



A Note on HIPAA and 42 CFR Part 2

Dispelling the Myths about Justice-Health Information Sharingⁱ

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On June 17, 2014 the National Governor's Association (NGA), with funding from the Bureau of Justice Assistance (BJA), hosted a two-day policy academy for three state pilot project sites (Illinois, Iowa, and Kansas) concerning the exchange of information between justice and health entities. The goal of the meeting was to breakdown misperceptions concerning the sharing of information between health/service providers and justice agencies as well as to begin the strategic planning process for each respective site. HIPAA (Health Insurance Portability and Accountability Act of 1996) and 42 CFR Part 2 (Title 42: Public Health, Part 2—Confidentiality of Substance Abuse Patient Records) are two of the most commonly cited barriers to cross-domain information sharing (Abernathy, 2014; Matz, 2013; Treatment Research Institute [TRI], 2011).ⁱⁱ However, it is much less an issue than many may believe, and it is also only one of many other more pressing issues including executive buy-in and frontline acceptance. This brief dispels the myths of these federal regulations, demonstrates the palatable potential of justice-health exchanges, and references the many tools available from the Global Justice Information Sharing Initiative (a.k.a., GLOBAL) to aid these information exchange prospects.

HIPAA, 42 CFR Part 2, ACA

To be clear, the privacy provisions of HIPAA and 42 CFR Part 2 are of utmost concern to institutional corrections (i.e., jail, prison) because they are required to offer health and medical services within their facility, an obvious consequence of maintaining custody and confinement. Institutions may contract out for medical services which reduces their culpability under these federal regulations. Regardless, HIPAA's Lawful Custody Exceptionⁱⁱⁱ explicitly allows correctional institutions to access inmates' health information without consent if the information is necessary to provide health care to the individual or to ensure the safety and security of the inmate and others housed or working in the facility.^{iv} Note, service providers are not always aware of, or exercise, this exception (Williams, 2014). This exception also applies to any emergency in which staff of a service provider agency are at risk (within the institution or the community), relevant to law enforcement and probation/parole agents as well.

HIPAA liability is contingent largely on whether the institution in question is deemed a "covered entity." A covered entity is an institution in which there exists; 1) documentation of session information for the purpose of reporting health care, 2) requests for the review of health care records to perform services, or 3) payment of health care claims (Williams, 2014). **Probation/parole agencies are not classified as "covered entities" and are not subjected to the provisions of HIPAA or subsequent liabilities.** Further, 42 CFR Part 2 only applies to service providers that publically identify themselves as a substance abuse/mental health treatment provider and are federally conducted or receive federal funds

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in any form, whether or not the funds directly pay for substance abuse services.^v Providers that do not meet these parameters are not held by these confidentiality regulations. As such, probation/parole departments are not held to the standards or liabilities of 42 CFR Part 2, though it will have an impact on service providers' capacity and willingness to share information with community supervision agencies as it pertains to substance abuse and mental health treatment.^{vi}

That said, *protected health information* (PHI) probation/parole officers receive through interviews with clients can be utilized and re-disclosed to others so long as its use is for official capacity in regards to the client's release and supervision (Abernathy, 2014).^{vii} Probation/parole officers cannot receive PHI from service provider programs without the consent of the probationer/parolee. Courts can, and do, however require a waiver of confidentiality for substance abuse and mental health information as a condition of release from jail to probation or prison to parole. Failure to furnish required information (e.g., confirmation of treatment completion) could result in revocation of their conditional supervision. Note, legally speaking, compared to free citizens the expectation of privacy is practically non-existent for inmates and parolees, and greatly reduced for probationers (see Adelman, 2007; 2002). In effect, there are four circumstances in which probation or parole officers may gain access to a client's PHI; 1) the client voluntarily provides the information to the officer, 2) the client voluntarily completes a legally compliant consent form permitting the service provider to release the desired information, 3) as a condition of supervision the client forfeits their ability to refuse consent and is compelled to permit the service provider(s) to release the desired information, or 4) a court order authorizes the disclosure and is combined with a subpoena to compel the service provider to relinquish said information (Abernathy, 2014).^{viii}

Finally, the Affordable Care Act (ACA) of 2010 concerns the eligibility of incarcerated individuals and those under probation/parole supervision to receive Medicaid assistance (Abernathy, 2014). Probation/parole agencies, regardless of the law, will wish to enhance their clients' reintegration (a.k.a., reentry, continuity of care) potential by supporting and encouraging probationers/parolees to utilize Medicaid for assistance acquiring medical, behavioral, and substance abuse services. Like HIPAA, the new eligibility requirements of ACA will have a decidedly more complex impact on institutional corrections than community corrections agencies.

Myths about Information Sharing

As should be clear, the apprehension surrounding HIPAA and 42 CFR Part 2 is largely exaggerated and misguided. These federal regulations do not prohibit the sharing of information between justice and health organizations. Clearly, the intent of these regulations is to protect the privacy of free citizens. It also, perhaps inadvertently, supports the sensible sharing of information on inmates, probationers, and parolees; whom legally have a reduced expectation of privacy (Adelman, 2007; 2002). Becki Goggins of SEARCH, with former experience in information sharing from the Alabama Department of Corrections, at the NGA Policy Academy highlighted ten myths about justice-health information sharing (Goggins, 2014). These myths are presented in **Table 1** and contrasted with the reality of justice-information sharing.

