IL HIE Legal Task Force
Substance Abuse Workgroup
December 2, 2010
Meeting Notes

In-Person Attendees:
Renée Popovits, Popovits & Robinson
Jay Readey, Healthcare Consortium of Illinois
Harrison White, Gateway Foundation
Bill Connors, Seaquest Technologies
Theodora Binion-Taylor, Illinois Department of Human Services, Division of Alcoholism and Substance Abuse

Attended by Phone:
Allen Sandusky, South Suburban Council on Alcohol and Substance Abuse
Sara Howe, Illinois Alcohol and Drug Dependency Association
Rachel Dvorken, Sinai Health System
Mike Simko, Walgreens
Rick Nance, DHS Division of Alcohol and Substance Abuse

Office of Health Information Technology:
Mark Chudzinski
David Kim
Amanda Swanson

Renée Popovits opened the meeting at 1:35 p.m., hosted by OHIT at the State of Illinois J.R. Thompson Center in Downtown Chicago, with a telephone conference call-in number.

Renée started the meeting with a brief discussion of the Workgroup's efforts in recruiting new members:

Nora Byrne – only interested in working with the Mental Health Workgroup, no longer interested in joining the Substance Abuse Workgroup
Amy Tarr – DHS – interested in participating in the Workgroup

Next the minutes from the November 18 meeting were reviewed and discussed. Harrison White moved to approve the minutes as amended. Jay Readey seconded that motion. The minutes were approved by the members and therefore the motion was carried and the minutes were approved as amended.

Renee then went on to identify and briefly discuss the items that had been distributed to all of the members since the last meeting:

1. Controlled substances law
2. Sample authorization used by a behavioral health provider in Illinois
3. Sample authorization developed for the DASA-DCFS initiative to comply with 42 CFR Part 2, HIPAA and state laws

4. First round of FAQs from SAMHSA and ONC addressing electronic health records
5. Copy of Popovits & Robinson comments to the FAQs
6. Copy of comments from SAVTA to the FAQs
7. Copy of Renée's article published in Behavioral Healthcare Magazine in April, 2010
8. 3 policies that include charts from 2002 addressing minor's rights under 42 CFR Part 2 and personal representatives and minors under the mental health confidentiality laws.
9. 42 CFR Part 2 (the federal confidentiality regulations) (see section 2.32 on the prohibition on re-disclosure)

Mark Chudzinski then suggested the Workgroup consider writing an updated Workgroup charter which incorporates the information gained from the group's work.

Renée then brought the discussion to the Alcoholism and Drug Dependency Act proposed revisions. An update was provided by Sara Howe. A draft of the proposed revisions had been sent to the LRB this week. She did not expect to hear back from the LRB for about one month. The proposed revisions were described as mostly cleaning up the language of the Act, but it was noted that some new information was added. She also noted that they were still looking for a sponsor for these proposed revisions. A copy of the draft proposed revisions would be made available to the members of the Workgroup at the next meeting. Included with the draft would be a one page fact sheet. It was mentioned that they were not sure the draft specifically addressed any health information exchange issues or concerns, but a portion does mention "aid of electronic technology," and this section may need to be revisited and added to at a later time.

Renée then mentioned that she had informed Dr. Wesley Clark of SAMHSA that the Substance Abuse Workgroup had met for the first time on November 18 and that the Workgroup is beginning to address confidentiality, consent, medical emergency and re-disclosure issues related to addiction treatment and health information exchanges. She received a reply from Dr. Clark explaining that SAMHSA had just had an Agency level discussion of the August letter written by Renée in response to the FAQs issued by SAMHSA and ONC, and the agency will be addressing the concerns over the next few weeks. It is expected that a response to the concerns addressed in the letter will be received in mid to late December.

Renée then brought the discussion to the Controlled Substances Act. It was mentioned that a workgroup with key stakeholders is to look at amending the Act to make sure it is more consistence with federal regulations and over the next 2-3 meetings will look at the proposed language. Some key issues were identified as being both methadone clinic logs and prescription monitoring, which both can involve both handwritten and electronic recording.

