of the work of the taskforce and tell you a little bit about the work we've done so far and where we plan to head in the near future.

As an initial matter, we would be remiss if we didn't thank Meredith Pumphrey, who is providing our staff support. If you've dealt with Meredith, she's had the unenviable task of having to help script Dr. Miller and me. In advance, we apologize for anything that we screw up deviating from your script.

(Slide.)

MR. BURDE: Our purpose today is to give

you an overview of the taskforce, to summarize our

activities and to explain the criteria that we are using to the other taskforce. To create the heuristics we will use to examine existing state laws with respect to the provision of health care and to make recommendations about potential changes, one of the things you will note as we were listening to Dr. Leavitt and Jodi and Jerry Hinkley, who is a colleague in the health bar, and to our colleagues from the other taskforce, these issues don't stop along taskforce lines.

Very clearly, the things we are doing are integrated. We know, for example, that the choice of law issues the Privacy and Security Taskforce deals with we are dealing with as well. In fact, I'm representing health information exchanges across the country and choice of law is extremely important, especially as these efforts cross state lines. Likewise, it would be important for us to integrate our efforts should the National Governors Association choose to do so with the uniform law commissioners.

If they're addressing the same issues, it

would be silly for us to ignore the efforts they are

putting in on the very same topics. We may even wish to see if we can work together on those issues.

(Slide.)

MR. BURDE: As you know, the Health Care Practice Taskforce is charged with supporting the State Alliance on issues regarding regulatory, legal and professional standards that impact the practice of medicine and the adoption of interoperable health information exchange.

(Slide.)

MR. BURDE: To take on this charge, the taskforce currently has 13 members. They are divided here or are representatives of the following kinds of different professionals and stakeholders in the system.

MS. MILLER: The membership includes broad representation of health care constituents, including representatives from across the country in both public and private sectors. In addition, the state governments of the great states of North Dakota, North Carolina and Indiana are presented. I would be

remiss in not mentioning, though not explicitly

represented in this list, clearly as all of us in this room are health care consumers, so there's another constituency that's included on this slide.

At the January meeting of the State Alliance, members indicated that you would like the Health Care Practice Taskforce to examine issues of licensure and liability and how they relate to e-health. So the February meeting of the Health Care Practice Taskforce included presentations from representatives of cross-state telehealth information exchange. We had a representative from the state medical board, a legal expert and representatives of national professional medical organizations.

(Slide.)

MR. BURDE: For the next several slides, we will be discussing the highlights that we garnered from these meetings and the presentations as well as the discussions following those presentations. Most states have laws or regulations regarding the practice of e-health care.

Just so everyone is on the same page, I

want to talk about e-health Care for a moment to say

that e-health care is really an evolving area. This area currently would be considered to include clinical informatics and telehealth services. Those areas would be information exchange among physicians to physicians, physicians to patients, patients to physicians, the transmission of stand-alone or implanted medical devices over the Internet or over the telephone into electronic health records or into a physician's office or other ancillary system and even a variety of virtual businesses currently being offered by IDNs today. These include remote second opinions and virtual visits.

When we discussed licensure, there are several points which were discussed and presented during these meetings and the first is that state licensure really was an impediment to the delivery of e-health care across state lines. The next is that medical licensure criteria and the process to obtain medical licensure is almost identical. So if a physician has a license in one or more state, when they go to another state, they have to go through the

same processes to obtain a license in that next state

as well as the waiting to obtain that license.

We also heard from a representative of the Boards of Licensure and they're overwhelmed and the wait is often quite long. Nationally, it's quite clear that we're driving toward the goal of standardization of care across our country. The discussion became clear that we really see no reason not to have state medical licenses, particularly with examples of very remote areas that are receiving tele-health services that are working across state lines.

The other thing that became clear is that it's difficult for states to enforce and administer licenses and provide quality oversight across state lines. These are areas we want to look at further.

(Slide.)

MR. BURDE: Next was the discussion around liability. Jodi Daniel already gave you some great examples regarding the areas of liability that tele-health and e-health open up, but there are some more obscure ones. These would included when an

electronic health record is implemented in the

system, in the health care delivery system and there is an expected consequence that is negative and impacts patients. Who's liable? Is that the physician? Is that the in house information technology expert that has implemented the system or is that the vendor?

What we're finding is that we truly, and this was definitely across the group of our taskforce, believe that e-health does promote safety, quality and efficiencies and cost reduction regarding care. However, there are studies that there are consequences that are unexpected from things such as electronic health records. So we're expecting, again, as e-health is evolving that liability issues will evolve as well.

