

July 2012

Southeast Regional HIT-HIE Collaboration (SERCH): Final Report

ONC State Health Policy Consortium Project: Health Information Exchange in Disaster Preparedness and Response

Prepared for

**Office of the National Coordinator for Health Information Technology
US Department of Health and Human Services**
300 C Street SW
Washington, DC 20201

Submitted by

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EXECUTIVE SUMMARY

Health information technology (health IT) and health information exchange (HIE) hold great promise for improving health and health care. The passage of the American Recovery and Reinvestment Act (The Recovery Act), and with it the Health Information Technology for Economic and Clinical Health Act (HITECH) of 2009, provided funding for a wide range of programs and activities designed to accelerate the adoption of health IT and the implementation of HIE. Among these are the State Health Information Exchange Cooperative Agreement Program (State HIE Program) and the State Health Policy Consortium (SHPC). The State HIE Program has provided over \$547 million in grant support to States and/or State-Designated Entities (collectively referred to in this report as the State HIEs) to establish HIE capacity among health care providers and hospitals, while SHPC supports multistate initiatives to develop solutions to policy challenges specific to interstate HIE. Both initiatives are funded and led by the Office of the National Coordinator for Health Information Technology (ONC).

To date, there has been limited research on how HIE could be leveraged to provide timely access to clinical information in response to a disaster. The best way to ensure that health information can be accessed during an emergency is to ensure that it can be accessed during routine care. As connectivity through HIE expands, opportunities to link exchange efforts with emergency preparedness and response to provide health information to providers and patients in response to a disaster will expand. This work reflects the reality, however, that during the interim period of individual state efforts and varying HIE implementation timelines, a phased approach has been deemed by this project to be the most appropriate strategy. In this regard it is important to build on the lessons learned over many years, including the work done to access medical information following the displacement of more than a million people during and after Hurricanes Katrina and Rita in 2005.

The Southeast Regional HIT-HIE Collaboration (SERCH) project on Health Information Exchange in Disaster Preparedness and Response began in November 2010 and includes representatives from Alabama, Arkansas, Florida, Georgia, Louisiana, and Texas. The consortium's goal was to develop a strategic plan for sharing health information data among the Southeast and Gulf States during and following a declared natural disaster. The consortium members carefully assessed the challenges of accessing medical records and coordinating health care information for patient populations displaced due to a disaster. This report includes an actionable plan for incorporating HIE into disaster planning. The phased approach suggested by SERCH supports immediate progress in the absence of routine, widespread HIE. It also addresses key legal, technical, and governance issues and offers a list of steps that States can take to align their HIE planning activities with ongoing

emergency preparedness activities. The following subsections offer an overview of these key topic areas and a summary of the recommendations put forth.

ONC provided financial and technical support for this project, but did not impose top-down solutions. Ultimately, this was a project by States and for States, but with support from the Federal government.

Legal

Legal issues, and more specifically the privacy and security of information, remain critical even during a disaster situation. Privacy and security of protected health information (PHI) are covered by Federal and State laws and each must be considered in disaster-related exchange of PHI.

Variations in State approaches to authorization, permitted uses of health data, and consent to disclose information may also impact access to records. The report proposes a memorandum of understanding (MOU) that offers a limitation of liability for wrongful release of records in a disaster.

Technical

The SERCH team also assessed the participating State HIE projects, focusing on their overall approach and stage of HIE development, data-sharing partners, and HIE services offered. Their findings indicate that a mix of HIE models are being deployed and that little or no cross-State exchange of electronic health information is currently taking place. Given the variation in models and implementation timelines, the SERCH team has proposed a phased approach to incorporating HIE into preparedness that recognizes and responds to evolving availability of information and technology.

Governance

The report outlines strategies that HIE organizations can use to interact with other government agencies, specifically the agency designated by the National Response Framework as responsible for Public Health and Medical Services, known as Emergency Support Function #8 (ESF #8). Planning for disasters requires a lead agency to pull together both public and private interests and create working relationships among relevant agencies and organizations, both inside and outside of State government.

Recommendations

Finally, the report includes five recommendations that any public or private organization planning to share electronic health information during a disaster should consider. These recommendations are focused on the activities of State HIEs. The five recommendations for the State HIEs are:

1. Understand the State's disaster response policies and align with the State agency designated for Emergency Support Function #8 (Public Health and Medical Services) before a disaster occurs.
2. Develop standard procedures approved by relevant public and private stakeholders to share electronic health information across State lines before a disaster occurs.
3. Consider enacting the Mutual Aid Memorandum of Understanding to establish a waiver of liability for the release of records when an emergency is declared and to default state privacy and security laws to existing Health Insurance Portability and Accountability Act (HIPAA) rules in a disaster. States should also consider using the Data Use and Reciprocal Support Agreement (DURSA) in order to address and/or expedite patient privacy, security, and health data-sharing concerns.
4. Assess the State's availability of public and private health information sources and the ability to electronically share the data using HIE(s) and other health data-sharing entities.
5. Consider a phased approach to establishing interstate electronic health information-sharing capabilities.

Taken together, these recommendations offer a path forward for other States that wish to integrate disaster planning and HIE efforts. Combining these two important health care functions will help ensure that when a disaster strikes, patients and providers will have better access to information and be better able to provide appropriate care.

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1. BACKGROUND AND SCOPE

1.1 Background

Health information technology (IT) is the use of computer hardware and software to privately and securely store, retrieve, and share patient health and medical information. Health information exchange (HIE) is the movement of health information electronically across multiple organizations. Exchanging health information is important to make sure that health care providers have access to the most up-to-date information about patients so they can make more informed decisions about their care.

The American Recovery and Reinvestment Act (The Recovery Act) of 2009, and, with it, the Health Information Technology for Economic and Clinical Health (HITECH) Act, obligated over \$22 billion of Federal support for health IT. Under HITECH, the Federal Government established a range of programs to support the adoption of electronic health records (EHRs) and accelerate the implementation and availability of mechanisms for providers and health systems to exchange information rapidly and securely.

Among these programs are the State Health Information Exchange Cooperative Agreement Program (State HIE Program) and the State Health Policy Consortium (SHPC). The State HIE Program has provided over \$547 million in grant support to States and/or State-Designated Entities (collectively referred to in this report as the State HIEs) to establish HIE capacity among health care providers and hospitals, while SHPC supports multistate initiatives to develop solutions to policy challenges specific to interstate HIE. Both initiatives are funded and led by the Office of the National Coordinator for Health Information Technology (ONC).

In parallel to these activities, a group of States, including Alabama, Arkansas, Florida, Georgia, Kentucky, Louisiana, Mississippi, North Carolina, South Carolina, Tennessee, and Virginia, formed the Southeast Regional Health IT-HIE Collaboration (SERCH). The goal of SERCH is to consider common regional solutions for health IT and HIE, specifically how the Southeast region might solve interstate issues and pool resources to stretch limited dollars. The group's focus is on knowledge sharing, coordinating resources across grant programs within and between the States, and aligning program and policy decisions as much as practical. In addition, as grant opportunities arise, the SERCH States consider partnering with one another (either collectively or as a subset of States).

In 2010, a subset of the SERCH group, including Alabama, Arkansas, Georgia, Florida, Louisiana, and Texas submitted an application for funding through SHPC.³ Since the Southeast States are often affected by the same disaster, they frequently support recovery

³ Mississippi had originally intended to participate in this work, but was unable to do so due to resource constraints.

and displaced persons when a disaster occurs elsewhere in the region. For example, displaced Florida residents may temporarily or permanently move to Georgia. While they are displaced, they may need emergent or routine care, even though their medical records are hundreds of miles away.

The goal of this project was to examine the legal and technical issues of HIE during disaster situations and to develop a framework for States to review and assess their legal and technical infrastructure. From this examination, the group developed an actionable plan to improve HIE capabilities in response to a disaster. The ultimate goal of this work was to provide better access to patient information both during and in the aftermath of disaster situations to improve patient care and health outcomes. ONC's role in this project was to provide support for the States involved in the SERCH group to devise State-level solutions, not to impose top-down requirements on what should be done. Ultimately, this was a project by States and for States, but with support from the Federal government.

1.2 Scope

This report provides information about the requirements necessary to enable interstate data exchange following a disaster. The report includes assessments of the statutory and regulatory barriers to HIE within each State, an analysis of the barriers to HIE from a multistate perspective, and recommendations to resolve the barriers from a regional perspective. Finally, the report includes a roadmap for State disaster planning that lays out potential steps for incorporating HIE into disaster planning.

The SERCH group recognizes that perhaps the best way to ensure that health information can be accessed during the infrequent disaster is to make sure that it can be exchanged during everyday care and during common medical emergencies. However, the work of the SERCH group was limited to examining what needs to be accomplished prior to when State HIEs become fully operational and data begin to be exchanged ubiquitously.

1.3 Review of Existing Literature

The first step of the project was to conduct a literature scan. The scan focused on lessons learned from Hurricanes Katrina and Rita as well as other disasters during which accessing and using health information was problematic for patient care. References supporting this literature review are provided in **Appendix A**.

In the 15-year period between 1992 and 2007, natural disasters such as the historic Hurricanes Andrew, Katrina, and Rita and manmade disasters, such as the 2010 Gulf oil spill, illustrated the myriad technical, communication, logistical, and legal challenges inherent in disaster planning, preparedness, and response. The evacuation of over a million people in the aftermath of Hurricanes Katrina and Rita demonstrated the vulnerability of paper-based health record systems. Evacuees, residents left behind in the wakes of the

hurricanes, and their physicians were unable to reconstruct much-needed medical records, particularly prescription histories. The lessons learned from these natural disasters spanning multiple States have demonstrated the need for neighboring States to work together and the value of health IT for improved medical record exchange among the Southeast and Gulf States.

The first effort to address multistate cooperation came following Hurricane Andrew when questions were raised about the ability of Federal and State governments to manage the consequences of disasters. Florida Governor Lawton Chiles initiated discussions through the Southern Governors Association to develop a State-to-State mutual aid agreement, which led to the Southern Regional Emergency Management Compact (SREMAC) in 1993.⁴ In 1995, the SREMAC was broadened to include all States and renamed the Emergency Management Assistance Compact (EMAC). The National Emergency Management Association (NEMA) was created to administer the EMAC.⁵ In 1996 the EMAC became Federal law (Public Law 104-321) when Congress ratified it.

The EMAC addressed multistate planning for disasters, sharing resources among States during disasters, liability for emergency responders coming into a State that had declared a disaster, recognizing licensing from neighboring States, and providing assistance in advance or in place of aid from the Federal Emergency Management Agency (FEMA).⁶ The EMAC thus represents a contractual agreement among States to come to one another's assistance following a disaster and a mechanism for State governments to work across geographic and political boundaries. EMAC member States may request assistance when disaster strikes or is deemed imminent; the agreement also establishes a procedure to request assistance. The EMAC also outlines responsibilities of States requesting assistance and States providing assistance.

Although EMAC is an agreement among States, catastrophic disasters can overwhelm a State's resources, requiring it to seek assistance from the Federal government.⁷ In the case of a presidentially declared disaster, impacted States work with FEMA to seek Federal financial assistance to cover costs of emergency response efforts that may include eligible

⁴ Suburban Emergency Management Project (SEMP) (2006). *Emergency Management Assistance Compact (EMAC): Southern Born*. Retrieved from http://web.archive.org/web/20070813175340/http://www.semp.us/publications/biot_reader.php?BiotID=351 on June 15, 2012.

⁵ Emergency Management Assistance Compact (EMAC). *EMAC and Mutual Aid History*. Retrieved from http://www.emacweb.org/index.php?option=com_content&view=article&id=89&Itemid=257 on October 10, 2011.

⁶ Lindsay, B. R. (2008). *The Emergency Management Assistance Compact (EMAC): An Overview*. Congressional Research Service, Government and Finance Division, July 21, 2008. Retrieved from <http://opencrs.com/document/RL34585/> on October 10, 2011.

⁷ Federal Emergency Management Agency (2007). *Robert T. Stafford Disaster Relief and Emergency Assistance Act, as amended, and Related Authorities, FEMA 592, June 2007*. Retrieved from http://www.fema.gov/pdf/about/stafford_act.pdf on January 13, 2012

missions conducted under EMAC. EMAC allows successful collaboration that enables its members to request resources and provide timely assistance to States in need.

The public health emergency preparedness literature has grown significantly over the past decade. A recent article reviewing the emergency preparedness literature between 2000 and 2008 found that almost two-thirds of the public health emergency preparedness literature focused on the preparedness and planning phase of the disaster life cycle (see **Appendix A**). The authors point to the challenges of overlapping jurisdictions, responsibilities of emergency response, and miscommunication. Additional challenges confront health care workers attempting to treat patients whose medical records have been lost or who have evacuated to another State to escape disaster. These challenges include the following:

- Inability to communicate/share/transmit health information;
- State variations on issues related to privacy of health records (above the HIPAA “privacy floor”);
- Credentialing of health care providers; and
- Destruction of medical records.

Hurricane Katrina led to a number of papers and reports on disaster response and recovery that provide a rich base for understanding the need for health IT during a disaster.

Immediately following Hurricane Katrina, the Congressional Research Service (CRS) assessed the public health challenges in responding to the disaster (see **Appendix A**). Of immediate concern to public health officials were water supplies and dehydration, sewage disposal, threats of food and waterborne illness, heat stress, and an array of injuries. More serious problems arose with the emergency evacuation of hospital patients when power and food supplies were cut off. Field hospitals and triage centers were overwhelmed, with urgent calls from hospitals for more medical personnel. The Department of Health and Human Services deployed volunteer health professionals to the affected areas, as long as the requesting State recognized their licensure and certification. The report noted that one of the challenging aspects of accepting mutual aid in this case was the ability to verify an individual’s credentials, and pointed to the Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP), designed to assist State and local authorities in verifying the status of volunteer health care workers as a potential solution. However, at the time of Hurricane Katrina, ESAR-VHP was still in development and not available for use.

With respect to health IT, the CRS report noted that the Veteran’s Administration (VA), which uses the VistA electronic health record system, provided nearly uninterrupted care to several hundred veterans who had to be evacuated from its medical centers. As the nation’s largest integrated health system, the Veterans Health Administration (VHA) has invested heavily in information technology to ensure accountability for quality of care and to improve system efficiency. The system contains information such as medications, procedures, x-rays and imaging, and laboratory tests, and serves a wide variety of professionals, regardless of

setting. Within the VHA, all information for veterans was available through the VistA EHR, allowing the VA doctors to access records for any patients who found their way from the Gulf Coast to other veterans' facilities around the nation.

In June 2006, a joint publication by the Markle Foundation, American Medical Association, Gold Standard, RxHub, and SureScripts presented a comprehensive review of the successes and failures of emergency responses to Hurricanes Katrina and Rita (see literature review bibliography in **Appendix A**). This report focused on KatrinaHealth, an online service designed to help individuals affected by Hurricane Katrina, to work with their health care providers to access their electronic prescription medication records. The service was piloted within two weeks of the hurricane making landfall and was officially available nationwide within one month. Key lessons learned from the development of KatrinaHealth were the need for advanced planning and coordination of existing stakeholders and resources prior to a disaster.

In the same year, the General Accountability Office reported on the stresses placed on the health care system in New Orleans following Hurricane Katrina and Health Affairs issued a special publication summarizing the challenge of rebuilding and improving the city's health care system and its devastated health care safety net (see literature review bibliography in **Appendix A**). The study made several recommendations:

- Immediately engage in advance planning.
- Leverage existing resources.
- Address system and electronic health record design issues.
- Integrate emergency systems into daily routine.
- Improve communications strategies.
- Overcome policy barriers.
- Develop and institute mutual aid agreements.

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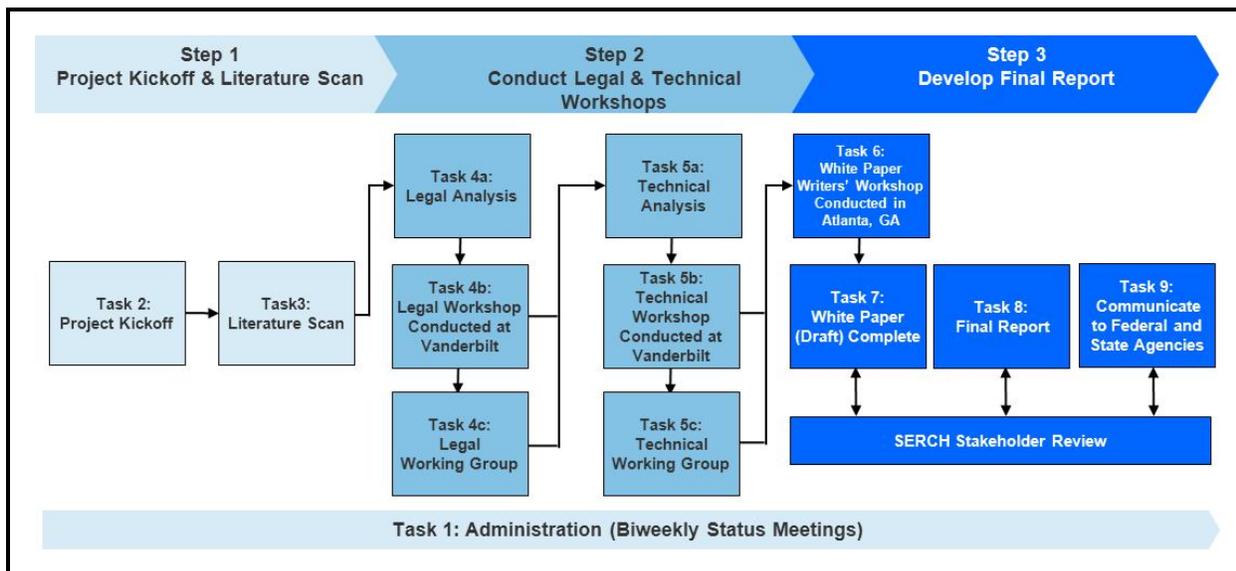
2. METHODS

To most effectively examine the issues related to using HIE during a disaster, the SERCH team divided its work into two focus areas: legal and technical. Work in both focus areas began by constructing a data collection tool that each State could use to gather information in a single, logical format (see **Appendix B**). States' responses to the tool were compiled into a single document and reviewed for key takeaways. A summary of the legal analysis across States is provided in **Appendix C** and a summary of the technical analysis is provided in **Appendix D**. Following the completion of the legal and technical analyses, the group convened two in-person workshops to review, synthesize, and consolidate the information.

The original intent was to address the two focus areas sequentially. However, it quickly became apparent that the tasks might be performed more effectively if completed concurrently. Each in-person meeting included staff with both technical and legal/policy backgrounds, allowing for issues to be examined more fully. Following the analyses and in-person meetings, the group prepared an initial draft of this report. The group came together for a final in-person meeting to discuss the draft and explore the issue of governance and integration with emergency preparedness activities more broadly.

Figure 2-1 illustrates the process that was followed to develop this report.

Figure 2-1. SERCH Project Approach



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3. LEGAL ISSUES

The privacy and security of health record data is one of the major legal issues in health information exchange. The recent HITECH amendments to the HIPAA regulations and penalties aimed at enhancing protection of the privacy and security of patients' health information has increased health care providers' and patients' sensitivity to this issue. Privacy and security protections, however, do not necessarily impede the appropriate exchange of information in a declared disaster.

Even during a disaster, when health information is exchanged, the privacy and security of that information must be maintained. Privacy includes a patient's rights to control who has access to his or her health information and the purposes for which that access is obtained.⁸ The term "information security" means protecting information and information systems from unauthorized access, use, disclosure, disruption, modification, or destruction to provide integrity, confidentiality and availability.⁹ Both the privacy and security of health information held by most health care providers, health plans, and clearinghouses (collectively called Covered Entities or CEs) are governed at the Federal level by the HIPAA Privacy and Security Rules¹⁰ as amended recently under HITECH.¹¹ Other Federal and State laws impact the privacy and security of health information, particularly information that relates to behavioral health, substance abuse treatment, genetic information, and HIV/AIDS data.¹²

When disasters cause substantial numbers of people to be relocated away from their primary sources of health care, obtaining secure access to displaced patients' protected health information (PHI) takes on new urgency. Historically, States have maximized resources during disasters by using the Emergency Management Assistance Compact (EMAC), a mutual aid agreement between States and territories of the United States to share resources during natural and manmade disasters, including terrorism.¹³ Because EMAC complements the national disaster response system and is used alongside Federal assistance or when Federal assistance is not warranted, EMAC may be a vehicle to address the cooperative exchange of health information during a disaster. The SERCH team has

⁸ 68 Fed R 34 at p. 8335 (February 20, 2003).

⁹ 44 USC 3542 (b)(1)

¹⁰ 45 C.F.R. Parts 160, 164.

¹¹ On February 17, 2009, President Obama signed into law the American Recovery and Reinvestment Act of 2009 (ARRA). Contained in a section of ARRA are provisions called the Health Information Technology for Economic and Clinical Health Act (HITECH); these provisions extend the original requirements related to administrative, physical, and technical safeguards that applied to covered entities under HIPAA to the business associates of those covered entities.

¹² See *generally* 42 C.F.R. Part 2 and the Genetic Information Nondiscrimination Act of 2008 (GINA), Pub. L. No. 110-233, 122 Stat. 881 (2008). For further information about applicable state laws, see Appendix C.

¹³ EMAC is the first national disaster-relief compact since the Civil Defense and Disaster Compact of 1950 to be ratified by Congress. Since ratification and signing into law in 1996 (Public Law 104-321), 50 states, the District of Columbia, Puerto Rico, Guam, and the U.S. Virgin Islands have enacted legislation to become EMAC members. See <http://www.emacweb.org>.

developed a Memorandum of Understanding (MOU) template as a starting point for States to use to complement the EMAC (provided in **Appendix E**). This template is an example of the type of MOU that might facilitate the exchange of data for patient care in an urgent or emergency situation.

Moreover, any State law precluding a PHI transmission in a disaster could be preempted by agreements for sharing data sets and by a clearly defined disaster declaration that suspends State rules or laws that conflict with HIPAA or HITECH standards. Consequently, the remaining discussion of legal issues about exchange of health information after a disaster assumes that the appropriate authority in the State has issued a disaster declaration, and that release of health information will be governed by the Federal privacy and security standards in HIPAA, HITECH, and other applicable Federal law and regulations.

