Legal Update 2020
CalQIC

Friday, March 13, 2020
9:30 a.m. – 12 noon
Embassy Suites Hotel, Seaside, CA

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This presentation is for informational purposes only. Nothing in this presentation is intended as legal advice, and the presenters do not intend to create an attorney-client relationship. Questions about specific situations should always be directed to your legal counsel.
Agenda

- New Laws
- Confidentiality – 42 CFR Part 2
- Homelessness and Multi-disciplinary Teams
- Ethics, Your Rights, and Social Media
New Laws
Scope of Practice
AB 1514 (eff. 9/12/19) – Certification for Special Telecommunication Device

- Existing law allows physicians, audiologists, optometrists, other healthcare professionals, as well as Physician Assistants (PAs) to certify an individual as deaf or hearing impaired, having a speech disability, visual impairment, or otherwise disabled by medical condition so that individual can participate in State PUC program to provide telecommunication devices for use by disabled individuals at no additional charge.

- Now, ability to certify has been extended to Nurse Practitioners (NPs) as well.
Physician supervision does not require physical presence of physician, or countersigning of charts, but does require:

- adequate supervision that is spelled out in practice agreement
- availability of supervising physician by phone or other electronic means at time of patient examination
More flexibility - practice agreement now defines supervision details rather than the law - agreement requirements spelled out in greater detail (see B&P Code §3502.3)

Not changed: physicians shall not supervise more than 4 PAs at any one time

New provisions clarifying how hospitals, clinics and medical groups may utilize PAs with more flexible supervision by multiple physicians
(eff. 1/1/20) - telehealth services expanded to include qualified autism services provider or qualified autism service professional certified by a national entity

Other sections clarify that face-to-face contact between provider and patient is not required under the Medi-Cal program for health care provided by asynchronous store and forward services (i.e., the transmission of patient’s medical information from originating site to provider at distant site).
(eff. 1/1/21) – Contracts issued, renewed, amended on or after 1/1/21 between a health plan and a health care provider shall specify that the plan shall reimburse the provider for telehealth services on the same basis and to same extent that the plan is responsible for the same services through in-person dx, consultation, or treatment.

- but this does not apply to Medi-Cal managed care plans that contract with the state under sections 14000 et seq, 14200 et seq, or 14591 et seq of the W&I Code.
Laws Protecting Patients
AB 630 – Patient Protection

Beginning on or after **July 1, 2020**, mental health professionals licensed or registered with the **Board of Behavioral Sciences**, prior to providing psychotherapy, must

- **give clients a notice in at least 12-point font** telling them that the Board of Behavioral Sciences receives and responds to complaints about licensees, and
- tells clients **how to contact the Board** to file complaints.
AB 328 – Marrying a Dependent Adult

- Express presumption of fraud or undue influence if trust or will makes a gift to a care custodian by a dependent adult if the gift is made to
  - a care custodian who commenced a marriage, cohabitation, or domestic partnership with a dependent adult while providing services to that dependent adult or
  - within 90 days after those services were last provided,
  - and the transfer occurs or the trust or will is signed less than 6 months after the marriage, cohabitation or domestic partnership commenced

- Also, care custodian who is not mentioned in will, but who is a “surviving spouse” where marriage occurred while services being provided or within 90 days after services last provided, will not receive a share of the estate under Probate Code unless that person can prove by clear and convincing evidence that the marriage was not the product of fraud or undue influence
SB 464 – Establishes the CA Dignity in Pregnancy and Childbirth Act (H&S Code 123630 et seq.)
(eff. 1/1/20)

Amends laws re: patient rights:

- adds right to be free of discrimination on basis of race, color, religion, ancestry, national origin, disability, medical condition, genetic information, marital status, sex, gender, gender identity, gender expression, sexual orientation, citizenship, primary language, or immigration status as set forth in Civil Code 51

- requires that information be given to patients by hospitals on how to file a complaint with the State Dept. of Public Health, Dept. Fair Employment and Housing, and Medical Board of CA
Health & Safety Code 123630 et seq. (new law) recognizes in statute that US maternal mortality rate is highest in the developed world and that for women of color, the rate remains three to four times higher than for White women; legislative findings spelled out in the statute include:

- Black women make up 5 percent of the pregnancy cohort in CA but 21 percent of the pregnancy-related deaths;
- pregnancy-related deaths among Black women are more likely to be miscoded; thirty-five percent of these deaths were miscoded in California misidentifying them as other deaths;
- access to care, socioeconomic status and general physical health do not fully explain the disparity, and a growing body of evidence shows that there is unfair and unequal treatment by the health system; and,
- implicit bias is a key cause that drives health disparities in communities of color, but at present no requirement for implicit bias testing or training.

