The Florida Bar Continuing Legal Education Committee
and the Health Law Section

The Master Class:
Legal Issues with Mental Health and Substance Abuse

COURSE CLASSIFICATION: INTERMEDIATE LEVEL

September 13, 2019

Live and Webcast Presentation:
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- Rights and liabilities of parties to construction projects
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Highlights of the new edition include:

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Highlights of the ninth edition:

- Impact of the Obergefell decision on same-sex marriages with respect to title considerations
- Discussion of local government financing of energy-related qualifying improvements under F.S. 163.08
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Sample forms, worksheets, and checklists are provided to aid the practitioner. Highlights of the new Tenth Edition include:

- Complete update and rewrite of Chapter 5
- Liability Coverage
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- Case law reviewed and updated
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Continued on next page
**REAL PROPERTY LAW (continued)**

<table>
<thead>
<tr>
<th>Title</th>
<th>PUB. #</th>
<th>ISBN</th>
<th>eISBN</th>
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<thead>
<tr>
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<th>PUB. #</th>
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Common Questions About CLER

1. What is CLER?
   CLER, or Continuing Legal Education Requirement, was adopted by the Supreme Court of Florida in 1988 and requires all members of The Florida Bar to continue their legal education.

2. What is the requirement?
   Over a 3 year period, each member must complete 33 hours, 5 of which are in the area of ethics, professionalism, substance abuse, or mental illness awareness, and 3 hours in technology.

3. Where may I find information on CLER?
   Rule 6-10 of the Rules Regulating The Florida Bar sets out the requirement. All the rules may be found at www.floridabar.org/rules.

4. Who administers the CLER program?
   Day-to-day administration is the responsibility of the Legal Specialization and Education Department of The Florida Bar. The program is directly supervised by the Board of Legal Specialization and Education (BLSE) and all policy decisions must ultimately be approved by the Board of Governors.

5. How often and by when do I need to report compliance?
   Members are required to report CLE hours earned every three years. Each member is assigned a three year reporting cycle. You may find your reporting date by logging in to your member portal at member.floridabar.org.

6. Will I receive notice advising me that my reporting period is upcoming?
   Four months prior to the end of your reporting cycle, you will receive a CLER Reporting Affidavit, if you still lack hours.

7. What happens if I am late or do not complete the required hours?
   You run the risk of being deemed a delinquent member which prohibits you from engaging in the practice of Florida law.

8. Will I receive any other information about my reporting cycle?
   Yes, you will receive reminders prior to the end of your reporting cycle, if you have not yet completed your hours.

9. Are there any exemptions from CLER?
   Rule 6-10.3(c) lists all valid exemptions. They are:
   1) Active military service
   2) Undue hardship (upon approval by the BLSE)
   3) Nonresident membership (see rule for details)
   4) Full-time federal judiciary
   5) Justices of the Supreme Court of Florida and judges of district, circuit and county courts
   6) Inactive members of The Florida Bar
10. Other than attending approved CLE courses, how may I earn credit hours?
   Credit may be earned by:
   1) Lecturing at an approved CLE program
   2) Serving as a workshop leader or panel member
   3) Writing and publishing in a professional publication or journal
   4) Teaching (graduate law or law school courses)
   5) University attendance (graduate law or law school courses)

11. How do I submit various activities for credit evaluation?
   Applications for credit may be found on our website, www.floridabar.org.

12. How are attendance hours posted on my CLER record?
   You must post your credits online by logging in to your member portal at member.floridabar.org.

13. How long does it take for hours to be posted to my CLER record?
   When you post your CLE credit online, your record will be automatically updated and you will be able to see your current CLE hours and reporting period.

14. How may I find information on programs sponsored by The Florida Bar?
   You may wish to visit our website, www.floridabar.org/cle, or refer to The Florida Bar News. You may also call CLE Registrations at 850/561-5831.

15. If I accumulate more than 30 hours, may I use the excess for my next reporting cycle?
   Excess hours may not be carried forward. The standing policies of the BLSE, as approved by the Supreme Court of Florida specifically state in 6.03(b):
   ... CLER credit may not be counted for more than one reporting period and may not be carried forward to subsequent reporting periods.

16. Will out-of-state CLE hours count toward CLER?
   Courses approved by other state bars are generally acceptable for use toward satisfying CLER.

17. If I have questions, whom do I call?
   You may call the Legal Specialization and Education Department of The Florida Bar at 850/561-5842.

   While online checking your CLER, don’t forget to check your Basic Skills Course Requirement status.
PREFACE

The course materials in this booklet were prepared for use by the registrants attending our Continuing Legal Education course during the lectures and later in their offices.

The Florida Bar is indebted to the members of the Steering Committee, the lecturers and authors for their donations of time and talent, but does not have an official view of their work products.

CLER CREDIT
(Maximum 9.0 hours)

General ............................................. 9.0 hours Substance Abuse ......................... 2.5 hours Mental Illness ............................... 2.0 hours

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Seminar credit may be applied to satisfy both CLER and Board Certification requirements in the amounts specified above, not to exceed the maximum credit. Refer to Chapter 6, Rules Regulating The Florida Bar, see the CLE link at www.floridabar.org for more information about the CLER and Certification Requirements.

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CLE COMMITTEE MISSION STATEMENT

The mission of the Continuing Legal Education Committee is to assist the members of The Florida Bar in their continuing legal education and to facilitate the production and delivery of quality CLE programs and publications for the benefit of Bar members in coordination with the Sections, Committees and Staff of The Florida Bar and others who participate in the CLE process.

COURSE CLASSIFICATION

The Steering Committee for this course has determined its content to be INTERMEDIATE.
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Beverly Binner, Roanoke, VA
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LECTURE PROGRAM

8:15 a.m. - 8:30 a.m.  Welcome and Administrative Matters  
Barry Herrin, Atlanta, GA

8:30 a.m. - 9:15 a.m.  Mental Health and Substance Abuse Treatment in the Hospital Setting  
Kirk Davis, Tampa, FL  
Isabelle Conti, St. Petersburg, FL  
Chief Anthony Holloway, St. Petersburg, FL

9:15 a.m. - 9:30 a.m.  Break

9:30 a.m. - 10:30 a.m.  Mental Health and Substance Abuse Treatment in the Hospital Setting (Continued)  
Kirk Davis, Tampa, FL  
Isabelle Conti, St. Petersburg, FL  
Chief Anthony Holloway, St. Petersburg, FL

10:30 a.m. - 11:30 a.m.  Mental Health and Substance Abuse Care in the Academic Setting  
Beverly Binner, Roanoke, VA  
Daniel A. Jones, Boca Raton, FL

11:30 a.m. - 12:15 p.m.  Active Shooter Response and Preparedness in Health Care  
Frank Harper, Phoenix, AZ

12:15 p.m. - 1:15 p.m.  Lunch & Legislative Agenda and Government Response to Legalized Marijuana and the Opioid Crisis  
TBD

1:15 p.m. - 2:15 p.m.  An Update on 42 CFR Part 2  
Gina Bertolini, Raleigh, NC

2:15 p.m. - 2:30 p.m.  Break

2:30 p.m. - 3:30 p.m.  Telemedicine - Issues and Challenges in Providing Mental Health Services and Combating the Opioid Epidemic  
Lee Bentley, Tampa, FL  
Ashley V. Makris, Tampa, FL

3:30 p.m. - 4:30 p.m.  Florida's Lawyer Assistance Program for Attorneys with Mental Health and/or Substance Abuse Issues  
John Lesko, Pompano Beach, FL

4:30 p.m. - 4:30 p.m.  Adjournment
TABLE OF CONTENTS

MENTAL HEALTH AND SUBSTANCE ABUSE TREATMENT IN THE HOSPITAL SETTING
Kirk Davis, Tampa, FL
Isabelle Conti, St. Petersburg, FL
Chief Anthony Holloway, St. Petersburg, FL

I. Patient Rights ................................................................. 1.1
II. Recent Changes in Involuntary Examination .................... 1.2
III. Involuntary Examination .................................................. 1.5
IV. Voluntary Admissions ....................................................... 1.8
V. Application and Recommendation ..................................... 1.10
VI. Treatment Options .......................................................... 1.13
VII. Policies and Procedures .................................................. 1.14
VIII. Clinical Records and Confidentiality [§394.4615] ........... 1.15
IX. Involvement of Other Personnel, Patient Healthcare Surrogates, and Law Enforcement .... 1.16
X. Law Enforcement .............................................................. 1.17
XI. What Happens Next ........................................................ 1.18
XII. Examples of Florida Survey Deficiencies ......................... 1.19
XIII. Mental Health Issues – Overview ...................................... 1.21

MENTAL HEALTH AND SUBSTANCE ABUSE CARE IN THE ACADEMIC SETTING
Beverly Binner, Roakoke, VA
Daniel A. Jones, Boca Raton, FL

I. Introduction ................................................................. 3.1
II. Challenges ................................................................. 3.1
III. Solution ................................................................. 3.3

