Law & Ethics for
Behavioral Healthcare Providers
County of Santa Clara

Friday, September 27, 2019
8:30 Registration
9:00 a.m. – 4:30 p.m. Training
2455 Masonic Drive, San Jose, CA

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Garrett Consulting Group, LLC
415-924-4980
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Agenda
- Legislative Update
- Confidentiality
- Mandated Reporting
- Healthcare & Social Media: Ethical Considerations

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
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

End of Life Option Act, continued

- 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

AB 2850, CNA Instruction, continued

- 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)
<table>
<thead>
<tr>
<th>SB 849 – Medi-Cal Physicians/. Dentists Loan Program</th>
</tr>
</thead>
<tbody>
<tr>
<td>➢ 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.</td>
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<tr>
<td>➢ Provides loan assistance payments to qualifying, recently graduated physicians and dentists who serve beneficiaries of certain Medi-Cal health care programs</td>
</tr>
</tbody>
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<tr>
<th>AB 2138 – Professionals/Businesses - Revocation/Suspension of License</th>
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</thead>
<tbody>
<tr>
<td>➢ Limits licensing board’s ability to automatically deny applicant with previous criminal convictions more than 7 years old, with some exceptions</td>
</tr>
<tr>
<td>➢ 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</td>
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<tr>
<th>AB 2487 – Physicians’ opioid training</th>
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<tbody>
<tr>
<td>➢ 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)</td>
</tr>
</tbody>
</table>
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
  • opioid is prescribed concurrently with rx for benzodiazepine
  • 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

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 (but not PHFs) 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/30miles

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
➢ does not apply to PHF’s but 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

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, 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)

AB 2088 – Minor Records.
- 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 2099: 5150 Application Form

*Copy = Original*

- A copy of the W&I 5150 written application form SHALL be treated as an original!!
- Added to the 5150 statute to dispel the myth (never the law!) that ambulance drivers or LPS-designated facilities needed the “wet ink original” in order to act (e.g., some facilities “required” it, and used it as an excuse to turn away the patient)
- Insistence on the “original” would now violate the law
5150 Application –
New Form (06/18)

New 5150 Application Form
• [www.dhcs.ca.gov](http://www.dhcs.ca.gov); click on “Forms, Laws & Publications” - DHCS 1801 (06/18)
• Form now has space to document:
  ✓ Historical course of the person’s mental disorder
  ✓ Information gleaned from others that supports “probable cause” determination – reflects W&I 5150.05, the law that requires third-party relevant info to be considered

AB 1968: Weapons Prohibitions – Applied to Certain Mental Health Patients

➢ Amends/replaces Welfare & Institutions Code 8103
➢ Effective January 1, 2020: CA will impose a lifetime ban on gun ownership* for those involuntarily admitted (W&I Code 5151) into a locked designated LPS facility as danger to self or danger to others after having already been admitted one or more times during the preceding year (365-day period of time)

* “... shall not purchase or possess, or attempt to purchase or possess, or have in his or her possession, custody, or control a firearm or other deadly weapon...”

AB 1968 – Weapons Prohibitions (cont.)

➢ Prior to or concurrent with discharge, patients must be given information about the prohibition, and about their right to petition a court for a hearing regarding lifting the ban
➢ Facility must provide copy of the most recent DOJ “Patient Notification of Firearm Prohibition and Right to Hearing Form” to the patient
➢ DOJ must update the form and distribute to facilities by January 1, 2020
AB 1968 – Weapons Prohibitions (cont.)

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

• Note: current law, still in effect through 2019, requires the facility to forward the form to the superior court on behalf of the patient if the patient requests a hearing at the time of discharge, unless patient states that he or she wants to submit the form to the superior court.

AB 1968 – Weapons Prohibitions (cont.)

➢ Amended language in W&I 8103 says that the form requesting a court hearing “shall include an authorization for the release of the person’s mental health records, upon request, to the appropriate court…”

• Note the HIPAA prohibition against “compound authorizations” at 45 CFR 164.508(b)(3)
• Hopefully the authorization will be “separate” from the petition when the DOJ “updates” their form...

Gun Violence Restraining Orders (GVRO’s)

➢ Since 1/1/16 CA law has allowed individuals (family members, household members) and law enforcement the ability to temporarily prevent access to firearms by those in crisis – includes prohibition on possess or purchase guns or ammunition or relinquish them (if already owned)

• Temporary GVRO – 21 days
• Subsequent hearing – extended for up to one year

➢ Similar to existing domestic violence laws in all 50 states, involves a court hearing and clearly defined due process protections
GVRO’s - continued

- Who can petition the court?
  - Immediate family – spouse or domestic partner, parents, children, siblings, grandparents, grandchildren and their spouses including step-parents or step-grandparents
  - Any other person who lives in or regularly resides in the household, or who in the last 6 months has lived in or regularly resided in the household
  - Conservators
  - Law enforcement
  - Others who can ask law enforcement to investigate and file the petition

SB 1200, effective 1/1/19 – all court and filing fees have been eliminated for petitioning for a gun violence restraining order, including fees associated with having law enforcement serve a GVRO

AB 2983: Voluntary Patients and Psychiatric Holds

- 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
The problem of insisting that a person be put on a hold, even though he or she voluntarily agrees to a transfer or to the inpatient admission for psychiatric care, seems to have increased over the years, oftentimes not for patient care-related reasons:

- Insurance plans have reportedly refused to pay for “voluntary” inpatient mental health care (“we only pay for emergency care, and it’s not an emergency if the person is willing to receive treatment voluntarily!”)
- Ambulance drivers have stated they “feel safer” if person is on a hold, and won’t transport unless a hold is placed

Forcing the hold for these reasons adds to the stigma that the individual faces (in and out of the system), and also often burdens the patient with additional legal, social, and treatment consequences.

