Oregon Association of Hospitals and Health Systems

Release Planning for Patients Treated for Behavioral Health Crisis in Hospital Emergency Departments

Interpretative Guidelines for Oregon Hospitals

February 2019

PURPOSE

This document is meant to offer interpretative guidance for Oregon hospitals implementing House Bill 3090 (2017)[1] related to emergency department release planning for patients experiencing a behavioral health crisis. The guide offers a checklist for providers to ensure they are communicating with the patient and family to support the best outcomes following release from a hospital emergency department.

This guidance incorporates related requirements applicable to all lay caregivers from House Bill 2023 (2015)[2], House Bill 3378 (2015)[3] as well as clarifications regarding the disclosure of protected health information from House Bill 2948 (2015).[4] Corresponding regulatory language from federal law and existing state statutes provide additional resources for providers to understand the legal requirements of implementing this new state law and aid in conducting effective hospital policies.

Release planning begins the moment the patient presents at an emergency department. Therefore, hospitals should be actively working through the elements outlined here throughout the patient's stay in order to support timely release and effective post-release care.

This is not legal advice. All organizations should consult with their own legal counsel in developing their emergency department policies related to the release of a patient being treated for a behavioral health crisis.

[1] Codified at ORS 441.053.
[2] Codified at ORS 441.196.
[3] ORS 441.198.
[4] ORS 192.567.

Oregon Association of Hospitals and Health Systems

Release Planning Worksheet for Patients Experiencing a Behavioral Health Crisis in the Emergency Department

To be completed by the provider

Patient Name: _____ **Date:** _____

DOB/Medical Record #: _____

- ☐ Ask the patient if they would like to identify a family member, friend, or other support person ("lay caregiver") who will provide assistance to the patient following their release from the hospital. Particularly vulnerable patients, such as those experiencing a behavioral health crisis should be encouraged to designate a support person to aid in their post-release care. If a lay caregiver is identified, note the designation in the patient's medical record.
  - ☐ For a patient who is younger than 14 years of age, the lay caregiver is a parent or legal guardian of the patient.
  - ☐ For a patient who is younger than 18 years of age but at least 14 years of age, the lay caregiver is the patient's parent or legal guardian unless the legal guardians refuse or there are clear clinical indications to the contrary such as sexual abuse by the guardian or evidence of emancipation. To the extent a legal guardian is not designated as the lay caregiver due to clinical indicators, those reasons should be noted in the medical record. A patient aged 14 to 18 may also designate a lay caregiver of their choice.

  Lay Caregiver Name: _____

  Relationship to Patient: _____

- ☐ If a lay caregiver is identified, encourage the patient to sign an authorization to disclose relevant protected health information. Note in the medical record if patient authorization is obtained. Information to share with the patient and lay caregiver prior to release should include, but need not be limited to:
  - ☐ The hospital's criteria and reasons for initiating release.
  - ☐ The patient's diagnosis, treatment recommendations, and outstanding safety issues.
  - ☐ Risk factors for suicide and what steps to take if danger exists, such as ridding the home of firearms/other means of self-harm and creating a plan to monitor and support the patient.
  - ☐ The patient's prescribed medications including dosage, explanation of side effects, and process for obtaining refills, as applicable.
  - ☐ Available community resources including case management, support groups, and others.
  - ☐ The circumstances under which the patient or lay caregiver should seek immediate medical attention.

- ☐ Conduct a behavioral health assessment, a suicide risk assessment and if indicated develop a safety plan and lethal means counseling.
  - ☐ Providers should seek input from the patient's designated lay caregiver, including interviews and patient history.
  - ☐ Providers may accept unsolicited information from family and friends not authorized for disclosure.

- Conduct a needs assessment to understand the long-term needs of the patient. The assessment should include questions regarding the patient's income, housing situation, insurance, and aftercare support, among others. The lay caregiver should be included in this conversation. At minimum, the assessment should help the provider determine:
  - The patient's capacity for self-care, including but not limited to:
    - The risk that the patient may engage in self-harm as identified in assessments.
    - The patient's support network in place at the location of anticipated release.
    - Patient resources and ability to access prescribed medications or travel to follow-up appointments.
  - The patient's need for community-based services.
  - Appropriate placement for the patient, including whether the patient may return to the place from which they resided prior to hospital care or if additional resources are needed.

- Coordinate the patient's care and transition to inpatient or outpatient treatment. Providers should share the treatment plan with the patient and lay caregiver and provide an explanation of:
  - The next level of care and what the patient should expect from inpatient or outpatient treatment.
  - Contact information for the inpatient or outpatient care including address and phone number of the site/provider.

- Schedule a follow-up appointment for no later than seven days after release.
  - If a follow-up appointment cannot be scheduled within seven days, document the applicable barriers in the patient's medical record.

- If possible, arrange caring contacts for no later than 48-hours after release.
  - Contact information for the caring contact organization or provider, if not the hospital personnel, including address and phone number of the site/provider.

- As necessary, provide instructions or training to the patient and lay caregiver prior to release. Instructions should address how to provide assistance to the patient and may include securing and administering medications, safety plans, name and location of follow-up appointment and community resources, or any other anticipated assistance relating to the patient's condition.

- Notify the designated lay caregiver in advance of patient release or transfer.

