

INFORMATION SHARING

IN MEDICAL-LEGAL

PARTNERSHIPS:

Foundational Concepts and Resources



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Executive Overview

This brief is intended for use by participants in Medical-Legal Partnerships (MLPs) as an overview and analysis of the legal issues relevant to interdisciplinary information sharing. MLPs bring healthcare practitioners and legal services providers together to address civil legal issues that present a barrier to a patient's good health. In order to effectively facilitate patient access to the legal services that can ultimately improve health, it is critical that healthcare practitioners and legal services providers be able to share information. MLPs are designed to encourage and enable this communication, but the information privacy legal framework may still present obstacles, both real and perceived, to effective information sharing.

The legal framework for information privacy can be complex to navigate, particularly when dealing with multiple federal and state laws in conjunction with varying organizational policies, procedures, and cultures. However, the legal framework for information privacy should not be thought of as a barrier to sharing information for MLPs. On the contrary, there are numerous opportunities to share information among MLP stakeholders within the boundaries of that legal framework.

The most significant federal law within the legal framework for health information privacy is the Health Insurance Portability and Accountability Act (HIPAA). The medical partner in an MLP is subject to HIPAA and can only share information in accordance with its provisions, no matter the information recipient or the intended goal of the information sharing. However, HIPAA includes numerous provisions permitting disclosure of information with and without patient consent, which may apply depending on the context within which the information sharing occurs.

There is wide variation across MLP designs and accordingly, wide variation in their information-sharing needs, practices, and preferences. Much as there is no one-size-fits-all approach to establishing and operating an MLP, neither is there a single way to share information in a legally sound manner. Relevant considerations with regard to the application of the legal framework to a particular MLP include the MLP's structure and degree of integration across medical and legal partners, the existing or possible options for a patient consent process, and the relevant information management systems and practices. Under HIPAA, patient consent is central to any information-sharing model and therefore, patient consent is currently the most common foundation of MLP information-sharing models. Highly integrated MLP's also may wish to explore HIPAA's permissive disclosures for non-consent-based models.

This brief addresses these concepts in detail, starting with an introduction to common issues MLPs face in sharing information. The brief then discusses features that will influence the model and method of information sharing an MLP uses, beginning with the MLP's structure. Three possible structural models are identified based primarily on the degree of integration between the medical and legal partners with a discussion of how information management may differ across these models. The brief then describes potential consent processes that may be used in an MLP, identifying five basic paths from initial health-care encounter through legal outcome wherein consent can be obtained and information disclosed. Several considerations and questions are highlighted for MLPs to consider when deciding on the information-sharing model that best fits their needs. The brief ends with a discussion of non-consent-based models within the confines of the current legal framework. Included with this brief are three appendices. Appendix A provides a detailed overview of the relevant federal and state laws in the information privacy legal framework. Appendix B includes a list of resources for MLPs, and Appendix C includes a glossary of commonly used terms and abbreviations.

MLPs are an innovative method of addressing social determinants that can cause significant health problems for vulnerable patients. It is critical that MLPs be able to share information as freely and easily as possible while still operating safely within applicable laws and regulations that protect patient privacy and client confidentiality. This brief is intended to help MLPs strike that balance effectively and efficiently.

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Introduction

The American healthcare system is experiencing significant change, recognizing that an array of medical, social, geographic, and other demographic factors impact patient and population health. Critical to the success of this transformation is the ability of stakeholders to exchange patient health information beyond a medical office visit, including sharing information with non-medical support service providers (e.g., social and legal services). Data sharing models that support access to patient information across and beyond traditional settings of care delivery, including non-medical support personnel and services, are necessary to improve and maintain healthcare quality and safety and reduce cost growth. Activities essential for individual and public health, such as coordination of medical and non-medical services, public health surveillance, health promotion and education, and population health management cannot be successfully achieved without access to patient health information across a continuum of engaged stakeholders.

Consider the following scenario: a patient comes to a health clinic for medical care. During the visit, the healthcare practitioner recognizes that the patient has not only a medical issue, but potentially a legal issue as well (e.g., wrongful utility shut-off) that is further complicating the patient’s health status. The healthcare practitioner would like to refer the patient to an attorney for legal assistance; however, the healthcare practitioner is unsure whether s/he may share information about the patient with a legal services provider.

This is a common scenario that Medical-Legal Partnerships (MLPs) across the country are working to address by creating infrastructures that enable healthcare practitioners and legal services providers to share relevant information. MLPs are designed to enable healthcare practitioners and legal services providers to communicate directly in order to address legal issues that may impact a patient’s health status. However, these communications may implicate federal and state privacy and security laws, such as the Health Insurance Portability and Accountability Act of 1996 (commonly referred to as HIPAA).

This brief is designed to provide an overview of the federal legal privacy framework that governs patient information sharing between healthcare practitioners and legal services providers in an MLP setting (with a primary focus on HIPAA), describe MLP structures that enable information sharing in compliance with the legal framework, and offer a platform to further support MLP initiatives designed to encourage and enable patient information sharing in an MLP setting for the health of the patient. This brief

also includes an overview of the privacy legal framework (See Appendix A) as well as a list of relevant resources and tools to support MLP efforts to design and/or enhance existing information sharing arrangements between healthcare practitioners and legal services providers (See Appendix B) and a glossary of commonly used definitions and abbreviations (See Appendix C).

It is important to note that any analysis and discussion included in this brief addresses common issues and considerations faced generally by the MLP community. Individual MLPs may vary in their approaches, including operations and partnership arrangements. Furthermore, state law requirements related to privacy and security of health information vary. As such, individual MLPs always should consult with legal counsel to ensure compliance with both federal and state law as well as any other relevant legal requirements (e.g., contractual arrangements).

Health Information — The Legal Framework

At their core, MLPs are designed to encourage and enable communication between healthcare practitioners and legal services providers. Information shared between healthcare practitioners and legal services providers often includes patient name and contact information as part of a referral for services provided by a healthcare practitioner to a legal services provider. Other relevant information also may be provided depending upon the potential legal issues identified and their connection to a patient's health care.

Sharing patient information in this manner may implicate federal and state privacy laws and trigger certain requirements for either the healthcare practitioner and/or the legal services provider. Most notable of the federal laws is HIPAA and its related regulations (HIPAA Rules). HIPAA only applies to Covered Entities (i.e., health plans, most providers, and healthcare clearinghouses) and their Business Associates (collectively referred to as "Regulated Entities"). HIPAA permits Regulated Entities to share certain patient information

(referred to as "protected health information" or "PHI") for a number of purposes (e.g. treatment, payment, and healthcare operations; public health and certain law enforcement-related activities) without patient authorization. PHI includes a broad range of individually identifiable information relevant to a patient's health, healthcare, or payment for healthcare, including name, phone number, and address. Disclosure of PHI for other purposes, including those not specifically addressed by HIPAA, requires patient authorization.²

An MLP, as a collaborative intervention or entity, is not directly subject to HIPAA. They are not providers, health plans, or clearinghouses. Furthermore, they are not acting as Business Associates of these Covered Entities in the MLP context since providing legal services to a patient does not constitute work the MLP is doing *on behalf* of a Covered Entity. Rather, the services are provided to the patient for the patient's benefit.³ However, healthcare practitioners participating in an MLP are Covered Entities and must comply with HIPAA. Furthermore, legal services providers participating in an MLP may receive PHI from Covered Entities and as such must be cognizant of the requirements Covered Entities must meet as it relates to PHI a healthcare practitioner may share with a legal services provider. Finally, legal services providers participating in MLPs are directly subject to state confidentiality and privilege requirements that may be triggered if/when a services provider shares information about a patient's legal issues/status with a healthcare practitioner.

As such, patient consent plays a critical role in both of these junctures — from the healthcare practitioner to the legal services provider and from the legal services provider to the healthcare practitioner. As illustrated by the MLP models described below, a healthcare practitioner must obtain written patient authorization⁴ prior to sharing any identifiable information with a legal services provider (e.g., name, phone number). Furthermore, a legal services provider must obtain written patient consent prior to releasing any information about the patient's legal issue/status with the healthcare practitioner. In both instances, the patient consent must clearly indicate the person to whom identifiable information will be

provided, the purpose of the disclosure, and the information to be disclosed. This is generally true regardless of the level of integration between the MLP-participating healthcare practitioners and legal services providers, although an MLP in which the medical and legal partners are completely integrated (see Model 3 below) may consider whether its information-sharing model potentially allows more liberal sharing under HIPAA's permissive disclosure provisions (discussed further below).

Models of Information Sharing

Because MLPs vary widely in their structure, financing, scope, relationships with partners, and risk tolerance, there is wide variation in their information-sharing practices. The following areas are particularly significant when considering what practices will best serve the goals of a particular MLP: Structure (including degree of integration of medical services and legal services), Consent Process, and Information Management.