- It also can harm the formation of a good therapeutic relationship, leading to less than optimal outcomes
- AND, it has ALWAYS violated the LPS Act principles of “least restrictive means” (W&I 5150 and 5151)

Privacy and Confidentiality

- General Review – Everyday Breaches
- Review of 42 CFR Part 2 changes
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?”

HIPAA – Every Day Breaches To Watch Out For

➤ “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

42 CFR Part 2: Confidentiality and Substance Use Disorder Records

Introduction
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"

What does "federally assisted" mean?

- Basically, the SUD program could, or does, have a relationship with the federal government
- The relationship types vary, but usually relate to finances, licensure, or registration
  - e.g. Medicare participation, DEA registration, IRS tax benefits, et al.
Are county SUD programs “part 2 programs”?

- Generally, county SUD programs meet the definition of “part 2 program”

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!”

Disclosing Part 2 Records: §2.31 Written Consents
§2.31 written consents

- Strong rule of thumb: Those holding part 2 records can only disclose/redispose the records with the patient’s written consent
  - Oral consent is rarely sufficient!
- The most common type of written consent under Part 2 is the §2.31 written consent

Elements of the §2.31 written consent: #1

- (1) The patient’s name
  - “Thomas Chong”

Elements of the §2.31 written consent: #2

- (2) Who may disclose the record
  - “The Manchester County Substance Use Disorder Program”
  - “Dr. Deborah Woodruff”
### Elements of the §2.31 written consent: #3

**3. Explicit description of what may be disclosed**

- “My urinalysis results from January 1, 2018 – March 31, 2018.”
- Tip: Always include date ranges in the description!

### Elements of the § 2.31 written consent: #4

**4. Identity of the recipient(s)**

- Reference the “Recipient Table” (infra)
- Who may receive the records? To whom does the patient want the records sent?

### Elements of the §2.31 written consent: #4 (continued)

<table>
<thead>
<tr>
<th>RECIPIENT TYPE</th>
<th>REQUIRED INFO ABOUT THE RECIPIENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual(s)</td>
<td>Name of the individual(s)</td>
</tr>
<tr>
<td>Treating provider entity(ies)</td>
<td>Name of the treating provider entity(ies)</td>
</tr>
<tr>
<td>Third-party payer entity(ies)</td>
<td>Name of the third-party payer entity(ies)</td>
</tr>
</tbody>
</table>
Elements of the §2.31 written consent: #4 (continued)

<table>
<thead>
<tr>
<th>RECIPIENT TYPE</th>
<th>REQUIRED INFO ABOUT THE RECIPIENT</th>
</tr>
</thead>
</table>
| Non-treating provider entity(ies) (other than third-party payer entity(ies)) | Name of the non-treating provider entity(ies), PLUS:  
  • Name of individual(s); or  
  • Name of entity(ies) with a treating provider relationship; or  
  • General designation(s) identifying: (a) individual(s) with a treating provider relationship, and/or (b) entity(ies) with a treating provider relationship |

Elements of the §2.31 written consent: #5

1. **Notice to patients re: general designations**
   - “I confirm my understanding that, upon my request and consistent with 42 CFR §2.13(d), I must be provided a list of entities to which patient information has been disclosed pursuant to the general designation. _______ (initials)”
   - Tip: Wise to have the signatory initial this notice!

Elements of the §2.31 written consent: #6

1. **The purpose of the disclosure**
   - “To comply with the terms of my probation, I must disclose my attendance record and lab results.”
   - In other words, why does the patient want to disclose the records?
Elements of the §2.31 written consent: #6 (continued)

- What problems do you see here?:
  - **What may be disclosed?** “My full SUD record from 2018.”
  - **Purpose?** “To comply with the terms of my probation, I must disclose my attendance record and lab results.”

Elements of the §2.31 written consent: #6 (continued)

- What problems do you see here?:
  - **What may be disclosed?** “My attendance record from 2018 and my lab results from 2018.”
  - **Purpose?** “To comply with the terms of my probation, I must disclose my full SUD record.”

Elements of the §2.31 written consent: #7

- (7) A statement that the consent is subject to revocation at any time
  - “This consent is subject to revocation at any time.”
Elements of the §2.31 written consent: #8

- (8) The date, event, or condition upon which the consent will expire if not revoked before
  - “Please state the date, event, or condition upon which this consent will expire if not revoked before: ________________”

Elements of the §2.31 written consent: #9

- (9) Patient’s/authorized individual’s signature

Elements of the §2.31 written consent: #10

- (10) The date on which the consent is signed
Elements of the §2.31 written consent: #11

> (11) All other federal and state-required elements (i.e. HIPAA notices, etc.)

- e.g. “Manchester County SUD Program may not condition treatment, payment, enrollment or eligibility for benefits on whether the patient signs this consent.”
- Reference 45 CFR §164.508(c); CA Civ. Code §56.11; et al.

