REPORT OF THE DEPARTMENT OF BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES

Information Sharing Process Between Jails and Community Service Boards Pursuant to SB1644 (2019), (Chapter 685, 2019)

TO THE GOVERNOR AND THE GENERAL ASSEMBLY OF VIRGINIA

SENATE DOCUMENT NO. 4

COMMONWEALTH OF VIRGINIA
RICHMOND
2020

COMMONWEALTH of VIRGINIA

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COMMISSIONER

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January 6, 2020

The Honorable Thomas K. Norment, Jr., Co-chair
The Honorable Emmett W. Hanger, Jr., Co-chair
Senate Finance Committee
The Honorable Chris S. Jones, Chair
House Appropriations Committee
900 East Main Street
Richmond, VA 23219

Dear Senator Norment, Senator Hanger, and Delegate Jones:

Senate Bill (SB) 1644 (Chapter 609, 2019 Acts of Assembly) requires the Department of Behavioral Health and Developmental Services (DBHDS) to convene a work group to include representatives of the Office of the Attorney General, Community Services Boards (CSBs), local and regional jails, and such other stakeholders as it deems necessary to study the issue of and develop a plan for the sharing of protected health information of individuals with mental health treatment needs who have been confined to a local or regional jail in the Commonwealth and who have previously received mental health treatment from a Community Services Board or Behavioral Health Authority (BHA) in the Commonwealth.

SB1644 specified that the plan shall include a mechanism for (i) determining if an individual confined in a local or regional jail has previously received treatment from a Community Services Board or Behavioral Health Authority in the Commonwealth and (ii) in cases in which such person has received such treatment, transferring protected health information related to such treatment from the identified Community Services Board to the sheriff or superintendent of the local or regional jail in which the person is confined. SB1644 required DBHDS to report by October 1, 2019, to the Governor and the General Assembly on (a) development of the plan, (b) the content of the plan, and (c) the steps necessary to implement the plan, including any statutory or regulatory changes and any appropriations.

In accordance with this item, please find enclosed the report for SB1644 (2019). Staff at the Department are available should you wish to discuss this request.

Sincerely,

Alison Land
Commissioner

Cc:
The Honorable Daniel Carey, MD
Susan E. Massart
Mike Tweedy

Virginia Department of Behavioral Health & Developmental Services

Information Sharing Process Between Jails and Community Service Boards Pursuant to SB1644 (2019)

November 1, 2019

DBHDS Vision: A Life of Possibilities for All Virginians

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Executive Summary

SB1644 (2019) required the Department of Behavioral Health and Developmental Services (DBHDS) to convene a work group to include representatives of the Office of the Attorney General, Community Services Boards (CSBs), local and regional jails, and such other stakeholders as it deems necessary to study the issue of and develop a plan for the sharing of protected health information of individuals with mental health treatment needs who have been confined to a local or regional jail in the Commonwealth and who have previously received mental health treatment from a Community Services Board or Behavioral Health Authority (BHA) in the Commonwealth. SB1644 specified that the plan shall include a mechanism for (i) determining if an individual confined in a local or regional jail has previously received treatment from a Community Services Board or Behavioral Health Authority in the Commonwealth and (ii) in cases in which such person has received such treatment, transferring protected health information related to such treatment from the identified Community Services Board to the sheriff or superintendent of the local or regional jail in which the person is confined. SB1644 required DBHDS to report by October 1, 2019, to the Governor and the General Assembly on (a) development of the plan, (b) the content of the plan, and (c) the steps necessary to implement the plan, including any statutory or regulatory changes and any appropriations.

DBHDS reviewed several possible strategies to create a statewide sharing system to include existing data sharing systems used by different entities, the procurement of a commercially available data sharing system, and the repurposing of an existing data matching system for the new purpose of identifying individuals in jails who have previously received services from CSBs. Each option had its own benefits and risks/limitations. A workgroup of subject matter experts was convened and it was decided a pilot of expansion of the use of an existing data matching system would be useful and could help guide the development of a future, robust data matching system. The pilot project would also allow DBHDS to identify the true costs and barriers of operating such a system. In order to create this pilot project, however, an infusion of both one-time and ongoing funds would be needed. One time funds of $144,000 and ongoing funds of $65,000 would be essential as DBHDS currently lacks the resources to support the development and operation of the proposed system. DBHDS also identified a legislative change that, regardless of whether or not the project is funded, would facilitate the sharing of prior treatment records with jails. The following report provides the framework for a plan for sharing Protected Health Information (PHI) of individuals with mental health treatment needs who are incarcerated in Virginia’s local and regional jails and who have received services from a Community Services Board or a Behavioral Health Authority.