STRUCTURE/INTEGRATION

MLPs may be structured in a variety of ways. In most cases, the medical and legal partners are separate organizations. There is typically some formal relationship between the two organizations, memorialized in a legal agreement or memorandum of understanding (MOU). The agreement generally spells out any financial arrangement between the two organizations in addition to detailing how the partnership will work, including how referrals of patients for legal services will be made and what information will be shared. The relationship may be as limited as a referral network in which participating health-

care practitioners may refer patients with legal needs to a participating legal services provider. On the other hand, the relationship may be very integrated, with substantial sharing of information between healthcare practitioners and legal services providers, location of legal services on site at a health care organization, and shared use of electronic health record (EHR) systems. (See Figures 1 and 2.)

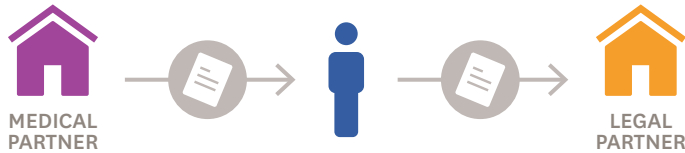
In some cases, the medical and legal partners in an MLP are part of the same organization. Although this scenario may allow the greatest integration of medical and legal services, different models exist depending on how the organization is structured and its preferences. An organization may choose to retain a referral model from medical to legal services even within its four walls.

There is also variety in what service providers are involved in the partnership. At a minimum, there are physicians and attorneys, but there may also be paralegals, social workers, and administrative staff. Some of these may serve as intermediaries between the medical and legal partners in an MLP.

The figures below illustrate the variation in the structure of MLPs and the degree of integration. Figure 1 gives three possible structural models for MLPs, including significant characteristics. The arrows show the flow of information from one partner to the other. Figure 2 is a table developed by the National Center for Medical-Legal Partnership describing different levels of integration possible within MLPs regardless of the structure.

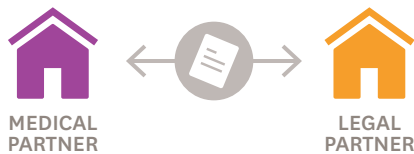
FIGURE 1: POSSIBLE STRUCTURAL MODELS OF MLPS

POSSIBLE MODEL 1: REFERRAL NETWORK



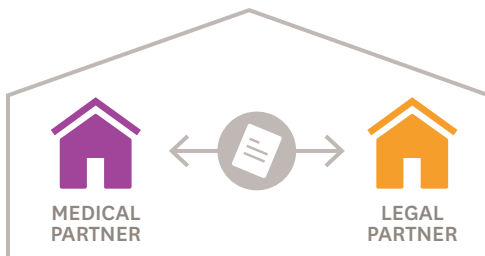
- One or more medical partners agree to refer patients with potential legal issues to a participating legal partner.
- Medical partner gives legal partner’s contact information (such as a business card) to patient but does not directly communicate with legal partner on patient’s behalf.
- Any PHI transferred from medical partner to legal partner is requested by and transferred by patient.
- Legal partner does not communicate directly with medical partner.

POSSIBLE MODEL 2: COORDINATING STAFF



- Medical partner and legal partner agree to form MLP with some staff designated to coordinate identification and referral of appropriate cases.
- Dedicated staff (e.g., social workers, care managers, paralegals) may be employed by either party but are typically located on-site at the medical partner.
- Dedicated staff may be responsible for obtaining consent to share PHI with legal partner and/or facilitating communication between the MLP partners.

POSSIBLE MODEL 3: ONE ORGANIZATION



- Medical partner and legal partner are both part of the same organization.
- Referrals are made either by the medical partner directly or by dedicated staff within the organization.
- The MLP partners may share information using a common internal information management system, though a firewall may be maintained between PHI and legal information in that system.

FIGURE 2: VARYING DEGREES OF INTEGRATION

(Developed by National Center for Medical-Legal Partnership, 2014, www.medical-legalpartnership.org)

AUTONOMY ➔ **INTEGRATION**

	REFERRAL NETWORK	PARTIALLY INTEGRATED MLP	FULLY INTEGRATED MLP
Healthcare institution's view of legal services	Legal needs loosely connected to patient well-being; legal professionals are valued allies, but separate from HC services.	Legal needs connected to patient health; Legal care is complementary/ancillary to HC services.	Legal needs are tightly connected to patient health; Legal care is integrated part of HC services.
Relationship between healthcare and legal institutions	Small legal team loosely connected to small number of HC providers who make case referrals for individual assistance	Legal agency formally recognized by HC institution as a partner, but services often restricted to single unit/clinic. HC engagement at front-lines but not within HC administration.	Legal institution formally recognized by HC institution as part of healthcare team and service system. HC engagement at all levels including administration.
Patients' access to legal care	Patients are inconsistently screened for health-harming legal needs and have inconsistent access to legal assistance from lawyers.	Screened clinic patients get regular access to legal assistance from lawyers, but not all patients and not across institution.	All patients are screened for same health-harming legal needs and have some regular access to legal assistance from lawyers.

INFORMATION MANAGEMENT

Medical partners and legal partners in an MLP have separate recordkeeping requirements and documentation needs that are specific to the services they deliver and as such they utilize separate systems. For example, healthcare practitioners keep medical records (e.g., electronic health record designed to capture health information) and legal services providers use case management systems designed to capture legal information. When information from a patient's health record needs to be shared with a legal services provider, a patient may obtain the requested information from their medical record and provide it to the legal services provider or the patient may direct the health care provider to provide the requested information directly to the legal services provider. In a highly-integrated MLP, the EHR may be used for certain joint purposes (e.g., scheduling, referrals), but the medical record system is still separate from the legal case management system.

Some MLPs would like the legal partner to have access to the medical partner's electronic health record or participate in healthcare encounters with patients so that any legal issues

can be more easily identified and all relevant information can be obtained. Although there are certainly efficiencies to be gained with this model, there are also potential dangers, particularly if information related to a patient's legal case is put into the medical record where it may not be protected from disclosure with routine release of the patient's medical record to other providers (e.g., in pursuit of disability benefits or other applications requiring medical records) or if subpoenaed or otherwise requested as part of a legal proceeding.

CONSENT PROCESSES

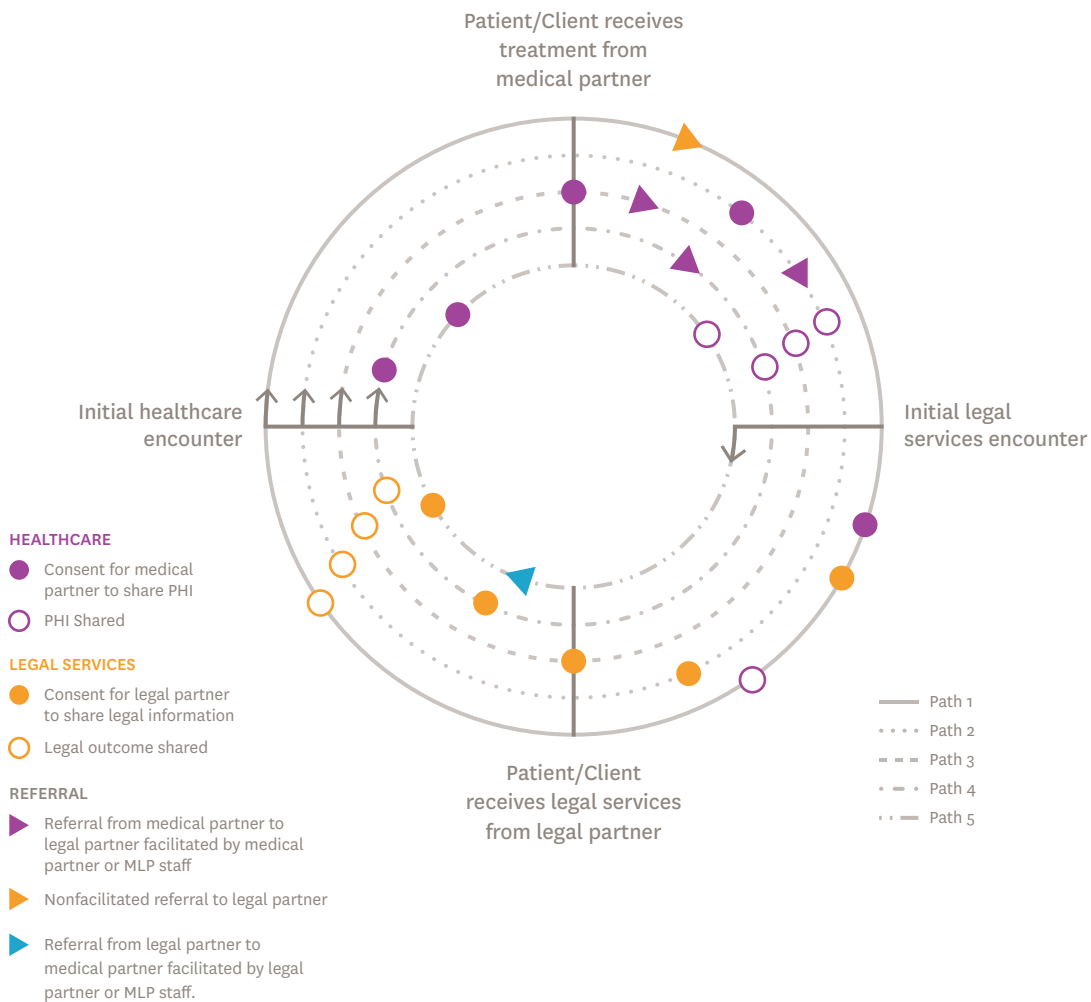
Consent requirements will vary depending on what information is being shared and by whom. If a healthcare practitioner is sharing PHI, the specific requirements for a valid HIPAA authorization must be met.⁵ As discussed above, all healthcare practitioners who share PHI for a purpose other than a HIPAA-permissible purpose (e.g., treatment, payment, operations) must get formal, written authorization from the patient to share that information. An authorization to share information with legal services providers can be obtained from the patient

