

New York eHealth Collaborative Policy Committee Meeting
March 15, 2022
2 p.m. – 3:30 p.m.
Meeting Notes

A meeting of the NYeC Policy Committee was held on March 15, 2022. Present via telephone or videoconference were:

Policy Committee Voting Members

Art Levin, Chair, Center for Medical Consumers
Dr. Lawrence Brown, START Treatment & Recovery Centers
Dr. David Cohen, Maimonides Medical Center
Dr. Ram Raju, Health Disparities Consultant
Louann Villani, Ontrak Health
Lorna Thorpe, NYU
Taiymoor Naqi, Hixny
Steve Allen, HealtheLink
Chuck Bell, Consumer Reports
Alan Cohen, JASA

Other Attendees

Judy Mendoza, Rochester RHIO
John Sheehan, Rochester RHIO, BOC Representative
Nance Shatzkin, Bronx RHIO
Liana Prosonic, HealtheConnections
Patricia Burandt, HealtheLink
Todd Rogow, Healthix
Magdalena Mandziewska, Healthix
James Kirkwood, NYS DOH
Deirdre Depew, NYS DOH
Chelsea Sack, NYS DOH
Dan Schiller, NYS DOH
Geraldine Johnson, NYS DOH
Ken Wiczera, NYS DOH
Molly Finnerty, NYS OMH
Carmen Barber, NYS OMH
Tammy Harris, OPWDD
Meg Vijayan, OPWDD
Jennifer Rosenbaum, Office of the Aging
Alana Stelline, Office of the Aging
David Lee, New York City Department of Health and Mental Hygiene (NYCDOHMH)
Puja Khare, GNYHA
Zeynep Sumer King, GNYHA
Tom Hallisey, HANYS
Renee Olmsted, Oneida Health Care
Dr. Kirby Black, Oneida Health Care

David Horrocks, NYeC
Cindy Sutliff, NYeC
Alison Bianchi, NYeC
Don Juron, NYeC
Kathryn Lucia, NYeC
Sam Roods, NYeC
Bob Belfort, Manatt
Alex Dworkowitz, Manatt

The meeting was called to order by Mr. Levin at 2 p.m.

I. Welcome and Introductions

Mr. Levin welcomed the Committee members and provided an overview of the agenda and meeting materials. Mr. Levin introduced David Horrocks, the new CEO of NYeC. Mr. Horrocks described his background in health information technology, and he noted that he was currently CEO of CRISP, Maryland's state designated health information exchange. Other members of the Committee introduced themselves to Mr. Horrocks.

II. Federal and State Updates

Ms. Bianchi said she understood that both the state senate and assembly bills provided for level funding for the SHIN-NY, which was the same as the executive budget as released in January. She said NYeC was continuing to monitor state budget discussions.

III. DOH Update

Mr. Kirkwood said that the most recent version of the SHIN-NY policies and procedures (v3.9) have been approved and are now available on DOH's and NYeC's websites. He said DOH was still continuing to engage in significant work related to the COVID-19 response.

IV. All-In Consent Policies

Ms. Sutliff said it was the Committee's role to determine how SHIN-NY policies may be revised to advance the all-in consent framework. Mr. Levin provided a history of consent under the SHIN-NY, noting that initially the focus was on privacy and the need for public support for the SHIN-NY, and therefore statewide policies developed and approved were not very flexible. He said that given the current healthcare information technology environment advances in SHIN-NY policy development has entered a new era where flexibility and modernization are important to enable greater use and participation in the SHIN-NY.

Ms. Sutliff explained that the Committee and the NYeC board had already approved the concept of an all-in consent model, under which a consumer can sign one form that permits the sharing of

information with all of the consumer's current and future treating providers. She said some SHIN-NY policies will need to be updated and/or new ones developed as well as the development of new consent forms that comply with both HIPAA and 42 C.F.R. Part 2. She explained that under this new model, health plans and health systems will ask consumers for all-in consent, but the traditional single-provider consent model would continue to exist in parallel until critical mass was reached and the current consent model is phased out.

