

March 31, 2009

# Health Information Security and Privacy Collaboration

## HSPLC Roadmap: Analytical Framework and Collaborative Recommendations

Prepared for

**RTI International**

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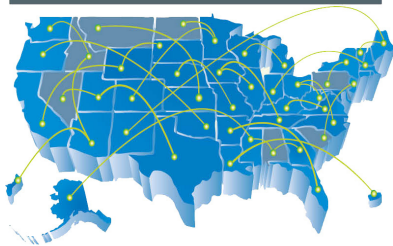
Prepared by

Harmonizing State Privacy Law Collaborative

Florida, Kansas, Kentucky, Michigan, Missouri, New Mexico, Texas

Health Information Security & Privacy

**COLLABORATION**



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# Harmonizing State Privacy Law Roadmap

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## **Acknowledgments**

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## Executive Summary

The Harmonizing State Privacy Law Collaborative (HSPLC) was formed under the Health Information Security and Privacy Collaboration (HISPC) to support the implementation of both intra- and interstate electronic health information exchange (HIE) by assisting states to identify, analyze, and address state laws that may impact HIE. State and federal laws are sometimes antiquated and can be inconsistent in terms of definitions, organizational structure, and content. While national efforts to guide HIE advancement are underway, including the development of definitions and standards, there is no definitive guidance for states to address disparity in their laws. With grassroots HIE efforts developing nationwide, states are now moving forward to address issues related to electronic health information exchange and recognize that the harmonization of state laws will be beneficial to facilitating interstate electronic health information exchange and protecting health information.

Through extensive research, the HSPLC identified best practices for categorizing, evaluating, and reforming state laws related to electronic disclosure of health information. We developed a set of tools (“Analytical Framework”) and an accompanying narrative to guide states through the process which we call the “Roadmap.” Regardless of where each state is in its legislative process, the HSPLC believes this Roadmap can be used to begin the state’s review of its privacy and security laws related to electronic health information exchange on a common basis with other states. The Roadmap includes an Analytical Framework with component tools, suggestions for engaging stakeholders, and recommendations for initial legislative priorities based on the collective experience of the HSPLC.

Two tools have been designed for this purpose:

Comparative Analysis Matrix (CAM): The CAM is a collection of almost 150 subject matter areas typically addressed by state law that involve or may impact the use and disclosure of health information (e.g., treatment disclosures, public health disclosures, payment-related disclosures). The CAM is designed to facilitate the comparison and analysis of state laws by providing a consistent and structured means for users to undertake the enormous task of identifying and assembling those laws involving the use and/or disclosure of health information. The subject matter areas serve not only as a “map” of the topics that should be considered when surveying health information law, but they also provide the organizational framework for grouping identified laws for comparison and evaluation.

Assessment Tool: The purpose of the Assessment Tool is to assist stakeholders to identify and obtain consensus on priority recommendations for legislation. This tool will enable a state to identify and analyze relevant state statutes and establish a priority order for potential statute modernization efforts. In addition, these tools have the potential to allow states to identify nonlegislative solutions to address identified issues. While the Assessment Tool provides guidance in prioritizing recommendations, through the process of careful analysis and the interaction of a stakeholder group, the exercise promotes new opportunities for consensus solutions to be identified.

Each HSPLC state participated in an initial test of the CAM and Assessment Tool. In comparing findings reported by the states, the Collaborative determined that the HSPLC states shared common legislative priorities related to needs for a core HIE law; standardizing definitions;

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standards for access to information in emergencies; standards for “universally” accepted patient authorization; standards for security; and identification, reconciliation, and clarification or removal of unique state law barriers for specially protected categories of health information.

The initial test of the CAM and Assessment Tool also identified or confirmed many positive features of the Analytical Framework, some of which were expected and some unexpected. These include the following:

Structure—As expected, one of the most potentially valuable aspects of the CAM is the identification of common subject matter topics across the states regardless of the organizational structure of state statutes. This will facilitate communication and collaboration across the states, which is a fundamental goal of the HSPLC.

Adaptability—Although the states participating in the HSPLC vary in size, resources, and experience in the HISPC, they were able to adapt the tools to their needs.

Insight—Many states were surprised that the exercise of using the tool led to new insights in their understanding of the legal landscape and the magnitude of the task.

Population Health—The HSPLC believes the CAM has great potential to serve the needs of stakeholder groups that may wish to concentrate on health information exchange to support population health issues such as quality improvement, disease management, and the ability to gather data for research purposes.

The Roadmap was designed to assist states in achieving interstate HIE. An important benefit of the Roadmap is that it encourages states to reach out to other states, where both have incorporated and used the Roadmap to conduct a review of their statutes. The HSPLC believes that states will have a greater likelihood of success in achieving legislative reform that facilitates interstate HIE if they use the Roadmap to begin to harmonize state laws and that, ultimately, all states will benefit from the development of workable information exchange standards and practices within and among states. The HSPLC will bring the Roadmap to state and national organizations for review and ask that these organizations disseminate the final Roadmap and encourage its use by states.

## HSPLC Roadmap Report:

### Introduction and Purpose

The Harmonizing State Privacy Law (HSPLC) was formed under the Health Information Security and Privacy Collaboration (HISPC) to support the implementation of both intrastate and interstate electronic health information exchange (HIE) by assisting states in identifying, analyzing, and reforming their

laws that relate to HIE.

*Extensive discussions and activities with stakeholders during the first phase of HISPC (2006–07) determined that an overall lack of clarity in legal standards, and the interpretation of those standards, has created multiple barriers to the adoption of HIE.*

Currently, state and federal laws are inconsistent in terms of definitions, organizational structure, and content, and the relevant statutes and regulations are fragmented

across many areas. In recent years, some states have adopted legislation to provide greater privacy and security protections for electronic health information exchange and electronic health records.<sup>1</sup> However, definitions and standards for electronic health records and electronic health information exchange are continuing to evolve, and while some guidance and standards are currently available, there is no clear consensus on how to best implement privacy and security protections at the state level. State-level stakeholders recognize that a greater harmonization

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<sup>1</sup> Update to October 9, 2007, Report on State Laws Related to Electronic Health Records and Electronic Health Information Exchange, Harmonizing State Privacy Law Collaborative, Health Information Security and Privacy Collaboration, June 30, 2008.



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of state laws would benefit electronic health records and electronic health information exchange and that part of the solution may be reform of state laws combined with revisions in federal laws.

Extensive discussions and activities with stakeholders during the first phase of HISPC (2006–07) determined that an overall lack of clarity in legal standards, and the interpretation of those standards, has created multiple barriers to the adoption of HIE. While certain “barriers” to the electronic exchange of health information are important to protect the individual’s privacy interests (e.g., requiring authorization to access medical information for marketing purposes), unnecessary and unintended barriers resulting from inconsistencies in state law can prevent the timely and appropriate exchange of information for individual patient medical treatment or population health activities. Whether the movement to transform health care through the adoption of health information technology involves grassroots efforts, state-specific initiatives, federal leadership, or

any combination thereof, the availability and use of common tools and resources for establishing consistent legal terminology and principles within and among states are essential elements for success.

### Research Methods

To assist states with the identification and adoption of legal standards and practices that facilitate electronic health information exchange, the HSPLC has developed a set of analytical tools and a narrative guide—presented here as a “Roadmap.” The HSPLC developed the Roadmap through

### *Principles critical for a thorough analysis of the state law in relationship to HIE:*

- 1. Laws must be surveyed.*
- 2. Laws must be logically organized.*
- 3. Laws must be analyzed in relation to HIE.*
- 4. Feasibility of changing the law must be determined.*

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extensive research to identify the best practices for identifying, evaluating, and reforming state laws related to the use and disclosure of health information, including all forms of electronic health information exchange. The HSPLC began this process by collecting and reviewing existing legal analysis documents obtained from a wide range of sources, including both HISPC member and nonmember states. Examples of collected documents include Health Insurance Portability and Accountability Act of 1996 (HIPAA) preemption analyses, deliverables from HISPC Phases I and II, and state-initiated reports. The HSPLC supplemented these documents by gathering information from online search tools for primary and secondary legal research sources such as state codes and legal periodicals. In collecting and analyzing this information, the HSPLC identified common content and organizational themes among the analyzed documents. Based on this review, the HSPLC developed consensus regarding overarching principles.

### *Four Principles*

The HSPLC determined that the following four principles are critical for a thorough analysis of the state law relationship to electronic health information exchange:

1. Laws must be surveyed.

A survey of state statutory and regulatory law involving or affecting the exchange of health information (whether paper or electronic) must be conducted.

2. Laws must be logically organized.

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Identified laws must be organized into logical subject matter areas for review and analysis.

3. Laws must be analyzed in relation to HIE.

Each law (or “gap” in the law) must be reviewed and analyzed to determine whether a change in the law would facilitate the adoption of HIE within the state and among states.

4. Feasibility of changing the law must be determined.

For laws identified as requiring change, a consistent analytical process for determining the feasibility and priority of that change must be applied.

## Overview of Roadmap Components

### ***The Comparative Analysis Matrix (CAM)***

*The CAM is designed to facilitate the comparison and analysis of state law by providing a consistent and structured means for identifying and assembling state laws involving use or disclosure of health information and comparing state law and related HIPAA provisions or other relevant federal laws.*

*The CAM contains almost 150 subject matter areas.*

In light of the four principles identified above, the HSPLC created the Roadmap to include the following key components: an Analytical Framework (“Framework”), a narrative guide to using the Framework, and a set of general recommendations for “harmonizing” state laws. The conclusion of the Roadmap describes the highlights and pitfalls of the process of creating the Roadmap as well as lessons learned by each state.

The Framework component of the Roadmap consists of two interrelated tools:

- Comparative Analysis Matrix
- Assessment Tool

### ***The Comparative Analysis Matrix (CAM)***

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The CAM is a collection of almost 150 subject matter areas typically addressed by state law that involve or may impact health information exchange (e.g., treatment disclosures, public health disclosures, payment-related disclosures). The CAM is designed to facilitate the comparison and analysis of state law by providing a consistent and structured means for users to undertake the enormous task of identifying and assembling state laws involving use or disclosure of health information and all forms of electronic health information exchange. The subject matter areas serve not only as a “map” of the topics to consider when surveying health information law but also provide the organizational framework for grouping identified laws for

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*The Assessment Tool criteria are specifically designed to measure the feasibility of implementing a recommended change in a law by evaluating factors such as:*

*how that change impacts the development and use of health information exchange;*

*the ease of reaching consensus among stakeholders regarding the change; and*

*whether the change would strengthen, weaken, or have no effect on consumer privacy protection.*

comparison and analysis purposes. A key component of the CAM is an evaluation of whether the state law is more stringent than the federal HIPAA or other relevant federal law. Since a motivating force behind efforts to implement HIE is its potential for positive impact on *both* patient care and population health, the CAM specifically asks users to analyze laws in terms of patient care and population health.<sup>2</sup>

### *The Assessment Tool*

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The Assessment Tool consists of a set of criteria for the evaluation of each law (or “gap” in the law) identified as important to the implementation of HIE. It can be used with the CAM to facilitate solution-oriented discussion in addressing the issues identified. The criteria are specifically designed to measure the feasibility of implementing a recommended change in a law by evaluating factors such as how that change impacts the development and use of health information exchange, the ease of reaching a consensus among stakeholders regarding the change, and whether the change would strengthen, weaken, or have no effect on current privacy and security protections.

The Analytical Framework (i.e., the CAM and the Assessment Tool) is fully described in this Roadmap report together with suggestions for involving stakeholders and recommendations for initial legislative priorities based on the collective experience of

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<sup>2</sup> The ONC-Coordinated Federal Health IT Strategic Plan: 2008-2012, Department of Health & Human Services, Office of the National Coordinator for Health Information Technology, June 2008.

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*Since a motivating force behind efforts to implement HIE is its potential for positive impact on both patient care and population health, the CAM provides for the separate analysis of patient care and population health.*

the HSPLC states. Our intent is that the Roadmap be used by states to begin to review their state's privacy and security laws related to health information exchange on a common basis with other states regardless of where they are in their legislative process.

The next section of this report describes the Roadmap process steps in detail. It discusses the foundational work and resources necessary to use the analytical tools most effectively, suggestions for use of the CAM and the Assessment Tool in facilitating discussions and interactions with stakeholders, and suggestions for ways to extend the process to a broader audience of policy makers and key legislative supporters.

## ***Considerations for staffing requirements:***

*Populating the CAM requires engaging legal expertise to perform the analysis.*

*Use of a Legal Work Group with specialized expertise in state health law is recommended to review the analysis for completeness and accuracy.*

*The Assessment Tool is best used in a facilitated meeting setting.*

*Expect that it will take several meetings with follow-up communications for group dynamics to produce consensus.*

## **Initial Process Steps**

### Participatory Methods

In identifying and evaluating state privacy and security laws that may affect electronic health information exchange, the process should begin with convening stakeholder organizational representatives and legal and health information technology experts. This process includes a number of steps:

1. assess existing resources, including agency leadership, to determine how this work will be coordinated with existing initiatives related to health information exchange;
2. identify or form an advisory group of stakeholders as necessary; and
3. obtain the necessary legal and staff support to complete the work.

Undoubtedly, this activity will occur in parallel with work in other areas, such as the development of interorganizational agreements, sustainable plans for coordinated HIE efforts, establishment of electronic consent processes, and outreach to consumers and providers. In addition, the legal analysis aspect of this work that will form the basis for any potential legislative recommendations will provide an educational resource for health care providers and other stakeholders.

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## Staffing Requirements

Before beginning to populate the CAM, it is important to complete an assessment of available resources in your state to complete such an analysis. Additionally, populating the CAM will require legal analysis in the context of electronic health information exchange and expert contributions from those knowledgeable in health law, the development of legislation, and electronic health information exchange. The initial work of populating the CAM is probably best accomplished through project staff with oversight from a designated review body such as a Legal Work Group (LWG) whose use in this process is highly recommended. Ideally, an attorney who has expertise in health law and is knowledgeable about the goals and challenges presented by electronic health information exchange should be engaged by the project. The attorney needs to be engaged for a sufficient allotment of time (200–250 hours) to perform the analysis and carry it forward through the review process with the LWG until there is consensus or near consensus on the contents of the CAM. Another approach would be to assign sections to volunteers from the LWG.

