

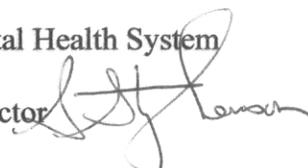


Department of
Mental Health

Ted Strickland, Governor
Sandra Stephenson, Director

January 27, 2010

TO: Stakeholders, Ohio Community Mental Health System

FROM: Sandra Stephenson, MSW, MA, Director 

SUBJECT: Dissemination of Responses to Frequently Asked Questions (FAQ)
About Amendment to Ohio's Statute Governing Exchange of
Psychiatric Treatment Information in the Publicly Funded Mental
Health System

I am writing in follow up to my original memorandum of October 14, 2009, regarding the amendment to Ohio's statute governing exchange of psychiatric treatment information in the publicly funded mental health system. Subsequent to that memorandum, we solicited questions relating to the statute change from all of you, and have incorporated the questions you sent into a set of Frequently Asked Questions (FAQ) below. ODMH staff drafted responses to the questions, in consultation with a small group of consumers, consumer advocates, and providers.

The statute change supports better alignment with HIPAA requirements and affords our system great opportunities to improve continuity of care, position our system to adapt to health care reform and standardized health care technology, and achieve efficiencies. I encourage you to review the FAQ responses carefully and begin work in your local communities to better understand and take action on the improvement opportunities resulting from this statute change.

ODMH staff will be working with the small workgroup that assisted with the FAQ document to develop additional technical assistance materials over the next two months. We will keep you informed about these efforts.

Thank you for your attention in this matter.

Establishing mental health as a cornerstone of overall health

30 East Broad Street
Columbus, Ohio 43215
mentalhealth.ohio.gov

614 | 466-2297
614 | 752-9696 TTY
614 | 752-9453 Fax

FAQs Relating to the Amendment to ORC 5122.31(A)(7)

The information provided herein is not provided as legal advice. Rather, we describe the Department's intent in seeking the statutory amendment and, in consultation with constituent representatives, provide clarifying information about anticipated impacts on the operations of Ohio's publicly funded mental health system. These FAQs relate specifically to the state statutory change in ORC 5122.31 (A)(7) and should not be interpreted as addressing all aspects of confidentiality, HIPAA, or other related state and federal laws. All affected persons or entities are advised to consult with their legal counsel to determine compliance requirements under state and federal law relating to the exchange of health information and the impact of this statutory change on operations, policies and procedures.

- **Applicability/Reach of Statute**

- 1) **Q** - Since O.R.C. 5122.31(A)(7) is part of the civil commitment statute does the revision apply to information sharing for continuity of care purposes only in the context of a consumer/patient who is involved in the civil commitment process or does it apply to all consumers/patients regardless of their legal status or involvement with civil commitment?

A – This section of the statute is applicable to all consumers served in the publicly funded community mental health system. The statute's reach is extended by rule as follows: OAC 5122-27-08, applicable to agencies providing publicly funded mental health services or licensed or certified by ODMH, provides that each request for information shall be accompanied by an authorization for release of the information except as specified in ORC 5122.31. OAC 5122-14-13, applicable to inpatient psychiatric service providers licensed by ODMH, requires that providers have written policies and procedures regarding the release of information and confidentiality that are compliant with ORC 5122.31.

- 2) **Q** - The exchange of information between hospitals is limited to those within the department. Would a release be required to exchange with a private hospital beyond what is permissible in emergency situation?

A – OAC 5122-14-13, applicable to inpatient psychiatric service providers licensed by ODMH, requires that providers have written policies and procedures regarding the release of information and confidentiality that are compliant with ORC 5122.31. Therefore, the same circumstances for authorized exchange of information would be applicable to licensed private hospitals.

3) **Q** - 5122.31(A)(7) specifically refers to "hospitals within the department, other institutions and facilities within the department, and community mental health agencies." Are Boards of Alcohol, Drug Addiction and Mental Health Services or Community Mental Health Boards included among the entities that can exchange protected health information for the purposes of continuity of care?