3.1 Phased Approach

While exchange is occurring among providers and hospitals within closed networks, and a handful of regional health information exchanges (HIEs) are operating across the consortium States, none of the member States had an operational statewide HIE network as of September 2011 (Florida had launched its Direct Secure Messaging service by July 2011). However, the SERCH team agreed that Phase 1 could involve foundational development in which data sharing will likely to be limited to transmissions shared in point-to-point encrypted transmissions. These transmissions will consist of data from personal health records (PHRs), cloud-based electronic health records (EHRs), claims data, and other data sources more fully described in the technical section of this paper. Privacy provisions incorporated into the data use agreements between HIE services vendors will provide the protections necessary for safe transmissions. Additionally, as discussed below, many of these vendors may act as agents for health care providers. Consequently, both the regulatory requirements of HIPAA and contractual provisions will apply to protect these transmissions. As the infrastructure is improved, the subsequent phases leverage the technical capacities available to provide more integrated access. By Phase 3, when most exchanges will be completed via the States' HIEs, the SERCH team anticipates that a sophisticated set of participation agreements, privacy policies, and business associate agreements (BAAs) will be in place to protect all data disclosures. **Appendix D** provides data from a cross-state analysis of the progress expected towards more highly functioning HIE services across the participating States.

3.1.1 Applicable HIPAA Privacy and Security Standards

Whether information is exchanged directly between two provider organizations or a provider organization and a disaster relief entity tasked with assisting or coordinating patient care, certain HIPAA provisions apply. The following discussion incorporates the proposed HITECH modifications to the HIPAA requirements to provide an overview of the applicable law and

how it might be applied in a disaster. The SERCH team has limited the scope of disclosures discussed here to those made for treatment as defined by HIPAA, as well as public health reporting and disaster victim identification. All other types of disclosures including payment and operational disclosures are outside the scope of this discussion.

3.2 HIPAA Privacy Standards (Privacy Rule)

The HIPAA Privacy Standards are found in 45 C.F.R., Part 160 and Part 164 Subpart E, and apply to the use and disclosure of individually identifiable health information created or received by Covered Entities (CEs) called protected health information or PHI. Pursuant to the HITECH Act,¹⁴ use and disclosure restrictions of the Privacy Rule apply to all entities acting for or on behalf of a CE. These entities are referred to as business associates (BAs). BAs must also adhere to any additional CE privacy policies that are incorporated in the agreements they are required to have with CEs, generally called business associate agreements.¹⁵

In general, CEs are allowed to release a patient's PHI to the patient or someone authorized to act on the patient's behalf. CEs are also permitted to use and disclose PHI for treatment purposes if the information is sent to another CE such as a physician.¹⁶ After Hurricane Katrina, the U.S. Department of Health and Human Services (HHS), through the Office for Civil Rights (OCR), released guidance clarifying that treatment includes: (a) sharing information with other providers; (b) linking patients to available providers in the areas where the patients had relocated; and (c) coordinating patient care with emergency relief workers and others who can help patients find appropriate health care services.¹⁷ Additionally, a CE may release a patient's information to a BA after obtaining satisfactory assurance that the associate will safeguard the information.¹⁸ This release is usually accomplished by executing a business associate agreement.

In addition to treatment disclosures, natural disasters may result in public health surveillance, investigation, and intervention activities to identify and mitigate issues impacting population health. Such activities may depend on the ability of the public health agency or other appropriate government authority to access medical information, both in the community impacted by the disaster and at sites where displaced populations may seek medical attention or referral. To the extent that these disclosures are made to authorized

¹⁴ HITECH Act §13404 codified at 42 U.S.C. §17934 and amending 45 C.F.R. §§164.502; 164.504.

¹⁵ 45 C.F.R. §164.501 et seq (2010).

¹⁶ 45 C.F.R. §164.501; §164.502(a)(1)(i) and (ii). "*Treatment* means the provision, coordination, or management of health care and related services by one or more health care providers, including the coordination or management of health care by a health care provider with a third party; consultation between health care providers relating to a patient; or the referral of a patient for health care from one health care provider to another."

¹⁷ See Sept. 4, 2005 Waiver under Section 1135 of the Social Security Act. Available at <http://www.hhs.gov/katrina/ssawaiver.html>.

¹⁸ 45 C.F.R. §164.502(e) (2010).

public health or other appropriate government authorities, specific patient authorization for disclosure of PHI is not required.¹⁹

As the experience of Hurricane Katrina revealed, when individuals and families are forced to evacuate from a disaster area, family members sometimes lose track of one another. After a disaster, certain PHI may be released to law enforcement officials to identify or locate individuals. However, this information is typically limited to name and address, date and place of birth, blood type, type of injury, date and time of treatment, date and time of death, if applicable, and a description of distinguishing physical characteristics such as height, weight, gender, race, hair and eye color, scars, tattoos, and the presence or absence of facial hair.²⁰ A CE may not disclose PHI related to an individual's DNA or DNA analysis, dental records or typing, or samples or analysis of body fluids or tissue without a court order or administrative subpoena issued in conformance with HIPAA.²¹

CEs may also use or disclose PHI "...to notify or to assist in notifying, identifying, or locating a family member or other person responsible for the care of the individual, of the individual's location, general condition or death if the CE reasonably infers from the circumstances, ...based on the exercise of professional judgment, that the individual does not object to the disclosure."²² In addition, CEs may coordinate with "...a public or private entity authorized by law or by its charter to assist in disaster relief efforts...to help locate or notify appropriate family or persons responsible for the care of an individual who may have to relocate as a result of a disaster."²³

A CE may, consistent with applicable law and standards of ethical conduct, use or disclose PHI if the CE has a good faith belief that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of an individual, or the public, and that the disclosure is likely to prevent or lessen the threat.²⁴ Although this provision is coupled with language related to specific threats from an individual to another individual, the broad language of the first part of the provision has been cited in guidance issued by HHS²⁵ supporting disclosure to protect individuals and the public during the triage of displaced populations.

The language cited above does not clarify whether a good-faith belief will provide full protection against an enforcement action for wrongful disclosure of PHI in all

¹⁹ 45 C.F.R. §164.512(b)(1) (2010).

²⁰ 45 C.F.R. §164.512(f)(2)(i) (2010).

²¹ 45 C.F.R. §164.512(f)(ii) (2010).

²² 45 C.F.R. §164.510(b)(1) and (2) (2010).

²³ 45 C.F.R. §164.510(b)(4) (2010).

²⁴ 45 C.F.R. §164.512(j)(1)(i) (2010).

²⁵ Attachment 1, Hurricane Katrina Bulletin: HIPAA Privacy and Disclosure in Emergency Situations (September 2, 2005). Available at

<http://www.hhs.gov/ocr/privacy/hipaa/understanding/special/emergency/enforcementstatement.pdf>

circumstances.²⁶ As referenced earlier, after Hurricane Katrina, the Secretary of HHS issued a waiver²⁷ exempting providers from compliance with requirements to obtain a patient's permission to speak with family members or friends as set forth in §164.510²⁸ or to honor a patient's request to restrict communication about their PHI as set forth in §164.522²⁹ of HIPAA. It should be noted that, in general, granting a patient's request for restrictions on disclosure is up to the discretion of the CE. However, once certain provisions of HITECH are implemented, CEs will be required to grant the requested restriction if the disclosure is to a health plan for payment or health care operations and the information involved pertains solely to a health care item or service for which the provider involved has been fully paid out of pocket.³⁰ The waiver also authorized providers to "...share patient information as necessary to identify, locate, and notify family members, guardians, or anyone else responsible for the individual's care of the individual's location, general condition, or death."³¹

The waiver further extended the authorization to disclose PHI for these purposes to BAs of CEs, but specified that the requirements for obtaining assurance of compliance by the BA were not unlimited. CEs were granted a 30-day grace period to "cure" the noncompliance by obtaining a business associate agreement and additional extensions based on reasonable cause and a showing of good faith efforts by the CE, its BAs, and their agents "... both to protect the privacy of patient's PHI and to execute the agreements required by the Privacy Rule as soon as practicable."³²

When the OCR guidance was released post-Hurricane Katrina, individuals had the right to an accounting of disclosures for PHI disclosed for certain purposes other than treatment, payment, and health care operations, such as certain public health and law enforcement activities, whether such disclosure was from an electronic record or a hard copy.³³ Subsequently, HITECH expanded the accounting of disclosure requirements to include those disclosures made for treatment, payment, and health care operations and directed HHS to draft implementing rules.³⁴ As a preliminary step in this rulemaking process, HHS released a Notice of Proposed Rulemaking (NPRM) for the accounting of disclosures modification made

²⁶ Generally, both federal and state statutes authorizing declarations of disaster also authorize the issuing governmental entity to modify, suspend or otherwise waive statutory or administration requirements that impede response to and recovery from a disaster. (See *generally* 42 U.S.C. §5141 and State-specific emergency management statutes cited in Appendix C of this paper.)

²⁷ September 4, 2005 Waiver Under Section 1135 of the Social Security Act. Available at <http://www.hhs.gov/katrina/ssawaiver.html>.

²⁸ Providing for disclosure to help notify or assist in locating and notifying a family member or other person responsible for the care of the individual.

²⁹ Providing for restricting disclosure for purposes of treatment or payment.

³⁰ HITECH Act §13405(a) codified at 42 U.S.C. §17935 and amending §164.522 of HIPAA.

³¹ Attachment 1, *supra* note 14.

³² *Id.*

³³ 45 C.F.R. §164.528.

³⁴ HITECH Act §13405(c) codified at 42 U.S.C. §17935.

by HITECH.³⁵ This NPRM clarifies an individual's rights to an accounting for disclosure of his or her PHI, and also creates a right for a patient to know who has accessed his or her PHI.³⁶ Specifically, the NPRM proposes that patients will be entitled to know who has accessed their PHI for treatment, payment, or health care operations purposes *if the PHI was maintained electronically in a designated record set*³⁷ (emphasis added). Although as proposed, this requirement would not appear to apply to oral disclosures or certain other written disclosures (such as fax or e-mail of medical information via an external email program),³⁸ as electronic exchange of health information matures, more disclosures would qualify as being subject to an accounting. We note that the final rules for accounting of disclosure may or may not change from those proposed in the NPRM.

3.3 HIPAA Security Standards (Security Rule)

The exigencies of a disaster create opportunities for inappropriate access to and misuse of patients' PHI, and sending or receiving entities must take the steps necessary to protect such information to the fullest extent possible. The security provisions of HIPAA apply only to PHI that is created, received, maintained, or transmitted in an electronic format (e-PHI).³⁹ In guidance, however, OCR has noted: "e-PHI also includes telephone voice response and fax systems because they can be used as input and output devices for electronic information systems. e-PHI does not include paper-to-paper faxes, video teleconferencing, or messages left on voice mail, because the information being exchanged did not exist in electronic form before the transmission. In contrast, the requirements of the Privacy Rule apply to all forms of PHI, including written and oral."⁴⁰

Providers and disaster relief agencies that function as BAs of providers during such times need to understand the requirements of the Security Rule's administrative, physical, and technical safeguards designed to protect patients' e-PHI, especially those specifying the requirements to establish procedures that allow facilities to access or recover lost data⁴¹ and to access electronic health information during an emergency.⁴² In addition, providers should pay close attention to the standards and implementation requirements of the Security Management Standard,⁴³ the first of the administrative safeguards set forth in the Security Rule. The Security Management Standard incorporates a requirement that CEs "...establish

³⁵ HIPAA Privacy Rule Accounting of Disclosures Under the Health Information Technology for Economic and Clinical Health Act, Notice of Proposed Rulemaking, 76 Fed. Reg. 31426, 31432 (May 31, 2011).

³⁶ Id. at 31429.

³⁷ HITECH Act §13405(c) codified at 42 U.S.C. §17935.

³⁸ Id. at 31436.

³⁹ *Summary of HIPAA Security Rule*, U.S. Department of Health & Human Services. Available at <http://www.hhs.gov/ocr/privacy/hipaa/understanding/srsummary.html>.

⁴⁰ OCR, Frequently Asked Questions. Available at <http://www.hhs.gov/ocr/privacy/hipaa/faq/securityrule/2010.html>.

⁴¹ 45 C.F.R. §164.310(a)(2)(i) (2010).

⁴² 45 C.F.R. §164.312(1)(2)(ii) (2010).

⁴³ 45 C.F.R. §164.308(a)(1) (2010).

[a contingency plan] for responding to an emergency or other occurrence...that damages systems that contain [E-PHI]”.⁴⁴ Two specific issues that also deserve special focus are the requirements for access authorization and audit controls. The Security Rule requires that CEs (and their BAs) “... assign a unique name and/or number for identifying and tracking user identity.”⁴⁵ It also requires that an EHR have the ability to monitor and review who has accessed, viewed, and/or shared records in the system.⁴⁶ These are key security protections during a disaster to prevent bad actors from taking advantage of a potentially chaotic situation.

3.4 Liability

As the foregoing OCR guidance and Katrina waiver experience demonstrate, the anticipated disclosures of PHI by CEs and BAs in a disaster for treatment, identification, and location, and disclosures made to lessen a threat of serious or imminent harm can, in all probability, be made without liability concerns. However, indemnification is not clear in all instances. Although one approach may be to contractually indemnify BAs and agents acting in a disaster, BAs who exceed the permissible disclosures in HIPAA may be potentially liable. Both OCR and States’ Attorneys General may enforce HIPAA compliance and the breach reporting requirements and enhanced penalties for covered entities imposed by HITECH.⁴⁷ As a result, CEs and BAs remain concerned about potential liability for improper disclosure in a disaster situation.

HITECH defines a reportable breach as “...the unauthorized acquisition, use, or disclosure of [PHI] which compromises the security or privacy of such information, except when an unauthorized person to whom such information is disclosed would not reasonably have been able to retain such information.”⁴⁸ Although the Final Rule for implementation of the HITECH breach notification requirements has not been approved at the time of this paper, an Interim Final Rule⁴⁹ addresses several issues that may be applicable in disasters.

First, the Interim Final Rule clarifies that use of limited data sets subject to a data use agreement that are used for public health activities may include birth year *or* certain zip code information and still be exempt from breach notification requirements. Second, at the present time, breach notification requirements are triggered if the patient’s PHI is not secured via a technology or methodology that renders it “... unusable... to unauthorized individuals.”⁵⁰ Finally, the Interim Final Rule specifies that the security of patient data must be based on technology or methodology that “is developed or endorsed by a standards

⁴⁴ 45 C.F.R. §164.308(a)(8) (2010).

⁴⁵ 45 C.F.R. §164.312(a)(2)(i) (2010).

⁴⁶ 45 C.F.R. §164.312(b) (2010).

⁴⁷ HITECH Act §13402 codified at 42 U.S.C. §17930.

⁴⁸ HITECH Act §13400 codified at 42 U.S.C. §17930.

⁴⁹ 45 C.F.R. Parts 160 and 164 (August 2009).

⁵⁰ 45 C.F.R. Parts 160 and 164;

<http://www.hhs.gov/ocr/privacy/hipaa/understanding/coveredentities/hitechrfi.pdf>.

developing organization that is accredited by the American National Standards Institute.”⁵¹ These final two points have generally been interpreted to mean that PHI must be encrypted.

3.5 Next Steps

Clearly, the issues are complex and the road to HIE during a disaster will require cooperation through both legal agreements and policy decisions to adopt HIPAA as the ceiling for privacy and security protections. Consortium States are considering the following action steps as a result of this analysis.

Legal Phase 1

- Determine the appropriate parties to an MOU-type agreement in the State, including the parties authorized to execute the document.
- Develop a contact list of legal stakeholders with whom discussions about disaster HIE can be initiated.
- Make necessary amendments and modifications to the MOU template.
- Consider addressing transmission from a variety of data sources including PHRs, health claims databases, and EHRs.
- Consider how your State will identify and authenticate authorized users during disaster transmissions.
- Consider what policies need to be in place to facilitate use of direct secure messaging in a disaster.

Legal Phase 2

- Examine your State’s privacy laws to identify internal inconsistencies and conflicts with Federal law.
- Make necessary changes to participation agreements between the State HIE and participants to address disaster situations.
- Address the emergency or “break the glass” scenarios in policies, and with HIE vendors, consider disaster recovery plan amendments and disaster contingency policy as required by HIPAA Security Standards.
- Consider whether or not your State’s opt in/opt out policy, whether in draft or final form, adequately addresses exigent circumstances that might override individual consent.
- Develop training and consumer education material to address HIE access with providers during a disaster.
- Coordinate with stakeholders regarding “break the glass”/exigent releases, specifically those related to schools that have added privacy protections as a result of the Family Educational Rights and Privacy Act (FERPA).

⁵¹ HITECH Act §13402(h) codified at 42 U.S.C. §17932(h).

4. TECHNICAL ISSUES

The SERCH group initially understood that access to health information during a disaster will be greatly facilitated by the successful deployment of HIE and that this is the core intent of the Recovery Act grants provided by the State HIE Cooperative Agreement Program. The entities that received these funds (State HIEs) are currently working to enable HIE capacity, but they are not expected to deploy such capacity over a uniform timeline. Thus, the SERCH project included a survey of HIE capacity across member States to assess when these services will become functional, which would impact the level of preparedness respective to each State.

The group recognized that several key themes and trends will impact the technical evolution of HIE and that such an evolution will likely occur through a phased process. The SEARCH group also acknowledged that key to successful development of HIE will be the use of consistent technical standards in the deployment of State HIEs. In the context of emergency preparedness, specifically, the group also examined the issue of minimum data sets and the need to ensure telecommunications connectivity.

4.1 *Survey of Participating States*

The project team conducted a technical survey of HIE capability within participating States. The purpose of the survey was to identify (1) current and planned statewide HIE capacity through 2014, and (2) privacy and security policies that impact the exchange of health information in each State (full results of the survey can be found in **Appendix C**). Assessed topics included overall approach and stage of HIE development, data-sharing partners, HIE services, and key privacy and security policy considerations. Results of the survey include the following findings:

- Different HIE models are being deployed at varying paces across States. Several States are initially emphasizing “push” capabilities of secure messaging (including efforts to leverage the Nationwide Health Information (NwHIN) Direct implementation protocol).
- SERCH States’ phased, incremental implementations are expected to reach critical mass by 2013, with most States expecting statewide HIE operation by June 2014.
- Little or no cross-State exchange of electronic data is taking place today.
- The projected volume of clinical data available for exchange depends on rates of health IT adoption and participation in statewide HIE.
- SERCH States vary significantly in their approaches to authorization or consent to disclose information. Some States have no policies and some have legislation pending to require patient authorization for the exchange of medical records over an HIE.

These results paint a challenging picture for cross-State data exchange in the short run. Greater coordination during the planning and implementation of HIE efforts should mitigate some of these potential difficulties.

4.2 Themes and Trends

The project team identified a number of themes and emerging trends that will affect the ability of statewide HIE to develop and, therefore, affect the degree to which statewide HIE can be used as a component of interstate data exchange.

First, PHR use is likely to increase gradually over the next several years based on the following observations:

- An increased emphasis by the Federal Government on consumer health information;
- Increasing prevalence of PHRs tethered to health plans seeking to engage patients in improved outcomes, or to patient portals provided by the increase in EHR adoption due to Meaningful Use requirements and market competition; and
- Increasing prevalence of smart phones and mobile computing devices that enable greater access to data.

Most PHRs today are provided by health plans or by patient portals in providers' offices, either as standalone products or as part of an EHR. These PHRs can be referred to as tethered because they contain claims, medication history, and lab results entered by a single source such as health plans and other clinical records entered by the physician practice into the patient portal. Tethered PHRs are more prevalent because they are supported and maintained by employers, payers, and providers who offer a patient interface as part of their EHR system implementation. Patients do not need to put any effort into populating these systems with data, but they do need to know how to access them. The ability to access a tethered PHR could be critical following a disaster because it offers an immediate pathway to patient records. "Untethered" PHRs are standalone applications to which individuals can register and store their own health data, such as Microsoft Health Vault.[®] These could gain in popularity as more sources of health data help populate the PHR, independent of organizational affiliation. As more data become housed within PHRs, these data are potentially available for use in a disaster. The mix of clinical data and user-generated information contained in untethered PHRs should be considered. This mix of data may or may not be of clinical value following a disaster. PHRs that distinguish between clinician-generated and patient-generated information would resolve this issue.

Another PHR resource is the emergence of "Blue Button" services from HHS that allow individuals to download their information from the VA⁵² and Medicare,⁵³ as well as the ONC

⁵² United States Department of Veterans Affairs. (October 12, 2011). *Blue Button*. Available at <http://www.va.gov/bluebutton/>.

⁵³ Centers for Medicare & Medicaid Services. (August 17, 2011). *Blue Button Initiative*. Available at https://www.cms.gov/NonIdentifiableDataFiles/12_BlueButtonInitiative.asp.

initiative for consumer health data, which should drive more patients to use these capabilities.⁵⁴ Efforts are underway today to get additional organizations to host a “Blue Button” type service to make clinical data available to an individual’s PHR.

A second trend—largely spurred by the CMS EHR Incentive Program—relates to the deployment of EHR systems in hospitals, clinics, and provider offices. EHR deployment in the past few years has occurred with standalone, client-server configurations installed in providers’ offices, or in IT centers in hospitals and larger practices and clinics. The trend in smaller provider offices today is toward the deployment of cloud-based systems that are not physically installed on-site in clinical locations. These cloud-based deployments are housed remotely from the local clinical environment and often have redundancy and business continuity capabilities far exceeding the typical clinical enterprise. This trend will likely become more popular as the EHR vendors offer applications as service models rather than client-server configurations. As more health information is stored in locations independent of the clinical setting—and, therefore, not as susceptible to the effects of a localized event—the data should be more readily available at the time of a disaster.

A third trend involves the evolution of HIE itself. HIE projects often incorporate two approaches for clinical information exchange. The first are generally categorized as “push” models. They include fixed point-to-point connections, such as the delivery of lab results to a provider EHR system through a direct feed. Push mechanisms also include more flexible point-to-point connections—such as the type of secure e-mail enabled by the NWHIN Direct protocol, which is a set of specifications for a secure, scalable, standards-based way to establish universal health addressing and transport for participants to send encrypted health information directly to known, trusted recipients over the Internet.⁵⁵ These push transactions allow providers to send a broader set of health information to other providers they know and with whom they have a relationship.

The second approach, a “pull” model, allows a clinician to query a system and receive a listing of records in response. In the pull model, the transactions are largely repeatable events between known parties who develop a data-trading relationship (often unidirectional) and who use the HIE to transport their data. The NWHIN CONNECT project is one example of a pull model software platform, which provides specifications for various core services, enterprise infrastructure components, and system applications to allow for HIE between participants.⁵⁶ HIE pull capabilities that allow a provider to query the HIE for information about a patient for whom the provider is authorized to view data are becoming more

⁵⁴ Office of the National Coordinator for Health Information Technology. (n.d.). Pledge. Available at <http://www.healthit.gov/pledge/>.

