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The Association of Health Information Outsourcing Services (AHIOS) is pleased to submit the written testimony below to the National Committee on Vital and Health Statistics (NCVHS) Subcommittee hearing on "Minimum Necessary and the Health Insurance Portability and Accountability Act (HIPAA)".

The AHIOS group was established in 1996, with a mission to strengthen and enhance the health information management outsourcing industry while promoting excellence in handling and dissemination of confidential patient-identifiable information. To this end, a large component of our work as an organization is involved with pursuing fair and equitable treatment of the industry through legislative, regulatory, and legal processes.

Ultimately, our goal as an organization is:

- to ensure that healthcare organizations will always have cost-effective resources for outsourcing their health information functions; and
- that in outsourcing they gain not only fiscal relief but access to a cadre of specialists who have the industry's most advanced training and tools at their disposal for safeguarding one of healthcare's most precious and complex resources: *confidential patient information*.

The organization's list of member companies and the values and code of ethics may be found at www.ahios.org

We appreciate this opportunity to provide testimony to the subcommittee as part of its important roles in:

- Understanding challenges and potential areas of clarification in light of these practices;
- Review of new and emerging technology developments;
- Consideration of evolving policy direction that may be needed; and
- Identification of areas where outreach, education, technical assistance, or guidance may be useful.

Our testimony focuses on the barriers observed in meeting the minimum necessary requirements in our efforts in the ethical release of health information.

Areas Presenting the Largest Daily Industry Challenges:

1. Workers' Compensation Requests
 - a. 45 CFR 164.512(l) permits covered entities to disclose PHI to workers' compensation insurers, State administrators, employers, and other persons or entities involved in workers' compensation systems, without the individual's authorization:
 - i. As authorized by and to the extent necessary to comply with laws relating to workers' compensation or similar programs established by law that provide benefits for work-related injuries or illness without regard to fault. This includes programs established by the Black Lung Benefits Act, the Federal Employees' Compensation Act, the Longshore and Harbor Workers' Compensation Act, and the Energy Employees' Occupational Illness Compensation Program Act. See 45 CFR 164.512(l).
 - ii. To the extent the disclosure is required by State or other law. The disclosure must comply with and be limited to what the law requires.
 1. **Many states do not have laws regarding workers' compensation and the disclosure of medical records**
 - iii. For purposes of obtaining payment for any health care provided to the injured or ill worker. See 45 CFR 164.502(a)(1)(ii) and the definition of "payment" at 45 CFR 164.501.
 - b. **However, covered entities are required reasonably to limit the amount of PHI disclosed under 45 CFR 164.512(l) to the minimum necessary to accomplish the workers' compensation purpose.**
2. Electronic Medical Records (EMR)
 - a. EMRs do not always have the capability to limit unnecessary information from a print subset
 - i. If one wants to limit information, all they can do is redact records, which is a risky venture.
 - ii. Redaction often cannot be performed electronically, posing another issue.
3. Request letters are being used to narrow the scope of the broader authorization
 - a. Often reliance is given to the broader authorization for coverage because of the time and effort required to review and discern the specific information contained within the request letter.
4. Providers often utilize generic subsets of information in an effort to minimize information released, regardless of the stated specific need for minimal information.

Consideration of Evolving Policy Direction That May Be Needed:

1. EMRs need a required set of interoperability standards to ease the process of sharing minimum necessary information.
2. The following is identification of areas where outreach, education, technical assistance, or guidance may be useful.
 - a. A higher skill set/specialization is required of the staff who release patient information:
 - i. Understanding of Medical Terminology and Anatomy & Physiology for linking correct/minimum necessary information to the request need
 - ii. Understanding when a request for information may present a challenge to the minimum necessary requirement and present for technology review to eliminate challenge.
 - iii. Staff performing the release of information process should be specifically trained in this knowledge, and undergo testing of their understanding by internal evaluation modes or by use of the Certified Release of Information Specialist (CRIS) exam offered by AHIOS.
3. Inpatient, outpatient, and office records often present a challenge when attempting to identify the correct patient for an information release. A unique patient identifier would be helpful in linking the information within multiple healthcare systems and settings.
4. Data Segmentation requirements should be required of EHR systems.
 - a. Data segmentation provides a potential means of protecting specific elements of health information, both within an EHR and in broader electronic exchange environments, which can prove useful in implementing current legal requirements and honoring patient choice.
 - b. In addition, segmentation holds promise in other contexts; the electronic capture of data in structured fields facilitates the re-use of health data for operations, quality improvement, public health, and comparative effectiveness research.
 - c. Data segmentation in the health care context can support granularity of choice with respect to the following:
 - i. What specific data are eligible for exchange (from individual data elements to defined categories of data, such as all behavioral health records)
 - ii. Who has access to the information (from individual providers to other health care entities);
 - iii. Under what circumstances access is granted (e.g., emergency access, treatment, etc.); and
 - iv. For what period of time access is granted (e.g., unlimited, one-time access, etc.)