A – The language of ORC 5122.31(A)(7) does not include boards of alcohol, drug addiction and mental health services. However, this change in law does not change other subsections of this law or other laws governing access to PHI by boards of alcohol, drug addiction and mental health services

4) **Q** - Does the new law apply only to MACSIS clients or would it apply to any client of a CMHC, including those that may be full fee, those that use insurance, etc.?

A – ORC 5122.31 is applied to entities licensed or certified by ODMH pursuant to OAC Chapters 5122-14 and/or 5122-27. These provisions are applicable to the entity as a whole, not on the basis of payor source for an individual client.

5) **Q** - Can you please address and clarify whether CMHCs are permitted by this statutory language change to exchange information with Medicaid HMO's without a specific release?

A - It is the ODMH's intent that Medicaid HMO's providing active care management services to clients would be able to receive information from mental health provider organizations covered under this statute change. ODMH considers such care management services provided by Medicaid HMOs to be integral to the client's treatment and health services and thus to fall within the scope of continuity of care.

6) **Q** - Are COS [Consumer Operated Services] able/going to be able to receive information from provider organizations serving our members?

A - The exchange of information covered under this statute change is only authorized between provider organizations and "other providers of treatment and health services." A consumer operated service organization (COS) would only be able to receive information covered under the statute change if the COS provided treatment services. A COS certified to provide CPST services could receive such information. However, a COS certified only to provide Consumer Operated Services would not be able to receive information covered under the statute change.

7) **Q** – Would a client rights advocate have access to a client’s PHI under the statute?

A – This change in the law does not change the law regarding client rights advocates’ access to a client’s PHI.

- **Definition of Terms**

8) **Q** – What constitutes a “community mental health agency”?

A - ORC § 5122.01(H) provides a definition - “Community mental health agency” means any agency, program, or facility with which a board of alcohol, drug addiction, and mental health services contracts to provide the mental health services listed in section 340.09 of the Revised Code.”

9) **Q** - What is the definition of "psychiatric record" as intended in this provision?

A – It is ODMH’s intent that “psychiatric record” means the individual client record maintained by community mental health agencies. The content of the individual client record is described in OAC Chapters 5122-14 and 5122-27, and would include, but not be limited to, history, assessment(s), treatment plan, progress notes and discharge plan.

10) **Q** - How is "other pertinent information" being defined? Does this include non-health related information such as education records, court documents, financial information, etc.?

A - “Other pertinent information” would include information that another provider of treatment or health services would require in order to provide effective care and treatment for the person. Examples would include such things as payer source, and certain demographic information, such as veteran status, that may or may not be part of the psychiatric record.

11) **Q** - Who meets the definition of "other providers of treatment and health services"? Are these entities always HIPAA Covered Entities?

A – Other providers of treatment and health services would be those who provide medical and other health care services that are recognized by licensing authorities and payors as health care services. Examples of such providers include the following: other Behavioral Healthcare Providers (psychiatrists, qualified mental health specialists, psychologists, counselors, social workers, marriage and family therapists); physicians (family practice, internists, specialists); nurses (RNs, LPNs, nurse practitioners); physician assistants; pharmacists; dietitians; physical and occupational therapists; nurses’ aides; home health aides; care managers. Examples of settings/roles of providers include: primary care providers; family medicine providers; specialty care providers; hospitals; care

managers/community health workers; managed care organizations and care managers working at these organizations; other social service agencies who coordinate care of clients; rehabilitation facilities; and, home health care.

HIPAA defines health care providers as providers of medical or health services and persons or organizations that furnish, bill for or are paid for health care in the normal course of business. HIPAA defines treatment to include the provision, coordination or management of health care and related services, consultation between providers relating to an individual or referral of an individual to another provider of health care. These definitions would encompass the providers described above.

- 12) **Q** - HIPAA allows disclosure of information for "treatment" purposes, but does not define "continuity of care". What is the definition of "continuity of care" and is it defined in state statute or rule? Similarly, which provision, HIPAA or state law, is more stringent and would be considered the floor?

