Continuum of Care Reform in California: How data sharing between child welfare, behavioral health and physical health care systems supports new treatment models for youth and their families

National Behavioral Health Information Management Conference and Exposition
April 27, 2017
Carlsbad, CA

California Department of Social Services
Department of Health Care Services
Objectives

- Overview of Continuum of Care Reform
- Data Sharing and Governance
- Example of data sharing for mental health
- Considerations when establishing a shared data process
What is the Continuum of Care Reform?

- The Continuum of Care Reform (CCR) draws together existing and new reforms to the child welfare services program.

- Designed out of an understanding that children who must live apart from their biological parents do best when they are cared for by committed nurturing family homes.

- Ensures services and supports provided to the child or youth and his or her family are tailored toward maintaining a stable permanent family.

- Reliance on congregate care should be limited to short-term, therapeutic interventions.
Fundamental Principles of CCR

• Children should not have to change placements to get the services and supports they need.

• Group care will be primarily utilized only for short-term therapeutic care.

• Services and supports will be tailored to the strengths and needs of a child and delivered in a family-based environment.

• Agencies serving children including child welfare, probation, mental health, education and other community service providers should collaborate effectively to surround the child and family with needed services, resources, and supports rather than requiring a child, youth, and caregivers to navigate multiple service providers.
How can data support this effort?

- Provide state-level input regarding implementation
- Providing county-level data for monitoring and implementation at the individual level
Establishment of Data Sharing Agreements

• 3-way agreements between DHCS, CDSS and counties that opt into an agreement

• Matched data between clients in the Child Welfare Services/Case Management System (CWS/CMS) and Medi-Cal claims shared with parties to an agreement

• Counties can receive matched data in one of two ways:
  o Global Data Sharing Agreement
  o Psychotropic Medication Data Sharing Agreement
# Data Sharing Agreements

<table>
<thead>
<tr>
<th>Execution between CDSS &amp; DHCS</th>
<th>Global Data Sharing Agreement</th>
<th>Psychotropic Medication Data Sharing Agreement</th>
</tr>
</thead>
<tbody>
<tr>
<td>All County Info. Notices</td>
<td>April 9, 2015</td>
<td>December 2, 2016</td>
</tr>
<tr>
<td>Population</td>
<td>ACIN I-36-15</td>
<td>ACIN I-87-16</td>
</tr>
<tr>
<td>Available Data</td>
<td>Children and non-minor dependents receiving CWS</td>
<td>Dependent children 0-17 years old in out-of-home care on psychotropic medication</td>
</tr>
<tr>
<td>Purpose for Use</td>
<td>Eligibility, Demographic, Medical, Mental Health, Payment &amp; Medication</td>
<td>Data pertaining to psychotropic medications, including lab tests and psychosocial data</td>
</tr>
<tr>
<td>Business Associate Addendum</td>
<td>Permissible Purposes enumerated the GDSA</td>
<td>Health oversight activities, as specifically defined in Title 45 of the CFR section 164.512(d)</td>
</tr>
<tr>
<td>Number of Signatory Counties</td>
<td>23</td>
<td>6</td>
</tr>
</tbody>
</table>
CDSS/DHCS
Data Governance

• Agreement that no reports are released without the approval of executive leadership for each Department
  o Ensures understanding of the information
  o Increases accuracy of the data/reporting
  o Promotes awareness of the findings to inform policy decisions

• Agreement that reports undergo privacy review to protect consumer confidentiality
CDSS/DHCS Data Collaboration

• Annual meeting to establish/revisit data reporting priorities
  o Leadership and staff from each Department
  o Community Partners and Stakeholders

• Bi-monthly inter-Departmental research staff team meetings
  o Project management and progress updates
  o Cross-training
  o Troubleshooting

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Building a Linked Data System

Established a Data Warehouse environment which stores matched data.
What does the linked data tell us?

- Mental Health Utilization Reports
- Psychotropic Medication Utilization Reports
Mental Health Utilization
Background

To inform efforts to improve mental health services for children in the Child Welfare System (CWS) the CDSS and DHCS have collaborated to produce two reports:

- CDSS produces a “Quarterly Report on Mental Health Services Utilization for Children/Youth in the Child Welfare System.” The quarterly reports supplement the annual Performance Outcomes System reports (POS).

