Care Coordination within the context of criminal justice reform: Should the same restrictions on data privacy and security still apply?

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And

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The COCHS Approach: Public Safety and Community Health

• Public safety and public health systems are intertwined.

• Similarly, the health of the justice-involved population is intertwined with the health of the general population.

• Connecting health care in the criminal justice system to health care in the greater community preserves the investments jurisdictions make in their vulnerable justice-involved populations.
Goals

1. List two examples of criminal justice reforms that are bringing behavioral health professionals into more collaborative relationships with criminal justice personnel;

2. List at least two examples in which more information shared by behavioral health providers with such criminal justice entities as Drug Court or Probation may or may not benefit clients.

3. Define care management portals for criminal justice re-entry and evaluate the tradeoffs of sharing client information through them to support care coordination;

4. Describe how some states and counties are devising creative ways to share more client information while remaining compliant with HIPAA and 42CFR.2.
Why Do We Care About Privacy?

• Readiness for treatment is an incredible victory.
• Not all of our partners understand the complexities of substance abuse treatment
  – Denial of parental rights due to methadone treatment
  – Eviction from shelters
  – Bars to employment
Health Insurance Portability and Accountability Act (HIPAA)

- Broad law that governs health insurance privacy.
- Regarding Substance Abuse:
  - Health care providers treating patients experiencing a drug or alcohol overdose, who wish to share the patient’s health information with family members, friends, or others involved with the patient’s care or payment for care
- Generally, providers can disclose information when they receive a subpoena, discovery request, or administrative request.
The Tension: Does 42 CFR §2 Do More Harm Than Good?

• On the one hand, restrictions that are too tight might lead to inefficiencies in shared care

• On the other hand, too few restrictions could lead to unjust outcomes
42 CFR § 2

- Regulation promulgated in accordance with 42 USC § 290dd-2
- Governs *substance use disorder* patient records in certain, limited circumstances.
- Applies to Federally assisted “programs”
What is a Federally Assisted Program?

• “[other than a general medical care facility]. . .any person or organization that holds itself out as providing, and provides, alcohol or drug abuse diagnosis, treatment, referral for treatment or prevention.” 42 CFR § 2.11.

• Patient records for those patients who receive treatment (or diagnosis or referral for treatment) from

  (a) an identified unit of a general medical facility that holds itself out as providing, and provides, alcohol or drug abuse diagnosis, treatment or referral for treatment, or

  (b) medical personnel or other staff in the general medical care facility whose primary function is to provide those services
Protected Information

• Information that would identify a patient, either directly or indirectly, as having or having had a substance use disorder, or being or having been a patient in a federally-assisted “program”
Disclosure

• No disclosure without *written* patient consent or unless another exception applies (and there are no new exceptions).
  – There is a prohibition on redisclosure
  – Can disclose to those subcontractors listed in the consent form, but cannot disclose for activities related to a patient’s diagnosis, treatment, referral for treatment, or care coordination.
How to Disclose

• Consenting to disclosure has changed in the new regulations finalized this year.
<table>
<thead>
<tr>
<th>If the recipient is...</th>
<th>Then the form must include:</th>
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<tbody>
<tr>
<td>An Individual</td>
<td>The Name of the Individual</td>
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<tr>
<td>An entity with a treating provider relationship</td>
<td>The name of the entity</td>
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<tr>
<td>Third-Party Payer</td>
<td>The name of the entity</td>
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<td>An entity <em>without</em> a treating provider relationship</td>
<td>Name of the entity, <em>and:</em></td>
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<td>• Name of individual participant(s)</td>
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<td>participants or class of participants, who has</td>
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<td>treating provider relationship</td>
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NEW CHANGES IN AMOUNT TO SHARE

• SAMHSA has made the requirements about the amount of sharing and kind of sharing to be more specific

• Form must *explicitly* describe the substance use disorder-related information to be disclosed, and with sufficient specificity to allow the disclosing program or other entity to comply with the request.
  – Okay: All my substance abuse records
  – Not okay: All my records
Other Changes

• Qualified Service Organizations
  – now includes population health management services
  – QSO Agreements have been tightened to avoid the QSOAs being used as a workaround to consent.
  – Care coordination was not added to the QSO list of permissible services

• Record Security
  – Both Part 2 programs and “lawful holders” *must* have established formal policies and procedures for security of records (aligns closely with HIPAA Security rules)
New Patient Rights

- Right to “list of disclosures” after a written request for disclosures
- Consent form must contain information about the rights to disclosure.
Questions?

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