HIPAA panel Bend 9/16/2014

Hello. Thanks to all of you for attending this evening, and for being interested in this topic. As Eileen indicated, my name is Jerry Gabay. I have a JD from the U of Oregon. I am a member of the NAMI Oregon state board of directors; co-chair of Providence Health System's collaborative council for behavioral health, and co-author of the Oregon Psychiatric Physician's Association suicide prevention checklists which are available in paper tonight but also by googling "Oregon suicide prevention checklists." Dr. Stewart Newman, a psychiatrist on the faculty of OHSU and in private practice in Ptld, and I received the Oregon Psychiatric Association's Access Award for 2013 for creating these documents.

For the past 4 years I have been on a crusade to increase the amount of communication providers have with the families (by blood, legal relationships, or affinity). There is ample literature indicating that extensive communication is a best practice for therapy and suicide prevention. But ample communication is not standard proceedure. Why? I believe that is because many, perhaps most practitioners have a misunderstanding of HIPPA which has both blinded them to the need to communicate as well as to the legal and ethical strictures that encourage communication.

The Office of Civil Rights is the enforcement arm for HIPAA. What does it have to say about HIPAA and communication?

1. "Where a patient is not present or is incapacitated, a health care provider may share the patient's information with family, friends, or others involved in the patient's care or payment for care, as long as the health care provider determines, <u>based on professional judgment</u>, that doing so is in the <u>best interests of the patient</u>… These may include circumstances in which a patient is suffering from temporary psychosis or is under the influence of drugs or alcohol.

Otherwise, if the patient has capacity and objects to the provider sharing information with the patient's family member, the provider may only share the information if doing so is consistent with applicable law and standards of ethical conduct, and the <u>provider has a good faith belief that the patient poses a threat to the health or safety of the patient or others</u>, and the family member is reasonably able to prevent or lessen that threat. See 45 CFR 164.512(j). For example, if a doctor knows from experience that, when a patient's medication is not at a therapeutic level, the patient is at high risk of committing suicide, the doctor may believe in good faith that disclosure is necessary to prevent or lessen the threat of harm to the health or safety of the patient who has stopped taking the prescribed medication, and may share information with the patient's family or other caregivers who can avert the threat.

Let me point out that this is a very clear statement of the provider being able to use her/his professional judgment to communicate contrary to the expressed desires of the patient.

Specifically, when a health care provider believes in good faith that such a warning is necessary to prevent or lessen a serious and imminent threat to the health or safety of the patient or others, the Privacy Rule allows the provider, consistent with applicable law and standards of ethical conduct, to alert those persons whom the provider believes are reasonably able to prevent or lessen the threat. These provisions may be found in the Privacy Rule at 45 CFR § 164.512(j).

Source = http://www.hhs.gov/ocr/privacy/hipaa/understanding/special/mhguidance.html (2014)

The same guidance speaks to how the "Privacy Rule defers to State or other applicable laws that expressly address the ability of the parent to obtain health information about the minor child. In doing so, the Privacy Rule permits a covered entity to disclose to a parent, or provide the parent with access to, a minor child's protected health information when and to the extent it is permitted or required by State or other laws (including relevant case law)." *This is expressly the case in Oregon, despite the ability of a minor 14 or over to consent to mental health treatment.*

See also:
http://www.hhs.gov/ocr/privacy/hipaa/understanding/coveredentities/personalrepresentatives.pdf

Even in these exceptional circumstances, where the parent is not the "personal representative" of the minor, the Privacy Rule defers to State or other laws that require, permit, or prohibit the covered entity to disclose to a parent, or provide the parent access to, a minor child's protected health information.

2. Letter to the Nation, January 13, 2013 from Leon Rodriguez, then Director of OCR:

Message to Our Nation's Health Care Providers:
In light of recent tragic and horrific events in our nation, including the mass shootings in Newtown, CT, and Aurora, CO, I wanted to take this opportunity to ensure that you are aware that the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule does not prevent your ability to disclose necessary information about a patient to law enforcement, family members of the patient, or other persons, when you believe the patient presents a serious danger to himself or other people.

The HIPAA Privacy Rule protects the privacy of patients' health information but is balanced to ensure that appropriate uses and disclosures of the information still may be made when necessary to treat a patient, to protect the nation's public health, and for other critical purposes, such as when a provider seeks to warn or report that persons may be at risk of harm because of a patient. When a health care provider believes in good faith that such a warning is necessary to prevent or lessen a serious and imminent threat to the health or safety of the patient or others, the Privacy Rule allows the provider, consistent with applicable law and standards of ethical conduct, to alert those persons whom the provider believes are reasonably able to prevent or lessen the threat. Further, the provider is presumed to have had a good faith belief when his or her belief is based upon the provider's actual knowledge (i.e., based on the provider's own interaction with the patient) or in reliance on a credible representation by a person with apparent knowledge or authority (i.e., based on a credible report from

a family member of the patient or other person). These provisions may be found in the Privacy Rule at 45 CFR § 164.512(j).

Director Rodriguez goes on to specify that under these provisions, a health care provider may disclose patient information, including information from mental health records, if necessary, to law enforcement, family members of the patient, or any other persons who may reasonably be able to prevent or lessen the risk of harm.

3. What about the threat of a malpractice suit for improper communication? One of the nation's leading insurers for colleges and universities has written the following:

It is important to note that an educational institution is far more likely to be sued and suffer severe monetary loss in defending its failure to notify parents or other family members about a student's psychological or self-injurious condition than it is from notifying parents about such conditions.