DR. MILLER: Currently, there is a lack of medical malpractice cases regarding e-health and health information technology, so we don't really a lot of information on caselaw out there yet. There's limited availability of professional liability insurance for e-health care. But we noted that

additional professional liability insurance is a

process and expense and it may actually serve as a barrier to e-health care rather than adoption.

(Slide.)

DR. MILLER: Next we actually had Jodi present to us regarding clinical laboratory amendments or CLIA. This had been recommended as an issue to be examined by the American health information community. CLIA refers to state law on who is the authorized person to order tests and receive tests. This is very critical in encouraging e-health care. When someone goes to have a test done, is that test then only available to the provider who requested the test? Is it available to the patient whose information it is? And is it available or would it be available at the patient's request to another specialty physician or other physician that the patient wants to have that information flow to?

You've already heard that there's a lot of health information out there that maybe start to move around to a variety of systems and you've already

heard then what are the challenging of defining your

electronic health record or defining the legal medical record. What we found was that states can amend state laws governing who is the authorized person to order tests and receive tests. We want to make sure that our recommendations around this would serve to enable e-health care.

(Slide.)

DR. MILLER: In summary, again, the taskforce all agreed that health information technology and e-health care should be designed to enable the practice of 21st Century medicine, enhancing patient safety, quality of care, outcomes and cost efficiencies. The barriers to the adoption of e-health tools that can be addressed by state governments do include licensure, malpractice insurance or the necessity of even having malpractice insurance specific to e-health, liability and then regulations pertaining to health information exchange such as laboratory information exchange or result information exchange as well as e-prescribing.

(Slide.)

DR. MILLER: We developed criteria for our

health care practice taskforce work products, which include -- we do not want -- these products will not establish barriers to the practice of medicine. They will not create an excessive burden on health care providers. They will ensure protection to the public and then finally, these products will promote the adoption by all health care constituents of e-health tools, again, to enhance patient safety, quality and care efficiency.

(Slide.)

MR. BURDE: Again, given the goals and criteria, the heuristics I mentioned before that we created to address these issues, to summarize very simply, we want to recommend to the Alliance a structure that will enable the practice of medicine using health information technology across state lines. So to summarize all that we've done we have to look at what's happening now and understand the impediments that currently exist, such as oversight and enforcement and come up with recommendations for you to consider as to how states, given their

existing jurisdictions and existing concerns about

consumers within those states might yet enable health information technology that will improve health care.

(Slide.)

MR. BURDE: Again, how do state laws hinder that exchange? Some of those laws are privacy and security laws. Others have to do with the practice of medicine, have to do with the use of laboratory services for radiological tests and so on. We are examining the breath of those services to figure out where state laws need to change.

With respect to liability, as I described the first time I was here, we're in a new world with respect to the use of information. The question undoubtedly, the caselaw will evolve, but what we really need to see is really two things and what we will strive to provide you with our recommendations regarding, one, any changes which might be necessary to limit the risks assumed by providers to use health information technology to improve care and to reduce costs. That could involve working with the National Association of Insurance Commissioners, for example.

We've discussed extensively integrating our efforts

with the NAIC because in the studies that have been done and admittedly, they're hardly broad-based studies, there has been shown to be a reduction in error and adverse events from the use of certain kinds of health information technology. Shouldn't that be reflected in the cost of insurance for those professional liability insurance for those who are using the technology? That may be a vehicle for helping to incentivize adoption. That's something we will be examining and we'll discuss with you at a later date.

(Slide.)

MR. BURDE: Again, this is more of what we've already discussed and it's there in front of you. I won't bore you with further discussion of what we're doing with respect to licensure or the suggested solutions.

(Slide.)

MR. BURDE: We're going to look at liability, though. I have to tell you, having listened to a variety of others and help write papers

and worked on journals with other of my colleagues in

the health law bar, we all cite the same cases. We all start with T.J. Hooper and we go through Suinger v. EGFR and the other four or five cases out there with respect to technology and health care. It's a waiting game or you can be proactive. We will discuss in our work product ways that states might be proactive in this regard.

(Slide.)

MR. BURDE: Finally, this coming April we're going to be looking at the licensure issue, specifically examining what state boards of medicine, nursing do, how states examine laboratory issues. In May, we're going to be finalizing that component of our work.

(Slide.)

MR. BURDE: In June and thereafter, addressing the other issues that have arisen in this discussion. Again, as Dr. Miller point out so very well, our goal is to identify the impediments that exist in state law now, to recommend solutions, to use the existing resources that are out there,

whether it's the insurance commissioners or the

uniform state law commissioners or anybody else that's out there doing this work so that what we can present to you doesn't require that NGA or the Alliance reach out to do those things. Our job is to present that to you as a package so that you have the information in front of you and can make recommendations from there.

