Using HIEs to Connect Behavioral and Physical Health
Now and the Future
Lyman Dennis, MBA, PhD
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El Dorado Health Consulting

Executive Director
ConnectHealthcare (an HIO)
HIO vs HIE

HIO

HIE

Server

Database
Q1  HIE experience?
A Case Study

Large Scale Clinic System

Electronic Health Record

Hospital Emergency Department
Assessment, controversy and retreat

• Confidentiality switch in EHR is three screens deep: home/advanced/structure. Not always used.
• BH leadership does not trust that BH staff will always turn the switch.
• IT agrees to run a screening program nightly to identify any substance use patient with the confidential switch off.
• Clinic agrees to seek authorization for data release from all patients.
• BH leader says risk is still too great.
• Hospital leadership says data (including substance use data) is needed to provide proper patient care.
• Clinic compliance officer says clinic should not provide files.
This Talk
1995
Community Health Information Networks (CHINs). OCHIN.

2004
Regional Health Information Organizations (RHIOs). From President George W. Bush’s Health Information Technology Plan” CalRHIO.

2009
Health Information Exchanges (HIEs) and HIOs. American Recovery and Reinvestment Act of 2009.
Exemplars

Santa Barbara County Care Data Exchange, 1998
• Dr. David Brailer / $10 million from CHCF
• Closed in December 2006, several months after operations began.
• Providers had not realized benefit.
• No ongoing financial support.

CalRHIO, 2005
• Dr. Molly Coye, $10 budget over 5 years.
• Some work in Orange County.
• In five years, unable to find a way forward.
• CalRHIO and CAeHC were competitors to be the ARRA-designated agency but unable to reach agreement.
Exemplars - 2

Cal INDEX, 2014

• David Watson with $80 million in funding from Blue Shield of California and Anthem Blue Cross
• Did not gain traction.
• In early 2017, Cal INDEX merged with Inland Empire HIE to form Manifest MedEx, also with significant funding.
Types of HIE

Community HIE

Enterprise HIE
Federated vs Repository

At query location

At provider locations

At repository location

At query location

Provider locations
CA: urban dense / rural sparse

Red = 3k+ pop’n / sq. mile

Yellow = rural (Economic Research Svc)
## HIos/HIEs in CA

<table>
<thead>
<tr>
<th>Central Coast Health Connect</th>
<th>OCPRHIO (Orange Co.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Central Valley HIE</td>
<td>RAIN Live Oak HIE</td>
</tr>
<tr>
<td>ConnectHealthcare</td>
<td>Redwood MedNet</td>
</tr>
<tr>
<td>Cottage Community HIE</td>
<td>San Diego Health Connect</td>
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<td>Lanes (LA)</td>
<td>Santa Cruz HIO</td>
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<tr>
<td>Manifest MedEx</td>
<td>San Joaquin Community HIE</td>
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<tr>
<td>Marin Health Gateway</td>
<td>SacValley MedShare</td>
</tr>
<tr>
<td>NCHIIN (Humboldt)</td>
<td></td>
</tr>
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</table>
Nationally

58 regional HIEs

Many enterprise HIEs
Variations in data exchange

<table>
<thead>
<tr>
<th>Mode</th>
<th>Provenance</th>
<th>Strategy</th>
<th>Connections</th>
<th>Status</th>
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<tbody>
<tr>
<td>eHealth Exchange</td>
<td>ONC</td>
<td>Point-to-point</td>
<td>HIEs, agencies, providers</td>
<td>Clumsy, limited use</td>
</tr>
<tr>
<td>Carequality</td>
<td>Some EHR vendors</td>
<td>Web of links</td>
<td>EHR-to-EHR</td>
<td>90% acute</td>
</tr>
<tr>
<td>Commonwell</td>
<td>Cerner + other EHRs</td>
<td>Web of links</td>
<td>EHR-to-EHR</td>
<td>60% ambulatory</td>
</tr>
<tr>
<td>Epic Care Everywhere</td>
<td>Epic EHR</td>
<td>Connect Epic</td>
<td>Epic-to-Epic</td>
<td>Epi-to-Epic + Carequality</td>
</tr>
<tr>
<td></td>
<td>(medical centers)</td>
<td>instances</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Regional HIEs</td>
<td>ARRA HITECH</td>
<td>Regional</td>
<td>Providers, others</td>
<td>Growing but white space</td>
</tr>
<tr>
<td></td>
<td>funding</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Patient Centered Data Home</td>
<td>National assn of HIEs (SHIEC)</td>
<td>Link HIEs based on pt home zip</td>
<td>Regional to national</td>
<td>Growing but not yet soup</td>
</tr>
<tr>
<td>Emergency Dept info Exchange</td>
<td>Vendor’s idea</td>
<td>National ED data repository</td>
<td>National repository</td>
<td>State-by-state growth</td>
</tr>
</tbody>
</table>
Patient Centered Data Home