Summary of the Problem

National research has shown that 70% of offenders have a substance use disorder, and approximately 17–34 percent have a serious mental illness—rates that greatly exceed those found in the general population[1]. In Virginia, 34.48% (2,395) of females and 16.74% (5,457) of males were reported as having a mental illness. Of the total jail general population count, 19.84% (7,852) were known or suspected to be mentally ill and 10.42% were known or suspected of suffering from a serious mental illness (SMI)[2]. Serious mental illness is generally defined as the individual having a serious mental illness includes diagnoses of psychosis, bi-polar disorder, major depressive disorder, or post-traumatic stress disorder. In contract, per the National Institute of Mental Health (NIMH), the prevalence rate of any mental health illness in America in the community is 18.9% and the prevalence rate of Serious Mental Illness is 4.5%. Thus, in Virginia while the rate of any mental illness in jails is comparable (although slightly higher) to the community prevalence rate, the rate of SMI in jails is twice that found in the community. The over-representation of individuals with behavioral health disorders in prisons and jails is multi-faceted and complex phenomena. Stigma, discrimination, flaws across multiple systems, and barriers to care each contribute and exacerbate the problem. Multiple efforts have been made to reduce the number of individuals with serious mental illness from the criminal justice system and better respond to their needs. Despite efforts to divert individuals from the criminal justice system, individuals with serious mental illness continue to be incarcerated in Virginia's local and regional jails at rates higher than expected.

Jails admit new individuals into their care 24 hours a day, seven days a week. While one of the primary functions of jails is to protect public safety by keeping individuals detained and away from the general public, they are also tasked with meeting the needs of the individuals within their care. While not designed, funded, or staffed as hospitals or psychiatric units, the Supreme Court of the United States has repeatedly ruled that jails have a constitutional obligation to provide for the medical needs (which includes mental health needs) of the inmates within their care. While there are some exceptions/limitations placed on these obligations, the general expectation is that jails will provide care and treatment for significant health conditions. Because jails operate 24/7 they are often faced with admitting and housing individuals in crisis and do not have access to prior treatment records or other relevant information that can assist in providing appropriate services to these individuals. Individuals vary in their ability and willingness to share information on past treatment and medications they are/were prescribed. Because of resource and staffing limitations, jails do not have licensed, trained

[1]Substance Abuse and Mental Health Services Administration. Screening and Assessment of Co-occurring Disorders in the Justice System. HHS Publication No. (SMA)-15-4930. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2015. https://store.samhsa.gov/system/files/sma15-4930.pdf

[2] 2018 Mental Illness in Jails Report, State Compensation Board https://www.scb.virginia.gov/docs/2018mentalhealthreport.pdf

clinicians/physicians on staff 24/7 who can independently diagnose and begin treatment for individuals thus the need for prior treatment records becomes paramount.

The importance of having information available is critical to ensure continuity of care for an individual transitioning from the community into a jail. Having a system in place to share information assists with reducing the risks of critical incidents in jails and improving the outcomes once the individual returns to the community.

As a point of clarification, it is important to understand that both federal and state laws govern the sharing of protected health information. All states must follow the federal laws related to sharing of PHI (e.g. HIPAA, 42 CFR, etc.) but they must also follow state laws.

