Informing Clinicians Committee Meeting Summary
October 25, 2006

Audio Conference
***Host Site:* Assistant Director's Office**
Illinois Department of Public Health
5th Floor
535 W. Jefferson St.
Springfield

Committee Members
Ellen Brull, M.D., Chair
Craig Backs, M.D.
Beth Hackman
Bill Kempiners
Dan Litoff, M.D.
Edward Mensah, PhD
Gordon Schiff, MD

Guests
Jonathan Dopkeen, Ph.D.
Patrick Gallagher, ISMS

Staff Members
Ariel Katz, M.D.
Jeff W. Johnson

Dr. Ellen Brull convened the committee meeting at 9 a.m. She explained that the purpose was to review the draft legislative recommendations from the Steering Committee with respect to how it relates to the goals and objectives adopted by the committee.

The committee began by discussing Section 3 (a), the composition of the authority's board of directors. Bill Kempiners indicated that the provision in an earlier version proposing a 31-member board of directors should be reinstated. Dr. Craig Backs agreed noting that this was a recommendation of taskforce members and should be retained. What the General Assembly does with the recommendation is another matter.

Dr. Brull noted that it was the consensus of the committee that the composition of the board of directors be changed back to the 31 members listed in the earlier Steering Committee draft. *(The changes recommended by the committee have been incorporated in the attached "Informing Clinicians Committee" version of the draft legislation.)*

The discussion then moved to the appointing authority. Mr. Kempiners indicated that the Governor should make the appointments from persons "nominated" by generally recognized statewide organizations representing the various categories listed in the board composition. The committee agreed to his change.

In response to the criticism that the large board of directors would make managing more difficult, the members indicated that the composition was necessary to ensure the broad based stakeholder participation required for the successful implementation of EHR in Illinois. Dr. Backs noted that if the board of directors desired to form a smaller executive committee, they should be given that ability. It was agreed that a new section be added providing for the

adoption of rules governing the management of the authority, which may include the adoption of an executive committee.

In Section 4(a), the members agreed to replace the phrase “to provide optimal care by treating physicians” with “to patients.” They felt this would make the provision clearer.

There was some discussion regarding Section 5(b) – the provision dealing with technical assistance. The members wanted “and organizational” assistance to be added to the section.

Dr. Gordon Schiff suggested the addition of language calling for the authority to help to stimulate, facilitate, and coordinate research for better understanding the implementation and use of EHR in the State. The committee concurred with the recommendation and agreed to the addition.

A final suggestion was to separate the authority’s power to establish a fee structure into its own section.

Members were told that at least one more meeting would be necessary to adopt a final committee report.

The meeting adjourned at 10:50 a.m.

Outline of the Electronic Health Records Taskforce Draft Legislative Recommendations

Outline of Draft Legislation

Article I

1. Short Title. This Act shall be known as the Illinois Electronic Health Records Act. **[Need to come up with a more compelling title and name for the authority.]**

2. Purpose of Act

3. The Illinois Electronic Health Records Authority **[Need to come up with a more compelling title and name for the authority.]**is created.

a) The authority shall be governed by a 31-member board of directors, with the 27 public members to be appointed by the Governor from those persons nominated by generally recognized statewide organizations representing hospitals, physicians, nurses, consumers, third-party payers, pharmacists, federally qualified health centers, long-term care facilities, laboratories, mental health clinics, and home health agencies. The composition of the board of directors shall consist of the following persons:

i) The director or his or her designee of the departments of Healthcare and Family Services, Human Services and Public Health;
ii) The Regional Administrator,

Comments/Purpose

This section will detail the purpose of the Act, which may be a synthesis of the goals adopted by the Taskforce committees.

This section establishes the Illinois Electronic Health Records Authority (authority) and sets the composition of the governing board. The composition of the board of directors represents a broad group of stakeholders who are needed to ensure the successful implementation of health information exchange.

The Informing Clinicians Committee recommended that the size of the board of directors be left as originally agreed to by the Steering Committee. They felt the mission of the authority demands strong and adequate participation by stakeholders. This is realized by the 31 member board.