If you have any questions, we'd be pleased to answer them.

GOVERNOR DOUGLAS: Thank you so much Howard, Holly for your hard work on this taskforce and for your recommendations today and the plan of work for the coming months.

Our plan, as I suggested, is to review the revised work products that have been proposed by the two taskforces and talk about the scope and direction and see if there's any other advice or any other ideas we'd like to give to them.

Are there any specific questions about the presentations by Howard and Holly at this point?

Herb?

REPRESENTATIVE CONAWAY: I had to take

note of the desire to create a national standard. I can just imagine, you name it. You're in a rural part of the country. I think physicians practicing there will have some interesting things to say about whether or not they want to be held to the same standard of care as a physician in a metropolitan area where both physicians and patients have access to the highest level of technology to advanced patient care. I do have a concern about this idea of a national standard.

My own view is, my own thought is that a lot of these standards are localized, are regional and there's a good reason for that. If you're going to assert that someone has breached their duty, that duty has to be breached on what's going on in the practice in their region. I just have a concern about the creation of a national standard, what that would mean given the fact that there are disparate resources available to both physicians and patients across the country.

I also wanted to mention issues around

laboratory results, particularly in the context of

personal health records. Those laboratory results are really things that are for interpretation by a physician. I have a real concern about the ability of patients to interpret this data, so that I would say that, generally, full-blown access to laboratory data by patients would not be advisable. I do think, however, that some subset of laboratory information that will help the patient advance their interest in preventive care, I think, is very important. We have initiatives in health care, EGFR. They should know what their cholesterol so they can advance their preventive health measures in the office. Do they need to know whether or not some liver enzymes are a couple of ticks out of the norm? I can't imagine why a patient would need to know that necessarily outside the context of their visit to the doctor's office.

That access should be focused on advancing -- the personal health record should be focused on patients to advance their interest in preventive health, not trying to interpret things, which many people don't have the capability of doing.

MR. BURDE: Thank you, Representative

Conaway. I appreciate what you're saying. We'll be looking at that as well as the contrary view that as consumers are accepting more responsibility, at least financially, for their own health coverage it becomes difficult to say to a consumer who has paid for a laboratory test that he or she should not see the result. Even if they weren't paying for it, it would be a difficult thing to say.

REPRESENTATIVE CONAWAY: I didn't say they shouldn't have access to it. I was talking about in the context of personal health records. Those discussions should take place in the practice setting where patients have access. They should have access to a personal record cluttering that interaction with a lot of material that will create more confusion than allowing someone to advance their interest in preventive health. I think we should go to drive patients to the office to deal with those, such as cancer prevention and risk reduction of physicians and that's the important thing.

By the way, I don't mean to be overly

critical of this. I know that you're involved in

health law and we're discussing recommendations that touch on liability. I'm curious to know whether or not you're involved in medical malpractice in this area. If you are, I'd like you to say so. And if you are, whether you're involved in medical malpractice defense or medical malpractice on the other side because I think the kind of recommendations that come out of this conference will be very much affected by the position, the involvement one has in the medical regulatory system.

MR. BURDE: Thank you for the question, Representative Conaway. It's a very good one. Let me assure you the next time any one of my clients sees me in court representing them they should go quickly hire another attorney. I don't appear in court. I don't represent either plaintiffs or defendants in medical malpractice actions. My experience comes from representing different kinds of organizations as they try to develop health information exchange.

One of the greatest impediments that we

see to developing health information organizations

and health information exchange is the question of liability identification for use of information. If you look, for example, at what happened and what was the most expensive effort to date, which was the Santa Barbara effort, which closed down, I believe, last week if not last month. The issue on which they spent the most time and money was liability indemnification. I don't know that that's what killed it, but it certainly kicked it in the shins a lot. It something we have to examine and I don't come to it with any bias other than it's an issue we need to address.

GOVERNOR DOUGLAS: Jim?

GOVERNOR GERINGER: Mr. Chairman, I guess that brings up a broader question for all the taskforces. I would pass along this observation from Dr. John Kitchaber, former governor of Oregon. In his discussions and evaluations of the Medicaid program said if we were to start from scratch there was no way we would adopt what we currently have. It's just ludicrous. The difficulty is there are so

many entrenched interests. So for the taskforces you

all have a very significant challenge in how to recognize an entrenched versus an objective interest.

I guess the question raised by Senator Conaway is pertinent to all areas, not just the issue of liability. There's no clear guidance I can give you, but I would suggest that you at least step back from time to time and say this sounds really good or really bad. Now what could be an entrenched interest in maintaining this or throwing this out. In other words, ask the question from time to time from a policy perspective or where we might lose perspective. In general, I like the provisions you propose. I have no objection to that. I particularly like the suggestion from the Health Information Protection Taskforce that you show a range of state approaches, not just one right answer. That's going to be helpful because each state will want to see, well, what do I do differently.

