Legislative Update for Behavioral Health Providers

CalQIC 2019
Seaside, California

Date: Friday, March 15, 2019
Time: 9:30 a.m. – 12:00 noon
Location: Embassy Suites
1441 Canyon Del Rey, Seaside, CA

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Legislative Update.

➢ End of Life Option; Advance Directives
➢ Healthcare Professions – Licensing, Training, etc.
➢ Drug Prescribing
➢ Hospitals and Healthcare Entities
➢ Health Insurance; Medi-Cal
➢ Minor Consent; Minor Rights
➢ Mental Health
➢ Confidentiality – 42 CFR Part 2
End of Life Option Act – Litigation to Block It

- Law went into effect June 9, 2016
- A group of plaintiffs challenged the law
  - The plaintiffs argued that the CA legislature did not properly pass the law according to legislative rules for special session
End of Life Option Act, continued

- A Superior Court judge ruled in favor of the plaintiffs on May 24, 2018
- The judge’s ruling invalidated the Act for a short time
- The Court of Appeal reversed the Superior Court judge
For now, the End of Life Option Act is fully effective.
However, plaintiffs may continue to challenge it.
Be on the lookout for continued litigation.
AB 282 – End of Life Option Act (clarification) (eff. 1/1/19)

➢ Adds clarification to the End of Life Option Act
➢ The State cannot use Penal Code 401 to prosecute those who comply with the End of Life Option Act
  • (Penal Code 401 makes it a felony to aid, advise, or encourage suicide)
AB 3211 – AD’s and Organ Donation

➢ Probate Code §4701 created a standardized form for advance health care directives
➢ This law modifies some of the form’s language to make it more user-friendly
➢ Specifically, it modifies some language concerning organ and tissue donation
AB 2281 – Lab Techs - Scope of Practice

- Expands the scope of practice for medical lab techs
- Such techs may now perform microscopic urinalysis, most blood smear reviews, and automated ABO/Rh testing, et al.
- This expanded scope of practice aligns CA law with federal law
AB 2850 – CNA Teaching Programs

➢ This law makes certified nursing assistant programs more accessible
➢ Students can now complete their 60-hour precertification training online
Any licensed vocational nurse or registered nurse with at least two years’ experience* may provide the precertification training instruction (but only in “live” settings).

*Instructors’ experience must include at least one year’s experience with chronically ill or elderly patients.
SB 1280 – Small House Skilled Nursing Facilities Pilot Program

➢ Extends program that recognizes skilled-nursing care in home-like non-institutional settings for six more years to 1/1/26 (had been due to sunset 1/1/20)
SB 1003 – Respiratory Therapists

➢ Bolsters the power of the Respiratory Care Board of California
➢ Under this law, the Respiratory Care Board of California is the only state agency that can define or interpret the practice of respiratory care
Likewise, the Board is the only state agency that can identify those respiratory tasks, services, and procedures that require formal education and training.
SB 849 – Medi-Cal Physicians/Dentists Loan Program

➢ Health budget trailer bill that has legal changes needed to implement the budget and establishes the Prop 56 Medi-Cal Physicians and Dentists Loan Repayment Act to be developed and administered by DHCS.

➢ Provides loan assistance payments to qualifying, recently graduated physicians and dentists who serve beneficiaries of certain Medi-Cal health care programs.
AB 2138 – Professionals/Businesses - Revocation/Suspension of License – effective 7/1/20

- Limits licensing board’s ability to automatically deny applicant with previous criminal convictions more than 7 years old, with some exceptions
- Can still deny if crime was substantially related to qualifications, functions or duties of the profession, or was a serious felony or financial crime related to abuse of fiduciary duties
AB 2487 – Physicians’ opioid training

Currently physicians must take a CE on pain management and treating terminally ill and dying patients; this provides as an alternative that a physician take a one-time course on opiate-dependent patient treatment and management (MAT)
AB 2086 – CURES – Controlled Substance Utilization Review and Evaluation System

