

Information Management for State Health Officials

**Meeting the Challenges Presented by the
HIPAA Privacy Rule in Public Health Practice**

State Health Examples

Meeting the Challenges Presented by the HIPAA Privacy Rule in Public Health Practice: State Health Agency Case Stories

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The Association of State and Territorial Health Officials is the national non-profit organization representing the state and territorial public health agencies of the United States, U.S. Territories, and the District of Columbia. ASTHO'S members, the chief health officials in these jurisdictions, are dedicated to formulating and influencing sound public health policy, and assuring excellence in state-based public health practice.

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Executive Summary

In 1996, the Health Insurance Portability and Accountability Act (HIPAA) was enacted. Among other things, Congress sought to standardize healthcare related electronic transactions through HIPAA in recognition that advances in technology could affect the privacy of health information. The resulting HIPAA Privacy Rule was adopted by the U.S. Department of Health and Human Services (DHHS) to address these concerns. The rule went into effect on April 14, 2003.

The Privacy Rule was not intended to directly affect the public health community. The Centers for Disease Control and Prevention (CDC) and other organizations have provided significant guidance on the impact of the Rule on public health research and practice. However, many issues require additional clarification.

This report addresses three major issues that states have encountered since the implementation of the HIPAA Privacy Rule: accounting for disclosures, legislative implications, and resource implications.

Although the implementation of the HIPAA Privacy Rule has created challenges for many, as this report shows, it has also protected the privacy of individual health information.

Accounting for Disclosures

State public health agencies have concerns regarding the accounting for disclosures provision of the HIPAA Privacy Rule, which requires covered entities to provide a list of any outside reporting of a patient's health information to the patient upon request. Covered entities¹ have become more cautious when sharing information with public health

authorities.² Tennessee experienced a significant reduction in receipt of information from covered entities as a result of the HIPAA Privacy Rule. In Washington state, the requirements regarding accounting for disclosures reminded healthcare providers that state law already mandated charting all disclosures of healthcare information, except those to third-party payers. Implementing state statutes that are consistent with or more stringent than the Privacy Rule helped North Dakota to address this concern. The California Department of Health Services received a limited number of requests for accounts of disclosures, and was able to address this issue with relative ease. South Carolina experienced difficulty in interpreting the accounting for disclosures provision before the Office of Civil Rights and the CDC provided additional information.

Legislative Implications

Due to the complexity of the HIPAA Privacy Rule, many states felt the need to develop, amend, or repeal their state statutes to become compliant with the Rule. Hawaii and North Dakota conducted preemption analyses. Missouri set up a legal council to review state laws and ensure that they followed the guidelines set forth in the HIPAA Privacy Rule. The Kentucky Department for Public Health (KDPH) passed a bill and enacted a state regulation establishing guidelines for sharing immunization information. They also asked providers to report information on immunization required by the KDPH. The Massachusetts Department of Public Health amended state laws to receive important environmental health information from the medical community.

Resource Implications

Since the implementation of the HIPAA Privacy Rule, state public health agencies have worked together to make certain the guidelines set in the Privacy Rule are being followed. A concern now

¹ Covered entity-- health plan, healthcare clearinghouse, or healthcare provider as defined by the HIPAA Privacy Rule [45 CFR 160.103]

² Public health authority-- agencies acting under a grant of authority that are responsible for public health matters as part of their office mandate [45 CFR 164.501]

is to maintain the confidentiality of protected health information³ while maintaining a relationship between covered entities and public health authorities that allows the sharing of information. Several states have shared their experiences in setting up Privacy Offices that can be used as resources for states in understanding the complexity of the HIPAA Privacy Rule.

Conclusions

Public health authorities consider the privacy of individuals essential and of utmost importance. Because of this, state public health agencies have implemented privacy policies and procedures to protect information from being used inappropriately. In the future, public health will have the continued responsibility of communicating its goal to use information in a legally and ethically proper manner to protect the public while simultaneously maintaining the privacy of individuals.