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. Patient’s/authorized individual’s signature
10. Date on which the consent is signed
11. All other federal and state-required elements
“Universal releases”

- Tip: Do not disclose part 2 records through a “universal release”
  - Universal releases often lack consent elements that Part 2 requires (e.g. an explicit description of SUD info, recipients named by name, etc.)
- Instead, use a stand-alone §2.31 consent

Samples

- Legal Action Center has sample §2.31 consents
- lac.org ➔ What We Do ➔ Resources ➔ Substance Use ➔ Confidentiality ➔ Sample Forms
  - It takes a few steps, but the samples are there!

Redisclosure Warnings
Redisclosure warnings

- Each disclosure made with the patient’s written consent must be accompanied by a written redisclosure warning.
- This warning needs to stand alone; i.e. do not place the warning on the patient’s written consent form.
- Two options for this warning:

Redisclosure warnings: Option 1 (The Dickens option)

- “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’s 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 by the written consent of the individual whose information is being disclosed or further permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose (see §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 §§2.12(c)(5) and 2.65.”

Redisclosure warnings: Option 2 (The Hemingway option)

- “42 CFR part 2 prohibits unauthorized disclosure of these records.”
Disclosures Without the Patient’s Written Consent

Disclosures within the part 2 program

- Personnel within the part 2 program may disclose necessary info to each other re: diagnosis, treatment, and referral
  - Remember: The part 2 program may not disclose info to those outside of the part 2 program—including other healthcare providers—unless the patient has provided written consent!

Bona fide medical emergencies

- §2.51(a): “... 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.”
FDA emergencies

- §2.51(b): “Patient identifying information may be disclosed to medical personnel of the Food and Drug Administration (FDA) who assert a reason to believe that the health of any individual may be threatened by an error in the manufacture, labeling, or sale of a product under FDA jurisdiction, and that the information will be used for the exclusive purpose of notifying patients or their physicians of potential dangers.”

Crimes on the premises or against part 2 program personnel

- The part 2 program may disclose necessary info to law enforcement re:
  - A patient’s commission or threat of a crime on the premises
  - A patient’s commission or threat of a crime against part 2 program personnel

Child abuse reporting

- Child abuse: The part 2 program may disclose info necessary to complete a child abuse report
Elder abuse reporting; Dependent adult abuse reporting; Tarasoff warnings

- Part 2 programs must make these reports/warnings when legally required to do so
- However, part 2 programs cannot link the part 2 program to the report/warning
- Likewise, the reporter cannot link the patient to the part 2 program
- The reporter must remain “anonymous”

Workarounds

The “phone book” method
Pre-list local probation officers, judges, etc.
on the consent

- If practicable, the §2.31 consent would pre-list potential recipients by name, allowing the patient to “check” all those to whom the disclosure may be made.

Officer Ian Curtis, Manchester County Probation Department
Officer Bernard Sumner, Manchester County Probation Department
Officer Peter Hook, Manchester County Probation Department
Officer Stephen Morris, Manchester County Probation Department

Self disclosure
Self disclosure

- Directly hand the patient a copy of his own record
- Once the patient is “holding” his own record, the patient may distribute it however he likes
- The patient is not beholden to 42 CFR Part 2!

Mandated Reporting

- Child Abuse/Neglect
- Elder/Dependent Adult Abuse/Neglect
- Injuries from Assaultive Behavior/Gunshot Wounds
- Tarasoff “Duty to Warn and Protect”
- Alzheimer’s Disease and Lapses of Consciousness (DMV Reports)

Child Abuse and Neglect Reporting Act (CANRA): PEN §§ 11164 – 11174.3
Who is a Mandated Reporter Under CANRA?

“Mandated reporter”

- §1165.7(a): “As used in this article, ‘mandated reporter’ is defined as any of the following: . . .”
  - (1 – 46, with further subdivisions for many of these numbers!)
  - Here is a sampling . . .

“Mandated reporter” (continued)

- “(15) A social worker, probation officer, or parole officer.”
- “(21) A physician and surgeon, psychiatrist, psychologist, dentist, resident, intern, podiatrist, chiropractor, licensed nurse, dental hygienist, optometrist, marriage and family therapist, clinical social worker, professional clinical counselor, or any other person who is currently licensed under Division 2 (commencing with Section 500) of the Business and Professions Code.”
  - BPC Division 2 concerns “Healing Arts”
“Mandated reporter” (continued)

- “(26) A state or county public health employee who treats a minor for venereal disease or any other condition.”
- “(34) An employee of any police department, county sheriff’s department, county probation department, or county welfare department.”
- “(38) An alcohol and drug counselor.”

Unsure whether or not you are a “mandated reporter” under CANRA? Please read §11165.7!

Scope of employment creates reporting duties

- §11166(a): “[A] mandated reporter shall make a report . . . whenever the mandated reporter, in the mandated reporter’s professional capacity or within the scope of the mandated reporter’s employment, has knowledge of or observes a child whom the mandated reporter knows or reasonably suspects has been the victim of child abuse or neglect.”
Employer notice to mandated reporters

§11166.5(a)(1): “[A]ny mandated reporter . . . prior to commencing his or her employment, and as a prerequisite to that employment, shall sign a statement on a form provided to him or her by his or her employer to the effect that he or she has knowledge of the provisions of Section 11166 and will comply with those provisions.”

What is Child Abuse?

“Child”

§11165: “Child” “means a person under the age of 18 years.”

