North Carolina **Medical Society**

Established 1849 *Leadership in Medicine*

August 25, 2010

The North Carolina Health Information Exchange
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To Whom It May Concern:

On behalf of the NC Medical Society and our 12,000 physician and physician assistant members, I am writing to provide input on the draft North Carolina Statewide Health Information Exchange Operational Plan. We believe that the development of the NC Health Information Exchange (NC HIE) is an important endeavor and, if done properly, has the potential to positively improve quality, cost-effectiveness, and efficiency in the health care system.

Overall, we are pleased with the general direction outlined in the draft operational plan. We particularly like the qualified organization approach in Section 3 as it provides physicians and other health care providers with more options for connecting to the state HIE. That said, and so as not to unnecessarily delay or increase the cost of implementation, we would like to see that potential qualified organizations that meet minimum NHIN standards have some flexibility in meeting NC HIE standards that exceed those of the NHIN.

Our primary concern with regard to the operational plan relates to patient consent. We understand that the no-consent approach even for treatment purposes is less politically feasible in an era of more widespread sharing of health information electronically. However, if the overarching purpose of the NC HIE is to improve the quality, cost-effectiveness, and efficiency of health care, then the best approach (assuming appropriate standards and safeguards are in effect for those handling protected health information) is that consent would not be needed for treatment purposes—everyone and all their health information would be in the HIE (except the federally-assisted alcohol and drug abuse treatment facilities or programs, which have disclosure restrictions under federal law). The further we get from this approach, the further the NC HIE will be from maximizing its quality, cost-effectiveness, and efficiency potential.

Again, we understand that the no-consent approach may not be politically viable in an environment of electronic health information exchange where the stakes are higher with more people having access to that information. With this in mind, we can support an opt-out approach. That said, we have serious reservations about allowing for a partial opt-out whether it is giving patients the ability to prohibit specific providers from disclosing information into the HIE or to restrict access to certain information. Opt-out, whether partial or complete, will require physicians to obtain information through methods that are currently used and are widely viewed to be inefficient and burdensome (getting the information from the patient, who may or may not have or wish to provide that information, or directly from the other providers, which takes staff time and effort at both ends). The partial opt-out by provider, however, raises an additional concern if prohibited information is later incorporated or co-mingled into the record maintained by another physician (who is not prohibited by the patient from disclosing to the HIE) and that information subsequently gets disclosed into the HIE.

While the patient consent issue has received significant attention, we think that further discussion is warranted. We also suggest that we not commit to a particular opt-out approach at this time and recommend that Subsection 8.5, page 101, under **Consent for Treatment Purposes** be amended as follows:

> *The NC HIE will pursue an Opt-Out model for the exchange of patient health information through the NC HIE for treatment purposes that includes all available data from all provider types (i.e., a change in law that would allow data from mental health providers, nursing homes, adult care homes, and home health agencies to be included. ~~and that allows consumers to restrict disclosure of data to the exchange on a provider-by-provider basis. In cases where information is filtered out, records accessed by treating providers would contain a notification that the record may not be complete.~~*
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> *The NC HIE will conduct further research on the pros and cons and feasibility of allowing more granular patient control over what information is disclosed to or access through the exchange, taking into account evolving technology and with an eye toward the impact that more granular patient control may have on both provider and patient participation in the HIE.*

With regard to financing, we would like the principles under subsection 9.6 to embrace equitable cost sharing so that the smaller providers are not burdened with paying the same amount as larger, better capitalized, providers. One way to address this would be to adding the underlined language to the fourth bullet on page 117 as follows:

> *Be paid for by all participants and beneficiaries of health information exchange, including the state, in a fair and equitable manner*

We appreciate the massive effort that went into the development of the operational plan and support the general approach. We look forward to continuing to work with the NC HIE in the future.

Sincerely,

Robert W. Seligson
Executive Vice President, CEO

Copy: Douglas Sheets, MD, President
John Mangum, MD, President-Elect
Mark Bell, CIO, NCHA