➢ Allows prescribers to get list of patients for whom they are listed as being the prescriber in the CURES system
AB 2760 – Opioid Prescribing

➢ Requires prescriber to offer a prescription for naloxone hydrochloride or similar drug to patient and/or family on overdose prevention and response when:
  • dosage for patient is 90 or more morphine milligram equivalents (mme)/day OR
  • opioid is prescribed concurrently with prescription for benzodiazepine OR
  • patient presents w/ increased risk for overdose or when risk of overdose due to high dose to which patient is no longer tolerant
AB 2789 – Electronic Prescribing

➢ Requires all prescribers and all pharmacies to have capability to transmit and receive electronic prescriptions on or after 1/1/22
➢ All prescriptions must be transmitted electronically after that date, with some exceptions
AB 2863 – Prescription Drug Costs

➢ Pharmacy must inform customer when price of medicine is lower than their co-pay, unless pharmacy automatically charges the lower price (e.g., drug is $19.50 and co-pay is $20)

➢ Insurance company cannot charge co-pay higher than actual retail cost of drug
SB 1448 – Physicians’ disclosure of probationary status to patients

➢ July 1, 2019 - Requires MDs, ODs, podiatrists, acupuncturists, chiropractors and naturopathic doctors to notify patients in writing of their probationary status

➢ Excludes: unconscious patients, ED and urgent care center patients, and unscheduled visits including consultations in inpatient facilities
Local EMS agencies must submit quarterly data to the Emergency Medical Services Agency regarding ambulance patient offload times.

The Emergency Medical Services Agency must then make semi-annual reports to the Commission on Emergency Medical Services re: ambulance patient offload times.
The Emergency Medical Services Agency, in collaboration with local EMS agencies, must submit a report to the State by December 1, 2020 with recommendations on how to reduce ambulance patient offload times.
AB 2679 – Hospital Laundries (IC)

➢ By January 1, 2020, hospitals must adopt and implement laundry policies that satisfy the most recent infection control standards

➢ The state will rely on the standards set out by the Center for Disease Control and Prevention, and the Centers for Medicare and Medicaid Services
SB 1254 – Hospital pharmacy must develop medication profiles
➢ Hospitals with more than 100 beds must obtain accurate medication profile on high-risk patients on admission
➢ If certain conditions are met, pharm. tech. or intern pharmacists may perform this task
➢ Hospital must determine who is high-risk and timeframe for completion of profile
SB 1138 – Vegan Options for Patients

➢ Requires hospitals, acute psych, skilled nursing, intermediate care special hospitals and nursing facilities (PHFs not specified) to make available wholesome, plant-based meals for patients in accordance with their physician’s orders (no animal products or byproducts including meat, poultry, fish, dairy or eggs)
SB 1152 – Hospital Discharge Planning for Homeless Patients

- Hospitals must include homeless patient discharge planning in their policies and offer
  - clothing to patients whose own clothes are weather inappropriate,
  - a meal
  - medications
  - referral for infectious disease screening
  - appropriate vaccinations
  - transportation if destination w/in 30 minutes/30 miles
SB 1152, Discharge Planning, Homeless Patients, continued

- hospital must keep log of homeless patients discharged

- bill does not preempt local ordinances (e.g., LA County) that might require more

- PHFs not specified, but these procedures may be considered “standard of care”
AB 2861 – Drug Medi-Cal providers & telehealth

➢ Requires reimbursement to certified drug Medi-Cal provider when services provided through **telehealth**, when medically necessary and in accordance with state plan, to extent federal financial participation is available

➢ Requires DHCS to adopt regs by 7/1/22 to implement this bill (3-1/2 years. notice!!)
SB 1287 – Definition of “Medically Necessary” Services

- Aligns state law with federal Medicaid standard that requires coverage for services that correct or ameliorate defects or physical and mental illnesses.
- DHCS and its contractors must update coverage documents, handbooks and related materials, also by 7/1/22.
SB 910 – Protections from Health Insurer Abuse (short-term policies)

➢ Prohibits health insurers from issuing, amending, selling, renewing, or offering a “short-term limited duration” policy
• “Short-term limited duration” policies last fewer than 12 months
Short-term limited duration policies can discriminate against pre-existing conditions, and they do not have to provide coverage for essential health benefits.

