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**Indiana University Opioid Use Disorder ECHO:**

**Statement of Collaboration**

**About the Project**

This mission of Project ECHO® (Extension for Community Healthcare Outcomes) at Indiana University is to develop the capacity to safely and effectively treat Opioid Use Disorder (OUD) in rural and underserved areas and to monitor outcomes of treatment. In pursuit of this mission, Project ECHO® faculty, staff and partners have dedicated themselves to sharing knowledge in order to expand access to best-practice medical care across the US and globally.

**Commitment to Collaboration- Community Provider**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, agree to join the OUD ECHO as a community provider; I acknowledge and accept that all sessions will be recorded, and will participate during the program period of March 21, 2018 through June 6, 2018 (Wednesdays 12-1:30pm, EDT). As part of the OUD ECHO program, I am committed to:

1. Participating in teleECHO clinics (with my camera turned on) every week, including presenting patient cases, providing comments, and asking questions.
2. Presenting a minimum of three patient cases during the program period.
3. Providing clinical updates and de-identified outcome data on patients, as needed.
4. Completing period survey evaluations to improve services to participating providers and other ECHO partners.

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Participant Name (Print) Participant Email

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Participant Signature Date

Your treatment team members (i.e., nurses, pharmacists, social workers, community health workers, and any other health care providers) are highly encouraged to participate in the weekly clinics. Please list the names and contact information for key staff who will participate in or support the teleECHO clinics at your site on a regular basis.

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| **Team Member** | **Role** | **Email** |
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Please sign and return to Kristen Kelley:

[OUDECHO@iu.edu](mailto:OUDECHO@iu.edu)

**Commitment to Collaboration- OUD ECHO Team**

Project ECHO is a highly collaborative effort; therefore, the OUD ECHO Team at Indiana University is committed to working with you and other community partners. The OUD Project ECHO offers the following:

1. Free CME credit from the Indiana University School of Medicine Division for Continuing Education for participating in teleECHO clinics (1.5 hour2 = 1.5 CME).
2. Regular didactic presentations on OUD-related topics, including diagnosis, treatment, and monitoring.
3. Collaborative patient case-reviews presented by community providers, with timely written documentation of recommendations made during the ECHO session.
4. Guidance outside of teleconference times for emergent questions or issues, as needed.

The OUD Project ECHO is a teaching/learning collaborative including the OUD ECHO Team and Community Health Care Providers, and as such, does not provide direct patient care or consultations. Community Health Care Providers assume sole responsibility for the care of their patients under the ECHO model.

**Confidentiality and Privacy of Patient Information**

Dear Provider,

As a provider who is participating in the OUD ECHO program with the Indiana School of Medicine, you have an ethical and legal duty to keep patient information confidential. Federal law known as the Health Insurance Portability and Accountability Act of 1996 (HIPAA) forbids healthcare providers from disclosing patients’ protected health information, expect upon written authorization by the patient or as otherwise permitted by law.

Please remove all Protected Health Information (PHI) from your OUD ECHO case presentations. Even when PHI is not used, patients may have unique constellations of social and medical conditions that, if the information in their

case presentation were discussed outside of the ECHO setting, may allow identification. Out of respect for the ECHO participants and their patients, please do not share presentations that are not yours outside of the ECHO setting.

Some general guidelines:

* Share or discuss patient information only if it is necessary to do your work and only in appropriate locations
* Access patient information only if you need that information to do your work.
* Ensure confidentiality when you handle all protected healthcare information.
* No protected healthcare information should be included in the HCV ECHO Case Form or included during case-based discussions.

Provider Agreement

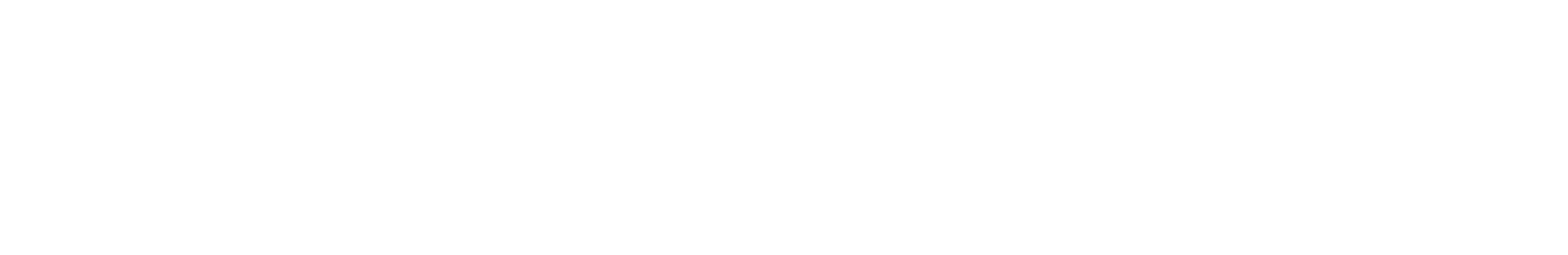
I have received and reviewed all information that I was given about patient privacy and confidentiality. I understand the importance of appropriate use and disclosure of patient protected health information. I agree keep protected healthcare information confidential.