5. The source of all information contained in the patient's health record should be appropriately documented for providers to determine the reliability, quality and relevance of the data.
6. Further clarification is needed on patient directed access under 45 CFR 164.524 to a designated patient representative who is not the patient's personal representative under 45 CFR 164.502(g).
 - a. Will minimum necessary now apply to such patient directed third party requests? These normally would have been released under an authorization:
 - i. Giving the patient the right to revoke his or her authorization;
 - ii. Specifying the use of the disclosed information;
 - iii. Specifying an expiration date for the authorization via a date or event; and
 - iv. Alerting the patient to the potential for the disclosed information to be subject to redisclosure

Outreach, Education, Technical Assistance, or Guidance May Be Useful in the Following Areas:

1. Education to the requestor population on specification of information type, date ranges, authorization signatures & dates, etc.
2. Disallowing the use of "any and all information" related to a specific event or condition to be used when making a request for patient information.
3. Educate the community on the benefit of working with staff and/or vendors that provide staff specifically trained and/or certified in the specialty of releasing patient information or engage HIM credentialed employees who contain the medical education needed to perform the job correctly
4. Data Segmentation presents several challenges:
 - a. Technical considerations, including the use of structured data. Legacy systems and provider documentation practices (e.g., reliance on free-text fields) often result in the recording of unstructured data. This scenario can complicate segmentation, which relies on the documentation of information in a structured and codified manner that can be managed through the application of rules engines and other intelligence systems, and also eliminates the ease of data analysis.
 - b. Defining "sensitive information." Pre-determining categories of information can ease the implementation of segmentation – both technically and logistically – but many patients express a strong preference for systems that enable them to convey their personal preferences more fully.
 - c. Consumer engagement. Some approaches to segmentation would require and support deeper engagement on the part of the patient in determining and

assigning segmentation preferences. These require consideration not only of the capacity of patients in this respect, but also their motivation to assume responsibility for the potentially daunting tasks associated with assigning and recording such preferences.

- d. Provider reluctance in obtaining, documenting, and honoring patient preferences with respect to personal health information. They also rely on the availability of accurate and relevant health information in order to provide appropriate and high-quality care. Segmentation policies must address the needs and concerns of providers as well as patients, including their concerns regarding quality and safety of the care provisions, workflow implications, and liability.

Review of New and Emerging Technology Developments:

According to the 2016 HIMSS Connected Health Survey,ⁱ “clinical technology and consumer-oriented technology are converging around widely accepted platforms.” The survey showed that approximately half of hospital respondents used three or more connected health technologies. The top three technologies included mobile optimized patient portals (58 percent), apps for patient education and engagement (48 percent) and remote patient monitoring devices (37 percent). In addition, nearly 50 percent of respondents said their organizations would expand the use of connected health technologies.

With half of all hospitals using connected health technologies, and more than a third of those facilities relying on patient generated health data (PGHD), health care providers need to determine how to handle the deluge of data that could be coming from patients via apps, devices and portals.

PGHD has the potential to help organizations reduce costs, improve patient satisfaction and increase quality of care. Costs go down and outcomes get better when patients are engaged. More data can help enhance clinical advice. Patients trust advice more when they feel their voice is heard.

We thank NCVHS for conducting the review hearing and for providing this opportunity to submit testimony. We would be happy to answer questions or to provide any additional information.

Respectfully Submitted
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