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Region 5, Center for Medicare and Medicaid Services (CMS); iii) 3 hospital representatives, 1 of whom shall be small rural hospital; iv) 5 Physicians, 1 of whom shall be from a rural practice, 1 of whom shall be a primary care physician, 1 of who shall be a specialist, 1 of whom shall be from a small group practice, and, 1 of whom shall be from a multi-specialty clinic; v) 3 consumers; vi) 5 payer and employer representatives – 1 of whom shall represent a Blue Cross/Blue Shield health service corporation; 1 of whom shall represent a commercial insurer; 1 of whom shall represent a local payer; 1 of whom shall represent a self-insured employer; and 1 of whom shall be an employer recommended by the a generally-recognized employer trade organization which represents a broad base of employers within the state; vii) 3 Pharmacists – 1 of whom shall represent a large chain; 1 of whom shall be an independent pharmacist; and, 1 of whom shall be employed by a health care institution or be a consultant pharmacist to care organizations; viii) 2 representatives from federally qualified health	

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centers as defined in Section 1905 (l)(2)(B) of the federal Social Security Act;

ix) 2 long-term care facilities, 1 of who shall represent a multi-facility organization of five or more facilities throughout the state, and 1 of whom shall represent an independently-owned facility;

x) 1 representative of a home health agency;

xi) 1 representative of a mental health clinic or facility;

xii) 1 nurse; and

xiii) 1 representative of a diagnostic center.

b) The chair shall be elected by a majority of the directors on the Board.

c) 3-year staggered terms of office.

d) Directors entitled to reimbursement of expenses.

e) The Governor may remove a director in case of incompetence, neglect of duty, or malfeasance in office, after service on him of a copy of the written charges against him and an opportunity to be publicly heard in person or by counsel in his own defense upon not less than 10 days notice.

f) The board of directors shall develop rules governing its management, which may include, but not be limited to the establishment of an executive committee.

Comments/Purpose

An earlier draft included the following attendance standard: "Directors who fail to attend 2/3rds of meetings without excused absences held by the board during a 12-month period shall forfeit their position." Some concern was expressed regarding the board's ability to enforce that standard, but there remains a concern that to develop the technical knowledge to effectively govern requires a substantive commitment to meeting attendance.

The members of the Informing Clinicians Committee recognized that the board may want to create an executive committee to oversee certain administrative functions.

Outline of Draft Legislation	Comments/Purpose
g) The board of directors is empowered to hire an executive director and staff.	
4. The authority shall:	One of the key functions for the authority will be the establishment of a health information exchange that will serve as a "hub" or "highway" to facilitate the exchange of health information among health care providers within Illinois and other states. This state exchange is not intended to preclude the development of local health information exchanges. Rather the Taskforce viewed this function as the record locator service (RLS) outlined in the Connecting for Health Common Framework.
a) establish a state electronic health information exchange to link with local, other state and nationwide health information exchanges, third-party payers or interoperable health care provider systems to provide for the secure sharing of health information to provide optimal care to patients ~~by treating practitioners~~, improve the healthcare system and the health of the population;	The Taskforce Steering Committee took a strong stand that Illinois should not maintain a central repository for all patient health records. However, it was noted that the authority will need to ensure the exchange has the means to capture population health data. Under the Common Framework model, providers retain control over their records. An RLS serves as an index for identifying where patient records are maintained. Depending upon how the authority develops the model, the health care provider may be informed of the location of the records or the information can be sent automatically. The Taskforce also believes that the authority will need the flexibility to respond to emerging technology or models as it develops the state health information exchange. It is anticipated that financial savings can be attained by adopting tested technology.

