OPPORTUNITIES FOR INFORMATION SHARING TO ENHANCE HEALTH AND PUBLIC SAFETY OUTCOMES

A Report by the Criminal Justice and Health Collaboration Project

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- **Scott Parker** served as the project manager, convened the working group, and was the lead author of this report.
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- **Kamala Mallik-Kane** of the Urban Institute extensively contributed to the project methodology, co-facilitated the working group, and wrote major portions of the report.
- **Aaron Horvath** of the Urban Institute contributed to the issue overview and wrote preliminary versions of the information exchanges documented in this report.
- **Janeen Buck Willison** of the Urban Institute helped to conceptualize the project methodology, co-facilitated the working group, advised on the prioritization of information exchanges, and provided several thoughtful critiques of this report.

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[1] See Appendix A for a fully defined list of acronyms and abbreviations.

[2] See Appendix B for more a full list of working group members and participating organizations, as well as for more information about the IJIS Institute and the Urban Institute.

1 EXECUTIVE OVERVIEW

Information sharing between the criminal justice and healthcare communities has the potential to enhance both public safety and health outcomes by reducing redundancies, enhancing continuity of care, and generating efficiencies in both domains. Thirty-four (34) beneficial opportunities for inter-domain information exchange were identified by a BJA-sponsored working group of experts from both the health and justice communities. Used judiciously, and with the necessary legal and technical safeguards to protect privacy and confidentiality, bi-directional sharing of health information between community-based care providers and correctional institutions can be used to divert individuals from the criminal justice system (when appropriate), better provide for their health needs while under justice supervision, and prepare for a successful post-release transition to the community. Information from community-based healthcare providers can enhance the ability of corrections officials to appropriately diagnose issues associated with continuity of care and to ensure no gap in service when incarcerated. Likewise, information from the criminal justice community—including risk assessments, correctional health records, correctional treatment history, and court dates—can support health providers in their care of justice-involved clients.

1.1 Issue Overview

The criminal justice system comes into contact with many people with extensive health needs. Harnessing health and criminal justice data can help to increase this population's access to health care and has the potential to improve health-related public safety outcomes. Nearly 7 million Americans—1 in 34—are either incarcerated or under criminal justice supervision, and many frequently cycle in and out of the criminal justice system. The justice-involved population is more likely to suffer from chronic physical health, mental health and substance abuse conditions than the general population. These chronic physical and behavioral health conditions are correlated with poorer reintegration outcomes, such as decreased employment, as well as increased re-arrest and re-incarceration rates. Most people who become involved in the justice system return home. Addressing their physical and behavioral health needs is an important concern not only for the affected individuals and the criminal justice system, which is legally required to provide for the health needs of incarcerated persons, but also for communities across the United States. Community-based health providers are likely to have clients in common with the criminal justice system, especially in distressed communities.

Information sharing between criminal justice and community-based health service systems can facilitate collaborative responses to improve both health and related public safety outcomes. Better outcomes have the potential to reduce healthcare and criminal justice system costs. Information from community-based provider agencies can help justice agencies more effectively respond to individuals with health concerns and avert serious health crises that may arise under custody. Examples include improved law enforcement (LE) responses to people in mental health crisis, appropriate diversions from the criminal justice system (*e.g.* drug courts), and prescription continuity for those who are incarcerated. Information sharing from the justice system back to the community supports reentry planning and facilitates continuity of care. Treatment retention contributes to stable or improved health outcomes, whereas disruptions in treatment can lead to decreased functioning or substance use relapse. Coordinated care has been shown to result in lower healthcare expenditures for populations with multiple health needs. Gains in health status may lead to improvements in post-release reintegration and employment, as well as decreased reoffending.

Additionally, the current economic climate makes it imperative to maximize existing information and resources. Criminal justice and community-based agencies often conduct similar assessments and collect similar information when each system encounters clients. By sharing information, agencies can: capitalize on information obtained by those best equipped to collect it; reduce errors (*e.g.* when transcribing prescription information); decrease staff time spent on gathering information; and, increase the quality and efficiency of client interactions. The impending implementation of health care reform under the *Patient Protection and Affordable Care Act of 2010*, as well as recent incentives to encourage the adoption of electronic health records (EHR), make this an opportune time advance the potential of cross-system information exchange. With support from the BJA, the IJIS Institute and the Urban Institute (UI), aided by a working group of health and justice stakeholders, have identified and documented a range of opportunities for beneficial, cross-system information exchange between criminal justice and health entities.

1.2 Key Findings

The working group identified 34 information exchange opportunities between *community-based health entities* (broadly defined to include physical health, mental health, pharmacy, and substance abuse treatment providers) and the *criminal justice system*. Each of the 34 information exchange opportunities is detailed in an "Information Exchange Synopsis" format in this report (see Section 4).

The overarching goal of information exchange between community-based health providers and the criminal justice system is to ***promote treatment continuity of care for the benefit of both the individual and overall public safety***. Other goals were ***facilitating alternatives to incarceration, improving the quality of offender reentry into the community, reducing likelihood of recidivism and reducing redundant re-assessments***.

Based on recommendations form the working group, BJA chose the following two areas for further development as Implementation Scenarios (see Section 5):

1) *Reentry into the Community after Incarceration* (Exchange Synopses 19, 20, 21, 30, and 34); and,
2) Community-based Treatment with Effective Criminal Justice Supervision (Exchange Synopses 25, 26, 27, 28, and 29).

While there are a number of administrative, privacy, and technical challenges to be addressed in order to fully implement these scenarios, an implementation of the selected exchanges could achieve the following benefits:

- Reduce or eliminate staff time for some tasks—and, therefore, reduce time and cost overall
- Automate several information processes desired by both stakeholder groups
- Increase accessibility if critical information
- Increase accuracy and timeliness of information enabling more effective continuity of care

More efficient and beneficial information exchange processes should lead to better healthcare for the target population, as well as reduced recidivism and, ultimately, safer communities.

1.2.1 Beneficial Uses by the Criminal Justice System

Many identified information exchanges illustrate how health information could enhance criminal justice operations at nearly every stage of the criminal justice process, from initial encounters with police, through the court process, to incarceration and reentry. Four (4) overarching needs for health information in the criminal justice system were identified across these multiple information exchanges:

1) Assessing an unknown situation
2) Appropriate diversion from the criminal justice system
3) Providing continuity of care for persons in custody
4) Effective community supervision of defendants and offenders

1.2.1.1 Assessing an Unknown Situation

Criminal justice practitioners expressed a need for health information to formulate the most appropriate response when they first encounter someone. This need occurs in a number of different criminal justice contexts, when a particular agency makes its first contact with an individual. For example,

- Police officers are dispatched to respond to someone behaving erratically
- Jails receive a new arrestee to hold in pre-trial custody
- Specialized courts (*e.g.* drug courts) receive a new case for consideration
- Parole receives a new offender to supervise in the community

In some of these situations, health information from the community may be the only source of information available. In others, information from community-based providers may serve as a valuable supplement to assessments conducted by the justice system.

1.2.1.2 Appropriate Diversion from the Criminal Justice System

Non-incarcerative responses to criminal behavior are sometimes preferred to achieve better case outcomes and conserve resources. For example, eligible arrestees may participate in a drug court if substance abuse problems are linked to their criminal behavior. Defendants agree to participate in court-ordered treatment and court supervision in lieu of jail time. Diversion programs need strong collaborations between the health and justice systems, and information sharing is an important part of this collaboration to:

- Demonstrate eligibility for the diversion program by documenting behavioral health problems that, if treated, may reduce criminal behavior;
- Monitor compliance with the program through attendance records, drug testing results, and progress reports; and,
- Promote compliance through increased awareness of court conditions, dates of court appearances, and dates of meetings with supervision officers.

Presently, this type of information is often shared through personal contacts and paper records but electronic data exchanges may improve efficiency. Additionally, the availability of electronic information may help to extend the reach of these programs. Diversion programs sometimes rely on *ad hoc* referrals to identify eligible individuals (*e.g.* from prosecuting or defense attorneys). Electronic information could be used to facilitate more universal screening processes, whereby all individuals meeting certain screening criteria come to the attention of the program.

1.2.1.3 Providing Continuity of Care for Persons in Custody

Disruptions in health care and medication regimes are key problems when individuals with chronic health problems cycle in and out of the justice system. Consistent treatment approaches to chronic disease management and timely receipt of medication are necessary to maintain health and avoid dangerous health crises, such as decompensation among people with mental illness or spikes in blood glucose levels among people with diabetes. There are two dimensions to this issue:

1) **When an individual is taken into custody, whatever health care or medication s/he was using is suddenly disrupted**. This situation may be exacerbated by the stresses caused by the arrest and incarceration, potentially leading to an acute health crisis. In addition to the harm to the individual, a health crisis creates a disruption in the facility and requires mobilization of correctional officers and resources. Timely access to health information is critical to re-establishing an individual's medication regime to avoid such a situation. It is also important to note that correctional facilities have a legal obligation to provide necessary health care to those in its custody and can be held liable for failing to do so.

2) **When an individual is released from custody, s/he may lose access to health care, medications, and addiction treatment**. This puts the individual at risk for negative health outcomes and potential re-incarceration if their health problems (*e.g.* addiction) are related to criminal behavior. In addition to the consequences for the individual, the loss in health status after release is an inefficient use of resources. Linkages to health care after release, supported with health information exchange, can help to maintain continuity of care and avert these negative outcomes.

1.2.1.4 Effective Community Supervision of Defendants and Offenders

With the use of alternatives to incarceration comes the need to effectively supervise offenders. Various agencies at different points in the criminal justice system have responsibility for supervising individuals in the community, including pre-trial release, probation, diversionary programs, and post-incarceration supervision, such as parole. These entities have common needs for health information, including:

- Matching individuals to appropriate community-based programs to meet service needs and reduce re-offending;
- Monitoring compliance with supervision conditions such as drug testing and program attendance; and
- Responding to noncompliance with appropriate sanctions.

Utilizing information from health providers informs supervision officers about relevant health conditions, thus allowing them to refer them to appropriate programs and consider alternative responses to problematic behaviors. For example, missed appointments with the supervision officer may prompt a conversation with an offender's mental health clinician and an adjustment to the treatment plan rather than automatically triggering a revocation. Additionally, efficiencies can be gained if justice supervision agencies are able to access program attendance and drug testing records from health program, such as addiction treatment centers.

In addition to these overarching themes, working group members identified other instances when health information is transmitted to the justice system, including:

- **Health information is sometimes used as evidence by the justice system.** Health care providers encounter injuries that may have resulted from a crime and report these to LE. This includes

reports of suspected child abuse, intimate partner violence, elder abuse, prescription drug abuse, or driving while intoxicated. Historically, these have been reported by phone but there is potential for electronic and transmission of records to serve as evidence in criminal prosecutions.

- **Health providers transmit medical bills to justice agencies**. This mainly occurs when inmates receive health care from community-based providers. For example, an arrestee is hospitalized after booking into a detention center. In a more specialized instance, crime victim compensation programs utilize medical billing information to document expenses incurred by crime victims and to provide compensation or restitution to the victim. Electronic data exchange may improve the efficiency of these program operations.

1.2.2 Beneficial Uses by Healthcare Providers

Many of the identified information exchange opportunities focused on how information generated by the justice system could enhance or improve healthcare. The majority of these information exchanges are within the context of a collaborative, back-and-forth relationship between justice and health, whereas others are unidirectional needs for information from the justice system. While multiple, specific information exchanges were identified, they centered on these six key healthcare information needs:

1) Assessing an unknown situation
2) Decision-making on program eligibility
3) Public health surveillance
4) Determining the whereabouts of clients and facilitating continuity of care
5) Collaborating on and coordinating care of inmates during incarceration
6) Planning for offenders' reentry into the community

1.2.2.1 Assessing an Unknown Situation

The criminal justice population is typically uninsured, and, consequently, receives fragmented care from multiple community providers, including emergency rooms (ERs). Individual providers are likely to have little information on a given patient's medical, mental, substance abuse, or prescription history, and the information they do have is often solely based on what the individual reveals. Depending on a person's justice involvement, jail or prison health records may be the most comprehensive source of medical history information. Community-based health providers could use health records from the justice system to supplement what they learn from their initial encounter with a patient, such as medical history, past diagnoses, and prescription medications taken. With this, community-based providers can make an informed decision as to whether to continue previous treatment approaches.

1.2.2.2 Decision-Making on Program Eligibility

Health service programs, such as residential drug or mental health treatment facilities, need to assess potential clients' risk for violence and other behavioral problems when evaluating whether they can work with a particular individual. Security risk assessments that are routinely conducted by justice agencies are a valuable source of such information.

1.2.2.3 Public Health Surveillance

The justice-involved population has disproportionately high rates of many serious health conditions—so much so that jails are considered to be a catchment area for conditions such as HIV, sexually transmitted diseases (STDs), hepatitis, and tuberculosis. Correctional facilities routinely screen for these conditions. Alternately, inmates requesting health care may present with these conditions. Like other health care providers, clinicians in correctional settings have a responsibility to notify the local health department of reportable communicable diseases. Electronic transmission may increase the efficiency, timeliness, and completeness of reporting.

1.2.2.4 Determining the Whereabouts of Clients and Facilitating Continuity of Care

When individuals with chronic health conditions are arrested, their health treatment regimens are interrupted. These may be clients receiving daily medication therapy or clients in the substance abuse treatment process. Information on arrest and detention from the justice system is valuable for the health care providers of these individuals to explain why clients missed appointments and continue to need treatments. Providers can subsequently coordinate with the criminal justice authority to share treatment records and to plan for release.

1.2.2.5 Collaborating on and Coordinating Care of Inmates during Incarceration

Correctional facilities may utilize providers outside the facilities to provide needed services. Inmates may be transported for hospitalization or specialty services. Conversely, non-correctional providers may use telemedicine to treat inmates, or may deliver services periodically inside the facility. In these cases, there needs to be a free exchange of information between corrections and the health provider. Health assessments by the correctional facility need to be shared with the community provider to supplement the community provider's work with the inmate. Findings or follow-up from the external medical care, such as a discharge summary, should then be returned to the correctional facility.

1.2.2.6 Planning for Offenders' Reentry into the Community

Correctional facilities generate information that can be used to support inmates' transitions back to the community through collaborations with community providers. Assessment information and pre-release service utilization information can assist community-based providers with continuity of care. Information on expected release dates helps discharge planners and community providers prioritize and coordinate on care plans. Transition plans may be co-developed by corrections and community providers but, at minimum, transition plans should be provided to community-based providers. Finally, information on criminal charges, including violent crimes, and disciplinary infractions can be used to both support program referrals (*e.g.* to determine eligibility) and to alert community-based providers so they have a more complete understanding of the client.

1.2.3 Types of Information to be Exchanged

As seen above, the types of information to be exchanged between health and justice agencies considerably vary. Importantly, while many information exchanges involve sensitive health information, other beneficial information exchanges involve non-sensitive information. The full range of information that would be valuable to exchange includes (in no particular order):

- Dates in and out of the criminal justice system (*e.g.* dates of arrest and release, dates on and off probation and parole supervision)
- Criminal charge, violence risk, and recidivism risk
- Court dates

- Documentation of injuries or evidence of a crime
- Program attendance
- Information on current life circumstances (*e.g.* housing, employment, family support)
- Summary health status information (*e.g.* indicator that someone has health issues, without specifying what those are)
- Health diagnoses (*e.g.* listing of specific medical or mental health conditions)
- Detailed medical or treatment records (including treatment for substance abuse addictions)
- Prescription drug information
- Medical bills
- Drug testing results

1.2.4 Implementing Information Exchange: Challenges and Opportunities

All of the information exchanges in this report were thought to be achievable by the working group; though, of course, there are privacy, technological, budgetary, and administrative concerns to be addressed.

Most notably, health information privacy laws, such as *Health Insurance Portability and Accountability Act (of 1996)* (HIPAA) and *Code of Federal Regulations (CFR) 42 Part 2*, govern the sharing of personally identifiable health information. Structures for obtaining appropriate consent from the individuals involved need to be developed; and, information exchanges may need to be accompanied by evidence of client consent. Use of peer groups can sometimes accelerate the process of achieving needed consent agreements. Additionally, working group members pointed to the importance of formal interagency agreements to govern the information exchange and the allowable uses of the data, as well as to build trust between the information exchange partners. Working group members also pointed to various technological solutions, such as data segmentation, that can be used to identify those portions of information that can or cannot be shared.

Additionally, criminal justice and health programs widely vary in their adoption of electronic recordkeeping systems. While some of the collaborations identified in this report are already in place, it is often the case that information is presently exchanged through personal contact and paper-based records. For example, health information may be requested through a telephone call and sent as hardcopy or by fax. Information exchanges have the potential to be more efficient and secure if they are electronically completed. This is possible even if agencies still maintain paper-based records (*e.g.* the automated transmission of a PDF copy of a report, as an alternative to copying and mailing a hardcopy).

Strong leadership is essential to getting information exchanges off the ground. Because the implementation of information exchanges can be challenging, the working group stressed the importance of vision and commitment to ensure support of what can be a time- and resource-intensive process. Moreover, stakeholders may have to undergo a challenging transition before gains in efficiency are achieved. Once implemented, however, information exchange between health and justice entities has tremendous potential to improve both health and public safety outcomes.

1.3 Next Step Recommendations

Numerous recommendations for future efforts are included in the report (see Section 6). At a high-level, these include:

- Criminal Justice and Health Collaboration Project, Phase II – a continuation of this project to:
  - Update this report to a 'Version 2' to include additional juvenile and privacy information and add new exchange synopses; and,
  - Create service specification(s) for high-value exchange synopses and implement proof of concept pilot(s) in state and local jurisdictions.
- Support the *Patient Protection and Affordable Care Act (ACA)*, specifically the Medicaid Program by:
  - Facilitating enrollment by utilizing, via automated processes, criminal justice records;
  - Facilitating program management by utilizing, via automated processes, prison and jail admission and release dates; and,
  - Developing electronic mechanisms for transmitting health claims and reimbursements for pretrial detainees.

2 BACKGROUND

2.1 Project Overview

Information sharing between the criminal justice and healthcare systems has the potential to enhance both public safety and health outcomes, reduce redundancies, and generate efficiencies in both systems. For example, making correctional medical records accessible to community-based health providers upon an inmate's release can facilitate continuity of care, thus enabling ex-offenders to stay healthy and maintain legal employment. Similarly, making community-based treatment records accessible to the criminal justice system upon an individual's entry into custody can inform the facilities, improve initial assessments, minimize disruptions in treatment, and enhance security. Yet, information sharing related to justice-involved individuals remains a critical challenge for the criminal justice, physical healthcare, mental healthcare, substance abuse treatment, and other treatment services domains. Constraints include a variety of administrative, legal, financial, policy, and technological barriers.

The IJIS Institute, under sponsorship of the BJA, and in collaboration with the UI, identified and prioritizes opportunities for information sharing between justice and health organizations through a project team of subject matter experts (SMEs) from the criminal justice and health and human services communities. Finally, the working group developed a forward-looking strategy and a high-level plan for the creation and expansion of the criminal justice and health collaboration to share health data for the identified scenarios. This step will include recommendations for agencies that could serve as future pilot locations to evaluate the effectiveness of recommended new exchanges.

The criminal justice system comes into contact with many people with extensive health needs; harnessing health and criminal justice data can help to increase this population's access to health care and has the potential to improve health-related public safety outcomes. Nearly all persons who become involved in the justice system return home, so addressing their physical and behavioral health needs is an important concern not only for the affected individuals and the criminal justice system, but also for communities across the United States. Community-based health providers are likely to have clients in common with the criminal justice system, especially in distressed communities. Information sharing between criminal justice and community-based service systems can facilitate collaborative responses to improve both health and related public safety outcomes.

Large numbers of individuals cycle between criminal justice and community settings each year. Nearly 7 million individuals—1 in 34 adults—were under some form of criminal justice authority on a given day in 2011, including roughly 1.5 million people in prison, 735,000 in jails, and nearly 5 million under either probation or parole supervision[3]. This large population often cycles in and out of incarceration. Jails process roughly 12 million admissions and releases over the course of a year, which represents about 9 million unique individuals – many of whom are incarcerated for just hours or days, while awaiting

[3] Glaze, Lauren E. and Erica Parks (2012). *Correctional Populations in the United States*, 2011. Bureau of Justice Statistics Bulletin. Washington, DC. NCJ 239972. November.

arraignment or trial[4]. Prisons, which typically incarcerate convicted offenders for one or more years, release an estimated 700,000 inmates each year, about two-thirds of whom are re-incarcerated within three years[5]. This "revolving door" phenomenon, coupled with low rates of post-release health insurance coverage, means that justice-involved individuals often receive fragmented health care, alternating between correctional health care and an array of safety-net health care providers in the community[6].

Physical and behavioral health problems are disproportionately prevalent within the justice-involved population. Statistics are most widely available on incarcerated persons, who suffer from chronic, infectious, and mental illnesses at higher rates than the general population[7]. Prevalence rates for HIV/AIDS are 2- to 9-fold greater than the general population; tuberculosis, 4-fold; hepatitis C, up to 10-fold; schizophrenia, 4-fold; and bipolar disorder, 2-fold[8]. Justice-involved persons are also much more likely to use controlled substances. Nearly half of prisoners report having used cocaine and nearly a quarter having used opiates; over half report drug use in the month prior to the offense for which they were incarcerated[9]. Taken together, over 80% of returning prisoners have a physical, mental, or substance-related condition, and 40% of men and 60% of women have multiple conditions[10].

The high prevalence of health conditions among the justice-involved population poses challenges for all components of the criminal justice system, including: LE officers, the courts, jails and prisons, and community supervision agencies.

Jails and prisons, in particular, have a constitutional responsibility to provide care in accordance with community standards to those in their custody. Failure to provide adequate care to persons in custody violates the Eighth Amendment prohibiting cruel and unusual punishment and exposes correctional systems to civil liability and monetary damages[11/12]. While criminal justice facilities are not designed to provide health care, they must still confront and respond to the health problems of persons in their

4 Solomon, Amy L., Jenny W.L. Osborne, Stefan F. LoBuglio, Jeff Mellow, and Debbie A. Mukamal. (2008). *Life After Lockup: Improving Reentry from Jail to the Community*. Washington, DC: The Urban Institute, May. Retrieved from: http://www.urban.org/UploadedPDF/411660_life_after_lockup.pdf

[5] Langan, Patrick and David Levin (2002). *Recidivism in Prisoners Released in 1994*. Washington, DC: Bureau of Justice Statistics.

[6] Mallik-Kane, K and CA Visher (2008). *Health and Prisoner Reentry: How Physical, Mental, and Substance Abuse Conditions Shape the Process of Reintegratio*n. Washington, DC: Urban Institute.

[7] National Commission on Correctional Health Care (2002). *The Health Status of Soon-to-be Released Prisoners (Volume 1)*. Chicago, IL.

[8] Davis, LM and S Pacchiana (2004). "Health Profile of the State Prison Population and Returning Offenders: Public Health Challenges." *J Correct Health Care*, 10: 303-31.

[9] Mumola, C. J., & Karberg, J. C. (2007). *Drug use and dependence, state and Federal prisoners*, 2004. Washington DC: Bureau of Justice Statistics.

[10] Mallik-Kane, K and CA Visher (2008), "*Health and Prisoner Reentry*"

[11] *Estelle v. Gamble, 427 U.S. 97* (1976).

[12] Greifinger, Robert B. (2007). "Thirty Years Since Estelle v. Gamble: Looking Forward, Not Wayward." *Public Health Behind Bars: From Prisons to Communities*. New York: Springer.

custody. For example, individuals entering the criminal justice system upon arrest often experience acute health crises related to disruptions in prescription medication, withdrawal from addictive drugs, or psychological distress resulting from arrest and incarceration. In addition to the harm to the individual, such acute crises can disrupt safety and orderly operations within correctional facilities. Expenditures for inmate health care generally comprise between 9 and 30 percent of total correctional budgets[13].

While much attention is focused on jails and prisons, all parts of the criminal justice system confront challenges related to the health of the individuals they encounter. Many police agencies, for example, have developed crisis intervention protocols for responding to individuals in a mental health crisis. Additionally, many jurisdictions have developed diversion programs such as drug courts, mental health courts, and specialized probation to address the underlying behavioral health problems of many criminal defendants.

From a broader community perspective, the health problems of the criminal justice population are important because of correlations with poor reintegration outcomes (*e.g.* housing, employment, and family reunification) and repeated cycling though the criminal justice system[14]. Poorly managed physical health, mental health and substance abuse problems can limit opportunities to find and maintain legal employment—a key component of successful reintegration that has been shown to reduce recidivism[15]. Disease transmission to the community is also a concern with chronic communicable diseases like HIV, hepatitis, and tuberculosis. Some mental illnesses, left untreated, may manifest as dangerous or erratic behaviors that prompt an LE response.

Additionally, untreated substance abuse increases the likelihood of re-incarceration because: the acquisition and possession of many drugs is illegal; users often engage in criminal activity to finance drug purchases; users risk violence and arrest when accessing the illegal drug market; and, the pharmacological effects of alcohol and some drugs may increase the risk of violent or criminal behavior[16].

While inmates often receive health care in prison, the transition to the community can be risky. The first two weeks after release, in particular, are associated with a 12-fold increase in mortality[17]. Health status and health care utilization often significantly drop after release. In one study of released prisoners, receipt of care dropped by roughly 50 percent within two months of release; self-assessments of health

[13] Schaenman, Philip S., Elizabeth Davies, Reed Jordan, and Reena Chakraborty. (2013) *Opportunities for Cost Savings in Corrections Without Sacrificing Service Quality: Inmate Health Care*. Washington, DC: The Urban Institute, February. Retrieved from: http://www.urban.org/UploadedPDF/412754-Inmate-Health-Care.pdf

[14] Mallik-Kane, K and CA Visher, "*Health and Prisoner Reentry*"

[15] Visher, Christy, Sara Debus-Sherrill, and Jennifer Yahner (2008). *Employment after Prison: A Longitudinal Study of Releasees in Three States*. Washington DC: The Urban Institute. Retrieved from: http://www.urban.org/publications/411778.html

[16] Wish, Eric D. (1990-1991). "U.S. Drug Policy in the 1990s: Insights from New Data from Arrestees." *The International Journal of the Addictions*. 25(3A):377-409.

[17] Binswanger, IA, MF Stern, RA Deyo, PJ Heagerty, A Cheadle, JG Elmore and TD Koepsell (2007). "Release from prison—a high risk for death for former inmates." *NEJM*, 356(2): 157-65.

declined over time; and, one-third of persons with health conditions utilized costly ER care[18]. Interrupted care for chronic illness imposes considerable costs in the community[19] and, for those who are subsequently re-incarcerated, greater costs in corrections.

Continuity of care between criminal justice and community-based health systems is vital to improving the health of this medically needy population, managing healthcare costs, and interrupting the costly cycle of repeated offending, arrest, and incarceration. A public health model of correctional health care, implemented in Hampden Country, Massachusetts, uses health care providers from community-based clinics to provide care to inmates during incarceration, with the goal of linking clients to the same clinics after release. Evaluation results have shown post-release treatment retention and decreases in self-reported alcohol and drug use[20]. There is further evidence that care coordination reduces healthcare expenditures. In Maryland, for example, care coordination for substance-abusing clients was correlated with a savings of $1,000 per person[21].

Information sharing fosters connections and transitions between criminal justice and community-based systems, and is an important link within a chain of events hypothesized to improve outcomes. The exchange of medical records from one system to the other, for example, supports a larger coordination effort to help clients bridge the transition between community and corrections settings. Cross-system referrals combined with health information sharing are intended to facilitate continuity of treatment for chronic physical and behavioral health conditions. Treatment retention contributes to stable or improved health outcomes, whereas disruptions in heath treatment can lead to a worsening of health status, acute health crises, or relapses. Once achieved, gains in physical and behavioral health status may lead to improvements in post-release reintegration and employment, and may reduce reoffending. (Consider, for example, the difference between a recovering addict who abstains while receiving methadone maintenance therapy and another who relapses after losing access to treatment and is subsequently rearrested for drug possession.)

Health information sharing may also serve to improve health outcomes by improving the quality and completeness of information available for decision-making by both criminal justice and community-based service providers. Health information from the community is potentially beneficial to the justice system during initial encounters with individuals to: aid in initial assessments; identify candidates for criminal justice diversion; minimize disruptions in treatment; and, manage chronic conditions as consistently as practicable. Conversely, the sharing of health information from the criminal justice system to community-based providers supports pre-release planning, informs community-based

[18] Mallik-Kane, K and CA Visher, "*Health and Prisoner Reentry*"

[19] Wakeman, SE, ME McKinney and JD Rich (2009). *Filling the Gap: The Importance of Medicaid Continuity for Former Inmates*. J Gen Intern Med 24(7): 860–2.

[20] Hammett, Theodore M., Cheryl Roberts, Sofia Kennedy, and William Rhodes (2004). *Evaluation of the Hampden County Public Health Model of Correctional Health Care*. U.S. Department of Justice, National Institute of Justice: Washington DC. NCJ 215772.

[21] Abrams, Michael T., Seung Ouk Kim, Jayne M. Miller, Yngvild Olsen, and Jose J. Arbelaez. (2013). *Have Existing "Coordination/Integration" Efforts Yielded Medicaid Expenditure Savings*? Presented at the Performance and Evaluation Committee Meeting, Baltimore Substance Abuse Systems, Inc., January 31.

providers about health care received during incarceration, and facilitates informed decision-making about treatment continuity. Information sharing helps to fill critical gaps in treatment records, particularly for those individuals who frequently cycle between the criminal justice system and the community, receiving fragmented care from a wide range of safety-net providers.

In addition to health records, information sharing may also include other types of criminal justice-generated information (*e.g.* arrest and release dates; criminal histories; and risk scores) to facilitate communication between criminal justice and community-based partners working with clients in common. These types of information sharing can facilitate community-based "in-reach" into jails and prisons to locate clients and maintain treatment continuity. Additionally, information from the criminal justice system can be used to support eligibility determinations for community-based programs and alternatives to incarceration.

Gains in efficiency can be expected through a combination of automation and information sharing. The current system of fragmented care undoubtedly leads to redundancies. Criminal justice and community-based agencies often conduct similar assessments and collect similar information when each system encounters clients. By sharing information, agencies can capitalize on information obtained by those best equipped to collect it; reduce errors (*e.g.* when transcribing prescription information); decrease staff time spent on gathering information; and, increase the quality and efficiency of client interactions. While there will be situations when agencies should independently collect similar information, efficiencies can be gained by developing mechanisms and parameters for sharing information in a timely and appropriate manner.

The current economic climate makes it imperative to maximize existing information and resources. Impending health care reform, under the *ACA*, and recent incentives to encourage the adoption of EHR, make this an opportune time to further the issue of cross-system information exchange. With support from the BJA, the IJIS Institute and UI were tasked with identifying opportunities for beneficial, cross-system information exchange between criminal justice and health entities.

2.2 Purpose of this Document

This report was designed as a resource for the justice and health fields to:

- Identify the full range of beneficial information exchanges between the criminal justice and healthcare systems;
- Provide detail on specific information exchanges within the context of routine criminal justice and health operations;
- Serve as a guide to policymakers and practitioners seeking to implement information exchange, by offering detail on workflow and implementation issues; and,
- Offer a "blueprint" to certain specific information exchanges through the development of technical use cases.

2.3 Intended Audience

Generally, the intended audience is those stakeholders within the criminal justice and health domains that have an interest, or would benefit from, the electronic exchange of information between the two domains for enduring public safety and continuity of care for offenders. These benefits could include

improved efficiency—in terms of cost, time, or a combination thereof—and improved health and justice outcomes for justice-involved individuals.

2.4 Project Methodology

The project drew on the expertise of a working group of criminal justice and health stakeholders to identify, document, and prioritize beneficial information exchanges. At a high-level, the methodology consisted of:

1) Reviewing the existing literature on collaboration and information sharing between the criminal justice and healthcare systems
2) Assembling a group of criminal justice and health SMEs as well as IT industry representatives[22]
3) Convening a 2-day brainstorming discussion with the working group to identify the full range of potentially beneficial cross-domain information exchanges
4) Clarifying and expounding on the workflows and data required for each identified information exchange through a series of follow up teleconferences with the working group
5) Prioritizing the information exchanges through additional teleconferences with the working group, an external stakeholder survey, and discussions with senior staff at BJA[23]

Collectively, the working group included policy-oriented individuals, often with previous experience in direct practitioner roles, who were invited to participate and agreed to do so on a voluntary basis. Individuals provided perspectives from LE agencies, courts and court services, corrections, probation and parole, offender reentry, correctional health, community-based behavioral health treatment, public health, health information technology, and research organizations. Federal representatives from the Office of the National Coordinator for Health Information Technology (ONC) and the BJA also participated.

The project convened a 2-day working group in June 2012 for the initial identification of beneficial information exchanges. Participants were encouraged to think expansively and to brainstorm possibilities for beneficial information exchange to include both exchanges already implemented in certain jurisdictions or desired information exchanges yet to be developed. Proposed information exchanges could be in either direction: information that originates in the criminal justice system could be shared with the healthcare system and vice versa. To maximize the value of this discussion, the project team conducted a review of the literature and distributed read-ahead materials to the working group on the range of information sharing possibilities, their potential benefits, and implementation challenges.

One particular challenge the project encountered was to determine the methodology for identifying potential information exchanges – *i.e.* how to walk through/between the domains in an organized way

[22] See Appendix B for a list of the working group membership.

