

**BRIEF FILED  
WITH MOTION**

**IN THE SUPREME COURT OF APPEALS OF WEST VIRGINIA**

**NO. 14-0965**

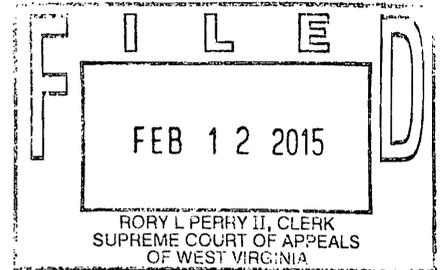
**E.H., et al.,**

**Petitioners Below, Respondents on Appeal,**

**v.**

**KHAN MATIN, M.D., et al.,**

**Respondents Below, Petitioners on Appeal.**



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**RESPONDENTS E.H., ET AL.'S BRIEF**

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## INTRODUCTION

Petitioner herein and Respondent below, the West Virginia Department of Health and Human Resources, Bureau for Behavioral Health and Health Facilities (DHHR), asks this Court to reverse a circuit court order entered on August 27, 2014. (App. 335-49.) The order at issue addresses DHHR's sudden refusal to comply with legislative rule, its prior agreements, and court orders, by interfering with the work of the patient advocates—a program required by West Virginia law to protect patient civil rights in state operated psychiatric facilities. In June 2014, contrary to its practice of the past twenty-five years, DHHR without warning began limiting the advocates' access to patients, patient records, and hospital staff.

Patient advocacy services were established in West Virginia's state psychiatric hospitals for the very purpose of creating a long-term solution to the problems brought to light by this mandamus action, by creating an ongoing mechanism for oversight and resolution of improper patient treatment without court intervention. Patient advocacy services were initially created through the Behavioral Health Services Plan adopted by DHHR in the 1980s. In 1990, with agreement of DHHR, a court order was entered moving the services to a contractee rather than a direct DHHR employee, to ensure that the patient advocates were not hindered by conflicts. In 1995, this system was adopted into law. For over twenty-five years, the patient advocacy services have brought to light violations of patient rights and ensured that those violations were remedied and the patients' rights protected. DHHR's recent claim, in the third of its series of appeals, that patient advocacy services must be limited because they *violate* patient rights turns the whole program on its head in a thinly veiled attempt to relieve itself of this vital oversight mechanism.

In this appeal, DHHR asserts that the patient advocates, who are required by law and contracted with DHHR, may not access the very patient records they need in order to perform their

responsibilities. DHHR's arguments mistake the role of the patient advocates as well as the meaning and purpose of privacy laws. DHHR asserts two rationales for its position: that disclosure of patient records violates the patients' constitutional right to privacy and that it violates the patients' rights under the federal Health Insurance Portability and Accountability Act (HIPAA). Both of these arguments are no more than a smokescreen for DHHR's clear attempt to interfere with necessary oversight of its hospitals' provision of treatment to their patients. Indeed, DHHR's argument that it simply wishes to protect patient rights through this appeal is belied by the clearly stated wishes of its own patients who have independently lodged grievances against the new "privacy" policy, in an attempt to restore their access to meaningful advocacy services. DHHR's position is also not shared by the lead agency on privacy issues, the West Virginia State Health Care Authority, which found no HIPAA violation and thus has not made any report of privacy breach to the federal oversight agency, patients, or their families. Nor is DHHR's position shared by the very lawyers that it hired to examine its compliance with HIPAA, who found no conflict between the state law requiring disclosure to the patient advocates and HIPAA's privacy regulations. Finally, the true motivation behind DHHR's policy change is demonstrated by the fact that DHHR made no effort to investigate the advocates' roles or purpose before unilaterally denying them access to patient information, that it implemented overly stringent authorization requirements and other limitations that violate HIPAA, and that it has failed to notify even a single patient of the purported breach.

As is demonstrated below, the circuit court order accurately applied federal privacy law and state patient rights regulations and determined that the two could work in tandem to ensure that rights of some of the State's most vulnerable residents would be protected. As the circuit court found, HIPAA permits DHHR to share records with the patient advocates because the advocacy

services are part of the health care operations of its psychiatric hospitals. 45 C.F.R. § 164.506. HIPAA also, alternatively, permits the disclosures because they are required by law and are part of health oversight activities. 45 C.F.R. §§ 164.512(a), 164.512(d)(1). As a result, and because the order is otherwise well supported by both the facts and the law as demonstrated below, it should be affirmed.

## STATEMENT OF THE CASE

### I. The Behavioral Health System Plan & Patient Advocacy

This action was originally filed by the petitioners below as an original jurisdiction petition for mandamus, in response to egregious violations of section 27-5-9 of the West Virginia Code regarding the unnecessary institutionalization of West Virginians with mental disabilities in abhorrent conditions in the state psychiatric facilities. See E.H. v. Matin, 168 W. Va. 248, 284 S.E.2d 232 (1981) (Matin I). In response to this Court's ruling, in October 1983, the parties agreed and the court adopted the West Virginia Behavioral Health System Plan, to be implemented by DHHR with oversight by the court, ensuring protection of patient rights and provision of appropriate treatment. See E.H. v. Matin, 189 W. Va. 102, 104, 428 S.E.2d 523, 525 (1993) (Matin II).

As part of the Behavioral Health System Plan, DHHR was required to establish a patient advocacy system within the state hospitals to protect the rights of the patients on an ongoing basis. See Order, E.H. v. Matin, 81-MSIC-585 (Cir. Ct. Kan. Cty., Feb. 20, 1990) (App. 400). The patient advocates were originally DHHR direct employees, located within the hospitals. However, in the late 1980s, issues arose regarding improper personal relationships between the patient advocates and the hospital administrators. To remedy the problem of potential conflicts, the court monitor issued formal recommendations that DHHR be required to contract with an external entity to

provide patient advocacy services. Id. No party objected, and this requirement was adopted by court order. Id.

DHHR immediately contracted with Legal Aid of West Virginia (LAWV) to provide patient advocacy services, and LAWV has remained in that role since that time. LAWV's responsibilities include providing advocacy services, assisting with and investigating individual grievances, conducting abuse and neglect investigations, educating staff and patients about patient civil rights, and monitoring and ensuring overall compliance with patient civil rights at William R. Sharpe Hospital and Mildred M. Bateman Hospital (collectively, "the Hospitals"). (See App. 175:24-80:3, 229:14-17, 253:13-20, 267:16-20 (hearing transcript), 27-33 (Grant Agreement); 424 (Report to the Court and the Parties, noting that Respondent contracts with LAWV to provide advocacy services); W. Va. C.S.R. §§ 64-59-20.1, 64-59-20.2.16.b. Importantly, prior to June 2014, DHHR recognized and supported these multiple essential functions including providing both individual and systemic advocacy, including explaining those roles in materials distributed to patients.<sup>1</sup> (See App. 795 (explaining that the patient advocates "serve patient needs in individualized and systemic ways"), App. 789-94.)

In 1995, these requirements (along with several other requirements of the Behavioral Health System Plan) were permanently incorporated into the West Virginia Code of State Rules. See W. Va. C.S.R. §§ 64-59-1, 64-59-20. In addition to setting forth the proper procedures and requirements for patient advocacy, legislative rule established numerous patient rights that must be observed by the hospital. Included among these was the right to confidentiality. See W. Va.

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<sup>1</sup> DHHR's repeated assertions that the patient advocates do not conduct systemic reviews are simply wrong. Giving DHHR the benefit of the doubt, these inaccuracies likely arose from the fact that DHHR counsel has changed at least nine times since 2009. Current DHHR counsel was not present at any of the discussions, hearings, and meetings that were held between 2009 and 2014. In contrast, the undersigned has served as counsel on this action since 2008, together with counsel who initially filed this action and pursued this case since 1981.

C.S.R. § 64-59-11. This provision specified that

Records shall only be disclosed: . . . To providers of health, social, welfare services involved in caring for or rehabilitating the client. The information shall be kept confidential and used solely for the benefit of the client. **No written consent is necessary for** employees of the department, comprehensive behavioral health centers serving the client, or **advocates under contract with the department.**

W. Va. C.S.R. § 64-59-11.5.1.d (emphasis added). This requirement of disclosure to the patient advocates was intentionally designed to ensure that the advocates could fulfill their roles and responsibilities.

Court monitoring continued until 2002 to ensure DHHR's compliance with its statutory duties. State ex rel. Matin v. Bloom, 223 W. Va. 379, 382, 674 S.E.2d 240, 243 (2009) (Matin IV). In 2002, the court, by agreement of the parties, dissolved the office of the court monitor and removed the case from the active docket; it retained, however, authority to re-open the case should certain unresolved issues remain problematic. Id. at 383, 674 S.E.2d at 244. At the request of the then-Secretary of DHHR, an Office of the Ombudsman was created within DHHR to assist with continued compliance. Id.

In 2008, the Ombudsman issued a report revealing that DHHR's treatment and care of patients at the Hospitals had reached deplorable conditions. Matin IV, 223 W. Va. at 383, 674 S.E.2d at 244. The report was based, in large part, on information provided by the patient advocates located at the Hospitals. As a result, the circuit court re-opened the case and scheduled an evidentiary hearing. See id. at 384, 674 S.E.2d at 245. DHHR objected and filed a writ of prohibition with this Court arguing that the circuit court had exceeded its authority and was encroaching on the authority of the legislative and executive branches. Id. at 384-85, 674 S.E.2d at 245-46.

Ruling that the circuit court was within its authority, this Court expressed alarm regarding

the conditions for patients at the psychiatric hospitals:

[T]his report details a severe overcrowding problem at the hospital. This problem has resulted in patients having diminished or virtually no privacy; patients not having access to private bathrooms; patients not having access to shower facilities on a daily basis; male patients not being able to shave on a daily basis; and patients sustaining injuries from tripping over cots when there are three patients to one room. . . .

In general, the portrait that emerges from the Ombudsman's reports is that of a hospital that is overcrowded with patients, most of whom are frustrated by living on top of each other, being denied privacy and not having daily access to basic grooming needs. . . . Specifically, the term 'Dickensian Squalor' that Justice Neely used to describe the hospital in 1981 is an apt description of the hospital that emerges from the Ombudsman's July 3, 2008 report.

Matin IV, 223 W. Va. at 384, 674 S.E.2d at 244-45 (2009). Ultimately, this Court refused to issue the writ, holding that "the circuit court has the power to ensure that patients are receiving treatment guaranteed to them under W. Va. Code § 27-5-9." Id. at 381, 674 S.E.2d 242.

