Justice to Health Exchanges: Understanding the Myths Surrounding the Health Insurance Portability Accountability Act (HIPAA)

March 24, 2015
3:00-4:30 pm ET

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NCJA National Criminal Justice Association

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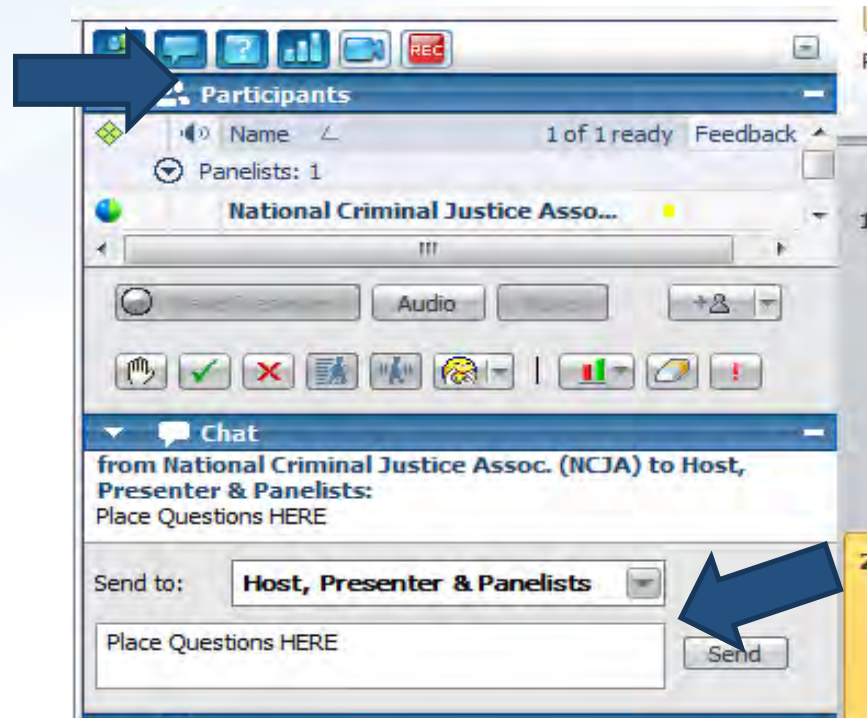Toll-free dialing restrictions: http://www.webex.com/pdf/tollfree_restrictions.pdf
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By the end of this session, you will:

- Understand and be able dispel the "myths" surrounding HIPAA and 42 CFR Part 2;
- Have a greater awareness of how states and local jurisdictions are moving forward with justice to health information exchanges;
- Understand the benefits of using national standards to facilitate these secure information exchanges; and
- Know where to access more information and how to leverage example agreements to advance justice to health exchanges in your state.

Presenters

Tammy Woodhams, Senior Staff Associate, NCJA (Moderator)

Kate Tipping, JD, Public Health Advisor, Substance Abuse and Mental Health Services Administration

Becki Goggins, Director, Law and Policy, SEARCH

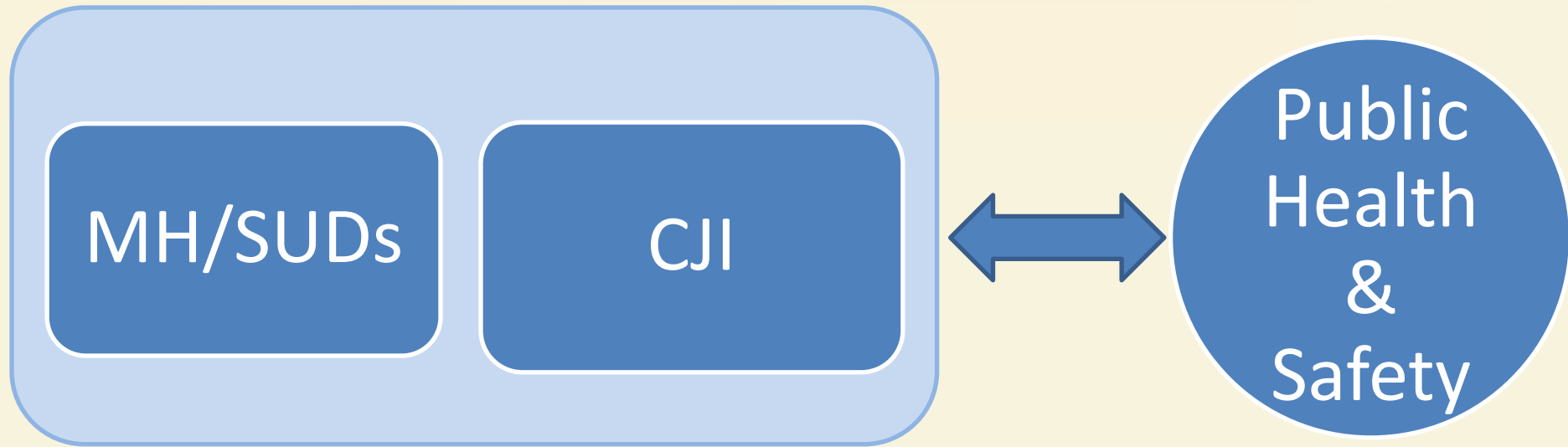Richard Fiore, ASSURE Project Sponsor, State of Alabama