- DHCS produces an annual Performance Outcomes System report detailing mental health service utilization for all children in the Medi-Cal system as well as specifically for children in the CWS.
Mental Health Utilization Reports

• The reports seek to answer the questions:
  o How many children/youth in the CWS are receiving mental health services?
  o What is the nature of these services?

• Data includes:
  o “Penetration rates” defined as one or more SMHS
  o “Engagement rates” defined as five or more SMHS
Methods for Matching

• Data from the CWS/CMS for children in the CWS and children in the DHCS MIS/DSS were matched.

• The process for the match involved using a probabilistic, multi-step, multi-method algorithm of exact and inexact matches based on a combination of name, social security number, and date of birth records between the two systems.

• All children with an open child welfare case between July 1, 2014 to June 30, 2015 (State Fiscal Year; SFY 2014-15) were included in the analysis.

• Medi-Cal claims for Specialty Mental Health Services (SMHS) during this time period were analyzed.
Populations Included

Analyses were conducted for:

1. Children with an open Child Welfare Case

2. Children in foster care
Main Findings

• Children with an Open Case:
  o 135,823 children had an open child welfare case
  o 41.7% (56,612) had 1+ SMHS claims
  o Of these children, 73.5% (41,635) had five or more days of SMHS claims.

• Children in Foster Care:
  o 88,187 children were in foster care at some point
  o 47.2% (41,667) had 1+ SMHS claims
  o Of these children, 74.8% (31,154) had five or more days of SMHS claims.
Findings: Specialty Mental Health Service Utilization SFY 2014-15

<table>
<thead>
<tr>
<th></th>
<th>Unique Count of Children</th>
<th>Children with One or More SMHS</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children with Open Cases</td>
<td>135,823</td>
<td>56,612</td>
<td>41.7%</td>
</tr>
<tr>
<td>Children in Foster Care</td>
<td>88,187</td>
<td>41,667</td>
<td>47.2%</td>
</tr>
</tbody>
</table>

1 Data Source: CWS/CMS and MIS/DSS extracted on October 17, 2016.
Children/Youth in Foster Care
## Children/Youth in Foster Care Age Breakouts SFY 2014-15

<table>
<thead>
<tr>
<th>Child Age²</th>
<th>Total # of Children</th>
<th>Children with 1+ Days of SMHS</th>
<th>Percent by Age</th>
<th>Penetration Rate</th>
<th>Children with 5+ Days of SMHS</th>
<th>Engagement Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-2</td>
<td>17,574</td>
<td>4,306</td>
<td>10.3%</td>
<td>24.5%</td>
<td>2,206</td>
<td>12.6%</td>
</tr>
<tr>
<td>3-5</td>
<td>14,286</td>
<td>6,190</td>
<td>14.9%</td>
<td>43.3%</td>
<td>4,220</td>
<td>29.5%</td>
</tr>
<tr>
<td>6-11</td>
<td>21,235</td>
<td>12,778</td>
<td>30.7%</td>
<td>60.2%</td>
<td>9,855</td>
<td>46.4%</td>
</tr>
<tr>
<td>12-17</td>
<td>23,424</td>
<td>14,829</td>
<td>35.6%</td>
<td>63.3%</td>
<td>12,004</td>
<td>51.3%</td>
</tr>
<tr>
<td>18-20</td>
<td>11,668</td>
<td>3,564</td>
<td>8.6%</td>
<td>30.5%</td>
<td>2,869</td>
<td>24.6%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>88,187</strong></td>
<td><strong>41,667</strong></td>
<td><strong>100%</strong></td>
<td><strong>47.2%</strong></td>
<td><strong>31,154</strong></td>
<td><strong>35.3%</strong></td>
</tr>
</tbody>
</table>

1 Data Source: CWS/CMS and MIS/DSS extracted on October 17, 2016.

2 Child age was calculated as of the last date of service for those with a SMHS claim, and as of the latest Medi-Cal eligibility month for those without a SMHS claim.

Non-SMHS provided through non-EPSDT-funded school services, grant-funded, or Mental Health Services Act funded services are excluded.

