COMMENTS OF THE LEGAL ACTION CENTER
TO THE U.S. DEPT. OF HEALTH AND HUMAN SERVICES,
SUBSTANCE ABUSE & MENTAL HEALTH SERVICES ADMINISTRATION

RE: NOTICE OF PUBLIC LISTENING SESSION, 83 FED. REG. 1041 (JAN. 9, 2018)
SUBMITTED FEBRUARY 6, 2018 VIA ELECTRONIC MAIL

I. OVERVIEW AND INTRODUCTION TO LEGAL ACTION CENTER’S COMMENTS

The Legal Action Center (“LAC”) is the only non-profit law and policy organization in the United States whose sole mission is to fight discrimination against people with histories of addiction, HIV/AIDS, or criminal records, and to advocate for sound public policies in these areas.

Our comments reflect nearly four decades of experience and expertise in applying and interpreting the federal law and regulations at 42 U.S.C. § 290dd-2 and 42 C.F.R. Part 2 (referred to collectively here as “Part 2”). LAC attorneys regularly provide legal advice, technical assistance, and trainings on Part 2 to treatment programs, welfare and child welfare systems, law enforcement and criminal justice officials, courts, and public health officials. LAC also collaborates with policy makers at the federal, state, and local levels regarding public policies to expand access to treatment and to protect the confidentiality of people in treatment.

As recognized by Congress in enacting the original legislation, it is important to guarantee the confidentiality of substance use treatment records in order to encourage individuals with substance use disorders to enter treatment. In a moment of historic rates of substance use-related mortality, the decision to enter treatment is often a matter of life and death, and LAC strongly urges against the erection of any new barriers to treatment.

As a member of the Campaign to Protect Patient Privacy Rights, LAC, together with over 100 of the nation’s leading addiction treatment, recovery, health care and advocacy organizations, supports Part 2’s core confidentiality protections and the following principles:

- The heightened privacy protections in Part 2 are as critically important today as when they were enacted more than 40 years ago;
- In the midst of the worst opioid epidemic in our nation’s history, we must do everything possible to increase – not decrease – the number of people who seek treatment;
- Substance use disorders are unique among medical conditions, because of the criminal consequences and discrimination associated with the disease;
- Patients in substance use disorder treatment should retain the right to consent when and to whom their records are disclosed;
- Effective integration of substance use disorder treatment with the rest of the healthcare system is critically important, and information exchange in accordance with confidentiality law and current technology is now possible;

1 For a complete list of the members of the Campaign to Protect Patient Privacy Rights, visit https://lac.org/wp-content/uploads/2017/09/CPPart2-Principles-.pdf.
Part 2 provides safeguards for patients against disastrous results where the Health Insurance Portability and Accountability Act (“HIPAA”) would not; and

The confidentiality protections must be maintained in order to protect patient privacy and encourage people with opioid and other substance use disorders to enter treatment.

LAC submits the following comments in response to SAMHSA’s request for input concerning the effect of Part 2 on patient care, health outcomes, and patient privacy as well as potential regulatory changes and future sub-regulatory guidance:

- **Part 2 promotes patient care, health outcomes, and patient privacy.**

  Part 2’s confidentiality protections encourage individuals with substance use disorder to enter treatment by assuring them their treatment information will not be disclosed without their consent and building trust between patients and providers. Because Part 2 encourages people to enter and remain in treatment, which in turn makes it more likely they will manage and survive their illness, Part 2 improves patient care and health outcomes. Many people with substance use disorders would not enter treatment if Part 2’s privacy protections did not exist due to fear of discrimination by health care providers and others. LAC believes that it is possible to integrate substance use disorder treatment and effectively share substance use disorder treatment records without compromising the core protections in Part 2 that have formed the bedrock of patient expectations since the 1970s.