## **II. 2009 Evidentiary Hearings and Agreed Order Requiring Systemic Monitoring**

In April 2009, following this Court's decision in Matin IV, the circuit court conducted a two-day evidentiary hearing. At these hearings, evidence included testimony from patient advocates that established that the state psychiatric hospitals were severely overcrowded and mismanaged, leading to gross violations of patient rights. Patient advocates testified that, pursuant to their authority, they had conducted audits of the conditions at the hospitals, focusing on the patient rights set forth in legislative rule. The audits revealed systematic violations of patient rights at the hospitals, including the use of "chemical restraints" (i.e., sedating medications) to subdue patients rather than providing adequate treatment or care. Under these conditions, patients were not even capable of lodging individual grievances. Importantly, without unrestricted access to the patient records and facilities, the patient advocates never could have provided this valuable evidence. (See, e.g., App. 716-18.)

Following the evidentiary hearing, the circuit court ordered the parties to mediation, during which the parties reached a variety of agreements. Those agreements, memorialized in the 2009 Agreed Order, include the requirement that DHHR ensure systemic monitoring of those issues highlighted in the patient advocates' audits of the hospitals: "Bateman and Sharpe Hospitals will fully comply with W. Va. C.S.R. sections 64-59-1 to -20. Periodic review shall be established for compliance with sections 64-59-12, -13, -14, -15.1.7, -15.1.12, -15.2, -15.3, -16.4.2." Agreed Order, E.H. v. Matin, No. 81-MISC-585, at ¶ 10(d) (Cir. Ct. Kan. Cty., July 2, 2009) ("2009 Agreed Order") (App. 405).

### **III. Patient Advocacy from 2009 to 2014**

In accordance with the 2009 Agreed Order (and as intended by the parties in drafting said Order), DHHR immediately contracted with the LAWV patient advocates to continue their auditing responsibilities in order to comply with this provision. (See App. 24 (requiring LAWV to "Produce a report to inform Judge Bloom, the Hartley Court Monitor and both sides of Hartley . . . of any progress or lack of progress in implementing areas of Legislative Rule Title 64 Code of State Rules (CSR) Series 59, Behavioral Health Client Rights, within Sharpe and Bateman by the end of the grant period.").)

The parties to this matter further began regularly meeting with the court monitor. At these meetings, the central role of the patient advocates and the necessity of their unconstrained access to records has often been discussed. For instance, on January 5, 2010, the parties agreed that the patient advocates would create an assessment tool for the required audits, to enable DHHR to comply with paragraph 10(d) of the 2009 Agreed Order. (App. 411.) On March 31, 2010, DHHR agreed that quarterly audits should be conducted by providing the patient advocates with complete access to at least two patients from each unit (regardless of whether the patients had filed

grievances), and on May 5, 2010, the parties finalized the audit instrument and notified the patient advocates “to begin its implementation.” (App. 729, 734.) Thereafter, audits were conducted by the patient advocates as set forth in the 2009 Agreed Order. (See App. 738.) Over time (as they had in 2009), the audits revealed issues that were later resolved in this litigation, including, for example, DHHR’s failure to provide adequate community integration to patients as required by law. In 2010 and again in 2012, the patient advocates’ responsibilities were discussed in detail in response to formal “requests for resolution” filed with the court. These issues were resolved with DHHR’s agreement that the patient advocates had the responsibility to file systemic grievances, conduct systemic audits, and that the patients had the right to an appeal process for their individual grievances, all of which required unconstrained review of patient records. (See App. 413-25, 739-48.)

Consistent with this understanding of the patient advocates’ role, prior to late June 2014, DHHR provided the patient advocates with full access to computerized patient records and to the patient wards and other areas of the hospitals. (See App. 199:6-7.) Access to patient records allowed the advocates to fulfill their responsibilities to investigate grievances and resolve complaints without revealing the nature of the investigation to DHHR, to timely investigate abuse and neglect allegations, and to review overall compliance with patient rights, such as monitoring DHHR’s use of seclusion and chemical or physical restraints. (See, e.g., App. 271.)

HIPAA was passed in 1996 and amended in 2002. In recognition of the advocates’ role, DHHR has trained the patient advocates annually on HIPAA’s requirements; the patient advocates also enter into confidentiality agreements with DHHR. (App. 218:1-2, 261:4-12.) The advocates receive the same training as Hospital staff. (App. 261:16-18.) In addition, after the passage of HIPAA, DHHR amended its contract with LAWV to clarify that LAWV is a “business associate”

of DHHR, as defined by HIPAA. (App. 49-52.) This addendum sets forth additional responsibilities relating to patient confidentiality. (Id.) DHHR also developed privacy notices for patients in compliance with HIPAA, taking into consideration the role of the patient advocates and explicitly advising patients that their information would be shared with the patient advocates without their signed authorization, pursuant to HIPAA's provision permitting disclosure for the purposes of "health care operations." (App. 777-88.) After the court monitor was reinstated in 2009, DHHR ensured that his access to patient records also complied with HIPAA by drafting an order that that was then entered by the circuit court to enable the court monitor to access the records pursuant to HIPAA's provision allowing disclosures as "required by law." See Order, E.H. v. Matin, 81-MISC-585 (Cir. Ct. Kan. Cty., Feb. 12, 2010) (App. 428-31).<sup>2</sup>

In order to ensure compliance with HIPAA and other patient confidentiality requirements, DHHR's Hospitals each have a Privacy Officer. The Hospital Privacy Officers report to the Privacy Officer for DHHR's Bureau for Behavioral Health and Health Facilities (BHBF), who, in turn, reports to the Privacy Officer located in the Office of General Counsel for DHHR. (App. 207:2-9.) DHHR's Privacy Officer reports to the State Privacy Office, which is located in the West Virginia State Health Care Authority (HCA). (App. 207:2-9, 209.) Under the leadership of these designated privacy officers and its counsel, DHHR took steps to ensure that the patient advocacy program complied with HIPAA, including those described above. At no point, however, did DHHR's privacy officers or counsel note any concerns that the patient advocacy program violated HIPAA. To the contrary, they explicitly determined that disclosures to the patient advocacy program complies with HIPAA, as set forth in the privacy notices. (App. 779, 785.) Indeed, analyses completed in 2013 and 2014 for DHHR (while it was pursuing this appeal), did not

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<sup>2</sup> "Business associates," "health care operations," and "required by law" are defined terms within HIPAA that permit disclosure without specific signed authorization, as discussed below.

identify any conflicts between HIPPA and state law requiring that advocates be provided access to patient records without signed authorizations. (See App. 532, 760-776.)

#### **IV. Sudden Denial of Timely Access to Records and Patients**

Nonetheless, in late June 2014, without notice or warning, DHHR revoked the ability of the patient advocates to immediately access patient records. Shortly thereafter, DHHR began imposing ever increasing restrictions on the patient advocates, making their work resolving individual grievances, investigating abuse and neglect, and conducting systemic audits nearly impossible. (See App. 189:20-22, 254:13-14, 256:14-15, 263:8-10.) DHHR's new restrictions included prohibiting immediate or timely access to patient records, requiring extensive disclosures to DHHR of ongoing grievances, taking away the patient advocates' keys to the units, grossly restricting access to patients, and prohibiting the patient advocates from conducting systemic audits altogether. (App. 254-66.) DHHR further restricted the patient advocates' access to office equipment and restrooms.

In response, LAWV immediately contacted DHHR to resolve this matter suggesting, among other things, that DHHR obtain signed authorizations from patients at the time that they enter the Hospitals to enable advocacy services to be timely and adequately provided. DHHR refused all such suggestions. Faced with DHHR's refusal to collaborate to find a solution, LAWV contacted counsel for Respondents herein, because the new policy violated patient rights as established by this case and legislative rule. A motion for emergency relief was filed with the circuit court on July 22, 2014, in an attempt to timely resolve this matter and permit the resumption of patient advocacy services. (App. 1-65.)

## **V. August 1 Evidentiary Hearing**

### **A. Restrictive Authorization Requirements**

A hearing was held on August 1, 2014, at which it was revealed that DHHR had begun requiring that the patient advocates obtain signed releases from each patient, the patient's guardian if one existed, and the individual with medical power of attorney for that patient before obtaining any information from that patient, or even potentially having a conversation with the patient. Patient advocates are only advised of the identity of a guardian or health care surrogate after they receive a signed release from the patient; DHHR requires that the patient advocates obtain the signature of the guardian and/or surrogate, regardless of whether or not the individual has been declared incompetent. (App. 257:15-22.) The signed release must disclose the precise reason for the record review, and the release must be tied to a specific grievance, thereby alerting DHHR to the investigation that is taking place. (App. 201:8-11, 225:24-226:1, 229:21-24.) DHHR further requires that the release set forth exactly what documents the advocate is requesting, which reveals information about the grievance or investigation before it is resolved and is sometimes impossible, given that the advocates may not know what documentation exists in the file to request. (App. 263:2-7.) In addition, DHHR requires that the end date for any release must be the date on which the release is submitted; as a result, if the patient files another grievance the following day, a new release must be obtained, including obtaining another signature from the guardian or surrogate, which is often time intensive. (App. 265:18-266:4.)

### **B. Refusal to Allow Systemic Audits**

Testimony further revealed that as of June 2014, DHHR began unilaterally denying the patient advocates access to patient records to review the Hospitals for systemic violations of patient rights or to complete the audits required by the 2009 Agreed Order. (See, e.g., App. 237.) The

information obtained by the patient advocates regarding systemic conditions at the Hospitals was central in this case in 2009, which brought to light serious and chronic violations of patient rights. (See, e.g., App. 717 ¶ 14 (citing to record testimony from patient advocates for finding that overcrowding was resulting in violations of patient rights).) By barring the patient advocates from conducting systemic audits, DHHR has enabled itself to systemically violate patient rights with impunity—precisely the situation that the patient advocacy system was established to prevent.

### **C. Restricted Access to Patients & Patient Units**

The evidence further demonstrated that DHHR was not permitting the patient advocates to speak with patients without first obtaining a signed release from the patient's surrogate or guardian regarding the specific grievance. (App. 256:17-19.) This policy essentially renders the grievance process a nullity for those patients who are not literate or able to fill out forms, by barring the patient advocates from discussing a grievance with a patient before paperwork is completed. Patient advocates are further obstructed from providing services for patients by DHHR's new policy not to advise the patient advocates of when patients enter the Hospitals, are moved to different units, or are discharged from the Hospitals. (App. 259:16-18.) DHHR further no longer permits Hospital staff to talk to the advocates without specific signed releases for that specific interaction. (App. 256:15-17.) In addition, patient advocates no longer are advised of the staffing plans, so they are unaware of which staff are on a given unit on a given day, impacting the ability to investigate grievances and resolve informal concerns raised by patients. (App. 259:13-15.)

