Cal QIC Annual Conference
Monterey, CA

Legal Issues Update

Friday, March 23, 2012
9:00 a.m. – 12 noon
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Provider, Planner and Faculty Disclosures

- No commercial Support to this CME activity
- Provider, planner and speaker has no relevant financial relationships to disclose
- No conflicts identified

Agenda

- State and Federal Update
- Documentation: Consent, Abuse Reports
- Confidentiality: multi-disciplinary teams; integrated care
- Consent for Minors: Caregivers /Delegated Third Party
- Sealed records (juveniles)
- Scope of Practice
- Other questions

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State laws – eff. 1/1/12

- AB 332 – increases fines for elder/dependent adult financial abuse (theft, embezzlement, forgery, fraud, identity theft and other identity crimes) to up to $10,000 plus penalties/assessments and jail or prison sentence
- AB 1293 – allows assets of defendant to be frozen after just one instance of theft or embezzlement from elder/dependent adult if necessary to help victims receive restitution

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State laws –cont.

- SB 718 – authorizes county or long-term-care ombudsman to implement confidential Internet elder/dependent adult abuse/neglect reporting tool
- SB 233 – brings state law into line with EMTALA law that permits qualified medical personnel in ED's to perform medical screening examinations and to determine whether condition has stabilized, as permitted within the scope of their licensure

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State laws –cont.

- SB 146 – cleans up last year's law (AB 583) requiring certain health care professionals (e.g., physicians and nurses) to communicate to patients their name, license type, and highest level of academic degree in writing or in a prominent display in an area visible to clients – this law exempts LPCC's from the requirement (MFTs and LCSWs were exempted in original bill)

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AB 583 – Health Care Providers Disclosures to Patients

- All licensed health care providers (but not MFTs, LCSWs, clinical lab techs, respiratory therapists, hearing aid dispensers, veterinarians and those working in 24 hour care facilities) must distribute to patients in writing at first visit, or post in **24-point type**:

1. their name,
2. license type and
3. highest level of education (not RNs or Pharm.)
4. MD's who are Bd Certified must list that too

AB 583 exceptions – <u>don't</u> post info

- Marriage and Family Therapists
- Licensed Clinical Social Workers
- Licensed Professional Clinical Counselors (per SB 146)
- Clinical Laboratory Technicians
- Respiratory Therapists
- Hearing Aid Dispensers
- Veterinarians
- Licensees working in 24-hour Care Facilities
- Certified Drug and Alcohol Counselor's not licensed by the State

AB 583 – These Licensees <u>DO</u> Post Info

- MDs/ODs
- RNs
- NPs/PAs
- LVNs
- Psych Techs
- Psychologists
- Dentists
- Hygienists
- Perfusionists
- Opticians/Optometrists
- Pharmacists
- LPCCs (not anymore)
- Physical Therapists
- Occupational Therapists
- Chiropractors
- Speech Pathologists/Audiologists
- Dietitions
- Others under B&P Code, Div. 2, "Healing Arts"

State laws –cont.

- AB 956 – MFT registered interns or trainees, prior to performing professional services, must provide each client with name of his/her employer and indicate whether he/she is under the supervision of a licensed person – any advertisements by or on behalf of such interns or trainees must also contain certain specified information

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State laws -cont

- SB 24 – requires that if you must notify patient of a privacy breach (SB 541), such notification must be written in plain language and contain specified information, including contact info re: the breach, what was breached, and if possible the date, estimated date, or date range of the breach; if breach is large (500 or more) the notification to the state attorney general must be submitted electronically

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State laws –cont.

- SB 850 – Electronic health record systems must automatically record and preserve any change to, or deletion of, any electronically stored information

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State laws –cont.

- SB 913 – permits probation officers to authorize a medical examination that complies with the regulations adopted by the Corrections Standards Authority for a minor taken into temporary custody; if minor is retained in custody, PO may authorize medical or dental treatment recommended by examining physician and considered necessary for the health of the minor (PO must make reasonable attempt to notify and obtain consent of parent and if parent objects, PO must get court order)

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State laws –cont.

- SB 422 – permits physician to share HIV test results with local public health agency staff (not just local health officer) and permits local pubic health agency staff to "anonymously" contact spouses, sexual partners, and needle-sharing partners for referral for testing and counseling

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State laws –cont.

- SB 929 – requires hospitals, clinics and birthing centers that discharge any child under 8 years of age to provide and discuss information on child passenger restraint systems to the parents or person to whom the child is released (old law impacted children under 6 or under 60 pounds)

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State laws –cont.