⁵⁵ The Direct Project. (n.d.). *The Direct Project Implementation Group home page*. Available at <http://wiki.directproject.org/>.

⁵⁶ U.S. Department of Health and Human Services, Office of the National Coordinator for Health Information Technology. (n.d.). *Connect Community Portal*. Available at <http://www.connectopensource.org/>.

widespread. As pull model HIEs become more prevalent, they increase the potential availability of information in a disaster.

Each model has strengths and vulnerabilities in a disaster. While fixed point-to-point connections are the most vulnerable to physical disruption due to their fixed end points, flexible point-to-point connections could be quickly reestablished as soon as Internet connectivity and access to local data are restored following a disaster. Cloud-based EHR deployment enhances that ability to recover. HIE query/response systems that are properly configured for business continuity can quickly enable access to health data by accessing the repositories of cloud-based EHRs directly, or the backup repositories of hospitals, even when the source providers are not available. However, federated systems with multiple data sources may be more vulnerable to gaps in data availability than centralized systems.

4.3 Phased Approach

Based on analysis of survey responses and the market trends and themes identified above, the project team identified a three-phase plan for the technical aspects of providing access to data during a regional disaster (see Table 4-1).

Table 4-1. Phased Approach to Technical Aspects of Data Access During a Disaster

Phase 1 (Sept 2011–June 2012)	Phase 2 (July–Dec 2012)	Phase 3 (Jan 2013–June 2014)
<ul style="list-style-type: none"> ▪ Encourage enrollment in NwHIN Direct ▪ Leverage PHRs ▪ Leverage cloud-based EHR systems ▪ Leverage claims data ▪ Leverage EHR vendor data aggregation ▪ Identify, publicize, and enable access to data ▪ Capture and house data from point-to-point data 	<ul style="list-style-type: none"> ▪ Increase use of NwHIN Direct ▪ Integrate the NwHIN Direct standard with other secure messaging platforms ▪ Integrate provider directories for physician discovery across States ▪ Improve capabilities of State HIE Networks ▪ Evaluate, develop, and deploy data access services 	<ul style="list-style-type: none"> ▪ Continue use of NwHIN Direct ▪ Deploy fully functioning State HIEs ▪ Implement cross-State physician credentialing services ▪ Implement cross-State identification of patients ▪ Evaluate need for data access services

In **Phase 1**, strategies are pursued to leverage available data sources as broadly as possible. Statewide HIEs may not be required for this stage, as the State can help coordinate with stakeholders to make existing data available. In the near term, States can:

- **Encourage enrollment in NwHIN Direct:** Flexible point-to-point messaging, such as NwHIN Direct, empowers providers to exchange records securely and reliably,

from one provider to another. To use the secure messaging, however, providers must have a NwHIN Direct address and have a digital certificate acquired on their behalf. If available during a disaster, point-to-point messaging can enable critical communication of information—even just notes and comments about patient diagnosis and treatment—in most cases from any Web browser. Without preregistration *before* a disaster, however, this capability will be significantly diminished. Additionally, many EHR vendors include secure messaging capability in their applications. If a provider is using a vendor-specific secure messaging function, it could also serve the same purpose of point-to-point delivery of medical records. The downside of the vendor-specific platforms is that they will only send secure messages within the vendor EHR network, thus limiting their general use among different vendors. Reconciliation of these different platforms using NwHIN Direct as the standard is an important step to take. Vendors are being encouraged to leverage the Direct standard, which may also be required as part of EHR certification at some point in the future.

- **Leverage PHRs:** PHRs are an important source of health information and should be leveraged wherever possible, particularly tethered PHRs since they typically have more clinical and encounter data available than untethered PHRs. Many patients are completely unaware that their providers and/or health plans provide access to a rich set of health data. HIEs should work with the State-Designated Entity for HIE (State HIE), health plans, EHR vendors with patient portals, and standalone PHR vendors to provide access to data and exchange of records during a disaster. Even if a patient does not know how to access his or her health care information in a PHR, the caretaker of that information should be able to make it available in accordance with applicable privacy and security rules. In addition, informational campaigns aimed at both providers and the public at large should publicize the availability of these data and encourage patients to register for access. During a disaster, providers should encourage patients to access PHR data and make them available for treatment purposes. Data from tethered PHRs should be more acceptable to providers as their source(s) can be more readily verified.
- **Leverage cloud-based EHR systems:** EHR applications based in the cloud can provide more reliable business continuity to providers during a disaster because the applications for accessing patient records and patient data usually reside in secure vendor-based repositories far from the disaster site. The experience among Regional Extension Centers is that physicians tend to adopt these cloud-based, Software-as-a-Service model EHRs more than the client server models that are standalone systems within the provider practice. States should work with cloud-based EHR vendors to create interfaces with their repositories to make patient records accessible following a disaster. States should negotiate interfaces whenever possible with vendors to ensure that patient records are available. Federal surveys should track the uptake of cloud-based EHR use and adoption, ideally at the county level.
- **Leverage claims data:** Insurance claims data contain a wealth of information about the diagnosis and treatment of patients, including medication histories, lab results, diagnoses, procedures, and administrative encounter information. The State HIE and the lead agency should work with health plans, including Medicaid, to negotiate the release of available data following a disaster, if not already available as a data source on the HIE network. On the technical side, State-level HIEs and local HIEs should work in advance with health plans so that they convert claims data into formats the HIE supports. Health plans typically host a wide range of transformation services that can restructure the health plan data into Continuity of Care Documents (CCD) format or into unstructured data, such as PDF and other document formats.

- **Leverage EHR vendor data aggregation:** Many EHR system vendors are creating and deploying services that aggregate data across clinical deployments of their particular products. They are deploying these services primarily to promote and support interoperability among their clients, but this feature could become a useful data source in a disaster. These data usually exist in the cloud and, like cloud-based EHR systems, are less susceptible to local service interruptions. States must plan in advance to avoid violating data use agreements that may be in place between vendors and their customers.
- **Identify, publicize, and enable access to data:** Other local, State, and National data sources may be available and accessible to providers in disasters. Public health registries, payer and clinical lab databases, and even research data may be available. Caution must be taken to use these data only within the bounds of their policy and State and Federal law. States should consider ways to make data within their control easily accessible as appropriate to providers within their States and beyond in a declared emergency. This should include appropriate mechanisms to prevent unauthorized access during disasters.
- **Capture and house point-to-point data:** Many HIEs facilitate the exchange of point-to-point data—particularly laboratory results and to a lesser extent laboratory orders. The capture and storage of these data may provide significant benefits in a disaster and the subsequent loss of connectivity between the end-points in these transactions. Although there are implications to HIE architecture, policy, and resources, States should consider the routine capture of these data and their retention centrally for potential use in a disaster. States must take care to avoid violating established data use agreements that govern these transactions and that may not allow data passing through the HIE to be retained. States may want to negotiate with specific document repository vendors to maintain control of medication history and lab results for access following a disaster, if the State HIE is not configured to repose such documents.

In the wake of expanding HIE capabilities, **Phase 2** builds upon the near-term strategies and includes the following:

- **Increase use of NwHIN Direct:** In Phase 2, more providers should be registered to use the NwHIN Direct standard. Furthermore, this means of secure, point-to-point exchange of data should become more available and prevalent. Current State projects exploring the use of NwHIN Direct in different settings should increase its flexibility and scope of services. Increased familiarity and use of NwHIN Direct during routine times will allow for more comfortable use during and following a disaster.
- **Integrate the NwHIN Direct standard with other secure messaging platforms:** With the spread of cloud-based EHRs that provide secure messaging functionality, the use of secure point-to-point communications between providers should increase. However, vendor-based secure messaging applications create new silos of communication that need to be integrated for seamless exchange of health records. Recognizing the challenges, ONC has established a Standards and Interoperability Framework. They are developing use cases that define the interoperability requirements for high-priority health care data exchange in an interoperable environment. The State HIE should work with ONC and EHR vendors to leverage the emerging NwHIN Direct standards that will allow interoperability of secure messaging platforms.

- **Integrate provider directories for physician discovery across States:** To support provider discovery for NwHIN Direct, most States are developing provider and participant directories that list physicians and others available to send and receive secure messages using NwHIN Direct. The directories are being developed to cover participants within each State, but the need to locate providers across State borders will become vital to the medical response effort during and following a disaster. To this end, States need to implement methods to integrate their State-level directories with those in other States. Integration across States should become part of the initial planning for each State-level provider directory to reduce the need to reprogram the directory capabilities after they are built. Additionally, ONC is actively working on standards for provider directory interoperability that may lead to a virtual national registry.
- **Improve capabilities of State HIE Networks:** In Phase 2, State HIE networks will continue to mature, and the delivery of clinical summaries, medication histories, lab results, and other clinical data should be facilitated by implementing query/response functionality. The deployment of these more advanced query/response tools will position the State HIE networks to be leveraged during and following a disaster to allow providers inside and outside the State to query for patient records. The State HIE should lead the coordination with local HIEs, laboratories, payers, EHR vendors, disaster backup repositories, and other State HIEs to develop interfaces that allow queries for patient records to be submitted and health information to be delivered. These interfaces should be in accord with ONC interface standards. Specific interfaces to deal with CCD, records from payers, or HL7 message feeds from laboratories should be enabled. In addition, the State HIE should also work with neighboring States to sign participation agreements pertinent to each State-level HIE so that the network connectivity is ensured before a disaster strikes.
- **Evaluate, develop, and deploy data access services:** Because participation in HIEs is likely to mature slowly over the next several years, alternative data access services could provide an interim solution for disaster responses. Modeled in concept after KatrinaHealth, the data access service is envisioned to provide federated access (i.e., a minimum of data stored centrally) to readily available health data through an Internet-based portal for providers treating patients from a disaster zone. The exact data sets available will likely differ based on State and region. Some data may reside in national data stores (e.g., medication history data with SureScripts or pharmacy benefit management [PBM] systems), while other data could be locally sourced. The driving principle of these interim solutions is not to “let the perfect become the enemy of the good”—these data sources need to be assembled quickly, and compromises will need to be made regarding sophistication of data aggregation and presentation. Interim solutions may be difficult to achieve and bringing them online could take significant amounts of time. The evaluation aspect of this work would have to consider the tradeoffs with approaches that focus on other efforts, like Direct or State HIE Networks. To avoid duplication of effort, the lead agency for disaster preparedness and the State HIE should develop and maintain a relationship to better coordinate access to data and exchange of records during a disaster.

In **Phase 3** we expect State HIE services to mature and replace some of the interim strategies deployed in earlier phases, and to include the following:

- **Continue use of NwHIN Direct:** Point-to-point, secure messaging protocols like NwHIN Direct and EHR-based applications will continue to be used as the State HIE integrates health care data more completely. Point-to-point exchange of health

information and correspondence will continue as providers incorporate secure messaging into their daily communication patterns. By Phase 3, the interoperability difficulties among competing secure messaging platforms will ideally be addressed, using NwHIN Direct as the baseline standard. The integration of point-to-point, secure messaging applications and the query/response capabilities of the HIE should be developed into mutually supportive activities. For example, a provider should be able to locate a patient record using the HIE, submit a request for the record, and have it returned via secure messaging. This development and communication activity should be encouraged and supported in the long term.

- **Deploy fully functioning State HIEs:** Based on each State's Strategic and Operational Plan for HIE as part of its Cooperative Agreement with ONC, State HIEs should be able to connect a majority of their providers with HIE services. These HIEs should continue to develop and increase both the extent of their services and the sophistication of their operations. As State and local HIEs develop, they will need to keep up with innovations in cloud-based provider EHRs and vendor-based HIE hubs, with vendors offering document repository services and organizations established to facilitate lab reporting, biosurveillance, public health reporting, and data analytics. The increased maturity of HIEs will increase capabilities to support data queries during and following a disaster. By the end of Phase 3, States should be well on their way to developing fully functional HIE services. As HIE services develop, States should work to enable cross-State data exchange.
- **Implement cross-State physician credentialing services:** By Phase 3, States should have agreed on the policies and technical capabilities to enable cross-State exchange. At a minimum, tools and strategies to authenticate authorized providers among State-level HIEs should be available. Critical to interoperable exchange will be the ability to recognize provider credentials across jurisdictional boundaries. Under the EMAC, States that have declared a disaster emergency may accept the professional credentials of licensed clinicians in neighboring States.⁵⁷ This acceptance should be extended to medical professionals before a disaster, and each State or local HIE should accept the certification of providers who are authenticated to access a neighboring State's HIEs. While recognizing that credentialing across borders is a contentious issue, such acceptance could reduce the workload of conducting duplicative credentialing and will facilitate providers in neighboring States to log onto each other's State or local HIE to query for patient records. A second step is to create a single sign-on between State and local HIEs, so that a provider could query records in another State without having to log into another HIE. Resolving the issue of cross-State authentication to State and local HIEs before a disaster strikes will increase the chances that timely patient records will be available at the point of care.
- **Implement cross-State identification of patients:** Creating trust relationships among HIEs should be encouraged by enabling State and local HIEs to query for patient records across State boundaries. Currently, most HIEs are being developed with Master Patient Indexes (MPIs) that map patients in local medical service areas; some State HIEs are working on State-level MPIs that cover all patients in the State. Some form of synchronization of local or State-level MPIs must be allowed for patient record queries to discover records in the MPIs of neighboring States. One approach is to use a common set of identifiers across each State for each patient so that requests for data could locate the appropriate records for the correct patients. This method runs the risk of records assigned to the wrong person or records dropped

⁵⁷ Kalis, M. (2006). EMAC and environmental health in emergency response. *Journal of Environmental Health*, 69(10), 61-62.

because of duplicate identification. Another approach is to develop an enterprise MPI to synchronize patients across a multistate region. While this approach could generate better matching of patients and records across the region, the expense and complexity may make it unfeasible. Patient identification and record matching remain a key challenge in deploying successful HIE services.

- **Evaluate need for data access services:** The data access services to be deployed in Phase 2 are designed to have a limited life span. It is expected that HIE capabilities deployed in Phase 3 will obviate the need for these services. Useful tools, however, often are very slow to sunset and their use may persist longer than originally planned. During this phase the use and usefulness of the data access services need to be examined and the service should be decommissioned, maintained, or even enhanced based on the needs at that time.

4.4 Use of Standards

Key to these strategies is the use of consistent technical standards in the deployment of State HIEs and some of the special services described above. The strategies being discussed are inherently collaborative, but State HIEs develop largely independently of one another. Reliance on Federal (especially ONC) standards is, therefore, particularly relevant to ensure consistency and compatibility across State deployments. Existing initiatives, like NWHIN CONNECT and Direct, are natural starting points for multistate interoperability.

4.4.1 Data Set Considerations

A subset of the project team also examined the notion of a minimum data set required in a disaster. The challenge historically has been to produce the best medical outcome possible with the limited amount of data available from a patient's health record. On some level, this could be as simple as providing a patient's medication history, as was done during Katrina and subsequent disasters. However, access to patient information digitally captured and made available through HIEs will, over time, dramatically impact care delivery in both routine and crisis situations.

Health records typically contain a wide range of information including administrative and clinical data. These data include medical information for current and past encounters such as complaints, diagnoses, tests, reports, notes, medications, and treatment procedures. These data are combined with relatively static patient information such as demographics, financial data, insurance coverage, and family and social history to form the complete patient health record.

In viewing such a large potential repository, the workgroup first examined available or emerging standards to help decide what information to share and how it could be exchanged. The team concluded that the proposed data set frameworks already being discussed nationally should be leveraged for emerging HIEs. Most health care stakeholders are most likely already proceeding in this direction. These data include electronic care summaries that are being mandated by the Final Rule for Health Information Technology

including Criteria for Meaningful Use Stage One (CCD/CCR). The SERCH team concluded that:

- Rather than creating its own minimum standard data set, current and future work should leverage the standards being developed.
- Any approach the SERCH project takes should align with the ONC Standards and Interoperability Framework initiative and principles developed as part of that effort.
- Rather than focus on specifying a minimum data set, allow data set sources to contribute as much of the data within the proposed data set as they are able.
- Patient identifiers are critical data set elements to be supplied regardless of how robust the information from the data source is.

4.5 Ensuring Telecommunications Connectivity in Disasters

In any disaster setting, telecommunications connectivity is the key to the deployment of information services. Yet, during and immediately following a disaster, these services are often disrupted, and may be either not available at all or available only in certain locations. Any disaster preparedness plan should include a strategy for ensuring access to telecommunications links for emergency communications and HIE. Many States have emergency communications plans to ensure that emergency personnel can communicate during a disaster. For example, Florida requires that hospitals and emergency responders be connected via mobile data communication circuits for disaster response.⁵⁸ Louisiana allows emergency responders to use the Government Emergency Telecommunications Service when regular telecommunications are disrupted, using calling cards that prioritize their connections. In conjunction with this program is Wireless Priority Service that allows emergency personnel to initiate calls when cellular networks are congested by giving them priority cellular access.⁵⁹ Such services should be leveraged for the delivery of health information to the greatest extent possible, and should be incorporated into any strategic plan for HIE during and following a disaster. Note, however, that data services require considerably more bandwidth than voice or text messaging and may compete with these critical services for available communications capacity.

4.6 Takeaways

- States should promote the use of Federal (especially ONC) standards to ensure consistency and compatibility across State deployments.
- States should inventory and evaluate potential health data sets—even from unconventional sources like PHRs and claims data—and enable access to those sources wherever possible.

⁵⁸ *The Florida Emergency Medical Services Communications Plan, Volume 1 (Fourth Edition)*. (2011). Division of Telecommunications, Department of Management Services.

⁵⁹ State of Louisiana, Division of Administration. (n.d.). *OTM Catalog of Services Government Emergency Telecommunications Service (GETS) and Wireless Priority Service (WPS)*. Accessed at <http://doa.louisiana.gov/otm/catalog/gets&wps.htm> on October 9, 2011.

- States should enable secure point-to-point communications between providers and other stakeholders as baseline functionality for interoperability (e.g., Direct).
- States should leverage national standards, such as the CCD, to provide a standard format that organizations can expect to generate and receive. Allow data sources to contribute as much of the data within the data set as they are able. Patient identifiers are critical data set elements to be supplied regardless of how robust the information from a data source might be.

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5. GOVERNANCE OF DISASTER PLANNING AND EMERGENCY RESPONSE

Planning for disasters requires the creation of working relationships among agencies and organizations, both inside and outside State government. Relationships need to be developed among the following stakeholders to ensure medical records are delivered to the point of care during and following a large disaster: Governor's office, attorney general's office, emergency management, public health agency, the State HIE, the Medicaid agency, health plans, hospitals, EHR vendors, health information organizations (HIOs) and others, including essential points of contact in other States.

Working with all of these partners implies the need for a single lead entity or coordinated agency to provide governance for creating data-sourcing relationships before a disaster, working with the various public and private agencies and organizations to deliver medical records in response to the disaster, and coordinating continued access to medical records during the recovery period from a disaster. This section outlines suggested requirements for the roles that the lead organization should play and how HIE should become embedded in the preparation and planning process that already exists at the regional, State, and Federal levels.

5.1 Current Framework for Emergency Preparedness

The agencies currently responsible for health care disaster planning and response in all SERCH States are also responsible for Emergency Support Function #8 (ESF #8), Public Health and Medical Services, as defined by the National Response Framework.⁶⁰ These agencies are given statutory authority within the State for disaster planning and response and should logically lead any disaster planning for HIE, in close coordination with the State HIE and other agencies or organizations that lead disaster planning, response, and recovery.

The designated ESF #8 lead agency may vary by State, but typically the State public health agency or a specialized division within the agency serves in this role. For example, in Florida the ESF #8 agency is the Florida Department of Health, which coordinates support from the Agency for Health Care Administration, the American Red Cross, Agriculture and Consumer Services, Business and Professional Regulation, Elder Affairs, Environmental Protection, Military Affairs, and the Florida Funeral Directors Association, while the State HIE itself is run directly by the Agency for Health Care Administration.

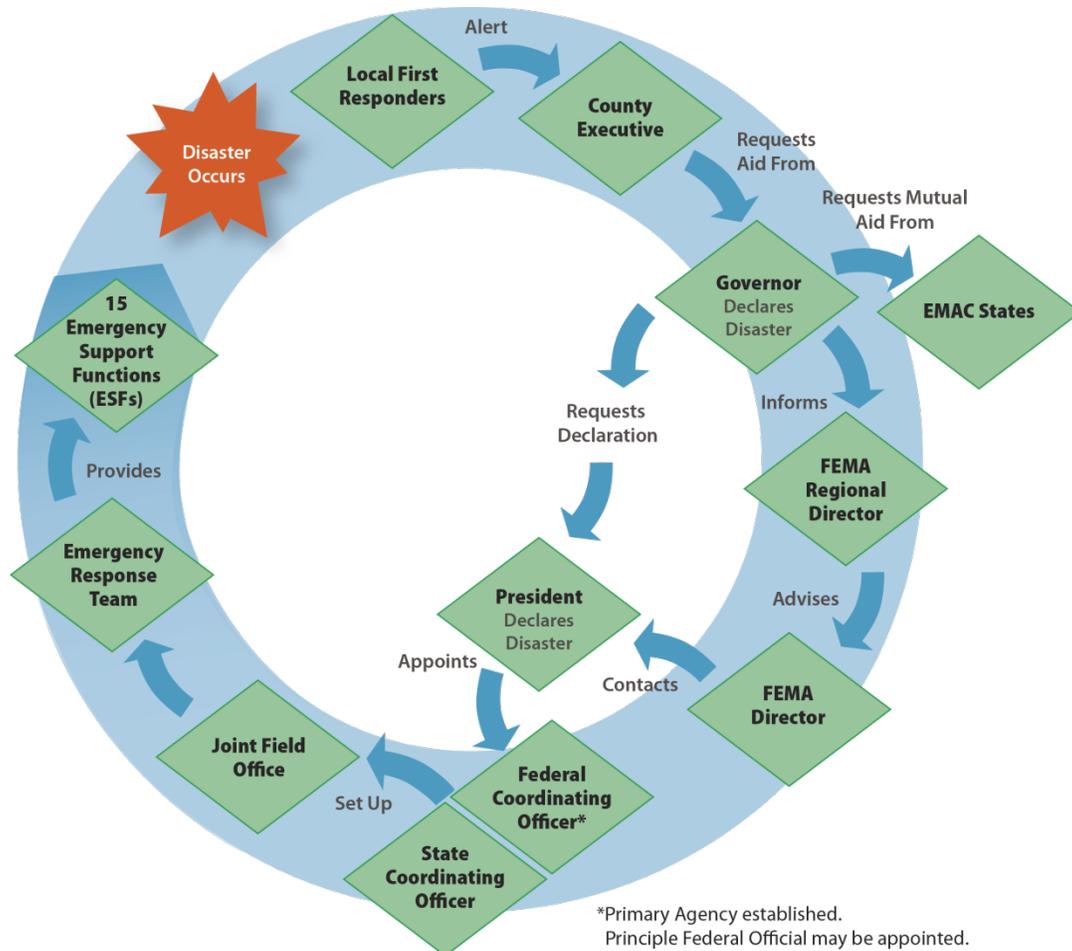
Once the ESF #8 lead agency and partner resources are exhausted and the State needs additional assistance, the Governor's office will typically initiate a disaster declaration. At

⁶⁰ U.S. Department of Homeland Security. (2008, January). *National Response Framework*. Available at <http://www.fema.gov/pdf/emergency/nrf/nrf-core.pdf>.

this time ESF #8 assets are released at the Federal level and additional support is provided to the State. Together the State, with Federal support, will work within the National Response Framework, which enables a single, all-discipline, all-hazards framework for Federal and State response to disasters. The National Response Framework links all levels of government, private sector, and nongovernmental organizations to coordinate a unified emergency response following a disaster. The framework is built on five principles, which cover the levels of coordination and action needed following a disaster (see Figure 5-1):

- Engaged partnerships;
- Tiered response;
- Scalable, flexible, and adaptable operational capabilities;
- Unity of effort through unified command; and
- Readiness to act.