At the hearing it was further revealed that even after the motion for emergency relief was filed, DHHR continued instituting new restrictions on the patient advocates. BHHF Commissioner Victoria Jones, DHHR Privacy Officer Lindsey McIntosh, and Patient Advocate Sharon Reed each confirmed that during the week of July 28, 2014, again without notice or warning, DHHR

revoked the patient advocates' keys that provided them with the ability to visit patient wards and to freely move about the Hospitals. (App. 180:20-181:10, 214:10-14, 254:14-18, 263:11-13.) Patient advocates may now only enter the units accompanied by a DHHR escort. (App. 182:12-15, 254:14-18.) Commissioner Jones testified that DHHR no longer allowed the patient advocates to walk around the units, converse with patients, or sit in the common areas at times that they choose. (App. 184:12-16.) Instead, DHHR only permits patient advocates to talk or meet with patients if the patient specifically requests a meeting with an advocate and signs the appropriate releases. (App. 190:16-24.)

#### **D. Lack of Investigation or Required Reporting**

Despite DHHR's assertion that the new restrictions were required by HIPAA, over the six weeks leading up to the hearing, DHHR had not developed or provided a written policy setting forth the limitations on and requirements for access to patients, patient records, staff, or patient wards. (App. 256:21-22.) Furthermore, although these changes in procedure occurred at the direction of DHHR's Privacy Officer, Lindsey McIntosh, Ms. McIntosh admitted that she had effectively done no investigation into the patient advocates' roles or responsibilities prior to eliminating their access to patient records, staff, and patients, despite that this information is central to determining how HIPAA applies. (See App. 210-211, 213, 227, 236, 239, 240, 266.) Indeed, prior to revoking access to patients and their records, Ms. McIntosh did not visit the Hospitals, speak with the patient advocates, meet with LAWV, or even review DHHR's patient advocacy contract with LAWV. (*Id.*) Ms. McIntosh further admitted that she did not conduct any review in the instant case to determine the advocates' roles pursuant to the court's orders and DHHR's prior agreements with the court and court monitor. (*Id.*) As a result, prior to the August 1 hearing, Ms. McIntosh was unaware that it is the role of the patient advocates to investigate compliance with

patient rights at the hospitals overall; she further did not know that these activities were required by court order in order to resolve DHHR's past violations of patient rights. (App. 227:21-228:2, 230-232.) Testimony further revealed that DHHR had not revoked access to records and patients for other contracted agencies that operate within the hospitals, such as liaisons with the comprehensive behavioral health care agencies; instead, DHHR had solely targeted the patient advocates in instituting its new regime. (App. 193-197.)

At the hearing, DHHR also admitted that it had not, and apparently did not intend to, consult with the federal oversight agency (the Department of Justice's Office of Civil Rights (OCR)) regarding the purported twenty years of HIPAA violations, nor has it notified the federal government or patients and their families of the purported breach of confidentiality. (App. 185, 248, 249.) Commissioner Jones and Privacy Officer McIntosh both testified that they are aware that, in the event of a true HIPAA breach, they are required to make reports to OCR and to patients, despite that they have not done so. (*Id.*) The only action DHHR took was to file a privacy breach complaint with the HCA on July 25, 2014, over a month after DHHR suddenly restricted the patient advocates' access to information and days after the motion for emergency relief was filed. (App. 774.) In that complaint, DHHR explains that the patient advocates do not have to obtain signed authorizations from patients pursuant to legislative rule. (App. 774.) DHHR further states that it is "unsure of the level of harm" and notes that "Kanawha Circuit Court Judge Louis H. Bloom is in the process of determining if the DHHR improperly cut off advocate access to patient medical records." (App. 774.)

#### **E. DHHR's New System Violates Patient Rights**

Testimony at the hearing revealed that DHHR's new policy had an immediate detrimental impact on advocacy services at the Hospitals. First, as DHHR's witnesses testified, DHHR no

longer permits the advocates to conduct audits or observe and report on system-wide issues. DHHR's requirement of an individual grievance on the authorization forms makes it impossible for advocates to view system-wide information for auditing purposes. In addition, the elimination of access to patient units and patients has made it impossible for patient advocates to interview patients who have not filed grievances and observe the general conditions of the Hospitals. Without these avenues of investigation, DHHR has eliminated the advocates' ability to conduct audits or otherwise investigate the Hospitals' overall compliance with patient rights. (See, e.g., App. 271:1-16.)

Second, patient advocates can no longer conduct abuse and neglect investigations within the time period outlined by law due to DHHR's requirement that the advocates obtain written authorization signed by a healthcare surrogate or guardian. (App. 257:1-6.) Abuse and neglect allegations are further not being properly or timely reported to the advocates because of concern that staff can no longer speak with advocates. (App. 257:9-12, 264:1-10.)

The new policy further makes it impossible for the patient advocates to timely and appropriately assist patients with grievances. The requirement of several signatures by guardians and others creates substantial delay, and the requirement that the advocates identify requested records by name makes it impossible to obtain necessary records for an investigation because records are entered inconsistently by DHHR's staff. (App. 257:5-6, 263:2-7.) Even after obtaining the written authorization, it can take up to thirty days to the Hospitals to provide the requested records. (App. 256:2-4.) Moreover, many patients have limitations that make it difficult to read or contact advocates independently, and without the ability of advocates to speak with patients and enter the units freely, patients are inhibited from lodging appropriate grievances. (App. 255:7-22, 258:9-259:12.) In addition, patients are deterred by the exposure required by the new regime, in

which their communications with the patient advocates are not confidential, due to the requirements of Hospital escorts and disclosure of sensitive information, including the nature of the allegation and the investigation, in the authorization forms. (App. 254:21-255:1, 260:1-5.) Indeed, without access to records, and with the time limits and other limitations placed on the authorizations, advocates can no longer investigate whether a patient is being punished or their medication is being changed in retribution for filing a grievance. (App. 171:8-16.)

#### **F. Patients File Grievances on DHHR's Violations of their Rights**

Recognizing that DHHR's new policy violates their rights, patients at the Hospitals have submitted grievances setting forth their concerns that the new procedures have undermined the advocacy services, including the advocates' ability to timely resolve grievances. (App. 262:2-13, 851-56.<sup>3</sup>) One such grievance, signed by all patients on the unit, states in part: "The patient advocates have been denied access to the patients [sic] medical behavioral records. We all agree that they cannot perform their advocacy duties without the privilege to compare what is written pertaining to any and all formal complaints and issues." (App. 852.) Another grievance from a different unit requests as a resolution that

the advocates here at Sharpes have person access to my and all patients records as it was before, so that rights, in the Patients Bill of Rights are not violated any longer. . . . The advocates should be allowed to view patient records without a release of information. Advocates are being hendered needlessly and the grievance process is not being completed quickly enough to protect patients from rights violations.

(App. 853 (errors in the original).) The grievance goes on to express concern that the restrictions

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<sup>3</sup> The patient grievances are being filed simultaneously with this brief a motion to amend the appendix. As explained in said motion, DHHR erred in its preparation of the appendix by filing an unredacted letter from the patient advocate to the court monitor, which identified two patients by name, misidentified as Petitioner's Exhibit 3 from the August 1, 2014, hearing. In fact, Petitioner's Exhibit 3 was comprised of a redacted version of the letter and its enclosures. In contrast to DHHR's improper disclosure of patient identifying information, the patient advocate who provided this exhibit at the hearing redacted all identifying information prior to disclosing it, to ensure that all relevant patient privacy protections were met.

make it impossible for the patient advocates to investigate a grievance lodged by a patient who has witnessed mistreatment of another patient and creates the ability for Hospital employees to tamper with investigations. (App. 855.) In short, as the patient aptly notes, the restrictions on advocacy services violate the patients' statutory rights.

#### **VI. August 2014 Orders & HCA's Instruction to Withdraw Privacy Breach Complaint**

After reviewing submissions by the parties and conducting an evidentiary hearing, the court entered a detailed fifteen page order on August 18, 2014, which it reentered as an amended order with minor alterations on August 27, 2014. (App. 322-28; 335-49.) The order carefully explained that HIPAA does not require the new procedures established by DHHR, pursuant to several exceptions set forth in the law to ensure that patient rights are protected. The circuit court further enumerated the evidence that DHHR's new policy dramatically interferes with the ability of the advocates to timely and appropriately fulfill their responsibilities, as mandated by legislative rule and the orders in the instant case. (Id.) Because the order makes clear that DHHR's compliance with state law requiring disclosure to the advocates does not violate HIPAA, the order protects DHHR from hundreds of thousands of dollars in federal sanctions for its purported HIPAA breach.

On August 21, 2014, the date scheduled for a meeting between HCA (the lead state agency regarding patient privacy) and DHHR regarding its privacy breach complaint, HCA instructed DHHR to withdraw the incident report in light of the circuit court's ruling that the existing practice of disclosures to the advocates did not violate HIPAA. (See App. 776.) Indeed, as explained by DHHR, HCA determined that DHHR "needed to give the [patient record] access back" to the patient advocates and that DHHR's prior practice of disclosing patient information to the patient

advocates (as required by state law) did not breach HIPAA. (Dec. 3, 2014, Hrg. Tr. 37.)<sup>4</sup> Nonetheless, inexplicably, DHHR refused to comply with Judge Bloom's order and with the directive of the HCA. To this day, DHHR persists with the practices that the circuit court found violative of the law, including limiting access to patient units, indefinitely delaying abuse and neglect investigations, withholding records after receiving signed authorizations, requiring signatures of third parties for competent patients, and refusing to provide the patient advocates with the locations of patients within the hospital. (Id. at 19-27.)

Rather than comply with the circuit court order and the directive of the HCA, which provided it with assurances that it could protect patient privacy and protect the patients' rights to advocacy services, DHHR filed this appeal and moved for a stay, extending restrictions on the patient advocates' exercise of their responsibilities for as long as possible. After a stay was granted, Respondents herein moved to expedite this matter in hopes of reaching a resolution as quickly as possible, so as to mitigate any negative impact on patient care and patient rights. In opposing this request, DHHR misrepresented to this Court that it was working to resolve the matter and avoid the appeal. In fact, as was revealed at a hearing before the circuit court, DHHR had no intention of working toward resolution. (See Resp. Opp. To Mot. for Enlargement of Time.) As the State's lead privacy agency (HCA) and the State's own outside counsel has already determined, DHHR's appeal is wholly unsupported by state or federal law and is contrary to the mission of our state behavioral health care system, as established by the Legislature.