20 HIEs
Q2. Familiar with these HIE methods?
Trust frameworks

• Agreement
• Certificates

Examples
• Direct Trust (person-to-person)
• eHealth Exchange, Carequality, Commonwell (DURSA)
• Epic (Epic agreement)
• CTEN (CalDURSA)
• TEFCA (new from ONC)
Sustainability

Publicly supported
• ARRA grants for many in 2013
• Some state HIEs
• Grants to supplement

Member supported
• Subscriptions
• Product fees
• Volume-based fees

Payer supported
• Payer quality bonus
  • Data contribution
  • Threshold
• Reimbursement tiers based on HIE participation
Barriers to participation in HIE
Future of HIE & Interoperability?

No question about interoperability

Unclear how different models will relate and which will thrive
Behavioral Health
Q3. Audience

Behavioral health
Substance use treatment
Legal
Compliance
Management
Other
All discussion is about treatment!

Not payment or health care operations.
Mental Health Information: HIPAA

• No transmission of professional notes
• Mental health information can move as physical health information (under HIPAA)
Mental Health Information: California Law

State Health Information Guidance (SHIG)
Primary California Laws

• Confidentiality of Medical Information Act (CMIA) CA Civil Code §56 et seq.

• CA Welfare and Institutions Code (WIC). Various including Lanterman-Petris-Short Act at §5328 et seq. (LPS)

• CA Health and Safety Code (HSC) including §11845.5, 123110 and 123125.

• CA Code of Regulations Title 9 – Rehabilitation and Developmental Services including §10568(c).
Mental health record to HIO for treatment by data sharing partners

- The information may be disclosed to providers of health care, health care service plans, contractors, or other health care professionals or facilities for purposes of diagnosis or treatment of the patient. This includes, in an emergency situation...

CA Civil Code §56.10(c)(1).
Lanterman Petris Short Act

• Passed in 1967, 29 years before HIPAA envisioned electronic exchange of health information

• The Act applies to patients who are voluntarily or involuntarily treated in an institutional (nonprivate) setting.

• The Act ended hospital commitment by the judiciary system, except for criminal sentencing such as for sexual offenders and the gravely disabled.
Can a mental health provider share information with a physical health provider?

Source: Scenario 1, SHIG, pp. 42-46.
Can a physical health provider share information with a mental health provider?

Source: Scenario 2, SHIG, pp. 47-51.
Substance Use
Can a substance use provider share information with another substance use provider?

Provider not subject to 42 CFR Part 2 [(1) federally funded & (2) hold self out as SU provider]

• General health information necessary for diagnosis and treatment may be shared

Subject to 42 CFR Part 2
Does Provider belong to the Part 2 program or a QSO?

• Yes. Information can be shared.

• No. Patient authorization is required to share patient information.

Source: Scenario 3, SHIG, pp. 52-55.
Qualified Service Organization Agmt

- A qualified service organization (QSO) provides administrative, professional or clinical services to a Part 2 program under a written agreement indicating that the organization is bound by the regulations applying to the Part 2 program and that it will legally resist any attempt to obtain unauthorized access to the patient records. [This is parallel to a Business Associate Agreement.] A QSO cannot provide general medical services (e.g., primary care).

- A Part 2 program may enter into a Qualified Service Organization Agreement with entities that provide covered services, e.g., with an FQHC system. Patient consent is not required.
Qualified Service Organization

• Q: Can a QSO agreement (QSOA) be used to facilitate communications between a Part 2 program and an HIO?

• A: Yes. A QSOA can allow a HIO to:
  • Hold patient data.
  • Receive and review requests for disclosures to third parties.
  • Facilitate the electronic exchange of patient information through the HIO network.

• Once a QSOA is in place, the Part 2 program can freely communicate patient information to the HIO so long as that is limited to information needed by the HIO to provide services to the program. The HIO can also communicate patient information back to the Part 2 program. Patient consent is not needed with a QSOA in place.
Q4. Any of you involved with QSOAs?
HIO Information Sharing
Q6. How many of you represent Mental health treatment organizations Substance use treatment organizations Both
Mental health data & HIE
California Law & HIPAA
Can a mental health provider share and store MH information in an HIO?