This law all but eliminates them from the marketplace.
AB 3189 - Minor Consent

➢ Family Code 6930 (added) – minors 12 and older who state that they are injured as a result of intimate partner violence may consent to medical care related to the dx or tx of the injury and the collection of medical evidence with regard to the alleged intimate partner violence.

➢ “intimate partner violence” means
  • intentional or reckless infliction of bodily harm,
  • perpetrated by a person with whom the minor has or has had a sexual, dating, or spousal relationship.
AB 3189, Minor Consent, continued

➢ Family Code §6930 does not apply (is not needed) when the minor is an alleged victim of rape or sexual assault because minor consent is already established by existing law:

• Family Code §6927 (rape)
• Family Code §6928 (sexual assault)

➢ Note: All three are reportable as child abuse
AB 3189, Minor Consent law, puzzling language...

Family Code 6930 notes that if the provider believes that *a report is required under Penal Code 11160 (gunshot wounds, assaultive or abusive conduct reporting), then

• 1) minor must be told that report will be made and

• 2) there must be an attempt to tell the parent or guardian **unless the parent or guardian committed the intimate partner violence**
*A PC 11160 report would only be made if the event/injury does not trigger a child abuse report, so ... ?? could this be envisioning an accidental gunshot wound unintentionally but “recklessly” caused by an intimate partner?

**And if the parent or guardian is the perpetrator under this law, isn’t that itself reportable as child abuse because they meet the definition of an intimate partner ?? (intimate partner = someone with a sexual, dating or spousal relationship with minor)
Short detour – current status of mandated reporting of certain sex crimes

➢ All healthcare providers are “mandated reporters” including all mental health and substance use disorder counselors

➢ Two triggers for a report:
  • Knowledge of the abuse or neglect
  • Reasonable suspicion (you do not need proof or evidence, just a reasonable belief it happened)
What must be reported?

• Sexual abuse including assault, rape, incest or exploitation

  ▪ Exploitation – 1/1/15 (AB 1775) – includes a person who depicts a child in, or who knowingly develops, duplicates, prints, downloads, streams, accesses through any electronic or digital media, or exchanges, a film, photograph, videotape, video recording, negative, or slide in which a child is engaged in an act of obscene sexual conduct ...
What must be reported? continued

- Exploitation – 1/1/15 (AB 1775) – includes a person who Does NOT exempt “sexting” between teens
  - regardless whether it is consensual
  - or harmful
What must be reported? continued

- Exploitation – 1/1/15 (AB 1775) – makes “sexting” between teens a reportable event (child pornography)
  - the only exception is unknowingly/accidentally opening a text message with images
Also, we still don’t have clarity on “crimes against nature”

- Reportable sexual abuse includes sexual assault or sexual exploitation defined by the following:
  - ...rape, incest, and certain “crimes against nature” such as Penal Code 288a (oral sex) and Penal Code 286 (sodomy) – AB 1505 (Garcia, 2014) voted down by Assembly in May 2015 and then withdrawn
  - 2013 Dept. of Consumer Affairs Senior Attorney opinion – interpret these activities, when consensual, like intercourse and apply age rules before reporting – NOT the law though

- Certain consensual sexual activity (even though it may be illegal) is only reportable when certain age discrepancies exist (otherwise NO report of consensual behavior):
  - Victim is under 16, partner is 21 or older (intercourse)
  - Victim is 14 or 15, partner is 10+ years older (lewd & lascivious behavior)
  - Victim is under 14, partner is 14 or older, or of “disparate age”
Child abuse reporting – continued

➢ AB 1505 – Introduced in 2014 (Garcia) – attempt to clarify this; also noting discriminatory aspects (LGBTQ) of law as currently written; voted down by Assembly in May 2015, bill withdrawn after that.