Outline of Draft Legislation	Comments/Purpose
b) adopt privacy, security, operational and technical standards for entities connecting to the state health information exchange. Where applicable, these standards shall be consistent with federal or nationally recognized standards;	These standards are analogous to the "rules of the road." The authority will need to ensure that providers accessing the state health information exchange – the highway: have interoperable systems to exchange data; uses established data standards; and can be trusted to maintain the privacy of the information sent or received. The standards adopted for Illinois must be consistent with national standards to achieve the goal of sharing health information. There was discussion about expanding the authority's power to include adopting standards for all health information exchange activities, regardless of whether the state health information exchange was involved in the transaction. The point was made that this would turn the authority into a regulatory agency distracting it from its main functions of facilitating the exchange of health information and fostering the adoption of EHR. Furthermore, covered entities retain their responsibilities for complying with federal and state privacy and security requirements.
c) ensure the privacy and security of data held or processed by the state health information exchange in accordance with federal and state laws and regulations;	Not only will the authority need to ensure that users of the state health information exchange can protect their data, it must put safeguards in place to protect its own data.
d) cooperate with the Department of Public Health, Department of Healthcare and Family Services and the Department of Human Services on measures to utilize state health information exchange data to meet public health needs.	As noted in a draft of Improving Population Health Committee's goal, objectives and issues document, "one of the critically valuable deliverables of the exchange of Electronic Health Records is the ability to improve the health of individuals, communities, state, and nation by ongoing disease surveillance systems, accelerating the speed of clinical research, and improving quality of care." In developing the state health information exchange, the authority needs to incorporate procedures to enable other state agencies to capture data that will improve population health in Illinois.

Outline of Draft Legislation	Comments/Purpose
e) adopt standards for research requests, which shall include the review of such requests by an institutional review board appointed or designated by the board of directors and which shall follow Federal standards for institutional review boards created to review medical research.	Although the research benefits to be derived from the state health information exchange will be some years down the road, this will become an inevitable and important function. However, access to this information must be carefully controlled to ensure protection of patient privacy and confidentiality. The Improving Population Committee is suggesting the creation of a "State of Illinois Privacy Board" to review research requests and provide oversight.
5. The authority shall foster the adoption of health information exchanges and interoperable electronic health records systems by Illinois health care providers by:	A critical function identified by several taskforce committees is the need to encourage and help health care providers adopt electronic health record systems and local health information exchanges.
a) coordinating with health care providers and payers to plan for and implement health information exchanges and standards for participation, taking into account the confidentiality of patients in accordance with federal and state laws and regulations;	The Interconnecting Clinicians Committee identified technical assistance as a need that must be met. The Informing Clinicians Committee noted the importance of programs like DOQ-IT – a federally funded initiative to guide physicians through the process of adopting EHR. Whether provided by authority staff or through grants or contracts to outside entities, this technical assistance should be directed toward expanding EHR use, not as a measure for lowering a provider's vendor support cost for existing systems.

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b) providing technical and organizational assistance to health care providers where not otherwise available;	The Interconnecting Clinicians Committee identified technical assistance as a need that must be met. The Informing Clinicians Committee addressed the importance of removing technical, workflow and organizational barriers that arise with the implementation and maintenance of electronic health record systems. Programs like DOQ-IT – a federally funded initiative should be considered to guide physicians through the process of adopting EHR. Whether provided by authority staff or through grants or contracts to outside entities, this technical assistance should be directed toward expanding EHR use, not as a measure for lowering a provider's vendor support cost for existing systems.
c) educating health care providers on the benefits of interoperable electronic health records systems; d) promoting the public acceptance and use of electronic health records and personal health records through public education;	A major focus of the Informing Clinicians Committee was the need to provide education to providers. The committee heard a presentation about the educational and technical assistance benefits of DOQ-IT. All taskforce committees have raised the issue of educating the public on the benefits of EHR and the safeguards that are available to prevent disclosure of personal health information. The Personalizing Health Committee also addressed the need for the public to be educated as to the benefits and use of Personal Health Records (PHR).
e) subject to the availability of funds, providing financial assistance for the acquisition of EHR systems and interoperable health information technology; and	Financial assistance to providers, local health information exchanges, RHIOs or SNOs, and low-income PHR users was a need identified by 3 taskforce committees. The Personalizing Health Committee is considering tax incentives or direct subsidies to help persons in medically underserved areas access PHR. Whether this assistance is through grants or