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## Children/Youth in Foster Care
### Race/Ethnicity Breakouts SFY 2014-15

<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
<th>Total # of Children</th>
<th>Percent by Race/Ethnicity</th>
<th>Children with 1+ Days of SMHS</th>
<th>Penetration Rate</th>
<th>Children with 5+ Days of SMHS</th>
<th>Engagement Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Black</td>
<td>18,736</td>
<td>21.3%</td>
<td>9,587</td>
<td>51.2%</td>
<td>7,440</td>
<td>39.7%</td>
</tr>
<tr>
<td>White</td>
<td>20,322</td>
<td>23.0%</td>
<td>9,050</td>
<td>44.5%</td>
<td>6,730</td>
<td>33.1%</td>
</tr>
<tr>
<td>Latino/Hispanic</td>
<td>45,904</td>
<td>52.1%</td>
<td>21,637</td>
<td>47.1%</td>
<td>15,988</td>
<td>34.8%</td>
</tr>
<tr>
<td>Asian</td>
<td>1,938</td>
<td>2.2%</td>
<td>874</td>
<td>45.1%</td>
<td>651</td>
<td>33.6%</td>
</tr>
<tr>
<td>Native American</td>
<td>1,105</td>
<td>1.3%</td>
<td>426</td>
<td>38.6%</td>
<td>307</td>
<td>27.8%</td>
</tr>
<tr>
<td>Missing</td>
<td>182</td>
<td>0.2%</td>
<td>93</td>
<td>51.1%</td>
<td>38</td>
<td>20.9%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>88,187</td>
<td>100%</td>
<td>41,667</td>
<td>47.2%</td>
<td>31,154</td>
<td>35.3%</td>
</tr>
</tbody>
</table>

1 Data Source: CWS/CMS and MIS/DSS extracted on October 17, 2016. 
2 Race/ethnicity is based on CWS/CMS. Child Race/ethnicity is collapsed based on 31 codes from two CWS/CMS variables, one indicating “Race” and the other a “Hispanic Indicator.” For children with a positive “Hispanic Indicator” race/ethnicity was categorized as “Latino/Hispanic” regardless of “Race” category. Non-SMHS provided through non-EPSDT-funded school services, grant-funded, or Mental Health Services Act funded services are excluded.
# Children/Youth in Foster Care

## Specialty Mental Health Service Type

<table>
<thead>
<tr>
<th>SMHS Types²</th>
<th># of Children with One or More SMHS while in Foster Care³</th>
<th>% of Children with One or More SMHS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Health Services (MHS)</td>
<td>40,193</td>
<td>96.5%</td>
</tr>
<tr>
<td>Case Management</td>
<td>17,519</td>
<td>42.1%</td>
</tr>
<tr>
<td>Medication Support</td>
<td>11,180</td>
<td>26.8%</td>
</tr>
<tr>
<td>Intensive Case Coordination (ICC)</td>
<td>6,784</td>
<td>16.3%</td>
</tr>
<tr>
<td>Intensive Home Based Services</td>
<td>4,875</td>
<td>11.7%</td>
</tr>
<tr>
<td>Crisis Intervention</td>
<td>2,679</td>
<td>6.4%</td>
</tr>
<tr>
<td>Therapeutic Behavioral Services (TBS)</td>
<td>2,475</td>
<td>5.9%</td>
</tr>
<tr>
<td>Inpatient</td>
<td>1,530</td>
<td>3.7%</td>
</tr>
<tr>
<td>Crisis Stabilization</td>
<td>1,481</td>
<td>3.6%</td>
</tr>
<tr>
<td>Day Rehabilitation</td>
<td>750</td>
<td>1.8%</td>
</tr>
<tr>
<td>Day Treatment</td>
<td>356</td>
<td>0.9%</td>
</tr>
<tr>
<td>Psychiatric Health Facility (PHF)</td>
<td>124</td>
<td>0.3%</td>
</tr>
<tr>
<td>Crisis Residential</td>
<td>45</td>
<td>0.1%</td>
</tr>
<tr>
<td>Adult Residential</td>
<td>*</td>
<td>*</td>
</tr>
</tbody>
</table>

SFY 2014-15

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Notes for the Specialty Mental Health Service Type SFY 2014-15 Table

1 Data Source: CWS/CMS and MIS/DSS extracted on October 17, 2016.
2 For description of SMHS Types see the Medi-Cal SMHS Supplement Document.
3 Child count is unduplicated within each service type but may be duplicated across service types. A child may be counted in several different service types. Values of 10 or under are suppressed.
Non-SMHS provided through non-EPSDT-funded school services, grant-funded, or Mental Health Services Act funded services are excluded.
Intensive Home Based Services