A common misconception is that the federal Health Information Portability and Accountability Act (HIPAA) restricts the disclosure of student health records maintained by educational institutions that operate hospitals, health plans, and health-care providers. In fact, the basic privacy provisions of HIPAA do not apply to student health records. Under HIPAA, once student health information is included in an "education record," it becomes subject to FERPA's privacy and disclosure rules. In addition, "treatment" records of students 18 years of age or older that are made or maintained by a student's treating physician or other medical professional are exempt from HIPAA's privacy provisions.

A sample policy on parent notification states in part:
The college reserves the right to notify parents or guardians, regardless of the student's age, status, or conduct, in health or safety emergencies, hospitalizations, or when in our judgment, the health or wellbeing of the student or others may be at risk.

United Educators: Risk Research Bulletin
April 2005; Students With Mental Health Problems: When Should Parents Be Notified?

4. Skip Simpson, is a nationally noted malpractice attorney, perhaps the leading attorney in the nation on mental health malpractice. He points out that lawsuits are filed for failure to communicate with an adverse result (e.g. death), rather than inappropriate disclosure.

He has written:

When considering the "imminence criteria" focus not on the question of estimating the timing of an attempt but on a gut check on how worried the clinician is about leaving a patient unprotected. When a clinician is uncertain about whether or not a patient is going to attempt suicide, erring on the side of safeguarding makes sense. Loved ones and the communities in which they live expect clinicians to protect their patients.

"If there are two ways to care for a patient, the safest way should be selected . To do otherwise means an unnecessary danger to the patient."

5. But I don't want to fixate upon the circumstances where there is a good faith belief a patient is suicidal. Because it is good therapy to involve others, whom the patients rely upon, in their treatment. Cf. numerous documents including SAMSHA's National Strategy for Suicide

Prevention. The two points I wish to make here are that providers can always listen to what family says….but need to take the time to do so. And providers should always seek out whomever is in a position to support the patient's recovery and seek an authorization to communicate with them. Many providers do not, or do not really advocate to get their patients to sign an authorization. Those who figure out who the patient trusts, and who wishes to help, can often succeed in getting that release signed. And of course, take the time to communicate once the authorization is signed.

6. Families all over the nation are clamoring for greater communication to save the lives of their loved ones, the nearly 40,000 who take their lives each year, and the many more who attempt but do not succeed. In response to this, Rep. Tim Murphy, (R-PA) introduced a bill this session that would have made family members in certain circumstances the personal representatives of patients for communication purposes. Given the paralysis of Congress, this bill will die at the end of session.

The Bazelon Center for MH law opposes the bill for a variety of related reasons. But it was with interest that I read a quote from Jennifer Mathis, director of programs at Bazelon:
"There are already exemptions in HIPAA that allow providers to talk to family or caregivers when the patient is a danger to self or others, but they are not often used. Providers may be 'hiding behind HIPAA' so they don't have to talk with families."

www.kaiserhealthnews.org/Stories/2014/June/04

7. Special Populations:

There are several scenarios that will require increased scrutiny and discretion on the part of the provider prior to communicating with the family. A patient seeking care from an abusive family situation or youth seeking care only on the condition of confidentiality must be treated as a special case, as will with serious substance abuse issues. Alcohol and drug treatment have more restrictions upon them related to confidentiality and must be handled with great discretion. And in all cases, it is not appropriate to disclose psychotherapy notes.

For patients of a sexual or gender minority, such as LGBT patients, issues of confidentiality become even more important and limiting disclosures needs to be done with great care. Per the recommendations of the AACAP Practice Parameter on Gay, Lesbian, or Bisexual Orientation, Gender Nonconformity, and Gender Discordance in Children and Adolescents (though equally applicable to adult patients):

"Clinicians should bear in mind potential risks to patients of premature disclosure of sexual orientation, such a family rejection or alienation from support systems, which might precipitate a crisis."

We believe that for the vast majority of treatment scenarios, however, involvement of the family will enhance care and reduce both the risk of suicide and the risk of a malpractice suit.

OCCAP, Suicide Prevention Checklist, 2013.

8. A common misperception is that HIPAA requires an authorization before any communication can take place. However, "Medical professionals can talk freely to family and friends, unless the patient objects.

No signed authorization is necessary. Health care workers may not reveal confidential information about a patient or case to reporters, but they can discuss general health issues." Susan McAndrew, Deputy Director of Health Information Privacy, U.S. Department of Health and Human Services, quoted in: Gross, Jane. *Keeping Patients' details private, even from kin.* New York Times, July 3, 2007.

9. Finally, there was mention of applicable ethics in OCR's documents. Virtually every major national professional association has an exception for communicating with family under certain circumstances; harm to self is always one of those circumstances. This includes: AMA, American Psychiatric Assn, Am Psychological Assn, Am Nurses Assn, and the Nat'l Assn of Social Workers.

To summarize my presentation:

- HIPAA was intended to facilitate communication, not stifle it….but has had opposite results.
- There are many exceptions to confidentiality built into HIPAA, among which are where patient does not object; is not competent to object or allow; is a danger to self or others; or is a minor or college student.
- Best practices suggest the greater the communication the better.
- Practitioners are better protected against lawsuits by communicating rather than being silent in many, perhaps most, circumstances.
- Essentially all major professional organizations recognize need to communicate outside authorization under certain circumstances.