The Virginia Joint Commission

JCOTS

on Technology and Science

Electronic Medical Records Advisory Committee
July 31, 2006 1:00 p.m.
Speaker's Conference Room, 6th Floor, General Assembly Building

- **Call to order, roll call; introduction of members.**

Delegate Sam Nixon, chairman of the Electronic Medical Records Advisory Committee, called the meeting to order. The members of the advisory committee and JCOTS staff introduced themselves.

- **Chairman's opening remarks.**

Delegate Nixon opened the meeting by expressing his interest in the development of standards regarding electronic medical records, and horizontal and vertical data sharing issues in addressing electronic medical records. He indicated that the federal government had developed a Global Justice XML Data Model (Global JXDM) to facilitate the sharing of justice information at the local, state, and national level and to improve interoperability. He suggested that such an approach might serve as a model in the medial records realm.

- **Overview of the role of JCOTS advisory committees.**

Staff provided a brief introduction to the committee about the role of JCOTS in establishing science and technology policy in the Commonwealth, and how the various advisory committees work with JCOTS in establishing this policy. A copy of this presentation is available on the JCOTS website.

- **Overview of the Electronic Medical Records in the Commonwealth.**

The Honorable Aneesh P. Chopra, Secretary of Technology, provided the advisory committee with a synopsis healthcare information technology efforts in the Commonwealth. A copy of his powerpoint presentation is available on the JCOTS website.

He indicated that healthcare information technology is atop the national agenda, with President Bush calling for most Americans to have an electronic health record by 2014, and with a goal of developing a interoperable health information technology

infrastructure. This effort will be driven by the states. The underlying importance of developing an electronic health record lies not only with the potential cost savings, but also with the opportunities it presents for improving the quality of patient care. However, current projections from George Washington University indicate that at the current rate of adoption, states will fall short of this 2014 goal.

A recent survey in Virginia indicates that only 17% of small practice physicians have adopted an electronic medical records system. Solo practitioners struggle with the costs of implementation, and rural practitioners often do not have access to broadband and other technology that facilitates the adoption of such systems. Of the surveyed physicians, only 4% utilize seven of the 11 components of an electronic medical record.

Virginia has also made a commitment to electronic health records. The 2007-2008 budget created an Advisory Committee on Electronic Health Records, and allocated $1.55 million over two years for grants to encourage the adoption of electronic medical records. In addition, Governor Kaine recently signed Executive Order 29 creating the Health Information Technology Council. The Secretaries of Technology and Health will lead this effort, which will solicit pilot projects through a "Request for Information." Full membership of the Council is expected to be announced soon.

• Discussion & formulation of work plan.

Delegate Nixon began the discussion by asking the committee members what role the state should play in moving forward on this issue -- i.e. what policy changes are necessary; what should the state do to facilitate the use of electronic medical records.

Members expressed their views that electronic medical records are a complex and expensive issue, but that the effort will be worthwhile. Because of this complexity and expense, however, information sharing has become obstructed. One member suggested that a basic feasibility study was necessary, to reference the architecture on a scalable level.

Other committee members suggested that in order to succeed, efforts needed to start at a very basic level, such as ensuring that small medical groups have a basic computing infrastructure and access to broadband, before even beginning the discussion about electronic medical records.

It was noted that interoperability is key. Many groups have already made significant investments in this area. The industry as a whole needs to look at lessons learned, and best practices that have emerged from these experiences. Delegate Nixon suggested that the committee look further into the issue as to whether standards exist, and what states can do to implement the use of these standards. Secretary Chopra indicated that the federal government sets certification standards, clinical standards, and administrative standards. Virginia has adopted the HIPAA standards for billing, but despite this, bills are still rejected. Even if standards are adopted, one needs to make sure that the standards are used well, and that the system is running efficiently.

One member suggested that the business model needs to be changed for medical records. Patients fill out numerous information and processing forms. Perhaps patients need to be incentivized to be accountable for their own records.

Delegate O'Bannon shared his concern with overcoming the proprietary nature of hospital systems. He saw a need to get entities who have a lot of data to share that data. For example, the data could be used to create a common base for practitioners, and there is no system for pharmacists to share information with doctors.

Another committee member noted that technology is not the end goal of electronic medical records -- the goal is to enhance patient care. This should be the guiding principal in seeking to understand the resource and practice culture issues that might act as barriers to effective data sharing.

Secretary Chopra shared that President Bush had convened a panel to look at standards for data sharing. The panel decided to set standards at a local level using local models. Four different approaches and projects are underway -- including two led by Northrop Grumman and IBM -- with different philosophical approaches. He suggested that Virginia could try to recreate this experiment, to see if small ideas exist that can link data sharing with cost savings.

Senator Wampler added that he would like to hear from groups around the Commonwealth that have already begun to look at this issue. For example, CareSpark, a regional effort in Southwest Virginia, Tennessee, and West Virginia, might be able to share their experiences.

• Actions for next meeting.

The committee identified several potential agenda items for future meetings, including:

- The impact on RFID technology
- Portable medical records concepts
- HIPAA, and barriers to data sharing
- Concept of data ownership
- Patient privacy
- Health care costs borne by employers
- Input from regional health information providers, such as CareSpark, MedVirginia, and a community-based model being developed in Northern Virginia in cooperation with George Mason University
- Physician experiences with proprietary data