Kate Tipping, JD

Public Health Advisor, Health Information Technology

Center for Substance Abuse Treatment

Substance Abuse and Mental Health Services Administration

March 24, 2015

CJ Behavioral Health *is* Public Health

MH/SUDs   CJI   ⟷   Public Health & Safety

➔ MH/SUDs and CJ involvement (CJI) are interlinked public health & safety issues.

➔ Addressing MH/SUDs can reduce CJI, simultaneously improving public health and safety while reducing related economic burdens.

Privacy Regulations

➔ Not meant to prevent information sharing but to set the standards for how to share

➔ Federal laws are a baseline, states may adopt more strict regulations

➔ Most states have laws that are stricter than HIPAA, few have laws that are stricter than Part 2

➔ State laws vary widely, presenting challenges for developing unified policy solutions or solutions that work across states, also difficult for technology vendors to develop functionality

Overview

➔ Privacy of health information is governed by Federal and State law

➔ Two Federal laws govern confidentiality of health information, including alcohol/drug patient records:
  – HIPAA
  – 42 CFR Part 2

➔ There are also many State laws protecting certain health information such as— Mental health, HIV/AIDS, reproductive health

What is HIPAA?

➜ **H**ealth **I**nsurance **P**ortability and **A**ccountability **A**ct of 1996 – HIPAA Privacy, Security and Breach Notification Rules (HIPAA Rules)

➜ Federal law

➜ Establishes a floor (minimum) of safeguards to protect privacy of "protected health information" (PHI)

➜ Applies to PHI no matter how it is shared (electronic, written, or oral form)

➜ Establishes patient rights

HIPAA

➔ Who is covered by HIPAA?

- "Covered entities"
  - Health care providers
  - Health plans
  - Health care clearinghouses
- **If** they transmit health information <u>electronically</u> in connection with certain **covered transactions** (e.g., generally concerning billing and eligibility)

HIPAA

➔ Allows certain categories of information sharing without a patient's authorization:

➔ Treatment, health care business operations, or payment;

➔ Other permitted uses, including, for example:

– Public health activities

– Health oversight, including government agencies providing public benefits

– Judicial and administrative proceedings

– Law enforcement purposes.

➔ One exception is psychotherapy notes. Authorization must be obtained before this information can be shared.

HIPAA

➔ Disclosures should be limited to the 'minimal necessary' to achieve the purpose for which the disclosure is permitted

➔ While HIPAA does not require consent for many transactions many providers or organizations may choose to use them to build trust with patients

➔ Most of the myths are related to over interpretation of the privacy rule while often overlooking the highly important security regulations

When does the HIPAA allow CEs to disclose protected health information to law enforcement officials?

➔ **To comply with a court order or court-ordered warrant, a subpoena or summons issued by a judicial officer, or a grand jury subpoena**

➔ **To respond to an administrative request**

➔ **To respond to a request for PHI for purposes of identifying or locating a suspect, fugitive, material witness or missing person**

➔ **To respond to a request for PHI about a victim of a crime, and the victim agrees**

HIPAA and CJ: Permitted Disclosures

➔ **To report PHI to law enforcement when required by law**

➔ **To alert law enforcement to the death of the individual**

➔ **To report PHI that the covered entity in good faith believes to be evidence of a crime that occurred on the covered entity's premises**

➔ **When responding to an off-site medical emergency, as necessary to alert law enforcement about criminal activity**

➔ **When consistent with applicable law and ethical standards:**

- – To a law enforcement official reasonably able to **prevent or lessen a serious and imminent threat to the health or safety of an individual or the public** (45 CFR 164.512(j)(1)(i)); or

- – **To identify or apprehend an individual who appears to have escaped from lawful custody** (45 CFR 164.512(j)(1)(ii)(B)).