Another question I have then, and it relates, I guess, back to the personal health records versus others. There's personal health records,

electronic health records, electronic medical record.

I don't know what's what. I sort of know. Maybe you ought to have some description of that because it sounds like, in any case, the patient ought to own every one of them. I'd like to have that definition established. If I've paid for it, maybe in the context of that, who owns the record. So we'll have a lab result regardless of who needs to interpret it. Is there an aspect that this is personal. It's mine because it's all about me or is it proprietary because it's someone's judgment applied to it. Differentiating between personal privacy and proprietary privacy might be an issue to look at.

The last thing -- I guess I don't know how to raise the question, but it's in terms of, I guess, the first taskforce reported looking at what was the rationale behind previous state laws. Can you anticipate current trends of where they might go? For instance, we're all being googled in some fashion. I can't imagine what I'll do when all the other web crawlers that are out there have discovered about me and the others just like the students found

in a project on technology there were all kinds of

information that was in the database. Google doesn't even know what they have, but as various states have set up these centralized databases or discovered mechanism, can we anticipate maybe looking at something like Google. Eric Schmidt, I sure, would be willing to at least sit down and talk about the CEO of Google what's going on out there and their network of servers -- how they do and don't authorize access to information that they discover. You might be able to anticipate ways to ensure privacy or to anticipate where things could go astray and just ask T.J. Maxx how quickly things can go astray because Google is becoming so ubiquitous in everything that we do. If you could anticipate where these laws might go and the context of these huge databases that are being acquired worldwide, the repositories are worldwide. They're not just located in the U.S.

MS. HUNT: One thing I'll kind of jump in that's kind of interesting. Google now has a free EMR out there and it's ad based. That would be an interesting discussion to hear.

GOVERNOR GERINGER: Google's business

model is entirely generating revenue through advertising. To induce acceptance of that, we will put a free EHR out there if you'll give us your data. We'll give you homeland security protection if you'll give us your data. It's all in the data. When you relinquish that data, you're giving something up. You've chosen to help them. That's something to at least consider.

GOVERNOR DOUGLAS: Governor Shaheen.

GOVERNOR SHAHEEN: Just to follow up on that a little bit, as I look at the list of taskforce members, they're all really stakeholders in the system. With all due respect, Dr. Miller, I think while we are all consumers of health care, we're not consumers in the way that my 85-year-old mother, who doesn't have a college education and thinks anything her health care provider, whether it's the lab technician or the doctor, tells her is gospel.

I would encourage you to think about getting some input from some real consumers of health care who don't have a stake in the system, but who

very much are affected by what's decided.

GOVERNOR DOUGLAS: Give some thought to that and I know the Information Protection Taskforce has a consumer member and perhaps the other taskforce could give some thought to that.

David?

MR. SUNDWALL: Thank you for your presentations. They were very informative. I always feel like I'm coming to school when I come to these meetings. I have a number of comments. But first of all, the interstate licensure. That's fascinating to me. Because our state lines are so porous in the Intermountain West, which covers a huge area, there's a lot of interchange with neighboring states -- Wyoming and others -- that we couldn't really practice without our colleagues. Is there such thing and maybe Mr. Burde I'll ask you this. It's kind of a two tiered licensure. In other words, states are pretty parochial and protective of the numbers of providers that are going to practice medicine in the boundaries of their state. Can there be some kind of licensure that is for consultative purposes? Has the

FSMB got something that will give that allowance with

some liability protection without enabling one to practice within the boundaries of the state?

MR. BURDE: In fact, there is a model law extent which has its issues. From my perspective, it has its issues. Nevertheless, it tries to accomplish the two-tiered system. There are other approaches. For example, nurses are covered in many states by a multi-state nursing licensure compact. That's one of the things we're going to examine as a potential way for states to agree that a license in one state would suffice for practice in another.

Again, we're going to explore the various mechanisms that might exist to enable practice across state lines because it's becoming much more common. We also need to examine how that might undercut existing system's quality oversight and enforcement. We don't want to lose the consumer protection component of what boards of medicine do, acknowledging that mostly what they do is sanction financial and substance abuse issues. Nevertheless, they exist as the forum for consumers to try to have

their concerns addressed. We need to recognize that

as we work towards a multi-state compact or multi-state license.