Virginia Law Related to Information Sharing

Over the last several years, the Virginia General Assembly has had a keen interest in the provision of behavioral healthcare to incarcerated individuals. Numerous workgroups have been convened and the General Assembly has requested various studies related to this topic. During the 2019 General Assembly Session, HB1942 was successful in becoming law and made clear the jailor's right of access to inmates' prior treatment records. Amendments made to Virginia Code §53.1-133.03 made clear that the jail administrator is entitled to treatment records when such information is necessary for the provision of healthcare to the person in jail; to protect the health and safety of the person, other residents, and staff; and to maintain the security and safety of the facility. While HB1942 made clear the jail administrator's right to treatment information, the bill did not address the community provider's obligation to share protected health information. Currently the Code of Virginia is silent on provider's need to affirmatively provide treatment information to jails. While some providers' legal counsel have advised them to provide the information (for the intention of §53.1-133.03 appears clear) other providers have been advised that absent an affirmative obligation to provide the information they should not voluntarily provide the information without a signed consent from the individual.

It should be noted that Virginia Code §37.2-804.2 is a section of the Code which in fact does affirmatively require providers to share health information (upon request), however, this code section only applies to individuals undergoing an involuntary civil commitment proceedings pursuant to §37.2-800 et seq. and is not applicable to individuals in jails.

Federal Law Related to Information Sharing

There are two major federal laws which govern the sharing of health information, namely the Health Insurance Privacy and Accountability Act (HIPAA) and 42 CFR §2.2. Codified in 1996, HIPAA provides safeguards for individual's health information and federal penalties for providers who breach the individual's privacy rights. HIPAA, however, does provide exceptions when health information can be shared without the individual's consent. The major exception to the need for specific authorization for the release of PHI is that medical care providers may

release information to other providers and entities who are participating in the patient's care. HIPAA allows the release of information without the patient's authorization when, in the medical care providers' best judgment, it is in the patient's interest. The exceptions to HIPAA are permissive and not obligatory thus resulting in varying interpretations about the ability or need to share information. Publications from several federal agencies make clear that under HIPAA community providers may provide PHI to jail treatment providers, however, whether a provider will or will not provide such information often depends on the legal advice provided by counsel. HIPAA laws are permissive (i.e. they allow for sharing) but do not necessarily mandate sharing.

The second major area of federal law pertaining to the sharing of health records is 42 CFR §2.2 which pertains to the release and use of health records related to substance use treatment. Recognizing the stigma and discrimination about substance misuse the federal government enacted 42 CFR §2.2 to impose restrictions and limitations on the sharing and use of substance abuse treatment records. 42 CFR §2.2 prohibits the sharing of such records without valid consent with the exception that information may be shared in response to a court order or during a medical emergency. While Congress is currently reviewing amendments to 42 CRF §2.2 to attempt to better align it with HIPAA, currently the law prohibits the sharing of any treatment records related to substance abuse treatment without a signed consent. This prohibition will limit some of the information shared if/when the current project is enacted for even state law cannot over-ride 42 CRF §2.2

The Importance of Privacy in Behavioral Health

While indeed the time it takes to access individual's prior treatment records and the barriers one must overcome to get those records is often extremely frustrating it is imperative that caution be taken when deciding whether to share information and how much information to share. While federal and state laws do allow for the sharing of prior treatment records, there are limits and conditions placed on the sharing. Under HIPAA it is generally the "minimum necessary" to accomplish the task standard while Virginia Code limits sharing to "may be necessary for the treatment of the person". These protections serve a purpose and providers must be cautious about sharing. It is clear that prejudice still exists against individuals with behavioral health challenges and that the sharing of information can, in certain circumstances, result in harm rather than help. It is also essential for individuals who seek treatment to feel confident that what they tell their providers will remain confidential and that the information will only be disclosed when it is in their best interest. Eroding confidentiality protections could result in fewer people seeking treatment and individuals being reluctant to fully share their experiences with providers for fear the information will be shared with others and used against them at some later point in time. While indeed creating a statewide system to facilitate the sharing of prior treatment information with jail staff is a noble and necessary endeavor, it must be approached with some caution and appreciation of the potential unintended consequences of sharing PHI.

Process for Developing a Plan for Information Sharing with Jails

Upon Governor Northam's signing of SB1644 into law, DBHDS began work on developing the plan outlined in the bill. It should be noted that DBHDS had been informally attempting to address this issue for the last several years but with the signing of the bill the efforts became more focused and concentrated.