HIPAA and CJ: Permitted Disclosures

➔ **For certain other specialized governmental law enforcement purposes, such as:**

- **To federal officials authorized to conduct intelligence, counter-intelligence, and other national security activities**

- **To respond to a request for PHI by a correctional institution or a law enforcement official having lawful custody of an inmate**

What is 42 CFR Part 2?

➔ Regulations implementing Federal drug and alcohol confidentiality law (42 U.S.C. § 290dd-2)

➔ Federal law

➔ Governs confidentiality of alcohol and drug treatment information

➔ The purpose of 42 CFR Part 2 and other regulations prohibiting disclosure of records relating to substance abuse treatment   (except with the individual's consent or a court order after good cause is shown) is *to encourage individuals to seek substance abuse treatment without fear that by doing so their privacy will be compromised and/or they will suffer from bias.*

42 CFR Part 2 Applies to Federally Assisted Services

➡️ Applies to federally assisted individual or entity that "***holds itself out as providing, and provides, alcohol or drug abuse diagnosis, treatment or treatment referral***".

– Unit within a general medical facility that **holds itself out** as providing diagnosis, treatment or treatment referral.

Disclosure

➜ Patient consent must be obtained before sharing information from a substance abuse treatment facility that is subject to 42 CFR Part 2

➜ Disclosure:

- "A communication of patient identifying information, the affirmative verification of another person's communication of patient identifying information, or the communication of any information *from the record* of a patient..." (42 CFR 2.11)

- Even acknowledging that an individual is (or was) a patient at a Part 2 facility is a breach of the regulations

Revocation of Consent

"The written consent must state that it is revocable upon the passage of a specified amount of time or the occurrence of a specified, ascertainable event. The time or occurrence upon which consent becomes revocable may be no later than the final disposition of the conditional release or other action in connection with which consent is given."

Restrictions on Redisclosure and Use

"A person who receives patient information under this section may redisclose and use it only to carry out that person's conditional release or other action in connection with which the consent was given."

Exceptions

→ Limited exceptions for disclosure without consent :

- Medical emergencies
- Child abuse reporting
- Crimes on program premises or against program personnel
- Communications with a qualified service organization of information needed by the organization to provide services to the program
- Public Health
- Research
- Court order
- Audits and evaluations

42 CFR Part 2 and CJ: Permitted Disclosure

→ Generally cannot disclose information without subpoena and court order - arrest/search warrant not sufficient

→ Can disclose for crime committed by patients on program premises or against program personnel or a threat to commit such a crime

→ Addiction treatment records may not be used to initiate/substantiate criminal charges (42 CFR 2.1) but can be used for revocations

42 CFR Part 2 and CJ: Permitted Disclosure

→ Disclosures by a treatment entity providing services to a court-ordered patient (post-adjudication, 42 CFR 2.35)

→ Diagnosis made "solely for the purpose of providing evidence for use by law enforcement authorities"

→ If facility is not identified publicly as only an alcohol or drug abuse facility, patient's presence may be acknowledged if do not reveal alcohol or drug abuse (42 CFR 2.13)

42 CFR Part 2 and CJ: Permitted Disclosure

➔ A program may disclose information about a patient to those persons within the criminal justice system which have made participation in the program a condition of the disposition of any criminal proceedings against the patient or of parole or other release from custody if

- Disclosure only to those who need the information for monitoring/supervision
- Written consent of the patient (but revocation rule does not apply)

Resources

→ To help providers in the behavioral health field better understand privacy issues related to Health IT, SAMHSA, in collaboration with ONC has created two sets of Frequently Asked Questions (FAQs).

- These FAQs can be accessed at: http://www.samhsa.gov/healthprivacy/docs/EHR-FAQs.pdf and

- http://www.samhsa.gov/about/laws/SAMHSA_42CFRPART2FAQII_Revised.pdf

→ OCR's guidance on sharing information related to mental health:

- http://www.hhs.gov/ocr/privacy/hipaa/understanding/special/mhguidance.html

State Laws

➔ State laws often provide additional protections for HIV infection, mental health information, genetics, drug and alcohol abuse, minors, domestic violence.