Figure 5-1. The National Response Framework (Adapted from FEMA)



5.2 Establish a Lead Organization to Support State and Regional Planning for HIE during Emergencies and Disasters

Effective preparedness is a critical precondition for successful response. As described above, the ESF #8 agencies must bring government and private sector capabilities together into an organizational structure that provides support, resources, and services. Their primary operational responsibility is to assist Federal, State, and local governments by enabling first responders from different jurisdictions and disciplines to work together. For HIE, similar relationships must be forged so the capabilities can be properly and quickly leveraged during a disaster. Public and private entities must be contacted, relationships built, plans coordinated, and agreements about roles and responsibilities of each organization established. We propose that in each State, a single organization must be designated to pull together both public and private interests and coordinate their activities related to HIE and to leverage its capabilities. This entity will take the lead as a governing body to integrate HIE into emergency preparedness planning, and align public and private stakeholders in government, health care, and emergency management. Additionally, the lead organization should be responsible for communicating regionally with other States likely to provide relief or mutual aid in a major disaster.

The State HIE and the ESF #8 agencies in each State seem to have a natural alliance. The ESF #8 agencies are responsible for the following health care activities, to which HIE is a logical addition:

- Assessing public health and medical needs following a disaster;
- Public health surveillance and coordinating with State health agencies;
- Coordinating medical care personnel, medical equipment, and supplies;
- Patient evacuation; and
- Ensuring the safety and security of drugs, biologics, medical devices, blood supply, and food.

By bringing together the State HIE and the ESF #8 agencies in each State, disaster planning can leverage the capability of both State and local HIEs in disaster response, in the State, and across State borders. After a disaster, HIE services can be used to identify people fleeing from the disaster—using a Master Patient Index (MPI)—and validate them as patients. HIE services can also locate physicians using a provider directory and ensure that health care data are moving appropriately and securely. These operational functions align with the responsibilities of the ESF #8 agencies and the Emergency Assistance Compacts of each State. The lead organization responsible for integrating HIE could be an existing entity, such as the ESF #8 agency or the State HIE, or a new body created to achieve the objectives and functions outlined below to coordinate and integrate HIE services into disaster planning and response activities.

5.2.1 Governance

The lead organization should govern and oversee the integration of HIE into emergency planning, response, and recovery following a disaster. It should coordinate emergency management, State agencies, public and private health care stakeholders, and information technology interests such as State and local HIEs. In the public sector, stakeholders could include the Governor's Office, Legislature, State HIE, public health agency, emergency management agency, State agencies tasked with maintaining emergency communications, and local agencies that undertake public health, emergency planning, and response. In the private sector, stakeholders should include the health professional associations, health plans, hospitals, medical societies, regional HIOs, EHR vendors, and telecommunications companies.

The lead organization should organize the relevant parties needed to plan the emergency medical response before a disaster, to oversee the mechanisms of data exchange that will ensure the delivery of medical records to the point of care during a disaster, and to oversee the coordination of activity following a disaster to ensure that recovery efforts are successful. The role of the ESF #8 agency would generally be to facilitate whatever HIE infrastructure exists or will exist, and then to plan for and address critical gaps that emerge in a disaster. The ESF #8 agencies maintain committees of stakeholders at the Federal, State, and local levels that can coordinate stakeholders within the community while maintaining communications with the lead organization. The lead organization must be involved in coordinating communications and activities with all public and private stakeholders in disaster planning. The lead agency, ESF #8 agency, and the State-Designated Entity should all coordinate their plans prior to a disaster.

5.2.2 Planning

The lead organization's first task is to establish planning activities that include the appropriate public and private organizations to share basic information to support HIE strategic planning. Establishing an agreement that incorporates HIE into existing disaster response processes is critical. Initial discussions should create a plan that will leverage both trained staff and proven disaster protocols with the growing availability of electronic clinical data to support public health and medical services currently provided by the ESF #8 agencies.

Once the framework is established to include HIE in disaster planning, the lead organization should work with the Governor's Office and the appropriate State agencies to consider this project's draft Memorandum of Understanding (MOU) (Appendix E) for a waiver of liability for the release of records containing PHI when an emergency is declared. The lead organization should work with the Governor's Office to review the MOU with the participating Consortium States and to move toward enacting its main principles. The lead entity should also coordinate with related State agencies, such as the Department of Health

or other State HIEs that would be affected by the MOU. Additionally, State legislatures may take an interest in enacting statutory language similar to that in the Emergency Management Assistance Compact (EMAC) that would incorporate into State law the immunity and indemnification provisions included in the draft MOU.

Working with the emergency management agency should also entail collaborative planning so emergency plans are complemented by the provision of health care data. The lead organization should work with the State agency for emergency communications to plan for leveraging the emergency communications channels for possible use during a disaster to exchange health data. The lead organization should also reach out to the private telecommunications companies to ensure that communications channels are secured following a disaster. Emergency planning should entail the use of satellite links, if necessary, cell phones, and accelerated Internet reconnection to facilitate the delivery of health information to the point of care. The lead organization, with governing board oversight, should take advantage of programs that make telecommunications reconnection a priority following a disaster. The lead organization can also work with the State telecommunications agency and private telecommunications companies to facilitate their cooperation and mutual efforts.

Leveraging Lessons Learned for Future Planning

Less than a week after Hurricane Katrina hit the gulf coast, HIE experts around the country began to coordinate to develop a resource which would become KatrinaHealth.org. Organizations such as Gold Standard, Rx Hub, SureScripts, and the Veterans Health Administration, came together to leverage their individual resources into a single, secure resource which provided essential pharmacy information to those treating disaster victims. The effort was enormously successful, but was created to respond to this singular emergency; it was shut down after 90 days. While this was an invaluable resource during the disaster, much time was spent setting the system up, and trying to notify providers about KatrinaHealth.org after the storm. The tool was not used to its full potential.

What if accessing that system had become part of providers' normal business operations *before* the disaster? Careful planning related to health information exchange is essential to ensuring our response to future disasters can be more efficient and more effective in providing access to patient medical records.

The lead organization should contact nongovernmental, private organizations that are data sources, that have a stake in health care provision, and that provide emergency services. Data sources could include health plans, which hold both administrative and clinical data, national e-prescribing vendors such as SureScripts and Emdeon, Medicaid and Medicare, and both hospital and ambulatory EHR systems that either repose medical data in the cloud or in offsite backup locations. All of these data sources maintain valuable health data that could be available during a disaster. The lead organization should take a proactive approach to establishing and maintaining relationships with these data sources and consider developing business association agreements, MOUs, and contracts, as appropriate, with them in anticipation of a disaster. Such actions should all be conducted with governing

board oversight. To the greatest extent possible, the ESF #8 agency would build off of whatever HIE infrastructure currently exists or will exist. It would also plan for and address critical gaps that emerge in a disaster. The point of these efforts is to build relationships and capacity; it is not to build the technical infrastructure.

Additionally, the lead organization should communicate with other States likely to provide relief in a major disaster. At a minimum, adjoining States must know the processes and points of contact for each other, and ideally take part in each other's training and exercises. This need intensifies as we become more connected technologically through HIEs. Lead agencies of States directly impacted by disaster should be aware of the situations and events that will allow providers in other States to access patient information within the disaster-affected State's HIE. Working through details of those situations can take time and should be planned for well in advance. The State HIE should play an important role in this outreach and should align subscription requirements for intrastate HIE with those of other States. For example, subnetworks can connect to a State-level HIE through a subscription agreement between the State HIE and the participant. The subscription agreement is similar to the NwHIN DURSA or a data-sharing agreement between partners in that it states the requirements of participation and the mutual responsibilities of each partner. A similar type of agreement could be enacted between State HIEs to establish the legal basis for exchanging records between State partners.

HIE and the Future of Disaster Response and Recovery

Lessons from past disasters have shown that the availability of patient health information is essential and that the technical capacity exists for it to happen quickly and appropriately. Building on the success of KatrinaHealth.org, the In Case of Emergency Prescription Database (ICERx) was created in September 2008. ICERx provided appropriate and authorized access to comprehensive medication history for those affected by a disaster, but became unavailable in April 2011. Can State HIEs and emergency preparedness organizations work together to ensure that information is consistently available, and possibly even expanded beyond basic prescription information? Through the work of this project, we envision a future of response and recovery where:

- The expanding HIE frameworks provides consistent, appropriate, and automatic access to authorized providers treating disaster-affected patients.
- Patients dealing with the stress of a disaster would not have to bear the burden of recalling the specific details of a previous condition or the treatment they are receiving for a chronic disease.
- Providers would be armed against the consequences of treating patients without knowing essential information about their medical history.

5.2.3 Response

If the pre-emergency planning processes described above have been effectively executed, the stakeholders should be ready to act immediately when a disaster strikes. The ESF #8

agency in the State already has plans in place to manage communications and coordination of disaster response activities. If these plans include mechanisms to provide access to health data, responders could be in a position to contact the data sources directly and provide data access at both the disaster site and population dispersal sites. If the MOU proposed by this group has been adopted in the planning phase, a waiver of liability for any inadvertent transmission of protected health information (PHI) will apply once the Governor's office declares a state of emergency, allowing data to be exchanged for purposes of treatment as allowed under HIPAA to those who need it, such as unresponsive victims.

The lead organization for HIE integration should maintain constant contact with the emergency management agency to provide medical records where and when needed. As the capacity of HIE grows in each State, this could include more than just medication history. It could include the transmission of basic clinical data that would allow the doctors treating displaced patients to provide higher quality, continuous care. To support a future in which disaster response leads the way for patient-centered care, the lead organization should coordinate the requests for medical records with the State-level HIE, local HIEs, local officials, and medical personnel. Providing HIE services is a beneficial addition to existing disaster response plans, if properly aligned to the current activities of the ESF #8 agency and Federal, State, and local emergency management resources.

5.2.4 Recovery

Following the disaster, HIE will be important in delivering medical records for patients who are repatriated to their home community, or from emergency shelters to the hospitals where patients are admitted. Records from another State or city must be sent to the patients' primary care physicians or specialists who deliver care after the disaster. Efficient delivery of these records will be an important factor in resettling displaced patients who have returned home. Disasters often have a long tail as recovery efforts continue. However, they are generally considered closed when all local responders have been demobilized.

The lead organization should also assess the success of the response from each public and private sector organization involved in the exchange of health care data and should submit a report to the governance board. The board should then determine any appropriate adjustments to make in relationships among the stakeholders, contractual agreements, MOUs, and flow of communications. What has worked well should be identified and supported, and what has not worked should be adjusted and amended. With an iterative approach, a fully functional response to disasters to deliver medical records at the point of care can be developed. A clear audit trail must always be maintained so individual transactions can be traced back to their origin.

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6. RECOMMENDATIONS

Each State's readiness to share electronic health information in response to a disaster can be expedited and greatly improved by taking important steps now to implement the appropriate policies, legislation, governance agreements, budget, legal agreements, and technology infrastructure and capacity to share health data electronically. The SERCH team developed five recommendations any public or private organization should consider when planning to exchange electronic health information during a disaster. The five recommendations are:

1. Understand the State's disaster response policies and align with the State agency designated for Emergency Support Function #8 (Public Health and Medical Services) before a disaster occurs.
2. Develop standard procedures approved by relevant public and private stakeholders to share electronic health information across State lines before a disaster occurs.
3. Consider enacting the Mutual Aid Memorandum of Understanding to establish a waiver of liability for the release of records when an emergency is declared and to default state privacy and security laws to existing Health Insurance Portability and Accountability Act (HIPAA) rules in a disaster. States should also consider using the Data Use and Reciprocal Support Agreement (DURSA) in order to address and/or expedite patient privacy, security, and health data-sharing concerns.
4. Assess the State's availability of public and private health information sources and the ability to electronically share the data using HIE(s) and other health data-sharing entities.
5. Consider a phased approach to establishing interstate electronic health information-sharing capabilities.

Each recommendation is explained more fully in the sections that follow.

<p>1. Understand the State's disaster response policies and align with the State agency designated for Emergency Support Function #8 (Public Health and Medical Services) before a disaster occurs.</p>
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The Federal Government requires each State to document its disaster response policies and procedures, and requires each State to have a designated agency that coordinates and/or supports the delivery of ESF #8 services during a disaster: health, medical, and mortuary services.

The SERCH team recommends that each State HIE take the time to review the State's disaster response policies and governance structure, and collaborate with the State's ESF #8 agency. The State's disaster response policies may not address sharing of health information during a disaster. Reviewing the State's disaster response policies provides the

opportunity to modify the disaster response policy appropriately to enable health information data sharing and leverage existing disaster response infrastructure.

In governance, each State should have already identified a lead emergency response organization for disaster response, and the State HIE should clearly identify its role and responsibilities with the State's emergency response lead organization. The State HIE can be expected to support, and in some cases lead, the exchange of health information inside and outside of the disaster area.

Finally, the State HIE must collaborate with the State's ESF #8 agency and determine the appropriate integration points to leverage existing disaster response communication protocols, practices, and disaster response infrastructure (e.g., mobile satellite trucks) to share health information in a disaster. Also, the State HIE will benefit from engaging the ESF #8 State agency because the ESF #8 State agency has already established relationships with the local communities, neighboring States, and vendors. The ESF #8 agency also maintains a documented Continuity of Operations Plan for disaster response support.

2. Develop standard procedures approved by relevant public and private stakeholders to share electronic health information across State lines before a disaster occurs.

Following Hurricanes Katrina and Rita, the Southern Governors' Association recommended that States implement (before the disaster) the processes to be followed during a disaster. Planning is a valuable foundation and element of national preparedness as well. As the Federal Emergency Management Agency (FEMA) has noted, preparation allows for responses that save lives, protect property, and meet basic human needs after a catastrophic incident.⁶¹ Currently, States have varying levels of HIE implementation; some are in the planning phases, while others have moved to implementation or are nearing operational capacity. Regardless of where the State HIE is on their HIE implementation lifecycle, HIE data-sharing success will be based upon the people/business relationships, data-sharing policies, legal agreements, and trust established between the public and private health-sharing entities. HIE outcomes will not be optimal unless these steps have been completed properly.

Subsequently, the SERCH team recommends that the lead agency for each State's disaster planning and response take the initiative to either lead or coordinate the completion of the following key activities to better prepare for interstate health information sharing:

⁶¹ U.S. Department of Homeland Security. (2011, September). *National Preparedness Guidelines*. Available at <http://www.fema.gov/library/viewRecord.do?id=3773>.

- Identify and facilitate the resolution of State-specific legal issues or data-sharing agreements that impede interstate electronic health information sharing.
- Identify public and private health data sources available in the State and implement the technology approach for public and private entities to share health data across State lines.
- Conduct a distinct scope of functionality verification to confirm the State’s ability to exchange, or coordinate HIE with other States before a disaster.
- Ensure State HIE alignment with the ESF-8 State agency, leveraging the assets, protocols, communication, and governance processes already established.
- Facilitate public or private entity trust concerns or political concerns that may preclude health data sources from being available for interstate health information sharing.

3. Consider enacting the Mutual Aid Memorandum of Understanding to establish a waiver of liability for the release of records when an emergency is declared and to default State privacy and security laws to existing Health Insurance Portability and Accountability Act (HIPAA) rules in a disaster. States should also consider using the Data Use and Reciprocal Support Agreement (DURSA) in order to address and/or expedite patient privacy, security, and health data-sharing concerns.

HIPAA allows for the use and disclosure of patient health information for treatment, securing payment for services, or for internal processes related to a health care entity’s operations. The SERCH team’s focus for HIPAA relates to releasing patient health information for treatment and for certain public health and law enforcement actions.

In a disaster situation, there is concern that providers in States that have more stringent statutes for patient privacy and security than HIPAA requires would not be able to share medical information with providers in other States. In those cases, the SERCH team recommends that States should consider amending their emergency management statutes to ensure that, *in the event of a disaster requiring relocation of people away from the disaster site, the appropriate authority in the State has the power to temporarily suspend more stringent State medical information privacy laws, and require that health care providers comply with HIPAA for release of patient information.*⁶² The authority to suspend State law would stem from the MOU signed among member States, but as a nonstatutory agreement, the MOU alone may not have the authority to suspend State law. The EMAC statutes in each member State could be amended such that the Governor would have the authority to suspend State laws requiring specific patient consent for the duration of the emergency. Although disaster recovery is often a drawn-out process, a disaster is

⁶² Other Federal laws, including 42 C.F.R. Part 2 which applies to certain drug and alcohol abuse patient records, could not be changed by State action and any proposal to limit liability for sharing covered information in a disaster situation would need to be made at the Federal level.

considered closed when responders are demobilized at the local level. If necessary, the temporary shift to HIPAA could be terminated earlier based on the terms of the MOU or other government action. (The SERCH team has developed a Memorandum of Understanding (MOU) template, provided in **Appendix E**, as a starting point for States to use to complement the EMAC).

In addition, some States require patients to opt in to HIE participation and/or to receive notice that their health information may be released to another entity by electronic means. In these States, the SERCH team recommends they consider amending both their patient authorization forms and their notice of privacy practices (that HIPAA currently requires of all entities) to include a reference that, *in the event of a public emergency involving a natural disaster or public health emergency, patients' information will be made available in accordance with guidance from HIPAA as amended by the HITECH Act*. Since the HIPAA Security Rule requires audit controls, audit records will still be available to ensure appropriate access to information and prevent bad actors from taking advantage of a volatile situation.

States should also review whether current law is a barrier to releasing health information about patients who have to relocate away from their medical homes in the aftermath of a disaster to law enforcement officials, public health authorities, and organizations responsible for coordinating health care access. Often, this requires States to permit the release of health information without patient authorization.

As State HIEs become operational, HIE participation agreements will be executed between providers and the HIEs. The SERCH team recommends that States examine existing models for HIE participation agreements, such as the DURSA model, as they may be modified to address in advance standards and requirements for release of patient information in the aftermath of a disaster. Similarly, States should examine existing business associate agreements to develop a model agreement that complies with HIPAA requirements and that can be quickly modified for use with additional exchange participants as may be needed in the aftermath of a disaster.

4. Assess the State's availability of public and private health information sources and the ability to electronically share the data using HIE(s) and other health data-sharing entities.

Disasters are unpredictable in scale and magnitude; therefore, it is important for State disaster planning activities to consider and include health data sources that may come directly from private and public health entities. The SERCH team recommends that States plan to engage public and private health data entities to share health information in a disaster. Private and public health information entities include health delivery organizations, integrated delivery networks, Medicaid systems, regional health information organizations,

commercial health payers, e-prescribe networks, health information service providers, and cloud-based electronic health record (EHR) vendors. Health information sharing during a disaster should not rely solely on the State HIE, but more on an effective network of health information-sharing networks.

Equally essential will be the use of personal health records. These records will become increasingly important as personal health record adoption, both tethered and untethered, continues to grow in local communities. Personal health records, while not clinical records, can still provide important health information (e.g., patient medical history, medications, and allergy information) that can prove vital to clinicians providing medical attention to people in the disaster or displaced due to the disaster. Tethered personal health records are available now by some health plans, health delivery systems, and physician practices, and they are valuable health data sources.

After identifying the public and private health data sources within the State, the SERCH team recommends adopting health data-sharing standards created by recognized health organizations (e.g., HITSP, HL7 and the S&I Framework) along with medical technology standards (e.g., RxNorm, SNOMED and LOINC) to better allow public and private health data entities to share electronic health information across jurisdictional lines. Adopting these data-sharing standards promotes interoperability, which aligns to Federal Health Architecture standards, and provides a common set of standards for various health entities to share health information.

Finally, for those State HIEs that are currently planning their capabilities, open-source technology tools (e.g., NwHIN, Direct) should be considered as effective and available tools to facilitate health information sharing in a disaster.

5. Consider a phased approach to establishing interstate electronic health information-sharing capabilities.

The SERCH team recommends that State HIEs plan to establish interstate electronic health information-sharing capabilities for disaster response now, using available health data sources, technology tools and already established ESF #8 agency assets, protocols, and infrastructure. Over time, the State HIE can add to its interstate electronic health information-sharing capability as HIE adoption grows in local communities, and more HIEs come online.

Additionally, the SERCH team developed a three-step phased approach as a roadmap for States HIEs to consider. This roadmap outlines an approach to incrementally build interstate electronic health information-sharing capabilities. As outlined in the technology section of this report (see *Section 4.4 Phased Approach*) the approach includes:

- Phase 1: Leverage existing systems of storing and transporting electronic clinical data, such as personal health records and cloud-based EHRs, as well as claims data, to supply information as needed for treatment at the point of care.
- Phase 2: Leverage the growth in the use of data exchange among providers and begin implementation of regional, cross-State directories to provide data access services in a disaster. This data would be made available between States to treat disaster victims, protected fully under HIPAA privacy and security guidelines, if the proper legal and technical infrastructures outlined in this report have been put in place during Phase 1.
- Phase 3: Leverage fully functioning State HIE capacity to allow fully integrated patient look-up and physician authentication services.

