

**Illinois Health Information Exchange
Legal Task Force
General PHI Workgroup Meeting
December 15, 2010
Meeting Notes**

In Person Attendees

Patricia King, Swedish Covenant Hospital
Valerie Montague, Ungaretti & Harris
Joyce Slattery

Office of Health Information Technology

David Kim

Attended by Phone

Robert Kane, Illinois State Medical Society
Tracey Salinski, Arnstein & Lehr
Melissa January, Dinker & Biddle

Patricia King opened the meeting at 10:30AM. The group reviewed the draft Guidance for Workgroups dated 11/16/2010. Included in the draft Guidance was a timeline that called upon workgroups to formulate a work plan by 1/15/2011, and submit the first draft of a white paper by 3/15/2011. The group felt this timeline might be aggressive.

With regard to the draft charter for the Legal Task Force dated 10/21/2010, the group agreed that licensing laws concerning behavioral health (Clinical Psychology Licensing Act, Clinical Social Work and Social Work Practice Act, Marriage and Family Therapy Licensing Act, Professional Counselor and Clinical Professional Counselor Licensing Act) were outside the scope of the this workgroup and probably belong to the Behavioral Health Workgroup. Concerning the remaining licensing laws, there is an indirect relationship between these statutes and HIE, in that the licensing laws generally provide that a licensed professional can be disciplined for breach of confidentiality. One member pointed out the difference between confidentiality and consent to disclosure of information. The licensing acts refer to professionals and their duty of confidentiality, while the Medical Patient Rights Act involves consent. Members felt that existing licensing laws do not need to be changed, but that any new HIE laws or regulations should keep the licensing laws in mind.

A question was asked whether there was any case law under the Medical Practice Act where a physician has been found liable or disciplined for breach of privacy. One member stated that there is case law clarifying when a physician-patient relationship exists, and the duty of confidentiality arises. The physician-patient relationship may begin when the patient makes an appointment with the doctor, and thereafter the physician is obligated to maintain confidentiality. However, there is a law enforcement exception to the Medical Practice Act that allows law enforcement to get medical records in certain circumstances.

The group turned their discussion to HIPAA. HIPAA pre-empts state laws, except those laws that are more protective of patient rights than HIPAA. One respect in which HIPAA expanded patient

rights involved the patient's right to access his/her record. Prior to HIPAA, a patient did have a right under Illinois law to a copy of the medical records kept by a hospital, but not the medical records kept by a doctor.

A participant noted that a pre-emption analysis had been done for the Illinois Department of Public Health at the time that the HIPAA Privacy Standards came into effect. A question asked in the draft charter was whether Illinois law should expressly provide for a business associate exception. A participant suggested that if Illinois were to craft a Business Associate exception, it should track federal law since the material to interpret Business Associates (such as the FAQ section on the Office of Civil Rights website) is broader and more robust than anything that a state might have.

The draft charter quoted the provision in the Medical Patient Rights Act prohibiting disclosure of the "nature or details of services provided to patients" without written waiver, except for disclosures to "parties directly involved with providing treatment to the patient or processing payment" or "where otherwise authorized or required by law". When the HIE discloses a patient's identity, this is a disclosure since it would acknowledge that the patient received treatment. The HIE is not directly involved in providing treatment or payment, but it would fit under the definition of health care operations as defined in the HIPAA Privacy Standards. The group felt that the most critical issue to examine was whether Illinois law prohibiting disclosure without patient consent was more stringent than HIPAA.

The Medical Patient Rights Act also prohibits withholding medical services if the patient refuses to sign a release. The group thought the law referred to signing a release of liability. *[Following this meeting, it was confirmed that the Medical Patient Rights Act does prohibit conditioning provision of medical services on the patient signing a waiver of confidentiality; the provision prohibiting release of liability is contained in the Medical Practice Act, 225 ILCS 60/29.]*

The group then looked into the issue of whether the HIE would be considered an agent of the hospital. Common law principles of agency were discussed. The *Gilbert* case was mentioned, where a hospital-based physician was found to be an agent of a hospital, irrespective of the fact that the physician was an independent contractor and not an employee. This was due to the patient's expectations that a physician assigned by the hospital would be an agent.

The group then turned on the issue of what it would take for a hospital to be comfortable to share information with the HIE. The general consensus was patient consent would ease the concerns of a hospital.

Next, the group talked about the "break the glass" emergency situation where a patient lacks capacity to give consent and no one with authority to give consent on the patient's behalf can be found. In such a situation, consent to medically necessary treatment is implied. However, the question was asked if there is implied consent to treat, is there implied consent to submit or retrieve information from an HIE. The group felt that the issue depended on the facts such as

if the patient was temporarily or permanently disabled and what kind of information was being retrieved (blood type, allergies versus treatment for drug abuse ten years ago.).

The group then discussed what should set the standard for confidentiality. The sources of standard for confidentiality are case law, HIPAA, and state laws. Future HIE legislation and regulations should not set the standard. The group briefly touched on breach of privacy causes of actions and thought it was not an impediment to HIE.

The group felt at his time that it would be helpful for Illinois to adopt an HIE specific statute to deal with these issues since many other statutes depend on other laws. Specifically, the group felt that the HIE law should address whether the HIE is “opt-in” or an “opt-out” system.

The workgroup concluded by summarizing the issues. They stress the desirability of an HIE specific law. They decided to address the contents of the white paper for the next meeting. In the next meeting they decided to look at the Minnesota HIE law. The group also discussed input from other stakeholders in general PHI such as nursing homes.

The group agreed that Wednesdays are a good day to meet in general. They set a tentative meeting date and time of January 5, 2011 at 10:30AM.

Comments from the public were solicited; no additional comments were received.

Meeting was adjourned at 11:50AM.