### **SUMMARY OF THE ARGUMENT**

DHHR asserts four assignments of error in an attempt to overturn the circuit court's order

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<sup>4</sup> DHHR refused to include in the appendix the transcript of a hearing held on December 3, 2014, when DHHR's withdrawal of the complaint was revealed. That transcript is before this Court as attached to Respondents' opposition to DHHR's motions for enlargement of time.

restoring access to patients, patient units, and patient records to the patient advocates. Because none of the assignments of error are availing, this Court should affirm the circuit court's order and permit the patient advocates to resume their activities protecting the rights of patients in the State's psychiatric hospitals.<sup>5</sup>

In its first assignment of error, DHHR asserts that disclosure of patient records to the patient advocates violates the constitutional right to privacy. While Respondents herein agree that privacy is an important and fundamental right, consideration of this constitutional issue is not required to resolve this appeal, and there is no support for DHHR's position that this right was violated by the patient advocates accessing patient records to complete their legally mandated duties. As a result, this assignment of error should be rejected.

Second, DHHR asserts that the circuit court erred in holding that HIPAA permits disclosure of patient records to the patient advocates. DHHR argues instead that it should be permitted to impose stringent authorization requirements on any access to patient records. However, as the circuit court correctly held, HIPAA does not require the extreme action undertaken by DHHR. Instead, several HIPAA provisions apply that explicitly permit DHHR to disclose patient information to the patient advocates for the purpose of carrying forth their legal responsibilities. These include that the advocacy services and disclosures are part of the health care operations of the facilities, see 45 C.F.R. § 164.506(c)(1); that they are required by law, see 45 C.F.R. § 164.512(a), (c), (e); and that the disclosures are for the purpose of health oversight activities, see 45 C.F.R. § 164.512(d)(1). As a result, the disclosures are wholly permitted by HIPAA. Further, given the patient advocates' responsibilities to file grievances and conduct systemic audits, full disclosure of patient records complies with the minimum necessary standard. See 45 C.F.R. §

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<sup>5</sup> Respondents disagree with DHHR's assertion that the circuit court's order was final, but choose to focus their arguments on the substantive assignments of error.

164.514(d). Finally, even if HIPAA did mandate a signed authorization (which it does not), the circuit court correctly held that DHHR’s requirements for said authorization are improper and designed solely to frustrate the effectiveness of the patient advocates. As a result, this assignment of error should be rejected as well.

The third assignment of error—that the circuit court made two erroneous factual findings in its order—is similarly unavailing. Not only did the circuit court not err, DHHR fails entirely to explain how such an error would impact the outcome of this case. As a result, even if such a factual error was made, it would be harmless.

Accordingly, the circuit court’s order should be affirmed so that access to patient records is restored to the patient advocates, permitting them to resume their duties protecting patients committed to the State psychiatric hospitals.

**STATEMENT REGARDING ORAL ARGUMENT AND DECISION**

Respondents respectfully submit that this case is appropriate for oral argument under Rule of Appellate Procedure 19(a), as it presents a narrow issue of settled law concerning application of existing privacy protections to the patient advocates in the State psychiatric hospitals. While the legal issue is narrow and settled, oral argument may assist the Court in developing a clear understanding of the factual and procedural issues. Respondents respectfully suggest that the issues on appeal may be appropriately addressed through a memorandum decision.

**ARGUMENT**

**I. Standard of Review**

Should this Court determine that the orders below are “final” for purposes of this appeal, this Court reviews a circuit court’s final order under an abuse of discretion standard. Syl. Pt. 4, Burgess v. Porterfield, 196 W. Va. 178, 469 S.E.2d 114 (1996). Findings of fact are only

overturned if they are “clearly erroneous,” whereas questions of law are reviewed de novo. Id. “In this Court’s review of a lower court determination, this Court may not overturn a finding simply because it would have decided the case differently, and this Court must affirm ‘[i]f the [circuit] court’s account of the evidence is plausible in light of the record viewed in its entirety[.]’” Francis v. Bryson, 217 W. Va. 432, 436, 618 S.E.2d 441, 445 (2005) (quoting Anderson v. City of Bessemer City, 470 U.S. 564, 573-74 (1985)). This Court may not make credibility determinations based on the record; rather, the circuit court, which heard the testimony first hand, is in the best position to make these determinations. Id. (citing Michael D.C. v. Wanda L.C., 201 W. Va. 381, 388, 497 S.E.2d 531, 538 (1997)). Further,

[a]n appellant must carry the burden of showing error in the judgment of which he complains. This Court will not reverse the judgment of a trial court unless error affirmatively appears from the record. Error will not be presumed, all presumptions being in favor of the correctness of the judgment.

State ex rel. Evans v. Robinson, 197 W. Va. 482, 486, 475 S.E.2d 858, 862 (1996) (quoting syl. pt. 2, Waco Equip. v. B.C. Hale Const., 387 W. Va. 381, 387 S.E.2d 848 (1989)). Because the circuit court’s rulings below are clearly supported by the evidence in the record and the law, the circuit court has not abused its discretion and the challenged order should be affirmed.

## **II. No Conflict Exists Between the Fourteenth Amendment and the Circuit Court’s Order.**

As its first assignment of error, DHHR contends that the circuit court’s August 27, 2014, order violates the Fourteenth Amendment’s right of “privacy of personal matters.” (Pet. Br. 14.) DHHR asserts that the circuit court ignored this constitutional consideration and erred by failing to “balance the advocates’ interests in blanket disclosure against the patients’ rights to individual privacy.” (Pet. Br. 16.) This allegation is misleading, however, given that DHHR never asked the circuit court to balance such considerations. Rather, DHHR included only one short paragraph on

this topic in its brief in response to Respondents' Motion for Emergency Relief, which cited only one (inapplicable) case and provided no context or explanation of how the alleged constitutional violation was relevant to the facts before the court. (App. 77.) DHHR did not raise the alleged constitutional issues during the hearing on August 1, 2014, nor did it include any reference to the constitutional right to privacy in the proposed order it submitted following the August 1, 2014, hearing. (See App. 97-279, 280.) Accordingly, DHHR cannot now allege error by the circuit court in failing to address the constitutional right to privacy, when DHHR barely raised the issue before the circuit court, and thereafter abandoned it.

The circuit court correctly reached its legal conclusions regarding the disclosure of patient records to patient advocates by limiting its decision to the interpretation of the statutes governing such disclosures. Because the dissemination of patient medical records in this context is governed by federal and state statutes, and because DHHR did not challenge HIPAA or any West Virginia statute as unconstitutional, the circuit court correctly refrained from addressing DHHR's constitutional arguments. It is "the obligation of the Judicial Branch to avoid deciding constitutional issues needlessly." Christopher v. Harbury, 536 U.S. 403, 417, 122 S. Ct. 2179, 2188 (2002); see also Harshbarger v. Gainer, 184 W. Va. 656, 660, 403 S.E.2d 399, 403 (1991) ("It is a fundamental rule of constitutional adjudication that constitutional questions are avoided unless absolutely necessary."). Here, the circuit court followed that well-established tenant of constitutional adjudication, and refrained from engaging in a constitutional question that did not need to be decided.

To be clear, the alleged constitutional violation raised by DHHR in this appeal is simply a red herring. Respondents do not, and have not ever, disputed that a constitutional right to privacy exists for the patients at the state psychiatric hospitals. Rather, Respondents agree with DHHR's

proposition that “the Fourteenth Amendment’s right to informational privacy forbids the indiscriminate disclosure of state psychiatric records.” (Pet. Br. 14.) Because no party herein is seeking the *indiscriminate* disclosure of psychiatric records or disputing that the patients committed to the Hospitals have a right to privacy that DHHR must respect and enforce, DHHR’s argument has no impact on this appeal.

The dispute in this case is not whether a right to privacy exists, but whether that right to privacy is violated by permitting the patient advocates to access patient records in the course of their investigations of abuse and neglect allegations, patient grievances, and audits of hospital conditions, as they are required to do by state law protecting patient rights. This is a question governed by the state and federal laws that have been enacted to ensure that patient privacy is protected, and does not in any way challenge the underlying constitutional right to privacy. Accordingly, this Court must merely decide whether the disclosure of records in this context is permitted under federal and state statutes. If it concludes that such disclosures are not authorized, there is no need to address the alleged constitutional violation. Thus, the only way the constitutional issues would become relevant would be if this Court finds that HIPAA provides one or more exemptions authorizing the disclosure of protected health information in the narrow context presented in this case, but ruled *sue sponte* that HIPAA, or some portion thereof, violates the Fourteenth Amendment to the United States Constitution.

While the numerous cases cited by DHHR support the proposition that individuals have privacy rights that are protected by the Fourteenth Amendment, none of the cases address the factual circumstances presented in this case. Indeed, many of the cases cited do not even deal with health information. See, e.g., Nixon v. Admin. of Gen. Serv., 433 U.S. 425 (1977) (challenging constitutionality of the Presidential Recordings and Materials Preservation Act); Nat’l Aeronautics

and Space Admin. v. Nelson, 562 U.S. 134 (2011) (challenging background checks for federal contract employees at NASA).

Of the cases cited by DHHR that do address the disclosure of health information, each relates to a public disclosure, not a limited disclosure to legally mandated patient advocates who are bound by confidentiality requirements. For example, DHHR cites Jaffee v. Redmond, 518 U.S. 1 (1996), for the proposition that effective psychotherapy depends upon an atmosphere of trust between patients and their psychotherapists or counselors, and thus that “the mere possibility of disclosure” can interfere with the success of the treatment. (Pet. Br. 17.) Jaffee, however, concerned the disclosure of psychotherapy notes in the context of a civil court proceeding in which a plaintiff, the administrator of an estate of an individual shot and killed by a police officer, sought the psychotherapy notes of the defendant, the police officer who shot the deceased, in hopes of establishing guilt with regard to the shooting. Id. at 4-5. The Supreme Court, therefore, considered whether psychotherapy privilege exists under the federal rules of evidence, and found that it did, noting that if the privilege were rejected, confidential conversations between patients and their psychotherapists would be chilled “particularly when it is obvious that the circumstances that give rise to the need for treatment will probably result in litigation.” Id. at 11-12. Clearly, no such concern exists in the instant case, in which the health information being disclosed is not being provided to an adverse party or being disclosed for the purposes of litigation. Rather, the patient advocates’ review of health information is being done for the benefit of the patients whose information is reviewed, either in the context of investigating alleged abuse and neglect, or in assisting a patient with a grievance that the patient has brought to the advocate’s attention. Moreover, it is undisputed that this review is conducted in confidence without public disclosure of any protected health information.