Intent of legislature to reduce the effects of implicit bias in pregnancy, childbirth, and postnatal care so that all people are treated with dignity and respect by their healthcare providers.
Eff. 1/1/20: A hospital that provides perinatal care, or an alternative birth center/primary care clinic licensed to provide services as an alternative birth center services under H&S Code 1204.3, shall implement an evidence-based implicit bias program for all health care providers involved in the perinatal care of patients within those facilities.
Implicit bias program shall include:

- Identification of previous or current unconscious biases and misinformation
- Identification of personal, interpersonal, institutional, structural, and cultural barriers to inclusion
- Corrective measures to decrease implicit bias at the interpersonal and institutional levels, including ongoing policies and practices for that purpose.
- Information on the effects including but not limited to ongoing personal effects of historical and contemporary exclusion and oppression of minority communities
- Information about cultural identity across racial or ethnic groups
- Information about communicating more effectively across identities, including racial, ethnic, religious and gender identities
- Discussion on power dynamics and organizational decision-making
- Discussion on health inequities within the perinatal care field, including information on how implicit bias impacts maternal and infant health outcomes
- Perspectives of diverse, local constituency groups and experts on particular racial, identity, cultural, and provider-community relations issues in the community
- Information on reproductive justice
Health care providers at hospitals and alternative birth centers involved in perinatal care shall complete **initial basic training**, and complete a refresher course **every two years** thereafter, or more frequently if deemed necessary by the facility.

If a physician is not directly employed by the facility, the facility shall **offer** the training to the physician (training can be at an off-site facility), and may accept certificates of training from other facilities.
Death Certificates - two sections

- **First section**: basic information about name of decedent, date of birth, age at death, occupation etc.

- **Second section**: information about medical condition and cause of death; **now must also include additional information regarding the pregnancy status** of the decedent consistent with the data elements included on the US Standard Certificate of Death.
AB 2193 – Maternal Mental Health

- Beginning 7/1/19, licensed healthcare providers who provide prenatal or postpartum care have had to screen, or offer to screen, for maternal mental health problems.
- Also required health plans, by 7/1/19, to develop maternal mental health programs.
AB 3032 – Education on Maternal Mental Health

Eff. 1/1/20 – hospitals with perinatal units must have a program in place to provide education and information to appropriate healthcare professionals and patients about maternal mental health conditions.
SB 425 – Reports of Sexual Abuse or Misconduct to Licensing Boards (eff. 1/1/20)

- Section 805.8 added to Business & Professions Code
  - Requires a healthcare facility, health plan or other entity that grants privileges or employs a health care professional, to,
    - within 15 days of receiving a written allegation of sexual abuse or sexual misconduct against one of its healthcare providers,
    - file a report with that professional’s licensing board.
  - “Sexual misconduct” means inappropriate contact or communication of a sexual nature.
  - Willful failure to report = fine up to $100,000 against entity, and reporting of individual who should have reported but willfully chose not to.
AB 189 – Child Abuse Mandated Reporters: adds Autism Service Providers (1/1/20)

- Qualified autism services providers, professionals, and paraprofessionals, now added to list of individuals who are mandated reporters under California Child Abuse and Neglect Reporting Act (CANRA) - Penal Code 11165.7(a)(47)
Reporting Sexual Abuse and Exploitation

- 2014 AB 1775 expanded CANRA definition of “sexual exploitation” knowingly printing, developing, duplicating, downloading, streaming, or accessing through any electronic or digital media a film, photograph, video recording, etc. in which a child is engaged in an act of obscene sexual conduct (this included “sexting” and viewing e-porn involving minors)

- Lots of discussion since then as to whether legislature meant to include sexting; also, mental health professionals argued that patients would hesitate to get help with e-porn addictions if they feared being reported as child abusers
Dec. 26, 2019 – Mathews v. Becerra; CA Supreme Court reversed an appellate court decision that had held that:
- patients who viewed internet child porn had no reasonable expectation of absolute privacy in therapeutic treatment, and
- reporting requirements do not amount to a serious invasion of privacy

Supreme Court said the right to privacy might override the therapists’ CANRA reporting duties in the limited circumstances of this case, where therapists argued
- their patients pose no serious danger of engaging in “hands on” sexual abuse or exploitation, and
- that it would disincentivize patients with sexual disorders or addictions from seeking treatment.

Court did not determine that AB 1775 was unconstitutional; rather it remanded it back for further factual development designed to determine whether the statute serves its intended purpose of protecting children.
New Laws Concerning Prescribing
AB 2086 - CURES – Access to Provider’s Own List of Patients (eff. 1/1/19)

- Allowed prescribers to get list of patients for whom they are listed as being the prescriber in the CURES system
AB 149: Security of prescription forms

- Created HSC § 11162.2
- This law took effect March 11, 2019
  - CA passed it as an “urgency statute”
- Let’s look at why CA passed it as an “urgency statute” . . .
AB 149: Security of prescription forms (continued)

➢ Backstory:

▪ AB 1753 (2018) set out some new security requirements for prescription forms
  • E.g. Unique serial numbers on each prescription form “in a manner prescribed by the DOJ”
▪ AB 1753 did not put a deadline on the DOJ for creating the serial number system
AB 149: Security of prescription forms (continued)

Fast-forward to now:

- This new law, effective 3/11/19, gave the DOJ a hard deadline for creating the serial number system (Jan. 1, 2020)
- It also **added** a few more security requirements to prescription forms . . .
AB 149: Security of prescription forms (continued)

- Two new requirements:
  - the unique serial numbers must also be “utilizable as a barcode that may be scanned by dispensers.”
  - the serialized number shall be compliant with current National Council for Prescription Drug Program Standards.