- Telehealth Advancement Act of 2011 (signed by Governor 10/7/11; effective 1/1/12)
  - AB 415 – Updates California telehealth laws and permits streamlined credentialing of distant site telehealth professionals at service site hospital as permitted by CMS; does not require face-to-face nor demonstration that in-person is not available; requires only verbal consent (that must be documented in record); all confidentiality/ privacy rules apply

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Telemedicine questions

Questions:

- *Does distant site have to be CMS certified?* NO
- *What are risks re: privacy and security issues when using telehealth provider?* Any rules re: security of telemedicine equipment and storage of records? HIPAA and HITECH rules apply (reasonable measures to protect privacy and security per NIST standards)
- *Does telemedicine require additional consent form?* NO
- *How can policies protect the MHP from liability?* Best protection is through appropriate credentialing, and the telemedicine contract with the provider that includes insurance and indemnification clauses

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Federal Laws

- EMTALA (Emergency Medical Treatment and Active Labor Act) – can hospital ED transfer unstable psych patient (on 5150) to County Crisis Stabilization Unit (CSU)?
- CMS implies: "maybe"

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5150 Law, EMTALA and CSU's

EMTALA basics:

when a person…comes to a hospital…seeking medical care…regardless of ability to pay…

the hospital must perform a medical screening exam (MSE) to determine …

if there is an emergency medical condition (EMC), and if there is, …

must stabilize it prior to discharging or transferring the patient (or transfer to a facility that can)

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EMTALA and 5150's -continued

- 5150 patients are by definition suffering from a psychiatric "Emergency Medical Condition" but if the facility is not a designated LPS 72 hour evaluation and treatment facility,
  - it cannot admit the patient involuntarily, and
  - often has no staff that can "stabilize" a psych emergency
- Traditionally, hospital ED's thought this meant they MUST transfer to another HOSPITAL that had a locked unit (a "designated" LPS 72 hour evaluation and treatment facility)

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the "letter"

- November 12, 2009 letter
- CMS implies that transfer of an unstable psych patient to a Crisis Stabilization Unit (stand-alone or connected to a hospital or PHF), might not violate EMTALA
- CMS suggests "transfer policies to assess the capabilities of CSUs to provide appropriate stabilizing treatment to individuals with psychiatric emergency medical conditions"

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Federal laws –cont.

- SAMHSA has two Frequently Asked Questions documents prepared by the Legal Action Center that address Health Information Exchanges, consent forms, mergers, name changes, etc.
  - 12/08/11 - Applying the Substance Abuse Confidentiality Regulations 42 CFR Part 2
  - Oct. 2010 – Applying the Substance Abuse Confidentiality Regulations to Health Information Exchange (HIE)
- http://www.samhsa.gov/healthPrivacy/docs/EHR-FAQs.pdf

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Documenting consent

- Consent – permission to treat, acceptance of treatment plan should be documented in writing
- Informed consent – client has been educated about benefits and risks of proposed treatment and alternatives
- Medication consent – required for voluntary patients in inpatient settings

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Missing documentation

- Without documentation it is likely you will be denied reimbursement under some programs
- You can "argue" that you got permission but if there is nothing in writing unlikely you'll win the argument (if not required, we can argue "actual consent" is implied by behavior)
- Check with program on issue of "late" charting and "addendums" after the fact (some may not permit these additions to the chart long after treatment has been provided)

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Documenting Mandated Abuse Reporting

- progress note (date, time, name of person you spoke with, what you reported)
- child abuse – fax/send written CDJ form SS-8572 w/in 36 hours
- elder/dependent adult abuse – fax/send DSS "Report of Suspected Dependent Adult/Elder Abuse" (SOC 341) within 2 business days

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Documenting mandated reporting

- Law does not require you to keep copy, but risk management concerns make it prudent to keep one in a safe place (per your policy)
- Safe place could be:
  - In the chart (should not be defined as part of the "designated record set" and is NOT part of the chart for "access" purposes)
  - In the risk management office in locked drawer with incident reports
  - In administration/director of nurses/medical director's office in locked drawer

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Confidentiality: Multi-disciplinary teams

- Multi-disciplinary teams – two types
  1. Only health care providers: Collaboration for treatment purposes, may be from various disciplines
  2. Mixed teams: Health care providers and non-healthcare providers (e.g., social services, law enforcement, probation, school, Bd. of Supervisors)

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MDTs – healthcare providers only

- If you have mental health information, W&I Code 5328(a) lets you disclose patient PHI without authorization:
  - in communications to other qualified professionals (any discipline), in the provision of services or appropriate referrals, who have "medical or psychological responsibility" for the patient's care

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MDT's – healthcare providers only

- If members of the team do not have medical or psychological responsibility for the client's care you should
  - Obtain authorization, or
  - Treat it as a consultation (insert responsibility), or
  - Have business associate agreements in place (e.g., educational exchange, but minimum necessary rule suggests that PHI should be de-identified)

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MDTs – Mixed Teams

- there are several possible ways to handle confidentiality issues:
  - The EASIEST: get written authorization!

    OR
  - Ask others to de-identify the information ("we have a 27 year old homeless female who recently received services from the shelter but was then arrested for public intoxication and is now back on the streets and in need of behavioral health services – can you help?")

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Mixed Teams (no authorization) – handling confidentiality issues –cont.

- Participate only as a "consultant" to educate others about mental illness
- Provide specific "generic" input that does not identify the individual who is being discussed as someone you know
  - "what you are describing sounds like your client "Ms. Smith" is suffering from a treatable mental condition and we probably can help if you'd like to refer her"
  - and, if you create an individually identifiable record about someone you hear about at the MDT, treat it as PHI !