IHBS Minutes Per Unique Beneficiary
By Service Fiscal Year

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Intensive Care Coordination

ICC Minutes Per Unique Beneficiary
By Service Fiscal Year

FY 11-12 (n = )
FY 12-13 (n = 88)
FY 13-14 (n = 4,373)
FY 14-15 (n = 6,757)
## Children/Youth in Foster Care
### Placement Type Breakout SFY 2014-15

<table>
<thead>
<tr>
<th>Placement Type</th>
<th>Children in Foster Care</th>
<th># of Children with One or More SMHS while in Foster Care</th>
<th>Penetration Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group Home</td>
<td>9,175</td>
<td>6,680</td>
<td>72.8%</td>
</tr>
<tr>
<td>County Shelter/Receiving Home</td>
<td>342</td>
<td>249</td>
<td>72.8%</td>
</tr>
<tr>
<td>Foster Family Agency Certified Home</td>
<td>21,678</td>
<td>12,273</td>
<td>56.6%</td>
</tr>
<tr>
<td>Foster Family Home</td>
<td>6,552</td>
<td>3,915</td>
<td>59.8%</td>
</tr>
<tr>
<td>Relative/NREFM Home</td>
<td>28,617</td>
<td>14,356</td>
<td>50.2%</td>
</tr>
<tr>
<td>Guardian Home</td>
<td>2,485</td>
<td>815</td>
<td>32.8%</td>
</tr>
<tr>
<td>Court Specified Home</td>
<td>404</td>
<td>117</td>
<td>29.0%</td>
</tr>
<tr>
<td>Pre-Adoptive</td>
<td>9,333</td>
<td>1,018</td>
<td>10.9%</td>
</tr>
<tr>
<td>Supervised Independent Living Placement</td>
<td>5,690</td>
<td>911</td>
<td>16.0%</td>
</tr>
<tr>
<td>Non-Foster Care</td>
<td>1,367</td>
<td>624</td>
<td>45.6%</td>
</tr>
<tr>
<td>Missing</td>
<td>746</td>
<td>709</td>
<td>95.0%</td>
</tr>
</tbody>
</table>

**Received SMHS while in Foster Care at Some Point During Time Period**
- Total: 86,389, Penetration Rate: 47.2%

**In Foster Care at Some Point During Time Period but Received SMHS While In Home**
- Total: 1,798

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1. Data Source: CWS/CMS and MIS/DSS extracted on October 17, 2016.
2. Placement Type was determined by identifying the child’s placement as of the last date of service for those with a SMHS claim, and the child’s last placement during the time period for those without a SMHS claim.

Non-SMHS provided through non-EPSDT-funded school services, grant-funded, or Mental Health Services Act funded services are excluded.
## Children/Youth in Foster Care
### Length of Stay Breakout SFY 2014-15

<table>
<thead>
<tr>
<th>Length of Stay in Foster Care²</th>
<th>Total # of Children</th>
<th>Percent</th>
<th>Children with 1+ Days of SMHS</th>
<th>Penetration Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-6 Months</td>
<td>21,375</td>
<td>24.2%</td>
<td>9,392</td>
<td>43.9%</td>
</tr>
<tr>
<td>7-12 Months</td>
<td>16,652</td>
<td>18.9%</td>
<td>9,430</td>
<td>56.6%</td>
</tr>
<tr>
<td>13-24 Months</td>
<td>22,314</td>
<td>25.3%</td>
<td>10,428</td>
<td>46.7%</td>
</tr>
<tr>
<td>25-36 Months</td>
<td>10,476</td>
<td>11.9%</td>
<td>4,674</td>
<td>44.6%</td>
</tr>
<tr>
<td>37-48 Months</td>
<td>5,320</td>
<td>6.0%</td>
<td>2,472</td>
<td>46.5%</td>
</tr>
<tr>
<td>49-60 Months</td>
<td>3,105</td>
<td>3.5%</td>
<td>1,390</td>
<td>44.8%</td>
</tr>
<tr>
<td>61-120 Months</td>
<td>5,764</td>
<td>6.5%</td>
<td>2,612</td>
<td>45.3%</td>
</tr>
<tr>
<td>121 Months or More</td>
<td>3,181</td>
<td>3.6%</td>
<td>1,269</td>
<td>39.9%</td>
</tr>
<tr>
<td>Total</td>
<td>88,187</td>
<td>100%</td>
<td>41,667</td>
<td>47.2%</td>
</tr>
</tbody>
</table>

