Ask QM FAQs

Special Topic

Letters & Release of Information

February 17, 2021

Mental Health Question: All clinicians on our team were under the impression that our psychiatrist needs to follow the same HIPPA/Legal and ethical in regards to consulting with providers outside our BHRS system-meaning you need an ROI to consult regarding a client's mental health and/or AOD issues.

Q1: Our MD is saying that an ROI is not needed between doctors discussing shared cases, since they are consulting about the medical care of the same patient they're both treating.
Is this true?

A1: Yes this is true, two treatment providers (not only MDs any clinical staff working with the client) with a shared client *may* share treatment related information without consent from the client.

However, it is best practice to talk with your client about this in advance, you may obtain written consent from the client for transparency with the client.
For Mental Health, an ROI is not required for mandated reporting/managing risk to self/others - 5150/current treatment providers/ payment/ operations.

When sharing information, with and without client consent, only the minimum amount of information necessary for the purposes of the disclosure should be shared.

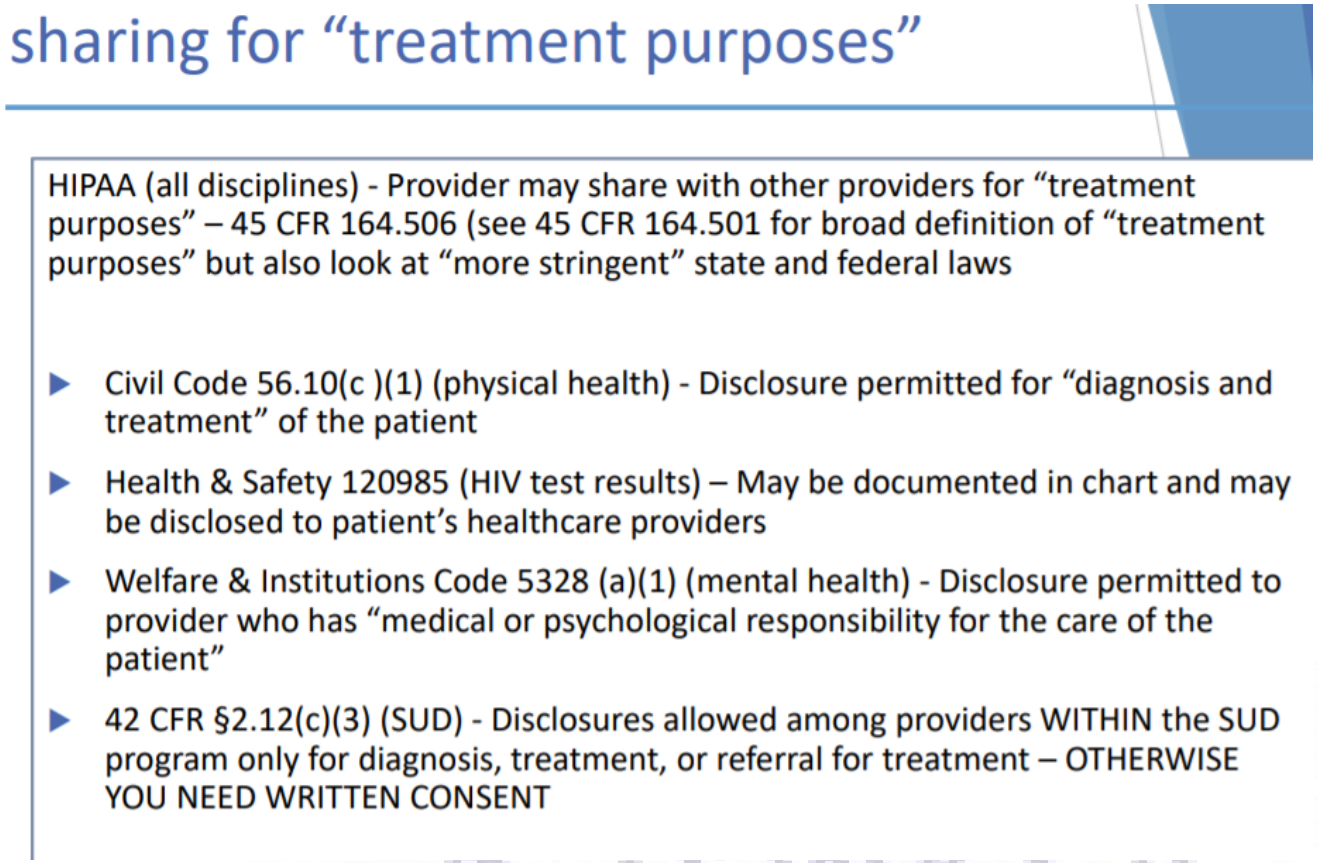
Q2: Mental Health Question:

To clarify, can a BHRS Psychiatrist communicate with an outside provider/agency or private practice without an ROI?