at the same time the healthcare practitioner obtains the patient's consent for treatment. This may be done as part of the hospital or health center's intake process, provided that the authorization to share PHI meets specific HIPAA requirements. Alternatively, healthcare practitioners may seek authorization to share PHI with a legal services provider after a potential legal issue is identified during the course of treatment or care management. The scope of the authorization may vary as well. The patient may give broad permission for any relevant information to be shared by their healthcare practitioner with a legal services provider, or the patient may give permission for only limited PHI (such as their name and contact information) to be shared. The legal services provider must also obtain consent from the patient before they disclose confidential information to anyone, including the referring healthcare practitioner. Some information may also be protected by attorney-client privilege. MLPs may also choose to have each patient specify the scope of information that may be shared between the medical and legal partners in their individual cases.

Figure 3 below illustrates several consent processes that an MLP may adopt. The exact process will vary from one organization to another but in all cases, the patient/client must consent to the sharing of PHI from the medical partner to the legal partner and must also consent to the sharing of information from the legal partner to the medical partner. Beginning with the healthcare encounter, the arced lines illustrate paths an MLP may take. The following five paths are illustrated in Figure 3:

- ■ ■ **In Path 1**, a patient/client (P/C) visits a medical partner (MP) for treatment and the MP refers the patient to the legal partner (LP) by giving the patient contact information for the LP organization. P/C visits LP to discuss the legal issue and LP agrees to provide services to the patient/client. LP determines that it needs PHI from MP about the patient/client and thus instructs the patient/client to ask MP to provide the information. MP obtains authorization to disclose the PHI from P/C and subsequently provides it to LP. LP obtains consent from P/C to share the outcome of the legal services provided with MP and subsequently does so.
- ● ● **In Path 2**, P/C visits MP for treatment. After the treatment encounter, MP discovers or confirms a possible legal issue. MP contacts P/C to obtain authorization to share PHI with LP and contacts LP on P/C's behalf. P/C visits LP and receives legal services. LP obtains consent from P/C to share the outcome of the legal services provided MP and subsequently does so.
- ■ ■ **In Path 3**, P/C visits MP for treatment and MP identifies a possible legal issue. At the time of the treatment encounter, MP obtains authorization to share PHI with LP and contacts LP on P/C's behalf. P/C visits LP and receives legal services. LP obtains consent from P/C to share the outcome of the legal services provided with MP and subsequently does so.
- ● ● **In Path 4**, P/C visits MP and MP obtains authorization to share PHI with LP if indicated at the same time as it obtains consent for treatment. P/C receives treatment and MP identifies a possible legal issue at that time. MP contacts LP on P/C's behalf. P/C visits LP and receives legal services. LP obtains consent from P/C to share the outcome of the legal services provided with MP and subsequently does so.
- ■ ■ **In Path 5**, P/C visits LP for legal services. LP identifies a need for a medical assessment to support P/C's legal case. LP refers P/C to MP for treatment and medical documentation to support the legal case and obtains consent to share information about the case with MP. P/C visits MP and receives medical treatment/assessment. MP obtains authorization to share P/C's PHI with LP and subsequently does so. LP uses the PHI to support P/C's legal case.

FIGURE 3: EXAMPLE PATHWAYS FOR CONSENT AND DISCLOSURE OF INFORMATION



Bottom Line and Considerations

As discussed above, information exchange between medical and legal partners in an MLP is allowable under HIPAA and other applicable laws. HIPAA should not be thought of as a barrier to establishment of MLPs or to effective communication between medical and legal partners. There are a number of ways for MLPs to accomplish the goal of sharing information between medical and legal partners through patient consent. Furthermore, highly integrated MLPs are exploring non-consent-based models as well (see discussion below).

KEY CONSIDERATIONS

As MLPs consider information-sharing models to determine the model that best fits their structure and culture and meets the needs of their patient population, there are a host of factors and elements that MLPs should consider. These key considerations in the bulleted list below, as well as the key questions below, are designed to highlight key areas that will play an important role in determining the most appropriate information-sharing model.

Any particular vulnerabilities or concerns unique to their patient population;

- The degree of their patients' health and legal literacy;
- The organization's tolerance for risk;
- Resource requirements and structural capacity;
- Relevant organizational policies and procedures;
- Applicable state law requirements; and
- Contractual or similar obligations.

KEY QUESTIONS

Building upon the key considerations described above, the following key questions are designed to help MLP partners, in consultation with their leadership teams and legal counsel, identify the parameters and features of an information-sharing model that best meets their needs.

1. **What agreements are in place governing the MLP relationship and what do they require?**
2. **What laws apply to the partner organizations?**
 - If the medical partner is a community health center or substance abuse treatment center, for example, special rules apply under federal law and possibly also state law that have implications for how information must be managed.⁶ In addition, state laws may include special information-related protections for certain types of patients (e.g., minors) and certain types of health information (e.g., mental health information).
 - If the legal partner is an educational institution where students are involved in providing MLP services (e.g., a school-based legal clinic), there may be rules under state law that govern scope of practice for law students, including rules that affect communications with clients and medical partners.
3. **What restrictions, if any, are attached to the organizations' funding?**
 - Whether the organizations are funded by grants or by billing for services, there may be restrictions on the use of funds for certain activities. For example, an MLP may wish to fund a staff member to facilitate coordination and information sharing between the medical and legal partners but the funding available for that position may be restricted to healthcare services. In addition, some types of funding arrangements (e.g., federal HRSA grants to Community Health Centers⁷) may require special confidentiality protections.
4. **What structural model will best suit the information-sharing needs of the MLP partners and the patients/clients? Are there any goals that are not being met or processes that could be better aligned?**
 - It may be that a referral model between separate entities with no shared resources (i.e., Figure 1, Model 1) is sufficient to accomplish the goals of a particular MLP. On the other hand, it may be that a more integrated model (i.e., Figure 1, Model 3) would improve case management and allow the legal partner to address legal issues that affect patient health more consistently and comprehensively than a referral model would allow.
 - Do the MLP partners view themselves as separate entities that are collaborating to meet the needs of patients/clients or do the MLP partners view themselves as part of a single patient/client care team? If the latter, an integrated model (e.g., Figure 1, Model 3) may best fit the needs of the MLP partners. As noted above, highly integrated MLPs may pursue consent-based models of information sharing and explore more fluid information-sharing models under HIPAA's permissive disclosure provisions.
5. **What consent process will suit the needs of the patients/clients and the MLP partner organizations?**
 - Some patient populations may be more resistant to having their information shared (e.g., sensitive health conditions, undocumented immigrant status).
 - Some patients may have lower health/legal literacy or need a more personalized process to understand the scope and implications of the consent requested of them, while a simple form as part of registration may suffice for others.

6. What information systems are already in place and do they serve the needs of the MLP?

7. What kind of information and how much information should be shared?

- For example, should the patient/client be asked to authorize the specific information to be shared or simply be asked to authorize that any health information may be shared with the legal partner at the discretion of the medical partner?
- In addition, consider implications of including legal information in a medical record or of giving medical partners access to legally privileged information (e.g., potential loss of attorney-client privilege).

There are no “right” answers to these questions; rather, thinking through them with input from legal counsel, administration, and healthcare practitioners may assist MLPs in determining what information-sharing model best meets the needs of their organizations and their patient populations. For example, a patient population with lower levels of health and legal literacy may warrant a consent process wherein the healthcare practitioner walks through the authorization process with each patient/client, rather than seeking broad consent during intake. In this case, the MLP may not wish to use the Path 4 consent process, and may find that the Path 3 process (which gives healthcare practitioners the opportunity to discuss authorization during a treatment encounter) is the best fit.