³ Protected health information-- individually identifiable health information as defined by the HIPAA Privacy Rule [45 CFR 160.103]

About ASTHO

The Association of State and Territorial Health Officials (ASTHO) is the national nonprofit organization representing the state and territorial public health agencies of the United States, the U.S. Territories, and the District of Columbia. ASTHO's members, the chief health officials of these jurisdictions, are dedicated to formulating and influencing sound public health policy and to assuring excellence in state-based public health practice. Guided by ASTHO's policy committees, the organization addresses a variety of key public health issues and publishes newsletters, survey results, resource lists, and policy papers that assist states in the development of public policy and in the promotion of public health programs at the state level.

About the HIPAA Task Team

Due to the complexity of the Health Insurance Portability and Accountability Act (HIPAA) rules coupled with the timeframe for implementation, ASTHO formed a group that could identify and share states' needs for HIPAA Privacy Rule implementation. The purpose of the HIPAA Task Team (HTT) is to identify issues that impact primarily state health departments --recognizing many of these same issues will pertain to local health departments. The HTT, which has been in place for more than three years, consists of senior leaders in state health departments as well as members of the National Association of County and City Health Officials, ASTHO affiliate organizations, and other interested organizations. ASTHO has provided leadership by developing forums for states and other interested parties to discuss the HIPAA rules as they pertain to public health.

ASTHO is working with the Centers for Disease Control and Prevention (CDC) Health Information Privacy Office (Robin Ikeda, MD, MPH, Associate Director of Science, Epidemiology Program Office, CDC; Beverly Dozier, JD, Privacy Rule Coordinator, CDC; and Linda S. Shelton, Management Program Analyst), to

continue the HTT forums and to write issue reports on the topics considered in each forum.

The topic for this third issue report is: "The HIPAA Impact on Public Health," and includes a review of four major issues involving the HIPAA Privacy Rule.

The information in this paper is largely based on presentations made by Michelle Marks, Chief, Office of HIPAA Compliance, California Department of Health Services; Chiyome Fukino, MD, MPH, Director, Hawaii State Department of Health; Clyde Bolton, Director of Resource Management, Kentucky Department for Public Health; Sarah Wilding, Acting Senior Deputy, Kentucky Department for Public Health; Suzanne Condon, Director, Center for Environmental Health, Massachusetts Department of Public Health; Nancy Hoffman, RN, MSN, Deputy Center Director, Center for Health Information Management and Education (CHIME), Missouri Department of Health & Senior Services; Mike Mullen, Assistant Attorney General, Office of the North Dakota Attorney General, North Dakota Department of Health; Sandra Sturgis, Director of HIPAA, Tennessee Department of Health; Kathy Stout, Senior Policy Advisor, HIPAA Privacy Office, Office of the Secretary, Washington State Department of Health; Melissa Burke-Cain, Senior Assistant, Office of Attorney General, Washington State Department of Health; and James J. Gibson, MD, MPH, State Epidemiologist and Director, Bureau of Disease Control, South Carolina Department of Health and Environmental Control.

Introduction

To reflect on the first anniversary of the HIPAA Privacy Rule, the April 2004 ASTHO HIPAA Task Team teleconference and issue paper were developed to highlight some of the issues states have encountered since its implementation. The four questions posed to speakers on the teleconference and addressed in this paper are:

- What are the major actions taken by state public health agencies as a result of the HIPAA Privacy Rule to protect the privacy of individuals?
- What experiences have state public health agencies had concerning the accounting for disclosures provision of the HIPAA Privacy Rule?
- What have been the legislative implications for state public health agencies as a result of the HIPAA Privacy Rule? (What state laws have been changed or developed as a result of the HIPAA Privacy Rule?)
- What have been the resource implications as a result of the HIPAA Privacy Rule?

Protection of Privacy

California

Although the HIPAA Privacy Rule was not intended to directly affect the public health community, state public health agencies have encountered many issues since last year's implementation of the HIPAA Privacy Rule. The guidelines set forth in the HIPAA Privacy Rule have impacted states' methods of maintaining the privacy of individuals' health information. Michelle Marks, Chief, Office of HIPAA Compliance, California Department of Health Services (CDHS), shared California's experiences and the measures they have taken to protect individual health information.