As a first step, DBHDS explored other information sharing platforms which already exist in the Commonwealth that are designed to facilitate information sharing between providers (regardless of location/affiliation). During the 2017 Virginia General Assembly, the Emergency Department Care Coordination Program (EDCC) was codified via budget language to establish a single, statewide technology solution to connect all hospital emergency departments in the Commonwealth. The EDCC is designed to ensure sharing of patient information for high risk, high utilizer clients who present at various emergency departments. It is designed to enhance care coordination and ensure providers are aware of prior emergency department contacts. While the intention is for CSBs to eventually have access to and enter data into the EDCC, feedback received from the CSBs was that few were currently using the EDCC and many were skeptical whether they would eventually fully utilize the system. Feedback also suggested that even if CSBs utilized the EDCC, it would only be for a subset of the clients served, namely those who present and are assessed by the CSB emergency services staff in the ED, and therefore would not have information on a majority of the clients receiving services from the CSB. DBHDS also had some preliminary discussions with the Virginia Department of Health, who oversees the EDCC, about the possibility of including jail healthcare staff in the set of providers who could access the data. When it became clear the EDCC as unlikely to meets the needs outlined in SB1644 such conversations were ceased.

To assist in the development of the plan, research was also conducted to determine how other states have approached the issue and successfully share protected health information. Texas was identified as a state that had successfully adopted a system that allows for the sharing of protected health information between their version of Community Services Boards and their jails. Texas Health and Safety Code §614.017 (See Appendix A) is a state law that requires disclosure of information that may be protected health information under HIPAA. It states that agencies shall accept and disclose information relating to a special needs offender including information about the offender's identity, needs, treatment, social, criminal, and vocational history, supervision status and compliance with conditions of supervision, and medical and mental health history for the purposes of continuity of care and services. Exceptions to this pertain to sharing of psychotherapy notes and information protected under federal regulations covered in 42 CFR part 2 (information that would identify an individual as having received or applied for treatment for alcohol or substance use), which requires consent from the individual. An electronic data interchange was created between the Department of State Health and Human Services and the Department of Public Safety that allows for a real time data exchange to support continuity of care for individuals with mental illness that are involved with the criminal justice

system. In the original version of the data exchange, information was returned to the criminal justice agency within 72 hours however it was revised to create a real time exchange of data that is currently in place.

While this model adopted by the state of Texas seems ideal on the surface, in order to implement a similar process in Virginia, a change in code would be required as well as development of a statewide data exchange system, which would be costly. Virginia does not currently have a centralized system where real time data is housed therefore the capacity to implement a real time data exchange does not currently exist. One of the advantages in Texas is that all of the local behavioral health authorities (equal to CSBs in Virginia) utilize the same electronic health record system and all of the jails utilize the same jail management system. This allows for a data sharing process to be developed with much more ease. In Virginia, there is no consistency in the electronic records that are utilized across CSBs/BHAs or the jails therefore standardized information sharing cannot be automated the way it is in Texas (without great effort, time, and expense to write different data queries for each of the different data systems).

DBHDS also researched other publically available data platforms that can match different data sets to identify individuals who appear in both data sets. The Law Enforcement Information Exchange (LinX) was explored. The LinX system is used by many public safety entities to gather information about individuals and to identify trends in data. While the LinX as currently configured would not meet our needs, conceivably it or other data matching programs could be programmed to cross match different data sets to identify individuals who appear in both sets. Data sharing agreements would need to be executed to allow for the sharing of the various data sets. Research would need to be conducted to ensure whatever system was selected complies with both federal and state privacy laws. There was not sufficient time allocated during the course of this study to delve deeply into all the various data matching systems although should the General Assembly wish to explore this option the relevant research could be executed.

During the summer of 2019, DBHDS convened a work group comprised of individuals from CSBs, local and regional jails, the Office of the Attorney General, an advocacy group and others. The purpose was to discuss how to develop a plan for information sharing between CSBs and local and regional jails in Virginia considering current laws and regulations. Attention was given to balancing continuity of care and maintaining privacy of the individual. The system utilized in Texas was reviewed with the group as a model for how Virginia could develop such a system. Since all CSBs do not use the same electronic record and all jails do not use the same jail management systems, there is no way to duplicate the process that Texas developed (without significant funding, time, and effort). The members shared their perspectives about how data might be shared and the limitations of various methodologies.

