

**ASSISTED OUTPATIENT TREATMENT PROGRAM**  
**Guidance for AOT Program Operation**  
**Reissued February 2014**  
**(Guidance previously located in: Assisted Outpatient Treatment Programs –**  
**Standards for Assisted Outpatient Treatment (AOT) – issued May 2004)**

**KEY AREAS OF QUALITY IMPROVEMENT**

**Clinical Risk Information:** Sound clinical decision-making requires accurate risk-specific information. It is widely recognized that past violent behavior is a significant predictor of future behavior. Comprehensive risk specific information promotes the development of treatment plans that are attentive to both the management of risk and the quality of clinical services.

**Coordination of Care:** The coordinated interrelationship of service providers is critical to the successful delivery of the array of services offered to AOT recipients. Integration of inpatient, outpatient, residential, Care Manager, ACT, and community support staff, centered around an individualized service plan, provides a stage for coordinating services critical to risk reduction, quality of care, and positive clinical outcomes for recipients.

**Missing Persons:** Analysis of the AOT data set related to persons designated as missing indicates a significant correlation to previous violent incidents and homelessness. AOT is a strategy to reduce risk and every effort must be made to locate individuals who are deemed missing while under the AOT court order. Missing person for AOT is defined as a person who has had no credible contact within the last 24 hours or cannot be located within a 24hr period.

**Residential Placements:** Access to suitable and acceptable residential placements is an essential component of an AOT service plan.

**PROGRAM STANDARDS**

1. All available information about an individual for whom a court order is being pursued, particularly information regarding the management of high risk behaviors, is shared with all parties involved in AOT-related decision making, treatment/service planning, and service provision, including information developed during AOT investigations and copies of referral packets for Care Manager or Assertive Community Treatment services, as appropriate.
2. Upon hospital discharge, a person under court order is accompanied to his or her place of residence by the assigned Care Manager /ACT team member/treatment provider or another designee of these programs. Agencies can be reminded of the federal and State policy that allows Medicaid billing for clients during the 90 days of hospitalization prior to discharge, to encourage participation in the discharge planning process. If possible, non-hospitalized persons who receive AOT court orders are similarly accompanied home from AOT court hearings. In situations where an escort from court is not feasible, a telephone contact is made by the Care Manager /ACT team or treatment provider within 24 hours after the court hearing, and a follow-up face-to-face contact is scheduled within the next few days.

3. If sufficient prior consultation among providers and the development of a relapse prevention plan have not already occurred, within two weeks of a final court order a meeting is convened with all identified providers to review their responsibilities under the court-ordered treatment plan and to develop a relapse prevention plan that addresses the recipient's identified risk factors.
4. A written procedure for immediate execution of a Removal Order/Pick-up order, including a specific protocol for missing person, is provided to all parties who may be involved in the process.
5. A system is in place for immediately notifying the County Director/designee, Care Manager /ACT, and other involved service providers when a person under court order has an unexplained absence in treatment programs or places of residence.
6. In an AOT patient cannot be located, and has had no credibly reported contact within **24 hours** of the time the Care Manager or ACT Team received either notice that the patient had an unexplained absence from a scheduled treatment appointment, or other credible evidence that an AOT client could not be located, the person will be deemed missing.
7. The County Mental Health Director or designee shall be aware of the residential setting proposed or in place for the subject of every AOT Petition within his/her county, whether or not housing is a proposed category of service. Such knowledge is for the purpose of promoting change in situations in which such residential setting is deemed to substantially compromise the patient's attempts to live safely in the community.
8. The County Mental Health Director or designee notifies the State Office of Mental Health Field Office AOT Program Manager of any publicly funded mental health provider refusing treatment or housing to a person under court order.

## REPORTING REQUIREMENTS

To help support OMH's statutorily mandated oversight and monitoring of the AOT program, the following updated reporting requirements are effective immediately.

1. Within 24 hours of learning that an AOT recipient is missing, (has had no credibly reported contact within **24 hours** of the time the Care Manager or ACT Team received either notice that the patient had an unexplained absence from a scheduled treatment appointment, or other credible evidence that an AOT client could not be located) the County Mental Health Director or designee must submit a Significant Event Report to the State Office of Mental Health Field Office AOT Program Manager.
2. The County Mental Health Director or designee must send a weekly update on the status of and efforts to locate each missing person under court order to the State Office of Mental Health Field Office AOT Program Manager.

## MODEL POLICIES/PROCEDURES

### For Standard #6

#### A. Discovery of Missing AOT Patient

1. Treatment providers providing any of the services which are part of an AOT patient's treatment plan should promptly notify the applicable Care Manager or ACT Team if an AOT patient has an unexplained absence from a scheduled appointment. Treatment providers should document the circumstances of the absence, and document their efforts to provide notice of the absence.
2. Care Managers and ACT teams shall document the date and time of receipt of any notice from treatment providers pursuant to the above procedure, or receipt of any other credible evidence that an AOT patient cannot be located and may be missing.