➢ Reports still required.
One final note

➢ Attorney-client privilege trumps child abuse reporting mandate if you are hired as an expert in a legal matter

• Elijah v. LA Superior Court (May 8, 2013), California Court of Appeal, 2nd District (Los Angeles) therapist was hired by defense counsel in a criminal case (arson) to evaluate a child for competence to stand trial

• Court held: the attorney-client privilege trumps child abuse reporting by the therapist; necessary in order to preserve the constitutional right to fair trial and due process
AB 3189, Minor Consent, summary

➢ Allows minor to consent to treatment that minor might not have been able to consent to before (treatment for injuries caused by alleged intimate partner violence)

➢ Consent rights do not affect duty to report child abuse (apples and oranges)
Permits minor to provide written addendum of up to 250 words to his or her record if patient believes the records are incomplete or incorrect (adult patients already have this right); HIPAA also gives patients the right to “correct” the record (no limit on words)

This applies to minors who have the right to consent to their care (emancipated, self-sufficient, sensitive services) who would have the right to access their own record under H&S 123110
AB 2193 – Maternal Mental Health

➢ Requires that by 7/1/19, licensed health care providers who provide prenatal or postpartum care to screen or offer to screen a mother for maternal mental health conditions

➢ Requires health care service plans by 7/1/19 to develop, consistent with sound clinical principles and practices, a maternal mental health program
AB 3032 – Education on Maternal Mental Health.

➢ Requires hospitals with perinatal units to develop and implement by 1/1/20 a program to provide education and information to appropriate healthcare professionals and patients about maternal mental health conditions.
AB 1968 – Mental Health

- Eff. 1/1/20 – Gun prohibition for person admitted on more than one 72-hour hold in a year, extended to lifetime prohibition
- DOJ must update form and facilities must give updated form to patients on discharge telling them about their right to petition court
Copy of the written application stating circumstances under which person is placed on involuntary 72 hour hold MUST be honored as the original.
AB 2983 – Prohibits requiring voluntary patient to be put on a hold

➢ General acute care hospital or acute psychiatric hospital cannot insist, as a condition of admission, that a patient voluntarily seeking mental health care be first place on a 5150 involuntary hold
  • Once again, the legislature seems to have “forgotten” about PHFs...
SB 1045 – Pilot – Conservatorships

Establishes procedure for LA, SF and San Diego counties to create new type of conservatorship for individuals who have had 8 or more 5150’s within a 12 month period.

Could be initiated by County sheriff or County Mental Health Dept.

Requires less restrictive means, and only applies if person does not meet LPS-Conservatorship criteria.
Privacy and Confidentiality

➢ New State Laws

➢ Review of 42 CFR Part 2 changes

➢ General Review – Everyday Breaches
AB 375 – California Consumer Privacy Act (CCPA) – eff. 1/1/20

➢ Consumers have right to know what info the business holds and to restrict it from selling or sharing their information
➢ Business must delete their info if requested by a customer
➢ Non-profits are exempt from the definition of “business” and information covered by CMIA and HIPAA is also exempt
➢ Clean up legislation -- SB 1121 -- clarified this and included clinical research as well as info held by a Business Associate
SB 244 – Personal Information

➢ Prohibits local public agencies, including counties and districts, from using information or documents obtained for the purpose of issuing local identification cards

➢ Authorizes city, county, or hospital district to collect info from undocumented immigrants to assess eligibility and to administer public health services
SB 244, Personal Information, continued

- Prohibits the information from being disclosed except as required to administer services
- Clarification letter from Sen. Lara (sponsor of bill) spelling out legislative intent that SB 244 not be interpreted to prevent collection of information to assess or treat a patient and should be interpreted to permit disclosures specifically authorized by state and federal privacy laws.
42 CFR Part 2 – Substance Use Disorder Confidentiality Regulations