Additional Notes:

Clinician Signature: _____ **Date:** _____

Interpretive Guideline Details

Applicability 6
Behavioral health crisis 6
Hospital Emergency Department 6
Release 6
Additional Requirements 7
Publicly Available 7
Documentation 7
Defining the Lay Caregiver 9
Adult Patients 9
Minor Patients 10
Patient Authorization to Disclose Protected Health Information 11
Personal Representatives: When No Authorization Is Required 11
Disclosure of Information for Un-Emancipated Minor Patients 12
Disclosure with Patient Authorization 13
Disclosures Permitted without Patient Authorization 14
Information to Include in an Authorized Caregiver Disclosure 16
Conducting the Behavioral Assessment 18
Additional Requirements Related to Suicide Attempts by Minors 19
Conducting the Needs Assessment 21
Coordination of Care and Case Management 22
Coordination of Care 22
Case Management 22
Arranging Caring Contacts or follow-up service 23
Scheduling Follow-Up Appointment 25
Notifying the Lay Caregiver of Discharge 26

Applicability

House Bill 3090 (2017), now codified as ORS 441.053, requires hospitals emergency departments to adopt and implement policies for the release of "a patient presenting with a behavioral health crisis."[5] This standard means the law applies:

1. To hospital emergency departments
2. Upon patient release
3. When a patient has been seen or treated for a behavioral health crisis.

Behavioral health crisis

> "Behavioral health crisis" means a disruption in an individual's mental or emotional stability or functioning resulting in an urgent need for immediate treatment to prevent a serious deterioration in the individual's mental or physical health.[6]

Hospital Emergency Department

OHA rules do not define "hospital emergency department", they do define "hospital" and "emergency medical services". The term is recommended to apply to hospitals who provide emergency medical services.

> "Hospital" means:
>
> (a) A facility with an organized medical staff and a permanent building that is capable of providing 24-hour inpatient care to two or more individuals who have an illness or injury and that provides at least the following health services:
>
> (A) Medical;
>
> (B) Nursing;
>
> (C) Laboratory;
>
> (D) Pharmacy; and
>
> (E) Dietary; or
>
> (b) A special inpatient care facility as that term is defined by the authority by rule.[7]

> "Emergency Medical Services" means medical services that are usually and customarily available at the respective hospital in an emergency department and that must be provided immediately to sustain a person's life, to prevent serious permanent disfigurement or loss or impairment of the function of a bodily member or organ, or to provide care to a woman in labor where delivery is imminent if the hospital is so equipped and, if the hospital is not equipped, to provide necessary treatment to allow the woman to travel to a more appropriate facility without undue risk of serious harm.[8]

Release

The law does not define "release". The law does reference at a minimum, the policies must meet the requirements in ORS 441.196 for hospital policies regarding the release of a patient who is being seen in the emergency department for a behavioral health crisis.

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[5] ORS 441.196(2).
[6] ORS 441.053
[7] ORS 442.015(15).
[8] OAR 333-500-0010 (11).

Additional Requirements

Publicly Available

Hospital policies for the release of a patient from the emergency department who is being seen for a behavioral health crisis must be in writing and made publicly available.[9] The requirement for a written policy exists at both the state and federal level.[10]

The requirement for public availability is specific to the inpatient psychiatric discharge policy and is carried over to the emergency department and emergency services requirement for policies to be publicly available. This may be achieved in a method left up to hospital including posted on the hospital's website and provided to each patient and to the patient's lay caregiver in written form upon admission to the hospital or emergency department and upon discharge from the hospital or release from the emergency department. The written form provided to a patient and lay caregiver may be a summarized version of the policy that is clear and easily understood, for example in the form of a brochure. An individual does not need to be a patient of the hospital to request a copy of the facility's emergency department release planning for patients experiencing a behavioral health crisis policy.

OHA rules contained within Oregon Administrative Rules (OAR) chapter 333, divisions 505, section 0055, discharge planning requirements define "publicly available".

> "Publicly available" means posted on the hospital's website and provided to each patient and to the patient's lay caregiver in written form upon admission to the hospital or emergency department and upon discharge from the hospital or release from the emergency department. The written form provided to a patient and lay caregiver may be a summarized version of the policy that is clear and easily understood, for example in the form of a brochure.

OAHHS is creating a brochure that may be used by the hospital as the written form provided to the patient and/or lay caregiver summarizing release process for a patient being seen in the emergency department for a behavioral health crisis.

Documentation

Discharge planning required for patients seen in the emergency department for a behavioral health crisis are subject to several documentation requirements. These requirements are noted throughout this guidance, but also noted here in consolidated form to ensure compliance.

All hospitals are required to maintain a medical record for patients admitted for care.[11] The medical record of a patient being seen in the emergency department for a behavioral health crisis must include:

- Discharge/Release planning documentation.[12]
- Signed authorization for the disclosure of protected health information.[13]

[9] ORS 441.196(2); OAR 333-505-0055(3).
[10] 42 CFR 482.43.
[11] OAR 333-505-0050(1).
[12] OAR 333-505-0050(2)(k).
[13] 45 CFR § 164.508.

- The lay caregiver designated by the patient or legally applicable caregiver if the patient is a minor.
- If the minor is 14 or older and the provider does not to designate the legal guardian or parent as a lay caregiver due to cause, the reasons for that determination.[14]

[14] ORS 109.675.

Defining the Lay Caregiver

- *Have a member of the patients' care team ask the patient if they would like to identify a family member, friend, or other support person ("lay caregiver") who will provide assistance to the patient following their release from the hospital.*

As an initial step, hospital emergency departments must offer all patients being seen for a behavioral health crisis the opportunity to designate a "lay caregiver."[15] Lay caregiver is the statutory term however hospitals may feel free to use other terms to describe the functional role of the lay caregiver such as support person. For the purpose of this guidance document the term lay caregiver encompasses the role of a support person or other organizational term of art meaning a non-medical personal associate of the patient that assists with tasks following release from the emergency department.