[23] See Appendix B for list of participating stakeholders/organizations

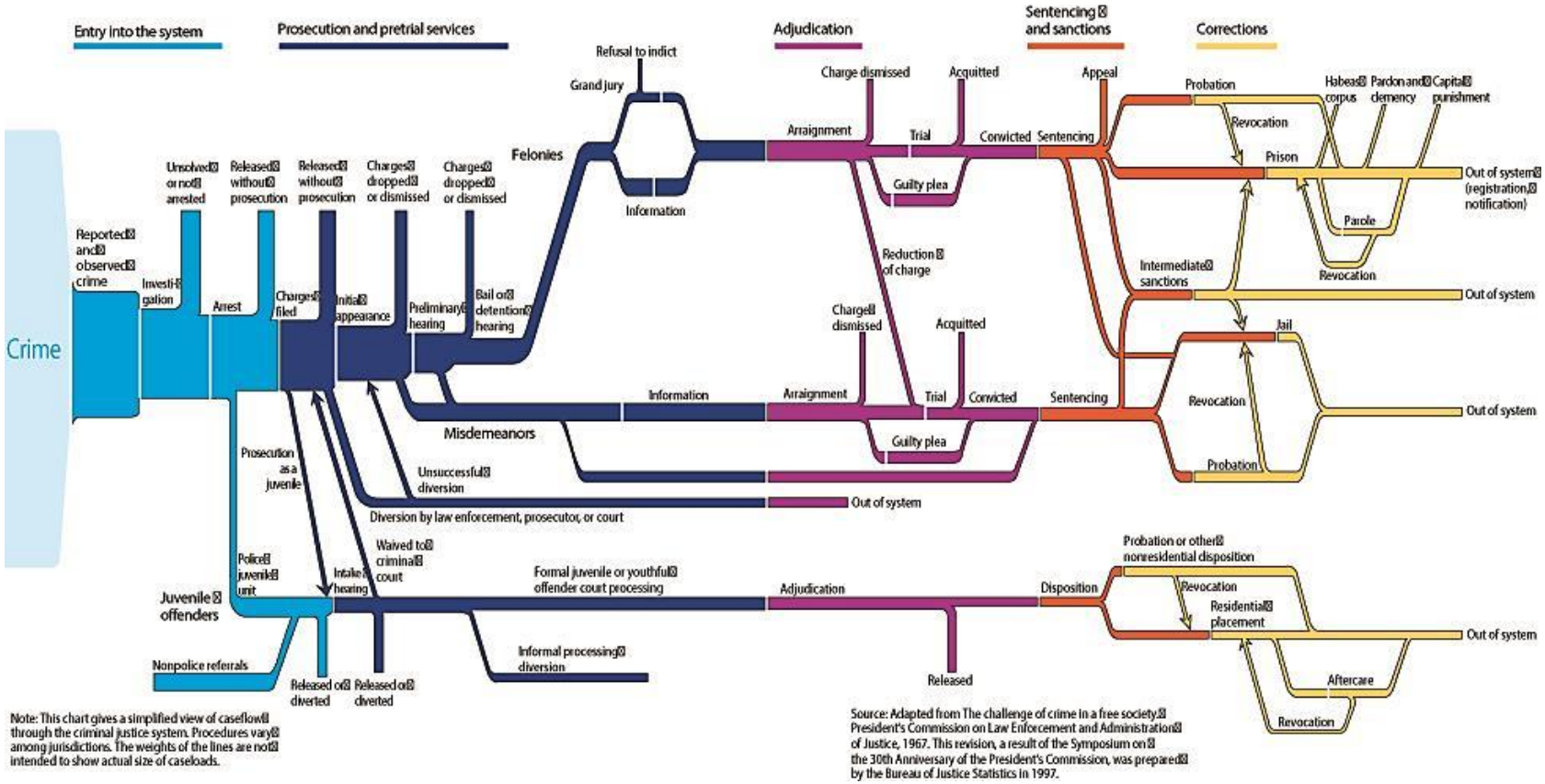
to ensure the greatest opportunity for exchange discovery and identification. Since the components of the criminal justice domain are somewhat linear (or can be examined from that standpoint – see Figure 1) and the components of the health domain are less structured, it was decided to use the criminal justice process as the "walk-through." This provided an organized method to examine various subgroups and their interactions with the other domain. There was no preference given to the criminal justice domain over the health domain in any way – it was merely a methodology used for discovery as described.

Following the initial meeting, the project team documented all of the potential information exchanges as narrative stories describing the general purpose and content of each. The project team then led the working group through a systematic review of the potential information exchanges over a series of nine teleconferences. Over the course of these calls, the project team documented and verified the context, workflow, and information flow of each information exchange. Additionally, working group members discussed the potential benefits and implementation challenges of each information exchange, as well as the prioritization factors listed in Section 2.7. The project team developed information exchange synopses for each (following the template in Section 2.8). Through this process, certain similar information exchanges were consolidated. Some initially identified information exchanges were dropped from consideration if the working group concluded that the information exchange would be completely infeasible or that there was only a minimal benefit. The resulting 34 information exchange synopses are presented in Section 4.2.

Once the information exchange synopses were developed, the project team led the working group through a prioritization discussion. The purpose was to generate a short list for consideration by BJA. Senior staff at BJA concluded that two information sharing needs were paramount because of the potential benefit, and because of the potential for bi-directional information exchange. These two information sharing needs: ***Reentry into the Community after Incarceration*** and ***Community-based Treatment with Effective Criminal Justice Supervision*** were chosen for further development into detailed information sharing scenarios. These are presented in Section 5.

FIGURE 1. SEQUENCE OF EVENTS IN THE CRIMINAL JUSTICE SYSTEM

What is the sequence of events in the criminal justice system?



Note: This chart gives a simplified view of caseflow through the criminal justice system. Procedures vary among jurisdictions. The weights of the lines are not intended to show actual size of caseloads.

Source: Adapted from The challenge of crime in a free society. President's Commission on Law Enforcement and Administration of Justice, 1967. This revision, a result of the Symposium on the 30th Anniversary of the President's Commission, was prepared by the Bureau of Justice Statistics in 1997.

2.5 Terminology

The terms used in this document to reference various criminal justice and health entities are intended to be universal, since terms vary from jurisdiction to jurisdiction, from one organization to another and between criminal justice and health. Therefore, it is hoped that the below groups and subgroups, which are used in this document, will: first, provide readers with a common understanding of the references made herein, thereby avoiding distraction around specific terminology; and, second, provide readers with a clarification as to where a specific entity typically "fits" into the document. Note that a given entity may fit into more than one subgroup.

Health Stakeholders encompass a range of health provider types in the community.

For the purposes of this document, the *Health Stakeholders* are divided into three main subgroups: Physical Health, Mental Health, and Substance Abuse. The table below shows some of the agencies, provider types, and staff roles that address the physical health, mental health, and substance abuse conditions of the justice-involved population. Additional stakeholder groups include pharmacies and health insurance providers.

TABLE 1. HEALTH STAKEHOLDERS

DOMAIN	SUBGROUPS	TYPICALLY INCLUDE (BUT ARE NOT LIMITED TO) ENTITIES SUCH AS:
Health	**Mental Health (MH)**	• Mental health treatment providers; counseling services; case managers – Could also include: Hospitals; Emergency Rooms; Veterans Health Administration (VA); Federally Qualified Health Centers (FQHCs); Medicaid, Social Security Disability Insurance; Public Health Departments; schools
	Physical Health (PH)	• Doctors, nurses; clinics (including HIV/AIDS services); hospitals, ERs; labs – Could also include: Case management; VA; FQHCs; Medicaid, Social Security Disability Insurance; Public Health Departments
	Substance Abuse (SA)	• Substance abuse treatment providers; counselors; case managers; clinics and programs – Could also include: Case management; VA; FQHCs; Public Health Departments; schools

Criminal Justice Stakeholders span the full spectrum of the criminal justice process from arrest through adjudication, sentencing, and corrections.

For the purposes of this document, the *Criminal Justice Stakeholders* are divided into six subgroups: Law Enforcement, Initial Detention, Pre-Trial Release or Supervision, Courts and Court-based Programs, Corrections, and Community Corrections. The table below shows some of the agencies, provider types, and staff roles associated with each of these stages for the criminal justice process.

TABLE 2. CRIMINAL JUSTICE STAKEHOLDERS

DOMAIN	SUBGROUPS	TYPICALLY INCLUDE (BUT ARE NOT LIMITED TO) ENTITIES SUCH AS:
Criminal Justice	**Law Enforcement**	♦ Police officers, sheriffs, state troopers, and investigators; dispatchers; forensics personnel; non-sworn Law Enforcement Agency (LEA) staff; victim advocates/assistants
	Initial Detention	♦ Jails including booking, intake, and jail medical staff
	Pre-Trial Release or Supervision	♦ Prosecutors, defense attorneys, or appointed counsel; judges; victim services/advocacy; pre-trial services agencies; Treatment Alternatives for Safe Communities (TASC) programs; case managers – Could also include: Probation officers in some jurisdictions
	Courts and Court-Based Programs	♦ General trial courts; specialized courts; problem solving courts; diversion courts (and their judges, case managers, other court-based and community-based staff); prosecutors and defense attorneys – Could also include: Pre-trial and probation staff
	Corrections (*e.g.* Jail, Prison)	♦ Booking/intake staff and custody staff; jail medical/healthcare staff (in-house or 3rd party); classification staff; discharge planning staff; administrative staff; programming staff (education, academic, vocational); "Releasing prisons" or specialized reentry facilities; halfway houses; "correctional Treatment facilities" focused on recovery from substance abuse – Could also include: Immigration and Customs Enforcement in some states
	Community Corrections (*e.g.* Probation, Parole)	♦ Parole boards; parole investigators; probation and parole officers; government or privately funded halfway houses, group homes or organized treatment centers – and the staff that manage them; boot camps

2.5.1 Additional Terminology

- Criminal justice *supervision* can occur at multiple stages of case processing and can involve different agencies, including pre-trial services, courts and TASC programs, community corrections, probation, and parole.
- For information exchanges that are geared toward initial detention (local lock-ups, booking centers, and jails administered by local agencies), the working group attempted to be consistent in using the term *detention facility*.
- While prison information management systems are typically known as Offender Management Systems (OMS) and jail information management systems are typically known as Jail Management Systems (JMS), for purposes of this report, both systems will be referred to as *Offender Management Systems (OMS)*.
- When referring to the broader detention/correctional facility environment (*e.g.* a local lockup, jails, and prisons administered by both local and state agencies), the working group attempted to be consistent in using the term *correctional facility*.

2.6 Guidelines Used for the Identification of Information Exchanges

1) Minimum requirements were: criminal justice/health cross domain information exchange; and, the resulting exchange is deemed to be beneficial to at least one domain.
2) While there may be many challenges to implementing a given exchange, the existence of these challenges were not grounds for exclusion. The project took a deliberate stance that "anything is possible," and working group members were encouraged to be expansive in their thinking.
3) In discussing beneficial information sharing, the working group identified a number of opportunities to better communicate health information within the criminal justice system. For example, prisons might provide a treatment summary to parole officers upon release. While the exchange of health information across different stages of criminal justice processing may be needed and beneficial, such examples are not included in this document. Instead, the emphasis here is on cross-domain exchange of information between health and justice entities.

2.7 Adult versus Juvenile Dynamic

The information exchanges included herein were compiled from a generic standpoint – without specific regard to adult versus juvenile implementation issues – although it is fair to say the typical assumption was an adult focus; however, numerous information exchanges could be used for juveniles – depending on the implementation parameters, jurisdiction, state law, and local environment. The reader should make her/his own assessment regarding the applicability of a particular information exchange for an implementation to include information involving juveniles.

2.8 Basic Assumptions

Several assumptions apply to every information exchange. Any implementation of an exchange must comply with these assumptions:

- The person's identity is known or can be verified.
  - It is vital that the information from one information source is applied to the correct person in the recipient's caseload or information system.
- The requested information is available and accessible (see the 'Data Sources' table entry for the respective information exchange).
- The information can be shared from a privacy perspective (*i.e.* in accordance with Federal laws including *HIPAA* and *42 CFR Part 2*, as well as state and local laws and policies).
  - Before exchanging health information, it is first necessary to determine whether each party is a Covered Entity (CE) as defined by *HIPAA*. If the sender is a CE, then patient authorization may be needed to transfer personal health information, and there are restrictions on the re-transmission of health information received from a CE.
  - Additionally, provisions of *42 CFR Part 2* apply to many substance abuse and mental health treatment providers, and require additional client consent to release personally identifiable data about treatment participation. Privacy rules also apply to certain types of criminal justice information like arrest or juvenile records.

- The information can be shared from a security perspective (*e.g.* FBI *CJIS Security Policy*).
- The information can be shared from a technology perspective [*e.g.* an electronic version of the information is available or can be created; network infrastructure exists and is available between the provider and receiver system(s)].
- The exchange partners have obtained all necessary consent to share information, and the information to be exchanged includes documentation of the appropriate consent.
- Appropriate Memoranda of Understanding (MOUs) and business agreements are in place between the information exchange partners, containing provisions for retention, distribution, and redistribution of information.
  - This is especially important to build trust and facilitate information exchanges between those who are and are not *HIPAA* covered entities. Non-CEs are not bound to protect the privacy of health information in the same way as CEs; and, in the absence of formal agreements, CEs may be unwilling to share their clients' data with non-CEs.
- In the implementation of each information exchange, consider whether data segmentation and/or filtering techniques may need to be employed in order to conform to law, regulations, and/or policies.
  - *Data segmentation* refers to a technical method of applying "tags" to particular data fields, specifying the rules for how and with whom the data may or may not be exchanged. For example, a client may consent to sharing medical history with all providers in a network but may require transfer restrictions for substance abuse treatment records to a single provider (see Section 3.2.1).
- The sender may appropriately provide the information in light of the above.
- The receiver may appropriately receive the information in light of the above.

2.9 Prioritization

After the initial brainstorming and identification of beneficial information exchanges, the working group members reviewed each information exchange with respect to each of the prioritization measures described below. Information exchanges that were not sufficiently beneficial or achievable were eliminated from consideration. The working group then considered which information exchanges would be most beneficial, and advanced a short list of high priority information exchanges to BJA for consideration. Using the working group's recommendations, BJA selected two issue areas—Reentry after Incarceration and Effective Community Supervision—as information exchange scenarios for further development.

- Benefit to Criminal Justice and Health
  - How important/beneficial is the exchange for the criminal justice and health communities?
  - Does it provide key information to decision-makers for making better decisions?
  - Does it improve the quality of information available to practitioners?
  - Does the exchange ensure responsiveness on the order of seconds or minutes versus days or weeks?
  - Would its implementation boost overall effectiveness and productivity?

- Solution Implementability
  - How compelling is the business case for the exchange?
  - Would implementation of the exchange require an unreasonable cost?
  - Does it involve criminal justice and health partners who have traditionally worked well together and shared information, or are likely to be willing to share?
- Problem Definition
  - How well do we understand the exchange?
  - Does it have a well understood underlying set of business practices and requirements?
  - Does it have an unambiguous structure and meaning?
- Technological Simplicity
  - Would the implementation involve relatively simple technology?
- Privacy/Policy/Legal Constraints
  - How much of a concern are privacy, policy, and legal issues with regard to the exchange?
  - Do current Federal and state regulations allow for the implementation (*e.g. HIPAA*, *42 CFR Part 2*, etc.)?
  - Are the security, confidentiality, privacy, and data-handling rules for personally identifiable information well understood?

Based on their professional expertise and experience, the working group recommended the identified information exchanges based on the perceived benefit to the communities. This resulted in the following two lists: "Criminal Justice Use of Health information" and "Health Use of Criminal Justice information" (in numerical order):

Criminal Justice Use of Health information

- #13: Detention and correctional facilities receive health information about new admissions to: (a) inform inmate management decisions before a medical screening can occur; and, (b) supplement the facility's intake health assessment.
- #18: Correctional facilities (*e.g.* detention, jail or prison) receive a discharge or treatment summary from community-based providers after a person under custody receives care.
- #23: Judges, defense attorneys, and/or prosecutors receive physical and behavioral health information to make decisions about pre-trial release and other alternatives to incarceration.
- #29: Criminal justice supervision agencies receive information from health providers to establish context for client behavior and to promote alternative responses to noncompliance (rather than revocation and incarceration).

Health Use of Criminal Justice information

- #9: Health providers receive arrest and detention dates to: (a) help them account for their clients' whereabouts; and, (b) facilitate continuity of care in the detention facility.
- #10: Health providers receive an inmate's actual date of release from detention facilities to conduct client outreach and facilitate continuity of care.

- #17: Community-based providers receive health information from detention or correctional facilities when treating inmates during incarceration, either on- or off-site.
- #20: Community-based providers receive health records of soon-to-be released inmates as part of reentry planning to facilitate continuity of care.
- #24: Community-based programs receive information on the court conditions and offender restrictions to promote compliance among justice-involved clients.
- #32: Community-based providers receive information from assessments conducted in support of the criminal justice process [*e.g.* pre-sentence investigation reports or (PSI)] to supplement their intake processes and to prepare for justice-referred clients.

Of interest is that each of the selected information exchanges shortlisted by the working group involve:

- ***All three major Health subgroups***:
  - Mental Health,
  - Physical Health, and
  - Substance Abuse; and,
- ***More than one of the Criminal Justice subgroups***:
  - Law Enforcement,
  - Initial Detention,
  - Pre-Trial Release or Supervision,
  - Courts and Court-based Programs,
  - Corrections, and
  - Community Corrections.

3 IMPLEMENTATION ISSUES AND POTENTIAL CHALLENGES

The working group's main objective was to identify the full range of beneficial information exchanges between criminal justice and health, regardless of the level of challenge. At the same time, members highlighted key considerations and challenges[24] to be addressed in the course of successfully implementing any given information exchange:

- Privacy and consent
- Technical capability
- Data quality and timeliness
- Cost
- Organizational leadership and trust

3.1 Privacy and Consent

Privacy laws and policies at the Federal, state, and local levels intersect to govern the release of both criminal justice and health information—and, information sharing must occur within this legal and ethical framework.

Numerous privacy regulations have arisen out of citizens' desires to keep sensitive criminal justice and health information about themselves confidential. An overarching goal is to protect individuals from real and potential harms that may arise when personal and sensitive information is divulged. These include shame or embarrassment, stigmatization, discrimination (*e.g.* in housing or employment), harassment, and even bodily harm. Health privacy laws are intended to reduce barriers to needed care by assuring clients of the confidentiality of their sensitive health information, thus shielding individuals from these harms.

While the emphasis of this discussion is on the privacy of health information, it bears remembering that much criminal justice information is also sensitive and protected. Information on warrants, arrests, and pre-trial proceedings, for example, is protected by law under the presumption of innocence; alleged criminal activity should not be held against a person when guilt has not been proven in a court of law. Information on criminal activity by juveniles is also strictly protected under the belief that minors are not legally culpable to the same extent as adults. By contrast, information on convictions and sentencing of adults are matters of public record and more widely available.

Highlighted below are three of the most salient Federal health information privacy laws with respect to health and justice information sharing[25]. Federal law provides a minimum standard to which states and localities must adhere, but state and local privacy protections may be more stringent. Given the

[24] See Appendix D for additional information on implementation challenges.

[25] See Appendix D for detailed descriptions of pertinent health and justice information sharing laws.

complexity and diversity of laws across the nation, agencies would be well served to involve legal counsel in the implementation of information exchanges.

3.1.1 Health Insurance Portability and Accountability Act (of 1996)

HIPAA provides a baseline level of protection for health information. *HIPAA* defines a category of protected health information (PHI) and further designates health care providers, health plans, and health care clearinghouses CEs who must comply with *HIPAA* regulations on the disclosure of health information.

- **Consent** – Written client authorization is usually needed for a *HIPAA* CE to release health information outside the context of care provision, medical billing, and health care operations. Exceptions are listed below.
- **Re-transmission of information** – *HIPAA* generally prohibits the re-transmission of health information without client authorization to do so. This means that a provider who is a CE is restricted from sharing information it obtained elsewhere with a third party.
- **CE status of information exchange partners** – While health providers are generally defined as CEs under *HIPAA*, criminal justice entities often are not. The CE status of the recipient of health information has implications for information sharing.
  - Health providers who are CEs may be reluctant to transmit health information to a non-covered entity, such as a local jail, because a non-CE is not comparably bound by *HIPAA* to protect the information it receives.
  - Criminal justice agencies may need to determine their CE status in consultation with legal counsel. Being a CE carries administrative responsibilities in relation to protecting health information privacy.
  - Health providers and non-CE agencies may need to enter into formal Business Associate Agreements (BAAs) specifying standards for data protection in order to exchange information.
- **Exceptions**[26] **–** Some disclosures of PHI to criminal justice entities are permissible without client authorization. Examples include:
  - Required crime reporting (*e.g.* abuse, neglect, or domestic violence);
  - Under court order, warrant, subpoena, or administrative request; and,
  - Certain emergency situations.

[26] See Appendix D for a full list of exceptions.

3.1.2 Health Information Technology for Economic and Clinical Health Act (of 2009)

HITECH extends and strengthens the protections introduced by *HIPAA*. *HITECH* extends *HIPAA* requirements to the business associates of covered entities; governs health data banks; and, promulgates up-to-date electronic data transmission standards.

- ***42 CFR Part 2*** – Sometimes abbreviated as "*Part 2*," refers to the Federal regulations that protect the confidentiality of substance abuse treatment records. It is intended to promote access to substance abuse treatment services by protecting individuals from the stigma and risks of being identified as a substance abuser. Its provisions and consent requirements are more stringent than *HIPAA*. Notably, it restricts the use of substance abuse treatment records to identify, investigate, or criminally prosecute patients; however, it does permit treatment information to be shared with the criminal justice system if an individual is undergoing substance abuse treatment as a condition of their prosecution.

3.1.3 Informed Consent

Client consent is an essential component to successfully sharing health information, barring certain narrowly defined circumstances or emergencies.

By law, clients must grant their approval to release health information and to be informed of how the information may be used. Meaningful and transparent consent procedures support patient empowerment and engagement in their own care, and build trust between the patient and health care provider. These are critical to quality, patient-centered care.

Health information sharing across health and criminal justice boundaries similarly requires clients to know how their information will be shared and to what purpose. Justice-involved clients' inherent mistrust of the criminal justice system makes it all the more important, from an ethical standpoint, that consent procedures are understandable and transparent. Consent documents should be tailored to the low literacy levels[27] often observed in this population.

Clear consent documents and procedures engender trust not only between the patient and provider, but also between the health and justice entities sharing information. Health providers are often very cognizant of their responsibility to keep client information confidential, but the complexity of health privacy laws means there is often confusion[28] about what must be protected. Precise and understandable consent procedures delineate the terms under which information can be shared and with whom.

[27] In the US, adults with a high level of literacy are at 19%, a low level of literacy are at 49.6%, and a moderate level of literacy at 31.4% according to the 2003 National Assessment of Adult Literacy (NAAL), sponsored by the National Center for Education Statistics (NCES).

[28] Gross, Jane (2007). "Keeping Patients' Details Private, Even From Kin," New York Times. Retrieved from: http://www.nytimes.com/2007/07/03/health/policy/03hipaa.html?pagewanted=all&_r=0; and, Caramenico, Alicia (2012). "HIPAA confusion a barrier to transitional care," FierceHealthcare. Retrieved from: http://www.fiercehealthcare.com/story/hipaa-confusion-barrier-transitional-care/2012-05-30

Evidence of client consent is an important part of the information exchange when PHI is involved. Both the sender and recipient need to maintain evidence of the client's consent to transmit information, as well as the terms and conditions of the consent. For example, the health information transmitted from a *HIPAA* CE may not be re-transmitted and the recipient of that information will need to know it cannot further share the information. Additionally, client consent to share information may be time-limited, and both the sender and recipient need to be aware of the expiration date of the consent. It may also be important for the recipients of health information to maintain logs of when the information was accessed and by whom.

3.2 Technical Considerations

Electronic health records (EHR) systems are beneficial, but not essential, to exchanging health information between justice and health. Many of the information exchanges identified by the working group can be accomplished without EHRs, since other standards for electronic health information exchange, such as "Direct," (see Section 3.2.3) can be used to securely transmit health records as scanned or PDF documents.

Additionally, many beneficial health and justice information exchanges involve data other than health records, including prison or jail admission and release dates, treatment attendance records, and criminal justice assessments. This information is likely to come from electronic data sources, such as a correctional facility's management information system (MIS).

3.2.1 ONC Data Segmentation for Privacy Initiative

In 2011, the ONC launched its Data Segmentation Initiative to address some of the privacy concerns related to the sharing of sensitive information. *Data segmentation* "refers to the process of sequestering from capture, access or view certain data elements that are perceived by a legal entity, institution, organization or individual as being undesirable to share[29]" – it is basically a method for identifying who gets what data and when.

Breaking down health information into fine pieces allows data holders to identify particular pieces of information and to apply Federal, state, local, and organizational polices, as well as client authorizations to the exchange of specific protected client/patient information. Oftentimes, protected information may accompany other less sensitive information, together in the form of a record or case file. The exchange of the less sensitive data (and the entire case file) may be impeded by it being intermingled with protected data. Data segmentation allows for the disaggregation of specific data elements and for the application to specific elements more or less restrictive policies and authorizations relating to exchange. Data segmentation can increase authorized sharing of PHI as well as the application of information exchange policies that limit unauthorized release of protected information. Functionalities that allow for data segmentation could facilitate the sharing of vital information.

[29] Goldstein, Melissa M. and ALison L. Rein (2010). *Data Segmentation in Electronic Health Information Exchange: Policy Considerations and Analysis*. Prepared for the ONC. Retrieved from: http://www.healthit.gov/sites/default/files/gwu-data-segmentation-final.pdf

3.2.2 Current Adoption of EHR Systems

Roughly one-half of physicians in the United States had adopted an EHR system by 2011, and roughly another quarter were planning to do so within the next year. Most—85 perfect—reported satisfaction with their EHR system, and about three-quarters believed it enhanced patient care.[30]

Adoption of EHRs, however, is highly variable across specialties and settings. For example, over two-thirds of cardiologists use EHRs in comparison to one-quarter of ophthalmologists.[31] Usage in behavioral health setting is even lower. One-fifth of behavioral health providers utilize EHRs, but relatively few meet Federal meaningful use (MU)[32] standards.[33] Adoption of EHRs in correctional settings appears to be low, according to members of the working group and based on an Association of State Correctional Administrators (ASCA) survey[34], which indicated 14, or 35.5 percent, of state correctional departments use EMR.

Cost seems to be the greatest barrier to the implementation of EHR. Behavioral health providers cited upfront costs and ongoing maintenance as the top two reasons for not having implemented EHRs.

3.2.3 The Direct Project: An Alternate Means of Electronic Information Exchange

The Direct Project[35] seeks to benefit patients and providers by improving the transport of health information, making it faster, more secure, and less expensive. The Direct Project facilitates "direct" communication patterns with an eye toward approaching more advanced levels of interoperability than simple paper can provide.

The Direct Project specifies a simple, secure, scalable, standards-based way for participants to send authenticated, encrypted health information directly to known, trusted recipients over the Internet. It focuses on the technical standards and services necessary to securely push content from a sender to a receiver and not the actual content exchanged; however, when these services are used by providers and organizations to transport and share qualifying clinical content, the combination of content and Direct-Project-specified transport standards may satisfy some Stage 1 MU requirements. For example, a

[30] Jamoom, E., Beatty, P., Bercovitz, A., Woodwell, D., Palso, K., & Rechsteiner, E. (2012). "Physician adoption of electronic health record systems." *National Center for Health Statistics Data Brief*, (98), 1-8.

[31] Centers for Disease Control and Prevention (CDC) (2012). "Percentage of physicians with electronic health record (EHR) systems that meet Federal standards, by physician specialty — physician workflow survey." *Morbidity and Mortality Weekly Report*, 61(35), 710.

[32] For additional information on MU, visit: http://www.cdc.gov/ehrmeaningfuluse/

[33] National Council for Community Behavioral Healthcare (2012). *HIT adoption and readiness for meaningful use in community behavioral health: Report on the 2012 national council survey*. Retrieved from: http://www.thenationalcouncil.org/galleries/business-practice files/HIT Survey Executive Report.pdf

[34] ASCA (2010). "Electronic Medical Records Survey." Washington Department of Correction. Retrieved from: http://www.asca.net/articles/784

[35] For additional information on the Direct Project, such as workgroups, models, standards, services, reference implementation and documentation, visit: http://wiki.directproject.org/

primary care physician (PCP) who is referring a patient to a specialist can use the Direct Project to provide a clinical summary of that patient to the specialist and to receive a summary of the consultation.

3.2.4 Data Quality and Timeliness

The age of available information is critical to good decision-making. Historical information may be adequate for some information exchanges, but other situations require dynamic information that reflects the current situation. One of the goals of information sharing between health and justice is to reduce the redundancy associated with repeated assessments of the same client. At the same time, there is a tension between the efficiency of using previously collected information and the need to generate new assessments and information. The use of outdated health information, for instance, has the potential to cause negative outcomes and to increase liability. A key implementation issue is developing parameters around the age of information to be included in an exchange.

Knowledge of historical information can be beneficial and sufficient if it promotes appropriate action. For example, a treatment provider that receives a client's medical history may use it to assess the client's current health status and determine the extent to which historical conditions require continued care. Alternately, a crisis intervention team may be dispatched to respond to a call for service (CFS) involving someone with a history of mental illness, providing an opportunity to reconnect with services.

Other situations, however, require more timely information. Information about current health status, for example, is needed to make decisions about housing within a detention facility (*e.g.* housing in the general population, infirmary, a specialized mental health unit, or perhaps a community hospital).

Time lags in updating information may diminish the utility of some information sources. State prescription drug monitoring program databases, for example, are a potential source of information for corroborating defendants' claims of legally possessing controlled substances, such as medical marijuana; however, these datasets may not include patients' most recent prescription purchases since pharmacies typically report dispensing data every 1-2 weeks.

There is a risk that the use of historical rather than current information would lead to pre-determined or prejudicial responses. For example, people with a history of mental illness may be stigmatized as being unstable when, in fact, their conditions may be well managed. This may lead to pre-determined, and potentially inappropriate, responses in an encounter with LE.

A related issue is whether certain information should have an "expiration date." Criminal justice agencies sometimes compute violence risk scores for individuals, which community-based programs may consider when evaluating program eligibility. These scores may indefinitely reside in data systems, long after a person has desisted from criminal activity. Reliance on this information, long after the fact, may unduly restrict needed access to services.

3.3 Cost

Working group members were optimistic about the potential for information sharing to improve the level of information available, reduce some redundancies, and improve outcomes; however, there was uncertainty about the extent to which these exchanges would impact costs. In the short term, setting up an information exchange is time- and resource-intensive – as agencies negotiate cross-boundary agreements, develop the programmatic and technical infrastructures for sharing information, and train staff on new procedures. Gains in efficiency are likely to follow an initial transition period, during which agencies adapt to a new means of doing business. Working group members felt that improvements in practice would ultimately yield savings to society as a whole due to enhanced health and public safety

outcomes; however, policymakers and practitioners must consider how investments in information sharing would affect the budgets of individual agencies, and the extent to which costs and savings may accrue across agency boundaries.

3.4 Organizational Factors: Trust and Leadership

Health and justice practitioners need to trust one another with the information they exchange, as noted in the discussion on informed consent, above (see Section 3.1.3). Both parties need to understand the terms under which information can be shared and the allowable uses of the information. Formal agreements, such as MOUs, between the organizations sharing information both reflect and perpetuate this trust.

Another element of trust is a mutual understanding of the appropriate decisions to be made with shared information. Without trust that the shared information will lead to mutually agreed-upon, appropriate responses, parties may withhold information instead of freely exchanging it.

Leadership is essential because organizations must work through numerous challenges to launch a successful information sharing initiative. The effort requires champions who can sway powerful stakeholders and commit time, staff, and monetary resources to the process.

4 CATALOG OF BENEFICIAL CRIMINAL JUSTICE AND HEALTH INFORMATION EXCHANGE SYNOPSES

This section provides a comprehensive list of all of the beneficial, cross-domain information exchanges identified by the project's working group of criminal justice and health stakeholders. These information exchanges address a variety of information needs across the full spectrum of the criminal justice system and a wide array of health provider types. IT professionals refer to these as *information exchanges*. Each information exchange or *information exchange synopsis* describes the following:

- Type of information needed;
- Context in which information sharing occurs;
- Specific parties involved in the information exchanges;
- Direction of the information flow; and,
- Specific challenges and issues to consider in the implementation of the information exchanges.

The working group used the stages of the criminal justice system as a framework for identifying beneficial health and justice information exchanges, but information might flow in either direction—from health to justice, or from justice to health.

For example, the working group was asked to think about initial encounters with LE and discuss ways in which information about physical health, mental health, or substance abuse would improve the law enforcement response. Conversely, working group members brainstormed ways in which information about law enforcement encounters may be beneficial to a broad range of health providers and stakeholders. In this manner, the working group discussed potentially beneficial information exchanges between health and subsequent criminal justice stages, including pre-trial detention and alternatives; courts and adjudication; corrections; and, post-conviction supervision.

4.1 Criminal Justice and Health Connections Matrix

The matrix below summarizes the multiple opportunities for information sharing across the full spectrum of the criminal justice system with a range of health provider types. For each information exchange, the matrix indicates the relevant criminal justice stage(s), and the type(s) of health providers that are likely to be involved:

- *MH* for mental health
- *PH* for physical health (including HIV/AIDS services)
- *RX* for prescription-related information
- *SA* for substance abuse.

Criminal justice and health practitioners can easily scan this matrix to locate the information exchanges that are relevant to them, and to identify potential information exchange partners. Note that some information exchanges are applicable to more than one stage of the criminal justice process and multiple provider types. For example, the information needed to supervise pre-trial defendants in the community is often similar to the information needed to supervise convicted offenders on probation or parole. Detailed descriptions of each information exchange, including the context, workflow, and specific implementation considerations follow this matrix.