42 CFR Part 2 – Final rule
(effective March 21, 2017)

- New definitions
- New rules re: emergency exception
- New security requirements
- New authorization form requirements
Lessons learned in last 2 years

➢ People still don’t know if they are a Part 2 program or not!
  • Look at 42 CFR 2.11 and 2.12
➢ There is no such thing as a “universal release” that will work in MDT settings
  • Unless everyone is willing to name non-treating provider recipients by name it can’t work
  • Unless every disclosure shares the same purpose it doesn’t work
➢ Using different forms for different destinations may be the easiest way after all
  • See LAC.org (click on Resources > Substance Use > Confidentiality > Sample Forms > Specific Form)
Major changes of note

➢ Intended to modernize 42 CFR Part 2 by facilitating the electronic exchange of SUD information for treatment and other legitimate healthcare purposes while ensuring appropriate confidentiality protections

• Definitions (2.11) Simplified and Clarified
  ▪ Revised definitions include: patient, patient identifying information, program, qualified service organization (QSO), records, and treatment.
  ▪ Added definitions for: Part 2 program, substance use disorder, treating provider relationship, and withdrawal management
42 Part 2 – Emergency Exception

• medical emergency exception revised:

- disclosure is permitted in an emergency only if person is not able to provide prior informed consent
<table>
<thead>
<tr>
<th>Old</th>
<th>New</th>
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<tr>
<td>§ 2.51 – Medical Emergencies. “...may be disclosed to medical personnel who have a need for information about the patient for the purpose of treating a condition which poses an immediate threat to the health of any individual and which requires immediate medical intervention...”</td>
<td>§ 2.51 Medical emergencies. “...may be disclosed to medical personnel to the extent necessary to meet a bona fide medical emergency in which the patient's prior informed consent cannot be obtained....”</td>
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</table>
• **Security (2.16)** – Part 2 Programs and other lawful holders of Part 2 information must have formal policies and procedures addressing security, including sanitization of associated media for both paper and electronic records
## Old vs. New Regulation: Security

<table>
<thead>
<tr>
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<th>New</th>
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<tr>
<td><strong>2.16 Security for written records.</strong></td>
<td><strong>2.16 Security for records</strong></td>
</tr>
<tr>
<td>(a) Written records which are subject to these regulations must be maintained in a secure room, locked file cabinet, safe or other similar container when not in use; and</td>
<td>(a) The part 2 program or other lawful holder of patient identifying information must have in place formal policies and procedures to reasonably protect against unauthorized uses and disclosures of patient identifying information and to protect against reasonably anticipated threats or hazards to the security of patient identifying information. These formal policies and procedures must address: (1) Paper records, including: (i) Transferring and removing such records; and (ii) Destroying such records, including sanitizing the hard copy media associated with the paper printouts, to render the patient identifying information non-retrievable; and (iii) Maintaining such records in a secure room, locked file cabinet, safe, or other similar container, or storage facility when not in use; and (iv) Using and accessing workstations, secure rooms, locked file cabinets, safes, or other similar containers, and storage facilities that use or store such information; and (v) Rendering patient identifying information non-identifiable in a manner that creates a very low risk of re-identification (e.g., removing direct identifiers). (2) Electronic records, including: (i) Copying, downloading, forwarding, transferring, and removing such records; and (ii) Destroying such records, including sanitizing the electronic media on which it was stored, to render the patient identifying information non-retrievable; and (iii) Maintaining such records; and (iv) Using and accessing electronic records or other electronic media containing patient identifying information; and (v) Rendering the patient identifying information non-identifiable in a manner that creates a very low risk of re-identification (e.g., removing direct identifiers). (b) [Reserved]</td>
</tr>
<tr>
<td>(b) Each program shall adopt in writing procedures which regulate and control access to and use of written records which are subject to these regulations.</td>
<td>(b) [Reserved]</td>
</tr>
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</table>
Notice to Patients.

