

ILLINOIS OFFICE OF HEALTH INFORMATION TECHNOLOGY
(OHIT)

ILHIE LEGAL TASK FORCE

RECOMMENDATIONS OF
BEHAVIORAL HEALTH LEGAL WORK GROUP

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Behavioral Health Legal Work Group

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This memorandum summarizes the work product of the Behavioral Health Legal Work Group (“BHLWG”) and addresses the following questions:

- (i) *What barriers does the Illinois Mental Health and Developmental Disabilities Confidentiality Act¹ (the “IMHDDCA” or the “Act”), as well as Illinois licensing laws applicable to mental health professionals² (“Licensure Laws”), present to establishing and operating a state-wide health information exchange (“HIE”) in Illinois?³*
- (ii) *What changes might be made to the IMHDDCA and Licensure Laws to facilitate establishment and operation of the state-wide HIE?*

In answering the above questions, the BHLWG applied the following principle adopted by the HIE Legal Task Force Executive Committee (“Executive Committee”): the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) would provide the baseline for use and disclosure of health information utilizing the HIE. Thus, identification of barriers and development of recommendations focused on the gaps between HIPAA and the IMHDDCA and Licensure Laws (the IMHDDCA and Licensure Laws collectively referred to herein as “Mental Health Laws”).

Given the above-described approach, it is important to note that the IMHDDCA, as well as numerous Licensure Laws, were written years ago, with no significant comprehensive revision since their initial adoption. With the passage of HIPAA and its subsequent implementation in 2003, the gaps and inconsistencies between state and federal law became apparent, making implementation of privacy safeguards difficult for the health care community. State Mental Health Laws are more restrictive than HIPAA with respect to the use and disclosure of mental health and developmental disability information (“Mental Health Information”). Plans to implement a state-wide HIE have only served to highlight this issue. Failure to “narrow the gap” between state and federal law not only creates additional administrative hurdles, but may result in isolation of the mental health community from the HIE and other helpful initiatives as existing Mental Health Laws make participation infeasible. This isolation, in turn, may have significant harmful effects on mental health patients who could benefit from participation in the HIE and other initiatives.

A. Barriers Presented by the IMHDDCA

Specific barriers presented by the IMHDDCA to establishing and implementing the state-wide HIE include the following items:

¹ 740 ILCS 110/1—17 (2012).

² The BHLWG reviewed licensure laws applicable to professionals who are most likely to provide mental health services, including licensure acts regulating physicians, nurses, clinical psychologists, clinical social workers, marriage and family therapists, and professional counselors.

³ 20 ILCS 3860/1—999 (2012). A core purpose for establishing the Illinois HIE, as articulated by the legislature, is “to improve the safety, quality, and value of health care, to protect and keep health information secure, and to use the health information exchange system to advance and meet population health goals.” 20 ILCS 3860/5 (2012).

1. IMHDDCA exceptions do not encompass disclosures for all contemplated purposes to be served by the HIE. The IMHDDCA precludes disclosure of Mental Health Information without a patient’s written consent *unless* an exception is set forth within the IMHDDCA.⁴ In this regard, the IMHDDCA restricts behavioral health providers from identifying to the HIE the existence of this type of patient record as there is no exception that would allow even the identification of an individual receiving mental health or developmental disability services. Moreover, disclosures that may be made without consent for treatment, payment, and health care operations purposes (including quality assessment and peer review) are significantly more limited than those that may be made under HIPAA and as contemplated to be made through the HIE. While there have been some recent changes to the IMHDDCA to allow for greater coordination of care between providers without patient consent, this initiative is limited to Public Aid Recipients and does not allow for the breadth of treatment and coordination of care activities permitted under HIPAA.⁵

2. Patient consent requirements do not fit the HIE model. Of primary concern is the IMHDDCA prohibition on “blanket” consents and the requirement that advance consent specify *in detail* the nature of the information to be disclosed as well as the party to whom disclosure will be made.⁶ If an HIE participant signs a consent in Year 1, it is impossible to know the Mental Health Information that might exist in Year 2 for the patient, which Mental Health Information would be subject to transmission using the HIE, or to whom the Mental Health Information will be disclosed. In addition, a consent compliant with the IMHDDCA must indicate a calendar date for expiration. This requirement has operational ramifications with respect to the length of a consent used for the HIE, as well as how HIE participants might renew an expired HIE consent. HIPAA, on the other hand, does not require patient consent for disclosures and uses of Mental Health Information for a broad spectrum of treatment, payment, and health care operations purposes.⁷

