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Guidance for OMH Programs Regarding the Disclosure of Protected Health Information for Treatment Collaboration, Hospital Discharge Planning, or Care Coordination

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This guidance addresses the issue of whether patient protected health information (PHI), including mental health clinical information governed by section 33.13 of the New York State Mental Hygiene Law (MHL), may be shared by and with OMH providers for treatment or care coordination purposes. As a reminder, the Federal Health Insurance Portability and Accountability Act (HIPAA) allows information sharing for the purposes of treatment and care coordination, with or without patient consent. This guidance focuses on facilities and programs subject to Section 33.13 of the Mental Hygiene Law. It is intended to clarify questions around legal requirements of consent related to Guidance on Evaluation and Discharge Practices for MHL §9.39 Emergency Departments, Comprehensive Psychiatric Emergency Programs (CPEPs), and Psychiatric Inpatient Units.

This guidance is applicable to:
1. OMH operated facilities and
2. Programs that have a nexus to OMH through
   a. licensure,
   b. a local or unified services plan approved by OMH,[1]
   c. or an agreement, including an agreement through which OMH may provide funding to a provider.[2]

OMH is aware there may be programs that have not disclosed such information, possibly due to a lack of clarity about their applicable legal authority to do so. The purpose of this Guidance is to clarify OMH's position that PHI, including mental health clinical information governed by section 33.13 of the MHL, may be shared by and between OMH licensed inpatient and outpatient providers, including Comprehensive Psychiatric Emergency Programs, and other OMH providers if they meet the above criteria, including providers of OMH-funded programs, with or without patient consent. This guidance will also address OMH provider communication with other individuals involved in the patient's life with or without patient consent.

This guidance does not apply to substance use disorder treatment records from OASAS certified treatment programs, which are governed by additional federal confidentiality protections

[1] A local or unified services plan is a local comprehensive planning document for all mental hygiene services maintained by every local government unit pursuant to Article 41 of the MHL. Local or unified services plans contain all licensed or funded mental health, addiction, and developmental disability services providers, including services funded by the state or a city or county. Providers may obtain information about the providers included in one or more local or unified services plan from OMH or directly from a county director of community services (DCS). OMH will work to clearly outline all entities providing services pursuant to a contract with OMH or a local or unified services plan to make it easier for providers to confirm such entities' nexus to OMH.
[2] MHL § 33.13(d); 45 C.F.R. §§ 164.502(a)(1)(ii); 164.506(a).

requiring written consent to disclose except in a medical emergency.[3] This guidance also does not apply to SUD treatment records an OMH provider originally obtained from an OASAS certified treatment program, which remain subject to the same strict protections.

Disclosure of Patient PHI without a Signed HIPAA Authorization or Consent Form

All OMH providers meeting the above criteria, including Article 28 hospital inpatient psychiatric units licensed by OMH and Comprehensive Psychiatric Emergency Programs (CPEPs), are allowed under both HIPAA and subdivision (d) of section 33.13 of the MHL to use or disclose PHI for treatment or care coordination purposes with other parties without a signed consent form, provided the other party is an OMH operated facility or there is a nexus between the other party and OMH through:

- licensure,
- a local or unified services plan approved by OMH[4],
- or an agreement, including an agreement through which OMH may provide funding to a provider.[5]

Confidential information disclosed must be limited to what is necessary for the third party to have, based on the reason for disclosure.[6] Disclosures of PHI must be documented in the clinical record.[7]

Below is a non-exhaustive list of situations in which information governed by the MHL is allowed to and should be disclosed to ensure patient safety and optimize health outcomes for individuals with mental health conditions. In these situations, the term "patient" may refer to both minors and adults. For unemancipated minors, the term "patient" may refer to a minor or their legally authorized representative, such a parent or legally appointed guardian.