A – Neither ORC nor OAC provides a definition for continuity of care, though the term is used elsewhere in statute and rule. HIPAA defines treatment to include the provision, coordination or management of health care and related services, consultation between providers relating to an individual or referral of an individual to another provider of health care. For purposes of this statute change, ODMH considers continuity of care to refer to the objective of coordinating treatment and health services among entities providing such services to a person. Continuity of care can include referrals for treatment and health services between providers of such services. Examples of continuity of care include the following:

- Psychiatrist at community mental health agency performs a medical lab test for client who does not have access to primary care and shares results of test with clinic where client is referred
- CPST staff arranges respite care for client who is at risk of being hospitalized and provides psychiatric treatment information to respite staff
- Outpatient nurse practitioner provides psychiatric treatment information to hospital staff in context of discharge planning
- CPST worker attends treatment team meeting for hospitalized client to promote smooth transition to the community and shares treatment information about client's outpatient psychiatric care
- Nurse at the mental health center provides information to community pharmacist about types of medications prescribed for client
- Psychiatrist at the community mental health center provides information about client's outpatient psychiatric treatment with the staff at the crisis stabilization unit
- CPST worker shares medication history and treatment information with a client's primary medical care provider to coordinate physical healthcare with mental healthcare

- Counselor at the community mental health center refers client to additional services at another provider or client is being discharged from one provider to another
- CPST staff coordinates hospital discharge with Care Manager from an MCO

Pursuant to 45 CFR 160.201-.205, HIPAA preempts state law except in specified circumstances, for example, when state law provides more protection of an individual's privacy rights or gives an individual more control over his/her own records. HIPAA permits the disclosure of protected health information without the individual's specific authorization where the disclosure relates to the provision, coordination or management of health care and related services, consultation between providers relating to an individual, or referral of an individual to another provider for health care. [45 CFR 164.501, .502] Ohio's law now permits the same disclosure for these purposes.

- **Implementation Issues**

- 13) **Q** - Who determines whether an exchange of consumer PHI is necessary to facilitate continuity of care - the provider supplying the information, the requesting provider, or both? How will the consumer have input?

A – The determination of which information is necessary to facilitate continuity of care will be a clinical decision and will depend upon the individual situation. HIPAA requires that only the minimum necessary protected health information should be shared and such information should only be shared with those who have a need to know. Final decisions about the information to be shared may require dialogue between providers. The goal is to ensure provision of the best and most appropriate care for the individual and to facilitate the sharing of information that supports the goal. The expectation is that a provider will explain its general practices regarding the use and disclosure of protected health information in the Privacy Notice and make a good faith effort to obtain written acknowledgement of receipt of the Notice of Privacy Practices, as required by HIPAA. Providers should also review their Consent to Treatment and update the language to address the state statutory changes to the extent the Consent to Treatment document addresses use and disclosure of information and establish a process for reviewing these changes with consumers as appropriate.

- 14) **Q** – Who makes the determination that something qualifies as “other pertinent information”? How will the consumer be consulted in determining whether particular information is pertinent before it is exchanged?

A – Protected health information is any information that identifies an individual and relates to health care provided or paid for relating to the individual. HIPAA requires that only the minimum necessary protected

health information should be shared and such information should only be shared with those who have a need to know. The expectation is that a provider will explain its general practices regarding the use and disclosure of information in the Privacy Notice and make a good faith effort to obtain written acknowledgement of receipt of the Notice of Privacy Practices, as required by HIPAA. Providers should also review their Consent to Treatment and update the language to address the state statutory changes to the extent the Consent to Treatment document addresses use and disclosure of information and establish a process for reviewing these changes with consumers as appropriate.

- 15) **Q** – Once PHI is determined necessary to facilitate continuity of care and is transferred, what personnel of the receiving provider will have access to the PHI? Practitioners only, or will all direct care staff have access?