After the initial analysis of the CAM is complete, the LWG can assist in reviewing the analysis for completeness, ensuring that all relevant sections of law have been identified. The LWG might focus on questions or differences of opinion about areas where state law is more stringent than HIPAA and bring these issues to resolution through additional research or clarification of the applicable law.

Working with stakeholders to develop recommendations, including specific legislative proposals as well as nonlegislative recommendations, requires staffing for meeting coordination and



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facilitation. The Assessment Tool of the Analytical Framework can be self-administered but is best used in a facilitated meeting setting. A meeting facilitator can use the Assessment Tool interactively with the group. The level of resources required for meeting facilitation and project management depends on whether the group is newly formed, the prior experience of the members in addressing these issues, and the scope identified for possible legislative changes. A minimum of 250–500 combined hours for project management and facilitation may be required to achieve consensus from a diverse group of health care providers. Often, several meetings with follow-up communications are required for group dynamics to produce consensus.

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### Participatory Principles

#### ***Convening stakeholders:***

*Develop a stated mission and vision.*

*Strive for consensus, not universal agreement.*

*Take smaller steps initially, building trust.*

*Maintain neutrality and independence.*

*Address knowledge gaps around concepts.*

*Periodically reassess progress.*

The process of convening stakeholders will be unique for each state and reflect the composition of local and regional provider organizations, insurance organizations, and other entities and their inherent working relationships. The process of consensus building during the legal analysis can be straightforward and relatively short, or protracted and at times contentious.

The key is to remain focused on the long-term objective: to recommend feasible legislative changes and build continuing support and informed advocacy for both legislative and nonlegislative recommendations and actions.

Participatory and consensus building concepts are based on respect for the process and all participants. In managing stakeholder groups, it is important to:

- Develop a stated mission and vision and refer to them as needed to remind everyone of their agreement toward the larger goal.
- Recognize that unanimous support is unlikely; however, consensus among a critical mass is realistic.
- Take smaller steps in the beginning. Build a history of cooperation and increased trust while viewing each step in the process as a stepping stone to the next larger step.

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### ***Work Groups, state-designated steering committee, composition:***

*Include a range of stakeholders that might be affected by the proposed legislation:*

*providers;*

*payers; and*

*units of state government.*

*Attorneys who specialize in health law will bring needed expertise.*

*Consumer advocates with alternative or opposing viewpoints should be included from the outset.*

*Include people who have experience with the legislative process.*

- Ensure a process that maintains neutrality and independence in convening the group. This provides an environment where stakeholders will feel more confident that their individual perspectives will be addressed and each will feel more committed to the overarching goal of legislative changes.
- Address gaps around concepts related to health information technology and legal requirements to provide participants with an understanding of the underpinnings and implications of their decisions.
- Maintain transparency to support trust among stakeholders.
- Periodically reassess progress and expectations, and make adjustments as needed while maintaining focus on the larger objective of successful legislative changes.

The selection of knowledgeable and committed participants in the formal oversight committees is important for the success of the process. States that have participated in HIPSC will have a state-designated steering committee that can be engaged by forming subcommittees or through the creation of additional Work Groups such as a Legal Work Group. Generally, it is best to include a wide range of stakeholders that might be affected by the proposed legislation, including providers, payers, and representatives from relevant state government agencies and departments. Attorneys specializing in health law can bring needed expertise. Consumer advocates, notably those with alternative or opposing viewpoints, should be included from the outset. Include people with experience with the legislative

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process who can assist when the initiative is ready to be put forward in a legislative proposal.

It is usually helpful to give people an idea of the time commitment, such as the number of meetings to be held and expectations regarding work assignments. Keep in mind that individuals representing stakeholder associations may need time to obtain approvals or will need to issue a disclaimer that allows some discussion without committing their organization to a particular position. Even though associations may be constrained in their ability to participate, a broader base of support will be obtained by involving stakeholder associations.

Once the process for stakeholder participation has been created, the next step is to conduct a comprehensive assessment of state laws related to the use and disclosure of electronic health records. The Analytical Framework can be used to assist this process.

### ***State Experience Notes (Florida):***

*The Florida Legal Working Group consists of 25 members from diverse backgrounds including medical, legal, consumers, information technology and other stakeholders. Membership includes the Florida Hospital Association, Florida Medical Association, Florida Justice Association, Florida Department of Health, health plans, AARP, and others. The members hold extensive expertise and knowledge in the areas of law, health care, and legislation. The diversity of the group ensures a range of viewpoints in developing recommendations.*

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## *Application of Analytical Framework:*

### *Guide to Use With Stakeholders*

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The Analytical Framework is designed to give states a common approach to analyze state laws while providing some flexibility in the assessment of priorities. States differ in the development of regional health information organizations, state-level health information organizations, and in their priorities for advancing health information technology–related initiatives. The Analytical Framework can be used by states to address intrastate issues or in multistate collaborative efforts to address interstate issues.

While the Analytical Framework can be used in different ways, certain approaches and steps in the process are recommended for best results. Regardless of how the analytical tool is to be applied, the first step is to populate the Comparative Analysis Matrix with citations to applicable legal authority. This is a foundational step that will accrue greater benefits as more states complete the process.<sup>3</sup>

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<sup>3</sup> A copy of the CAM is included in the Appendix of this report. The Analytical Framework (CAM and Assessment Tool) and completed CAMs for each state participating in the Collaborative will be posted on their websites as listed in the Appendix.

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## Comparative Analysis Matrix

Key steps in the process of populating the CAM are as follows:

1. Review the Subject Matter categories of the CAM and prepare to work within the categories provided by becoming familiar with the organization structure.
2. Review the definitions of patient-focused health care and population health attached to the CAM. These definitions are from the Office of the National Coordinator for Health Information Technology-Coordinated Federal Health IT Strategic Plan: 2008–12.
3. Populate the CAM with each applicable state law and compare to HIPAA or other relevant federal or state laws, including references.
4. Identify any relevant gaps in law. It is possible that there may be certain subject matter categories where there is no applicable state law thereby creating a potential gap (“gaps”).<sup>4</sup>
5. Consult with health law experts and other stakeholders and revise the contents of the CAM, including the identification of gaps, as necessary.
6. Obtain agreement from health law experts and other stakeholders on any laws considered to be more stringent

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<sup>4</sup> As used by the HSPLC in this process, a “gap” is an area of the law that is silent or otherwise ambiguous with respect to HIE and that results in a barrier to the implementation or use of HIE within the state.

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than HIPAA or other relevant federal laws, as these laws relate to patient-focused health care.

7. Obtain agreement from health law experts and other stakeholders on any laws considered to be more stringent than HIPAA or other relevant federal laws, as these laws relate to *population health*.

The review process may be extended to a wider range of stakeholders prior to finalizing the CAM analysis.

Once the CAM is completed, the analysis can be extended in a number of ways to accommodate the needs of the respective state initiative. The Analytical Framework includes an Assessment Tool, in two alternate formats, for assessing the benefits and feasibility of making legislative changes. The Assessment Tool, developed by the HSPLC, contains five criteria to evaluate the impact of changes in law(s) to facilitate electronic health information exchange and the feasibility of changing specific state laws to better address an electronic environment.

### Assessment Tool

Initially, stakeholders may decide to focus on specific subject matter areas where there is a need or perceived need for legislative action to begin the process. Alternatively, stakeholders may elect to use the Assessment Tool across all subject matter categories that relate to electronic health information exchange. Stakeholders should also have an opportunity to decide where they will focus their efforts and, to the extent practicable, the venue for the assessment process, which may be meetings, conference calls, or through e-mail.

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### ***The Assessment Tool***

*Whereas the CAM is designed for consistency in use, the Assessment Tool may be modified to fit user preferences. Two alternate formats of the Assessment Tool are provided:*

#### *Multi Score Format*

*Score factors related to the feasibility and significance of making a change in the law.*

#### *Single Score Format*

*Focus on discussion of relative importance of criteria. May encourage greater participation in the process since stakeholders are not required to submit and, possibly later, defend multiple individual scores.*

Based on the experience of the HSPLC, it is important that all stakeholders involved receive consistent guidance on the intent, scoring, and definitions of the Assessment Tool.

The Assessment Tool may be used exactly as contained in this Roadmap or modified as agreed by stakeholders. Modification could include adding, deleting, or revising the review or assessment criteria; changes to the scoring process; or other changes the group views as beneficial in encouraging participation and reaching a consensus. The Roadmap contains two alternative Assessment Tool formats (see Appendix) which can be used as stakeholders determine which format best fits their needs:

#### Multi Score Format

The Multi Score Format can be used by individuals (or groups) to score factors related to the feasibility and significance of making changes in the law to facilitate electronic health information exchange. This format could be used in a facilitated session with a focus on specific criteria as the discussion proceeds. It also offers more precision in the assessment process that may be informative to the group. Preliminary scoring may also be completed by staff and reviewed and revised through a group process.

#### Single Score Format

The Single Score Format can be used by individuals or groups to identify the most important factors in assessing a proposed change in law and its priority rank. This format could be used in a group setting where the group decides the priority rank through facilitated discussion for each proposed change in a law after completing the tool individually. It provides less quantitative



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documentation than the Multi Score Format and may encourage greater participation in the process since stakeholders are not required to submit and, possibly later, defend multiple individual scores.

The purpose of the Assessment Tool is to assist stakeholders in identifying and obtaining consensus on priority recommendations for legislation or other nonlegislative solutions. It is important that the tool serves the needs of the group. It is possible that through the process of careful analysis, and the interaction of the group, new opportunities for consensus solutions will be identified. Once stakeholders determine their priority recommendations, the Analytical Framework can inform a wider audience of stakeholders and assist in gaining their support.

### ***State Experience Notes (Kansas):***

In testing the CAM the Kansas Legal Work Group felt that the specific "purpose" of the tool needed to be very clearly laid out.

- Is the purpose technical in nature (i.e., to identify laws needing to be removed or revised as a result of antiquated language or lack of enforcement or relevance)?
- Or is the purpose to facilitate change in health information policy, and if so, what policy?
- Must ask: **"Why are we asking for change?"**
- Group members need to have a clear idea as to why they were evaluating and ranking the laws, and how their analysis would be used.

### *Engaging the legislature:*

*Review the legislature website for:*

*legislature session and schedule; and deadlines for bill filing and significant legislative dates.*

### **Outreach Strategy—Engaging Stakeholders in the Legislative Process**

Taking an idea and successfully turning that idea into a bill which can then become law requires a much deeper knowledge of how your legislature operates.

The first step is to understand the legislative process in your state. Different state legislatures are in session for different periods of time and have different leadership structures. Finding out when the legislature is in session and its schedule, how each chamber is run, whether there are key legislative leaders whose support will be critical, and how a bill is drafted are essential pieces of information to have before planning a trip to the capitol. Reviewing basic website information on deadlines for bill filing and significant legislative dates will also be helpful. Talking to lobbyists or politically savvy people in your Work Groups will provide an understanding of how and when to approach the legislature.

Also consider the roles that the governor, the governor's office, and state agencies, such as the department of health, play in the legislative process. Particularly for those of us involved in the HISPC project, which has been conducted by groups designated by governors, it is important to communicate with the governor's office and determine what role, if any, the governor's office can or may take in facilitating successful adoption of the bill. If state agencies are responsible for implementation, they will likely take their lead from the governor's office.

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### ***Engaging the legislature:***

*Consider the following:*

*the governor's role; and*

*key personnel in your legislature.*

*Work through health-related committees.*

*Also consider judiciary, state affairs, technology, or finance committees;*

*potential sponsors for proposed bill; and informational and educational meetings.*

The next step is to review key personnel in your legislature. First, you must know how bills are assigned to committees and which committees may hear your bill. Generally, health information technology bills will go through health-related committees, but they may also be seen in other committees. Research how bills are set to be heard in committee and before each chamber—the people who make those decisions must be informed and educated about your idea.

After determining the appropriate committees and the members on the committees, you can identify potential sponsors for proposed legislative changes. Potential sponsors will include members of leadership, committee members, other members with a strong history of policy interest in health IT-related areas, and members whose districts will be most impacted should the bill pass, such as a member whose district contains a large hospital. Before approaching potential sponsors, it is important to learn more about the politics in your legislature. In some states, it may be appropriate to see members of leadership or the committee chair first, regardless of whether those individuals are likely to sponsor your bill. Those members also may have recommendations about potential sponsors who could help ease the bill's passage. Look for members who are active in state or national task forces on health IT, who are active participants in the National Conference of State Legislatures' health committee, and those involved in other similar organizations.

Once a sponsor has been found, the information and education process can begin in earnest. Each member of the leadership and each member of the committees that will hear the bill should be notified about the bill, educated on what it does, and informed how it will help health care in the state. Go to these meetings

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prepared with a 1-page list of groups that support the bill (these endorsements should be gained through meetings with the relevant professional associations and similar groups), a 1-page memo with bullet points of the bill's key provisions, a 1-page memo of talking points on the bill, and a sense of how much the bill may cost and who may oppose it. If asked a question you are

***Educating and informing key stakeholders:***

*employees of state agencies and local health and human services agencies;*

*licensing agencies; and*

*technology agencies.*

not prepared for, do not be afraid to say that you do not know but will research the issue and get back with the member's office.

Members of the legislature are not the only targets for education. Advocates for the bill should also meet with employees of the state agencies likely to be involved in implementing the bill—generally, health and human services agencies, health care licensing agencies, and information

technology agencies.