1. A patient presents at a CPEP from an OPWDD-Certified Housing Program for an emergency evaluation and treatment and is discharged to that Housing Program with a referral to an OMH-licensed Mental Health Outpatient Treatment and Rehabilitative Services (MHOTRS, i.e., an outpatient clinic) program. Prior to the patient's discharge, the CPEP contacts the MHOTRS program requesting an urgent appointment for the patient. However, the patient does not provide consent to the disclosure of information to the MHOTRS program. Even without affirmative consent, the CPEP is legally authorized to and should supply sufficient demographic, contact, and clinical information to the MHOTRS program to

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[3] 42 U.S.C. 290dd-2, as amended; 42 C.F.R. Part 2. Please note that the US Department of Health and Human Services recently announced a final rule to implement changes to 42 C.F.R. Part 2 as required by Section 3221 of the Coronavirus Aid, Relief, and Economic Security Act. While the law still requires patient consent for the use and disclosure of SUD treatment records for treatment, payment, and health care operations purposes, which differs from HIPAA, the final rule streamlines consent requirements to minimize provider burden in obtaining multiple consents for different recipients and to enable better care coordination for individuals with SUD conditions.

[4] A local or unified services plan is a local comprehensive planning document for all mental hygiene services maintained by every local government unit pursuant to Article 41 of the MHL. Local or unified services plans contain licensed or funded mental health, addiction, and developmental disability services providers, including services funded by the state or a city or county. Providers may obtain information about the providers included in one or more local or unified services plan from OMH or directly from a county director of community services (DCS). OMH will work to clearly outline all entities providing services pursuant to a contract with OMH or a local or unified services plan to make it easier for providers to confirm such entities' nexus to OMH.

[5] MHL § 33.13(d); 45 C.F.R. §§ 164.502(a)(1)(ii); 164.506(a).

[6] MHL § 33.13(f).

[7] MHL § 33.13(f).

determine the urgency and appropriate scheduling of the aftercare appointment. This information may include, but is not limited to, precipitating factors which led to the hospital presentation, the course of treatment in the CPEP, and information about prescribed medications. A CPEP may also legally disclose the minimum information necessary to an OPWDD-Certified Housing Program if the housing program is included in the Local Services Plan.

2. An OMH provider meeting the above criteria, such as an Article 28 hospital inpatient psychiatric unit, CPEP, or MHOTRS program, receives a request for information regarding a patient being served by another provider meeting the criteria above, such as an Assertive Community Treatment (ACT) team, a homeless outreach program, or a Home-Based Crisis Intervention Team that has been trying to assist the patient. The inpatient psychiatric unit, CPEP, or MHOTRS program is legally authorized to and should supply sufficient clinical information about the patient to other OMH programs meeting the above criteria for treatment or care coordination purposes, even if the patient refuses to provide consent for the disclosure. The provider may, but is not required to, ask the other program for information to verify it is licensed or funded by OMH or included in the county's local or unified services plan for purposes of section 33.13(d) of the MHL. Providers may also obtain this information from their OMH Field Office or from a county director of community services.

3. An OMH provider meeting the above criteria, such as an Article 28 hospital inpatient psychiatric unit, CPEP, or MHOTRS program, becomes aware that a patient resides in an unlicensed mental health housing program funded by OMH. Housing programs play a critical role in ensuring the health and safety of their residents and may need clinical information, such as medication lists and appointment information, to perform these functions. Accordingly, an inpatient psychiatric unit, CPEP, or MHOTRS program is legally authorized to and should supply sufficient clinical information about the patient to the housing program upon request for treatment or care coordination purposes. The provider may, but is not required to, ask the housing program for information to verify it is licensed or funded by OMH or included in the county's local or unified services plan for purposes of section 33.13(d) of the MHL. Providers may also obtain this information from their OMH Field Office or from a county director of community services.

4. An OMH provider meeting the above criteria, such as a community residence, MHOTRS program, funded supported housing, or ACT team becomes aware that a patient was brought to a CPEP for an evaluation and reaches out to the CPEP to confirm the patient is there and offer collateral information. If requested by the CPEP or hospital unit where the patient was admitted, the OMH provider is legally authorized to and should share information, including clinical information, with the CPEP or hospital unit or treatment and care coordination purposes. The CPEP is legally authorized to confirm that the patient has presented in the CPEP and, if applicable, been admitted and share information, including clinical information with the OMH provider for treatment and care coordination purposes. These disclosures are authorized whether the patient is admitted to an OMH licensed inpatient psychiatric unit or an inpatient medical unit in the same hospital.[8]

5. An OMH provider meeting the above criteria, such as a Youth ACT team, becomes aware that an OMH designated Mobile Crisis provider included in the local services plan has been called to a family's residence. If requested by the Mobile Crisis provider, the OMH provider

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[8] MHL § 33.13(d) also authorizes mental hygiene facilities and other entities authorized by the Department of Health, such as medical facilities, to share information governed by the MHL without patient consent.

is legally authorized to and should share information, including clinical information, with the designated provider included in the local services plan.

