Published monthly by the
VIRGINIA DEPARTMENT OF HEALTH
Office of Epidemiology
P.O. Box 2448
Richmond, Virginia 23218
http://www.vdh.virginia.gov
Telephone: (804) 864-8141

VDH VIRGINIA DEPARTMENT OF HEALTH
Protecting You and Your Environment

PRESORTED
STANDARD
U.S. POSTAGE
PAID
Richmond, Va.
Permit No. 591

VIRGINIA
EPIDEMIOLOGY BULLETIN

Robert B. Stroube, M.D., M.P.H., Health Commissioner
Carl W. Armstrong, M.D., State Epidemiologist

Christopher Novak, M.D., M.P.H., Editor
Vickie L. O'Dell, Layout Editor

January 2006 Volume 106, No. 1

Protecting Health Information

Healthcare professionals in Virginia should be concerned about protecting the privacy of their patients. They may also worry that they may be violating professional standards or the law when they reveal patient information. But it is important that healthcare professionals understand that they have both a legal and a professional responsibility to protect the public health and that current federal and state laws and regulations fully support public health reporting practices. This article provides an overview of the applicable statutes to increase healthcare provider comfort with reporting requirements.

In This Issue:

HIPAA

Congress enacted the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to ensure that individuals retain health insurance coverage after leaving an employer and to provide standards for facilitating healthcare-related electronic transactions. In the process, Congress recognized that the shift of medical records from paper to electronic formats increases the potential for individuals to access, use, and disclose sensitive personal health data. The Department of Health and Human Services then developed the HIPAA Privacy Rule (Standards for Privacy of Individually Identifiable Health Information) to provide national standards for protecting health information. The HIPAA Privacy Rule regulates how specified individually identifiable health information, known as protected health information (PHI), that is transmitted or maintained in any form or medium (e.g., electronic, paper, or oral) may be shared.[1]

The HIPAA Privacy Rule applies to only the three types of businesses covered by HIPAA. These "covered entities" are:

a. **Health plans:** An individual or group plan that provides or pays the cost of medical care.
b. **Healthcare clearinghouses:** A public or private entity that processes or facilitates the processing of health information.
c. **Healthcare providers:** A provider of medical or health services or any person or organization who furnishes, bills, or is paid for healthcare in the normal course of business.[2]

Of note, health departments occasionally encounter non-covered

entities (e.g., restaurants, daycares) that inappropriately cite HIPAA as a reason for their resistance to reporting illness or releasing information during an investigation. This slows the public health response and impairs the ability of the local health department to act to protect others.[2]

Most healthcare professionals are aware that the HIPAA Privacy Rule limits the use and disclosure of an individual's PHI by a covered entity. What healthcare professionals may not know is that even for covered entities the HIPAA Privacy Rule contains numerous exceptions to this general rule (see 45 CFR 164.512). One significant exception involves the disclosure of PHI for public health activities.[2]

Public Health Activities and HIPAA

Public health practice requires the acquisition, use, and exchange of PHI for disease surveillance, program evaluation and planning, terrorism preparedness, outbreak investigation, and research. Such information enables public health authorities to implement mandated activities (e.g., identifying, monitoring, and responding to death, disease, and disability among populations) and accomplish public health objectives.[1] Therefore, public health authorities have a legitimate need for PHI to ensure the public health and safety.[3]

Balancing the protection of individual health information with the need to protect the public health, the **HIPAA Privacy Rule expressly permits covered entities to make disclosures that are required by other laws such as those that relate to public health purposes,** including:

- The reporting of disease or injury, or vital events (e.g., births or deaths);
- Conducting public health surveillance, investigations, or interventions;
- Reporting child abuse and neglect;
- Monitoring adverse outcomes related to food (including dietary supplements), drugs, biological products, and medical devices [see 45 CFR 164.512(b)(1)(i)].[1]

Therefore, as stated in 45 CFR 164.512 the HIPAA Privacy Rule does not supercede state statutes or administrative rules that require covered entities to disclose protected health information (e.g., disease reporting under *Code of Virginia* § 32.1-36 and *Virginia Administrative Code* 12VAC5-90-90).

While the information that must be disclosed should be the minimum necessary to accomplish the public health purpose, it is not limited to specific data elements such as those listed on Virginia's Confidential Morbidity Report (Epi-1) Form. Public health authorities may collect additional information and may review any medical record held by a healthcare professional or facility, as authorized by the *Code of Virginia* (§ 32.1-40). In this process, covered entities may rely on the public health authority to determine the minimum necessary information that should be provided [45 CFR 164.514(d)(3)(iii)(A)]. This provision should reassure healthcare professionals that providing additional information (e.g., medical and social history, treatment course, laboratory results, referrals, etc.) is permitted under the HIPAA Privacy Rule and Virginia state law.

