



***SAMHSA-HRSA
Center for Integrated
Health Solutions***

**PBHCI Substance Use Treatment
Capacity Building TA Series
(4/17/2014)**

**Explore Emerging Options for Exchange of
Patient Information**

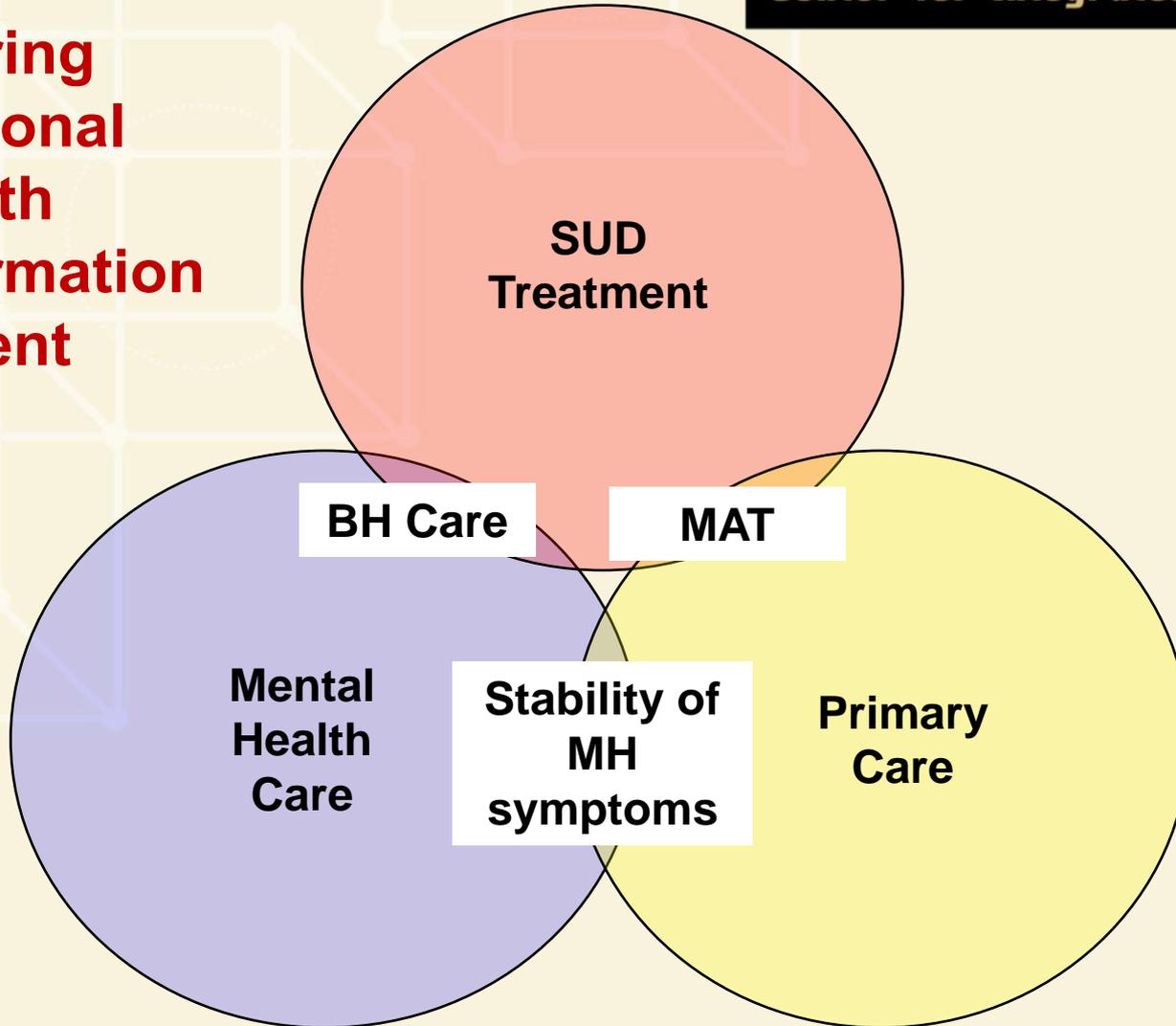
Colleen O'Donnell, MSW, PMP, CHTS-IM

Outline

- Ensure a common frame of reference including essential components of HIPAA and 42CFR Part 2
- Roles of Patient Consent and the Qualified Service Organization Agreement (link to template)
- What patient health information should be shared: the “who, what, when, why and how” of exchanging patient information
- Getting started
- Moving forward