- **SAMHSA’s recent amendments to Part 2 already offered powerful new tools to permit communication while maintaining confidentiality; SAMHSA should clarify the existing regulations before proposing additional amendments.**

  The 2017 and 2018 amendments to Part 2 made it even easier for Part 2 programs and healthcare providers to share substance use disorder information for health care purposes with patient consent. Many vendors, healthcare providers, and Part 2 programs have yet to implement these new tools and may not yet be aware of or fully understand all the implications of the last two rounds of rulemaking. Therefore, we recommend that SAMHSA postpone additional regulatory amendments, and instead, develop sub-regulatory guidance, provide trainings, and publish educational materials, model forms and practices, as SAMHSA indicated it would do in the preamble to the 2017 Final Rule.

- **Substance use disorder treatment providers should receive federal resources to adopt health information technology.**

  The Health Information Technology for Economic and Clinical Health (“HITECH”) Act of 2009 included financial incentives for healthcare providers to adopt health information technology, including electronic health records (“EHRs”). These incentive payments to adopt health information technology, however, did not extend to most mental health or substance use disorder treatment providers. Federal funding is necessary for Part 2 programs to be able to adopt health information technology.

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information technology, including EHRs, just as federal funding was necessary for general medical providers. The lack of available funding for Part 2 programs to meaningfully adopt health information technology is a significant barrier to integrated care.

- Federal incentives to adopt health information technology must also mandate that health information systems comply with state and federal confidentiality requirements, including Part 2.

Health information technology that permits integrated record management while maintaining patient privacy preferences currently exists, and is necessary for EHRs to comply with Part 2 as well as other federal and state laws that provide greater privacy protections for sensitive health information including substance use disorder, mental health, domestic violence, HIV/AIDS, reproductive health, and genetic testing information. Since the HITECH incentives did not include a requirement that health information technology comply with applicable privacy laws, any new incentives for substance use disorder treatment providers to adopt health information technology should also include a requirement that the technology comply with federal and state confidentiality laws, including Part 2.

II. Effect of Part 2 on Patient Care, Health Outcomes, and Patient Privacy

In response to the statutory mandate to consider the effect of Part 2 on “patient care, health outcomes, and patient privacy,” LAC respectfully submits that Part 2 improves patient care and health outcomes, and is critically important to patient privacy. Throughout these comments, LAC highlights the ways that privacy rights promote patient care and health outcomes, and the ways that Part 2’s heightened privacy protections are more appropriate for substance use treatment records than the more lax HIPAA standard.

A. Part 2 Improves Patient Care

Increasing the number of people with substance use disorder who seek and receive care is the first, and arguably most important, step toward improving patient care. Part 2’s privacy protections accomplish this by assuring patients that their information will be kept confidential, and that entering treatment will not expose them to discrimination. These assurances remain critical because individuals with substance use disorders continue to experience stigma and discrimination on account of their disease, including at the hands of medical professionals. Despite a growing medical consensus that addiction is a chronic medical illness, the historic view of substance use disorder as a “moral failing” remains pervasive even in the healthcare setting.³

Recent published studies indicate that health professionals generally have a negative attitude towards patients with substance use disorders, due at least in part to a lack of adequate education,

training, and support structures for working with this patient group.\(^4\) General practitioners and healthcare professionals of general psychiatry tend to have more negative attitudes than specialists in addiction services.\(^5\) Indeed, SAMHSA explicitly recognized the problem of discrimination by medical professionals in its January 2017 rulemaking.\(^6\)

Not only does discrimination by health professionals offend patients’ dignity, it diminishes the quality of patient care.\(^7\) One published study found that a patient’s perception of discrimination was a significant predictor of whether the patient dropped out of treatment.\(^8\) Another analysis found that health professionals tended to make shorter visits, show less empathy, and have diminished personal engagement when caring for patients with substance use disorders.\(^9\) Health professionals’ negative attitudes towards patients with substance use disorders results in “suboptimal healthcare delivery” and a lower quality of patient care.\(^10\)

Consider the story, reported by the American Association for the Treatment of Opioid Dependence, of a young mother who had been successfully maintained on methadone treatment for several years.\(^11\) While still in the hospital after delivering a healthy, full-term baby, the nurse caring for the mother came into the hospital room and threw a dose of take-home methadone at her, saying, “Feed this poison to your baby.” Despite long-standing scientific consensus that methadone is safe and effective for the management of opioid dependence during pregnancy and the early postnatal period, stigma and prejudice remain entrenched in many areas of the healthcare field.\(^12\) Behavior like this fails to meet a basic standard of patient care and discourages patients from seeking the healthcare services they need.

