



### In Attendance

#### Workgroup members:

Archie Alexander, MD, JD, LLM, Health law attorney/mediator	Y	Michael Gerleman, Availity		Jennifer Reck and Clarice Lee, Maximus	Y
Julian Armstrong, MD, Sandlot		Patricia Gray, University of Houston Law Center	Y	Edward Renteria, Jr. Blue Cross Blue Shield of Texas	
Kris Barton, Galveston HIE		Charles Harrison, Austin Travis County Integral Care	Y	Diana Resnik Seton Family Hospitals	Y
Sloan Cody, Centene Corporation		Derek Kang, MD, Texas Children's Hospital		Christy Rodgers Tenet Health System	
Kathleen Costello, Texas HHSC		Peter MacKoul, JD, HIPAA Solutions	Y	Bud Thompson, MD	
Angelyn Estwick, Texas DSHS	Y	Pamela McNutt, Methodist Health System	Y	Terry Turner, Harris County Hospital District	Y
Lewis Ethridge, Symantec		David Miller, Covisint	Y	Tracy Wade, CHRISTUS/St. Michael Health	
Susan Fenton, PhD, Texas State University		Robert Myles, Texas Health Resources	Y	LaDair Wright, Texas HHSC	Y
Lorraine Fernandes, Initiate	Y	Deborah Peel, MD, Patient Privacy Rights			
Celine Fynes, Dell		John Quinn, HL7			

#### Other attendees:

Carole Tamayo, ICC	Y	James Honn, CTG	Y	Jerry Miller, Texas Medicaid/TMHP	Y
Mirsa Douglass, Texas DSHS	Y	Radhika Iyer, CTG	Y	Liz Thelen, CTG	Y
Tony Gilman, THSA	Y	Scott Bullock, CTG	Y	Lynne Randall, CTG	Y
Larry Flournoy, Texas A&M University	Y	Mary Ann Kostusiak, CTG	Y	Andrea Cobb, TMA	Y
Brittani Bilse, Texas State Senate	Y	Luke Stone, Hillco Partners	Y	Jim Campbell, CTG	Y
Joe Eberle, CTG	Y	Brittani Bilse, Texas State Senate	Y		

### Agenda Items

#	Item Name	Item Owner	Time Allotment
1	<b>Introductions</b> <b>Meeting overview and agenda review</b>	Radhika Iyer	9:00–9:10 a.m.
2	<b>Overall Status Updates</b> <ul style="list-style-type: none"> <li>▪ Governance, Finance, Sustainability</li> <li>▪ Privacy &amp; Security</li> <li>▪ Consumer engagement and adoption</li> <li>▪ Technology Infrastructure</li> <li>▪ Environmental Scan</li> </ul>	Jim Honn	9:10–9:20 a.m.



**Discussion:**

Technology considerations:

- Consider populations/consumer base that will need significant assistance with technology
- Nonprofits with limited support staff and infrastructure may also need assistance
- Some users might need a physical helpdesk in order to be able to use the technology
- Technology Infrastructure (TI) Workgroup is exploring what shared services might be needed/available
- The operational plan will likely address this as a broad concept now, although it's likely to evolve into something more robust/mature over time

Privacy and security:

- If the Internet (including social media) is used for consumer portals or marketing, privacy and security policies and procedures must be established
- TI Workgroup is taking this into consideration, exploring technologies they can enable or not enable, investigating the maturity of technologies
- Just because a technology is not available today doesn't mean it won't be included in the plan, but the plan must communicate to ONC how that will be handled

Patient portal requirement:

- Under HITECH, one of the meaningful use criteria EMR vendors will have to certify to is the creation of and access to a portal
- Because this is/will be a national requirement, the TI workgroup must ensure that vendors don't just provide a solution specific to a particular state
- The portal requirement is loosely/broadly defined, so the TI workgroup has to first understand the definition
- This may be included in the operational plan but fleshed out in more detail later; it may be addressed simplistically at first for proof-of-concept, and developed more specifically later

*Participants: Jim Honn, Charles Harrison, Archie Alexander*

3	<b>Patient consent</b> <ul style="list-style-type: none"><li>▪ <b>Definitions</b></li><li>▪ <b>Consent models: Survey results</b></li><li>▪ <b>Vote on consent model</b></li><li>▪ <b>Universal consent form</b></li></ul>	<b>Radhika Iyer</b> <b>Patty Gray</b>	<b>9:20–9:50 a.m.</b>
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**Discussion:**

Patient consent:

- Combined comparative analysis was done in 2009
- The recommendation is to create a statewide consent form so all HIEs would use that

Infrastructure considerations:

