# ALTERNATIVE COMMUNICATION OF PROTECTED HEALTH INFORMATION PROTOCOL

## GUIDING PRINCIPLE

We are committed to a culture of recovery throughout our systems of care, in our interactions with one another, and with those persons and families who trust us with their care.

## OVERVIEW

- Pursuant the Health Insurance Portability and Accountability Act (HIPAA) of 1996, individuals have the right to request alternative means of communications from health care providers in order to ensure confidentiality.

- If alternative means of communication are not request, the Department of Mental Health and Substance Abuse (DMHSA) will freely communicate with the consumer through the standard means of telephone and/or post to the telephone number(s) and address(es) provided by the consumer.

- DMHSA believes it is important to ensure consumer's can receive communications regarding his/her Protected Health Information (PHI) in a way that makes the consumer feel safe.

## DEFINITIONS

- **Consumer:** Any individual who has received or is receiving services from DMHSA.
    - In the context of the protocol, when a consumer has a personal representative, the personal representative will fulfill the duties of the consumer in this protocol.

- **Personal Representative:** A person with a court order appointing them as guardian, or with a valid Durable Power of Attorney, or an Advance Directive signed by the consumer specifying the authority to review and make decisions regarding medical, psychiatric, treatment or habilitation concerns.

- **Protected Health Information (PHI):** Individually identifiable health information that is transmitted or maintained in any form or medium, by a covered entity, health plan or clearinghouse as defined under the Health Insurance Portability Accountability Act (HIPAA), 45 CFR Part 160 and 164.
    - **Individually Identifiable Health Information:** Any form, including demographic information, collected from an individual that:
        1. Is created or received by a healthcare provider, health plan, employer, healthcare clearinghouse; and

2. Related to the past, present, or future physical or mental health or condition of an individual; the provision of healthcare to an individual, and
    a. Identifies the individual, or
    b. There is reasonable basis to believe that the information can be used to identify the individual.

**STANDARDS OF CARE**

- Consumers at DMHSA have the right to request that the Department communicate PHI to him/her by alternative means or at alternative locations.

- The Department is not required to comply with the request for alternative communications, but will consider and may accommodate a request if it is determined to be reasonable and in the consumer's best interest.
    - The reasonableness of a request shall be based on whether the provider is impeded from conducting services/treatment as usual, information as to how payment will be handled, if applicable, and the specification of an alternative address or other method of contact.

    - If the consumer clearly states that failure to communicate by alternative means or to an alternative address could endanger him/her, DMHSA must accommodate the request by alternative means.

    - The Department's decision will not be based on the perceived merits of the request.

- The Department will not require an explanation for the request.

- A request for alternative communications must be made in writing.

- Medical records personnel shall manage requests for alternative communications.

**PROTOCOL**

Notification of Right:

- Staff shall inform the consumer that he/she has the right to request alternative communications of PHI.

Requests:

- If a consumer asks to make a request for alternative communications, medical records personnel will provide the consumer with a Request for Communications by Alternative Means/Location form.
    - The request must be provided in writing, signed and dated by the consumer.

- A DMHSA professional may assist the consumer in completing the form, if necessary.

Receiving Requests:

- Medical records personnel shall receive the written requests.
  - The request will not be reviewed until the form is completed and signed by the consumer.

Reviewing Requests:

- Upon receipt of the completed form, medical records personnel will forward the request to a member of the consumer's treatment team and/or designee by the next working day.

- The consumer's treatment team will review the request to determine whether it will be approved.

- The consumer's treatment team shall complete the "DMHSA Professional Disposition" section of the form and forward the form to medical records personnel by the fifth ($5^{th}$) working day of receiving the completed request.

Notification of Outcome:

- Within five (5) working days of receiving the professional's disposition, medical records personnel shall mail the Notice of Outcome letter.
  - A copy of the completed form shall be included in the letter.

  - Even if the request is denied, the letter shall be sent to the alternative address, if specified, for this communication only.

  - If the request is denied, and the consumer requested the Department to not mail any correspondences, the notification of denial shall be communicated using the alternative means specified on the form, for this communication only.

- The original form shall be filed in the consumer's record.

Approval of Request:

- If the request is approved, medical records personnel shall place or affix a clear indication of the communication by alternative means in the consumer's record and make the appropriate updates to the consumer's contact information.

Revocation of Request:

- An alternative communication request that is implemented remains in place until the consumer revokes it or until such time as the DMHSA determines that it no longer meets the reasonableness criteria.

- The Department may terminate the accepted request if:

- The consumer agrees to the termination in writing by completing the Revocation of Authorization/Request for Use and Disclosure of PHI form; or

- The consumer agrees to the termination verbally and the verbal agreement is documented (revocation).

- Such termination is only effective with respect to communications after the consumer has agreed to the termination of the request.

Termination Without the Consumer's Agreement:

- The Department may terminate the request without the consumer's agreement if the Department informs the consumer that the request is being terminated and the Department has reason to believe the termination will not cause harm to the consumer.

- Such termination is only effective with respect to PHI communicated after the Department has informed the consumer that it is terminating the request.
  - The Department must continue to abide by the request with respect to any communication before it informed the consumer of the termination of the request.

Inform by Mail:

- If the consumer is informed by mail that the Department is terminating the request, the notification shall be sent via certified mail, return receipt requested.

- The Department shall maintain a copy of the notification letter and of the return receipt with the form.

- The Department shall not terminate the request until it receives confirmation that the consumer has received the notification.

Inform In-person:

- It is preferable to have the consumer sign and date a revocation form. However, it will be acceptable to document that the consumer was notified in-person (i.e. during a counseling session) on the Request for Commination by Alternative Means/Location form.