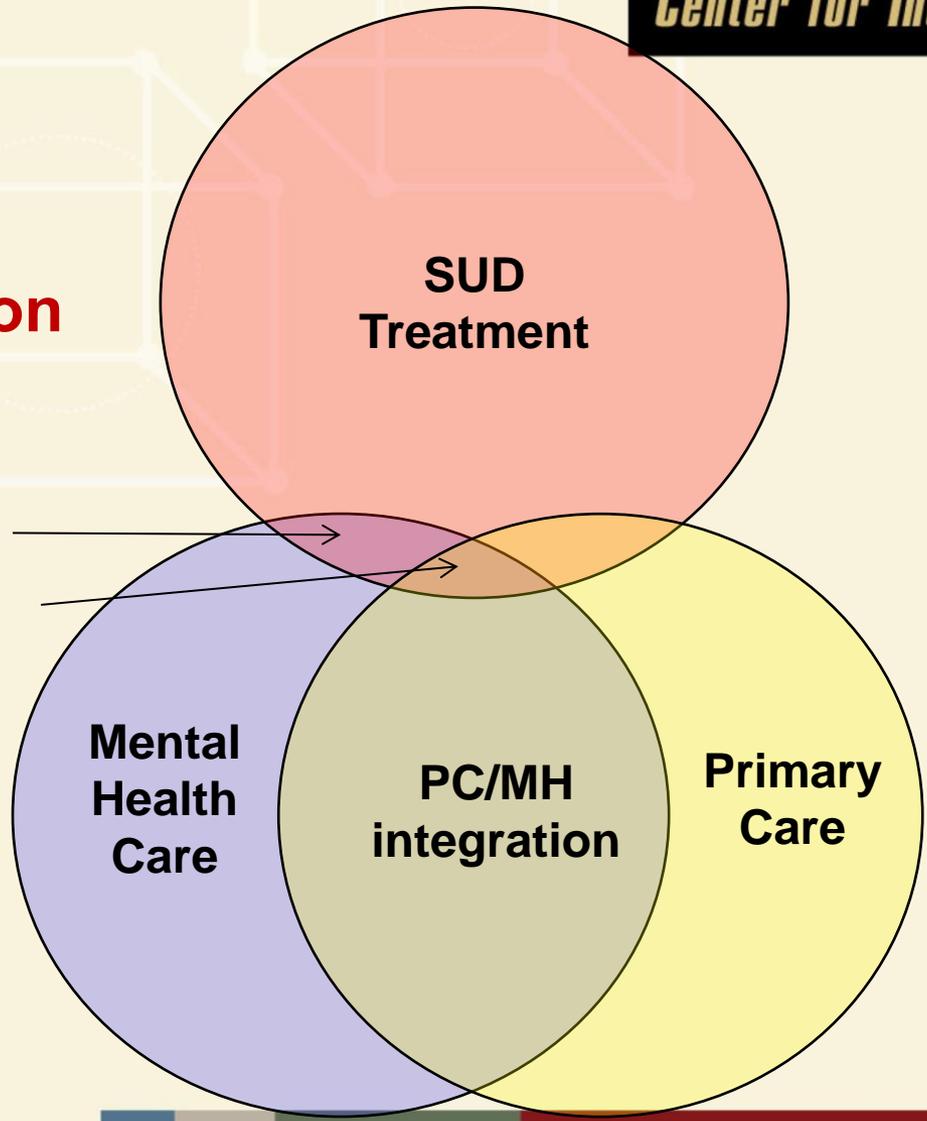
**Ensure a common frame of reference including
essential components of HIPAA and 42CFR Part 2,**

**Sharing
Personal
Health
Information
Recent
Past**



**Post HIPAA,
DATA
Waiver
Pre-
HITECH,
ACA,
MHPAEA**

**Sharing
Personal
Health
Information
Present**



Some BH
Some PBHCI

**Initial
implementation of
HITECH,
MHPAEA,
HIPAA changes
and ACA**

How are HIPAA and 42 CFR Similar?

How are HIPAA and 42 CFR Similar?

- Intended to support (not impede) the appropriate exchange of patient information
- Exchange of patient information is central to the quality of patient care (IOM)
- Confusion over what they both actually say about sharing personal health information (PHI)
 - What HIPAA really says:
<http://www.hhs.gov/ocr/privacy/hipaa/understanding/coveridentities/usesanddisclosuresfortpo.html>
 - What 42 CFR Part 2 really says:
http://www.lac.org/index.php/lac/webinar_archive

How are HIPAA and 42 CFR Different?

How are HIPAA and 42 CFR Different?