¹ Data Source: CWS/CMS and MIS/DSS extracted on October 17, 2016.
² Length of stay is calculated from the start of the most recent foster care episode through the end of the episode or end of the review period (June 30, 2015) if the episode did not end. Non-SMHS provided through non-EPSDT-funded school services, grant-funded, or Mental Health Services Act funded services are excluded.
<table>
<thead>
<tr>
<th>Medication Type</th>
<th>Children in Foster Care with a Paid Claim for Psychotropic Medication</th>
<th># of Children with One or More SMHS</th>
<th>Penetration Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Psychotropic</td>
<td>10,558</td>
<td>8,722</td>
<td>82.6%</td>
</tr>
<tr>
<td>Antipsychotic⁴</td>
<td>4,334</td>
<td>3,691</td>
<td>85.2%</td>
</tr>
<tr>
<td>Other Psychotropic⁵</td>
<td>6,224</td>
<td>5,031</td>
<td>80.8%</td>
</tr>
</tbody>
</table>

¹ Unduplicated children ages 0-17 were included.
² Data source: CWS/CMS 2016 Q3 Extract and MIS/DSS November 2016 Extract
³ Data for children in foster care with a Medi-Cal paid claim for psychotropic medication (Measure 5a) was matched to children with a paid claim for a SMHS during an open foster care episode. Non-SMHS provided through non-EPSDT-funded school services, grant-funded, or Mental Health Services Act funded services are excluded.
⁴ Children who received at least one paid claim for an antipsychotic medication.
⁵ Number of children who received a paid claim for other drug classes of psychotropic medications exclusive of antipsychotic medications.
Psychotropic Medication Utilization

- Medication claims were paid for 10,558 children and youth in foster care. Of these children, 8,722 (82.6%) also had a claim for a SMHS during the same time period.
  - 4,334 children received at least one paid claim for an antipsychotic medication,
  - the remaining 6,224 children received a paid claim for other drug classes of psychotropic other than antipsychotic.

- 85.2% of children with claims for antipsychotic medications received SMHS while 80.8% of children with other psychotropic medications received SMHS.
Counties Use of Shared Data for Psychotropic Medication

- Ensuring compliance with reporting and regulatory requirements
- Monitoring trends at a county level
- Informing treatment plans
- Facilitating continuity of care

Feedback from counties:
  - More in-depth examination of child health records
  - Review of county policies and practices
  - Some children are authorized for more medications than eventually are reflected in pharmacy claims
Summary

• In SFY 2014-15, 41.7% of children with an open child welfare case and 47.2% of children in foster care had a SMHS.

• Of the children who received a SMHS, the majority (73.5%) received 5 or more days of services.

• Children ages 6-17 had higher penetration rates than children of other age groups.

• Penetration rates were similar across race/ethnicity.

• Children in group homes had higher penetration rates than children in other placements.
Additional Information

- California Child Welfare Indicators Project (CC WIP)
  - [http://cssr.berkeley.edu/ucb_childwelfare/](http://cssr.berkeley.edu/ucb_childwelfare/)

- Mental Health Services Utilization Report (CDSS)
  - [http://www.cdss.ca.gov/inforesources/Foster-Care/Pathways-to-Well-Being](http://www.cdss.ca.gov/inforesources/Foster-Care/Pathways-to-Well-Being)

- Mental Health Performance Outcome System (DHCS)
  - [http://www.dhcs.ca.gov/services/MH/Documents/MedCCC/Library/POSMeasuresCatalog_Sept15Reporting_Final_1.11.15.pdf](http://www.dhcs.ca.gov/services/MH/Documents/MedCCC/Library/POSMeasuresCatalog_Sept15Reporting_Final_1.11.15.pdf)
Bringing Together Data From Different Systems

Pharmacy Claims
- Specialty Mental Health Claims
  - Mild to Moderate Mental Health Claims
    - Fee-For-Services
    - Managed Care
- Physical Health Claims
  - Fee-For-Services
  - Managed Care
  - Special Programs

