

**IL HIE Legal Task Force
Substance Abuse Workgroup
July 13, 2011
Meeting Notes**

In Person Attendees:

Mark Chudzinski, General Counsel, OHIT
Abraham Arnold, OHIT Legal Intern
Nate Inglesteinfeld, Chicago Lawyer's Committee
Embassie Susberry, Chicago Lawyer's Committee

Attended by Phone:

Rachel Davorkin Sinai
Rick Nance, Illinois Dept. of Human Services, Pharmacy & Clinical Support Services
Renee Popovits, Popovits & Robinson
Allen Sandusky, South Suburban Council on Alcohol and Substance Abuse
Harrison White, Gateway Foundation

Renee Popovits, co-chair of the Substance Abuse Workgroup, opened the meeting at 2:00p.m., hosted by OHIT at the State of Illinois J.R Thompson Center in Downtown Chicago, with a telephone conference call-in number. It was noted that notice of the meeting and the agenda were posted on the OHIT website and at the Chicago meeting location no later than 48 hours prior to the meeting. Roll was taken, and the ability of those attending by telephone to hear and participate was confirmed.

The minutes from the previous meeting were reviewed and discussed. A motion was made to amend the spelling of an attendees name and the motion carried.

Consent: An HIE consent packet was distributed containing the "Consent For Use And Disclosure Of Certain Types/Categories Of Protected Health Information" and Ms. Popovits began the discussion. It was noted that the issues to be discussed would be where the providers stood on the issue and there opt in opt out needed to be discussed.

In the ensuing discussion it was noted that no policy exists in Illinois but that examples of this did exist in Maine, Missouri and Road Island.

The discussion was altered to number 5 to give updates on SAMSAH FAQs. Here it was noted that SAMSAH is in the process of a second round of reviews in relation to consent and the approval of the FAQ's is still in the works but will be done as soon as possible. A standardized

consent form was released; while no FAQs have been released a standardized form is likely for the state level. From here the conversation shifted to issues with the consent form

The following issues were noted: explaining limits on disclosure and issues pertaining to re disclosure. The issues pertaining limits on disclosure where, What type of information will be released, whether it should be broader, tied to certain data elements and how this must be done. A problem was noted that by adding language about minimum necessary it could be interpreted that only the minimum information necessary is being provided which is more restrictive than what is required under HIPA making this possibly more restrictive than necessary. All parties agreed and suggested removing the terms minimum and necessary and noted that general health care and substance abuse have different standards. The final recommendation was that it would be advisable to look into how this relates to 42 CFR and look further into this.

From here the conversation shifted to whether the consent form was consistent with the continuity of care document because nothing in the list in the consent form included medications and it was explained that the list was just an example and not definite. Three basic options were discussed for what to include as options for a patients' rights to opt in or out.

The first was a right to submit all medical records. Issues noted with this were discomfort with patients, and that the ability for attorneys to be held liable if they are granted full access.

It was next suggested that a limited list of disclosures be provided leaving out more personal information. Problems noted with this were that attorneys aren't in the position to know what is truly needed by doctors, additionally doctors would be given medical records with gaps of missing data making the program ineffective. It was finally agreed that the best option here would be to discuss with medical personnel what information would be the most useful to have while still keeping it as limited as possible and have that be the only information included in the disclosure.

The next option discussed was allowing the patient to choose what records they allow to be released by initialing on the form next to which records they would like to exclude. It was noted that the sheet could specifically exclude, drug abuse, alcohol and mental health records. It was then noted that instead recipients could select which elements on the list of drug abuse, alcohol and mental health records they would like to exclude because some parties might want to have a doctor be given access to that. Added to this was the idea of giving the option of removing certain items from a given list or also allowing a full opt in if the recipient so chooses. Concerns noted with this option were that on a state level mental health and substance abuse records from local HIEs could exclude these options because of the work load. A solution offered was putting this in at the federal level for mandatory inclusion within local HIEs by amending state law to default to federal law. It was finally noted that allowing people to opt out of certain elements

could defeat the purpose and an idea of having a list of certain options should be created and then patients could either be all in or not in at all and the list would be safety items that wouldn't give up peoples highly personal information. The final explanation was that for the specific elements selected you are either all in or all out and legislative changes could be made to accommodate requirements for additional consent and how those changes can be reflected from the 2007 form to the 2011 form. In response the other states that have adopted ways around this were mentioned and it was determined that at the next meeting more information would be provided about how Maine, Rhode Island, and Missouri deal with said issues.

From here the conversation turned to what the rule would be in regard to the exchange of data through re disclosure of information as it relates to current law. Under current law certain information cannot be re disclosed without additional consent. It was explained that with mental health, alcohol or drug abuse records re disclosure is unclear as to whether information given from one provider to another is not ok without patients consent or if re disclosure only needs additional consent if a provider releases it to a third party. It was noted that likely it will be viewed that any exchange between providers will need to be ok'd through patient signature to re disclose. It was then noted that most physicians go by the TPO rules but it is unknown if smaller groups do. Problems here were that if the re disclosure is limited it may make the purpose unfulfilled.

The meeting was closed here and it was noted that not all items listed in the agenda were met. It was asked if there was any public comment and none was heard. Tasks for the next meeting were: Working with ER physician group on getting feedback from them and maybe having a meeting with them to discuss where the group currently stands. Additionally Mark will provide sample consent forms from other states on the all in opt out approach from Maine, Rhode Island and Missouri.

The next meeting was scheduled for early September and this sounded good to everyone and an outlook invite was agreed to be sent to all parties. Hearing no other business the meeting was closed.