MR. SUNDWALL: Okay. One other comment I wanted to make. I'm intrigued. In a couple of presentations we've heard a reference to CLIA being a barrier to share lab data. That caught me by surprise and I have a bit of uninformed perspective on CLIA in that I shared the CLIAC for CDC for four years. CLIA was enacted entirely kind of as a consumer protection to make sure that the doctors and patients could have confidence in the laboratory data provided. It's meant to regulate the laboratories. Certainly, not in my mind to serve as a barrier to information for doctors or patients. That did surprise me that some attorney scratched their head and said maybe CLIA is going to be a problem for us.

MR. BURDE: That's a misnomer. We've had this argument sort of behind the scenes. CLIA isn't the problem. It's the state implementation of laws with respect to who may order a test and who may receive the results that creates the issue. It's not

CLIA itself.

MR. SUNDWALL: I'm just surprised. That was entirely not the intent of CLIA.

The last comment I'll make and then I'll relinquish my time here. Between January and now, when we've met, we've talked about the need for some uniformity in laws on privacy. Dr. Hacker and Ms. Hunt, I appreciate our recommendation for model legislation. What surprised me a little bit was you almost assume that responsibility like maybe you were going to do that. If you can as a taskforce, so much the better.

I thought that, given the track record of FSMB of developing model legislation maybe they would be a source. I would hope governors that I think we can do a serve in our contribution to this e-health alliance if we will come out with a model legislation on privacy. Utah's been part of this project. I can't get the acronym quite right, HITSP. You've got to be careful with this acronym, but anyway, we've been part of that and we've identified what needs to be done.

While I also agree with Representative

Conaway that federal solutions often scare us, we do think model legislation will be welcome in this area, whether you do it or FSMB does it for us. Thank you.

GOVERNOR DOUGLAS: Or the commissioners on uniform laws as we discussed as well

Reed?

DR. TUCKSON: Just a quick process question, have you laid out or are you anticipating laying out some scenarios that allow you to sort of trace through if you were to sort of say what would happen if a patient moved across state lines or licensure issue for a physician. Do you have in your mind certain sort of scenarios that form the basis of then determining whether or not solutions actually solve real problems?

MR. BURDE: We'll probably approach it in two ways. One is, ideally, given what we know, how would we create a system? Of course, we're dealing with an existing system.

The other issue is to address the current use cases, as it were, so that we enable a system

that's already happening -- telehealth in rural areas

in western states, for example, e-prescribing all over the country, remote diagnoses of radiological exams and so on.

Having said that, we don't want to create a work product for your consideration that merely addresses the use cases that we know about because our resources are limited. We want to create a broader structure for you to build upon. Finally, there's an old maxim in law that hard cases make bad law. So we don't want to simply respond to every hard case and create a structure around it. We'd rather have something broad base that addresses most of the issues.

DR. TUCKSON: I think that sounds wise if it's possible to accomplish both by putting this in real life for the committees so that we could see, okay, here's an example of what we're trying to get at. I appreciate your judgment around not being limited to what you can touch and feel in front of you. But if you could sort of put into motion and maybe bring this to life a little more.

DR. MILLER: I think also, to Governor

Geringer's point, what we're also trying to do as part of the taskforce work is to project technologies into the future and look at what's coming. For example, implanted medical devices now have the capacity, though it's not turned on, to deliver care remotely. So we're trying to project where this would go in the future in every use case as we talk about e-health care across state lines. If a patient approaches a clinician for a consultation now and the patient does not represent where they're coming from or misrepresents what state they're coming from, the clinician has no way of knowing where that patient is because they are sent to a server that could be located anywhere in the country. So we are looking at the complexities and trying to anticipate future scenarios as well as current use cases.

DR. TUCKSON: That would, I think, be beneficial as we try to track what you're doing.

GOVERNOR DOUGLAS: Interesting issues.
Wayne?

MR. SENSOR: I too would like to thank the

committees for their work. It's very informative.

You're squaring up the issues nicely and I sincerely appreciate all four of your work.

Three brief comments. First, if I may, I'd like to underscore Governor Shaheen's comment about consumer input. As the leader of a health care system, I must say that many times I thought I knew the answer to what our patients wanted from us as a health care system only to ask the end consumer and find out that we didn't quite have it right. And whether, perhaps, as an alternative to asking a whole group of consumers to sit on your committees or subcommittees, certainly focus groups and other forums could secure that information. I would underscore the importance of that.

Secondly, there was one reference, Dr. Miller and Mr. Burde, you made in your presentation. Perhaps, for me, if it's not of interest to the rest of the Alliance, but you commented about consequences of e-health. I must say I'm not terribly informed as to the downside of that, which we are implicitly supporting. I'd be interested to learn a bit more

about that, perhaps, offline so that we can be

conscious of what are the downsides, if I got that right.