- Moral? If CA legislature wants something from you, deliver it ASAP . . . lest the State think of more things they want from you!
SB 569: Prescriptions during declared emergencies

- Created HSC §11159.3
- Part of CA’s “Pharmacy Law” authorizes the California State Board of Pharmacy to waive certain dispensing laws during times of declared federal, state, or local emergencies
  - For example, the Board could allow a pharmacist to re-dispense to a patient who cannot access his/her medications
SB 569: Prescriptions during declared emergencies

- SB 569 says that if the pharmacist dispenses a Schedule II substance pursuant to one of these “declared emergency” waivers, the pharmacist may dispense no greater than a **seven-day supply**

- Also, allows the Pharmacy Board to waive requirements for serialized prescription forms during declared emergencies
AB 528: CURES 2.0 reporting

- Law has various start dates
  - Some parts have concrete start dates, other parts could become operative at any moment
## AB 528: CURES 2.0 reporting (continued)

<table>
<thead>
<tr>
<th>Through Dec. 31, 2020</th>
<th>Beginning January 1, 2021</th>
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<tr>
<td>HSC §11164.1: Dispensers must report the dispensing of Schedule II, III, and IV drugs</td>
<td>HSC §11164.1: In addition, dispensers will have to report the dispensing of Schedule V drugs</td>
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<tr>
<td>HSC §11165: Dispensers must report “as soon as reasonably possible, but not more than seven [7] days after the date a controlled substance is dispensed”</td>
<td>HSC §11165: Must report to CURES 2.0 within one (1) working day</td>
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**AB 528: CURES 2.0 reporting (continued)**

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<td>HSC §11165.4(a)(1)(A)(i): “A health care practitioner authorized to prescribe, order, administer, or furnish a controlled substance shall consult the CURES database to review a patient’s controlled substance history before prescribing a Schedule II, Schedule III, or Schedule IV controlled substance to the patient for the first time and at least <strong>once every four months</strong> thereafter if the substance remains part of the treatment of the patient.”</td>
<td>HSC §11165.4(a)(1)(A)(i): “A health care practitioner authorized to prescribe, order, administer, or furnish a controlled substance shall consult the patient activity report or information from the patient activity report obtained from the CURES database to review a patient’s controlled substance history for the past 12 months before prescribing a Schedule II, Schedule III, or Schedule IV controlled substance to the patient for the first time and <strong>at least once every six months</strong> thereafter if the prescriber renews the prescription and the substance remains part of the treatment of the patient.”</td>
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### AB 528: CURES 2.0 reporting (continued)

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<td>HSC §11165.1: Physicians who do not hold a DEA registration cannot access CURES 2.0</td>
<td>HSC §11165.1: Physicians without a DEA registration “may submit an application developed by the department to obtain approval to electronically access information regarding the controlled substance history of the patient that is maintained by the department.”</td>
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SB 159 – HIV PEP and PrEP

➢ 1/1/20 – allows specially trained pharmacists to furnish pre-exposure (PrEP) and post-exposure (PEP) HIV prophylaxis

➢ Prohibits payers from subjecting antiretroviral drugs/therapies (ART) to prior authorization or step therapy with some exceptions.
AB 2487 – Education on MAT as alternative to Pain Management Training (eff. 1/1/19)

- 12-hour continuing education (CE) course on Medication Assisted Treatment (MAT) and treating opiate-dependent patients, may be taken as a condition of licensure by the Medical Board of California (MBC) as an alternative to the mandated 12 hour CE course on treating terminally ill and dying patients
AB 2760 (1/1/19) – Naloxone Hydrochloride Rx
AB 714 (eff. 9/5/19 – urgency measure) – clarified

- AB 2760: required prescriber to offer a prescription for naloxone hydrochloride or similar drug to patient and/or family on overdose prevention when the patient has a risk of overdosing because:
  1) patient taking 90 or more mme/day; or,
  2) patient risk is increased due to prior high dose, with no tolerance now, or prior overdose; or,
  3) patient concurrently prescribed an opioid and benzodiazepine.

- AB 714 clarified third bullet item in prior law; now states that the requirement only applies when prescribing an opioid within a year from the date a prescription for benzodiazepine has been dispensed to the patient;

- AB 714 also added one more risk factor to the list: patient has history of opioid use disorder (OUD)
New Law on Immunizations
SB 276: Immunizations and school children

  - Note: much of this law’s effective date depends on CA DPH developing protocols and a new standardized electronic reporting form
  - Law says that by January 1, 2021 at the latest...
SB 276: Immunizations and school children (continued)

…the State Department of Public Health “shall develop and make available for use . . . an electronic, standardized, statewide medical exemption certification form that shall be transmitted directly to the department’s California Immunization Registry (CAIR) . . . ”

- This will become the only immunization exemption document that a governing authority may accept
SB 276: Immunizations and school children (continued)

- HSC §120372(d): “The department, at a minimum, shall annually review immunization reports from all schools and institutions . . .”
  - Identify schools with lower than 95% immunization rate
  - Identify physicians who have submitted 5 or more in a calendar year
  - Identify schools that aren’t reporting
- Upon review, the State may revoke an exemption (and go after doctor’s license)
- Parents will then have 30 days to appeal the State’s revocation
SB 276: Immunizations and school children (continued)

➢ HSC §120372: “If the department determines that a physician’s and surgeon’s practice is contributing to a public health risk . . . the department shall report the physician and surgeon to the Medical Board of California or the Osteopathic Medical Board of California, as appropriate.”
New Laws – Mental Health Care
Applying the LPS Act, as Written

5150 – “hold and transport” (to “LPS designated facility”) or provide crisis stabilization

↑

big gap (this is where ED medical clearance happens)