### *State Experience Notes (Michigan):*

#### *Governance and Stakeholders*

*For the MiHIN Project, a statewide Steering Committee and six Work Groups—clinical, financial, governance, legal, regional, and technical—were established to address specific issues, foster statewide involvement, and provide recommendations. Health care leaders and experts representing major health care organizations, public health agencies, and public and mental health providers, government, providers, health care consumers and payers, information technology, academia, and others contributed their time and expertise to developing this report. Project management and oversight of all the Work Groups was provided by a team comprised of the Michigan Department of Community Health, the Michigan Department of Information Technology, the Michigan Public Health Institute, the Health Network Services Group, and the eHealth Initiative.*

*Some policy areas that could be addressed in a comprehensive electronic health records act include:*

- *consumer protections regarding personal health records (PHRs);*
- *coordination of HIPAA and state law;*
- *uniform patient authorization standards including authorizations by guardians;*
- *release of sensitive or other restricted records in an emergency; and*
- *definitions of electronic health records.*

## **HSPLC Findings and Recommendations**

States may also use this Roadmap for guidance in structuring the content of the proposals. The HSPLC has developed Initial Elements for State HIE Legislation (Initial Elements) which are the recommended priority areas for legislative change. The HSPLC created the CAM to provide a common approach for communication across the states participating in the HSPLC and other states that decide to undertake their own legal review. The Initial Elements are a starting point for legislative action which can be adapted to fit unique state needs.

### *Identification of Common Gaps and Priorities*

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In developing the Initial Elements, the Collaborative first identified common gaps and priorities across the HSPLC states. Individual members from each state participating in the HSPLC coordinated the completion of the Comparative Analysis Matrix and Assessment Tool within their respective states. Each consulted with their respective oversight and participatory groups to identify gaps in law as they relate to electronic health information exchange and other areas of law for recommended changes. Members documented stakeholder and/or pilot-group discussions about gaps and priorities related to health information exchange implementation within the HSPLC state.

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### ***What is a statutory gap?***

*An area of the law that is silent or otherwise ambiguous with respect to HIE and that results in a barrier to the implementation or use of HIE within the state.*

### ***What is a statutory priority?***

*An issue or subject matter area that may present an undue barrier to the implementation of HIE if not changed or clarified.*

As noted earlier for purposes of the HSPLC analysis, a “gap” is an area of the law that is silent or otherwise ambiguous with respect to HIE and that results in a barrier to the implementation or use of HIE within the state. A “priority” is an issue or subject matter area that may present a significant challenge to the implementation of HIE if not changed or clarified. Members of the HSPLC compared and discussed data and feedback received from each HSPLC stakeholder and pilot group that used the CAM and Assessment Tool. Based on this comparison, the Collaborative determined that HSPLC states generally shared the gaps and priorities related to:

- presence of a core law for addressing the use and disclosure of electronic health records (EHR) and electronic health information exchange;
- definitions of new and evolving terminology related to electronic health records;
- standards for access to information in emergencies;
- standards for “universally” accepted patient authorization for the electronic use and/or disclosure of health information;
- standards for security of electronic health information; and
- Identification, reconciliation, clarification or removal of unique state law barriers.

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These common gaps and priorities form the basis of the Initial Elements for State HIE Legislation and are discussed below. These are broad subject matter areas that the HSPLC recommends states review as a possible starting place when considering HIE legislation. Ideally, these topics will be addressed on a collaborative basis among states through the support of national and state organizations.

### *Initial Elements for State HIE Legislation*

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#### Core Electronic Health Exchange Law

Most states, including those in the HSPLC, do not have a law that expressly recognizes the existence of EHRs and establishes standards for exchange of health information contained in EHRs. As a result of this gap, stakeholder groups within and among states apply varying interpretations of the standards for the exchange of patient information contained in EHRs. For example, some stakeholders choose to extend existing state law standards that generally address the exchange of paper information to the electronic exchange of EHR data. Other stakeholders take the approach that, without standards or a framework for exchange, EHR data may not be disclosed or exchanged electronically. This variation in interpretation results in confusion, uncertainty, and apprehension among stakeholder

#### ***Purposes of core law:***

*recognize the existence and use of electronic health records; and*

*establish standards for exchange of health information.*

groups about the consequences of maintaining and disclosing EHRs.

To facilitate the adoption of HIE, states should consider expressly recognizing and setting standards that include the electronic



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maintenance and exchange of patient information contained in EHRs. Depending on the needs and priorities of the individual state, the scope of such a law may range from being comprehensive (e.g., a separate chapter of law specifically devoted to EHRs) to being more limited and clarifying in nature (i.e., recognizing that existing standards for the exchange of information apply to all mediums of data, including EHRs).

Specific components of EHR legislation that may be considered include the following:

### *Components of EHR legislation*

Adoption of national standards—A state may consider implementing a requirement that all EHRs be certified by a federally recognized body such as the Certification Commission for Healthcare Information Technology. In adopting this measure, consideration should be given to the need for currency in the referent standards and product listings. Furthermore, the law should clearly state whether it is a mandate for the use of EHRs as a recordkeeping medium.

Ownership/stewardship of records—A state may consider establishing the responsibilities different stakeholders have with respect to an EHR.

Identification of legal health record—A state may consider expressly recognizing that the EHR is the legal health record of the patient’s encounter with the organization.

### Definitions for New and Evolving Terminology

In completing the CAM and the Assessment Tool, the HSPLC determined that many states have not identified and defined terms relevant to HIE. The adoption of consistent HIE definitions

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may be challenged by the continual evolution of technology and usage in the industry. For example, some terms, such as “electronic health record” and “electronic medical record,” are often used interchangeably. In adopting HIE-related terms and definitions, states may consider expressly recognizing that more than one term can have the same definition (e.g., EHR and EMR may have identical definitions). The HISPC Cross Collaborative Glossary (created and posted separately) contains several industry definitions of HIE-related definitions. Below are examples of definitions currently used in existing or proposed state laws.

Electronic medical record—An electronic medical record is used by health care professionals to electronically document, monitor,

*The adoption of standard HIE definitions may be challenged by the continual evolution of technology and usage in the industry.*

and manage health care delivery within a care delivery organization; is the legal health record of the patient’s encounter with the care delivery organization, and is owned by the care delivery organization (Iowa Health Information Technology System; Division XXI; Iowa Health Information Technology System 135.154).

Health information technology—Health information technology means the application of information processing, with the storage, retrieval, sharing, and use of health care information, data, and knowledge for communication, decision making, quality, safety, and efficiency of clinical practice and may include, but is not limited to:

- a. an electronic health record that electronically compiles and maintains health information that may be derived from multiple sources about the health

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status of an individual and may include a core subset of each care delivery organization's electronic medical record, such as a continuity of care record or a continuity of care document a computerized physician order entry, electronic prescribing, or clinical decision support;

- b. a personal health record;
- c. an electronic medical record that is used by health care professionals to electronically document, monitor, and manage health care delivery within a care delivery organization, is the legal health record of the patient's encounter with the care delivery organization, and is owned by the care delivery organization;
- d. a computerized provider order entry;
- e. a decision support function; and
- f. tools to allow for the collection, analysis, and reporting of information or data on adverse events, the quality and efficiency of care, patient satisfaction, and other health care-related performance measures (Iowa Health Information Technology System; Division XXI; Iowa Health Information Technology System 135.154).

Electronic health record—Electronic health record means a secure, interoperable, electronic collection of a person's episodic and longitudinal health information, based upon interactions across multiple health care delivery organizations, that is web-based, allows for real-time transaction processing, and is accessed via a portal with appropriate authorization and in a manner that complies with all state and federal health record requirements (Iowa House File 2312 [81st General Assembly]).

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Electronic health record—Electronic health record means electronically originated and maintained health and claims information regarding the health status of an individual that may be derived from multiple sources and includes the following core functionalities:

patient health and claims information or data entry function to aid with medical diagnosis, nursing assessment, medication lists, allergy recognition, demographics, clinical narratives, and test results;

a results management function that may include computerized laboratory test results, diagnostic imaging reports, interventional radiology reports, and automated displays of past and present medical or laboratory test results;

a computerized physician order entry of medication, care orders, and ancillary services; and

clinical decision support that may include electronic reminders and prompts to improve prevention, diagnosis, and management and electronic communication and connectivity that allows online communication

- among physicians and health care providers; and
- among the Health and Human Services Commission, the operating agencies, and participating providers

(Tex. Hum. Res. Code § 32.101 [2007]).

Electronic personal health record—Electronic personal health record means an electronic, universally interoperable resource of health information based upon an individual patient's health history that is available to the patient throughout his or her life

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and is needed by an individual to make informed health decisions. The personal health record is stored and maintained in a secure, private environment, and only the individual patient may determine rights of access to the record. The personal health record is separate from, and does not replace, the records of a provider (2007 Bill Text CA S.B. 320).

Personal health record—Personal health record means an electronic, universally interoperable resource of health information based upon an individual patient's health history that is available to the patient throughout his or her life and is needed by an individual to make informed health decisions. The personal health record is stored and maintained in a secure, private environment, and only the individual patient may determine rights of access to the record. The personal health record is separate from, and does not replace, the records of a provider (2007 Bill Text CA S.B. 320).

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## Standards for Access to Information in Emergencies

While state laws allow health care providers to administer emergency treatment when a patient is unable to give or refuse consent, the same laws are often silent as to use of the patient's existing health information to support emergency treatment. As a result, providers may be hesitant to request access to or disclose the past medical information of a patient. However, as noted by the National Committee on Vital and Health Statistics (NCVHS),

“When an unconscious, delirious, or otherwise incompetent patient is treated in an emergency department, physician's office, or other health care setting, it may be extremely beneficial to have the individual's complete health information” (Letter from NCVHS to Secretary of Health and Human Services, RE: Individual control of sensitive health information accessible via the Nationwide Health Information Network for purposes of treatment, February 20, 2008).

***“Break the glass” scenario for sequestered health information, NCVHS recommendations:***

- *use of an audit trail to record the specifics of the incident;*
- *automatic trigger for review by the organization's privacy officer; and*
- *notification of the patient or the patient's legal representative about the use of the “break the glass” feature.*

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In electronic information systems that contain “sequestered” information (e.g., information related to mental health, substance abuse, fertility, etc.) or have other access controls, the ability to “break the glass” to permit access to all of the patient’s information is an important feature of patient care. In developing “break the glass” legislation, states may consider the following recommendations made by NCVHS:

- use of an audit trail to record the specifics of the incident;
- automatic trigger for review by the organization’s privacy officer; and
- notification of the patient or the patient’s legal representative about the use of the “break the glass” feature.

*“When an unconscious, delirious, or otherwise incompetent patient is treated in an emergency department, physician’s office, or other health care setting, it may be extremely beneficial to have the individual’s complete health information” (Letter from NCVHS to Secretary of Health and Human Services, RE: Individual control of sensitive health information accessible via the Nationwide Health Information Network for purposes of treatment, February 20, 2008).*

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### Standards for “Universally” Accepted Patient Authorization

State laws addressing required components of authorization to disclose health information vary from state to state and may or may not match federal requirements. As a result, the disclosure of patient information is sometimes unnecessarily delayed by

*State laws addressing required components of authorization to disclose health information vary from state to state and may or may not match federal requirements.*

providers insisting on the use of a facility-specific form. States may consider the approach taken by Oklahoma, which has developed a single standard authorization form for disclosure of health information. The Oklahoma

Standard Authorization Form contains the following features:

While health care providers are not required to use the form, they are required to honor it.

Instructions about completing the form are available to the patient. The instructions describe the form section by section and provide the patient with information about why some fields on the form are included.

Instructions about completing the form are available to the provider. The instructions not only educate providers about legal standards for disclosing information but also provide specific instructions to give to patients who are filling out the form.

The form may be accessed at the Oklahoma State Department of Health:

[http://www.ok.gov/health/Organization/HIPAA\\_Privacy\\_Rules/Oklahoma\\_Standard\\_Authorization\\_Forms.html](http://www.ok.gov/health/Organization/HIPAA_Privacy_Rules/Oklahoma_Standard_Authorization_Forms.html).



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## Security Standards of Electronic Information

Through the preliminary use of the CAM and Assessment Tool, the HSPLC determined that many states do not have comprehensive laws specifically addressing the security of electronic health information. Since certification bodies such as the Certification Commission for Healthcare Information Technology (CCHIT) evaluate products based on security features, states may consider requiring that EHR products be certified or adopt the security standards used by certification bodies. States may consider adopting security standards related to the following:

- Authentication—Require that each user of the system have a unique identification.
- Auditing—Define events to be audited; provide standards for retention of audit data.
- Access control—Define user privileges; consider “break the glass” provisions.
- Encryption—Require encryption during transmission encrypt “at-rest” data on portable devices.
- Contingency planning—Create standards for backup and availability of information during system outages.

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### Identification, Reconciliation, Clarification, or Removal of Unique State Laws

Through completing the CAM and Assessment Tool, the HSPLC determined that most states have a series of antiquated, fragmented, and nonstandardized laws that may be interpreted to create a barrier to the appropriate exchange of electronic health information. States may use the CAM and Assessment Tool to assist in identifying areas of law that could be updated. States may use an incremental approach to first address selected issues, or they may wish to undertake a comprehensive identification and analysis of state statutes and regulations. A comprehensive reform would be a resource-intensive task in most states. States may wish to create and fund a task force or governance body to oversee such a comprehensive review.

