



**DEPARTMENT of CHILDREN and FAMILIES**  
*Making a Difference for Children, Families and Communities*



Susan I. Hamilton, M.S.W., J.D.  
Commissioner

M. Jodi Rell  
Governor

December 4, 2008

**CCPA**  
DEC 08 2008  
**RECEIVED**

Connecticut Community Providers Association  
C/o Terry Edelstein  
35 Cold Springs Rd, Suite 522  
Rocky Hill, CT 06067

**Re: KidCare Data Submission Requirements**

Dear Ms. Edelstein,

As I am sure that you are aware, the Department of Children and Families (hereinafter "the Department" or "DCF") is statutorily charged with administering the Connecticut Community KidCare Program (KidCare). DCF has a statutory duty to provide reports to the General Assembly concerning the implementation of KidCare. As a provider of behavioral health or substance abuse prevention and treatment services funded, in part, by DCF, you are required by Connecticut General Statutes § 17a-22g(a) to provide case specific information to DCF for purposes directly connected with administering KidCare. The data must be provided in the manner specified by DCF.

This letter is to notify you that, in accordance with the KidCare mandate, the client specific data that you send to us must include client identification (i.e., name) regardless of whether an authorization has been signed by the client. We are requiring this information because of the data inaccuracies and limitations that have resulted from the current practice of allowing providers to blind client data. This directive will be effective with the implementation of the new Programs and Services Data Collection and Reporting System which is expected to go online 7/1/2009.

As discussed at the September 12, 2008 kickoff meeting at the Legislative Office Building, submitting client names and demographics will vastly increase data quality by allowing us to create a Client Registry. Be advised that this will be a provider-specific Client Registry. We will not share data between providers. This means that if Jane Doe is registered with Provider A and then presents for services from Provider B, Jane Doe will be separately registered by both providers. While this creates some duplication across the service system, it is necessary to ensure client confidentiality.

**Legal Provisions**

Connecticut General Statutes § 17a-22g (a) provides:

[t]he judicial branch and each state agency, community based program, organization or individual that provides behavioral health or substance abuse prevention and treatment

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programs that are operated, funded or licensed by the Department of Children and Families pursuant to sections 17a-20, 17a-114, 17a-145, 17a-147, 17a-149, 17a-151, 17a-152 and 17a-154 **shall provide case specific information to the department for purposes directly connected with the administration of Connecticut Community KidCare in such form and manner as the department requests.** The provisions of this section shall be subject to the confidentiality requirements as set forth in applicable federal law.

(Emphasis added). Consistent with this language, DCF does not require providers to share any patient records that are protected by “applicable federal law.” 42 U.S.C. § 290dd-3, 42 U.S.C. § 290ee-3 or the Health Insurance Portability and Accountability Act of 1996 (Pub. L. 104-191).

At the time § 17a-22g (a) was passed, some KidCare providers expressed the concern that state confidentiality provisions outlined in Connecticut General Statutes §§ 52-146c through 52-156o (mental health provider-patient privilege) might prohibit providers from sharing case specific information with DCF without a signed authorization by the client notwithstanding the unambiguous duty to provide case specific information to the Department pursuant to § 7a-22g (a).

Although the Department is sensitive to the importance of not doing harm to the psychologist-patient relationship, as a matter of statutory construction, this concern is unfounded. In general, state law mandates that mental health records are privileged.<sup>1</sup> However, it is a well-established legal principle that a specific statute trumps general statutory provisions. *See State v. Lutters*, 270 Conn. 198, 215 (2004) (“specific statutory provisions are presumed to prevail over more general statutory provisions dealing with the same overall subject matter.”) Section 17a-22g, as the only state law that governs disclosure for purposes of the KidCare program, must control over more general legislation making mental health communications confidential.

Likewise, it is well established that subsequent legislation controls over prior legislation. *See Keogh v. Bridgeport*, 187 Conn. 53 (1982) (“[L]ater enactments are presumed to repeal [or be inapplicable to] earlier inconsistent ones to the extent of the conflict, regardless of the specific or general character of the later enactment.”). In enacting the KidCare legislation, the legislature “is always presumed to know all the existing statutes and the effect that its action or non-action will have upon any one of them.” *Hatt v. Burlington Coat Factory*, 263 Conn. 279, 310 (2003). In accordance with these well-established principles, the later enactment must be deemed to control. If the legislature had intended to limit the provider’s duty to provide information under the KidCare program, it would have reflected that intent in § 17a-22g. The only limitations provided by that statute are the confidentiality provisions as set forth in applicable federal law.