↓

5151 – “assess and admit” (evaluation & treatment for up to 72 hours if less restrictive means not feasible)
Problems with 5150 law as written

➢ to this day…
  ▪ nothing in the law that addresses activities taking place in hospital Emergency Departments between 5150 and 5151
  ▪ no guidance in the law to address the medical clearance step and what to do if the patient refuses diagnostic testing
  ▪ no guidance in the law addressing what to do when a bed is not available and the clock has run
  ▪ no clarification on when the 72 hour clock starts! (at 5150? or at 5151? two laws with two different start times!)
AB 2099 – 5150 Application Form

Copy = Original

- Effective 1/1/19, law says a copy of the W&I 5150 written application form SHALL be treated as the original! (see W&I 5150(e))

- New State DHCS 1801 (MH 302) form (revised 12/2019 available, and should be used for continuity throughout the state!

- See other updated forms (e.g., 14 day and 30 day holds) as well

Last modified date: 1/27/2020 10:26 AM
https://www.dhcs.ca.gov/formsandpubs/forms/Pages/Mental_Health-Forms.aspx
Mental Health Certification Forms

DHCS 1800 (MH 300) (05/19): Electroconvulsive Treatment (ECT), Informed Consent Form
DHCS 1800 SP (06/2013): Electroconvulsive Treatment (ECT), Informed Consent Form (Spanish)

DHCS 1801 (MH 302) (12/2019): Application for Assessment, Evaluation, and Crisis Intervention or Placement for Evaluation and Treatment

DHCS 1802 (MH 303) (12/2019): Involuntary Patient Advisement
DHCS 1802 SP (06/2013): Involuntary Patient Advisement (Spanish)

DHCS 1803 (MH 306) (06/2013): Patient Rights Denial - Monthly Talley
DHCS 1804 (MH 307) (06/2013): Denial of Rights/Seclusion & Restraint - Monthly

DHCS 1805 (MH 308) (06/2013): Denial of Rights/Seclusion & Restraint - Quarterly

DHCS 1806 (MH 309) (02/2013): Convulsive Treatments Administered - Quarterly Report (use DHCS 1011)

DHCS 1807 (MH 560) (06/2013): Authorization for Release of Protected Health Information and Confidential Information
DHCS 1807 SP (06/2013): Authorization for Release of Protected Health Information and Confidential Information (Spanish)

DHCS 1808 (MH 1760) (12/2019): Notice of Certification


DHCS 1810 (01/2014): Inventory of County 5150 Designated Facilities
DHCS 1811 (MH 5671) (06/2013): Authorization for Release of Patient Information
DHCS 1812 (MH 5756) (06/2013): Voluntary Admission Application for Mentally Disabled Person

DHCS 1819 (02/19) Mental Health Services Act (MHSA) Prudent Reserve Assessment/Reassessment

DHCS 1820 (02/19) Annual MHSA Revenue and Expenditure Report and Adjustment Worksheet County Certification

DHCS 1821 (02/19) MHSA: Adjustments to Revenue and Expenditure Summary Worksheet

DHCS 1822A (02/19) Annual MHSA Annual Revenue and Expenditure Report Template and Instructions
Other Mental Health Forms

DHCS 1008 (02/13): Jail Services
DHCS 1009 (02/13): Conservatorships
DHCS 1010 (02/13): Involuntary Detentions
DHCS 1011 (02/13): Convulsive Treatments
DHCS 1735 Medi-Cal (M/C) Certification Transmittal (09/2014)
DHCS 1736 County-Owned and Operated Certification Application (09/2014)
DHCS 1737 County-Owned and Operated Provider Self-Survey Form (09/2014)
DHCS 1739 (07/13): Mental Health Professional Licensing Waiver Request
DHCS 1746 Director’s Designee Information (Rev. 10/14)
MC 5400 (05/2013): Application for Certification of Special Treatment Program (STP) Services

DHCS 1734 (10/19): Application for Certification of Social Rehabilitation Program Services
DHCS 1813 (11/2013) / MH8001/95: Application for Licensure Mental Health Rehabilitation Center (MHRC)

DHCS 1816 (05/19) Affidavit Regarding Client Money (MHRC)
DHCS 1814 (11/2013): Application for Licensure Psychiatric Health Facility (PHF) and Program
DHCS 1817 (06/14) Affidavit Regarding Patient Money (PHF)
DHCS 1815 (11/2013): Application for a Special Permit of Structured Outpatient Services (SOPS)
DHCS 1818 (07/2014) Criminal Record Approval Transfer Notification
DHCS 3007 (02/15) PERSONAL BACKGROUND HISTORY STATEMENT
DHCS 3085 (01/15) CRIMINAL BACKGROUND CHECK: CHARACTER REFERENCE

DHCS 3131 (10/19) Application for Mental Health Program Approval Short-Term Residential Therapeutic Programs (STRTP)
AB 1968 – Weapons Prohibitions (eff. 1/1/20)

- Amends/replaces W&I Code 8103
- Eff. 1/1/20 – Lifetime ban on gun ownership for those involuntarily admitted (W&I 5151) into locked designated LPS facility as danger to self (DTS) or danger to others (DTO) if individual has been admitted previously one or more times in the preceding year (365-day period of time)
AB 1968 - continued

Eff. 1/1/20 – Prior to or concurrent with discharge, patient must be given information about weapons prohibition, and right to petition the court

Use the most recent DOJ “Patient Notification of Firearm Prohibition and Right to Hearing Form”

download BOF 4009C (Rev. 01/2020) at

https://oag.ca.gov/sites/all/files/agweb/pdfs/firearms/forms/bof4009C.pdf
Upon or after discharge from a mental health facility, any person subject to firearms prohibitions pursuant to Welfare and Institutions Code (WIC) section 8103, subdivision (f)(1), may request a hearing from the superior court of his or her county of residence to determine whether his or her right(s) to own, possess, control, receive, or purchase firearms will be restored by court order. The court shall set a hearing date within 60 days of receipt of this request.