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Mixed Team – no authorization

- Remember, others, such as law enforcement, may be at liberty to identify the person, discuss the person, and make disclosures to others who attend the MDT, but you CAN'T make similar disclosures unless you have permission

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Confidentiality - suggestions for MDT participation when you know the person being discussed

- Get authorization from the patient or "patient representative"
- De-identify the information (sometimes almost impossible in small counties) so those present who shouldn't know who you are talking about, won't
- Enter into Business Associate Agreements that portray third parties as "part of the QI/QA process" and observe HIPAA minimum necessary rule

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Integrated care

- What must be done before you combine medical and mental health records? (not much)
- What must be done before you combine medical and/or mental health records with alcohol and drug treatment program records? (a lot)

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42 CFR Part 2 and Integrated care

- Federal confidentiality rules written 40 years ago re: drug and alcohol treatment programs were extremely restrictive because of stigma associated with that tx
- Much stricter than HIPAA and state laws that permit disclosures to all of an individual's providers for "treatment purposes"

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Integrated care

- Before you can allow access by other disciplines to drug/alcohol treatment program records via an integrated chart you must
  - have permission or
  - you must insure that those other providers are "within" the 42 CFR Part 2 program pursuant to a Qualified Service Organization agreement – and follow the same strict rules!

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Easiest: Get permission!

- Have every person who comes in for services at your integrated agency sign an authorization form (called "consent" under 42 CFR Part 2)

OR

- Wait until there needs to be a referral to AOD or from AOD and have individual sign form then

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Integrated Recordkeeping – Paper Chart

- With permission, ok to use one paper chart
- Without permission, drug and alcohol chart must be maintained separately and kept apart from other records (access only by treatment team WITHIN the drug/alcohol program and administrative staff with a need to know)

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Integrated Recordkeeping – Electronic Record

- Without permission, name connected to drug/alcohol doesn't register when entered into system
- With permission, name registers as being within the system and drug/alcohol information may be accessed on a need to know basis

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Non-parent consent for minors – **Caregiver's Affidavit**

- Family Code 6550 and 6552 permits consent by a non-parent adult relative with whom the child is living if a "Caregiver's Authorization Affidavit" is completed.
- Caregiver has same rights to consent to medical, dental and mental health care as a guardian (this includes consent for psychiatric medications)

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Caregiver's Affidavit –cont.

- "Guardian" consent is not quite as extensive as parent consent:
  - 14 and older minor – no surgery unless surgeon has consent from both the minor and the guardian; or court order; or emergency situation where guardian must act alone (Probate Code 2353)
  - No sterilization (Probate Code 2356)
  - No involuntary commitment (except 5150 etc), experimental treatment, or convulsive treatment (Probate Code 2356)

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Non-parent/guardian/caregiver consent for minor treatment

- If adult brings in a child and does not fit the criteria to complete the Caregiver Affidavit (e.g., non-relative) you will need permission or "authorization for third party to consent to treatment of minor lacking capacity to consent" from:
  - Parent, or
  - Guardian, or
  - Caregiver (who has signed Caregiver's Affidavit)

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Delegated authority (Family Code 6910)

- Get it in writing (does not have to be in any specific format, does not have to be dated or notarized)
- Ideally it will include emergency phone numbers so you can contact the parent to advise them of the care and discuss plans
- Note: not clear that Family Code 6910 covers mental health services so contacting the parent is even more important

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Delegated authority (Family Code 6910)

- Designated adult into whose care the minor has been entrusted can be identified by title and employer rather than by name
  - e.g., "Athletic Coach, John F. Kennedy High School, Sacramento, CA"
- Designated adult should not be the healthcare provider
- California Hospital Assn. form (CHA Form 2-3)

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New law re: minor consent

- Eff. 1/1/12 – AB 499 permits minors 12 and older to consent to medical care related to the prevention of sexual transmitted diseases (STDs) – important because some serious ones are preventable but not curable (e.g. HPV and HIV)
- Law already has allowed these minors to consent to diagnosis and treatment of STDs; now preventive care is available to them too

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Rights to access minor charts

- If minor consented to (or could have consented to) treatment, minor controls access to the chart (e.g., if parent wants to see it, or school seeks information, you need authorization from the minor)
- Once minor is 18, minor should be permitted to access chart from earlier years (law does not address this situation); if parents want access to chart from earlier years, you may want to check with adult child depending on the situation

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"sealed records"

- When minor is a ward or dependent of the Court, and Judge "seals" the court records, that doesn't preclude right of access to medical records under HIPAA;
- someone seeking "forensic" reports that are part of court record would have to petition the court

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Scope of Practice Documentation

- Always indicate your name and licensure or job title when making entries in the client's chart
- Auditors want to make sure that payers paid at appropriate reimbursement level based on provider and licensure level
- Scope of practice is defined by your licensing board; non-licensed staff must be directly supervised

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Questions?

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