By protecting people seeking and receiving substance use disorder care from stigma and discrimination, Part 2 encourages people to enter and remain in treatment and thus improves patient care.


\(^5\) Van Boekel, Comparison of Stigma among Specialties, supra note 4.

\(^6\) 82 Fed. Reg. at 6053.

\(^7\) Van Boekel, Stigma among Health Professionals, supra note 4.


\(^9\) Van Boekel, Stigma among Health Professionals, supra note 4 at 33.

\(^10\) Id.


\(^12\) See, e.g., SUBSTANCE ABUSE & MENTAL HEALTH SERVICES ADMIN., Methadone Treatment for Pregnant Women (2d ed. 2014), http://store.samhsa.gov/shin/content/SMA14-4124/SMA14-4124.pdf (first printed 2006).
Aligning Part 2 with a HIPAA Standard Is Unnecessary and Would Harm Patients

Allowing all substance use disorder treatment information to flow to all parts of the healthcare system without patient consent, as a HIPAA standard would allow, may initially seem benign or even desirable. However, such a change would result in disclosures that could negatively impact patient care while also damaging the lives of patients and their families. These negative consequences would outweigh any positive effects of moving to a HIPAA standard. Moreover, arguments in favor of moving to a HIPAA standard frequently ignore the tools available in Part 2 that permit disclosures and communications among healthcare providers.

First, Part 2 never prevents healthcare professionals from fulfilling their professional duty to engage directly with patients and inquire about their substance use history. Particularly in the context of the ongoing opioid crisis, best practices include a requirement that providers discuss opioid and substance use with patients prior to prescribing pain medication.13 Part 2 does not prevent a patient from discussing her substance use history with her doctor, and does not prevent doctors in general medical settings from making a note of a patient’s self-disclosed substance use history in the patient’s record.

Not only is engaging directly with patients considered best practice, it is also a necessary practice, since substance use disorder records frequently do not appear in EHR systems for reasons independent from Part 2. According to SAMHSA’s data, the vast majority of people with substance use disorders do not receive treatment;14 this substance use information will not appear in EHRs but is still relevant, and it is still incumbent on healthcare providers to try to solicit this information. EHRs also frequently fail to include substance use disorder treatment records due to the inadvertent effects of recent federal policy. Specifically, there are two main reasons why substance use disorder treatment records may not be in EHRs:

- While the HITECH Act of 2009 offered incentive payments to healthcare providers to adopt health information technology, the incentives did not extend to most substance use disorder treatment providers; without federal funding, many Part 2 programs cannot afford to adopt new health information technology including EHRs.
- To our knowledge, neither the HITECH Act, nor any federal agency has mandated that EHR systems comply with Part 2 in order to qualify for the incentive payments, even though the technology to enable compliance exists. In the absence of any such requirement, most EHR systems do not comply with heightened privacy requirements and Part 2 programs cannot participate.

To the extent that HIEs are unable to segment health records and therefore do not include substance use disorder patient records, LAC urges a technical solution to this technical problem; eliminating patient’s confidentiality protections is a short-term and partial solution at best. Part 2 is not the only reason that HIEs need to segment health data; numerous provisions of state and federal laws also include protections that necessitate data segmentation. Most states require confidentiality protections for substance use disorder information that are at least as protective as Part 2.\(^\text{15}\) Many state laws also provide heightened confidentiality protections for HIV-related information, mental health records, health records of minors, reproductive health records, sexual violence-related records, and more.\(^\text{16}\) Moreover, the technology already exists to segment health data, it is simply a question of allocating resources to make sure that the technology can be implemented.