While the law only requires providers to offer patients the opportunity to designate a lay caregiver, particularly vulnerable patients, such as those hospitalized for mental illness, should be encouraged to designate a support person to aid in their post-hospital care.

The caregiver may be any individual who, at the patient's request, agrees to be involved in the release process and aid the patient as necessary following their release from the emergency department. For a patient experiencing a behavioral health crisis, the lay caregiver is defined with more precision when the patient is also a minor. Below, relevant considerations for identifying the lay caregiver are provided for both adult and minor patients.

The patient must always be central to the identification and involvement of a lay caregiver. While patients have the right to designate a caregiver of their choosing to be involved in their care plan, hospitals should consider the mental and physical functioning of the lay caregiver relative to the patient. To the extent that a caregiver may create issues in caring for the patient hospital staff should be thoughtful in how the caregiver is involved. Similarly, for patients lacking a designated caregiver but for whom there is a viable option, staff should make efforts to involve a potential caregiver as much as allowable under state and federal law.

The lay caregiver and their relationship to the patient should be noted in the patient's medical record. Designation of the lay caregiver should be noted such that other health care professionals in the hospital are aware of the designation and the subsequent obligation to notify the caregiver of steps in the release planning process.

Adult Patients

For an adult patient the lay caregiver must be explicitly designated by the patient unless a guardianship or other legal arrangement exists. All patients have the right to designate a family member or representative of his or her choice and have that person notified of their admission and release from the hospital.[16] The lay caregiver should also be counseled on relevant patient information to prepare them for post-hospital care.[17]

[15] ORS 441.198(2)(b).
[16] 42 CFR § 482.13.
[17] 42 CFR § 482.43(5).

Minor Patients

In Oregon, individuals are deemed to have arrived at majority at the age of 18 years.[18] Individuals under the age of 18 are therefore minors and subject to additional clarification with respect to designating their caregiver following release from an emergency department after being seen for a behavioral health crisis.

- *For a patient who is younger than 14 years of age, the lay caregiver is a parent or legal guardian of the patient.*

For a patient who is younger than 14 years of age, a parent or legal guardian of the patient should be automatically designated as the lay caregiver.[19] In the absence of a parent or legal guardian, Oregon recognizes the right of a "relative caregiver" to intervene.[20] The relative caregiver is a competent adult related to the minor patient by blood, marriage or adoption who represents via affidavit that the minor child lives with the adult and that the adult is responsible for the care of the minor child.[21]

- *For a patient who is younger than 18 years of age but at least 14 years of age, the lay caregiver is the patient's parent or legal guardian unless the legal guardians refuse or there are clear clinical indications to the contrary such as sexual abuse by the guardian or evidence of emancipation. To the extent a legal guardian is not designated as the lay caregiver due to clinical indicators, those reasons should be noted in the medical record. A patient aged 14 to 18 may also designate a lay caregiver of their choice.*

For a patient who is at least 14 years of age, the lay caregiver may be an individual designated by the patient.[22] The parent or legal guardian will also be automatically designated as the lay caregiver unless the conditions of ORS 109.640 or ORS 109.675 are met. Such situations include when a minor has been sexually abused by the guardian or in the case on an emancipated minor.[23] An emancipated minor may include legal emancipation under the provisions of ORS 109.510 and 109.520 or 419B.550 to 419B.558 or a minor that may be deemed emancipated by virtue of having lived apart from the parents or legal guardian while being self-sustaining for a period of 90 days prior to obtaining treatment.[24]

Note that a minor aged 14 years or older may obtain treatment for a mental or emotional disorder or a chemical dependency, excluding methadone maintenance, without parental consent.[25] However, the parents of the minor should be involved prior to release from an emergency department unless the conditions of sexual abuse or emancipation described above apply.[26]

[18] ORS 109.510.
[19] ORS 441.196(1)(b)(A); OAR 333-505-0055(1)(b)(A).
[20] ORS 109.575(1).
[21] ORS 109.572.
[22] ORS 441.196(1)(b)(B); OAR 333-505-0055(1)(b)(B).
[23] ORS 109.675(2)(a).
[24] ORS 109.675(2)(b).
[25] ORS 109.675(1).
[26] ORS 109.675(2).

Patient Authorization to Disclose Protected Health Information

- *If a lay caregiver is identified, encourage the patient to sign an authorization to disclose relevant protected health information. Note in the medical record if patient authorization is obtained.*

In order to facilitate the release process and ensure communication with a designated lay caregiver, hospital should encourage patients to sign an authorization to allow the disclosure of relevant health information with the lay caregiver.[27] Providers should explain:

- the benefits of involving a lay caregiver including participating in the patient's discharge planning in order to provide appropriate support measures;
- that only the minimum necessary information will be shared;
- the benefits disclosing health information will have on the ability of a patient to see positive outcomes, and
- the ability to rescind the authorization at any time.

Note that this section outlines relevant state and federal regulations as they pertain to patients that do not have a legal guardian (i.e. adults). More specific discussion of allowable disclosures for other categories of patients is available below.