Joint Guidance on the Application of the Family Educational Rights and Privacy Act (FERPA) And the Health insurance Portability and Accountability Act of 1996 (HIPAA)

I. Introduction ................................................................. 3.8
II. Overview of FERPA .......................................................... 3.8
III. Overview of HIPAA .......................................................... 3.8
IV. Where FERPA and HIPAA may Intersect ......................... 3.10
V. Frequently Asked Questions and Answers ............................ 3.10
VI. Conclusion ................................................................. 3.18
VII. Privacy and Safety – Power Point Presentation ................. 3.51

ACTIVE SHOOTER RESPONSE AND PREPAREDNESS IN HEALTH CARE
Frank Harper, Phoenix, AZ

I. A Day Like No Other: A Case Study of the Las Vegas Mass Shooting .................................. 4.1
LEGISLATIVE AGENDA AND GOVERNMENT RESPONSE TO LEGALIZED MARIJUANA AND THE OPIOID CRISIS

TBD

AN UPDATE ON 42 CFR PART 2
Gina Bertolini, Raleigh, NC

I. Introduction to 42 CFR PART 2 ............................................................................................6.1
II. Recent Regulation Changes to Part 2 ................................................................................6.6
III. Conclusion and Next Steps for Part 2 ..............................................................................6.26
IV. Confidentiality of Substance Use Disorder Records Under 42 C.F.R. Part 2: “Areas of Turbulence” & the Winds of Change – Overview .........................................................6.29

TELEMEDICINE - ISSUES AND CHALLENGES IN PROVIDING MENTAL HEALTH SERVICES AND COMBATING THE OPIOID EPIDEMIC
Lee Bentley, Tampa, FL
Ashley V. Makris, Tampa, FL

I. What is Telemedicine? ...........................................................................................................7.1
II. Guidelines for Reimbursement ..........................................................................................7.1
III. Mental Health & The Opioid Crisis ...................................................................................7.6
IV. Federal and State Limitations .........................................................................................7.8
V. Enforcement Activities ......................................................................................................7.13
VI. Telemedicine Issues Associated with Behavioral Health and the Opioid Crisis – Overview ......................................................................................................................7.16

FLORIDA'S LAWYER ASSISTANCE PROGRAM FOR ATTORNEYS WITH MENTAL HEALTH AND/OR SUBSTANCE ABUSE ISSUES
John Lesko, Pompano Beach, FL

I. History of Florida Lawyers Assistance ...............................................................................8.1
II. Other Impairments .............................................................................................................8.2
III. The Various roles of FLA ...............................................................................................8.2
IV. FLA Currently ................................................................................................................8.4
V. Summary ..........................................................................................................................8.5
VI. Stress, Chemical Dependency, and Attorney Satisfaction ...............................................8.7
Lee Bentley’s practice includes the defense of False Claims Act and qui tam cases, internal investigations, and white-collar criminal matters. His experience also includes complex civil litigation involving government entities. Lee has handled trials and appeals in numerous federal and state courts and has served as sole or lead counsel in almost 40 civil and criminal jury trials. Prior to joining Bradley, Lee was the United States Attorney for the U.S. Attorney’s Office for the Middle District of Florida in Tampa. In that capacity, he oversaw more than 120 civil and criminal prosecutors. During his time as United States Attorney, his office led the country in number of qui tam cases prosecuted and was routinely one of the highest performing offices throughout the country.

Gina L. Bertolini is a partner in the Research Triangle Park office of K&L Gates, where she concentrates her practice exclusively on health law. Ms. Bertolini represents academic medical centers, health systems, community hospitals, physician practices, and ancillary providers. As a result of this diversified practice, her proficiency extends to federal and state regulatory compliance matters, Medicare and Medicaid reimbursement, faculty practice plan and other physician compensation models, health care fraud and abuse, the Emergency Medical Treatment and Labor Act (EMTALA), health care privacy and data protection issues including HIPAA and 42 CFR Part 2, health care group purchasing organizations (GPOs), and health care corporate governance matters. She likewise maintains an active transactional practice, representing health systems, physician practices, and ancillary providers in acquisitions and joint ventures. Ms. Bertolini is an active author and speaker on critical issues affecting the health care industry.

Beverly Binner serves as Senior Associate General Counsel at Carilion Clinic, a not-for-profit health care organization based in Roanoke, Virginia. She has been practicing in the field of health law for almost 20 years. Ms. Binner’s current practice includes providing guidance on transactional matters, licensure issues, regulatory matters including compliance with fraud and abuse laws, billing issues, privacy issues, expansion of service lines, telemedicine, third-party professional service relationships and various other health care and business related matters. Prior to transitioning to an in-house position in 2011, Ms. Binner was an associate at Moore & Van Allen, LLP in Charlotte, North Carolina practicing in the firm’s health law group.

Isabelle Conti started her Operating Room career in the Army Nurse Corp in 1986. She is a BSN graduate from University of Detroit-Mercy. She quickly became interested in Risk Management and Patient Safety and pursued a nursing track that included these interests. She is a master trainer for TEAMSTEPPS and was the first Certified Patient Safety Officer for her organization. For the last 20 years she has been with BayCare Risk and Insurance Services. Her primary responsibility is to provide clinical risk management services to St. Anthony’s Hospital, one of Pinellas County’s Baker Act receiving facility. In addition, the hospital has a psychiatric emergency room and inpatient psychiatric services. Ms. Conti participates in the hospital’s workplace violence prevention committee and takes an active role in the journey to zero harm for patient’s and team members.
KIRK DAVIS is the Chair of the Healthcare Practice Group for Akerman, LLP and represents hospitals and health systems in complex regulatory compliance issues and disputes with a focus on medical malpractice and peer review hearings. Kirk has decades of experience in the peer review process and has been involved in all aspects of hearings, from prosecuting physicians to defending medical staff and serving as a hearing officer. He helps hospitals comply with federal and state laws by recommending peer review best practices and procedures. Kirk is Board Certified in Health Law by The Florida Bar since 1995 and recognized by Chambers USA as a leading lawyer in healthcare.

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MENTAL HEALTH AND THE BAKER ACT

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Mental health crises happen daily in the hospital setting. This article focuses on the primary areas where mental health intersects with law enforcement, healthcare facilities and follow up care. It is imperative in the hospital setting to involve the multiple stakeholders in preparing for these mental health crises. Law enforcement is involved in the majority of these crises. With many healthcare systems having in-house counsel, working closely with them, risk management, compliance, internal security, and outside legal counsel is essential to address multiple potential situations. Our efforts are to highlight some of the more common areas of mental health crises, identify some plans of action and then follow up with satisfactory resolutions.

PART 1: INITIATION OF MENTAL HEALTH CRISSES

1. PATIENT RIGHTS

The Federal EMTALA law defines mental health crises even absent any other medical conditions. Patient have the same rights and hospitals have the same responsibilities to meet the emergency circumstances of individuals brought to their premises regardless of the nature of the emergency.

Hospitals are responsible for the stabilization of persons with “emergency medical conditions” and must maintain their safety until released or transferred after all such conditions have been stabilized.

The July 2, 2019, CMS Memorandum outlines some frequently asked questions on EMTALA and psychiatric hospitals. Succinctly, Medicare-participating psychiatric hospitals are required to comply with EMTALA requirements. Issues such as staff qualifications to perform a medical screening exam are addressed and the professional scope of practice can be reviewed. EMTALA requires hospitals to perform medical screening examinations within their capabilities. If there is a concern regarding a psychiatric emergency and they have clinical components, the hospital could satisfy its obligation to provide an appropriate medical screening exam if the professional provides the screening exam designed to identify emergency medical conditions and thereafter transfer the patient to a hospital with specialized services and equipment. Remember, if there is no emergency medical condition detected, EMTALA ends.
every patient that presents to a dedicated emergency department has an emergency medical condition. Finally, it is within the scope of practice for emergency physicians and practitioners to evaluate patients presenting with mental health conditions, the same with any other medical, surgical, or psychiatric presentation.

The Patient Rights outlined in the Mental Health Chapter §394.459 refer to receiving and treatment facilities. Further, Chapter 395 F.S. governing licensure of Florida hospitals requires that any hospital holding a person under the Baker Act must ensure that all rights are provided to such patients:

a. **Right to individual dignity.** It is the policy of the state of Florida that the individual dignity of the patient shall be respected at all times and upon all occasions, including any occasion when the patient is taken into custody, held, or transported.

b. **Right to treatment.** A person shall not be denied treatment for mental illness and services shall not be delayed at a receiving or treatment facility because of inability to pay. The least restrictive appropriate available treatment will be utilized based on the individual needs and best interests of the patient and consistent with optimum improvement of the patient’s condition.

c. **Additional Patient Rights.** Right to express and informed patient consent; Quality of treatment; Communication, abuse reporting, and visits; Care and custody of personal effects of patients; Voting in public elections; Habeas corpus; Right to participate in treatment and discharge planning.