One fear is that the new provisions in creating new offenses for pharmacy shopping and prescriber shopping might involve more confidentiality and privacy provisions. The definitions of both pharmacy shopping and prescriber shopping were discussed.

A scenario was proposed for discussion: A patient with five different prescriptions from a pain specialist who also sees an addictionologist who wants to put the patient on methadone. The patient doesn't want anyone else to know about the methadone. Would not sharing information regarding the methadone with the pain specialist constitute a violation under the Controlled Substances Act?

Competing concerns were raised: If the client chooses to maintain confidentiality regarding methadone treatment, this should not constitute a violation of the Act. However, patient safety concerns are implicated if such clients would choose not to consent to putting their information into the HIE.

A question was raised regarding the technological ability of EHR and HIE systems to provide an automatic electronic screening when a prescription first goes into the exchange, raising a red flag when potential drug interactions may occur. Although technological mechanisms addressing these issues are beyond the scope of this Workgroup, Mark offered to be the liaison between the Workgroup and other groups dealing with the technical aspects of the ILHIE.

It was also mentioned that some states are active in reporting systems, and state investigators use these systems in an effort to pinpoint pharmacy and prescriber shopping and go after violators. It was mentioned that the Illinois Prescription Information System give special consideration to methadone clinics, but information from other drug treatments still need to be addressed.

A concern was also raised with regard to consent by a patient to putting their information into the HIE for medical treatment purposes. If state police wanted to prosecute, would they be required to get a court order to access information in the HIE because the initial consent was limited to medical purposes only? Additionally, concerns were raised that suspicion would be created if a patient chose not to opt in. It was mentioned that efforts should be made to make it as easy as possible for patients to opt in to the HIE as a way to prevent medical mistakes arising from a lack of drug information available to physicians. A concern was voiced that patients, who may not have opted in, would nonetheless assume such information was available to their physicians electronically; opting in should be made easy to prevent unrealized patient expectations regarding disclosure such as this.

There was some discussion of the activities of other states. Some states have concluded that they will wait for federal guidance before addressing the exchange of substance abuse and behavioral health information, and have decided to get the HIE up and running for other patient information but keep substance abuse and behavioral health information out of the exchange. The Workgroup agreed, however, to press onward and strive to enable substance abuse information to be exchanged within the ILHIE from the first time it is operational.

Renée then brought the discussion to re-disclosure issues, and opened the floor for discussion by Workgroup participants to indentify what the issues and questions are,

and to voice any potential protections or restrictions on use that could be implemented.

Mark provided a bit of background information concerning the storage of patient information, and described the ILHIE as a federated model. Information would be deposited into the system at the provider, but exchanged electronically throughout the state. A patient can consent to first deposit their information into the HIE, and then consent to having that information withdrawn form the HIE.

Concerns were voiced about the record locator service and what information would be disclosed through this service. These services would indicate that a specific patient has information on file at ___ provider at ____ facility. Confidentiality could be breached if this service identifies a patient has information on file at, for example, a methadone clinic.

The need to have red flags indicating information is missing from the patient file available in the HIE was also discussed. It was pointed out that a physician would need to know, during a medical emergency, that there is something behind the glass to be broken. It was pointed out that IL does not have an express "break the glass" statute, and that this would be governed by federal law.

Concerns were also raised with regard to coming up with the particular language for consent to re-disclosure. It was suggested that maybe there be separate consents particular to provider and patient, each expressing different language.

Concerns were also raised regarding the need to educate providers on the consent process and HIE to enable providers to be comfortable with participating. Mark suggested it may be appropriate for the Workgroup to make a recommendation to the ILHIE Authority to take on an educational component.

Renée then opened the floor for public comment. There was none.

The next meeting of the Workgroup will focus on the charter. A written draft discussing the work of the Workgroup thus far will be distributed to participants by January 7. The next meeting will be held on January 18th, in the afternoon, and the draft and revisions to the charter will be discussed then. Any suggested changes to the draft should be sent prior to the Jan. 18th meeting.

The meeting was adjourned at 3:00 p.m.