And a third thing, just as a word of acknowledgement or appreciation. In the latter presentation, the reference to interstate medical licenses I find that very provocative. I find that very intriguing. I think this is a time for a bit of courage on all of our parts that have never been in my view finder. I applaud you. Once again, I'll be interested to see what solutions similar to nursing or whatever, solutions we can bring forward that perhaps could give it legs. Thank you.

GOVERNOR DOUGLAS: Jane?

COMMISSIONER CLINE: I would just make a comment about the discussions on liability. I think there are a couple of different types of liability we're talking about. We're talking about the breach of data, which T.J. Maxx has just come through. Commissioner Praeger and I have dealt with that with various insurers that have breached the data security issues, but then you also have the medical

professional liability and perhaps we ought to start

looking to the industry to get some involvement, to get their perspective with respect to how they would be viewing this and moving forward.

I think Representative Conaway had a very valid point, too. He also mentioned which side of the fence you're on. Are you the defense bar or are you the plaintiff's bar? Sally has been through the medical malpractice issues pretty significantly in West Virginia. When we moved forward, we did engage the plaintiff's bar as well as the defense bar as we crafted alternatives as well as industry. I think you might want to look at those stakeholders as well.

GOVERNOR DOUGLAS: Governor Bredesen?

GOVERNOR BREDESEN: I want to just add one thought to the consumer issue. I think Governor, I agree with you completely that it's important to incorporate that. I too have an 85-year-old mother. All I would urge you to do is find some transparent way of getting information to 85-year old mothers.

(Laughter.)

GOVERNOR BREDESEN: In Tennessee, we have

a professional class of consumer representatives who

like to go to meetings and whose view of what consumers think is appropriate I suspect is very different from what my mother thinks is appropriate and needed here. I think it's a little tricky than just having a consumer advocate sitting on the board. We really need to get some information about what 85-year-old mothers and fathers thing are important. I think that would be a very valuable contribution and might be surprising to us.

DR. MILLER: I just wanted to respond just briefly to Commissioner Cline. Another area of liability that we think at least merits consideration or your knowledge of is as we move towards an e-health model and as we move towards an e-health model and as that happens with personal health records and patients being able to move their information at their will, when will a patient be liable for omitting information that is going to a clinician? When will a patient be liable for not being compliant? I think that's a whole other area of liability that e-health will open up.

Certainly, when we talked in our

presentation about national standard of care, I think part of what we're referencing is certainly the whole notion under discussion right now of pay for performance. I think it's very clear in the pay-for-performance model that as we move into an electronic health record or electronic medical record world we will also be documenting when a clinician has actually ordered a test that the patient did not fill or complete.

GOVERNOR DOUGLAS: Those are interesting and complex issues to be sure. That's right while we're all here.

Jim?

GOVERNOR GERINGER: Mr. Chairman, I have a question for Mr. Hinkley if he's still here. I'll wait until this panel's questions are through.

GOVERNOR DOUGLAS: What we need to do -- Joy, you had a question?

MS. PRITTS: I had a process question for the privacy work group. I believe Mark Leavitt was mentioning that the level of complexity that we've

agreed could be accomplished in the different

standards. We suggested that there are several set standards that could accommodate differences in state laws, but if it got too complicated that they would not be able to do that. Do you anticipate, in your proceedings, to be working with people from CCHIT and HITSP to kind of take that into account when you're looking at the kinds of models, the choices they're looking at?

DR. HACKER: Sure. We've actually been hearing from HITSP. They're already on the agenda. As you're certainly seeing, it's complicated. A lot of folks have a piece of the pie. It's just a challenge. We have three pages of algorithms that we're going through as we try to develop how do we make decisions. It's also difficult to keep on focus because there are so many attractive things that you want to get into. So when we have the committee meetings, our job is to keep bringing everybody back to the table because it's privacy and security. That's what we're really focusing on.

GOVERNOR DOUGLAS: Senator Moore?

SENATOR MOORE: I just wonder how much are

our good samaritan laws with regard to the liability issue. We generally exempt people as long as there hasn't been gross negligence or willful misconduct and whether that broader standard will be something to look at as far as protection from liability.

On the issue of patient responsibility, I think that's a much trickier one to go down because the patient sometimes is unable to afford to comply. If you order a prescription that they can't afford to buy, for instance, and many patients come to the doctor because they didn't comply with health practices all along while they were growing up. I don't know where you draw the line on that liability issue for the patient.

GOVERNOR DOUGLAS: There's a lot to consider. We need to consider the proposed revisions to the work products for the two taskforces. If we could turn our attention to the one that's on the screen from the Health Information Protection Taskforce and Sally outlined the proposed changes that are in bold language earlier.