A2: Yes, if they are both current treatment providers, no ROI is needed.

Yes, the psychiatrist may speak with another **current treatment provider (primary care, health treatment, etc)**.

An ROI is not required by law regardless of if they are BHRS staff or not.



Q3: Do Psychiatrists and clinicians have different consents for treatment and release?

A3: No, we use the same forms. The ROI should be written for "San Mateo Behavioral Health & Recovery Services" not a specific program or individual.

Q4: Mental Health Question:

When do I need an ROI? When do I have to report a release of information to QM with an Incident Report?

A4: An ROI is required for communication with **a non-current treatment provider and other agencies/individuals that are not current treatment providers**.

Complete an Incident Report:

- If the client is closed to BHRS, there is no ROI, and information is released without a mandate.

- If there is a **disclosure without a ROI** when it is not for **mandated reporting/managing risk to self/others - 5150/current treatment providers/ payment/ operations**.

Q5: Mental Health Question:

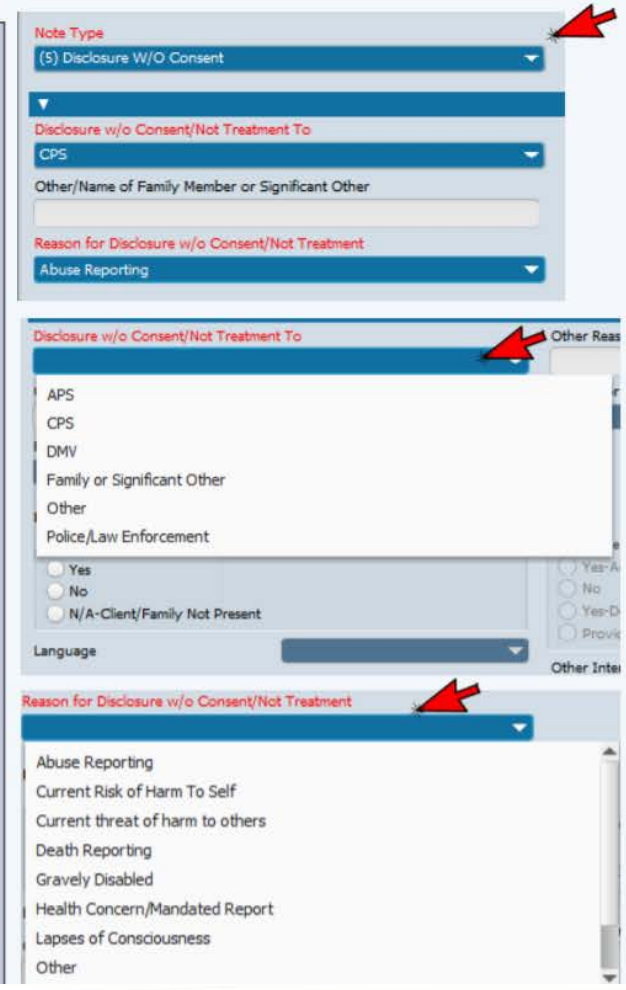
How do I document a disclosure without an ROI for mandated reporting or managing risk to self and others for 5150?

A5: Indicate in your progress note the reason for the disclosure without an ROI.

Form Name
Progress Notes with Face to Face-Disclosure Note Type

FAQs:
Q: I had to make a mandated report and did not have client consent, what do I do?

A: Use progress "Note Type", "Disclosure W/O Consent."



Pro Tip

A disclosure without consent is when you share a client's PHIis when you share a client's PHI without client consent, for a reason other than current treatment, payment, or operations.