TO: _______________________________ COUNTY SUPERIOR COURT.

☐ I hereby request a hearing for restoration of my right(s) to own or possess firearms.

☐ I hereby request a confidential private hearing for restoration of my right(s) to own or possess firearms.

Pursuant to WIC section 8103, subdivision (f)(5), you have the right to request a confidential private hearing that is not open to the public. This hearing will only be attended by persons relevant to your case unless the
AB 1968 - continued

- New law says that the facility **shall NOT** submit the form on behalf of the person subject to this subdivision.

- Note: prior law required the facility to **forward the form to the superior court on behalf of the patient** if the patient requested a hearing at the time of discharge, unless the patient stated that he or she wanted to submit the form.
Amends Health and Safety Code 1317 - General acute care hospitals or acute psychiatric hospitals cannot insist, as a condition of admission or acceptance of a transfer, that a patient voluntarily seeking mental health care be first placed on a 5150 involuntary hold.
Minor Consent
Sensitive Services – 2019 New Law

- Effective 1/1/19 – minors 12 and older who state 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 – Family Code 6930

- “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

- Note: minor consent does not change child abuse reporting responsibilities – intimate partner violence is reportable as child abuse!
Access and Control of Minor Records
Access to the record – adults and minors

- Adult patients, and minors who COULD have or DID consent to their own care, have a right to ACCESS their own record (45 CFR 164.524)
- Only exception is concern that access will cause death or serious physical harm to the patient or some other person
- Old California law (H&S 123115) that permits providers to deny access to a mental health record if it would “interfere” with therapeutic relationship or cause emotional harm has been superseded by HIPAA
- Same for old California law that gave provider the option of preparing a “summary” instead
Parents’ right to access their minor child’s record

- Health & Safety Code 123115 – limits parents’ right to access when:
  - Minor could have or did consent to the care
  - Regardless of discipline, when there is only parental consent (minor consent not possible), parental access can still be limited if provider fears:
    - Harm to therapeutic relationship
    - Harm to minor’s emotional well-being
    - Harm to minor’s physical well-being
Right to amend/addend records

- AB 2088 (eff. 1/1/19) - Permits minor to provide written addendum of up to 250 words to his or her record if minor 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 only 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
42 CFR Part 2 – Proposed Rule

Proposed Rule changing Part 2 published in Federal Register on 8/26/2019:
But first...

- Review of Part 2
- Definition of Part 2 Program
- Disclosures with consent (elements of written form)
What is 42 CFR Part 2?

42 CFR Part 2 ("Part 2") is a set of regulations that creates special confidentiality rules for:

- substance use disorder (SUD) records that are
- maintained/obtained/created by any "part 2 program"
What is a “part 2 program”?

- Individuals/entities/medical units that
  - hold themselves out as providing,
  - and do indeed provide,
  - SUD education, diagnosis, treatment, or referral

- Must be “federally assisted”
Besides part 2 programs, who else must follow 42 CFR Part 2?

- Anyone else who receives a “part 2 record” via a patient’s written consent
  - Part 2 records transfer Part 2 responsibilities to the “holder”
  - Think “hot potato!”
Elements of the §2.31 written consent: Checklist

- 1. Patient’s name
- 2. Who may disclose
- 3. Explicit description of what may be disclosed
- 4. Recipient(s)
- 5. Notice to patients re: general designations (initialed)
- 6. Purpose of the disclosure
Elements of the §2.31 written consent: Checklist (continued)

7. Statement that the consent is subject to revocation at any time
8. The date, event, or condition upon which the consent will expire if not revoked before
9. All other federal and state-required elements
10. Patient’s/authorized individual’s signature
11. Date on which the consent is signed
8/26/19 – Notice of Proposed Rulemaking

➤ SAMHSA proposed these changes to Confidentiality of Substance Use Disorder Patient Records regulations (42 CFR Part 2)

➤ Comments were due no later than 10/25/19
### §2.11: Definition of “records”

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<td>“Records means any information, whether recorded or not, created by, received, or acquired by a part 2 program relating to a patient (e.g., diagnosis, treatment and referral for treatment information, billing information, emails, voice mails, and texts).”</td>
<td>“... information <strong>conveyed orally</strong> by a part 2 program to a non-part 2 provider for treatment purposes with the consent of the patient does not become a record subject to this Part in the possession of the non-part 2 provider merely because that information is reduced to writing by that non-part 2 provider.”</td>
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## §2.31: Identifying recipients for disclosures

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| **Potential recipients:**  
• Named individuals or  
• **Named treating provider entities** or  
• Named third-party payer entities or  
• Named non-treating provider entities PLUS named individuals, or named treating provider entities, or general designations for treating providers | **Potential recipients:**  
• Named individuals or  
• **Named entities** or  
• Named HIE’s or named research institutions PLUS named individuals, or named entities, or general designations for treating providers |
§2.34: MAT programs and care coordination

