

## **The Ohio Health Information Partnership (OHIP) Position on Patient Consent Under Review**

There is no doubt that health information technology (HIT) is changing the way physicians practice medicine. The federal government, state governments, commercial payors, other healthcare providers, and more importantly patients, are demanding that physicians embrace and use HIT. This is especially true in the areas of electronic health records (EHR) and health information exchanges (HIE).

Implementing and using EHR software and electronically exchanging health information via HIE present many different issues for physicians. EHR and HIE are inextricably tied together for many reasons, but for physicians one reason is by far the most important – to receive incentive payments for the meaningful use of EHR software, physicians are required to electronically exchange health information with other healthcare providers in various patient care delivery settings. To do this requires a functional and interoperable HIE infrastructure.

The Ohio Health Information Partnership (OHIP) is the organization heading the development and implementation of the statewide HIE infrastructure. OHIP has developed a comprehensive HIE framework and selected a HIE vendor. From all accounts, OHIP intends to implement the statewide HIE (for various core functions initially) sometime in the second half of 2011. As part of OHIP's work in developing the statewide HIE, OHIP recently published its recommendations on the issue of patient consent. These recommendations, and the ramifications that would follow, have peaked the interests of all healthcare providers.

### **I. HIE and OHIP**

The notion of electronically exchanging EHRs and other health information among physicians and other healthcare providers is not a new development. In April, 2004, President Bush established what has become known as the Office of the National Coordinator for Health Information Technology, which at that time was delegated the task to develop a nationwide HIE infrastructure for the exchange and dissemination of EHRs for all Americans. President Obama continued the federal government's push to incentivize EHR use and the development of nationwide HIE in January, 2009, just months after being elected, when he promised that all Americans would have an EHR capable of being electronically exchanged throughout the

country by 2014. At the same time, states and other local stakeholders began to explore and develop statewide and regional HIEs. For instance, local stakeholders in northeast Ohio, including AMCNO, came together in a collaborative effort known as NEO-RHIO for the purpose of implementing a secure, confidential, patient-controlled environment for a HIE in northeast Ohio.

The federal government's push to encourage EHR adoption and the development and use of a nationwide HIE infrastructure led to the passage of the HITECH Act in early 2009. The HITECH Act authorizes millions of dollars to be paid to healthcare providers to help encourage and facilitate the use of EHR software. The HITECH Act also provided millions of dollars in the form of grants to states to help fund the creation and implementation of statewide HIEs.

To date, OHIP has been awarded almost \$15 million in federal grant money to facilitate the development and implementation of a statewide HIE. According to OHIP, a true statewide HIE will permit the exchange of health information across diverse patient care delivery systems throughout Ohio. In the words of President Obama and as reiterated by OHIP, statewide HIE will support clinicians in making cost effective, fact-based decisions that reduce medical errors, decrease redundant tests and improve care coordination with the help of timely and standardized data aggregation. OHIP has a vision for the statewide HIE that will make the exchange of health records sustainable, secure and allow for physicians and other healthcare professionals to have patient authorized access to health information.

## **II. OHIP's Opt-In Framework**

OHIP recently proclaimed that one of the most important elements in developing and implementing a statewide HIE is patient consent. In February, OHIP published its recommendations for addressing patient consent issues in connection with the statewide HIE. OHIP recommended that the statewide HIE operate under an opt-in framework for patient consent.

This opt-in framework requires that patients provide express written consent to participate in the statewide HIE. In other words, patients would need to sign specific consent forms before their health information is transmitted, shared, used or accessed via the statewide HIE. OHIP's recommendation of the opt-in framework is based on OHIP's view of Ohio patient

consent laws. According to OHIP, Ohio patient consent laws require that patients provide express consent before healthcare providers are permitted to share, use or access health information for treatment purposes of the patient. OHIP's position on patient consent requirements, especially in the situations involving the use or disclosure of health information for treatment, has caused significant concern in the healthcare provider community. While the legal justification for OHIP's position on patient consent is justifiable in some instances, but not without equally applicable and pervasive counter views, OHIP's position may have a more significant affect – physicians may elect not to participate in the statewide HIE.

### **III. Consequences of OHIP's Opt-In Framework**

An opt-in framework for Ohio's statewide HIE may create operational and administrative barriers for physicians attempting to participate in the HIE. For the majority of physicians that routinely disclose health information to other medical providers involved in the care of a particular patient, a requirement that an express authorization must be obtained would require the physician to re-design critical workflow aspects of his or her practice. Physicians would need to implement policies and procedures to ensure that all necessary authorizations are obtained and would need to monitor policies and procedures to ensure effectiveness. Physicians would also need to consistently verify and re-verify that all necessary consents have been obtained before sharing information. This verification and re-verification would need to occur each time the physician would like to share information with other treatment providers. For many physicians, the expense (in both time and money) associated with redesigning critical workflows would be significant enough to deter use of the HIE.