CDHS is responsible for both public health and Medicaid. HIPAA Privacy Rule implementation is the responsibility of the Office of HIPAA Compliance (OHC) within CDHS. The major action taken by CDHS as a result of the HIPAA Privacy Rule was notifying beneficiaries of Privacy Practices. Twelve different Notices of

Privacy Practices (NPP), which describe how medical information may be disclosed to access protected health information (PHI), were developed for each program (i.e., California Children's Services Program; Child Health and Disability Prevention Program; and Genetically Handicapped Persons Program) run by the CDHS. The NPPs, available in 13 languages and in Braille, were initially mailed to three-and-a-half million beneficiary households.

After an initial mailing, CDHS trained over 5,000 staff members to ensure continuous distribution of the NPPs to new program enrollees. An online training tracking system was also developed to monitor staff's training completion, send reminders to those staff still in the process of training, and establish a process for new employees to take the training in the allotted time.

In addition, phone tree lines and call centers were established to address any questions, requests, or issues regarding the HIPAA Privacy Rule for all the programs available at the CDHS. A Privacy Guidance Policy and Procedures document⁴ was also designed for every program, and training for each specific program was made available to the health oversight entities on their specific HIPAA Privacy Rule responsibilities.

A number of challenges were cited by OHC. Ensuring that employees across all programs understand that beneficiaries are entitled to their health information and identifying how to share that information were among the major concerns. To address these two issues, OHC coordinated administration of beneficiary access requests with other program areas to ensure consistency and timeliness. OHC also modified the language in all appropriate contracts to create business associate relationships.⁵ They were able to accomplish this in a timely manner and reduced much of the anxiety around data sharing.

⁴ California Department of Health Services.
<http://www.dhs.ca.gov>

⁵ Business associate- a covered entity participating in an organized health care arrangement that performs a function as defined by the HIPAA Privacy Rule [45 CFR 160.103]

Accounting for Disclosures

Accounting for disclosures has been a topic of concern among state public health agencies, and it has raised questions as to whether or not covered entities are permitted to share information as a result of this requirement. The Privacy Rule states that covered entities are required to account for any disclosures of PHI. Covered entities, in some cases, have been reluctant to send information to state public health agencies after the implementation of the Privacy Rule, citing the disclosure requirement as a difficulty. Washington, North Dakota, Tennessee, California, and South Carolina shared their experiences as to how they addressed this concern.

Tennessee

Before the Privacy Rule implementation, hospitals in Tennessee cooperated with the Tennessee Department of Health (TDH) with regard to reporting certain diseases, conditions, and/or symptoms. However, the cooperation decreased once the HIPAA Privacy Rule was implemented. In line with the Tennessee Hospital Association's (THA) guidelines, hospitals across the state refused to report data to TDH to avoid any administrative accounting implications. CDC published an MMWR supplement on the HIPAA Privacy Rule and Public Health in May 2003 that offered further explanation of the accounting requirements. However, THA, under guidance from the American Hospital Association, remained firm in its decision and explained that it would only accept a written interpretation directly from the Office of Civil Rights (OCR).

TDH eventually began receiving data from hospitals again after the question, "Where public health has access to all patient records, must each record be documented for accounting purposes?" was answered on the Frequently Asked Questions (FAQ) page of the OCR website.⁶ When this question and its answer were posted, it was immediately shared with THA and a bulletin went out to all hospitals.

⁶ <http://www.hhs.gov/ocr/index.html>

According to Sandra Sturgis, Director of HIPAA, TDH, "HIPAA has many outstanding features that protect the individual's health information, but really does not clarify public health authorities' uniqueness regarding compliance with this regulation."

Washington

Kathy Stout, Senior Policy Advisor, HIPAA Privacy Officer, Office of the Secretary, Washington State Department of Health (WA-DOH) explained that since Washington already had a statute in place that required providers to account for disclosures, this issue was not a concern for the state. The WA-DOH law RCW 70.02, Disclosure by a Health Care Provider, already established that "health care providers or facilities shall chart all the disclosures except to third party payers of health care information and such charting is to become part of the health care information."⁷ Therefore, because Washington's law already required accounting for disclosures, the HIPAA Privacy Rule accounting requirements did not create additional work for covered entities in Washington like it did in other states.

A remaining concern, however, is the issue of sharing information and disclosing PHI from a covered entity in Washington state to covered entities in another state and vice versa. It is still not clear to some providers that public health agencies, whether or not they are in the same state, can receive disclosed information from a covered entity. WA-DOH continues to work toward a resolution of this issue.