> NOTE: The column colors are only provided for ease of visualization. Shaded synopses indicated that it was shortlisted by the working group.

TABLE 3. CRIMINAL JUSTICE AND HEALTH CONNECTIONS MATRIX

MH = mental health; **PH** = physical health (incl. HIV/AIDS services); **RX** = prescription-related information; **SA** = substance abuse

Information Exchange Synopsis	Law Enforcement	Initial Detention	Pre-trial Release or Supervision	Courts and Court-based Programs	Corrections (*e.g.* jail, prison)	Community Corrections (*e.g.* probation, parole)
1) Emergency response dispatchers and/or LE officers receive an indicator of whether persons involved in a CFS have mental health or substance abuse problems in order to formulate an appropriate response (e.g. dispatch a crisis intervention team).	**MH** **SA**					
2) LE receives reports of suspected child abuse, intimate partner violence, or elder abuse from health providers in order to initiate an investigation.	**PH**					
3) LE, prosecutors, or defense attorneys receive prescription records in the course of investigating controlled substance charges.	**RX**					
4) LE receives Driving Under the Influence (DUI) or Driving While Intoxicated (DWI) testing results as evidence in a criminal investigation.	**PH**					
5) Criminal justice investigative agencies receive reports from health providers who suspect excessive use of force by law enforcement officers.	**PH**					
6) State criminal justice agencies receive an indicator of whether the nature of an individual's mental health or substance abuse problems legally disqualifies him or her from purchasing or carrying firearms.	**MH** **SA**					
7) Victim compensation program receives healthcare bills to reimburse and/or provide restitution for crime victims.	**MH** **PH** **SA**			**MH** **PH** **SA**		
8) Booking and detention facilities receive a "safe-to-detain" assessment after a health provider examines and/or treats an arrestee.	**MH** **PH**	**MH** **PH**				

MH = mental health; **PH** = physical health (incl. HIV/AIDS services); **RX** = prescription-related information; **SA** = substance abuse

Information Exchange Synopsis	**Law Enforcement**	**Initial Detention**	**Pre-trial Release or Supervision**	**Courts and Court-based Programs**	**Corrections (*e.g.* jail, prison)**	**Community Corrections (*e.g.* probation, parole)**
9) Health providers receive arrest and detention dates to: (a) help them account for their clients' whereabouts; and, (b) facilitate continuity of care in the detention facility.	**MH PH SA**	**MH PH SA**				
10) Health providers receive an inmate's actual date of release from a detention facility to conduct client outreach and facilitate continuity of care.	**MH PH SA**	**MH PH SA**				
11) Detaining agencies (e.g. sheriffs, police, jails, prisons) receive bills for health services provided to persons under their custody.	**MH PH**	**MH PH**			**MH PH**	
12) Correctional health records are populated with basic personal and demographic information from the facility's offender management system to reduce the time spent asking for redundant information and to eliminate duplicate data entry.		**MH PH RX SA**			**MH PH RX SA**	
13) Detention and correctional facilities receive health information about new admissions to: (a) inform inmate management decisions before a medical screening can occur; and, (b) supplement the facility's intake health assessment.		**MH PH SA**			**MH PH SA**	
14) Health departments receive notification about inmates with reportable communicable diseases, in accordance with public health reporting laws, to prevent disease transmission and care for the affected individual.		**PH**			**PH**	
15) Correctional health providers receive information about past prescriptions from community-based pharmacies to continue prisoners' previous medication regimens.		**RX**			**RX**	

MH = mental health; **PH** = physical health (incl. HIV/AIDS services); **RX** = prescription-related information; **SA** = substance abuse

Information Exchange Synopsis	**Law Enforcement**	**Initial Detention**	**Pre-trial Release or Supervision**	**Courts and Court-based Programs**	**Corrections (*e.g.* jail, prison)**	**Community Corrections (*e.g.* probation, parole)**
16) Community-based pharmacies receive inmate prescription orders from correctional health personnel.		**RX**			**RX**	
17) Community-based providers receive health information from detention or correctional facilities when treating inmates during incarceration, either on- or off-site.		**MH** **PH** **SA**			**MH** **PH** **SA**	
18) Correctional facilities (e.g. detention, jail or prison) receive a discharge or treatment summary from community-based providers after a person under custody receives care.		**MH** **PH** **SA**			**MH** **PH** **SA**	
19) Community-based service providers receive reentry plans from correctional discharge planners to coordinate reentry planning.		**MH** **PH** **SA**			**MH** **PH** **SA**	
20) Community-based providers receive health records of soon-to-be released inmates as part of reentry planning to facilitate continuity of care.		**MH** **PH** **SA**			**MH** **PH** **SA**	
21) Community-based providers receive discharge summaries or health records of released inmates to ascertain treatment during incarceration and/or facilitate continuity of care.		**MH** **PH** **SA**			**MH** **PH** **SA**	
22) Returning inmates receive copies of their correctional health records upon release as a means of both information transfer to community-based health providers and personal empowerment.		**MH** **PH** **SA**			**MH** **PH** **SA**	
23) Judges, defense attorneys, and/or prosecutors receive physical and behavioral health information to make decisions about pre-trial release and other alternatives to incarceration.			**MH** **PH** **SA**	**MH** **PH** **SA**		

MH = mental health; **PH** = physical health (incl. HIV/AIDS services); **RX** = prescription-related information; **SA** = substance abuse

Information Exchange Synopsis	**Law Enforcement**	**Initial Detention**	**Pre-trial Release or Supervision**	**Courts and Court-based Programs**	**Corrections (*e.g.* jail, prison)**	**Community Corrections (*e.g.* probation, parole)**
24) Community-based programs receive information on the court conditions and offender restrictions to promote compliance among justice-involved clients.			**MH PH SA**	**MH PH SA**		**MH PH SA**
25) Pre-trial, court-based, and post-conviction supervision programs receive status updates from behavioral health treatment providers to support compliance monitoring (e.g. program attendance, treatment adherence).			**MH SA**	**MH SA**		**MH SA**
26) Pre-trial, court-based, or post-conviction supervision personnel receive drug testing results from treatment providers (or their laboratories) to support compliance monitoring.			**MH SA**	**MH SA**		**MH SA**
27) Treatment providers receive client updates and compliance information from criminal justice supervision agencies to support the treatment process.			**MH SA**	**MH SA**		**MH SA**
28) Treatment providers receive notification of upcoming court dates to promote client compliance with court appearances.			**MH PH SA**	**MH PH SA**		
29) Criminal justice supervision agencies receive information from health providers to provide context for client behavior and promote alternative responses to noncompliance (rather than revocation and incarceration).			**MH PH SA**	**MH PH SA**		**MH PH SA**
30) Courts, criminal justice supervision programs, and/or reentry planning personnel receive information about community-based programs' eligibility criteria, service fees, and program capacity in order to link individuals to programs.			**MH PH SA**	**MH PH SA**	**MH PH SA**	**MH PH SA**

MH = mental health; **PH** = physical health (incl. HIV/AIDS services); **RX** = prescription-related information; **SA** = substance abuse

Information Exchange Synopsis	Law Enforcement	Initial Detention	Pre-trial Release or Supervision	Courts and Court-based Programs	Corrections (*e.g.* jail, prison)	Community Corrections (*e.g.* probation, parole)
31) Community-based service providers receive information on criminal charges and criminal justice risk assessments to assess defendants' eligibility or suitability for their programs.			**MH PH SA**	**MH PH SA**	**MH PH SA**	**MH PH SA**
32) Community-based providers receive information from assessments conducted in support of the criminal justice process (e.g. pre-sentence investigation reports or PSIs) to supplement their intake processes and prepare for justice-referred clients.			**MH PH SA**	**MH PH SA**	**MH PH SA**	**MH PH SA**
33) Court personnel receive health information from community-based providers to aid in the writing of pre-sentence investigation reports (PSIs).				**MH PH SA**		
34) Community-based providers receive inmates' expected release dates to coordinate reentry planning.					**MH PH SA**	

4.2 Information Exchange Synopses

The Information Exchange Synopsis provides a structured brief on each identified information exchange. It describes the exchange and the conditions under which information should be exchanged, identifies the partners in the information exchanges, defines the type of information to be shared, and indicates the direction of the information flow. For organization, consistency, and ease of comparison purposes, the Information Exchange Synopses are each presented in the table format below. This example is presented to provide the reader with the definitions and intent of each component.

TABLE 4. INFORMATION EXCHANGE SYNOPSIS TABLE FORMAT

Context	What context this information exchange has within the Criminal Justice and/or Health domains
Triggers	♦ List of anticipated events/actions that trigger the information exchange
Content Examples	♦ High-level examples of information exchange content—"presumed to include but not limited to…"
Information Flow	Basic flow of information related to the exchange—the "users," and their related entities as provided in the Terminology section (Section 2.5); identifies potential users of the exchange
Data Source Examples	♦ Examples of source data identified by the project—"include but not limited to…"
Assumptions	♦ Assumptions that apply to the particular information exchange
Specific Challenge Notes	♦ Specific citations regarding implementation challenges, if available and known
Related Guidelines & Standards	♦ Related guidelines and standards are provided
Implementation Notes	♦ Known pilots and implementations are provided, as well as other implementation notes

4.2.1 Exchange Synopsis 1

Emergency response dispatchers and/or LE officers receive an indicator of whether persons involved in a CFS have mental health or substance abuse problems in order to formulate an appropriate response (e.g. dispatch a crisis intervention team).

Context	Emergency response or dispatch centers receive calls regarding or involving persons behaving erratically or strangely. Alternately, LE officers may observe erratic or strange behaviors during patrols or traffic stops. The goal of this information exchange is to obtain and convey as much relevant information as possible to the officers who are responding to enhance the safety of the officers and citizens involved at the scene, and to promote the most appropriate response to the situation at hand. In this scenario, a dispatcher or LE officer requests information to: (a) determine whether this person has mental health or substance abuse problems; (b) obtain contact information for any current treatment providers; and/or (c) obtain additional information about known hazards or risks. This information can be used to generate many possible non-arrest responses to a given situation, including calling a relative, contacting a known treatment provider, dispatching a crisis intervention team, or transporting the individual to an ER.
Triggers	♦ A dispatcher or LE officer suspects that a person involved in a CFS (or observed on the street) is behaving erratically or strangely because of mental health or substance abuse problems.
Content Examples	♦ Personal identifiers [*e.g.* name, date of birth (DOB), social security number (SSN)] ♦ Emergency contact information ♦ Whether the person is currently under treatment ♦ Who currently or previously provided treatment ♦ Contact information for the treatment provider(s)
Information Flow	Dispatch Center or Law Enforcement (*inquiry*) ➔ Mental Health & Substance Abuse Treatment Providers (*response*) ➔ Dispatch Center or Law Enforcement (*use*)
Data Source Examples	♦ A database of all publicly-funded mental health clients in a given jurisdiction ♦ A "Medic-alert" type of registry for people who consent to have their health information shared with law enforcement and other emergency response personnel ♦ The VA ♦ Justice system-based records [*e.g.* the local jail's MIS or OMS, police records management systems (RMS)] ♦ A database of all publicly-funded substance abuse treatment clients in a given jurisdiction [*e.g.* Maryland's Alcohol and Drug Abuse Administration (ADAA) maintains such a database known as Statewide Maryland Automated Record Tracking (SMART)[36]]

[36] See Appendix F for additional information on SMART, as well as other success stories.

Assumptions	♦ Numerous basic assumptions apply to this Information exchange, and many of the other exchanges. For additional information on assumptions, refer to Section 2.6, Basic Assumptions. ♦ Determine the extent to which substance abuse and mental health records can legally and ethically be used for this purpose. State and local laws may govern the release of behavioral health information in addition to Federal laws, such as *HIPAA* and *42 CFR Part 2*. As a prerequisite to any information exchange, the partners must determine which laws are applicable to them, and take the appropriate measures to ensure that the information exchange is permissible (*e.g.* obtain client consent as needed and/or enter into a data sharing agreement specifying the allowable disclosure of the information).
Specific Challenge Notes	♦ There are heightened privacy and civil liberties concerns in this information exchange because it involves disclosing a person's mental health or substance abuse status to LE. ♦ Any implementation will need to determine the minimal amount of information needed that would allow LE to appropriately respond to a situation in progress. For example, should identification of a person in the behavioral health database be used by LE to call in clinical personnel or a crisis intervention team, with only the clinical members of the team having access to health information.
Related Guidelines & Standards	♦ None identified
Implementation Notes	♦ Ideally, LE would follow-up with the treatment provider to explain what transpired regarding the individual.

4.2.2 Exchange Synopsis 2

LE receives reports of suspected child abuse, intimate partner violence, or elder abuse from health providers in order to initiate an investigation.

Context	Health care providers are often mandated by state law to report suspected child abuse, domestic violence, or elder abuse. Reports have historically been made by telephone, but electronic reporting offers the possibility of increased efficiency and the ability to transmit relevant evidence, such as photographs of bruising.
Triggers	♦ A health care provider suspects that a patient's injuries resulted from abuse.
Content Examples	♦ Victim information (*i.e.* name, DOB, address) ♦ Suspect information (*i.e.* name, DOB, address) ♦ Reporting clinician and facility ♦ Medical records to support the allegation of abuse
Information Flow	Health care provider (*information push*) ➔ Law Enforcement (*use*)
Data Source Examples	♦ Healthcare facility records system
Assumptions	♦ Numerous basic assumptions apply to this information exchange (see Section 2.6). ♦ Determine the extent to which crime reporting is an allowable exception to Federal, state, and local privacy laws and policies that govern the release of personal health information. As a prerequisite to any information exchange, the partners must determine which laws are applicable to them, and take the appropriate measures to ensure that the information exchange is permissible (*e.g.* obtain client consent as needed and/or enter into a data sharing agreement specifying the allowable disclosure of the information).
Specific Challenge Notes	♦ None identified
Related Guidelines & Standards	♦ None identified
Implementation Notes	♦ Child protective services agencies and adult protective services agencies may be recipients of this information in addition to LE, depending on the reporting requirements in a particular state or locality.

4.2.3 Exchange Synopsis 3

LE, prosecutors, or defense attorneys receive prescription records in the course of investigating controlled substance charges.

Context	An individual who is investigated for the possession of a controlled pharmaceutical drug (*e.g.* medical marijuana, oxycodone or buprenorphine) may have a prescription for the controlled substance. The investigating officer initiates a search of pharmaceutical information to validate a person's legitimate use/possession of a controlled substance(s). The information received assists the officer in determining the most appropriate course of action. NOTE: Having a match in these databases does not automatically exonerate a person, as he or she could have obtained the prescription fraudulently.
Triggers	♦ A police officer investigates someone in possession of a controlled pharmaceutical drug who claims to have a legal prescription.
Content Examples	♦ Personal identifiers (*e.g.* name, DOB, SSN) ♦ Names and dates of prescription medications issued to the individual ♦ Doctors information who made prescriptions ♦ As needed, consent to have this information shared
Information Flow	LE, Prosecutor, or Defense Attorney (*inquiry*) ➔ Health (*response*) ➔ LE, Prosecutor, or Defense Attorney (*use*)
Data Source Examples	♦ State Prescription Monitoring Program (PMP) database ♦ Health information exchange records
Assumptions	♦ Numerous basic assumptions apply to this information exchange (see Section 2.6). For example, Federal, state, and local privacy laws and policies govern the transmission of personal health information. As a prerequisite to any information exchange, the partners must determine which laws are applicable to them, and take the appropriate measures to ensure that the information exchange is permissible (*e.g.* obtain client consent as needed and/or enter into a data sharing agreement specifying the allowable disclosure of the information).
Specific Challenge Notes	♦ If prescription medications are part of a person's substance abuse treatment (*e.g.* buprenorphine), then s/he would have had to have given consent per *42 CFR Part 2* to use pharmaceutical information for investigative purposes.
Related Guidelines & Standards	Prescription Monitoring Information Exchange (PMIX)[37]
Implementation	♦ Implementation should consider the timeliness of the PMP data in a given locality. While

[37] For additional information on PMIX architecture, visit: http://pmpalliance.org/content/prescription-monitoring-information-architecture-pmix

Notes	pharmacies in some states upload dispensing information to the state database daily, the time lag to upload records may be as long as one month. As such, state databases may not include patients' most recent prescription purchases. For this reason, the Alliance of States with Prescription Monitoring Programs (ASPMP) urges caution when using these data for drug investigations.[38]

[38] Prepared by Brandeis University (2012). *Prescription Drug Monitoring Programs: An Assessment of the Evidence for Best Practices*. Prepared for The Pew Charitable Trusts. Retrieved from: http://www.pdmpexcellence.org/sites/all/pdfs/Brandeis_PDMP_Report.pdf

4.2.4 Exchange Synopsis 4

LE receives Driving Under the Influence (DUI) or Driving While Intoxicated (DWI) testing results as evidence in a criminal investigation.

Context	A blood test may be needed to investigate an arrestee apprehended for DUI or DWI. Some state statutes require blood testing; or, the suspect may elect to have their blood tested instead of submitting to a breathalyzer test. In these cases, the LE officer brings the arrestee to a hospital or other healthcare facility to have blood drawn and tested.
Triggers	♦ A healthcare provider performs a blood test for use in a drunk or drugged driving investigation.
Content Examples	♦ Personal identifiers (*e.g.* name, DOB, SSN) ♦ Blood test results ♦ Blood test information (*e.g.* date, time, analyst name, contact information)
Information Flow	Health (*information push*) ➔ LE (*use*)
Data Source Examples	♦ Hospital or healthcare provider laboratory records system
Assumptions	♦ Numerous basic assumptions apply to this information exchange (see Section 2.6). ♦ Assuming that submitting these results in conjunction with an LE investigation is permissible under the Federal, state, and local privacy laws and policies govern the transmission of personal health information. As a prerequisite to any information exchange, the partners must determine which laws are applicable to them, and take the appropriate measures to ensure that the information exchange is permissible (*e.g.* obtain client consent as needed and/or enter into a data sharing agreement specifying the allowable disclosure of the information).
Specific Challenge Notes	♦ None identified
Related Guidelines & Standards	♦ None identified
Implementation Notes	♦ None identified

4.2.5 Exchange Synopsis 5

Criminal justice investigative agencies receive reports from health providers who suspect excessive use of force by law enforcement officers.

Context	While providing care to an arrestee, health care providers may suspect that injuries arose from the LE's use of force. Reports have historically been made by telephone, but electronic reporting offers the possibility of greater privacy for the reporter, increased efficiency, and the ability to transmit relevant evidence, such as x-rays or photographs of bruising.
Triggers	♦ A healthcare provider suspects that LE officers have used excessive force against an arrestee.
Content Examples	♦ Victim's personal identifiers (*e.g.* name, DOB, SSN) ♦ Nature of injuries sustained ♦ Medical records with evidence of alleged abuse ♦ Information regarding the suspected officers if available
Information Flow	Health (*information push*) ➔ LE (*use*)
Data Source Examples	♦ Hospital records including relevant clinicians' notes
Assumptions	♦ Numerous basic assumptions apply to this information exchange (see Section 2.6). ♦ Determine whether patient consent is required in light of Federal, state, and local privacy laws and policies govern the transmission of personal health information. As a prerequisite to any information exchange, the partners must determine which laws are applicable to them, and take the appropriate measures to ensure that the information exchange is permissible (*e.g.* obtain client consent as needed and/or enter into a data sharing agreement specifying the allowable disclosure of the information.
Specific Challenge Notes	♦ None identified
Related Guidelines & Standards	♦ None identified
Implementation Notes	♦ None identified

4.2.6 Exchange Synopsis 6

State criminal justice agencies receive an indicator of whether the nature of an individual's mental health or substance abuse problems legally disqualifies him or her from purchasing or carrying firearms.

Context	Persons attempting to purchase firearms, applicants for gun carry permits, and applicants for concealed weapons permits are often required to undergo a background check. State criminal justice agencies are responsible for determining eligibility. If any disqualifiers are found, then the purchase or permit is denied. Federal disqualifying factors include the illegal use of controlled substances, a history of involuntary mental health commitments or mental health adjudications, and other factors, such as criminal history and citizenship. State laws may have additional criteria. In this information exchange, the state criminal justice agencies request mental health and substance abuse information to determine whether the nature or extent of these problems meets the legal criteria for disqualification. NOTE: A non-specific denial is returned to the retailer or permit office without disclosing the reason for denial.
Triggers	♦ A background check for a firearms purchase or permit is requested.
Content Examples	♦ Personal identifiers (*e.g.* name, DOB, SSN) ♦ Dates of court-ordered commitment to inpatient or outpatient treatment ♦ Dates of repeated hospitalization for psychiatric treatment ♦ Mental health and substance abuse diagnoses
Information Flow	State Criminal Justice Agency (*inquiry*) ➔ Substance Abuse and Mental Health Providers (*response*) ➔ State Criminal Justice Agency (*use*)
Data Source Examples	♦ The NICS (contains records of mental health adjudications) ♦ Substance abuse treatment providers ♦ Mental health treatment providers
Assumptions	♦ Numerous basic assumptions apply to this information exchange (see Section 2.6). ♦ Determine the legal ***and*** ethical extent to which substance abuse and mental health records can be used for this purpose. State and local laws may govern the release of behavioral health information in addition to Federal laws such as *HIPAA* and *42 CFR Part 2*. As a prerequisite to any information exchange, the partners must determine which laws are applicable to them, and take the appropriate measures to ensure that the information exchange is permissible (*e.g.* obtain client consent as needed and/or enter into a data sharing agreement specifying the allowable disclosure of the information).
Specific Challenge	♦ Heightened privacy and civil liberties concerns must be addressed because this information

Notes	exchange involves identifying a person's mental health or substance abuse status to LE.
Related Guidelines & Standards	♦ NICS[39]
Implementation Notes	♦ To some extent, this implementation exists through the FBI's NIC; however, states' legal criteria for firearms purchases and permits may be more stringent, necessitating the use of additional information.

[39] For additional information on the FBI's NICS, visit: http://www.fbi.gov/about-us/cjis/nics/general-information/fact-sheet

4.2.7 Exchange Synopsis 7

Victim compensation program receives healthcare bills to reimburse and/or provide restitution for crime victims.

Context	Crime victims may incur medical costs due to being victimized. The victim's costs may be reimbursed by a state or local crime victims' compensation fund; alternately, a court may order that restitution be provided to the victim. While rules and procedures vary across the nation, some form of cost verification is likely to occur. In this information exchange, an appointed victims' compensation representative submits an inquiry to the appropriate healthcare providers and obtains the necessary documentation.
Triggers	• A crime victim applies for reimbursement of her/his medical costs. • A victims' compensation representative prepares information for a court restitution decision.
Content Examples	• Personal identifiers (*e.g.* name, DOB, SSN) • Health care services provided • Dates of service • Costs (*i.e.* the total cost of service, any amount paid by insurance, and the patient's share)
Information Flow	Victims Compensation Representative (*inquiry*) ➔ Healthcare Provider (*response*) ➔ Victims Compensation Representative (*use*)
Data Source Examples	• Healthcare Treatment and Cost Records
Assumptions	• Numerous basic assumptions apply to this information exchange (see Section 2.6). For example, Federal, state, and local privacy laws and policies govern the transmission of personal health information. As a prerequisite to any information exchange, the partners must determine which laws are applicable to them, and take the appropriate measures to ensure that the information exchange is permissible (*e.g.* obtain client consent as needed and/or enter into a data sharing agreement specifying the allowable disclosure of the information). • The victim gives consent to the crime victims' compensation representative to obtain this information of her/his behalf. • The medical provider has authorization to share information on the nature of the services provided with the victim compensation program, or can otherwise attest to the legitimacy of the services provided.
Specific Challenge Notes	• None identified
Related Guidelines & Standards	• None identified
Implementation Notes	• None identified

4.2.8 Exchange Synopsis 8

Booking and detention facilities receive a "safe-to-detain" assessment after a health provider examines and/or treats an arrestee.

Context	Detention facilities typically will not book and admit a person who is obviously in need of immediate medical attention, for both liability and cost reasons. The facility may require a "safe-to-detain" assessment before booking an individual with suspected health needs. LE officers are responsible for obtaining the "safe-to-detain" examination because they are accountable for arrestees' safe-keeping prior to booking. An LE officer takes the arrestee to be examined by a hospital ER or other healthcare provider. Upon completion of the examination, a clinician may provide a "safe-to-detain" assessLElaw enforcement.
Triggers	♦ Completion of a "Safe-to-detain" assessment for an arrestee
Content Examples	♦ Personal identifiers (*e.g.* name, DOB, SSN) ♦ Description of services rendered ♦ Medical status information (*i.e.* "Safe-to-detain" assessment)
Information Flow	Hospital or healthcare provider (*information push*) ➔ Detention Facility (*use*)
Data Source Examples	♦ Hospital or healthcare provider records system
Assumptions	♦ Numerous basic assumptions apply to this information exchange (see Section 2.6). For example, Federal, state, and local privacy laws and policies govern the transmission of personal health information. As a prerequisite to any information exchange, the partners must determine which laws are applicable to them, and take the appropriate measures to ensure that the information exchange is permissible (*e.g.* obtain client consent as needed and/or enter into a data sharing agreement specifying the allowable disclosure of the information).
Specific Challenge Notes	♦ The transmission of a "safe-to-detain" assessment may be exempt from *HIPAA* client authorization requirements because the information impacts the safety and security of the institution. Nevertheless, advice from legal counsel is recommended because other state and local privacy laws may govern the information flow.
Related Guidelines & Standards	♦ None identified
Implementation Notes	♦ None identified

4.2.9 Exchange Synopsis 9

Health providers receive arrest and detention dates to: (a) help them account for their clients' whereabouts; and, (b) facilitate continuity of care in the detention facility.

Context	Ongoing health treatment in the community is interrupted when a person is arrested or booked into a detention facility. Providing a notification of arrest and/or detention to healthcare, substance abuse, and mental health providers would allow them to account for their clients' whereabouts, advocate for their clients' health needs, and facilitate continuity of treatment during incarceration. This information exchange could be initiated by either justice or health. 1) The LE or detaining agency could send a daily or weekly roster of all persons admitted to a predetermined group of providers. 2) The LE or detaining agency could first query a database of treatment clients and, upon finding a match, send the provider a notification of detainment. 3) Providers could subscribe to updates about a pre-determined list of clients. 4) Providers could query information about a particular client (*e.g.* if someone who receives treatment for chronic health problems misses a scheduled appointment).
Triggers	• A person is arrested and booked into a local detention facility. • Alternate: A health provider's client misses a scheduled appointment.
Content Examples	• Personal identifiers (*e.g.* name, DOB, SSN) • Date of arrest/detainment • Location where he/she is housed • Date of release, if known
Information Flow	LE/Detention Facility (*information push*) ➔ Healthcare, Substance Abuse, and Mental Health Providers (*use*) Alternate: Healthcare, Substance Abuse, and Mental Health Providers (*inquiry*) ➔ LE/Detention Facility (*response*) ➔ Healthcare, Substance Abuse, and Mental Health Providers (*use*)
Data Source Examples	• LE agency arrest or booking records • Jail or detention center booking records • OMS
Assumptions	• Numerous basic assumptions apply to this information exchange (see Section 2.6). • Determine whether it is legally and ethically appropriate to disclose that a person has been arrested and/or booked into detention. • Implementation options 2 and 3 would entail the detention facility LE knowing whether or not the arrestee is a client of a health provider, which is likely to be protected information under Federal, state, and local privacy laws and policies, such as *HIPAA* and *42 CFR Part 2*. As a prerequisite to any information exchange, the partners must determine which laws are applicable to them, and take the appropriate measures to ensure that the information exchange is permissible (*e.g.* obtain client consent as needed and/or enter into a data sharing agreement specifying the allowable disclosure of the information).

Specific Challenge Notes	♦ Of the four implementation options specified above, option 1 is likely to be the most feasible, with the fewest confidentiality concerns.
Related Guidelines & Standards	♦ None identified
Implementation Notes	♦ Giving providers the option to "subscribe" to receive information on their clients would tailor the information they receive. This may be preferable to a general broadcast of all persons released, which can be perceived as information overload because providers would have to sift through many other releases to identify their clients. ♦ Similar exchanges have been put into practice in Los Angeles, California and Pima County, Arizona.

4.2.10 Exchange Synopsis 10

Health providers receive an inmate's actual date of release from a detention facility to conduct client outreach and facilitate continuity of care.

Context	This information exchange is aimed at reconnecting released detainees with the health providers who treated them before incarceration. Individuals who received ongoing health services before detention may be able resume services with the same providers upon release, including: methadone maintenance clients; psychotherapy clients; and patients under medical care for chronic diseases, such as HIV or cancer. Detention facilities notify community-based treatment providers of detainees' actual release dates. This allows the treatment providers to conduct outreach in the community. The information could be provided in two ways: 1) Facilities notify individual providers when certain detainees have been released; or, 2) Facilities provide a daily list of releases to designated health providers. NOTE: This information exchange is geared toward a pretrial detention setting. It is very difficult for detention facility staff to anticipate release dates and engage in reentry planning because an inmate may be released at any time if s/he is able to post bail or bond. Exchange Synopsis 34 describes the sharing of expected release dates to facilitate reentry planning (*e.g.* in a jail or prison facility that incarcerates sentenced offenders).
Triggers	• A person receiving ongoing healthcare treatment (mental, physical, or substance) is released from a local detention facility.
Content Examples	• Personal identifiers (*e.g.* name, DOB, SSN) • Date of release • Length of stay • Contact information on release (if available) • Inmate consent to release health information
Information Flow	LE/Detention Facility (*information push*) ➔ Health Providers (*use*)
Data Source Examples	• Detention facility booking records • OMS
Assumptions	• Numerous basic assumptions apply to this information exchange (see Section 2.6). For example, Federal, state, and local privacy laws and policies govern the transmission of personal health information. As a prerequisite to any information exchange, the partners must determine which laws are applicable to them, and take the appropriate measures to ensure that the information exchange is permissible (*e.g.* obtain client consent as needed and/or enter into a data sharing agreement specifying the allowable disclosure of the information). • Determine whether it is legally and ethically appropriate to disclose that a person was recently incarcerated pre-trial.
Specific Challenge Notes	• None identified

Related Guidelines & Standards	♦ None identified
Implementation Notes	♦ Giving providers the option to "subscribe" to receive information on their clients would tailor the information they receive. This would be preferable to a general broadcast of all persons released, which may be perceived as information overload because providers would have to sift through many other releases to identify their clients.

4.2.11 Exchange Synopsis 11

Detaining agencies (e.g. sheriffs, police, jails, prisons) receive bills for health services provided to persons under their custody.

Context	LE agencies, detention facilities, and correctional facilities are legally responsible for the health and safety of all persons in their custody. In certain situations, this care is provided by a community-based healthcare provider: • An arrestee who needs medical care before being booked into a detention facility is brought to an ER or another health provider for treatment. • A detention facility or correctional facility transports an inmate to a hospital or ER for care beyond the capacity of the facility's medical staff. The health care provider subsequently bills the law enforcement agency for the medical treatment that was provided. An electronic information billing process may be more efficient than current paper-based processes.
Triggers	• An arrestee or inmate under custody receives medical care from a community-based provider.
Content Examples	• Personal identifiers (*e.g.* name, DOB, SSN) • Description of services rendered • Invoice information
Information Flow	Hospital or Healthcare Provider (*information push*) ➔ LE, Detention Facility, or Correctional Facility (*use*)
Data Source Examples	• Hospital or healthcare provider records system
Assumptions	• Numerous basic assumptions apply to this information exchange (see Section 2.6). • In general, transmission of medical billing information is permissible under, Federal, state, and local privacy laws and policies govern the transmission of personal health information; however, it must be verified that this holds true when a criminal justice agency is the payer. As a prerequisite to any information exchange, the partners must determine which laws are applicable to them, and take the appropriate measures to ensure that the information exchange is permissible (*e.g.* obtain client consent as needed and/or enter into a data sharing agreement specifying the allowable disclosure of the information).
Specific Challenge Notes	• None identified
Related Guidelines & Standards	• None identified
Implementation Notes	• None identified

4.2.12 Exchange Synopsis 12

Correctional health records are populated with basic personal and demographic information from the facility's offender management system to reduce the time spent asking for redundant information and to eliminate duplicate data entry.

Context	Individuals typically go through separate custody and health-related intake screening processes when they are incarcerated, with similar information collected more than once (*e.g.* name, DOB, SSN, demographics, socioeconomic status, and emergency contact information). This exchange would allow the initial custody intake records system to automatically populate the medical records system with this information rather than having the medical staff ask the same questions and re-enter redundant information. Alternately, information collected during the initial custody intake would be accessible to the medical intake personnel via a query. This scenario assumes: • That there are two separate records systems: one for general offender management and another for medical records; and, • The facility's medical records system is considered part of the health "domain" and/or is contracted to a separate health provider (*e.g.* a correctional health vendor or community-based agency).
Triggers	• An intake is completed and recorded in the correctional facility's records system. • Alternate: Initiated via query by medical personnel.
Content Examples	• Person data (*e.g.* name, DOB, SSN, emergency contact information) • Education history • Work history • Family relationships
Information Flow	Detention Facility Records (*information push*) ➔ Medical Records System (*use*) Alternate: Medical Records System (*inquiry*) ➔ Detention Facility Records (*response*) ➔ Medical Records System (*use*)
Data Source Examples	• OMS • Booking system
Assumptions	• Numerous basic assumptions apply to this information exchange (see Section 2.6). • Privacy constraints should not apply here because the information is not confidential. • The medical system in this scenario is not part of the detention facilities system; and, the medical component is outsourced. (*If the medical component were part of the detention facility, then there would be no cross-domain exchange of information*.)
Specific Challenge Notes	• None identified
Related Guidelines & Standards	• None identified

Implementation Notes	♦ Inmates may report conflicting information to booking and medical personnel. A procedure for resolving discrepancies needs to be instituted, including decision rules for which information takes precedence. ♦ This information exchange is applicable to a variety of facility types, including detention facilities, jails, and prisons.