II. **RECENT CHANGES IN INVOLUNTARY EXAMINATION**

In 2017, the Florida legislature revised Section 394.463 regarding involuntary examinations. The major change was that the examination period must be for up to 72 hours. For a minor, the examination shall be initiated within 12 hours after the patient’s arrival at the facility.

In 2018, the “Majority Stoneman Douglas High School Public Safety Act” was enacted. It had a broad sweeping impact on mental health. In addressing Section 394.463, the involuntary examination provisions, they addressed the initiation of an involuntary exam pursuant to an ex parte order by a court; law enforcement officer actions and the mental health certificates. What happens after a law enforcement officer acts in accordance with an ex parte order were the major changes.

**Section 394.463 – Involuntary Exam**

- Using reasonable physical force as is necessary to gain entry to the premises, he can take custody of the person who is the subject of the ex parte order. When practical, the law enforcement officer should have received crises intervention team (CIT) training.
• The law enforcement officer may seize and hold a firearm or any ammunition. if the person poses a potential danger to himself or others and has made a credible threat of violence against another person.

• If these actions take place at the person’s residence, the law enforcement officer may seek the voluntary surrender of firearms or ammunitions kept therein which have not already been seized. If the firearms or ammunition are not voluntarily surrendered, or if they were not seized or voluntarily surrendered when the person was taken into custody, the law enforcement officer may petition the appropriate court for a risk protection order against the person authorized, in newly created Florida Statute Section 790.401 defining risk protection orders.

• The seized materials must be available for return no later than 24 hours after the person taken into custody can document that he is no longer subject to involuntary examination and has been released or discharged from any inpatient or involuntary outpatient treatment provided or ordered.

• The exception is if a risk protection order has been entered that directs the law enforcement agency to hold the materials for a longer period of time or the person is subject to a firearm purchase disability (Florida Statute Section 790.065(2)) or ownership disability (Florida Statutes Section 790.064) then the process should take no longer than 7 days.

Section 790.065 – Firearm Possession or Ownership Disability

• Section 790.065(4) firearm possession or firearm ownership disability was created, that if a person who has been adjudicated mentally defective or who had been committed to a mental institution, they may not own a firearm or possess a firearm until relief from the firearm possession or ownership disability is obtained. The procedures for petitioning for relief are set out in the new statute.

Section 790.401 – Risk Protection Order

• Risk Protection Orders are outlined in newly created 790.401. The tie in with mental health is significant. The petition for a risk protection order is to prevent persons who are at high risk for harming themselves or others from accessing firearms or ammunition. The petitioner is defined as a law enforcement officer or agency. The petition must allege that:
  • The respondent poses significant danger of causing personal injury to himself or others by having a firearm or any ammunition in his custody or control or by purchasing, possessing or receiving the same and
  • Must be accompanied by an affidavit stating any specific statements, actions, or facts that give rise to a reasonable fear of significant dangerous acts by the respondent.
• He must identify the quantities, types, and locations of all materials that the petitioner believes to be in the respondent’s current ownership, possession, custody, or control.
• Petition must make a good faith effort to provide notice to a family or household member of the respondent and to any known third party who may be at risk of violence.
• The Court must order a hearing within 14 days. It must issue a notice of hearing to respondent. A temporary ex parte risk protection order may be issued pending the hearing. The Court must find by clear and convincing evidence that the respondent poses a significant danger. The order may be set for a time certain but not exceeding 12 months.
• The statute lists 15 grounds that the Court may consider for the risk protection order. The Court must consider whether a mental health evaluation is appropriate and may order it.
• If the subject has not already surrendered his firearms and ammunition the court order directs them to immediately surrender all firearms and ammunition in his custody, control and possession and his concealed weapon license.
• There are provisions for the surrender of, return and disposal of, and transfer of the firearms and ammunition. The orders are entered into a variety of uniform case reporting systems. Instructional and informational materials are required to be prepared and are available online. The Act took effect in March 2018 and by early July 2018 the press reported that Broward County had prepared 88 petitions and Pinellas County, 64. Statewide a total of 450 people were ordered to surrender guns.

• One case in Lakeland in June 2019, dealt with domestic violence. An alleged domestic violence victim’s wife was arrested for armed burglary for taking her estranged husband’s firearms to the Lakeland Police Department. She had an emergency protection order against him but the husband was in jail on a domestic battery charge. The husband was set to be released on bond, with court order not to own, buy, or carry firearms. However, the wife did not believe he would turn over his guns so she took the matter into her own hands. However, because Florida has no automatic enforcement mechanism to ensure that someone would get rid of the guns that are already in his possession. This is described as the “relinquishment gap.” It was pointed out that the courts can issue a warrant so that law enforcement can go in and retrieve the guns.

In 2019, the Florida Legislature passed changes to the laws related to carrying weapons by licensed medical professionals. Section 790.25 was amended to allow paramedics and others when responding to high risk incidents including hostages, hazardous surveillance, armed suicidal persons, barricaded suspects and high-risk felony warrant service can carry a weapon. The weapon however shall be issued by the law enforcement agency authorizing the tactical medical professional to carry it. The professional will have received training beforehand. It is specifically noted that this change does not authorize a tactical medical professional to carry, transport or store any firearm or ammunition on any fire apparatus or EMS vehicle.
III. INVOLUNTARY EXAMINATION

a. Mental Illness. A person may be taken to a receiving facility for involuntary examination if there is a reason to believe that the person has a mental illness and because of his or her mental illness:

i. The person has refused voluntary examination after conscientious explanation and disclosure of the purpose of the examination; or

ii. The person is unable to determine for himself or herself whether the examination is necessary; and

iii. Without care or treatment, the person is likely to suffer from neglect or refuse to care for himself or herself; such neglect or refusal poses a real and present threat of substantial harm to his or her well-being; and it is not apparent that such harm may be avoided through the help of willing family members or friends or the provision of other services; or

iv. There is substantial likelihood that without care or treatment, the person will cause bodily harm to himself or herself or others in the near future, as evidenced by recent behavior.

b. Involuntary Examination Process: An involuntary examination may be initiated by any one of the following means:

i. Court order. Form CF-MH 3001 “Ex Parte Order for Involuntary Examination”;

ii. A law enforcement officer. Form CH-MH 3052a “Report of Law Enforcement Officer Initiating Involuntary Examination”; or

iii. Specified Professional. A physician, clinical psychologist, psychiatric nurse, mental health counselor, marriage and family therapist, or clinical social worker may execute a certificate stating that he or she has examined a person within the preceding 48 hours and finds that the person appears to meet the criteria for involuntary examination and stating the observations upon which that conclusion is based. Form CF-MH 3052b “Certificate of Professional Initiating Involuntary Examination”.

1. A patient shall be examined by a physician or clinical psychologist at a receiving facility without unnecessary delay or may, upon the order of a physician, be given emergency treatment if it is determined that such treatment is necessary for the safety of the patient or others. The patient may not be released by the receiving facility or its contractor without the documented approval of a psychiatrist, a clinical psychologist, or if the receiving facility is a hospital, the release may also be
approved by an attending emergency department physician with experience in the diagnosis and treatment of mental and nervous disorders and after completion of an involuntary examination pursuant to this subsection. However, a patient may not be held in a receiving facility for involuntary examination longer than 72 hours.

2. A person for whom an involuntary examination has been initiated who is being evaluated or treated at a hospital for an emergency medical condition specified in Section §395.002 must be examined by a receiving facility within 72 hours. The 72-hour period begins with the patient arrives at the hospital and ceases when the attending physician documents that the patient has an emergency medical condition. If the patient is examined at a hospital providing emergency medical services by a professional qualified to perform an involuntary examination and is found as a result of that examination not to meet the criteria for involuntary outpatient placement pursuant to §394.4655(2) or involuntary inpatient placement pursuant to §394.467(1), the patient may be offered voluntary placement, if appropriate, or released directly from the hospital providing emergency medical services.

3. The finding by the professional that the patient has been examined and does not meet the criteria for involuntary inpatient placement or involuntary outpatient placement must be entered into the patient’s clinical record. Nothing in this paragraph is intended to prevent a hospital providing emergency medical services from appropriately transferring a patient to another hospital prior to stabilization, provided the requirements of §395.1041(3)(c) have been met:

A patient, whether stabilized or not, may be transferred to another hospital, which has the requisite service capability or is not at service capacity, if:

a. The patient, or a person who is legally responsible for the patient and acting on the patient’s behalf, after being informed of the hospital’s obligation under this section and of the risk of transfer, requests that the transfer be effected;

b. A physician has signed a certification that, based upon the reasonable risks and benefits to the patient, and based upon the information available at the time of transfer, the medical benefits reasonably expected from the provision of appropriate medical treatment at another hospital
outweigh the increased risks to the individual’s medication condition from effecting the transfer; or

c. A physician is not physically present in the emergency services area at the time an individual is transferred and a qualified medical person signs a certification that a physician, in consultation with personnel, has determined that the medical benefits reasonably expected from the provision of appropriate medical treatment at another medical facility outweigh the increased risks to the individual’s medical condition from effecting the transfer. The consulting physician must countersign the certification; provided that this paragraph shall not be construed to require acceptance of a transfer that is not medically necessary.