Hospital providers are subject at all times to the Health Information Portability and Accountability Act (HIPAA). This law was designed to protect the privacy and confidentiality of protected health information. Hospitals should check that they are interpreting HIPAA in such a way as to facilitate reasonable and necessary sharing of patient information, particularly for mentally ill patients that may be at risk of self-harm in the period following their release from the hospital. Providers are always required to follow federal law and should consult state law only where the state law for disclosure is more protective of patient privacy.

At the state level, House Bill 2948 (2015)[28] codifies into Oregon law when a provider may disclose protected health information without explicit patient authorization. The state law mirrors HIPAA regulations almost exactly with the addition of standards for patients being treated for mental illness. Additionally, in accordance with ORS 192.567, a health care provider may use or disclose protected health information to a person if the health care provider, consistent with standards of ethical conduct, believes in good faith that the disclosure is necessary to prevent or lessen a serious threat to the health or safety of any person or the public, and if the information is disclosed only to a person who is reasonably able to prevent or lessen the threat, including the target of the threat. Those elements are contained at the end of this section, which describes the type of health information providers should offer lay caregivers.

Personal Representatives: When No Authorization Is Required

In limited circumstances, a specific authorization to share protect health information may not be necessary for the hospital to make a health care disclosure. This occurs when the patient has a legally appointed personal representative. Note that the disclosure may only be made to the legal guardian or personal representative in these circumstances, which may or may not include the designated lay caregiver. The personal representative designation is narrower than the lay

[27] OAR 333-505-0055(2)(b)(A).
[28] ORS 192.567.

caregiver, so hospitals should not assume a lay caregiver is also a patient's personal representative unless there is evidence to the contrary.

For an adult or emancipated minor, a personal representative is any person with authority to act on behalf of an individual and make health care decisions such as an individual designated to hold power of attorney or in a declaration for mental health treatment.[29]

Hospitals, and other covered entities under HIPAA, must always treat a personal representative similarly to the individual with respect to privacy of health information.[30] Thus, the personal representative of a patient may request access to the patient's health information without a specific authorization for that disclosure. Typically, disclosure of protected health information is subject to a "minimum necessary" standard.[31] However, the minimum necessary requirement does not apply in situations in which a hospital has specific authorization from the patient for the disclosure, meaning it also does not apply when a personal representative has requested information.[32]

Hospital personnel always retain discretion to not recognize the patient's personal representative in the event that the hospital has a reasonable belief the patient has been or may be subjected to domestic violence, abuse, or neglect by the personal representative or the disclosure could endanger the patient; and in the exercise of professional judgment the disclosure would not be in the best interest of the patient.[33] Note that both prongs must be meant to withhold the information. Providers should document the evidence and belief of abuse and endangerment if not disclosing under this protection.

Disclosure of Information for Un-Emancipated Minor Patients

Un-emancipated minors are individuals under 18 years of age still residing with a legal guardian that have not initiated separation procedures. A parent, guardian, or other person authorized under law to act *in loco parentis* to make health care decisions for an un-emancipated minor must be generally treated as the patient's personal representative.[34] In the event a parent is acting as a minor patient's personal representative, the standards outlined in the Personal Representative subsection apply and no specific authorization is required for disclosure of protected health information.

However, minors have authority to act as an individual without the legal guardian operating as a personal representative when the minor may consent to treatment without parental consent under state law.[35] Oregon law does specifically allow minors aged 14 and older to consent to mental health treatment without parental consent,[36] thus providers should confirm whether such patients wish to have a parent or other legal guardian treated as a personal representative. In the case of a minor patient under the age of 14, providers should treat the parent as a personal representative unless there are indications of abuse or endangerment as described below.

[29] 45 CFR 164.502(g)(2).
[30] 45 CFR 164.502(g)(1).
[31] 45 CFR 164.502(b).
[32] 45 CFR 164.502(b)(2)(iii).
[33] 45 CFR 164.502(g)(5).
[34] 45 CFR 164.502(g)(3).
[35] 45 CFR 164.502(g)(3).
[36] ORS 109.675.

Hospital personnel always retain discretion to not treat a guardian as a minor patient's personal representative in the event that the hospital has a reasonable belief the patient has been or may be subjected to domestic violence, abuse, or neglect by the personal representative or the disclosure could endanger the patient; and in the exercise of professional judgment the disclosure would not be in the best interest of the patient.[37] Note that both prongs must be meant to withhold the information. Providers should document the evidence and belief of abuse and endangerment if not disclosing under this protection. For emancipated minors or minors for which the provider has concerns regarding abuse, the same standards that apply to adult patients should be used in determining whether disclosure of protected health information is allowable.

As a reminder, a personal representative under HIPAA is a narrower definition than the lay caregiver under state law. The personal representative designation is specific to allowable disclosure without an authorization, however a parent or legal guardian that is a lay caregiver may be entitled to disclosure based upon the patient's written authorization or permitted circumstance, described in the following subsections.

Disclosure with Patient Authorization

Hospitals and their associated health care professionals may disclose protected health information only as authorized by the individual or as permitted under HIPAA. Specific authorization by the patient is the most straightforward route to sharing relevant information with a lay caregiver. Hospitals should encourage patients being seen in an emergency department for a behavioral health crisis to sign an authorization of disclosure for their lay caregiver to aid in aftercare and positive long-term outcomes.

The disclosure of protected health information is subject to a "minimum necessary" standard necessary to accomplish the goals of the disclosure.[38] Patient authorization is always required for the disclosure of psychotherapy notes to a caregiver.[39] Patients may revoke an authorization at any time, but providers are not liable for disclosures made in reliance on that authorization.[40]

Patient authorizations must be valid and meet the requirements of HIPAA for the disclosure to be allowable.[41] A valid authorization is a written document in plain language containing the following six elements.