4.2.13 Exchange Synopsis 13

Detention and correctional facilities receive health information about new admissions to: (a) inform inmate management decisions before a medical screening can occur; and, (b) supplement the facility's intake health assessment.

Context	Individuals coming into detention or correctional settings may have physical, mental, or substance abuse issues that: (a) require treatment; and, (b) affect the facility's decisions on classification and appropriate housing. Such information may not be readily available until a medical intake assessment is conducted. Even then, supplemental information may be useful for treatment and other decisions made about the individual while under custody. Booking officers and/or medical staff interview incoming inmates to ascertain medical issues they need to take into consideration during incarceration. There are two reasons to supplement the information gathered from this interview with health information from community-based providers: 1) Self-reported health information may be unreliable when arrestees are hostile, intoxicated, or in withdrawal from drugs and alcohol. 2) There is a time lag between admission and the medical intake, which can occur as much as one week after admission. This information exchange is most widely applicable to pretrial detention settings, when individuals are first incarcerated; however, it is also applicable if individuals who were in the community before adjudication directly enter correctional facilities after sentencing.
Triggers	• A person is admitted to a detention or correctional facility.
Content Examples	• Person data (*e.g.* name, DOB, SSN, emergency contact information) • Medical and behavioral health diagnoses, including substance abuse • Current treatment information (including medication or treatment regimens) • Risk assessments • Contact information for the treatment provider
Information Flow	Detention or Correctional Facility (*inquiry*) ➔ Health Providers (*response*) ➔ Detention or Correctional Facility (*use*)
Data Source Examples	• Health Information Exchange (HIE) [*e.g.* a Regional Health Information Organization (RHIO), which compiles information across a range of health providers] • Major "safety-net" providers, such as public- or university-based clinic and hospital systems • Database of all publicly-funded mental and physical health clients in a given jurisdiction • "Medic-alert" type of registry for people who consent to have their mental and physical health information shared with criminal justice system actors • The VA • The current facility's OMS archive from prior incarcerations or other detention facilities that previously had custody of the individual

Assumptions	♦ Numerous basic assumptions apply to this information exchange (see Section 2.6). For example, Federal, state, and local privacy laws and policies govern the transmission of personal health information. As a prerequisite to any information exchange, the partners must determine which laws are applicable to them, and take the appropriate measures to ensure that the information exchange is permissible (*e.g.* obtain client consent as needed and/or enter into a data sharing agreement specifying the allowable disclosure of the information).
Specific Challenge Notes	♦ There are potentially two different criminal justice users of this information: (1) detention facility staff (*i.e.* who make housing determinations); and/or, (2) detention facility medical staff (*i.e.* who provide medical care). – Privacy restrictions on the information to be shared will vary for these two different implementations. A booking officer may receive a flag or alert that the individual needs medical attention, but is not given the details. By contrast, the detention facility's medical staff can receive more detailed information with appropriate client consent.
Related Guidelines & Standards	♦ None identified
Implementation Notes	♦ Hennepin County, Minnesota's adult detention center has implemented a similar information exchange. ♦ Implementation in a pretrial detention setting is more feasible because health providers would be in the same local area. State correctional providers would have to draw this information from a wider network of geographically dispersed health providers. ♦ Ideally, the detention facility can share information collected during the intake process (and/or subsequent work with an inmate) with community-based treatment providers on release (as in information exchange synopses 19, 20, and 21); however, there may be restrictions on the re-transmission of health information.

4.2.14 Exchange Synopsis 14

Health departments receive notification about inmates with reportable communicable diseases, in accordance with public health reporting laws, to prevent disease transmission and care for the affected individual.

Context	Certain communicable diseases [*e.g.* Hepatitis, tuberculosis, multidrug-resistant Staphylococcus aureus (MRSA), HIV/AIDS] must be reported to public health authorities by law. The purpose is to inform the public health authorities and prevent disease transmission to others (*e.g.* staff, other inmates, community members). Reporting may also trigger an enhanced level of care for the affected individual (*i.e.* visits from a public health nurse). The detention or correctional facility prepares a report in accordance with the requirements of the public health authority then electronically sends the report to the public health department. NOTE: This information exchange is equally applicable to detention facilities, jails, and prisons.
Triggers	♦ An individual is diagnosed with a reportable communicable disease at intake or during incarceration.
Content Examples	♦ Personal identifiers (*e.g.* name, DOB, SSN) ♦ Communicable disease information (*e.g.* diagnosis, lab results, diagnosis date)
Information Flow	Detention or Correctional Facility (*information push*) ➔ Public Health Department (*use*)
Data Source Examples	♦ Correctional facility's medical records system ♦ Lab records
Assumptions	♦ Numerous basic assumptions apply to this information exchange (see Section 2.6). For example, Federal, state, and local privacy laws and policies govern the transmission of personal health information. As a prerequisite to any information exchange, the partners must determine which laws are applicable to them, and take the appropriate measures to ensure that the information exchange is permissible (*e.g.* obtain client consent as needed and/or enter into a data sharing agreement specifying the allowable disclosure of the information).
Specific Challenge Notes	♦ Mandatory reporting of communicable diseases is most likely exempt from client consent requirements under health information privacy laws.
Related Guidelines & Standards	♦ None identified
Implementation Notes	♦ None identified

4.2.15 Exchange Synopsis 15

Correctional health providers receive information about past prescriptions from community-based pharmacies to continue prisoners' previous medication regimens.

Context	Many individuals in correctional settings need medications for either physical or mental health conditions, or as part of their substance abuse treatment. Communication between community-based pharmacies and correctional health may aid in ensuring prescription continuity upon incarceration. This information exchange would most often take place in a pre-trial detention facility, but may also occur when an individual is newly admitted to prison, especially if he or she had not been detained pre-trial. Medical staff in the detention or correctional facility requests information on the medications used by a given individual. A list of current and recently prescribed medications and dosages is sent from the community-based pharmaceutical system. Once the information is received, correctional medical personnel can evaluate the need to continue the previous medication regime and elect to become the new prescriber of those medications, assuming the role previously held by a community-based clinician. This information exchange can also flow in the opposite direction: when correctional clinicians prescribe medication to an individual, they can send an update to the community-based pharmaceutical database with the names and dosages of prescribed medicines. The ideal scenario may be a shared system into which correctional and community-based pharmacies share a common record on each individual. NOTE: This information exchange is most applicable to a pretrial detention setting, when very little is known about entering inmates; however, this is some applicability to prison settings if, for example, an inmate had not been in detention before sentencing.
Triggers	♦ Identification of health problems during intake into a correctional facility or if an inmate seeks care during incarceration. (Alternately—and more broadly—anyone's entry into a correctional facility could trigger this information exchange.)
Content Examples	♦ Personal identifiers (*e.g.* name, DOB, SSN) ♦ Prescription information (*i.e.* drug, dosage, doctor, date of prescription)
Information Flow	Correctional Medical Staff (*inquiry*) ➔ Community-based Pharmacy (*response*) ➔ Correctional Medical Staff (*use*)
Data Source Examples	♦ Community-based pharmacy database for prescriptions from prior incarcerations ♦ Corrections pharmacy
Assumptions	♦ Numerous basic assumptions apply to this information exchange (see Section 2.6). For example, Federal, state, and local privacy laws and policies govern the transmission of personal health information. As a prerequisite to any information exchange, the partners must determine which laws are applicable to them, and take the appropriate measures to ensure that the information exchange is permissible (*e.g.* obtain client consent as needed and/or enter into a data sharing agreement specifying the allowable disclosure of the information). ♦ The community-based pharmacy has previously dispensed prescribed medication to the individual.

Specific Challenge Notes	♦ None identified
Related Guidelines & Standards	♦ None identified
Implementation Notes	♦ None identified

4.2.16 Exchange Synopsis 16

Community-based pharmacies receive inmate prescription orders from correctional health personnel.

Context	Many individuals in correctional settings need medications for either physical or mental health conditions. Electronic transmission of prescriptions can improve efficiency and decrease potentially dangerous transcription errors when correctional facility medical staff use a designated community-based pharmacy for prescription fulfillment. Corrections medical staff sends the prescription to the designated community-based pharmacy for prescription fulfillment. The community-based pharmacy fulfills the prescription, then ships or transports the medication to the correctional facility. NOTE: This information exchange could take place in both pre-trial detention facilities and in jails or prisons housing sentenced offenders.
Triggers	♦ A clinician in a correctional facility (which uses a designated community-based pharmacy) prescribes medication for an inmate.
Content Examples	♦ Personal identifiers (*e.g.* name, DOB, SSN) ♦ Prescription information (*i.e.* drug, dosage, doctor, date of prescription, possibility of generics use)
Information Flow	Correctional Medical Staff (*information push*) ➔ Community-based Pharmacy (*use*)
Data Source Examples	Correctional medical records system
Assumptions	♦ Numerous basic assumptions apply to this information exchange (see Section 2.6). For example, Federal, state, and local privacy laws and policies govern the transmission of personal health information. As a prerequisite to any information exchange, the partners must determine which laws are applicable to them, and take the appropriate measures to ensure that the information exchange is permissible (*e.g.* obtain client consent as needed and/or enter into a data sharing agreement specifying the allowable disclosure of the information).
Specific Challenge Notes	♦ None identified
Related Guidelines & Standards	♦ None identified
Implementation Notes	♦ None identified

4.2.17 Exchange Synopsis 17

Community-based providers receive health information from detention or correctional facilities when treating inmates during incarceration, either on- or off-site.

Context	A person who is incarcerated in a detention facility, jail, or prison may need to receive care from a community-based health provider under several circumstances. The inmate may be taken outside the secure facility (*e.g.* to a hospital) or the community-based clinician may provide care inside the facility (*e.g.* through consultation or telemedicine). Correctional health records are used by the community-based provider to decide on the treatment approach. For example: A person in custody needs medical attention that exceeds the capabilities of the facility's medical resources. • An inmate requires hospitalization. • A community-based clinician provides care through telemedicine. • The correctional medical staff consults with a community-based specialist. • The correctional facility uses contracted community-based medical treatment providers for inmate medical care. Alternate Return: When the outside treatment is completed, the community-based provider could return a treatment or discharge summary back to the detention or correctional facility (as in Exchange Synopsis 18).
Triggers	• Correctional health care personnel seek outside medical services for an inmate.
Content Examples	• Personal identifiers (*e.g.* name, DOB, SSN) • Intake health assessment • Physical health, mental health, and substance abuse history • Risk assessments • Diagnostic examinations and tests conducted by the correctional medical staff • Medication and treatment records
Information Flow	Correctional Medical Staff (*information push*) ➔ Community-based Medical Provider (*use*) Alternate Return: Community-based Medical Provider (*information push*) ➔ Correctional Medical Staff (*use*)
Data Source Examples	• Intake health assessments • Correctional medical records system • Alternate Return: Community-based medical provider system

Assumptions	♦ Numerous basic assumptions apply to this information exchange (see Section 2.6). For example, Federal, state, and local privacy laws and policies govern the transmission of personal health information. As a prerequisite to any information exchange, the partners must determine which laws are applicable to them, and take the appropriate measures to ensure that the information exchange is permissible (*e.g.* obtain client consent as needed and/or enter into a data sharing agreement specifying the allowable disclosure of the information). ♦ The individual requires outside medical treatment. ♦ The correctional facility has a medical history on the inmate.
Specific Challenge Notes	♦ None identified
Related Guidelines & Standards	♦ None identified
Implementation Notes	♦ Inmates are sometimes transferred to other correctional facilities with more extensive healthcare facilities (*e.g.* within state or Federal systems). A similar information exchange between facilities would occur, but this is no longer a cross-domain information exchange.

4.2.18 Exchange Synopsis 18

Correctional facilities (e.g. detention, jail or prison) receive a discharge or treatment summary from community-based providers after a person under custody receives care.

Context	A detention or correctional facility has a person in custody that needs medical attention from a community-based healthcare provider or hospital. • In one version of this situation, the facility transports the inmate to the community-based provider for treatment. • In alternate versions of this situation, the community-based clinician provides care through telemedicine or provides care within in the facility. In either case, a treatment summary (*e.g.* with follow up recommendations and/or prescriptions) is sent to the facility to promote continuity of care.
Triggers	• Completion of treatment for a detainee or inmate of a correctional facility
Content Examples	• Personal identifiers (*e.g.* name, DOB, SSN) • Description of services rendered • Prescription information
Information Flow	Hospital or Healthcare Provider (*information push*) ➔ Detention Facility (*use*)
Data Source Examples	• Hospital or healthcare provider's records system
Assumptions	• Numerous basic assumptions apply to this information exchange (see Section 2.6). For example, Federal, state, and local privacy laws and policies govern the transmission of personal health information. As a prerequisite to any information exchange, the partners must determine which laws are applicable to them, and take the appropriate measures to ensure that the information exchange is permissible (*e.g.* obtain client consent as needed and/or enter into a data sharing agreement specifying the allowable disclosure of the information.
Specific Challenge Notes	• None identified
Related Guidelines & Standards	• This information exchange aligns with priorities established by the ONC.
Implementation Notes	• None identified

4.2.19 Exchange Synopsis 19

Community-based service providers receive reentry plans from correctional discharge planners to coordinate reentry planning.

Context	A current challenge in reentry planning is that multiple correctional and community-based service providers may work with a particular client and each may independently develop separate transition or reentry plans for the same inmate, potentially leading to conflicting messages, requirements, and plans for this individual. A promising practice is for multiple providers to co-develop a single, integrated transition/reentry plan for each soon-to-be released inmate. This plan is developed in the last six (6) months of incarceration and finalized 30-90 days prior to release. In this information exchange, corrections would first generate a list of inmates who are within the defined "pre-release" window of time, and then develop a draft transition plan for each inmate. The corrections discharge or reentry case manager would then send a draft transition plan to the specific service providers involved with or proposed for a given client, then receive and incorporate feedback from the other providers. Once the feedback is incorporated, the process is repeated for all service providers to review and approve the finalized transition/ reentry plan. Alternate: A more advanced strategy is for all providers to have shared access to a single reentry planning document or system, whereby all contribute to the development of the plan. NOTE: Coordinated reentry planning—and, therefore, this information exchange—are most likely to occur in a prison setting because the predictability of release dates makes reentry planning feasible. This is also possible in a jail setting with sentenced inmates because they also have somewhat predictable release dates. By contrast, this information exchange is least likely in a jail or detention setting with pretrial detainees because the unpredictability of release dates (due to bail and other court decisions) makes coordinated discharge planning very difficult to implement. That being said, some detention facilities do engage in discharge planning for selected unsentenced special needs individuals (*e.g.* detainees with severe physical and behavioral health needs).
Triggers	• An inmate is within a pre-specified number of days of her/his expected release date (*e.g.* the trigger – usually 6 months prior to release).
Content Examples	• Personal identifiers (*e.g.* name, DOB, SSN) • Expected release date • Discharge Plan
Information Flow	Correctional Facility (*information push*) ➔ Community-based Provider (*response*) ➔ Correctional Facility (*use*)
Data Source Examples	• The prison or jail's OMS provides the expected discharge date information that triggers the initiation of this process. Any existing discharge plans or needs assessments generated at intake may form the initial discharge plan that is then updated.

Assumptions	♦ Numerous basic assumptions apply to this information exchange (see Section 2.6). For example, Federal, state, and local privacy laws and policies govern the transmission of personal health information. As a prerequisite to any information exchange, the partners must determine which laws are applicable to them, and take the appropriate measures to ensure that the information exchange is permissible (*e.g.* obtain client consent as needed and/or enter into a data sharing agreement specifying the allowable disclosure of the information). ♦ Corrections, and all of the key service providers in the discharge planning process, are authorized to share a given inmate's information. Operationally, one of the providers would have to be designated as the coordinator for authoring the discharge plan and mediating any conflicts in the transition plans proposed by other providers.
Specific Challenge Notes	♦ None identified
Related Guidelines & Standards	♦ None identified
Implementation Notes	♦ This information exchange should be focused on only those service providers who are actively involved in reentry services for certain inmates. Providers may elect to "subscribe" to updates about their clients. A general broadcast of inmates' expected release dates to all community-based treatment providers in a certain area would *not* be useful and would be perceived as information overload.

4.2.20 Exchange Synopsis 20

Community-based providers receive health records of soon-to-be released inmates as part of reentry planning to facilitate continuity of care.

Context	A correctional clinician or discharge planner is referring a soon-to-be released inmate to a particular community-based provider for post-release services. Medical and behavioral health records are sent from the correctional facility to the community-based healthcare provider. This may be the full record or a treatment summary, as determined by the parties in the exchange. NOTE: Coordinated reentry planning—and, therefore, this information exchange—is most likely to occur in a prison setting because the predictability of release dates makes reentry planning feasible. This is also possible in a jail setting with sentenced inmates because they also have somewhat predictable release dates. By contrast, this information exchange is least likely in a jail or detention setting with pretrial detainees because the unpredictability of release dates (due to bail and other court decisions) makes coordinated discharge planning very difficult to implement; that being said, some detention facilities do engage in discharge planning for selected unsentenced special needs individuals (*e.g.* detainees with severe physical and behavioral health needs).
Triggers	♦ The correctional facility is preparing to release an inmate and a community-based provider has been identified to provide follow-up care post-release.
Content Examples	♦ Personal identifiers (*e.g.* name, DOB, SSN) ♦ Physical/medical health history ♦ Mental health history ♦ Substance abuse history ♦ Records of sick call requests NOTE: May encompass detailed or summary-level information – essentially any health information documented or generated during an incarceration.
Information Flow	Correctional Facility (*information push*) ➔ Community-based Healthcare Provider (*use*)
Data Source Examples	♦ Correctional Facility Medical Records
Assumptions	♦ Numerous basic assumptions apply to this information exchange (see Section 2.6). For example, Federal, state, and local privacy laws and policies govern the transmission of personal health information. As a prerequisite to any information exchange, the partners must determine which laws are applicable to them, and take the appropriate measures to ensure that the information exchange is permissible (*e.g.* obtain client consent as needed and/or enter into a data sharing agreement specifying the allowable disclosure of the information).
Specific Challenge Notes	♦ None identified
Related Guidelines & Standards	♦ None identified
Implementation Notes	♦ None identified

4.2.21 Exchange Synopsis 21

Community-based providers receive discharge summaries or health records of released inmates to ascertain treatment during incarceration and/or facilitate continuity of care.

Context	A healthcare provider in the community encounters a client who was recently incarcerated. The community healthcare provider submits a request to the detention or correctional facility to obtain healthcare records for the individual. The purpose is to facilitate continuity of care, potentially eliminate redundant assessments, and communicate the treatment provided during incarceration. Healthcare records are sent from the correctional facility to the community healthcare provider. This may be the full record or a treatment summary, as determined by the parties in the exchange. NOTE: This information exchange is equally applicable to detention facilities, jails, and prisons.
Triggers	♦ The community-based provider learns that a patient or client was recently incarcerated.
Content Examples	♦ Personal identifiers (*e.g.* name, DOB, SSN) ♦ Physical/medical health history ♦ Mental health history ♦ Substance abuse history ♦ Records of sick call requests. NOTE: May encompass detailed or summary-level information – essentially any health information documented or generated during an incarceration.
Information Flow	Community-based Healthcare Provider (*inquiry*) ➔ Correctional Facility (*response*) ➔ Community-based Healthcare Provider (*use*)
Data Source Examples	Correctional Facility Medical Records
Assumptions	♦ Numerous basic assumptions apply to this information exchange (see Section 2.6). For example, Federal, state, and local privacy laws and policies govern the transmission of personal health information. As a prerequisite to any information exchange, the partners must determine which laws are applicable to them, and take the appropriate measures to ensure that the information exchange is permissible (*e.g.* obtain client consent as needed and/or enter into a data sharing agreement specifying the allowable disclosure of the information).
Specific Challenge Notes	♦ None identified
Related Guidelines & Standards	♦ None identified
Implementation Notes	♦ None identified

4.2.22 Exchange Synopsis 22

Returning inmates receive copies of their correctional health records upon release as a means of both information transfer to community-based health providers and personal empowerment.

Context	Inmates may seek services from a wide array of community-based providers after release, who may or may not have been involved in reentry planning for the individual. Providing the inmate with his or her medical record or a health care summary (*e.g.* on a CD or flash drive) potentially informs and empowers the individual by giving her/him the means to convey medical history information to any future provider. In this scenario, the correctional facility's medical staff prepares a packet of information, copies it to a CD or flash drive (for example), and gives it to the inmate at release. NOTE: Although this is not a system-to-system information exchange, it is relevant to the goal of facilitating health care continuity. It is included within the scope of cross-domain information exchange because of the potential that an individual will give this information to his or her healthcare provider in the community.
Triggers	♦ Information is prepared when an inmate is nearing release and transferred to the inmate at release.
Content Examples	♦ Personal identifiers (*e.g.* name, DOB, SSN) ♦ Medical history ♦ Physical health, mental health, and substance abuse diagnoses ♦ Summary of treatment provided during incarceration, including prescription medications and dosage ♦ Discharge, transition or aftercare plans ♦ Records of sick call requests *Note*: Packet may encompass detailed or summary-level medical, mental health, or substance abuse assessment or treatment records – potentially any health information documented or generated during an incarceration.
Information Flow	Correctional Facility (*information push*) ➔ Inmate (*use*) ➔ "Future" Community-based Healthcare Provider (*use*)
Data Source Examples	♦ Correctional Facility Medical Records
Assumptions	♦ Numerous basic assumptions apply to this information exchange (see Section 2.6). For example, Federal, state, and local privacy laws and policies govern the transmission of personal health information. As a prerequisite to any information exchange, the partners must determine which laws are applicable to them, and take the appropriate measures to ensure that the information exchange is permissible (*e.g.* obtain client consent as needed and/or enter into a data sharing agreement specifying the allowable disclosure of the information. ♦ The success of this method of information transfer depends on the individual's ability to stay in possession of the information and to share it with community-based treatment providers when needed.
Specific Challenge Notes	♦ None identified

Related Guidelines & Standards	♦ None identified
Implementation Notes	♦ This information exchange has been implemented in New Jersey. ♦ A paper-based version of this information exchange takes place in Minnesota, where inmates are given a paper copy of their medical information at release.

4.2.23 Exchange Synopsis 23

Judges, defense attorneys, and/or prosecutors receive physical and behavioral health information to make decisions about pre-trial release and other alternatives to incarceration.

Context	Judges make pre-trial release and bail decisions when a defendant is formally charged at arraignment, which typically occurs 24-48 hours after arrest. Oftentimes, little to nothing is known about defendants' health status and health history at this time, even by their own defense attorneys if the attorney was just assigned to the case (*e.g.* a public defender who is assigned to cover all indigent defendants during a given arraignment shift). Having health information available at arraignment or a subsequent pre-trial hearing could prompt advocacy and decision-making about alternatives to pre-trial detention and conventional criminal case processing. These might include pre-trial release to a treatment program (*e.g.* requiring program attendance in lieu of bail) or referral to a specialized program (*e.g.* drug court or mental health court). In this scenario, a judge, defense attorney, or prosecutor's office requests an individual's health and treatment records information as part of the preparation for a court proceeding. The information is then shared between the judge, prosecutor, and defense attorney.
Triggers	♦ A defendant is scheduled for a pre-trial court hearing.
Content Examples	♦ Personal identifiers (*e.g.* name, DOB, SSN) ♦ Mental health diagnosis and history ♦ Medical diagnosis and history ♦ Substance abuse history ♦ Current treatment and providers
Information Flow	Judge, Prosecutor, or Defense Attorney (*inquiry*) ➔ Health Providers (*response*) ➔ Judge, Prosecutor, and Defense Attorney (*use*)
Data Source Examples	♦ Detention facility health system (NOTE: This information source is within the justice system.) ♦ A database of all publicly-funded mental and physical health clients in a given jurisdiction complete with mental health histories, medical histories, and treatment histories ♦ In the absence of a complete database, multiple databases for medical, mental health, and treatment providers, possibly accessed by court staff through a federated search[40]

[40] A *federated search* is an information retrieval technology that allows the simultaneous search of multiple searchable resources. A user makes a single query request that is distributed to the search engines participating in the federation. The federated search then aggregates the results that are received from the search engines for presentation to the user.

Assumptions	♦ Numerous basic assumptions apply to this information exchange (see Section 2.6). For example, Federal, state, and local privacy laws and policies govern the transmission of personal health information. As a prerequisite to any information exchange, the partners must determine which laws are applicable to them, and take the appropriate measures to ensure that the information exchange is permissible (*e.g.* obtain client consent as needed and/or enter into a data sharing agreement specifying the allowable disclosure of the information).
Specific Challenge Notes	♦ There are heightened privacy concerns in this information exchange because it involves disclosing a person's mental health or substance abuse status to prosecutors and judges involved in a case (presumably, there would be less concern over a defense attorney having access to such information to advocate for a client). Any implementation will need to determine the minimal amount of information needed that would allow prosecutors and judges, in particular, to appropriately respond to a case that comes before them.
Related Guidelines & Standards	♦ None identified
Implementation Notes	♦ None identified

4.2.24 Exchange Synopsis 24

Community-based programs receive information on the court conditions and offender restrictions to promote compliance among justice-involved clients.

Context	Individuals who are diverted to treatment from the criminal justice system are subject to certain criminal justice conditions. These may be routine conditions of supervision (*e.g.* a curfew or requirement to periodically check in at a supervision kiosk) or specific, special restrictions on a particular individual (*e.g.* a restraining order in a separate domestic violence case). Treatment providers who are aware of these conditions can help to promote compliance. Information on the full range of court restrictions helps community-based providers to prepare for the incoming individual, manage their caseload, and facilitate compliance with the court's restrictions. With this information, program activities can be structured or scheduled in such a way that clients can maintain compliance with court requirements. Alternately, information on court restrictions can help to identify logistical problems that may make a particular program unsuitable for a given client. Information on criminal justice conditions and restrictions can be sent to community-based providers at the time of client referral to the program. Subsequent updates would keep providers apprised of any new restrictions.
Triggers	♦ (1) Initial referral or placement in a community-based treatment program; and, (2) when new conditions or restriction are placed on the individual. ♦ Alternate: Upon request by the treatment provider or health-related diversion program.
Content Examples	♦ Personal identifiers (*e.g.* name, DOB, SSN) ♦ Court conditions, rulings and restrictions ♦ Protective Order information ♦ Restraining Order information
Information Flow	Court, Care Coordinator, or Supervision Officer (*information push*) ➔ Treatment Providers or Health-related Diversion Programs (*use*) Alternate: Treatment Providers or Health-related Diversion Programs (*inquiry*) ➔ Court, Care Coordinator, or Supervision Officer (*response*) ➔ Treatment Providers or Health-related Diversion Programs (*use*)
Data Source Examples	♦ Court Records System ♦ Pretrial, Probation, or Parole Supervision Database
Assumptions	♦ Numerous basic assumptions apply to this information exchange (see Section 2.6).
Specific Challenge Notes	♦ None identified
Related Guidelines & Standards	♦ None identified
Implementation Notes	♦ Initial implementation might focus on transmitting court conditions and restrictions at the time of program referral or placement. The capacity to transmit updated conditions for existing clients can be added later.

4.2.25 Exchange Synopsis 25

Pre-trial, court-based, and post-conviction supervision programs receive status updates from behavioral health treatment providers to support compliance monitoring (e.g. program attendance, treatment adherence).

Context	When courts mandate substance abuse or mental health treatment for a defendant, the individual must comply with treatment requirements or face sanctions, such as jail time. This can occur within different criminal justice contexts. • As a condition of pretrial release (*e.g.* in lieu of or in addition to bail) • As a condition of a diversion program such as a drug court or mental health court • As a condition of post-conviction probation or parole. Various criminal justice entities have responsibility for verifying client compliance, depending on the context in which treatment was mandated. For convenience, we use the term "criminal justice supervision agencies" to include pretrial services agencies, community-based case management agencies working with the court (*e.g.* TASC programs), probation agencies, and parole agencies. The criminal justice supervision agency needs information from community-based treatment programs to ensure that the individual is complying with court-mandated treatment (*e.g.* attending regularly, passing drug screenings, meeting other requirements involved in the treatment program). The criminal justice supervision agency may also request more qualitative or subjective information to gain a more holistic view and link the client to other services that may help in achieving positive outcomes (*e.g.* updates about a client's family or housing situation). Treatment providers may send any of the following to the supervision agency: • Confirmation of initial enrollment in the treatment program; or, alternately, failure to report to the treatment program. • Periodic status reports, which may include: attendance; drug testing results; medication compliance; client achievements; compliance with program rules; and, relevant updates regarding a client's employment, housing, financial situation, or family support. • Successful program completion. • Program termination for other reasons (*e.g.* stopped attending, disruptive behavior, failed to abide by program rules).
Triggers	• (1) Pre-designated stages; (2) based on new information/events/triggers; (3) at regular intervals; or, (4) at completion/cessation of program.
Content Examples	• Personal identifiers (*e.g.* name, DOB, SSN) • Initial intake and enrollment • Periodic status reports • Attendance • Drug test results • Compliance with program rules • Changes in employment, financial information, family support structure, or housing situation • (For completion/cessation) Date stopped, whether it was a successful or unsuccessful termination, and, if available, the client's current status

Information Flow	Treatment Providers (*information push*) ➔ Court/Criminal Justice Supervision Staff (*use*) Alternate: Court/Criminal Justice Supervision Staff (*inquiry*) ➔ Treatment Providers (*response*) ➔ Court/Criminal Justice Supervision Staff (*use*)
Data Source Examples	• Treatment provider record systems
Assumptions	• Numerous basic assumptions apply to this information exchange (see Section 2.6). For example, Federal, state, and local privacy laws and policies govern the transmission of personal health information. As a prerequisite to any information exchange, the partners must determine which laws are applicable to them, and take the appropriate measures to ensure that the information exchange is permissible (*e.g.* obtain client consent as needed and/or enter into a data sharing agreement specifying the allowable disclosure of the information). • Federal privacy laws permit the release of substance abuse treatment records in the context of court-mandated treatment. At the same time, specific procedures for obtaining client participation and cooperation (*e.g.* with representation by a defense attorney) should be developed in consultation with legal counsel.
Specific Challenge Notes	• There is a heightened privacy concern in this information exchange because information from treatment providers is being used within a criminal justice context. While the law permits this type of exchange, any implementation must determine the minimal amount of information needed for effective criminal justice monitoring. • Trust between treatment providers and criminal justice supervising agency is essential to the quality of information exchanged. It is helpful if treatment providers and the criminal justice supervision agency have a shared understanding of compliance and noncompliance, including similar expectations for the amount of relapse that is acceptable within the treatment process. Treatment providers may not fully communicate information to the criminal justice supervision agency if the justice system response to noncompliance is viewed as overly punitive. • Monitoring medication compliance is controversial—and, ethical issues must be addressed before clients and health providers agree to transmit this information as part of compliance monitoring. A patient's right to refuse medication must be balanced with the court's responsibility to monitor compliance.
Related Guidelines & Standards	• None identified
Implementation Notes	• This is currently being done in many courts and supervision programs through either oral or paper reports.

4.2.26 Exchange Synopsis 26

Pre-trial, court-based, or post-conviction supervision personnel receive drug testing results from treatment providers (or their laboratories) to support compliance monitoring.

Context	Persons under criminal justice supervision are typically required to remain sober or "clean." Routine or random drug and alcohol testing is conducted to monitor compliance with criminal justice requirements. Treatment facilities also test for drug and alcohol use to gauge treatment progress; and, the results of these tests may be useful to the courts to reduce redundant testing or supplement court-required testing. Drug test results are sent from the treatment providers (or the labs they utilize) to the criminal justice supervising agency. NOTE: This information exchange is a specific application of Exchange Synopsis 25.
Triggers	♦ Completion of a drug/alcohol test
Content Examples	♦ Personal identifiers (*e.g.* name, DOB, SSN) ♦ Drug test results
Information Flow	Treatment Providers (*information push*) ➔ Court Officers/Support Staff (*use*)
Data Source Examples	Treatment Provider record systems
Assumptions	♦ Numerous basic assumptions apply to this information exchange (see Section 2.6). For example, Federal, state, and local privacy laws and policies govern the transmission of personal health information. As a prerequisite to any information exchange, the partners must determine which laws are applicable to them, and take the appropriate measures to ensure that the information exchange is permissible (*e.g.* obtain client consent as needed and/or enter into a data sharing agreement specifying the allowable disclosure of the information). ♦ This exchange assumes that the pre-trial, court-based, or post-conviction supervision agency doesn't conduct its own drug testing.
Specific Challenge Notes	♦ Health care privacy laws generally permit this information exchange when substance abuse treatment is mandated by the criminal justice system. Client consent procedures may still be required. It may be sufficient if clients agreed to the court-ordered treatment under consultation with their defense attorneys.
Related Guidelines & Standards	♦ None identified
Implementation Notes	♦ This is currently being done in many courts and supervision programs through paper reports.

4.2.27 Exchange Synopsis 27

Treatment providers receive client updates and compliance information from criminal justice supervision agencies to support the treatment process.