### ***States Experience Notes (New Mexico):***

*Despite the failure of the legislation to pass, the introduction of the proposed legislation provided an opportunity to begin the process of educating legislators and the broader community about HIE:*

*Because HB 37 and special session HB 5 failed to pass during the 2008 legislative sessions, no changes have been made that would address the barriers to HIE in New Mexico resulting from outdated and fragmented laws.*

*Privacy remains the most significant legal issue facing the HIE in New Mexico. From the standpoint of proponents of the HIE, the most significant problem is that under New Mexico state law, disclosure of certain types of medical information (e.g., HIV/AIDS, mental health, and genetic information) requires patient authorization that exceeds the requirements imposed under the HIPAA Regulations. New Mexico HIE proponents, like those in other states, continue to struggle with addressing how to deal with the patchwork of protections afforded certain types of information. At present, it appears that the only practical means of addressing the issue, short of legislative change, is to require patient authorization for all disclosures to be made through the HIE.*

*Other privacy issues also surfaced during the attempt to pass HB 37 in New Mexico. Providers and health care organizations clearly opposed any effort to impose requirements that would have exceeded those imposed by the HIPAA Regulations. On the other side of the issue, the ACLU and other privacy advocates argued that the HIPAA Regulations were not strong enough on protection of patient privacy and sought to use HB 37 as a means of increasing patient privacy protections. During the special session in August 2008, legislators voiced concern about liability issues for providers. The potential benefits of the HIE were often seen as a secondary issue to these larger concerns, and the legislature, at least during the 2008 sessions, was unable to make a determination of the appropriate response.*

## *Nonlegislative Uses of CAM*

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While the goal of the Collaborative is to promote harmonization of state laws, the Collaborative recognizes that there are many nonlegislative solutions that will facilitate health information exchange. The ability to more readily identify relevant laws

*The Comparative Analysis Matrix provides framework for analysis that is:*

*user-friendly; and*

*clarifies requirements for security and privacy.*

across the states is an important potential benefit of the CAM. While there are good sources of educational materials on HIPAA, the availability of user-friendly references on applicable state law is limited. The CAM provides a common framework for analysis that is designed to address issues related to

the use and disclosure of electronic health records. It is also designed to be user-friendly and easy to maintain and keep current.

There is a clear need to educate the provider community on both HIPAA and state laws as well as security and privacy procedures. The need for educational resources at the state level has been well documented by the HISPC project and has led to the creation of the Provider Education Toolkit and Consumer Education and Engagement collaboratives. The CAM can assist stakeholders simply by providing clear information on the requirements for authorization in electronic health information exchange.

### *States Experience Notes (Missouri):*

#### *Interagency Coordination for Health Information Exchange*

*Building on the successes of HIE activity within MO HealthNet, an effort is underway to link state agencies so that their health information will be interoperable and can be more easily shared as appropriate. Information technology professionals at Missouri's Department of Social Services, the Department of Health and Senior Services, and the Department of Mental Health are in the early stages of this effort. All three state agencies are represented on Missouri's HISPC Steering Committee, so all of our stakeholders can stay informed on these efforts and use the knowledge to help others in the public and private sectors with similar initiatives.*

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### Provider Education Toolkit

#### ***Automated CAM:***

*web-based;*

*easily accessible by stakeholders, policy makers, educators, and the general public, and initially populated with Florida data; can also use this for other states' CAM results.*

To facilitate the use of the CAM as an educational tool, the Florida HISPC team engaged in a cross-collaborative project to create a federal and state statute crosswalk tool by automating the CAM. The crosswalk tool will consist of a web-based matrix for keyword searching the contents of the CAM and then linking the results to federal and state statutory citations. Retrieved results will include whether the subject matter area contains state laws that are more stringent than HIPAA. Since there will likely be different audiences for information about electronic health information exchange among treating practitioners and electronic health information exchange for purposes of population health, users will be able to select their areas of focus at the outset when using the tool. The tool is also designed to allow the addition of keyword searches as reported by users and added to the database by the agency or organization maintaining the tool.

Initially, the crosswalk tool will be released using the CAM populated with Florida data. It will provide an additional resource for the Florida Provider Education Toolkit (PET). The crosswalk tool will be posted on Florida's Privacy and Security Resource Center website for public use and maintained by the State of Florida. The crosswalk tool can be used by states that have completed the CAM with minimal additional costs required to load the data and prepare the tool for posting on a website. The crosswalk tool can greatly enhance the educational potential of the CAM by making the information readily accessible on the Web for use by health care stakeholders, policy makers, educators, and the general public.

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## *Roadmap Highlights, Pitfalls, and Lessons Learned*

At present, there are a number of states independently assessing the barriers to interoperable HIE and the lack of consistent legal standards to protect health information. Some states have even moved toward implementing potential solutions for the identified barriers. Unfortunately, these independent assessments, while valuable in addressing intrastate barriers, will not resolve the interstate barriers. Failure to create laws and standards with an eye to how health information will be exchanged at the interstate level will perpetuate the barriers and do little for the establishment of nationwide interoperable HIE.

*Failure to create laws with an eye to how health information will be exchanged at the interstate level will perpetuate the barriers and do little for the establishment of nationwide interoperable HIE.*

The primary aim of this project was to create a measurable reduction in the duplication of effort with regard to addressing laws related to the privacy and security of HIE and to ensure that knowledge is shared across state lines to facilitate learning and enable constructive dialogue and coordination.

As with any process, especially one involving collaboration, the CAM and the Analytical Framework were initially piloted by the Collaborative states to not only rank the current statutes in terms of relevance to HIE development but to also allow for the evaluation of the effectiveness of the tools and the identification of how best to manage working through the process.

The initial test of the Analytical Framework indicated that there were some improvements to be made to achieve the “best practices” of user orientation and ease of use. The changes made to the Analytical Framework by the HSPLC as a result—including revised directions and definitions for scoring—are an

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improvement. If there is an opportunity for future collaboration, additional changes may be made in response to suggestions from states that have used the tools. A complete description of the HSPLC state experiences in the application of the CAM and Assessment Tool is provided in the Appendix of this report.

The initial test of the CAM and Assessment Tool also identified or confirmed many positive features of the Analytical Framework, some of which were expected—and some, unexpected.

These include:

Structure—As expected, one of the most potentially valuable aspects of the CAM is the identification of common subject matter topics across the states regardless of the organizational structure of state statutes. This will facilitate communication and collaboration across the states, which are fundamental goals of the HSPLC.

Adaptability—Although the states participating in the HSPLC vary in size, resources, and experience in the HISPC, states were able to adapt the tools to their needs. The Assessment Tool allows states to assess and reassess focusing on subject matter areas of greatest interest. Furthermore, the Assessment Tool proved useful regardless of the inherent organization of a state's statutes. The resulting assessment and recommendations for statutory changes among the respective test states were different in many respects; however, the format and therefore the basis for discussion regarding interstate issues were uniform, bridging the disparate individual state needs and recommendations.

Insight—Many states noted that the exercise of using the tool led to new insights in their understanding of the legal landscape and



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the magnitude of task—which was an unexpected result, but not surprising. A comprehensive analysis of state laws in the context of electronic health information exchange would be expected to provide a deeper understanding of the issues. In addition to problem identification, other insights included identification of subject matter interrelationships, patterns in legal language, and opportunities for solutions. For example, the analysis provides an understanding of how the pieces of statute relate across topic areas and might be addressed in a stepwise approach.

*The CAM addresses both patient care and population health.*

Population health—An unexpected use of the Analytical Framework is its ability to address both patient care and population health issues. The HSPLC believes the CAM has great potential to serve the needs of stakeholder groups that may wish to concentrate on health information exchange to support population health such as quality improvement, disease management, and the ability to gather data for research purposes.

The HSPLC states had similar experiences in testing the Analytical Framework in that we were all reminded that this is a complex undertaking which requires a realistic appreciation for the time required to allow group dynamics to occur. State organizations, public and private, need to exercise leadership to define the context of what the stakeholder groups are being asked to accomplish as it relates to health information exchange. At the same time, the state organization should encourage interaction with stakeholders with varying viewpoints and expertise, allowing for the group to come to a common understanding of its purpose. Although the Roadmap can assist, the tools of the Analytical Framework cannot create this understanding until stakeholders have put the groundwork in place to appreciate the

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nature of the issues they wish to address and the goals they hope to achieve.

Some states may wish to first address intrastate issues to promote health information exchange development within their states. A plan for addressing intrastate issues that includes a realistic

*The Roadmap was designed to assist states in achieving interstate HIE. An important benefit of the Roadmap is that it encourages states to reach out to other states, where both states have incorporated and used the Roadmap in their statutory review. The HSPLC believes that this will enhance the likelihood of successful reform that facilitates interstate HIE.*

assessment of the resources required to accomplish the goals of the plan is essential. As noted in this Roadmap, modest but sufficient legal and other resources are necessary for a successful completion of the CAM and in the use of the Assessment Tool for identifying opportunities for legislative

reform. For these states, use of the Roadmap provides a foundation for later cross-border or multistate collaboration.

The Roadmap was designed to assist states in achieving interstate HIE. An important benefit of the Roadmap is that it encourages states to reach out to other states, where both states have incorporated and used the Roadmap in their statutory review. The HSPLC believes that states will have greater likelihood of success in achieving legislative reform that facilitates interstate HIE if they use the Roadmap to begin to harmonize state laws and that, ultimately, all states will benefit from the development of workable information exchange standards and practices within and among states. The HSPLC will bring the Roadmap to state and national organizations for review and ask that these organizations disseminate the final Roadmap and encourage its use.

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## Appendices

As part of the preparation of this report, the HSPLC sought comment from entities likely to be engaged in related activities. Members of the Collaborative are very grateful for the time and attention given by these groups for offering their insights and sharing their comments.

Several groups expressed general support without providing specific suggestions. One advised condensing the Executive Summary, and this recommendation was followed in the final draft.

The National Council of State Legislatures (NCSL) suggested additional review of HIE liabilities and penalties for violation of HIE statutes if adopted. They also proposed posting each state's completed CAM on a website that other states could access for purposes of assisting in state-to-state comparisons and assessments. They offered a cautionary note about respecting the balance between state and federal regulatory authority, noting that analysis of state privacy laws as either more or less stringent than HIPAA was useful but clarifying that states retain the power to make laws more stringent in response to concerns raised within a state.

The National Conference of Commissioners on Uniform State Laws (NCCUSL) suggested adding a resource reference to other groups involved in issues related to the work of the Collaborative, including entities that have successfully implemented an HIE system. Links to a sample of such resources have been added.

The HSPLC also submitted a draft of the report to representatives of national health data management organizations. Feedback suggested including a matrix for states that have completed the CAM in order to assist other states in understanding how to complete it. Reports from the HSPLC states are included in this report. In addition, Florida is in the process of developing an automated feature for the CAM that will allow keyword access for research into both state and federal statutes. Other feedback suggested including a review of Virginia's implemented HIE. Such a review was beyond the scope of this report.

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A final group suggested expanding the discussion of stakeholders that might be included. One specific group often overlooked in creating stakeholder groups is unions, which are noted not only for negotiating and providing for health benefits for their members but also have legislative expertise.

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## HSPLC State Contacts and/or Websites

### Florida

Website: <http://www.fhin.net/PSresourceCtr/index.shtml>

### Kansas

Website: <http://www.khpa.ks.gov/>

### Kentucky

Barbara Baker, Policy Advisor  
Office of the Secretary, Cabinet for Health and Family Services  
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Phone: 502-564-7042 X3873  
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E-mail: [BarbaraA.Baker@ky.gov](mailto:BarbaraA.Baker@ky.gov)  
Website: <http://ehealth.ky.gov/index.html>

### Michigan

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Cell: 517-204-8863  
Fax: 517-324-8370  
E-mail: [KCoyle@mphi.org](mailto:KCoyle@mphi.org)

### Missouri

Website: <http://mosecure4health.org/>  
E-mail: [HISPC@Primaris.org](mailto:HISPC@Primaris.org)

### New Mexico

Website: <http://www.lcfresearch.org/>

### Texas

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Website: <http://governor.state.tx.us/thcpc/>

E-mail: [stephen.palmer@governor.state.tx.us](mailto:stephen.palmer@governor.state.tx.us)

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## Harmonizing State Privacy Law Collaborative State Experiences

### Florida Experience

The Agency for Health Care Administration (Agency) is the state agency designated to participate in the Harmonizing State Privacy Law Collaborative project of the Health Information Security and Privacy Collaboration in Florida. During 2008, the Agency reconvened the Florida Legal Work Group (LWG), originally established during Phase I of HISPC, to participate in the HSPLC and review proposed Florida legislation incorporating recommendations the LWG issued in 2007. The recommendations were:

- 1) Align the hospital and physician inconsistencies in health information exchange as outlined in F.S. 395 and 456. This change will also address the emergency disclosure issue, with the exception of disclosure of information related to HIV/AIDS, substance abuse, and mental health. These areas will need to be addressed separately.
- 2) Address F.S. 483, related to labs.
- 3) Create a process for addressing uniform patient consent [authorization].

The LWG also assisted in the development of a federal and state law crosswalk tool based on the HSPLC Comparative Analysis Matrix as a resource for provider education. The Florida LWG consists of 25 members from diverse backgrounds, including medical, legal, consumer, information technology, and other stakeholders.

### Kansas Experience

Through the joint efforts of Harmonizing State Privacy Law collaborative and the Kansas Legal Work Group to identify, analyze, and address state laws that impact HIE, two key issues were identified: state laws and regulations are antiquated, paper-oriented, and sometimes conflicted; and the resulting confusion and fear of liability create a barrier to widespread adoption and use of HIT and HIE.

The HISPC Phase III project work was presented to the Kansas Health Policy Authority (KHPA) eHealth Advisory Council in 2008. The information was well received, and members agreed that a better understanding of how this work can be leveraged in Kansas was needed. More recently, the Kansas Senate Public Health and Welfare Committee has agreed to propose adoption of the Draft Resolution prepared in HISPC Phase II to the full Senate this legislative session. Passage of the Draft Resolution will facilitate further study of Kansas state statutes involving health information utilizing the Comparative Analytic Matrix and the Assessment Tool. In summary, the members of the Kansas HISPC team have been working with the leadership of the KHPA and the KHPA eHealth Advisory Council to ensure that Kansas will be positioned to fully leverage the work accomplished through HISPC Phases I, II, and III in the future work of harmonizing state statutes, policies, and regulations to foster the adoption of electronic health information.

### Kentucky Experience

Legislation enacted in 2005 with broad bipartisan support established a governing structure and objectives for health information exchange implementation in Kentucky. The Kentucky e-Health



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Network Board, which includes representation from the public and private sectors, developed a committee structure, convened annual stakeholder summits, and promoted e-prescribing. Research support is provided by state university faculty through the Kentucky Healthcare Infrastructure Authority. The state is also undertaking HIE initiatives under the auspices of a Medicaid Transformation Grant. Several health information exchanges are under development, and HealthBridge, an Ohio-based HIE, serves Kentuckians in the Cincinnati suburbs of northern Kentucky. Kentucky has a zealous HIT champion in its Lieutenant Governor, Daniel Mongiardo, MD. The state participated in HISPC from the outset and has been active in the HSPLC and Provider Education Toolkit Collaboratives. Drawing on the HISPC experience, the Legal Work Group reviewed HSPLC analytic tools and set priorities for regulatory revision, focusing initially on harmonization of facility licensure provisions.