• i.e. CANRA applies to emancipated minors (but exceptions exist)
“Child abuse or neglect”

§11165.6: “Child abuse or neglect” “includes physical injury or death inflicted by other than accidental means upon a child by another person, sexual abuse . . ., neglect . . ., the willful harming or injuring of a child or the endangering of the person or health of a child . . ., and unlawful corporal punishment or injury . . .. ‘Child abuse or neglect’ does not include a mutual affray between minors.”

“Neglect”

§11165.2: “Neglect” “means the negligent treatment or the maltreatment of a child by a person responsible for the child’s welfare under circumstances indicating harm or threatened harm to the child’s health or welfare. The term includes both acts and omissions on the part of the responsible person.”

“Willful harming or injuring of a child”

§11165.3: “The willful harming or injuring of a child or the endangering of the person or health of a child, means a situation in which any person willfully causes or permits any child to suffer, or inflicts thereon, unjustifiable physical pain or mental suffering, or having the care or custody of any child, willfully causes or permits the person or health of the child to be placed in a situation in which his or her person or health is endangered.”
“Serious emotional damage”

- §1166.05: “Any mandated reporter who has knowledge of or who reasonably suspects that a child is suffering serious emotional damage or is at a substantial risk of suffering serious emotional damage, evidenced by states of being or behavior, including, but not limited to, severe anxiety, depression, withdrawal, or untoward aggressive behavior toward self or others, may make a report to an agency specified in Section 11165.9.”
  - Please note that this is a “may report” statute

“Sexual abuse”

- §1165.1: “Sexual abuse” “means sexual assault or sexual exploitation . . .”
  - §1165.1(a) defines “sexual assault”
  - §1165.1(c) defines “sexual exploitation”
  - §1165.1(d) defines “commercial sexual exploitation”

“Sexual assault”

- Rape (§261)
- Unlawful sexual intercourse with a minor (aka “statutory rape”) when certain age disparities exist (§261.5(d))
- Rape in concert (§264.1)
- Incest (§285)
- Sodomy (§286)
“Sexual assault” (continued)
- Oral copulation (§287)
- Lewd or lascivious acts upon a child (§288(a), (b), and (c)(1))
- Sexual penetration (§289)
- Child molestation (§647.6)

“Sexual exploitation”
- §11165.1(c): “‘Sexual exploitation’ refers to any of the following: . . . (3) 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, except for those activities by law enforcement and prosecution agencies and other persons described in subdivisions (c) and (e) of Section 311.3.”

Determining What to Report
Knowledge or reasonable suspicion

§11166(a): “[A] mandated reporter shall make a report . . . whenever the mandated reporter . . . has knowledge of or observes a child whom the mandated reporter knows or reasonably suspects has been the victim of child abuse or neglect.”

“Reasonable suspicion” (continued)

§11166(a)(1): “‘Reasonable suspicion’ does not require certainty that child abuse or neglect has occurred nor does it require a specific medical indication of child abuse or neglect; any ‘reasonable suspicion’ is sufficient.”

Sexual assault and “unlawful sexual intercourse with a minor”

CANRA does not automatically require a report for all cases of “unlawful sexual intercourse with a minor” (aka “statutory rape”)

However, CANRA does require a report for cases of sexual intercourse between someone under 16 and someone 21 or older
Sexual assault and “unlawful sexual intercourse with a minor” (continued)

Partner under 16
AND
Partner 21 or older
AND
Sexual intercourse = Mandated report*

*No mandated report for partners who are spouses (see §261.5(a) exception)

CAUTION!

➢ Even when an activity does not automatically trigger a CANRA report, a report may still be required if other factors exist.
Sexual assault and “lewd or lascivious acts” upon children

- “Lewd or lascivious acts” may include sexual intercourse, as well as other sexual acts
- Per CANRA, mandated reporters must report:
  - “lewd or lascivious acts” upon children who are under 14
  - “lewd or lascivious acts” upon children who are 14 or 15 when the perpetrator “is at least 10 years older than the child”

Sexual assault and “lewd or lascivious acts” upon children (continued)

- CANRA’s reporting duties concerning “lewd or lascivious acts” upon children under 14 have troubled courts because the statute seemingly criminalizes all lewd or lascivious acts upon those under 14, including voluntary, consensual acts between and among those under 14
  - e.g. Voluntary, consensual acts between two 13 year-olds

Sexual assault and “lewd or lascivious acts” upon children (continued)

- So, what have the courts done?
Sexual assault and “lewd or lascivious acts” upon children (continued)

“Let a peremptory writ of mandate issue restraining the Attorney General of the State of California, and all California district attorneys, from henceforth and forever enforcing, implementing and administering the child abuse reporting law insofar as that law applies to voluntary, consensual sexual behavior among minors under the age of 14, bearing no indicia of actual sexual or other abuse in the judgment of the reporting professional involved. Nothing in this opinion shall be interpreted as interfering with the reporting law’s application to actual child abuse.” (181 Cal. App. 3d 245, 282.)

Sexual assault and “lewd or lascivious acts” upon children (continued)


“Mandated reporters . . . should not report voluntary ‘touching’ that otherwise may be deemed a ‘lewd and lascivious act’ when there is no other indication of abuse, neglect or duress and:

- One person is under 14 years old and his or her partner is under 14 years old.
- One person is 14 years old and his or her partner is under 24 years old.
- One person is 15 years old and his or her partner is under 25 years old.”

