Vermont Health Care Innovation Project
Health Data Infrastructure Meeting Agenda

March 16, 2016, 9:00-10:30am

Ash Conference Room (2nd floor above main entrance), Waterbury State Office Complex

Call-In Number: 1-877-273-4202; Passcode: 2252454

Item #	Time Frame	Topic	Presenter	Relevant Attachments	Action Needed?
1	9:00-9:10am	Welcome and Introductions; Minutes Approval	Simone Rueschemeyer & Brian Otley	Attachment 1: Draft February 17, 2016, Meeting Minutes	Approval of Minutes
2	9:10-9:20am	Project Updates • Event Notification System	Julia Sanders (PatientPing)		
3	9:20-9:50am	Discussion and Next Steps: Shared Care Plan Solution	Georgia Maheras	Attachment 3: Shared Care Plan Solution Proposal	
4	9:50-10:25am	Current Policies and Proposed Changes to 42 CFR Part 2 Requirements	Rachel Block	Attachment 4: Current Policies and Proposed Changes to 42 CFR Part 2 Requirements	
5	10:25-10:30am	Public Comment Next Steps, Wrap-Up and Future Meeting Schedule	Simone Rueschemeyer & Brian Otley	Next Meeting: Wednesday, April 20, 2016, 9:00-11:00am, Ash Conference Room (2nd floor above main entrance), Waterbury State Office Complex	

Additional Materials: February 2016 Status Reports – VHCIP Health Data Infrastructure Projects, available at http://healthcareinnovation.vermont.gov/sites/hcinnovation/files/HIE/VHCIP%20Status%20Reports%20for%20February%202016%20-%20HDI%20Focus%20Area.pdf.

Attachment 1: Draft February 17, 2016, Meeting Minutes

Vermont Health Care Innovation Project
HIE/HIT Work Group Meeting Minutes

Pending Work Group Approval

Date of meeting: Wednesday, February 17, 2016, 9:00am-11:00am, Ash Conference Room, Waterbury State Office Complex, 280 State Drive, Waterbury.

Agenda Item	Discussion	Next Steps
1. Welcome and Introductions; Minutes Approval	Simone Rueschemeyer called the meeting to order at 9:03am. A roll call attendance was taken and a quorum was present. Sue Aranoff moved to approve the January minutes by exception. Lou McLaren seconded. The minutes were approved, with one abstention (Richard Slusky).	
2. Update: Blueprint Clinical Registry	Craig Jones and Hans Kastensmith presented on the Blueprint's work to migrate the DocSite clinical registry to the new Blueprint Clinical Registry and to integrate data quality (Attachment 2). The Blueprint Clinical Registry is intended to create a triad of efforts within a learning health system: Design (to help work with providers across the state to foster primary care, moving toward a continuous improvement model health system); Implementation (to implement changes and put in supports to do that); and Research (to support health systems research going on around the state and provide the information back to providers to foster continuous improvement efforts). The clinical registry is currently receiving data from EMRs from 127 sites participating in the Blueprint program. Craig highlighted the importance of getting the data back to the source to work on data quality; key to the end game is the quality work to make the information useful to the end users. Nancy Marinelli asked if the Patient Experience survey data is coming from more sources than just the GMCB survey. Craig responded that they did look to see if they could combine other surveys from practices, etc., but the review revealed that the data (questions) were so varied that combining was too difficult. Pat Jones added that they have combined the surveys where possible to glean the broadest possible survey results.	