4. Within the 72-hour examination period or, if the 72 hours ends on a weekend or holiday, no later than the next working day thereafter, one of the following actions must be taken, based on the individual needs of the patient:

a. Release to law enforcement. The patient shall be released, unless he or she is charged with a crime, in which case the patient shall be returned to the custody of a law enforcement officer;

b. Release to voluntary outpatient. The patient shall be released, subject to the provisions of subparagraph a, for voluntary outpatient treatment;

c. Informed consent needed for voluntary. The patient, unless he or she is charged with a crime, shall be asked to give express and informed consent to placement as a voluntary patient, and, if such consent is given, the patient shall be admitted as a voluntary patient; or

d. Involuntary placement. A petition for involuntary placement shall be filed in the circuit court if inpatient treatment is deemed necessary or in the criminal county court, as defined in §394.4655(1), as applicable. When inpatient treatment is deemed necessary, the least restrictive treatment consistent with the optimum improvement of the patient’s condition shall be made available. When a petition is to be filed for involuntary outpatient placement, it shall be filed by one of the petitioners specified in §394.4655(4)(a). A petition for
involuntary inpatient placement shall be filed by the facility administrator.

c. One of the following must occur within 12 hours after the patient’s attending physician documents that the patient’s medical condition has stabilized or that an emergency medical condition does not exist:

i. The patient must be examined by a facility and released; or

ii. The patient must be transferred to a designated receiving facility in which appropriate medical treatment is available. However, the receiving facility must be notified of the transfer within 2 hours after the patient’s condition has been stabilized or after determination that an emergency medical condition does not exist.

d. Minors. For a minor, the examination shall be initiated within 12 hours after the patient’s arrival at the facility. A minor is any person under 18 years old who has not been married and has not had a court remove the disability of nonage. However, most references in the Baker Act are to persons “under the age of 18.” Therefore, one must consider a person age 0-17 as a minor for the purposes of the Baker Act and lack the legal capacity to provide consent for admission or treatment. A minor must provide assent (agreement) to be voluntary.

i. A child’s guardian is generally one or both his or her natural or adoptive parents. After a divorce, guardianship belongs to the parent or parents with custody. The mother of a child born out-of-wedlock is guardian of the child. In the absence of a parent, a guardian must be appointed by a court and can be a relative or other person interested in the welfare of the child.

ii. Persons under the age of 18 can consent to voluntary substance abuse services.

IV. VOLUNTARY ADMISSIONS

a. A person can be on voluntary or involuntary status under the Baker Act. However, to be on voluntary status, a person must be willing and competent to consent to admission and to treatment. If a person is “incompetent to consent to treatment”, he or she cannot be held under the voluntary provisions of the law §394.4625, §397.601:

i. “Incompetent to consent to treatment” means that a person’s judgment is so affected by his or her mental illness that the person lacks the capacity to make a well-reasoned, willful, and knowing decision concerning his or her medical or mental health treatment. §394.455(15)
ii. **Voluntary status.** The person is presumed to be able to exercise all of his/her rights under the law, including that of consenting or refusing consent to admission and/or treatment. If competent, they could go to any facility they chose, whenever they wished to go, and by whatever means. In such situations where a physician has certified the person’s competence to consent (also competent to refuse consent), the individual can then choose whether or not to accept a transfer. If the circumstance isn’t considered an emergency, EMTALA wouldn’t apply and a destination hospital wouldn’t have to accept a transfer even if it had the capacity and capability to managing the person’s care.

1. There is no requirement in the Baker Act for a Crisis Stabilization Units (CSU) to accept voluntary admissions.

2. There is a possibility of liability to the facility if the person does something dangerous to themself or others subsequent to the refusal. Staff should generally want to at least interview the person and anyone with them to determine if they may be eligible for involuntary examination under the Baker Act, but this is not required.

iii. **Involuntary examination.** Is for those persons who refuse to consent or even if not refusing, are not able to make well reasoned, willful, and knowing decisions. They are the individuals you believe have an emergency psychiatric condition but aren’t necessarily able to follow-through on care on their own.

b. Screening requirements: The Act law and rules primarily address individuals on an involuntary status. However, the following are specifically required for all persons, regardless of legal status:

i. Notification of individual’s case manager within 12 hours of arrival, with the individual’s consent.

ii. Physical examination within 24 hours of arrival by a health practitioner authorized by law to give such examinations.

iii. Within 24 hours after admission of a voluntary patient, the admitting physician must document in the clinical record that the individual is able to give express and informed consent for admission and treatment.

c. When on voluntary status in the Baker Act unit, prior to psychiatrically discharging the patient, the patient develops a medical complication and is transferred from the psychiatric unit and admitted to a medical floor, a transfer from one unit to another is not considered a “discharge” under the Baker Act. The entire facility is considered the receiving facility and cannot “discharge” a person who still meets involuntary criteria.
However, if the person who had been documented as both willing and able to be voluntary subsequently changes his or her mind, a discharge must be done within 24 hours unless a psychiatrist initiates a petition for involuntary placement.

d. An involuntary patient who applies to be transferred to voluntary status shall be transferred to voluntary status immediately, unless the patient has been charged with a crime, or has been involuntarily placed for treatment by a court pursuant to §394.467 and continues to meet the criteria for involuntary placement. When a transfer to voluntary status occurs, notice shall be given to the individual and the individual’s guardian, guardian advocate, health care surrogate or proxy, attorney, and representative, as provided in §394.4599.

To transfer the person from involuntary to voluntary, the following need to occur:

i. Completion and documentation of the initial mandatory “Involuntary Examination” by a physician or psychologist.

ii. Certification of competence to consent by a physician (recommended form CF-MH 3104).

iii. Application for Voluntary Admission (recommended forms: to receiving facility CF-MH 3040; to State Treatment Facility CF-MH 3098).

V. APPLICATION AND RECOMMENDATION

a. If the attending physician continues to document the emergency status of the patient, the clock isn’t ticking. The only purpose of stopping the Baker Act involuntary examination clock is the presumption that a psychiatric examination cannot be performed while a patient is in the middle of a medical emergency.

The 72-hour clock for involuntary examination under the Baker Act can stop when an emergency medical condition exists and starts back up when the emergency medical condition has been stabilized. It is also important that the person be ‘transferred’ to the medical hospital instead of ‘discharged’ to the hospital.

Administrative/Financial. Receiving facilities have the power to discharge a person who is found not to meet the criteria for involuntary placement. If the patient is transferred to a medical hospital and still meets the criteria for involuntary status, the ‘transfer’ instead of ‘discharge’ maintains his/her legal status. It is recognized that some type of administrative or financial ‘discharge’ must take place on the day of transfer to prevent incurring charges for the same person at two different facilities for the same day of care. However, the Baker
Act chart would reflect a transfer – similarly, to when a person is transferred to a State hospital.

b. **Post Medical Clearance**: Within 12 hours after medical clearance at an emergency department, a person on involuntary examination must either be:

i. **Transferred** to a designated receiving facility that has the capability and capacity to manage the person’s needs or examined by a physician or psychologist at the emergency department and released; or

ii. **Examined**: A person must undergo a mandatory initial involuntary examination within 72 hours of arrival at an emergency department for treatment of an emergency medical condition.

c. **Emergency Department Release.** Requirements for an emergency physician to release a person from involuntary examination status are – any licensed physician or clinical psychologist must conduct and document in the chart the initial Mandatory Involuntary Examination as follows:

i. Thorough review of any observation of the person’s recent behavior;

ii. Review [CF-MH 3100](#) “Transportation to Receiving Facility” form and review of the following:

1. **Ex Parte Order**

2. Report of [Law Enforcement Officer Initiating Involuntary Examination](#), (CF-MH 3052(a)) or

3. [CF-MH 3052(b)](#) “Certificate of Professional Initiating Involuntary Examination”.

iii. Conduct brief psychiatric history; and

iv. Conduct face-to-face examination in a timely manner to determine if person meets criteria for release. This must be documented ([CF-MH 3102](#), “Request for Involuntary Examination After Stabilization of Emergency Medical Condition” form is recommended).

d. **Emergency Department Involuntary Examination.** An involuntary examination can be completed at an Emergency Department (ED) that is not a part of a hospital designated as a Baker Act receiving facility as long as the involuntary examination is completed by a professional authorized to complete such examinations:

i. **Receiving Facility ED.** If the ED is part of a Baker Act receiving facility, these professionals would include psychiatrists, clinical psychologists, or ED attending physicians.
ii. Receiving Facility, Non-Receiving ED. If the ED is not part of a Baker Act receiving facility, then these authorized professionals would include any physician.

iii. Non-Receiving Facility ED. The Baker Act authorized law enforcement to transport an individual to an emergency department that is not a Baker Act receiving facility if the individual has a concurrent non-psychiatric medical emergency (FS 394.462(1)(h)). In this event, a psychiatrist, clinical psychologist at the hospital has authority to determine that the individual does not meet criteria for involuntary placement, and therefore to approve the individual’s release directly from the ED (FS 394.463(2)(g)).

e. Mechanical Restraint means a physical device used to restrict an individual’s movement or restrict the normal function of the individual’s body. For example: Lap buddies, belts, “geri” chairs, vests, or trays, which keep the body immobile in a wheelchair, and bed rails or belts, which keep people confined to their beds.