North Dakota

North Dakota Department of Health (NDDH), similar to Washington, already had laws in place requiring covered entities to account for disclosures when the HIPAA Privacy Rule was enacted. NDDH sent out periodic mailings that coincided with the HIPAA Privacy Rule compliance date to primary care physicians in

⁷ Disclosure by a Health Care Provider, Washington. Stat. Ann. 70-010-030 (1993). Available: <http://www.leg.wa.gov/RCW/index.cfm?section=70.02.020&fuseaction=section>

the state, notifying them that although the failure to report a condition is not a violation of the HIPAA Privacy Rule, it is a violation of North Dakota law. NDDH also made an appearance at a rural health care conference and communicated with the Medical Association and the Hospital Association on the importance of accounting for disclosures.

South Carolina

Prior to the implementation of the HIPAA Privacy Rule, the South Carolina Department of Health and Environmental Control (DHEC) set up a committee to address the accounting for disclosure provision and to plan an approach for educating and training the departmental staff. Because the committee consisted of attorneys and administrators, there were varying interpretations of the HIPAA Privacy Rule regarding what clinical activities were to be disclosed. To avoid any future complications, DHEC decided to train covered entities to document every disclosure from a patient's record. However, this approach was modified once OCR developed a FAQ website and the CDC's MMWR supplement entitled "HIPAA Privacy Rule and Public Health" was published. These two documents gave DHEC a clearer understanding of what type of information is requested in the accounting for disclosures provision.

According to James Jerry Gibson, State Epidemiologist, Bureau of Health Control, DHEC, the Department is working hard to educate its staff on the process of disclosing information, as well as reassuring covered entities that the process of accounting for disclosures is safe and uncomplicated. However, DHEC continues to experience resistance from some lawyers of covered entities who believe that reporting to public health authorities under the HIPAA Privacy Rule has created increased work and consumes more resources than it had previously.

California

California received a limited number of requests for accounts of disclosures and could address them on a case-by-case basis. CDHS faced more challenges defining the appropriate people to whom access to the state's public health information was to be given. According to Michelle Marks, they were able to address these issues "with a relative amount of ease."

Legislative Implications

The implementation of the HIPAA Privacy Rule has had some unintended consequences, including, in some cases, the withholding of health information from public health agencies. Some states have modified laws and statutes to ensure receipt of important information necessary for public health purposes.

Hawaii

Hawaii's comprehensive Privacy of Health Care Information Act covers the state's health privacy issues. Covered entities were previously permitted to share information with public health authorities under broad grants of authority. Recently, the Hawaii State Department of Health (HSDOH) completed a preemption analysis to identify and fill any gaps between the state's grants of authority and the HIPAA Privacy Rule. It was determined that many of the public health activities of HSDOH are already conducted in accordance with a state statute. The statute allows the department to "conduct [public health functions] after deeming logical investigations of diseases and injuries that threatened or are deemed by the department to threaten the public health and safety."⁸ However, since the HIPAA Privacy Rule was enacted, HSDOH has encountered resistance from community providers to disclose information that is not specifically identified in this or other state statutes. Because of this resistance, HSDOH is considering whether or not statutory amendments or modifications to its administrative rules are an appropriate solution.

⁸ General Powers and Duties of Hawaii State Department of Health, Hawaii. Stat. Ann. 321-1sub B (2003)

Further review continues on all other state laws that pertain to the privacy of health information.

North Dakota

Similar to Hawaii, NDDH also conducted a HIPAA Privacy Rule preemption analysis comparing North Dakota law to the HIPAA Privacy Rule. A coalition of North Dakota state agencies and healthcare organizations began meeting to coordinate efforts to achieve compliance with the HIPAA Privacy Rule. The coalition created task forces on privacy, security, and the Code Sets and Transactions Rule. Based on the preemption analysis, two separate pieces of legislation were drafted; the first is the civil commitment law for the mentally ill who are in need of treatment, and the second is an Omnibus HIPAA bill.⁹

Three sections of the civil commitment law were amended. The HIPAA Coalition determined that the following sections would achieve greater simplicity and uniformity if amended to conform to the HIPAA Privacy Rule.