The work group then reviewed/discussed the feasibility of utilizing already existing data sources to meet the intent of SB 1644. Currently, CSBs are required to submit specific data elements to DBHDS on services and episodes of care on a monthly basis through Community Consumer

Submission (CCS) thus DBHDS already receives data monthly on all individuals who receive or have ever received services through the CSBs. DBHDS has sufficient demographic information to assign a unique identifier to each individual and knows the types of services each individual has received from the CSB. It should be noted, however, that the data received is two months old and therefore does not include individuals who have received services within the last month(s). The information DBHDS receives is uploaded from the various CSB electronic health records and formatted into a standardized data-reporting format. The data uploads are time intensive and require several steps to ensure the data is properly formatted and accurately represent the services provided. Because of technology and staffing challenges, it became readily apparent that while having more up to date, live data would be beneficial for this project this was not practicably feasible. Getting live data would require a complete re-write of the various data interfaces and would be extremely costly.

DBHDS also, through a data sharing agreement, has access to the State Compensation Board (SCB) Local Inmate Data System (LIDS) data. The LIDS data provides a list of all individuals housed in local and regional jails across the Commonwealth at any given time. Jails upload their census data into the LIDS system through an interface between their offender management software programs and the LIDS data system. While in theory, LIDS data is up to date, currently State Compensation Board must manually transfer the data to DBHDS and because of workload issues, DBHDS only receives updated data monthly. DBHDS is exploring the feasibility of receiving more routine data from SCB LIDS data and the associated resource needs to make this occur. DBHDS has a data sharing agreement with the State Compensation Board to utilize the LIDS data to assess the effectiveness of some of our jail diversion initiatives. Conceivably the LIDS data could be used to identify individuals in jail who have previously received services from a CSB(s) although such use would fall outside the parameters of the current data sharing agreement thus a new agreement for this new purpose would need to be executed.

DBHDS operates a data warehouse in which numerous data systems to include LIDS and CCS feed data. It is conceivable that a query could be written to cross match the two data sources and identify individuals in jail who also have received services from a CSB(s) in the past. While the data warehouse can generate a list of such individuals, it does not have the capacity to subsequently notify the CSBs of those individuals to whom they have previously provided services who are currently in jail. Rather, this would need to be a manual process. While this system has many limitations including latency, it would be the most cost effective (in that it would use already existing data systems and require the build out of a new system), could be implemented the quickest, and hold some promise for utility to the jails. The overall sentiment of the workgroup seemed to be that with some minor funding to make this system operational, it might be useful to pilot this system to see how useful the information proved to be to jails, how time consuming it was to the CSBs to share the information, and whether indeed there was enhanced continuity of care once this information sharing was taking place on a routine basis.

Proposed Plan for Information Sharing

The LIDS and CCS3 data will be cross-matched to see if any individuals that are incarcerated in local or regional jails have received services from a CSB/BHA during the last year. This cross match will allow DBHDS to identify individuals in jail and what CSB/BHA they received services from. This is important as many individuals are incarcerated in different localities than they received services from. The system, as it is, will not allow for any outbound reporting which means that once that list is created DBHDS staff will need to send reports to the CSB/BHA informing them that someone that received services from them is in a local or regional jail. The frequency of these cross-matches will be dependent on the frequency by which DBHDS can received updated LIDS data as this will determine when there will be new data available to cross match, since it was determined it is not possible to increase the frequency of receiving CCS data without significant infrastructure changes. Upon being notified by DBHDS that a client they previously served is in jail, it would then be the responsibility of the CSB/BHA to contact the jail service provider and provide the necessarily information to enhance continuity of care. Since the data, being utilized is submitted from the CSB/BHA there are no privacy issues related to sending them a list of individuals who received services from them, however, current law would not permit DBHDS from directly sharing the lists of individuals with the jail. An individual's presence in jail is a matter of public record therefore that does not pose a privacy issue either. It should be noted, however, that while HIPAA allows for the sharing of information for the purpose of continuity of care, it does not mandate the sharing of information. Similarly, while state law makes clear the jail's right to certain information, Virginia law does not mandate the holder of such information to share the information. Currently there is much variability across CSBs as to their practice regarding sharing of information. On the advice of legal counsel, some CSBs will not share unless they have a signed release form. Others routinely share the information with their jails. So even if the above system is developed to identify individuals in jail who have previously received services, absent Code changes there likely will still be inconsistency in practices and some CSBs will, on the advice of legal counsel, decline voluntarily to share information with the jail absent a signed release. Despite these possible limitations, creating a statewide system will at least aid the CSBs in knowing which of their clients are in jail so that they can help in the coordination of care in the jail and upon the individual's release.