Context	Updates from criminal justice supervision agencies can be helpful to treatment providers to: (1) supplement their knowledge about clients; (2) alert providers to possible relapse; and, (3) inform providers when supervision has ended. All of these allow treatment providers to gain a more holistic understanding of their clients, which enables them to more effectively interact with clients. • In the course of regular interactions with or regarding an individual, probation and parole officers may become aware of client life circumstances that would provide treatment providers with more complete knowledge about the individual. Examples include changes in employment, income, family support, or housing. This information may alter the individual's eligibility for programs and/or the provider's treatment plan. • Compliance with criminal justice supervision can serve as an indicator of treatment success or failure. Missed appointments may signal relapse risk (among substance abusers) or that the current treatment regimen is not effectively controlling symptoms (in the case of mental health treatment). • An offender's drug test results when administered by the supervision authority. • Knowledge of when the criminal justice supervision term ends is also useful to treatment providers, as clients may be less motivated to comply with treatment once the risk of criminal justice sanctioning has passed.
Triggers	• Upon receiving updated information and/or on a predetermined frequency (*e.g.* daily or weekly)
Content Examples	• Personal identifiers (*e.g.* name, DOB, SSN) • Periodic status reports • Attendance records • Drug or alcohol testing results • Changes in employment, financial information, family support structure, or housing situation • For supervision termination include date ended, and, if available, the client's current status
Information Flow	Probation/Parole Officers (*information push*) ➔ Treatment Providers (*use*)
Data Source Examples	• Criminal justice supervision agency records, including case notes • Electronic monitoring compliance information (*e.g.* if client wears an ankle bracelet to track his or her movements) • Kiosk check-in information (*e.g.* if the supervision agency utilizes automated kiosks)

Assumptions	♦ Numerous basic assumptions apply to this information exchange (see Section 2.6). For example, Federal, state, and local privacy laws and policies govern the transmission of personal health information. As a prerequisite to any information exchange, the partners must determine which laws are applicable to them, and take the appropriate measures to ensure that the information exchange is permissible (*e.g.* obtain client consent as needed and/or enter into a data sharing agreement specifying the allowable disclosure of the information). ♦ Health privacy laws may not apply to the transmission of information generated by the criminal justice system, including drug testing results, but it is prudent to confirm any other confidentiality requirements in consultation with legal counsel.
Specific Challenge Notes	♦ None identified
Related Guidelines & Standards	♦ None identified
Implementation Notes	♦ Alternative Implementation: A shared database could be created that both the treatment providers and criminal justice supervision officers update. A particularly desirable capability would be a system that sends alerts or notifications when client information is updated, or when there has been notable change in client compliance or status.

4.2.28 Exchange Synopsis 28

Treatment providers receive notification of upcoming court dates to promote client compliance with court appearances.

Context	Individuals in court-mandated treatment must periodically appear in court for status hearings. They may also have court dates unrelated to the current case under supervision. Notification from the courts to the client and treatment provider may promote compliance with court appearances. If needed, the provider can make the appropriate modifications to the individual's schedule or treatment plan. This may help to reduce the number of warrants or re-incarcerations for failure to appear.
Triggers	Court dates are set or updated for a client in either the current or a separate case.
Content Examples	♦ Personal identifiers (*e.g.* name, DOB, SSN) ♦ New court dates ♦ Changes in court dates
Information Flow	Court Support Staff (*information push*) ➔ Treatment Providers (*use*)
Data Source Examples	♦ Court calendaring system
Assumptions	♦ Numerous basic assumptions apply to this information exchange (see Section 2.6).
Specific Challenge Notes	♦ Court dates are likely to be public information, but there may be exceptions when this information is protected (*e.g.* if the defendant is a juvenile).
Related Guidelines & Standards	♦ None identified
Implementation Notes	♦ None identified

4.2.29 Exchange Synopsis 29

Criminal justice supervision agencies receive information from health providers to provide context for client behavior and promote alternative responses to noncompliance (rather than revocation and incarceration).

Context	There may be underlying health reasons when individuals under criminal justice supervision (pre-trial, court-based, probation, or parole) behave in a way that would elicit a criminal justice sanction (*e.g.* missing appointments or failing to seek employment). For example, a change in medication could result in adverse side effects like increased forgetfulness or confusion that interfere with maintaining criminal justice supervision requirements. Therefore, health status information may assist in putting the behavior in context and, if appropriate, prompt supervision officers to seek non-punitive solutions. Staff from the supervising agency or program—aware that an individual's medical, mental health, or substance abuse problems could negatively impact behavior—request an update from the community healthcare or treatment provider when the individual fails to comply with supervision requirements. Alternate: Community healthcare and treatment providers may proactively inform staff from the criminal justice supervising agency when they have reason to believe that a treatment issue (*e.g.* change in medication) may negatively impact the individual's behavior from a supervision perspective.
Triggers	• Staff from the supervising agency or program observe noncompliance or other behaviors that may be explained by health issues. • Alternate: Healthcare providers observe or expect that a change in the individual's health situation may negatively impact behavior and compliance with criminal justice supervision.
Content Examples	• Personal identifiers (*e.g.* name, DOB, SSN) • Current health status, recently observed changes, and how it may impact behavior (*e.g.* adjusting to a new medication regime, or that a client's health has deteriorated)
Information Flow	Community Corrections (*inquiry*) ➔ Community Healthcare Providers (*response*) ➔ Community Corrections (*use*) Alternate: Community Healthcare Providers (*information push*) ➔ Community Corrections (*use*)
Data Source Examples	• Community healthcare databases
Assumptions	• Numerous basic assumptions apply to this information exchange (see Section 2.6). For example, Federal, state, and local privacy laws and policies govern the transmission of personal health information. As a prerequisite to any information exchange, the partners must determine which laws are applicable to them, and take the appropriate measures to ensure that the information exchange is permissible (*e.g.* obtain client consent as needed and/or enter into a data sharing agreement specifying the allowable disclosure of the information). • Community healthcare providers can help identify underlying issues that may explain a behavior. • There are alternative measures or sanctions that can be employed in reaction to particular behaviors when viewed as health issues.

Specific Challenge Notes	♦ There are heightened privacy concerns in this information exchange because it involves an information transfer from health providers to non-clinical criminal justice personnel who are in a position to sanction the client. Any implementation will need to determine the minimal amount of information needed that would allow probation or parole officers to appropriately respond to the situation. For example, the report from a health provider could indicate that a change in treatment was the likely reason for noncompliance without providing any detail on the nature of the treatment, medication, or diagnosis. Client consent may be needed for this information exchange, particularly if the provider is a mental health or substance abuse treatment provider. ♦ Health providers may be reluctant to share information with probation or parole officers. Doing so may erode trust if clients perceive the provider as an extension of criminal justice supervision. This, in turn, would compromise the quality of care.
Related Guidelines & Standards	♦ None identified
Implementation Notes	♦ This information may be verbally exchanged as needed in the context of specialized programs, like mental health court.

4.2.30 Exchange Synopsis 30

Courts, criminal justice supervision programs, and/or reentry planning personnel receive information about community-based programs' eligibility criteria, service fees, and program capacity in order to link individuals to programs.

Context	When considering alternatives to incarceration, criminal justice agencies (*e.g.* pre-trial services, courts, probation, and parole) need to know what treatment is locally available, and the capacities and eligibility requirements of such providers. Program fees and insurance requirements are additional factors to be considered when making a treatment referral. Currently, courts and other criminal justice entities are not necessarily aware of this information when making rulings regarding the individual. This information would also be valuable for reentry decisions. One implementation methodology would be for the local treatment providers to create a repository or database of this information and regularly update it on a periodic (*e.g.* daily or weekly) basis. This would provide an effective line of communication between the criminal justice system and treatment providers to ensure quick access to necessary information before a decision is made regarding treatment.
Triggers	• A defendant or offender is being considered for referral to a treatment program (*e.g.* as a diversion from conventional criminal case processing).
Content Examples	• Program information and services • Current capacity • Eligibility requirements • Insurance plan/provider compatibility
Information Flow	Community-based Treatment Programs (*information push*) ➔ Court, Criminal Justice Supervision, and/or Reentry Planning Personnel (*use*)
Data Source Examples	• Treatment program management records
Assumptions	• Numerous basic assumptions apply to this information exchange (see Section 2.6). For example, Federal, state, and local privacy laws and policies govern the transmission of personal health information. As a prerequisite to any information exchange, the partners must determine which laws are applicable to them, and take the appropriate measures to ensure that the information exchange is permissible (*e.g.* obtain client consent as needed and/or enter into a data sharing agreement specifying the allowable disclosure of the information). • Judge has time prior to ruling to consider options in terms of treatment facilities. • Different treatment facility options are available (assuming the court has decided treatment is the best option). • Treatment facilities can keep their information current. • The court (or other criminal justice system personnel) can access treatment facility information in a timely manner.

Specific Challenge Notes	♦ Program level information about treatment capacity and eligibility requirements is not confidential; however, confidential information may subsequently be exchanged when criminal justice agency personnel are in the process of making referrals or arranging treatment placements for clients. Consent procedures may need to be established to search for a treatment placement. It may be sufficient if defendants agree in consultation with their defense attorneys.
Related Guidelines & Standards	♦ None identified
Implementation Notes	♦ Methods to share information about program capacity have been developed among homeless service providers. These may be adapted to this context.

4.2.31 Exchange Synopsis 31

Community-based service providers receive information on criminal charges and criminal justice risk assessments to assess defendants' eligibility or suitability for their programs.

Context	Community-based programs (*e.g.* behavioral health) often use information on violence risk, criminal charge, and recidivism risk as part of their program eligibility criteria for initial acceptance into a program, and for ongoing, periodic reassessments of eligibility. Some programs, for example, do not work with violent offenders. Criminal justice staff in multiple roles (pretrial supervision, court-based programs, reentry planning, probation, and parole) send risk assessment information to community-based programs at the time of program referral. Additionally, criminal justice staff send any changes or relevant updates when they occur.
Triggers	♦ Upon referral to a community-based program ♦ Update is sent if charges or other pertinent information changes or is updated
Content Examples	♦ Personal identifiers (*e.g.* name, DOB, SSN) ♦ Violence risk assessment ♦ Recidivism risk assessment ♦ Criminal charges
Information Flow	Criminal Justice Staff (*information push*) ➔ Community-based Programs (*use*)
Data Source Examples	♦ Intake assessments ♦ Charging documents ♦ Court records management systems ♦ Pre-sentence investigation reports
Assumptions	♦ Numerous basic assumptions apply to this information exchange (see Section 2.6).
Specific Challenge Notes	♦ While this information may be contained in PSIs, the reports themselves may be legally protected, in part because they may contain information about juvenile adjudications. Information may need to be extracted from the PSI if full PSIs cannot be shared.
Related Guidelines & Standards	♦ None identified
Implementation Notes	♦ None identified

4.2.32 Exchange Synopsis 32

Community-based providers receive information from assessments conducted in support of the criminal justice process (e.g. pre-sentence investigation reports or PSIs) to supplement their intake processes and prepare for justice-referred clients.

Context	Many courts, pretrial services, jail, prison, probation, or parole entities conduct risk assessments and compile background information on defendants, including assessments of violence risk and recidivism risk. Specialized or problem-solving courts (like drug courts and mental health courts) may additionally conduct psychosocial and clinical assessments to evaluate program eligibility. These assessments may be shared with community-based treatment providers when considering alternatives to incarceration. In addition to the gains in efficiency—because the treatment providers may be able to review and modify recent assessments instead of conducting a new assessment—the receipt of these assessments helps treatment providers to: • Decide whether to accept a court referral; • Prepare for client intake; • Determine the treatment approach; and, • Manage the individual once accepted. Court-based staff (including a case management agency working in collaboration with the court) may initiate this information exchange in the initial stages of securing a treatment placement or at the time of client referral to a treatment provider. Alternately, the treatment provider may request assessment information upon enrollment of the individual. NOTE: This scenario is specific to courts, but similar information exchanges could also take place using assessments conducted in other stages of justice processing. Intake assessments conducted in pretrial, probation, correctional, or parole settings can similarly inform community-based treatment providers.
Triggers	• Completion of a court assessment and referral of an individual to a treatment program
Content Examples	• Personal identifiers (*e.g.* name, DOB, SSN) • Date of the assessment – to evaluate the timeliness of the information • Assessment information (*e.g.* violence risk scores, recidivism risk, psychosocial assessment, addiction screening results, psychiatric assessment) • PSI, or portion thereof
Information Flow	Court Officers/Support Staff (*information push*) ➔ Treatment Provider or Health-related Diversion Programs (*use*) Alternative: Treatment Provider or Health-related Diversion Programs (*inquiry*) ➔ Court Officers/Support Staff (*response*) ➔ Treatment Provider or Health-related Diversion Programs (*use*)
Data Source Examples	• Court records system • PSI reports database

Assumptions	• Numerous basic assumptions apply to this information exchange (see Section 2.6). For example, Federal, state, and local privacy laws and policies govern the transmission of personal health information. As a prerequisite to any information exchange, the partners must determine which laws are applicable to them, and take the appropriate measures to ensure that the information exchange is permissible (*e.g.* obtain client consent as needed and/or enter into a data sharing agreement specifying the allowable disclosure of the information). • While *HIPAA* privacy restrictions typically do not extend to courts (since they are not health providers), other consent requirements may exist or need to be developed. It may be sufficient if individuals agree to the sharing of this information in consultation with their defense attorneys, or for defendants to waive their privacy rights. • The court must complete an assessment (*e.g.* a PSI) on the individual, or have access to such an assessment.
Specific Challenge Notes	• Courts may be resistant to sharing PSIs because some of the information is protected. For example, a PSI may include information on juvenile adjudications. Implementation of this information exchange should consider excepting only the minimum needed information for sharing with a treatment provider.
Related Guidelines & Standards	• None identified
Implementation Notes	• A similar type of information exchange has been implemented in Minnesota, where information from PSIs is shared with social service providers in the community. This is a program funded through the *Second Chance Act*[41]. • This type of information sharing is more likely to occur in the context of a problem-solving court, where all parties (the judge, prosecutor, defense attorney, and clinical treatment provider) are committed to a shared goal of addressing the defendant's underlying behavioral health problems. The level of trust needed for this information exchange may not exist in a conventional court. • Depending on how the information is exchanged, it may be possible for the treatment provider to add to the assessment information through their own assessments, thus creating a richer assessment profile of the individual that may be useful to criminal justice and/or treatment personnel at a later time.

[41] For additional information on the *Second Chance Act*, visit: https://www.bja.gov/ProgramDetails.aspx?Program_ID=90

4.2.33 Exchange Synopsis 33

Court personnel receive health information from community-based providers to aid in the writing of pre-sentence investigation reports (PSIs).

Context	PSIs are compiled to help judges make sentencing decisions, including consideration of treatment placement as an alternative to incarceration. A significant portion of the PSI describes defendants' backgrounds, needs, and treatment history. PSIs may further indicate how successful or not past treatment approaches have been. Records from community-based treatment providers may be a valuable source of information for writing the PSI. This informs judges about treatment needs and past experiences in treatment programs and may promote successful outcomes by suggesting approaches to either try or to be avoided. Depending on the jurisdiction, PSIs may be written by pre-trial services officers, probation officers, or, in rarer instances, by prosecutors or defense attorneys. NOTE: While these individuals would request the information from treatment providers for the purpose of writing the PSI, judges are the end users of the information.
Triggers	♦ A pre-sentence investigation report is needed for an offender
Content Examples	♦ Personal identifiers (*e.g.* name, DOB, SSN) ♦ Treatment history (content may vary based on implementation and jurisdiction) ♦ Health-related diversion program history (content may vary based on implementation and jurisdiction)
Information Flow	Pre-trial Services or Probation Department (*inquiry*) ➔ Treatment Providers and Health-related Diversion Programs (*response*) ➔ Pre-trial Services of Probation Department (*use*)
Data Source Examples	♦ Treatment providers record systems ♦ Health-related diversion programs record systems
Assumptions	♦ Numerous basic assumptions apply to this information exchange (see Section 2.6). For example, Federal, state, and local privacy laws and policies govern the transmission of personal health information. As a prerequisite to any information exchange, the partners must determine which laws are applicable to them, and take the appropriate measures to ensure that the information exchange is permissible (*e.g.* obtain client consent as needed and/or enter into a data sharing agreement specifying the allowable disclosure of the information).
Specific Challenge Notes	♦ There are heightened privacy concerns in this information exchange because it involves disclosing a person's mental health or substance abuse status and treatment history to the courts for the purpose of sentencing. Any implementation will need to determine the minimal amount of information needed. Client consent procedures will likely need to be developed for this purpose.
Related Guidelines & Standards	♦ None identified
Implementation Notes	♦ None identified

4.2.34 Exchange Synopsis 34

Community-based providers receive inmates' expected release dates to coordinate reentry planning.

Context	Reentry plans for a particular inmate may be co-developed by correctional and community-based program staff, and plans are finalized in the 30-90 days before release. Correctional and community-based staff confer and prioritize their work around expected release dates, but a key challenge is that expected release dates may shift due to amended good-time calculations and/or parole decision-making. In this information exchange, correctional facilities would first need to periodically (*e.g.* daily, weekly or monthly) generate a list of inmates whose release dates have changed. The list would include the updated and original expected release dates, and flag inmates who are to be released sooner than originally anticipated. The list would then be shared with all correctional and community-based program staff involved in discharge planning. NOTE: Coordinated reentry planning—and, therefore, this information exchange—are most likely to occur in a prison setting because the predictability of release dates makes reentry planning feasible. This is also possible in a jail setting with sentenced inmates because they also have somewhat predictable release dates. By contrast, this information exchange is least likely in a jail or detention setting with pretrial detainees because the unpredictability of release dates (due to bail and other court decisions) makes coordinated discharge planning very difficult to implement; it is unlikely that detention facilities would even populate a field for expected release date for unsentenced detainees.
Triggers	• An inmate's expected release date changes, or the inmate's release date is within the timeframe to be included for release planning.
Content Examples	• Personal identifiers (*e.g.* name, DOB, SSN) • Expected release dates (original and updated) • Indicator of whether the expected release date is now sooner/later than originally anticipated
Information Flow	Correctional Facility (*information push*) ➔ Community-based Provider (*use*)
Data Source Examples	The prison or jail's OMS
Assumptions	• Numerous basic assumptions apply to this information exchange (see Section 2.6). For example, Federal, state, and local privacy laws and policies govern the transmission of personal health information. As a prerequisite to any information exchange, the partners must determine which laws are applicable to them, and take the appropriate measures to ensure that the information exchange is permissible (*e.g.* obtain client consent as needed and/or enter into a data sharing agreement specifying the allowable disclosure of the information). • Corrections has the authority to share expected release dates with all of the key service providers in the discharge planning process, assuming such a collaborative process occurs.
Specific Challenge Notes	• None identified
Related Guidelines & Standards	• None identified

Implementation Notes	♦ This information exchange should be focused on only those service providers who are actively involved in reentry planning for certain inmates. Providers may elect to "subscribe" to updates about their clients' expected release dates. A general broadcast of inmates' expected release dates to all community-based treatment providers in a given area would not be useful and would be perceived as information overload.

5 IMPLEMENTATION SCENARIOS

To visualize how a set of information exchanges may be used together to address current issues important to both criminal justice and health, two "implementation scenarios" were chosen:

1) Reentry into the Community after Incarceration; and,
2) Community-based Treatment with Effective Criminal Justice Supervision.

These scenarios were chosen not only for the significant connection to both domains, but also due to the potential to directly benefit their target populations, simplify stakeholder efforts, increase efficiency, and reduce costs.

These scenarios are not intended to provide a comprehensive, detailed business case, but rather to allow the reader to visualize, at a high level, how the information sharing exchanges can work together to benefit our communities.

> An actual implementation of the information exchanges identified in this document, or even an implementation scenario for that matter, would require participating criminal justice and health practitioners to vet the exchanges to be used and to reach consensus regarding exchange content, flow, users, security and privacy characteristics within the context of a specific jurisdiction because of the variability in practice from place to place.
>
> The scenarios that follow are for instructional use only.

5.1 Reentry into the Community after Incarceration

5.1.1 Issue

Although a presumption is made that criminal justice and health practitioners reading this report are familiar with the issues and impact of offender reentry, the following extract from the *Reentry In Brief* by the Federal Interagency Reentry Council in May 2011[42] is provided as an overview of the issue for criminal justice and health:

> *Each year, more than 700,000 individuals are released from state and Federal prisons. Another 9 million cycle through local jails. When reentry fails, the costs—both societal and economic—are high. Statistics indicate that more than two-thirds of state prisoners are rearrested within 3 years of their release and half are reincarcerated. High rates of recidivism mean more crime, more victims and more pressure on an already overburdened criminal justice system. The costs of imprisonment and jail also wreak havoc on state and municipal budgets. In the past 20 years state, spending on corrections has grown at a faster rate than nearly any other state budget item. The U.S.*

[42] Federal Interagency Reentry Council (2011). *Reentry In Brief*. Retrieved from: http://www.nationalreentryresourcecenter.org/documents/0000/1059/Reentry_Brief.pdf

> *now spends more than $68 billion on Federal, state and local corrections. Because reentry intersects with issues such as health and housing, education and employment, family, faith, and community well-being, many Federal agencies are focusing on the reentry population with initiatives that aim to improve outcomes in each of these areas.*
>
> ***Reentry is a public safety issue**. Nearly 2.3 million people are incarcerated in Federal, state and local prisons at any given time. More than 95 percent of these individuals will be released back to their home communities. Failure on probation and parole is a key driver of prison admissions in many states; parole failure alone accounts for about one-third of new prison admissions each year. With the high rates of recidivism noted above, evidence-based reentry strategies provide a major opportunity to increase public safety and reduce victimization.*
>
> ***Reentry is a public health issue**. Individuals released from prisons and jails represent a substantial share of the U.S. population carrying communicable diseases, accounting for nearly a quarter of the general population living with HIV or AIDS, almost a third of those with hepatitis C, and nearly 40 percent of people with tuberculosis. Appropriate interventions – especially upon return to the community – present a significant public health opportunity.*

Not only is reentry a major issue within criminal justice and health domains, but as Attorney General Eric Holder said, "Reentry provides a major opportunity to reduce recidivism, save taxpayer dollars, and make our communities safer."[43]

In this Implementation Scenario, a combination of five Exchange Synopses is used to address reentry in a complete fashion.

5.1.2 Implementation Scenario Overview

In this scenario, we use the following example of a prisoner reentry process:

5.1.2.1 Current Status

Prisoner "John Doe" is a 45-year-old male who was convicted of an armed robbery and is expected to be granted parole in 60 days. He is currently incarcerated in the State Prison. Doe has advanced HIV disease.

5.1.2.2 Plan

Doe's reentry plan calls for him to move to a residential care facility for chronically ill persons. The Sunset House facility was identified as the residential care facility Doe will be moving to.

> NOTE: Although this scenario only contains one treatment provider for simplification purposes, multiple treatment providers could be used.

[43] Holder, Eric, Attorney General (2011). "Attorney General Eric Holder Convenes Inaugural Cabinet-Level Reentry Council." Department of Justice Press Release. Inaugural Cabinet-Level Reentry Council meeting, January 5, 2011. Retrieved from: http://www.justice.gov/opa/pr/2011/January/11-ag-010.html

5.1.2.3 Event

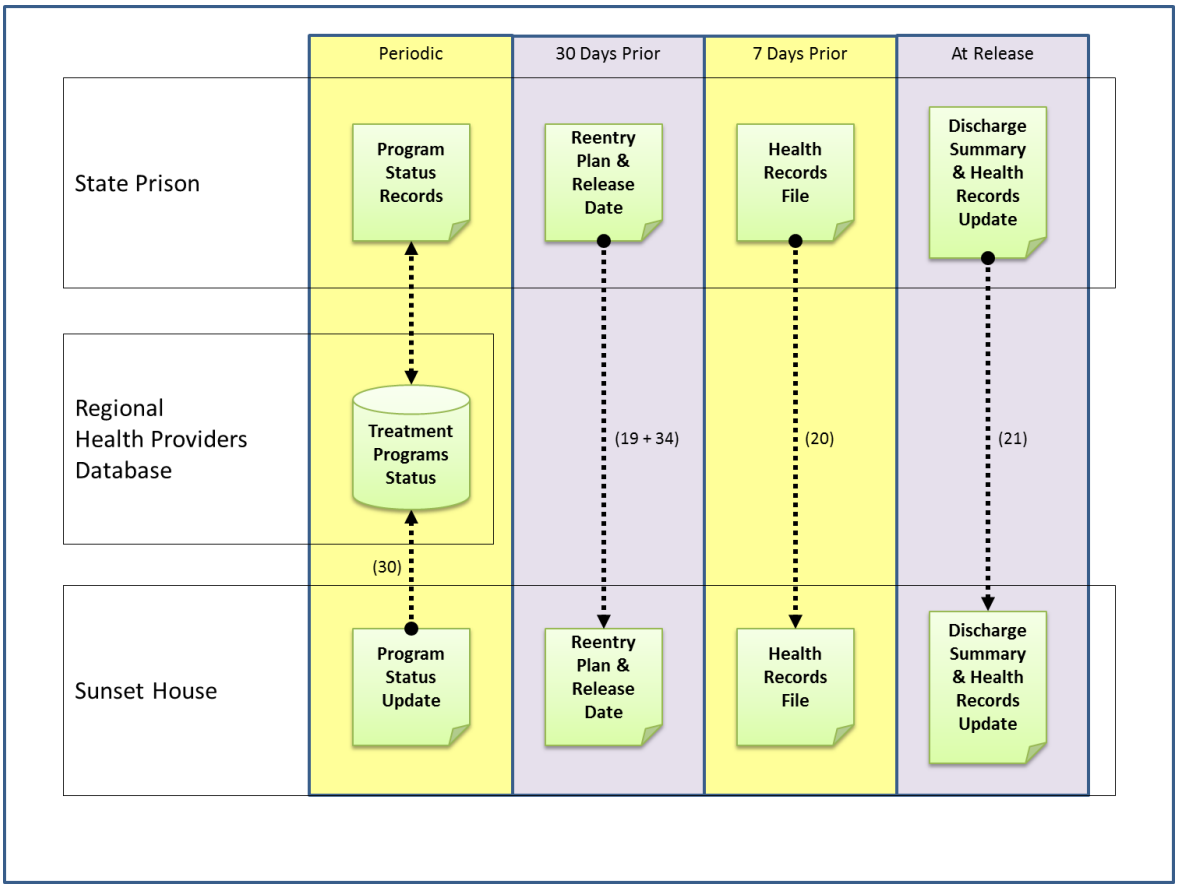
This scenario uses multiple information sharing exchanges, working in concert, to assist the reentry process and, theoretically, increase the health of persons in transition, reduce recidivism, lower costs to our communities, and benefit both health and justice domains. The table below depicts scenario events along with the information eXchange synopsis used to support the event.

TABLE 5. SCENARIO EVENTS AND EXCHANGE SYNOPSES USED: REENTRY INTO THE COMMUNITY AFTER INCARCERATION

SCENARIO EVENT	EXCHANGE SYNOPSIS USED
• To assist in the reentry plan creation, treatment providers pro-actively supply their programs' eligibility criteria, service fees, and program capacity to supervision programs and/or reentry planning personnel via a Regional Health Provider Database. • Reentry staff identify the Sunset House as having the capacity to accept John Doe at the time of his expected release. • Reentry staff make a referral to the Sunset House and contact the Sunset House to secure a treatment placement.	#30 – "Courts, criminal justice supervision programs, and/or reentry planning personnel receive information about community-based programs' eligibility criteria, service fees, and program capacity in order to link individuals to programs."
30 Days Prior to Release • Reentry planning personnel at State Prison provide Sunset House with Doe's expected release dates.	#34 – "Community-based providers receive inmates' expected release dates to coordinate reentry planning."
30 Days Prior to Release • Reentry planning personnel at State Prison provide Sunset House with Doe's reentry plan.	#19 – "Community-based service providers receive reentry plans from correctional discharge planners to coordinate reentry planning."
7 Days Prior to Release • Reentry planning personnel obtain a signed Release of Information (ROI) from John Doe and provide Sunset House with the latest health records for John Doe.	#20 – "Community-based providers receive health records of soon-to-be released inmates as part of reentry planning to facilitate continuity of care."
At Release • Reentry planning personnel at State Prison provide Sunset House with the John Doe's discharge summary and latest health updates.	#21 – "Community-based providers receive discharge summaries or health records of released inmates to ascertain treatment during incarceration and/or facilitate continuity of care."

The Business Process Modeling Notation (BPMN) diagram below shows the entire scenario at a high level, with a focus on the information exchanges.

FIGURE 2.BPMN DIAGRAM: REENTRY INTO THE COMMUNITY AFTER INCARCERATION SCENARIO



5.1.2.4 Scenario Information

Offender	John Doe
DOB	10-22-1968
Sex	M
SSN	123-45-6789
Charges	Armed Robbery
State ID	1234567890
Prison Facility	State Prison 123 Corrections Rd., Batesville, AZ 85001
Reentry POC	Officer William 602-555-1111 william@stateprison.gov
Residential Facility	Sunset House 222 W. Scotts Rd., Gammons, AZ 85002
Manager	Mark Manager 602-555-2222 mark@sunset.org

All names, locations, agencies, organizations, etc. in these scenarios are fictitious and used for illustration purposes only.

5.1.3 High-Level Timeline and Information Flows

NOTE: These are appropriate for illustrative purposes.

1) ***45 Days Prior to Release***—On a periodic basis, health providers in the Region automatically upload their availability to a regional health providers database, which is available to Department of Corrections (DOC) reentry staff statewide. When planning for John Doe's reentry, the reentry planning personnel at State Prison check the Regional Health Providers Database for available treatment providers in Gammons (the locale that Doe will be moving to in this example). In this case, reentry staff select the Sunset House, based on their availability, criteria, and fees, to continue Doe's treatment. Once selected, reentry staff makes a treatment referral, reentry staff confirms the pending placement with Sunset House, and the Reentry Plan is updated. As part of the reentry planning process, reentry staff obtain Doe's consent to share his health information (including prison case management records to include medical, mental health and relevant substance abuse treatment assessments, and services received while incarcerated) with Sunset House.

    a) A service specification[44] (see glossary for more information) built for Exchange Synopsis 30 was used by Sunset House's system to automatically upload their information on a daily basis.

    b) The figure below illustrates the process for a requesting program status.

[44] See Appendix E for additional information.

FIGURE 3. BPMN DIAGRAM: REQUESTING PROGRAM STATUS

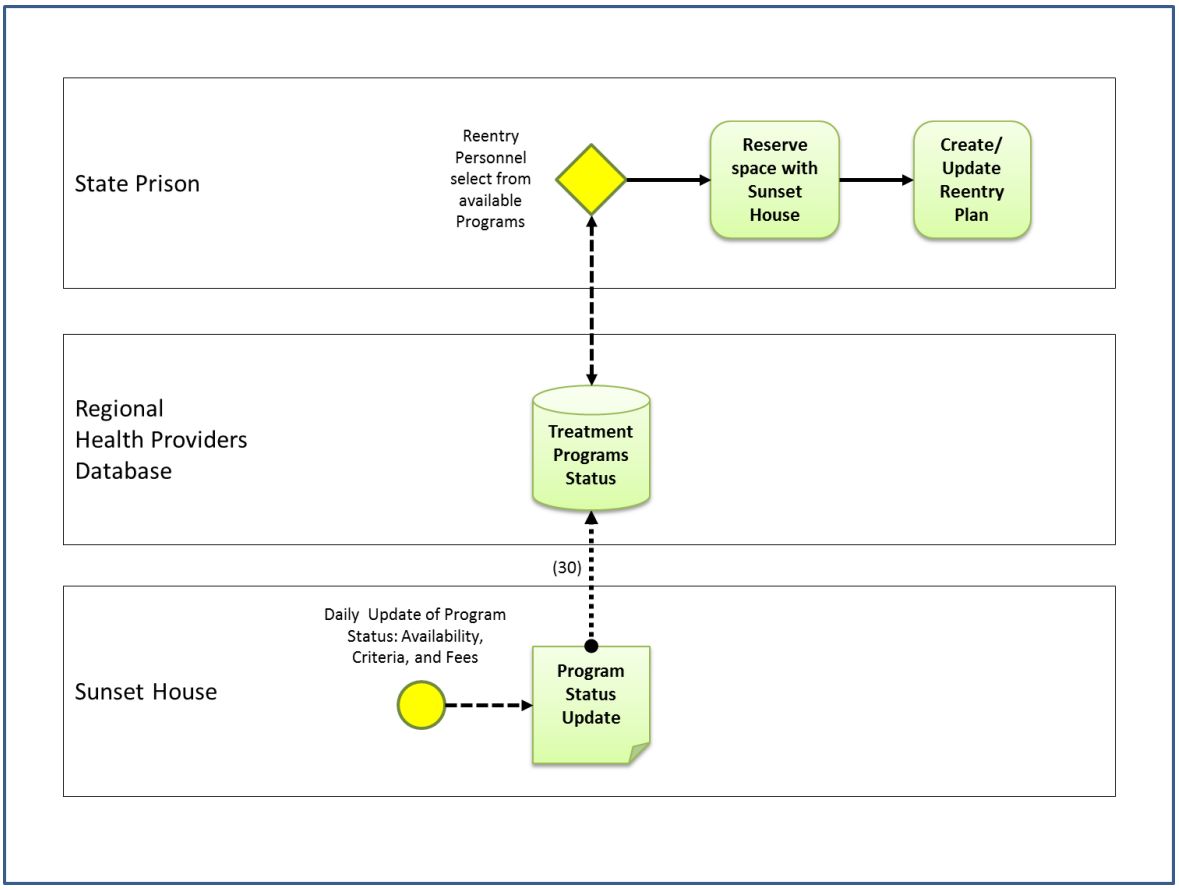


TABLE 6. EXCHANGE CONTENT SAMPLE: REQUESTING PROGRAM STATUS

DATA CATEGORY	DATA ELEMENT	SAMPLE DATA
Message Information	Message Type	Health Treatment Program Status Update
	Current Date	01-01-2013
To Agency	Agency Name	Regional Health Providers Database
From Agency	Agency Name	Sunset House
	Agency Street	222 W. Scotts Road
	Agency City	Gammons
	Agency State	Arizona
	Agency Zip	85002
	POC Name	Mark Manager
	POC Phone	602-555-2222
	POC Email	mark@sunset.org
Target Information	Current Openings	4
	Est. Openings in 1 week	4
	Est. Openings in 2 week	5
	Est. Openings in 3 week	5
	Est. Openings in 4 week	5
	Est. Openings in 5 week	5
	Est. Openings in 6 week	5
	Est. Openings in 7 week	5

DATA CATEGORY	DATA ELEMENT	SAMPLE DATA
	Est. Openings in 8 week	5
	Eligibility criteria	eligibility criteria (text field or attachment depending on implementation)
	Service fees	service fees (text field or attachment depending on implementation)
	Notes	other notes (text field or attachment depending on implementation)

2) ***30 Days Prior to Release***—State Prison reentry planning personnel finalize the Reentry Plan and electronically provide a copy to the appropriate providers – Sunset House in this case. Additionally, since the release date is solidifying, the expected release date is also provided.

   a) A service specification built for a combination of Exchange Synopsis 19 and Exchange Synopsis 34 was used by the State Prison Reentry personnel's system to send the information to Sunset House.

