

**Minnesota Privacy and Security Project
Legal Work Group
August 1, 2006**

Attending: Chair, Laurie Beyer-Kropuenske – Admin, Lois Dahl – Fairview, Deb DeBruin – U of MN, Beth Glode – Fredrikson & Byron, Rebecca Hasse – Allina, Dave Honan – Dept of Human Services, Warren Ortland – MN AIDS Project,

Staff: Jim Golden – Health, Kristin Loncorich – Health, Dave Orren – Health, Katie Engler - Admin, Mike Thorsen Rx2000, Mike DeWane – Rx2000

Meeting Notes

A. Call to Order and Updates

Chair Laurie Beyer-Kropuenske called the meeting to order and reviewed the meeting objectives.

Warren Ortland found two letters from national groups that describe privacy issues related to electronic health records. They are from the Health Privacy Project to Dr. David Brailer, National Coordinator for HIT at HHS dated January 18, 2005, and from the Consumer Coalition for Health Privacy to Scott Wallace, chair of the Commission on Systemic Interoperability, dated October 7, 2005. Copies of the two letters were distributed and will be available electronically. We anticipate discussing the content at a future meeting.

Katie Engler provided a brief presentation on the alternative issues list that was provided to the group. This document categorizes issues based on statutory or rule change, liability issues and “other.” Members were asked to review the alternative and provide feedback on what works and what doesn’t. Feedback can be given directly to Jim Golden or via the listserv.

Jim Golden reported on RHIO activities in Minnesota following his attendance at the recent rural health conference. A group of 67 organizations in the Duluth area - CHIC <http://www.medinfosystems.org/> has been collaborating since 1993 on administrative transactions like claims submission. They are in the process of creating a RHIO but will not be implementing a record locator service (RLS) and so will ask patients where they receive their care. They are working on policies, procedures and authentication issues. They have a unique situation because all but one hospital uses the same EHR software and so they are working with the vendor to implement a common, two-factor authentication system that uses a fob with random digit code the system.

Jim has been talking to Indiana and hopes to have a presentation at the August 15th meeting. He distributed an article from *Health Affairs* entitled *The Indiana Network For Patient Care: A Working Local Health Information Infrastructure*. This article has background information about the project. In anticipation of the presentation, members

were asked to send Jim specific questions for the people from the Indiana project. The deadline for submitting questions is August 10, 2006.

B. Current and Future Models for Health Information Networks

Updates and revisions have been made to the document from the July 11, 2006, meeting that showed the different models for health information networks. The general purpose of the document is to show how health record sharing could be enabled. To clear up some questions from the previous meeting, it was stated that our project is not suggesting that organizations be mandated to participate in a health information network. Also, participating in a health information network will be a cost for an organization, but it is a business decision that organizations may choose to make. Based on Indiana's experience with health information exchange, organizations often see benefits from participating in a health information network (e.g., improved quality and patient safety).

On page 3, public health was added to the network because of the various public health activities that could be assisted through the network. Examples of public health activities include the immunization registry, metabolic screening results and data needed by public health nurses to support their activities. Ultimately HIN implementation may permit the reporting of conditions in a standard format to a portal that the Department of Health. Similarly, such a HIN could be used as a tool to monitor disease outbreaks and public health threats

There may also be a need to add a public payor to the diagram; sharing is already occurring among county social services agencies, particularly to determine eligibility to participate in public programs.

On page 4, a portal that is controlled by each participant in the network has been added (the green circles). Indiana has utilized the portal concept in a different way – they have established a central portal. In Indiana, each participant owns its standardized records at the portal and makes them available for access. They are using common standards and have agreed on a coding methodology.

Pages 6 – 9 document four common situations that demonstrate that although a health information network diagram shows lots of organizations/people that might access health information, there are still controls that limit the access that will actually occur. When the pictures of these 4 situations are compared with the models on the earlier pages, the network looks a lot smaller.