- The Privacy & Security Workgroup has not yet discussed what type of data will be transmitted
- However, this issue will not be 'parked' indefinitely
- ONC requires the state to use about a third of the money for state to federal or interstate data sharing
- THSA anticipates that ONC will be very flexible in terms of how the funding is allocated
- As the implementation phase gets underway and privacy and security policies/procedures are further developed, money designated for both interstate and intrastate would be used to support those activities
- The issue does not have to be decided immediately, but it will need to be addressed through the framework this workgroup outlines

*Participants: Radhika Iyer, Tony Gilman, Lorraine Fernandes*



#### Consent under HIPAA vs. state law

- Correction to slide #12: Change 42 CFR 164.506 (Medicaid rule) to CFR 45 (HIPAA rule)
- Section 1 of 164.506: “Covered entities may use/disclose personal health information (PHI) for treatment, payment, and healthcare operations (TPO), except in situations that require authorization under 164.508 A2 and 3.” (psychotherapy notes, marketing, etc.)
- Consent is not required among covered entities to use/disclose PHI, but under section B covered entities MAY obtain consent to use/disclose PHI to carry out TPO
- Under HIPAA there is no “must,” but there are situations where Texas law is more stringent than HIPAA (e.g., AIDS etc.) and where consent is required
- Texas Medicaid did a study of other states’ consent laws and found four states that (at the time) had no consent whatsoever (Indiana, North Carolina, Massachusetts, and Arizona)
- There were as many that had no consent models as had opt-in or opt-out models
- It’s not a requirement for Medicaid, as covered entities
- Although it’s not a requirement, patients are sensitive about this and concerned about controlling or providing consent for the use of their medical records
- Those covered by 42 CFR Part 2 have different protections that are stricter than HIPAA and therefore supersede HIPAA. Many of those covered under this are Medicaid patients. There is a new tertiary review being done including what PTOs do with that information once they have it

*Participants: Radhika Iyer, LaDair Wright, Peter MacKoul, Archie Alexander, Charles Harrison*

#### Authorization:

- Look at HIPAA restrictions on authorizations. Part 45, 164.506A refers to the two situations under 508A2 (psychotherapy notes) and 508A3 (marketing). These are not mentioned in Radhika’s presentation, needs to be added.
- HITECH has also addressed authorizations and marketing—there are severe penalties associated with this
- Identify ‘land mines’ that will be important discussion points as a framework is developed/selected
- The overall issue is enforcement regarding consent. People are not being audited.
- Peter MacKoul has looked at Texas as well as other states (Alabama, California, etc.). Hasn’t looked at Texas recently but knows that it is basically following HIPAA and will change as HIPAA changes
- What we transmit in the HIE and what we will release (data elements) is critical. Psychotherapy notes for example cannot be released (there are other protections as well, e.g. substance abuse disorders). For example, if a primary care physician enters a patient’s disclosures about addiction into his/her EMR and that data is shared with other providers who treat the patient for unrelated purposes, that physician has committed a HIPAA violation).
- When psychology information is disclosed, it’s very difficult for an individual (patient) to overcome

*Participants: Peter MacKoul, Patty Gray, Archie Alexander, Radhika Iyer, Charles Harrison*

#### Consent at the Integrated Care Collaboration (ICC), case study:

- ICC’s authorization forms are used for care coordination or care management; providers go into the record to provide care
- ICC surveyed physicians that use its database: the physicians want the most current information but not a great deal of notes/history; ICC refers to its database as “a mile long and an inch wide;” it is not a deep record, not an EMR
- Providers want enough information to know what has been going on, medications, basic information that a patient is being seen by a psychiatrist or has a psychiatric diagnosis, but not details
- The type of health information shared at the statewide and national level is different from the information shared at the local level, where care is being provided

*Participants: Radhika Iyer, Carole Tamayo, Diana Resnick*



#### ICC authorization form:

- ICC uses an authorization form which lists all the providers in the repository and informs patient that they don't have to sign the authorization, but it will help in their care
- The authorization is good for two years under state law
- Form specifies to the patient that the information may include a mental health diagnosis, drug/alcohol abuse diagnosis, or HIV diagnosis/tests and treatment
- There has been a very low rate of revocation (one or two per year)
- Information is only shared by two providers if they have received security clearance
- Provider can only access the information online
- Once an authorization is signed at an ICC member provider's system, an electronic flag alerts ICC staff that that patient's record can be viewed online via the provider portal
- Authorization form originates from a source system (e.g., patient signs authorization form at Seton Clinics; clinic sets the flag which triggers online access through ICC; the clinic stores the electronic or paper authorization form in the patient's electronic or paper chart)
- PHI is not included for reporting purposes to any of the reporting (authorization must be signed for any PHI to be identified for care management purposes, for reporting)
- Each member organization understands that they have to approach their patients and educate them about the authorization in person