DHHR's reliance on Hirschfeld v. Stone, 193 F.R.D. 175 (S.D.N.Y. 2000) and Doe v. City of New York, 15 F.3d 264 (1994), are similarly misplaced. Those cases each address disclosures of private health information to the public at large; here, the patient advocates are bound by the same confidentiality agreements that are signed by all employees of the Hospitals, receive the same training in HIPAA as the Hospital employees, and pose no greater risk of publicly disclosing the records than the risk associated with any of the Hospital employees who have access to the records. Likewise, DHHR's only citation to West Virginia case law is similarly unhelpful. In Robinson v. Merritt, 180 W. Va. 26, 375 S.E.2d 204 (1988), this Court determined that medical records filed in support of workers' compensation claims were not subject to disclosure under West Virginia's Freedom of Information Act, West Virginia Code section 29B-1-4. Nothing in Merritt involved a constitutional right of privacy; rather, the case was solely focused on questions of statutory interpretation.

To be clear, Respondents do not dispute the underlying principal that medical records, and psychiatric treatment records in particular, must be maintained with the upmost care and protected from unauthorized public disclosure. That is simply not the issue presented in the instant appeal. Rather, the relevant question here is whether federal and state law permit the disclosure of patient records to the patient advocates contracted to provide advocacy services at the Hospitals, who are themselves are bound by confidentiality agreements. Because the answer to that question does not involve a constitutional challenge, this Court should follow the "fundamental rule of constitutional adjudication that constitutional questions are avoided unless absolutely necessary." Harshbarger, 184 W. Va. at 660, 403 S.E.2d at 403. For these reasons, DHHR's appeal of the circuit court order on this basis should be denied.

### **III. The Circuit Court Correctly Recognized that HIPAA Does Not Conflict with Disclosure of Patient Information to the Patient Advocates.**

In its second assignment of error, DHHR asserts that the circuit court's order violates HIPAA, because, it asserts, HIPAA requires signed authorizations and imposes other limitations before any disclosures of protected health information may be made to the patient advocates. As explained below, DHHR's arguments rely on a fundamental misunderstanding of the role of the patient advocates and the purpose and application of HIPAA.

#### **A. HIPAA balances privacy against “the public interest in using identifiable health information for vital public and private purposes”**

In 1996, Congress passed HIPAA. Pub. L. 104-191 (Aug. 21, 1996). As required by the Act, the Department of Health and Human Services (HHS) adopted comprehensive implementing regulations after notice and comment, known as the Privacy Rule.<sup>6</sup> As the agency explained, the purpose of the new law and regulations was:

- (1) To protect and enhance the rights of consumers by providing them access to their health information and controlling the inappropriate use of that information;
- (2) to improve the quality of health care in the U.S. by restoring trust in the health care system among consumers, health care professionals, and the multitude of organizations and individuals committed to the delivery of care; and
- (3) to improve the efficiency and effectiveness of health care delivery by creating a national framework for health privacy protection that builds on efforts by states, health systems, and individual organizations and individuals.

Standards for Privacy of Individually Identifiable Health Information, 65 Fed. Reg. 82462-01, at 82463. The agency went on to explain that it sought to balance the complex needs of the health care system, which required sharing of vast amounts of personal health information in order to function, with concerns about patient privacy. *Id.* at 82472 (discussing “the need to balance these competing interests—the necessity of protecting privacy and the public interest in using

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<sup>6</sup> For the purposes of this brief, the rule and the statute are jointly referred to as HIPAA.

identifiable health information for vital public and private purposes”). The privacy concerns specifically stemmed from the potential for misuse of personal health information for non-health reasons in ways that expose or harm the patient. Id. at 82463-72 (providing examples, including misuse of patient data to solicit business, make employment decisions, and make decisions about foreclosure on patient homes). The agency balanced these concerns with the need to efficiently disclose patient information to ensure proper treatment, research, and provision of health care related services. Id.

HIPAA establishes a regime to protect each of these considerations, by allowing broad disclosure of patient information, but only in appropriate circumstances. To accomplish this, HIPAA first defines “covered entities,” to which the provisions apply. 45 C.F.R. § 160.103. DHHR’s Hospitals are covered entities. Covered entities may obtain a general “consent” from patients, and must provide a notice of privacy rights that explains that the covered entities may share and disclose protected health information (PHI) as permitted by HIPAA. 45 C.F.R. §§ 164.506, 164.520. The general consent is different from the requirement of a specific signed authorization, which is only required in certain circumstances.<sup>7</sup> 45 C.F.R. § 164.506. HIPAA sets forth numerous situations in which the covered entity may disclose PHI without first obtaining a specific signed authorization from the patient. Among the dozens of permitted disclosures are three that are especially relevant here: disclosures for “health care operations,” disclosures “as required by law,” and disclosures for “health oversight activities.” See 45 C.F.R. §§ 164.506, 164.512(a), 164.512(d).

Even though these disclosures are permitted without a specific signed authorization form,

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<sup>7</sup> DHHR improperly uses consent and authorization interchangeably in its brief. Importantly, all patients in the hospital have received a notice of privacy rights and signed a consent; the issue here is whether an additional specific authorization is required.

HIPAA imposes several safeguards. For instance, psychotherapy notes generally cannot be disclosed without a signed authorization. See 45 C.F.R. § 164.508(a)(2). Additionally, in most circumstances only the minimum necessary information may be disclosed to meet the purpose of the disclosure. § 164.502(b). A covered entity may also create de-identified information. § 164.502(d). If a patient wishes to limit the disclosures further, the patient has a right to request restrictions on uses or disclosures of PHI, and the covered entity must comply with this request. § 164.522. Patients may also request restrictions on communications to ensure confidentiality. Id. The circuit court recognized these safeguards in its ruling, explaining that “[p]atient confidentiality is protected by the advocates’ obligation to comply with HIPAA and state law requiring that they keep PHI confidential.” (App. 344, 348.)

If a disclosure is not explicitly permitted by HIPAA, as explained above, the patient must sign a specific authorization form (in addition to the general consent) before the PHI can be disclosed. 45 C.F.R. § 164.508. When required, authorizations forms must include a description of the information to be disclosed; the name of the individual providing the authorization; identification of the entity making the disclosure; identification of the entity to whom the disclosure will be made; a description of the purpose of the disclosure, although ““at the request of the individual’ is sufficient;” an expiration date or expiration event, which may be in the future; and a signature of the individual and date. § 164.508(c)(1). Authorization forms are required to protect patient privacy, not to place limits on access to patient records. As HHS has explained, “[t]here are no limitations on the information that can be authorized for disclosure. If an individual wishes to disclose his or her entire medical record, the authorization can so specify.” 65 Fed. Reg. 82517. The purpose of the authorization requirement is to ensure that PHI is not disclosed indiscriminately for reasons unrelated to the operation of the health care system and provision of

treatment to the patient.

Finally, HIPAA sets forth a preemption provision. Under this provision, state laws are preempted if they are contrary to, and less restrictive than, the provisions of HIPAA. 45 C.F.R. §§ 160.201-.205. If the state law permits simultaneous compliance with HIPAA and the state law, the preemption provision does not apply. As explained below, because HIPAA permits disclosure to the advocates without signed authorizations, it is not in conflict with state law. As a result, the preemption provision does not apply.

DHHR's arguments misunderstand both the purposes of HIPAA and the careful application of its regime to protect patient privacy and, simultaneously, protect the private and public interest in a functioning health care system. DHHR's position seems to center around the fundamentally flawed—and unnecessarily adversarial—notion that protection of patient rights through advocacy is outside of its own mission; this could not be further from the case. In fact, patient advocacy is a central part of DHHR's Behavioral Health Services Plan and legislative rule setting forth the agency's responsibilities; this is because the advocacy system furthers the DHHR's role of providing adequate, appropriate, and meaningful care to the vulnerable patients in its Hospitals. As explained in more detail below (and as previously admitted by DHHR and the HCA), the patient advocacy system required by West Virginia law squarely fits into several categories of permissible disclosure under HIPAA—even though just one of the categories would be required to affirm the circuit court's order. As a result, the circuit court's order was proper and DHHR's revocation of the patient advocates' access to records was—and remains—contrary to law.

**B. The circuit court correctly found that disclosure to patient advocates without specific authorization is permitted by HIPAA.**

**1. The circuit court correctly found that the patient advocate system is part of DHHR's health care operations.**

HIPAA permits disclosure of PHI for health care operations without signed authorizations. See 45 C.F.R. § 164.506. "Health care operations" include quality assessment, patient safety activities, case management and care coordination, arranging for legal services and compliance programs, and "resolution of internal grievances." § 164.501. Notably, although "patient safety activities" is specifically defined, HHS has explained that general patient safety activities were already covered health care operations before this language was added to the Privacy Rule. See Modifications to the HIPAA Privacy, Security, Enforcement, and Breach Notification Rules Under the Health Information Technology for Economic and Clinical Health Act and the Genetic Information Nondiscrimination Act; Other Modifications to the HIPAA Rules, 78 Fed. Reg. 5566-01, 5592. HHS further has explicitly explained that "resolution of internal grievances" includes "resolution of disputes from patients . . . regarding quality of care or similar matters." 65 Fed. Reg. at 8291. Indeed, health care operations is a broad category, intended to cover "all activities . . . compatible with and related to treatment and payment." Id. at 82490. Notably, the types of activities that are *excluded* from health care operations are entirely unrelated to treatment or payment, including marketing, use of PHI by a non-health related division of a covered entity, disclosure to an employer for employment decisions, and fundraising. Id.

As DHHR has historically recognized, the patient advocacy program falls squarely within health care operations. The patient advocacy program was created by the Behavioral Health System Plan developed by DHHR and were originally employees of the Hospitals, tasked with ensuring that patient rights were being protected through resolution of individual and systemic

grievances. The program was developed so that DHHR's psychiatric hospitals would remain in compliance with the laws and regulations relating to patient treatment and rights and to avoid the need for unnecessary court intervention. The patient advocacy system was ultimately adopted by the legislature in the portion of the legislative rules that impose requirements on DHHR, and specifically that establish patient rights within DHHR's psychiatric hospitals. See W. Va. C.S.R. Tit. 64, Ser. 59. The responsibility to provide patient advocacy services is thus included in DHHR's responsibilities to provide treatment in accordance with patient rights. See W. Va. C.S.R. § 64-59-20. In fact, as established by legislative rule, Hospital employees and patient advocates work together to assist patients with filing grievances and to resolve the grievances, and patient advocates' responsibilities are listed together with the responsibilities of Hospital employees, Hospital administrators, Staff Development Officers, and the Director of the Office of Behavioral Health Services (now BHHF). Id. It is clear that this function is central to DHHR's health care operations as defined by the West Virginia legislature and, thus, by HIPAA.