Disclosure w/o Consent/Not Treatment To
- CPS
- APS
- Police/law enforcement
- DMV
- Family or significant other
- Other
- For other and Family Member State Name of Person

Reason for Disclosure w/o Consent/Not Treatment
- Abuse reporting
- Current risk of harm to self
- Current threat of harm to others/duty to warn/protect
- Death reporting
- Gravely Disabled
- Health Concern/Mandated Report
- Lapses of Consciousness
- Urgent safety/crisis situation
- Welfare check
- Other
- For other reason

Q6: A client's parent requested a letter stating that she must work from home to care for her child (client).
I provided a letter simply verifying youth's involvement in services but *not making the claim that mom needed to stay home*.

The client's parent reached out again asking if I could provide more information in my letter, as it was not sufficient.
What can I do?

A6: In your clinical judgement, if you feel that enhancing the letter you provided to include your recommendation that the mother increase time spent at home to support the mental health needs of child is appropriate, you may do so. However, be aware that anything you say/recommend in a letter you are responsible for backing up, should this be required.

(you might write: *At this time, you believe that the mother staying home with the child will benefit the child's mental health needs).*

Please be sure to review the letter with your supervisor prior to providing it to the mother.

Q7: I am an intern working at the regional clinics. I was wondering what the legalities are surrounding using my Kaiser access (which I have as I am currently rotating at a Kaiser location) to look up information on my BHRS clinic patients?

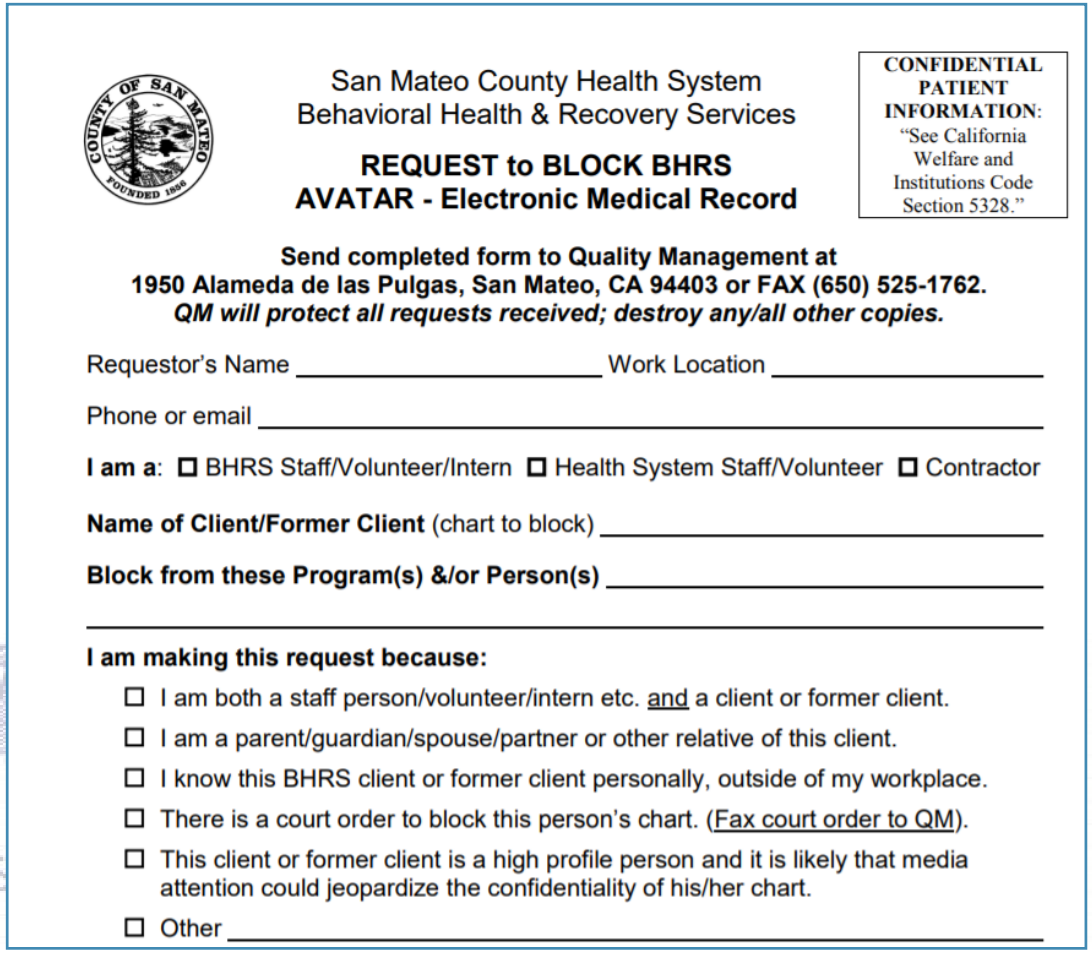
A7: Please do not look up BHRS clients in other organization's EHRs or vice versa.