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<sup>1</sup> Communications between a psychologist and a patient are only privileged “...in civil and criminal actions, in juvenile, probate, commitment and arbitration proceedings, in proceedings preliminary to such actions or proceedings, and in legislative and administrative proceedings...” Conn. Gen. Stat. § 52-146c(b). This same limitation applies to communications between a victim and a battered woman’s counselor or sexual assault counselor and between a patient and a physician, surgeon or health care provider. *See* Conn. Gen. Stat. §§ 52-146k and 52-146o. Most, if not all, of the information the Department is collecting does not fall with the meaning of the term “communications” as it is defined in the applicable state confidentiality statutes. *See* Conn. Gen. Stat. §§ 52-146c, 52-146d, 52-146k, 52-146o, 52-146p, 52-146q and 52-146s.

### **Inaccuracies resulting from blinded data**

Notwithstanding its strongly and continuously held position that the limited protection of the psychologist-client privilege did not pose any barrier to KidCare reporting, in the spirit of compromise, the Department previously entered into an interim agreement with providers during the implementation of this legislation. That interim agreement required providers to share case specific information with the Department through Advanced Behavioral Health (ABH) only in those cases where the individual clients authorized such disclosure. If the clients were unwilling to authorize the disclosure of identifying information to the Department, DCF agreed to allow ABH to "scrub" the data and provide it to the Department in a de-identified format. It was DCF's hope that this interim approach would allow the Department to comply with its statutory responsibility for administering and evaluating KidCare and providing the required reports to the General Assembly.

Unfortunately, this interim approach did not prove effective. As a result of the blinding of individual client records, the quality of DCF's reporting on KidCare programs was severely compromised. We were unable to provide a reliable accounting of the number of persons enrolled in these programs due to ambiguity associated with our methods of distinguishing persons in the absence of clear identification. As an example, the Care Coordination report for the period of January – March 2008 reported that 1,064 clients were "in care" at the start of the period and that the median length of stay for those "in care" at the end of the period was some 30 months. Since Care Coordination was designed to last 6 months on average, this statistic suggests either that this design is inappropriate, or, more plausibly, that the data are inaccurately recorded. We suspect the latter and hypothesize that the practice of blinding the data is at the root of this problem.

This hypothesis was confirmed in 2007 during a collaborative effort with providers to conduct Behavioral Health Data System (BHDS) data quality reviews on the Extended Day Treatment program data. We found that the practice of blinding data hampered the providers' own ability to track and report clients in the BHDS system. Providers reported that they could not determine which clients had been discharged because the data had been blinded with respect to name.

The inability of providers to track clients also led to the problem of duplicate submission of client records. This problem has been especially prevalent among the Outpatient Psychiatric Clinics for Children (OPCC) records that were universally blinded to DCF by ABH. As a result, the Department has been hampered in its ability to fulfill its statutory duty to report to the legislature on the KidCare Program.

### **Notification of changes**

This letter shall serve as notice to all KidCare providers that the identifiable case specific data requested by the Department for the Programs and Services Data Collection and Reporting System (PSDCRS) must be provided to the Department in accordance with Connecticut General Statutes § 17a-22g(a) regardless of whether an authorization has been signed by the client. As noted, we will implement this requirement with the inauguration of the PSDCRS system rather than applying it at this time to the remaining amount of time we will use BHDS.

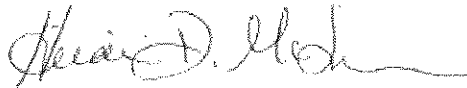
This letter shall also serve as notice that failure to provide this information in the form and manner requested by the Department may result in formal contract and/or licensing action by the

Department. We understand that providers must institute a process to inform clients that client identified data will be provided to DCF. Therefore, we will begin to enforce this policy clarification as of 7/1/2009 with the implementation of PSDCRS.

The Department appreciates the importance of adhering to all applicable confidentiality laws. DCF, too, has a vested interest in ensuring that the data collection process necessary to administer Connecticut Community KidCare does not impede the delivery of behavioral health services to children and families. Further, DCF does not intend to share information from one provider with other providers; nor will the information be shared with other divisions of DCF not directly involved with the KidCare initiative. Therefore, as always, the Department will treat all case specific information it receives from providers in a confidential manner in accordance with Connecticut General Statutes § 17a-22g(b) and applicable federal law

Thank you, in advance, for your cooperation. If you have questions or would like to discuss this in more detail, please feel free to contact Dr. Lou Ando, Bureau Chief, Continuous Quality Improvement at (860) 550-6550.

Very truly yours,

A handwritten signature in cursive script, appearing to read "Heidi D. McIntosh".

Heidi D. McIntosh, MSW  
Deputy Commissioner