Box 1. Revisions to North Dakota Law: *Civil Commitment for Treatment of Mental Illness*

- NDCC 25-03.1-43,¹⁰ Confidential Records, which listed the purposes for which PHI regarding a patient committed for treatment of mental illness be disclosed.¹¹
- Section 6, NDCC 25-03.1-44, of the bill repealed the section requiring an "accounting" for a disclosure of the patient's PHI.
- Section 5, NDCC 43-17-31, amended a section imposing a duty on a physician to transfer medical records to another physician when requested to do so by a patient, except if the records related to "psychiatric treatment." The Privacy Rule imposed special restrictions on the use and disclosure of "psychotherapy notes" so the HIPAA coalition concluded that the HIPAA Privacy Rule provided adequate protection related to treatment for mental illness.

⁹ Mullen, Michael J. (2002). [State Legislation to Simplify Compliance with the HIPAA Privacy Rule: The North Dakota Experience](#)

¹⁰ North Dakota Century Code

¹¹ Mullen, Michael J. (2002). [State Legislation to Simplify Compliance with the HIPAA Privacy Rule: The North Dakota Experience](#)

The Omnibus HIPAA legislation is a 19-page bill that has amended or repealed 29 sections scattered through many different titles and chapters of NDCC.¹² Many of the amendments were technical changes in language to conform to the terminology used in the HIPAA Privacy Rule (e.g. "consent" changed to "authorization").¹³ Although not every section of NDCC was amended to adopt the HIPAA Privacy Rule terminology, those regarding the disclosure of PHI were amended, which made it easier to train the covered entities and their staff to become compliant with the HIPAA Privacy Rule. These amendments were enacted April 14, 2003, coinciding with the compliance date of the HIPAA Privacy Rule. Several of the laws repealed or amended are in the box below.

Box 2. Revisions to North Dakota Law: *Omnibus HIPAA Health Information Legislation*

- Several sections, NDCC 23-07-02.2, 43-15-10 (1)(n), and 44-04-18.1(1), were amended to replace terms such as "release" and "divulge" with "disclose" or "disclosure".¹⁴
- Section 24, amending NDCC 44-04-18.1(1), the term "consent" was replaced with the term "authorization".¹⁵
- A section that was added into the North Dakota law defined the duties of a business associate. It determined if the business associate was a state or local agency and if they were acting as a business associate to another public entity. This allowed NDDH to use Business Associate agreements between government agencies.

There are still some state laws that are "more stringent" than the provision of the HIPAA Privacy Rule. North Dakota prohibits a public entity from disclosing confidential health information except in response to a court order;

¹² Mullen, Michael J. (2002). [State Legislation to Simplify Compliance with the HIPAA Privacy Rule: The North Dakota Experience](#)

¹³ Health and Information Disclosure, North Dakota. Stat. Ann. 211-1-29 (2003). Available: <http://www.state.nd.us/lr/assembly/58-2003/session-laws/documents/HEALTH.PDF>

¹⁴ Mullen, Michael J. (2002). [State Legislation to Simplify Compliance with the HIPAA Privacy Rule: The North Dakota Experience](#)

¹⁵ Mullen, Michael J. (2002). [State Legislation to Simplify Compliance with the HIPAA Privacy Rule: The North Dakota Experience](#)

a subpoena is not sufficient.¹⁶ In addition, covered entities must respect North Dakota law regarding PHI of a teenager who is aged 14 years or older. Such a teenager “may... receive...treatment for [a] sexually transmitted disease, alcoholism, or drug abuse without [the] permission, authority, or consent of a parent or guardian.”¹⁷ Besides these two situations, North Dakota can look primarily to the Privacy Rule to determine whether or not they may use or disclose PHI.