Child Welfare Services
DHCS Performance Outcomes System

• Foster Care and Open Child Welfare Cases Reports (matched with CDSS data)
  o Statewide Report.pdf
  o Small Population Counties.pdf
  o Medium Population Counties.pdf
  o Large Population Counties.pdf
  o Rural Population Counties.pdf
Specialty Mental Health Services by Age Group

Demographics Report: Unique Count of Children and Youth in Foster Care Receiving SMHS by Fiscal Year

Statewide as of August 3, 2016

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>Children 0-5 Count</th>
<th>Children 0-5 %</th>
<th>Children 6-11 Count</th>
<th>Children 6-11 %</th>
<th>Children 12-17 Count</th>
<th>Children 12-17 %</th>
<th>Youth 18-20 Count</th>
<th>Youth 18-20 %</th>
</tr>
</thead>
<tbody>
<tr>
<td>FY 11-12</td>
<td>9,438</td>
<td>24.2%</td>
<td>11,066</td>
<td>28.4%</td>
<td>16,830</td>
<td>43.2%</td>
<td>1,627</td>
<td>4.2%</td>
</tr>
<tr>
<td>FY 12-13</td>
<td>9,599</td>
<td>24.4%</td>
<td>11,397</td>
<td>29.0%</td>
<td>15,672</td>
<td>39.9%</td>
<td>2,601</td>
<td>6.6%</td>
</tr>
<tr>
<td>FY 13-14</td>
<td>10,277</td>
<td>25.1%</td>
<td>12,358</td>
<td>30.1%</td>
<td>15,338</td>
<td>37.4%</td>
<td>3,032</td>
<td>7.4%</td>
</tr>
<tr>
<td>FY 14-15</td>
<td>10,496</td>
<td>25.3%</td>
<td>12,928</td>
<td>31.1%</td>
<td>14,818</td>
<td>35.7%</td>
<td>3,261</td>
<td>7.9%</td>
</tr>
</tbody>
</table>

Fiscal Year 11-12 Age Group Distribution

- Children 0-5: 24%
- Children 6-11: 43%
- Children 12-17: 28%
- Youth 18-20: 4%

Fiscal Year 12-13 Age Group Distribution

- Children 0-5: 7%
- Children 6-11: 24%
- Children 12-17: 29%
- Youth 18-20: 40%

Mild to Moderate Mental Health Services

[Graph showing utilization of mild to moderate mental health visits per 1,000 member months]

Note: Data in this dashboard is preliminary and subject to change.

http://www.dhcs.ca.gov/services/Pages/MngdCarePerformDashboard.aspx
Considerations for the Data Sharing Landscape

- CalOHII - Patient Authorization Guidance Tool
- Key Questions to Pose before you disclose from CalOHII
- Fine Print: Rules for Exchanging Behavioral Health Information in California
- State Health Information Guidance (SHIG)
- Information Blocking Defined
CalOHII - Patient Authorization Guidance Tool

• Required elements of a valid authorization:
  o Code of Federal Regulations Title 45 section §164.508(c)(3)
  o California Civil Code sections §§56.11-56.14, §56.21

• Designed to help healthcare providers determine when they need to obtain a patient’s authorization to send that patient’s information to another provider

• Applies only to healthcare providers as defined by both HIPAA and the Confidentiality of Medical Information Act (CMIA)

http://www.chhs.ca.gov/OHII/Pages/Resources.aspx#PatientAuthorizationTool
**Key Questions to Pose Before You Disclose**

**Substance Abuse Treatment Records**

*When is a patient authorization NOT required?*

**Program**
- Emergency
- Research
- Court Order

**Community Mental Health Provider**
- Court Order
- Required by Law

**General Medical Facility**
- Court Order
- Required by Law

**Qualified Service Organization Communication**
- Required by Law
- Crime on Premises

**Internal Communications by professionals for TX, service, or prevention**
- Emergency
- Child Abuse
- Elder Abuse

**Internal Communications by professionals for TX, service, or prevention**
- Emergency
- Child Abuse
- Elder Abuse

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**Substance abuse treatment records**: Alcohol and drug abuse records, patient records, or discrete portions thereof, specifically relating to evaluation and treatment of alcoholism or drug abuse; any information, whether in writing, orally, electronically, or by other means. **Disclosure**: A communication of records containing “patient identifying information” (PII). PII: Includes name, address, social security number, fingerprints, photographs or other information by which patient’s identity can be determined with reasonable accuracy/speed identifying someone as having a past/current drug/alcohol problem and/or being a past or current patient in an alcohol/drug program.