Is the Alliance comfortable with those

changes? Herb?

REPRESENTATIVE CONAWAY: I did have a question about taking the pros and cons out. We, in the states, are going to have to decide on specifics in the statute. That's going to be based on evaluations of the pros and the cons. So I do have a concern to the extent that applicability doesn't include those kinds of things that allows legislators to make decisions. But I have a concern about that not being included in the applicability is fine, but I --

GOVERNOR DOUGLAS: Your reaction?

MS. HUNT: I think the reason we took out the words "pros and cons" is so we wouldn't attach a value judgement to it. I think what you will see is the high-level protection, lower levels of protection, the rationales and what that means. I think you'll be easily able to attack your own pro and con to it. We're just not going to label it that way.

GOVERNOR DOUGLAS: Herb's thinking about

it.

(Laughter.)

GOVERNOR DOUGLAS: Any other thoughts or questions on this document that is presented?

(No response.)

GOVERNOR DOUGLAS: We do need to approve it. Would there be a motion to approve the revisions?

SENATOR MOORE: So moved.

COMMISSIONER CLINE: Second.

GOVERNOR DOUGLAS: Further discussion? I suppose we have the right to revise it again.

(Laughter.)

GOVERNOR DOUGLAS: Are you ready for the question? If so, all in favor of approving the revisions say aye?

(Chorus of Ayes.)

GOVERNOR DOUGLAS: Opposed no.

(No response.)

GOVERNOR DOUGLAS: The ayes have it. We approve the revised work product.

Seriously, I had the same thought frankly

that Herb mentioned in reading it before the meeting.

I hope you'll consider that as you deliberate.

Why don't we turn to the Health Care Practice Taskforce revisions that are on the screen now? Howard and Holly talked about the licensure references and the proposed revisions. Are you comfortable with that? Are there any further questions about the bold language that's on the screen?

(No response.)

GOVERNOR DOUGLAS: If not, is there a motion to approve the revisions?

GOVERNOR GERINGER: Move approval.

VOICE: Second.

GOVERNOR DOUGLAS: Any discussions?

(No response.)

GOVERNOR DOUGLAS: Ready for the question.

All in favor say aye.

(Chorus of Ayes.)

GOVERNOR DOUGLAS: Opposed no.

(No response.)

GOVERNOR DOUGLAS: They ayes have it.

We've approved that revision.

(Slide.)

GOVERNOR DOUGLAS: There's a proposed new work product for this taskforce. That language is presented on the screen now. This relates to liability, specifically dealing with analyzing malpractice coverage. Any questions about that? Jim?

GOVERNOR GERINGER: I don't now if this is appropriate or not, but if we're going to look at liability in malpractice coverage, should there be a companion effort to look at tort reform?

GOVERNOR DOUGLAS: Howard?

(Laughter.)

MR. BURDE: Having worked with Commissioner Koch in Pennsylvania on malpractice reform there and still bearing those scars, we thought we'd limit the approach here to the narrow confines -- our risk here. But the fact is, if were to look at tort reform, we would have to look at tort reform for the manufacturers of the software and the hardware, for the providers who use it, for the

health information exchanges that may exist. Those

are important things to do. Some of that will be a function of what we accomplish here. But to look at tort reform, to say we're in that business I think would slow down the rest of the work. So I think we're going to more narrowly limit what we do and we may raise other issues.

GOVERNOR DOUGLAS: Thank you, Governor.

Sandy?

COMMISSIONER PRAEGER: I think beginning with this can perhaps lead us into tort reforms suggestions as we look at availability and the issues around malpractice insurance. Some of those things may emerge.

COMMISSIONER CLINE: I would agree with what Sandy has just suggested. In my personal experience with that and that's what did evolve as we studied the issues around affordability and availability or lack of in the State of West Virginia. That's what did evolve out of it -- this tort reform and some other issues.

GOVERNOR DOUGLAS: We'll see where it

leads. Any other questions about this proposed text?

(No response.)

GOVERNOR DOUGLAS: Moved by Sandy. Is there a second?

Phil?

GOVERNOR BREDESEN: Just one question. What was it that lead you to add this to the charge?

MR. BURDE: Our charge was to look at the professional licensure issues, the practice of medicine issues involved. That was the initial charge. Once you start examining the provision of health care, certainly what states do as regulators is important. Likewise, the private sector and the tort system have a huge impact on the availability of services and the willingness of participants in the system to actually participate. Again, part of this is my own experience working with health information exchanges across the country. You can't ignore this issue. This issue is front and center and part of every single health information exchange discussion. We would be doing you a disservice by not raising it.