Second, to the extent some stakeholders argue – based on anecdotal evidence – that Part 2’s protections actually perpetuate stigma and therefore negatively affect patient care, we strongly disagree. Privacy protections do not perpetuate stigma or undermine the message that addiction is a chronic medical illness – rather, it is arresting, prosecuting, and incarcerating people because of their illness that perpetuates stigma. Similarly, it is laws and policies that permit discrimination against people with substance use disorders and allow people to lose their housing, jobs, and custody of their children solely on the basis of their illness, which undermine the message that addiction is a chronic medical illness.

In its 40 years serving Part 2 programs and patients with substance use disorders, LAC has repeatedly seen these consequences first-hand. Although we hope to see the day when prejudice and discrimination are no longer the reality for people with substance use disorders – that time has unfortunately not yet arrived. In addition to the examples in LAC’s previous comments to SAMHSA in the 2014 Listening Session, the three client stories below highlight the diverse settings in which people with substance use disorder encounter stigma and discrimination:

- A judge told a LAC client that that even though she had been in recovery and free of illicit opioid use for over one year, she could not regain custody of her daughter unless she stopped taking doctor-prescribed methadone to treat her opioid use disorder.

- An employer denied a LAC client a job based on her “past prolonged drug use,” even though she had been in recovery for 10 years.

- A doctor refused to perform a check-up and mammogram for a LAC client, after she disclosed that she was taking doctor-prescribed methadone to treat her opioid use


\(^\text{16}\) See Joy Pritts et al., The State of Health Privacy, INSTITUTE FOR HEALTH CARE RESEARCH & POLICY (2d ed. 2002).
disorder. The doctor told her he “did not feel comfortable” providing care to her, and did not offer any referral to another provider.

The solution to overcoming stigma in the healthcare profession is not to eliminate the confidentiality protections that encourage people to seek treatment, but rather to address the issue of stigma by healthcare providers through education and improved training of healthcare professionals. Healthcare providers—even well-meaning ones—who do not acknowledge that disclosure of a patient’s substance use history can have catastrophic consequences for that patient are not serving their patient’s best interests or adhering to the principle of “first, do no harm.”

In LAC’s experience, many of the arguments in support of a HIPAA standard actually disregard or misinterpret Part 2’s applicability and the existing tools that permit communication between healthcare providers. For example:

- Part 2 permits the disclosure of substance use disorder information in order to address a medical emergency. Medical personnel can “break the glass” in a medical emergency if patient consent cannot be obtained, and immediately access any Part 2 program treatment records in the HIE.

- In the context of most hospital emergency departments, Part 2 does not interfere with medical staff’s ability to assess whether a patient is overdosing, ask a patient about substance use, screen a patient for evidence of substance use if necessary, or make a record of substance use-related information in the patient’s chart.

- Part 2 does not apply to general emergency room personnel, even if they refer a patient to the intensive care unit for an apparent overdose.

- Part 2 permits patients to authorize disclosures to all her treating providers – including future treating providers in hospital, health center, and private practice settings – through the mechanism of a written consent form.

**B. Part 2 Promotes Positive Health Outcomes by Encouraging Individuals to Enter and Remain in Treatment**

Part 2’s privacy protections encourage individuals with substance use disorders to enter and remain in treatment, which is a positive health outcome of paramount importance. Entering treatment is often a matter of life and death: for opioid-use disorders, medication-assisted treatment has been proven to reduce the rate of mortality by more than 50 percent.\textsuperscript{17} Indeed, in the recent Report by the President’s Commission on Combating Drug Addiction and the Opioid

Crisis, the Commission identified access to treatment as one of the most important priorities for national drug and public health policy.\textsuperscript{18}

Concerns about confidentiality continue to be one of patients’ greatest barriers to entering treatment, even with Part 2’s heightened privacy protections. According to SAMHSA’s most recent published data on the reasons why people report not entering treatment, confidentiality concerns are among the most common.\textsuperscript{19} In SAMHSA’s survey of people with unmet behavioral health treatment needs:

- 10.6% did not enter treatment because it might cause neighbors or their community to have a negative opinion;
- 9.5% did not enter treatment because it might have a negative impact on their job;
- 7.8% said they were concerned about confidentiality; and
- 7.2% did not want others to find out.\textsuperscript{20}

Given these statistics, there is no reason to think that eroding patient confidentiality requirements would have a positive impact on the number of people willing to enter treatment.