1. A description of the information to be used or disclosed;
2. The name or other specific identification of the person(s), or class of persons, authorized to make the requested use or disclosure;
3. The name or other specific identification of the person(s), or class of persons, to whom the covered entity may make the requested use or disclosure;
4. A description of each purpose of the requested use or disclosure;
5. An expiration date or an expiration event that relates to the individual or the purpose of the use or disclosure; and
6. Signature of the individual and date.[42]

[37] 45 CFR 164.502(g)(5).
[38] 45 CFR 164.502(b).
[39] 45 CFR 164.508(a)(2).
[40] 45 CFR 164.508(b)(5).
[41] 45 CFR 164.508(b).
[42] 45 CFR 164.508(c)(1).

When a patient has authorized the disclosure, the description outlined as element #3 may be recorded as "at the request of the individual," if the individual does not provide a statement of the purpose.

In addition to the six elements above, a valid authorization must contain language placing the individual on notice of:

1. The ability to rescind the authorization at any time;
2. The ability or inability to condition treatment, payment, or eligibility for benefits on the authorization; and
3. The potential for disclosed information to be re-disclosed by the recipient and no longer protected. [43]

Upon obtaining authorization from a patient for disclosure of health information, the hospital must provide the individual with a copy of the signed authorization.[44]

Disclosures Permitted without Patient Authorization

Under certain circumstances, hospitals and their associated health care professionals may disclose protected health information without a specific patient authorization. With respect to a designated lay caregiver, those unauthorized disclosures fall into three categories:

1. When the disclosure is implicitly agreed to and directly relevant to such caregiver's involvement,
2. When the individual patient lacks capacity and disclosure is in the best interest of the individual, or
3. To avert a serious threat to health or safety.

All allowable disclosures without patient authorization should occur under the first two situational categories, as hospitals should never release a patient if there is any immediate concern regarding the patient's health and safety or the health and safety of those near the patient. However, for the sake of completeness, legal standards relating to all situations are provided below.

When the disclosure is implicitly agreed to and directly relevant to such caregiver's involvement

Hospitals may use or disclose protected health information to family members and other support persons when the individual is informed in advance and had opportunity to agree, prohibit, or restrict the disclosure either implicitly or orally.[45] The protected health information must be directly relevant to such caregiver's involvement with the individual's health care.[46] For the purpose of Oregon law, this could include a caregiver designated by a patient receiving care at an emergency department for a behavioral health crisis.

In any instance in which the patient has an opportunity to object to disclosure and the health professional reasonably infers that there is no objection, the disclosure is allowable.[47] This situation will occur most commonly when a caregiver is present with a patient at the time at which a

[43] 45 CFR 164.508(c)(2).
[44] 45 CFR 164.508(c)(4).
[45] 45 CFR 164.510.
[46] 45 CFR 164.510(b)(1).
[47] 45 CFR 164.510(b)(2).

provider is offering information. The provider may ask the patient verbally whether she/he may disclose health information when another individual or caregiver is present, and may proceed with the disclosure upon the patient's verbal agreement.[48] Alternatively, the provider may take the patient's silence or lack of objection at the presence of the other individual as implicit assent for the other individual to be a party to the protected health information. In contrast to a written authorization, this assent should be considered conditional on the particular circumstance, and not evidence that future health information should be disclosed.

When the individual patient lacks capacity and disclosure is in the best interest of the individual

If the individual is not present or there is no opportunity to agree or object to disclosure due to patient incapacity or other emergency, providers may disclose health information in limited circumstances.[49] Specifically, if a health professional believes that the disclosure is in the best interests of the patient, they may disclose protected health information that is directly relevant to the person's involvement with the patient's care or needed for notification purposes.[50] Hospitals should exercise their judgment and experience with common practice to make reasonable inferences of the individual's best interest, particularly considering the role of lay caregivers in acting on behalf of the patient to pick up prescriptions, medical supplies, or other similar forms of protected health information.[51] As much as possible, hospitals should identify the criteria for such inferences in their written policies based on the practical experience of patients experiencing a behavioral health crisis.

Providers may also disclose protected health information when the patient lacks capacity. In the case of the parent or legal guardian of a child patient, the disclosure is always allowable unless the provider reasonably believes the disclosure would cause harm. If the provider believes there may be harm this should be documented in the medical record. Additionally, disclosure without explicit authorization is allowable if the patient lacks capacity.[52] Such disclosure must be consistent with any prior expressed preference of the patient and should be made based on the best interest of the patient. Hospital personnel should inform the individual and provide them with the opportunity to object as soon as practicable.

To avert a serious threat to health or safety

Finally, federal law also allows hospitals to disclose protected health information without authorization, written or implied, to prevent or lessen a serious threat to the health or safety of a person or the public.[53] The disclosure must be made in good faith and only to a person or persons reasonably able to prevent or lessen the threat.[54] However, this exception to patient privacy should never come into play, as any patient deemed to pose a serious threat is not appropriate patient for release unless the patient is being admitted or transferred to higher level of care.

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[48] 45 CFR 164.510(b)(2).
[49] 45 CFR 164.510(b)(3).
[50] 45 CFR 164.510(b)(3).
[51] 45 CFR 164.510(b)(3).
[52] 45 CFR 164.510(a)(3).
[53] 45 CFR 164.512(j)(1)(i).
[54] 45 CFR 164.512(j)(1)(i).