Print Name

Signature

Date

**HIPAA IDENTIFIERS**



Regarding the safeguarded of patient health information (whether written, orally stated, or in electronic format) ECHO complies with State and Federal guidelines.

When presenting your patient, please use the ECHO ID number and refrain from providing information contain- ing names, initials, living location, place of work, birth date, or any specific information about the patient that helps identify them as this is considered *"protected health information."* It is our responsibility to ensure the privacy of the protected health information is not disclosed.

1. **Names;**

###### HIPAA PHI: List of 18 Identifiers and Definition of PHI

11. Certificate/license numbers;

1. All geographical subdivisions smaller than a State, including street address, city, county, precinct, zip code, and their equivalent geocodes, except for the initial three digits of a zip code, if according to the current publicly available data from the Bureau of the Census:
   1. The geographic unit formed by combining all zip codes with the same three initial digits contains more than 20,000 people; and
   2. The initial three digits of a zip code for all such geographic units containing 20,000 or fewer people is changed to 000.
2. All elements of dates (except year) for dates directly related to an individual, including birth date, admission date, discharge date, date of death; and all ages over 89 and all elements of dates (including year) indicative of such age, except that such ages and elements may be aggregated into a single category of age 90 or older;
3. Phone numbers;
4. Fax numbers;
5. Electronic mail addresses;
6. Social Security numbers;

#### Medical record numbers;

1. Health plan beneficiary numbers;
2. Account numbers;
3. Vehicle identifiers and serial numbers, including license plate numbers;
4. Device identifiers and serial numbers;
5. Web Universal Resource Locators (URL);
6. Internet Protocol (I) address numbers;
7. Biometric identifiers, including finger and voice prints;
8. Full face photographic **images** and any comparable images; and
9. Any other unique identifying number, characteristic, or code (note this does not mean the unique code assigned by the investigator to code the data).

There are also additional standards and criteria to protect individual's privacy from re-identification. Any code used to replace the identifiers in datasets cannot be derived from any information related to the

individual and the master codes, nor can the method to derive the codes be disclosed. For example, a subject's **initials** cannot be used to code their data because the initials are derived from their name.

Additionally, the researcher must not have actual knowledge that the research subject could be

re-identified from the remaining identifiers in the PHI used in the research study. In other words, the information would still be considered identifiable is

there was a way to identify the individual even though all of the 18 identifiers were removed.





I (“Participant”) authorize The Trustees of Indiana University (“IU”), acting through its agents, employees, or representatives, to take photographs, video recordings, and/or audio recordings of me, including my name, my image, my likeness, my performance, and/or my voice (“Recordings”). I also grant IU an unlimited right to reproduce, use, exhibit, display, perform, broadcast, create derivative works from, and distribute the Recordings in any manner or media now existing or hereafter developed, in perpetuity, throughout the world. I agree that the Recordings may be used by IU, including its assigns and transferees, for any purpose, including but not limited to, marketing, advertising, publicity, or other promotional purposes. I agree that IU will have final editorial authority over the use of the Recordings, and I waive any right to inspect or approve of any future use of the Recordings. I acknowledge that I am not expecting to receive compensation for participating in the Recordings or for any future use of the Recordings.

I release and fully discharge IU, and its employees, agents, and representatives, from any claim, damages, or liability arising from or related to my participation in the Recordings or IU’s future use of the Recordings.

**I have read this entire Consent and Release Form, I fully understand it, and I agree to be bound by it.**

**I represent and certify that my true age is at least 18 years old, or, if I am under 18 years old on this date, my parent or legal guardian has also signed below.**

Location of Recordings

OUD ECHO Program

Date(s) of Recordings March 21, 2018 to June 6, 2018

Participant’s Signature Date **/ /**

Participant’s Printed Name Address City State Zip Phone Email

***If Participant is under 18 years old, then his/her parent or guardian must sign below.***

Parent/Guardian’s Signature Parent/Guardian’s Printed Name