Source: Scenario 20, SHIG, pp. 132-134.
A Business Associate Agreement is between a covered entity and a contractor (business associate) for the purpose of maintaining the security of protected health information and HIPAA compliance.
May an HIO participant entity access mental health information from the HIO?

Does HIO data recipient have medical or psychological responsibility for the patient?
• Yes. May access patient data.

Does the HIO data recipient have a BAA with the original data provider?
• Yes. May access patient data.

Is the information necessary for the recipient to file a claim?
• Yes. May access patient data.

Is the data needed to respond to a medical emergency?
• Yes. May access patient data.

No to all.
• Authorization is required.

Source: Scenario 22, SHIG, pp. 141-145.
Substance use & HIE
SAMHSA 42 CFR Part 2
Can a substance use provider store data on an HIO?

Source: Scenario 19, SHIG, pp. 128-131.

- QSOA
- Consent
What substance use information can a provider store on an HIO?

Without authorization, a SU program can disclose to an HIO:

- Patient demographics
- Diagnosis
- Prognosis
- Treatment information for use by treatment/prevention professionals

- In the same facility or program
- In the same qualified service organization (QSO)

With authorization

Source: Scenario 20, SHIG, pp. 128-131.
Can an HIE participant access substance use patient information from an HIE?

Is HIO data recipient employed by QSO for the patient’s substance use program?
• Yes. Recipient may access patient SU information.

Can HIO selectively restrict access to data so patient is not ID’d as a SU patient?
• Yes. Recipient may access patient SU information.

Is data needed so recipient can respond to a medical emergency?
• Yes. Recipient may access patient SU information.

If No to all above, authorization is required.

Source: Scenario 21, SHIG, pp. 135-140.
Consent options

To Whom:

1. Name of an individual
2. Name of an entity w treating provider relationship w patient
3. Name of an entity not a treating provider such as an HIE plus
   1. Name of a participants
   2. Name of an entity
   3. General designation, e.g., “all my treating providers”

HIE must track the list of disclosures to whom made.
Disclosure to whom?

Q: Can an HIO use a consent form that allows disclosure to “HIO members”?
A: No. 42 CFR Part 2 §2.31(a)(2) states that consent forms must include the name of individuals or organizations who will receive the Part 2 data. Such a consent should identify the organizations by a list or attachments. [Reason: Many individuals and providers do not have access to the Internet.]

Q: Can an HIO use a consent that would allow disclosure to future members of the HIO?
A: No. A new consent would be required.
Compliant Patient Consent

1. Name of Part 2 program
2. Name of person or entity to which disclosure is to be made
3. Patient name
4. Purpose of disclosure
5. Information to be disclosed
6. Signature of patient (or authorized person to give consent)
7. Date of signature
8. Consent subject to revocation until used.
9. Expiration date, event or condition.
Amount & kind of information to disclose

• “All of my substance use disorder records”
• Not “all of my records”
Consent Duration & Purpose

Q: Can a consent state that disclosure is good until consent is revoked by the patient?
A: No. Can be “upon my death.”

Q: Is “treatment” a sufficient description of the intended purpose of a disclosure?
A: Yes. But the data would then not be usable for disease management, QI, payment, etc.
Q: Must a Part 2 program notify the HIO that it may not redisclose data without patient consent?
A: Each disclosure with written patient consent must include a notice that the data may not be further disclosed without written consent. A specified paragraph must be used.

Q: Can a single consent form be used for the disclosure to the HIO and for redisclosure to other identified parties such as HIO members?
A: Yes, if the purposes of the disclosures are the same. The redisclosure paragraph is required for each subsequent redisclosure.
Actual BH HIOs in CA & Beyond
HIO participants decide
• How to submit data as physical health or behavioral health and
• What to submit

Data retained in separate databases

→

Behavioral health participants have access to both systems
Santa Cruz County Behavioral Health Division
• Bringing up Netsmart connection to HIE

In both systems
San Joaquin Community HIO

Participants
• County hospital
• County BH program

Data coded by program
• BH data provided to HIO but only available
  • Within the county BH organization
  • In emergency by “break the glass”
• First County BH department in CA to contribute data to a community HIE
SJ Behavioral Health Approach

• Limited Mental Health data set shared
  – Demographics, diagnoses, medications, allergies, and lab results
  – No substance use information (42.CFR.2) or psychotherapy notes
  – Data filtered on way out of EHR & further segmented in HIE