GOVERNOR BREDESEN: I guess the question

arises because, certainly, issues related to

liability and who is libel and so on are absolutely front and center. This seems to be very much about analysis of insurance to insure against those liabilities, which seems kind of a derivative issue to it. Ultimately, if there is liability somewhere there is some process to develop a way to insure against it.

MR. BURDE: Not always. And again, as the system evolves, the risk often evolves ahead of the risk management vehicles. Right now we're at the stage where the risk is actuarially measurable. In the absence of actuarial measurement, the private insurance companies are not going to provide coverage because they don't know what their outstanding liability might be. They can limit it by saying health system. You can have \$100,000 worth of coverage. But since they don't know how often that would be accessed, it's going to cost \$100,000 to get. So we need to examine how these different aspects fit together in order to provide you, again, with appropriate guidance with respect to how these

issues might be addressed.

DR. MILLER: The other point that came up in our group was that notion that as we have evolved, if there is malpractice insurance specific to e-health, that that may function as a barrier to either an IDM or a product practitioner or any provider being willing and offering these sorts of services. That's specifically why we wanted to take a closer look at this. We do want to look at the barriers to e-health evolution and be able to come back to this group with recommendations for states about how this might be considered.

GOVERNOR BREDESEN: Look, I don't have any objection to adding this to the thing. I certainly would vote for it. I would only say that I think we need to keep very focused, first of all, on what assignments of liability and the issues that are around it, which ultimately will drive whether insurance is available, what its costs are and whether it's an impediment. But doing this as a supplement to it, I have no objection to.

GOVERNOR DOUGLAS: Other questions?

(No response.)

GOVERNOR DOUGLAS: If we're ready for the question, all in favor of adopting the new work product say aye?

(Chorus of Ayes.)

GOVERNOR DOUGLAS: Opposed no.

(No response.)

GOVERNOR DOUGLAS: The ayes have it.
We've adopted that new text.

Thank you very, very much for your hard work and leadership on these taskforces -- tough issues, but you knew that when you agreed to sign on and we certainly look forward to continuing to work with you to flesh them out, address them and we hope make some real progress. Thank you so much.

Just a couple of quick announcements before we break. As the Alliance members know, we have a third taskforce and we're going to spend a little time this afternoon talking about it. It's the Health Information, Communication and Data Exchange Taskforce. I don't know if that lends itself to an acronym or not. We can work on it. The

first meeting is scheduled for May and we're still

working on the membership of that taskforce. If you have issues you think it ought to consider, we've got some time on the agenda this afternoon where we can discuss it.

For the Alliance members, our luncheon will be in the Arlington Room on the third floor of the hotel. Please proceed there as quickly as you can and we'll reconvene -- Jim?

GOVERNOR GERINGER: Is Mr. Hinkley still here?

GOVERNOR DOUGLAS: I don't know.

GOVERNOR GERINGER: I'll just tell you what I was going to propose as a question and see if we need to assign it to him or someone else.

He brought up the e-health initiative tracking center and tracking state legislation. Is there any way we can also track what's going on within the federal space? We assume HHS and ONC, in particular, are tracking all the things internally. I doubt if all of HHS is even tracking each other. How many others are out there that are implementing

things that are either tacticly or explicitly

affecting what we do?

For instance, Homeland Security with their disaster response and records that are used there -- the Veterans Administration, the Bureau of Indian Affairs, the Department of Defense? DoD alone has set all kinds of policy that implicit in how we view medical records. So it would handy if somebody could at least track what is out there, what is the current span of things? If not, let's change it because DoD is still changing, for instance, and so is the VA. Is there a way we can include that in his effort or should someone else be doing that?

GOVERNOR DOUGLAS: Good question.

Pandemic flu planning in a number of states or all states are engaged in as well.

Good point, Jim. I'm actually going to ask our staff to look at how best to track what's going on in different federal agencies and keep us apprised of it. But thank you for raising that. Obviously, there are a lot of things happening. Thanks.

MR. SUNDWALL: Can I just make one

comment? I was going to note on this point as well.
I would caution us not to think that state
legislative activity is a monitor of what's going on.
It might be what's recently going on, but as I read
the tracking it's kind of like, yeah, we're serious
and we're going to commission a study or a council.
Without sounding parochial, places like Utah are
really quite mature and we've got a decade of having
had Utah health information network. We have RHIO.
We have a Center for Health Excellence and Public
Health Informatics in the CDC, none of which have
state legislative enabling. So I would just caution
that the level of activity or capacity should not be
judge by a measure of recent rules, regulations or
laws.

GOVERNOR DOUGLAS: Thank you, David.

Shall we break and reconvene in an hour?

Thank you all.

(Luncheon recess.)