- Privacy and Security
 - Health Information Protection and Accountability Act (HIPAA)
 - Privacy rules identify national standards (45 CFR [Part 160](#) and Subparts A and E of [Part 164](#))
 - Security rules operationalize these standards (Subparts A and C of [Part 164](#))
 - Patient information protected by HIPAA can be exchanged between covered entities in the coordination of patient care without additional consent
 - Protected by DHS Office of Civil Rights, increased penalties in Stage 1
- Confidentiality
 - Confidentiality of Alcohol and Drug Abuse Patient Records Act ([42 CFR Part 2](#))
 - Identifies and operationalizes standards
 - Patient information cannot be exchanged without patient consent (some exceptions)
 - Criminal, not civil law :violation = moderate fines (\$500,- \$5,000) and possibility of prosecution (has never happened)

The Roles of Patient Consent and the Qualified Service Organization Agreement

How Do These Differences Affect When is Patient Consent Required?

Q5. Does 42 CFR Part 2 permit the disclosure of information without a patient's consent for the purposes of treatment, payment, or health care operations?

A5. Unlike HIPAA, which generally permits the disclosure of protected health information without patient consent or authorization for the purposes of treatment, payment, or health care operations, Part 2, with limited exceptions (i.e., medical emergencies and audits and evaluations), requires patient consent for such disclosures (42 CFR §§ 2.3, 2.12, 2.13).⁵ Some types of exchange, however, may take place without patient consent when a qualified service organization agreement (QSOA) exists or when exchange takes place between a Part 2 program and an entity with administrative control over that program.

What is a Qualified Service Organization?

A qualified service organization (QSO) means a person or organization that:

- 1) provides services to a [Part 2] program, such as data processing, bill collecting, dosage preparation, laboratory analyses, or legal, medical, accounting or other professional services or services to prevent or treat child abuse or neglect, including training on nutrition and child care and individual and group therapy, and
- 2) has entered into a written agreement with a program under which that person
 - a) acknowledges that in receiving, storing, processing or otherwise dealing with any patient records from the programs, it is fully bound by these regulations; and
 - b) if necessary, will resist in judicial proceedings any efforts to obtain access to patient records, except as permitted by these regulations.

Where a Part 2 program has entered into a QSOA with an entity that provides any of the covered services, and where the information exchanged is needed to provide the covered services, patient consent is not required. (42 CFR § 2.11)

Qualified Service Organization Agreement

- Sample of Qualified Service Organization that may also serve as a Business Associate Agreement can be found here: http://www.lac.org/doc_library/lac/publications/QSO-BA%20Agreement%20Form.pdf

**What patient health information should be shared:
the “who, what, when, why and how” of
exchanging patient health information**

Referral Loop

How can the PCP access referral results?

1. Critical information is effectively transferred from PCP to Specialty Provider

What is “critical information?” How is it “effectively” transferred?

2. Critical information is effectively transferred to the patient by PCP

5. The PCP has access to these findings, and receives updates if patient situation changes

Challenges

How is the “referral result” defined? How is it communicated?

4. The specialist communicates the results of the referral to the PCP

3. The specialist communicates critical findings to the patient

Note patient’s inclusion in communications among and between primary and specialty care providers

“Who” Shares the Information?

- Providers who are engaged in the patient’s care
- In the “health home,” “patient centered medical home model,” and “chronic care model” the Primary Care Provider leads the treatment team
- Care Coordinator ensures the appropriate flow of patient information, and the implementation of the recommended treatment protocols

What is the “Critical Information” to be Shared?

When is it Shared?

- “What” is already defined through national data standards
 - Comprised of key clinical information, minimally the problem list, medication list, medication allergies and diagnostic test results – but can contain much more
 - Referred to as the Continuity of Care Record (CCR), Transition Summary, Continuity of Care Document (CCD)
- “When” Used for managing transitions of care and referrals
 - Current patient data must follow the patient
 - Close the referral loop, keep others updated when information changes
 - <http://www.healthit.gov/>

Shared Patient Health Information

Originating Entity Information

Patient Information

<http://www.healthit.gov/providers-professionals/achieve-meaningful-use/menu-measures/transition-of-care>

- 1) Allergies and other adverse reactions
- 2) Medications (including current meds)
 - a. Admission medications history
 - b. Hospital Discharge Medications (if hospital)
 - c. IV Fluids administered (if hospital)
 - d. Medications administered
- 3) The problem list (diagnoses)
 - a. Active problems
 - b. History of past illness
 - c. Hospital Admission Diagnosis (if hospital)
 - d. ED diagnosis (if hospital)
 - e. Discharge diagnosis
- 4) List of surgeries (if hospital)
- 5) Diagnostic results (i.e., labs, imaging, etc.)

