

**Impact of Current Wisconsin Mental Health Consent Laws on WISHIN's Phase I and II Exchange Operations
And
Options for Phase II Exchange Models Compatible with Those Laws**

Executive Summary:

Wisconsin's WIRED for Health Strategic and Operational Plan calls for Wisconsin to identify and pass legislation to remove consent-related barriers to health information exchange. Wisconsin's mental health consent laws in §51.30, Wis. Stats., and §DHS 92.03, Wis. Admin. Code, laws have been identified both by WIRED and WISHIN as particularly problematic for statewide health information exchange. Both WIRED and WISHIN have worked to identify possible legislative solutions to such barriers.

However, the legislative process is not in WISHIN's control, and it is possible that no legislative solution may be signed into law. Thus, this paper analyzes the substantive impacts of Wisconsin's current mental health consent laws on WISHIN's proposed Phase I and Phase II health information exchange operations, and offers options for statewide health information exchange that WISHIN may choose to pursue that are consistent with current law.

Phase I Analysis

The Phase I Direct exchange model relies on a "push-type" exchange mechanism in which the disclosing provider directly controls and determines what information will be sent via the exchange as well as, when, to whom, and in what circumstances that information will be sent. This is directly analogous to sending information using exchange mediums currently used by providers such as fax, phone, mail, or email. Wisconsin's consent laws were written with these traditional exchange mechanisms in mind, and similarly, the laws appear compatible with the proposed Phase I Direct exchange model.

The current mental health consent laws remain a barrier to care coordination and extracting information from an EHR; however, these barriers do not appear to any more challenging to an exchange using Direct compared to an exchange using fax, phone, mail, or email.

Phase II Analysis and Options

Unlike the Phase I Direct exchange model which uses a "push-type" exchange mechanism, the Phase II exchange model uses a "pull-type" exchange mechanism. Pull-type exchanges are unlike traditional exchange mechanisms like fax, mail and email, because a disclosure from a WISHIN participating provider occurs passively without any direct act by the disclosing provider. The exchange is initiated by the requester, not the discloser. **Wisconsin's mental health consent laws, which require specificity as to what information is to be disclosed, to whom, for what purpose, etc., were not written with a "pull-type" of exchange mechanism in mind.**

It is also important to know that Wisconsin's protections for mental health information are defined not by the type of information, but rather by who creates the information. Thus, a record of a primary-care physician who diagnoses and treats mild depression is not subject to Wisconsin's mental health consent law while a record of a psychiatrist who diagnoses and treats mild depression is subject to the law. **Approximately 31 of 130 non-specialty hospitals in Wisconsin create and maintain such records protected by Wisconsin's mental health consent laws. It is more difficult to determine the number of clinics that create and maintain such records without further study. However, approximately 5% of Wisconsin's physician workforce are psychiatrists.**

WISHIN appears to have three options to develop a Phase II pull-type exchange that could be consistent with Wisconsin's mental health consent laws. The first two options would result in the exclusion of mental health providers from the exchange, while the third option would include mental health providers but may be financially or technically infeasible for WISHIN and/or significantly deter widespread use of the Phase II exchange by non-mental health providers.

Option 1: Exclude mental health providers from participating in WISHIN's Phase II exchange.

This option would exclude entities that maintain "treatment records" subject to Wisconsin's mental health consent laws from participating in the Phase II exchange.

WISHIN's exchange could avoid the barriers posed by Wisconsin's mental health consent law by excluding those entities that maintain records that are subject to Wisconsin's mental health consent laws. As a result, special consent management processes and technologies (assuming they are even feasible or possible under current law) would not be required for WISHIN or its remaining participants, lowering costs for both. Excluded providers could continue to use the Phase I Direct exchange to meet meaningful use requirements.

Option 2: Exclude §51.30 "treatment records" from WISHIN's Phase II exchange

This option would be implemented through contractual provisions in WISHIN's participation agreements that would 1) prohibit phase II participants from exchanging "treatment records" defined by §51.30, and 2) require a participant with §51.30 treatment records to enact technical and procedural safeguards to ensure §51.30 treatment records are not sent via/loaded on to the Phase II exchange.

Similar to Option 1, this option should allow WISHIN's exchange to avoid the barriers posed by Wisconsin's mental health consent law. However this option seeks to exclude, by contractual prohibition, the mental health records themselves from being a part of the WISHIN exchange rather than excluding the providers that create and maintain the mental health records. Also similar to Option 1, this should lower the cost to WISHIN and its participants by enabling the exchange of information without the need to implement special mental health consent management processes and technologies (assuming they are even feasible or possible under current law).