#### B. Investigation

1. The Care Manager or ACT team will contact any person or persons who may reasonably have knowledge of the AOT patient's whereabouts within 24 hours of initially receiving notice or credible evidence under A (2) above. Such persons may include, among others, family/significant others, legal guardian, co-residents/neighbors, employer and treatment providers. Efforts to contact persons who may have knowledge of the whereabouts of an AOT patient who may be missing should be documented, together with the results of those efforts.
2. The CM or ACT team will continue the investigation and contact the following if still not located, all within the next **24hrs** after the AOT patient's considered missing:
  - a. Local hospitals,
  - b. Morgues,
  - c. Shelters, and
  - d. Local jails

#### C. Notification to Police

1. Notwithstanding any other time periods established by this protocol, the police shall be notified as soon as there is credible evidence that the person may be dangerous to self or others, as provided for under applicable law and regulations.
2. If an AOT patient cannot be located, and has had no credibly reported contact within **24 hours** of the time the Care Manager or ACT team received either notice that the patient had an unexplained absence from a scheduled treatment appointment or other credible evidence that an AOT client could not be located, the person will be deemed missing.
3. Once the AOT patient is deemed missing, a Missing Person Report shall be filed with local police within 24 hours. In any event, a Missing Person Report shall be filed no later than **48 hours** after the initial notice of the AOT patient's unexplained absence, or receipt of any other credible evidence that an AOT patient may be missing.

4. The Director of Community Services (DCS) or his/her designee shall attempt to collaborate with local government officials, including appropriate law enforcement agencies, to develop a suitable mechanism for such filing of Missing Person Reports for AOT patients.

#### D. Significant Event Report

1. Once a person is determined to be missing, the Care Manager or ACT team must complete a Significant Event Report, consistent with standards developed by OMH, which is to be transmitted to:
  - a. The AOT Program, and
  - b. The DCS.

#### E. AOT Program's Role Following Receipt of the Significant Event Report

1. The AOT Program shall require that the missing AOT person's treatment providers assess the patient's status and the likelihood of imminent relapse or dangerous behavior.
2. Based upon this assessment, the AOT Program shall determine the appropriateness of an application for a Removal Order, consistent with the provisions of Mental Hygiene Law section 9.60(n).

#### F. Care Manager or ACT Team Follow-Up

1. The Care Manager or ACT team shall make daily calls to the residence of the missing AOT patient for the first three days after the patient is deemed missing, and weekly calls thereafter for the duration of the order, or until the missing AOT patient is located. Such contacts may occur more frequently, to the extent appropriate considering the circumstances of the particular case.
2. The Care Manager or ACT team shall make weekly calls to local hospitals, shelters, morgues, and jails in search of the missing patient for the following 2-month period, and thereafter, as appropriate, for the duration of the order.
3. Care Manager or ACT team must provide the AOT Program with weekly updates concerning efforts to locate the missing patient, and the results of such efforts.
4. The AOT Program shall provide weekly updates to the appropriate OMH Program Manager.

#### G. Procedure for Located Patients

1. If and when the patient is located, the Care Manager or ACT team shall promptly notify the AOT Program and the OMH Program Manager. The AOT program shall promptly notify the police department that the previously missing client has been located.

### **For Standard #7**

#### A. Appropriateness of Residential Setting for AOT Patients

1. If at any time during either the AOT Petition process, or the duration of an AOT order, the DCS or designee concludes that an AOT patient's residential setting is likely to substantially compromise the patient's attempts to live safely in the community, the DCS or designee shall:
  - a. Document the basis for his or her conclusion, and
  - b. Document any recommended alternative, more appropriate residential placement.
2. The DCS or designee shall attempt to arrange an alternative, more appropriate residential setting on a prioritized basis. Efforts to secure an alternative residential setting shall be documented, and such documentation shall include:
  - a. The availability of alternative residential settings,
  - b. The willingness of housing providers to accept the AOT patient, and
  - c. The willingness of the AOT patient to accept the suggested housing.
3. All efforts to secure an alternative more appropriate residential setting shall consider both the patient's preferences and the safety of the community.

## MEMORANDUM

**TO:** Directors of OMH – Licensed Hospitals  
Directors of State Psychiatric Centers  
AOT Program Directors  
AOT Program Coordinators

**RE:** Applicability of HIPAA to Kendra's Law Proceedings

**FROM:** John V. Tauriello

**DATE:** June 2, 2004

As you are probably aware, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 CFR Parts 160 and 164, is a federal statute that includes provisions which govern the development of uniform health information data standards and privacy standards. This federal statute "preempts" or takes precedence over, any contrary state law, unless the state law is more stringent than federal law, or a specific exception applies.

