



# Pittsburgh Regional Healthcare Initiative

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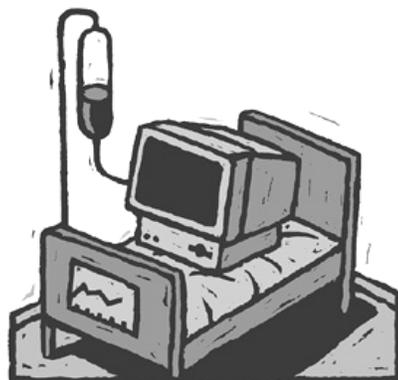
## Health Insurance Portability and Accountability Act **Demythologizing HIPAA**

In April 2003, Paul O'Neill asked a large group of decision-makers from health plans, laboratories and employers if they agreed that this would be a worthwhile goal for the Pittsburgh region: *to provide physicians with the data they need when they need it to treat patients with chronic conditions according to the best-known practices.*

When the group said yes, the Pittsburgh Health Information Network, or the PHIN, was born. Mr. O'Neill then challenged every stakeholder in the room to produce a list of the barriers they perceived to stand in the way of accomplishing this worthy goal.

In other words, Mr. O'Neill asked, "Why can't we?"

In the weeks that followed, stakeholders began sharing what they thought would surely be insurmountable legal and technical



hurdles. After all, the purpose of the PHIN would be to build a regional database to collect relevant data on diabetic and depressed patients, and make it readily available to physicians at the point of care—touchy business in the brave new era of the untested Health Insurance Portability and Accountability Act, known as HIPAA. This law, put in place to safeguard patient privacy, was seen as a potential show-stopper for the PHIN.

But PRHI's Depression and Diabetes Working Groups went to work researching and resolving each perceived barrier one by one. Legal questions revolved, not unexpectedly, around HIPAA and patient privacy, and we soon found ourselves involved in systematic "myth-busting." What we found was that rather than inhibit the PHIN, HIPAA

actually enabled it! Below are just a few of the barriers and assumptions we were able to resolve with expert legal advice on health privacy laws.

### *HIPAA Myth-busters*

**Myth 1:** By participating in a central chronic disease database, contributing data holders would have to rewrite and reprint their existing privacy and disclosure of information statements.

*Myth-Buster:* *If we organize under "the stipulations for Use and Disclosure of PHI for Healthcare Operations of Another Entity" provided for in HIPAA, then existing language already covers data sharing under the umbrella of healthcare operations. Relationships can be legally established through individual Business Associate Agreements with the organization managing the central database.*

**Myth 2:** Organizations that enter into a business associate contract with each other can be held liable for each other's misconduct. In other words, if one organization shares data with a third party and a patient's privacy is compromised, the initial organization will be liable.

*Myth-Buster:* *HIPAA has actually reduced liability by establishing an industry standard of due care. In other words, before HIPAA, what care providers were responsible for was not defined; now, parameters have been defined. Business Associate Agreements define the roles of the covered entities as they relate to sharing protected health information. Covered entities expect their associates to perform in the ways stipulated, but the **covered entities are not liable for their associates' behavior.** If there is a breach of protection, the covered entity should notify the associate and secretary, and should not provide any further protected health information (PHI) until the breach has been repaired.*

## **Demythologizing HIPAA**

**Myth 3:** In order for a patient's data to be shared across physicians treating the same patient, individual patient consent is required.

*Myth-Buster: Legally, individual patient authorization is not required. Because the chronic disease registry is sharing PHI under permissible disclosures (i.e. healthcare operations for quality improvement) patients are already being informed and giving authorization for this use in existing disclosure of information notices. However, in an effort to comply not only with legal requirements but also with reasonable expectations of privacy from practitioners and patients, we decided to build a system that would require patient consent for a treating physician to access data originating from other care providers.*

**Myth 4:** Perhaps diabetes data could be stored in a central regional repository, but not depression data, as mental health records have much more stringent privacy safeguards.

*Myth-Buster: The only additional protections from HIPAA for mental health data involve psychiatric notes (which the PHIN will not be collecting). In PA state law, the only additional protections on mental health data are for (A) Involuntary Outpatient care and (B) Inpatient care. We have confirmed that we can easily separate inpatient data from outpatient data through coding, and that involuntary outpatient data is so rare, it does not constitute a barrier to our model. To date we have not found any state laws providing additional protections to **voluntary outpatient mental health claims data**—(namely office visits and anti-depressant prescriptions and refills, the target data for PHIN)*

From this process, our task forces and working groups have learned not to take the first wave of concerns and fears at face value. Careful research can often resolve what at first blush appear to be insurmountable barriers.

Currently, the PHIN has enlisted two medical plans, two laboratories and 10 physician practices to conduct pilot testing of the system later this summer. We will continue to document progress in the *PRHI Executive Summary*.

To become involved in PRHI's Chronic Disease program, please contact Rebecca Smith, [rsmith@prhi.org](mailto:rsmith@prhi.org).