However, there is an identifiable, but likely minor, risk that §51.30 information would be exchanged despite the contractual prohibition, potentially implicating the re-release provisions. WISHIN and participants may seek contractual provisions or procedural and technical safeguards to address and mitigate that risk. **This may result in some additional cost to WISHIN and/or WISHIN participants compared to Option 1.**

Furthermore, due to EHR design, it may be impossible or very costly for hospitals and clinics that have both §51.30 information and general health information to exchange only general health information via the WISHIN Phase II exchange. Thus, **it seems likely that those providers excluded from WISHIN under Option 1 would voluntarily choose to not participate under Option 2.**

Option 3: No exclusions of mental health providers or §51.30 treatment records from WISHIN's Phase II exchange.

WISHIN would not seek to restrict the exchange of §51.30 information under this option. However, all exchanges would have to be compliant with §51.30, as applicable.

Both WISHIN and providers participating in such an exchange would likely need to create additional processes and technical solutions to participate in this type of WISHIN exchange. **These solutions will add to WISHIN's and its participants' costs, and may deter participation in WISHIN's Phase II exchange.** In particular, a re-release requirement of Wisconsin's mental health consent laws would appear to require providers that do not provide mental health care to add new processes and technical solutions to participate in the WISHIN exchange, thus adding to these providers' cost to participate in the WISHIN Phase II exchange. Furthermore, it is not clear that a pull-type exchange can be compliant with §51.30 and §DHS 92.03. **This uncertainty may further discourage providers from participating in the WISHIN Phase II exchange.**

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Wisconsin’s WIRED for Health Strategic and Operational Plan calls for Wisconsin to identify and pass legislation to remove consent-related barriers to health information exchange. Wisconsin’s mental health consent laws in §51.30, Wis. Stats., and §DHS 92.03, Wis. Admin. Code, laws have been identified both by WIRED and WISHIN as particularly problematic for statewide health information exchange. Both WIRED and WISHIN have worked to identify possible legislative solutions to such barriers.

However, the legislative process is not in WISHIN’s control, and it is possible that no legislative solution may be signed into law. Thus, this paper analyzes the substantive impacts of Wisconsin’s current mental health consent laws on WISHIN’s proposed Phase I and Phase II health information exchange operations, and offers options for statewide health information exchange that WISHIN may choose to pursue that are consistent with current law.

Statutory Highlights

Federal HIPAA:

- Permits disclosure of health care information without consent for purposes of treatment, payment, and health care operations.
- A patient may request a restriction on disclosures for purposes of treatment, payment, and health care operations, but the covered entity is not required to fulfill that request.

Federal AODA:

- Specific patient consents required for disclosures of Federal AODA records.

Wisconsin §146.82:

- Permits disclosure of most health care information without consent for purposes of treatment, payment, and health care operations.

Wisconsin §51.30 and §DHS 92.03 (mental health):

- Patient consent generally required for treatment, payment, and operations purposes. However there are over 27 separate exceptions to confidentiality under the statute.
- 51.30 and DHS 92.03 do not apply to all records with a mental health diagnosis. The provisions only apply to records made by psychologists, licensed clinical social workers, licensed marriage and family therapists, licensed professional counselors, and mental health “treatment facilities.” See below for more information.
- There are very specific requirements for what must be in the informed consent, as well as other requirements related to the consent, that are generally incompatible with a pull-type electronic health information exchange. See below.

51.30(1)(b)

(b) "Treatment records" include the registration and all other records that are created in the course of providing services to individuals for mental illness, developmental disabilities, alcoholism, or drug dependence and that are maintained by the department; by county departments under [s. 51.42](#) or [51.437](#) and their staffs; by treatment facilities; or by psychologists licensed under [s. 455.04 \(1\)](#) or licensed mental health professionals who are not affiliated with a county department or treatment facility. Treatment records do not include notes or records maintained for personal use by an individual providing treatment services for the department, a county department under [s. 51.42](#) or [51.437](#), or a treatment facility, if the notes or records are not available to others.

51.01(19)

(19) "Treatment facility" means any publicly or privately operated facility or unit thereof providing treatment of alcoholic, drug dependent, mentally ill or developmentally disabled persons, including but not limited to inpatient and outpatient treatment programs, community support programs and rehabilitation programs.

