Supporting WA State Behavioral Health Providers to Optimize Telehealth in Response to COVID-19

Q&A from BHI Telehealth Training Session #7 May 13, 2020:
Telehealth – 42 CFR Part 2 and HIPAA

Presenter: Christina Khaikin, Sally Friedman, Michael Graziano, Legal Action Center

Q: Would self harm of a youth done within the month constitute a medical emergency for MH referral to provider without written consent? I am a SUDP working in prevention and I am talking about referring to a mental health provider without a written consent.

A: As a threshold matter, it is important to note that Part 2 only applies to Part 2 programs and person who received patient-identifying information from Part 2 programs. Such providers who want to make a MH referral for a youth who threatened self-harm one month earlier may , according to SAMHSA guidance, use their discretion to determine whether a bona fide medical emergency exists. If written consent can be obtained either electronically or by some other means, SAMHSA's guidance probably does not apply. The medical emergency exception should be used when prior written consent cannot be obtained and sharing information is necessary to treat the medical emergency. See 42 CFR § 2.51

Q: Is there any flexibility for obtaining consent verbally for clients who don't have access to submit an electronic consent form? For example, people experiencing homelessness? Re: SUD clients experiencing homelessness, could medical emergency consent rules allow for redisclosure via the Collective platform? Collective is part of the EDIE/Pre-Manage system that King County and Washington State is implementing for care coordination. Collective Platform is a platform that hospitals and EDs use to notify caregivers (physical and behavioral) that their patients have gone to the hospital or the ED. It also can contain guidelines for ED personnel about treatment considerations (e.g., case managers the patient is working with).

A: 42 CFR Part 2 generally requires written patient consent to share patient identifying information unless an exception applies. There is not an exception for individuals experiencing homelessness. If the information is coming from the ED to caregivers or other providers, it is possible that Part 2 does not even apply because EDs generally are not Part 2 programs. (see coephi.org for resources about who is a Part 2 program). If the platform contains Part 2-protected information, the individual should have already provided written consent to share that information to the platform and to providers that access that platform. If not, there is an aspect of the Part 2 medical emergency exception that allows the medical provider to "break the glass" and access Part 2 protected information if it is necessary to treat the medical emergency. In all other cases, written consent would be needed unless a different exception applies.

Q: For risk/liability purposes, do you encourage provider agencies to develop policies on consent protocols, and confidential info exchange on non HIPAA platforms during the pandemic? If so, do you have a resource to use as example?

A: It is prudent to develop consent protocols, but I am not aware of an existing resource. Moreover, because OCR's Notification of Enforcement Discretion is new and temporary, it's possible that no such resources will be developed. In any case, the best practice is to, use the most secure platform available and avoid the use of platforms that are not HIPAA compliant, unless that is not possible.

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Q: I am a SUD provider and was told Zoom is HIPAA compliant, is that not accurate?
A: Zoom and Zoom for Healthcare are different products. You can see a list of products that represent they are "HIPAA Compliant" on OCR's Notification of Enforcement Discretion: https://www.hhs.gov/hipaa/for-professionals/special-topics/emergency-preparedness/notification-enforcement-discretion-telehealth/index.html
Q: How might a group help folks in supportive housing to access teleservices privately?
A: We suggest working with the site staff to identify a private space.
Q: How long ago would self harm have to have been to not be considered a medical emergency?
A: See answer to the first question, above.

For more information, please see:

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Behavioral Health Training, Workforce and Policy Innovation Center

Behavioral Health Providers across Washington State are on the front lines providing critical mental health and substance use treatment during an unprecedented public health emergency. State and federal guidelines continue to evolve so that more providers may use telehealth during the COVID-19 pandemic. Organizations from across the state have responded in amazing fashion to assure that providers across the continuum and age spectrum have access to information and resources necessary to help you begin or expand your use of telehealth.

https://bhi-telehealthresource.uwmedicine.org/Pages/About-Us.aspx

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Northwest (HHS Region 10)

MHTTC Mental Health Technology Transfer Center Network

Funded by Substance Abuse and Mental Health Services Administration

We provide training and technical assistance (TA) in evidence-based practices (EBPs) in SAMHSA's Region 10 (Alaska, Idaho, Oregon, and Washington). Our target workforce includes behavioral health and primary care providers, school and social service staff, and others whose work has the potential to improve behavioral health outcomes for individuals with or at risk of developing serious mental illnesses.

Funded by the Substance Abuse and Mental Health Services Administration (SAMHSA), the MHTTC Network includes 10 Regional Centers, a National American Indian and Alaska Native Center, a National Hispanic and Latino Center, and a Network Coordinating Office. This work is supported by grant SM 081721 from the Department of Health and Human Services, Substance Abuse and Mental Health Services Administration.

https://mhttcnetwork.org/centers/northwest-mhttc/home

www.mhttcnetwork.org/northwest https://bhi-telehealthresource.uwmedicine.org/