The impact of an opt-in framework on critical workflows is most apparent considering current practice in Northern Ohio. Most physicians in Northern Ohio do not distinguish between health information exchanged in an electronic format, versus medical information exchanged through a paper-based or oral format. If specific patient consent for provider-to-provider transfers of medical information in the context of the HIE is required, consistency could require the same for all other movements of health information between providers, whether by paper, telephone communication, oral communication or otherwise. Many physicians in Northern Ohio are not, on a uniform basis, currently operating in such a manner. For example, when a primary care physician refers a patient to a specialist physician for a consultation, the primary care

physician may not obtain a separate patient consent to share the patient's medical information with the specialist for review.

In addition, physicians would need to allocate office time with patients to inform them of the aspects of the authorization and the benefits of the HIE. While not significant on a patient-by-patient basis, the aggregate amount of time educating all of the physician's patients could be significant. This time would largely be uncompensated to the physician. These additional responsibilities and requirements may cause physicians to make practical decisions to forego using the HIE in favor of other more traditional methods to disclose health information.

An opt-in framework may also hamper patients' access to timely and appropriate healthcare. In an optimum situation, physicians would access the HIE for each patient prior to providing services. The opt-in framework would create a presumption that a particular patient had refused to sign the authorization if the physician was unable to locate the patient's information via the HIE. This presumption would apply categorically across the board to all treatment disclosures. Consequently, the physician would not receive, and would certainly be hesitant in asking for, all appropriate health information from any of the patient's current or former healthcare providers.

The reservations with an opt-in framework also relate to certain risk management matters. An opt-in framework sets a standard of care for all treatment uses and disclosures, not just those uses and disclosures made through the HIE. No logical basis exists to distinguish uses and disclosures through the HIE from other non-HIE disclosures for treatment purposes. This could certainly lead to physicians concluding that they need an express authorization to discuss treatment histories and medical conditions with other physicians via the telephone.

The use of express authorizations for treatment disclosures has always been viewed by physicians as a risk management tool. Many physicians have, from a risk management standpoint, decided to implement practices that require express authorizations for treatment disclosures. These risk management practices are designed to virtually eliminate any risk or liability exposure associated with disclosing health information for treatment purposes. OHIP's opt-in framework, however, makes these risk management practices look more like standard protocol, or even worse, absolute legal mandates.

Another example of potential problems with an opt-in framework is the HIPAA requirement that physicians are not permitted to condition care on a patient's refusal to sign an authorization. This would not necessarily affect care that physicians personally provide, since physicians can certainly assure their patients that all care personally provided by the physician will be unaffected and uninterrupted. The problem lies with assuring the patient that continued, follow-up, or subsequent care provided by other healthcare professionals will be unaffected by the patient's decision to refuse signing the authorization. The failure to sign the authorization would in all instances prevent the physician from sharing health information with other providers for treatment purposes. Physicians could not be assured that their patients will receive continued, uninterrupted, and adequate care without the ability to share medical information with other treatment providers.

The opt-in framework may ultimately result in patients providing express opt-in authorizations that are not supported fully by informed consent. When authorization is required for the use and disclosure of medical information, the hallmark component of a valid authorization is that it is provided by the patient with informed consent. The physician-patient relationship is supported by a high degree of trust on the part of the patient in the physician's knowledge, care and recommendations. Because of this high level of trust, patients rarely question the recommendations of their physicians. This is especially true for recommendations and requests that the patient may view as more administrative than healthcare related. A physician's request for an authorization to disclose health information would fall into this category. As a result, patients would likely sign the authorization without fully appreciating the significance of the authorization.

Make no mistake, OHIP has performed a wonderful job to date in developing a functional and interoperable statewide HIE. Many believe that Ohio's HIE infrastructure is one of the best in the country. However, OHIP's opt-in framework for patient consent is alarming to many healthcare providers, not just physicians. The overall goal of the statewide HIE is to facilitate the electronic exchange of health information. If physicians and other healthcare providers decide not to participate due to the inherent difficulties of an opt-in framework, OHIP may never achieve this goal.

*J. Ryan Williams is a member of the health care practice group at the law firm of Walter & Haverfield LLP and may be reached at [rwilliams@walterhav.com](mailto:rwilliams@walterhav.com). This article presents general information and education on legal developments and does not constitute legal advice.*