Meeting Attendees	
Name	**Organization**
Doug Nelson (Co-Chair)	Missouri Office of Administration
Sandy Johnson (Co-Chair)	St. Louis University School of Law
Alesha Adamson	Texas Health Services Authority
Ron Fitzwater	Missouri Pharmacy Association
Teresa Gerard	Blue Cross Blue Shield of KC, Kansas City Quality Improvement Consortium
Mary Jo Geldstein	St. Louis Area Business health Coalition
Scott Gronowsik	BJC HealthCare
Mark Gutchen	Misssouri Department of Social Services
Susan Hinck	Missouri Health Advocacy Alliance
Sharon Hoffarth	Primaris
Jeffrey Howell	Missouri State Medical Association
Pam Jodock	Anthem
Sandra Johnson	St. Louis University
Jessica Land	Patek & Associates
Melissa Manda	Missouri Coalition of Community Mental Health Centers
Thomas McAuliffe	Missouri Foundation for Health
Zachary Morgan	The MEPS Corporation
Tom O'Donnell	Polsinelli Shugart
Drew Oestreich	Pharmacy Agent Corporation
Brian Roy	Availity, LLC
Gerald Sill	Missouri Hospital Association
Jennifer Stilabower	Department of Health and Senior Services
Mahree Skala	Missouri Association of Local Public Health Agencies
Staff	
Laurie Hines	Missouri Department of Health and Senior Services
Melinda Dutton	Manatt Health Solutions
Helen Pfister	Manatt Health Solutions
Kier Wallis	Manatt Health Solutions

If you have comments or revisions please contact kwallis@manatt.com or 415.291.7414

Next Meeting	Tuesday, January 12, 2010, 11:30 am – 2:30 pm *Location TBD* *The Legal and Policy Workgroup will meet bi-weekly. In-person attendance is strongly recommended.*
Action Items	*Please contact Workgroup staff (contact information below) with questions about the Workgroup framework, process, or timeline.* ➢ Share "Inside CMS" article with Workgroup ➢ Share resources and information regarding liability with Workgroup ➢ Share with Technical Infrastructure Workgroup expectation that health information exchange (HIE) will focus on clinical decision-making support and tools ➢ Share information regarding opt-in v. opt-out success rates ➢ Workgroup members to send resources to Workgroup staff circulate or post to website ➢ Post and share Vermont's draft policies. ➢ Workgroup participants to provide feedback to kwallis@manatt.com by 1/4/2010. Alternatively, Workgroup can submit feedback through survey on State website: dss.missouri.gov/hie. ➢ Workgroup participants to send suggestions of additional stakeholders to ckrebs@primaris.org.
Content Reviewed *Materials are available online at dss.missouri.gov/hie*	➢ Stakeholder feedback from web survey and comments submitted via email ➢ Overview of key privacy and security issues o Consent, use and disclosure of information o Authorization o Authentication o Access o Audits o Breach ➢ Process for developing privacy and security policies o Phase 1: Identify Issues o Phase 2: Consent o Phase 3: Authentication, Audit, Access, and Authorization (Four As) o There are other areas that the Workgroup will be asked to address including potential modifications to state confidentiality laws and regulations; trust agreements; and interstate exchange ➢ Consent o There are a range of different approaches to "Consent" o Potential "Consent" principles o Purposes for which information may be used
Key Commentary & Discussion	➢ Once policies are developed, under whose authority are policies enforced? This is an example of a cross-Workgroup issue; the Governance Workgroup is making recommendations regarding the governance entity's authority to develop and enforce policies. ➢ Patient identification is critical to the success of HIE; there must be protections and adequate security in place to ensure consumer trust of the system. **Threshold Question Discussion** *These questions should be discussed under the assumption of the exchange of*

clinical information, not aggregated information for research purposes.

- There are public health implications of exchange and sharing of patient information; for example, immunization registries and data under Missouri law are not considered protected.
- There are laws in place that govern the use and access of health information; There are different rules governing the use of patient health information and aggregated information.
- An opt-in only approach to HIE may prevent the full realization of value from access to patient health information. , we prevent ourselves from realizing the full potential and goal of HIE.
- Individuals are concerned about being denied care/insurance coverage based on the availability of their health information
  - In New York, there are two different types of consent; one for treatment and providers to access information and the second for payers to access information. Patients must sign a second consent to enable payer access to data; this consent is independent of provider access to information.
- How is consent administrated in New York? Patients sign a consent form to allow provider or hospital access to data on a provider by provider basis. Once consent is executed it is maintained. *This is different than consent to upload.*
  - Is consent required to load data or access data? In New York it was determined that consent is required when there is access to the data. This is specific to the NY model.
- It is helpful to have a baseline understanding of Missouri law; there is an existing common law consent requirement that goes beyond HIPAA in the state of Missouri requiring consent in some circumstances.
  - Missouri providers are taking various approaches currently; there are outstanding questions about state law leading to disparate practices.
  - There are a series of cases regarding physician-patient privilege, but most are in the context of malpractice.
    - Some provider organization would advocate for a change in state law that sets HIPAA as the baseline for physician-patient privilege.
  - There are questions regarding physician liability in the context of HIE.
  - Recognizing existing ambiguities in the law, the Workgroup should aim to develop policy recommendations.