It does not include medical protective equipment, physical equipment or orthopedic appliances, surgical dressings or bandages, or supportive body bands or other restraints necessary for medical treatment, routine physical examinations, or medical tests; devices used to support functional body position or proper balance, or to prevent a person from falling out of bed, falling out of a wheelchair, or equipment used for safety during transportation, such as seatbelts or wheelchair tie-downs.

f. Chemical Restraint means the use of medication to effect immediate control of an individual’s behavior. It does not include the medication administered as treatment for a medical or psychiatric condition.

Psychotropic Medications. If the patient requires psychotropic medications, such as Ativan, Prozac, Xanax, Zoloft, the mandatory form CF-MH 3042b “Specific Authorization for Psychotropic Medications” must be completed by the physician; or the physician documents the necessity for the psychotropic medication meeting the criteria for Emergency Treatment Orders (ETO) (65E-5.1703).

i. ETO. The ETO for psychotropic medication supersedes the person’s right to refuse psychotropic medication if based upon the physician’s assessment that the individual is not capable of exercising voluntary control over his or her own symptomatic behavior and that the uncontrolled symptoms or behavior are an imminent danger to the person or to others in the facility.

ii. ETO For Minors, Incapacitated, Incompetent. When the emergency treatment with psychotropic medication is ordered for a minor or an incapacitated or incompetent adult, facility staff shall document
attempts to promptly contact the guardian, guardian advocate, or health care surrogate or proxy to obtain express and informed consent for the treatment in advance of administration where possible and if not possible, as soon thereafter as practical.

g. **Inpatient Suicidal Behavior**: A patient who is already on an inpatient unit begins to express suicidal behavior or statements. The specified professional can initiate the Baker Act involuntary examination form CF-MH 3052. Because the patient currently requires medical treatment, the physician will need to determine if the patient’s medical condition is stabilized for transfer to a receiving facility.

VI. **TREATMENT OPTIONS**

a. **Admission**: The patient’s medical condition is unstable, emotional state continues with potential suicide risks, and the physician determines that the patient should be admitted.

i. **Room assessment and removal of belongings**: Notification of key personnel per facility policy; remove all potentially harmful items from the patient’s room (wireless keyboards, telephone/call bell cords; electrical cords such as hair dryers, curling irons, etc., sharp or dangerous items such as razors, and scissors, medications, plastic trash can liners, IV tubing not in use, soda cans, breakable/glass items, laces ties, belts, bras, lighters/matches, hazardous liquids and gels, sharps containers should be less than 2/3 full). The patient should be dressed in a hospital gown (preferably paper or behavioral health accepted material), and personal belongings are retained. It is important to explain to the patient the purpose of removing these objects and substances.

ii. **Sitter/Observer**: The patient should be placed with a 1:1 sitter/observer. This sitter can help prevent elopement from the room or unit, and observe threatening behavior.

iii. **Non-receiving facilities are not required to perform a psychology consultation due to the patient still requiring medical treatment.**

b. **Discharge**: The patient’s medical condition is stable and the patient is no longer exhibiting suicidal risk behaviors. Document as appropriate.

c. **Referral to Community Health Sources**: The patient’s medical condition is stable and the patient continues to exhibit suicidal risk behaviors.

The non-designated/non-receiving facility completes the recommended form CF-MH 3102, “Request for Involuntary Examination After Stabilization of Emergency Medical Condition”; or
The attending physician documents the time the person had an emergency medical condition, the time the person’s medical condition had stabilized, or that an emergency medical condition did not exist.

One of the following must occur within 12 hours after the patient’s attending physician documents that the patient’s medical condition has stabilized or that an emergency medical condition does not exist:

The patient must be examined by a professional authorized by statute or released; or

i. The patient must be transferred to a designated facility in which appropriate medical treatment is available. However, the facility must be notified of the transfer within 2 hours after the patient’s condition has been stabilized or after determination that an emergency medical condition does not exist.

ii. Jail.


VII. POLICIES AND PROCEDURES

a. Receiving Facilities: A receiving facility means any public or private facility or hospital designated by the department [of Health] to receive and hold or refer, as appropriate, involuntary patients under emergency conditions or for mental health or substance abuse evaluation and to provide treatment or transportation to the appropriate service provider. The term does not include a county jail. §394.455(39)

Receiving facilities shall develop policies and procedures that expedite the transfer of persons referred from non-designated hospitals after examination or treatment of an emergency medical condition, within the 12 hours permitted by Section 394.463(2)(i) F.S.

b. Non-designated facility policies should include:

i. Documentation. Completion of and documentation of the mandatory CF-MH 3052 “Certificate of Professional Initiating Involuntary Examination” form if hospital professional initiated the Baker Act.

ii. Safe Environment. See Section VI (a)(i).

iii. Timeframes. Within 2 hours of medical clearance, receiving facilities must be notified. Within 12 hours of medical clearance, patients must be transferred to a receiving facility.
iv. Visitor restriction. It is recommended that the facility Baker Act policy include visitor restriction to those patients, such as limiting to two per room during standard visiting hours, and calling appropriate leadership, nurse manager/director, administrative supervisor, security, and/or risk manager with any request for variation to this restriction.

c. Recommendations.

Hospitals in conjunction with their various departments should consider having in place the following policies:

i. Consent for treatment in the context of a patient in police custody;

ii. EMTALA and the hospital’s screening procedures for patients who present in the custody of law enforcement;

iii. Patient privacy rights while in the custody of law enforcement;

iv. Hospital security and patient confinement in the context of the emergency department.

This training, education, and communication among all the involved personnel is very important. It is recommended that training will include regular updates through newsletters, email alerts, or pop-up screens regarding obligations under the various job duties at the hospital.

VIII. CLINICAL RECORDS AND CONFIDENTIALITY [§394.4615]

a. The Baker Act defines the clinical record to mean all parts of the record required to be maintained and includes all medical records, progress notes, charts, and admission and discharge data, and all other information recorded by a facility which pertains to the patient’s hospitalization and treatment. 394.455(6)

b. The Baker Act requires that persons have reasonable access to their clinical records, unless such access is determined by the person’s physician to be harmful to the person. Facilities and mental health professionals should make every possible effort to ensure person have this access.

c. There is no prohibition to an individual signing a release in order for a facility to provide the individual with his or her own records, assuming it applies to all patients served by the facility. But there is a requirement for facilities to develop its own policies and procedures to carry out this duty. Refer to F.S. 394.4615 and FAC 65E-5.250.

d. FS 395.3025 Licensed Facilities: Patient and personnel records; copies; examination:
i. Any §395 licensed facility shall, upon written request, and only after discharge of the patient...

ii. This section does not apply to records maintained at any licensed facility the primary function of which is to provide psychiatric care to its patients, or to records of treatment for any mental or emotional condition at any other licensed facility, which are governed by the provisions of FS 394.4615.

iii. This section does not apply to records of substance abuse impaired person, which are governed by FS 397.501.

e. The Baker Act provides that the clinical record shall be released when the patient or the patient’s guardian authorized the release. The guardian or guardian advocate shall be provided access to the appropriate clinical records of the patient. The patient or the patient’s guardian or guardian advocate may authorize the release of information and clinical records to appropriate person to ensure the continuity of the patient’s health care or mental health care.

f. Generally, hospitals may disclose protected health information (PHI) to law enforcement:

   i. To comply with a court order, subpoena or summons.

   ii. To identify a suspect, fugitive, material witness or missing person.

   iii. If disclosure is necessary for the health and safety of the individual or accompanying law enforcement.

   iv. To disclose a victim’s information if the victim verbally agrees to the disclosure, under certain circumstances.

IX. INVOLVEMENT OF OTHER PERSONNEL, PATIENT HEALTHCARE SURROGATES, AND LAW ENFORCEMENT

   a. Social Workers. Social Workers should be involved in all Baker Act patients and will aid in the coordination of sending referrals to the receiving facilities; contacting parents of minors, caretakers, durable powers of attorney, and health care surrogates.

   b. Psychiatrist or Clinical Psychologists.

      i. Non-designated facility. Psychiatrists or clinical psychologists are not required to have a consultation with the Baker Acted patient. The patient’s must be stabilized or determined that an emergency medical condition does not exist, and then transferred to a receiving facility within 12 hours so that a psychiatric evaluation is performed.
ii. **Receiving facility.** Psychologists are required to be consulted for receiving facilities within 72 hours after receiving the patient. Policies for receiving facilities must have policies and procedures that expedite the transfer of persons referred from non-designated hospitals after examination or treatment of an emergency medical condition, within the 12 hours permitted by F.S. **394.463.**

c. **Risk Managers.** Risk Managers may be consulted when there are questions about the timeframe, required forms, or situations such as if a receiving facility is at capacity and cannot take the patient.

d. **Law Enforcement.** The officer should take the person to a receiving facility if the patient does not have an emergency medical condition.

e. Community Resources.

f. In-House Counsel.

g. Parents.

h. Durable Power of Attorney and HealthCare Surrogates.

i. Caretakers.