Reaching Phase 3 will undeniably increase the capacity of those supporting the provision of health services during a disaster, as well as for routine care. The phased approach suggested in this report underscores that we should not, and do not need to wait for a fully integrated, cross-state health information exchange platform to become available in order to provide this data during a disaster. Although imperfect, a number of resources exist today, and efforts should move forward immediately to leverage them before the next major incident causes us to ask why we did not act sooner.

APPENDIX A: LITERATURE REVIEW BIBLIOGRAPHY

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**APPENDIX B:
DATA COLLECTION TOOL**

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Instructions

This Data Collection Tool is designed to collect information about your State's technical strategy for Statewide HIE. The information collected will identify architecture approaches, users, data sources, data types that will be available for exchange (and when).

There are four tabs:

- Statewide HIE
- Data Sharing Partners
- HIE Services
- Privacy and Security Policies

Below and embedded in each worksheet you will find instructions for completing the various fields. If you have any questions, please do not hesitate to contact Molly Smith (melsmith@manatt.com) or Lammot du Pont (ldupont@manatt.com).

Statewide HIE

Through this section, each State will provide the background information on approach to Statewide HIE and the current implementation status. We ask about current existing cross-border exchange (e.g. a medical trading area exchanging data not through a statewide HIE) to get a better understanding of how some entities have already overcome cross-jurisdictional issues. Several questions relate to the timing of service availability (vendor procurement date and HIE go live date). Finally, we ask about the implementation of disaster recovery plans and the use of off-site data centers. Responses to these questions provide information about the type of data that can be expected to be available during a disaster.

Data Sharing Partners

This section helps identify the types of data sharing partners the Statewide HIE expects to connect to through 2014. This information helps form an understanding of the data that will be available (and when) for each Statewide HIE. In the second column, we ask that you identify the type of data each DSP will share. For instance, will the entity connecting share lab results, medication history, demographics, or claims data? In the timeline, please identify how many of each kind of DSP will be connected cumulatively. In other words, if you bring on 2 hospitals in the first quarter of 2012 and 2 additional hospitals in the second quarter of 2012, put 2 as the value for first quarter 2012 and 4 as the value for second quarter 2012.

HIE Services

In this tab, we seek to understand the types of services offered by the Statewide HIE. Several services will be critical to coordinating exchange between unfamiliar entities, such as the Master Provider Index (enables routing) and the Master Patient Index (matching records). In addition, this provides insight into which data might be available to a provider during an emergency. Please mark an "X" along the timeline when the State expects the service to be available through the Statewide HIE.

Privacy and Security Policies

In this section, we are looking to understand whether your State has operationalized your legal framework. This will provide information on the potential technical barriers a system with one set of policies may encounter when it makes a request of a different system. From this information, we will be able to identify and recommend where technical interventions need to occur to ensure the fluidity of data according to the applicable policies during a declared disaster.

Key Technical Contact	Response (and additional instructions)
Name (Last, First)	<i>Enter the name of the person with technical expertise who Manatt can speak to related to this form.</i>
Organization	
Email	
Telephone	

#	Background Information on Statewide HIE	Response (and additional instructions)	Citation (i.e., Operational Plan, RFP, etc)
1	Is your State developing a Statewide HIE technical infrastructure? (Y/N)	<i>Some states may not be developing a Statewide HIE. Answer "no" if you are pursuing another strategy, such as unconnected RHIOs or working with vendors to enable cross-organizational exchange via DIRECT.</i>	
2	<p>Statewide HIE model (based on ONC designations): Please choose one of the following categorizations developed by ONC that best categorizes your current approach for statewide HIE.</p> <ul style="list-style-type: none"> • Option 1 - Elevator – Rapid facilitation of directed exchange capabilities to support Stage 1 meaningful use • Option 2 - Capacity-builder – Bolstering of sub-state exchanges through financial and technical support, tied to performance goals • Option 3 - Orchestrator – Thin-layer state-level network to connect existing sub-state exchanges • Option 4 - Public Utility – Statewide HIE activities providing a wide spectrum of HIE services directly to end-users and to sub-state exchanges where they exist 		<p>Where available, please include links to online citations, e.g., to your State Plan, to an RFP, etc.</p> <p>This is a drop down menu for choosing one of the four options</p>
3	Description of Statewide HIE approach	<i>Please include here information from your Strategic and Operational Plans that describe your overall technical approach for statewide HIE.</i>	This information can be drawn directly from your State Plan.
4	Statewide HIE Go-Live Date	<i>What date will Statewide HIE services FIRST be available?</i>	
5	Exchange standards / protocols:	<i>How is data shared from data share partners (source of the data) to the Statewide HIE? For instance, are the transactions standards-based? Are they conducted via web services? Other?</i>	
6	Approach to processing data transaction	<i>Are transactions processed real-time or batch? It is important to know whether data collected is from different date ranges (e.g., a requestor should be informed if some data received from a query is several months old (due to that State's batch processing schedule) while other data returned from another state is real-time).</i>	Here we are interested in information exchange that is not occurring through the Statewide HIE but across state borders either point-to-point or through a regional collaboration.
7	Description of any existing cross-border exchange activity	<i>Please include any information for entities that share information across jurisdictional boundaries, for example, a medical trading area that operates in multiple States.</i>	

# Background Information on Statewide HIE	Response (and additional instructions)	Citation (i.e., Operational Plan, RFP, etc)
8 Does the Statewide HIE use an off-site data center? (Y/N) If yes, where? (City, State) If not, is the State planning on using one?	<i>Please identify where your data is physically stored. This information is important to assess what data may be available during a disaster.</i>	
9 Has the Statewide HIE developed disaster recovery plans? (Y/N) If yes, please attach.	<i>Please provide a copy of any disaster recovery plans adopted by the HIE.</i>	<div data-bbox="1451 402 1724 496" style="border: 1px solid black; padding: 5px; width: fit-content;"> If any disaster recovery plans are available, they would be helpful sources of information of the requirements included. </div>
10 Are entities or organizations that connect to the Statewide HIE required to have a disaster recover plan? (Y/N)	<i>Please indicate if the Statewide HIE requires connecting entities (e.g. hospital, RHIO, provider) to have a disaster recovery plan.</i>	
11 Are entities or organizations that connect to the Statewide HIE required to have data back up capabilities? (Y/N)	<i>Please indicate if the Statewide HIE requires connecting entities (e.g. hospital, RHIO, provider) to have a disaster recovery plan.</i>	

Type of Entity Participating in Statewide HIE	Types of Data to Be Provided thru Statewide HIE	Status of Data Sharing Agreement (completed, in development, not started)	Federal FY 2012				Federal FY 2013				Federal FY 2014			
			Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Private/Non-Profit Sector														
Hospitals														
Longterm Care Facilities														
Physician Practices														
Clinics														
RHIOs														
HIEs (hospital, vendor, or community based)														
Laboratories														
Pharmacies														
Claims Clearinghouses														
Commercial Health Plans														
Self-insured Employers														
Public Sector														
State-managed clinics/facilities														
School-based clinics														
Correctional facilities														
Medicaid														
CHIP														
Immunization Registry														
Public health														
Others...														

Enter the type of data that will be available from this data sharing partner, e.g., lab, medication history, demographics, claims, etc.

In this timeline, please enter the cumulative number of DSPs that will have been connected up to and including each quarter. In other words, if you connect 2 hospitals in Q2 of 2013 but you already have 5 connected, enter 7 for the total number of hospitals connected by Q2 2013.

#	Statewide HIE Timeline - Services Offered	Location of Service (State, Regional, Enterprise, NA)	Calendar Yr 2011		Calendar Yr 2012				Calendar Yr 2013				Calendar Yr 2014			
			Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Core Services																
1	Message / Record Routing / Return Receipt															
2	Transaction Logging															
3	Terminology Service															
4	Transformation Service															
5	Record Locator Service															
Directories																
6	Provider Directory															
7	Master Patient Index															
8	Health plan directory															
9	Lab Directory															
Privacy and Security																
10	Audit Trail															
11	Identity Management and Authentication															
12	Consent Management															
Care Summaries																
13	CCD/CCR Repository															
14	Translation Services															
NwHIN																
15	CONNECT															
16	DIRECT															
Laboratory Services																
17	Lab ordering															
18	Lab results delivery															
Radiology Services																
19	Rad ordering															
20	Rad text results delivery															
21	Rad image delivery															
Public Health Reporting																
22	Immunization Registry															
23	Syndromic Surveillance															
24	Lab Results for Notifiable Conditions															
Medication Management																
25	Medication History															
26	Medication Reconciliation															
27	e-Prescribing															
Other																
28	Quality Reporting and Analytics															
29	Clinical Decision Support															

Please indicate if the service is to be hosted at the state-level, or if the service will be offered by organizations at the regional or enterprise level

Please put an "X" in the cell indicating when this service is expected to be made available Statewide through the HIE.

#	Statewide HIE Privacy and Security Policies	Instructions	Citation
1	Statewide HIE Privacy and Security Policies	<p>Does the state have Statewide policies for privacy and security? Specifically, do you have statewide policies and/or requirements for:</p> <ol style="list-style-type: none"> 1) Access 2) Authentication 3) Audit 4) Break-the-glass <p>If yes, what do these policies cover and is a copy available for review? In no, does the state have a plan for developing statewide HIE policies and when would such plans be available?</p>	<p>Please provide copies of any publicly available documents or links to online citations.</p>
2	<p>Approach to Consent. Select one of four options with respect to your current or planned approach for consent:</p> <ul style="list-style-type: none"> • Option 1- Opt In Seek advance consent from consumers to include their health information in an HIE; • Option 2- Opt Out Provide consumers the right to "opt out" of having their health information in an HIE; • Option 3- Notice Only Include all consumers' health information in an HIE, with notice to or education of consumers about the process; or • Option 4- Combination Take a blended approach, employing Options 1-3 as appropriate, depending on the particular uses of information and who has access to the HIE. • State will not have a uniform statewide consent policy <p>(Definitions available at: http://www.azgita.gov/ehealth/nispc/ConsumerConsent.pdf)</p>		<p>This is a drop down menu for choosing one of the five options</p>
3	If the approach is a "hybrid," when does consent apply?	Please describe the scenarios when consent applies.	
4	Where is consent managed (Statewide HIO, RHIO, provider)?	Indicate whether consent is obtained and/or managed at the statewide HIO, a RHIO, the provider, the RHIO, or other.	

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APPENDIX C: INTEGRATED LEGAL ANALYSIS

This section presents the applicable citations for each State's laws relevant to health information, including those that govern privacy, security, and exchange. This section demonstrates the range of laws at play across the States participating in the SERCH consortium and offers other States and opportunity to complete a baseline assessment of the legal environment in their own State. This information builds on the work developed under the Health Information Security and Privacy Collaboration (HISPC), specifically work of the Harmonizing State Privacy Law collaborative.⁶³

⁶³ Information from this project can be found at <http://healthit.hhs.gov/portal/server.pt?open=512&objID=1280&PageID=16053&mode=2&cached=true>

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Table C-1. Summary of Legal Analysis Across SERCH States

Item No.	Subject Matter	State Law Citation	More Stringent for Patient Care	More Stringent for Population Health	Issues/Comments
1	Comprehensive general privacy act	AR: A.C.A. §14-14-110 N/A: AL, GA, LA, FL, TX	—	—	AR: This statute applies to local governments prohibiting the release of personal, medical, or other records where the right to individual privacy exceeds the merits of public disclosure
2	Comprehensive medical privacy act	AR: A.C.A. §16-114-201 TX: H&S Code 181-Medical Records Privacy N/A: AL, GA, LA, FL	—	—	TX: Relevant provisions are found in many other areas of code
3	Constitutional right to privacy	AR: Not specifically enumerated FL: Art. I, Sec. 23; See also Art. X, Sec. 22 (Parental Notice of Termination of a Minor’s Pregnancy); 390.01114, F.S. (Parental Notice of Abortion) LA: Art. I, Section 5 Case law: AL, GA N/A: TX	—	—	AR: Case law, See discussion at <i>Jegley v. Picado</i> , 80 S.W.3d 332 (Ark., 2002) GA: Personal Medical Records protected by GA’s constitutional right of privacy - (<i>Ussery v. Children’s HealthCare of Atlanta</i> - 289 Ga. 255 (656 S. E. 2d 882) (2008)
4	Electronic Information Health information exchange specific provision	AR: A.C.A. §25-42-102 FL: 163.62, F.S. (Limited - Collaborative Client Information Systems), 381.0022, F.S., (Authorizes DOH and DCF share confidential information on clients served by the respective agency); 402.115, F.S., (Authorizes DOH, DCF and APD to share confidential information on clients served by the respective agency). 408.051 F.S. (Electronic Health Record Exchange Act); 409.913, F.S. (Electronic Health Information Exchange for Health Care Fraud TX: 22 TAC 291.34; TX H&S Code 12.0124 - Electronic Transactions: State Medicaid Program N/A: AL, GA, LA	—	—	AR: Enabling legislation presented to General Assembly in 2011 legislative session

(continued)

Table C-1. Summary of Legal Analysis Across SERCH States (continued)

Item No.	Subject Matter	State Law Citation	More Stringent for Patient Care	More Stringent for Population Health	Issues/Comments
5	Electronic health/medical record specific provisions	AR: A.C.A. §25-32-101 and A.C.A. §25-18-701 et seq. FL: 456.43, F.S. (Limited to e-prescribing), 59A-3.270, F.A.C., (hospitals), 408.062, F.S. (Adoption and use of EHR); 408.0611(Electronic prescribing) GA: OCGA §31-33-81(c) TX: TX Gov Code §531.0315 - Implementing National Electronic Data Interchange Standards for Health Care Information N/A: AL, LA	—	—	—
6	Breach of security reporting - general	AR: A.C.A. §4-110-101 FL: 817.5681, F.S. (General); 282.0041(7)(Enterprise IT Services Management); 282.318, F.S. (Breach notification applicable to Enterprise IT Services Management) LA: R.S. 51:3071, et seq. TX: Bus & Comm Code 4-48-103 N/A: AL, GA	—	—	AR: Arkansas Personal Information Protection Act, Act 1526 of 2005 and amendments thereto codified at A.C.A. §4-110-101; also Dept. of Information and Technology Regulation SS-70-008, Physical and Logical Security for Information Technology Resources
7	Breach of security reporting - health records	AR: A.C.A. §4-110-101 FL: 817.5681, F.S. N/A: AL, GA, LA, TX	—	—	FL: While not specific to electronic health records, the statute would have limited applicability to electronic health records
8	Telehealth/telemedicine	AR: A.C.A. §17-95-206 FL: 364.0135, F.S. (Promotion of broadband deployment, in part, for telemedicine); 458.3255, F.S., (Telemedicine Ordering Limitations); 64B8-9.014, F.A.C and 64B15-14.008, F.A.C., (Relating to Internet Prescribing) 64C-8.001(Use of telemedicine in provision of Child Protection Team Services) LA: R.S. 45: 835-838 TX: Fam Code 266.003; Gov Code 487; Gov Code 531; H&S Code 35.0041; Occ Code 107,111; H&S Code 109.012; Ins. Code 1455; H&S Code 62.157 N/A: AL, GA	—	—	AR: Licensure of the distant provider must be with the Arkansas State Medical Board

(continued)

Table C-1. Summary of Legal Analysis Across SERCH States (continued)

Item No.	Subject Matter	State Law Citation	More Stringent for Patient Care	More Stringent for Population Health	Issues/Comments
9	Electronic signatures	AR: A.C.A. §25-31-104 and §25-18-701 et seq. (UETA) FL: 668.004, F.S. LA: R.S. 40:1299.40.1 TX: Bus & Comm Code 43 N/A: AL, GA	—	—	—
10	Personal health records	TX: TX Government Code §531.161 - Access to Records N/A: AL, AR, GA, LA, FL	—	—	—
11	Uniform Electronic Transactions Act	AR: A.C.A. §25-32-104, Act 722 of 2007 FL: 668.50, F.S. LA: R.S. 40 Part XXII – A TX: Bus & Comm Code 43 N/A: AL, GA	—	—	AR: The Arkansas Uniform Electronic Transactions Act
12	Technical security of electronic systems	AR: A.C.A. 25-4-105 FL: 282.318, F.S. TX: Bus & Comm Code 43 N/A: AL, GA, LA	—	—	FL: Applies to State government
13	Patient access	AR: A.C.A. §16-46-106 FL: 456.057(6), F.S., 395.3025(1), F.S. GA: OCGA §31-33-8(e) TX: Fam Code 107.006; Fam Code 162.018; 22 TAC 681.45; 22 TAC 165.3 N/A: AL, LA	—	—	GA: Copy provided to patient in electronic or tangible form

(continued)

Table C-1. Summary of Legal Analysis Across SERCH States (continued)

Item No.	Subject Matter	State Law Citation	More Stringent for Patient Care	More Stringent for Population Health	Issues/Comments
14	Record retention requirements	AR: A.C.A. §25-18-604 FL: 456.057(11), F.S. , (Health Care Providers); Implied, 395.3025, F.S., (Hospitals); See also regulations governing licensed health providers, 64B1-10.001, F.A.C., (Acupuncture); 64B8-10.001 - 10.004, F.A.C., (Medical Doctors); 64B15-15.001 - 15.006, F.A.C., (Osteopathic Doctors); 64B33-4.001, F.A.C., (Athletic Trainers); 64B2-17.0055 - 17.0065, F.A.C. (Chiropractors); 64B4 - 9.001 - 9.002, F.A.C., (Licensed Clinical Social Workers, Marriage and Family Therapist and Mental Health Counselors); 64B5 - 17.002, F.A.C., (Dentists); 64B6 - 6.007, F.A.C., (Hearing Aid Specialists); 64B9 - 11.001 - 11.002, F.A.C., (Nurses); 64B13 - 3.003, F.A.C., (Optometrists); 64B17-6.0042 - 6.005, F.A.C., (Physical Therapist); 64B18 - 15.002 - 15.002, F.A.C., (Podiatrists); 64B19 - 19.002 - 19.006, F.A.C., (Psychologists); 64B20 - 9.006, F.A.C., (Speech-Language Pathologists); 64B24 - 7.014, F.A.C., (Licensed Midwife); 64J-1.014, F.A.C., (EMT). TX: Bus & Comm Code 43 N/A: AL, GA, LA	—	—	AR: Arkansas Records Retention Act, Policy Driven
15	Health/Medical Records - General Medical records Privacy	AR: A.C.A. §16-46-403, 404 LA: La CE Art. 510 TX: H&S Code Chp. 181; Med. Records Privacy; §§241.152, 241.153, 241.155, 241.204 [hospitals]; §82.008 [cancer registries] Case law: AL N/A: FL, GA	—	—	—
16	Records retention requirements	—	—	—	AR: Medical records must be retained by hospitals for 10 years GA: Patient records must be retained for 10 years

(continued)

Table C-1. Summary of Legal Analysis Across SERCH States (continued)

Item No.	Subject Matter	State Law Citation	More Stringent for Patient Care	More Stringent for Population Health	Issues/Comments
17	Right to amend the medical record	TX: H&S Code 181.01(2) N/A: AL, AR, FL, GA, LA	—	—	—
18	Patient access	AR: A.C.A. §23-76-129 and A.C.A. §16-46-106. AL: Ala Admin Code 540-X-9-10 GA: OCGA §31-33-2 (b) FL: 456.057(6), F.S.; 395.3025(1). F.S. LA: R.S. 40:1299.96; R.S. 40:2144; LAC 48:I:9319; LAC 41:I:9859 TX: TX Health and Safety Code §611.008 - Request by Patient; TX Health and Safety Code §611.0045 - Right to Mental Health Records; TX Health and Safety Code §595.004 - Right to Personal Records; TX Family Code §162.018 - Access to Information	—	—	AR: Arkansas has a special privilege permitting doctors to deny giving patients or their attorneys or guardians certain medical records upon a showing of “detrimentality” (Ch.16-46-106). Otherwise, access by patients and their attorneys are covered under A.C.A. 23-76-129 and A.C.A. 16-46-106 GA: Records must be provided within 30 days from receipt of lawful request
19	Ownership of medical records	FL: 456.057(1), F.S., 395.3025(Hospitals - implied), See also regulations governing licensed health providers, 64B1-10.001, F.A.C., (Acupuncture); 64B8-10.001 - 10.004, F.A.C., (Medical Doctors); 64B15-15.001 - 15.006, F.A.C., (Osteopathic Doctors); 64B33-4.001, F.A.C., (Athletic Trainers); 64B2-17.0055 - 17.0065,F.A.C. (Chiropractors); 64B4 - 9.001 - 9.002, F.A.C.,(Licensed Clinical Social Workers, Marriage and Family Therapist and Mental Health Counselors); 64B5 - 17.002, F.A.C., (Dentists); 64B6 - 6.007, F.A.C., (Hearing Aid Specialists); 64B9 - 11.001 - 11.002, F.A.C., (Nurses); 64B13 - 3.003, F.A.C., (Optometrists); 64B17-6.0042 - 6.005, F.A.C., (Physical Therapist); 64B18 - 15.002 - 15.002, F.A.C., (Podiatrists); 64B19 - 19.002 - 19.006, F.A.C., (Psychologist); 64B20 - 9.006, F.A.C., (Speech-Language Pathologists); 64B24 - 7.014, F.A.C., (Licensed Midwife) LA: R.S. 40:1299.96 TX: 22 TAC 165 Case law: AL, AR NA: GA	—	—	AR: Physician owns the record

(continued)

Table C-1. Summary of Legal Analysis Across SERCH States (continued)