One other significant factor that led the North Dakota HIPAA Coalition to adopt the framework of the HIPAA Privacy Rule is the fact that a large segment, almost one third, of the population of North Dakota lives within 25-50 miles of the Minnesota border. Additionally, some clinics that are located within a 100-mile stretch into northwestern Minnesota are affiliated with the health care organizations in Fargo and Grand Forks, which are situated along the North Dakota’s eastern border. Therefore, minimizing the differences between requirements under the HIPAA Privacy Rule and state privacy laws are considered to be a beneficial goal.¹⁸

Kentucky

The Kentucky Department for Public Health (KDPH) was predominantly concerned with sharing immunization information. Most children go to more than one provider in order to complete an immunization series. When the HIPAA Privacy Rule was enacted, many providers were reluctant to share this information with the KDPH. A collaboration between KDPH, the Kentucky Medical Association (KMA), Department of Education, and the Kentucky Pediatric Society, however, is working to implement changes, develop an infrastructure for these entities to help influence child health policy at the state level, and create a more comfortable environment for information sharing under the HIPAA Privacy Rule.

¹⁶ Consistent with NDCC 44-04-18.11(2)

¹⁷ Consistent with NDCC 14-10-17

¹⁸ Mullen, Michael J. (2002). State Legislation to Simplify Compliance with the HIPAA Privacy Rule: The North Dakota Experience.

Kentucky providers particularly had concerns about whether or not it was appropriate to share information with schools without getting parental release. As a result, Senate Bill 184, Immunization Reporting, was recently passed to clarify any confusion. The bill states that “any health care provider that administers or supervises an immunization authorized under this chapter or otherwise required by the Department for Public Health shall report information about the immunization upon request by or as required by the department.”¹⁹ According to Clyde Bolton, Director of Resource Management, KDPH, this helped the state of Kentucky achieve two things: developing an immunization registry and sharing information between providers and public health agencies.

The second piece of implementing guidance that was created and approved in Kentucky as a result of the HIPAA Privacy Rule is the Immunization Data Reporting and Exchange regulation.²⁰ It establishes the basic ingredients of data exchange and provides covered entities with a definition of “public health entity” and “public health interest.” KDHE worked with KMA to draft the language and coordinate with other agencies to provide standard language to help ease some of the burden when sharing information between covered entities and health agencies. According to Sarah Wilding, Acting Senior Deputy, KDPH, and Clyde Bolton, the implementation of the Immunization Reporting bill and the Immunization Data Reporting and Exchange regulation helped KDPH move forward with the appropriate sharing of privacy information.

Massachusetts

The Massachusetts Department of Public Health (MDPH) also took actions to amend state laws to receive important environmental health information. At the same time that MDPH began

¹⁹ Immunization Reporting, Kentucky. SB 184 (2004). Available:

<http://www.lrc.state.ky.us/record/04rs/SB184/bill.doc>

²⁰ Immunization Data Reporting and Exchange, Kentucky. State Ann. 902-2-055 (2004). Available: <http://www.lrc.state.ky.us/kar/902/002/055reg.htm>

to collect data for the Massachusetts/CDC Environmental Public Health Tracking Network,²¹ which entails collecting environmental health data from covered entities, the HIPAA Privacy Rule went into effect.²² The concurrent implementation of both these projects in April 2003 created a series of unexpected barriers, mainly because covered entities were now more cautious about reporting data to public health authorities. The perceived ambiguity in the HIPAA Privacy Rule regarding data sharing with public health authorities and liability concerns caused hospitals and health care providers to withhold access to confidential information. The existing Massachusetts regulations on public health access to private medical information were not specific enough to readily satisfy covered entities. This prompted a re-examination of applicable laws pertaining to the need for access to medical records and health information.²³

MDPH officials decided that, although the type of data collection they wanted to implement was allowable under the HIPAA Privacy Rule, it was necessary to amend state laws to reduce legal burdens on physicians and the medical community as well as to facilitate public health surveillance. The amendment established a list of diseases dangerous to the public's health, requiring hospitals with care providers to provide such situations to MDPH upon request. These amendments also established reporting, surveillance, isolation, and quarantine requirements for communicable diseases. The amendment included confidentiality requirements for any health data collected under that law by MDPH or Local Boards of Health. The addition of environmental health surveillance data in the amendment was also significant, as previously the regulations focused on only reportable diseases and intervention.²⁴

²¹ <http://www.mass.gov/dph/beha/beha.htm>

²² Condon, Suzanne K. (2004). Public Health Surveillance and HIPAA

²³ Condon, Suzanne K. (2004). Public Health Surveillance and HIPAA

²⁴ Condon, Suzanne K. (2004). Public Health Surveillance and HIPAA

Missouri

In Missouri, the Department of Health and Senior Services (MDHSS) formed a legal council that later also served as a resource team. The legal council reviewed the state laws to ensure they comply with the HIPAA Privacy Rule. Members of the legal council, who later became Privacy Officers, worked with the Governor's and Attorney General's offices to standardize the language in their statutes with that used in the HIPAA Privacy Rule to increase its effectiveness in state and local public health activities. The legal council also worked with the Attorney General's office to delineate the penalties for HIPAA Privacy Rule violations.