Public Health Protection of PHI

Public health authorities may maintain, use, and disclose data consistent with applicable laws, regulations, and policies. In the process, public health authorities have a long history of respecting the confidentiality of an individual's PHI. Virginia law also carefully protects individually identifiable patient information as well as information related to the healthcare providers reporting the PHI (*Code of Virginia*, § 32.1-41).

For example, the Virginia Freedom of Information Act (FOIA) (*Code of Virginia*, § 2.1-3700 *et. seq.*—available at www.vdh.virginia.gov/Admin/FOIA.asp) guarantees citizens of the Commonwealth and representatives of the media access to records held by public bodies, public officials, and public employees. And every effort is made to fully comply with any and all FOIA requests. However, public health authorities will not release an individual's medical or mental records, except for review by the individual [*Code of Virginia*, § 2.1-3705.5(1)]. Although an action (subpoena) can be filed to compel access to these records (just as a healthcare provider's records may be subpoenaed), the Commissioner's legal representative may petition the court to have unjustifiable subpoenas quashed.[2]

However, there are occasions when, in the interests of protecting the public, this information may need to be released. For example, the *Code of Virginia* (§ 32.1-36.D) would allow the State Health Commissioner to release information to an individual's employer if the patient's employment responsibilities required contact with the public and the nature of the patient's disease and nature of contact with the public constituted a threat to the public health.

Conclusions

The 1996 Health Insurance Portability and Accountability Act's Privacy Rule clearly allows the sharing of PHI with public health authorities who are authorized by law to collect or receive such information.[1] In addition, healthcare professionals should be aware that the *Code of Virginia* (§ 32.1-38) states that any person making a required report or disclosure is immune from any related civil liability or criminal penalty unless such person acted with gross negligence or malicious intent. These protections for reporting cases to

Inspection of Records

The State Health Commissioner, or his/her designee, may inspect any medical record of a healthcare provider in the course of investigation of conditions of public health importance (*Code of Virginia* § 32.1-40)

public health authorities facilitate the operation of programs that control disease, injury, or disability in Virginia.[1]

However, covered entities should remember that, while the HIPAA Privacy Rule permits disclosures of PHI to public health authorities without authorization, covered entities must still comply with the requirements related to those disclosures.[1] For example, prior to releasing health information it is reasonable to ensure that the person or agency requesting the PHI is a legitimate public health authority (e.g., provide credentials or proof of government status).[3] In addition, since covered entities must be able to provide an individual, upon request, with an accounting of certain disclosures of PHI, it would be reasonable to document the disclosure in the patient record.[1] Healthcare professionals may request that a public health official reviewing a medical record document their name, title, affiliation, and the time and date of review. Together, these actions protect healthcare providers, patients, and the public safety.

For additional information on HIPAA and the HIPAA Privacy Rule, go to www.hhs.gov/ocr/hipaa/.

References

1. CDC. *Morb Mortal Wkly Rep.* 2003. 52:1-12.
2. Center for Public Health Law Partnerships. Public Health Law Bench Book for Indiana Courts. 2006. (Accessed 1/26/2006, at www.publichealthlaw.info/IN-BenchBook.pdf).
3. Campos-Outcalt, D. 2004. *J Fam Pract.* 53(9):701-4.

Flu Corner

Influenza Activity in Virginia and the U.S.

As of February 4, 2006, for the 2005-2006 influenza season in Virginia the Division of Consolidated Laboratory Services (DCLS) has confirmed 29 cases of influenza A/H3, one influenza A/H1, two influenza A untyped, and one influenza B by DFA, RT/PCR, and/or culture. Fourteen cases were from the southwestern, four from the northwestern, seven from the eastern, six from the central, and two from the northern health planning regions. A commercial laboratory also reported one confirmed case of influenza A by DFA from a central region resident. Three laboratory confirmed outbreaks have been reported as of February 4, 2006 (one each in the eastern, central, and southwestern regions).

Nationally, as of February 4, 2006, nine U.S. states (including Virginia) have reported widespread activity, 21 states and D.C. have reported regional activity, 13 states have reported local influenza activity, and six states have reported sporadic activity. The proportion of deaths attributable to pneumonia and influenza in 122 cities monitored by the Centers for Disease Control and Prevention (CDC) has remained below the epidemic threshold.

The CDC reports that during the week ending February 4, 2006, 333 of 2,401 specimens (13.9%) tested by the World Health Organization (WHO) and National Respiratory and Enteric Virus Surveillance System (NREVSS) laboratories were positive for influenza. Since October 2, 2005, WHO and NREVSS laboratories have tested a total of 61,861 specimens for influenza viruses with 4,466 (7.2%) positives detected.