3. The IMHDDCA limits the conduct of research. With few exceptions, individual patient consent is required in order to use the patient’s Mental Health Information for research purposes. Even research using de-identified data and limited data sets, as well as preparatory and retrospective chart reviews, are not clearly possible under the current IMHDDCA. This is in sharp contrast to HIPAA. One of the contemplated applications of the HIE is the conduct of research, and existing Mental Health Laws, unless modified, would largely exclude Mental Health Information from this activity.

4. The IMHDDCA is outdated for application of an electronic medical record. The IMHDDCA does not distinguish between internal access to a record (a “use” per HIPAA) and external release of a record (a “disclosure” per HIPAA). Nor does the Act address the maintenance or transmission of Mental Health Information in an electronic format. Thus, health care providers, payors, and others face particular challenges in integrating Mental Health Information into an electronic medical record—the building block of the HIE.

⁴ 740 ILCS 110/5 (2012).

⁵ See, Section 9.4 of the IMHDDCA. 740 ILCS 110/9.4 (2012).

⁶ 740 ILCS 110/5(b)-(c) (2012).

⁷ The one exception is HIPAA’s treatment of “psychotherapy notes,” disclosure of which, with very limited exception, requires a written authorization from the patient. 45 C.F.R. §164.508(a)(2).

5. The IMHDDCA does not accommodate current business models. The Act does not provide express authorization for disclosure of Mental Health Information to a “business associate” as defined by HIPAA. However, the Act does provide for a “record custodian,” which, arguably, is analogous to a business associate performing the limited function of maintaining records.⁸ Neither the Act nor case law provides concrete guidance on the functions that a records custodian may perform. Nor does the Act or case law provide concrete guidance on use of agents by a therapist. It is likely that the HIE, along with the providers, payors, and other entities that provide and obtain information to and through the HIE, will utilize third parties to facilitate the HIE which, under HIPAA, qualify as business associates. In addition, the HIE itself may be a business associate to providers and payors. The duties performed by these business associates are likely to be broader than what is contemplated under the IMHDDCA for “record custodians.” Accordingly, without amendment, the IMHDDCA would preclude disclosure of mental health information to these agents and contractors, including HIEs.

6. IMHDDCA establishes processes that are redundant of HIPAA, resulting in administrative inefficiency. It would be helpful if the IMHDDCA were modified to mirror HIPAA with respect to patient rights (e.g., amendment of records, receipt of accounting of disclosures, etc.). The HIE may need to accommodate the exercise of various patient rights (e.g., the HIE may need to establish an account of disclosures mechanism as required by HIPAA). Again, maintaining parallel processes is administratively cumbersome.

7. The scope of IMHDDCA is broad and unclear. The IMHDDCA applies to “records” and “communications.” In this regard, “record” means any record kept by a therapist or by an agency in the course of providing *mental health or developmental disabilities services*.⁹ “Communication” is any communication made by a recipient or other person to a therapist (including a communication made in front of other persons) during or in connection with provided mental health or developmental services.¹⁰ Importantly, “therapist” means a psychiatrist, *physician*, psychologist, social worker, or *nurse* providing mental health or developmental disabilities services.¹¹

While records kept by psychiatrists and other mental health care workers are identifiable and constitute information covered by the IMHDDCA, “therapist,” as defined in the IMHDDCA, also encompasses general physicians and nurses (i.e. non-mental health professionals) providing mental health and developmental disabilities services. In this regard, consider the following scenarios:

- First, based upon the above definitions, a primary care physician or other non-psychiatrist physician who diagnoses depression and records it in the general medical record essentially makes that general medical record into a “record” subject to the IMHDDCA.
- Second, it is unclear under the IMHDDCA whether or not a physician who states in the record, “...possible depression. Refer to Dr. Psychiatrist...” is creating a

⁸ “Record custodian” means “a person responsible for maintaining a recipient's record.” 740 ILCS 110/2 (2012).