➔ Mental health records are treated as ultra-sensitive in many jurisdictions.

➔ Each state approaches the confidentiality of mental health records from their own perspective

➔ EHR systems have to recognize this variability in state statutes and regulations.

SEARCH

Privacy Issues for Justice and Health Exchanges: Separating Fact From Fiction

Becki Goggins
Director, Law and Policy
SEARCH - The National Consortium for
Justice Information and Statistics

Justice and Health

Information Exchanges

1. There is no need to share information
2. We do not want to share – perhaps not really a myth, but a mindset
3. The law will not allow us to share health information
4. Incompatible data formats make it impossible to share information
5. We will have to issue credentials to and manage external users
6. You cannot move PII and PHI around safely on the Internet
7. You cannot restrict access to data to prevent unauthorized persons from viewing it
8. It is too hard to get executive leadership's support – okay, this is not always a myth
9. It is too hard to get people to use the information if you make it available
10. **IT'S TOO EXPENSIVE!**

- Behavioral Health Example
  - According to the Bureau of Justice Statistics
    - 56.2% of state prison inmates have a mental health problem
    - 64.2% of local jail inmates have a mental health problem
    - 74.1% of inmates with mental health problems have a history of substance abuse (SA) or dependency
    - 55.6% of inmates without mental health problems have a history of substance abuse or dependency
  - Almost all of these individuals will be returned to the community
  - As states move from a hospital-based MH/SA treatment model to a community-based delivery system, it is imperative that persons with mental illness or addiction disorders have continuity of care when they leave incarceration. If not, prisons will become the primary providers of mental health and substance abuse treatment providers.
- Delivery of appropriate medical services – both in the community and in correctional settings – depends on having a complete medical profile of the patient. Ultimately, this saves time and money!

We do not want to share

- TOO BAD!

- With shrinking resources, everyone is being asked to "do more with less." Sharing information can improve efficiency in a number of ways:

  - Reducing redundant intake activities

  - Eliminating duplicate medical/psychological tests and procedures

- Information sharing improves patient care – whether in the community or in a correctional setting

  - Serious Mental Illness (SMI) diagnosis

  - Hypertension

  - Drug interactions

For those who are paying attention…

(There was no "Myth #2" – Not wanting to share is not a myth. Sometimes it is a fact.

However, it is an attitude that can be adjusted!)

Myth # 3 – The law will not allow us to share

BUSTED

- **Just because something is repeated often enough doesn't make** it true
- Health Insurance Portability and Accountability Act of 1996 (HIPAA)
  - Exemption for criminal justice purposes
  - Information may be shared with informed consent
- 42 CFR Part 2
  - Information may be shared with informed consent
  - Requires a separate consent from HIPAA
  - Does not allow information shared through the consent process to be used for prosecutions
- Warning
  - Check your state laws **–** they may be more restrictive
  - **Normally it doesn't matter –** with informed consent, most all things are possible

And now a word about consent…

- It must be informed
- It must specify who is allowed to share and receive information
- It must specify why information is to be shared
- There must be an expiration
  - Event – **judge terminates an individual's placement in a** program
  - Condition – individual successfully pays all fines, fees and restitution
  - Exact Date
- Client must be allowed to revoke it – there are exceptions to this rule for incarcerated individuals
- It must contain all required HIPAA and 42 CFR Part 2 notices

Myth # 4 - Incompatible data formats make it impossible to share information

BUSTED

- National Information Exchange Model (NIEM)
  - Provides common language for data sharing
  - Provides prescribed XML schemas
  - Provides meta-data about who, what, when and where data were collected to inform data recipient
- **Well I've heard the NIEM and HL7 standards are different**
  - They are different.
  - Bad News **–** this means there is not a perfect way to map all of the data from most Electronic Health Records (EHR) to a NIEM conformant payload.
  - Good News **– It doesn't matter. Most of what CJ practitioners** need is available in a structured format that can be mapped to NIEM.