• Opt-in, whereas rest of HIE is opt-out
  – 97% opt-in rate to date
  – Consent status captured via electronic signature, transmitted from EHR to HIE
Consent2Share

- An open-source software application
- Allows patients to specify online what BH health information they would like to share with primary care and specialty physicians
Data segmentation and consent
consent2share

- Open source
- Manages consent
- Segments data
- Integrates EHRs & HIEs
- Uses interoperability standards
- Applies client preferences
- Gives clients control
Considerations

• Need for highly skilled staff
• New policies, procedures, workflows
• New processes
• Patient and staff education
• Patient access to computers, tablets, etc. to enter preferences.
<table>
<thead>
<tr>
<th>Step</th>
<th>Activity</th>
<th>Duration (mo)</th>
<th>Est Cost ($000)</th>
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</thead>
<tbody>
<tr>
<td>1</td>
<td>Stakeholder education, stds, approach</td>
<td>1</td>
<td>25</td>
</tr>
<tr>
<td>2</td>
<td>Develop implementation plan</td>
<td>1</td>
<td>25</td>
</tr>
<tr>
<td>3</td>
<td>Integrate C2S in HIE</td>
<td>2-4</td>
<td>100</td>
</tr>
<tr>
<td>4</td>
<td>Enhance patient registration</td>
<td>1</td>
<td>15</td>
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<tr>
<td>5</td>
<td>Deployment C2S micro services (API)</td>
<td>6-9</td>
<td>400</td>
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<tr>
<td>6</td>
<td>Finalize C2S value set extensions</td>
<td>2-4</td>
<td>25</td>
</tr>
<tr>
<td>7</td>
<td>Prepare education materials</td>
<td>1-3</td>
<td>25</td>
</tr>
<tr>
<td>8</td>
<td>Connect behavioral health facilities to HIEs</td>
<td>1-3</td>
<td>10 each</td>
</tr>
<tr>
<td></td>
<td><strong>Total</strong></td>
<td><strong>615 + 10 ea</strong></td>
<td><strong>64</strong></td>
</tr>
</tbody>
</table>
Consent2Share Implementation Tools

• For Staff, Counselors and Physicians
  • Waiting room video
  • Flyers for Offices and Group Rooms
  • Client Brochures
  • FAQs
  • Client instructions for completing Consent2Share Policy
  • Consent2Share Website

• For Clients
  • Patient Journey Map
  • Staff workflows for Counselors and Front Desk
  • Staff roles and responsibilities
  • Staff instructions for creating client accounts
  • Scripts and talking points for staff and providers
  • Training and Consent2Share demo
  • Consent2Share Website overview
• Prior to C2S
  • Poor communication between Behavioral Health and Primary Care
  • Fragmented care coordination
  • Less than optimal health outcomes
• After C2S
  • Patient wishes in C2S mediate the data exchanged
Future of Behavioral & Physical Health and HIE
First cause of death under 50

- Hydrocodone
- Hydromorphone
- Oxycodone
- Oxymorphone
It is dangerous to treat a patient without knowing:

- Problem list
- Medications
- Lab results
- Allergies
A few well-known MH & SU sufferers

<table>
<thead>
<tr>
<th>Buzz Aldrin</th>
<th>Jon Hamm</th>
</tr>
</thead>
<tbody>
<tr>
<td>Betty Ford</td>
<td>Kristen Bell</td>
</tr>
<tr>
<td>Drew Barrymore</td>
<td>Robin Williams</td>
</tr>
<tr>
<td>Brad Pitt</td>
<td>Sir Elton John</td>
</tr>
<tr>
<td>Tipper Gore</td>
<td>Abraham Lincoln</td>
</tr>
<tr>
<td>Prince Harry</td>
<td>Benjamin Disraeli</td>
</tr>
<tr>
<td>Frank Lloyd Wright</td>
<td>Charles Schwab</td>
</tr>
<tr>
<td>George Washington</td>
<td>Leonard Bernstein</td>
</tr>
<tr>
<td>Ted Turner</td>
<td>Winston Churchill</td>
</tr>
</tbody>
</table>
Changing mores, regulation & technology

• Lucia Savage, former Chief Privacy Officer, ONC
  • “Important to keep rules simple in harmony with HIPAA.”
• Occasional bills to simplify SAMHSA approach.
• Trade off between number of people who die because information not present and protecting reputations of SUs.
• Better to outlaw discrimination than data sharing.
Forecast: Bill Beighe, Lyman Dennis
For the good of the patient care, data should not be denied if it can be shared under HIPAA.