Another topic that was addressed in the work group was the type and amount of information that will be shared. There was consensus that information needs to be shared with the jails for the purposes of continuity of care however, there should be limits in order to respect the individual's right to privacy. The list of services from CCS3 data was reviewed and the group identified those types of services which would be indicative of the types of clients for whom information would be most useful for the jails to know. The identified services for which individuals who received these services would be identified for the jails included: case management services, psychiatric services, and pre-screening/crisis information. The workgroup also opined that for jails it would

be most imperative to receive information on individuals who had received services within the last year. While having received services longer ago might be informative, the group agreed that the sharing of such old information would be less relevant (to the current treatment needs) and that the potential negative effects of sharing such information and not respecting individuals' right to privacy outweighed the benefits. Finally, the workgroup reviewed the types/scope of information that should be shared. The list included:

- Diagnoses (excluding SA diagnoses which cannot be shared under 42 CFR)
- Medications/prescriptions
- Incidents of self-injury (dates and description of self-injury)
- Types of services being provided

While the collection of data from CCS and LIDS is already in place and operational, it is not currently being utilized in this way therefore it requires some initial costs to set up development and automation of the systems in order to submit data with increased frequency and to have the capacity to cross match the data that is being submitted. There will also be costs associated with increased staff time to manage the data and disseminate the information to the CSBs/BHAs. The data sharing agreement between DBHDS and SCB would also need to be updated to include the use of the data for this purpose. Not knowing the volume of cases where the CSB will need to share information with jails, it is hard to estimate whether the sharing can be accomplished with existing resources or whether new resources would be needed. Again, starting this project as a pilot project will help DBHDS begin to gather information about the volume of cases.

Limitations of Proposed Plan

Because there is a delay in data that is submitted, it is not possible to gather data in real time and will have at least two month latency in CSB data. This means that an individual that initiated services, for the first time, within two months of their incarceration would like not be captured using this process. While this is not ideal, it would be an improvement compared to not having any way to share any of this information.

This system would assist with information sharing between jails and CSBs/BHAs but would not include any other providers. While many of the individuals in the jail receive services through their local CSB/BHA many do not. Those with Medicaid or private insurance likely receive services through a private provider or other community based services provider. This plan for information sharing would not apply to those providers. Federal law would prohibit the sharing of treatment information for individuals who have received substance abuse services.

Cost of the Proposed Plan

While CCS and LIDS are already operational data systems, they are not currently being used for this purpose. The most feasible option given the infrastructure in place at this time would be automate the process and share the information with the CSBs/BHAs.

The CSBs/BHAs would continue to send data on a monthly basis and the SCB will increase the frequency that LIDS data is sent to once weekly. The information will be cross-matched and a list would be created that would have individuals list by the CBS/BHA that provided services to them. Staff will need to manually extract the data and provide a list that will be sent out to each CSB/BHA. This option will take approximately 120 hours to develop automation and is something that DBHDS can complete with current resources however, staff will need to be hired to manage the data and send the information out to the CSB/BHA. DBHDS would need to hire one FTE at the Program Administrative Specialist (Salary of approximately $50,000 + benefits = $65,000) in order to manage the data coming in from SCB weekly and from CSBs/BHAs monthly. The FTE would also be tasked with following up with CSBs/jails to ensure information is shared and to identify opportunities to improve the data sharing system. In addition to the above identified cost, the SCB would require funding to automate their system in order to have the data sent to DBHDS on a weekly basis. SCB would need approximately 800 hours of IT time to develop the system where the data could be sent to DBHDS on a weekly basis. The estimated cost of that would be approximately $144,000 ($180/hour) for SCB. This is a one-time cost. This process would provide data with a two-month latency from the CSB/BHA and one week latency on the LIDS data therefore individuals on the list may no longer be in jail and/or individuals who initiated services within the last two months would not be included in the data.