A – ORC § 5122.31 specifies some limitations on use of disclosed health information. Additionally, HIPAA requires that a covered entity identify persons or classes of persons in its workforce that need access to PHI to carry out their duties, define the types of information to which they need access and any conditions to their access, and make reasonable efforts to limit access as defined. [45 CFR 164.514(d)(2)]

- 16) **Q** – How will a consumer be notified when PHI is exchanged and to whom it has been released?

A – The expectation is that a provider will explain its general practices regarding use and disclosure of information in the Privacy Notice and make a good faith effort to obtain written acknowledgement of receipt of the Notice of Privacy Practices, as required by HIPAA. Providers should also review their Consent to Treatment and update the language to address the state statutory changes to the extent the Consent to Treatment document addresses use and disclosure of information and establish a process for reviewing these changes with consumers as appropriate. HIPAA requirements relating to accounting for disclosures of information generally do not require an accounting of releases for treatment purposes except as set forth in the American Recovery and Reinvestment Act of 2009 and federal regulations soon to be issued relative to implementation.

- 17) **Q** – If a client signs a release or consent form authorizing an exchange of PHI, what is the duration of the release/consent before it expires? How often will a release/consent form be updated?

A – The time period for the effectiveness of the release must be included on the authorization document. OAC 5122-27-08 addresses the duration of an authorization for release of information for entities subject to ODMH certification rules – the rule states that the duration cannot be longer than

six months unless documentation reflects that the client agrees to a longer time period.

- 18) **Q** - How will releases signed prior to the enactment of the statute be treated?

A – This statutory change has no impact on previously executed authorizations for release of information. To the extent that the law now permits an additional limited exchange without the need for a specific release, if a consumer wishes to restrict the disclosure of health information to other providers for purposes of continuity of care, the consumer should address the request to his or her provider(s). Providers should notify consumers of any changes to their privacy practices, which would include an update on how they intend to handle the sharing of PHI.

- 19) **Q** – What type of documentation is required to show that the patient was informed and did not object to the sharing of information with others? If the patient objects, no information of any kind is to be shared, correct?

A – It is expected that providers will address this type of information sharing in the Notice of Privacy Practice and/or Consent to Treatment and will be able to obtain a client's prior consent to the sharing of described types of information among described providers or types of providers. There are circumstances described in law when disclosure may be required regardless of whether the individual consents. These are generally described in the Notice of Privacy Practice.

- 20) **Q** – Another subsection of ORC § 5122.31 - (A)(1) - states "If the person identified, or the person's legal guardian, if any, or if the person is a minor, the person's parent or legal guardian, consents, and if the disclosure is in the best interests of the person, as may be determined by the court for judicial records and by the chief clinical officer for medical records;" -- does that mean the chief clinical officer can disclose information because (s)he determines it is in the best interest of the person, despite objections of the patient or legal guardian?

A – The provision you cite – ORC 5122.31(A)(1) - requires both consent from the individual or the parent/legal guardian and a determination that the disclosure is in the best interest of the person. However, that subsection is one in a list of several exceptions to the general prohibition against disclosure of information.

- 21) **Q** – If the client has to be given the opportunity to object to information being shared, does there have to be a discussion with the client prior to each time/instance that provider will share information? If so, not sure how this helps beyond what getting release would do.

A – It is expected that providers will address this type of information sharing in their Notice of Privacy Practice and/or Consent to Treatment and be able to obtain a client's prior consent to the sharing of described types of information among described providers or types of providers that would cover all such similar instances. The expectation would be that the consent would be obtained only one time but would broadly cover a range of exchanges, including exchanges for continuity of care purposes.

- **Restrictions on Disclosures and Requests for Restrictions**

22) **Q** - What exactly does "restriction" include? What are "specific disclosures of information" which can be restricted? How will a consumer know what is in their record and what information they may want restricted? Can a consumer restrict one note or part of a note?

A – HIPAA does not define specific parts of an individual's record that may be subject to a request for restrictions on uses or disclosures. A consumer continues to have the same access to his or her record as previously existed under both state and federal law in order to determine the content of his or her record. A consumer may request specific use or disclosure restrictions with regard to any element in the record. It should be noted, however, that agreed upon restriction(s) will not be effective to prevent uses or disclosures permitted or required to be made to the Secretary of Health and Human Services to investigate or determine compliance with HIPAA, other uses or disclosures required by law, or where the individual's authorization or opportunity to object is not required.