Prior to suddenly changing course in June 2014, DHHR recognized that the patient advocacy services were part of its health care operations. As required by HIPAA, DHHR distributes a "Notice of Privacy Practices" to the patients at the hospitals. As late as September 23, 2013, this Notice explained to patients:

We may use your health information, or disclose it to others, for a number of different reasons. This notice describes these reasons. For each reason we have written a brief explanation. We also provide some examples. These examples do not include all of the specific ways we may use or disclose your information; however, any time we use your information, or disclose it to someone else, it will fit one of the reasons listed here.

....

**3. Health Care Operations.** We may use your health information for activities that are necessary to operate this organization. . . . We may disclose your health information, as necessary, to others who we contract with to provide administrative

services. This includes our lawyers, auditors, accreditation services, consultants, **and patient advocates**, for instance.

(App. 778-79 (final emphasis added); see also App. 783-88.) The notice goes on to explain that patient information can be disclosed without signed authorization for the purposes described therein, including to the patient advocates. (App. 780.) The notice also appropriately advises patients of their rights to request restrictions, confidential communications, and an accounting of disclosures, and to file a complaint. (App. 780-82.) Notably, DHHR reports no patient complaints regarding the disclosure of information to the patient advocates.

In a remarkable about-face, DHHR now asserts that patient advocacy is not part of its health care operations. DHHR's argument appears to be that, because the patient advocates assist patients in raising concerns to the Hospital, they are not part of the Hospital's operations. But, as the guidance explains, a Hospital's operations extend to ensuring appropriate quality of care and handling grievances, even when they bring to light a problem in the Hospital's conduct. DHHR claims that the "resolution of grievance" provision in the regulation "does not include disclosure to outside patient advocates" and "does not apply in the same way to 'disputes' a *patient* brings against a hospital," citing the federal register. (Pet. Br. 36.) In fact, HHS has said just the opposite: it provides the example that a disclosure would be for health care operations if made to outside individual representing an employee in that employee's dispute with the hospital. 65 Fed. Reg. at 82491. Notably, HHS explains that disclosure would be appropriate to an employee representative, even though that person is "not providing services to or for the covered entity." Id. In contrast to DHHR's argument, this example supports the conclusion that the patient advocates are included in health care operations: a disclosure would be appropriate to a patient representative (i.e., the patient advocate) for the patient's dispute with the hospital. Indeed, HHS explains that "disputes from patients . . . regarding the quality of care" are explicitly included in health care operations.

Id. Similarly, accreditation groups are included in “health care operations” and likely are also “business associates” of the covered entity, notwithstanding that they might deny accreditation or highlight problems with the entity’s operation. Id. at 82610-11.

DHHR’s confusion extends to its assertion that the patient advocate audits are not part of health care operations, because, it asserts, their audits are “an activity external to the hospital.” (Pet. Br. 37.) DHHR’s argument would mean that outside audits by accreditation entities would not be included in its health care operations, because those audits would not be conducted internally. But this is contradicted by the HHS guidance. 65 Fed. Reg. at 82610-11. Indeed, the regulation assumes that a covered entity would appropriately contract with another entity to conduct audits or assist with compliance functions, in accordance with generally accepted auditing principals. Similarly, the regulation recognizes that many functions of health care operations of a covered entity may be contracted with or provided by an independent entity. See, e.g., 65 Fed. Reg. at 82491 (explaining that health care operations may include disclosures to business associates who are providing services for the covered entity as well as disclosures to outside groups or individuals that are not providing services to the entity, but that are involved in the covered entity’s operations).

DHHR’s argument relies on the faulty premise that it is in an adversarial relationship with the patients, rather than its interests and those of the patients aligning. (See Pet. Br. 36 (characterizing the patient advocates’ activities as being “on behalf of patients, not hospitals”).) While hopefully even private hospitals view their central mission as providing patient appropriate care and respecting patient rights, this is the only mission for hospitals operated by the State, which are established for the sole public purpose of serving the needs of vulnerable West Virginians. In short, the only reason the patient advocates exist is to support the Hospitals’ mission and, thus,

their operations. As a result, disclosures to the patient advocates without authorizations is permitted by HIPAA.

Importantly, the patient advocates' role is included in health care operations whether or not the advocates are acting "on behalf of" the Hospital. If the patient advocates are engaging in health care operations and acting "on behalf of" the Hospital, they qualify as business associates under HIPAA. See 45 C.F.R. § 160.103. Yet not all entities participating in health care operations are business associates. See 65 Fed. Reg. at 82491 ("Disclosures for health care operations may be made to an entity that is neither a covered entity nor a business associate of a covered entity;" elsewhere explaining that disclosure to an employee representative would be permitted, but the representative would not be a business associate). In other words, health care operations comprise a larger category than that of business associates, and although the two categories overlap, they are not entirely coextensive. As a result, for the purpose of determining whether disclosure without authorization to the patient advocates is appropriate, it does not matter whether the advocates are providing services for the Hospitals, so long as they are engaging in activities related to furthering treatment at the Hospitals. See 45 C.F.R. § 164.501 (including resolution of grievances, quality improvement and patient safety activities, case management and care coordination, compliance programs, etc.); 65 Fed. Reg. at 82490.

That said, it is worth noting that DHHR has categorized the patient advocacy provider as its business associate as set forth in the contract between the two entities. (App. 47-52.) As a business associate, disclosure is permitted without authorization. 45 C.F.R. § 164.502(e)(1). As described above, this characterization was appropriate, because DHHR chose LAWV as the contractee to provide the patient advocacy services (both related to individual grievances and systemic auditing) that DHHR is required to provide by legislative rule and the 2009 Agreed Order.

(See, e.g., supra Statement of the Case Parts I-III; see also App. 857 (DHHR letter explaining that the advocates “operate under contract with the Department” and “are agents of the Department”).) As a result, as DHHR has historically recognized, LAWV is providing these services for, or on behalf of, DHHR. See 45 C.F.R. § 160.103 (defining a business associate as a person that provides services “on behalf of” the covered entity).<sup>8</sup>

Disclosure of patient information to the patient advocates is appropriate because the advocacy services are part of the health care operations of the Hospitals. This conclusion alone requires affirmance of the circuit court order. However, in an abundance of caution, Respondents address two other categories that would alternatively give DHHR the right to disclose patient information to the patient advocates, and allow them to fulfill their legal duties.

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<sup>8</sup> DHHR spends considerable space in its discussion of the “business associate” provision arguing that the systemic auditing and grievances are not included in the patient advocates’ role. First, this is largely irrelevant to the question of whether LAWV is a business associate of DHHR. Moreover, DHHR’s assertions are simply inaccurate. Systemic audits have always been a part of the advocates’ role, as demonstrated by (1) the systemic reports the advocates made to the then Ombudsman in 2008 leading to the reopening of this case; (2) the systemic audits they conducted and testified to for the 2009 hearings on Hospital conditions; (3) DHHR’s choice of the LAWV advocates to complete the required audits set forth in the 2009 Agreed Order; (4) DHHR’s agreement on the auditing instrument and the decision to use a random sample of two patients from each unit for each audit as reflected in the minutes of the meetings of the parties; (5) DHHR’s agreement regarding the role of the advocates to complete systemic grievances as reflected in the court monitor’s reports in response to a request for resolution on that very topic; and (6) DHHR’s inclusion of the auditing requirement in its contract with LAWV. (See App. 24, 405, 411, 413-25, 729, 734, 738, 739-48, 789-94, 795.) Further, in contrast to DHHR’s argument, the term “audit” means “a methodical examination and review,” not advocacy for individual patients as DHHR asserts. See Webster’s 7<sup>th</sup> New Collegiate Dictionary 58 (1963). Finally, DHHR absurdly relies on privacy officer Lindsey McIntosh’s testimony in support of its position. However, as Ms. McIntosh testified, prior to taking the stand she had not reviewed this history of this case or the contract with LAWV, nor had she interviewed the patient advocates about their role. As a result, it comes as no surprise that she was unaware of the advocates’ true responsibilities.

DHHR goes on to disavow its own contract agreement with LAWV, stating that it never meant the language that it drafted. Of course, DHHR undoubtedly had competent counsel prepare its contracts and make determinations regarding the terminology used therein, and the contract is consistent with DHHR’s prior understanding that the advocates are agents of DHHR. (App. 857.) While contracting parties certainly cannot intentionally subvert HIPAA through language in their agreements, the contract language nonetheless supports the conclusion that all parties recognized that LAWV is DHHR’s business associate.

**2. In the alternative, the circuit court correctly found that the patient advocate system is required by law.**

HIPAA provides that disclosures may also be made without authorization when the disclosure is “required by law.” 45 C.F.R. § 164.512(a). “Required by law” is defined as:

a mandate contained in law that compels an entity to make a use or disclosures of protected health information and that is enforceable in a court of law. Required by law includes, but is not limited to, court orders and court-ordered warrants, subpoenas or summons issued by a court, . . . ; and statutes or regulations that require the production of information . . . .

45 C.F.R. § 164.103. Section 164.512(a) permits disclosures required by law, provided that the disclosures comply with any restrictions imposed by the applicable law. See 65 Fed. Reg. at 82525; 78 Fed. Reg. at 5618 (“We take this opportunity to clarify that the Privacy Rule at § 164.512(a) permits a covered entity to use or disclose protected health information to the extent that such use or disclosure is required by law and the use or disclosure complies with and is limited to the relevant requirements of such law.”) Because West Virginia law requires that disclosures be made to the patient advocates to enable them to complete their duties, the disclosures are appropriate without a signed authorization.

As set forth above, the patient advocacy system is required by court order and by legislative rule. Specifically, legislative rule requires that patient advocates must be located in each behavioral health facility. W. Va. C.S.R. § 64-59-20.1. Patient advocates—at the request of a patient or on their own initiative—may file grievances related to any aspect of client “care, treatment, housing services, accommodations, etc.” § 64-59-20.2. Grievances may be orally made by a patient to an advocate, or they may be in writing. § 64-59-20.2.1. After receipt of a grievance, the patient advocate may be required to investigate and DHHR must then resolve the grievance and take any necessary corrective action. § 64-59-20.2.4-.8. Patient advocates are required to investigate abuse and neglect grievances within eight hours of receiving the grievance. § 64-59-20.2.9. “As part of

the investigative process the advocate shall have access to all staff members, pertinent records and documents and shall interview witnesses and take statements as appropriate.” Id. Patients have the right to an internal appeal. § 64-59-20.2.13. Patient advocate responsibilities are further set forth as follows:

Client or patient advocates shall assist clients in registering and filing grievances, acknowledge grievances, conduct investigations of grievances, notify the administrator of results of grievance investigations, assure that abuse/neglect grievances have been reported to Adult Protective Services, educate staff regarding client rights and maintain accurate documentation of all grievances and investigations.