Disclosure of information without an explicit written authorization should always be limited to the minimum necessary to accomplish the intended purpose of the use, disclosure, or request.[55]

Information to Include in an Authorized Caregiver Disclosure

- *The hospital's criteria and reasons for initiating release.*
- *The patient's diagnosis, treatment recommendations, and outstanding safety issues.*
- *Risk factors for suicide and what steps to take if danger exists, such as ridding the home of firearms/other means of self-harm and creating a plan to monitor and support the patient.*
- *The patient's prescribed medications including dosage, explanation of side effects, and process for obtaining refills, as applicable.*
- *Available community resources including case management, support groups, and others.*
- *The circumstances under which the patient or lay caregiver should seek immediate medical attention.*

The above listed criteria are recommended for hospitals to include in an allowable disclosure to the caregiver of a patient being release from an emergency department after being seen for a behavioral health crisis. Oregon law specifically notes that caregiver disclosures should include the patient's prescribed medications and the circumstances under which the patient or lay caregiver should seek immediate medical attention.[56]

In addition, the Oregon health information privacy law notes a number of these factors appropriate for disclosure to a lay caregiver meeting the requirement for written authorization or one of the disclosure exceptions.[57] Those factors include:

- The patient's diagnoses and the treatment recommendations;
- Issues concerning the safety of the patient, including risk factors for suicide, steps that can be taken to make the patient's home safer, and a safety plan to monitor and support the individual;
- Information about resources that are available in the community to help the patient, such as case management and support groups; and
- The process to ensure that the patient safely transitions to a higher or lower level of care, including an interim safety plan. [58]

It is essential to remember that often the families of patients experiencing a behavioral health crisis are not well informed on diagnosis or hospital procedures. Hospital personnel should remember that family and other caregivers are lay persons and explain in plain language hospital processes, standards, and reasons for release. Designated caregivers should know the patient's diagnoses and relevant information regarding the recommended treatment and any outstanding issues or signs the patient may be decompensating.

The hospital should provide the lay caregiver with all relevant information regarding transition to the next level of treatment and supports available in the community for both the patient and family. As discussed further, hospital personnel should be particularly explicit in describing the patient's

[55] 45 CFR 164.502(b).
[56] ORS 441.196(2)(a).
[57] ORS 192.567(3).
[58] ORS 192.567(3)(d).

risk factors, if any, for suicide and offering suggestions regarding risk mitigation and signals for persons in the patient's support network to monitor.

Hospitals should always feel free to modify this list and include more information as is relevant to a particular patient situation. Where the patient has authorized disclosure of information to a designated caregiver, hospitals should endeavor to provide more information to ensure the lay caregiver is fully apprised of the patient's status upon release and prepared for any follow-up care.

Conducting the Behavioral Assessment

- ☐ *Conduct a behavioral health assessment, a suicide risk assessment and if indicated develop a safety plan and lethal means counseling.*

Oregon law requires that a patient being seen in the emergency department for a behavioral health crisis is to receive a behavioral health assessment by a behavioral health clinician, a suicide risk assessment, and if indicated develop a safety plan and lethal means counseling.[59] Hospital policy should clearly state how and what factors determine that a patient is experiencing a behavioral health crisis and what factors garner developing a safety plan and/or lethal means counseling.

"Behavioral health assessment" means an evaluation by a behavioral health clinician, in person or using telemedicine, to determine a patient's need for immediate crisis stabilization.[60]

"Behavioral health clinician" means:
(A) A licensed psychiatrist;
(B) A licensed psychologist;
(C) A certified nurse practitioner with a specialty in psychiatric mental health;
(D) A licensed clinical social worker;
(E) A licensed professional counselor or licensed marriage and family therapist;
(F) A certified clinical social work associate;
(G) An intern or resident who is working under a board-approved supervisory contract in a clinical mental health field; or
(H) Any other clinician whose authorized scope of practice includes mental health diagnosis and treatment.[61]

"Suicide Risk Assessment" is not defined and therefore a hospital policy should clearly state how and what factors determine that a patient needs suicide risk assessment and which hospital personnel can administer this assessment. The National Suicide Prevention Lifeline has created Suicide Risk Assessment Standards that may be used as guidance or reference in the development of policy and procedures.[62]

"Safety plan" means a written plan developed by a patient in collaboration with the patient's lay caregiver, if any, as facilitated by a health care provider that identifies strategies for the patient or lay caregiver to use when the patient's risk for suicide is elevated or following a suicide attempt.[63]

While lethal means counseling is not defined in statute or rulemaking "Lethal Means Counseling" may include providers implementing counseling strategies to help patients at risk for suicide, and their families, reduce access to lethal means, including but not limited to firearms.[64]

[59] OAR 333-505-0070(4)(b).
[60] ORS 743A.012
[61] ORS 743A.012
[62] https://suicidepreventionlifeline.org/wp-content/uploads/2016/08/Suicide-Risk-Assessment-Standards-1.pdf
[63] OAR 836-053-1403 ORS 743A.168
[64] OAR 309-023-0110

Providers must complete all assessments in a timely manner so as not to delay release of the patient.[65] The assessments should be included in the patient's medical record as part of their patient record and release plan.[66]

- *Providers should seek input from the patient's designated lay caregiver, including interviews and patient history.*

Providers should endeavor to involve family and friends of the patient in the suicide risk assessment, safety planning, and lethal means counseling for the best information on the individual's state of mind and environmental risks. Patients have the right to be involved in their care planning, and this right extends to individuals designated by the patient to act in a representative capacity.[67] As such, in conducting the suicide risk assessment, hospital staff should seek input from the patient's lay caregiver, including obtaining information about the patient's history, prior behavior, living situation, and any other relevant information.