Agenda Item	Discussion	Next Steps
	Hans Kastensmith further described the data loading process: every time a clinical encounter occurs, the message is sent to VITL and the data is sent to the registry system, which then unwraps the data and puts the information into the Blueprint data dictionary to translate it into a consistent format. This normalizes the data so that all other extracts coming out of the system are in the same format. In the end, what the system needs need is highly structured, normalized data – the more complete the information, the better will be the information that end users are receiving. VHCURES – note the number of patients who are able to be linked to the clinical registry based on the full data set in the VHCURES database. Because the data can be tied back to the patient and the provider, this allows the linking between claims and clinical data to allow further analysis around quality measures and allows the development of models that can be given back to the medical homes for further analysis. Data extracts to the ACOs will allow ACOs to engage in quality improvement projects and do care management. Richard Slusky asked if this is duplicating the data or if it is the same thing that an ACO would see in their own systems. The Blueprint is working closely with the ACOs to avoid duplication. There also needs to be independent evaluation, outside of the work that the ACOs would do on their own. It is further likely that the ACOs and the State will be doing different things with the data. Lou McLaren asked if the unlinked practices are without EMRs – Craig and Hans clarified that it may also be a decision on the part of the practice and also that the number of unlinked practices is steadily going down as more and more practices are working on their data quality and working with VITL. Lou asked about the number of practices who will never go to EMR – is that known? Hans responded that most of them are physicians who will be retiring and don't find the value in converting for a short period of time. There are a handful of practices whose system cannot produce, for various reasons, a CCD (Continuity of Care Document.) Some are still procuring new EMRs; VITL can eventually replay the former messages to produce historical data once the system is in place. Craig also highlighted the fact that, within the data, we're beginning to see numbers that appear to be representative of the population of that general area – which means we are getting to the point of critical mass where data coming through VITL is actually representative of population health within a particular health service area. Note that this is true for many measures, but not for all. Hans provided a technical migration update: • There are several vendors involved in the project. Capitol Health Associates is managing the overall project; VITL is hosting the environment and will maintain the system/backups; MDM is doing development and standing up the system; there is also a security vendor. • Project status update: Mostly green (meaning on track); there are some delays in non-critical areas, but overall, the project is solidly on target.	

Agenda Item	Discussion	Next Steps
	• Go live on schedule for April, with a data extract to be produced on time. This data extract will be linked to the clinical data to produce the next report cards for the health service areas. This is important because the medical home payments will now be partially based on the clinical measures. A question was posed about the funding for the project. Funding is partially through the federal SIM funds ($1M for acquisition of license) and the rest was State funded through the IT fund. Covisant still owns the primary license but the State owns their own license of the software – we can't re-sell it but could develop against it. The State would have to ask permission to re-sell. Derivative works go back to Covisant, while the state maintains a perpetual license, one time, fully paid. Covisant has the right to incorporate our changes into the code, but it will likely never happen as they are getting out of this line of work and won't have the resources to devote to it. Craig also noted that the ACOs are now asking the Blueprint to re-engineer the data; the key is working together to see the use of the different data sets to drive the health system activity. The culture has changed around data use. Brian Otley asked about the real-world stories (non-technical) to relate the successes, the corners being turned, to engage more of the larger conversation around the development of the health system data. It's powerful and helps understand the value in investing in the system.	
3. Updates	Georgia Maheras provided several project updates: *Core Team update: DLTSS Gap Remediation; DA/SSA Data Quality Improvement:* The Core Team approved the DLTSS Gap Remediation project and the DA/SSA Data Quality Improvement projects at its January 29, 2016, meeting. The DLTSS Gap Remediation project is discussed further in the next agenda item. *Terminology Services:* An agreement with VITL to provide Terminology Services (focusing on improving data quality in the VITL infrastructure) will be up and running by June 30th. This will impact a large subset of the data to allow it to be further utilized across the system. Georgia also noted that four projects were under discussion recently in the HIT/HIE area. The summary is that the Core Team approved two, discussed above, and two others are still pending. The ACO Gap Remediation and ACO Data Informatics projects may come back to this group for prioritization and further steps. *Telehealth Pilots*: There are two apparent awardees. For one, contract negotiations are nearly done; the other needs federal guidance around payments made to clinicians, as it relates to Medicaid and Medicare payment to those same clinicians. A question was posed whether the delay around federal guidance will impact the timing. The response is yes – it could impact one proposal significantly and render it void. There are also discussions ongoing with the CMMI related to the timelines based on the delay.	
4. DLTSS Gap Remediation	*DLTSS Gap Remediation:* Sue Aranoff (DAIL) and Judith Franz and Christina Choquette (VITL) presented from Attachment 4.	