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	loans, the role of bonding in providing the funding for these initiatives are open questions. **[A question has been raised as to whether this financial assistance can take the form of the direct provision of software to providers in areas of need. The purchase of software and the provision of that software to providers in certain areas would be deemed financial assistance under this proposed section of the legislation.]**
f) helping to stimulate, facilitate, and coordinate research for better understanding the implementation and use of EHR in the State.	The Informing Clinicians Committee proposed the addition of this section to encourage research on the implementation of EHR in Illinois.
6. The authority may terminate or suspend a participating entity's link to the state health information exchange or a researcher's access to exchange data for non-compliance with adopted standards.	The establishment of a trust relationship is widely acknowledged as the critical element in assuring public acceptance of EHR. The authority can only permit entities to participate in the state health information exchange if they meet standards of trust. Conversely, the authority must be able to act and act swiftly to address entities that breach that trust. The authority will need a range of options to sanction entities in non-compliance with its rules.
7. The authority may accept federal, state, local and private funding.	This grants the authority the ability to receive funding. This original section contained both the authority to receive funds and the authority to establish a fee schedule. Members of the Informing Clinicians Committee felt that these authorities should be in separate sections.
8. The authority shall have the power to establish a fee schedule for products and services.	A goal would be for the Authority to achieve financial sustainability by the sunset provision of 2014. The development of an operational and self-sustaining business model is recognized as infeasible during the developmental and implementation process, given the need to develop common infrastructure and provider-

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	based adoption.
9. The Electronic Health Records Fund is created for use by the authority. All monies received by the authority shall be deposited into the fund. Funds deposited in such fund shall be used for no purpose other than as directed by the authority's board of directors.	A new fund is needed in which to deposit monies received by the authority, and from which to expend those monies.
10. The provisions of "The Illinois Administrative Procedure Act", as now or hereafter amended, are hereby expressly adopted and incorporated herein as though a part of this Act, and shall apply to all administrative rules and procedures of the authority under this Act.	Standard legislative provision addressing appeals process.
11. Rules. The authority shall promulgate administrative rules necessary to implement, interpret, and make specific the provisions of this Act.	Standard provision empowering the authority to promulgate rules.
12. Transfer of relevant state assets to the authority???	Current developmental efforts in Health Information Exchange may exist as assets controlled by parties engaged in EHR development, including IDPH. This provision would allow for the transfer of those assets, as may appropriate, whether singly or jointly held, to the Authority (e.g., the IHN).
Article II	
13. By 2015, health information technology systems used by state agencies and contractors must be interoperable and comply with national standards.	This is intended as a state version of the Executive Order issued by the President on August 22, 2006, that ordered federal agencies to: "1) Utilize, where available, HIT systems and products that meet recognized interoperability standards when such systems and products are used for the direct exchange of health information between agencies and with non-Federal entities …

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	2) Require in contracts or agreements with health care providers, health plans, or health insurance issuers that it will also use, where available, HIT systems and products that meet recognized interoperability standards." Taskforce members felt that a timetable was needed for implementation of this mandate.
14. The Electronic Health Records Taskforce Act is amended by changing Section 10 as follows: (Extend EHR Taskforce's role to include advisory function to authority.)**[Concerns were expressed as to whether the Taskforce should continue after the authority is operational.]**	Taskforce members felt that their work is not finished upon the completion of the report and plan on December 31, 2006. They feel the taskforce should continue to provide guidance to the new authority. The central question with regard to this issue is: What action(s) could/should be taken to avoid an interruption of 9 months in the EHR development process, including pursuing grants and other funding opportunities for EHR adoption?
15. The State Finance Act is amended by adding Section 5.6XX as follows: (30 ILCS 105/5.6XX new) Sec. 5.6XX. The Electronic Health Records Fund.	Housekeeping provision related to the new fund.
Article III	
16. Article I of this Act is repealed on December 31, 2014.	This is slight variation of the sunset provision suggested by the Steering Committee. Originally suggested to be a 5-year sunset, there was some concern while preparing this document that the authority would be just getting to the critical phases of development when the fear of the sunset would harm the authority's ability to attract staff. It was suggested that 2 additional years were needed to enable the authority to hit its full potential.

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17. Effective date. This Act takes effect upon becoming law.	