Sexual assault and “lewd or lascivious acts” upon children (continued)
Sexual assault and “lewd or lascivious acts” upon children (continued)

- Partner under 14
  - AND
  - Partner under 14
    - AND
    - Lewd or lascivious act =
      - Use professional judgment

Sexual assault and “lewd or lascivious acts” upon children (continued)

- Partner under 14
  - AND
  - Partner 14 or older
    - AND
    - Lewd or lascivious act =
      - Mandated report

Sexual assault and “lewd or lascivious acts” upon children (continued)

- Partner who is 14 or 15
  - AND
  - Partner at least 10 years older
    - AND
    - Lewd or lascivious act =
      - Mandated report
CAUTION!

- Even when an activity does not automatically trigger a CANRA report, a report may still be required if other factors exist.

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How to Report

- Report to law enforcement or the county welfare department

  §1165.9: “Reports of suspected child abuse or neglect shall be made by mandated reporters . . . to any police department or sheriff’s department, not including a school district police or security department, county probation department, if designated by the county to receive mandated reports, or the county welfare department.”
Law enforcement, etc. must accept the report

§11165.9: “Any of those agencies shall accept a report of suspected child abuse or neglect . . . even if the agency to whom the report is being made lacks subject matter or geographical jurisdiction to investigate the reported case, unless the agency can immediately electronically transfer the call to an agency with proper jurisdiction.”

Immediately report via telephone, then submit written report

§11166(a): “The mandated reporter shall make an initial report by telephone to the agency immediately or as soon as is practicably possible, and shall prepare and send, fax, or electronically transmit a written followup report within 36 hours of receiving the information concerning the incident.”

Complete CA’s reporting form

§11168: “The written reports required by Section 11166 shall be submitted on forms adopted by the Department of Justice . . . Those forms shall be distributed by the agencies specified in Section 11165.9.”
Complete CA’s reporting form (continued)

- Use CA form “BCIA 8572” for written reports
  - BCIA: Bureau of Criminal Information and Analysis (a branch of the CA Dept. of Justice)
- https://oag.ca.gov/sites/all/files/agweb/pdfs/childabuse/ss_8572.pdf?

Joint knowledge

- §11166(h): “When two or more persons, who are required to report, jointly have knowledge of a known or suspected instance of child abuse or neglect, and when there is agreement among them, the telephone report may be made by a member of the team selected by mutual agreement and a single report may be made and signed by the selected member of the reporting team.”

Joint knowledge (continued)

- §11166(h): “Any member who has knowledge that the member designated to report has failed to do so shall thereafter make the report.”
Reporting to colleagues, employers, supervisors, etc. is not a substitute

- §11166(i)(3): “Reporting the information regarding a case of possible child abuse or neglect to an employer, supervisor, school principal, school counselor, coworker, or other person shall not be a substitute for making a mandated report to an agency specified in Section 11165.9.”

Supervisors cannot report on behalf of employees

- §11166(i)(1): “The reporting duties under this section are individual[] . . . An internal policy shall not direct an employee to allow the employee’s supervisor to file or process a mandated report under any circumstances.”
- But please note: Internal policies may direct employees who are not mandated reporters to immediately notify supervisors of potential child abuse

Reporters may remain anonymous from their employer

- §11166(i)(2): An employer’s “internal procedures shall not require any employee required to make reports pursuant to this article to disclose the employee’s identity to the employer.”
Some anonymity

  - “The identity of all persons who report under CANRA shall be confidential and disclosed only:
    - Among agencies receiving or investigating mandated reports;
    - To counsel in certain cases arising out of a report;
    - To a licensing agency when abuse or neglect in out-of-home care is reasonably suspected;
    - When those persons waive confidentiality; or
    - By court order.”
Immunity for reporters

- §11172(a): "No mandated reporter shall be civilly or criminally liable for any report required or authorized by this article, and this immunity shall apply even if the mandated reporter acquired the knowledge or reasonable suspicion of child abuse or neglect outside of his or her professional capacity or outside the scope of his or her employment."

CA may pay mandated reporters' attorneys' fees

- §11172(d)(1): "[A] mandated reporter may present a claim to the Department of General Services for reasonable attorney's fees and costs incurred in any action against that person on the basis of making a report required or authorized by this article if the court has dismissed the action upon a demurrer or motion for summary judgment made by that person, or if he or she prevails in the action."

CA may pay mandated reporters' attorneys' fees (continued)

- §11172(d)(1): “Attorney's fees awarded pursuant to this section shall not exceed an hourly rate greater than the rate charged by the Attorney General of the State of California at the time the award is made and shall not exceed an aggregate amount of fifty thousand dollars ($50,000)."
Elder and Dependent Adult Abuse and Neglect Reporting

Elder Abuse and Dependent Adult Civil Protection Act (W & I Code 15600-15659; Penal Code 368)

Protects:
- Adults aged 65 and older
- Dependent Adults:
  - Aged 18–64, in a 24-hour care facility
  - Aged 18-64, with physical or mental limitations that restrict their ability to carry out normal activities or protect their rights

What must be reported?
- physical abuse, including sexual abuse
- neglect
- financial abuse
- false imprisonment
- kidnapping

What must be reported? continued
- abandonment by someone who has taken on role as caretaker
- isolation
- other treatment that results in physical harm or pain or mental suffering
- deprivation of care, goods or services necessary to avoid physical harm or mental suffering
What may be reported?

Mandated reporters (and others) may report to the person’s health care provider (or to the police with permission from the patient):

• concerns about other forms of abuse such as intimidation, or

• cruel treatment that endangers an elder’s or dependent adult’s emotional well-being.

Who must report?