Concluding Remarks

While there are certainly barriers to the sharing of information between justice and health agencies, they are not insurmountable. HIPAA and 42 CFR Part 2 clearly do not preclude probation/parole agencies from engaging in information sharing projects with health organizations. They do, however, require agencies to be sensible and deliberate in how, when, and with whom they allow to access potentially sensitive PHI. Technical limitations such as differing data elements, user restrictions, and distinct data definitions do present complications, but can be overcome using Global tools such as the National Information Exchange Model (NIEM), Global Reference Architecture (GRA), and Global Federated Identity and Privilege Management (GFIPM). These interoperable tools also help

reduce costs and implementation time. Finally, given the overlap in clientele between justice and health populations (Matz, 2013; Matz, Wicklund, Douglas, & May, 2012), and the support demonstrated by the NGA Policy Academy pilot states, there is a clear desire to engage in information sharing and enhance continuity of care, reentry, and reintegration.

TABLE 1: Justice-Health Information Sharing: Myth vs. Reality

Myth*	Reality
1. There is no need to share information.	<i>Continuity of care</i> is paramount to successful reintegration and reentry (Matz, 2013; Matz et al., 2012). Further, as reported by SAMSHA, the criminal justice system continues to be the largest referral to substance abuse treatment providers, comprising 36.9% of all referrals. Of the criminal justice referrals, 34.6% concerned probation/parole (Tipping, 2014). Finally, the IJIS Institute has produced a detailed report containing an extensive list of use case scenarios in regards to justice-health information sharing (Parker, Mallik-Kane, & Horvath, 2013).
2. There is no desire to share information.	The overlap in clientele is extensive (Matz, 2013; Matz et al., 2012; Tipping, 2014), both criminal justice professionals and the health community see value in improving cross-domain collaboration, as evidenced by the three pilots in attendance at the NGA meeting.
3. Federal law does not permit the sharing of information.	The parameters and exceptions discussed in this paper and many other reports demonstrate this is not the case (Abernathy, 2014; Matz, 2013; TRI, 2011).
4. Incompatible data formats prohibit the sharing of information.	Using different standards for Information sharing between justice and health does not have to be complicated or prohibit an exchange from occurring. Global tools such as NIEM ^{ix} and GRA ^x allow distinct justice information systems to communicate via an independent intermediary by translating needed justice and health data elements into a common format, without the need to alter the original source of information. Note, Global has been considering ways to increase efficiency in sharing information between justice-health agencies (Global Standards Council Justice-to-Health Services Task Team, 2014; Global Strategies Solutions Working Group, 2014). Global is working on building interoperable justice extensions within the Health Standards and Interoperability (S&I) Continuity of Care Document. This cooperative approach between justice and health will provide for a larger national presence of electronic records and data quality (Despite Federal investments in Health IT, data exchange lags, 2014).
5. The issuance of credentials and management of external users is unmanageable.	A MOU (Memorandum of Understanding) with the partner agency can be used to outline rules of information use. The partner agency, however, can be responsible for management of user access and rights. GFIPM ^{xi} is available from Global.
6. Information cannot be transferred safely through the internet.	Information can be securely transmitted via web services using encryption and certificates.
7. Data cannot be restricted or limited by user credential.	See #5. GFIPM is available from Global.
8. Executive leadership is not interested in sharing information.	Executives from the three pilots at the NGA policy academy displayed considerable interest. A business case is available from SEARCH to help garner support (Matz et al., 2012).
9. People will not use the information even if it is shared.	Inconclusive. There are few formal evaluations of information exchange projects. Projects need to be assessed in terms of their efficiency, effectiveness, and enabling benefits (McEwen & Groff, 2013; Matz, Hageman, Brewer, & Chawla, 2014).
10. It's expensive.	Benefits need to be weighed by the costs associated with the exchange, which Global has worked diligently to reduce by focusing on interoperability and reuse. However, further research is needed to assess the long-term cost/benefit of the exchanges.

* Myths column adapted from Becki Goggins' (2014) presentation at the National Governors' Association (NGA) Policy Training Academy in Washington D.C. on June 17, 2014.

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ⁱⁱ These regulations were implemented to a) reduce negative attitudes, b) foster trust, c) preserve privacy, d) encourage help-seeking behavior, and e) balance personal liberties and public health/safety (Tipping, 2014). Specifically, the purpose of 42 CFR Part 2 is to encourage patients to seek substance abuse treatment without fear that by doing so their privacy will be compromised.

ⁱⁱⁱ See 45 CFR 164.512(j)(1)(ii)(B)

^{iv} For more on health information sharing needs concerning intake into jail or prison see Trestman and Aseltine (2014).

^v 42 CFR Part 2 applies to federally funded entities that provide alcohol drug abuse diagnosis, treatment or treatment referral. Such entities require patient consent prior to releasing personal information. Further, the mere acknowledgement that an individual is (or was) a patient at a Part 2 facility is a breach of the regulations (Tipping, 2014).

^{vi} Note, HIPAA and 42 CFR Part 2 establish minimum standards for protecting PHI. State laws possessing less stringent protections are overridden by the federal regulations, while states with more stringent guidelines take precedent (Abernathy, 2014). As such, agencies should be aware that their state law could be more restrictive and, if so, must abide by those laws accordingly.

^{vii} Re-disclosure must only be for use in an official capacity and necessary to carry out the duty of community supervision. Note, special circumstances exist in which a service provider is permitted to share information without patient consent including; 1) medical emergencies, 2) child abuse reporting, 3) crimes on program premises or against program personnel, 4) evaluations and research (de-identified data), and 5) under authority of a court order (Tipping, 2014).

^{viii} A sample consent form is available from Abernathy (2014), along with guidance on required elements per HIPAA and 42 CFR Part 2.

^{ix} For more information on the National Information Exchange Model (NIEM) please visit www.niem.gov.

^x For more information on the Global Reference Architecture (GRA) please visit <https://it.ojp.gov/default.aspx?area=nationalInitiatives&page=1015>.

^{xi} For more information on Global Federated Identity and Privilege Management (GFIPM) please visit <http://www.gfipm.net/>.