Why is Patient Information Shared?

From “Crossing the Quality Chasm”

Six Challenges

- Reengineered care processes
- Effective use of information technologies
- Knowledge and skills management
- Development of effective teams
- Coordination of care across patient-conditions, services, sites of care over time

Six Aims for Improvement

- Safe, Effective, Patient-centered, Timely, Efficient, Equitable

How is patient information shared?

How is Critical Information Shared?

- State or Regional Health Information Exchange
<http://www.healthit.gov/providers-professionals/health-information-exchange/getting-started-hie>
- Nationwide Health Information Network “Direct”
<http://wiki.directproject.org/User+Stories>
 - Simple, secure, scalable (a type of email system)
 - Point-to-point transmission / receipt on network of verified providers
 - Supports policies and procedures that ensure adherence to HIPAA and 42 CFR Part 2
 - More info <http://nwhin.siframework.org/Direct+Project+Basics>

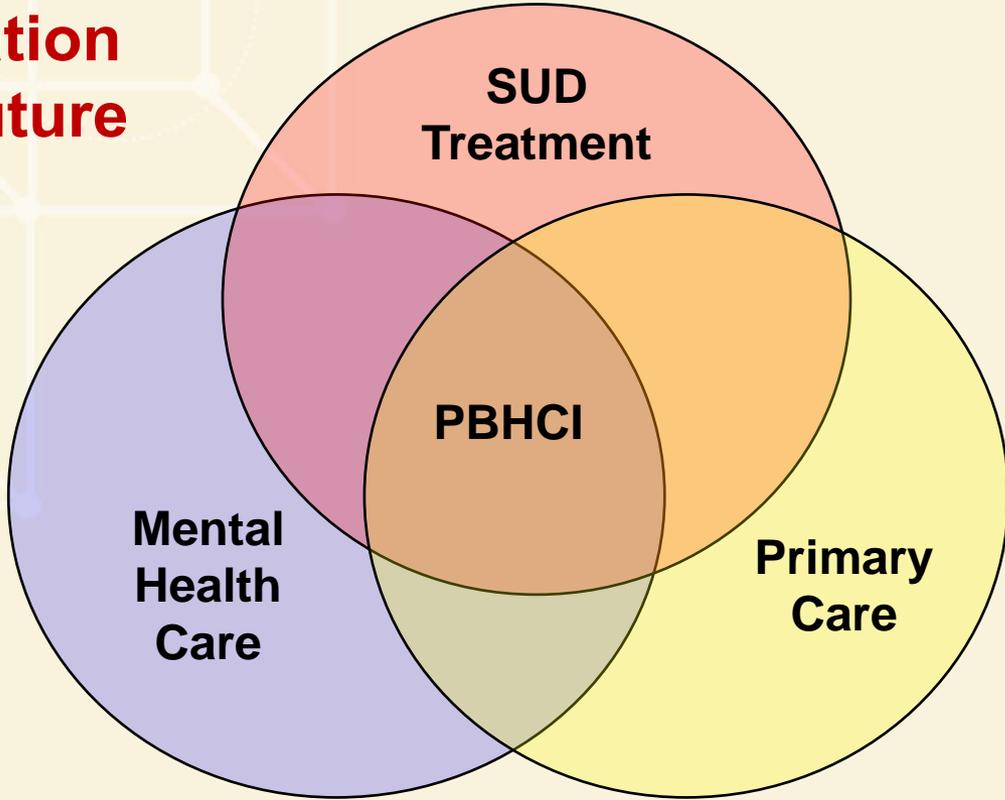
Getting Started

- Convene stakeholders to identify common goals that support a shared vision (within and external to agency)
- Confirm Executive and Clinical Leadership buy-in and support
- Either identify the existing group that can assume this project, or create a new governance committee composed of decision-makers who are authorized to move forward
- Pinpoint where and how organizational infrastructure may be affected
- Define expected outcomes i.e., “to support data-driven care,” “to meet the standard for Meaningful Use”)
- Pilot on a small network of providers and patients, using PDSA

Moving Forward

- Apply change management - expect and anticipate barriers and challenges
- Use a validated, reliable model for full implementation
- Cultivate support throughout the organization (i.e., evaluate impact on staff workflows, seek feedback from staff and from patients, identify project champions among staff and peers)
- How will you monitor for quality assurance?

**Sharing
Personal
Health
Information
Near Future**



**Post full
implementation
of HITECH and
ACA, initial
implementation
of Excellence
in Mental
Health Act**