### **Michigan Experience**

The Michigan Public Health Institute (MPHI) has been active in HISPC since the project's inception in 2006. Michigan currently serves as the cochair for the Harmonization State Privacy Law Collaborative.

Michigan's HISPC Legal Work Group, convened in 2007 in conjunction with the Michigan Health Information Network (MiHIN) Conduit to Care Project, had previously been assigned the responsibility to identify legal barriers to the development of electronic health information exchange. The LWG developed a "top ten" list of recommendations for Michigan's Health Information Technology Commission. The Commission then determined if the recommendations should be addressed by the state legislature and policy makers, with the overall goal of facilitating and supporting effective HIE.

In 2008, the LWG was again asked to convene and review and rank the list of legal recommendations. It was clear to the LWG that the list of legal priorities for HIE had shifted, in large part due to an increased comfort and familiarity with certain legal issues relevant to HIE, the advancement of technology, and the development of industry guidance. In addition, the American Recovery and Reinvestment Act of 2009 has addressed many of the issues identified by the LWG as possible barriers to HIE in Michigan.

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## **Missouri Experience**

Primaris was designated by Missouri's governor to lead the state's participation in the Health Information Security and Privacy Collaboration. Joining in Phase III (April 2008), Missouri worked with the Harmonizing State Privacy Law Collaborative and the Provider Education Toolkit (PET) Collaborative.

Joining collaboratives "already in progress" presented distinct challenges. One was the imperative to build communication, relationships, and trust among participants in the steering committee. Because members represent various stakeholder constituencies, each with its own agenda, it takes time to recognize that there will be a set of goals that they can champion in common.

A similar challenge was that veteran states in HSPLC had functioning Legal Work Groups which had been in operation through Phases I and II. Most of the LWGs provided extensive expertise in the areas of law, health care, and legislation and had a history of working together in support of a better climate for health information exchange. Missouri had no such group to call upon.

Missouri managed to meet each of these challenges with support from HISPC and advice from our sister states. A full description of those efforts can be found appended to the HSPLC final report.

## **New Mexico Experience**

The New Mexico Health Information Collaborative (NMHIC), created and operated by Lovelace Clinic Foundation (LCF), is developing the only statewide electronic HIE. NMHIC anticipates that the exchange will become operational for patient health care in fall 2009. The privacy and security of electronic health information has been a concern of NMHIC since its inception in 2004.

As a result of LCF's participation in the HISPC project, numerous state laws have been identified as possible impediments to electronic health information exchange.

There have been three attempts to address state law issues affecting HIE. Two bills introduced in legislative sessions in 2008 failed to pass, and legislation introduced in January 2009 is currently under consideration by the legislature.

Effecting changes in patient privacy laws, no matter how well-intended, is difficult. The process involved legitimate debate over the appropriate levels of privacy and security, as well as concerns about provider liability and other issues, including concern that the legislation mandated the use of electronic medical records. As the process continued, however, legislators have become better informed on the issues and more able to consider policy choices in the context of HIE. It is believed that this will eventually result in changes to state law that will ameliorate current state law impediments to HIE in New Mexico.

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## **Texas Experience**

The Harmonizing State Privacy Law Collaborative is being conducted by the University of Houston's Health Law & Policy Institute under contract with the Texas governor's office. Texas's participation, begun in 2008, is under the direction of a steering committee consisting of representatives from the offices of the governor, lieutenant governor, and Speaker of the Texas House of Representatives. The steering committee and the Health Law & Policy Institute also worked with a larger ongoing stakeholder group that has been involved in supporting development of HIT in Texas over the past 4 years.

The Texas focus was on development and application of the Comparative Analysis Matrix and the Assessment Tool. The experience highlighted the complexity of achieving consistency within Texas's own codes and statutes but also provided direction in developing priorities for legislative action. These priorities include clarifying patient/provider privilege, ownership of medical records, patient consent and authorization requirements, and facility-specific provisions to ensure consistency where applicable. In addition, Texas's priorities include developing consistent and comprehensive definitions to support creation of a comprehensive privacy act.

Several HIT- and HIE-related bills have been filed. Two of the most significant are HB 1218 by Rep. Donna Howard, which would direct the creation of a pilot project to allow secure exchange of electronic health information between the Texas Health and Human Services Commission and local or regional networks, and SB 7 by Sen. Jane Nelson, which includes provision for creating an HIE system with the Texas State Children's Health Insurance Program (SCHIP) and the Medicaid program. Sen. Nelson has also filed SB 286, SB 287, SB 288, and SB 289, all of which also address electronic data processing and exchange with the Texas Medicaid and SCHIP.

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## **Resources and Links for National and State Health Privacy**

### **American Health Information Management Association (AHIMA)**

Founded in 1928 to improve the quality of medical records, AHIMA is committed to advancing the HIM profession in an increasingly electronic and global environment through leadership in advocacy, education, certification, and lifelong learning.

<http://www.ahima.org/>

### **Association of State and Territorial Health Officials (ASTHO)**

ASTHO is the 501(c) (3) nonprofit membership association representing the chiefs of state and territorial health agencies and the 120,000 individuals who work for them. It is supported by 57 members, senior state and territorial health agency leadership, an active Alumni Society of former members, a network of 20 affiliated organizations, and staff.

[http://www.astho.org/index.php?template=about\\_astho.html](http://www.astho.org/index.php?template=about_astho.html)

### **eHealth Initiative**

The eHealth Initiative and the Foundation for eHealth Initiative are independent, nonprofit affiliated organizations whose missions are to drive improvement in the quality, safety, and efficiency of health care through information and information technology.

<http://www.ehealthinitiative.org/>

### **Health and Human Services Office for Civil Rights**

Federal civil rights laws and the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule together protect your fundamental rights of nondiscrimination and health information privacy. Civil rights help to protect you from unfair treatment or discrimination because of your race, color, national origin, disability, age, sex (gender), or religion. The Privacy Rule protects the privacy of your health information; it says who can look at and receive your health information and also gives you specific rights over that information. In addition, the Patient Safety Act and Rule establishes a voluntary reporting system to enhance the data available to assess and resolve patient safety and health care quality issues and provides confidentiality protections for patient safety concerns.

<http://www.hhs.gov/ocr/>

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## **Healthcare Information and Management Systems Society (HIMSS)**

HIMSS has created a Privacy and Security Steering Committee to guide implementation of strategic initiatives that promote the privacy and security of health care information and management systems. This Committee has set the following goal: "By 2014, all entities who use, send, or store health information meet requirements for confidentiality, integrity, availability and accountability based on sound risk management practices, using recognized standards and protocols."

[http://www.himss.org/ASP/topics\\_privacy.asp](http://www.himss.org/ASP/topics_privacy.asp)

## **National Academy State Health Policy (NASHP)**

NASHP is a nonprofit, nonpartisan, public policy think tank addressing pressing health care policy issues of concern to state governments.

<http://www.nashp.org/>

## **National Association of County and City Health Officials (NACCHO)**

NACCHO is the national organization representing local health departments. NACCHO supports efforts that protect and improve the health of all people and all communities by promoting national policy, developing resources and programs, seeking health equity, and supporting effective local public health practice and systems.

<http://www.naccho.org/>

## **The National Committee on Vital and Health Statistics (NCVHS)**

NCVHS was established by Congress to serve as an advisory body to the Department of Health and Human Services on health data, statistics, and national health information policy. It fulfills important review and advisory functions relative to health data and statistical problems of national and international interest, stimulates or conducts studies of such problems, and makes proposals for improvement of the nation's health statistics and information systems. In 1996, the Committee was restructured to meet expanded responsibilities under the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

<http://www.ncvhs.hhs.gov/index.htm>

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## **The National Conference of Commissioners on Uniform State Laws (NCCUSL)**

NCCUSL, now 117 years old, provides states with nonpartisan, well-conceived, and well-drafted legislation that brings clarity and stability to critical areas of the law. NCCUSL's work supports the federal system and facilitates the movement of individuals and the business of organizations with rules that are consistent from state to state.

<http://www.nccusl.org/>

## **National Council of State Legislatures (NCSL)**

States have a vital role to play as the health sector transforms from a paper to an electronic system. The Health Information Technology Champions (HITCh) project was created to help facilitate this transformation by establishing and developing state legislative policy expertise around health IT. HITCh is developing a core of legislative expertise related to health IT policy across states and at the NCSL to create a base for continuing policy analyses in this rapidly evolving area.

<http://www.ncsl.org/programs/health/forum/hitch/>

## **National Governors Association (NGA)**

Founded in 1908, NGA is the collective voice of the nation's governors and one of the most respected public policy organizations in Washington, DC. NGA provides governors and their senior staff members with services that range from representing states on Capitol Hill and before the presidential administration on [key federal issues](#) to developing [policy reports](#) on innovative state programs and hosting networking seminars for state government executive branch officials. The [NGA Center for Best Practices](#) focuses on state innovations and best practices on issues that range from education and health to technology, welfare reform, and the environment. NGA also provides management and technical assistance to both new and incumbent governors.

<http://www.nga.org/>

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## **Health Information Privacy Organizations**

### **Organizations**

Many organizations are working on privacy and confidentiality issues at different levels, from policy to implementation guides. The following are some of these organizations. Inclusion of these organizations does not imply any endorsement of the organizations or the positions they propound.

#### **American Civil Liberties Union (ACLU)**

The Technology & Liberty Program monitors the interplay between cutting-edge technology and civil liberties, actively promoting responsible uses of technology that enhance privacy and freedom while opposing those that undermine our freedoms and move us closer to a surveillance society.

[http://www.aclu.org/privacy/relatedinformation\\_publications.html](http://www.aclu.org/privacy/relatedinformation_publications.html)

#### **Center for Democracy and Technology (CDT)**

It is widely recognized that developments in health information technology (HIT) have the potential to improve health care quality, reduce costs, and empower consumers to play a greater role in their own care. However, little progress has been made on resolving the privacy issues associated with the growing liquidity of personally identifiable health information.

CDT's Health Privacy Project will take on key policy questions, including the proper role of notice and consent, the right of patients to access their own health records in electronic formats, identification and authentication, secondary uses, and enforcement mechanisms. It will address both the traditional exchange of records among providers and payers, as well as new consumer access services and Personal Health Records.

<http://www.cdt.org/healthprivacy/>

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## **Privacy International**

Privacy International is monitoring the enactment of legislation implementing the European Union's Directive 95/46/EC on the protection of individuals with regard to the processing of personal data (data protection directive). PI is also monitoring other countries and companies' compliance with the directive and transborder data flows. PI intends pursuing legal action on behalf of European citizens against companies which violate European privacy rules by transferring information to countries which do not have adequate protections. Finally, PI also monitors the development of privacy regulations around the world.

[http://www.privacyinternational.org/index.shtml?cmd\[342\]\[\]=c-1-Data+Protection+and+Privacy+Laws&als\[theme\]=Data%20Protection%20and%20Privacy%20Laws&conds\[1\]\[category.....\]=Data%20Protection%20and%20Privacy%20Laws](http://www.privacyinternational.org/index.shtml?cmd[342][]=c-1-Data+Protection+and+Privacy+Laws&als[theme]=Data%20Protection%20and%20Privacy%20Laws&conds[1][category.....]=Data%20Protection%20and%20Privacy%20Laws)

## **Privacy.Org**

This information website is a joint project from the Electronic Privacy Information Center (EPIC) and Privacy International is the site for daily news, information, and initiatives on privacy.

<http://privacy.org/archives/000006.html#000006>



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## **State and Federal Agencies**

Many state and federal agencies are becoming more involved in issues regarding electronic health information exchange. One such agency is listed below, and several more will be added to this list in time.

### **Food and Drug Administration (FDA) Sentinel Initiative**

On May 22, 2008, FDA launched the Sentinel Initiative with the ultimate goal of creating and implementing the Sentinel System—a national, integrated, electronic system for monitoring medical product safety.

The Sentinel System will enable FDA to query multiple, existing data sources, such as electronic health record systems and medical claims databases, for information about medical products. The system will enable FDA to query data sources at remote locations, consistent with strong privacy and security safeguards. Data sources will continue to be maintained by their owners.

<http://www.fda.gov/oc/initiatives/advance/sentinel/>

## **International Organizations and Websites:**

### **Data Protection—European Commission**

Developments of a frontier-free Internal Market and of the so-called “information society” increase the cross-frontier flows of personal data between Member States of the European Union (EU). In order to remove potential obstacles to such flows and to ensure a high level of protection within the EU, data protection legislation has been harmonized. The European Commission also engages in dialogues with non-EU countries in order to insure a high level of protection when exporting personal data to those countries. It also initiates studies on the development on the European and international levels on the state of data protection.

[http://ec.europa.eu/justice\\_home/fsj/privacy/](http://ec.europa.eu/justice_home/fsj/privacy/)

### **European Union (EU): European Union Data Protection Directive**

This is Directive 95/46/EC of the European Parliament and of the Council of 24 October 1995 on the protection of individuals with regard to the processing of personal data and on the free movement of such data.

<http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=CELEX:31995L0046:EN:HTML>

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## **European Union Health information Projects**

The European Commission's work on producing comparable information on health, in order to produce health indicators, is based on different projects selected for funding in the framework of the health information strand of the [Health Monitoring Programme \(1997–2002\)](#) and on the [Programme of Community Action in the Field of Public Health \(2003–08\)](#).

[http://ec.europa.eu/health/ph\\_information/indicators/projects\\_en.htm](http://ec.europa.eu/health/ph_information/indicators/projects_en.htm)

## **Organization for Economic Co-Operation and Development (OECD), Information Security and Privacy**

The OECD Working Party on Information Security and Privacy (WPISP) develops policy options to sustain trust, information security, and privacy in the global networked society.