Welfare & Institutions Code §15630

(a) Any person who has assumed full or intermittent responsibility for the care or custody of an elder or dependent adult, whether or not he or she receives compensation, including administrators, supervisors, and any licensed staff of a public or private facility that provides care or services for elder or dependent adults, or any elder or dependent adult care custodian, health practitioner, clergy member, or employee of a county adult protective services agency or a local law enforcement agency, is a mandated reporter.

Mandated reporters include “care custodians”

W&I 15610.17. “Care custodians” means an administrator or an employee of any of the following public or private facilities or agencies, or persons providing care or services for elders or dependent adults, including members of the support staff and maintenance staff:

(a) Twenty-four-hour health facilities, as defined in Sections 1250, 1250.2, and 1250.3 of the H&S Code.
(b) Clinics.
(c) Home health agencies.
(d) Agencies providing publicly funded in-home supportive services, nutrition services, or other home and community-based support services.
(e) Adult day health care centers and adult day care.
(f) Secondary schools that serve 18- to 22-year-old dependent adults and postsecondary educational institutions that serve dependent adults or elders.
(g) Independent living centers.
(h) Camps.
(i) Alzheimer’s Disease day care resource centers.
(j) Community care facilities, as defined in Section 1562 of the Health and Safety Code, and residential care facilities for the elderly, as defined in Section 1569.2 of the Health and Safety Code.
(k) Respite care facilities.
(l) Foster homes.
(m) Vocational rehabilitation facilities and work activity centers.
Who must report – continued

**AB 575 – Effective Jan. 1, 2018** - expands the definition of “health practitioner” for the purpose of the mandated elder and dependent adult abuse reporting to include SUD counselors; defines SUD counselor as a person providing counseling in an SUD program (*note confidentiality issues)

What triggers report?

- Report must be made by mandated reporter who in his or her professional capacity or within the scope of employment:

  1. **has observed or has knowledge of abuse or neglect**, or
  2. **is told by elder or dependent adult that he or she has experienced abuse or neglect**, or
  3. **reasonably suspects abuse**
“being told about abuse” – W&I 15630(b)(3)(A) exception

A physician, registered nurse or “psychotherapist” as defined in Evidence Code 1010 does not have to report if:

1. Mandated reporter has been told that there is physical abuse, abandonment, abduction, isolation, financial abuse or neglect, AND
2. Reporter is unaware of independent corroborating evidence, AND
3. Elder/dependent adult has been dx with mental illness or dementia or is conserved due to mental illness or dementia, AND
4. Reporter reasonably believes, in the exercise of clinical judgement, that the abuse did not happen.

How/when to report

Immediately by phone to local law enforcement or APS:

• your name,
• the name and age of the subject of the report,
• present location of the subject,
• names and addresses of family members of others responsible for the subject’s care,
• nature and extent of condition,
• date of incident,
• other information requested by the agency, such as what led to the reasonable suspicion

How to report -continued

➢ Written report sent within two working days -- sooner if physical abuse in long term case setting – in that case do it immediately (law says within 2 hours – why wait?)

• Use DSS “Report of Suspected Dependent Adult/Elder Abuse” (SOC 341)
• Download at: https://www.cdss.ca.gov/cdssweb/entres/forms/English/SOC341.pdf
Where to report

- in long-term care facility report to:
  - the local ombudsperson or law enforcement agency (immediately if physical abuse)

- in state mental hospital or DD center report to:
  - DMH or DDS or to local law enforcement agency

- in any other place, report to
  - adult protective services agency or local law enforcement

Documentation

- Progress note: who you spoke to, date and time, plus “gist” of the conversation

- Keep copy of written report per your facility’s policy

Confidentiality – HIPAA

HIPAA: 45 CFR 164.512

- (a) disclosures permitted when required by law
- (c) about victims of abuse, neglect or domestic violence
Note: HIPAA requires you to notify patient of report

45 CFR 164.512(c)(2):
Client/patient must be promptly informed that a report has been, or will be made, unless:
- It would place him or her a risk of serious harm or
- The report would go to a client/patient representative who is believed to be responsible for the abuse or neglect and it would not be in the best interest of the client/patient

Confidentiality - CA law
- Civil Code 56.10 (physical health info)
  8(b) 9 (disclosure required) When otherwise specifically required by law.
  8(c) 14 – (disclosure permitted) When otherwise authorized by law
- W&l Code 5328.5 - Mental health info may be disclosed to report elder/dependent adult abuse

42 CFR Part 2 – substance use disorder treatment programs
- No specific exception for elder abuse/neglect reports
- Report of elder abuse/neglect out of SUDs treatment programs should be “anonymous” as to the relationship of the client and the reporter to the SUD program (i.e. do not disclose that the client is receiving SUD services or that reporter is an SUD provider)
Reporting Gunshot Wounds and Suspicious Injuries

- Penal Code section 11160 et seq
  - This is not a domestic violence reporting law per se
  - Any of these types of wounds or injuries, regardless of the perpetrator, must be reported by certain healthcare providers
  - This law generally covers victims aged 18-64 (and accidental gunshot injuries) because it specifically does NOT apply if a child abuse report or elder/dependent adult abuse/neglect report is triggered

Who is a mandated reporter?
Any health practitioner who in professional capacity or within the scope of employment
> provides medical services
> for a physical condition
> to a patient whom
> he/she knows or reasonably suspects

Who?, continued
> is suffering from wound or other physical injury
  > caused by firearm (self, or other, accidental or intentional),
  > inflicted upon the person as a result of “assaultive or abusive conduct”
How/when to report

- Immediately by phone to local law enforcement agency.
- Written report within two working days.
- If two or more reporters are present and jointly have knowledge of reportable event they may agree among themselves to report as a team.