⁹ 740 ILCS 110/2 (2012).

¹⁰ 740 ILCS 110/2 (2012).

¹¹ 740 ILCS 110/2 (2012).

mental health record subject to the IMHDDCA. Does this preliminary review constitute the examination, evaluation, or diagnosis of a mental health condition?

- Third, consider a scenario in which a patient seeking non-mental health care services provides mental health information (e.g., as part of a medical history recorded in an encounter note). It is unclear if the inclusion of such information makes the encounter note a “record” subject to the IMHDDCA.

In all scenarios, health care providers, payors, and others face challenges identifying and segregating Mental Health Information from non-Mental Health Information. This, then becomes a challenge for the HIE if such identification and segregation becomes necessary.

B. Barriers Presented by Illinois Licensure Laws

Individual Licensure Laws often provide that disclosure of patient information requires patient consent unless an exception is provided. Exceptions in the Licensure Laws are often limited to only a few scenarios and far less than even the IMHDDCA provides or that the HIE would need. In addition, the interplay between the Licensure Laws and IMHDDCA is unclear. Typically, providers and payors follow the more restrictive law when a Licensure Law and the IMHDDCA overlap. Hence, this is an area that will require clarification and modification.

C. Recommended Changes to the IMHDDCA and Licensure Laws

Specific recommended changes to the IMHDDCA to facilitate the HIE by making it consistent with HIPAA include the following:

1. Create an additional exception to the requirement for written patient consent allowing disclosure through the HIE *or* modify consent requirements to facilitate the HIE by allowing use of a blanket or general consent.
2. Make IMHDDCA consistent with HIPAA with respect to research, de-identification, limited data sets, business associates, and patient rights.
3. Centralize within the IMHDDCA confidentiality requirements regarding Mental Health Information found in Licensure Laws.
4. Clarify the scope of IMHDDCA. Consider:
 - Defining mental health and developmental disability services as either those provided by specific providers and/or which refer to diagnosis or treatment of specifically-identified conditions.
 - The BHLWG supports treating “personal notes” under the IMHDDCA consistently with “psychotherapy notes” under HIPAA. The BHLWG, however, does not believe it appropriate that these notes be included within the HIE.

D. OTHER RECOMMENDATIONS

The BHLWG included three mental health clinicians. From a clinical perspective, they recommended that the following information be disclosed through the HIE due to its importance in providing medical care: medical history; assessment of violence or suicide risk; diagnoses; medications; vital signs and allergies; lab results. They considered the following to be of less importance for purposes of disclosure through the HIE: patient forms; evaluations; results of examinations; test results; treatment plans; provider correspondence; and outside records.

The BHLWG also suggests, as a possible framework for establishing adequate safeguards, development and application of several of the elements of a robust compliance plan within the HIE infrastructure. These include:

- The development and implementation of HIE safeguards;
- Appointment of an individual or committee, the focus of whom/which is to ensure compliance with HIE safeguards;
- The development of written agreements to be entered into by participating entities that contribute to and access from the HIE. The agreements should incorporate written policies and procedures governing the use of the HIE. Consideration should be given to requiring participating entities to maintain specified minimum levels of insurance; indemnification obligations; and remedies for non-compliant use.
- The implementation of a training program for use of the HIE, as well as a communication mechanism for all participating entities.
- The requirement that all who access the HIE have undergone a criminal background check.
- The establishment of a mechanism for reporting non-compliant behavior.
- The development of a robust auditing and monitoring program to ensure that HIE use is appropriate.

While it may be ideal to adapt the IMHDDCA to make it consistent with HIPAA with respect to “use” versus “disclosure” of data and incorporation of security measures, doing so may not be necessary to facilitate the HIE. Consideration, however, should be given to addressing these issues in the future. Consideration should also be given to scenarios where re-disclosure of information shared via the HIE might be appropriate.

Ideally, changes to the Act to mirror HIPAA should *reference* HIPAA rather than *repeat* HIPAA so that if there is a change in HIPAA, then the change automatically applies to the Act. Specific amendatory language consistent with the above recommendations has been provided to the HIE Executive Committee.

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