

Ohio Department of Mental Health (ODMH) Amendment to Ohio Revised Code 5122.31 (A) (7)

Frequently Asked Questions (FAQs) related to Continuity of Care and Confidentiality

The information provided herein is not provided as legal advice. Rather, we describe the Ohio Department of Mental Health'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 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 treatment services, operations, policies and procedures.

Substitute HB 1 aligns Ohio's mental health law with HIPAA's provisions allowing for the exchange of health information for treatment purposes without requiring the individual's authorization. The amended changes to O.R.C 5122.3 (A) (7) authorizes the exchange of psychiatric treatment information among community mental health agencies and other health care providers for purposes of continuity of health care. This amendment does not extend to non-treatment related areas such as the coordination and provision of housing, education, and employment services. This change has the effect of promoting consumer safety and quality of care while protecting privacy equivalent to the current guidelines for other healthcare information. If an individual wishes to restrict releases relating to his or her health information, HIPAA regulations provide consumers the right to request that a provider limit specified disclosures of information, including disclosures for treatment purposes.

ODMH Communications and Explanation of Amendment Purpose:

- On October 13, 2009 ODMH Director Stephenson wrote a letter to Community Mental Health Boards and Community Mental Health Providers to inform them of a language change in the mental health statute that was included in the operating budget bill (HB 1) passed in July 2009. The change became effective October 16, 2009. The Office of Consumer and Recovery Supports

forwarded the memo on to the Consumer Operated Service Directors and to their e-mail data base.

- For the next several months, consumer, advocate, provider and department representatives worked together to gather and draft responses to questions about the new law. On January 27, 2010 the Office of Consumer and Recovery Supports forwarded a FAQ document to mental health boards and provider organizations, requesting that it be forwarded on to the Consumer Operated Service Directors and to their e-mail contact data base.
- In addition, information about the law change was presented by Rick Tully, ODMH Office of System Transformation, at ODMH's March 5, 2010 Community Rights Training. The audience included community clients' rights officers, hospital clients' rights officers, and the acting director and other members of the Ohio Empowerment Coalition (the new statewide Consumer Advocacy Organization).
- Ongoing information is posted on the Consumer Supports and Client Rights section of ODMH's website (<http://mentalhealth.ohio.gov/what-we-do/protect-and-monitor/client-rights/index.shtml>).
- ODMH continues to believe it is critical that Ohio law be brought in line with HIPAA, to permit the exchange of mental health information among community mental health care providers and other health care providers for treatment purposes within the context of continuity of care.

What is HIPAA?

The Health Insurance Portability & Accountability Act (HIPAA) became law August 21, 1996. It was a federal bi-partisan bill based on the Kennedy-Kassebaum bill. The primary goal of the law is to make it easier for people to keep health insurance, and help the industry control administrative costs. HIPAA also included privacy and security provisions designed to protect individually identifiable health information from careless or inappropriate use or disclosure.

The HIPAA privacy rules apply to health care providers, health plans, and health care clearinghouses as defined in the rules as "Covered Entities." The following offers a brief overview of some of the HIPAA privacy provisions, including summary definitions of relevant terms.

What are Covered Entities?

HIPAA defines Covered Entities as:

- A. Health Plan – An individual or group plan that provides or pays the cost of medical care, specifically including many types of organizations and government programs as health plans.

- B. Health Care Clearinghouse – An entity that either processes or facilitates the processing of health information received from another entity in a nonstandard format into a standard format, or receives health information in a standard format from another entity and processes or facilitates the processing of health information into a nonstandard format.
- C. Health Care Provider – A provider of medical or health services and any other person or organization who furnishes, bills, or is paid for health care in the normal course of business.
- D. Health Care – Care, services, or supplies related to the health of an individual, including (1) preventive, diagnostic, therapeutic, rehabilitative, maintenance, or palliative care, and counseling service, assessment, or procedure with respect to the physical or mental condition, or functional status, of an individual that affects the structure or function of the body; and (2) sale or dispensing of a drug, device, equipment, or other item in accordance with a prescription.

What is Protected Health Information?

Individually identifiable information relating to the past, present or future physical or mental health, condition, treatment or payment for care of the individual is called "Protected Health Information," or PHI. However, certain types of records, including records held by an employer, are excluded from this definition.

The HIPAA privacy rules outline how PHI can be used or disclosed. Under HIPAA, PHI uses and disclosures are permitted for treatment and payment purposes, and as part of health care operations, without the individual's authorization.

What does the Minimum Necessary Standard mean?

Covered entities must make all reasonable efforts to request, use or disclose no more than the minimum amount of protected health information necessary to accomplish the intended purpose of the use or disclosure.

When a covered entity uses or discloses PHI, it must take reasonable steps to use only the minimum amount of information necessary to accomplish the task except when the information is used or disclosed for treatment purposes, to the individual, pursuant to the individual's authorization or for certain other purposes specified under the law.