Follow-up Q: What if my client signs an ROI between Kaiser and BHRS?"
A: You still need to follow the policy of BHRS and Kaiser. If you need a chart from BHRS for a Kaiser client, Kaiser Medical Records should request the chart and get a copy sent to them.

Q8:
We need to block staff person from accessing her family member's chart in Avatar. How do I do that?

A8: Please have the staff member complete attachment F "Staff Request to Block Chart" and return completed form to QM.
This block remains in place until the block is revoked.

https://www.smchealth.org/bhrs-policies/electronic-medical-record-security-and-electronic-signatures-17-01



San Mateo County Health System
Behavioral Health & Recovery Services

REQUEST to BLOCK BHRS AVATAR - Electronic Medical Record

CONFIDENTIAL PATIENT INFORMATION: "See California Welfare and Institutions Code Section 5328."

Send completed form to Quality Management at 1950 Alameda de las Pulgas, San Mateo, CA 94403 or FAX (650) 525-1762.
QM will protect all requests received; destroy any/all other copies.

Requestor's Name _____ Work Location _____

Phone or email _____

I am a: ☐ BHRS Staff/Volunteer/Intern ☐ Health System Staff/Volunteer ☐ Contractor

Name of Client/Former Client (chart to block) _____

Block from these Program(s) &/or Person(s) _____

_____

I am making this request because:

- ☐ I am both a staff person/volunteer/intern etc. and a client or former client.
- ☐ I am a parent/guardian/spouse/partner or other relative of this client.
- ☐ I know this BHRS client or former client personally, outside of my workplace.
- ☐ There is a court order to block this person's chart. (Fax court order to QM).
- ☐ This client or former client is a high profile person and it is likely that media attention could jeopardize the confidentiality of his/her chart.
- ☐ Other _____

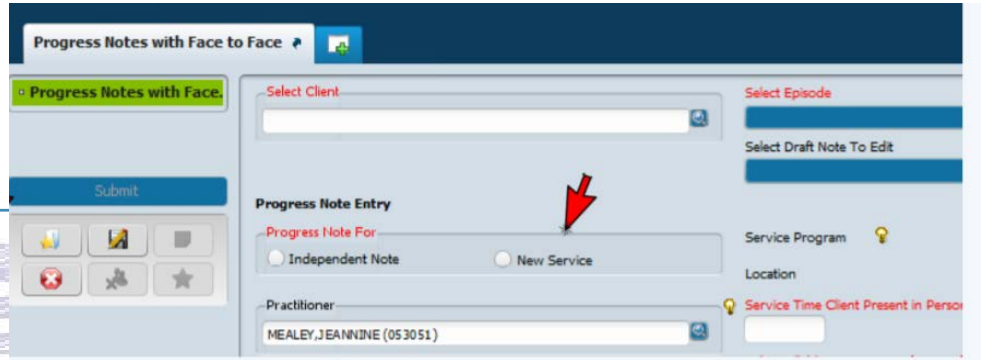
Q9: Do I open an episode to document a CPS report on a closed case? Family is not engaged in services.

A9: No need to open the client, if you do not plan to provide additional ongoing services to the client, you may document the CPS reporting in the last episode as a Progress Notes with Face to Face, independent note.

If you are planning on providing ongoing services to the client, and this contact occurred within 45 days of discharge, you may ask your admin to backout the discharge date and document in the existing episode.

Follow-up Q: What if the client is returning after 45 days? Do I have to open them in a new episode and create a new treatment plan?"

A: Yes, open a new episode and complete a new treatment plan.



"New Service" - use for open clients and select client
" Independent Note" - use for closed clients

Q10: Can clinical staff write letters for clients and/or family members?

A10: Yes, if it seems appropriate. Review the letter with your supervisor.

Common Letters Include:
Clearance letter for a client who wants to join the Military
Social Security
Immigration
Summary of treatment letter
Jury Duty excuse letter for a caregiver
Family Court Clearance letter
Letter to support client to remain in stable housing
Letter of support is being requested by lawyer in a case of unlawful eviction.
Letters for emotional support animal – for travel, for apartment
Letters that state if parent is ready/not ready to regain/maintain custody of their child
Letters regarding advocating for disability benefits/services

Letter Basic Guidelines

Make sure that you have a release of information authorization.