- **Isn't it a bad idea to give credentials to users outside of my organization?**
  - This is indeed a bad idea! It is not a good thing!
- Global Federated Privilege and Identity Management (GFIPM) allows systems to consume external credentials
  - Allows each participating agency to add, modify and disable users
  - **(Yes, it is a good thing!)**
  - Supports federated queries
- **To be fair…there is still work to do**
  - GFIPM is still very "justice-centric"
  - Efforts are underway to create new entity, user and resource attributes to support justice to health exchanges

Myth # 6 – You cannot move PII and PHI around safely on the Internet

BUSTED

- Data must be encrypted

- 2-factor authentication is required for PHI

- Global Reference Architecture (GRA)

  - A specialized way of implementing Services Oriented Architecture (SOA)

  - If you want a technical description of precisely how this **works, I have people you can call…**

  - Basically, what's important is that the "connector" and "adapter" services allow web services to access data securely in its native environment, translate it into a NIEM-conformant payload, and route it safely – and securely – to properly authorized users seeking information.

- Remember earlier when I mentioned entity, user and resource attributes?

- **Okay, well let's at least pretend you do…**

- GFIPM allows us to create a machine-readable way to automatically enforce complex access control rules

- Example

  - [Permit or Deny] a [Requestor] the ability to perform the requested [Action] on an information [Resource] for a specific business [Purpose] subject to one or more [Conditions] and [Data handling]

  - [Permit] a [Requestor – User from community Substance Abuse Treatment Provider] the ability to [Action – get document] from a [Resource – Prison EHR system] for a specific business [Purpose - Drug Treatment] subject to one or more [Conditions - Client Consent, Court Order, Client Referral for Drug Treatment] and data handling [Obligations - Encrypt Medical Records obtained, no Secondary Dissemination]

Myth # 8 - It is too hard to get executive leadership's support

- Sometimes this is true

- You have to make a sound business case

- It is really great when the idea comes from the top!

- You can't do a justice to health information sharing project without it

- **I wouldn't say this myth is** "busted," but I have seen it work!

  - Alabama's ASSURE Project

- You have to get your business users together sometimes to discuss what they would like to share. When they develop their own use cases, they see the value and don't need to be convinced.

- You have to make it easy

  - Single sign-on – i.e. federated query

  - Accept their "native" agency credentials

- You have to let them know that their information will be safe in the hands of partner entities. This means there has to be a level of trust in addition to all of the MOU's, data sharing agreements, etc. Once again, it helps to bring people together.

and feed them pizza if you can!
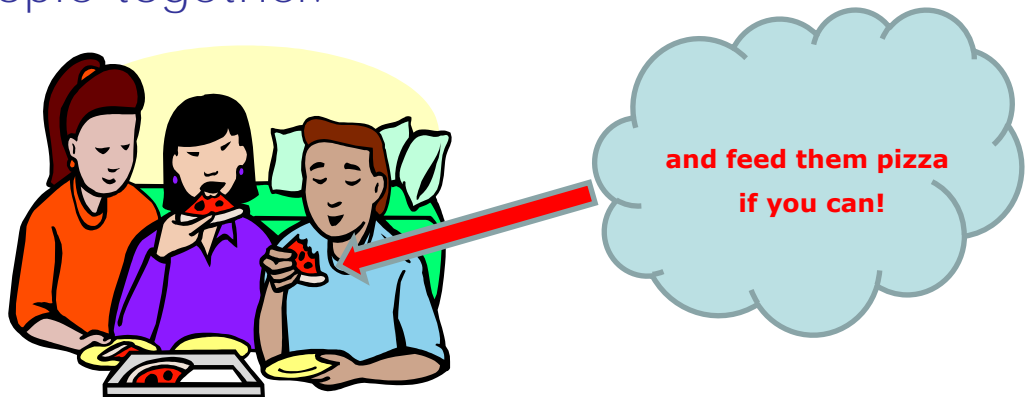
Myth # 10 – IT'S TOO EXPENSIVE!

- Technical Assistance available
  - Bureau of Justice Assistance (BJA)
  - SEARCH, The National Consortium for Justice Information and Statistics
  - **We are all here to help. You don't have to "**rip and replace**"** any of your current technologies.
- Often states can get very high-quality, low cost work through local universities.
- Once completed, the ASSURE portal in Alabama will have cost less than **$500K...this is BUDGET DUST** in the Health and Human Services (HHS) world. If you get buy-in from some of your state HHS agencies, they may be able to partner to fund your program.

