

Sharing client information in a care team

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This presentation is not Legal Advice or Authoritative Guidance

- This is one model for consent documentation and team-based information sharing.
- Features:
 - Clear, straightforward guidelines for care team members
 - Increased client-centeredness and accessibility
 - Incorporates consent documentation into other patient engagement activities
- There are other valid models; the Vermont Care Network has been working on its own consent form and sharing recommendations
- Seek legal advice within your organization before implementing any model

Sharing with Confidence

1. Have a reliable consent form
2. Know what to expect when sharing information in a team
3. Prepare for ongoing sharing responsibilities and eventualities

Sharing with Confidence: Consent Forms

The organization whose records you are requesting wants to know if consent is:

- Valid: Form satisfies HIPAA and/or Part 2
- Current: Most recent version of the form, not revoked or expired
- Clear: Easy for the records officer to understand and comply with
- Informed: Form accurately documents what the client intends to share

Sharing with Confidence: Following Each Others' Rules

Have a plan to address the mix of:

- Federal laws (HIPAA, 42 C.F.R. Part 2, Educational Records)
- State laws (Hospital Records, Skilled Nursing Facilities, Mental Health Records)
- Other privacy obligations (Medicaid provider agreements, Professional/Ethical standards, Mandatory reporting requirements)
- Provider privacy practices, norms, and policies

See Sample Group Sharing and Privacy Protocol

[For informational purposes - not legal advice]

Sample Group Sharing and Privacy Document

Notice of Privacy Standards

Only individuals authorized by the [CARE TEAM] **RELEASE OF INFORMATION FORM** may receive the protected information specified in the release.

Providers are advised to keep the information they receive pursuant to the release separate and distinct from the information obtained directly from the client in the course of practice.

Providers are expected to follow the confidentiality laws and ethical standards of their practice. Providers are also asked to do the following with information received pursuant to the release, even when not required to do so:

- Keep this information secure
- Use or disclose this information only as authorized by the release or with the client's written permission
- Seek legal advice after disclosing records in an emergency situation
- Seek legal advice if required to disclose records by law

NOTICES FOR PROVIDERS REGARDING PRIVACY REQUIREMENTS OF LAWS MORE STRINGENT THAN THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

The laws referenced below protect specific kinds of private information. This information should not be used or disclosed except as described in the release. Providers should contact the source of this information and/or seek legal advice if such use or disclosure is:

- Requested by the client or required for the client's treatment
- Required by law
- Made without permission or in an emergency

Part 2 Warning for [Part 2 Facility]'s Records

Information disclosed by [Part 2 Facility/Facilities] is protected by 42 CFR Part 2.

This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

[For informational purposes - not legal advice]

FERPA Warning for [Educational institution]

Personally identifiable information from an educational records disclosed by [Educational Institution] is protected by the Family Educational Rights and Privacy Act (34 CFR part 99). The disclosure of this information is made on the condition that the parties receiving this information will not disclose the information to any other party without the prior consent of the parent or eligible student, except as permitted by FERPA.

Title 18 Part 8 Warning

Any records created pursuant to State Mental Health Statutes (18 V.S.A. §§ 7101 - 9335) are protected by Vermont state law as well as HIPAA. These records may not be disclosed without written authorization except as permitted under state law. This law places restrictions on disclosures without authorization that are more stringent than HIPAA. Seek legal advice before disclosing such information without written permission.

Sharing with Confidence: Planning Beyond Initial Disclosure

- Plan for clients who want to change or withdraw consent
- Know what can be shared outside the team
- Ensure you have the permissions to enable evaluation of the program and reporting of successes and lessons learned

Tailoring Team Sharing

One Size May not Fit All

- Clients who are most likely to benefit from care coordination often have special privacy needs
- Broad groups of community providers rarely need access to a client's intimate or highly protected client information
- Teams that do require this level of access are often smaller and can be hand-picked by the client

Team Sharing

1. Identify the coordination activities that use protected information
2. Anticipate the team's information needs
3. Ensure that access to information is appropriate to the team's uses and needs

Team Sharing: Activities that Require Sharing

- Identifying clients who may benefit from coordinated care
- Organizing and evaluating progress of care teams
- Coordinating a client's care
- Approving uses of flexible funds

Team Sharing: Appropriate Level of Sharing

What information does the team need to share?