Please see the CDC website at www.cdc.gov/flu/weekly/fluactivity.htm for up-to-date details on influenza surveillance in the U.S.

Index to Volume 105 (by Issue Number)

Cases of Selected Notifiable Diseases Reported in Virginia*

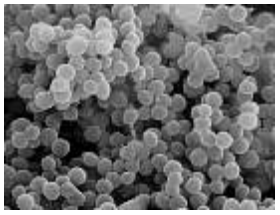
Disease	Total Cases Reported, December 2005						Total Cases Reported Statewide, January - December		
		Regions							
	State	NW	N	SW	C	E	This Year	Last Year	5 Yr Avg
AIDS	55	8	10	6	17	14	626	770	804
Campylobacteriosis	81	21	18	15	10	17	620	668	679
***E. coli* O157:H7**	10	2	6	1	1	0	52	41	58
Giardiasis	84	5	23	14	20	22	591	563	446
Gonorrhea	664	37	66	76	248	237	8,244	8,565	9,868
Hepatitis, Viral									
A	7	0	5	0	2	0	89	140	155
B, acute	10	2	1	4	1	2	141	303	228
C, acute	2	0	0	1	0	1	13	15	10
HIV Infection	96	7	18	12	34	25	837	873	877
Lead in Children†	77	8	6	19	28	16	656	703	762
Legionellosis	7	2	0	2	1	2	51	56	55
Lyme Disease	27	5	18	0	1	3	264	216	195
Measles	0	0	0	0	0	0	0	0	<1
Meningococcal Infection	1	0	1	0	0	0	35	24	37
Mumps	0	0	0	0	0	0	0	11	7
Pertussis	40	8	6	7	8	11	356	400	239
Rabies in Animals	44	14	14	10	5	1	495	474	537
Rocky Mountain Spotted Fever	9	0	1	2	1	5	120	45	34
Rubella	0	0	0	0	0	0	0	0	0
Salmonellosis	127	13	37	24	31	22	1,176	1,196	1,207
Shigellosis	12	2	6	2	0	2	129	167	585
Syphilis, Early§	17	0	9	2	2	4	284	224	209
Tuberculosis	99	7	53	4	16	19	355	329	315

Localities Reporting Animal Rabies This Month: Alexandria 1 raccoon; Augusta 2 raccoons, 1 skunk; Bath 1 bobcat; Bedford 2 skunks; Caroline 1 skunk; Carroll 1 raccoon; Charlotte 1 skunk; Fairfax 4 raccoons; Frederick 1 skunk; Goochland 1 raccoon; Hanover 1 raccoon; Loudoun 7 raccoons, 2 skunks; Montgomery 1 raccoon; Page 1 skunk; Patrick 1 raccoon; Pittsylvania 1 raccoon, 1 skunk; Powhatan 1 skunk; Roanoke 1 fox; Rockbridge 2 skunks; Rockingham 1 raccoon; Shenandoah 1 cat, 1 raccoon; Southampton 1 skunk; Spotsylvania 1 skunk; Surry 1 raccoon; Waynesboro 1 cat; Wythe 1 fox, 1 skunk.
Toxic Substance-related Illnesses: Adult Lead Exposure 13; Mercury Exposure 1; Pneumoconiosis 4.
*Data for 2005 are provisional. †Elevated blood lead levels ≥10µg/dL. §Includes primary, secondary, and early latent.

Community-Acquired Methicillin-Resistant *Staphylococcus aureus* Update

The July 2005 *Virginia Epidemiology Bulletin* (www.vdh.virginia.gov/epi/bulletin.asp) provided guidance to assist healthcare professionals in the clinical management of skin and soft tissue infections (SSTIs) caused by Community-Acquired Methicillin-Resistant *Staphylococcus aureus* (CA-MRSA). A December 2005 article by Ellis and Lewis in *Current Opinion in Infectious Diseases* provides updated information, including details on new anti-staphylococcal antimicrobial agents (e.g., linezolid, daptomycin, tigecycline, dalbavancin, and telavancin), a review of older therapies (e.g., doxycycline, minocycline, rifampin, trimethoprim-sulfamethoxazole (TMP-SMX), and clindamycin), and a reminder on the need for adequate drainage of purulent fluid collections in treating CA-MRSA SSTIs.

In particular, the authors note that in contrast to the typical dosage of **TMP-SMX** (e.g., as used to treat urinary tract infections), the appropriate adult dosage of TMP-SMX for CA-MRSA skin and soft tissue infections is **10 mg/kg/day** based on the trimethoprim component. For the average adult, this approximates to **two double strength tablets twice a day** (rather than one double strength tablet b.i.d., as recommended in the July 2005 VEB).



For additional details, see Ellis M W, Lewis JS. *Curr Opin Infect Dis*. 2005.18(6):496-501.