Looking Ahead — Considering a Non-Consent-Based Model

Information sharing through the MLP models discussed above is based wholly on obtaining patient consent. In order to comply with HIPAA in particular as it is currently interpreted and enforced by the U.S. Department of Health and Human Services Office for Civil Rights (OCR), patient authorization must be obtained prior to sharing PHI between a healthcare practitioner and a legal services provider regardless of the structure or level of integration of the MLP. However, as the American healthcare system continues to evolve and recognize non-medical factors that directly impact patient health, MLPs are working at the cutting edge demonstrating the benefits of integrating medical and legal services for their patient pop-

ulations. While it is unlikely that the current interpretation of HIPAA as it relates to information sharing in MLPs will change dramatically in the near future, there are two theories that MLPs may wish to consider further. These theories could potentially be used to support sharing of PHI between healthcare practitioners and legal services providers in a highly integrated MLP without obtaining patient authorization. Both theories involve defining information sharing in an MLP as permissible under two existing permitted disclosure categories — **treatment and healthcare operations**. Note, however, that even if OCR were to provide guidance in favor of a non-consent-based model for MLPs under any theory, other privacy considerations (e.g., ethical and practical considerations, special consent situations) discussed in this paper would still apply.

TREATMENT DISCLOSURES

The definition of treatment for purposes of the HIPAA permissive treatment disclosure that allows healthcare practitioners to disclose PHI without patient authorization is limited to provider-to-provider disclosures except for “coordination or management of health care by a provider and a third party.”⁸ Under this exception, a Covered Entity may disclose PHI to an entity other than a healthcare practitioner, such as an attorney or social services agency, to coordinate or manage care or services that relate to an individual’s physical or mental health condition. The scope of “services that relate to health” is unclear — services addressing social determinants that have a downstream effect on health, such as housing, may qualify, but there is currently no legal precedent to support this interpretation. For those who wish to advocate for a more expansive and holistic formal definition of healthcare treatment, it may be worth considering how the HHS Health Resources and Services Administration (HRSA) defines healthcare services with respect to Community Health Centers.⁹ HRSA funds the provision of “supportive and enabling” services. These assist patients in accessing and properly utilizing traditional medical care (such as case management) and support patients’ access to non-medical services that can impact health (such as child care, food banks, and employment counseling). HRSA explicitly identifies legal services/legal aid as a supportive/enabling service. This definition of healthcare may serve as an example for OCR consideration, enabling a broader definition of health

and healthcare in the HIPAA context. As this is a developing area of practice and law, MLPs should continue to consider the legal framework and document their decisions for information sharing in reference to the legal framework. In addition, MLPs should continue to consult legal counsel, OCR, and relevant state legal authority for guidance.

HEALTHCARE OPERATIONS DISCLOSURES

A Covered Entity also may disclose PHI to any entity to carry out its **own** healthcare operations activities. The term healthcare operations is broadly defined and includes: population-based activities related to case management, care coordination, improving health, and reducing health care costs; conducting or arranging for medical review and/or legal services to be provided to the Covered Entity; and customer service.¹⁰ Disclosing PHI without a patient's authorization in the MLP context could be characterized as an activity related to case management, care coordination, improving health, or reducing healthcare costs, but it is unclear whether individual patient referrals would qualify as a "population-based" activity or could be viewed as serving the Covered Entity's own operational purposes (as opposed to an activity on behalf of a patient). Again, as this is a developing area of practice and law, MLPs should continue to consider the legal framework and document their decisions for information sharing in reference to the legal framework. In addition, MLPs should continue to consult legal counsel, OCR, and relevant state legal authority for guidance.

As the concepts of health and health care continue to expand beyond traditional definitions limited to treating individuals' functional physical status within the confines of a hospital, doctor's office, or healthcare clinic, there may be opportunities for MLPs to expand and enhance their information-sharing practices to incorporate both consent and non-consent models. If these definitions are expanded to reflect a broader, evolving standard of health, MLPs could implement consent and non-consent-based models of information sharing in a way that explicitly conforms to the regulatory framework governing health information. However, until and unless such regulatory changes occur or clarifying guidance is issued, models that rely on HIPAA's treatment and/or operations exceptions remain legally untested even as they conform to a more global, patient-centered understanding of health and health care. While this transformation continues to evolve, there are numerous consent-based models of information sharing that meet the requirements of HIPAA and other federal and state laws as described above. MLPs have and continue to achieve great success using these consent-based models to integrate medical and legal services for their populations and may innovate and advocate for non-consent-based models as well.

APPENDIX A

A CLOSER LOOK AT KEY LAWS (LEGAL ANALYSIS)

(1) HIPAA

The HIPAA Privacy Rule attempts to balance patients' interest in the privacy of their identifiable health information with the need to exchange health information to enable the healthcare system to function efficiently. HIPAA, and the Privacy Rule in particular, are often misunderstood as extremely prohibitive of information exchange. On the contrary, the Privacy Rule recognizes numerous situations where healthcare stakeholders have a legitimate need to share information with each other and related entities. The Privacy Rule provides substantial latitude to use and disclose identifiable patient health information for a variety of healthcare- and business-related purposes.

In general, the HIPAA Rules govern protected health information, or PHI. PHI is health information about an individual that identifies the individual and was created or has been obtained by a healthcare provider, health insurer, healthcare clearinghouse,¹¹ or employer. Health information is information that relates to health care provided for the individual, to the past, present, or future payment for care provided to the individual, or to the individual's past, present, or future physical or mental health or condition.¹² Information is identifiable when it includes any of eighteen specific identifiers about the individual (see Table 1) or if there is a reasonable basis on which to believe that the information could be used to identify the individual.¹³ HIPAA's protections are afforded only to information meeting the definition of PHI — information that has been de-identified or that meets some but not all of the definition is outside HIPAA's scope.

HIPAA only governs what certain entities do with PHI. HIPAA regulates Covered Entities (healthcare clearinghouses and most health insurers and healthcare providers) and their Business Associates. Business Associates are entities (other than members of the Covered Entity's workforce) that create, receive, maintain, or transmit PHI in order to perform a function or activity¹⁴ on a Covered Entity's behalf or to provide certain services¹⁵ to or for a Covered Entity. Thus, an attorney who receives PHI from a Covered Entity in order to represent a patient is not a Business Associate — the attorney is not providing a legal service to the Covered Entity, nor is s/he performing a function or activity on the Covered Entity's behalf. If an attorney does provide a covered service to the Covered Entity, whether s/he is a Business Associate is

a fact-specific determination.¹⁶ Classification as a Business Associate requires that the entity do more than perform a service or function for a Covered Entity — access to PHI must be an integral component of providing the service or function for the Covered Entity.¹⁷

Individuals or entities that are not Covered Entities or Business Associates are not subject to HIPAA — to the extent that such individuals or entities obtain PHI (whether from a Covered Entity or otherwise), their use or disclosure of that PHI is not governed by HIPAA.

The Privacy Rule requires that Covered Entities obtain an individual's written authorization to disclose or use PHI, with several exceptions. The Rule lists multiple purposes for which a Covered Entity is permitted to disclose or use PHI without the individual's authorization as well as limited situations in which the Covered Entity is required to disclose PHI. The Privacy Rule prohibits any disclosure or use not authorized, permitted, or required. Note that access to an individual's PHI by an individual employed by or working with a Covered Entity would be considered a use of the PHI. Access to PHI must either be authorized by the patient or be for a purpose permitted by HIPAA (e.g., treatment, payment, or healthcare operations activities). When an attorney employed by a healthcare provider (i.e., MLP model 3) wishes to access a patient's PHI without written authorization, the purpose for which the access is sought must fall within one of the permissive disclosure exceptions described below.

Permissive Disclosures

There are three broad categories of permissive disclosures. The three broad categories are: (1) disclosures for treatment, payment, or healthcare operations activities (2) public benefit disclosures and (3) disclosures to patients' families and friends. The two categories relevant in the MLP context are disclosures made for the purposes of treatment, payment, or operations and "public benefit" disclosures. In all cases, a Covered Entity is permitted but not required to avail itself of any permissive disclosure. Further, while a Covered Entity need not obtain an authorization where disclosure is otherwise permitted, it may elect to do so (or may elect to obtain informal consent prior to disclosure).

Treatment, Payment, and Operations Disclosures

A Covered Entity may disclose PHI to any entity for its own or any healthcare provider's treatment activities. Treatment is defined as the provision, coordination, or management of health care¹⁸ and related services by provider(s), including coordination or management between a provider and a third party; consultation about a patient between or among providers; or a referral of a patient for care from one provider to another.¹⁹

A Covered Entity may also disclose PHI to any entity to carry out its own healthcare operations activities. Healthcare operations is broadly defined and includes: population-based activities related to case management, care coordination, improving health, and reducing health care costs; conducting or arranging for medical review and/or legal services to be provided to the Covered Entity; and customer service.²⁰

A Covered Entity may disclose to any entity to carry out its own payment activities. Payment, as it applies to providers, is defined as activities undertaken to obtain reimbursement for health care. This includes: billing; collections activities; health care service review, with respect to determining medical necessity, care appropriateness, or justification of charges; utilization review (including service precertification and preauthorization); and disclosure of certain PHI to consumer reporting agencies relating to reimbursement collection.²¹ A Covered Entity may also disclose PHI to any healthcare provider or other Covered Entity to enable that entity to carry out its own payment activities.