C. Consent-Related Issues for Health Information Exchange

To assist with the discussion, a scenario that includes an exchange and RLS was developed. There are some underlying assumptions about the scenario. They are:

- The organizations are not affiliated or related

- Demographic data flows from Fine Clinic to the RLS
- Request is made by Good Hospital to RLS to locate records on Patient X
- Good Hospital will directly ask Fine Clinic for the records of Patient X

The chart on page 4 of the handout shows all the possible combinations for consent. They all may not be desirable outcomes. The questions are being repeated to assist in understanding the responses.

Questions Related to Providing Data to RLS

1. Under current Minnesota law, would it be legal for Fine Clinic to provide Patient X's demographic information to the RLS without Patient X's consent?

Many providers would require consent to include the patient's demographic information in the RLS. However, there was disagreement about the need for consent. Some work group members pointed out that a patient's demographic data would be considered health information under HIPAA. Hence, many providers would get a consent prior to adding the data to the RLS, although this consent would not be required by HIPAA. Some providers have been given legal advice that because there is no definition for "health record" in Minnesota law, demographic information is not a "health record" and can be shared without consent.

It was also noted that if the name of the provider discloses the type of treatment (substance abuse clinic, HIV clinic, mental health), then a health record is being disclosed. Another issue is if demographic information is provided without consent, a spouse may learn that their partner is receiving treatment at an unexpected provider.

2. Under current Minnesota law, would it be legal for Fine Clinic to provide Patient X's demographic information to the RLS without Patient X's consent, if no one other than Fine Clinic were able to access the data without Patient X's consent? That is, all organizations load demographic information into the RLS, but accessing a particular patient's information requires the patient's consent.

Putting demographic information into the RLS is a disclosure under HIPAA. If there is a contractual relationship between the provider and the RLS, then loading the information into the RLS is a disclosure under HIPAA, but not under Minnesota law. If the RLS is the agent of the provider, then there is a HIPAA exception for the disclosure as well as being permitted under Minnesota law.

3. Under current Minnesota law, if Fine Clinic obtained Patient X's consent to include his data in the RLS, would that consent expire after one year?

If as many providers believe, Fine Clinic was required to get patient consent, then it will expire in one year.

There was a disagreement within the work group on the definition of "current treatment." Most organizations interpret this to mean a single episode of care. Others argued that the

statute simply requires a general consent for any current treatment and because this consent never expires the release to the RLS would not expire.

There is an operational issue if the consent expires after one year – how will the provider manage loading and unloading the data in the RLS? How will it be renewed? Is “current treatment” judged from the perspective of Fine Clinic or someone else?

4. What changes would be needed to allow patients to consent to include their data in the RLS until they revoke the consent?

If “current treatment” is interpreted as limited to an episode of care, then Minnesota Statutes 144.335 would need to be changed. This was

If “current treatment” is interpreted broadly, no changes are needed

5. What are your privacy-related concerns about including patient data in the RLS in general? With consent? Without consent, but with consent at other points in the process?

Does identifying the provider reveal medical information (substance abuse clinic, HIV clinic, mental health provider)? Does the patient expect to control the data in the RLS? There are concerns about misuse and breach, but they are not dependent on consent.

6. What are your liability-related concerns about including patient data in the RLS in general? With consent? Without consent, but with consent at other points in the process?

How does a provider manage a patient who wants very specific control over who has access? For example, what if the patient doesn’t authorize sharing but wants a record in the RLS “just in case” access might be needed? Can a provider honor a request that only providers A-Q but not Z get access? Can a provider honor a request that only certain physicians have access?

Can one consent that covers all flows of patient information be operationalized? There are problems if a patient wants to control the sharing by condition. For example, it’s okay to share information about patient’s asthma or diabetes, but not the mental health information.

There was also a discussion about when to obtain the consent. The choices appear to be (i) before data are loaded into the RLS; (ii) to access data in the RLS after they are loaded; and (iii) to share records based on what is found in the RLS.

There is a difference in the risk between loading the RLS and then obtaining consent to access it and obtaining consent before the RLS is loaded. The first option means the patient is more informed and makes their decision at the time the release is needed. This provides more privacy protection because the patient has more control. There was some discussion whether this later consent could be for all access or only for the provider who interacted with the patient. Consent before the RLS is loaded makes it more difficult for a patient to change their mind or to “break the glass” in the event of an emergency.