Item No.	Subject Matter	State Law Citation	More Stringent for Patient Care	More Stringent for Population Health	Issues/Comments
20	Physician/patient relationship	AR: Ark. Rule of Evidence 503 LA: La CE Art. 510; R.S. 37:1360.64 TX: Occ Code 151.01 -This section may be cited as the Medical Practice Act; Occ Code 159.002 - Confidential communications; Occ Code 159.003 - Exceptions; Occ Code 160 - Peer review and confidentiality Case law: AL NA: FL, GA	—	—	—
21	Violation guidelines - sanctions	AR: A.C.A. §16-114-208 FL: 456.072(1)(k), F.S.; 408.051(5), F.S. LA: R.S. 40:1009 TX: 22 TAC 190; H&S Code Chp. 181 N/A: AL, GA	—	—	FL: Allows for the imposition of fines and penalties by professional licensing boards for the failure to comply with any statutory obligation
22	Statutory right to sue for damages related to health information	AR: A.C.A. §16-114-201 et seq. TX: H&S Code §611.005 [mental health records] N/A: AL, FL, GA, LA	—	—	—
23	Common law right to sue for damages related to health information	AL: Hollander v Nichols, So. 3d 184 (Ala. 2009) FL: Southern Baptist Hospital of Florida v. Welker, 908 So.2d 317, (2005); Florida Department of Corrections v. Abril, 969 So.2d 201(2007) and Gracey v. Eaker, 837 So.2d 348 (2002) LA: La. C.C. art. 2315 N/A: GA, TX, AR	—	—	FL: Florida would allow for claims for common law intentional torts such, as "Intentional Infliction of Emotional Distress" and "Invasion of Privacy." Additionally, relatively recent Florida Supreme Court decisions would also seem to allow claims for unintentional torts such as "Negligent Infliction of Emotional Distress" and "Breach of Fiduciary Duty"
24	Criminal provisions - wrongful access	FL: 760.40(2)(a), F.S., (Genetic Information), 381.004(6), F.S., (HIV and STD), 817.568(2)(a), F.S., (Criminal Use of Personal Identification) GA: OCCA §16-10-94.1 TX: TX Government Code §552.352 - Distribution or Misuse of Confidential Information N/A: AL, LA, AR	—	—	GA: Destruction, alteration, or falsification of medical records is a criminal offense

(continued)

Table C-1. Summary of Legal Analysis Across SERCH States (continued)

Item No.	Subject Matter	State Law Citation	More Stringent for Patient Care	More Stringent for Population Health	Issues/Comments
25	Retention requirements	AR: AR: A.C.A. §25-18-604 AL: Ala Admin Code 540-X-9-10 FL: 456.057(11), F.S. , (Health Care Providers); Implied, 395.3025, F.S., (Hospitals); See also regulations governing licensed health providers, 64B1-10.001, F.A.C., (Acupuncture); 64B8-10.001 - 10.004, F.A.C., (Medical Doctors); 64B15-15.001 - 15.006, F.A.C., (Osteopathic Doctors); 64B33-4.001, F.A.C., (Athletic Trainers); 64B2-17.0055 - 17.0065,F.A.C. (Chiropractors); 64B4 - 9.001 - 9.002, F.A.C.,(Licensed Clinical Social Workers, Marriage and Family Therapist and Mental Health Counselors); 64B5 - 17.002, F.A.C., (Dentists); 64B6 - 6.007, F.A.C., (Hearing Aid Specialists); 64B9 - 11.001 - 11.002, F.A.C., (Nurses); 64B13 - 3.003, F.A.C., (Optometrists); 64B17-6.0042 - 6.005, F.A.C., (Physical Therapist); 64B18 - 15.002 - 15.002, F.A.C., (Podiatrists); 64B19 - 19.002 - 19.006, F.A.C., (Psychologist); 64B20 - 9.006, F.A.C., (Speech-Language Pathologists); 64B24 - 7.014, F.A.C., (Licensed Midwife); 64J-1.014, F.A.C., (EMT). LA: R.S. 40:1299.96; R.S. 40:2144 TX: See above N/A: GA	—	—	AR: Medical records must be retained by hospitals for 10 years

(continued)

Table C-1. Summary of Legal Analysis Across SERCH States (continued)

Item No.	Subject Matter	State Law Citation	More Stringent for Patient Care	More Stringent for Population Health	Issues/Comments
26	Medical record subpoenas	AL: Ala Code §12-21-6 AR: A.C.A. §20-9-310 FL: Rule 1.351 Fla.R.Civ.P; Rule 1.360 Fla.R.Civ.P. GA: OCCA §9-11-35 LA: R.S. 13:3715.1 TX: H&S Code Cpt. 241	—	—	AR: Arkansas law contains a Notice to Sue requirement FL: Allows for the production of records, including medical records in a civil suit. The individual whose records are to be disclosed is provided an opportunity to object. When the physical or mental condition of a party to a suit is in issue the opposing party may request an examination of the other party. GA: Physical and mental examinations may be compelled by subpoena
27	Children's medical records	AR: A.C.A. §20-16-808 GA: OCGA §49-5-40 and 41 LA: CHC Arts. 1409, 1460 and 1461 N/A: AL, FL, TX	—	—	AR: Parental consent for abortion not required for emancipated minors GA: Records of child victims of abuse and deprivation are confidential
28	CMS-State plan requirements - privacy protection	AL: Ala Admin Code 560-X-7 N/A: AR, FL, GA, TX LA: (Charles Daspit)	—	—	—

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Table C-1. Summary of Legal Analysis Across SERCH States (continued)

Item No.	Subject Matter	State Law Citation	More Stringent for Patient Care	More Stringent for Population Health	Issues/Comments
29	Mental health records	AL: Ala Code §§22-50-61 and -62; Ala Code §22-56-1 et seq AR: A.C.A. §20-50-101; A.C.A. §20-46-104 FL: 394.4615, F.S. GA: OCGA §24-9-21 LA: R.S. 28:171 TX: H&S Code Chp. 611; H&S Code §181.057 [offenders with mental impairments]	—	—	AR: 50-101: Interstate Compact on Mental Health requires sending State to provide all available medical records for a patient to receiving State in regard to transferring a patient for treatment or aftercare supervision. 46-104: Allows records, statements, notes, and other information collected by individuals, private, public or governmental hospitals or agencies to disclose to Arkansas State Hospital for purposes of conducting mental health medical research. GA: Confidential communications
30	Consent to Uses & Disclosures Patient consent/ authorization	AR: A.C.A. §16-114-206 GA: OCGA §31-33-2(a)(2); OCGA §31-9-6 FL: 456.057(7)(a), F.S., 395.3025(4), F.S., and 408.051(3), F.S. See also enhanced consent requirements for "sensitive conditions" including Florida Statutes §§381.004, 385.202, 392.65, 384.29, 394.4615, 395.404, 397.501 and 760.40 LA: R.S. 13:3734; R.S. 40:1299.53; C.C.P. art. 1465.1 TX: H&S Code 44.072-73; H&S Code 47.008; H&S Code 81.103; Occ Code 159.005 (e); H&S Code 611; H&S Code 116.0072 N/A: AL	—	—	GA: Patient written consent; Consent for medical or surgical treatment
31	Disclosure of nonpublic personal information	N/A: AL, AR, FL, GA, LA, TX	—	—	—

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Table C-1. Summary of Legal Analysis Across SERCH States (continued)

Item No.	Subject Matter	State Law Citation	More Stringent for Patient Care	More Stringent for Population Health	Issues/Comments
32	Limitations on redisclosure of health information	AR: A.C.A. §12-18-620,710,910; A.C.A. §12-18-909 FL: 456.057(12), F.S., 395.3025(7)(a), F.S. TX: Occ Code 159.002c; Occ Code 201.402c; Occ Code 201.405 (e); H&S Code 181.101 (3) N/A: AL, GA, LA	—	—	AR: Child maltreatment, juvenile code, HIV and communicable disease FL: Redisclosure statement required 381.004(3)(f), F.S., (HIV test results); 397.501(7)(a), F.S.,(Substance abuse service provider records)
33	Exceptions for emergency situations	AL: Ala Code §22-11A-38 AR: A.C.A. §17-95-101 -Good Samaritan Law and A.C.A. §17-95-203 FL: 456.057(7)(a), F.S., (Implied), 397.501(7)(a)(1), F.S. (Substance Abuse Providers), 408.051(3), F.S. TX: H&S Code 773 N/A: GA, LA	—	—	—
34	Restrict uses and disclosures	TX: H& S Code 181.101(2), (3); Occ Code 159.002c; Occ Code 159.005(e) N/A: AL, AR, FL, GA, LA	—	—	—
35	Family planning services	AL: Ala Admin Code Chapter 660-5-23 AR: A.C.A. §20-16-304 TX: Fam. Code Chp. 33[minors 7 abortion]; H&S Code §[prohibited acts re abortion] N/A: FL, GA, LA	—	—	—
36	Genetic information	AL: Ala Code §22-10A-1 to-3 AR: A.C.A. §20-35-103 FL: 760.40-.60, F.S. GA: OCGA §33-54-1 (1) LA: R.S. 22:213.7 TX: Ins. Code §21.73; Labor Code-various sections re discrimination; Occ Code §§58.101-58.104	—	—	GA: Genetic information belongs to the individual whose information is at issue

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Table C-1. Summary of Legal Analysis Across SERCH States (continued)

Item No.	Subject Matter	State Law Citation	More Stringent for Patient Care	More Stringent for Population Health	Issues/Comments
37	Minors/Children Children’s medical records	AL: Ala Code §26-16-96 GA: OCCA §49-5-40; OCGA §49-4A-7 LA: CHC arts. 1409, 1460 and 1461 TX: TX Family Code §107.006 - Access to Child and Information Relating to Child; TX Family Code §58.005 - Confidentiality of Records; TX Health and Safety Code §32.017 - Maternal and Infant Health Improvement, Records and Review N/A: AR, FL	—	—	GA: (5-40) Restricted access to records of child victims of abuse, physical injury, neglect, and sexual exploitation. (4A-7): Department of Juvenile Justice required to obtain medical services for children in its custody
38	Adoption - medical history info	AL: Ala Code §22-10A-31 AR: A.C.A. §9-25-101 GA: OCGA §19-8-23(d)(1) & (2) TX: TX Family Code §162.005 - Preparation of Health, Social, Educational, and Genetic History Report; TX Family Code §162.006 - Right to Examine Records; TX Family Code §162.0065 - Editing Adoption Records in Department Placement; TX Family Code §162.007 - Contents of Health, Social, Educational, and Genetic History Report; TX Family Code §162.008 - Filing of Health, Social, Educational, and Genetic History Report; TX Family Code §162.018 - Access to Information; TX Family Code §162.021 - Sealing File; TX Family Code §162.022 - Confidentiality Maintained by Clerk; TX Family Code §162.404 - Requirement to Send Information to Central Registry; TX Family Code §162.414 - Matching Procedures; TX Family Code §162.416 - Disclosure of Identifying Information; TX H&S Code §85.082 - AIDS and HIV LA: CHC articles N/A: FL	—	—	GA: When access to information authorized due to emergency or for medical diagnosis or treatment

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Table C-1. Summary of Legal Analysis Across SERCH States (continued)

Item No.	Subject Matter	State Law Citation	More Stringent for Patient Care	More Stringent for Population Health	Issues/Comments
39	Age of majority	AL: Ala Code §26-1-1 AR: A.C.A. §9-21-101 FL: 743.07(1), F.S. GA: OCGA §39-1-1(a) LA: CC Art. 29:1124-1127.1 TX: Civ P&R Code 129.001	—	—	AR and GA: Age 18
40	Emancipated minors	AL: Ala Code §26-1-1; Ala Code §22-8-5 AR: A.C.A. §9-26-104 FL: 743.015-095, F.S. GA: OCGA §15-11-207(b)(7) LA: CC Art. 365, et seq. TX: Fam Code 31	—	—	GA: Right to authorize own health care, medical care, dental care, and mental health care
41	Age consent requirements - mental health	AL: Ala Code §26-1-1 AR: A.C.A. §20-9-602 FL: 397.501(7)(e)(1), F.S. LA: R.S. 40:1096 TX: Fam Code 32.002-004 N/A: GA	—	—	—
42	Age consent requirements - other conditions	AL: Ala Code §26-1-1; Ala Code §22-8-4 AR: A.C.A. §20-9-602 FL: 743.06, F.S. (blood donation); 743.065, F.S. (care of minor child) LA: R.S. 40:1065.1, 1095 and 1097 TX: Fam Code 32.002-004 N/A: GA	—	—	AR: Married, emancipated, incarcerated, or sufficiently intelligent to understand the consequences of their consent

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Table C-1. Summary of Legal Analysis Across SERCH States (continued)

Item No.	Subject Matter	State Law Citation	More Stringent for Patient Care	More Stringent for Population Health	Issues/Comments
43	Personal representatives/ executors	AR: A.C.A. §28-1-101, Price v. Price 253 Ark 1124, 1137 FL: 731.201(27), F.S. GA: OCGA §29-2-2(a); OCGA §15-11-13 LA: CHC art. 1553, et seq; R.S. 40:1299.53 TX: Various probate and HR code sections N/A: AL	—	—	GA: Guardian of minor same as parent for child’s health care; legal custodian of a child
44	Guardianships/ conservators	AL: Ala Code Title 26, Chapter 2A and Chapter 4 AR: A.C.A. §28-65-203 FL: Ch 744 F.S. GA: OCGA §15-11-174 LA: CHC art. 1553, et seq; R.S. 40:1299.53 TX: Fam Code 107.002; TX Family Code §153.073 - Rights of Parents at All Times; TX Family Code §153.371 - Rights and Duties of Nonparent Appointed as Sole Managing Conservator; TX Family Code §153.3721 - Access to Certain Records by Nonparent Joint Managing Conservator; TX Family Code §153.375 - Annual Report by Nonparent Managing Conservator; TX Family Code §153.376 - Rights and Duties of Nonparent Possessory Conservator; TX Family Code §153.377 - Access to Child’s Records	—	—	GA: Child advocate’s right to access child’s records

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Table C-1. Summary of Legal Analysis Across SERCH States (continued)

Item No.	Subject Matter	State Law Citation	More Stringent for Patient Care	More Stringent for Population Health	Issues/Comments
45	Behavioral health	AR: A.C.A. §20-47-201 GA: OCGA §15-11-10 N/A: AL, AR, FL, LA TX: TX Family Code §55.11 - Mental Illness Determination; Examination Juveniles; TX Family Code §55.37 - Report of Child Unfit to Proceed b/c of Mental Illness; TX Family Code §55.38 - Commitment Proceedings in Juvenile Court for Mental Illness; TX Family Code §55.39 - Referral for Commitment Proceedings for Mental Illness; TX Family Code §55.40 - Report that Child is Unfit to Proceed as a Result of Mental Retardation; TX Family Code §55.41 - Commitment Proceedings in Juvenile Court for Mental Retardation; TX Family Code §55.42 - Referral for Commitment Proceedings for Mental Retardation; TX Family Code §55.55 - Report that Child is Not Mentally Ill or Mentally Retarded; Hearing on Objection; TX Family Code §55.56 - Report that Child has mental Illness; Initiation of Commitment Proceedings; TX Family Code §55.57 - Commitment Proceedings in Juvenile Court for Mental Illness; TX Family Code §55.58 - Referral for Commitment Proceedings for Mental Illness; TX Family Code §55.59 - Report that Child has Mental Retardation; Initiation of Commitment; TX Family Code §55.60 - Commitment Proceedings in Juvenile Court for Mental Retardation; TX Family Code §55.61 - Referral for Commitment Proceedings for Mental Retardation	—	—	GA: Community-based risk reduction program and access to behavioral health records
46	Patient authorization requirements	N/A: AL, AR, FL, GA, LA, TX	—	—	—

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Table C-1. Summary of Legal Analysis Across SERCH States (continued)

Item No.	Subject Matter	State Law Citation	More Stringent for Patient Care	More Stringent for Population Health	Issues/Comments
47	Health care powers of attorney	AL: Ala Code §22-8A-1 et seq AR: A.C.A. §28-68-306 FL: Ch 765 F.S. GA: OCGA §19-9-129(a) LA: R.S. 9:975 TX: H&S Code 166	—	—	GA: Grandparent’s power of attorney for grandchild
48	Health care power of attorney - mental health	AL: Ala Code §22-8A-1 et seq AR: A.C.A. §28-68-402 FL: 765.202(5), F.S. LA: R.S. 28:221, et seq. TX: H&S Code 166 N/A: GA	—	—	—
49	Child Protective Services	AL: Ala Admin Code Chapter 660-5-34 AR: A.C.A. §12-18-614 LA: CHC arts. 603 and 609 N/A: FL, GA	—	—	AR: Authorizes DHS and law enforcement to access child’s medical records during investigation
50	Minor wards of the state	AR: A.C.A. §9-27-301 et seq. FL: 39.407, F.S. GA: OCGA §15-11-13 TX: Various Fam Code Sections N/A: AL, LA	—	—	AR: See also A.C.A. §9-34-202 re: delivery to a medical provider or law enforcement of a child 30 days old or younger
51	School-based clinics	AR: A.C.A. §6-18-703 AR: A.C.A. §6-18-703 FL: 381.0056, F.S.; 1002.22, F.S. (revised in 2009) and 1002.225, F.S. LA: R.S. 44:17 TX: TX Educ Code 38.009—Access to Medical Records; TX Educ Code 38.0095—Parental Access to Medical Records N/A: GA	—	—	AR: Requires school-based clinics to maintain accurate records for distribution and prescribing of contraception, number of pregnancies, and STDs. Records maintained are confidential medical records
52	Child health plan for certain low-income children	N/A: AL, AR, FL, GA, LA, TX	—	—	—

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Table C-1. Summary of Legal Analysis Across SERCH States (continued)

Item No.	Subject Matter	State Law Citation	More Stringent for Patient Care	More Stringent for Population Health	Issues/Comments
56 (53)	Disease/Condition Specific Provisions Genetic information	AL: Ala Code Title 22, Chapter 10A AR: A.C.A. §20-35-103 FL: 760.40-60, F.S. GA: OCGA §33-54-1(1) LA: R.S. 22:213.7, R.S. 40:1299.1 TX: Occ Code 58	—	—	GA: Genetic information is the unique property of the individual
57 (54)	HIV/AIDS information	AL: Ala Code Title 22, Chapter 11A, Article 2 AR: A.C.A. §20-15-904 FL: 381.004, F.S. GA: OCGA §24-9-40.1; OCGA §24-9-47(b); OCGA §31-22-9.1 LA: R.S. 40:1300.14, R.S. 40:4; LAC 51:11:101 TX: Gov Code 501.054; TX H&S Code §85.031 - AIDS and HIV, State Grant Program to Community Organizations; TX H&S Code §85.062 - AIDS and HIV, Eligibility; TX H&S Code §85.063 - AIDS and HIV, Procedures and Eligibility Guidelines; TX H&S Code §85.082 - AIDS and HIV, Department Voluntary Testing Programs; TX H&S Code §85.086 - AIDS and HIV, Reports; TX H&S Code §85.088 - AIDS and HIV, State-Funded Health Clinics; TX H&S Code §85.115 - AIDS and HIV, Confidentiality Guidelines; TX H&S Code §85.131 - AIDS and HIV, Research on Nursing Care; TX H&S Code §85.132 - AIDS and HIV, Demonstration Projects in Nursing Facilities; TX H&S Code §85.142 - AIDS and HIV, Adoption of Policy; TX H&S Code §85.143 - AIDS and HIV, Content of Policy; TX H&S Code §85.204 - AIDS and HIV, Modification of Practice; TX H&S Code §85.260 - AIDS and HIV, Confidentiality; H&S Code Chapter 81, Subchapter F; Ins Code 38; Ins Code 545; 25 TAC §98.111; 25 TAC §98.24; 25 TAC §98.83	—	—	GA: Confidential nature of AIDS information; duty not to disclose confidential AIDS information; limitations on who may perform HIV testing

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Table C-1. Summary of Legal Analysis Across SERCH States (continued)

Item No.	Subject Matter	State Law Citation	More Stringent for Patient Care	More Stringent for Population Health	Issues/Comments
58 (55)	Sexually transmitted disease (STD) information	AL: Ala Code §22-11A-22 AR: A.C.A. §20-15-904 FL: 384.29, F.S., 384.29, F.S. (reporting); 384.30, F.S. (minors) LA: R.S. 40:1065, R.S. 40:4; LAC 51:11:101 TX: H&S Code Chapter 81, Subchapter C; 25TAC97 N/A: GA	—	—	—
59 (56)	Hepatitis C information	AR: A.C.A. §20-13-1501 et seq. and Arkansas State Board of Health, Rules and Regulations Pertaining to Communicable Disease FL: 381.003, F.S.; 64D-3.029 FAC LA: R.S. 40:4; LAC 51:11:101 TX: TX H&S Code §94.003 - State Plan for Hep C, Department Voluntary Testing Programs N/A: AL, GA	—	—	—
60 (57)	Adult mental health	AL: Ala Code §22-56-1 et seq AR: A.C.A. §20-47-201 et seq FL: 394.4615, F.S. GA: OCGA §37-7-166(a); OCGA §43-39-16 TX: H&S Code 611(a)(3), (6), (7), (b); H&S Code Title 7 LA: See above	—	—	GA: Limitations on release of adult mental health records; privileged communications as to adult mental health records

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Table C-1. Summary of Legal Analysis Across SERCH States (continued)

Item No.	Subject Matter	State Law Citation	More Stringent for Patient Care	More Stringent for Population Health	Issues/Comments
61 (58)	Communicable disease information	AL: Ala Code Title 22, Chapter 11A; Ala Admin Code Chapter 420-4-1 AR: A.C.A. §20-9-1206 FL: 381.003, F.S. LA: R.S. 40:4, LAC 51:11:101 TX: TX H&S Code §81.003; TX H&S Code §81.021; TX H&S Code §81.024; TX H&S Code §81.041; TX H&S Code §81.043; TX H&S Code §81.044; TX H&S Code §81.045; TX H&S Code §81.046; TX H&S Code §81.047; TX H&S Code §81.048; TX H&S Code §81.049; TX H&S Code §81.050; TX H&S Code §81.051; TX H&S Code §81.052; TX H&S Code §81.061; TX H&S Code §81.064; TX H&S Code §81.065; TX H&S Code §81.081; TX H&S Code §81.084; TX H&S Code §81.085; TX H&S Code §81.090; TX H&S Code §81.095; TX H&S Code §81.102; TX H&S Code §81.103; TX H&S Code §81.169; TX H&S Code §81.182; TX H&S Code §81.183; TX H&S Code §81.184; TX H&S Code §81.203; TX H&S Code §81.306; 25 TAC 97.06; 25 TAC 97.02; 25 TAC 97.11; 25 TAC 97.13; 25 TAC 97.72; 25 TAC 97.135; 25 TAC 96.402 N/A: GA	—	—	AR: Confidentiality of health care-associated infections
62 (59)	Substance abuse	AL: Ala Code §22-56-1 et seq AR: §6-18-703 FL: 397.501(7), F.S. GA: OCGA §26-5-17 TX: H&S Code 462; H&S Code 481; H&S Code 466.7; Occ Code 504 LA: See above	—	—	AR: ADH authorized to share records of drug dependent persons to law enforcement GA: Confidentiality of records for drug treatment

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Table C-1. Summary of Legal Analysis Across SERCH States (continued)