51.30(2)

(2) Informed consent. An informed consent for disclosure of information from court or treatment records to an individual, agency, or organization must be in writing and must contain the following: the name of the individual, agency, or organization to which the disclosure is to be made; the name of the subject individual whose treatment record is being disclosed; the purpose or need for the disclosure; the specific type of information to be disclosed; the time period during which the consent is effective; the date on which the consent is signed; and the signature of the individual or person legally authorized to give consent for the individual.

DHS 92.03(1)(n)

(n) Whenever information from treatment records is disclosed, that information shall be limited to include only the information necessary to fulfill the request.

DHS 92.03(1)(o)

(o) Any request by a treatment facility for written information shall include a statement that the patient has the right of access to the information as provided under [ss. DHS 92.05](#) and [92.06](#).

DHS 92.03(1)(p)

(p) The conditions set forth in this section shall be broadly and liberally interpreted in favor of confidentiality to cover a record in question.

DHS 92.03(2)(a)

(a) No person may disclose information or acknowledge whether an individual has applied for, has received or is receiving treatment except with the informed consent of the individual, as authorized under [s. 51.30 \(4\) \(b\)](#), Stats., or as otherwise required by law and as governed by this subsection.

DHS 92.03(3)(d)

(d) Each informed consent document shall include a statement that the patient has a right to inspect and receive a copy of the material to be disclosed as required under [ss. DHS 92.05](#) and [92.06](#).

DHS 92.03(1)(h)

(h) No personally identifiable information in treatment records may be re-released by a recipient of the treatment record unless re-release is specifically authorized by informed consent of the subject individual, by this chapter or as otherwise required by law.

Limited Statutory Impact on Phase I Operations (secure email through Direct)

Under the Direct model, the disclosing entity must take an active step in order to send patient information to another provider (i.e. create a message and attachments and send the message). Because a disclosing entity must take a particular action to initiate a disclosure, Direct is a “push-type” exchange mechanism.

Because the disclosing entity is in direct control of what information is being sent, to whom, and under what circumstances, the disclosing entity will know whether consent is needed to send the information and what must be consented to or noticed to the patient (i.e. 51.30 informed consent specificity and additional DHS 92.03 requirements).

It seems likely that provider participants in Direct exchanges will utilize existing consent procedures that are currently used when information is sent via fax. As is the case with fax, one would expect providers to get consents before sending 51.30 and AODA information via Direct, but not get consents to send 146.82 information.

BOTTOM LINE, because a disclosing provider using Direct must actively initiate a disclosure (push), existing Wisconsin and Federal consent laws do not create any new or unique barriers to sending information via Direct versus existing exchange mechanisms such as fax, phone, or mail. However, as discussed below, §51.30 and DHS 92.03 do create new significant and unique barriers to widespread use of on-demand “pull-type” exchange mechanisms contemplated in Phase II operations.

Administrative and Operational Solutions to Overcome Mental Health and AODA Related Consent

Barriers to Phase I Operations

It appears that the exchange of information using Direct through a HISP or secure email client presents the same mental health and AODA related consent barriers as existing exchange mechanisms such as fax, phone, or mail. Thus, no unique administrative or operational solutions related to mental health and AODA consent requirements appear necessary to implement WISHIN’s Phase I operations.

Statutory Impact on Phase II Operations (on-demand pull-type exchange):

Under the Phase II pull-type exchange model, if a disclosing provider agrees to participate in the WISHIN exchange, a disclosure from a disclosing provider to a requesting provider takes place passively without any direct act by the disclosing provider. The exchange is initiated by the requester not the discloser. This is unlike the Direct push-type

model in which the disclosing provider must act each time it discloses information to another provider by affirmatively sending the information via secure email.

WISHIN will require all participants in the Phase II exchange to agree to a common participation agreement that will govern what information may be sent, to whom, and under what circumstances. However, such agreement will govern exchanges in general and can only dictate the parameters of information exchange in general and not at a patient specific level. To illustrate, the agreement can say that participants will only exchange information that may be disclosed without consent, and only between providers that have a treatment relationship with the patient. However, the participation agreement by its nature cannot specify that Jane Smith's information may only be shared with Dr. Bill and only for the purposes of managing co-occurring diabetes and depression.

Because Phase II exchanges among WISHIN participating providers will take place passively without any additional direct act by the disclosing provider, a disclosing provider will not have an opportunity to gather an individual's consent that provides specificity as to what information may be sent, to whom, and for what purposes. Nor will the provider have an opportunity to provide any additional notices or statements that may be required for a particular type of disclosure.