Approximately 20 million people in the United States need substance use disorder treatment each year, but do not receive it.\textsuperscript{21} At the national level, the rate of deaths from drug overdoses are contributing to the shortening of average life expectancy in the United States.\textsuperscript{22} In the midst of the deadliest drug crisis in American history, we should be thinking of ways to \textit{improve} and \textit{supplement} protections for patients’ confidentiality in order to encourage more people to enter treatment – not the opposite.\textsuperscript{23}

In addition to encouraging individuals to enter treatment, Part 2 contributes to positive health outcomes by enabling patients to be forthcoming in treatment, secure in the knowledge that the information they disclose will remain confidential. Robust evidence supports the notion that patients are less forthcoming in the face of lower privacy protections.\textsuperscript{24} By empowering patients to control disclosure of their substance use disorder treatment information, Part 2 promotes

\begin{itemize}
  \item \textsuperscript{19} Beth Han et al., \textit{Receipt of Services for Behavioral Health Problems: Results from the 2014 National Survey on Drug Use and Health}, SAMHS A (Sept. 2015), https://www.samhsa.gov/data/sites/default/files/NSDUH-DR-FRR3-2014/NSDUH-DR-FRR3-2014/report2014.htm [https://perma.cc/3S9R-C2D6].
  \item \textsuperscript{20} \textit{Id.} Note that the survey included respondents with unmet behavioral health needs, which is defined to include mental illness as well as substance use disorders.
  \item \textsuperscript{21} \textit{Id.}
  \item \textsuperscript{24} \textit{See, e.g., Israel T. Agaku et al., Concern about Security and Privacy, and Perceived Control over Collection and Use of Health Information Are Related to Withholding of Health Information from Healthcare Providers, 21 Journal of the American Medical Informatics Association 374-78 (2014); Sarah C.M. Roberts & Amani Nuru-Jeter, Women’s Perspectives on Screening for Alcohol and Drug Use in Prenatal Care, 20 Women’s Health Issues 193 (May 2010), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5421454/}.
improved communication between patients and their treatment providers, and contributes to better health outcomes.

In contrast, a HIPAA standard would allow virtually unfettered disclosure of SUD patient records without consent to the full range of individuals and organizations involved in healthcare (including payment and operations) and law enforcement. HIPAA would also allow those entities to re-disclose those records without restriction, unlike Part 2. This would result in many people not obtaining the care they need for fear of being arrested and prosecuted, losing custody of their children, and suffering employment, insurance and other forms of discrimination.

C. Part 2 Is Crucial to Patient Privacy

Part 2 provides a crucial protection for patient privacy in the healthcare setting, in criminal prosecution and civil litigation, and in all other aspects of a patient’s personal environment by ensuring that patient records are disclosed only pursuant to patient consent or the strictly delineated exceptions in Part 2. As SAMHSA has consistently recognized, “[u]nauthorized disclosure of substance use disorder patient records can lead to a host of negative consequences, including loss of employment, loss of housing, loss of child custody, discrimination by medical professionals and insurers, arrest, prosecution, and incarceration.”

While health information technology represents a great stride forward for the future of healthcare in the United States, it also represents a growing source of data insecurity. In 2017, HIPAA-covered entities reported an unprecedented 341 breaches that affected at least 500 patients. Most disconcertingly for individuals with sensitive health data like substance use treatment information, the number of targeted data breaches (i.e., hacking) also appears to be on the rise. HIPAA does not meaningfully offer individuals a choice to “opt out” of the unprecedented advances in the electronic sharing of health information. Part 2, on the other hand, provides more tools for patients to control the flow of their protected substance use disorder information via the protections in Section 2.33 and the informational requirements for written consent in Section 2.31.