• Notice to Patients of Federal Confidentiality Requirements (in addition to HIPAA Notice of Privacy Practices)

• re: 42 CFR Part 2 provisions (2.22) may be provided electronically; must include info on where to report violations to government agencies
§ 2.22 Notice to patients of federal confidentiality requirements.

(a) **Notice required.** At the time of admission to a part 2 program or, in the case that a patient does not have capacity upon admission to understand his or her medical status, as soon thereafter as the patient attains such capacity, each part 2 program shall:

(1) Communicate to the patient that federal law and regulations protect the confidentiality of substance use disorder patient records; and

(2) Give to the patient a summary in writing of the federal law and regulations.
b) **Required elements of written summary.** The written summary of the federal law and regulations must include:

(1) A general description of the limited circumstances under which a part 2 program may acknowledge that an individual is present or disclose outside the part 2 program information identifying a patient as having or having had a substance use disorder.

(2) A statement that violation of the federal law and regulations by a part 2 program is a crime and that suspected violations may be reported to appropriate authorities consistent with section 2.4, along with contact information;

(3) A statement that information related to a patient's commission of a crime on the premises of the part 2 program or against personnel of the part 2 program is not protected;

(4) A statement that reports of suspected child abuse and neglect made under state law to appropriate state or local authorities are not protected; and

(5) A citation to the federal law and regulations.
Notice - continued

➢ (c) Program options. The Part 2 program must devise a notice to comply with the requirement to provide the patient with a summary in writing of the federal law and regulations. In this written summary, the Part 2 program also may include information concerning state law and any of the Part 2 program's policies that are not inconsistent with state and federal law on the subject of confidentiality of substance use disorder patient records.
Consent Requirements (2.31)

• Substance use disorder records must be specifically described

• Recipients who are third party payers, non-treating entities, and non-treating individuals must be named by name (not by job or role) – this means that sharing with Social Services Agency (CPS) is going to require a form that NAMES the social worker (case worker) BY NAME

• A named non-treating entity may receive records and redisclose them to participants in that non-treating entity but the release must also include either a named individual, a named entity with a treating provider relationship, or a general designation of individuals/entities with a treating provider relationship

• Always limit disclosures to what is on form, and the PURPOSE!

• Sample form, including a User-Friendly sample form is available
Old vs. New Regulation: Consent form

Old

§ 2.31 Form of written consent.

(a) Required elements. A written consent to a disclosure under these regulations must include:

1. The specific name or general designation of the program or person permitted to make the disclosure.

2. The name or title of the individual or the name of the organization to which disclosure is to be made.

3. The name of the patient....

New

§ 2.31 Consent requirements.

(a) Required elements for written consent. A written consent to a disclosure under these regulations may be paper or electronic and must include:

1. The name of the patient....

4. (i) The name(s) of the individual(s) to whom a disclosure is to be made; or

(ii) If the entity has a treating provider relationship with the patient whose information is being disclosed, such as a hospital, a health care clinic, or a private practice, the name of that entity; or

(iii) (A) If the entity does not have a treating provider relationship with the patient whose information is being disclosed and is a third-party payer that requires patient identifying information for the purpose of reimbursement for services rendered to the patient by the part 2 program, the name of the entity; or

(B) If the entity does not have a treating provider relationship with the patient whose information is being disclosed, and is not covered by (A) (a third-party payer), such as an entity that facilitates the exchange of health information or a research institution, the name(s) of the entity(ies); and

1. The name(s) of an individual participant(s); or

2. The name(s) of an entity participant(s) that has a treating provider relationship with the patient whose information is being disclosed; or

3. A general designation of an individual or entity participant(s) or class of participants that must be limited to a participant(s) who has a treating provider relationship with the patient whose information is being disclosed.