Public Benefit Disclosures

The public benefit disclosures are an expansive list of activities that support the general public's safety, health, and welfare. Covered Entities are permitted to disclose PHI without patient authorization in several circumstances, including: if required by state or other federal law (e.g., mandatory reporting statutes); to an authorized public health authority for public health investigations or interventions; and in the course of a judicial or administrative proceeding. Most of the public benefit exceptions have additional requirements, such as patient notification, or are narrow in terms of to whom the Covered Entity may make the disclosure.

While the public benefit disclosures do not generally facilitate disclosures for legal referral purposes, they do support disclosures that may be necessary in later stages of the MLP's relationship with the patient (such as if the patient is involved with a legal proceeding where medical records are relevant, or if a health-related issue, such as a housing safety concern, should be reported to a public health authority).

Authorized Disclosures

Covered Entities have the ability, at their discretion, to disclose [most] PHI to a third party designated by a patient in a valid authorization. An authorization must contain six specific elements (see Table 2) and be signed the individual.²² While an authorization must identify to whom

a Covered Entity may disclose PHI, this can be a specific person or a general class of persons (e.g., employees or volunteers at a legal aid provider). The authorization must also describe the purpose of the disclosure, but does not require great detail (e.g., "at the patient's request" or "for legal services"). In addition to the six required elements, the authorization must include several statements regarding the individual's rights related to the authorization (e.g., right to revoke the authorization).²³ Finally, the Covered Entity must provide a copy of the signed authorization to each patient.

A Covered Entity may use a standard authorization form for all patients; it must be written in plain language and include the core elements and required statements described above. When a Covered Entity obtains an authorization to disclose PHI, it may disclose PHI only in accordance with the terms of the authorization.

Other Requirements

Notice of Privacy Practices

Covered Entities are required to have a Notice of Privacy Practices (NPP), written in plain language, which addresses a number of issues. The NPP must include a description of each disclosure the Covered Entity is permitted²⁴ or required to make without the individual's authorization; in the case of treatment, payment, and healthcare operations disclosures, the Covered Entity must also include at least one example of each disclosure.²⁵ If a Covered Entity plans on disclosing PHI for a permissible purpose without first obtaining a patient's authorization, it **must** identify all such disclosures it will make in its NPP. A Covered Entity that will always seek patients' authorization before disclosing PHI in order to refer patients for legal services is not required to describe this process in its NPP, but may wish (and is permitted) to do so.

Minimum Necessary Requirement

In general, Covered Entities are required to limit all disclosures of PHI to the minimum amount of PHI necessary to accomplish the intended purpose of the disclosure.²⁶ However, this limitation does not apply to several disclosures, including disclosures to a provider for treatment purposes, any disclosures made pursuant to an individual's written authorization, or disclosures required by state or other federal law. When a provider is disclosing PHI for purposes of making a legal referral, the amount of information s/he may disclose will vary depending on the exception that s/he is utilizing. For example, a provider who has obtained a patient's authorization may disclose any PHI described in the authorization. A provider who has not obtained authorization and is disclosing for a healthcare operations activity may only disclose the exact PHI necessary to accomplish the intended purpose (e.g., customer service). The provider may use his or her professional judgment to determine what PHI is necessary to accomplish the purpose of the disclosure, but should be cautious to ensure that disclosure is narrow enough to satisfy the minimum necessary requirement.

(2) 42 CFR PART 2: CONFIDENTIALITY OF SUBSTANCE ABUSE PROGRAM RECORDS

Part Two of Title 42 of the Code of Federal Regulations protect the confidentiality of alcohol and drug abuse patient records.²⁷ The Part 2 regulations apply to “federally assisted” programs that provide alcohol or drug abuse diagnosis, treatment, or referral for treatment. Part 2 prohibits substance abuse programs from disclosing patient information that does or could identify the patient as a substance abuser without written consent,²⁸ which includes disclosing whether an individual is or has been a patient. There are limited exceptions to this prohibition (e.g., medical emergencies, governmental audits). Part 2 also prohibits entities that have received patient records directly from substance abuse programs from disclosing patient information.²⁹

Programs may disclose substance abuse patient information with valid written consent from the patient.³⁰ A valid consent must contain nine (9) specific elements (see Table 2).³¹ There are certain other requirements for consent in special circumstances (e.g., minors). These circumstances may require the use of modified consent forms, consent from a patients’ parent or guardian, and more limited disclosure options; providers who treat special populations (e.g., minors and mentally incompetent patients) must have separate protocols to manage these patients’ information.

(3) HRSA GRANTEES: COMMUNITY HEALTH CENTERS

The Health Resources and Services Administration (HRSA) provides grants under § 330 of the Public Health Services Act (PHSA) to health centers serving a medically underserved population. Community Health Centers (CHCs) are HRSA grantees, and while they are HIPAA Covered Entities, they are subject to more stringent requirements related to patient privacy. CHCs may only disclose patient information without patient authorization as is required by state or other federal law, for U.S. Department of Health and Human Services (HHS) audits, or as is necessary to provide services to the individual.³² “Services” include those related to primary health (e.g., preventive health services, medical social services), supplemental health (e.g., public health services, social services), services that promote and facilitate “optimal use” of primary and supplemental health services (including the services of outreach workers and eligibility assistance services³³ for, among other programs, Legal Aid³⁴),³⁵ and enabling services that support a patient’s access to non-medical, social, or other related services (including, specifically, legal services or legal aid).³⁶ These services may be provided directly by the HRSA grantee or by a third party that has a formal arrangement with the HRSA grantee to provide these services.³⁷

Most, if not all, disclosures contemplated in the MLP context would likely be considered part of service provision, as defined by the HRSA regulations. However, because CHCs are also considered Covered Entities, they may not disclose PHI without patient authorization in a way that would violate HIPAA. Unless a CHC could fit the disclosure within the treatment, payment, or operations or the public benefit permissive disclosure exceptions, PHI could not be disclosed (even where it would otherwise be permitted by the HRSA regulations).

There are no special consent-related provisions in the regulations governing CHCs; thus, HIPAA’s authorization requirements would apply.

(4) STATE LAW

States also have laws and regulations that govern information disclosure. Where state and federal law conflict, generally the law that is the most protective of patients’ rights controls. State laws may include requirements that are more stringent than federal laws, (e.g., by requiring authorization for an otherwise permissive disclosure) or may regulate entities or protect information outside the scope of federal laws (e.g., a non-Covered Entity’s use of PHI). State laws also interact with federal laws in other ways, such as when they require disclosure of PHI, which is a permitted disclosure under HIPAA’s public benefit exceptions. State laws may also provide special or extra protection for certain types of information, patients, or entities (e.g., minors, HIV test results, mental health providers). States are also generally responsible for regulating health insurers, public health entities, and provider licensure — laws in these categories may contain requirements related to data sharing, confidentiality, and patient consent. MLPs should seek guidance on the laws and regulations in their state that may govern information sharing or impact the way federal requirements, such as those set forth in the HIPAA Rules, are applied.

In addition to interacting with federal requirements, state laws and regulations also govern the practice of law. States have requirements governing attorney-client privilege, confidential communications with clients, the scope of legal practice, and professional ethics. These requirements may limit or define what information an attorney may share outside of the client relationship (with or without the client’s permission) as well as the scope of services an attorney may offer to a client. In addition to state law and regulation, the American Bar Association (ABA) publishes Model Rules for the practice of law, which many states adopt with minimal (or no) modification. Attorneys operating in the MLP context must be aware of state requirements and general professional codes of conduct that may impact interactions with potential and existing clients as well as medical partners. Further, these requirements may vary across the life of an attorney-client relationship, depending on the stage of representation and the purpose of the relationship.