LAC is not alone in recognizing the importance of patient privacy protections. When the U.S. Department of Health and Human Services issued the HIPAA Privacy Rule, it recognized: “While privacy is one of the key values on which our society is built, it is more than an end in itself. It is also necessary for the effective delivery of healthcare, both to individuals and to populations.” In the midst of the ongoing opioid epidemic and in the face of increasingly targeted breaches of medical information, now is not the time to experiment with loosening the longstanding confidentiality protections for patients with substance use disorders.

27 Id.
III. LAC’S PROPOSALS FOR FORTHCOMING REGULATORY AND SUB-REGULATORY ACTION

A. Further Regulatory Amendments Would Be Premature

LAC does not endorse any regulatory changes at this time. The recent rounds of rulemaking – including the 2017 Final Rule and the 2018 Final Rule – represent the most significant changes to Part 2’s protections in generations. In our experience, many stakeholders are only beginning to become aware of and grapple with the implications of these recent amendments, which have yet to go fully into effect at the time of SAMHSA’s listening session in January 2018. LAC encourages SAMHSA to allow stakeholders time to familiarize themselves with the current state of the law before further amending the legal protections for patients.

In particular, the recent amendments moved Part 2’s protections significantly closer to a HIPAA standard by expanding lawful holders’ authority to re-disclose patient records for the purposes of treatment and healthcare operations. For this reason, it is premature to amend the Part 2 regulations to further align with a HIPAA standard without waiting for these changes to go into effect and analyzing the consequences of such a change.

B. Sub-Regulatory Guidance Should Address Common Questions of Interpretation and Clarify Enforcement Priorities

LAC welcomes SAMHSA’s sub-regulatory guidance on the issues it identified in the preamble to the January 2017 Final Rule, including sub-regulatory guidance regarding best practices for electronic health records and the applicability of Part 2 to information disclosed in a medical emergency. Based on LAC’s experience providing technical assistance to providers, sub-regulatory guidance is particularly needed to clarify the mechanisms of Part 2’s recent changes to the consent provisions regarding disclosures to entities without a treating provider relationship.

LAC also urges SAMHSA to provide sub-regulatory guidance, educational materials, training, and outreach to help the field understand the ways that Part 2 permits communication of substance use disorder treatment records while protecting patient confidentiality. In particular, guidance on Part 2’s application to emergency room and integrated care settings would be useful. Finally, LAC highlights areas where SAMHSA could partner with other federal agencies to complement the recent changes to Part 2 and any forthcoming guidance.

Recommendation #1
Clarify permissible disclosures to entities without a treating provider relationship

SAMHSA should issue sub-regulatory guidance clarifying the way a patient may authorize disclosure of their records to entities like parole and probation departments, social services departments, law offices, and drug courts. SAMHSA should clarify that the requirement in Section 2.31(a)(4)(iii)(B)(1) to name an individual participant in the entity does not limit the disclosure to the named individual, but rather permits limited re-disclosure by the named

29 In total, SAMHSA indicated approximately 20 topics for sub-regulatory guidance. 82 Fed. Reg. at 6059-6104.
individual within the entity, to the extent disclosure is consistent with the consent form’s stated purpose of the disclosure, and as otherwise consistent with Part 2.

Patients of Part 2 programs routinely need to authorize disclosure of their records to parties outside of the healthcare system (e.g., parole and probation departments, social services departments, law offices, and drug courts). Prior to the 2017 amendments, consent forms only needed to specify “the name or title of the individual or the name of the organization” to which disclosure was to be made. For example, a patient used to be able to authorize disclosures “to the New York City probation department,” which allowed a patient to authorize disclosure prior to knowing the name of the individual probation officer assigned to the case.