Agenda Item	Discussion	Next Steps
	Background – The project was initially approved by the HDI Work Group to allocate up to $800K for this purpose. The focus has been on getting the right information to the right people at the right time. The focus has been on the Home Health Agencies (HHAs) and Areas Agencies on Aging (AAAs) based on the services provided to the DLTSS population. The Core Team approved the recommendation to allocate up to $785,000 for the project over the time period of 2/15/16-12/31/16. • Year 2: $167,000 • Year 3: $618,000 Judith Franz discussed how VITL will engage with the HHAs – those remaining who need connections. Some prior work has been done in this area. There are some intricacies around merging the AAAs into the system, as they are not quite health care organizations in the common sense of the word; key is the 'treating provider' definition under HIPAA, as well as how VITL has defined roles within the VHIE. Legal is working on this. Nancy Marinelli added that there are certain types of providers in the HHAs who are considered providers and that HHAs are 'covered entities' under HIPAA. The project will be implemented in phases: HHAs will be implemented in groups – first in a discovery phase to gather more understanding around the vendors currently being used by these agencies (including Bayada and VT inpatient respite facilities). There are two phases in VITL ACCESS – to allow the HHA to view the data and use the data in delivering clinical care, as well as to send their data into the VHIE. The three phases used by VITL to implement the project: • *Profile:* Up front discovery work to fully understand the organization, staffing and roles. This is critical to establishing effective roles-based access to the system. As well, the consent process occurs in this phase as it relates to allowing providers access to patient information in the VHIE. • *Enroll*: User designation and technical set up of the various user profiles. • *Launch*: Customized for the various providers across the organization; this phase also includes training. Phases: (reference slide 9) • *Phase 1*: February 15, 2016-June 30, 2016 4 agencies – 305 users • *Phase 2*: July 1, 2016-December 31, 2016 3 agencies – 170 users • *Phase 3:* July 1, 2016-December 31, 2016 5 agencies – 125 users	

Agenda Item	Discussion	Next Steps
	A question was asked whether the agencies are ready for implementation. Judith responded that readiness work can be adjusted based on the individual organizations who may want to pause or be part of the second wave of agencies –and vice versa with those agencies who may feel more ready to participate earlier. The approach is to work through the state regionally to bring agencies together for onboarding and training in the most convenient manner possible. Brian Isham asked about the ongoing costs and whether thought been put into ongoing costs once the SIM funding is done. The response is that sustainability planning will be done throughout the year to ensure that IT investments are made sustainable.	
5. Shared Care Plan and UTP Next Steps	Georgia Maheras presented from Attachment 5: SCÜP Project – Shared Care Plans and Universal Transfer Protocol: *Background*: The goal of the project is to create a technical solution to share care plans across a multi-organizational care team. Consent plays a large role in this process and there are a wide variety of organizations who might receive a shared care plan. As well, feedback was received (see slide 3) related to the number and variety of systems being used across the health system. There is also feedback from providers related to yet another tool being proposed for use, resulting in multiple and potentially duplicate work. Finally, the project team received feedback from the State concerned with not creating many one-off systems for use and rather being more strategic in implementing tools. There are a number of in-flight systems in this area, including MMISCare and a OneCare Vermont care management tool. As well, the State has suspended the MMIS Core and Integrated Eligibility system work. This change in the technology landscape creates the need for additional due diligence to ensure that systems integrate across workflows and technology. Additionally, in Bennington, the community is working on a pilot related to the workflows using the electronic system (EHR) that they had in place already at the hospital. Their pilot work consists of giving additional personnel permissions to use the system and working out the work flows. For these reasons, the project team will be taking additional time to conduct additional discovery before bringing a proposal for next steps back to this group.	
6. Public Comment, Next Steps, Wrap-Up, and Future Meeting Schedules	There was no additional public comment. **Next Meeting:** Wednesday, March 16, 2016, 9:00-11:00am, Ash Conference Room (2nd floor above main entrance), Waterbury State Office Complex, 280 State Drive, Waterbury.	