Examples of how Protected Health Information can be used or disclosed for Treatment, Payment and Healthcare Operations purposes

A. Treatment:

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. Treatment providers may use or disclose PHI to persons or entities involved in providing individuals with medical treatment or services. For example, information may be shared with an entity providing lab work or pharmacy services or to another provider for consultative purposes.

B. Payment:

Covered entities may use or disclose PHI in order to bill and process claims for services provided or to make payment for covered services received under an individual's benefit plan. For example, the claim form could include information that identifies the person, his or her diagnosis, and treatment of supplies used in the course of treatment.

C. For health care operations:

Covered entities may use or disclose PHI in order to operate their facilities. For example, PHI may be used in order to evaluate the quality of health care services an individual has received or to evaluate the performance of the health care professionals who provide health care services. PHI may also be provided to accountants, attorneys, consultants, and others in order to ensure compliance with the laws that affect them.

Consumer Rights of PHI under HIPPA

A. The right to request limits on the uses and disclosures of PHI:

Consumers have the right to ask that treatment providers limit how they use and disclose PHI. Treatment providers must consider a consumer's request but are not legally required to accept it. (Consumers may not limit the uses and disclosures that treatment providers are legally required or allowed to make.)

B. The right to choose how PHI is sent:

Consumers have the right to ask that a treatment provider send information to them at an alternate address (for example, to a post office box instead of a home address) or by alternate means (for example, by email or fax instead of regular mail). A treatment provider must agree to a consumer's request as long as they can easily do so.

C. The right to see and get copies of your PHI:

In most cases, consumers have the right to look at or get copies of their PHI from their treatment providers, but may need to make the request in writing. In certain situations, a consumer request may be denied. If the request is denied, the treatment provider needs to put into writing the reason for the denial and explain the right to have the denial reviewed. Treatment providers

are permitted to develop policies that charge consumers reasonable amounts for copies made.

D. The right to correct or update your PHI:

If a consumer believes there is a mistake in his/her PHI or that a piece of important information is missing, he/she has the right to request in writing that a treatment provider correct the existing information or add the missing information. The treatment provider has 30 days to respond in writing to a written consumer request.

Common Questions and Answers about the change to Ohio law:

Q1 - Can you please address and clarify whether Community Mental Health Centers are permitted by this statutory language change to exchange information with Medicaid HMO's without a specific release?

A1 - It is ODMH's intent that Medicaid or any HMO 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.

Q2 - Are COS [Consumer Operated Services] able/going to be able to receive information from provider organizations serving shared consumers?

A2 - 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** (community psychiatric support treatment) 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.

Q3 – What constitutes a "community mental health agency"?

A3 - 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."

Q4 - What is the definition of "psychiatric record" as intended in this provision?

A4 – 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.

Q5 - How is "other pertinent information" being defined? Does this include non-health related information such as education records, court documents, financial information, etc.?

A5 - “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.

Q6 - Who meets the definition of "other providers of treatment and health services"?

A6 – 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 and therefore must follow HIPAA privacy regulations.

Examples of providers (who are also required to follow HIPAA guidelines) 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 physical rehabilitation facilities
- Home health care

Q7 - 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?

A7 – Neither Ohio Revised Code nor Ohio Administrative Code 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. Ohio law is now aligned with HIPAA regulations.

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.

Some 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
- Community Supportive Psychiatric Treatment (CPST) staff (generically known as a case manager) 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 (Managed Care Organization).

Q8 - 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"?

A8 - 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".

Q9 - How will this impact the person who has a "Psychiatric Advanced Directive" restricting the exchange of personal treatment records without their consent?

A9 – 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 supersedes 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.

Q10 – How will the consumer be informed of the HIPAA complaint process and resources available to assist with an alleged violation?

A10 – Every agency is required to provide a written Notice of Privacy Practices to each person receiving services. The HIPAA complaint process is in the Notice of Privacy Practices (Privacy Notice). Should you need further information please visit the HIPAA section of the US Health and Human Services webpage:

<http://www.hhs.gov/ocr/privacy/hipaa/understanding/>

You can also call Kathryn Remer, ODMH Consumer Advocacy and Protection Specialist at (877)-275-6364.

Q11 – What if an unauthorized disclosure occurs? What steps do you need to take if you feel your rights have been violated?

A11 –This revision to the Ohio revised Code does not change the consequences established by HIPAA law.

Behavioral Healthcare is Health Care!

These changes mean that a consumer's consent for treatment includes permission for the exchange of mental health information with other treatment and health services providers, such as: private therapists, psychologists or psychiatrists; primary care providers; health specialists; and HMO; and Medicaid managed care plans. Community mental health providers will no longer be required to obtain written authorization (i.e. release of information) to exchange information with each specific treatment or health service provider when the purpose of the exchange is to facilitate continuity of care.

All consumers have the right and responsibility to discuss their healthcare information with their mental health provider(s), including what information would be important for other providers to know and any concerns about sharing specific information with specific other providers.

Providers still must comply with 42 Current Federal Register Part 2 as it relates to the confidentiality of alcohol and drug abuse patient records.