In addition to information exchange between mental hygiene programs with a nexus to the Office of Mental Health as described above, a separate provision within section 33.13 (d) of the MHL allows OMH authorized providers to share confidential information governed by the MHL without patient consent for treatment and care coordination purposes with other entities authorized to provide, arrange for or coordinate health care services by OMH, OASAS, OPWDD, or the Department of Health (DOH), such as medical facilities licensed by DOH. The provision applies to health care providers authorized by DOH, such as hospitals, Federally-Qualified Health Centers (FQHCs), Independent Practice Associations (IPAs), patient centered medical homes, licensed home care services agencies, and residential health care facilities, as well as managed care organizations, subcontracted behavioral health organizations that manage behavioral health services on behalf of a managed care organization, health home care management agencies, and other care management programs, as long as the individual is enrolled in or receiving services from the entity. The provision does not apply to primary care or other licensed professionals that are not authorized by DOH to provide services, even if such providers are enrolled in the Medicaid program.

A Note about Psychiatric Emergency Services in Emergency Departments

OMH is aware of instances where Article 28 hospital emergency departments that receive and treat individuals with psychiatric conditions have refused to communicate information with OMH licensed or funded, designated, or any other community-based mental health care providers, such as an individual's ACT team, without a signed consent form. **Information disclosures by Article 28 hospital emergency departments are not subject to MHL section 33.13 and are governed by the HIPAA rules, the public health law (PHL) and other federal and state confidentiality protections.** As the HIPAA rules allow disclosure of PHI for the purposes of treatment and care coordination, Article 28 hospital emergency departments should share such information with OMH licensed or funded, designated, or any other community-based mental health care providers, with or without patient consent**.**

Such disclosures are encouraged to ensure individuals receive appropriate follow-up care and reduce avoidable emergency department use. However, certain information if obtained from an OMH or OASAS provider may be subject to prohibitions on redisclosure. For example, information about SUD treatment obtained from OASAS-certified programs may be subject to additional federal confidentiality protections that require consent to redisclose such information to another provider.

In addition, OMH providers are authorized to disclose confidential information governed by the MHL with hospital emergency departments without patient consent for treatment and care coordination purposes pursuant to section 33.13(d) of the MHL. This is because hospital emergency departments are entities authorized by DOH to provide health care services for the same patient.

Disclosure of Patient PHI with a Signed Authorization or Consent Form

OMH providers may disclose PHI for treatment and care coordination purposes with third parties, with the consent of the patient or someone authorized to make health care decisions on the patient's behalf, such as a health care proxy or legal guardian for an adult, or by the legal

representative of a minor, which may be documented in writing.[9] Programs may use form OMH 11C – Authorization for Release of Health Information (Including Alcohol/Drug Treatment and Mental Health Information) and Confidential HIV/AIDS-related Information or another HIPAA compliant authorization form for this purpose. OMH providers must obtain written consent from the patient or someone authorized to make health care decisions on the patient's behalf, such as a health care proxy or legal guardian for an adult, or by the legal representative of a minor, to access, use or disclose PHI to third parties for purposes other than those allowed by the HIPAA rules or MHL such as treatment and care coordination purposes.

Disclosure of Patient PHI to Other Individuals Involved in the Individual's Life

As discussed in other recently issued guidance regarding discharge practices, Article 28 hospitals[10] must make efforts to obtain information about patients from non-hospital sources to improve discharge planning, care coordination and patient health outcomes. The purpose of this section is to clarify the applicable law regarding such communications.

PHI, including mental health clinical information governed by section 33.13 of the MHL, such as the fact of an individual's presentation or admission to an inpatient psychiatric unit or CPEP, may be disclosed to any identified party with the authorization of the patient or someone authorized to make health care decisions on the patient's behalf, such as a health care proxy or legal guardian for an adult, or by the legal representative of a minor.