§ 64-59-20.2.16.b. In order to enable these responsibilities to be carried out, but to accord patients necessary privacy, the rule sets forth requirements for confidentiality in the grievance process. § 64-59-20.2.15. The rule also explains that “[n]o written consent is necessary for employees of the department, comprehensive behavioral health centers serving the client, or advocates under contract with the department.” § 64-59-11.5.1.d.<sup>9</sup>

Pursuant to these legislative rules, DHHR must disclose patient information to the advocates, without requiring written consent, as necessary for them to complete their responsibilities in a timely fashion. § 64-59-20. In order to provide the required advocacy services as explicitly set forth in the rule, patient advocates must be able to sufficiently review patient records to identify systemic or individual problems for patients who are not able to raise those issues; this is impossible if they have to obtain individual consent first, because they will not know from whom to seek consent. They must also be able to talk freely with patients to receive oral grievances, which DHHR will not currently allow them to do. And they must be provided adequate

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<sup>9</sup> DHHR bizarrely asserts that this provision does not apply because, it claims, patient advocates are not under contract with DHHR. (Pet. Br. 28.) Not only does this defy logic and commonsense definitions of the terms at issue, it also is contrary to DHHR’s own assertions its Privacy Breach Complaint to the HCA, which explicitly recognizes the applicability of this provision. (App. 774; see also App. 857 (BHHR director explaining that the advocates “operate under contract” with DHHR).)

access to records to timely investigate grievances—including within the eight hour timeframe for abuse and neglect investigations, which is currently impossible under DHHR’s requirement that the advocate locate a guardian or surrogate, obtain a signature, and then wait up to thirty days for the requested records. Moreover, legislative rule explicitly requires that all records and staff be made immediately available for abuse and neglect investigations, and that signed consents not be required otherwise. §§ 64-59-20.2.15, 60-59-11.5.1.d. As the patients themselves have recognized in the grievances they have filed, the advocates simply cannot fulfill their responsibilities without access to patients, patient units, and patient records. This denial of adequate advocacy services alone violates patient rights. (See App. 851-56.) The patient advocacy obligations are enforceable in court, as the instant controversy demonstrates. As a result, disclosure to the patient advocates without the cumbersome restrictions imposed by DHHR is required by law. See 45 C.F.R. § 164.103 (required by law includes state regulations).

In addition, orders in this case mandate that the patient advocates have access to sufficient records to conduct audits of the Hospitals as set forth in the 2009 Agreed Order, to ensure systemic compliance with the legislative rules governing patient rights. (See App. 405, 726-38.) As established by prior court order, the court monitor’s formal recommendations also have the force of order if no party objects. Here, DHHR agreed with formal recommendations that formalized the patient advocates’ roles in filing systemic grievances. (See App. 739-48, 424.) Finally, the circuit court’s order explicitly ruled that the disclosures were necessary to fulfill the advocates’ function and, to clarify any ambiguity, ordered DHHR to provide the disclosures to the patient advocates. (App. 347-49.) Together, these court orders clearly require that patient information be disclosed to the patient advocates for the purpose of conducting systemic audits as well as identifying cause for systemic grievances; this, of course, cannot be carried out if an individualized, specific

authorization is required from each patient. The disclosures are thus required by court order, and as a result, fall into the category of being required by law. 45 C.F.R. § 164.103 (required by law includes court orders). Indeed, in light of the court orders, the HCA directed DHHR to withdraw its privacy compliant to HCA, given that the order explicitly met the “required by law” exemption under HIPAA.

DHHR makes several conclusory arguments that the “required by law” provision does not apply. (Pet. Br. 39-40.) First, DHHR argues that “state law permits release of ‘pertinent’ records after an individual patient consents to a Legal Aid advocate working on his or her behalf.” (Pet. Br. 39.) This is simply not the case. Indeed, as demonstrated by DHHR’s lack of citation for its assertion, there is no requirement anywhere in the legislative rule or court order that a patient explicitly consent to advocacy services. Moreover, legislative rule does not “permit” release of records, it requires that release. W. Va. C.S.R. § 64-59-20.2.9 (“the advocate shall have access to all staff members, pertinent records and documents” (emphasis added)).<sup>10</sup> Even if this was not made explicit in the legislative rule, the very nature of the advocates’ responsibilities requires disclosure, as set forth above. In other words, the state law is violated when the patient advocates are denied immediate access to patient records because they cannot fulfill their responsibilities as established by legislative rule and court order, including to timely resolve complaints, accept oral grievances, identify and file systemic grievances, and conduct systemic audits. Timely disclosure without authorizations is thus required by law.

DHHR next argues that the “required by law” provision only applies during a judicial or administrative proceeding. (Pet. Br. 39.) This is contrary to the language of the regulation, which

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<sup>10</sup> To the extent that DHHR finds the word “pertinent” to be meaningful here, Respondents herein do not dispute that patient advocates should only access pertinent records; however, in order to conduct their systemic auditing responsibilities, nearly all patient records are pertinent.

explicitly states that the provision includes regulations and court orders. 45 C.F.R. § 164.103. Moreover, the court orders that require disclosure to the patient advocates were issued in the course of a judicial proceeding—the proceedings of the instant case. DHHR’s third point, that a disclosure “required by law” must be enforceable in a court of law, is also unavailing. (Pet. Br. 39-40.) The patient advocates’ responsibilities as set forth in legislative rule and in the orders of this case are enforceable in a court of law; indeed the order on appeal does just that. DHHR fails to offer any explanation of why the regulations and court orders (some of which DHHR itself agreed to) are somehow not enforceable, instead claiming again that the orders purportedly “supersede . . . HIPAA.” (*Id.*) Of course, this is not the case—the orders require appropriate disclosures to ensure compliance with applicable laws and regulations. As a result, those disclosures are required by law, and signed authorizations are not required.

**3. In the alternative, the circuit court correctly found that the patient advocate system is engaged in health oversight activities.**

As yet another alternative ground permitting disclosure to the patient advocates, the circuit court held that the patient advocates were engaged in health oversight activities. HIPAA explains:

A covered entity may disclose protected health information to a health oversight agency for oversight activities authorized by law, including audits; civil, administrative, or criminal investigations; inspections; licensure or disciplinary actions; civil, administrative, or criminal proceedings or actions; or other activities necessary for appropriate oversight of: (i) The health care system; . . . or (iv) Entities subject to civil rights laws for which health information is necessary for determining compliance.

45 C.F.R. § 164.512(d)(1). These disclosures may be made without a signed authorization. *Id.* A “health oversight agency” includes “a person or entity acting under a grant of authority from or contract with such public agency . . . that is authorized by law to oversee the health care system . . . or to enforce civil rights laws for which health information is relevant.” 45 C.F.R. § 164.501. In addition, “[o]verseeing the health care system” includes “oversight activities that involve

resolution of consumer complaints.” 65 Fed. Reg. at 82492. The patient advocates fall under this provision because they are acting under contract with DHHR to conduct oversight activities authorized by law—that is, the auditing and complaint resolution activities required by court order and legislative rule.

DHHR argues that this provision does not apply because, first, LAWV is not created and organized under state law. (Pet. Br. 35.) This assertion is misleading in two respects. First, while LAWV is not created by state law, the patient advocacy system is created and organized by state law. See W. Va. C.S.R. § 64-50-20. In addition, the provision explicitly applies to entities providing oversight through a contract with the agency, as the patient advocates are doing here. In contrast, the provision does not apply to entities undertaking private, rather than public, functions, “such as private-sector accrediting groups.” 65 Fed. Reg. at 82492. Because the patient advocates are serving the public function of resolving patient complaints and enforcing civil rights laws through investigating grievances and providing audits to the court monitor and the court in this action, they fall within this provision.

**C. Access to Patients, Patient Units, and Patient Records Complies with the Minimum Necessary Standard, When Applicable.**

As demonstrated above, disclosures may be made to the patient advocates because they are participating in health care operations, disclosure is required by law, and they are engaged in health oversight activities. However, as also explained, protections exist for patients even when no authorization is required. One such protection is the requirement that the covered entity only make the minimum disclosure necessary. See 45 C.F.R. § 164.502(b). This provision applies to disclosures for health care operations and health oversight activities; it does not apply to disclosures required by law. § 164.502(b)(2)(v). The standard provides: “a covered entity . . . must make reasonable efforts to limit protected health information to the minimum necessary to

accomplish the intended purpose of the use, disclosure, or request.” § 164.502(b)(1). To accomplish this goal, the covered entity is required to identify the individuals who need access to records and identify the categories of PHI to which that the person needs access. § 164.514(d). When disclosure is routine and recurring, individualized determinations do not need to be made; instead, the entity simply must implement appropriate policies and procedures. Id. Full disclosure of medical records is permissible under the minimum necessary standard. 65 Fed. Reg. at 82544-45 (providing examples, including that nurses may require access to all records on their ward, individuals involved in treatment may require full access to records, and accreditation organizations may require full access to records, all of which would be permissible under the minimum necessary standard).

DHHR asserts that full disclosure to the advocates of PHI does not meet the minimum necessary standard. This is not the case. First, because the advocacy services are required by law, the standard does not apply. See supra. Moreover, DHHR’s argument is based on its mistaken belief (despite years of experience to the contrary) that the patient advocates’ role is limited to assisting individual grievances. This misunderstanding likely arises from the fact that DHHR’s privacy officer failed entirely to conduct a meaningful investigation regarding the role of the patient advocates so as to determine what information is necessary for them to fulfill their responsibilities before revoking access. DHHR’s failure to do so violates the minimum necessary requirement. See 45 C.F.R. § 164.514(d)(2)(i)(B). In fact, as demonstrated above, the patient advocates have always been required to conduct systemic audits (see, e.g. App. 24, 734), to independently initiate grievances without request by patients, W. Va. C.S.R. § 64-59-20.2, and to file systemic grievances (see, e.g., App. 739-48). These activities simply cannot be conducted without full access to patient records; as a result, the minimum necessary, like in the examples

above, is full disclosure. In order to comply with the provision, all DHHR must do is create an appropriate policy, for example, stating that patient advocates may only access records during working hours and for the purpose of investigating, resolving, or filing a grievance, or to conduct an audit of compliance with patient civil rights. See 65 Fed. Reg. at 82544-45 (providing examples of appropriate policies).