There was some discussion whether a patient could consent once for all future access – they don’t ever want to be asked again. It was agreed that the patient education for this would be difficult as there is no way to plan for what will be sensitive to the patient in the future – or for the patient’s children.

Questions Related to Accessing Data from RLS

7. If data from Fine Clinic were provided to the RLS with Patient X's consent, would there be any legal restrictions on Good Hospital accessing the data without consent for treatment purposes?

Depending on the definition of "current treatment," there may be a one year limit on the access by Good Hospital.

Consent that expires in one year is an operational issue. Many providers scan the signed consent form into their electronic system once each year to demonstrate that consent was obtained.

It might be possible to make a statutory change to permit a consent limited to the deposit of demographic information into an RLS to last longer. One option would be to allow the demographic data to remain until the consent is revoked.

8. If data from Fine Clinic were provided to the RLS with Patient X's consent, are there legal restrictions on Good Hospital prohibiting it from accessing the data without consent for non-treatment purposes?

The purpose of this question is to discuss access for payment, fundraising, marketing and operations. The content of the consent will control the outcome.

9. If there are not explicit legal restrictions in Question 8, do you anticipate that this would be an issue addressed in the policies and procedures of the health information network and integrated into the contractual arrangements for participating in the network? Do you have concerns about addressing these issues contractually?

The contract will need to outline appropriate uses of the information. The question was raised about policing use of the RLS and how can the participants ensure that the RLS data are only used for treatment? The cost of policing will need to be incorporated as well as building the systems to address potential misuse.

The contract will also have to define misuse and how individuals and/or organizations will be disciplined. It was noted that privacy advocates may want the discipline issue address in statute, rather than in a contract.

10. Assume that it were possible to provide data to the RLS without Patient X's consent, but that Patient X's consent is required for Good Hospital to access the RLS and obtain patient data. What documentation would you expect Good Hospital to maintain? What documentation should they be required to provide the RLS? What stands in the way of providing the RLS any and all documentation electronically?

The disclosing organization is concerned about the documentation as they currently have the liability for improper disclosure. The organization receiving the information is far less concerned currently. Is there a reason not to shift some of the responsibility to the requesting organization to make appropriate requests?

Other states have addressed fraudulent requests for records. See Colorado Revised Statutes 18.4-412 (<http://198.187.128.12/colorado/lpext.dll?f=templates&fn=fs-main.htm&2.0>) and Maine.

The HIPAA disclosure for public health may be a model for what is needed so that the disclosing organization can rely on the requester to demonstrate why the sharing occurred.

Members were asked to review questions 14-20 and email comments to Jim by August 10, 2006.

D. Issues Identified During Meeting

What follows is a list of the issues raised during the course of the meeting.

1. Is there a way to have “records,” “data,” and “personal health information” defined in the same way for both HIPAA and Minnesota law?

It was noted that earlier discussions identified the flexibility that is currently possible under Minnesota law because some terms are not defined and that there is a risk in setting definitions – flexibility may be lost and the terms may not be defined as desired by all. However, a counter argument was made that the lack of definitions leads to variation in interpretation and practices. Similarly, the lack of definitions leads to organizations taking the most conservative possible definitions, which unnecessarily restricts the exchange of health information.

2. From whose perspective should “current treatment” be viewed? The provider holding the records? The patient? Someone else?
3. There is no uniform interpretation of “current treatment” that provides an exception to the consent requirement. Most providers interpret that statute to mean an episode of care. Others argued that any provider currently treating the patient is providing current care.
4. In order to operationalize a RLS, Minnesota law may need to be changed so that a patient’s consent for the release of demographic information and record location does not expire unless revoked.
5. Currently, the law is structured so that the disclosing organization has all the responsibility for ensuring that the disclosure of health information is appropriate. Should the law be changed to shift some of the burden to the requesting organization to make appropriate requests?