- Client identity and treatment relationship
- Specific diagnosis
- Reason for proposed expenditure of flexible funds
- Information specific to client goals and services

Team Sharing: Appropriate Access

What kind of team does the activity call for?

- Full community team to choose a panel of clients
- Client-chosen team to coordinate care
- Sub-team to discuss sensitive information
- Committee to recommend expenditures of team funds

Documenting Consent: Not as Scary as it Seems

- An accessible form may take less time for clients to read and sign, even if it is longer than one page
- A readable release can make it easier for providers to answer client's questions
- Consent form becomes another opportunity to engage with the client and introduce the concept of team based care

Client-Centered Consent Documentation

Accessible Form

- Plain language: Reading level as close to grade 5 as possible (regulatory language is written at a graduate school level education, around grade 18)
- 14 point Arial is considered an accessible font for many with learning differences or impaired vision

Tools for presenting further information

- Camden cards can suggest providers and types of information to share

Client-Centered Consent Documentation

Client-Direction

- Inform clients if any members are required to participate, but allow them to include or exclude members whenever possible
- List the kinds of information the team has to share, but allow clients to authorize other sharing of other information only if it is needed and they are comfortable with the group having access to it
- If appropriate, include a description of the information the team will not share

Client-Centered Consent Documentation

- Addresses the needs of the team and the client
- Explains the risks and advantages of sharing information with a team
 - Prepares client and team to address situations such as consent revocation and mandatory reporting
 - Reminds client of team members' different privacy practices

Example 1: Community Group Consent

Activities: Identifying suitable clients, helping clients create care teams, evaluating team performance, and identifying best practices and lessons learned

- Large team discusses every client
- Small set of patient information needed
- Substance Use and Mental Health Treatment providers observe but do not need not participate
- Client is able to keep sensitive information private, team does not need to worry about Part 2 or protections for state mental health records

**[COMMUNITY GROUP]
RELEASE OF INFORMATION FOR [Learning Collaborative]
PROJECT**

Name

Date of Birth

I WANT TO SEE IF TEAM BASED CARE COULD HELP ME

A Community Group of local care providers is trying out team based care. They want to see if small teams of care providers can get people with [target condition] healthy faster.

I would like the Community Group members to talk to each other about whether team based care is right for me. If the group thinks they can help, they will help me choose a Care Team and keep track of its progress.

I know that I have a right to keep working with the members of the Community Group even if I tell them not to share my information.

MEMBERS OF THE COMMUNITY GROUP

These are all of the providers who are members of the Community Group:

1. [A]
2. [B]
3. [C]
4. [D]
5. [Etc.]

WHAT THE COMMUNITY GROUP CAN SHARE

The members of the Community Group will have permission to share the following information with each other:

1. My full name
2. Whether they have worked with me
3. My current health problems
4. My recent medical history
5. Updates about my Care Team

HOW THE COMMUNITY GROUP WILL RESPECT MY PRIVACY

The Community Group needs my written permission to talk about anything that is not listed above.

The members of the Community Group will not share any of the information listed above if it would show that I have:

1. Issues related to mental health
2. Problems with drug or alcohol use
3. HIV or AIDS
4. Family court issues
5. A criminal history
6. Other legal issues

WHAT HAPPENS TO MY INFORMATION ONCE IT IS SHARED

1. I know that **my health records could be shared again**. Health information that is shared may no longer be protected under the privacy law known as HIPAA.
2. I know that some of the Community Group members do not have to follow the privacy law known as HIPAA. They will be careful to protect my privacy, but **HIPAA does not protect the records I share with them**.

HOW TO END THIS RELEASE

If I do not cancel this release, **it will end on its own [in one year]**.

I can also set my own end date here:

End Date

I can cancel this release at any time in writing or by contacting:

[Person X]

[Address]

[City], VT [ZIP]

[Phone]

Members of the Community Group will let each other know that this release has been cancelled.

I know that even if I cancel this release, the Community Group members may still have a right to keep and use information that has already been shared.

I know that I have a right to keep working with my providers even if I tell them to stop sharing my information.

SIGNATURE

I know this release will only start once I sign and date this page.

I know that I have a right to keep working with my providers even if I tell them not to share my information.