**X. LAW ENFORCEMENT**

a. When any law enforcement officer has custody of a person based on either criminal or minor criminal behavior that meets the statutory guidelines for involuntary examination under this part, the law enforcement officer shall transport the person to the appropriate facility within the designated receiving system pursuant to a transportation plan implemented by each county. §**394.462**

i. All Baker Act Receiving Facilities must complete the form **CF-MH 3125** “Application for Designation as a Receiving Facility” to be designated as a receiving facility.


b. When any law enforcement officer has arrested a person for a felony and it appears that the person meets the statutory guidelines for involuntary examination or placement under this part, such person shall first be processed in the same manner as any other criminal suspect.
c. The nearest receiving facility must accept persons brought by law enforcement officers for involuntary examination.

d. If the appropriate law enforcement officer believes that a person has an emergency medical condition as defined in §395.002(8)(a), the person may be first transported to a hospital for emergency medical treatment, regardless of whether the hospital is a designated receiving facility. Emergency medical condition means a medical condition manifesting itself by acute symptoms of sufficient severity, which may include severe pain, such that the absence of immediate medical attention could result in serious jeopardy to patient health, impairment to bodily functions, or serious dysfunction of any bodily organ or part.

i. The appropriate emergency medical personnel provide evaluation of patient.

ii. EMTALA (Federal) / Emergency Access §395.1041 (Florida Mini EMTALA). At a minimum, a hospital will generally have to assess and stabilize the patient if the patient has an emergency medical condition.

e. Assault and Battery: Section 784.07 Assault or Battery of Law Enforcement Officers. . . Emergency Care Providers. . . Specifically addresses an emergency care provider which includes physicians, employees, agents, or volunteers at hospitals who are employed, under contract or otherwise authorized by the hospital to perform duties directly associated for the care and treatment rendered by the hospital emergency department or the security thereof if assaulted or battered, have remedies. The person who has committed the assault or battery faces anywhere from a first degree misdemeanor to a first degree felony with severe penalties thereafter.

XI. WHAT HAPPENS NEXT

Placement if homeless.

One of the major concerns is placement of the homeless. Florida does not want to have a repeat of the California cases of dumping people in the street.

http://www.sacbee.com/opinion/op-ed/soapbox/article82826997.html

For example, Florida has addressed the Adult Mental Health System of Services in three elements - treatment, rehabilitation, support.

a. Treatment: Four main elements – medications, individual therapy, crisis intervention, and when necessary, psychiatric hospitalization

b. Rehabilitation: After care services, comprehensive community service teams, day-night services, educational services, Florida self-directed care, supportive housing and employment, mental health club houses; and residential level 3.
c. **Support**: Case management, daycare services, drop-in/self-help centers, incidental expenses, information and referral, prevention, residential level 4, respite services, and room and board with supervision levels 1-3.

**XII. EXAMPLES OF FLORIDA SURVEY DEFICIENCIES**

Recent citations from Agency for Health Care Administration (AHCA) include:

a. **Involuntary Exam Criteria**. “Certificate of Professional Initiating Involuntary Examination” form **CF-MH 3052b** was incomplete, and revealed an omission in the documentation of ‘time’. The form was signed by the physician, but the ‘phone number’ and ‘address of professional’ who signed the form was not completed.

**CF-MH 3052B** form reflected the patient’s diagnosis as “suicidal thought”. The mandatory check box areas following the diagnosis were incomplete and not filled out by the initiating physician. These areas were left blank. These areas read, “And because of the mental illness (check all that apply) a. Person has refused voluntary examination after conscientious explanation and disclosure of the purpose of the examination. Either (check all that apply) a. Without care or treatment said person is likely to suffer from neglect or refuse care for himself/herself, and such neglect or refusal poses a real and present threat of substantial harm to his/her well-being and it is not apparent that such harm may be avoided through the help of willing family members or friends or the provision of other services, AND/OR b. There is substantial likelihood that without care or treatment the person will cause serious bodily harm to (check one or both) self/others in the near future, as evidenced by recent behavior.”

Page 2 of the patient’s CF-MH 3052b form did not have the printed name of the professional and phone number, including area code, completed.

b. **Emergency Medical Conditions**. Based on interview, record review, and review of facility policy, the facility failed to transport 2 of 3 patients under a Baker Act to a psychiatric receiving facility within 12 hours following the determination that the patient was medically cleared and clinically stable for transfer to the psychiatric receiving facility.

It is recommended to use form **CF-MH 3102** “Request for Involuntary Examination After Stabilization of Emergency Medical Condition.”

c. **Patient Rights to Consent**. Based on interview and record interview, the facility failed to obtain a consent form for a psychotropic medication that had been ordered and administered for 2 of 3 Baker Act patient records reviewed.

Mandatory form **CF-MH 3042B** “Specific Authorization for Psychotropic Medications” must be completed unless there is medical necessity pursuant to 65E-5.1703 Emergency Treatment Orders, which then must be documented as appropriate.
d. CMS issued an immediate jeopardy notice to Mount Sinai Medical Center in Miami Beach. The allegations were an employee accused of sexual battery on a patient had been allowed to continue working directly with patients in the mental health unit. The patient who was assaulted was under a Baker Act. The concerns were lack of action by the governing body, violation of patient rights and violations of the quality assessment performance improvement plans. 

Miami Herald, July 3, 2019, June 17, 2019, Letter from Mount Sinai to Department of Health & Human Services Regarding CMS Certification Number (CCN) 10-0034.

RESOURCES:

Baker Act Manual and Florida Statutes: 
http://www.myflfamilies.com/service-programs/mental-health/baker-act

DCF Mental Health Website: 
http://www.myflfamilies.com/service-programs/mental-health

Baker Act Benchguide - Florida Courts: 

healthIT.gov

FL Admin Code 64B8-9.0141 & 64B15-14.0081

Health Care Providers Balance Patient Rights and Law Enforcement Authority in the Hospital Setting, AHLA Journal of Health & Services Law – Vol. 11, No. 3

NOTE: I WANT TO THANK MICHELLE L. ROBINSON, MBA, RTR, CPHRM, CPHA, LSSBB, HEALTH FIRST, INC., ROCKLEDGE, FLORIDA (THE PRIOR AUTHOR) FOR HER ASSISTANCE IN PREPARING PORTIONS OF THIS ARTICLE
Three Learning Objectives

I. Initiation of Behavioral Path
II. Elements of a Plan of Action
III. Law Enforcement Issues

In the News...
In the Tampa Bay area:

- One in six people suffers from depression.
- One in twelve has a substance abuse disorder.
- There is only one mental health professional for every 700 people in Florida.
- Leaders from organizations around Tampa Bay are forming a nonprofit called The West Central Florida Mental Wellness Coalition. These include major hospital systems, local politicians, law-enforcement agencies, school districts, non-profits and businesses.
- It has three primary goals:
  - public awareness to get people educated on the scope of the mental health issue,
  - increase urgent care access for behavioral health, and
  - provide resources for patients seeking mental health help.
- This group is going to raise awareness and break the stigma in a big way across four counties (Hillsborough, Pinellas, Pasco, and Polk).
- One desire is to address keeping mental health and substance abuse patients out of jails and emergency rooms where they are not always getting the most appropriate care.
- “We could potentially be the model for the rest of the country.”

Tampa Bay Times, June 11, 2019

All Hillsborough deputies will learn how to de-escalate a mental health crisis
• The Hillsborough County Sheriff’s Office is revamping the training program that teaches deputies how to handle people in the throes of a mental health crisis.

• The 40-hour crisis intervention training is mandatory for the entire force of about 2,400 sworn deputies.

• The rationale for the changes lies in the large number of calls involving people with mental health issues.

Hillsborough Sheriff Chronister said, “I think where we can make a lot of improvement is with de-escalation, and part of the de-escalation is deputies being more familiar with, and able to identify, individuals in crisis.”

• National data shows mental health crises are often a factor in officer-involved shootings.

• Crisis intervention training teaches officers how to recognize signs and symptoms of specific mental health illnesses and how to verbally and, if necessary, physically de-escalate situations without using deadly force when possible.

The curriculum will also put a larger focus on military veterans suffering from post-traumatic stress disorder and drug-induced mental health episodes.

• Collaborations include: Hillsborough’s State Attorney and Public Defender offices, Crisis Center of Tampa Bay, NaphCare, Northside Behavioral Crisis Center, Florida Mental Health Institute and Department of Veterans Affairs.

• The Public Defender also praised the sheriff’s new policy, calling it another way to help “decriminalize mental illness.”

• In Pinellas, the goal is for every patrol and detention deputy to attend a 40-hour training program offered by the National Alliance on Mental Illness (NAMI).