Reporting form

- Use the California Emergency Management Agency (CalEMA) standard form called the “Suspicious Injury Report” (CalOES 2-920)
- See resources at California Clinical Forensic Medical Training Center

Documentation

- Progress note: who you spoke to, date and time, plus ”gist” of the conversation
- Keep copy of written report per your facility’s policy
Reporting - cont

➢ Report required even if person who has suffered the injury has died (regardless of cause of death), and even if evidence of reportable conduct was discovered during autopsy

➢ Victim must be notified of report (verbal ok) unless it will cause:
   • Risk of serious harm to patient
   • Personal representative would receive report and is believed to be responsible for the abuse, neglect or other injury and would not be in the best interests of the patient

Documentation in chart

Penal Code 11161 recommends, but doesn’t require, that you document in the medical record of the person who is subject of the report the following:

➢ Any comments by the injured person about past domestic violence or regarding the name of any person suspected of inflicting the wound or injury, or other assaultive or abusive conduct

➢ A map of the injured person’s body showing and identifying the injuries and bruises at the time of the health care

➢ A copy of the written report

Confidentiality - HIPAA

➢ HIPAA: 45 CFR 164.512 permitted uses:

   • (a) uses and disclosures required by law
   • (f) law enforcement purposes (as required by law to report certain types of injuries)
Confidentiality - CA law

- Civil Code 56.10 (physical health info)
  - (b) (9) (disclosure required) When otherwise specifically required by law.
  - (c) (14) – (disclosure permitted) When otherwise authorized by law
  - (note: report would not be made by mental health or substance use disorder treatment program provider because they are not mandated reporters under this law)

Confidentiality, continued

- Reports must be kept confidential and in no case shall person suspected or accused of inflicting wound or injury have access to information about the injured person’s whereabouts
- Reports may be given upon written request to an elder death review team or domestic violence review team in certain circumstances
- In court proceeding or administrative hearing privilege does not apply to the information required to be reported under this law

Reporting Disorders Characterized by Lapses of Consciousness (so DMV can restrict driving privileges)
Reporting Disorders Characterized by Lapses of Consciousness

- Physician must report when patient 14 and older is diagnosed with a disorder characterized by lapses in consciousness, defined at 17 CCR §2806 as medical conditions that involve:
  1. A loss of consciousness or a marked reduction of alertness or responsiveness to external stimuli AND
  2. The inability to perform one or more activities of daily living (bathing, dressing, teeth, cooking, shopping, paying bills, etc.) AND
  3. Impairment of the sensory motor functions necessary to operate a motor vehicle (e.g., integration of seeing, hearing, thinking, and reacting with physical movement, e.g., to stop a car from entering an intersection with a green light to avoid hitting a pedestrian)

Exceptions to reporting (17 CCR 2812)

- If patient’s sensory motor functions are impaired to the extent that the patient is unable to ever operate a motor vehicle
- Patient states he or she does not drive and states he or she never intends to drive, and physician believes it
- Situation has been previously reported by the physician and physician believes that a patient has not operated a motor vehicle
- There is documentation in the patient’s record that the diagnosis has already been reported by a different provider and physician believes the patient has not operated a motor vehicle

Examples of diseases that might trigger such a report per 17 CCR §2806

- Alzheimer’s disease and related disorders (those illnesses that damage the brain causing irreversible progressive confusion, disorientation, loss of memory and judgement)
- Seizure disorders
- Brain tumors
- Narcolepsy
- Sleep apnea
- Abnormal metabolic states including hypo- and hyper-glycemia associated with diabetes
- Note: visual impairments are not reportable
Filing Report

- If physician believes condition is met, report must be filed w/in 7 calendar days (1 week)
- If report is not required, physician “may” nonetheless report if he or she reasonably and in good faith believes it will serve the public interest
- If several doctors treat a patient (e.g., in the emergency room) only one report is required; policy and procedure should address this
- Document that report was made and that the patient was counseled not to drive

Form: CDPH 110 C
“Confidential Morbidity Report”

- Form available from your local health department; after you submit to local health officer, he or she will in turn report patient’s name, age and address to the DMV (where it remains confidential)
- Alternatively you can report via California Public Health Department Reportable Disease Information Exchange (CalREDIE): https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/CalREDIE.aspx
- Keep copy of report!

If patient recovers...

- Physician may send letter to DMV requesting that the patient’s right to drive be re-evaluated (with permission from patient)
Charting
- Document the diagnosis
- Document that patient was questioned about driving
- Document whether exception applies based on answers and fact that physician believes the patient (or not)

Immunity/liability
- A physician who reports a patient diagnosed as having a disorder characterized by lapses of consciousness is not civilly or criminally liable
- A physician who doesn’t report, may be liable for failing to report if patient drives and injures someone!