In order to have data that is in real time an entirely new system would have to be developed. This system would need to have the ability to collect data from all of the different electronic health records that the CSBs/BHAs use and to be able to collect data from the jail management systems that the jails use on a daily basis. This system would then need to be able to report out to the necessary entities.

Legislative Amendments That Would Support Information Sharing

An Amendment to the Code of Virginia could support more consistent information sharing with jails. As mentioned earlier, while HIPAA does allow for information sharing without signed releases they do not mandate sharing. Additionally, while more recent changes to the Code of Virginia §53.1-133.03 and §53.1-40.10 have made clear the jails and prisons right to have access to health information the changes have not made clear the obligation of treatment providers to provide the information to the jails. There is a section of the Code of Virginia that does make clear a providers obligation to share information with others. Virginia Code §37.2-804.2 does require health care providers to share information, however this code section is specific to sharing information about individuals undergoing proceedings pursuant to the civil commitment proceedings outlined in that chapter and are not applicable to individuals in jail. Mirroring some of the language contained in §37.2-804.2 (to include the immunity from civil liability granted to the healthcare provider for disclosing information) into Virginia Code §53.1-133.03 (or other relevant Code section) would make clear the health care providers obligation to share information with the jail. It would bring consistency of information sharing across the Commonwealth. While HIPAA would remain permissive, the fact Virginia Code was mandatory

would over-ride the permissiveness of HIPAA and would require sharing. The remaining challenge, however, would be to create a mechanism to trigger the information sharing. As written in §37.2-804.2 the healthcare provider must share information upon request. Jails, however, often do not know which inmates have received previous services and from whom they received the services. Therefore, it would be challenging jails to make a request – unless there was some standing request made by each jail to each provider. Rather it seems more realistic to modify the language copied from §37.2-804.2 (and included in §53.1-133.03 (1) to state:

"Any health care provider as defined in §32.1-127.1:03 who has been notified that an individual to whom they provided services is incarcerated shall disclose to the jail any information that is necessary and appropriate for the continuity of care. Any health care provider disclosing records pursuant to this section shall be immune from civil liability for any harm resulting from the disclosure, including any liability under the federal Health Insurance Portability and Accountability Act (42 U.S.C. §1320D et seq.) as amended, unless the provider disclosing such records intended the harm or acted in bad faith."

Another approach would be to codify the requirement that DBHDS perform the cross-matching function and the requirement that community providers share information to the jails. This was the approach taken in Texas. A copy of the code that was implemented in Texas is included in Appendix A as a sample of how to codify this process.

Conclusion

There is a clear need for developing a system for sharing protected health information for individuals with treatment needs that are incarcerated in local and regional jails in Virginia. The plans outlined in this report provide a way that Virginia can develop a system of sharing information and better assisting individuals with mental health needs in the jails. This does not provide a solution for everyone who is incarcerated, only those who have received services from a CSB/BHA. It also does not ensure that data is captured in real time but allows information to be available in a way that is currently not available. In order to determine if the information-sharing plan outlined in this report would be feasible and provide useful information, a pilot program could be developed between jails and CSBs/BHAs in a region. During the work group, there was varying opinions about how much of an issue this was and how much information a jail would want regarding an individual. The implementation of a pilot program may assist with determining the finer points of what is needed. Upon completion of the pilot program more specific information may be gleaned that would help drive the most effective and efficient way to share the information. In the meantime, an amendment to the Code of Virginia would facilitate the sharing of information regardless of whether or not a statewide data matching system is pursued.