While OMH providers should always attempt to obtain such authorization from individuals or their legally authorized representatives, PHI may also be disclosed to certain parties when the individual has not or cannot provide such authorization due to incapacity or in an emergency situation. In such circumstances, the MHL permits the disclosure of PHI without patient authorization to:

- Legal guardians, including MHL Article 81 and SPCA Article 17-A guardians for individuals with intellectual or developmental disabilities and legal guardians of minors,
- Family members that meet the definition of a qualified person under section 33.16 of the Mental Hygiene Law, including a parent of a minor or a parent, spouse, adult child, or adult sibling of an adult patient where such individual is authorized pursuant to law, rule or regulation to provide consent to any treatment provided to the individual,
- Individuals entitled to legal notices pursuant to sections 9.29 and 9.33 of the Mental Hygiene Law, where applicable, and
- Any appropriate persons when necessary to prevent imminent serious harm to the patient or client or another person.[11] Clinicians must exercise their clinical judgment in making such determinations, which must be documented in the patient's record.

Disclosure of PHI to Local Government Units

The access, use and disclosure of PHI to the counties, including the Director of Community Services (DCS) and Single Point of Access (SPOA) is covered under MHL 33.13(c)(12). OMH programs may disclose PHI, including clinical records or clinical information, to a DCS or their

[9] Note that neither HIPAA nor the MHL requires written authorization for disclosures for treatment or care coordination purposes, however providers may choose to document that consent was obtained, where required by the MHL, as a best practice for compliance purposes. MHL § 33.13(c)(7); 45 C.F.R. §§ 164.506(b); 164.508.
[10] https://omh.ny.gov/omhweb/guidance/omh-doh-evaluation-discharge-guidance.pdf
[11] MHL §33.13(c)(9)(v).

designee without consent, provided that such director or their designee requests such information in the exercise of their statutory functions.

The DCS, or their designee may disclose PHI, including clinical records or clinical information, to an OMH provider without consent if the provider is an OMH operated facility, or if there is a nexus between the provider and OMH through licensure, a local unified services plan approved by OMH, or through an agreement with OMH, including an agreement through which OMH may provide funding to the provider.

Ethical Considerations

OMH providers should always make reasonable attempts to obtain consent from patients to facilitate communication with other service providers and collaterals, where clinically appropriate. If no signed consent can be obtained due to patient refusal or incapacity, providers may legally, and are expected to as part of their OMH licensure and OMH guidance, share the minimum necessary information in order to provide needed care, and for appropriate aftercare and care coordination with other services providers, including OMH operated facilities, providers that have a link with OMH through licensure, a local unified services plan approved by OMH, or through an agreement with OMH, including an agreement through which OMH provides funding to the provider.

Further Guidance

Providers should be aware of recent and pending developments in federal law related to the exchange of health information. First, since April 2021, providers have been required to comply with the 21st Century Cures Act information blocking final rule.[12] The rule, which applies to electronic PHI only, prohibits certain practices, including incorrectly citing a federal or state law as a basis for not sharing electronic PHI as information blocking. Providers may be subject to enforcement and future penalties by the United States Department of Health and Human Services, Office of Inspector General, for engaging in information blocking. Providers should also be aware of proposed changes to the HIPAA privacy rules intended to clarify a covered entity's ability to disclose PHI to social services agencies, community-based organizations, home and community-based service (HCBS) providers, and other third parties for care coordination purposes.[13] The proposal would also replace the professional judgment privacy standard with a standard based on a good-faith belief that a disclosure is in the best interest of the individual. Providers should refer questions about these recent and pending developments to their own counsel.

[12] 45 C.F.R. Part 171.

[13] Proposed Modifications to the HIPAA Privacy Rule To Support, and Remove Barriers to, Coordinated Care and Individual Engagement, 86 Fed. Reg. 6446 (Jan. 1, 2021) (to be codified at 45 C.F.R. pts. 160, 164), https://www.federalregister.gov/documents/2021/01/21/2020-27157/proposed-modifications-to-the-hipaa-privacy-rule-to-support-and-remove-barriers-to-coordinated-care.