Questions have arisen as to whether the federal HIPAA privacy standards affect the exchange of information in the context of Kendra's Law (Assisted Outpatient Treatment or "AOT") petitions, and the treatment of such patients. As a result of our review, this Office has determined that HIPAA does not preempt current state law, and therefore AOT administrators and clinicians may continue to exchange clinical information to the extent necessary, subject to the same state and federal limitations in existence prior to the implementation of the HIPAA regulations in April 2003.

The attached document describes the specific HIPAA regulatory provisions which provide authority to exchange clinical information under various scenarios. We have also provided a summary of these provisions for ease of reference. Please refer to the actual regulations for the complete text.

Please feel free to contact The Office of Mental Health Counsel's Office if you have any additional questions pertaining to the applicability of HIPAA to Kendra's Law proceedings, at (518) 474-1331.

Attachment

cc: Robert Myers  
Robyn Katz  
Susan Shilling  
Jeannie Straussman  
Joseph Reilly  
Bill Schmelter  
Thomas Wallace  
Joseph Lazar

**Disclosure of Clinical Information as Part of Assisted Outpatient Treatment Programs**

The following are examples of appropriate sharing of clinical information, as part of AOT procedures or programming:

- *Disclosure of information required to develop an AOT petition.* Where disclosures are necessary in order to provide a court with an adequate factual basis to *decide* a petition, such disclosures without patient consent or authorization are permitted by HIPAA under the “required by law” (§164.5m), and “in the course of a judicial proceeding” (§164.512(e)) regulatory exceptions.
- *Disclosures by physicians* in the course of providing required testimony in AOT proceedings are authorized by the “in the course of a judicial proceeding” exception to the consent/authorization requirement.
- *Disclosures to a court, or between and among providers, regarding court ordered services are permitted without patient consent/authorization under the “required by law,” and “use/disclosure of information required by law” exceptions to HIPAA. In addition, patient consent is not required when the disclosure is for treatment, payment or healthcare operation purposes, to the extent already permitted by law.*
- *Disclosures by health or mental health professionals pursuant to Kendra’s Law may be Authorized as part of an effort to lessen or prevent a serious threat to health or safety (§164.512(j)).*
- *Disclosures which are necessary in order for county (or New York City) officials and AOT administrators to fulfill their reporting obligations are also appropriate under HIPAA. The sharing of information between the Commissioner of the State of Mental Health, directors of AOT programs, and other program officials are permitted, to the extent they are necessary for the Commissioner or his designee to fulfill the Agency’s “health oversight” function (see §164.501 and §164.512(d)(3)).*

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Below is a summary of provisions found in HIPAA regulations, which permit the disclosures described above:

**§164.501: Health oversight agency** means an agency or authority of the United States, a State, a territory, a political subdivision of a State or territory...or a person or entity operating under a grant of authority from or contract with such public agency...that is authorized by law to oversee the health care system (whether public or private) or government programs in which health information is necessary to determine eligibility or compliance, or to enforce civil rights laws for which health information is relevant.

**§164.512(3)** PHI may be disclosed to health oversight agencies for oversight activities authorized by law, including licensure or disciplinary actions.

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**§164.501: Required by law:** a mandate contained in law that compels a covered entity to make a use/disclosure of PHI and that is enforceable in a court of law...it includes, but is not limited to, court orders and court ordered warrants, subpoenas or summons issued by a court, grand jury,...inspector general, or an administrative body authorized to require the production of information; a civil or an authorized investigative demand; Medicare conditions of participation...; and statutes or regulations that require the production of information, including statutes/regulations that require such information if payment is sought under a government program providing public benefits.

**§164.512(a):** A covered entity may use/disclose PHI to the extent that such use/disclosure is required by law and the use/disclosure complies with and is limited to the relevant requirements of such law.

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**§164.512(j) Health and Safety:** A covered entity may use/disclose PHI (consistent with law & professional conduct) if it believes in good faith that the disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person (per preamble to the HIPAA regulations, consistent with the Tarasoff case) or the public and is being made to a person or persons reasonably able to prevent or lessen the threat, or is necessary for law enforcement authorities to identify/apprehend an individual. If disclosure is to be made to one other than the target, the information cannot have been obtained in the course of treatment to affect the propensity to commit the criminal conduct or through a request by the individual to initiate or to be referred for treatment, counseling or therapy to address such propensity.

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**§164.512(e): Course of Judicial Proceeding:** PHI can be released without patient consent in the course of any judicial or administrative proceeding in response to an order of a court or administrative tribunal, provided release is limited to that PHI expressly responsive to a subpoena, discovery request, or other lawful process if the covered entity has made reasonable efforts to give the patient notice of the request or the covered entity is assured that reasonable efforts have been made to secure a qualified protective order.