• St. Petersburg Police Chief Anthony Holloway also wants all of his officers to take the alliance’s training and is working toward that goal.

Pasco County Sheriff’s Office to introduce new team focused on mental health

The Mental Health and Threat Assessment Team will begin its work in October.
Pasco County Sheriff’s Office announced Monday it will create a new unit of deputies and case workers dedicated to the mental health needs of the county. The Mental Health and Threat Assessment Team plans to interact directly with people who are experiencing mental health crises with emphasis on those who have been repeatedly detained under the Baker Act.

Deputies responded in 2018 to nearly 20,000 calls related to mental health issues. The team will also connect them with local partners who provide care, like BayCare Behavioral Health and Novus Detox.

The unit will consist of a lieutenant, a sergeant, a social worker, two case managers and six deputies. Pasco County hopes it can some day create a mental health emergency room through proceeds from a nationwide lawsuit against opioid distributors and manufacturers.

Police say Mikese Morse, 30, was driving along New Tampa Boulevard June 24, 2018 when he saw Mr. Pedro Aguerreberry riding his bike with his two young sons. Morse then turned his car around, crossed a lane of traffic, tore across a swath of grass and intentionally crashed into the trio.

Mr. Aguerreberry died shortly afterward at the hospital, the three year old was treated for a broken leg and the eight year old suffered minor injuries. Morse’s mother says that he wasn’t in his right mind and “This is truly the result of a mental health system failure.” Morse’s father went on to say “We spent over 10 years to prevent our son from getting into a situation where he caused harm.”

Morse had been held for mental health assessment under the Baker Act at least four times. Morse went to the police on June 12 rambling about “energy projections” and told the officer not to let him leave or he might hurt someone. He was then taken to Gracepoint. During this stay at Gracepoint his parents say their son attacked a lawyer. Yet he was allowed to leave Gracepoint on June 19. Morse posted videos online shortly before the fatal crash rambling about “energies changing” and saying “I’m going to kill somebody.”
SSM Health has instituted an initiative which encourages security guards to be a more integrated part of the care team, actively communicating with patients and clinical staff to obtain a better sense of situations that could be potentially violent and intervene before they escalate.

**Firearm Removal**

- Risk Protection Orders
- Florida only allows Law Enforcement Officers to petition
- Keep guns away from people who are at high risk of committing violence.
- Removal of firearms dependent on the respondents cooperation.

She Was Arrested For Taking Her Husband’s Guns. But The Law Left Her Little Choice.

Huffington Post
June 25, 2019
One case in Lakeland in June 2019, dealt with domestic violence. An alleged domestic violence victim's wife, was arrested for armed burglary for taking her estranged husband's firearms to the Lakeland Police Department. She had an emergency protection order against him but the husband was in jail on a domestic battery charge. The husband was set to be released on bond, with a court order not to own, buy, or carry firearms. However, the wife did not believe he would turn over his guns so she took the matter into her own hands. However, Florida has no automatic enforcement mechanism to ensure that someone would get rid of the guns that are already in his possession. This is described as the "relinquishment gap." It was pointed out that the courts can issue a warrant so law enforcement can go in and retrieve the guns.

Involvement of Other Personnel, Patient Healthcare Surrogates and Law Enforcement

- Social Workers
- Psychologists
- Risk Managers
- Law Enforcement
- Community Resources
- In-House Counsel
- Parents
- Durable Power of Attorney and Healthcare Surrogates
- Caretakers

Admission by Voluntary Status

Person Admitted on Voluntary Status (No Duty for Mental Health Professionals to Initiate Involuntary Examination)

Certified by Physician to be Competent to Consent to Treatment (Well Reasoned, Willful & Knowing Medical and Mental Health Decisions)

Full Disclosure of All Aspects of Treatment Provided to Patient Before Setting Indications

Release Within 24 Hours

File Petition for Placement (BA32) with Clerk of Court within Two Court Working Days

Firearm Prohibition Notice NOT Filed With Clerk of Court

Patient Requests Discharge or Refuses Treatment
Admission by Involuntary Status

Person Admitted to Receiving Facility on Involuntary Status After Initiation by Circuit Judge, Law Enforcement or Authorized Mental Health Professional, (BA  52 or Ex Parte) Request Transfer to Voluntary Status

“Firearm Prohibition” Forms Filed to Clerk of Court Do Not File Firearm Prohibition Forms Exam, and Criteria Are Met for Involuntary Placement (BA32) Petition is Filed (BA32) Release From Facility Certification by Physician to be Competent to Consent to Voluntary Admission Certification Dangerousness and BA32 Was Filed or Would Have Been Filed if Not Voluntary Proceed to Hearing or Discharged and Petition Dismissed Certification by Physician to be Competent to Consent to Voluntary Admission Request Transfer to Voluntary Status

The Baker Act Florida Mental Health Act Fiscal Year 2017/2018 Annual Report

- Suicide and Self-Harm: Three quarters (77.36%) of involuntary examinations were based on evidence of harm to self. Self-harm includes suicidal ideation or suicide attempts. However, it is important to understand that self-harm is not synonymous with suicide. Self-harm can also include behaviors such as cutting and bodily harm that does not have suicidal intent.
**RISK SCREENS - COLUMBIA SUICIDE
RATING SCALE SCREENER**

**SUICIDE IDEATION DEFINITIONS AND PROMPTS:**

- **Wish to Be Dead:**
  - Have you wished you were dead or wished you could not die?
  - Person endorses thoughts about a wish to be dead or not want to live anymore, or wish to fall asleep and not wake up.

- **Suicidal Thoughts:**
  - Have you actually had any thoughts of killing yourself?
  - General non-specific thoughts of wanting to end one's life/commit suicide. "I've thought about killing myself" without general thoughts of ways to kill oneself/associated methods, intent, or plan.

- **Suicidal Thoughts with Method without Specific Plan or Intent to Act:**
  - Have you been thinking about how you might do this?
  - Person endorses thoughts of suicide and has thought of at least one method during the assessment period. This is different than a specific plan with time, place or method details worked out. "I thought about taking an overdose but I never made a specific plan as to when, where, or how I would actually do it... and I would never go through with it."

- **Suicidal Intent without Specific Plan:**
  - Have you had these thoughts and had some intention of acting on them?
  - Active suicidal thoughts of killing oneself and patient reports having some intent to act on such thoughts, as opposed to "I have the thoughts but I definitely will not do anything about them."

- **Suicidal Intent with Specific Plan:**
  - Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?
  - Thoughts of killing oneself with details of plan fully or partially worked out and person has some intent to carry it out.

- **Suicide Behavior Question:**
  - Have you ever done anything, started to do anything, or prepared to do anything to end your life?
  - Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump, or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc.

**RISK SCREENS - COLUMBIA SUICIDE
RATING SCALE SCREENER**

1. **Wish to Be Dead:**
   - Have you wished you were dead or wished you could not die?
   - Person endorses thoughts about a wish to be dead or not want to live anymore, or wish to fall asleep and not wake up.

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4. **Suicidal Intent without Specific Plan:**
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   - Active suicidal thoughts of killing oneself and patient reports having some intent to act on such thoughts, as opposed to "I have the thoughts but I definitely will not do anything about them."

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   - Thoughts of killing oneself with details of plan fully or partially worked out and person has some intent to carry it out.

6. **Suicide Behavior Question:**
   - Have you ever done anything, started to do anything, or prepared to do anything to end your life?
   - Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump, or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc.
   - "Why this within the past 3 months?"
## Environmental Risks

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<th>Yes</th>
<th>No</th>
<th>N/A</th>
<th>Comment</th>
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<tbody>
<tr>
<td>1.</td>
<td></td>
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<td>No cell phones, cords, clothing, jewelry, electronic devices etc. are allowed.</td>
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<td>2.</td>
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<td>Patient should only have wrap around gowns and/or pajama bottoms with snap closures being used.</td>
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<td>3.</td>
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<td>When utilizing visual monitoring be sure all ligature risks are visible (e.g., door hinges, hooks on the back of doors, pipes under sinks).</td>
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<td>4.</td>
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<td>Remove unnecessary equipment and furniture from room (e.g., Thermometer, gloves, hygiene items, C-pap machine).</td>
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<td>5.</td>
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<td>Patient’s closets and lockers should all be emptied.</td>
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<td>6.</td>
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<td>All chemicals, including alcohol-based hand rub, Sani wipes, cleaning supplies should be removed from patient room.</td>
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<td>7.</td>
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<td>Needle boxes should be removed from room.</td>
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<td>8.</td>
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<td>Disposable medium-weight bendable plastic cutlery should be used and accounted for after meals (Under Fat Hood Tray).</td>
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<td>9.</td>
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<td>Remove wall mounted Blood Pressure cuffs.</td>
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<td>10.</td>
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<td>All cords attached to window blinds and coverings should be removable.</td>
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<td>11.</td>
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<td>Remove all unnecessary flow meters and vacuum regulators from room.</td>
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<td>12.</td>
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<td>All TMs should know where the key or device is located to quickly unlock a patient’s door (e.g., bathroom).</td>
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<td>13.</td>
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<td>All extra linens should be removed from the room.</td>
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<td>14.</td>
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<td>Ensure that all electrical power cords on adjustable beds, TV’s and other Electrical devices are secured and bundled with zip ties. Make sure bed can still be mechanically lowered for CPR positioning. (Contact facilities if needed.)</td>
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<td>15.</td>
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<td>Ensure that all electrical power cords on adjustable beds, TV’s and other Electrical devices are secured and bundled with zip ties. Make sure bed can still be mechanically lowered for CPR positioning. (Contact facilities if needed.)</td>
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<td>16.</td>
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<td>When patient is in the bathroom Constant Visual Observation should be maintained since most ligature risks cannot be removed (see list).</td>
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<td>17.</td>
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<td>Nurse call or emergency call switches without breakaway cords</td>
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<td>Clothing hooks on the doors</td>
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<td>Wall mounted soap or hand hygiene dispensers</td>
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<td>Grab and towel bars</td>
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Environmental Risks