NOTE: Exchange Synopses #19 and #34 could be implemented separately as well, but in this implementation, they are combined.

   b) The figure below illustrates the process for sharing an expected release date notification and a Reentry Plan.

FIGURE 4. BPMN DIAGRAM: SHARING AN EXPECTED RELEASE DATE NOTIFICATION AND A REENTRY PLAN

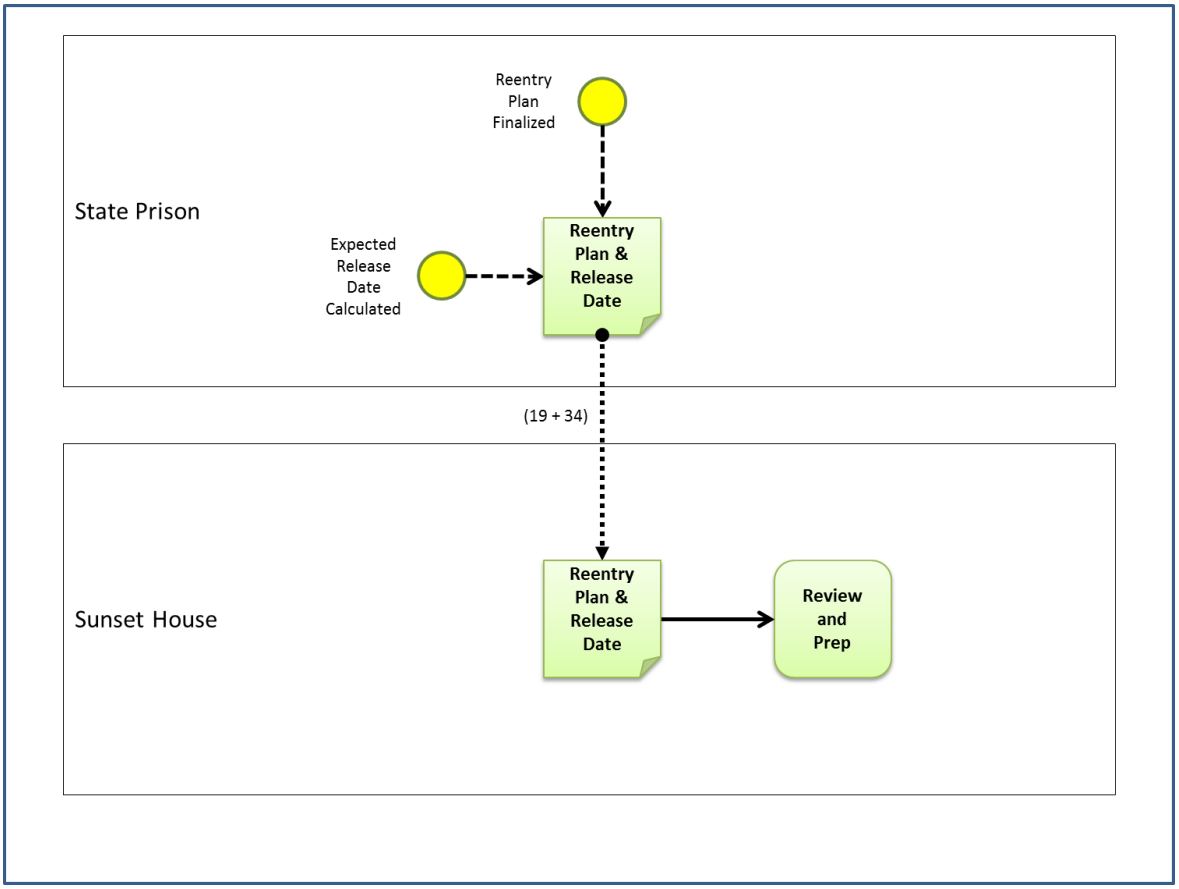


TABLE 7. EXCHANGE CONTENT SAMPLE: SHARING AN EXPECTED RELEASE DATE NOTIFICATION AND A REENTRY PLAN

DATA CATEGORY	DATA ELEMENT	SAMPLE DATA
Message Information	Message Type	Reentry Plan & Expected Release Date
	Current Date	01-15-2013
To Agency	Agency Name	Sunset House
	POC Name	Mark Manager
	POC Phone	602-555-2222
	POC Email	mark@sunset.org
From Agency	Agency Name	State Prison
	Agency Street	123 Corrections Road
	Agency City	Batesville
	Agency State	Arizona
	Agency Zip	85001
	POC Name	Officer William
	POC Phone	602-555-1111
	POC Email	william@stateprison.gov
Person Information	Offender Name	John Doe
	Offender DOB	10-22-1968
	Offender Sex	M
	Offender SSN	123-45-6789
	Offender Charges	Armed Robbery
	Offender State ID	1234567890
Target Information	Expected Release Date	02-15-2013
	Reentry Plan	Reentry plan including substance abuse info and treatment to date (text field or attachment depending on implementation)

3) ***7 Days Prior to Release***—State Prison reentry planning personnel electronically send John Doe's health records (the prison's complete health file) to the Sunset House. (In this case, consent had been given by Doe during the reentry planning process.)

   a) A service specification built for Exchange Synopsis 20 was used by the State Prison Reentry personnel's system to send the information to the Sunset House.

   b) The figure below illustrates the process for sharing health records.

FIGURE 5. BPMN DIAGRAM: SHARING HEALTH RECORDS

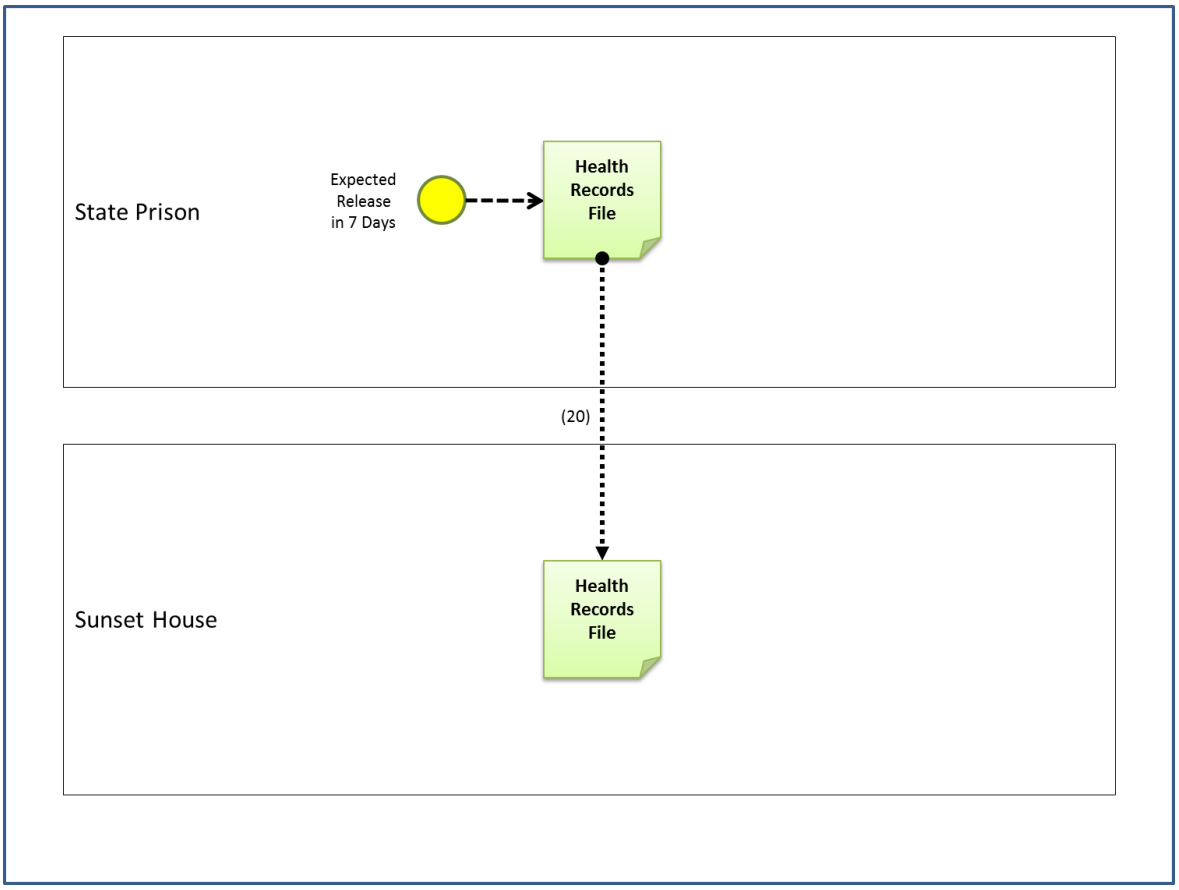


TABLE 8. EXCHANGE CONTENT SAMPLE: SHARING HEALTH RECORDS

DATA CATEGORY	DATA ELEMENT	SAMPLE DATA
Message Information	Message Type	Health Records
	Current Date	02-09-2013
To Agency	Agency Name	Sunset House
	POC Name	Mark Manager
	POC Phone	602-555-2222
	POC Email	mark@sunset.org
From Agency	Agency Name	State Prison
	Agency Street	123 Corrections Road
	Agency City	Batesville
	Agency State	Arizona
	Agency Zip	85001
	POC Name	Officer William
	POC Phone	602-555-1111
	POC Email	william@stateprison.gov
Person Information	Offender Name	John Doe
	Offender DOB	10-22-1968
	Offender Sex	M
	Offender SSN	123-45-6789

DATA CATEGORY	DATA ELEMENT	SAMPLE DATA
Health Records	Health Information	Medical records information (including prison case management records to include medical, mental health and relevant treatment assessment and services received while incarcerated) (text field or attachment depending on implementation)
Consent	Consent Info	Consent to share health information (text field or attachment depending on implementation)

4) ***At Release***—State Prison reentry planning personnel electronically send John Doe's discharge summaries and health records to the Sunset House. (In this case, consent had been given by Doe during the reentry planning process.)

   a) A service specification built for Exchange Synopsis 21 was used by the State Prison Reentry personnel's system to send the information to the Sunset House.

   b) The figure below illustrates the process for sharing the discharge summary and health records.

FIGURE 6. BPMN DIAGRAM: SHARING THE DISCHARGE SUMMARY AND HEALTH RECORDS

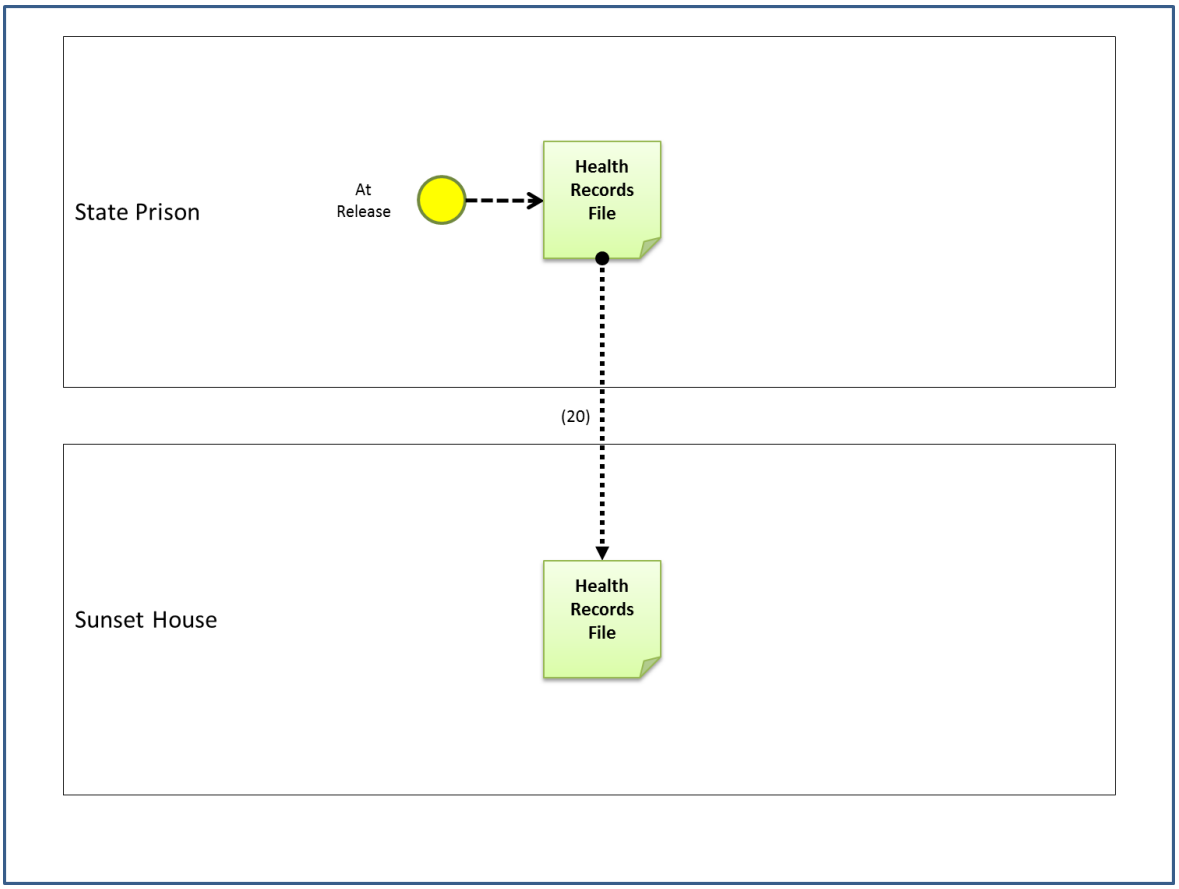


TABLE 9. EXCHANGE CONTENT SAMPLE: SHARING THE DISCHARGE SUMMARY AND HEALTH RECORDS

DATA CATEGORY	DATA ELEMENT	SAMPLE DATA
Message Information	Message Type	Health Records
	Current Date	02-15-2013
To Agency*	Agency Name	Sunset House
	POC Name	Mark Manager
	POC Phone	602-555-2222
	POC Email	mark@sunset.org
From Agency	Agency Name	State Prison
	Agency Street	123 Corrections Road
	Agency City	Batesville
	Agency State	Arizona
	Agency Zip	85001
	POC Name	Officer William
	POC Phone	602-555-1111
	POC Email	william@stateprison.gov
Person Information	Offender Name	John Doe
	Offender DOB	10-22-1968
	Offender Sex	M
	Offender SSN	123-45-6789
Discharge Summary	Discharge Information	Discharge report (text field or attachment depending on implementation)
Health Records Update	Health Update	Medical records information (including prison case management records to include medical, mental health and relevant treatment assessment and services received while incarcerated) (text field or attachment depending on implementation)
Consent	Consent Info	Consent to share health information (text field or attachment depending on implementation)

5.1.4 Results and Benefits

TABLE 10. REENTRY INTO THE COMMUNITY AFTER INCARCERATION – RESULT AND BENEFITS

MILESTONE	SAMPLE OLD PROCESS	NEW AUTOMATED PROCESS	BENEFITS
Program Information (Periodic)	• No automatic sharing of treatment program availability, criteria, or fees	• Treatment provider systems automatically upload their program availability, criteria, and fees with no manual effort	• Phone call time for prison reentry staff and treatment provider staff to share program availability, criteria, and fees reduced

MILESTONE	SAMPLE OLD PROCESS	NEW AUTOMATED PROCESS	BENEFITS
45 Days Prior to Release	• Prison reentry staff manually phones all providers in the appropriate area to determine their projected availability, criteria, and fees (all of which is subject to change) – *Est. 30-60 minutes* • Reentry staff collates the information, selects the provider(s), and phones them to solidify the placement – *Est. 20 minutes*	• Prison reentry staff reviews current Provider Availability on Treatment capacity database – *Est. 10 minutes* • Reentry staff collates the information, selects the provider(s), and phones them to solidify the placement – *Est. 20 minutes*	• Savings of 20-50 minutes of effort • Health provider shared availability with prison automatically – no manual intervention • Prison has instant and up-to-date information on programs w/o any manual intervention
30 Days Prior to Release	Once prison reentry staff finalizes the Reentry Plan, paper copies are made and mailed or faxed to the provider(s) – *Est. 20 minutes to copy; and, up to 4-5 days to receive*	Once prison reentry staff finalizes the Reentry Plan, an electronic copy is sent to each provider(s) – *1 minute to send and receive*	• Savings of 19 minutes of effort and 4-5 days for information to transfer • Health provider receives Reentry Plan from prison automatically • Prison provided Reentry Plan via a click of the mouse
7 Days Prior to Release	• Prison reentry staff makes paper copies of health records and mails to the provider(s) – *Est. 20 minutes to copy; and, up to 4-5 days to receive*	• Prison reentry staff sends an electronic copy of health records to each provider(s) – *1 minute to send and receive*	• Staff time reduced or eliminated for prison reentry staff and treatment provider staff to share needs assessments, prison programming received, completion status and fees – *Savings of 19 minutes of effort and 4-5 days for information to transfer* • Health provider receives health records from prison automatically • Prison provides health records via a click of the mouse

MILESTONE	SAMPLE OLD PROCESS	NEW AUTOMATED PROCESS	BENEFITS
At Release	• Prison reentry staff makes paper copies of discharge summary records and health records updates (if any) and mails or faxes to the provider(s) (Est. 20 minutes to copy, up to 4-5 days to receive)	• Prison reentry staff sends an electronic copy of discharge summary records and health records updates (if any) to each provider(s). (1 minute to send and receive)	• Staff time reduced or eliminated for prison reentry staff and treatment provider staff to share needs assessments, prison programming received, completion status and fees. Savings of 19 minutes of effort and 4-5 days for information to transfer. • Health provider receives discharge summary records and health records updates from prison automatically. • Prison provides discharge summary records and health records updates via a click of the mouse.
Benefits Summary	• Staff time reduced or eliminated for prison reentry staff and treatment provider staff to share needs assessments, treatment program availability, criteria, prison programming received, completion status and fees • More information readily accessible • More accurate and up to date information provided • Reduction of staff effort; and, therefore, reduced time and cost ***More efficient and beneficial reentry process should lead to better healthcare for target population, improved continuity of care, reduced recidivism and safer communities***		

5.2 Community-based Treatment with Effective Criminal Justice Supervision

5.2.1 Issue

Criminal justice and health practitioners reading this report are likely to be familiar with the issues surrounding continuity of care for persons simultaneously involved with both systems. This "continuity of care" issue has become one of the key phrases used in the area of criminal justice and health collaboration – particularly when referring to benefits of information exchange between the two domains. Even so, little has been done to date regarding national efforts to standardize information exchanges to support these issues.

The following excerpts from "Coordinating Effective Health and Mental Health Continuity of Care"[45] underscore the need and issues:

- "An estimated 25 to 40 percent of inmates in U.S. prisons have significant health care conditions that will require continuity of care services upon release."
- "Fifteen to 20 percent of mentally ill inmates have serious disorders, which require continuity of care."
- "Obstacles to providing continuity of care include failure to coordinate service delivery."
- "Enhancing continuity of care could involve inter- and intra-agency case management coordination and communication."

The two key circumstances regarding the continuity of care for persons who are both in treatment and under the supervision of the criminal justice system are:

1) An incarcerated person who is receiving treatment from a community-based provider (actual services could be provided either inside the facility or out), and
2) A person in a supervised status (pre-trial, probation or parole) who is simultaneously undergoing treatment from a community-based provider as a condition of their criminal justice supervision.

In this Implementation Scenario, a combination of five Exchange Synopses is used to address continuity of care for persons in the second circumstance above.

5.2.2 Implementation Scenario Overview

In this scenario, we use the following example of a person in treatment and under supervision:

5.2.2.1 Current Status

Offender "John Doe" is a 32-year-old male who was convicted of an assault and sentenced to supervised probation.

5.2.2.2 Plan

As a probation condition, Doe is required and consents to attend anger management counseling and have periodic drug tests because of his history of violent behavior and substance use. He is currently under the supervision of the District Probation Office. He is receiving outpatient anger management counseling at ABC County Mental Health. Doe reports to Acme Laboratory Services for weekly drug testing.

5.2.2.3 Event

This scenario uses multiple information sharing exchanges, working in concert, to support criminal justice compliance and engagement in treatment, increase the health of persons, reduce recidivism,

[45] McVey, Catherine (2001). "Coordinating Effective Health and Mental Health Continuity of Care." *Corrections Today*, Volume: 63, Issue: 5, pp. 58-62. Retrieved from: https://www.ncjrs.gov/App/Publications/abstract.aspx?ID=190462

lower costs to our communities, and benefit both health and justice domains. The table below depicts scenario events along with the information eXchange synopsis used to support the event.

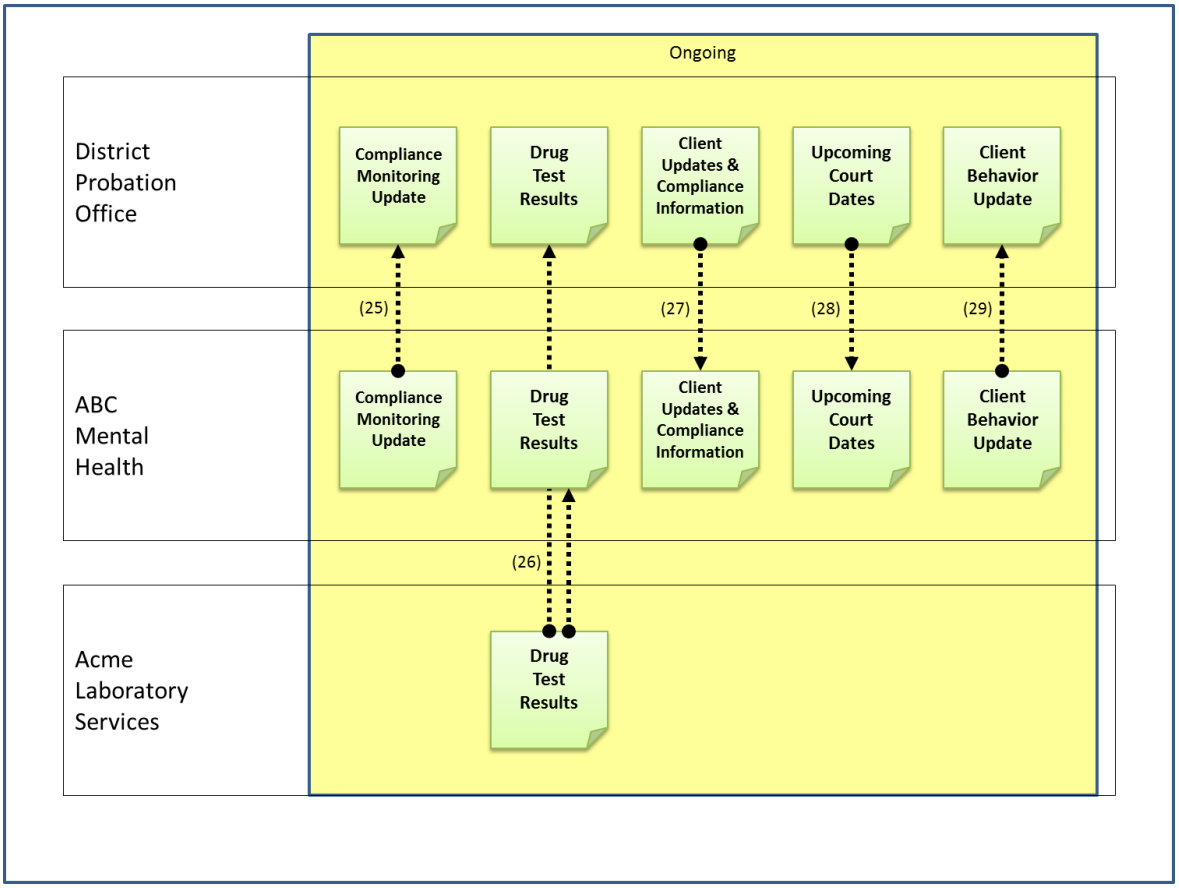
TABLE 11. EVENTS AND EXCHANGE SYNOPSES USED: COMMUNITY-BASED TREATMENT WITH EFFECTIVE CRIMINAL JUSTICE SUPERVISION SCENARIO

SCENARIO EVENT	EXCHANGE SYNOPSIS USED
• Doe has an appointment at ABC Mental Health, triggering an information exchange that sends an attendance update to the District Probation Office.	#25 – "Pre-trial, court-based, and post-conviction supervision programs receive status updates from behavioral health treatment providers to support compliance monitoring (*e.g.* program attendance, treatment adherence)."
• Doe has an appointment at Acme Laboratory Services and his drug test results are recorded, triggering an information exchange that sends the test results to the District Probation Office and to the ABC Mental Health Program.	#26 – "Pre-trial, court-based, or post-conviction supervision personnel receive drug testing results from treatment providers (or their laboratories) to support compliance monitoring."
• Doe informs his probation officer that his employer and work schedule have changed, which affect his ability to attend currently scheduled probation check-ins and anger management sessions. • This information is entered into the District Probation Office records system, triggering an information exchange that sends an action alert to the treatment providers (ABC Mental Health). • Doe's probation officer and mental health treatment provider then offer him alternate times to attend.	#27 – "Treatment providers receive client updates and compliance information from criminal justice supervision agencies to support the treatment process."
• Doe is assigned a new court date, which is entered into the District Probation Office records system, triggering an information exchange that sends the court date to the treatment provider (ABC Mental Health).	#28 – "Treatment providers receive notification of upcoming court dates and to promote client compliance with court appearances."

SCENARIO EVENT	EXCHANGE SYNOPSIS USED
• Doe missed an appointment with his Probation Officer and later gave a nonsensical explanation. • The Probation Officer phones or emails the treatment providers to ask if there were any recent changes in Doe's circumstances or treatment that may have prompted the noncompliance. • The treatment staff explains any recent developments in Doe's treatment of personal circumstances that may help to explain his behavior (within the established bounds of doctor-patient confidentiality). • This interpersonal exchange helps the probation officer formulate an appropriate response to Doe's noncompliance. • The Probation Officer requests the latest status and assessment information, which is electronically provided via the information exchange.	#29 – "Criminal justice supervision agency receives information from health provider to provide context for client behavior and promote alternative responses to noncompliance (rather than revocation and incarceration)."

The figure below shows the entire scenario at a high level, with a focus on the information exchanges.

FIGURE 7. BPMN DIAGRAM: COMMUNITY-BASED TREATMENT WITH EFFECTIVE CRIMINAL JUSTICE SUPERVISION SCENARIO



5.2.2.4 Scenario Information

Offender	John Doe
DOB	10-22-1980
Sex	M
SSN	123-45-6789
Charges	Assault
State ID	1234567890
Probation Agency	District Probation Office 222 Water St., Metropolis, VA 12301
Probation Officer	Officer Forge 804-555-1111 forge@dpo.gov
Counseling Services	ABC Mental Health 123 Angus Rd., Metropolis, VA 12302
Counselor	Katherine Counselor 804-555-2222 katherine@abc.org
Drug Testing Agency	Acme Laboratory Services 109 5th St., Metropolis, VA 12302
Technician/POC	Beverly Technician 804-555-3333 beverly@acme.com

All names, locations, agencies, organizations, etc. in these scenarios are fictitious and used for illustration purposes only.

5.2.3 High-Level Timeline and Information Flows

1) ***Compliance Monitoring Updates***—This update could be set to occur: (i) at pre-designated stages; (ii) based on new information/events/triggers; (iii) at regular intervals; or, (iv) at completion/cessation of program.

    a) In this example, the exchange is automatically triggered by a new entry/update of Doe's record in the ABC Mental Health record system. The exchange sends attendance data (not the medical record) to the District Probation Office system and the system flags it for review by the assigned case officer. The case officer can then review the update and make appropriate determinations regarding compliance with probation conditions and/or adjust the supervision plan as appropriate.

    b) A service specification built for Exchange Synopsis 25 is used by the ABC Mental Health and the District Probation Office systems to automatically send/receive the data.

The figure below illustrates the process for sharing compliance information.

FIGURE 8. BPMN DIAGRAM: SHARING COMPLIANCE INFORMATION

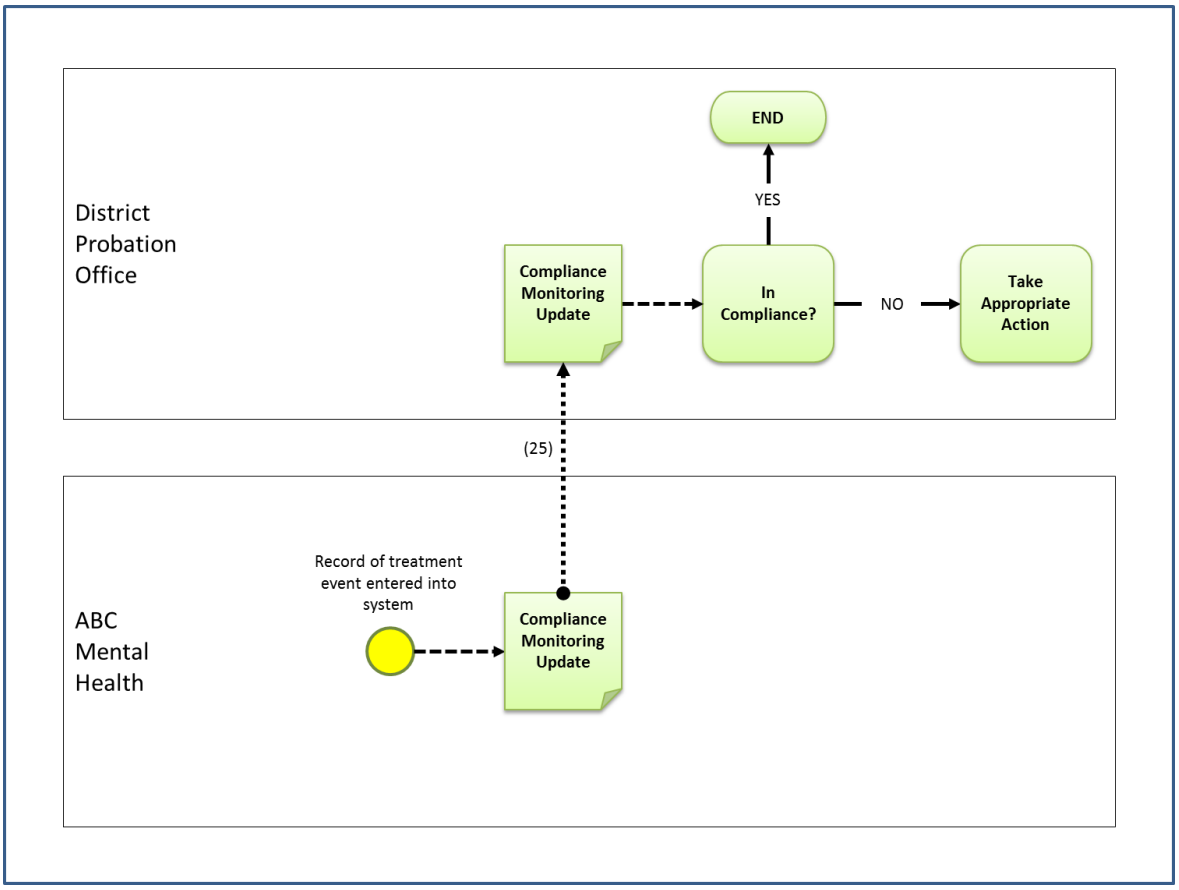


TABLE 12. EXCHANGE CONTENT SAMPLE: SHARING COMPLIANCE INFORMATION

DATA CATEGORY	DATA ELEMENT	SAMPLE DATA
Event Information	Message Type	Compliance Monitoring Update
	Current Date	06-15-2013
To Agency Information	Agency Name	District Probation Office
	Agency Street	222 Water Street
	Agency City	Metropolis
	Agency State	Virginia
	Agency Zip	12301
	POC Name	Officer Forge
	POC Phone	804-555-1111
	POC Email	forge@dpo.gov
From Agency Information	Agency Name	ABC Mental Health
	Agency Street	123 Angus Road
	Agency City	Metropolis
	Agency State	Virginia
	Agency Zip	12302
	POC Name	Katherine Counselor
	POC Phone	804-555-2222
	POC Email	katherine@abc.org
Person Information	Offender Name	John Doe

DATA CATEGORY	DATA ELEMENT	SAMPLE DATA
	Offender DOB	10-22-1968
	Offender Sex	M
	Offender SSN	123-45-6789
Update	Event Date	06-14-2013
	Event Type	Counseling Session
	Narrative	Relevant progress notes for compliance monitoring (text field or attachment depending on implementation)

2) ***Drug Test Results***—These updates are set to occur at the completion of each drug test (when testing results are entered into system).

   a) In this example, the exchange is automatically triggered by a new drug test results entry in Doe's record in the Acme Laboratory Services record system. The exchange sends the data to the District Probation Office system and ABC Mental Health Provider and flags it for review by the assigned case officer. The case officer can then review the update and make appropriate determinations regarding compliance with probation conditions (*e.g.* praise the client for compliance or issue a sanction for noncompliance). Doe's clinician at ABC Mental Health Provider can address the results in a treatment context as well.

   b) A service specification built for Exchange Synopsis 26 is used by the Acme Laboratory Services, the District Probation Office, and the ABC Mental Health Provider systems to automatically send/receive the data.