Inform via telephone:

- If the consumer is informed by telephone, this action shall be documented on the Request for Alternative Communication form.
  - The termination shall be effective as of the date the consumer is informed by telephone.

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Notation for Termination:

- When any of the above termination actions are taken, the request will be revoked/terminated.
    - Medical records personnel shall complete the Revocation box on the form.
    - The consumer's contact information shall be updated.

Retention of Form:

- DMHSA will maintain a record of approved requests for communications by alternative means/location. This record shall be retained for six (6) years from the date it was created or the date it was last in effect, whichever is later.

**REFERNCES**

- 45 CFR §164.522

**FORMS**

- Request for Communication by Alternative Means/Location form
- Notice of Outcome for Request for Communication by Alternative Means/Location letter
- Revocation of Request/Authorization for Use and Disclosure of PHI form
- Complaint of Privacy Violation form

APPROVED: W.I. Aflague

Wilfred Aflague
Director

Date: 6/14/12



**Version:** 1
**Effective:** 6/13/2012

| REVOCATION/TERMINATION |
|---|
| Date Terminated: _____ |
| Initials of Rcver:_____ |


# Department of Mental Health & Substance Abuse

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790 Governor Carlos G. Camacho Road
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## REQUEST FOR COMMUNICATION BY ALTERNATIVE MEANS/LOCATION

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Consumer Last Name** | | **Consumer First Name** | | **Chart Number** | | **Date of Birth** | |
| **Consumer's Street Address** | | | | | | | |
| **City, State, Zip Code** | | | **Phone Number** | | | | |

**1. Request**

**Written communications** *(initial one):*

___ Please mail all correspondences to me at the following address.

___ Please mail only _____
(specify the PHI) to the following address, and all other correspondences to my mailing address.

___ Please do not mail any correspondences to my address(es). Instead, please correspond using the specified means(i.e. telephone) :_____

Address:_____

City:_____ State:_____ Zip Code:_____

___ Please use an envelope that does not identify mail as coming from DMHSA.

**Telephone Communications** *(check one):*

___ Please always call me at the following phone number: _____

___ Please call me at _____ only for _____

_____ (specify reasons) and call my home number for all other reasons.

**Leaving messages** *(check one):*

___ It is alright to leave a message for me with whoever answers the phone at the above number.

___ Please do not leave a message for me with anyone who answers the phone at the above number.

**Voicemail** *(check one):*

___ It is alright to leave messages for me on the answering machine/voicemail at the above number.

___ Please do not leave a message for me on the answering machine/voice mail at the above number.

# REQUEST FOR COMMUNICATION BY ALTERNATIVE MEANS/LOCATION

**Other Alternatives** (please specify the PHI and type of mean/location):

_____

_____

**2. Protection**

___ No harm will occur if this is denied.

___ Harm will occur if this is denied. Please state any harm that may occur if this is denied:

_____

_____

_____

**3. CONSUMER ACKNOWLEDGEMENT OF CONDITIONS OF AMENDMENT**

- I understand DMHSA cannot require me to provide an explanation for my request.
- I understand DMHSA can condition the provision of an alternative means of communication on: (a) information as to how payment will be handled, if applicable, (b) the specification of an alternative address or other method of contact, and (c) whether providers are impeded from conducting services/treatment as usual.
- I understand that DMHSA will accommodate reasonable requests if I provide a reasonable alternative means or location for communication.
- I understand that, if DMHSA agrees to the request (whether all or in part), then DMHSA will follow the agreement of alternative means/location until one of the following events occurs: (1) I agree to or request in writing that the request be terminated, (2) DMHSA notifies me that it is terminating the agreement to alternative means/location. If DMHSA terminates the agreement, then the termination is effective only with respect to information communicated after the date of the termination.

**By signing below, I acknowledge I understand the conditions of Amendment.**

_____ _____

Signature of Consumer or Personal Representative Date

_____ _____

Print Name Personal Representative's Title (e.g., Guardian)

**DEPT. MENTAL HEALTH AND SUBSTANCE ABUSE USE ONLY**

Date Received by Medical Records Personnel: _____ Rcvr Signature: _____

**DMHSA PROFESSIONAL DISPOSITION:**

_____Your request for alternative communications has been **accepted.**

_____Your request for alternative communications has been declined. This request is not reasonable because:

_____The request will impede in the usual service/treatment operations.

_____ Alternative address or method of contact is not identified.

_____ Other:_____

*(If you feel your privacy rights have been violated you may file a complaint, in writing, on the Complaint of Privacy Violation form available at Medical Records at the address at the top of this form.)*

**Comments:**_____

| **Professional Name:** | Date: | Time: |
|---|---|---|
| **Signature:** | | |

# REQUEST FOR COMMUNICATION BY ALTERNATIVE MEANS/LOCATION

**MEDICAL RECORDS RESPONSIBILITIES** (initial all items/steps that apply)
**NOTICE OF OUTCOME:**

_____*Notice of Outcome letter* sent to consumer on _____ (date).

| **Medical Records Personnel:** | Date: | Time: |
|---|---|---|
| **Signature:** | | |

**UPDATE INFORMATION (If approved):**

____ Notated/updated appropriate forms/documents on _____ (date).

**TERMINATION OF REQUEST (Optional):**

_____ Consumer revoked request in writing on _____ (date). [Attach revocation form]

_____The above named consumer was notified on _____ (date) by medical records personnel that this request was terminated. *(Initial appropriate box)*

_____In-person

_____By telephone

_____By mail [Attach notification]

| **Medical Records Personnel:** | Date: | Time: |
|---|---|---|
| **Signature:** | | |

→**Routing:** Original to consumer's chart. Copy enclosed in letter.