TABLE 1: DIRECT IDENTIFIERS (HIPAA SAFE HARBOR DE-IDENTIFICATION METHOD)

Names
<p>All geographic subdivisions smaller than a state, including street address, city, county, precinct, ZIP code, and their equivalent geocodes, except for the initial three digits of the ZIP code IF, according to the current publicly available data from the Bureau of the Census:</p> <ul style="list-style-type: none"> · The geographic unit formed by combining all ZIP codes with the same three initial digits contains more than 20,000 people OR · The initial three digits of a ZIP code for all such geographic units containing 20,000 or fewer people is changed to 000
All elements of dates (except year) for dates that are directly related to an individual , including birth date, admission date, discharge date, death date, 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
Telephone numbers
Fax numbers
Email addresses
Social security numbers
Medical record numbers
Health plan beneficiary numbers
Account numbers
Certificate/license numbers
Vehicle identifiers and serial numbers, including license plate numbers
Device identifiers and serial numbers
URLs (Web Universal Resource Locators)
IP (Internet Protocol) address numbers
Biometric identifiers, including finger and voice prints
Full-face photographs and any comparable images
Any other unique identifying number, characteristic, or code

TABLE 2: AUTHORIZATION AND CONSENT REQUIREMENTS

REQUIRED ELEMENTS:	HIPAA	PART 2³⁸
1. Specific description of information	X	X
2. Identify person(s) or entity authorized to make the requested disclosure	X	X
3. Identify person(s) or entity authorized to receive the requested information	X	X
4. Describe the intended use(s) of the requested information	X	X
5. The expiration date or event	X	X
6. Date signed	X	X
7. Signature (and/or electronic signature where acceptable) of the individual or his/her personal representative	X	X
INCLUDE THE FOLLOWING INFORMATION:		
The individual's right to withdraw authorization (if any) and any applicable exceptions to that right.	X	X
Whether any benefits may be conditioned on releasing the information and applicable consequences of refusal to consent. This includes stating that refusal will involve no penalty or loss of benefits where relevant.	X	
The potential for re-disclosure of the information (if any). This includes stating that information may not be re-disclosed without further authorization, where applicable.	X	X
MEET THE FOLLOWING REQUIREMENTS:		
Authorization written in plain language	X	
Individual provided with a copy of the form	X	

APPENDIX B

RESOURCES AND TOOLS FOR MLPS RELATED TO INFORMATION SHARING

CONFIDENTIALITY, ETHICS, AND INFORMATION-SHARING RESOURCES

1. Poverty, Health, and Law Textbook. Chapter 6: Ethical Issues in Medical-Legal Partnership. Paula Galowitz, JD, MSW; Jerome Tichner, JD; Paul R. Tremblay, JD; Steven D. Blatt, MD. https://www.amazon.com/Poverty-Health-Law-Medical-Legal-Partnership/dp/1594607796/ref=sr_1_1?ie=UTF8&qid=1498069453&sr=8-1&keywords=poverty+health+and+the+law
2. Multidisciplinary Representation of Patients: Potential for Ethical Issues and Professional Duty Conflicts in the Medical-Legal Partnership Model. Journal of Health Care Law and Policy, 2010 Symposium: Obstacles to the Development and Use of Pharmacotherapies for Addiction. Marcia M. Boumil, Debbie F. Freitas, Cristina F. Freitas. <http://digitalcommons.law.umaryland.edu/cgi/viewcontent.cgi?article=1264&context=jhclp>
3. The Devil is in the Data: Sharing Information is Key to Promoting Integration. Webinar focusing on solutions to barriers of information sharing in medical-legal partnerships. https://www.anymeeting.com/WebConference/RecordingDefault.aspx?c_psrId=E953DC86854630
4. The Creation of HIPAA Culture: Prioritizing Privacy Paranoia over Patient Care. Jessica Jardine Wilkes. <http://digitalcommons.law.byu.edu/lawreview/vol2014/iss5/7/>
5. Health Information & the Law, a project of the George Washington University, designed to provide translational research and analysis related to the federal and state legal framework that governs the use and exchange of health information. <http://www.healthinfo.org/>

RESOURCES ON THE MEDICAL-LEGAL PARTNERSHIP APPROACH

1. The National Center for Medical-Legal Partnership, website. Includes setting specific resources for different kinds of providers and issue briefs, and an MLP Toolkit that offers sample Memorandums of Understanding. <http://medical-legalpartnership.org/>
2. Webinar: MLP Memorandum of Understanding (MOU) Development led by Samantha Morton (MLPB). A recording of the webinar may be found here: <http://www.anymeeting.com/NCMLP/E952DE87804C3A>
3. MLPB. General Resource page, includes links to various publications surrounding integration of social support services and health care, as well as case studies from other medical-legal partnerships. Search publications here: <http://www.mlpboston.org/publications>
4. Whitman-Walker Health Legal Services Information, website. Shows various resources detailing the different areas they provide legal services for, and the ways in which they provide those services. <https://www.whitman-walker.org/legal/legal-services/>

APPENDIX C

ABBREVIATIONS AND DEFINITIONS³⁹

Attorney-Client Privilege. Ensures confidentiality of client-lawyer communications and extends to information disclosed for the purpose of legal representation. Attorney-client privilege applies only to information that is not available from any source outside of representation; attorneys may not disclose information relating to representation in the absence of their client's informed consent.⁴⁰

Business Associate (with respect to HIPAA Rules). A person or entity other than a member of a Covered Entity's workforce who:

1. Creates, receives, maintains, or transmits protected health information for a HIPAA-regulated function or activity (e.g., claims processing or administration, data analysis, processing or administration, utilization review, quality assurance, patient safety activities listed at 42 CFR 3.20, billing, benefit management, practice management, and repricing) on behalf of a Covered Entity;
2. Provides legal, actuarial, accounting, consulting, data aggregation, management, administrative, accreditation, or financial services to or for a Covered Entity;
3. A Health Information Organization, E-prescribing Gateway, or other person that provides data transmission services with respect to protected health information to a Covered Entity and that requires access on a routine basis to such protected health information;
4. A person that offers a personal health record to one or more individuals on behalf of a covered Entity;
5. A subcontractor that creates, receives, maintains, or transmits protected health information on behalf of the Business Associate.

Civil Legal Aid Services Provider. Civil Legal Aid is free legal assistance to low- and middle-income people with legal issues that are non-criminal. Civil Legal Aid Providers help individuals access basic necessities such as healthcare, housing, government benefits, employment, and educational services.⁴¹

Community Health Center. An entity which, through its staff and supporting resources or through contracts or cooperative arrangements with other public or private entities, provides for all residents of its catchment area: primary health services, supplemental health services, referrals, environmental health services, and information on the availability and proper use of health services.⁴²

Consent (to disclose information). The Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule permits, but does not require, a Covered Entity voluntarily to obtain patient consent for uses and disclosures of protected health information for treatment, payment, and health care operations. Covered Entities that do so have complete discretion to design a process that best suits their needs. By contrast, an "authorization" is required by the Privacy Rule for uses and disclosures of protected health information not otherwise allowed by the Rule.⁴³

Consent (to legal representation). A verbal or written agreement in which an individual agrees to receive legal counsel from an attorney.

Consent (to treatment). An individual consents to treatment when they give written or verbal permission prior to any medical exam or intervention. An individual who is unable to consent on their own may have an authorized surrogate who is permitted to consent for them.

Covered Entity (with respect to HIPAA Rules). A health plan, health care clearinghouse, or a healthcare provider who transmits any health information in electronic form in connection with a HIPAA-covered transaction.

Disclose (with respect to 42 CFR Part 2). To communicate any information identifying a patient as being or having been diagnosed with a substance use disorder, having or having had a substance use disorder, or being or having been referred for treatment of a substance use disorder either directly, by reference to publicly available information, or through verification of such identification by another person.

Disclose (with respect to HIPAA Rules). To release, transfer, provide access to, or divulge in any manner information outside the entity holding the information.

Electronic Health Record (EHR). An EHR is a digital version of a patient's paper medical chart. EHRs are real-time, patient-centered records that make information available instantly and securely to authorized users.⁴⁴

Health Care (with respect to HIPAA Rules). Care, services, or supplies related to the health of an individual (e.g., preventive, diagnostic, therapeutic, rehabilitative, maintenance, or palliative care, and counseling, service, assessment, or procedure with respect to the physical or mental condition, or functional status, of an individual or that affects the structure or function of the body; sale or dispensing of a drug, device, equipment, or other item in accordance with a prescription).

Health care operations (with respect to the HIPAA Rules). Any of the following activities of a Covered Entity to the extent that the activities are related to covered functions:

- Conducting quality assessment and improvement activities, including outcomes evaluation and development of clinical guidelines, provided that the obtaining of generalizable knowledge is not the primary purpose of any studies resulting from such activities; patient safety activities (as defined by PSQIA); population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, contacting of health care providers and patients with information about treatment alternatives; and related functions that do not include treatment;
- Reviewing the competence or qualifications of health care professionals, evaluating practitioner and provider performance, health plan performance, conducting training programs in which students, trainees, or practitioners in areas of health care learn under supervision to practice or improve their skills as health care providers, training of non-health care professionals, accreditation, certification, licensing, or credentialing activities;
- Except as otherwise prohibited, underwriting, enrollment, premium rating, and other activities related to the creation, renewal, or replacement of a contract of health insurance or health benefits, and ceding, securing, or placing a contract for reinsurance of risk relating to claims for health care (including stop-loss insurance and excess of loss insurance);
- Conducting or arranging for medical review, legal services, and auditing functions, including fraud and abuse detection and compliance programs;
- Business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the entity, including formulary development and administration, development or improvement of methods of payment or coverage policies; and
- Business management and general administrative activities of the entity (e.g., management activities relating to implementation of and compliance with HIPAA; customer service, including the provision of data analyses for policy holders, plan sponsors, or other customers, provided that protected health information is not disclosed to such policy holder, plan sponsor, or customer; resolution of internal grievances; the sale, transfer, merger, or consolidation of all or part of the covered entity with another covered entity, or an entity that following such activity will become a Covered Entity and due diligence related to such activity); and
- Creating de-identified health information or a limited data set, and fundraising for the benefit of the Covered Entity.