Resource Implications

Implementation of the HIPAA Privacy Rule has required additional resources for both covered entities and state public health agencies. Some state public health agencies have established resource teams to attend to any concerns that covered entities and public health authorities faced regarding the HIPAA Privacy Rule. The resource teams, usually composed of HIPAA Privacy Rule experts, helped with the education and training portion of the implementation of the Rule and ensured that the changes made during the implementation phase of the Rule are maintained.

Missouri

Nancy Hoffman, Deputy Center Director, Center for Health Information Management and Education (CHIME), MDHSS, stated that the implementation of the HIPAA Privacy Rule created challenges for MDHSS. MDHSS is considered a hybrid entity²⁵ because of the nature of the functions it performs. It is also important to note that the Medicaid agency in Missouri is not part of MDHSS. At first, covered

²⁵ Hybrid entity-- a single legal entity that is a covered entity, whose business activities include both covered and non-covered functions, and that designates health care components in accordance with paragraph § 164.105(a)(2)(iii)(C) as defined by the HIPAA Privacy Rule [45 CFR 164.103]

entities wanted to err on the side of caution rather than taking the chance of “over-reporting” by sharing PHI.²⁶ However, by creating a resource team, MDHSS was able to educate and respond to concerns about the HIPAA Privacy Rule.

The legal council created by MDHSS served as a resource team for the HIPAA Privacy Rule. The council educated public health staff as well as covered entities on privacy guidelines. The council also became a resource for local public health agencies through which locals could identify the steps needed to become compliant with the HIPAA Privacy Rule.

One of MDHSS’s main goals was to educate public health and covered entities about the HIPAA Privacy Rule. MDHSS created pamphlets that outlined the major concerns and possible resolutions regarding the implementation of the HIPAA Privacy Rule. The pamphlets were distributed to local health agencies and MDHSS staff. Fortunately, the statutes in Missouri previously required public health agencies to share information widely, so the roles of public health authorities, covered entities, etc. were already familiar.

Hawaii

Other states have also provided HIPAA Privacy Rule resources to their Departments of Health, similar to Missouri’s legal council. In Hawaii, five employees of HSDOH and one contractor were hired to address privacy concerns. Ultimately, a Privacy Office was established and HSDOH is planning to add one person to provide additional support for privacy issues. The Privacy Office also created program contacts, establishing a liaison between each program in HSDOH and the Privacy Office. Information about each program’s progress with the HIPAA Privacy Rule is collected from the liaison and then disseminated appropriately to the program, branch, section, and unit levels.

²⁶ If covered entity discloses more information than the “minimum necessary” as defined by the HIPAA Privacy Rule (consistent with section [45 CFR 164.502 (b)(1)]), it is in violation of the Rule

HSDOH also hired an attorney who had previously worked on HIPAA Privacy Rule issues in the private sector. That attorney is currently the lead HIPAA employee and has aided the Attorney General’s office with HIPAA Privacy Rule compliance issues.

North Dakota

North Dakota received funding that was previously used for privacy and security and created a Privacy and Security Officer position. However, due to budget cuts, NDDHS could not continue to fund the position. The responsibilities originally assigned to the Privacy and Security Officer have now been divided and distributed to other staff.

California

CDHS created the Office of HIPAA Compliance (OHC) to ensure HIPAA compliance implementation for all HIPAA rules and to ensure programs carry out ongoing functions associated with compliance. OHC staff members, in conjunction with the CDHS Privacy Officer, continue to ensure that the changes made during the implementation of the HIPAA Privacy Rule are maintained and continue to be supported. OHC is able to address many challenges that have resulted from the HIPAA Privacy Rule. In order to save nearly \$3 million for a separate mailing, the initial Medi-Cal Notice of Privacy Practice (NPP) was included with a regularly scheduled quarterly mailing to all beneficiaries. CDHS also established a monthly mailing process to all new enrollees, coupling mailings whenever possible. Other smaller CDHS health programs established continuous mailings to all new enrollees depending on the enrollment cycle. In an effort to reduce mailing and publication costs, the CDHS converted all NPPs into a tri-fold format, thereby reducing the mailer to two pages instead of six.