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<td>“A central registry and any withdrawal management or maintenance treatment program to which information is disclosed to prevent multiple enrollments may not re-disclose or use patient identifying information for any purpose other than the prevention of multiple enrollments or to ensure appropriate coordinated care with a treating provider that is not a part 2 program unless authorized by a court order under subpart E of this part.”</td>
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### §2.34: MAT programs and care coordination (continued)

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<td>“A central registry and any withdrawal management or maintenance treatment program to which information is disclosed to prevent multiple enrollments may not re-disclose or use patient identifying information for any purpose other than the prevention of multiple enrollments unless authorized by a court order under subpart E of this part.”</td>
<td>Info that a central registry may provide to a non-part 2 treating provider, for treatment purposes: <em>(1)</em> The name, address, and telephone number of the member program(s) in which the patient is enrolled; <em>(2)</em> Type and dosage of any medication for substance use disorder being administered or prescribed to the patient by the member program(s); and <em>(3)</em> Relevant dates of any such administration or prescription.”</td>
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§2.36: Disclosing to prescription monitoring programs (e.g. CURES 2.0)

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<tr>
<th>Current</th>
<th>Proposed</th>
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<td>Under §2.31, no one can disclose SUD information to prescription monitoring programs (PMP’s) like CURES 2.0 unless the patient has provided written consent. With a patient’s written consent, however, someone could disclose SUD information to a PMP.</td>
<td>§2.36 (new section to the regulation): “A part 2 program or other lawful holder is permitted to report any SUD medication prescribed or dispensed by the part 2 program to the applicable state prescription drug monitoring program if required by applicable state law. A part 2 program or other lawful holder must obtain patient consent to a disclosure of records under § 2.31 prior to reporting of such information.”</td>
</tr>
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<td>NOTE: This is already possible under §2.31 of the current regulation; this proposal does not appear to change the regulation in any substantive way.</td>
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## §2.63: Confidential communications

<table>
<thead>
<tr>
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<td>“(a) A court order under the regulations in this part may authorize disclosure of confidential communications made by a patient to a part 2 program in the course of diagnosis, treatment, or referral for treatment only if: . . . (2) The disclosure is necessary in connection with investigation or prosecution of an extremely serious crime allegedly committed by the patient, such as one which directly threatens loss of life or serious bodily injury, including homicide, rape, kidnapping, armed robbery, assault with a deadly weapon, or child abuse and neglect[.]”</td>
<td>“(a) A court order under the regulations in this part may authorize disclosure of confidential communications made by a patient to a part 2 program in the course of diagnosis, treatment, or referral for treatment only if: . . . (2) The disclosure is necessary in connection with investigation or prosecution of an extremely serious crime, such as one which directly threatens loss of life or serious bodily injury, including homicide, rape, kidnapping, armed robbery, assault with a deadly weapon, or child abuse and neglect[.]”</td>
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</table>

**NOTE:** The proposed regulation would amend § 2.63(a)(2) by removing the phrase “allegedly committed by the patient”.

Garrett Consulting Group, LLC
www.garrettconsulting.com
Multi-disciplinary Team Models—Helping Homeless Patients
Homelessness – Definition (federal)

- HEARTH Act
  - Individuals and families who:
    - Lack a fixed, regular, and adequate nighttime residence (includes a subset for individuals who resided in an emergency shelter or place not meant for human habitation, or who are exiting an institution where they temporarily resided); or
    - Will immediately lose their primary nighttime residence (within 14 days) (eviction or notice to quit or terminate lease); or
    - Are fleeing, or are attempting to flee domestic violence, dating violence, sexual assault, stalking, or other dangerous or life-threatening conditions that relate to violence against the individual or a family member.
    - Unaccompanied youth and families with children who are defined as homeless under other federal statutes even though they would not otherwise qualify under this Act.
Homelessness – Definition (CA)

Health & Safety Code 1262.4

(b) For purposes of this section, “homeless patient” means an individual who lacks a fixed and regular nighttime residence, or who has a primary nighttime residence that is a supervised publicly or privately operated shelter designed to provide temporary living accommodations, or who is residing in a public or private place that was not designed to provide temporary living accommodations or to be used as a sleeping accommodation for human beings.
Myths

- Homelessness is caused by substance use and mental health problems.
Facts

- Policy experts & advocates agree: the leading cause of homelessness is not mental illness, or substance abuse;

- The leading cause of homelessness is that people can’t afford homes.
Facts

- California has 22 units available for every 100 extremely low-income households (National Low Income Housing Coalition, *The Gap, 2019*)
Numbers

- 553,000 experiencing homelessness on a single night in 2017
- 130,000 people homeless on a single night in CA in 2018
- In 2016, 4.6 million people in poor households were doubled up with family and friends, a common precursor to becoming homeless
Sheltered vs. Unsheltered

- NY – about 5% of homeless population unsheltered (NY has a “right to shelter”)
- CA – 68% unsheltered
Myth

➢ Homelessness almost entirely involves single males.
Some numbers reflecting homelessness for kids (from Jennifer Friend, CEO, Project Hope Alliance)

- Homeless living situations for kids often includes moving in with family/friends, living in motels, hotels or camp grounds, staying in shelters, or sleeping in cars, parks, public spaces, abandoned buildings, bus or train stations, etc.