[www.oecd.org/sti/security-privacy](http://www.oecd.org/sti/security-privacy)

## **Council of Europe, Personal Data Protection**

In order to secure for every individual, whatever his or her nationality or residence, respect for his or her rights and fundamental freedoms, and in particular his or her right to privacy, with regard to automatic processing of personal data relating to him or her, the Council of Europe elaborated the Convention for the Protection of Individuals with regard to Automatic Processing of Personal Data which was opened for signature on 28 January 1981. To this day, it still remains the only binding international legal instrument with a worldwide scope of application in this field, open to any country, including countries which are not members of the Council of Europe.

[http://www.coe.int/T/E/Legal\\_affairs/Legal\\_co-operation/Data\\_protection/Background/](http://www.coe.int/T/E/Legal_affairs/Legal_co-operation/Data_protection/Background/)

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## **CAM and Assessment Tools: Instructions and Definitions**

Background: The Comparative Analysis Matrix (CAM) and the Assessment Tool are designed to address state law issues related to electronic health records (EHR) and electronic health information exchange (HIE) by providing stakeholders: (1) a means to identify and categorize state statutes related to the privacy and security of health information that are relevant to EHR and HIE, and (2) a process for the systematic assessment of those statutes. The assessment, with a defined methodology, allows states to determine how to address statutes that may be, for example, out of date, missing critical language relevant to privacy and HIE, or that contain language creating unnecessary barriers to HIE.

The initial population of the subject matter categories of the CAM must be completed prior to any assessment. States may prefer to assemble a Legal Work Group or obtain the assistance of a smaller group of health care attorneys and privacy officers to do the initial population of the Subject Matter Areas of the CAM prior to utilization of the CAM and the Assessment Tool by stakeholder groups. Locating applicable state statutes and regulations is a step that should be conducted by knowledgeable parties familiar with state legislation and health information privacy.

Ideally, the CAM and Assessment Tool are intended to be used by groups of stakeholders, in meetings with both a meeting facilitator to provide guidance and structure to the meeting, as well as a meeting chairperson, with knowledge of both state HIE activities and state laws related to health care. Each state will determine how many stakeholder groups to utilize and the makeup of the stakeholder groups. States should consider including a representative group of stakeholders from various fields to participate in the work group. Possible stakeholders might include health law attorneys, health IT experts, high-level health department staff, consumer groups, high-level hospital staff, privacy compliance officers, and providers.

Population of Subject Matter Area tables: The Subject Matter Area tables have been developed to provide a listing of general areas of state law that should be examined to determine the impact of state law on electronic medical records and electronic health information exchange. While the list is comprehensive, it may not include all relevant areas in a specific state and, in populating the Subject Matter Area tables, any missing relevant areas of law that are applicable in a particular state should be added.

The Subject Matter Area tables are populated by reviewing a state's laws and regulations to determine whether the subject matter is addressed. If so, the title of the statute (both the official title and the "known as" title) as well as the citation to the statute or regulation should be inserted in the Citation/Link column.

Preliminary steps: Prior to filling out the CAM and the Assessment Tool, stakeholders should be briefed on the status of current HIE development within the state. States participating in the Collaborative prepared a short "state of the state" on HIE development as a first step in this process. While this is the recommended approach, not all states will have the ability to draft such a report and, in lieu of providing this type of background information, some type of initial presentation to the stakeholder group on the status of HIE in the state is recommended.

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Assumptions: In order to establish a consistent perspective, the reviewing stakeholder group should accept (for purposes of this process only) the following assumptions: (1) full implementation of HIE is inevitable over time; (2) all clinical information will be available to clinicians at point of care; and (3) secondary uses of the data, such as for population health, will be permitted.

Review process: During the meetings, the stakeholder group will be working from the CAM. The primary goal of the stakeholder group will be to review the CAM and develop a list of priorities to be addressed by the state in order to facilitate HIE in the state.

Scope: The scope of the stakeholder meetings is limited to determining the priority areas of state law that need to be changed, creating a list of legislative priorities, and drafting a subsequent report detailing those priorities and the reasoning behind them. In addition, while the scope of the stakeholder meetings includes determining “the what” in regard to what areas of state law need action; the scope does not include determining “the how” in regard to how the state should make the recommended changes.

Description of Tool: The CAM and the Assessment Tool consist of a series of tables, one for each Subject Matter Area. The selected stakeholder group should review the statutes and regulations included in the Citation/Link column to determine whether changes may be appropriate to facilitate the use of electronic medical records and electronic health information exchange.

Because the HIPAA Regulations provide the basic rules for the use and disclosure of health information across the United States, the CAM is meant to identify those areas of state law and regulations that: (1) are more stringent than the HIPAA Regulations, and (2) impose a barrier to the use of electronic medical records or electronic health information exchange.

As used in the CAM, “more stringent than HIPAA” means that a provision of the state law or regulation imposes requirements not otherwise required under the HIPAA Regulations for the use or disclosure of health information.

As used in the CAM, “Patient Care” generally refers to uses and disclosures of health information for treatment of a patient as treatment is defined under the HIPAA Regulations.

As used in the CAM, “Population Health” generally refers the appropriate, authorized, and timely access and use of electronic health information to benefit public health, biomedical research, quality improvement, and emergency preparedness.

The column “References to Related State/Federal Law and Legislative Proposals” is intended to allow insertion, if applicable, of additional relevant or useful information related to the particular subject matter area.

Assessment Tool: The Assessment Tool consists of the five areas of measurement: A-Facilitates HIE Development, B-Ease of Reaching Consensus, C-Positive Impact on Patient Focused Health Care, D-Positive Impact on Population Health, E-Effect on Consumer Privacy Protection. These measurements are used to assess various factors related to each statute or rule for which a determination has been made that change is necessary in an effort to reach consensus about how to approach needed changes. After discussion, the reviewing stakeholder group should reflect the

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consensus of the group by indicating the corresponding number (shown on the left of the items listed below) on the Assessment Tool. In addition to capturing numerical scores, we recommend that notes and comments be recorded and drafted into a narrative to accompany the recommendations, ensuring that the reasoning behind the recommendations is captured. Use of the Assessment Tool not only provides a relevant list of statutes and regulations that need attention, it also fosters and facilitates discussion among stakeholders that educate the stakeholders about issues facing electronic health records and electronic health information within the state.

### **Response Categories and Applicable Scale**

**Facilitates HIE Development.** *In this assessment, the stakeholder group should assess whether a change in the identified statute or regulation would make it more likely that a health information exchange would become operational and able to effectively exchange health information within the state.*

1 = Little Effect

2 = Neutral

3 = Significant Effect

**Ease of Reaching Consensus Among Stakeholders** (e.g., cultural/regional attitudes, economic impact, nonstate aftereffects). *In this assessment, the stakeholder group should assess the ease of achieving a change in the identified statute. How difficult or easy will it be to reach consensus among stakeholders for the change in order to implement HIE development and remove existing barriers?*

1 = Difficult to change

2 = Neutral

3 = Easy to change

**Positive Impact on Patient-Focused Health Care.** *Patient-focused care is defined as care that takes into consideration the values and preferences of the patient. It enables the transformation to higher quality, more cost-efficient, patient-focused health care through electronic health information access and use by care providers and by patients and their designees. In this assessment, the stakeholder group should assess whether a change in the identified statute or regulation would make it more likely that patient-focused health care in the state would be improved as a result of the change.*

1 = Little Effect

2 = Neutral

3 = Significant Effect

**Positive Impact on Population Health.** *Enable the appropriate, authorized, and timely access and use of electronic health information to benefit public health, biomedical research, quality improvement, and emergency preparedness. In this assessment, the stakeholder group should assess whether a change in the identified statute or regulation would make it more likely that population health would be improved within the state.*

1 = Little Effect

2 = Neutral

3 = Significant Effect

**Effect on Consumer Privacy Protection** (maintains appropriate consumer privacy protection). *In consumer/patient privacy protection, the basic rights of individuals include: (1) the right to have your health information safe and secure, (2) the right to be informed about disclosure of your health information, and (3) the right to choose who receives your health information. In this*

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*assessment, the stakeholder group should assess the effect of a change in the identified statute or regulation on consumer privacy protection in the state.*

*1 = Reduces consumer  
privacy protection*

*2 = Neutral*

*3 = Enhances consumer  
privacy protection*

**CAM/Assessment Tools**

**Table 1. Subject Matter Area: Privacy-Specific Provisions**

<b>Comparative Analysis Matrix and Assessment Tool</b>	<b>Citation /Link</b>	<b>More Stringent than HIPAA for Patient Care?</b>	<b>More Stringent than HIPAA for Population Health?</b>	<b>References to Related State/ Federal Law &amp; Legislative Proposals</b>	<b>Subject Matter to be Ranked?</b>	<b>Comments</b>	<b>Facilitates HIE Development (Based on current HIE development in the state)</b>	<b>Ease of Reaching Consensus Among Stakeholders (e.g., cultural/ regional attitudes, economic impact, non-state after-effects)</b>	<b>Positive Impact on Patient-Focused Health Care</b>	<b>Positive Impact on Population Health</b>	<b>Consumer Privacy Protection</b>	<b>TOTAL (Optional)</b>
<b>Response Categories and Applicable Scale</b>	—	Y/N	Y/N	—	Y/N	—	1=Little Effect 2=Neutral 3=Significant Effect	1=Difficult to change 2=Neutral 3=Easy to change	1=Little Effect 2=Neutral 3=Significant Effect	1=Little Effect 2=Neutral 3=Significant Effect	1=Reduces 2=Neutral 3=Enhances	—
Comprehensive general privacy act	—	—	—	—	—	—	—	—	—	—	—	—
Comprehensive medical privacy act	—	—	—	—	—	—	—	—	—	—	—	—
Constitutional right to privacy	—	—	—	—	—	—	—	—	—	—	—	—
Restrictions on use of Social Security Number	—	—	—	—	—	—	—	—	—	—	—	—

**Table 2. Subject Matter Area: HIPAA-Based and Other Federally Based Provisions**

<b>Comparative Analysis Matrix and Assessment Tool</b>	<b>Citation /Link</b>	<b>More Stringent than HIPAA for Patient Care?</b>	<b>More Stringent than HIPAA for Population Health?</b>	<b>References to Related State/ Federal Law &amp; Legislative Proposals</b>	<b>Subject Matter to be Ranked?</b>	<b>Comments</b>	<b>Facilitates HIE Development (Based on current HIE development in the state)</b>	<b>Ease of Reaching Consensus Among Stakeholders (e.g., cultural/ regional attitudes, economic impact, non-state after-effects)</b>	<b>Positive Impact on Patient-Focused Health Care</b>	<b>Positive Impact on Population Health</b>	<b>Consumer Privacy Protection</b>	<b>TOTAL (Optional)</b>
<b>Response Categories and Applicable Scale</b>	—	Y/N	Y/N	—	Y/N	—	1=Little Effect 2=Neutral 3=Significant Effect	1=Difficult to change 2=Neutral 3=Easy to change	1=Little Effect 2=Neutral 3=Significant Effect	1=Little Effect 2=Neutral 3=Significant Effect	1=Reduces 2=Neutral 3=Enhances	—
Provisions adopting HIPAA requirements	—	—	—	—	—	—	—	—	—	—	—	—
Provisions adopting other federally based provisions	—	—	—	—	—	—	—	—	—	—	—	—



**Table 3. Subject Matter Area: Health Information Provisions**

<b>Comparative Analysis Matrix and Assessment Tool</b>	<b>Citation/Link</b>	<b>More Stringent than HIPAA for Patient Care?</b>	<b>More Stringent than HIPAA for Population Health?</b>	<b>References to Related State/Federal Law &amp; Legislative Proposals</b>	<b>Subject Matter to be Ranked?</b>	<b>Comments</b>	<b>Facilitates HIE Development (Based on current HIE development in the state)</b>	<b>Ease of Reaching Consensus Among Stakeholders (e.g., cultural/regional attitudes, economic impact, non-state after-effects)</b>	<b>Positive Impact on Patient-Focused Health Care</b>	<b>Positive Impact on Population Health</b>	<b>Consumer Privacy Protection</b>	<b>TOTAL (Optional)</b>
<b>Response Categories and Applicable Scale</b>	—	Y/N	Y/N	—	Y/N	—	1=Little Effect 2=Neutral 3=Significant Effect	1=Difficult to change 2=Neutral 3=Easy to change	1=Little Effect 2=Neutral 3=Significant Effect	1=Little Effect 2=Neutral 3=Significant Effect	1=Reduces 2=Neutral 3=Enhances	—
Health information exchange specific provisions	—	—	—	—	—	—	—	—	—	—	—	—
Electronic health/medical record specific provisions	—	—	—	—	—	—	—	—	—	—	—	—
Breach of electronic security reporting—General	—	—	—	—	—	—	—	—	—	—	—	—
Breach of electronic security reporting—Health records	—	—	—	—	—	—	—	—	—	—	—	—
Telehealth/telemedicine provisions	—	—	—	—	—	—	—	—	—	—	—	—
Electronic signatures	—	—	—	—	—	—	—	—	—	—	—	—

<b>Comparative Analysis Matrix and Assessment Tool</b>	<b>Citation/Link</b>	<b>More Stringent than HIPAA for Patient Care?</b>	<b>More Stringent than HIPAA for Population Health?</b>	<b>References to Related State/ Federal Law &amp; Legislative Proposals</b>	<b>Subject Matter to be Ranked?</b>	<b>Comments</b>	<b>Facilitates HIE Development (Based on current HIE development in the state)</b>	<b>Ease of Reaching Consensus Among Stakeholders (e.g., cultural/ regional attitudes, economic impact, non-state after-effects)</b>	<b>Positive Impact on Patient-Focused Health Care</b>	<b>Positive Impact on Population Health</b>	<b>Consumer Privacy Protection</b>	<b>TOTAL (Optional)</b>
Personal health records	—	—	—	—	—	—	—	—	—	—	—	—
Uniform Electronic Transactions Act	—	—	—	—	—	—	—	—	—	—	—	—
Technical security of electronic systems provisions	—	—	—	—	—	—	—	—	—	—	—	—