Alabama Secure Sharing Utility for Recidivism Elimination (ASSURE)
Project Overview

Justice-to-Health Exchanges:
Understanding the Myths Surrounding Health Insurance Portability and Accountability Act (HIPAA) and Addressing Challenges to Cross-Domain Information Sharing

National Criminal Justice Association
via webinar

24 March 2015

Richard Fiore

ASSURE Project Sponsor

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Purpose of ASSURE Project

- **Create a secure, web-based portal to share appropriate information regarding clients, probationers and inmates**

- **Organizations involved**
    - Alabama Department of Mental Health (ADMH)
    - Community Mental Health Centers (CMHC)
    - ADMH Substance Abuse Contract Providers
    - Alabama Board of Pardons and Paroles (ABPP)
    - Alabama Department of Corrections (ADOC)

- **Alabama Department of Corrections**
  - 3,000 inmates in active mental health caseload
  - 4,100 inmates participating in a substance abuse program
  - Nearly all of these offenders will re-enter the community!

- **Alabama Board of Pardons and Paroles**
  - Responsible for ensuring that persons under supervision participate in court-ordered mental health and substance abuse treatment services

- **Alabama Department of Mental Health**
  - Operates two state hospitals
  - Provides funding for the 25 Community Mental Health Centers and contract substance abuse that provide community based treatment services
  - Provides the vast bulk of services for criminal justice involved individuals – both pre-release and post-release

- **According to the USDOJ**
  - 56.2% of state prison inmates have a history of mental illness and/or behavioral health problems
  - 64.2% of local jail inmates have a history of mental illness and/or behavioral health problems
  - 74.1% of inmates with a history of mental illness and/or behavioral health problems have a history of substance abuse or dependency
  - 55.6% of inmates without a history of mental illness and/or behavioral health problems have a history of substance abuse or dependency
- **Over 95% of these individuals will return to the community**

- Increase effectiveness and efficiency of the intake and classification process
  - ADMH, ABPP, DOC, CMCHs, SA Providers
- Reduce reliance on emergency department services
  - Refer people leaving correctional facilities to community-based behavioral health and substance use treatment services
  - Providing clinical information to assist with their treatment
- Ensure timely access to essential medications for people entering or leaving jail or prison
  - Link correctional health providers to ADMH and community-based behavioral health services
- Reduce recidivism by ensuring that offenders – whether in a community or incarceration setting – receive services matched to their individual needs
  - Educational, Vocational, Rehabilitation, Treatment

- **Improve communication among entities responsible for providing and coordinating mental health and substance use services**

- **Improve continuity of care to individuals who move between incarceration and the free world**

- **Increase awareness of availability of community-based mental health services**

- **Produce a more accurate and complete profile of offenders**
    - Sentenced to DoC
    - Receiving behavioral health and substance use services through mental health clinics funded through ADMH
    - Under the supervision of ABPP

- Allow probation officers to monitor probationers' compliance with court-ordered mental health and substance abuse treatment (25)

- Allow intake and classification personnel at ADOC to be aware of inmates with a history of serious mental illness (13)

- Allow community mental health and substance abuse providers to view diagnosis and treatment history of offenders re-entering the community (21)

Numbers in parenthesis indicate reference to item in *Criminal Justice and Health Connections Matrix* from IJIS/Urban document **Opportunities for Information Sharing to Enhance Health and Public Safety Outcomes**

See **https://c.ymcdn.com/sites/ijis.site-ym.com/resource/resmgr/Docs/Opps_Info_Sharing_Enhance_He.pdf**