Information Sharing Workgroup Members		
Bruce Cruser Executive Director Mental Health America of Virginia	**Robyn deSocio** Executive Secretary State Compensation Board	**Michael Schaefer, Ph.D., ABPP** Assistant Commissioner for Forensic Services Virginia Department of Behavioral Health & Developmental Services
Jana Braswell, MS Behavioral Health/Criminal Justice Specialist Virginia Department of Behavioral Health & Developmental Services	**Christine Schein, LCSW** Forensic Operations Manager Virginia Department of Behavioral Health & Developmental Services	**Allyson Tysinger, Esq.** Senior Assistant Attorney General/Chief Office of the Attorney General
Bobby Russell Superintendent Western Virginia Regional Jail	**Leslie Weisman, LCSW** Client Services Entry Bureau Chief Arlington Community Services Board	**Dr. Susan Williams** Virginia Department of Corrections
Jennifer Faison Executive Director VACSB	**Tamara Starnes, LPC** Chief Clinical Officer Blue Ridge Behavioral Healthcare	**Timothy Trent** Superintendent Blue Ridge Regional Jail Authority
Brandon Rodgers Director of Operations Western Tidewater Community Services Board	**Bob Horne, MSEd., LPC** Director of Board Operations Norfolk CSB	**Marissa Fariña-Morse, LPC** Service Director-Diversion First Fairfax/Falls Church CSB
Katie Boyle Virginia Association of Counties	**Mike Taylor** Sheriff Pittsylvania Sheriff's Office	**Aileen L. Smith** Virginia Beach CSB
Kemba Jennings Virginia Department of Corrections	**Heather Zelle, J.D., Ph.D.** Associate Director of Mental Health Policy Research Institute of Law, Psychiatry, & Public Policy	**Karen Nicely** Board of Corrections
Suzanne Somerville Arlington Community Services Board	**Ashley Hall, LCSW** Behavioral Health/Criminal Justice Specialist Virginia Department of Behavioral Health & Developmental Services	

Appendix A

Texas Code Section §614.017

(a) An agency shall:

(1) accept information relating to a special needs offender or a juvenile with a mental impairment that is sent to the agency to serve the purposes of continuity of care and services regardless of whether other state law makes that information confidential; and

(2) disclose information relating to a special needs offender or a juvenile with a mental impairment, including information about the offender's or juvenile's identity, needs, treatment, social, criminal, and vocational history, supervision status and compliance with conditions of supervision, and medical and mental health history, if the disclosure serves the purposes of continuity of care and services.

(b) Information obtained under this section may not be used as evidence in any juvenile or criminal proceeding, unless obtained and introduced by other lawful evidentiary means.

(c) In this section:

(1) "Agency" includes any of the following entities and individuals, a person with an agency relationship with one of the following entities or individuals, and a person who contracts with one or more of the following entities or individuals:

(A) the Texas Department of Criminal Justice and the Correctional Managed Health Care Committee;

(B) the Board of Pardons and Paroles;

(C) the Department of State Health Services;

(D) the Texas Juvenile Justice Department;

(E) the Department of Assistive and Rehabilitative Services;

(F) the Texas Education Agency;

(G) the Commission on Jail Standards;

(H) the Department of Aging and Disability Services;

(I) the Texas School for the Blind and Visually Impaired;

(J) community supervision and corrections departments and local juvenile probation departments;

(K) personal bond pretrial release offices established under Article 17.42, Code of Criminal Procedure ;

(L) local jails regulated by the Commission on Jail Standards;

(M) a municipal or county health department;

(N) a hospital district;

(O) a judge of this state with jurisdiction over juvenile or criminal cases;

(P) an attorney who is appointed or retained to represent a special needs offender or a juvenile with a mental impairment;

(Q) the Health and Human Services Commission;

(R) the Department of Information Resources;

(S) the bureau of identification and records of the Department of Public Safety, for the sole purpose of providing real-time, contemporaneous identification of individuals in the Department of State Health Services client data base; and

(T) the Department of Family and Protective Services.

(2) "Special needs offender" includes an individual for whom criminal charges are pending or who after conviction or adjudication is in custody or under any form of criminal justice supervision.

(3) "Juvenile with a mental impairment" means a juvenile with a mental impairment in the juvenile justice system.

(d) An agency shall manage confidential information accepted or disclosed under this section prudently so as to maintain, to the extent possible, the confidentiality of that information.

(e) A person commits an offense if the person releases or discloses confidential information obtained under this section for purposes other than continuity of care and services, except as authorized by other law or by the consent of the person to whom the information relates. An offense under this subsection is a Class B misdemeanor.