**Table 4. Subject Matter Area: Health/Medical Records in General**

<b>Comparative Analysis Matrix and Assessment Tool</b>	<b>Citation/Link</b>	<b>More Stringent than HIPAA for Patient Care?</b>	<b>More Stringent than HIPAA for Population Health?</b>	<b>References to Related State/Federal Law &amp; Legislative Proposals</b>	<b>Subject Matter to be Ranked?</b>	<b>Comments</b>	<b>Facilitates HIE Development (Based on current HIE development in the state)</b>	<b>Ease of Reaching Consensus Among Stakeholders (e.g., cultural/regional attitudes, economic impact, non-state after-effects)</b>	<b>Positive Impact on Patient-Focused Health Care</b>	<b>Positive Impact on Population Health</b>	<b>Consumer Privacy Protection</b>	<b>TOTAL (Optional)</b>
<b>Response Categories and Applicable Scale</b>	—	Y/N	Y/N	—	Y/N	—	1=Little Effect 2=Neutral 3=Significant Effect	1=Difficult to change 2=Neutral 3=Easy to change	1=Little Effect 2=Neutral 3=Significant Effect	1=Little Effect 2=Neutral 3=Significant Effect	1=Reduces 2=Neutral 3=Enhances	—
Records retention requirements	—	—	—	—	—	—	—	—	—	—	—	—
Patient access	—	—	—	—	—	—	—	—	—	—	—	—
Ownership of medical records	—	—	—	—	—	—	—	—	—	—	—	—
Accounting for disclosures	—	—	—	—	—	—	—	—	—	—	—	—
Specific re-disclosure prohibitions	—	—	—	—	—	—	—	—	—	—	—	—
Redisclosure statement required	—	—	—	—	—	—	—	—	—	—	—	—
Disposition/destruction of records	—	—	—	—	—	—	—	—	—	—	—	—

**Table 5. Subject Matter Area: Consent/Authorizations**

<b>Comparative Analysis Matrix and Assessment Tool</b>	<b>Citation/Link</b>	<b>More Stringent than HIPAA for Patient Care?</b>	<b>More Stringent than HIPAA for Population Health?</b>	<b>References to Related State/Federal Law &amp; Legislative Proposals</b>	<b>Subject Matter to be Ranked?</b>	<b>Comments</b>	<b>Facilitates HIE Development (Based on current HIE development in the state)</b>	<b>Ease of Reaching Consensus Among Stakeholders (e.g., cultural/regional attitudes, economic impact, non-state after-effects)</b>	<b>Positive Impact on Patient-Focused Health Care</b>	<b>Positive Impact on Population Health</b>	<b>Consumer Privacy Protection</b>	<b>TOTAL (Optional)</b>
<b>Response Categories and Applicable Scale</b>	—	Y/N	Y/N	—	Y/N	—	1=Little Effect 2=Neutral 3=Significant Effect	1=Difficult to change 2=Neutral 3=Easy to change	1=Little Effect 2=Neutral 3=Significant Effect	1=Little Effect 2=Neutral 3=Significant Effect	1=Reduces 2=Neutral 3=Enhances	—
Patient consent requirements	—	—	—	—	—	—	—	—	—	—	—	—
Patient authorization requirements	—	—	—	—	—	—	—	—	—	—	—	—
Disclosure for emergency situations	—	—	—	—	—	—	—	—	—	—	—	—

**Table 6. Subject Matter Area: Minors**

<b>Comparative Analysis Matrix and Assessment Tool</b>	Citation /Link	More Stringent than HIPAA for Patient Care?	More Stringent than HIPAA for Population Health?	References to Related State/ Federal Law & Legislative Proposals	Subject Matter to be Ranked?	Comments	Facilitates HIE Development (Based on current HIE development in the state)	Ease of Reaching Consensus Among Stakeholders (e.g., cultural/ regional attitudes, economic impact, non-state after-effects)	Positive Impact on Patient-Focused Health Care	Positive Impact on Population Health	Consumer Privacy Protection	TOTAL (Optional)
<b>Response Categories and Applicable Scale</b>	—	Y/N	Y/N	—	Y/N	—	1=Little Effect 2=Neutral 3=Significant Effect	1=Difficult to change 2=Neutral 3=Easy to change	1=Little Effect 2=Neutral 3=Significant Effect	1=Little Effect 2=Neutral 3=Significant Effect	1=Reduces 2=Neutral 3=Enhances	—
Age of majority	—	—	—	—	—	—	—	—	—	—	—	—
Emancipated minors	—	—	—	—	—	—	—	—	—	—	—	—
Age consent requirements—Mental health	—	—	—	—	—	—	—	—	—	—	—	—
Age Consent requirements—Other conditions	—	—	—	—	—	—	—	—	—	—	—	—

**Table 7. Subject Matter Area: Patient Proxies**

<b>Comparative Analysis Matrix and Assessment Tool</b>	<b>Citation/Link</b>	<b>More Stringent than HIPAA for Patient Care?</b>	<b>More Stringent than HIPAA for Population Health?</b>	<b>References to Related State/Federal Law &amp; Legislative Proposals</b>	<b>Subject Matter to be Ranked?</b>	<b>Comments</b>	<b>Facilitates HIE Development (Based on current HIE development in the state)</b>	<b>Ease of Reaching Consensus Among Stakeholders (e.g., cultural/regional attitudes, economic impact, non-state after-effects)</b>	<b>Positive Impact on Patient-Focused Health Care</b>	<b>Positive Impact on Population Health</b>	<b>Consumer Privacy Protection</b>	<b>TOTAL (Optional)</b>
<b>Response Categories and Applicable Scale</b>	—	Y/N	Y/N	—	Y/N	—	1=Little Effect 2=Neutral 3=Significant Effect	1=Difficult to change 2=Neutral 3=Easy to change	1=Little Effect 2=Neutral 3=Significant Effect	1=Little Effect 2=Neutral 3=Significant Effect	1=Reduces 2=Neutral 3=Enhances	—
Personal Representatives/Executors	—	—	—	—	—	—	—	—	—	—	—	—
Guardians	—	—	—	—	—	—	—	—	—	—	—	—
Health Care Power of Attorney	—	—	—	—	—	—	—	—	—	—	—	—
Health Care Power of Attorney—mental health	—	—	—	—	—	—	—	—	—	—	—	—

**Table 8. Subject Matter Area: Health Condition-Specific/Situation-Specific Provisions**

<b>Comparative Analysis Matrix and Assessment Tool</b>	<b>Citation/Link</b>	<b>More Stringent than HIPAA for Patient Care?</b>	<b>More Stringent than HIPAA for Population Health?</b>	<b>References to Related State/Federal Law &amp; Legislative Proposals</b>	<b>Subject Matter to be Ranked?</b>	<b>Comments</b>	<b>Facilitates HIE Development (Based on current HIE development in the state)</b>	<b>Ease of Reaching Consensus Among Stakeholders (e.g., cultural/regional attitudes, economic impact, non-state after-effects)</b>	<b>Positive Impact on Patient-Focused Health Care</b>	<b>Positive Impact on Population Health</b>	<b>Consumer Privacy Protection</b>	<b>TOTAL (Optional)</b>
<b>Response Categories and Applicable Scale</b>	—	Y/N	Y/N	—	Y/N	—	1=Little Effect 2=Neutral 3=Significant Effect	1=Difficult to change 2=Neutral 3=Easy to change	1=Little Effect 2=Neutral 3=Significant Effect	1=Little Effect 2=Neutral 3=Significant Effect	1=Reduces 2=Neutral 3=Enhances	—
Genetic information	—	—	—	—	—	—	—	—	—	—	—	—
HIV/AIDS information	—	—	—	—	—	—	—	—	—	—	—	—
Sexually transmitted disease information	—	—	—	—	—	—	—	—	—	—	—	—
Hepatitis C information	—	—	—	—	—	—	—	—	—	—	—	—
Adult mental health	—	—	—	—	—	—	—	—	—	—	—	—
Children's mental health	—	—	—	—	—	—	—	—	—	—	—	—
Communicable disease information	—	—	—	—	—	—	—	—	—	—	—	—
Alcohol addiction	—	—	—	—	—	—	—	—	—	—	—	—
Drug addiction	—	—	—	—	—	—	—	—	—	—	—	—
Reproductive rights	—	—	—	—	—	—	—	—	—	—	—	—
Minor wards of the state	—	—	—	—	—	—	—	—	—	—	—	—

<b>Comparative Analysis Matrix and Assessment Tool</b>	<b>Citation/Link</b>	<b>More Stringent than HIPAA for Patient Care?</b>	<b>More Stringent than HIPAA for Population Health?</b>	<b>References to Related State/ Federal Law &amp; Legislative Proposals</b>	<b>Subject Matter to be Ranked?</b>	<b>Comments</b>	<b>Facilitates HIE Development (Based on current HIE development in the state)</b>	<b>Ease of Reaching Consensus Among Stakeholders (e.g., cultural/ regional attitudes, economic impact, non-state after-effects)</b>	<b>Positive Impact on Patient-Focused Health Care</b>	<b>Positive Impact on Population Health</b>	<b>Consumer Privacy Protection</b>	<b>TOTAL (Optional)</b>
Adult wards of the state	—	—	—	—	—	—	—	—	—	—	—	—
Reporting of abortions	—	—	—	—	—	—	—	—	—	—	—	—
Victims (domestic violence, sex assault, etc.)	—	—	—	—	—	—	—	—	—	—	—	—
Futile Care Provisions	—	—	—	—	—	—	—	—	—	—	—	—
Other proxies	—	—	—	—	—	—	—	—	—	—	—	—



**Table 9. Subject Matter Area: Health Provider–Specific Provisions**

<b>Comparative Analysis Matrix and Assessment Tool</b>	<b>Citation/Link</b>	<b>More Stringent than HIPAA for Patient Care?</b>	<b>More Stringent than HIPAA for Population Health?</b>	<b>References to Related State/Federal Law &amp; Legislative Proposals</b>	<b>Subject Matter to be Ranked?</b>	<b>Comments</b>	<b>Facilitates HIE Development (Based on current HIE development in the state)</b>	<b>Ease of Reaching Consensus Among Stakeholders (e.g., cultural/regional attitudes, economic impact, non-state after-effects)</b>	<b>Positive Impact on Patient-Focused Health Care</b>	<b>Positive Impact on Population Health</b>	<b>Consumer Privacy Protection</b>	<b>TOTAL (Optional)</b>
<b>Response Categories and Applicable Scale</b>	—	Y/N	Y/N	—	Y/N	—	1=Little Effect 2=Neutral 3=Significant Effect	1=Difficult to change 2=Neutral 3=Easy to change	1=Little Effect 2=Neutral 3=Significant Effect	1=Little Effect 2=Neutral 3=Significant Effect	1=Reduces 2=Neutral 3=Enhances	—
Pharmacy records	—	—	—	—	—	—	—	—	—	—	—	—
Emergency services (ambulance/ EMT)	—	—	—	—	—	—	—	—	—	—	—	—
Health profession licensing	—	—	—	—	—	—	—	—	—	—	—	—
Health profession accreditation	—	—	—	—	—	—	—	—	—	—	—	—
Professional counselors	—	—	—	—	—	—	—	—	—	—	—	—
Utilization, peer & quality review	—	—	—	—	—	—	—	—	—	—	—	—

**Table 10. Subject Matter Area: Facility-Specific Provisions**

<b>Comparative Analysis Matrix and Assessment Tool</b>	<b>Citation/Link</b>	<b>More Stringent than HIPAA for Patient Care?</b>	<b>More Stringent than HIPAA for Population Health?</b>	<b>References to Related State/Federal Law &amp; Legislative Proposals</b>	<b>Subject Matter to be Ranked?</b>	<b>Comments</b>	<b>Facilitates HIE Development (Based on current HIE development in the state)</b>	<b>Ease of Reaching Consensus Among Stakeholders (e.g., cultural/regional attitudes, economic impact, non-state after-effects)</b>	<b>Positive Impact on Patient-Focused Health Care</b>	<b>Positive Impact on Population Health</b>	<b>Consumer Privacy Protection</b>	<b>TOTAL (Optional)</b>
<b>Response Categories and Applicable Scale</b>	—	Y/N	Y/N	—	Y/N	—	1=Little Effect 2=Neutral 3=Significant Effect	1=Difficult to change 2=Neutral 3=Easy to change	1=Little Effect 2=Neutral 3=Significant Effect	1=Little Effect 2=Neutral 3=Significant Effect	1=Reduces 2=Neutral 3=Enhances	—
Hospitals	—	—	—	—	—	—	—	—	—	—	—	—
School-based clinics	—	—	—	—	—	—	—	—	—	—	—	—
Imaging labs and centers	—	—	—	—	—	—	—	—	—	—	—	—
Testing and clinical labs	—	—	—	—	—	—	—	—	—	—	—	—
Assisted living facilities	—	—	—	—	—	—	—	—	—	—	—	—
Drug & alcohol treatment facilities	—	—	—	—	—	—	—	—	—	—	—	—
Rehabilitation facilities	—	—	—	—	—	—	—	—	—	—	—	—
Home health agencies	—	—	—	—	—	—	—	—	—	—	—	—
Hospice	—	—	—	—	—	—	—	—	—	—	—	—

**Table 11. Subject Matter Area: Payers/Insurance Company Provisions**

<b>Comparative Analysis Matrix and Assessment Tool</b>	<b>Citation/Link</b>	More Stringent than HIPAA for Patient Care?	More Stringent than HIPAA for Population Health?	References to Related State/Federal Law & Legislative Proposals	Subject Matter to be Ranked?	<b>Comments</b>	Facilitates HIE Development (Based on current HIE development in the state)	Ease of Reaching Consensus Among Stakeholders (e.g., cultural/regional attitudes, economic impact, non-state after-effects)	Positive Impact on Patient-Focused Health Care	Positive Impact on Population Health	Consumer Privacy Protection	<b>TOTAL (Optional)</b>
<b>Response Categories and Applicable Scale</b>	—	Y/N	Y/N	—	Y/N	—	1=Little Effect 2=Neutral 3=Significant Effect	1=Difficult to change 2=Neutral 3=Easy to change	1=Little Effect 2=Neutral 3=Significant Effect	1=Little Effect 2=Neutral 3=Significant Effect	1=Reduces 2=Neutral 3=Enhances	—
Health insurance related provisions	—	—	—	—	—	—	—	—	—	—	—	—
HMO provisions	—	—	—	—	—	—	—	—	—	—	—	—
Medicaid/Medicare related provisions	—	—	—	—	—	—	—	—	—	—	—	—