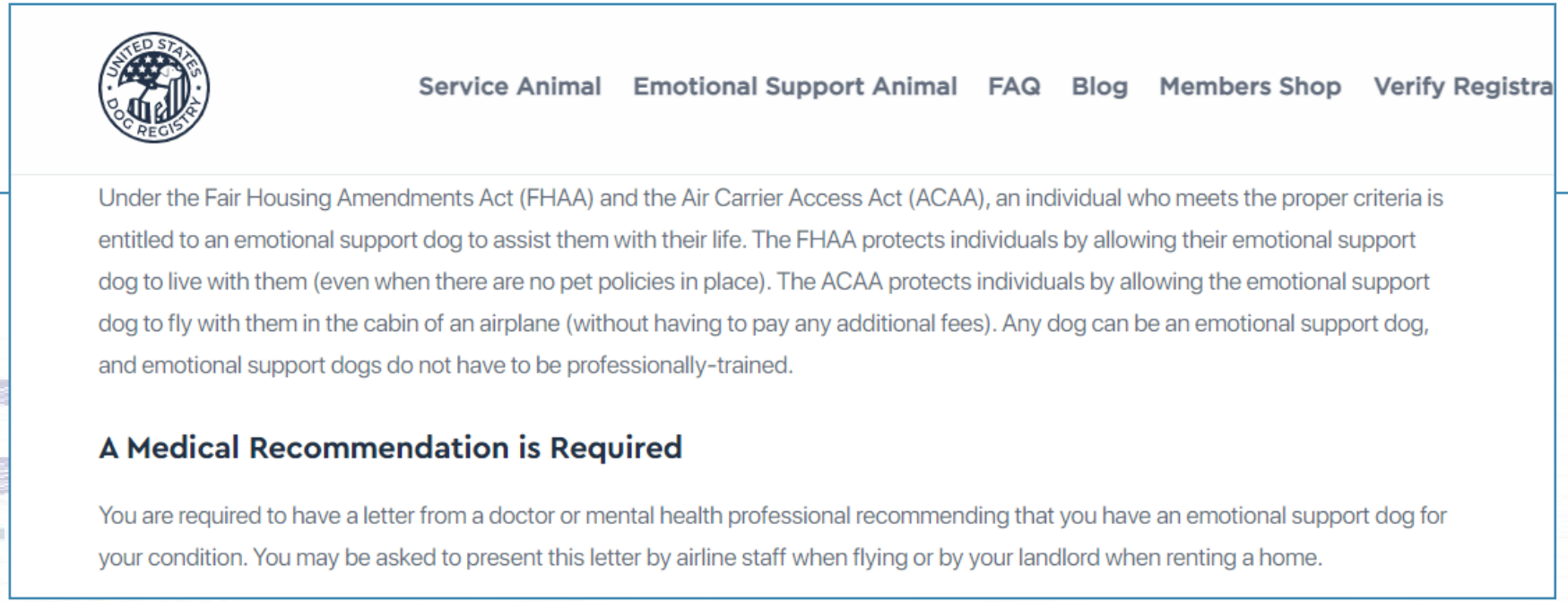
1. The letter should be about 1 page (2 TOPS)
2. It should be just the facts
3. AVOID making predictions about the future
4. Usually address the letter to “To whom it may concern” and give the letter to the client/family
5. Add your contact information - use letterhead

Things that you might include:

1. The type of services provided (individual, group, family, case management etc..), to whom (child, parent etc.…), the length of time the client has been seen.
2. The general areas of treatment/DX, if appropriate, addressed (i.e. trauma, depression, anxiety…)
3. A statement about the recommended course of treatment (number of treatment sessions per week and length of treatment, etc..) which can include the parent's involvement in the client's treatment.
4. General statements about the progress of your work with the client.

Q11: I wanted to clarify what the QM policy is around requests to assist with registering Emotional Support Animals. My understanding is that we are **not** allowed to write a letter or be involved, and only doctors can?