Health Information (with respect to HIPAA Rules). Any information, including genetic information, whether oral or recorded in any form or medium, that is created or received by a healthcare provider, health plan, public health authority, employer, life insurer, school or university, or healthcare clearinghouse and that relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual.

Health Plan (with respect to HIPAA Rules). An individual or group plan that provides, or pays the cost of, medical care (as defined in the Public Health Service Act).

Health Resources & Services Administration (HRSA). HRSA is an agency of the U.S. Department of Health and Human Services. It is the primary federal agency for improving health care to people who are geographically isolated, economically or medically vulnerable, helping those in need of high quality primary health care, people living with HIV/AIDS, pregnant women and mothers. HRSA also supports the training of health professionals, the distribution of providers to areas where they are needed most and improvements in health care delivery. HRSA oversees organ, bone marrow and cord blood donation. It compensates individuals harmed by vaccination, and maintains databases that protect against health care malpractice, waste, fraud and abuse.⁴⁵

Healthcare Practitioner. Any individual authorized to provide health-care services, including a doctor of medicine, nurse practitioner, physician assistant, allied health professional, social worker, case worker, case manager, or case coordinator.

Healthcare Provider (with respect to HIPAA Rules). A provider of services (as defined in Medicare statute), a provider of medical or health services (as defined in Medicare statute), and any other person or organization who furnishes, bills, or is paid for health care in the normal course of business.

Individual (with respect to HIPAA Rules). The person who is the subject of protected health information.

Individually Identifiable Health Information (with respect to HIPAA Rules). Health information that is created or received by a health care provider, health plan, employer, or health care clearinghouse that identifies the individual or with respect to which there is a reasonable basis to believe the information can be used to identify the individual.

Legal Clinic. A legal clinic that is run through a law school by students and faculty and typically provides services through legal aid.

Medical-Legal Partnership (MLP). MLPs unite the medical community and the legal community under a common mission to address and prevent health-harming social conditions for patients and for communities. An MLP embeds attorneys and paralegals in a healthcare setting to work with and alongside other members of the healthcare team. Together they screen for and treat health-harming legal needs — related to insurance, public benefits, housing, education, employment, legal status, and safety — to improve health and well-being, and reduce health care utilization.⁴⁶

Memorandum of Understanding (MOU). An MOU is a formal agreement creating a partnership between two or more public or private entities that outlines agreed upon duties and responsibilities for each party.

Minor (with respect to 42 CFR Part 2). An individual who has not attained the age of majority specified in the applicable state law, or if no age of majority is specified in the applicable state law, the age of 18 years.

Office for Civil Rights (OCR). Through the federal civil rights laws and Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule, OCR protects fundamental nondiscrimination and health information privacy rights by teaching health workers, social service workers, and communities about civil rights, health information privacy, and patient safety laws. Additionally, OCR investigates civil rights, health information privacy, and patient safety confidentiality complaints to identify discrimination or violation of the law and take action to correct problems.⁴⁷

Payment (with respect to HIPAA Rules). Except as otherwise prohibited, activities undertaken by a health plan to obtain premiums or to determine or fulfill its responsibility for coverage and provision of

benefits under the health plan or by a healthcare provider or health plan to obtain or provide reimbursement for the provision of health care, to the extent that such activities relate to the individual to whom health care is provided (e.g., determinations of eligibility or coverage (including coordination of benefits or the determination of cost sharing amounts), and adjudication or subrogation of health benefit claims; risk adjusting amounts due based on enrollee health status and demographic characteristics; billing, claims management, collection activities, obtaining payment under a contract for reinsurance (including stop-loss insurance and excess of loss insurance), and related health care data processing; review of healthcare services with respect to medical necessity, coverage under a health plan, appropriateness of care, or justification of charges; utilization review activities, including precertification and preauthorization of services, concurrent and retrospective review of services; and disclosure of certain PHI to consumer reporting agencies relating to collection of premiums or reimbursement).

Primary Health Services (with respect to Community Health Centers).⁴⁸ All of the following services:

1. Diagnostic, treatment, consultative, referral, and other services rendered by physicians, and, where feasible, by physician's extenders, such as physicians' assistants, nurse clinicians, and nurse practitioners;
2. Diagnostic laboratory services and diagnostic radiologic services;
3. Preventive health services, including medical social services, nutritional assessment and referral, preventive health education, children's eye and ear examinations, prenatal and post-partum care, prenatal services, well child care (including periodic screening), immunizations, and voluntary family planning services;
4. Emergency medical services, including provision, through clearly defined arrangements, for access of users of the center to health care for medical emergencies during and after the center's regularly scheduled hours;
5. Transportation services as needed for adequate patient care, sufficient so that residents of the catchment area served by the center with special difficulties of access to services provided by the center receive such services; and
6. Preventive dental services provided by a licensed dentist or other qualified personnel, (e.g., oral hygiene instruction, oral prophylaxis, and topical application of fluorides) and the prescription of fluorides for systemic use when not available in the community water supply.

Supplemental Health Services (with respect to Community Health Centers).⁴⁹ Health services which are not included as primary health services and which are:

1. Inpatient and outpatient hospital services;
2. Home health services;
3. Extended care facility services;
4. Rehabilitative services (including physical and occupational therapy) and long-term physical medicine;
5. Mental health services, including services of psychiatrists, psychologists, and other appropriate mental health professionals;
6. Dental services other than those provided as primary health services;
7. Vision services, including routine eye and vision examinations and provision of eyeglasses, as appropriate and feasible;
8. Allied health services;
9. Pharmaceutical services, including the provision of prescription drugs;
10. Therapeutic radiologic services;
11. Public health services (including nutrition education and social services);
12. Ambulatory surgical services;
13. Health education services; and
14. Services, including the services of outreach workers, which promote and facilitate optimal use of primary health services and services referred to in the preceding subparagraphs of this paragraph and, if a substantial number of individuals in the population served by the center are of limited English-speaking ability, the services of outreach workers and other personnel fluent in the language or languages spoken by such individuals.

Program (with respect to 42 CFR Part 2). An individual or entity (other than a general medical facility) or an identified unit within a general medical facility that holds itself out as providing, and provides, substance use disorder diagnosis, treatment, or referral for treatment or medical personnel or other staff in a general medical facility whose primary function is the provision of substance use disorder diagnosis, treatment, or referral for treatment and who are identified as such providers. To be considered a Part 2 program, the individual or entity must receive federal assistance.

Program Director (with respect to 42 CFR Part 2). Either an individual, if the Part 2 program is that individual, or the individual designated as director or managing director, or individual otherwise vested with authority to act as chief executive officer of the part 2 program, if the Part 2 program is an entity.

Patient (with respect to 42 CFR Part 2). Any individual who has applied for or been given diagnosis, treatment, or referral for treatment for a substance use disorder at a part 2 program. Patient includes any individual who, after arrest on a criminal charge, is identified as an individual with a substance use disorder in order to determine that individual's eligibility to participate in a part 2 program. This definition includes both current and former patients.

Patient identifying information (with respect to 42 CFR Part 2). The name, address, social security number, fingerprints, photograph, or similar information by which the identity of a patient, as defined in this section, can be determined with reasonable accuracy either directly or by reference to other information. The term does not include a number assigned to a patient by a part 2 program, for internal use only by the part 2 program, if that number does not consist of or contain numbers (such as a social security, or driver's license number) that could be used to identify a patient with reasonable accuracy from sources external to the part 2 program.

Person (with respect to HIPAA rules). A natural person, trust or estate, partnership, corporation, professional association or corporation, or other entity, public or private.

Protected Health Information (with respect to HIPAA rules). Individually identifiable health information transmitted by or maintained in any form or medium. PHI excludes individually identifiable health information in education records covered by FERPA, in a Covered Entity's employment records, or regarding a person who has been deceased for more than 50 years.

Psychotherapy Notes (with respect to HIPAA Rules). Notes recorded (in any medium) by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of the individual's medical record. Psychotherapy notes excludes medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, and any summary of diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date.

Public Health Authority (with respect to HIPAA Rules). An agency or authority of the United States, a State, a territory, a political subdivision of a State or territory, or an Indian tribe, or a person or entity acting under a grant of authority from or contract with such public agency, including the employees or agents of such public agency or its contractors or persons or entities to whom it has granted authority, that is responsible for public health matters as part of its official mandate.