The figure below illustrates the process for sharing drug test results.

FIGURE 9. BPMN DIAGRAM: SHARING DRUG TEST RESULTS

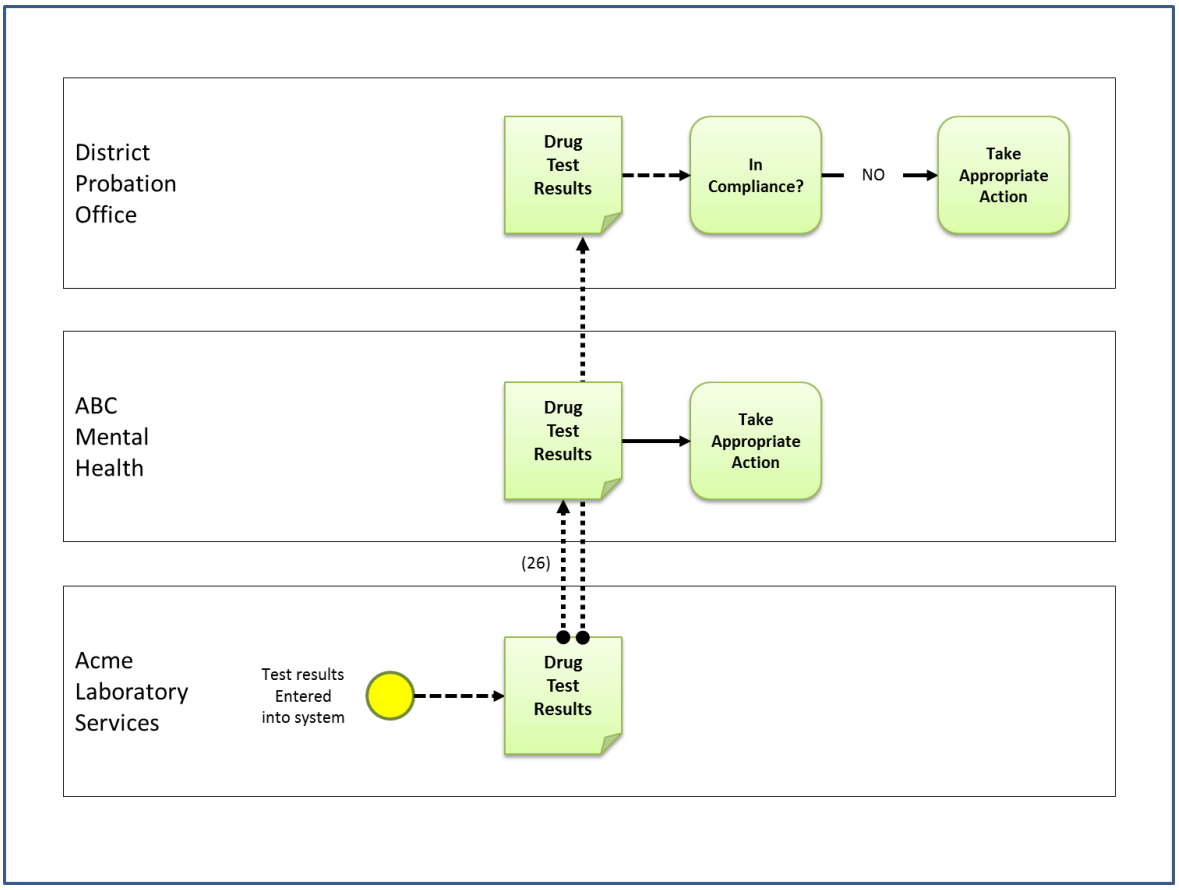


TABLE 13. EXCHANGE CONTENT SAMPLE: SHARING DRUG TEST RESULTS

DATA CATEGORY	DATA ELEMENT	SAMPLE DATA
Event Information	Message Type	Drug Test Results
	Current Date	07-18-2013
To Agency Information	Agency Name	District Probation Office
	Agency Street	222 Water Street
	Agency City	Metropolis
	Agency State	Virginia
	Agency Zip	12301
	POC Name	Officer Forge
	POC Phone	804-555-1111
	POC Email	forge@dpo.gov
From Agency Information	Agency Name	Acme Laboratory Services
	Agency Street	109 5th Street
	Agency City	Metropolis
	Agency State	Virginia
	Agency Zip	12303
	POC Name	Beverly Technician
	POC Phone	804-555-3333
	POC Email	beverly@acme.com
Person Information	Offender Name	John Doe

DATA CATEGORY	DATA ELEMENT	SAMPLE DATA
	Offender DOB	10-22-1968
	Offender Sex	M
	Offender SSN	123-45-6789
Update	Event Date	07-15-2013
	Event Type	Drug Test
	Drug Test Results	Test and Results (text field or attachment depending on implementation)

3) ***Client Updates and Compliance Information***—These updates are set to occur when triggering information is entered into or updated in the offender's record at the monitoring agency's system.

   a) In this example, the exchange is automatically triggered by a change in the offender's employment and work schedule. The exchange sends the data from the District Probation Office system to all active providers on file – in this example, there is only one, the ABC Mental Health. The treatment providers update their records and use this information to know when Doe is working and coordinate with him to reschedule appointments.

   b) A service specification built for Exchange Synopsis 27 is used by the District 9 Probation and Parole Office to automatically send the data to the ABC Mental Health systems.

The figure below illustrates the process for sharing updated compliance information and requirements.

FIGURE 10. BPMN DIAGRAM: SHARING UPDATED COMPLIANCE INFORMATION AND REQUIREMENTS

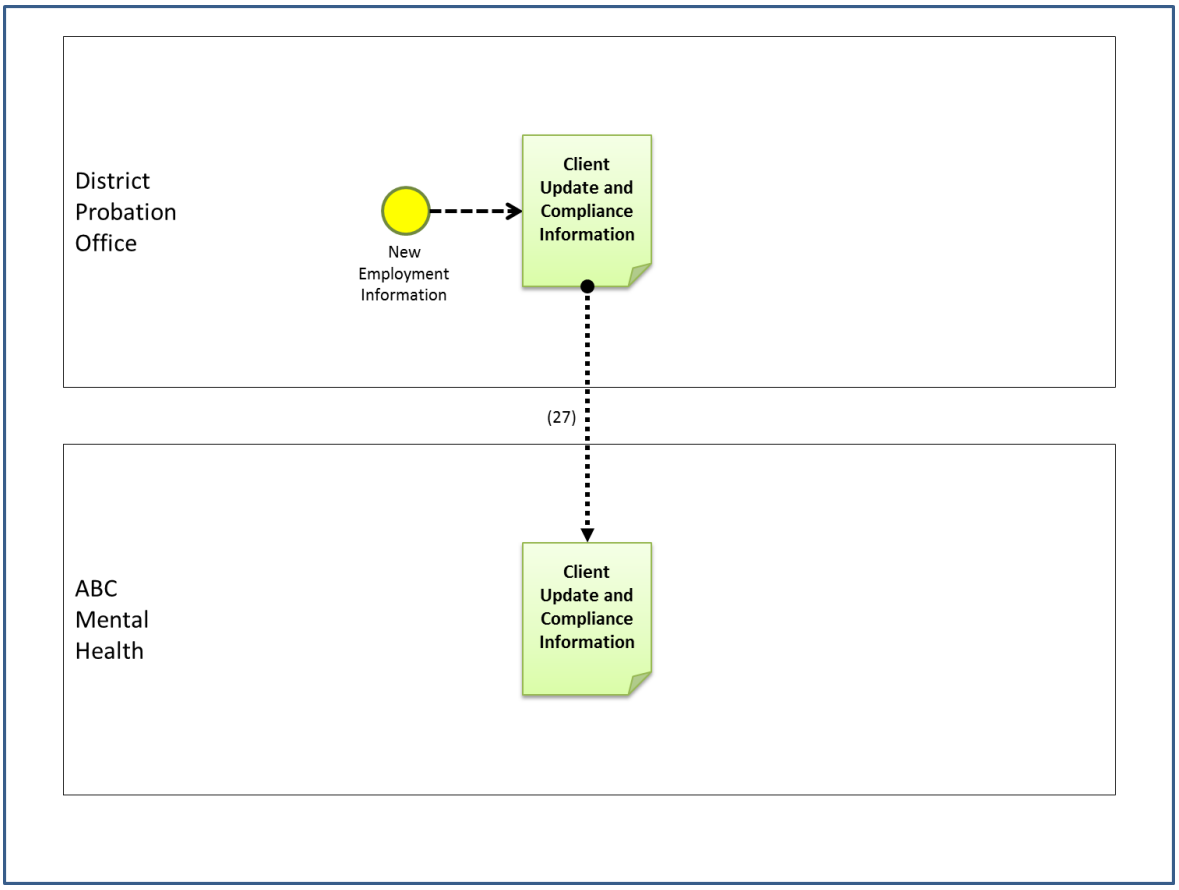


TABLE 14. EXCHANGE CONTENT SAMPLE: SHARING UPDATED COMPLIANCE INFORMATION AND REQUIREMENTS

Data Category	Data Element	Sample Data
Event Information	Message Type	Client Update and Compliance Information
	Current Date	08-06-2013
To Agency Information	Agency Name	ABC Mental Health
	Agency Street	123 Angus Road
	Agency City	Metropolis
	Agency State	Virginia
	Agency Zip	12302
	POC Name	Katherine Counselor
	POC Phone	804-555-2222
	POC Email	katherine@abc.org
From Agency Information	Agency Name	District Probation Office
	Agency Street	222 Water Street
	Agency City	Metropolis
	Agency State	Virginia
	Agency Zip	12301
	POC Name	Officer Forge
	POC Phone	804-555-1111
	POC Email	forge@dpo.gov

Data Category	Data Element	Sample Data
Person Information	Offender Name	John Doe
	Offender DOB	10-22-1968
	Offender Sex	M
	Offender SSN	123-45-6789
Update	Event Date	08-05-2013
	Event Type	Employment Information Update
	Narrative	Narrative (text field or attachment depending on implementation)

4) ***Upcoming Court Dates***—These updates are generated when a new court date is entered, or change is made to previously entered court dates, in the criminal justice monitoring agency's system.

   a) In this example, the exchange is automatically triggered by a new court date entry for Doe in the District Probation Office system. The exchange sends the data to the active provider on file – ABC Mental Health. The treatment provider uses this information to take appropriate action regarding Doe's scheduled court date

   – [An outpatient treatment provider, as in this case, may simply remind Doe of his upcoming court or reschedule an appointment if it conflicts with the court date. If Doe were in a residential treatment program, then the provider may need to make logistical arrangements to help Doe attend (*e.g.* put him on the facility's transportation assistance list for that day). Alternately, a provider may elect not to do these things if their treatment approach for Doe is to encourage him to take responsibility for his schedule and meeting his court obligations.]

   b) A service specification built for Exchange Synopsis 28 was used by the District Probation Office to send the data automatically to the ABC Mental Health.

The figure below illustrates the process for sharing upcoming court dates.

FIGURE 11. BPMN DIAGRAM: SHARING UPCOMING COURT DATES

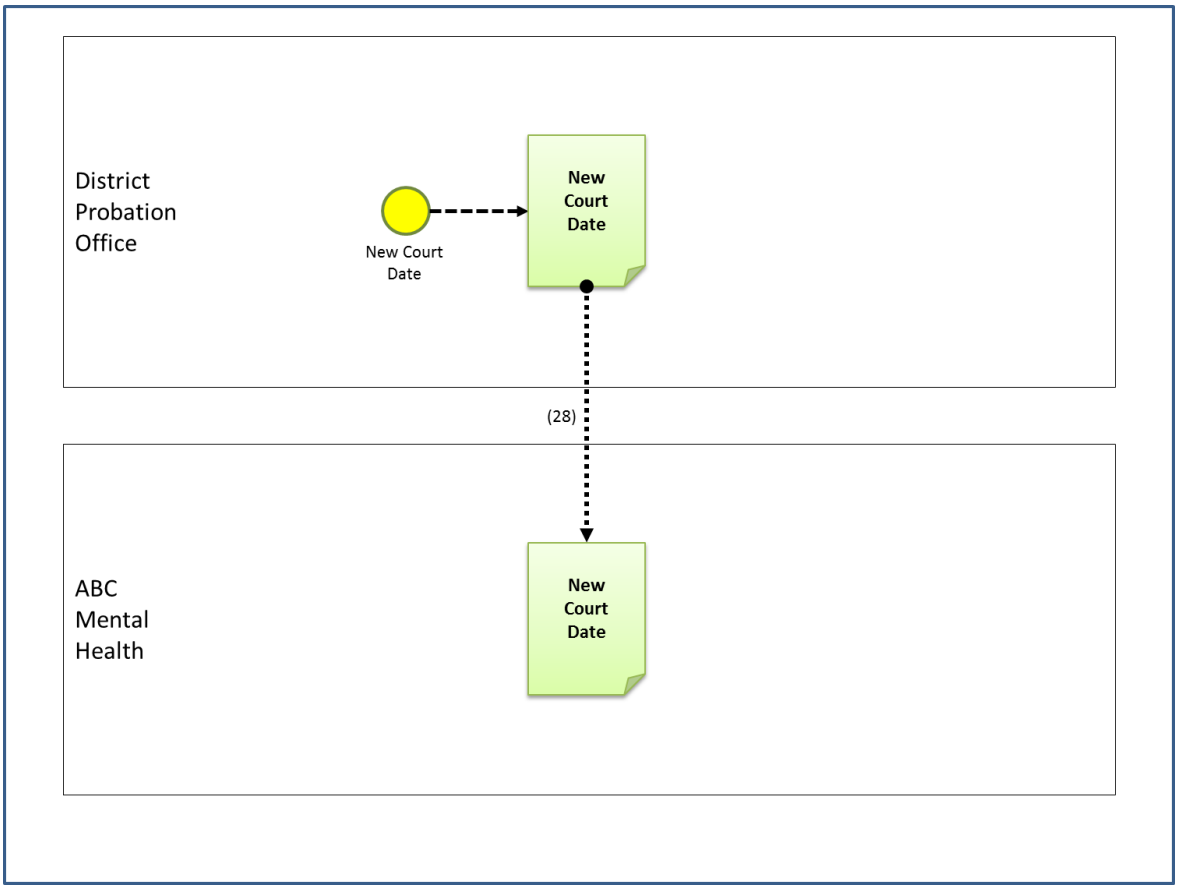


TABLE 15. EXCHANGE CONTENT SAMPLE: SHARING UPCOMING COURT DATES

DATA CATEGORY	DATA ELEMENT	SAMPLE DATA
Event Information	Message Type	Court Date Notification
	Current Date	09-10-2013
To Agency Information	Agency Name	ABC Mental Health
	Agency Street	123 Angus Road
	Agency City	Metropolis
	Agency State	Virginia
	Agency Zip	12302
	POC Name	Katherine Counselor
	POC Phone	804-555-2222
	POC Email	katherine@abc.org
From Agency Information	Agency Name	District Probation Office
	Agency Street	222 Water Street
	Agency City	Metropolis
	Agency State	Virginia
	Agency Zip	12301
	POC Name	Officer Forge
	POC Phone	804-555-1111
	POC Email	forge@dpo.gov
Person Information	Offender Name	John Doe

DATA CATEGORY	DATA ELEMENT	SAMPLE DATA
	Offender DOB	10-22-1968
	Offender Sex	M
	Offender SSN	123-45-6789
Update	Event Type	New Court Date
	Court Date	10-14-2014
	Court	Metropolis District Court
	Street	501 E. Jefferson Street
	City	Metropolis
	State	Virginia
	Zip	12303

5) ***Client Behavior Update***—This exchange would typically be triggered by a behavioral status change observed by a treatment provider; or, it could be initiated by a query by the criminal justice supervision agency seeking information regarding a behavioral change.

   a) In this example, Doe missed a regular supervision meeting with the probation officer and when asked later, gave a nonsensical explanation. The Probation Officer phones or emails the ABC Mental Health to ask if there were any recent changes in Doe's circumstances or treatment that may have prompted the noncompliance. The treatment staff explains any recent developments in Doe's treatment of personal circumstances that may help to explain his behavior (within the established bounds of doctor-patient confidentiality). This interpersonal exchange helps the probation officer formulate an appropriate response to Doe's noncompliance. The Probation Officer requests the latest official status and assessment information, which is electronically provided via the information exchange. This update is captured in the records system for documentation.

   b) A service specification built for Exchange Synopsis 29 is used by the ABC Mental Health to share the information with the District probation Office.

The figure below illustrates the process for sharing behavioral status and assessment information.

FIGURE 12. BPMN DIAGRAM: SHARING BEHAVIORAL STATUS AND ASSESSMENT INFORMATION

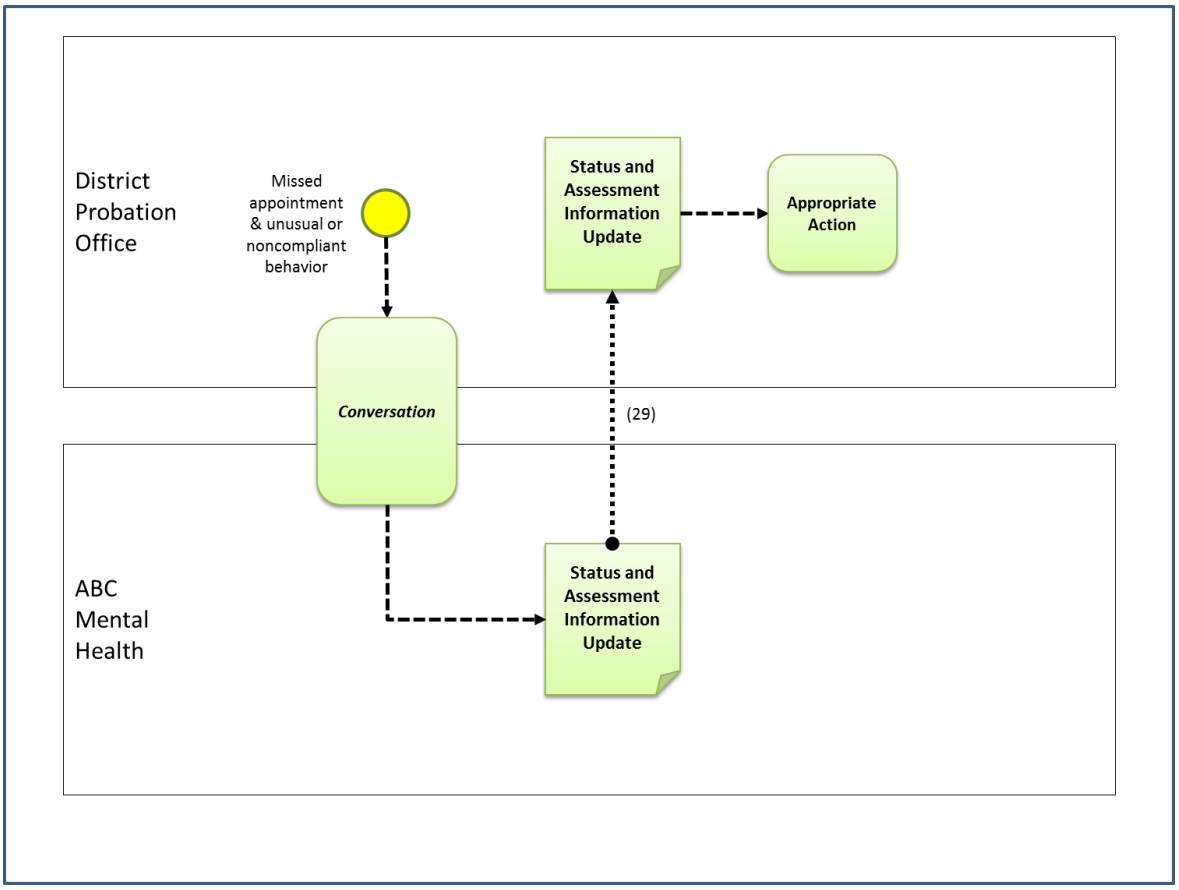


TABLE 16. EXCHANGE CONTENT SAMPLE: SHARING BEHAVIORAL STATUS AND ASSESSMENT INFORMATION

DATA CATEGORY	DATA ELEMENT	SAMPLE DATA
Event Information	Message Type	Behavioral Status Assessment
	Current Date	11-19-2013
To Agency Information	Agency Name	District Probation Office
	Agency Street	222 Water Street
	Agency City	Metropolis
	Agency State	Virginia
	Agency Zip	12301
	POC Name	Officer Forge
	POC Phone	804-555-1111
	POC Email	forge@dpo.gov
From Agency Information	Agency Name	ABC Mental Health
	Agency Street	123 Angus Road
	Agency City	Metropolis
	Agency State	Virginia
	Agency Zip	12302
	POC Name	Katherine Counselor
	POC Phone	804-555-2222
	POC Email	katherine@abc.org
Person Information	Offender Name	John Doe

DATA CATEGORY	DATA ELEMENT	SAMPLE DATA
	Offender DOB	10-22-1968
	Offender Sex	M
	Offender SSN	123-45-6789
Inquiry Response	Narrative	Narrative response to inquiry (text field or attachment depending on implementation)

5.2.4 Results and Benefits

TABLE 17. COMMUNITY-BASED TREATMENT WITH EFFECTIVE CRIMINAL JUSTICE SUPERVISION – RESULT AND BENEFITS

ACTIVITY	SAMPLE OLD PROCESS	NEW AUTOMATED PROCESS	BENEFITS
Doe has an appointment at ABC Mental Health and his medical record is updated.	• *If shared*, a medical update summary copy may be mailed or a phone call made to the Probation Officer for compliance determination and/or Probation Plan update	• Treatment provider system automatically sends attendance update to Probation Officer with no manual effort	• Savings of phone call (or hardcopy mailing time) for treatment staff • Savings of phone call time (or hard copy review) by Probation Officer • Elimination of time lag
Doe has an appointment at Jefferson Area Drug Services and his drug test results are recorded	• Drug test results are likely faxed to the Probation Officer for compliance determination and/or Probation Plan update	• Treatment provider system automatically sends drug test results to Probation Officer with no manual effort	• Savings of hardcopy mailing time for treatment staff • Elimination of time lag
Doe's employment status changes (employer and schedule)	• *If shared*, employment update summary copy may be faxed or a phone call made to the treatment providers for appropriate action	• Probation system automatically sends employment update to treatment provider with no manual effort	• Savings of phone call (or hardcopy mailing time) for treatment staff • Savings of phone call time (or hard copy review) by Probation Officer • Elimination of time lag

ACTIVITY	SAMPLE OLD PROCESS	NEW AUTOMATED PROCESS	BENEFITS
Doe is assigned a new court date	• This does not typically happen under present practice, but working group members felt it was an innovative way to decrease revocation rates for failure to appear	• Probation system automatically sends new court date to treatment provider with no manual effort	• Savings of phone call (or hardcopy mailing time) for Probation Officer • Savings of phone call time (or hard copy review) by treatment staff • Potential to decrease revocation rates for failure to appear
Doe misses an appointment with his Probation Officer and later gave a non-nonsensical explanation. The Probation Officer asks the treatment provider for information regarding any recent changes in Doe's status or treatment. Provider sends update.	• *If inquiry is made*, Probation Officer likely calls treatment providers requesting input made to the treatment providers for appropriate action	• Probation Officer calls treatment providers regarding possible behavioral change • Treatment providers send updated status and assessment to Probation Officer	• Increased accuracy • Ability to attach records and test results • Fully documented transaction
Benefits Summary	• Staff time reduced or eliminated for probation and treatment provider staff to share status updates, drug test results, client updates and compliance information, upcoming court dates, and inquiry/responses regarding client behavior • Automation of several information types desired by both stakeholders • More accurate and up to date information provided • Reduction of staff effort; and, therefore, reduced time and cost ***More efficient and beneficial supervision process should lead to better healthcare for target population, reduced recidivism and safer communities***		

6 NEXT STEP RECOMMENDATIONS

This report serves as a resource for local criminal justice and health stakeholders to guide strategic planning processes in which they decide on the implementation of specific information sharing initiatives. As stakeholders develop and implement any information exchange, it will be important to develop measures and mechanisms to determine whether the exchange is working as intended. Questions to be addressed include whether the amount of information exchanged increased and practitioner assessments of whether the information exchanged has been beneficial. To further the adoption of criminal justice and health information exchanges, Federal agencies, state agencies, or private foundations may consider establishing local demonstration projects to answer these and additional questions about implementation impacts. Such a demonstration project would document the lessons learned in a number of pilot sites and evaluate implementation impacts, such as improved retention in treatment, reduced assessment time, improved health status and functioning, fewer gaps in access to prescription medications in the community, and criminal justice outcomes (*e.g.* reductions in drug abuse, criminal activity, and recidivism). Several recommended, potential projects are below.

6.1 Criminal Justice and Health Collaboration Phase 2 Project

A Phase II continuation of this project is highly recommended to:

- Select one or more Information Exchange Synopses for creation of appropriate service specification packages and implementation of those services as pilot implementations.
  - This could result in a proof of concept, lessons learned, and technical and business templates for future criminal justice-health implementations.
- Explore and document the application of these information exchange synopses to the juvenile justice arena.
- Examine and document privacy constraints for each Information Exchange Synopsis.
- Add (potential) new Information Exchange Synopses[46], including:
  - Submission of mental health records to the NICS
  - Corrections/detention submission of immunization records to the department of health registry
  - Corrections/detention requests immunization records from the department of health registry
  - Corrections/detention submits cancer records to the department of health registry
  - Corrections/detention requests cancer records from the department of health registry
  - Corrections/detention submits syndromic surveillance records to the department of health registry

[46] These particular exchanges were suggested for potential inclusion into this document but were provided too late in the process to allow the Working Group to appropriately vet them.

- Corrections/detention requests syndromic records from the department of health registry

One of the deliverables of this project was to provide a recommended Project Charter, Goals, Deliverables, and Participants for the recommended Phase 2 Criminal Justice and Health Collaboration Project. These are provided in Appendix C.

6.2 Potential Future Information Exchanges under Health Care Reform

The implementation of health care reform in 2014 under the *ACA* creates additional opportunities for criminal justice and health information exchange that generally do not yet exist in today's policy landscape. Most notably, the expansion of Medicaid health coverage to low-income adults under age 65 (the so-called "childless adult" population) is expected to increase access to health care among criminal justice-involved persons in those states that opt to participate. Information exchange between criminal justice agencies and Medicaid agencies have the potential to facilitate enrollment and to manage benefits as follows.

6.2.1 Criminal Justice Records to Facilitate Enrollment into Medicaid

The majority of the justice-involved population is expected to qualify for Medicaid on the basis of low income (133 percent of the Federal poverty level or below). Some state Medicaid agencies that already extend coverage to low-income childless adults have established "presumptive eligibility" policies, whereby justice-involved individuals are enrolled in Medicaid in anticipation that most will meet the eligibility requirements. In Connecticut, for example, soon-to-be released inmates submit a simplified Medicaid application containing only brief demographic and contact information. Applications are approved in an expedited manner and benefits are activated when the Medicaid agency receives notification of the actual release. This is presently done as a paper-based application process but could potentially be accomplished through a combination of client consent and electronic data transfer to the Medicaid agency.

6.2.2 Admission and Release Dates from Incarceration to Manage Medicaid Benefits

Current Federal regulations prohibit Medicaid from reimbursing care that is provided during incarceration. Rather than terminate benefits on admission to prison or jail, some states have developed policies to suspend benefits on admission and reinstate benefits on release. Electronic transfer of admission and release dates to the Medicaid agency can enhance the efficiency of this process, especially after 2014, when larger numbers of persons entering jail can be expected to have Medicaid. A secondary benefit is to avoid the lapse in treatment after release allowing continuous care of seriously ill persons being released from custody.

6.2.3 Potential Medicaid Coverage of Services to Incarcerated Individuals Who Are "Pending Disposition"

Under the *ACA*, persons who are awaiting trial in jail may enroll and receive services from health plans participating in a state's health insurance exchange. Present Medicaid policy does not allow reimbursement for the care of detainees who are "pending disposition," (*i.e.* incarcerated while awaiting trial because they could not meet bail requirements), but there are efforts underway to bring Medicaid provisions for this population in line the ACA. Should this occur, jail systems and Medicaid

agencies may develop electronic mechanisms for transmitting health claims and reimbursements for pretrial detainees.

7 APPENDICES

7.1 APPENDIX A: Acronyms and Abbreviations

TABLE 18. ACRONYMS AND ABBREVIATIONS

ACRONYM OR ABBREVIATION	DEFINITION
42 CFR Part 2	*Confidentiality of Alcohol and Drug Abuse Patient Records*
ACA	*Patient Protection and Affordable Care Act*
ADAA	Maryland's Alcohol and Drug Abuse Administration
ANSI	American National Standards Institute
APPA	American Parole and Probation Association
ASCA	Association of State Correctional Administrators
ASPMP	Alliance of States with Prescription Monitoring Programs
BAA	Business Associate Agreement
BHIPS	Behavioral Health Integrated Provider System
BJA	Bureau of Justice Assistance
BJS	Bureau of Justice Statistics
BPMN	Business Process Modeling Notation
bSAS	Baltimore Substance Abuse Systems, Inc.
CAD	computer aided dispatch
CDC	Centers for Disease Control and Prevention
CE	Covered Entity (*HIPAA*)
CFR	*Code of Federal Regulations 42 Part 2*
CFS	call for service
CMBHS	Clinical Management for Behavioral Healthcare System
DHS	Department of Homeland Security
DOB	Date of Birth
DOC	Department of Corrections
DOJ	U.S. Department of Justice
DSTU	draft standards for trial use
DUI	Driving Under the Influence
DWI	Driving While Intoxicated
EHR	electronic health records
ER	Emergency Room (Hospital)
FBI	Federal Bureau of Investigation
FDA	Food and Drug Administration
FQHC	Federally Qualified Health Center
GFIPM	Global Federated Identity and Privilege Management
GJXDM	Global Justice XML Data Model
Global	Global Justice Information Sharing Initiative (DOJ)
GPRA	*Government Performance and Results Act*
GRA	Global Reference Architecture
HIE	Health Information Exchange
HIPAA	*Health Insurance Portability and Accountability Act (of 1996)*
HITECH	*Health Information Technology for Economic and Clinical Health Act*
HL7	Health Level Seven International

ACRONYM OR ABBREVIATION	DEFINITION
IEPD	Information Exchange Package Documentation
IJIS	IJIS Institute
ISO	International Organization of Standardization
IT	information technology
JIEM	Justice Information Exchange Model
JMHCP	Justice and Mental Health Collaboration Program
JMS	Jail Management System
LE	Law Enforcement
LEA	Law Enforcement Agency
LEITSC	Law Enforcement Information Technology Standards Council
MH	Mental Health
MIS	Management Information System
MOU	Memorandum of Understanding
MRSA	multidrug-resistant Staphylococcus aureus
MU	meaningful use
NAAL	National Assessment of Adult Literacy
NASADAD	National Association of State Alcohol and Drug Abuse Directors
NCES	National Center for Education Statistics
NICS	National Instant Criminal Background Check System
NIEM	National Information Exchange Model
NIJ	National Institute of Justice
NOMS	National Outcome Measures
OJP	Office of Justice Programs (DOJ)
OMS	Offender Management Systems
ONC	Office of the National Coordinator for Health Information Technology
Part 2	*See *42 CFR Part 2*
PCP	primary care physician
PDMP TTAC	Prescription Drug Monitoring Program Training and Technical Assistance Center
PH	Physical Health
PHI	protected health information
PMIX	Prescription Monitoring Information Exchange
PMP	Prescription Monitoring Program
PSI	Pre-Sentence Investigation (Report)
QSOA	*Qualified Service Organization Agreement*
RHIO	Regional Health Information Organization
RMS	Records Management System
ROI	Release of Infomation
SA	Substance Abuse
SDO	standards developing organization
SEARCH	The National Consortium for Justice Information and Statistics
SMART	Statewide Maryland Automated Record Tracking (ADAA)
SME	subject matter expert
SOA	service-oriented architecture
SSN	Social Security Number
STD	sexually transmitted diseases
SUD	substance use disorder
TASC	Treatment Alternatives for Safe Communities

ACRONYM OR ABBREVIATION	DEFINITION
TEDS	Treatment Episode Data Set
UI	Urban Institute
VA	Veterans Health Administration
WITS	Web Infrastructure for Treatment Services
XML	eXtensible Markup Language

7.2 APPENDIX B: Contributors

7.2.1 Lead Author Organizations

7.2.1.1 About the IJIS Institute

The IJIS Institute, a 501(c)(3) nonprofit corporation, represents industry's leading companies who collaborate with local, state, tribal, and Federal agencies to provide technical assistance, training, and support services for information exchange and technology initiatives. The IJIS Institute unites the private and public sectors to improve mission-critical information sharing for those who protect and serve our communities.

The IJIS Institute was founded in 2001 as a result of the U.S. Department of Justice's interest in raising private sector participation in the advancement of national initiatives affecting justice and public safety, and more recently homeland security. Today, the IJIS Institute represents the leading companies serving these and other related sectors. The IJIS Institute provides assistance to government agencies by bringing industry to the table in a constructive role, and continuing to drive toward achieving high regard for the companies that are dedicated to helping the public sector find high-value solutions. The IJIS Institute is funded through a combination of Federal grants, industry contributions, and partnership agreements.