Confidentiality – HIPAA
- HIPAA: 45 CFR 164.512 permitted uses:
  - (a) uses and disclosures required by law
  - (j) uses and disclosures to avert a serious threat to health or safety
Confidentiality

- Civil Code 56.10 (physical health info)
  - (b) (9) (disclosure required) When otherwise specifically required by law.
  - (c) (14) – (disclosure permitted) When otherwise authorized by law

- HIPAA – 45 CFR 164.512 (a) and (j)
  - (a) When required by law
  - (j) Uses and disclosures to avert a serious threat to health or safety

Tarasoff “Duty to Warn/Protect”

- Tarasoff v. Regents of UC
  California Supreme Court held that therapist has “duty to warn and protect” reasonably identifiable third parties by notifying them, and law enforcement if appropriate, if therapist knows, or should reasonably know, that client poses serious risk of harm

  - Civil Code 43.92 – enacted to “overrule” the part of Tarasoff that required a warning if therapist “reasonably should have known” of threat

Civil Code 43.92 continued

- Provides immunity to “psychotherapists” as defined by Evidence Code 1010 from liability for failure to predict and/or warn of a client/patient’s violent behavior when:
  
  1. a client communicates a serious threat against a reasonably identifiable victim or victims, and
  2. the psychotherapist discharges their “duty to warn/protect” by notifying law enforcement and the victim
Evidence Code 1010

As used in this article, “psychotherapist” means a person who, or is reasonably believed by the patient to be:

(a) A person authorized to practice medicine in any state or nation who devotes, or is reasonably believed by the patient to devote, a substantial portion of his or her time to the practice of psychiatry.
(b) A person licensed as a psychologist under Chapter 6.6 (commencing with Section 2900) of Division 2 of the Business and Professions Code.
(c) A person licensed as a clinical social worker under Chapter 14 (commencing with Section 4991) of Division 2 of the Business and Professions Code, when he or she is engaged in psychotherapy under a credential issued by the Board of Behavioral Science.
(d) A person who is serving as a school psychologist and holds a credential authorizing that service issued by the State Board of Education.
(e) A person licensed as a marriage and family therapist under Chapter 13 (commencing with Section 4980) of Division 2 of the Business and Professions Code.
(f) A person registered as a psychological assistant who is under the supervision of a licensed psychologist or board certified psychiatrist as required by Section 2913 of the Business and Professions Code.
(g) A person registered as an associate clinical social worker who is under supervision as specified in Section 4996.23 of the Business and Professions Code.
(h) A person registered with the Board of Psychology as a registered psychologist who is under the supervision of a licensed psychologist or board certified psychiatrist.
(i) A psychological intern as defined in Section 2911 of the Business and Professions Code who is under the supervision of a licensed psychologist or board certified psychiatrist.

(Added by Stats. 2017, Ch. 573, Sec. 75. (SB 800) Effective January 1, 2018.)

Confidentiality – HIPAA

➢ HIPAA: 45 CFR 164.512
• (a) disclosures permitted when required by law
  (disclosure should be limited to the relevant requirements of the law)

• (j)(1)(i) disclosure permitted consistent with applicable law and ethical conduct if disclosure is necessary to prevent or lessen a serious and imminent threat to health or safety
Confidentiality – CA law

- W&I 5328 (a)(18) If the patient, in the opinion of his or her psychotherapist, presents a serious danger of violence to a reasonably foreseeable victim or victims, then any of the information or records specified in this section may be released to that person or persons and to law enforcement agencies and county child welfare agencies as the psychotherapist determines is needed for the protection of that person or persons. For purposes of this paragraph, “psychotherapist” has the same meaning as provided in Section 1010 of the Evidence Code.

Threats communicated at SUD Treatment Programs

- Warnings out of SUD treatment programs should be “anonymous” as to the relationship of the client and the reporter to an SUD program (i.e. do not disclose that the client is receiving SUD services or that provider works at SUD program)

Ethics and Social Media

- Dual Relationships and Boundaries
- Individual Viewpoints and Free Speech
- Discrimination and Harassment
- Yelping
Dual relationships.

- If you are two things to the same person, and one of those things is healthcare professional, you have a "dual relationship" – can include Facebook "friending".
- Problematic if it detracts from, or undermines the therapeutic relationship (and benefit that the patient gets from that relationship).
- When is it especially problematic, but unfortunately something we sometimes see in the County setting? (answer: forensic requests from the Court).

Dual relationships – other problems

- Client may ask for favors if you are perceived to be "friends" outside of therapy - Why might that be bad?
- Client might expect special treatment (this is also why accepting gifts is unwise)
  - Example: requests for "off the clock" counseling
- Other clients might think the client is getting special treatment and resent it
- Outside relationship might suffer causing provider direct personal harm

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 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 YouTube

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?

Social media – your free expression vs. patients’ privacy rights

- Unless you have permission, there is no exception for disclosing PHI on social media or anywhere else
  - PHI doesn’t have to be explicit ("naming names")
  - Example: RIP Edith
  - Example: “fun at the petting zoo” photos
  - Example: defending self from Yelp or in the newspaper from a letter to the editor ("person who says I'm a bad provider is just mad I won't give her more oxy's!")
What would you do?

You just got a notice from your child’s school that he has been assigned a new Special Education teacher. You instantly recognize the unusual name as belonging to a problem client you had five years ago who tried to get you fired, threatened to sue you, and then reported you to your licensing board. She also trolled you on Facebook for two years until finally leaving you alone. You check the school’s website where pictures are posted of all of their teaching staff, and see that it is indeed your old client. The school won’t let you change teachers unless you have a good reason. What now?

Issues?
1.
2.
3.
4.
5.

Other Risks & Ethical Challenges

• Tape-recording/video taping – do clients have a right to tape?
  • “First Amendment Audits” put on You Tube
  • 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)