**Table 12. Subject Matter Area: Employer-Specific Provisions**

<b>Comparative Analysis Matrix and Assessment Tool</b>	<b>Citation/Link</b>	<b>More Stringent than HIPAA for Patient Care?</b>	<b>More Stringent than HIPAA for Population Health?</b>	<b>References to Related State/Federal Law &amp; Legislative Proposals</b>	<b>Subject Matter to be Ranked?</b>	<b>Comments</b>	<b>Facilitates HIE Development (Based on current HIE development in the state)</b>	<b>Ease of Reaching Consensus Among Stakeholders (e.g., cultural/regional attitudes, economic impact, non-state after-effects)</b>	<b>Positive Impact on Patient-Focused Health Care</b>	<b>Positive Impact on Population Health</b>	<b>Consumer Privacy Protection</b>	<b>TOTAL (Optional)</b>
<b>Response Categories and Applicable Scale</b>	—	Y/N	Y/N	—	Y/N	—	1=Little Effect 2=Neutral 3=Significant Effect	1=Difficult to change 2=Neutral 3=Easy to change	1=Little Effect 2=Neutral 3=Significant Effect	1=Little Effect 2=Neutral 3=Significant Effect	1=Reduces 2=Neutral 3=Enhances	—
EHR	—	—	—	—	—	—	—	—	—	—	—	—
Provisions related to employers	—	—	—	—	—	—	—	—	—	—	—	—
Pre-employment screenings	—	—	—	—	—	—	—	—	—	—	—	—
Employee assistance programs	—	—	—	—	—	—	—	—	—	—	—	—

**Table 13. Subject Matter Area: Public Health Reporting**

<b>Comparative Analysis Matrix and Assessment Tool</b>	<b>Citation/Link</b>	<b>More Stringent than HIPAA for Patient Care?</b>	<b>More Stringent than HIPAA for Population Health?</b>	<b>References to Related State/Federal Law &amp; Legislative Proposals</b>	<b>Subject Matter to be Ranked?</b>	<b>Comments</b>	<b>Facilitates HIE Development (Based on current HIE development in the state)</b>	<b>Ease of Reaching Consensus Among Stakeholders (e.g., cultural/regional attitudes, economic impact, non-state after-effects)</b>	<b>Positive Impact on Patient-Focused Health Care</b>	<b>Positive Impact on Population Health</b>	<b>Consumer Privacy Protection</b>	<b>TOTAL (Optional)</b>
<b>Response Categories and Applicable Scale</b>	—	Y/N	Y/N	—	Y/N	—	1=Little Effect 2=Neutral 3=Significant Effect	1=Difficult to change 2=Neutral 3=Easy to change	1=Little Effect 2=Neutral 3=Significant Effect	1=Little Effect 2=Neutral 3=Significant Effect	1=Reduces 2=Neutral 3=Enhances	—
Newborn screening	—	—	—	—	—	—	—	—	—	—	—	—
Vital records (birth/death certificates)	—	—	—	—	—	—	—	—	—	—	—	—
State Department of Health reporting (reporting certain conditions to state)	—	—	—	—	—	—	—	—	—	—	—	—
Reports to other state agencies	—	—	—	—	—	—	—	—	—	—	—	—
Immunization reporting	—	—	—	—	—	—	—	—	—	—	—	—
Registries	—	—	—	—	—	—	—	—	—	—	—	—
Information sharing in public emergencies	—	—	—	—	—	—	—	—	—	—	—	—

**Table 14. Subject Matter Area: State Facilities/Medical Records**

<b>Comparative Analysis Matrix and Assessment Tool</b>	<b>Citation/Link</b>	<b>More Stringent than HIPAA for Patient Care?</b>	<b>More Stringent than HIPAA for Population Health?</b>	<b>References to Related State/Federal Law &amp; Legislative Proposals</b>	<b>Subject Matter to be Ranked?</b>	<b>Comments</b>	<b>Facilitates HIE Development (Based on current HIE development in the state)</b>	<b>Ease of Reaching Consensus Among Stakeholders (e.g., cultural/regional attitudes, economic impact, non-state after-effects)</b>	<b>Positive Impact on Patient-Focused Health Care</b>	<b>Positive Impact on Population Health</b>	<b>Consumer Privacy Protection</b>	<b>TOTAL (Optional)</b>
<b>Response Categories and Applicable Scale</b>	—	Y/N	Y/N	—	Y/N	—	1=Little Effect 2=Neutral 3=Significant Effect	1=Difficult to change 2=Neutral 3=Easy to change	1=Little Effect 2=Neutral 3=Significant Effect	1=Little Effect 2=Neutral 3=Significant Effect	1=Reduces 2=Neutral 3=Enhances	—
Other state facilities	—	—	—	—	—	—	—	—	—	—	—	—
Public health clinics	—	—	—	—	—	—	—	—	—	—	—	—
Correctional facilities (adult)	—	—	—	—	—	—	—	—	—	—	—	—
Correctional facilities (minors)	—	—	—	—	—	—	—	—	—	—	—	—
State hospitals	—	—	—	—	—	—	—	—	—	—	—	—
State Freedom of Information Act	—	—	—	—	—	—	—	—	—	—	—	—

**Table 15. Subject Matter Area: Penalties/Remedies**

<b>Comparative Analysis Matrix and Assessment Tool</b>	<b>Citation/Link</b>	<b>More Stringent than HIPAA for Patient Care?</b>	<b>More Stringent than HIPAA for Population Health?</b>	<b>References to Related State/Federal Law &amp; Legislative Proposals</b>	<b>Subject Matter to be Ranked?</b>	<b>Comments</b>	<b>Facilitates HIE Development (Based on current HIE development in the state)</b>	<b>Ease of Reaching Consensus Among Stakeholders (e.g., cultural/regional attitudes, economic impact, non-state after-effects)</b>	<b>Positive Impact on Patient-Focused Health Care</b>	<b>Positive Impact on Population Health</b>	<b>Consumer Privacy Protection</b>	<b>TOTAL (Optional)</b>
<b>Response Categories and Applicable Scale</b>	—	Y/N	Y/N	—	Y/N	—	1=Little Effect 2=Neutral 3=Significant Effect	1=Difficult to change 2=Neutral 3=Easy to change	1=Little Effect 2=Neutral 3=Significant Effect	1=Little Effect 2=Neutral 3=Significant Effect	1=Reduces 2=Neutral 3=Enhances	—
Statutory right to sue for damages related to health information	—	—	—	—	—	—	—	—	—	—	—	—
Common law right to sue for damages related to health information	—	—	—	—	—	—	—	—	—	—	—	—
Criminal provisions—Wrongful access	—	—	—	—	—	—	—	—	—	—	—	—
Administrative penalties for wrongful disclosure	—	—	—	—	—	—	—	—	—	—	—	—

**Table 16. Subject Matter Area: Litigation-Related Provisions**

<b>Comparative Analysis Matrix and Assessment Tool</b>	<b>Citation/Link</b>	<b>More Stringent than HIPAA for Patient Care?</b>	<b>More Stringent than HIPAA for Population Health?</b>	<b>References to Related State/Federal Law &amp; Legislative Proposals</b>	<b>Subject Matter to be Ranked?</b>	<b>Comments</b>	<b>Facilitates HIE Development (Based on current HIE development in the state)</b>	<b>Ease of Reaching Consensus Among Stakeholders (e.g., cultural/regional attitudes, economic impact, non-state after-effects)</b>	<b>Positive Impact on Patient-Focused Health Care</b>	<b>Positive Impact on Population Health</b>	<b>Consumer Privacy Protection</b>	<b>TOTAL (Optional)</b>
<b>Response Categories and Applicable Scale</b>	—	Y/N	Y/N	—	Y/N	—	1=Little Effect 2=Neutral 3=Significant Effect	1=Difficult to change 2=Neutral 3=Easy to change	1=Little Effect 2=Neutral 3=Significant Effect	1=Little Effect 2=Neutral 3=Significant Effect	1=Reduces 2=Neutral 3=Enhances	—
Medical record subpoenas	—	—	—	—	—	—	—	—	—	—	—	—
Patient/provider privilege	—	—	—	—	—	—	—	—	—	—	—	—
Workers' comp disclosures	—	—	—	—	—	—	—	—	—	—	—	—



**Table 17. Subject Matter Area: Law Enforcement**

<b>Comparative Analysis Matrix and Assessment Tool</b>	<b>Citation/Link</b>	<b>More Stringent than HIPAA for Patient Care?</b>	<b>More Stringent than HIPAA for Population Health?</b>	<b>References to Related State/Federal Law &amp; Legislative Proposals</b>	<b>Subject Matter to be Ranked?</b>	<b>Comments</b>	<b>Facilitates HIE Development (Based on current HIE development in the state)</b>	<b>Ease of Reaching Consensus Among Stakeholders (e.g., cultural/regional attitudes, economic impact, non-state after-effects)</b>	<b>Positive Impact on Patient-Focused Health Care</b>	<b>Positive Impact on Population Health</b>	<b>Consumer Privacy Protection</b>	<b>TOTAL (Optional)</b>
<b>Response Categories and Applicable Scale</b>	—	Y/N	Y/N	—	Y/N	—	1=Little Effect 2=Neutral 3=Significant Effect	1=Difficult to change 2=Neutral 3=Easy to change	1=Little Effect 2=Neutral 3=Significant Effect	1=Little Effect 2=Neutral 3=Significant Effect	1=Reduces 2=Neutral 3=Enhances	—
DUI test results	—	—	—	—	—	—	—	—	—	—	—	—
Abuse & neglect	—	—	—	—	—	—	—	—	—	—	—	—
Other disclosures to law enforcement	—	—	—	—	—	—	—	—	—	—	—	—

**Table 18. Subject Matter Area: Research**

<b>Comparative Analysis Matrix and Assessment Tool</b>	<b>Citation/Link</b>	More Stringent than HIPAA for Patient Care?	More Stringent than HIPAA for Population Health?	References to Related State/Federal Law & Legislative Proposals	Subject Matter to be Ranked?	<b>Comments</b>	Facilitates HIE Development (Based on current HIE development in the state)	Ease of Reaching Consensus Among Stakeholders (e.g., cultural/regional attitudes, economic impact, non-state after-effects)	Positive Impact on Patient-Focused Health Care	Positive Impact on Population Health	Consumer Privacy Protection	TOTAL (Optional)
<b>Response Categories and Applicable Scale</b>	—	Y/N	Y/N	—	Y/N	—	1=Little Effect 2=Neutral 3=Significant Effect	1=Difficult to change 2=Neutral 3=Easy to change	1=Little Effect 2=Neutral 3=Significant Effect	1=Little Effect 2=Neutral 3=Significant Effect	1=Reduces 2=Neutral 3=Enhances	—
Disclosures for research	—	—	—	—	—	—	—	—	—	—	—	—

**Table 19. Subject Matter Area: Statutory Definitions**

<b>Comparative Analysis Matrix and Assessment Tool</b>	<b>Citation/Link</b>	<b>More Stringent than HIPAA for Patient Care?</b>	<b>More Stringent than HIPAA for Population Health?</b>	<b>References to Related State/Federal Law &amp; Legislative Proposals</b>	<b>Subject Matter to be Ranked?</b>	<b>Comments</b>	<b>Facilitates HIE Development (Based on current HIE development in the state)</b>	<b>Ease of Reaching Consensus Among Stakeholders (e.g., cultural/regional attitudes, economic impact, non-state after-effects)</b>	<b>Positive Impact on Patient-Focused Health Care</b>	<b>Positive Impact on Population Health</b>	<b>Consumer Privacy Protection</b>	<b>TOTAL (Optional)</b>
<b>Response Categories and Applicable Scale</b>	—	Y/N	Y/N	—	Y/N	—	1=Little Effect 2=Neutral 3=Significant Effect	1=Difficult to change 2=Neutral 3=Easy to change	1=Little Effect 2=Neutral 3=Significant Effect	1=Little Effect 2=Neutral 3=Significant Effect	1=Reduces 2=Neutral 3=Enhances	—
Electronic Medical Record	—	—	—	—	—	—	—	—	—	—	—	—
Electronic Health Record	—	—	—	—	—	—	—	—	—	—	—	—
Health Information Exchange	—	—	—	—	—	—	—	—	—	—	—	—
Health Information Organization	—	—	—	—	—	—	—	—	—	—	—	—
Personal Health Record	—	—	—	—	—	—	—	—	—	—	—	—
Consent	—	—	—	—	—	—	—	—	—	—	—	—
Authorization	—	—	—	—	—	—	—	—	—	—	—	—
Privacy	—	—	—	—	—	—	—	—	—	—	—	—
Confidentiality	—	—	—	—	—	—	—	—	—	—	—	—

## NOTES

Subject Matter Area Progress Notes	Status/Tracking Comments
Privacy-Specific Provisions	—
HIPAA-Based and Other Federally Based Provisions	—
Health Information Provisions	—
Health/Medical Records in General	—
Consent/Authorizations	—
Minors	—
Patient Proxies	—
Health Condition-Specific/Situation-Specific Provisions	—
Health Provider-Specific Provisions	—
Facility-Specific Provisions	—
Payers/Insurance Company Provisions	—
Employer-Specific Provisions	—
Public Health Reporting	—
State Facilities/Medical Records	—
Penalties/Remedies	—
Litigation-Related Provisions	—
Law Enforcement	—
Research	—
Statutory Definitions	—