Item No.	Subject Matter	State Law Citation	More Stringent for Patient Care	More Stringent for Population Health	Issues/Comments
63 (60)	Reproductive rights	AR: A.C.A. §20-16-301 FL: 743.065(1), F.S. (Medical services during pregnancy); 390.01114, F.S. (parental notice of abortion) TX: Fam Code 33 N/A: AL, GA, LA	—	—	AR: Authorizes Arkansas Reproductive Health Monitoring System, publishes no identifying information only statistical data
64 (61)	Adult wards of the state	AL: Ala Code Title 22, Chapter 52 FL: 410.037, F.S. (disabled adults, home care); 410.605, F.S. (disabled adults, community care) TX: Various H&S and Penal Code Sections; Gov Code 501 N/A: GA, LA, AR	—	—	—
65 (62)	Emergencies/disasters	AL: Ala Code Title 22, Chapter 12 AR: A.C.A. §20-13-209 TX: H&S Code 773.092(e)(3), (6), (7) - confidentiality of communications during provision of emergency medical services; TX Government Code §418.175 - Emergency Management, Certain Information Confidential N/A: FL, GA, LA	—	—	—
56 (63)	Organization/ Facility-Related Employers	AL: Workers Compensation: Ala Code §25-5-77 GA: OCGA §34-9-207 (a) TX: Labor Code 21 Unknown: LA N/A: AR, FL	—	—	FL: 448.076, F.S. (pre-employment sickle cell screening), 166.0444, F.S., 110.1091, F.S., 125.585, F.S. (employee assistance program) GA: Waiver by employee of privilege or confidentiality of medical records relating to workplace injury

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Table C-1. Summary of Legal Analysis Across SERCH States (continued)

Item No.	Subject Matter	State Law Citation	More Stringent for Patient Care	More Stringent for Population Health	Issues/Comments
57 (64)	Pharmacy records	AR: A.C.A. §20-64-216 FL: Ch 465 F.S.; See also 64B16-27.800 F.A.C. GA: OCGA §33-24-59.4 LA: R.S. 40:1006 TX: Occ. Code 551.003; Occ Code 562.052; 22 TAC 291.34(k) N/A: AL	—	—	AR: Records of narcotic prescriptions are confidential and shall be disclosed by pharmacists only to Federal, State, county or municipal officers whose duty it is to enforce State and Federal laws related to narcotic drugs GA: Insurers must protect confidentiality of pharmacy and medical records
58 (65)	Correctional facilities (adult)	AR: A.C.A. §12-29-401 FL: 945.10(1), F.S. GA: OCGA §42-4-4(a)(2); OCGA §42-5-2 TX: Various Penal Code sections N/A: AL Unknown: LA	—	—	AR: Dept. of Correction and Community Correction authorized to access records of incarcerated persons for treatment and insurance purposes GA: Duty of sheriff to furnish medical aid and care and access to medical care; responsibilities of government unit with custody for inmate's care including access to medical services
59 (66)	Correctional facilities (minors)	AR: A.C.A. §9-28-801 FL: 985.18, F.S. GA: OCGA §49-4A-7 TX: Various sections of Fam Code N/A: AL Unknown: LA	—	—	GA: Department of Juvenile Justice required to provide or obtain medical, surgical, hospital and dental care for minors in custody

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Table C-1. Summary of Legal Analysis Across SERCH States (continued)

Item No.	Subject Matter	State Law Citation	More Stringent for Patient Care	More Stringent for Population Health	Issues/Comments
60 (67)	Imaging labs and centers	AR: A.C.A. §17-106-103 et seq. FL: 408.07, F.S. (18) GA: OCGA §31-7-1 et seq. TX: State regs mirror Federal regs N/A: AL, LA	—	—	FL: “Diagnostic-imaging center” means a freestanding outpatient facility that provides specialized services for the diagnosis of a disease by examination and also provides radiological services. Such a facility is not a diagnostic-imaging center if it is wholly owned and operated by physicians who are licensed pursuant to chapter 458 or chapter 459 and who practice in the same group practice and no diagnostic-imaging work is performed at such facility for patients referred by any health care provider who is not a member of that same group practice.” GA: Statutory regulations of imaging centers
61 (68)	Health care facilities	AR: A.C.A. §20-9-101 et seq AL: Ala Admin Code Chapter 420-5-1 et seq GA: OCGA §31-7-285 LA: CHC art. 1416; LAC 41:1:9855 through 9861; LAC 41:1:9841; R.S. 40:2144 TX: H&S Code Title 4; H&S Code 241.152(a) FL	—	—	GA: Patients’ rights to confidentiality in health care facilities TX: Disclosure of health information by hospitals
62 (69)	School-based clinics	AR: §6-18-703 FL: 381.0056, F.S.; 1002.22, F.S. (revised in 2009) and 1002.225, F.S. TX: Educ Code 38 N/A: GA Unknown: LA	—	—	—

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Table C-1. Summary of Legal Analysis Across SERCH States (continued)

Item No.	Subject Matter	State Law Citation	More Stringent for Patient Care	More Stringent for Population Health	Issues/Comments
63 (70)	HMOs/insurance companies	AL: Ala Code §27-21A-1 et seq; Ala Admin Code Chapter 420-5-6 AR: A.C.A. §23-76-116 GA: OCGA §45-18-19 LA: R.S. 22:2020 TX: Ins Code 843	—	—	AR: HMOs required to submit annual and summary reports to insurance commissioner, complaint registries maintained. HMO required to permit Insurance Commissioner or Director of ADH to examine complaint system including medical records as necessary for protection of the public interest. GA: Confidentiality of claims forms and records in possession of insurers and health plans
64 (71)	Testing labs	GA: OCGA §31-22-2 (a) FL: 483.181(2), F.S. (clinical labs) (revised 2009) TX: State regs mirror Federal regs N/A: AL, LA, AR	—	—	GA: Clinical labs must be licensed
65 (72)	Emergency services (Ambulance/EMT)	AL: Ala Admin Code Chapter 420-2-1 AR: A.C.A. §20-13-806 FL: 401.30, F.S., 64J-1.014, F.A.C. GA: OCGA §31-11-1 thru 31-11-9 TX: H&S Code 773 N/A: LA	—	—	AR: Creates trauma registry and collects data admitted to a facility through the ER, a trauma center or directly to a special care unit GA: Emergency medical services
66 (73)	Regulatory agencies	AL: Stat Health Planning and Development Agency, Ala Admin Code Chapters 410-1-1 to 410-1-12 AR: A.C.A. §20-7-303 TX: TX Government Code §774.002 - Duty to Exchange Information; TX Health and Safety Code §12.097 - Confidentiality Requirements N/A: FL, GA, LA	—	—	AR: State Board of Health authorized to compile and disseminate health data collected by ADH, all information is to be deidentified

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Table C-1. Summary of Legal Analysis Across SERCH States (continued)

Item No.	Subject Matter	State Law Citation	More Stringent for Patient Care	More Stringent for Population Health	Issues/Comments
67 (74)	Public Health Reporting Communicable diseases	AL: Ala Code Title 22, Chapter 11A AR: A.C.A. §20-15-904 FL: 381.003, F.S. GA: OCGA §31-12-2; OCGA §31-22-7(a) LA: R.S. 40:4, LAC 51:11:101 TX: TX H&S Code §81.003; TX H&S Code §81.021; TX H&S Code §81.024; TX H&S Code §81.041; TX H&S Code §81.043; TX H&S Code §81.044; TX H&S Code §81.045; TX H&S Code §81.046; TX H&S Code §81.047; TX H&S Code §81.048; TX H&S Code §81.049; TX H&S Code §81.050; TX H&S Code §81.051; TX H&S Code §81.052; TX H&S Code §81.061; TX H&S Code §81.064; TX H&S Code §81.065; TX H&S Code §81.081; TX H&S Code §81.084; TX H&S Code §81.085; TX H&S Code §81.090; TX H&S Code §81.095; TX H&S Code §81.102; TX H&S Code §81.103; TX H&S Code §81.169; TX H&S Code §81.182; TX H&S Code §81.183; TX H&S Code §81.184; TX H&S Code §81.203; TX H&S Code §81.306	—	—	AR: Physician or other provider who tests a patient positive for HIV or other venereal disease must report test results to ADH GA: Pandemic/epidemic reporting to public health; clinical lab reporting - infectious diseases
68 (75)	Newborn screening	AL: Ala Code §22-20-3; Ala Admin Code Chapter 420-10-1 AR: A.C.A. §20-15-1504 FL: 383.14, F.S. GA: OCGA §31-12-6 LA: R.S. 40:1299.1 TX: 25 TAC 37.503(d); 25 TAC 37.50725; TAC 37.509; 25 TAC 37.51025; TAC 37.511; 25 TAC 73.21; H&S Code 47.008, 87; H&S Code §47.003; H&S Code §47.005; H&S Code §47.007; H&S Code §47.008	—	—	GA: Mandatory screening of all newborns

(continued)

Table C-1. Summary of Legal Analysis Across SERCH States (continued)

Item No.	Subject Matter	State Law Citation	More Stringent for Patient Care	More Stringent for Population Health	Issues/Comments
69 (76)	Vital records (birth/death certificates)	AL: Ala Code Title 22, Chapter 9A AR: A.C.A. §20-18-304 FL: Ch. 382.025, F.S.; 382.008, F.S. GA: OCGA §31-10-1 LA: R.S. 40:34, 44 and 47 TX: H&S Code 191, 192, 193; 25 TAC 181.9	—	—	AR: Unlawful for any person to permit inspection or disclosure of information contained in vital records or vital reports or to copy a part of any record except as authorized by statute GA: State Office of Vital Records responsible for birth and death certificates State Office of Vital Records responsible for birth and death certificates
70 (77)	Registries - cancer, disease, EMS/trauma	AL: Cancer: Ala Code §22-13-33; Head and Spinal Injury: Ala Code §22-11C-7 AR: A.C.A. §20-15-201, 401, 502 FL: 381.0011, F.S., (General Authority of Dept. of Health), 381.003(1)(e), F.S., (Immunizations), 385.202, F.S., (Cancer), 381.0031, F.S., (Diseases of Public Significance), 395.404, F.S. (Trauma Registry Data) GA: OCGA §31-11-110 (4); OCGA §31-15-5(8); OCGA §44-5-158; OCGA §31-18-1 LA: R.S. 40:1299.84, R.S. 40:31.41, et seq, R.S. 40:1065, R.S. 40:31.63, R.S. 40:31.1 TX: H&S Code §87.006; H&S Code §87.007; H&S Code §87.008; H&S Code §87.009; H&S Code §87.010; H&S Code 92; H&S Code 161; H&S Code 181; H&S Code 773.001; 25 TAC 103.3; 25 TAC 37.306, 37.511; 25 TAC 91.3; 25 TAC 157; 25 TAC §91.4	—	—	AR: Creates registries allowing reports to ADH for cancer, positive tests in newborns for PKU, hypothyroidism, galactosemia, or sickle-cell anemia, Reye's syndrome, SIDS, infant hearing screens, childhood immunizations, breast cancer GA: Acute stroke registry; cancer registry; organ donor registry; statewide registry for traumatic brain and spinal cord injuries
71 (78)	Immunization reporting	AL: Ala Code §22-11B-1 et seq AR: A.C.A. §20-15-201, 401, 502 FL: 381.003, F.S. GA: OCGA §31-12-3.1 (a); OCGA §31-12-3(a) LA: R.S. 44:17 TX: H&S Code 161	—	—	GA: Single repository for vaccination records; power to require vaccinations

(continued)

Table C-1. Summary of Legal Analysis Across SERCH States (continued)

Item No.	Subject Matter	State Law Citation	More Stringent for Patient Care	More Stringent for Population Health	Issues/Comments
72 (79)	Professional Status Health profession licensing	AL: Physicians - Ala. Admin. Code Chapter 540-X-1; Nurses - Ala. Admin. Code Chapter 610-X-1; Pharmacists - Ala. Admin. Code Chapter 680-X-1; Optometrists - Ala. Admin. Code Chapter 630-X-1; Physical Therapists -Ala. Admin. Code Chapter 700-X-1 AR: A.C.A. §17-95-201 et seq. FL: Ch. 456 F.S.,(Generally); 64B1-10.001, F.A.C., (Acupuncture); 64B8-10.001 - 10.004, F.A.C., (Medical Doctors); 64B15-15.001 - 15.006, F.A.C., (Osteopathic Doctors); 64B33-4.001, F.A.C., (Athletic Trainers); 64B2-17.0055 - 17.0065,F.A.C. (Chiropractors); 64B4 - 9.001 - 9.002, F.A.C.,(Licensed Clinical Social Workers, Marriage and Family Therapist and Mental Health Counselors); 64B5 - 17.002, F.A.C., (Dentists); 64B6 - 6.007, F.A.C., (Hearing Aid Specialists); 64B9 - 11.001 - 11.002, F.A.C., (Nurses); 64B13 - 3.003, F.A.C., (Optometrists); 64B17-6.0042 - 6.005, F.A.C., (Physical Therapist); 64B18 - 15.002 - 15.002, F.A.C., (Podiatrists); 64B19 - 19.002 - 19.006, F.A.C., (Psychologist); 64B20 - 9.006, F.A.C., (Speech-Language Pathologists); 64B24 - 7.014, F.A.C., (Licensed Midwife) GA: OCGA §43-6-7; OCGA §43-10A-7 thru 43-10A-20; OCGA §43-34-8 thru 43-34-11 LA: R.S. 37:1745.13, et seq. TX: Occ Code Title 3	—	—	GA: RN Licensing; licensing requirements for professional counselors & social workers; physician licensing
73 (80)	Health professional accreditation	AR: A.C.A. §17-95-107 N/A: AL, LA, FL, TX, GA	—	—	AR: Policies are promulgated for Centralized Credentials Verification System
74 (81)	Penalties/ Remedies Statutory right to sue for damages related to health information	GA: OCGA §16-9-93 (g)(1) TX: Various H&S Code Sections, 22 TAC sections N/A: AL, AR, FL, LA	—	—	GA: Civil damages authorized for computer invasion of privacy of medical information

(continued)

Table C-1. Summary of Legal Analysis Across SERCH States (continued)

Item No.	Subject Matter	State Law Citation	More Stringent for Patient Care	More Stringent for Population Health	Issues/Comments
75 (82)	Common law right to sue for damages related to health information	AL: Hollander v Nichols, So. 3d 184 (Ala. 2009) FL: Southern Baptist Hospital of Florida v. Welker, 908 So.2d 317, (2005); Florida Department of Corrections v. Abril, 969 So.2d 201(2007) and Gracey v. Eaker, 837 So.2d 348 (2002)'gf\? LA: La. CC art. 2315----- N/A: GA, TX, AR	—	—	—
76 (83)	Public Health Emergencies Definition of public health emergency	AL: Ala Code §31-9-3(4) AR: A.C.A. 12-75-107 FL: 381.00315, F.S. GA: OCGA §31-12-1.1 LA: R.S. 29:766 TX: Health & Safety Code §81.003(7)	—	—	GA: Public health emergency defined
77 (84)	Definition of disaster	AR: A.C.A. §12-75-103 (2) and A.C.A. §12-85-101 FL: 110.102, F.S.; 252.36, F.S. GA: OCGA §38-3-91 LA: R.S. 29:782 TX: Gov. Code §418.004(1) N/A: AL	—	—	AR: Statute defines "Disaster" as "a natural or technological event as defined in A.C.A. §12-75-103(2) where victims cannot recover without assistance when such disaster is designated at Level II or above in the American National Red Cross Regulations and Procedures FL: Definition of disaster for purposes of State employees utilizing administrative leave to serve as volunteers during disaster; emergency management powers of the Governor GA: Declaration of disaster by President or by Governor TX: includes epidemics
78 (85)	—	—	—	—	—

(continued)

Table C-1. Summary of Legal Analysis Across SERCH States (continued)

Item No.	Subject Matter	State Law Citation	More Stringent for Patient Care	More Stringent for Population Health	Issues/Comments
79 (86)	Miscellaneous Restrictions on use of social security number	AR: A.C.A. §4-110-101, PIPA FL: 119.071, (4)(a)(1), F.S., 119.071(5), F.S. 817.568, F.S., also 817.5681, F.S. (See also 690 - 128.025(1)(i), F.A.C.) GA: OCGA §10-1-398.8 TX: B&C Code 20.02; B&C Code 35.58 N/A: AL, LA	—	—	GA: Protection from disclosure of social security number
80 (87)	Health research	AR: A.C.A. §20-7-303 FL: Ch. 405, F.S., 408.061(10), F.S. GA: OCGA §24-9-40.2; OCGA §50-18-101(a); OCGA §37-4-125; OCGA §37-7-166; OCGA §33-24-59.4(b) TX: Various in Educ, H&S, and Gov Codes N/A: AL, LA	—	—	FL: Disclosures for research GA: Confidentiality of raw research data; Use of confidential records for bona fide research; Clinical records of persons with developmental disabilities; Clinical records of persons with addictive diseases; Confidentiality of medical information obtained from pharmacies by insurers

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**APPENDIX D:
TECHNICAL ANALYSIS**

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SERCH Consortium
Disaster Preparedness and HIE

June 22-23, 2011

Statewide HIE Models and HIE Services

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Availability of Statewide HIE Services Methodology

3

Established vision of fully functional statewide HIE based on the ability to search and access

- clinical summaries
- lab results
- med history

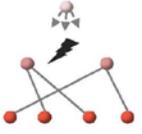
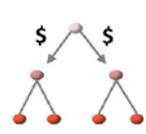
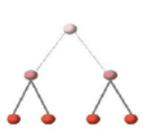
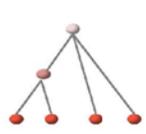
Assessed architecture considerations, deployment of statewide HIE services and implementation of Direct protocols across three intervals

Established three levels of status for statewide HIE

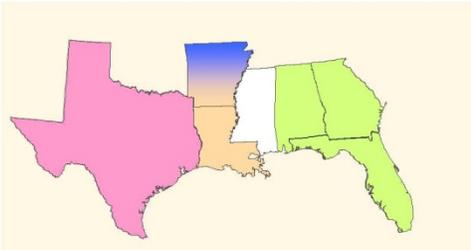
- Design (i.e., contract for statewide services signed,
- Early implementation (i.e., Pilots in accordance w/statewide HIE plan)
- Operational (i.e., statewide HIE network able to exchange data listed above to all connected nodes)

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Statewide HIE Implementation Models for State & Sub-state Interactions

Elevator	Capacity-builder	Orchestrator	Public Utility
			
<p>Overview:</p> <ul style="list-style-type: none"> • Rapid facilitation of directed exchange capabilities to support Stage 1 MU <p>Technical Considerations:</p> <ul style="list-style-type: none"> ✓ Initial phase includes promotion of directed exchange services ✓ Includes services such as provider directories or certificate authority where they could lower cost or improve services of vendor-supplied directed exchange solutions ✓ Future phase may include more robust, modular state-level shared services; 	<p>Overview:</p> <ul style="list-style-type: none"> • Bolstering sub-state exchanges thru financial & tech support, tied to performance goals <p>Technical Considerations:</p> <ul style="list-style-type: none"> ✓ Phase 1 includes development and implementation of funding program (creation of eligibility criteria, review and section process, and program monitoring and evaluation) ✓ Phase 2 may transition to Orchestrator model providing thin backbone of state-level shared services to facilitate node-to-node exchange and other value-added services 	<p>Overview:</p> <ul style="list-style-type: none"> • Thin-layer state-level network to connect existing sub-state exchanges <p>Technical Considerations:</p> <ul style="list-style-type: none"> ✓ Phase 1 includes focus on directed exchange (“push”) to connect sub-state networks in alignment w/ Stage 1 MU requirements; common core services include: (1) messaging hub, (2) security services, (3) provider directory. ✓ Phase 2, may include expansion of core infrastructure to support query/retrieve (“pull”) of patient data and other value-added services 	<p>Overview:</p> <ul style="list-style-type: none"> • Statewide HIE provides wide spectrum of HIE services directly to end-users and to sub-state exchanges <p>Technical Considerations:</p> <ul style="list-style-type: none"> ✓ Phase 1 includes connecting stakeholders to existing infrastructure and enhancements to support Stage 1 MU ✓ May include provisioning of end-user applications and other services such as hosting, training, help-desk
<p>States in This Category:</p> <ul style="list-style-type: none"> • IL, IA, OH, WI 	<p>States in This Category:</p> <ul style="list-style-type: none"> • IN, MI, NJ, TX 	<p>States in This Category:</p> <ul style="list-style-type: none"> • CA, FL, MA, MO, NH, NY, NC, OR, TN, WA 	<p>States in This Category:</p> <ul style="list-style-type: none"> • DE, ID, MD, ME, NE, NM, RI, SC, UT, VT

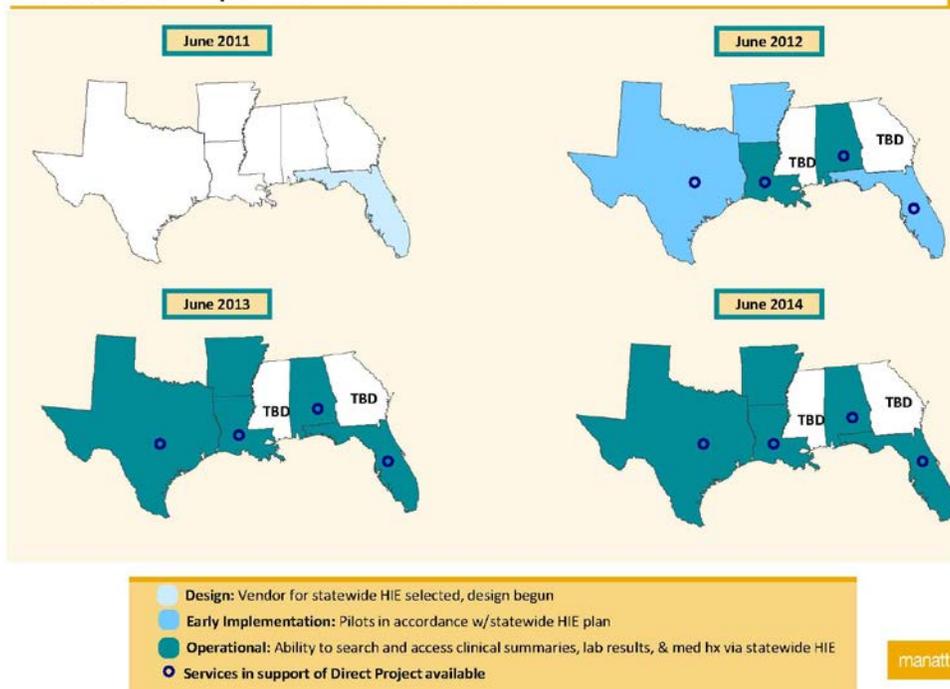
Statewide HIE Implementation Overview of Coalition Models

Elevator	Capacity-builder	Orchestrator	Public Utility
			

Findings

- Heterogeneous environment with a mix of models
- Four Coalition states (AL, AR, FL, GA) initially focusing on rapid deployment of “push” capabilities and adding “pull” capabilities over time

Statewide HIE Implementation Forecasted Expansion of Services



Availability of Statewide HIE Services Summary Findings

1. Currently very little cross border exchange

- AL: none at this time
- AR: Currently, there is no interstate HIE taking place in the state of Arkansas outside of the Trauma systems, hospitals along the borders of Oklahoma and Tennessee and limited public health related exchanges. Primarily these exchanges are not taking place in an electronic environment.
- FL: Providers exchange by FAX, courier or within closed provider systems. Participation in the NwHIN is planned with no set start date. Interstate use of Direct Secure Messaging also being explored.
- GA: The Southeastern TeleHealth Resource Center (SETRC) serves as a focal point for advancing the effective use of TeleHealth and support access to TeleHealth services in rural and underserved communities in the southeastern region of the United States.
- LA: katrinahealth.org; LINKS IIS with access from many states
- TX: None reported

2. States' capabilities to exchange data via statewide HIE services not expected to reach "critical mass" until 2013

3. Support for exchange via Direct specifications anticipated to be widely available in near term

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Data Available through Statewide HIE

Nature, Pace, and Volume

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Data Available through Statewide HIE

Overview

Methodology

- Assessed timing and volume of data from various sources
- Created three thresholds of data volume

Findings

- States planning to bring on data sources incrementally
- Claims systems readily accessible in near term, clinical systems more slowly
- Projected volume of clinical data dependent on rates of health IT adoption and participation in statewide HIE
- Real time vs. batch
 - AL = Realtime exchange. In that the HIE will not be a repository, it is expected that information exchanged will be timely, especially with direct referrals. Administrative data (e.g. claims, eligibility, etc) will be nightly updates.
 - FL = Transactions are processed real-time. However, participating networks are not required to process real-time. Minimum requirements are stated in the Subscription Agreement. As proposed: The Participant shall make its data available for a minimum look-back period of 18 months up to and including current available data and update the available data daily.
 - GA = TBD
 - LA = Objective of all interfaces is to be real-time but will accommodate batch as needed for a particular client.
 - TX = Transactions are processed by individual HIEs on either a real-time or batch mode depending on their business model.