- Grades K-6 – number of homeless students increased by 70% in past 10 years (this kind of experience delays language, literacy, and social-emotional development; correlated with poor classroom engagement and social skills)

- Grades 7-12 – 1 out of 18 students experience homelessness; graduation rate of homeless students is 64% (all other students: 84%); homeless youth are 87% more likely to drop out of school than their housed peers; youth with a high school diploma is 346% less likely to be homeless as an adult

- Homeless children are more than twice as likely to have health problems and three times more likely to experience severe medical problems
Homelessness and Health

- Between 35-40% of homeless individuals report fair or poor health (compared to 10% of total population)
- Overall poor functional status (“50 is the new 70”)
- Prevalence of geriatric conditions worse
- Mortality rates
  - more than 1,000 homeless people died on the streets of LA last year according to LA Dept. of Public Health
  - age 25-44: 9-10 times higher
  - Age 45-84: 4-5 times higher
Increased Focus on “Unsheltered” Homeless Individuals

- Funding and programs targeting “high utilizers”
  - Whole Person Care – 2016 – five year program
  - Discharge Planning for Homeless Patients – SB 1152
  - Other MDTs that focus on individuals recently released from correctional settings, or on probation, or those receiving social services (e.g., family reunification services, First 5), veterans programs, mental health court, drug court

- What seems to be missing at times are concepts of consent and non-consent, and confidentiality
For example, in homeless discharge law (SB 1152, eff. 1/1/19), what about privacy?

- H&S 1262.5(n)
  - (4) Unless the homeless patient is being transferred to another licensed health facility, the policy shall require the hospital to identify a postdischarge destination for the homeless patient as follows, with priority given to identifying a sheltered destination with supportive services:
    - (A) A social services agency, nonprofit social services provider, or governmental service provider that has agreed to accept the homeless patient, if he or she has agreed to the placement. Notwithstanding paragraph (2) of subdivision (k) and subdivision (l), the hospital shall provide potential receiving agencies or providers written or electronic information about the homeless patient’s known posthospital health and behavioral health care needs and shall document the name of the person at the agency or provider who agreed to accept the homeless patient.
Multi-Disciplinary Teams
MDT information sharing – the problem

- Multiple disciplines =
- Multiple privacy laws =
- Multiple things to consider!
- Successful collaboration requires information sharing, so solutions need to be found
Best solution

- Get permission in writing from the individual at the same time you offer services at the beginning
  - Provide outreach workers with blank authorization forms – “universal forms” often don’t work universally!
  - And, if SUD is involved, use of a separate SUD Part 2-compliant form is strongly recommended (individual names of members of the MDT must be included on the form)
MDTs – making the confidentiality puzzle work

➢ Two ”types” of MDTs
  ▪ **Type 1** - all members of team = healthcare providers
  ▪ **Type 2** – mixed team = includes healthcare + social services + criminal justice + schools + housing + food + legal + other assistance
Type 1 – MDTs and medical privacy laws that allow sharing for “treatment purposes”

- HIPAA (all disciplines) - Provider may share with other providers for “treatment purposes” – 45 CFR 164.506 (see 45 CFR 164.501 for broad definition of “treatment purposes” but also look at “more stringent” state and federal laws
- Civil Code 56.10(c)(1) (physical health) - Disclosure permitted for “diagnosis and treatment” of the patient
- Health & Safety 120985 (HIV test results) – May be documented in chart and may be disclosed to patient’s healthcare providers
- Welfare & Institutions Code 5328 (a)(1) (mental health) - Disclosure permitted to provider who has “medical or psychological responsibility for the care of the patient”
- 42 CFR §2.12(c)(3) (SUD) - Disclosures allowed among providers WITHIN the SUD program only for diagnosis, treatment, or referral for treatment – OTHERWISE YOU NEED WRITTEN CONSENT
Type 2 – MDTs and privacy law barriers (that can be resolved with written authorization!)

- For example, Whole Person Care seeks to provide services to group of individuals defined by:
  - Frequent 911 callers
  - Frequent visits to Emergency Departments (ED’s)
  - Frequent re-admissions to Hospitals
  - Frequent arrests
  - Unresolved mental health, substance use, medical and dental problems
  - Social service needs: food, shelter, clothing, GED/job training, driver’s license/ID, unresolved legal issues (e.g., outstanding warrants), medical insurance, SSI, veterans’ benefits, transportation, etc.
Type 2 MDTs and funding initiatives ($)

- An example (why Whole Person Care and similar projects are popular)
  - Aurora Sinai Medical Center in Milwaukee identified 313 patients who were responsible for 1,827 emergency department (ED) visits in 4 month period of time
  - 39 of these “high utilizers” were selected and assigned social workers who developed a plan for each that included assigned doctor at clinic, transportation to appointments, child care, and help making first appointment, follow-up appointments, food, shelter, etc.
  - In the first four months of this project, visits by these 39 people to the Aurora Sinai ED fell by 68%; cost to care for them fell from $1.5 Million to $440,000.
  - They used the $1 million in savings to open a community care clinic and an onsite urgent care clinic where patients coming to the ED, who do not have an emergency medical condition, can receive more appropriate, and less expensive care.
Sharing PHI with MDT under HIPAA
2 “must” and 4 “may” gates
HIPAA “musts” and “mays”