or

http://www.urban.org/publications/412788.html

System Requirements

- Computer

- Internet connection

- User name and password

- Printer (for those who will be responsible for enrolling clients in consent registry)
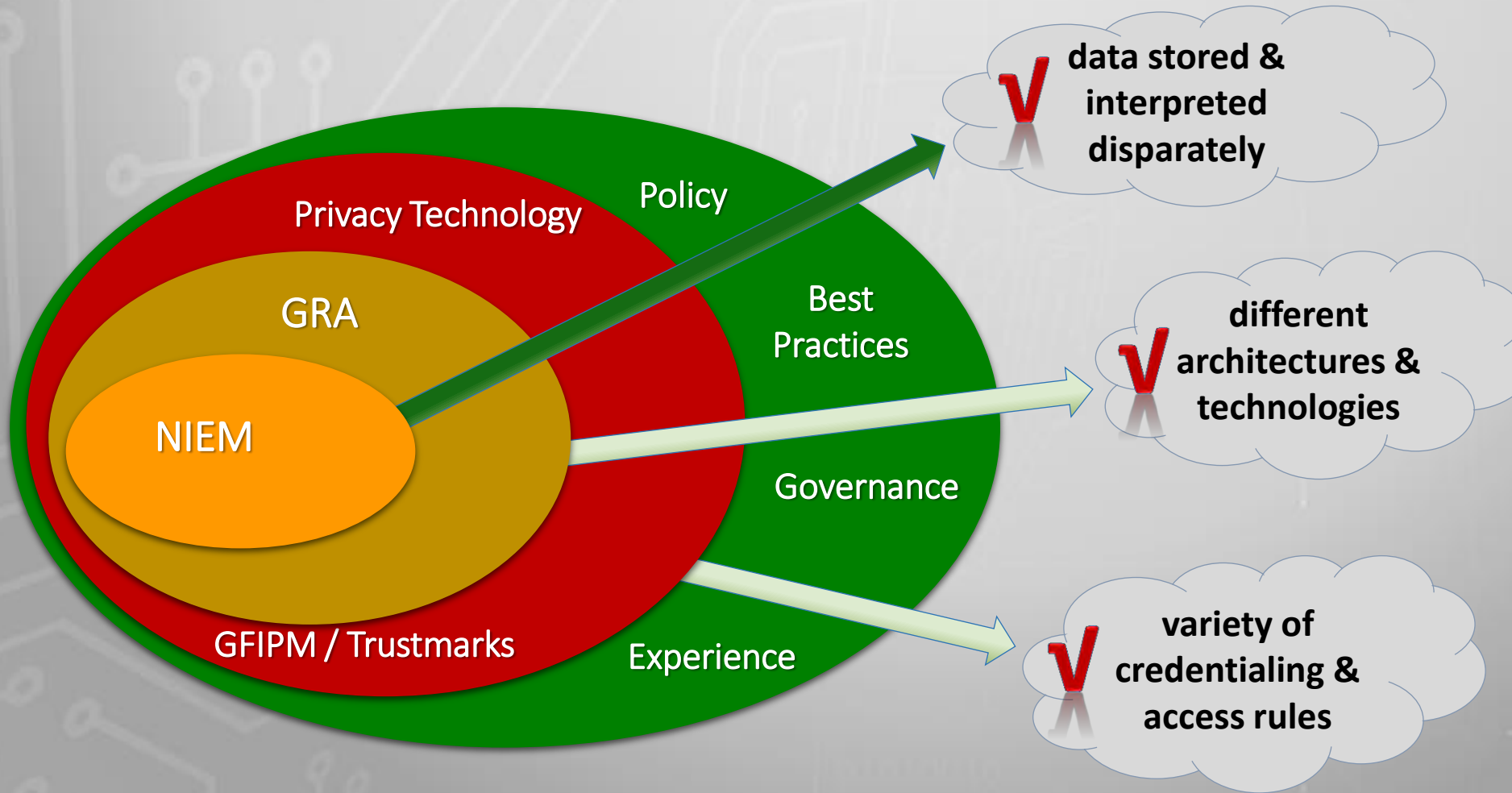
- **Promotes information sharing among agencies that have not shared information previously**
  - Criminal justice officials may not understand laws governing access to behavioral health information
  - Mental health and substance abuse treatment providers may not understand laws governing access to criminal justice information
- **Information to be shared is very sensitive and people often do not understand the laws governing access to this information**
  - Health Insurance Portability and Accountability Act of 1996 (HIPAA)
  - Code of Federal Regulations, Title 42: Public Health, Part 2 Confidentiality of Substance Abuse Patient Records (42 CFR Part 2)

- Stakeholders need to be assured that their data will be protected

- System users need to be convinced that is really is okay to share data as long as the access rules are followed

- Clients need to understand how their data will (and will not) be used

- It is very good!

- It is free!

- There are additional companion documents available in case you need more information or need to provide additional resources to project partners
  - Privacy Impact Assessment Template
  - Global Privacy Resources Booklet
  - Policy Review Checklist
  - Executive Summary for Justice Decision Makers

- For more information please visit: it.ojp.gov/global

- **Purpose Statement** – describes purpose of the privacy policy and the project

- **Policy Applicability and Legal Compliance** – explains when policy applies and references applicable laws governing data to be exchanged

- **Governance and Oversight** – explains governance process

- **Definitions**

- **Information** – describes what types of data are to be shared

- **Acquiring and Receiving Information** – describes who may receive information under what circumstances

- **Information Quality Assurance** – explains how participating agencies engage in QA activities

- **Collation and Analysis** – Describes requirements for analyzing data. (This is more for agencies that employ intelligence analysts and may not apply to all projects.)