23) **Q** – How does a consumer request a restriction? How will this request be documented?

A – HIPAA requires that a covered entity (CE) permit an individual to request that the CE restrict disclosures for treatment, payment and operations purposes and maintains documentation of agreed upon restrictions. HIPAA also mandates that a CE have in place policies and procedures implementing the regulations. However, HIPAA does not specify the specific content of the policies and procedures. A consumer should request information about the provider's policies and practices relating to requests for restrictions directly from the provider. This will be further addressed in forthcoming technical assistance materials.

24) **Q** - Who is responsible for educating consumers/parents/legal guardians about their right to restrict releases of information?

A – Except for the requirements relating to the provision of Privacy Notices, there are no legal mandates for any entity to provide such education. OAC 5122-27-08(B)(7) requires an agency's Release of Information form to include a statement about the client's right to request a

shorter duration for the release. Additionally, OAC 5122:2-1-02 requires a Client Rights Officer to ensure that a client is fully informed about all rights, including rights relating to confidential personally identifying information. Finally, all sectors of the public mental health system should participate in educating consumers and their representatives about their rights relating to the privacy of their health information. In order to facilitate such activities, ODMH is convening a small planning group comprised of consumers and provider organizations to assist in the development of technical assistance documents to assist consumers and providers in understanding and implementing this statute change.

25) **Q** – If a consumer does not initially request any restrictions, but does so at a later time, how will this be implemented?

A – There is not a time frame during which a consumer must request the restriction. However, a restriction agreed upon by the provider would only apply to disclosures made after the request has been made by the consumer and agreed to by the provider.

26) **Q** - How will this impact the person who has a "Psychiatric Advanced Directive" restricting the exchange of personal treatment records without their consent?

A – This provision does not change the law relating to Durable Powers of Attorney for Healthcare (ORC Ch. 1337) or Declarations for Mental Health Treatment (ORC Ch. 2135). ORC 2135.04(D) provides that an operative Declaration for Mental Health Treatment supercedes a general Consent for Treatment if provisions of the two documents conflict. ORC 2135.04(C) provides that a treatment provider act in accordance with the declaration, reasonable practices and applicable law.

- **Applicability to Alcohol and Drug Records**

27) **Q** - Because "psychiatric records" likely contain information on the identity, diagnosis, prognosis, and/or treatment of any alcohol and other drug use condition that may be present, can a provider disclose AoD information contained in a "psychiatric record" under this provision and still be in compliance with federal AoD confidentiality requirements under 42 CFR Part 2? What does a provider need to do to exchange AoD information contained in a "psychiatric record"?

A – ORC § 5122.31 addresses mental health records. Disclosure of alcohol and drug addiction records and information is governed by federal law. Providers must comply with the requirements set forth in 42 CFR Part 2 relating to alcohol and drug addiction treatment records. See http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr&tpl=/ecfrbrowse/Title42/42cfr2_main_02.tpl

28) **Q** - What happens if the patient refuses to sign a consent for release of the substance abuse information (per CFR 42) that is incorporated into the treatment of a dual diagnosis patient?

- * How does this improve the quality if this information cannot be released but other information can be released?
- * It seems that it increases the administrative burden for staff who treat patients with co-morbid problems
- * How would one keep this information from being transmitted in the EMR?

I understand that the CFR 42 is federally mandated and not a state mandate but would it not be possible to bring the CFR 42 in alignment so that we could exchange information with other CD treatment providers? I know we were able to get the CFR changed to allow for reporting of child and elder abuse so it would seem like we might be able to do the same here, or is that wishful thinking? The same logic would apply for CD as it does for mental health - and given that around 20-30% of patients seen have this co-morbidity it would help to have some clarification.