-- Robert Moore, MD, MPH, MBA
Within 5 years --

All patient data will be completely integrated and available for the treating provider.

Bill Beighe, Santa Cruz HIO
Lyman Dennis, ConnectHealthcare
Other???

ADDITIONAL SLIDES
Q: What providers are covered “programs” under 42 CFR Part 2?
A: Has these elements:
  • Federally funded – any federal funds, tax exempt, Medicare, etc. Not private programs.
  • An identified SU facility or identified unit of a facility providing SU services. Not privately reimbursed physicians providing SU services.

Q: Does Part 2 permit the disclosure of data without a patient’s consent (for treatment)?
A: With the exception of medical emergencies, Part 2 requires patient consent.
Substance Use Information 2

Q: What patients covered?
A: Diagnosis or treatment for SU at a federally assisted program

Q: What records covered?
A: Received or acquired by a federally assisted SU program

Q: Part 2 protection?
A: Any information disclosed by a Part 2 program that identifies an individual as having a current or past SU problem or treatment by a Part 2 program.
Direct Administrative Control

• Consent is not required to exchange information within a Part 2 program.

• Consent is not required when information is exchanged between an entity that has direct administrative control over the program.

• When a Substance Use program is part of a larger behavioral health or general health program,
  • Administrative information can be exchanged with the larger program.
  • Patient information may not be exchanged (unless a QSOA is in place).
Q: Can an HIO reveal an encounter in a mixed use facility if it does not reveal that the patient was in the Part 2 program?
R: Yes.
Emergency 1

Q: Can any health care provider determine that a medical emergency exists?
A: Yes. Any treating provider.

Q: If a medical emergency exists, can the entire Part 2 record be released?
A: Yes. The HIO could release the entire record.
Q: Can a medical emergency be documented by a check in a drop down box?

A: No. The Part 2 program must document:
1. Name and affiliation of medical personnel receiving the information
2. Name of the person making the disclosure
3. Date and time of the disclosure
4. Nature of the emergency
Emergencies p. 3

Q: Do medical emergencies include mental health emergencies?
A: Yes. An emergency requires immediate medical intervention.

Q: How is a medical emergency documented?
A: The information in a normal consent plus the identity of the provider determining that a medical emergency existed.

Q: Can Part 2 information disclosed in a medical emergency be redisclosed by an HIO without patient consent?
A: Yes, but information redisclosed must be necessary to carry out the purpose of the disclosure. This is true even if the patient previously refused to disclose information to the recipient.
Parent and minor

Q: Is the consent of a parent enough for an HIO to access the Part 2 data of a minor?

A: No. The minor’s consent is always required. Parental consent is required if state law requires it.
HIE Model Disclosure

• Mental health data
  • Most allowable without consent
  • Limitations: clinical notes, some LPS Act limits require consent
  • Organizations with separate MH and SU treated separately

• Substance use data
  • To whom:
    • “to HIE and all its participants.” Must be listed.
    • Redislosure applies outside the HIE
    • Track viewing of data
Forecast Future Role of HIEs
Groups of HIE models

• eHealth Exchange
• Carequality
• CommonWell

• All use eHealth Exchange
• Query from a portal and bring record to the portal – not part of the EHR or enterprise HIE
• Providers do not want this approach for themselves.
• This lets organizations say they do exchange but make it inconvenient.
Epic Care Everywhere

• Allows queries across Epic users (major hospital systems)
• Automated queries done at night prior to patient appointments
• Fast, effective, workflow friendly
• You get what you pay for
SHIEC Patient Centered Data Home (links HIEs)

- Not expensive
- Useful
- Being pursued aggressively
- Will happen
EDIE (Emergency Department Information Exchange)

• Being rolled out rapidly
• Not simple, though it looks that way
• Will continue
• Acquisition target for Epic perhaps
Organized Health Care Arrangement (OHCA)

• HIPAA permits providers in separate legal entities that provide healthcare to a common set of patients to designate themselves as an Organized Health Care Arrangement.

• The joint notice of privacy practices must clearly indicate the included organizations.

• The OCHA allows the included organization to share PHI for treatment, payment and operations.
An OCHA must

• Hold themselves out to the public as participating in a joint arrangement.