Designated caregivers should receive a copy of suicide risk assessment(s), safety planning, and lethal means counseling upon release as well as an explanation of how the assessment was conducted if that information was not previously shared.

While the standard should be to involve family in suicide assessment and prevention, hospital staff should always consider the particular facts of a patient situation and may opt to not include family members if staff feels that to do so would be counterproductive for that specific patient and/or situation.

- *Providers may accept unsolicited information from family and friends not authorized for disclosure.*

In some instances, a patient may object to the disclosure of protected health information to all potential caregivers. The patient's objection prevents hospital staff from offering family members any affirmative information regarding the patient's treatment. However, neither federal nor state law prohibits providers from accepting unsolicited information from friends of relatives of a patient.

When confronted with such situations, providers should not engage in conversation, but if approached, request that family members leave any information in writing. Acceptance of a written statement does not constitute acknowledgement of any patient information and is not a violation of the patient's request for privacy.

Additional Requirements Related to Suicide Attempts by Minors

Oregon law has additional requirements for hospitals treating minor patients as the result of a suicide attempt. Specifically, hospitals treating patients less than 18 years of age as a result of a suicide attempt must report statistical data regarding the attempt to OHA on a standardized form.[68]

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[65] 42 CFR 482.13(b)(5).
[66] 42 CFR 482.13(b)(6).
[67] 42 CFR 482.13(b)(2).
[68] ORS 441.750, ORS 441.755. Form available at https://public.health.oregon.gov/DiseasesConditions/InjuryFatalityData/Documents/ASADForm.pdf

Hospitals may withhold patient name and other identifying information in the event the facility has privacy concerns with the disclosure.

The law further requires a hospital treating a minor following suicide attempt to provide the individual with information and referral to community resources, crisis intervention, or other interventions deemed appropriate by the patient's attending medical staff.[69]

[69] ORS 441.750.

Conducting the Needs Assessment

- *Conduct a needs assessment to understand the long-term needs of the patient.*

A needs assessment is a particularly critical component of release planning for patients experiencing a behavioral health crisis. The needs assessment may be conducted as early as patient admission but should be reassessed as necessary if there are factors that may affect continuing care needs.[70] A needs assessment should include questions regarding the patient's income, housing situation, insurance, and aftercare support, among others. The lay caregiver may be included in this conversation, with an explanation of the purpose of the needs assessment and its role in the release planning process.

At minimum, the assessment should help the provider determine the patient's capacity for self-care, need for community-based services, and potential appropriate placements.

The results of the needs assessment should be discussed with the patient and any designated lay caregiver.[71] A copy of the needs assessment should also be included with the patient's medical record as part of their release plan.[72]

Hospitals should reassess their needs assessment as part of its discharge planning reassessment, periodically to ensure it is responsive to patient and caregiver needs.[73]

[70] 42 CFR 482.43(c)(4).
[71] 42 CFR 482.43(b)(6).
[72] 42 CFR 482.43(b)(6).
[73] 42 CFR 482.43(e).

Coordination of Care and Case Management

A hospital shall adopt, maintain and follow written policies that state a process to coordinated care and for case management of a patient from the emergency department who is being seen for a behavioral health crisis.

Coordination of Care

- *Coordinate the patient's care which may include notification to a patient's primary care provider, referral to another provider including peer support.*

A hospital emergency department may coordinate a patient's care through activities which may include notification to a patient's primary care provider, referral to other provider including peer support, follow-up after release from the emergency department, or creation and transmission of a plan of care with the patient and other provider.

> "Coordination of care" means the process of coordinating patient care activities as well as the facilitation of ongoing communication and collaboration with lay caregivers by community resource providers, health care providers, and agencies to meet the multiple needs of a patient by:
> (a) Organizing and participating in team meetings; and
> (b) Ensuring continuity of care during each transition of care.[74]
>
> "Peer support" means a peer support specialist, peer wellness specialist, family support specialist or youth support specialist as those terms are defined in ORS 414.025 and who are certified in accordance with OAR chapter 410, division 180.[75]

Case Management

- *Case management that includes a systematic assessment of the patient's medical, functional and psychosocial needs.*
  - *May include an inventory of resources and supports recommended by a behavioral health clinician, indicated by a behavioral health assessment, and agreed upon by the patient.*

A hospital emergency department may establish a process for case management that may include a systematic assessment of the patient's medical, functional and psychosocial needs and may include an inventory of resources and supports recommended by a behavioral health clinician, indicated by a behavioral health assessment, and agreed upon by the patient.

> "Case management" means the management of services that are provided to assist an individual in accessing medical and behavioral health care, social and educational services, public assistance and medical assistance and other needed community services identified in the individual's patient-centered care plan.[76]

[74] OAR 836-053-1403 ORS 743A.168
[75] ORS 414.025
[76] OAR 836-053-1403 ORS 743A.168

Arranging Caring Contacts or follow-up service

- *If possible, arrange caring contacts for no later than 48-hours after release.*
  - *Contact information for the caring contact organization or provider including address and phone number of the site/provider.*

Hospitals must establish a process to arrange caring contacts between a patient and a provider or follow-up services for the patient in order to successfully transition a patient to outpatient services. Caring contacts may be conducted in person, via telemedicine or by phone. Caring contacts if possible must be attempted within 48 hours of release if a behavioral health clinician has determined a patient has attempted suicide or experienced suicidal ideation.