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Data Sources Available via Statewide HIE

June 2012

10

	RHIOs	Hospitals	Practices & Clinics	Medicaid	CHIP	Commercial Payers	Public Health	Immuniz	Labs	Pharmacy
AR	NA	●	①	●	●	●	●	●	●	①
AL	TBD	○	○	●	--	●	TBD	TBD	○	① ¹
FL	TBD	○	TBD	● ²	--	● ²	TBD	TBD	--	--
GA	TBD	TBD	TBD	TBD	TBD	TBD	TBD	TBD	TBD	TBD
LA	TBD	TBD	TBD	TBD	TBD	TBD	TBD	TBD	TBD	TBD
MS	TBD	TBD	TBD	TBD	TBD	TBD	TBD	TBD	TBD	TBD
TX ³	○	○	○	●	TBD	TBD	TBD	TBD	○	○

- Less than 25% of entities exchanging data through Statewide HIE
- ① 25% -75% of entities exchanging data through Statewide HIE
- Greater than 75% of entities exchanging data through Statewide HIE

Notes

1. Alabama is planning to have access to pharmacy data through connectivity with Surescripts
2. Florida will provide access to Medicaid data through the Medicaid Health Information Network, which will continue to be a separate network
3. Texas's goal is to have 16 operational HIEs in the 2nd quarter of FFY 2012



Data Sources Available via Statewide HIE

June 2013

11

	RHIOs	Hospitals	Practices & Clinics	Medicaid	CHIP	Commercial Payers	Public Health	Immuniz	Labs	Pharmacy
AR	NA	●	●	●	●	●	●	●	●	●
AL	NA	TBD	TBD	●	--	●	●	●	○	①
FL	TBD	①	TBD	● ²	--	● ²	TBD	TBD	--	--
GA	TBD	TBD	TBD	TBD	TBD	TBD	TBD	TBD	TBD	TBD
LA	TBD	TBD	TBD	TBD	TBD	TBD	TBD	TBD	TBD	TBD
MS	TBD	TBD	TBD	TBD	TBD	TBD	TBD	TBD	TBD	TBD
TX ³	①	①	①	●	TBD	TBD	TBD	TBD	①	①

- Less than 25% of entities exchanging data through Statewide HIE
- ① 25% -75% of entities exchanging data through Statewide HIE
- Greater than 75% of entities exchanging data through Statewide HIE

Notes

1. Alabama is planning to have access to pharmacy data through connectivity with Surescripts
2. Florida will provide access to Medicaid data through the Medicaid Health Information Network, which will continue to be a separate network
3. Texas's goal is to have 16 operational HIEs in the 2nd quarter of FFY 2012



Data Sources Available via Statewide HIE

June 2014

12

	RHIOs	Hospitals	Practices & Clinics	Medicaid	CHIP	Commercial Payers	Public Health	Immuniz	Labs	Pharmacy
AR	NA	●	●	●	●	●	●	●	●	●
AL	TBD	TBD	TBD	●	--	●	●	●	○	○
FL	TBD	●	TBD	● ²	--	● ²	TBD	TBD	--	--
GA	TBD	TBD	TBD	TBD	TBD	TBD	TBD	TBD	TBD	TBD
LA	TBD	TBD	TBD	TBD	TBD	TBD	TBD	TBD	TBD	TBD
MS	TBD	TBD	TBD	TBD	TBD	TBD	TBD	TBD	TBD	TBD
TX ³	○	○	○	●	TBD	TBD	TBD	TBD	○	○

- Less than 25% of entities exchanging data through Statewide HIE
- 25% -75% of entities exchanging data through Statewide HIE
- Greater than 75% of entities exchanging data through Statewide HIE

Notes

1. Alabama is planning to have access to pharmacy data through connectivity with Surescripts
2. Florida will provide access to Medicaid data through the Medicaid Health Information Network, which will be continue to be a separate network
3. Texas's goal is to have 16 operational HIEs in the 2nd quarter of FFY 2012



Data Disclosure/Access/Consent



Data Disclosure/Access/Consent Overview

Methodology

- Collected information on the statewide privacy and security policies of each state.
- Focused on consent, particularly where consent is managed and whether states have implemented opt-in, opt-out or hybrid consent approaches.

Findings

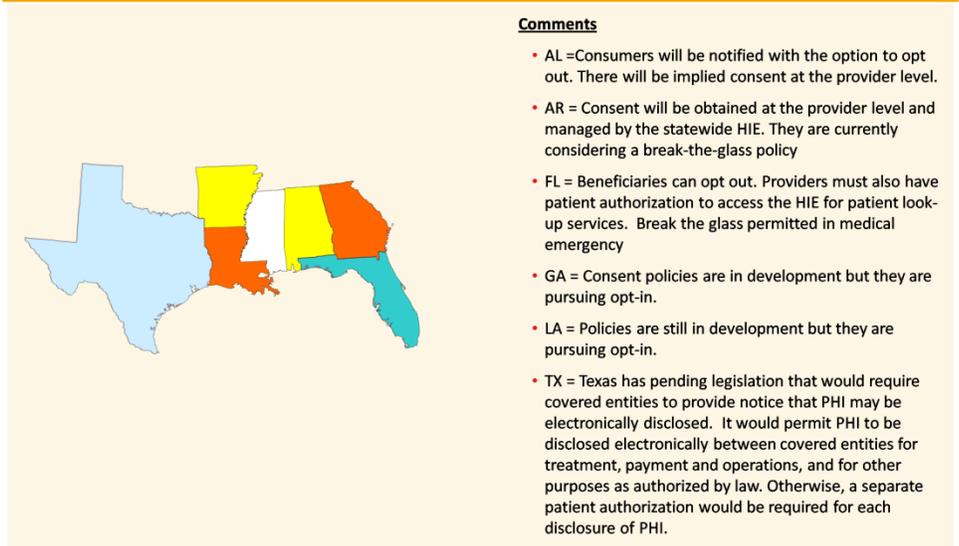
- Significant variation in states' approaches.
- Not all states have developed and approved privacy and security approaches.
- Security barriers related to authentication, authorization, access controls, and audits must be addressed, many of which have not been fully defined in the states.
- Legislation regarding privacy is pending in some states.

Other Considerations

- Provider understanding of consent policies may impede implementation of adopted policies during a disaster.
- The federal government has previously offered flexibility with respect to enforcement of privacy rules during declared emergencies.
- Some populations and certain types of data are often subject to different consent policies.



Data Disclosure/Access/Consent State Approaches



● Option 1: Opt-in	● Hybrid
● Option 2: Opt-out	● Consent Policies in Development



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APPENDIX E: TEMPLATE FOR MUTUAL AID MEMORANDUM OF UNDERSTANDING

This Memorandum of Understanding (MOU) is made and entered into by and among the signatory political Jurisdictions within the States of Alabama, Arkansas, Florida, Georgia, Louisiana, Mississippi, Tennessee, Texas and Florida (hereinafter referred to as the Southeastern Regional Consortium for Health Information Exchange (SERCH) and their respective Emergency Management Systems.

Recitals

WHEREAS, the parties to this MOU may find it necessary to exchange Protected Health Information (PHI) as that term is defined by the Health Information Portability and Accountability Act and amendments thereto for the purposes of providing health care services and treatment during Emergencies and may require the assistance of another party or other parties; and,

WHEREAS, it is desirable that the exchange of PHI between political subdivisions, municipal corporations, tribes, public health agencies, medical professionals and emergency relief workers be made available to respond to such Emergencies; and,

WHEREAS, it is desirable that each of the parties hereto should assist one another when such Emergency occurs by providing such PHI as is available and needed including the sharing of PHI and other Sensitive Health Information for the purpose of providing treatment and coordination of care, and,

WHEREAS, it is desirable that a MOU be executed for the exchange and use of certain health data in order to support treatment and coordination of care of persons displaced as a result of such Emergency and,

WHEREAS, it is desirable that the manner of authorizing exchange of such health data be resolved in advance of such Emergency;

NOW, THEREFORE, IT IS HEREBY AGREED by and between each and all of the signatories hereto as follows:

1. Purpose

The purpose of this MOU is to define the terms and procedures for the exchange of PHI which may be used among participating parties for Permitted Uses or Disclosures during an Emergency. The sharing of PHI by the parties may include sharing PHI with medical providers, emergency medical personnel, Alternate Sources of Health Care Data and others, including hospitals and clinics, and linking patients with available providers in areas where

the patients have relocated after an Emergency. In addition, the parties contemplate the sharing of PHI for the coordination of care to persons such as emergency relief workers or others that can help patients affected by an Emergency find appropriate health services. The authority for the sharing of PHI between the Parties to this MOU is based upon the Privacy Rule set out in the Health Information Portability and Accountability Act. (HIPAA), 45 C.F.R. §164.501 *et seq* and the Emergency Management Assistance Compact (EMAC), which provides that each county and incorporated city and town of a state may appropriate and expend funds, make contracts and obtain and distribute equipment, materials and supplies for emergency management purposes. Tribal contracting authority will be in accordance with each Tribe's laws.

2. Scope

The Scope of this MOU is to (1) provide the procedures to notify the Requesting and Providing Parties of the need for the exchange of health information and emergency assistance; (2) to identify available resources for health information exchange and emergency medical response; and, (3) to provide a mechanism for compensation for the utilization of resources.

3. Definitions

Alternate Sources of Health Care Data shall include other entities that may, if needed serve as a source of Health Care Data, including, but not limited to private laboratory test results, prescription history from a pharmacy or pharmacy benefit manager, and immunization registries.

Authenticated User shall mean an individual or entity authorized by the Requesting Party to request PHI for individual treatment or for coordination of care of individuals displaced to the Requesting Party's Jurisdiction. An authenticated user may also be a licensed health care provider in the Requesting Party's Jurisdiction.

Director is the Director of the ___(insert state head of EMAC)___.

Emergency or Emergencies means any disaster, emergency, or contingency situation which requires a collaborative effort among multiple Jurisdictions.

Health Care Data shall mean that information which is requested by a Requesting Party, or disclosed by a Providing Party that includes, but is not limited to protected health information, including sensitive health information as further defined in this document and as those terms are defined in 45 C.F.R. §160.103 of HIPAA, 45 C.F.R. Part 2, or other statute.

Health Care Operations shall have the meaning set forth in 45 C.F.R. §164.501.

Individual shall mean a person who is the subject of PHI, and shall have the same meaning as the term “individual” is defined in 45 C.F.R. §160.103 and shall include a person who qualifies as a personal representative in accordance with 45 C.F.R. §164.502(g).

Jurisdiction means an entity (including Political Subdivisions, as that term is defined in the several states, and tribal governments) which (1) has the authority to act, within a defined geographical area especially in times of emergency and (2) is a party to this MOU.

Memorandum of Understanding (MOU) means this document, the Southeastern Regional Consortium for Health Information Exchange Mutual Aid Memorandum of Understanding which is an addendum to the signing states’ participation in the Emergency Management Compact.

Permitted Uses or Disclosures shall mean disclosures for treatment of the individual who is the subject of the PHI requested, for payment for services rendered to the individual the subject of the PHI requested, and for Health Care Operations provided that the Requesting Party has a treatment relationship with the individual who is the subject of the PHI requested. A Requesting Party may re-disclose information about a patient the subject of a request to another Requesting Party in order to satisfy the Permitted Uses defined herein.

Prohibited Uses or Disclosure shall include the sale of PHI or re-disclosure, except for such public health or law enforcement purposes authorized by the HIPAA Privacy Rule unless written individual authorization is obtained.

Responding Party includes a Jurisdiction providing aid in the event of an Emergency. It also includes designated emergency relief providers such as the American Red Cross.

Requesting Party includes the Jurisdiction requesting aid in the event of an Emergency. It also includes designated emergency relief providers such as the American Red Cross.

Sensitive Health Information shall include health information related to substance abuse, sexually transmitted diseases, mental health, reproductive health, genetics, domestic violence, and minors.

Treatment shall have the meaning set forth at 45 C.F.R. §164.501 of the HIPAA Regulations.

4. Procedures for Requesting Assistance

A Requesting Party, which needs assistance in obtaining the PHI of displaced persons relocated to the Requesting Party’s Jurisdiction due to an Emergency is authorized to request the PHI from any party to this MOU. All requests for PHI from the Requesting Party must come from an Authenticated User of the Requesting Party’s designated agency. Requests should specify whether the Emergency is the subject of a federal or state disaster declaration, what PHI is needed, whether the PHI requested is a Permitted Use or Disclosure

and the estimated period of time during which the exchange of the PHI shall be required, if known.

5. Providing Party's Assessment of Availability of Resources and Ability to Render Assistance

Subject to the terms of this MOU, the Providing Party shall make reasonable efforts to assist the Requesting Party in providing the PHI requested. In all instances, the Providing Party shall render such PHI as it is able to provide consistent with its state laws, taking into consideration the federal guidance proved by the Office of Civil Rights in providing PHI during any Presidential declaration of Emergency. See <http://www.hhs.gov/ocr/privacy/hipaa/understanding/special/emergency/enforcementstatement.pdf>.

The Providing Party shall be the sole judge of what PHI it is able to provide and to furnish to the Requesting Party pursuant to this MOU. In addition, the Receiving Party shall certify the licensure and/or authentication of all medical professionals, hospitals, clinics, or other Emergency workers receiving PHI as requested by the Providing Party. The Parties agree that no PHI shall be used for a Prohibited Use or Disclosure.

6. Implementation Plan

Each party should develop an Emergency Operations Plan (EOP) that includes a process to provide for the effective exchange of PHI. The EOP should include a designation of data warehouses, both public and private, available during an Emergency and the Alternate Sources of Health Care Data authorized to provide or receive assistance under this MOU. A copy of the EOP should be provided to the designated contact for each state upon execution of the MOU.

7. Contact List

Each Party shall develop a contact list as outlined in Attachment A, which shall be provided to the _____ for distribution to all other parties to this MOU.

8. Reimbursement Procedures

If the Requesting Party is seeking reimbursement for health care services rendered from any government funded health care assistance program, whether local, state or federal, the Requesting Party must declare its intent to seek such reimbursement in conjunction with the request for PHI, and shall, as soon as practicable after delivery of the services for which reimbursement is sought, provide documentation verifying delivery of the services in a form approved by the Requesting Party's Jurisdiction. The Providing Party shall reimburse the Requesting Party all allowable costs and expenses as set forth in the governing statutes of the Providing Party covering payment for services rendered by the Requesting Party.

9. Personnel Compensation and Insurance

The Requesting Party and the Providing Party shall be responsible for all compensation and insurance coverage of their respective employees and equipment. Each Requesting and Providing Party shall bear the risk of its own actions, as it does with its day-to-day operations, and determine for itself what kinds of insurance, and in what amounts, it should carry.

10. Immunity

The parties shall have such immunity for inadvertent release of health data as provided by applicable state, federal or tribal law. For the duration of a disaster declaration, HIPAA regulations shall govern release of health data even if a signing state's law is more stringent.

11. Indemnification

To the fullest extent permitted by law, each party agrees to defend, indemnify, and hold harmless the other party and the other party's officers, agents, and employees from all claims, losses, and causes of actions arising out of, resulting from, or in any manner connected with the release of PHI.

12. Term

This MOU shall be effective on the date it is recorded with the Secretary of State. Except as otherwise provided in this MOU, this MOU shall terminate 10 years after the effective date. This MOU, upon mutual consent of the parties may be extended for a period of time not to exceed 10 years. Any modification or time extension of this MOU shall be by formal written amendment and executed by the parties hereto.

13. Non-Discrimination

All parties to this agreement shall not discriminate against any employee, client or any other individual in any way because of that person's age, race, creed, color, religion, gender, sexual orientation, disability, national origin, or immigration status in the course of carrying out Party duties pursuant to this MOU.

14. Compliance with Laws

Each party shall comply with all federal, tribal, state and local laws, rules, regulations, standards and Executive Orders, as applicable, without limitation to those designated within this MOU. Any changes in the governing laws, rules and regulations during the terms of this MOU shall apply but do not require an amendment.

15. Non-appropriation

Notwithstanding any other provision in this MOU, a party may terminate its participation in this MOU if for any reason the party does not appropriate sufficient monies for the purpose of maintaining this MOU. In the event of such cancellation, the terminating party shall have no further obligation to the other parties other than for payment for services rendered prior to cancellation.

16. No Third Party Beneficiaries

Nothing in the provisions of this MOU is intended to create duties or obligations to or rights in third parties not parties to this MOU or affect the legal liability of any party to the MOU by imposing any standard of care different from the standard of care imposed by law.

17. Entire Agreement

This document constitutes the entire MOU between the parties pertaining to the subject matter hereof. This MOU shall not be modified, amended, altered or extended except through a written amendment signed by the parties and recorded with the respective Secretaries of State or Tribal government as appropriate.

18. Jurisdiction

Nothing in this MOU shall be construed as otherwise limiting or extending the legal Jurisdiction of any party. Nothing in this MOU is intended to confer any rights or remedies to any person or entity that is not a party.

19. Conflict of Interest

This contract is subject to cancellation for conflict of interest pursuant to applicable state or federal law, the pertinent provisions of which are incorporated herein by reference.

20. Severability: Effect on Other Agreements

It is expressly understood that this MOU shall not supplant existing agreements between some of the parties, which do provide for the exchange or furnishing of certain types of services on a compensated basis.

21. Severability

If any provision of this MOU is held to be invalid or unenforceable, the remaining provisions shall continue to be valid and enforceable to the full extent permitted by law.

22. Responsibility of the Federal Emergency Management Agency (FEMA)

Nothing within this MOU limits or restricts the duties and obligations the FEMA may have to respond to the Emergency of any party.

23. Effective Date

This MOU shall become effective as to each party when adopted by resolution and executed by the governing body of the Jurisdiction, and shall remain operative and effective as between each and every party that has heretofore or hereafter executed this MOU, until participation in this MOU is terminated by the party. The termination by one or more of the parties of its participation in this MOU shall not affect the operation of this MOU as between the other parties thereto.

24. Execution Procedure

Execution of this MOU shall be as follows: This MOU, which will be designated as the **“Southeastern Regional Consortium for Health Information Exchange Mutual Aid Memorandum of Understanding”** shall be executed in counterparts by the governing body of each party. Upon execution, the counterpart will be filed with the Secretary of State and the Tribal government as applicable and be provided to the Director. This MOU will be effective between all parties who execute this MOU even if it is not executed by all eligible Jurisdictions.

25. Termination

Termination of participation in this MOU may be effected by any party as follows: Notice of termination will be given to the _____ 20 days prior to termination. A party shall by resolution of its governing body terminate its participation in this MOU and file a certified copy of such resolution with the Secretary of State or the Tribal government, and a copy will be provided to the _____. The parties to this MOU understand and acknowledge that this MOU is subject to cancellation by any party.

26. Dispute Resolution

In the event of any controversy, which may arise out of this MOU, the parties agree that the matter shall be arbitrated as provided in _____ or applicable Tribal law. The method of arbitration and the selection of arbitrators shall be decided by the mutual agreement of the parties at such time as arbitration services are needs.

SERCH Mutual Aid Memorandum of Understanding

Signature Page

(Name of Jurisdiction)

IN WITNESS WHEREOF, the parties hereto each sign this SERCH Mutual Aid MOU signature page. The signor warrants that he or she has been duly authorized to commit the Jurisdiction to participate in the MOU by formal approval of the Jurisdiction's governing body.

(Signing Authority)

Date

ATTEST: _____
(Attesting Authority)

Date of formal approval by governing body: _____ the attorney for the above entity has determined that the foregoing MOU is in proper form and is within the powers and authority of the entity as granted under the laws of this State and the applicable Tribal government.

(Attorney)

Date

ATTACHMENT A: Contact List (SERCH)

Points of Contact

Date:

Name of Jurisdiction:

Mailing Address:

City, State, Zip Code:

Authorized Representatives to Contact for Mutual Aid Assistance Primary Contact

1st Alternate	2nd Alternate
Name	Name
Title	Title
24-Hour Phone Number	24-Hour Phone Number
Address	Address
Day Phone Number	Day Phone Number
Night Phone Number	Night Phone Number
Fax Number	Fax Number
E-mail	E-mail