Threshold Question: Should affirmative consent be required for exchange of patient health information through Missouri's statewide HIE network?*

- There are different models for administering consent.
- The Technical Infrastructure Workgroup will consider how to implement the consent process.

Threshold Question: Where and by whom should consent be obtained?

- There is a concern among consumers about the accuracy of the information in their health records. Consumers may be more willing to disclose/permit access to their records if they can review their information and ensure its accuracy.
- The workability of consent should be balanced with notification, etc.
- Even the most robust HIE will not have perfect and complete information. Providers will not be able to assume a comprehensive view of patient health information. The role of the patient-provider interaction will remain important; the more robust the data set is, the

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better equipped the physician is to interact with his or her patient.
  - Systems will still be giving clinicians *better access* to patient information than is accessible now.
  - There is a tension between the physician's right to access/view patient information.

Threshold Question: Should sensitive information be filtered or otherwise treated differently?

  - There are a series of statutes governing specific consent limitations – to establish an opt-in or opt-out you would have to take into consideration requirements under current statute to consider disclosure under different situations.
  - Information may be restricted based on the role of the provider.
  - Technology providers will have to accommodate privacy and security requirements and policies; technologies as they exist today may not be as sophisticated as will be required.
  - Segregating information by role would lend to a federated model
  - Medical and malpractice claims are an issue to the extent a clinician relies on information in an HIE and that information is incomplete or incorrect; it isn't clear what the implications of this are.
  - For providers to develop the trust required to participate in HIE, what legal protections are necessary?
    - Liability issues may be addressed through contractual arrangements between the governance entity and providers
    - Liability issues may also be addressed by legislation
    - Liability concerns will be identified in the Strategic Plan; the Workgroup will revisit this issue with local counsel.

Threshold Question: Should different uses of information require different levels of consent?

  - Access by providers and payers to information may require different levels of consent
  - Quality improvement and research activities may require specific consent

Threshold Question: Should there be a hierarchy of uses that require more/less consumer involvement?

  - HIPAA sets for treatment, payment, and operations as appropriate uses of information; should different protections be attributed to these uses?
  - In New York, level one consent applies to treatment and quality uses, but there is a difference between provider and payer access for level one uses; level two uses have been tabled for the time being (e.g. research and marketing). New York doesn't require consent for public health uses.
  - Consumers may be comfortable with their provider viewing information, but not their employers, health plans, etc. There may be a hierarchy around consumers' comfort with disclosing information. HIE projects typically start with clinical information exchange because consumers are most comfortable with this.
  - Different uses may result in different pathways for consent; treatment may receive the most streamlined consent.
- Existing law provides the starting point; there are a set of consumer expectations and policy issues that go beyond existing law. There are also ambiguities in existing law.
- Do we have existing laws that we can borrow from? Laws were written for a

	paper-based world; do we need to provide new protections for providers and consumers to enable trust and participation in HIE? o Federal standards will not address state law. o The Workgroup agreed to address information for purposes of treatment first; HIE should not interfere with a provider's obligation to mandatory public health reporting (non-interference principle)
Key Decisions	➢ The Workgroup should address consent in the context of treatment ➢ The Workgroup agreed to prioritize the uses of patient health information for treatment, public health, and use by Medicaid. ➢ The Workgroup agreed that HIE should not interfere with a provider's obligation to mandatory public health reporting (non-interference principle) ➢ The Workgroup would like to explore what is possible through contracting as a tool for implementing policies. ➢ Liability concerns will be identified in the Strategic Plan; the Workgroup will revisit this issue with local counsel.
Next Meeting	➢ Review draft strategic plan content; the draft plan will be posted for the Workgroup's review 72 hours in advance of the meeting. Workgroup members will be alerted by email blast. ➢ Continue discussion of threshold questions and consent.
Workgroup Staff Contact Information	➢ Laurie Hines - Laurie.Hines@dhss.mo.gov ➢ Melinda Dutton – mdutton@manatt.com ➢ Helen Pfister – hpfister@manatt.com ➢ Kier Wallis – kwallis@manatt.com