Providers that have information governed by §51.30 and §DHS 92.03, are obligated by those provisions to have the informed consent of the patient prior to the disclosure. Such informed consent must meet the requirements of those provisions and the disclosing entity may have additional obligations it must fulfill regarding the disclosure. Pursuant to those laws, the disclosing entity and not the requesting entity bears those obligations.

Re-release provisions may subject providers participating in a Phase II exchange that are not otherwise subject to Wisconsin's mental health consent laws due to a redisclosure provision in DHS 92.03(1)(h) that provides: "No personally identifiable information in treatment records may be re-released by a recipient of the treatment record unless re-release is specifically authorized by informed consent of the subject individual, by this chapter or as otherwise required by law."

Approximately 31 GMS hospitals (eligible to receive Meaningful Use incentives) in Wisconsin have an inpatient psychiatric unit. Approximately 5% of Wisconsin physician workforce are psychiatrists.

Providers that have information governed by §51.30 and §DHS 92.03 may choose to not participate in Phase II pull-type exchange if:

- The provider does not believe that the participation agreement can provide enough specificity to enable a disclosure compliant with the informed consent and disclosure provisions of §51.30 and §DHS 92.03.
- The provider does not believe that a general informed consent obtained prior to the need for a disclosure can provide enough specific to allow a later disclosure compliant with the informed consent and disclosure provisions of §51.30 and §DHS 92.03 (For example, can a
- The provider does not believe that the disclosure provisions of §51.30 and §DHS 92.03 allow it to disclose information based on an express or implied representation from the receiving provider that the receiving provider has received the patient's informed consent to have the provider disclose §51.30 information.
- The provider is not comfortable from a risk management and compliance perspective with relying on an informed consent gathered by the receiving provider on behalf of the disclosing provider.

- The provider does not believe that §DHS 92.03(1)(o) can be complied with in a pull-type exchange system. §DHS 92.03(1)(o): “Any request by a treatment facility for written information shall include a statement that the patient has the right of access to the information as provided under ss. DHS 92.05 and 92.06.”
- The provider is a hospital or multi-specialty clinic whose EHR cannot segregate §51.30 information from other health care information, and the implementation of the Phase II pull-type exchange would require it to implement new processes necessary to comply with §51.30 but which are not necessary for other exchange mechanisms such as Direct, fax, phone, or mail.
- The provider would need to modify its EHR or implement additional technology to prohibit the WISHIN pull-type exchange from pulling §51.30 information that the provider has not received consent to disclose.

Providers that do not have information governed by §51.30 and §DHS 92.03 may choose to not participate in WISHIN’s Phase II pull-type exchange if:

- The provider believes that it must undertake new obligations or new expenses because it may receive information from other providers that is governed by §51.30 and §DHS 92.03. To avoid such obligations, a provider may choose to only participate health information exchange networks that limit exchange to information that may be shared without consent. Examples of potential new obligations are below:
- Example 1: The provider believes that it could receive information from a §51.30 provider, and upon receiving information from such provider, the receiving provider believes it may be in violation of §DHS 92.03(1)(h) if it re-releases information without directly obtaining the patient’s informed consent for re-release, or the re-release was not specifically authorized in the patient’s original informed consent (which the receiving provider would not have a copy of).
- Example 2: As a result of the belief described above, the provider determines that it would be necessary to modify its EHR or implement additional technology in order to prohibit the WISHIN pull-type exchange from pulling any §51.30 information it may have received from a §51.30 provider but for which consent for re-release was not given pursuant to §DHS 92.03(1)(h).
- NOTE: Concerns raised by the above two examples could be compounded by the fact that the receiving provider may not know which information is and which information is not §51.30 information (not all mental health information is §51.30 information, but general information such as weight, blood pressure, etc., documented in a “treatment facility” may be §51.30 information).

Administrative and Operational Solutions to Overcome Mental health and AODA-Related Consent

Barriers to Phase II Operations

WISHIN appears to have two options to develop a Phase II pull-type exchange that could avoid the problems posed by Wisconsin’s mental health consent laws. A third option to allow all records, including mental health records, to be exchanged via the Phase II exchange may not be financially or technically feasible for WISHIN and/or may significantly deter widespread use of the Phase II exchange by non-mental health providers.

Option 1: Exclude mental health providers from participating in WISHIN's Phase II exchange.

This option would exclude entities that maintain "treatment records" subject to Wisconsin's mental health consent laws from participating in the Phase II exchange.