• Jointly perform
  • utilization review
  • Quality assessment and improvement
• Federally Qualified Health Centers (FQHC) typically are not considered a ‘program’ by definition. If the FQHC is licensed by the State of California under CA Code of Regulations Title 9 § 10568(c), the FQHC would be subject to 42 C.F.R. Part 2 regulations.
Social Determinants of Health

Source” JSI, July 11, 2017
## Diagnosis

<table>
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<tr>
<th>Economic Stability</th>
<th>Neighborhood and Physical Environment</th>
<th>Education</th>
<th>Food</th>
<th>Community and Social Context</th>
<th>Health Care System</th>
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</thead>
<tbody>
<tr>
<td>Employment</td>
<td>Housing</td>
<td>Literacy</td>
<td>Hunger</td>
<td>Social integration</td>
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<tr>
<td>Income</td>
<td>Transportation</td>
<td>Language</td>
<td>Access to healthy options</td>
<td>Support systems</td>
<td>Provider availability</td>
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<td>Expenses</td>
<td>Safety</td>
<td>Early childhood education</td>
<td>Social integration</td>
<td>Community engagement</td>
<td>Provider linguistic and cultural competency</td>
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<tr>
<td>Debt</td>
<td>Parks</td>
<td>Vocational training</td>
<td>Support systems</td>
<td>Discrimination</td>
<td>Quality of care</td>
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<td>Medical bills</td>
<td>Playgrounds</td>
<td>Higher education</td>
<td>Community engagement</td>
<td></td>
<td></td>
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<tr>
<td>Support</td>
<td>Walkability</td>
<td></td>
<td></td>
<td>Discrimination</td>
<td></td>
</tr>
</tbody>
</table>

### Health Outcomes

Mortality, Morbidity, Life Expectancy, Health Care Expenditures, Health Status, Functional Limitations
Can a mental health provider share information with another mental health provider?

**Patient not covered by LPS Act**
- Mental health information can be shared

**Covered by LPS Act**

Does Mental Health Provider have medical or psychological responsibility for the patient?
- Yes. Information can be shared.
- No. Patient authorization is required to share patient information.

Source: Scenario 3, SHIG, pp. 52-55.
Can a physical health provider share information with a mental health provider?

**Patient not covered by LPS Act**

- Mental health information can be shared

**Covered by LPS Act**

Does Mental Health Provider have medical or psychological responsibility for the patient?

- Yes. Information can be shared.
- No. Patient authorization is required to share patient information.

Source: Scenario 2, SHIG, pp. 47-51.
Substance Use Information

Q: Can substance use records be included in HIEs?
A: Yes, with patient consent.

Q: Does HIO structure matter – repository, federated, hybrid
A: No. All provide patient information.

Q: Does Part 2 require original wet signed consents?
A: No. A facsimile or photocopy of a consent form is adequate as is an electronic consent valid under applicable law.
HIO Part 2 Data Sharing

Q: Can Part 2 information disclosed to an HIO by consent or under a QSOA be made available to other HIO members?
A: Only if the patient signs a compliant consent form, unless a QSOA is in place between the parties.

Q: Do HIO no-option, opt-our or opt-in models affect Part 2 data.
R: No. The Part 2 rules are independent of the option rules being used by the HIO and its participating providers.
Disease management

Q: Can an HIO disclose Part 2 data for Disease Management purposes without patient consent.

A: No. Not unless the patients are deidentified.
SJCHIE Founding Members
SJCHIE Initial Functionality

- Longitudinal patient record look-up
- Notifications / alerts
- Meaningful Use 2 related services
  - Direct messaging
  - Public health reporting
  - MU-2 certified patient portal
Contributors

• Whole Person Care
• CURES & PDMP
• Initiatives to allow access to records to support whole person care
Multi-party Consent Forms

Q: Are multi-party consent forms permitted?
A: Yes. If patients want to authorize all or many member of the HIO to access their Part 2 record as well as to exchange information with one another, the multi-party consent form must list the name of each organization to which disclosures are authorized and for what purpose.
Disclosure to on-call coverage

Q: Can an HIO consent allow for the disclosure to on-call coverage?
A: Yes, if those providing on-call coverage are named by individual or organization.

Q: Can a Part 2 patient consent enable multiple disclosures?
A: Under a Part 2 patient consent, information may be disclosed multiple times, as long as the consent has not yet expired and the entities to whom the information is to be disclosed, the nature of the information, and the purpose for the disclosure specified in the consent form are still the same. A separate consent form does not need to be obtained each time a disclosure of Part 2 records is made.