> "Caring contacts" mean brief communications with a patient that starts during care transition such as discharge or release from treatment, or when a patient misses an appointment or drops out of treatment, and continues as long as a qualified mental health professional deems necessary;

A hospital may facilitate caring contacts through contracts with a qualified community-based behavioral health provider, or through a suicide prevention hotline.

> "Qualified mental health professional" means an individual meeting the minimum qualification criterion adopted by the Oregon Health Authority by rule for a qualified mental health professional.[77]

If a hospital does not facilitate caring contacts through contracts with a qualified community-based behavioral health provider, or through a suicide prevention hotline a hospital may facilitate caring contacts through a hospital provider. For purposes of this subsection "provider" includes a behavioral health clinician, peer support specialist, peer wellness specialist, family support specialist or youth support specialist.

> "Family support specialist" means an individual who meets qualification criteria adopted by the authority under ORS 414.665 and who provides supportive services to and has experience parenting a child who:
>
> (A) Is a current or former consumer of mental health or addiction treatment; or
>
> (B) Is facing or has faced difficulties in accessing education, health and wellness services due to a mental health or behavioral health barrier
>
> A "family support specialist" may be a peer wellness specialist or a peer support specialist.[78]

> "Peer support specialist" means any of the following individuals who meet qualification criteria adopted by the authority under ORS 414.665 and who provide supportive services to a current or former consumer of mental health or addiction treatment:
>
> (a) An individual who is a current or former consumer of mental health treatment; or
>
> (b) An individual who is in recovery, as defined by the Oregon Health Authority by rule, from an addiction disorder.[79]

> "Peer wellness specialist" means an individual who meets qualification criteria adopted by the authority under ORS 414.665 and who is responsible for assessing mental health and substance

[77] OAR 836-053-1403 ORS 743A.168
[78] ORS 414.025
[79] ORS 414.025

use disorder service and support needs of a member of a coordinated care organization through community outreach, assisting members with access to available services and resources, addressing barriers to services and providing education and information about available resources for individuals with mental health or substance use disorders in order to reduce stigma and discrimination toward consumers of mental health and substance use disorder services and to assist the member in creating and maintaining recovery, health and wellness.[80]

"Youth support specialist" means an individual who meets qualification criteria adopted by the authority under ORS 414.665 and who, based on a similar life experience, provides supportive services to an individual who:

(A) Is not older than 30 years of age; and

(i) Is a current or former consumer of mental health or addiction treatment; or

(ii) Is facing or has faced difficulties in accessing education, health and wellness services due to a mental health or behavioral health barrier.

A "youth support specialist" may be a peer wellness specialist or a peer support specialist.[81]

Additionally, as noted previously, for minors receiving treatment following a suicide attempt, Oregon law places additional requirements on hospitals to provide the minor patient with information and referral to community resources, crisis intervention, or other appropriate level of care following discharge.[82] Hospitals should consider applying these standards to any individual, minor or adult, receiving mental health treatment for a suicide attempt.

[80] ORS 414.025
[81] ORS 414.025

Scheduling Follow-Up Appointment

- *Schedule a follow-up appointment for no later than seven days after release from a hospital emergency department.*

Pursuant to Oregon's discharge law, hospitals have an affirmative obligation to schedule a follow-up appointment for patients being seen for a behavioral health crisis within seven days of being released from a hospital's emergency department.[83] Importantly however, Oregon law anticipates hospitals will endeavor to achieve follow-up within seven days for all patients being seen in an emergency department for a behavioral health crisis, regardless of payer.

In the event a patient is transferred, the follow-up appointment is not applicable as the transferee hospital takes on the obligations associated with the Oregon discharge law. Stated differently, hospitals should only schedule the follow-up appointment when the patient is being released to a lower level of outpatient or home-based care.

Hospitals must provide the next stage provider with all necessary medical information as needed for follow-up or ancillary care.[84]

- *If a follow-up appointment cannot be scheduled within seven days, document the applicable barriers in the patient's medical record.*

In the event that the hospital staff is unable to schedule a follow-up appointment within seven days, or if follow-up is not necessary because patient is being admitted or transferred to an inpatient setting, this should be documented in the patient's medical record as part of the release/transfer plan. When the appointment cannot be made due to specific factors such as limited resources in the area or limited availability for particular services, that should be noted in the patient's medical record. Providers should be sure to ask the patient, family, and lay caregiver about the availability of non-traditional sources of care such as school-based or veteran's health care services.

It is further recommended that hospitals separately maintain a de-identified record of barriers to the seven-day follow-up requirement for the purpose to identifying local gaps in step-down care.

[83] ORS 441.196(2)(e); OAR 333-505-0055(4)(b)(E).
[84] 42 CFR 482.43(d).

Notifying the Lay Caregiver of Discharge

- *Requirement to notify the designated lay caregiver in advance of patient release or transfer.*

The final requirement for release planning of a patient being seen in an emergency department for a behavioral health crisis is to notify any designated lay caregiver of the patient's release from the hospital.[85] This notice should be provided enough in advance to allow the lay caregiver to be present if that is necessary. Notice to caregivers should never delay a patient's release.[86] Notice must be provided of any release from the facility, including transfer to another acute care setting.[87]

[85] ORS 441.198(2)(e).
[86] ORS 441.198(6)(a); OAR 333-505-0055(3)(e); 42 CFR 482.13(b)(5).
[87] ORS 441.198(2)(e).