- **Merging Records**

- **Use and Redress** – describes how data may be used and what recourse is available if it is misused

- **Security Safeguards** – describes technical and physical requirements for protecting data

- **Information Retention and Destruction**

- **Accountability and Enforcement** – describes auditing requirements and penalties for misusing the system

- **Training**

- **Consent** – ASSURE requires consent from all clients/probationers/inmates prior to allowing data to be shared. Most criminal justice data does not require consent.

- **HIPAA and 42 CFR Part 2**
  - These laws govern access to health and substance abuse treatment information.
  - It is very important to understand these laws when developing policies and technical specifications for project.
  - If you are responsible for project and you don't understand these laws, find someone who does to help you our.

- **Privacy Officer** – This doesn't have to be a full time job, but ultimately you need someone who is responsible for completing the policy.

- **Legal**

- **Information Technology**

- **Business Users**

- **Management**

- Not everyone will participate in drafting each section, but you will need to consult with *each and all* of these groups at some point in time.

- **Use the tools that are available** – it will make your life simpler and bring you peace!

  - Okay. This might be an exaggeration, but it will make sure you don't totally overlook any key issues that need to be covered.

- **Try to find someone who has done this before to help you out.** There are lots of people who can steer you in the correct direction.

  - Global

  - Institute for Intergovernmental Research (IIR)

  - National Criminal Justice Association (NCJA)

  - SEARCH

- **Remember the importance of privacy** – good projects can get shut down if privacy protections are not built in from the beginning.

Global Information Sharing Toolkit

https://it.ojp.gov/gist/search

Glossary for Justice / Health / IT

http://www.cochs.org/speaking-same-language

Additional Resources

- www.it.ojp.gov

- www.jispnet.org

OJP Justice Information Sharing Web

JISP

Justice Information Sharing Practitioners Network

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2 GETTING STARTED

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inks and Announcements

Welcome to the JISP website!

Our virtual network connects more than 1,200 local, state, regional, and tribal justice

In The Know

Recent Blog Posts

JISP Launches a New Website!

By: *Tammy Woodhams* one year ago

Community Activity

Latest Conversations

Webinar: Understanding the Myths Surrounding Health...

Recent Activity | **Discussions** 74 | **Library** 155 | **Blogs** 1 | **Events** 173 | **Members** 1.1K

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  - NASCIO
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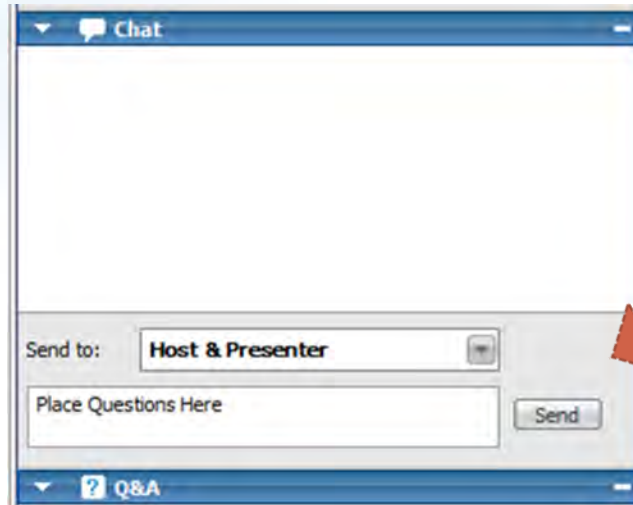
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- Connect Consortium Privacy Policy
- IACP PIA REPORT FOR UTILIZATION OF LICENSE PLATE RE
- INFORMATION SHARING IN CJ-MH COLLABORATIONS: WOF OTHER PRIVACY LAWS
- NGA ISSUE BRIEF: PRIVACY POLICIES FOR JIS
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Q & A

To submit questions for the presenters please use the chat feature on the right hand side of your screen.
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Presenters & Contact Information

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Richard Fiore, ASSURE Project Sponsor, State of Alabama, Richard.Fiore@myalabama.gov

Tammy Woodhams, senior staff associate, NCJA (Moderator), twoodhams@ncja.org

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Please Join Us For Our Next Webinar

Building an Information Sharing Environment
May 14, 2015
3:00-4:30 PM ET

Today's slides and a recording of this webinar will be available at:

http://www.ncja.org/webinars-events/state-jis-enhancement