*Please note that there may be other permitted or required disclosures under the law. Contact your attorney for advice.*

**The Information Practices Act** (Civil Code § 1798-1798.78) applies to state agencies. Staff should check with their legal office regarding permissive uses and disclosures under the IPA.
KEY QUESTIONS TO POSE BEFORE YOU DISCLOSE

MENTAL / BEHAVIORAL HEALTH TREATMENT RECORDS

DRAFT

When is a patient authorization NOT required?

The following uses and disclosures are permitted:

- Board, commission, or administrative agency for adjudication
- Required by law
- Health Oversight Agencies
- Limited uses for internal training programs
- Probate Court Investigator
- Provider Competency Review
- Third party for encoding, encrypting, anonymizing data
- Coroner Investigation
- Court Order
- Elder & Child Abuse
- Emergency Medical Personnel
- Inmates: TX, health, safety, good order facility
- Funeral Directors
- Payment
- Payor Billing
- Treatment
- Disability Rights California
- Nat’l Defense – Protect President
- Organ Procurement Agency
- Patient Representative
- Public Health Reporting
- Quality Assurance
- Search Warrant
- Secretary of US DHHS
- State or Federal Disaster Relief Agency

Note: If you are an acute psychiatric hospital, inpatient psychiatric unit, government-operated hospital or clinic, or a health care provider serving involuntarily detained mental health patients, refer to the Lanterman-Petris Short Act Patient Authorization Tool.

In All Cases:

- Validate the identity and authority of the individual requesting the information
- Develop internal written procedures and train employees on the requirements
- Limit the disclosure to what is described in the authorization
- Account for the disclosure within the patients record as required by the HIPAA Privacy Rule
- Designate individual(s) to process disclosure requests

"Please note that there may be other permitted or required disclosures under the law. Contact your attorney for advice."

Published 6/6/2014
**Key Questions to Pose Before You Disclose**

**All Information for Providers Subject to the Lanterman Petris Short (LPS) Act**

When is a patient authorization NOT required?

### What are some scenarios?
- As needed for the protection of federal and state elective constitutional officers and their families
- As needed to protect reasonably foreseeable victims from serious danger of violence
- Conservatorship proceedings
- Court order for administration of justice
- Crime on the premises
- For aid, insurance, medical assistance—minimum necessary
- For conducting health care services and/or mental health treatment, developmentally disabled services for ward, dependent of juvenile court or those taken into temporary custody or petition to remove
- In facility communications between professionals providing services or referrals
- Protection and advocacy > Disability rights of California
- Upon patient death

### Disclose to whom?
- Appointed developmental decision maker for a minor, dependent or ward
- Coroner
- Correctional Agencies
- Court
- County Social Worker
- Custodial Guardian
- Probation Officer
- QA Committee
- Secretary of US DHHS

### Who Must Comply?
- Service providers of patients who are involuntarily treated or evaluated and of patients who are voluntarily treated in a:
  - Community program (refer to your legal counsel)
  - Community program specified in the W.I.C.S. 4000-4390 and 6000-6008
  - County psychiatric ward, facility or hospital
  - Federal hospital, psychiatric hospital or unit
  - Mental health rehabilitation center (Welfare and Institutions Code § 5675)
  - Private institution, hospital, clinic or sanitarium which is conducted for the care and treatment of persons who are mentally disabled
  - Psychiatric health facility (Health and Safety Code § 1250.2)
  - Skilled nursing facility with a special treatment program service unit for patients with chronic psychiatric impairments
  - State developmental center
  - State mental hospital

*Please note that there may be other permitted or required disclosure under the law. Contact your attorney for advice.*
**Fine Print: Rules for Exchanging Behavioral Health Information in California**

- Funded by California Health Care Foundation
- Produced by Manatt, Phelps & Phillips

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**Sharing Behavioral Health Information Under Federal and California Law**

1. **START HERE**

2. **HIPAA**
   - Is the provider seeking to share the patient’s medical information with another provider for purposes of treating the patient?
     - Yes
     - No