A11: Any clinical staff may write a letter to support the client's need for an Emotional Support Animal. The registering agency may or may not accept the letter; however you may write the letter if you think it is appropriate.
https://usdogregistry.org/information/#esa



Sample Emotional Support Animal

Date

To Whom it May Concern,

(Name) is under my professional care for treatment of a medical condition. I have prescribed an emotional support animal as part of the treatment program developed for (Name). The presence of this emotional support animal is necessary for (Name's) mental health. I am a licensed (Title). My license number is (xxxxx).

Please allow (Name) to be accompanied by their emotional support animal.

Signature

Provider printed name & title

Q12: I made a mistake regarding a progress note and am wondering the best approach to amend the issue. It doesn't have the note body, so wondering what to do? I did put the correct time and everything else is correct, I just need to add the info to justify the note.

A12: Please use the Avatar form "Append Progress Note" and add in the information, so it will be added to the finalized progress note.

Progress Notes with Face to Face-
"Oops, I made a mistake"

FAQs:

Q: I realized I made an error on a progress note I submitted. How do I correct this?

A:
1. Use the "Append Progress Note" or
2. "Progress Note Error Correction Request" or
3. Write a new progress note.

Q: Can you delete a finalized progress note?
A: No

Progress Note Error Correction Request is for correcting billing information, such as:

- Date of Service
- Service Duration
- Service Charge Code/Type of Service
- # of Clients in Group
- Location Code
- Duplicate Entry
- Wrong Co- Practitioner, Wrong Episode, Wrong Client.

Any clinician/supervisor can correct a progress note, even if they did not write the original note.

Append Progress Note is for adding information to a completed progress note.
Appended information that is added is attached to the original note.

- Any clinician/supervisor can append a progress note, even if they did not write the original note.
- If information needs to be added or corrected to the content of a finalized note that required a co-signature, a new note must be written to address mistakes or additions of the original note's content.

Q13: Can a letter be accepted to verify the legal guardianship of a non-parent caregiver and is this sufficient to be able to screen and refer the client for services?

A13: Yes, a letter may be accepted as proof of legal guardianship of the client. That person may consent for treatment. Make sure this is documented and the letter is scanned into Avatar.

To keep other people from seeing what you entered on your form, please press the Clear This Form button at the end of the form when finished.

Caregiver's Authorization Affidavit

Use of this affidavit is authorized by Part 1.5 (commencing with Section 6550) of Division 11 of the California Family Code.

Instructions: Completion of items 1 - 4 and the signing of the affidavit is sufficient to authorize enrollment of a minor in school and authorize school-related medical care. Completion of items 5-8 is additionally required to authorize any other medical care. **Print clearly.**

The minor named below lives in my home and I am 18 years of age or older.

1. Name of minor: _____.
2. Minor's birth date: _____.
3. My name (adult giving authorization): _____.
4. My home address (street, apartment number, city, state, zip code):
   _____
   _____
   _____
5. ☐ I am a grandparent, aunt, uncle, or other qualified relative of the minor (see page 2 of this form for a definition of "qualified relative").
6. Check one or both (for example, if one parent was advised and the other cannot be located):
   - ☐ I have advised the parent(s) or other person(s) having legal custody of the minor of my intent to authorize medical care, and have received no objection.
   - ☐ I am unable to contact the parent(s) or other person(s) having legal custody of the minor at this time, to notify them of my intended authorization.

TO HEALTH CARE PROVIDERS AND HEALTH CARE SERVICE PLANS:

1. No person who acts in good faith reliance upon a caregiver's authorization affidavit to provide medical or dental care, without actual knowledge of facts contrary to those stated on the affidavit, is subject to criminal liability or to civil liability to any person, or is subject to professional disciplinary action, for such reliance if the applicable portions of the form are completed.

Here is a standard form that may be used:
https://www.courts.ca.gov/documents/caregiver.pdf

COVID-19 Incident Reporting Update 2-10-2021

- A **staff** member who tests positive for COVID-19 and has been **in contact with other staff, clients, or has been to your facility**
- A **client** who tests positive for COVID-19 and has been **in contact with staff, other clients, or has been to your facility**
- Continue to report any death of a client as usual

Critical Incident Reports must never be filed or referenced in a client's chart or in an employee's personnel record. Incident report forms can be sent or faxed to Quality Management. Click Here for the Critical Incident Policy 93-11. Click here for the Critical Incident Reporting Form

County Staff please send the incident report to HS_BHRS_QM@smcgov.org **Contracted Programs** can send incident reports via secure email to HS_BHRS_QM@smcgov.org or send via fax to **650-525-1762**

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