Even in the theoretical world in which the advocates' role was limited to individual grievances, DHHR has not complied with the minimum necessary requirement; instead it has revoked all access to PHI without signed authorization and significant delay. At a minimum, DHHR should be providing immediate access to patient records for those who have filed a grievance without a signed authorization. DHHR has made no "reasonable effort" to do so. In short, once the advocates' role is properly understood, it is clear that DHHR's prior disclosure practices complied with the minimum necessary standard.

**D. DHHR Is Violating State Law By Imposing Improperly Stringent Restrictions on the Patient Advocates that Interferes with Performance of Their Duties.**

DHHR does not challenge two central components of the circuit court's order. First, DHHR does not—and indeed cannot—challenge the conclusion that its newly imposed restrictions interfere with the patient advocates' abilities to fulfill their responsibilities to protect patient rights. HIPAA was never intended to serve as a hindrance to patient services or civil rights; DHHR, however, has improperly used it as a tool to accomplish this end. Instead, HIPAA was carefully designed to allow health information to be shared when it benefited the patient, but restrict access when there was no such public or private reason for disclosure. As described in detail above, DHHR's new policy has a meaningful negative impact on patient advocacy services.

Second, DHHR does not challenge the circuit court's holding that its new authorization policy—apparently only applied to the patient advocates—violates HIPAA. Nonetheless, with the

stay of the circuit court's order in place, DHHR continues to apply these improper requirements. Specifically, DHHR requires signatures of guardians and surrogates, even when a patient is competent to sign for herself, in violation of sections 16-30-3, -6, and -7 of the West Virginia Code. See also State ex rel. AMFM, LLC v. King, 230 W.Va. 471, 740 S.E.2d 66 (2013). DHHR further requires the patients to provide a specific purpose in the authorization, thereby divulging the nature of the investigation; this is prohibited by HIPAA, which allows a patient to state that the disclosure is "at the request of the individual" if he does not wish to explain the request. 45 C.F.R. § 164.508(c)(iv). HIPAA also permits an individual to not specify an end-date for the authorization; in contrast, DHHR requires a new authorization to be provided for each day that an investigation continues. § 164.508(c). HIPAA also permits an individual to disclose her entire medical record; DHHR, however, insists that only limited disclosures may be made and that the authorization specifically name each document. 65 Fed. Reg. at 82517. Thus, the circuit court's order must be upheld to protect the patients and their advocates from this discriminatory and improper application of HIPAA, which violates the patients' right to patient advocacy services.

Finally, to the extent that DHHR truly believes that it has been breaching HIPAA by disclosing information to the patient advocates for the past twenty years, it has violated HIPAA by failing to contact each of those patients and notify them of the breach within sixty days. See 45 C.F.R. § 164.404. DHHR has similarly failed to notify the media, as it is required to do for a breach relating to more than 500 West Virginia residents or notify the Secretary of HHS. See 45 C.F.R. §§ 164.405, 164.406. DHHR's failure to comply with these requirements is at a minimum perplexing, and draws into question its ongoing insistence that it solely wishes to protect patient privacy and comply with HIPAA.

#### **IV. The Circuit Court's Order Correctly Applied HIPAA**

In sum, the circuit court's order is well supported, because HIPAA permits disclosure to the patient advocates through its provisions for health care operations, activities required by law, and health oversight activities. Further, as the circuit court found, DHHR can meet the minimum necessary requirement while simultaneously providing the advocates with appropriate access to PHI to enable them to fulfill their responsibilities. For these reasons and the others outlined above, Respondents request that DHHR's second assignment of error be rejected.

#### **V. The Circuit Court Did Not Make Erroneous Findings, and, Regardless, Any Error Would Be Harmless.**

In its third assignment of error, DHHR contends that the circuit court erred in two of its factual findings. Specifically, DHHR alleges that the circuit court incorrectly found that the Hospitals "forbade all advocate's access to patients and records" and "forbade patients from consenting to the disclosure of their records." (Pet. Br. 2.) Instead, DHHR asserts that patient advocates are permitted to talk to patients and staff, and can access patient records or "access confidential information orally" with "signed patient consent (or patient's guardian consent)." (*Id.*) DHHR does not explain, however, how these alleged factual errors are in any way relevant to the ultimate legal conclusions reached by the circuit court. Consequently, even if the circuit court made these alleged findings, which is clearly not the case, and even if these alleged findings were in error, which they were not, such findings are harmless and do not impact the circuit court's ultimate legal holdings that are the subject of dispute in this appeal.

DHHR first contends that the circuit court incorrectly found that "the hospitals had forbidden any access to patients in person or to their records . . ." (Pet. Br. 41.) As an initial matter, this is a clear misstatement of the circuit court's findings. (*See* App. 335-49.) Nowhere in the order does the circuit court state that the patient advocates are forbidden any access to patients

in person or to patient records; rather, the circuit court clearly found, based on numerous cites to the record, that patient advocates are given access to patient units but only with a hospital escort, and are permitted access to patient records and permitted to discuss confidential patient information orally with the patients, but only after obtaining signed authorizations. (See App. 337-38, 340.) Thus, the circuit court found that DHHR had placed limitations on the patient advocates' access to patients and their records; it did not find that the hospitals had forbidden any access to patients or records. (Id.) DHHR's characterization of the circuit court's order as stating that the hospitals "forbade all advocates' access to patients and records" is simply wrong and DHHR's assignment of error on this basis is without merit. (Pet. Br. 2).

Not only is DHHR's characterization of the circuit court's order misleading, the records clearly demonstrates ample support for the factual findings actually made by the circuit court. Patient advocate Sharon Reed, the only witness during the August 1, 2014, hearing who actually worked in one of the Hospitals and could attest from personal experience as to what was happening in the Hospital, testified that in the month prior to the hearing, patient advocates had been denied "immediate access to the patients' medical records. And on Wednesday we were denied access to the units without escort by staff." (App. 254.) She further explained that, by requiring a staff escort onto patient units, patient trust "starts to dissolve" and patients do not feel comfortable approaching her to discuss problems. (App. 254-55.) Ms. Reed additionally testified that she had received conflicting instructions as to whether she was permitted to speak with patients without first obtaining signed authorizations. She stated that "[t]he CEO [of Sharpe Hospital] told us that . . . patients weren't allowed to talk to us unless we had releases signed." (App. 256.) Although she noted that this statement had been contradicted by a nurse manager, the hospital CEO is in a position of authority greater than that of a nurse manager, indicating that the CEO's statement is

the official policy of the hospital.

In addition, DHHR's own witness, BHHF Commissioner, Victoria Jones, similarly testified that the advocates were not allowed on units without an escort (App. 182), and could not access patient units freely and converse with patients freely, because "it's my understanding that from the HIPAA perspective it's not just a document or a medical record. It's also verbal information." (App. 184.) Given this testimony, the circuit court was well within its discretion to find that DHHR had limited patient advocate's access to patients, both in person and to their medical records. Accordingly, the circuit court did not commit clear error in its findings of fact on this issue. See Burgess, 196 W. Va. 178, 469 S.E.2d 114, at syl, pt. 4 ("We review challenges to findings of fact under a clearly erroneous standard . . .").

Moreover, even if the circuit court's findings were in error, such error would be harmless. See McDougal v. McCammon, 193 W. Va. 229, 238-39, 455 S.E.2d 788, 797-98 (1995) (test for harmlessness is whether "after stripping the erroneous evidence from the whole, that the remaining evidence was independently sufficient to support the verdict and that the judgment was not substantially swayed by the error."); Burns v. Goff, 164 W. Va. 301, 306, 262 S.E.2d 772, 776 (1980) (application of the doctrine of error in civil cases is "firmly established."). Indeed, as clearly set forth herein, this Court is being asked to interpret state and federal law to determine what access patient advocates should be given to PHI. Whether the circuit court correctly found that certain access was being denied as of the hearing on August 1, 2014, is irrelevant to the legal determination of what access should be permitted under state and federal law. Consequently, even if this Court were to find that the circuit court's factual findings were clearly erroneous, such error would be harmless in that it would have no impact on the legal interpretation of HIPAA and state statutes.

DHHR additionally asserts that the circuit court erred in allegedly finding that the Hospitals

“forbade patients from consenting to the disclosure of their records.” (Pet. Br. 2.) Once again, this is a complete misstatement of the circuit court’s order. (See App. 335.) Nowhere in the order does the circuit court state that patients have been forbidden from consenting to disclosure of their records. Rather, the circuit court found in its August 27, 2014, Amended Order, that DHHR “now require[s] that the advocates obtained signed releases from each patient, the patient’s guardian, and a person with medical power of attorney for that patient.” (App. 337.) Clearly, the circuit court stated that patients can consent to the disclosure of their own medical information, but further clarified (as DHHR admits) that further consent must also be obtained from a guardian, if one is appointed, and that DHHR requires signatures from the health care surrogate, if one has been designated. (Id.) This is not a factual error; indeed, DHHR’s own privacy officer testified that “if a patient has a guardian, then that, that guardian would be the one. I mean, that’s the one who is making decisions for that patient. And so that guardian . . . would be the one that would give access or, or not.” (App. 200.) Thus, there is no dispute that, where a guardian has been appointed, the guardian must sign off on the authorization form. Moreover, Ms. Reed, the patient advocate at Sharpe Hospital, testified that she has been told that advocates must obtain signatures from healthcare surrogates on the patient authorization release form, whether or not the patient has been declared incompetent. (App. 257-58.) Consequently, the circuit court’s findings in this regard are not clearly erroneous.

As with the first alleged error, not only did the circuit court have ample basis for its factual finding, but the finding itself is essentially irrelevant to the issues on appeal. Consequently, even if this Court were to determine that the circuit court clearly erred in its factual findings on this issue, such error would be harmless, as the judgment would not be “substantially swayed by the error.” McDougal, 193 W. Va. at 238-39, 455 S.E.2d at 797-98. For these reasons, this assignment

of error provides no basis for reversing the circuit court's order.

### CONCLUSION

For the reasons stated herein, Respondents respectfully request that the Court affirm the circuit court's order and permit the patient advocates to resume their duties by reinstating the status quo of the past twenty-five years.

**Respectfully submitted,  
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herein and Petitioners below,  
By counsel,**

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IN THE SUPREME COURT OF APPEALS OF WEST VIRGINIA

NO. 14-0965

WEST VIRGINIA DEPARTMENT OF HEALTH  
AND HUMAN RESOURCES, BUREAU FOR BEHAVIORAL  
HEALTH AND HEALTH FACILITIES,

Petitioners,

v.

E.H., et al.,

Respondents.

**CERTIFICATE OF SERVICE**

I, Lydia C. Milnes, counsel for the Respondents in the above-styled matter, do hereby certify that I have served a true and exact copy of the foregoing *Response Brief* upon counsel for the Respondents via hand delivery on this 12th day of February, 2015, as follows:

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