VHCIP Health Data Infrastructure Work Group Member List

Sue 1°
Lou 2°
Motion to approve by exception
Motion carried
one abstention

Wednesday, February 17, 2016

Member		Member Alternate		Minutes	
First Name	Last Name	First Name	Last Name		Organization
Nancy	Marinelli ✓	Susan	Aranoff ✓		AHS - DAIL
		Gabe	Epstein ✓		
Joel	Benware	Dennis	Boucher		Northwestern Medical Center
		Jodi	Frei		Northwestern Medical Center
		Chris	Giroux		Northwestern Medical Center
Eileen	Underwood ✓	Peggy	Brozicevic		AHS - VDH
Amy	Cooper				HealthFirst/Accountable Care Coalition of the Green Mountains
Steven	Cummings				Brattleboro Memorial Hopsital
Mike	DelTrecco				Vermont Association of Hospital and Health Systems
Chris	Dussault	Angela	Smith-Dieng		V4A
		Mike	Hall		Champlain Valley Area Agency on Aging / COVE
Leah	Fullem ✓	Abe	Berman		OneCare Vermont
Michael	Gagnon ✓	Kristina	Choquete ✓		Vermont Information Technology Leaders
Eileen	Girling	Mary Kate	Mohlman ✓		AHS - DVHA
Dale	Hackett				Consumer Representative
Emma	Harrigan	Tyler	Blouin		AHS - DMH
		Kathleen	Hentcy		AHS - DMH
		Brian	Isham ✓		AHS - DMH
Paul	Harrington ✓				Vermont Medical Society
Stefani	Hartsfield ✓	Molly	Dugan		Cathedral Square
		Kim	Fitzgerald		Cathedral Square and SASH Program

VHCIP Health Data Infrastructure Work Group Member List

Member		Member Alternate		Minutes	Wednesday, February 17, 2016
First Name	Last Name	First Name	Last Name		Organization
Kaili	Kuiper ✓	Trinka	Kerr		VLA/Health Care Advocate Project
	Joined late ✓				
Brian	Otley ✓				Green Mountain Power
Kate	Pierce				North Country Hospital
Darin	Prail ✓	Diane	Cummings ✓		AHS - Central Office
Kim	McClellan	Todd	Bauman		DA - Northwest Counseling and Support Services
		Randy	Connelly ✓		DA - Northwest Counseling and Support Services
Ken	Gingras	Russ	Stratton		VCP - Northwest Counseling and Support Services
Sandy	Rousse	Arsi	Namdar		Central Vermont Home Health and Hospice
Julia	Shaw	Lila	Richardson		VLA/Health Care Advocate Project
Heather	Skeels	Kate	Simmons		Bi-State Primary Care
Richard	Slusky ✓	Pat	Jones ✓	A	GMCB
Chris	Smith ✓	Lou	McLaren ✓		MVP Health Care
Kelly	Lange	James	Mauro		Blue Cross Blue Shield of Vermont
	26		26		