Conclusion

This paper explored the approaches of nine states' to addressing the protection of individuals' privacy, accounting for disclosure provisions, state legislative changes, and resource implications as affected by the HIPAA Privacy Rule. Each state public health agency has tailored its approach to its particular situation. ASTHO's HIPAA Task Team members have commented on the value of sharing approaches and best practices in improving their own projects and creating more effective public health programs.

As we begin to address privacy issues in light of the possibility of an electronic health record, the experiences of state public health agencies' implementation of the HIPAA Privacy Rule will be of particular relevance. The electronic health record will draw focus to public health's ability to easily collect larger amounts of information. However, the responsibility to protect the privacy of individuals will remain paramount.

Public health authorities consider the privacy of individuals essential and of utmost importance. Because of this, state public health agencies have implemented privacy policies and procedures in order to protect information from being used inappropriately. In the future, public health will have the continued responsibility of communicating its goal to use information in a legally and ethically proper manner to protect the public while simultaneously maintaining the privacy of individuals.

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Office of Civil Rights. OCR Guidance explaining significant aspects of the Privacy Rule, 2002. Department of Health and Human Services. <http://hhs.gov/ocr/hipaa>

CDC. Guidelines for defining public health research and public health nonresearch. www.cdc.gov/od/ads/opspoll1.htm

HIPAA Privacy Rule and Public Health Guidance from CDC and the U.S. Department of Health and Human Services, 2003. www.cdc.gov/mmwr/preview/mmwrhtml/su5201a1.htm

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Health and Information Disclosure, North Dakota. Stat. Ann. 211-1-29 (2003). www.state.nd.us/lr/assembly/58-2003/session-laws/documents/helth.pdf

Online Resources

Federal Government Resources

Center for Disease Control and Prevention-Privacy Guidelines www.cdc.gov/privacyrule

Center for Disease Control and Prevention-Division of Public Health Surveillance and Informatics www.cdc.gov/epo/dphsi/index.htm

Department of Health and Human Services Office of Civil Rights-HIPAA Guidelines www.hhs.gov/ocr/hipaa/

National Center for Health Statistics www.cdc.gov/nchs/default.htm

National Committee on Vital and Health Statistics www.ncvhs.hhs.gov/

National Health Information Infrastructure <http://aspe.hhs.gov/sp/nhii/>

National Institutes of Health <http://privacyruleandresearch.nih.gov>

State Government Resources

California www.dhs.ca.gov

Hawaii www.hawaii.gov/doh

Kentucky <http://chs.ky.gov/publichealth>

Massachusetts www.mass.gov/dph/dphhome.htm

Missouri www.health.state.mo.us

North Dakota www.health.state.nd.us

South Carolina <http://www.scdhec.net>

Tennessee <http://www.state.tn.us/health>

Washington www.doh.wa.gov

Associations, Nonprofit Organizations, and Academic Institutions

American Hospital Association-HIPAA
www.hospitalconnect.com/aha/key_issues/hipaa/index.html

American Medical Association
www.ama-assn.org/ama/pub/category/4234.html

Association of State and Territorial Health
Officials www.astho.org

Georgetown University Health Privacy Project
<http://healthprivacy.org>

Joint Healthcare Information Technology
Alliance www.jhita.org

National Association of Health Data
Organizations www.nahdo.org

National Association of Insurance
Commissioners
www.naic.org/privacy/initiatives/health_privacy.htm

National Governors Association
www.nga.org/center/HIPAA

Public Health Grounds HIPAA Privacy Rule:
Enhancing or Harming Public Health?
www.publichealthgrandrounds.unc.edu

Stanford University Medical School-HIPAA
<http://irt.stanford.edu/privacy/hipaa>

Workgroup for Electronic Data Interchange-
Strategic National Implementation Process
www.wedi.org/snip



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