3. **Patient consent required**
   - Is the record a substance abuse record that was either: a) obtained by a federally assisted drug or alcohol abuse program; b) maintained in connection with a substance abuse treatment effort that is conducted, regulated, or assisted by the California Department of Health Care Services?
     - Yes
     - No

4. **Patient consent required**
   - Is the provider seeking to share psychotherapist notes?
     - Yes
     - No

5. **Patient consent required**
   - Is the record a mental health record that was obtained by a government mental hospital, a private hospital that treats involuntarily detained patients, a community residential treatment system, or another provider operating under a government-funded program falling under the Lanterman-Petris-Short Act?
     - Yes
     - No

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*Patient consent would not be required if the information was being shared for another purpose allowed under HIPAA, such as for payment or health care operations.

State Health Information Guidance (SHIG)

- Office of Health Information Integrity (CalOHII) in the California Health & Human Services Agency is developing the SHIG with support from the California Health Care Foundation.
- Non-binding but authoritative guidance for non-state entities, that clarifies federal and state laws about when, how and why behavioral health patient information can be exchanged between behavioral health providers and other providers involved in coordinating patient care.
State Health Information Guidance Cont.

• Will clarify patient protection laws by describing:
  o how the state sees information sharing
  o what you can do with information
  o who can share information
  o who can obtain information
  o for what purposes the information can be used

• Target audience:
  o Physicians, Nurses, Hospital Administrators, CEOs, CIOs, CMIOs, CSOs, attorneys, social workers, case managers, etc.

Inquiries about SHIG should be directed to Elaine Scordakis, Assistant Director at CalOHiI at Elaine.Scordakis@ohi.ca.gov

April 27, 2017
Information Blocking: Report to Congress 2015

- **Interference.** Some act or course of conduct that interferes with the ability of authorized persons or entities to access, exchange, or use electronic health information. (policies, business practices, etc.)

- **Knowledge.** Decision to engage in information blocking must be made knowingly.

- **No Reasonable Justification.** Conduct that is objectively unreasonable in light of public policy.

Subtitle C of title XXX of the Public Health Service Act (42 U.S.C. 300jj–51 et seq.) is amended by adding at the end the following:

SEC. 3022. INFORMATION BLOCKING. (a) DEFINITION

(1) IN GENERAL.—In this section, the term ‘information blocking’ means a practice that—

(A) except as required by law or specified by the Secretary pursuant to rulemaking under paragraph (3), is likely to interfere with, prevent, or materially discourage access, exchange, or use of electronic health information; and

(B)(i) if conducted by a health information technology developer, exchange, or network, such developer, exchange, or network knows, or should know, that such practice is likely to interfere with, prevent, or materially discourage the access, exchange, or use of electronic health information; or

(ii) if conducted by a health care provider, such provider knows that such practice is unreasonable and is likely to interfere with, prevent, or materially discourage access, exchange, or use of electronic health information.
Data Sharing and Integration

• Common goals to support outcomes
• Identify result to be achieved from data sharing
• Create environments to support data sharing
  o Legal and Policy
  o Technical
• Monitor processes and outcomes
Each play contains data strategies, approaches and actions a Department may use to administer programs and address policy issues

1. Define: goals & objectives
2. Assess: tools & capabilities
3. Implement: plan & strategy
4. Evaluate: outcomes & impacts
5. Share: progress & results

https://chhsdata.github.io/dataplaybook/
CHHS Data De-identification Guidelines

• CHHS Data Subcommittee convened a workgroup to develop the Agency-wide data de-identification guidelines to assist departments in assessing data for public release.

• Support CHHS governance goals to reduce inconsistency of practices across departments, align standards used across departments, facilitate the release of useful data to the public, promote transparency of state government, and support other CHHS initiatives, such as the CHHS Open Data Portal.

• Available at https://chhsdata.github.io/dataplaybook/
Includes data and visualizations from 12 CHHS departments and offices

152k total users since Nov 2014

233+ total datasets published

Convert PDF Reports to Open Data Tables

Match Identifiers and Link Datasets

Source Data Stories

Create API-Driven Web Visualizations and Web Apps

chhs.data.ca.gov
datanews.chhs.ca.gov
THANK YOU

FOR QUESTIONS CONTACT:  CMHPOS@DHCS.CA.GOV
Child Welfare Data Analysis Bureau  cwsdata@dss.ca.gov

April 27, 2017  51