VHCIP Health Data Infrastructure Work Group
Attendance Sheet 2/17/2016

	First Name	Last Name		Organization	Health Data Infrastructure
1	Susan	Aranoff	here	AHS - DAIL	M
2	Joanne	Arey		White River Family Practice	A
3	Ena	Backus		GMCB	X
4	Susan	Barrett		GMCB	X
5	Todd	Bauman		DA - Northwest Counseling and Support Se	MA
6	Joel	Benware		Northwestern Medical Center	M
7	Tyler	Blouin		AHS - DMH	MA
8	Richard	Boes		DII	X
9	Dennis	Boucher		Northwestern Medical Center	MA
10	Jonathan	Bowley		Community Health Center of Burlington	X
11	Jon	Brown	here	HSE Program	X
12	Peggy	Brozicevic		AHS - VDH	M
13	Martha	Buck		Vermont Association of Hospital and Health	A
14	Shelia	Burnham		Vermont Health Care Association	X
15	Wendy	Campbell		Planned Parenthood of Northern New Engl	X
16	Narath	Carlile			X
17	Kristina	Choquette	here	Vermont Information Technology Leaders	MA
18	Peter	Cobb		VNAs of Vermont	X
19	Amy	Coonradt		AHS - DVHA	S
20	Amy	Cooper		HealthFirst/Accountable Care Coalition of t	M
21	Diane	Cummings	here	AHS - Central Office	S
22	Steven	Cummings		Brattleboro Memorial Hopsital	M
23	Becky-Jo	Cyr		AHS - Central Office - IFS	X
24	Mike	DelTrecco		Vermont Association of Hospital and Health	M
25	Molly	Dugan		Cathedral Square and SASH Program	MA
26	Chris	Dussault		V4A	M
27	Jennifer	Egelhof	phone	AHS - DVHA	X
28	Nick	Emlen		DA - Vermont Council of Developmental an	X
29	Gabe	Epstein	here	AHS - DAIL	MA

30	Karl	Finison		OnPoint	X
31	Jamie	Fisher		GMCB	X
32	Kim	Fitzgerald		Cathedral Square and SASH Program	MA
33	Erin	Flynn	Phone	AHS - DVHA	S
34	Paul	Forlenza	Phone	Centerboard Consultingt, LLC	X
35	Jodi	Frei		Northwestern Medical Center	MA
36	Leah	Fullem	Phone	OneCare Vermont	M
37	Michael	Gagnon	here	Vermont Information Technology Leaders	M
38	Daniel	Galdenzi		Blue Cross Blue Shield of Vermont	X
39	Joyce	Gallimore		Bi-State Primary Care/CHAC	X
40	Lucie	Garand		Downs Rachlin Martin PLLC	X
41	Christine	Geiler	here	GMCB	S
42	Ken	Gingras		Vermont Care Partners	M
43	Eileen	Girling		AHS - DVHA	M
44	Chris	Giroux		Northwestern Medical Center	MA
45	Al	Gobeille		GMCB	X
46	Stuart	Graves		WCMHS	X
47	Dale	Hackett		Consumer Representative	M
48	Mike	Hall		Champlain Valley Area Agency on Aging / C	MA
49	Emma	Harrigan		AHS - DMH	M
50	Paul	Harrington	Phone	Vermont Medical Society	M
51	Stefani	Hartsfield	here	Cathedral Square	M
52	Kathleen	Hentcy		AHS - DMH	MA
53	Lucas	Herring		AHS - DOC	X
54	Jay	Hughes		Medicity	X
55	Brian	Isham	here	AHS - DMH	MA
56	Craig	Jones	here	AHS - DVHA - Blueprint	X
57	Pat	Jones	here	GMCB	S
58	Joelle	Judge	here	UMASS	S
59	Kevin	Kelley		CHSLV	X
60	Trinka	Kerr		VLA/Health Care Advocate Project	MA
61	Sarah	Kinsler		AHS - DVHA	S
62	Kaili	Kuiper	Phone	VLA/Health Care Advocate Project	M
63	Kelly	Lange		Blue Cross Blue Shield of Vermont	MA
64	Charlie	Leadbetter		BerryDunn	X
65	Kelly	Macnee		GMCB	MA
66	Carole	Magoffin		AHS - DVHA	S
67	Georgia	Maheras	here	AOA	S