A – Nothing in the statute change affects the restrictions currently in place in 42 CFR Part 2. However, we do recognize the challenges presented to provider organizations serving dual disorder clients when regulatory requirements differ across the mental health and alcohol and drug addiction systems. While nothing can be done at the state level to modify the requirements of 42 CFR Part 2, ODMH will work with the Ohio Department of Alcohol and Other Drug Addiction Services (ODADAS) to improve coordination in the exchange of health care information for dual disorder clients as we develop technical assistance materials to assist provider organizations in implementing the statutory change. 42 CFR Part 2 is available at:

http://ecfr.gpoaccess.gov/cgi/t/text/textidx?c=ecfr&tpl=/ecfrbrowse/Title42/42cfr2_main_02.tpl

- **Training and Technical Assistance Issues**

29) **Q** - Rick's email states that ODMH, in consultation with constituent representatives, will provide clarifying information - and goes on to advise affected persons or entities to consult with their legal counsel on the impact of the change. How will consumer operated services and statewide consumer organizations such as OEC have independent legal counsel? Will consumers be equally represented for consultation?

A – The technical assistance resources listed above hopefully will minimize the need for legal counsel. However, consumers will be advised how to access such assistance as part of the technical assistance materials under development.

30) Q - Who will provide the education/training and when? Will consumers be trainers?

A – ODMH is convening a small planning group comprised of consumers and provider organizations to assist in the development of technical assistance documents to assist consumers and providers in implementing the statute change. Consumers will be actively involved in the development of these technical assistance materials and whatever training programs are recommended by the small planning group.

31) Q - Will consumer operated services/peer support services be trained and educated on all facets of ORC § 5122.31?

A – Yes - consumer operated services representatives will be involved in the development of technical assistance materials and training programs referenced in the above response and the training programs will be made available to consumer operated services programs.

32) Q – How will the FAQ explain the HIPAA rules that allow the release of PHI without the consumer’s consent, the HIPAA rules that require consumer consent, and how the Ohio statute reflects these rules?

A – It is outside the scope of this FAQ effort to generally explain HIPAA rules relating to the disclosure of health information. A covered entity’s Privacy Notice serves that function. In addition to the responses to specific questions included here, ODMH is convening a small planning group comprised of consumers and provider organizations to assist in the development of technical assistance documents to address the statute change’s relationship to HIPAA and to assist consumers and providers in implementing the statute change.

33) Q – How will the FAQ clearly set forth the limitations of the information sharing?

A – In addition to the responses to specific questions included here, ODMH is convening a small planning group comprised of consumers and provider organizations to assist in the development of technical assistance documents to assist consumers and providers in implementing the statute change.

- **Miscellaneous**

34) Q - What information may be disclosed to family members involved in a client's care? Does this type of exchange always require written authorization? Can family members be considered "other providers of treatment and health services"?

A – This change in the law does not impact the law regarding sharing of information with family members. Family members, as such, are not considered to be “other providers of treatment and health services”.

35) Q – What if an unauthorized disclosure occurs? What steps will be taken to mitigate?

A – This statutory change has no impact on the application of laws relating to unauthorized disclosures and duties to mitigate.

36) Q – How will the consumer be informed of the HIPAA complaint process and resources available to assist with an alleged violation?

A – This information is already required to be provided in the Notice of Privacy Practices (Privacy Notice).

37) Q - If someone other than the consumer discovers a violation, how will the consumer be notified?

A – This statutory change has no impact on the application of laws relating to unauthorized disclosures and duties associated with discovery of such disclosures. Information about a covered entity’s duties relating to a consumer’s health information is to be set forth in the Privacy Notice.

38) Q - Does this new law conflict with the ethical standards or state law regarding the practice of psychologists, counselors, or social workers which require confidentiality?

A – This question is outside the scope of this FAQ – it requires the advice of your own attorney.

39) Q - Does this conflict with the ODMH client rights policy which states "the right to confidentiality of communications and/or all personally identifying information within the limitations and requirements for disclosure of various funding and certifying sources, state or federal statutes, unless a release of information is specifically authorized by the parent or guardian"?

A – This disclosure would fall within the category of disclosures allowed by state statute.