(1) When using a general designation, a statement must be included on the consent form that the patient (or other individual authorized to sign in lieu of the patient), confirms their understanding that, upon their request and consistent with this part, they must be provided a list of entities to which their information has been disclosed pursuant to the general designation (see § 2.13(d)).
<table>
<thead>
<tr>
<th>RECIPIENT TYPE</th>
<th>REQUIRED INFO ABOUT THE RECIPIENT</th>
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<tbody>
<tr>
<td>Individual</td>
<td>Individual’s name</td>
</tr>
<tr>
<td>Treating provider entity</td>
<td>Name of the treating provider entity</td>
</tr>
<tr>
<td>Third-party payer</td>
<td>Name of the third-party payer</td>
</tr>
<tr>
<td>Non-treating provider entity (other than third-party payers)</td>
<td>Name of the non-treating provider entity, PLUS:</td>
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<tr>
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<td>• Name of individual(s); or</td>
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<td>• Name of entity(ies) with a treating provider relationship; or</td>
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<td></td>
<td>• General designation(s) identifying: (a) individual(s) with a treating provider relationship,</td>
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<td></td>
<td>and/or (b) entity(ies) with a treating provider relationship</td>
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</tbody>
</table>
Patient “self-disclosure” – alternative way of communicating to third parties?

➢ We know the following is NOT ok after March 21 2017:
  ▪ “my probation officer”
  ▪ “my CPS Case Worker”
  ▪ “my child’s IEP team” or
  ▪ “my public defender”
  ▪ “the Tragic County Sheriffs’ Department liaison to the Back on Track MDT Program”

➢ ...so, you could instead provide the information to those third parties as a “self-disclosure” from the patient by simply giving the patient the following letter on your stationary, to deliver him or herself to an MDT, or other non-treating third party:
Dear Jeremy,

Congratulations on your clean random urine test that was done last Tuesday! Way to go!! I bet your probation officer will be happy with these lab results too! : )

Best regards,

Sally Smith
Certified Substance Abuse Counselor
Tragic County SUD Program
Self-disclosure

➢ For an MDT, Probation Diversion Program or the Courts, the County SUD program could (ahead of time) submit a list of sample signatures and names of providers who would likely sign such a release, and a copy of the program’s stationary, which would then be useful in reducing fraud.

➢ Similarly, a copy of selected pages of the patient chart could also be provided to the patient pursuant to “access” rules and the patient could then submit the scanned copies to the individual, MDT or other entity (e.g., Probation or Social Services Dept.) that was in need of the information in order to provide the patient with services.
“Lawful Holder” of SUD information must follow 42 CFR Part 2 (this is an individual or entity that received SUD information pursuant to patient Consent)

So, a County Social Worker must also follow Part 2 when he or she wants to use, disclose or access the information

Section 2.32 – Prohibition on Re-disclosure – Each disclosure made with the patient’s written consent must be accompanied by one of the following written statements:
Re-disclosure warning #1

➢ “This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR Part 2). The federal rules prohibit you from making any further disclosure of information in this record that identifies a patient as having or having had a substance use disorder either directly, by reference to publicly available information, or through verification of such identification by another person unless further disclosure is expressly permitted or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose (see section 2.31). The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at sections 2.12(c)(5) and 2.65.”
Re-disclosure warning #2

➢ “42 CFR Part 2 prohibits unauthorized disclosure of these records.”
Remember: Basic Privacy Rule (Applicable to All Disciplines)

➢ Don’t talk unless you **MUST** or **MAY**!

➢ If you aren’t sure:
  - “may I put you on hold for just a minute?” or
  - “would you mind waiting here for just a minute?” or
  - “can I get your name and number and call you back?”
“Hi, I’m Sally, John’s wife. I’m calling to verify the time of his appointment tomorrow.”

“Hi I’m John. Sally asked me to pick up her prescription today – which pharmacy should I go to.”
HIPAA Breaches, continued

“This is Tragic County Elementary School and we’re trying to get a phone number for Timmy Johnson’s father. Can you help us out?”