Implications of Option 1:

- With minor exceptions (private pay patients for example) all information exchanged on the WISHIN exchange could be exchanged without consent pursuant to HIPAA and state law if the exchange is used exclusively for treatment, payment, or operations.
- Re-release provisions of §51.30 are not implicated. Participants in the WISHIN exchange that are not mental health providers will not need to adopt new consent related to processes or technologies in order to participate. **Keeps costs low for participants, which should encourage participation in WISHIN's exchange.**
- Complexity of WISHIN's consent management model and technologies are significantly reduced by excluding §51.30 information. **Keeps costs low for WISHIN, which should encourage participation in WISHIN's exchange.**
- Approximately 31 out of approximately 130 GMS hospitals in Wisconsin have an inpatient psychiatric unit and would be excluded from WISHIN's exchange
- Approximately 5% of Wisconsin's physician workforce are psychiatrists. Their clinics, and possibly some multi-specialty clinics that employ psychiatrists, psychologists and licensed mental health professionals, would be excluded from WISHIN's exchange.

Option 2: Exclude §51.30 "treatment records" from WISHIN's Phase II exchange

This option would be implemented through contractual provisions in WISHIN's participation agreements that would 1) prohibit phase II participants from exchanging "treatment records" defined by §51.30, and 2) require a participant with §51.30 treatment records to enact technical and procedural safeguards to ensure §51.30 treatment records are not sent via/loaded on to the Phase II exchange.

Implications of Option 2:

- With minor exceptions (private pay patients for example) all information exchanged on the WISHIN exchange could be exchanged without consent pursuant to HIPAA and state law if the exchange is used exclusively for treatment, payment, or operations.
- Assuming participants adhere to the contractual prohibition, re-release provisions of §51.30 are not implicated. Participants in the WISHIN exchange that are not mental health providers should not need to adopt new consent related to processes or technologies in order to participate. **Keeps costs low for participants, which should encourage participation in WISHIN's exchange.**
- Due to EHR design, it may be impossible or very costly for hospitals and clinics that have both §51.30 information and general health information to exchange only general health information via the Phase II exchange. Thus, **it seems likely that those providers excluded from WISHIN under Option 1 would voluntarily choose to not participate under Option 2.**

- Complexity of WISHIN’s consent management model and technologies are significantly reduced by excluding §51.30 information. **Keeps costs low for WISHIN, which should encourage participation in WISHIN’s exchange.**
- There is an identifiable, but likely minor, risk that §51.30 information would be exchanged despite the contractual prohibition, potentially implicating the re-release provisions. WISHIN and participants may seek contractual provisions or procedural and technical safeguards to address and mitigate that risk. **This may result in some additional cost to WISHIN and/or WISHIN participants compared to Option 1.**
- Option 2 is similar to the approach that the well-established Indiana Health Information Exchange took to federal AODA records. Because of the special consent requirements of federal AODA records, Indiana’s exchange does not accept AODA records in its exchange. (Indiana law allows the exchange of mental health information without consent). Note however, that it appears that EHR vendors are segregating AODA information from the rest of the medical record because of the universally applicable federal law. Because only some states treat mental health information differently than general health information, it is my understanding that most EHR vendors’ products do not similarly segregate mental health information from the rest of the medical record. Thus, Indiana’s AODA approach may not be as feasible for Wisconsin mental health information since EHR products are not segregating mental health information in the same way as AODA information.
- Approximately 31 out of approximately 130 GMS hospitals in Wisconsin have an inpatient psychiatric unit.
- Approximately 5% of Wisconsin’s physician workforce are psychiatrists.

Option 3: No exclusions of mental health providers or §51.30 treatment records from WISHIN’s Phase II exchange.

WISHIN would not seek to restrict the exchange of §51.30 information under this option. However, all exchanges would have to be compliant with §51.30, as applicable.

Implications of Option 3:

- As discussed earlier, it is not clear that a pull-type exchange can be compliant with §51.30 and §DHS 92.03. **This uncertainty may lead providers to not participate in the WISHIN Phase II exchange.**
- Those providers that determine that a pull-type exchange is clearly compatible with §51.30 and §DHS 92.03 requirements will likely need to create new processes and technical solutions to participate in the WISHIN exchange and be compliant with those requirements. **These solutions will add to the providers cost to participate in the WISHIN phase II exchange.**
- WISHIN will likely need to create additional processes and technical solutions to ensure that its systems are compliant with the §51.30 and §DHS92.03 requirements. **This will add to WISHIN’s costs.**
- The re-release requirement of § DHS 92.03 would appear to require providers that do not provide mental health care to add new processes and technical solutions to participate in the WISHIN exchange. **This would add to these providers’ cost to participate in the WISHIN Phase II exchange.**