For more information:

- Visit the website: http://www.ijis.org/
- Read the blog: *IJIS Factor Blog*
- Follow Twitter: @ijisinstitute
- Join the conversation on LinkedIn:
  - IJIS Institute group
  - *Justice and Public Safety Information Sharing* group

7.2.1.2 About the Urban Institute

The Urban Institute (UI) is a nonprofit, nonpartisan policy research and educational organization that examines the social, economic, and governance challenges facing the nation. It provides information, analyses, and perspectives to public and private decision makers to help them address these problems and strives to deepen citizens' understanding of the issues and trade-offs that policymakers face.

Established in Washington, DC in 1968, UI investigates social and economic problems confronting the U.S. and the government policies and programs designed to alleviate them. UI has become nationally known and respected as an objective and nonpartisan source of information and analysis for informed policy deliberation and debate. Through conceptual work, program evaluations, and policy studies, Institute researchers across nine policy centers contribute to the knowledge available to policymakers, officials, and the public concerned with formulating and implementing more efficient and effective government policy.

UI's expertise spans both justice and health policy. UI's Justice Policy Center (JPC) conducts research and evaluation designed to improve justice and public safety policies at the national, state, and local level. JPC has expertise on a range of issues within criminal justice, including policing, court programs, Federal case processing, gangs, prisoner reentry, crime and drug prevention, human trafficking, assessments of juvenile and criminal justice legislation, and evaluability assessments and evaluations of specific criminal justice programs. UI's Health Policy Center (HPC) researchers analyze trends and underlying causes of

changes in health insurance coverage, access to care, and use of health care services by the entire U.S. population.

More information about the Urban Institute is available at www.urban.org.

7.2.2 Working Group Members

The IJIS Institute and The Urban Institute express our appreciation to the following individuals who made this report possible:

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Jim Douglas	SEARCH
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Aaron Horvath	Urban Institute
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Emily Turner	Council for State Governments
Tim Walker	PCG Consulting
Joel Warmolts	Treatment Alternatives for Safe Communities (TASC) (IL)
Greg Warren	Baltimore Substance Abuse Systems (MD)

7.2.3 Organizations Providing Additional Input

The IJIS Institute and The Urban Institute express our appreciation to the following organizations who contributed to this report:

- American Probation and Parole Association (APPA)
- Association of State Correctional Administrators (ASCA)
- Council of State Governments (CSG)
- Health and Human Services (HHS)
- Marquis Software
- Office of Administration Justice Network (JNET)
- Pennsylvania Department of Corrections
- University of Kansas, School of Social Welfare
- Vera Institute of Justice

7.3 APPENDIX C: Phase 2 Recommendations

7.3.1 Phase 2 Project Charter

7.3.1.1 Recommended Objective Statement

Information sharing related to justice-involved individuals presents a critical challenge for the criminal justice, healthcare, mental health, and substance abuse treatment services domains. The ability to share information among these domains can dramatically affect public safety and the justice process and the quality and continuity of care provided to these individuals. Information of interest among both communities includes: medical history, mental health/program assessment information, drug prescription history, disciplinary history, threat assessment levels, and behavioral issues. A lack of information sharing results in work-related ignorance and missed opportunities to most effectively assist and/or supervise individuals. This cross-domain information sharing between criminal justice and health is too important to not continue moving forward.

7.3.1.2 Recommended Primary Goals

1) Create formal Criminal Justice and Health cross-domain service specification(s) and pilot implementation(s). These will result in a toolset to enable jurisdictions to repeat the implementation(s) for their own use and reap the benefits thereof.
2) Update the *Opportunities for Information Sharing to Enhance Health and Public Safety Outcomes* document to incorporate applications in juvenile justice, as well as other potential implementations that emerge.

7.3.2 Phase 2 Project Deliverables

- Establish a SME Working Group
- Complete *Opportunities for Information Sharing to Enhance Health and Public Safety Outcomes*, Version 2
- Develop a GRA-conformant Service Specification(s) for the selected high-value information exchange
- Implement the Service Specification(s) as a proof of concept pilot
- Complete final report, to include:
  - Pilot Implementation Outcomes,
  - Lessons Learned, and
  - Future Recommendations

7.3.3 Phase 2 Project Participants

- Stakeholders representing ***criminal justice*** at all levels (Federal, State, Local and Tribal) across all phases of the system (law enforcement, pre-trial services, initial detention, courts, court support services, corrections, and community corrections)
- Stakeholders representing ***health*** at all levels (Federal, State, Local and Tribal) across all phases of the system (mental health, physical health, substance abuse and prescription medications)
- Industry representatives that are SMEs on criminal justice and/or health exchanges

The total size of the group is estimated to be approximately **~20-25 participants**. The suggested roles and responsibilities for participants include the following.

7.3.3.1 Project Management Team

- Manage and guide the schedule, deliverables, and budget
- Facilitate project calls and web conferences
- Perform other tasks as appropriate

7.3.3.2 Team Members

- Provide subject matter expertise
- Participation in the face-to-face working group meeting(s)
- Participation in follow-up conference calls/web conferences to review/edit the draft materials and deliverables
- Additional non-scheduled time to review and comment on document drafts
- Additional work assignments as agreed to by participant

7.4 APPENDIX D: Additional Implementation Challenges Information

7.4.1 HIPAA

HIPAA, codified in *45 C.F.R. § 160*, *162* and *164*, set national standards for protecting the privacy of patients' health information and for electronic records of health care transactions[47]. Health information and PHI are defined in *45 C.F.R. § 160.103*.

- *Health information* consists of information on medical and mental health conditions, information on receipt and information on payment for receipt of services for these conditions.
- *PHI* is health information that is recorded or maintained in any type of medium and which directly identifies, or provides a ground for identifying an individual.

There are no restrictions on the use or disclosure of de-identified health information. *HIPAA* applies to three categories of "covered entities" health care providers, health plans, and health care clearinghouses (*§ 160.103*).The standards set by *HIPAA* are minimal standards. If a state law is more protective of health information, then the state law takes precedence over *HIPAA*.

In general, PHI may not be disclosed without written authorization of the individual who is the subject of the disclosure, but a few exceptions are permitted. Consent is not required for entities to disclose information for treatment, payment and health care operation purposes, as well for disclosures to other entities, so long as the entities have had a relationship to the individual, and the information is relevant to this relationship (*§ 164.501, § 164.506*). Disclosures are also permitted for entities to maintain a facility directory; authorization is not required in such cases, but individuals must be given the opportunity to agree or object to the request (*§ 164.510*). In most cases, when PHI is disclosed, it is advised that only the minimum amount of information required to satisfy the purpose of the disclosure be included (*§ 164.502*); however, full disclosure (*i.e.* more than the minimum necessary) is permitted for treatment purpose requests generated by health care providers (*§ 164.502*) and when required by law and requested via a court order or subpoena (*§ 164.512*).

Authorized legal disclosures, without consent, include disclosures related to public health surveillance, investigations, and interventions; for routine health care operations; for judicial and administrative proceedings and law enforcement purposes (*45 C.F.R. § 164.512*); and, research[48]. Consent for disclosure of PHI is not required in cases where disclosure is required by law. This includes disclosure of PHI about an individual whom the covered entity reasonably believes to be a victim of abuse, neglect, or domestic violence and when this disclosure is required by law (*§ 164.512(c)*).

[47] U.S. Department of Health & Human Services (*n.d.*). "The privacy rule." Retreived from: http://www.hhs.gov/ocr/privacy/hipaa/administrative/privacyrule/index.html

[48] Coffey, R. M., Buck, J. A., Kassed, C. A., Dilonardo, J., Forhan, C., Marder, W. D., & Vandivort-Warren, R. (2008). "Transforming mental health and substance abuse data systems in the United States." *Psychiatric Services*, 59(11), 1257-1263.

In addition, a covered entity may disclose PHI without consent in the course of any judicial or administrative proceeding in response to a court order or, with certain assurances, to a subpoena, discovery request, or other lawful process (*§ 164.512(e)*). PHI may also be released without patient consent to law enforcement authorities under six circumstances[49]:

1) As required by law under court order, warrant, subpoena, or administrative request
2) To identify or locate a suspect, fugitive, material witness or missing person
3) In response to a law enforcement official's request for information about a crime victim or suspected crime victim
4) To alert law enforcement personnel of the person's death if the covered entity believes that criminal activity caused the death
5) When a covered entity believes that protected health information is evidence of a crime that occurred on its premises
6) In a medical emergency not occurring on the premises of the covered entity when necessary to inform law enforcement authorities about the commission, nature, or location of a crime, crime victim or perpetrator" (*§ 164.512(f)*).

7.4.2 HITECH Act

On February 17, 2009, the *American Recovery and Reinvestment Act of 2009* was signed into law. *Title XIII in Division A, SEC. 13001 through SEC. 13424* and *Title IV in Division B, SEC. 4001* through *SEC. 4302*, cover the *HITECH* portion of the *American Recovery and Reinvestment Act*.

HITECH enhances existing safeguards and increases penalties for unauthorized disclosure of PHI. Written contractual requirements are now mandated for external business associates who receive PHI from covered entities (*SEC. 13404, 13408*). If business associates obtain PHI, then they are permitted to use and further disclose the protected information in a manner set forth by the contract (*45 C.F.R. § 164.504*); however, prior to *HITECH*, business associates were only subjected indirectly to *HIPAA* regulations through a BAA with a covered entity; the *HITECH* Act made it so that the business associate is now directly subjected to the same *HIPAA* regulations as the covered entity[50]. *HITECH* amended penalty regulations (*42 U.S.C. § 1320d–5*) against unsanctioned disclosures of covered entities so that they will be applicable to business associates (*SEC. 13401*). *HITECH* also aimed to ensure that security protections are incorporated in the electronic exchange of health information. While *HIPAA* established security standards (*e.g. 45 CFR 164 §164.306*, *308*, *310*, *312*), *HITECH* promulgated electronic data transmittal standards that are more up-to-date with current technology via *45 CFR 170 §170.205*, *210* and *299*.

[49] Snavely, K., Taxman, F., & Gordon, S. (2005). "Offender-based information sharing." In A. Pattavina (Ed.), *Information technology and the criminal justice system*. Thousand Oaks, CA: Sage. pp. 195-22

[50] HIMSS (2009). *Business associate agreements under the HITECH Act: A summary of policy and legal issues for the U.S. Department of Health and Human Services (HHS) Office of Civil Rights (OCR)*. Chicago, IL: Healthcare Information and Management Systems Society.

7.4.3 42 CFR Part 2

Substance abuse treatment records can be considered a special type of PHI, guidelines for which are set forth in *Confidentiality of Alcohol and Drug Abuse Patient Records* (*42 CFR Part 2*). The provisions of *42 CFR Part 2* apply to a health agency that is operated or assisted in any way by a Federal agency and prohibit disclosure of health records containing patient identity, diagnosis, and drug abuse treatment information without patient consent (*§ 2.1*). When consent is provided it must include, the name of the individual or organization to which disclosure is to be made, the purpose of the disclosure, how much and what kind of information is to be disclosed and the date, event, or condition upon which the consent will expire if not already revoked. This expiration date, event, or condition must insure that the consent will last no longer than reasonably necessary to serve the purpose for which it is given (*§ 2.31*).

The provisions of *Part 2* have important ramifications for information exchange within the substance abuse treatment system as well as between the substance abuse and criminal justice systems.

> *"Without patient consent, personally identifiable substance abuse treatment records cannot be re-disclosed for routine health care operations outside the organization from which the data were obtained; thus, independent treatment professionals may not share data about individual clients without client consent."*[51]

The length of time client consent is active can influence the coordination of services as well as influence the ability of programs to evaluate the long term impacts of their services. While *HIPAA* and *Part 2* do not contain mandated expiration of consents, some states limit the length of time a patient authorization for release of information to one year. After one year client consent must again be provided. This can interrupt the sharing of information upon which treatment coordination had been based. In addition, programs that wish to assess post-treatment client outcomes (*e.g.* hospitalization, return to treatment, homeless services) are often restricted by the one year limitation due to inability to locate and regain authorization for release of protected information.

With proper consent, *Part 2* allows for sharing of drug abuse treatment information with the criminal justice system[52]. If a patient is involved in the criminal justice system and their enrollment in a treatment program is a required condition of their prosecution, then this health/treatment information is available to the criminal justice professionals (attorney, probation and parole officers, and court staff) for the purpose of monitoring a patient's treatment progress (*§ 2.35*). Importantly, however, drug abuse treatment records may not be "except as authorized by a court order […] used to initiate or substantiate any criminal charges against a patient or to conduct any investigation of a patient" (*§ 2.1 (c)*); however, court orders for release of treatment information are typically limited to investigation or prosecution of very serious crimes, when the treatment information is of substantial use to the investigation or

[51] Coffey, R. M., *et al* (2008). "Transforming mental health"

[52] Petrila, J., & Fader-Towe, H. (2010). *Information sharing in criminal justice-mental health collaborations*. New York: Council of State Governments Justice Center.

prosecution and when the public interest needs for disclosure outweigh patient harm that could result from disclosure[53].

[53] Snavely, K., Taxman, F., & Gordon, S. (2005). "Offender-based information sharing"

7.5 APPENDIX E: Related Information, Standards, and Guidelines

7.5.1 Information Sharing in Criminal Justice-Mental Health Collaborations

This is a guide[54] intended to help criminal justice officials work with health professionals to better use both systems' information, when appropriate, to reduce criminal justice involvement among people with mental illnesses and provide better links to treatment.

7.5.2 Prescription Drug Monitoring Program Training and Technical Assistance Center

The Prescription Drug Monitoring Program Training and Technical Assistance Center (PDMP TTAC)[55] at Brandeis University provides support, resources, and information to PDMPs, Federal partners, organizations, and other stakeholders to further the efforts of PDMPs in curtailing prescription drug abuse and diversion while ensuring access to controlled medications for patients with legitimate medical need.

7.5.3 National Information Exchange Model

The National Information Exchange Model (NIEM)[56] is a partnership of the U.S. Department of Justice, Department of Homeland Security, and Department of Health and Human Services. It is designed to develop, disseminate and support enterprise-wide information exchange standards and processes that can enable jurisdictions to effectively share critical information in emergency situations, as well as support the day-to-day operations of agencies throughout the nation.

NIEM enables information sharing, focusing on information exchanged among organizations as part of their current or intended business practices. The NIEM exchange development methodology results in a common semantic understanding among participating organizations and data formatted in a semantically consistent manner. NIEM will standardize content (actual data exchange standards), provide tools, and managed processes.

NIEM builds on the demonstrated success of the Global Justice XML Data Model (GJXDM). Stakeholders from relevant communities work together to define critical exchanges, leveraging the successful work of the GJXDM, and further enhancing the capabilities of the NIEM model by developing Information Exchange Package Documentation (IEPD)[57].

[54] For additional information on the guide, visit: http://consensusproject.org/jc_publications/info-sharing

[55] For additional information on the PDMP TTAC, visit: http://www.pdmpassist.org/

[56] For additional information on the NIEM, and the associated training, standards, and events, visit: http://www.niem.gov

[57] For additional information on the IEPD Clearinghouse, visit: http://www.it.ojp.gov/framesets/iepd-clearinghouse-noClose.htm

7.5.4 Health Level Seven International

Health Level Seven International (HL7)[58], an ANSI-accredited standards developing organization (SDO), is the global authority on standards for interoperability of health information technology. With members in more than 55 countries, HL7 is deeply involved in worldwide efforts to improve healthcare through information technology and is a founding member of the Joint Initiative Council, an international council on global health informatics standardization that is committed to developing a single standard for a single purpose. HL7 also has an agreement with the International Organization of Standardization (ISO) through which HL7 submits its ANSI-approved standards or draft standards for trial use (DSTUs) directly to ISO for approval.

Founded in 1987, HL7 International is a nonprofit organization comprised of more than 4,000 worldwide members who represent hundreds of healthcare vendors, providers, payers, government agencies, consultants and others. In the U.S. alone, 90 percent of the largest health information system vendors are HL7 members. Volunteers perform HL7's standards development work.

HL7 does not develop software. It creates standards that allow healthcare information to be communicated across and between healthcare enterprises and communities. HL7 standards facilitate the exchange of clinical and administrative data among health information systems. Specifically, HL7 provides a comprehensive framework and related standards for the exchange, integration, sharing, and retrieval of electronic health information that supports clinical practice and the management, delivery, and evaluation of health services.

The most widely used HL7 specifications are messaging standards that enable disparate healthcare applications to exchange key sets of clinical and administrative data. HL7's Version 2.x messaging standard is arguably the most widely implemented standard for healthcare in the world. In 2009, it was published as an ISO standard. In the U.S., the HL7 Version 2 messaging standard is deployed at most healthcare facilities and is an international ISO standard. The HL7 Version 3 messaging standard is used by U.S. government agencies such as the Food and Drug Administration (FDA) and the VA. Version 3 is also widely used outside the U.S. in countries such as Canada, the United Kingdom, the Netherlands, Germany and Mexico.

7.5.5 Global Reference Architecture

The Global Reference Architecture (GRA)[59] is a service-oriented reference architecture for information sharing. The GRA adheres to the principles of service-oriented architecture (SOA), which are somewhat technical in nature but boil down to three things.

- **First**, when partners share information between justice systems, they implement a "layer" of technology in between so that the systems are "insulated" from one another, removing direct dependencies while reducing stovepipe systems. This allows a greater degree of flexibility and autonomy between the information sharing partners.

[58] For additional information on HL7, visit: http://www.hl7.org/

[59] For additional information on the GRA, visit: http://www.it.ojp.gov/GRA

- **Second**, information sharing projects follow accepted and well-established open-industry standards whenever possible, rather than solutions and approaches proprietary to particular vendors. This allows everyone to participate, regardless of the vendor or technology used—and allows independence in these choices.
- **Third**, by adopting a formal governance structure, the partners strive for a common approach and a common technology infrastructure, rather than doing things on a project- or agency-specific basis. This tends to reduce the cost and effort of information sharing by eliminating redundancy and enabling better utilization of resources.

A *reference architecture* is a set of documents that the technologists—developers, architects, project managers— in a jurisdiction can use to accelerate the planning process for information sharing, while simultaneously aligning the final outcomes with proven best practices. A reference architecture is a tool practitioners can use to make it easier to develop a well-conceived, formal approach to designing information sharing solutions/systems. A key benefit of reference architecture is that it helps promote consistent thinking and approaches among the people who use it, even if they have not shared information with each other.

7.5.6 Justice Information Exchange Model

The Justice Information Exchange Model (JIEM)[60] was developed by the BJA and The National Consortium for Justice Information and Statistics (SEARCH) to assist justice agencies in the sharing of information. JIEM is a combination of three interrelated components: 1) JIEM Methodology; 2) JIEM Reference Model; and, 3) JIEM Modeling Tool.

JIEM Methodology refers to a structured approach to documenting the information to be exchanged. This involves capturing the exact information to be shared as well as the communicator and the recipient of that information, the timing of the exchange, responses that may occur as a result of the exchange, relative importance, and privacy considerations.

The *JIEM Reference Model* is a repository of various information exchanges conducted in the past that contain business functions common to many jurisdictions and defined or refined from previous JIEM exchanges. In other words, the Reference Model is a collection of previous experiences that may prove useful in new exchanges without the need to duplicate work that has already been completed – why reinvent the wheel when it's right in front of you.

Finally, the *JIEM Modeling Tool* is a software package that allows practitioners to build a model of their proposed information exchange. This tool is used to ensure compliance to Global Justice XML Data Model and NIEM standards and results in the development of an IEPD that can be used for implementation, as well as replication in other jurisdictions. JIEM standardizes the process of creating information exchanges between justice agencies while also developing a growing library of IEPDs that can used to replicate exchanges in other jurisdictions in the country without the need to start from the beginning.

[60] For additional information on JIEM, visit: http://www.search.org/programs/info/jiem/tool/

7.5.7 Justice and Mental Health Collaboration Program

The Justice and Mental Health Collaboration Program (JMHCP)[61] was created by the *Mentally Ill Offender Treatment and Crime Reduction Act of 2004* (*Public Law 108-414*) in response to requests from state government officials to recommend improvements to the criminal justice system's response to people with mental illness. The purpose of the program is to increase public safety by facilitating collaboration among the criminal justice, juvenile justice, mental health treatment, and substance abuse systems to increase access to treatment for this unique group of offenders.

Many related new items, sources, and publications are available on the JMHCP website; however, particularly noteworthy publications include:

- *Statewide Law Enforcement/Mental Health Efforts: Strategies to Support and Sustain Local Initiatives*
- *Information Sharing in Criminal Justice-Mental Health Collaborations: Working with HIPAA and Other Privacy Laws*

7.5.8 2013 Report on Impact of Coordination/Integration on Medicaid Expenditures for Persons with Substance Use Disorders

In the report[62], quantitative Medicaid expenditure savings in for patients with substance use disorders (SUDs) were correlated with the "coordination of care reputation" of those patients' providers. The data showed that estimates for per person Medical savings are on the order of $1,000 a year. This translates to calculated savings of just over $7 million in the population studied (a 59% sample of Maryland Medicaid enrollees with substance use disorders).

Furthermore, this work was validated by separate correlations, showing that "coordination of care" was also significantly associated with reduced inpatient service use. The cost savings detailed by this report is a powerful argument for better coordination/integration of care.

[61] For additional information on JMHCP, visit: https://www.bja.gov/ProgramDetails.aspx?Program_ID=66

[62] For additional information on the report, visit [Baltimore Substance Abuse Systems, Inc., (bSAS)]: http://www.bsasinc.org/about-bsas/publications/

7.6 APPENDIX F: Success Stories

7.6.1 SMART and WITS

The SMART system [formerly called HIDTA Automated Tracking and Treatment System (HATTS)[63]] was developed in 2003 and is based upon the national Web Infrastructure for Treatment Services (WITS) platform[64]. SMART provides fully electronic clinical records for individuals who are involved in the substance abuse treatment system by supporting real-time collaboration between drug treatment facilities, drug courts, and other state and local agencies, while meeting all Federal and state confidentiality regulations.

SMART enables treatment providers to report case data online and provides interoperability through eXtensible Markup Language (XML). A web browser and internet connection are all that is needed to access and enter data into the SMART system[65]. SMART is an example of a centralized information exchange; it utilizes a central storage database of identifiable client information to and from which collaborators submit and query data. Multiple agencies maintain information in one database and the application software is installed and maintained at the central site. Using an online interface, treatment providers enter admission, treatment encounters, referral and discharge data for their clients into the SMART system. Data entry is through the various SMART system modules' data entry forms and SMART performs data checks to ensure the data's veracity. In addition, agencies receive monthly reports to let them know which client records have incomplete admission or discharge data[66]. Training is mandatory for SMART system users[67] and serial training, rather than a single session approach, is recommended for users[68].

An agency can view the data it has submitted to SMART, as well as treatment information that other SMART system participants, with client consent, have authorized the agency to view for purposes of integrated treatment planning. SMART enables treatment referrals and consent collection through eConsent (or electronic consent) which manages processes associated with the electronic consent and disclosure of client records while complying with *Part 2 § 28* and *HIPAA* rules[69]. eConsent enables electronic information exchange with other organizations involved in drug treatment, such as probation

[63] SEARCH (2003b). *Public domain drug court software: Functions and utility*. Washington, D.C.: BJA.

[64] Institute for Governmental Services and Research (2010). *About SMART*. Retrieved from: http://www.igsr.umd.edu/SMART/about.php

[65] WITS Collaboration Center (2008). *WITS basics: Information tour*. Retrieved from: http://www.witsweb.org/basics_infotour.asp

[66] Shupe, C., & Sherman, S. (n.d.). *SMART: Maryland's online data collection and clinical record system*. Retrieved from: http://www.nasadad.org/resources/s%20Implementation%20of%20WITS_3%20Presentation%20Cindy%20Shupe.pdf

[67] WITS Collaboration Center (2008). "WITS basics"

[68] Snavely, K., Taxman, F., & Gordon, S. (2005). "Offender-based information sharing"

[69] Institute for Governmental Services and Research (2010). "About SMART"

and parole offices. If a referral is made by a facility that is on-line, SMART automatically forwards records and reports to the extent permitted by confidentiality rules and releases[70].

SMART's drug court module further facilitates case management across substance abuse and criminal justice systems by simplifying stakeholders' access to drug court assessment and admissions data, current criminal justice information, drug test results, sanctions and compliance with community supervision requirements. In 2010, mental health courts were introduced to SMART[71]. In addition, to case management functions, WITS functionality allows SMART to comply with Treatment Episode Data Set (TEDS), National Outcome Measures (NOMS), *Government Performance and Results Act (GPRA)*, and block grant reporting requirements[72]. Thus, SMART performance measures can be generated at client, agency, and system levels[73].

7.6.2 BHIPS/CMBHS

The Behavioral Health Integrated Provider System (BHIPS) is a web-based clinical information system for substance abuse and mental health service providers. Developed in Texas and implemented in five other states, BHIPS is being superseded in Texas by the Clinical Management for Behavioral Healthcare System (CMBHS), which is used for assessing and treating mental health as well as substance abuse disorders[74]. Upon completion, CMBHS will have interfaces with the Department of Public Safety (Jail Diversion), Texas drug courts; and, the Office of Court Administration. BHIPS/CMBHS is similar to SMART in that it is a centralized online database of identifiable client information to and from which collaborators submit and query data in real time via a web-based application[75]. This online database allows for seamless gathering, updating, and exchange of client information in real time. BHIPS/CMBHS is *Part 2*- and *HIPAA*-compliant. A consent form signed by the client must be on file before identifying information is shared across provider organizations.

BHIPS/CMBHS is an example of a hybrid model of information exchange in that, in addition to performing data transfer between agencies through an online server, also utilizes a data warehouse server to which data from the online server is downloaded nightly. De-identified data is created from the on-line information system and stored in this data warehouse. This stored data is used for reporting TEDS, NOMS, GPRA and block grant reporting requirements. This storage database also provides on-demand reports to providers and benchmarking with contracted performance measures and other provider outcomes throughout the State.

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[70] WITS Collaboration Center (2008). "WITS basics"

[71] Office of Problem-Solving Courts (2010). *Annual Report: Problem-solving courts, fiscal year 2010*. Annapolis, MD: Administrative Office of the Courts.

[72] WITS Collaboration Center (2008). "WITS basics"

[73] Snavely, K., Taxman, F., & Gordon, S. (2005). "Offender-based information sharing"

[74] O'Donnell, C. (2009). *Executive leadership guidelines for developing a behavioral electronic health record system technology plan*. Washington, DC: National Data Infrastructure Improvement Consortium (NDIIC), Inc.

[75] National Association of State Alcohol and Drug Abuse Directors (NASADAD) (2006). *Texas Behavioral Health Integrated Provider System (BHIPS)*. Washington, D.C.

7.6.3 Hampden County Sheriff's Department Reentry Information Sharing Pilot Site Project

The purpose of the BJA Offender Reentry Information Exchange project[76] was to use Global Justice Information Sharing Initiative (Global) standards, such as the GRA, the NIEM, and the Global Federated Identity and Privilege Management (GFIPM) to improve reentry information sharing between the Hampden County Sheriff's Department (Massachusetts) and community-based service providers. The project, led by the ASCA, and in collaboration with the IJIS Institute and the American Parole and Probation Association (APPA), uses the information sharing architecture conforming to NIEM and GRA standards to give the Hampden County Sheriff's Department the ability to share reentry information with organizations that would be providing services to offenders being released from the County jail.

Hampden County, which releases about 2,200 offenders a year, identified a set of information sharing capabilities that could be used by the corrections community to exchange information with law enforcement, public safety, human/social services partners, and other community resources that participate in the offender reentry process.

In order to ensure basic privacy considerations, Hampden County obtains a waiver from each inmate, which is kept in the system before any information is released. The waiver allows the offender's information to be shared with service providers for one year from the date of signature. Additionally, ASCA, with the pilot project team, developed a Reentry Information Sharing Guideline and Template that will be of use to the reentry implementations. The "template" provides the reader with: an overview of *HIPAA*/*Part 2* and how it relates (*i.e.* applies or does not apply) to corrections; a glossary of *HIPAA* and *Part 2* definitions; guidance on consent authorizations and a sample "compliant" consent form; guidance on Qualified Service Organization Agreement (QSOAs)/BAAs and a sample QSOA/BAA; and, a *HIPAA* and *Part 2* guidance and a sample court order.

This project specifically focused on developing IEPDs and service specifications to push information from the Hampden County Sheriff's Department to a variety of service providers (medical service providers, psychiatric service providers, recovery service providers) using two mechanisms. For those providers that do not have any infrastructure, the information will be pushed to a portal and the provider will be able to review and download the information. Those providers that have systems and are willing to ingest the information electronically, an automated exchange will be sent. Artifacts of this project available to leverage into other jurisdictions include: GRA service specification design artifacts for each capability; project governance; project charter; IEPDs; and, service specifications.

The exchange went live in early 2012. Service providers are now able to log in and get information about offenders about to be released to the community. For providers lacking infrastructure, the information is pushed to a portal where providers are able to review and download the information. Providers able to ingest the information electronically receive an automated data exchange. To ensure privacy, Hampden County obtains a signed waiver from each inmate allowing his or her information to be shared with service providers for one year. Different types of information are shared, depending on the profile

[76] For additional information, contact **John Kenney**, *Assistant Superintendent*, Hampden County Sheriff's Department, Ludlow, MA by phone (413-858-0904) or email (john.kenney@SDH.state.ma.us.).

of the person requesting information. The exchange has recently expanded to share medical information with a community-based medical facility. Future enhancements are planned to enable Hampden County to send an email notification and inmate photo to a service provider when the inmate is referred to the service provider. Service providers, in turn, will be able to inform the Sheriff's Department about their encounters with the inmate.

7.7 APPENDIX G: Additional Reference Works

Reference works that were quoted verbatim or paraphrased are included in footnotes where appropriate; however, there are additional reference works listed here that were used in the creation of this document.

Burch, A. M., DOJ, Bureau of Justice Statistics (BJS) (2012). *Sheriff's offices 2007 - statistical tables* (NCJ 238558).

Burke, B.; Gil-Garcia, J. R.; and, Pardo, T. A. (2008). "Sustainable cross-boundary information sharing." *Integrated Series In Information Systems*, 17, 421-438.

Debus-Sherrill, Sara; Visher, Christy; and, Yahner, Jennifer (2008). *Employment after Prison: A Longitudinal Study of Releasees in Three States*. Washington DC: The Urban Institute. Retrieved from: http://www.urban.org/publications/411778.html

Gebo, Erika and John T. Kirkpatrick (2002). "The challenge of collaboration: Information sharing between law enforcement and medical communities." *The Justice Professional*, 15:1, 19-28. Retrieved from: http://dx.doi.org/10.1080/08884310212824

Goldstein, M. M., & Rein, A. L. (2010). *Data segmentation in electronic health information exchange: Policy considerations and analysis*. Washington, DC: Department of Health Policy, School of Public Health and Health Services, George Washington University.

Goldstein, Melissa M. (2012). *Health Information Privacy in the Correctional Environment*. Community Oriented Correctional Health Services (COCHS) Issue Paper. Retrieved from: http://www.cochs.org

Hamblin, Allison; Mahadevan, Roopa; Neese-Todd, Sheree; and, Stephen A. Somers (2010). *Medicaid and Criminal Justice: The Need for Cross-System Collaboration Post Health Care Reform*. Center for Health Care Strategies, Inc.

Harron, Ashley; Festinger, PhD, Jason; and, David S. Matejkowski, PhD, and (2012). *Opportunities for Information-Sharing Between Criminal Justice And Community Substance Abuse Treatment Systems*. Treatment Research Institute.

Law Enforcement Information Technology Standards Council (LEITSC), DOJ, National Institute of Justice (NIJ). (2008). *Law enforcement computer aided dispatch (CAD) systems*. Retrieved from: http://www.it.ojp.gov/documents/LEITSC_Law_Enforcement_CAD_Systems.pdf

LoBuglio, Stefan F.; Mellow, Jeff; Mukamal, Debbie A.; Osborne, Jenny W.L.; and, Solomon, Amy L. (2008). *Life After Lockup: Improving Reentry from Jail to the Community*. Washington, DC: The Urban Institute. Retrieved from: http://www.urban.org/UploadedPDF/411660_life_after_lockup.pdf

McKinney, M.E.; Rich, J.D.; and, Wakeman, SE (2009). "Filling the Gap: The Importance of Medicaid Continuity for Former Inmates." *Journal of General Internal Medicine* 24(7): 860–2.

National Association of State Alcohol and Drug Abuse Directors. (2006). *Texas BHIPS*. Washington, D.C.

National Reentry Resource Center (2013). *Reentry Facts*. Retrieved from: http://www.nationalreentryresourcecenter.org/facts

Perbix, M. (2011). "BJA offender reentry report." Presentation delivered at: SEARCH membership meeting.

Petrila, John, JD, LLM (2007). *Dispelling the Myths about Information Sharing Between the Mental Health and Criminal Justice Systems*. The CMHS National GAINS Center for Systemic Change for Justice-Involved People with Mental Illness.

RAND Health (2011). *Online guide helps health organizations adopt electronic health records*. Retrieved from: http://www.rand.org/news/press/2011/12/14.html

SEARCH (2013). *Improving the national instant background screening system for firearms purchases: Recommendations by search (Version 1)*. Retrieved from website: http://www.search.org

Wish, Eric D. (1990). "U.S. Drug Policy in the 1990s: Insights from New Data from Arrestees." *The International Journal of the Addictions*. 25(3A):377-409.