“This is Tragic County Probation Department and we’re looking for Mr. Derek Johnson. Do you have current contact information for him?”
HIPAA Breaches, continued

➢ Waste baskets
➢ Desk tops
➢ Meeting rooms
➢ Sign in sheets
➢ Phone calls in public places
➢ Message machines
Ethics and Social Media

➢ Dual Relationships and Boundaries
➢ Individual Viewpoints and Free Speech
➢ Discrimination and Harassment
➢ Yelping.
Boundary Issues.

➢ When the healthcare professional uses, or allows, the underlying professional relationship to be used as a springboard for a second relationship, e.g., going into business with your client

➢ If romance is part of the second relationship it can lead to criminal charges, loss of license or loss of job!

➢ What about asking client to go to Bd of Supervisors meeting to support funding for drop-in mental health clinic?
Social media - it seems that healthcare providers are held to a higher standard ...

➢ “Just shoot ‘em at the border and save $ on the wall” and “Hey, if you run from the police, don’t be surprised if you get shot, Stupid.” Kaiser L&D Nurse fired last summer after public responded to her Facebook Posts & Responses

➢ A former first-year Cleveland Clinic resident published a public apology in January 2019 after the hospital released details of her termination for an offensive social media history from 2011-2017 that surfaced in 2018.

➢ Uber driver: “I’m not your driver.” Neurology resident’s words to the effect of “Do you know who I am?” videotaped by bystanders and posted to You Tube
Why do you think a healthcare professional may be held to a different standard?

➢ What are some ways your private conduct could reflect on your program?
➢ How does your private conduct impact your patients?
➢ How does your private conduct impact funding of your program?
➢ Would it be different if you were in private practice and didn’t work for a public entity or clinic?
Other Risks & Ethical Challenges

• Tape-recording/video taping – do clients have a right to tape?
  ▪ “First Amendment Audits” that are put on YouTube
  ▪ Signage to make sure patients’ privacy is protected:

Because we care about your privacy, photography, audio and video-taping are not allowed in this building.
Photography, tape recording/video-taping policy

➢ Policy: no photography, audio-taping or video-taping
  • Privacy issues for other patients
  • Privacy issues for provider
  • Patient safety issues – it can impact care!

➢ You can have case by case exceptions (e.g., complicated informed consent, training, for benefit of patient)
“me too”

➢ More complaints from patients are now being filed – time for chaperones?

and...

More complaints from providers
“Me Too” - Sorting It All Out …

- **Criminal acts**: sexual assault, battery, rape, child abuse (including consensual sexual behavior with underage minors), elder/dependent adult abuse -> prison

- Criminal sexual against a patient = Adverse Event Reporting

- **Rude public and private behavior** (not illegal, no employment relationship) -> public shunning, political and/or business repercussions

- **Discrimination/sexual harassment in the workplace** between employees -> termination (can include criminal acts and rude behavior)
Speaking of rude...

- Protecting your staff from discrimination and harassment from the public
  - Employer is responsible to take reasonable steps to protect employees from discrimination and harassment even if it is from outside third parties
- Risk managers are reporting more complaints of rude and objectional remarks made by patients towards staff.
Citations/Resources

➢ Child Abuse/Neglect: Penal Code 11164-11174.3
➢ Elder & Dep. Adult Abuse/Neglect: W&I Code 15600-15659; Penal Code 368
➢ Gunshot Wounds & Assaultive/abusive Conduct: Penal Code 11160-11161
➢ Reporting Lapses of Consciousness: Health & Safety Code 103900; Title 17 CCR 2800-2812
➢ California Civil Code 42.90; Tarasoff v. Regents of University of California, (1976) 17 Cal. 3d 425
➢ California Hospital Association – calhospital.org (publications include the CHA California Health Information Privacy Manual - 2018)
Questions