I know I have a right to get a copy of this form.

Signed by me or my representative

Date

If signed by representative, reason why my representative is allowed to sign for me

Signature of my parent or guardian if I am too young to sign by myself

Example 2: Care Team Consent

Care team works directly with client

- Client can limit access to sensitive information by
 - Limiting the team to a set of trusted providers, or
 - Signing a separate release to give sensitive information to just to the lead care coordinator
- Client can choose to share more information in the future

**[CARE TEAM] RELEASE OF INFORMATION FORM [Subject to
Validation by Legal Representative]**

Name

Date of Birth

I WANT MY PROVIDERS TO WORK AS A TEAM

I am choosing a team of supports and service providers to work together on my care. I am a part of this team and I am in charge of my care decisions. I will choose the information my team can share to work on my care.

The providers listed below will be part of my team if I write my initials next to the words "Add this provider." **I can keep seeing my providers even if I do not put them on my team.**

- [A] _____ Add this provider
- [B] _____ Add this provider
- [C] _____ Add this provider
- [D] _____ Add this provider
- [E] _____ Add this provider
- [F] _____ Add this provider

I can also add other providers to my team by listing them here:

HOW MY TEAM WILL USE MY INFORMATION

[My team is allowed to use my private information to help me make a plan for my care. My team will be allowed to share this plan with each other and give each other updates about my care. Members of my team will also be allowed to use my private information to help me apply for services.]

INFORMATION MY TEAM CAN SHARE

I give the whole team permission to share information that I choose on this form with the other members of the team.

BASIC HEALTH AND SERVICE INFORMATION

I give the providers on my team permission to:

1. Share my [name and date of birth]
2. Say whether I am one of their clients
3. Share my health needs, my goals and my care plan
4. Share information about the services and public assistance I receive
5. Share a list of my income and resources
6. Tell each other when I have appointments and if I miss appointments
7. Give each other updates on my progress
8. [List any other info needed to run the team]

OPTIONAL INFORMATION

I give my team permission to share the information I have selected from the list below. **It can be shared only if I write my initials on the line next to it.**

<input type="checkbox"/> [Substance Use]	<input type="checkbox"/> [D]
<input type="checkbox"/> [Mental Health]	<input type="checkbox"/> [E]
<input type="checkbox"/> [List other sensitive types of information]	<input type="checkbox"/> [F]

I also give my team permission to share the private information that I list here:

LAWS THAT PROTECT MY PRIVACY

The Privacy Law known as HIPAA protects my health information. Some of the providers on my team may not have to follow this law. These providers will be careful to protect my privacy, but **HIPAA does not protect the records I share with them.**

I know that **my health records could be shared again.** This could include some information about substance use, HIV/AIDS status, and mental health. Information that is shared may no longer be protected under the privacy law known as HIPAA.

I know that **records of substance use or mental health treatment from [Part 2 or Title 18 providers]** are protected by other laws. I know that my team will be told not to share these records with anyone who is not on the team without my written permission.

OTHER WAYS MY INFORMATION CAN BE SHARED

1. I know that there can be times when my team members do not need my permission to share my information.
2. I know that some of my team members may need to report if they find out about **something that is against the law.**
3. I know that some of my team members may need to tell someone if they know that **someone could be in danger,** or if I could be in danger.
4. I know that I can sign **other release forms** to let my team members share my information for other reasons.

I know that I can ask my team members if I have questions or concerns about how my information can be shared.

HOW TO END OR CHANGE THIS RELEASE

I know that this release will end on its own [if I do not see any of the members on my team for one year.]

I can also set my own end date here:

_____ End Date

I can cancel or change this release by contacting:

[Person X]

[Address]

[City], VT [ZIP]

[Phone]

[Person X] will then tell my team that this release has been cancelled. I know that even if I cancel this release, my team members may still have a right to keep and use information that has already been shared.

SIGNATURE

I know this release will only start once I sign and date this page. I know that **if I do not give the team permission to share my information, they will not be able to work together as a team** or share a plan for my care.

I know that **I have a right to keep working with my team members even if I tell them not to share my information.**

I know I have a right to get a copy of this form.

Signed by me or my representative

Date

Reason why my representative is allowed to sign for me

Signature of my parent or guardian if I am too young to sign by myself