68	Steven	Maier	here	AHS - DVHA	S
69	Nancy	Marinelli	here	AHS - DAIL	M
70	Mike	Maslack			X
71	James	Mauro		Blue Cross Blue Shield of Vermont	MA
72	Kim	McClellan		DA - Northwest Counseling and Support Se	MA
73	Lou	McLaren	here	MVP Health Care	MA
74	~~Jessica~~	~~Mendizabal~~		AHS - DVHA	S
75	MaryKate	Mohlman	here	AHS - DVHA - Blueprint	M
76	Todd	Moore		OneCare Vermont	X
77	Stacey	Murdock		GMCB	X
78	Arsi	Namdar		VNA of Chittenden and Grand Isle Counties	MA
79	Mark	Nunlist		White River Family Practice	X
80	Miki	Olszewski		AHS - DVHA - Blueprint	X
81	Brian	Otley	here	Green Mountain Power	C/M
82	Annie	Paumgarten	here	GMCB	S
83	Kate	Pierce		North Country Hospital	M?
84	Darin	Prail	here	AHS - Central Office	X
85	Amy	Putnam		DA - Northwest Counseling and Support Se	M
86	Amy	Putnam		VCP - Northwest Counseling and Support Se	M
87	David	Regan		GMCB	X
88	Paul	Reiss		HealthFirst/Accountable Care Coalition of t	X
89	Lila	Richardson		VLA/Health Care Advocate Project	MA
90	Laurie	Riley-Hayes		OneCare Vermont	A
91	~~Greg~~	~~Robinson~~		OneCare Vermont	MA
92	Sandy	Rousse		Central Vermont Home Health and Hospice	M
93	~~Beth~~	~~Rowley~~		AHS - DCF	X
94	Simone	Rueschemeyer	here	Vermont Care Network	C/M
95	Tawnya	Safer		OneCare Vermont	X
96	Larry	Sandage	here	AHS - DVHA	S
97	Julia	Shaw		VLA/Health Care Advocate Project	M
98	Kate	Simmons		Bi-State Primary Care/CHAC	MA
99	Heather	Skeels		Bi-State Primary Care	M
100	Richard	Slusky	here	GMCB	M
101	Chris	Smith	phone	MVP Health Care	M
102	Angela	Smith-Dieng		V4A	MA
103	Russ	Stratton		VCP - HowardCenter for Mental Health	M
104	Richard	Terricciano	here	HSE Program	X
105	Julie	Tessler		VCP - Vermont Council of Developmental a	X

106	Bob	Thorn		DA - Counseling Services of Addison County	X
107	Tela	Torrey		AHS - DAIL	X
108	Matt	Tryhorne		Northern Tier Center for Health	X
109	Win	Turner			X
110	Sean	Uiterwyk		White River Family Practice	X
111	Eileen	Underwood	New.	AHS - VDH	M
112	Beth	Waldman		SOV Consultant - Bailit-Health Purchasing	X
113	Julie	Wasserman		AHS - Central Office	S
114	Richard	Wasserman, MD, MPH		University of Vermont - College of Medicine	X
115	David	Wennberg		New England Accountable Care Collaborati	X
116	~~Spenser~~	~~Weppler~~		GMCB	MA
117	~~Bob~~	~~West~~		Blue Cross Blue Shield of Vermont	M
118	Kendall	West		Bi-State Primary Care/CHAC	X
119	James	Westrich		AHS - DVHA	S
120	Bradley	Wilhelm		AHS - DVHA	S
121	~~Cecelia~~	~~Wu~~		AHS - DVHA	S
122	Gary	Zigmann		Vermont Association of Hospital and Health	X
					122

Judith Franz - VITL

Tim Tremblay - Blue Print

Roger Tubby - GMCB

Mary Smith - DOC

Ben Watts - DOC

Hans Kastensmith - Vendor/BP

Attachment 3: Shared Care Plan Solution Proposal

Shared Care Plan Solution Proposal

Georgia Maheras, Esq.
Project Director
VHCIP Health Data Infrastructure Work Group
March 16, 2016