Mr. Dworkowitz described the SHIN-NY policies that may need to be amended to allow for the all-in consent model. For example, he noted that the provision on naming of QEs may need to be clarified to indicate that there is no requirement to name a QE on a consent form. Similarly, the policy regarding transmittals to non-participants could be clarified to permit transmittals to non-participants to occur based on an all-in consent.

Mr. Levin said an ad hoc workgroup would be convened to help refine these potential policy revisions and help move the process along as quickly as possible with recommendations to the full Policy Committee for consideration and approval.

Dr. Brown said he liked the policy of all-in consent, adding he liked the idea of options in the form. For example, he said that some patients may prefer to permit disclosures of many types of their information but not behavioral health data. Ms. Sutliff responded that a move to more granular options would occur over time. Mr. Allen noted that discussions on granularity had so far focused on the ability to select different providers, rather than the ability to select different classes of data.

Ms. Sutliff said NYeC in collaboration with Manatt was in the process of developing the new all-in consent forms, which have been presented to the QEs for their input. She said the forms would also be presented to the Committee for review.

Dr. Raju also expressed support for the concept of all-in consent. He said they needed to take into account the circumstances under which consent is obtained, particularly the fact that patients often sign whatever is put in front of them. He said it was important to keep this in mind when considering that the all-in consent can potentially be a lifelong consent. He asked whether they would want to consider a policy of re-validating consent some period of time after the consent was signed. Ms. Villani agreed, saying they do not want to ask someone to sign in the middle of a crisis. Mr. Naqi noted that there are certain safeguards built into the SHIN-NY model, and if a patient was experiencing an emergency the patient should not be asked to sign the form.

Ms. Thorpe said it could be difficult to re-consent 30 days later. Mr. Belfort said it may not be practical to send follow-up letters to thousands of patients, but sending a follow-up text message to patients about their consent selection could be more realistic.

V. Oneida Proposal

Ms. Sutliff reminded the Committee about Oneida Health's proposal, under which a provider that had broken the glass to access patient information during an emergency could continue to

have access to view what happened to the patient after the patient was transferred to another facility. She said the continued access would be for quality improvement purposes.

Ms. Sutliff said it was a good proposal and its intentions were well taken, but that the proposal needed to be further examined from a legal perspective as related to state law.

Mr. Bell asked if the patient would still be unconscious and unable to provide consent at the time of access. Ms. Olmsted, Oneida Healthcare attendee, responded that the patient will be in another facility at the time, and therefore there would be no basis for Oneida to obtain consent. She added that the second facility may obtain consent, but that consent would only apply to that second facility, not Oneida. She said that at times the attending physician will contact the other facility, and they view it more as a learning opportunity. Dr. Black noted that this often occurs in situations where a patient had a cardiac arrest and had to be transferred, and Oneida would like to know whether there was a brain bleed or other information that was relevant to understanding how the patient ultimately fared.

Dr. Raju said the purpose was not to improve the care for the particular patient who had been treated, but for future patients who may be admitted for similar reasons. Dr. Black agreed.

Mr. Allen said this was not a “break the glass” case but rather a proposed consent exception for quality improvement purposes. Ms. Olmsted agreed.

Mr. Belfort said there was no question that Oneida’s proposal was permitted under HIPAA, but noted the SHIN-NY model was to require consent even when not required under HIPAA. He noted there are other scenarios where disclosure was permitted under HIPAA but the policies still require consent.

Dr. Black noted that the SHIN-NY allows a user to access the necessary information in 2-3 minutes. He said that in 95% of cases Oneida has access because the patient has signed a consent form or it is a minor patient and a parent or guardian has signed on behalf of the minor. But in 5% of cases there is no consent. Ms. Finnerty said she applauded Oneida for being interested in what happened to its patients after they leave the emergency room.

Dr. Black said that Oneida uses Meditech, and most of the surrounding hospitals use Epic, which allows them to communicate via Care Everywhere. Mr. Naqi said they needed to think strategically about these issues, since the Epics of the world are allowing broader access than the SHIN-NY.

Dr. Brown said it was a very interesting question, and he saw both sides of the issue. He said he was looking forward to further discussions on the issue.

VI. Closing

Mr. Levin said the next meeting would take place on April 20. He thanked the Committee and adjourned the meeting.