Qualified service organization (with respect to 42 CFR Part 2). An individual or entity who has a written agreement with a Part 2 program to provide services to the program (e.g., data processing, bill collecting, dosage preparation, laboratory analyses, or legal, accounting, population health management, medical staffing, or other professional services, or services to prevent or treat child abuse or neglect, including training on nutrition and child care and individual and group therapy) and comply with relevant regulations in doing so.

Records (with respect to 42 CFR Part 2). Any information, whether recorded on paper or electronically or not recorded at all, that is created by, received, or acquired by a part 2 program relating to a patient (e.g., diagnosis, treatment and referral for treatment information, billing information, emails, voice mails, and texts).

Substance use disorder (with respect to 42 CFR Part 2). A cluster of cognitive, behavioral, and physiological symptoms indicating that the individual continues using the substance despite significant substance-related problems such as impaired control, social impairment, risky use, and pharmacological tolerance and withdrawal.

Regulated Entities. All Covered Entities (CEs) and Business Associates (BAs).

Substance Abuse and Mental Health Services Administration (SAMHSA). An agency within the U.S. Department of Health and Human Services that leads public health efforts to advance the behavioral health of the nation. SAMHSA's mission is to reduce the impact of substance abuse and mental illness on America's communities.⁵⁰

Treating provider relationship (with respect to 42 CFR Part 2). Where a patient is, agrees to, or is legally required to be diagnosed, evaluated, and/or treated, or agrees to accept consultation for any condition by an individual or entity that undertakes or agrees to undertake diagnosis, evaluation, and/or treatment of the patient, or consultation with the patient, for any condition.

Treatment (with respect to 42 CFR Part 2). Care of a patient suffering from a substance use disorder, a condition which is identified as having been caused by the substance use disorder, or both, in order to reduce or eliminate the adverse effects upon the patient.

Treatment (with respect to HIPAA Rules). The provision, coordination, or management of health care and related services by one or more healthcare providers, including the coordination or management of health care by a healthcare provider with a third party; consultation between healthcare providers relating to a patient; or the referral of a patient for health care from one healthcare provider to another.

U.S. Department of Health and Human Services (HHS). It is the mission of the HHS to enhance and protect the health and well-being of all Americans by providing for effective health and human services and fostering advances in medicine, public health, and social services.⁵¹

Use (with respect to HIPAA Rules). The sharing, employment, application, utilization, examination, or analysis of individually identifiable health information within an entity that maintains such information.

ENDNOTES

1. Protected health information (PHI) is health information about an individual that identifies the individual and was created or has been obtained by a healthcare provider, health insurer, healthcare clearinghouse, or employer.
2. HIPAA uses the term “authorization” to describe patient consent that meets certain HIPAA-specified requirements. See Appendix A and Table 2 for further discussion of HIPAA authorization requirements.
3. A Business Associate has access to PHI in the course of providing services to or functions or activities on behalf of a Covered Entity; thus, any access to PHI by a Business Associate must be in the context of providing services or functions to the Covered Entity in order to fall within the scope of its Business Associate activities. See Appendix A for more detail about Business Associates.
4. Please see the Appendix A and Table 2 for further discussion of HIPAA authorization requirements.
5. See Appendix A and Table 2 for further discussion of HIPAA authorization requirements.
6. For example, 42 CFR Part 2 governs the confidentiality of medical records maintained by substance abuse treatment programs; § 330 of the Public Health Services Act governs the confidentiality of records maintained by Community Health Centers. See below for further discussion of these and other relevant laws and their requirements.
7. See generally, 42 U.S.C. § 254b (2015) and 42 C.F.R. Part 51c (2017).
8. 45 C.F.R. § 164.501 (2017).
9. See, e.g., Bureau of Primary Health Care, Service Descriptors for Form 5A (2008). Available here: <https://bphc.hrsa.gov/about/requirements/scope/form5aservicedescriptors.pdf>.
10. 45 C.F.R. § 164.501 (2017).
11. A public or private entity that either: (1) processes or facilitates the processing of health information received from another entity in a nonstandard format or containing nonstandard data content into standard data elements or a standard transaction; or (2) receives a standard transaction from another entity and processes or facilitates the processing of health information into nonstandard format or nonstandard data content for the receiving entity.
12. 45 C.F.R. § 160.103 (2017).
13. 45 C.F.R. § 164.514 (2017).
14. This includes, but is not limited to: claims processing or administration; data analysis, processing or administration; utilization review; quality assurance; patient safety activities listed at 42 CFR 3.20; billing; benefit management; practice management; and re-pricing.
15. Limited to: legal, actuarial, accounting, consulting, data aggregation, management, administrative, accreditation, or financial services
16. Health Information & the Law. Flowchart: Are You A Business Associate? (last updated: July 1, 2013). Available at: http://www.healthinfolaw.org/sites/default/files/article-files/BA%20Flowchart_FINAL.pdf.
17. Office of the Secretary, U.S. Department of Health and Human Services, Modifications to the HIPAA Privacy, Security, Enforcement, and Breach Notification Rules Under the Health Information Technology for Economic and Clinical Health Act and the Genetic Information Nondiscrimination Act; Other Modifications to the HIPAA Rules. 78 Fed. Reg. 5566, at 5572 (2013).
18. Health care is defined as care, services, or supplies related to an individual’s health (i.e., physical or mental health condition) (45 C.F.R. § 160.103 (2017)).
19. 45 C.F.R. § 164.501 (2017).
20. 45 C.F.R. § 164.501 (2017).
21. 45 C.F.R. § 164.501 (2017).
22. 45 C.F.R. § 164.508(c)(1) (2017).
23. 45 C.F.R. § 164.508(c)(2) (2017).
24. Note that if the Covered Entity’s policy is not to avail itself of certain permissive disclosures, the NPP need only list the permissive disclosures the Covered Entity is permitted to and does make.
25. 45 C.F.R. § 164.520 (2017).
26. 45 C.F.R. § 164.502(b) (2017).
27. 42 C.F.R. Part 2. (2017).
28. 42 C.F.R. § 2.1(a) (2017).
29. 42 C.F.R. § 2.12(d)(2)(iii) (2017).
30. 42 C.F.R. § 2.33. (2017).
31. 42 C.F.R. § 2.31(a) (2017).
32. 42 C.F.R. § 51c.110 (2017).
33. 42 U.S.C. § 254b(b)(1)(A)(iii) (2015).
34. Bureau of Primary Health Care, Service Descriptors for Form 5A, at p. 16 (2008). Available here: <https://bphc.hrsa.gov/about/requirements/scope/form5aservicedescriptors.pdf>.
35. 42 C.F.R. § 51c.102 (2017).

36. Bureau of Primary Health Care, Service Descriptors for Form 5A, at p. 23 (2008). Available here: <https://bphc.hrsa.gov/about/requirements/scope/form5aservicedescriptors.pdf>.
37. Bureau of Primary Health Care, Service Descriptors for Form 5A, at p. 1 (2008). Available here: <https://bphc.hrsa.gov/about/requirements/scope/form5aservicedescriptors.pdf>.
38. 42 C.F.R. 2.31(a) (2017).
39. Definitions with respect to HIPAA Rules come from 45 C.F.R. §§ 160.103 and 164.501 (2017); definitions with respect to Part 2 come from 42 C.F.R. § 2.11 (2017).
40. Michmerhuizen, S. Confidentiality, Privilege: A Basic Value in Two Different Applications. American Bar Association May 2007. Retrieved from http://www.americanbar.org/content/dam/aba/administrative/professional_responsibility/confidentiality_or_attorney.authcheckdam.pdf
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42. 42 CFR 51c.102
43. What is the difference between “consent” and “authorization” under the HIPAA Privacy Rule? U.S. Department of Health and Human Services. Retrieved from <https://www.hhs.gov/hipaa/for-professionals/faq/264/what-is-the-difference-between-consent-and-authorization/index.html>
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48. 42 C.F.R. § 51c.102(h) (2017).
49. 42 C.F.R. § 51c.102(j) (2017).
50. About Us. Substance Abuse and Mental Health Services Administration. Retrieved from <https://www.samhsa.gov/about-us>
51. About HHS. U.S. Department of Health and Human Services. Retrieved from <https://www.hhs.gov/about/>

MISSION

The mission of the National Center for Medical-Legal Partnership (NCMLP) is to improve the health and well-being of people and communities by leading health, public health, and legal sectors in an integrated, upstream approach to combating health-harming social conditions. Over the past several years, NCMLP has helped increase the number of medical-legal partnerships in the U.S. to nearly 300. These partnerships serve children, chronically ill adults, the elderly, Native Americans, and veterans. NCMLP spearheads this work in four areas: (1) transforming policy and practice across sectors; (2) convening the field; (3) building the evidence base; and (4) catalyzing investment.

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