**MUST**
- To Secretary of DHSS
- To patient seeking “access”

**MAY**
- For *treatment*, payment or operations
- With written authorization
- With verbal authorization
- Without authorization
Treatment defined – 45 CFR 164.501

_Treatment_ means the provision, coordination, or management of healthcare and related services by one or more _health care providers_, _including the coordination or management of health care by a health care provider with a third party_; _consultation between health care providers relating to a patient_; or _the referral of a patient for health care from one health care provider to another._
Sharing (without authorization) for “Treatment” under more stringent CA and federal laws

- **CMIA - Civil Code 56.10(c)(1) (physical health)** – The information may be disclosed to providers of health care, health care service plans, contractors, or other health care professionals or facilities for purposes of diagnosis or treatment of the patient.

- **LPS - Welfare & Institutions Code 5328 (a)(1) (mental health)** – In communications between qualified professional persons in the provision of services or appropriate referrals, or in the course of conservatorship proceedings. The consent of the patient, or his or her guardian or conservator, shall be obtained before information or records may be disclosed by a professional person employed by a facility to a professional person not employed by the facility who does not have the **medical or psychological responsibility for the patient’s care.**

- **42 CFR Part 2 (SUD)** – disclosures allowed among members of the treatment team **WITHIN the SUD program only**
Part 2 Exception that permits sharing of SUD info for Tx Purposes: Medical Emergencies

42 CFR §2.51 - Patient identifying information 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, or
- FDA if necessary for notification purposes (e.g. dangerous or mislabeled drug)
SUD Consent Form Work-arounds

- **Self-disclosure** – individual is not subject to privacy law constraints
  - for example, individual can come to meeting and provides copies of his/her chart or discharge summary directly to those who are present

- **Phone book method** – list everyone who “might” attend the MDT?

- **Go to the top** – name the Director of the SSA or Head of the CA Dept. of Motor Vehicles?
If CA law makes an exception to privacy, HIPAA still applies if HIPAA is more stringent

- So if you have an MDT situation where a law specifically permits the team to talk; you still have HIPAA and the “treatment purposes” definition to deal with if you try to use the TPO pathway
- No other exception fits for homeless teams, leaving only the “with authorization” HIPAA pathway
- Best solution: get written authorization!
Ethics, Your Rights, and Social Media
Ethics in the news

- **Beyond Burnout** – experts now talking about “moral injury” suffered by doctors, similar to PTSD in soldiers, when they are blocked from providing best care to their patients by barriers or requirements set up by the current “system of healthcare” and perceived interference by health plans.

- Physician suicide rate more than twice that of general population (4/10 report burnout)
2/17/20 – America Psychological Association (APA) CEO issues letter calling for immediate halt to sharing immigrant youths’ confidential psychotherapy notes with ICE

- APA expressed shock and outrage that federal Office of Refugee Resettlement has been sharing confidential psychotherapy notes with US ICE to deny asylum to some immigrant youths (based on formal memorandum of agreement entered into between ORR and ICE in April 2018)
- Unaccompanied minors are required to undergo therapy in US detention shelters
- Therapists were asked to develop and report to ICE on “additional information” about children by asking them during therapy about previous gang or criminal activity ...information that will get them deported once reported to ICE!
Privacy Issues and Social Media

➢ **1st amendment auditors**
  ▪ Posting videos of your facility/patients/staff on YouTube

➢ **Responding to negative yelps**
  ▪ How do you defend yourself against falsehoods?
The dangers of YouTube

- The Burger King bather
- The Taco Bell licker
- The Dairy Queen guzzler
- The Jacksonville Naval Hospital Pediatric Unit baby dancer and bird flipper (also posted to Snapchat)

  - www.businessinsider.com: Want to know how to lose your job at a naval hospital? Post photos of yourself and a coworker flashing the finger at a newborn infant. If that’s not enough, you can call the fresh babies “mini Satans.” If you’re really gunning for that boot out the door, you can film yourself making an infant dance to rap music (50 Cents’ In Da Club).
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 YouTube
The dangers of Facebook

- HR Professionals being told it is corporate negligence to NOT check applicants’ Facebook pages prior to scheduling an interview

- In healthcare
  - “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 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.
Facebook - continued

Jennifer Kent, Director, CA Department of Health Care Services since 2014, fired in September 2019

- Capitol lobbyists circulated a screenshot of a Facebook post that appeared to be from her private Facebook page criticizing anti-vaccination protesters (which was then picked up by LA Times)
So what did Jennifer Kent privately post that got her fired from her very good job?

The Capitol is filled with a bunch of flat-earthers today. My poor sweet Bacteria Bear is dripping with unvaccinated booger-eater germs

#believeinscience
#vaccinatetyourgoddamnkids
Not limited to healthcare of course

- 1 Million Moms group objected to use of “d-word” in recent Burger King ad for Impossible Burger where unsuspecting Whopper-lover is given an impossible burger and exclaims, “damn, that’s good!”
- Internet went nuts, of course, and someone suggested that the “d-word” was “delicious”!
“me too”

- More claims by employees of inappropriate comments
- More claims by patients of inappropriate conduct – remember, written allegations now must be reported to licensing boards under new law (SB 425)
Truth be told....

➢ We’re all upset!
But, it’s the weekend, and we are in a beautiful place....
QUESTIONS?