The recent changes to the consent provisions permit patients to authorize disclosures to an entity, but only if the entity has a treating provider relationship with the patient, or if the entity is a third-party payer. If a patient wishes to disclose to an entity that does not meet the definition of either “treating provider” or “third-party payer,” the patient must also name an individual “participant” of the entity. We are concerned that unless SAMHSA clarifies the ways in which patients can authorize disclosures to non-treating provider entities, it will impede disclosures that need to be made in order to fulfill the consent form’s stated purpose.

In the alternative, if SAMHSA decides to amend the regulatory language, LAC proposes amending Section 2.31(a)(4)(i) or Section 2.31(a)(4)(iii)(B)(1) to conform the regulations with the pre-2017 language, permitting disclosures to “the name or title of the individual or the name of the organization.”

**Recommendation #2**

**Clarify Part 2’s enforcement protections, perform outreach, and provide sample forms, education materials, training**

LAC encourages SAMHSA to consider issuing sub-regulatory guidance and educational materials regarding the enforcement of Part 2 (Sections 2.3 and Section 2.4). The 2017 amendments to the Final Rule removed the outdated penalty information and conformed the regulatory language with the statutory language. LAC believes that clarifying the relevant provisions of Title 18 – in particular, Section 3571, concerning penalties and fines – that apply to violations of Part 2, and the ways in which U.S. Attorneys offices may seek to enforce Part 2, would be helpful to both the treatment provider field and U.S. Attorneys.

SAMHSA indicated in the preamble to the January 2017 Final Rule that it would consider issuing sample consent forms for general consents and criminal justice-specific consent forms, as well as other types of education and outreach materials. LAC agrees that these sample consent forms will be of great utility to stakeholders.

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31 These terms are defined at 42 C.F.R. § 2.11: the definition of “treating provider relationship” requires an element of healthcare provision; the definition of “third-party payer” is limited to individuals or entities that pay or agree to pay for diagnosis or treatment.
Recommendation #3
Clarify the ways in which Part 2 applies to integrated care and emergency room settings

LAC also welcomes SAMHSA’s proposed guidance on topics that clarify the ways in which Part 2 applies to integrated care settings and emergency room settings. First, SAMHSA should issue sub-regulatory guidance on the definition of “program,” including the ways that Part 2 applies to substance use treatment providers in community behavioral health organizations, mixed-use facilities that provide both primary care and behavioral health services, and general medical facilities that employ specialized substance use disorder counselors.

Second, SAMHSA should issue guidance similar to the recent Office for Civil Rights guidance clarifying the role of HIPAA in emergency room situations. Guidance, training, and educational materials regarding the applicability of Part 2 in emergency rooms would help dispel the misperception that patient confidentiality inhibits medical care in emergency settings.

Recommendation #4
Coordinate with other federal agencies to ensure Part 2 protections are uniformly applied

Substance use disorder treatment providers deserve the same incentives to obtain and install electronic health records that general medical practices received through the HITECH Act. As a condition of receiving the incentives, the electronic health records systems should be mandated to comply with Part 2’s requirements. As the executive agency tasked with regulating the field of substance use disorder treatment, LAC urges SAMHSA to take a leadership role in bringing these issues to the attention of Congress and the other relevant executive agencies.

V. CONCLUSION

As SAMHSA considers these and other comments from stakeholders, we urge you to give the greatest weight to the comments made by patients, consumers, and their families, as these are the people who will be most profoundly and personally affected by any changes to Part 2. More than 200 individuals submitted public comments in favor of maintaining privacy protections for their substance use disorder treatment information in response to SAMHSA’s request for comments in 2014. There is no evidence to indicate that there have been significant improvements since 2014 with respect to the scope of discrimination and degree of legal consequences facing patients living with substance use disorder. Indeed, as the opioid emergency continues unabated, maintaining strict confidentiality of substance use disorder records becomes more important than ever to an even greater number of people who now find themselves experiencing the health challenge of substance use disorder.