*Workgroup participants may review the ICC authorization form on THSA secure website.*

*Participants: Radhika Iyer, Carole Tamayo, Diana Resnick*

#### Developing a consent form for Texas:

- Need to review most if not all consent forms currently used in Texas; the intention is to create a universal consent form, but it will be a process
- The state subgroup can continue to meet after the July meeting; a consistent group of state stakeholders/representatives needs to look through the requirements and forms and come up with a universal consent form that will be presented to the THSA for final approval and hopefully implementation
- Note: Texas state law is more stringent than HIPAA in many ways, including consent

#### Built-in protections:

- ICC has built-in protections for release of information to be used for public health, analysis issues, and presentation; patients must be notified that their information will become part of an aggregation of information (e.g. in order to track contagions)
- ICC's system allows for the suppression of sensitive data and data by organization; members with very sensitive data may elect to have any type of encounter/visit data suppressed even if an authorization has been signed
- In case of emergency, ICC Board of Directors allows a 'break the glass' option to provide information to emergency department providers if needed (this is the only 'break the glass' option ICC uses)

*Participants: Radhika Iyer, Peter MacKoul, Patty Gray, Charles Harrison, Carole Tamayo*

#### Hybrid consent model:

- Just as the TI Workgroup is considering a hybrid technology model, there can be a hybrid consent model: an ONC white paper issued March 2010 stated that some electronic exchange systems can permit multiple consent models to coexist
- For example, in those using opt-out models, in order to accommodate a variety of provider preferences, have permitted provider entities to make their own determinations as to whether the patients under their care are required to give affirmative consent (opt-in) even when not required by the general policies in the electronic exchange
- The Medicaid Privacy & Security Workgroup is considering such a model because it would provide an extra layer of protection for the clients and serve the agency's needs; Workgroup is currently investigating this option, discussing



business use cases and possible pitfalls

- Existing opt-in policies used in the RHIOs would not be disrupted (provider would still obtain permission from the client to request/receive Medicaid claims data from the Medicaid office)
- Client would also have the opportunity to opt out of the HIE itself
- This provides two levels of protection—possibly an opt-in model used at the provider level and an opt-out model used at the agency level; the two levels would both have to agree (consent) in order for the information to flow
- Consider whether the consent is designed to protect the patient or simply authorize the transfer of information (where consent is only equal to efficiency—what is the most efficient consent form we can put together so that we can send data?) Is it a hybrid that takes patient reality and their concerns into consideration or are we looking at it from a pure technology standpoint.
- Workgroup needs to determine whether it prefers a technology-centric or patient-centric model

*Participants: LaDair Wright, Peter MacKoul*

Recommendations vs. policies:

- The discussions this workgroup is having are important to fully vet these issues and contribute recommendations—need to be able to discuss the different perspectives on many of these questions
- The Texas Legislature may also have opinions about privacy/security/consent
- Operational plan will include the timeline for coming to decisions on some of these issues
- The strategic and operational plans require goals, milestones, and a timeline for making decisions around these questions
- Do not have to actually produce a universal consent form for Texas for the strategic/operational plans
- The TI Workgroup faces similar situation: operational plan will have some level of detail, but final technology decisions/products will be made during implementation phase
- The strategic plan may be less detailed (there will be further work to do on the road to implementation), but all ONC requirements will at least be covered/addressed
- It will take a long time to reach consensus but for this step the goal is to have options to consider

*Participants: Archie Alexander, Tony Gilman, Joe Eberle, Radhika Iyer*

Consent forms used by the State of Florida (presented by Patty Gray):

- Florida has two separate consent forms:
  - Consent to disclose all information: What “all information” means is explained on a separate page given to the patient. Includes substance abuse, mental health status (but specifically excludes psychotherapy notes as defined under HIPAA), birth control/family planning, communicable disease including HIV/TB/STDs, and genetic information. Also explains where that information is likely to come from, to whom it will be given, etc. This option is for patients who want all of their doctors to have access to all of their information
  - Consent to limited disclosure: Patient uses a checklist to specify of what information can be disclosed (if they check every box, they are told to sign the first form). Patient may designate to whom the information may be given and for what purpose the information can be given
- Florida is in the process of writings its rules; these forms are not approved/finalized
- Florida has had an ongoing legal workgroup for at least three or four years with representatives from a variety of groups
- There appears to be an inconsistency in an earlier draft of Florida’s consent form regarding disclosure of psychotherapy information
- Both of Florida’s forms (New York has similar forms) are essentially opt-in; those forms might be able to be modified or used for an opt-out scenario if that is what the workgroup decides to do; Florida’s draft form is useful in how it lists the different types of information



Consent in other states:

- There may be different levels of difficulty with any consent model: e.g., Delaware has an opt-out model but it is very hard to opt out while Maryland has a no consent model (kind of opt-out) but it's easy to opt out
- The three opt-out states the Medicaid Privacy & Security Workgroup had three different ways for patients to opt out: Tennessee's Medicaid administrator has an agency form that must be used as prescribed; Alabama will accept any form that states the client wishes to opt out; South Carolina will allow you to call in on an IVR and record a voice message to opt out
- THSA should consider using something similar to what Medicaid and SCHIP are using; there might be a defined population there that is a good group to start with
- Providers don't want to try to figure out who is opt-in or opt-out; efficiency is an issue to consider versus protection

*Participants: Patty Gray, Archie Alexander, Peter MacKoul, LaDair Wright*

*Workgroup participants may review the 2010 draft of Florida's consent forms on THSA secure website*

Recommendations to THSA Board of Directors:

- CTG has been asked to present consent options to the THSA Board on June 24
- CTG will present the findings of the consent survey
- No recommendations regarding consent forms will be provided at that time
- Peter MacKoul is interested in participating in any future meetings in which a consent form for Texas is drafted or discussed; can offer his legal research and experience
- At the June 24 Board meeting, only a possible consent model will be discussed; the development of the consent form may occur over the next six, twelve, or eighteen months
- Any consent model discussed by this workgroup is only a *recommendation*
- After the strategic and operational plans have been submitted, ongoing privacy and security recommendations will be handled by a privacy and security task force; that group will be responsible for developing a consent form to suggest to the THSA Board of Directors
- The THSA Board will consider draft strategic and operational plans at the end of July; in order for the workgroups to continue their work, they need to present their current discussions, options that have been considered, and any recommendations on which consensus has been reached
- The Board can provide some strategic direction to the workgroups (agree, don't agree, consider x) so that there aren't any major surprises in the draft plans presented to the Board in July, or elements that the Board fundamentally disagrees with
- It is expected that there will be one statewide consent form used among by all payors, including Medicaid

Fine points of opt-out:

- Is opt-out an "all or nothing" model? Any of the models considered can have different variations; first consider what model to work from, then develop plans from there—none are 'all or nothing'
- Example: In Delaware, patients' information may be available on the network but the patient may still opt out of anyone querying their record without getting consent; the information goes into the network but the patient still controls how it is used/disclosed. Patients can provide consent for just a limited time.
- Opt-out with exceptions assumes that the patient/client can specify information to exclude, but a straight opt-out model does not mean that the agency/releaser cannot specify certain sensitive information that will not be released to any provider/patient because of the various laws that govern the release of that information
- Models talk about what the patients' choices are, but organizations have options too to modify the opt-out model to satisfy their needs

Suggestions:

- Consider 'consent fatigue' in the context of a patient-centric plan



Tiger committee:

- Archie Alexander suggests the formation of a ‘tiger committee’ (subgroup) following the lead of what’s happening at the federal level, to aggressively vet the consent options/models, including principle stakeholders from Medicaid and CHIP
- Under 531.908 THSA is supposed to work collaboratively with Medicaid
- Coordination with Medicaid is already occurring on a weekly/daily basis, as well as through LaDair Wright’s participation on this workgroup; THSA is also coordinating with the RECs and other federally-funded HIT programs

*Participants: Peter MacKoul, Radhika Iyer, Patty Gray, Lynne Randall, Archie Alexander, LaDair Wright, Lorraine Fernandes, Tony Gilman*

Comparative analysis:

- We have a comparative matrix done in 2009 which clarifies the gaps between federal and Texas laws
- To vet that document and update it, so one of Angie Estwick’s law students will update that document by June 17 (it is hoped that this can be shared with the Board at the meeting on the 24<sup>th</sup>)

*Workgroup participants may review the 2009 comparative matrix on THSA secure website. The update will also be posted there when it becomes available.*

4	<b>Trust agreements</b> <ul style="list-style-type: none"><li>▪ <b>Business associate checklist</b></li><li>▪ <b>Approach for managing trust agreements</b></li></ul>	<b>Radhika Iyer</b>	<b>9:50–10:15 a.m.</b>
5	<b>Marketing and communications</b> <ul style="list-style-type: none"><li>▪ <b>Purpose</b></li><li>▪ <b>Approach</b></li></ul>	<b>Radhika Iyer</b>	<b>10:15–10:30 a.m.</b>
6	<b>Preparation for July 14 meeting</b>	<b>Radhika Iyer</b>	<b>10:30–10:45 a.m.</b>
7	<b>Open Discussion</b>	<b>All</b>	<b>10:45–11:00 a.m.</b>

*Items 4–7 will be discussed at a later meeting.*