To Recap

- **Shared Care Plans** are a technical solution to share care plans across a care team.
  - Consent: Must be person-directed and allow for appropriate access across health care and non-health care organizations.
  - Business Requirements: Key features include…
    - Accessibility across the continuum of care
    - Can be integrated into existing workflows and technology
    - Logins are minimized
    - Adaptability

Process to Date

- Discovery including:
  - Dozens of key interviews (providers, IT folks).
  - Business case identification (business and technical requirements gathered).
  - Decision to NOT procure a new solution or do an RFP because there were solutions “in-flight” in 2015.
- What did we learn?
  - At least six solutions in some phase of deployment .
  - There are some major barriers: sign-on fatigue and consent being key.
  - Sustainability of the solution is a real question.

Possible Solutions to Address Barriers

- Policy/Tech solutions:
  - VHIE Consent Policy Review/Revision
- Technology Solutions:
  - MMISCare
  - Care Navigator
  - Others: Windsor, Newport, Bennington, VCHIP, and likely more

VHIE Consent Policy Review/Revision

- **State and VITL are currently reviewing the VHIE consent policy and considering revisions.**
  - This is an area of ongoing work:
    - New SAMHSA proposed rule and State discussions.
    - Building on previous work funded through the State's HIE Implementation Advanced Planning Document (IAPD), which drew on HITECH funds.
  - State and VITL will continue to collaborate in this area, with work to continue through SFY17.
    - Funding: Non-SIM federal funds, possibly SIM funding.
    - Stay tuned for future updates!

Staff Recommendation

- Proposal:
  - Do not pursue technology at this time; focus on consent and remaining HDI initiatives (including those that are approved already).

Discussion

Attachment 4: Current Policies and Proposed Changes to 42 CFR Part 2 Requirements

Current Federal Policies and Proposed Changes to 42 CFR Part 2 Requirements

Rachel Block

VHCIP Health Data Infrastructure Work Group

March 16, 2016

Disclaimer

- This is informal policy guidance and not legal advice!

Introduction

- Current Federal rules place specific restrictions on sharing of PHI relating to SA treatment (often referred to as “Part 2”) beyond “standard” HIPAA and state requirements
- SAMHSA has proposed new rules seeking to clarify and modernize these requirements
- This presentation highlights selected key policy issues with respect to the proposed rules

Consent Policy – Part 2

- Current Federal policy: Names of individuals who are receiving and disclosing information are required. The policy cannot refer generally to all participating providers. Individual providers, not just entities, need to be identified.
- Proposed Federal rule: A general designation of provider(s) receiving information is permitted but the patient must be given a list of participating providers who receive information under the general designation, and this list needs to be updated when additional providers are added. Name of program or provider disclosing Part 2 protected information is still required.

Consent Form: Part 2 Policies

- Proposed Federal Rule: The consent form must include an explicit description of the amount and kind of substance use disorder treatment information that may be disclosed.

Where Does Part 2 Apply?

- Part 2 protects the confidentiality of any patient records which are maintained in connection with the performance of any federally assisted program or activity relating to substance abuse education, prevention, training, treatment, rehabilitation, or research.
- Under the proposed rule, general medical practices are not considered “programs” except that Part 2 restrictions would apply to an identified unit and medical personnel in a general medical practice whose primary function is provision of SA treatment.

E-Rx and Prescription Drug Monitoring Programs

- "SAMHSA decided not to address issues pertaining to e-prescribing and PDMPs in this NPRM. SAMHSA concluded that the part 2 program e-prescribing and PDMPs are not ripe for rulemaking at this time due to the state of technology and because the majority of part 2 programs are not prescribing controlled substances electronically."

For more detailed information

- https://www.federalregister.gov/articles/2016/02/09/2016-01841/confidentiality-of-substance-use-disorder-patient-records
- http://www.samhsa.gov/about-us/who-we-are/laws/confidentiality-regulations-faqs
- http://www.samhsa.gov/sites/default/files/topics/health_info_tech/42-cfr-part-2-proposed-rule-webinar-slides.pdf