<table>
<thead>
<tr>
<th>No</th>
<th>NPSG.01.01.01 Use at least two patient identifiers when providing care, treatment and services.</th>
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<tbody>
<tr>
<td>18</td>
<td>Ensure that all doors to service and supply rooms are locked when staff members are not physically present.</td>
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<tr>
<td>19</td>
<td>Remove all plastic trash can liners from every area accessible to patients (e.g., Pt room and Bathroom).</td>
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</table>

Emergency Room

Non-Receiving Facility ER Responsibilities

- Involuntary Exam triggered by Law Enforcement or ER physician, receives a medical screening examination
- ER certifies no emergency medical condition

Time Frames

- Within 2 hours Hospital must notify receiving facilities
- Within 12 hours Hospital must transfer the patient to a receiving facility
- Under Baker Act - unless DCF has designated a facility they may not hold and/or treat persons on an involuntary basis for mental illness
Policies and Procedure Recommendations

- Hospitals in conjunction with their various departments should consider having in place the following policies:
  
  - Consent for treatment in the context of a patient in police custody;
  
  - EM/ALA and the hospital’s screening procedures for patients who present in the custody of Law Enforcement;
  
  - Patient privacy rights while in the custody of LE;
  
  - Hospital security and patient confinement in the context of the Emergency Department.

This training, education, and communication among all the involved personnel is very important. It is recommended that training will include regular updates through newsletters, email alerts, or pop-up screens regarding obligations under the various job duties at the hospital.

Emergency Room Care of the Patient Policy & Procedure (P&P)

- Medication reconciliation: This is important to make sure no medications are stopped that might have detrimental impact on the patient’s condition.
- Environment of Care issues: (see Suicidal Intent with Specific Plan and Suicide Behavior Questions).
- Appropriate work attire:
  - Strangulation risks
  - Eyeglasses
  - ID lanyards
- Cultural diversity awareness
- Self defense
  - Can I fight back?
- Appropriate physical restraint use

Regulatory Issues and Responses

- Documentation of a competency assessment.
- Emergency Temporary Order (“ETO”) vs. Consent for Psychotropics
- Forms related to involuntary admissions:
  - Cumbersome and do ED physicians need to be trained on the Baker Act forms/laws?
  - Best practice continuing medications vs. waiting for psychiatric evaluation.
  - If patient is determined to be a harm to self or others, timing of signing of forms
- General consent to treat before capacity assessment before psychotropic consent?

STOP - Help us fix it!!
Psychotropic Consent Form

- Documentation risks, benefits, alternatives.
- Length of time to appoint a guardian advocate in the absence of a healthcare surrogate or proxy.
- Refusal of patient to provide consent and/or provide collateral information to locate proxy.
- Side effects that are common! Who would consent?

Guess the Med?

1. Drowsiness, dizziness, lightheadedness, drooling, nausea, weight gain, or tiredness may occur. If any of these effects persist or worsen, tell your doctor or pharmacist promptly.
2. Dizziness and lightheadedness can increase the risk of falling. Get up slowly when rising from a sitting or lying position.
3. Remember that your doctor has prescribed this medication because he or she has judged that the benefit to you is greater than the risk of side effects. Many people using this medication do not have serious side effects.
4. Tell your doctor right away if you have any serious side effects, including difficulty swallowing, muscle spasms, shaking (tremor), mental/mood changes (such as anxiety, restlessness), interrupted breathing during sleep.
5. This medication may rarely make your blood sugar rise, which can cause or worsen diabetes. Tell your doctor right away if you have symptoms of high blood sugar such as increased thirst/urination. If you already have diabetes, check your blood sugar regularly as directed and share the results with your doctor. Your doctor may need to adjust your diabetes medication, exercise program, or diet.
6. This drug may also cause significant weight gain and a rise in your blood cholesterol (or triglyceride) levels. These effects, along with diabetes, may increase your risk for developing heart disease. Discuss the risks and benefits of treatment with your doctor. (See also Notes section.)
7. Risperidone may rarely cause a condition known as tardive dyskinesia. In some cases, this condition may be permanent. Tell your doctor right away if you develop any unusual/uncontrolled movements (especially of the face, lips, mouth, tongue, arms or legs).
8. This medication may increase a certain natural substance (prolactin) made by your body. For females, this increase in prolactin may result in unwanted breast milk, missed/stopped periods, or difficulty becoming pregnant. For males, it may result in decreased sexual ability, inability to produce sperm, or enlarged breasts. If you develop any of these symptoms, tell your doctor right away.
9. Get medical help right away if you have any very serious side effects, including severe dizziness, fainting, seizures.
10. This medication may rarely cause a very serious condition called neuroleptic malignant syndrome (NMS). Get medical help right away if you have any of the following symptoms: fever, muscle stiffness/pain/tenderness/weakness, severe tiredness, severe confusion, sweating, fast/irregular heartbeat, dark urine, signs of kidney problems (such as change in the amount of urine).

Psychotropic Medication Consent

- AHCA activity ➔ deficiencies
- Patients on a Baker Act must give consent for psychotropic medications
- Emergency Treatment Order (exception) = high burden
Emergency Treatment Order and Psychotropic Medications

- ETO supersedes the patient’s right to refuse.
- Must be fast acting.
- Close documentation that if the behavior is left uncontrolled, present and immediate danger to the patient or other persons in the facility will occur.
- ETO’s are specific to Florida Mental Health Act.
- What happens when patient is not a Baker Act and behavior poses a risk?
- Is this a chemical restraint?
General Authorization for Treatment Except Psychotropic Medications

I, the undersigned, a competent adult,

✓ guardian, guardian advocate, or
✓ health care surrogate/proxy hereby authorize the professional staff of this facility to administer as specified below.

0 Routine medical care (Initials of Person or Authorized Decision Maker)

El Psychiatric Assessment

El Other (Specify & Initial)

Understand that more information will be provided to me before my informed consent will be requested for the administration of any psychotropic medications.

I understand that my consent can be revoked orally or in writing prior to, or during the treatment period.

I have read and had this information fully explained to me and I have had the opportunity to ask questions and receive answers about the treatment.

(Initials of Person or Authorized Decision Maker)

Signatures:

Signature of Competent Adult

Date

Signature of Witness for Person

Date Time

Signature of: (check one when applicable) Date Time

Guardian

Guardian Advocate

Health Care Surrogate

Health Care Proxy

If I am the guardian advocate, health care surrogate, or health care proxy for the person, I certify that I have met and talked with the person and the person’s physician in person, if at all possible, and by telephone, if not about the proposed treatment prior to signing this form.

Talked to person on: (date) DIn person 013y telephone. If not in person, explain why not.

Talked to person’s physician on: __(date) DIn person 013y telephone. If not in person, explain why not.

Signature of: (check one when applicable) Date Time

Guardian

Guardian Advocate

Health Care Surrogate

Health Care Proxy

Signature of Witness for Substitute Decision-Maker Date Time

The person shall always be asked to sign this authorization form. However, if the person is a minor, is incapacitated, or is incompetent to consent to treatment, the consent of his or her guardian, guardian advocate, or health care surrogate/proxy is required. Court orders, letters of guardianship, or advance directives must be retained in the clinical record if an individual other than the person signs the consent to treatment, The guardian, guardian advocate, or health care surrogate/proxy must agree to keep the facility informed of their whereabouts during the term of the hospitalization.

See s. 394.459(3), Florida Statutes

CF-1V11-1 3042a, Feb 05 (obsoletes previous editions) (Recommended Form) BAKER ACT

Florida Resources

  https://www.usf.edu/cbcs/baker-act/
- Crisis Services - Baker Act - Forms
- We have attached a list of resources at the end of this presentation for your consideration.

I. Emergency Room

- On average hospital wide 90 Code Grays monthly.
  - Average 4 team members injured per month.
  - Those seeking medical attention, probably a higher number.
  - Nationally ED nurses surveyed stated 100 percent have been verbally assaulted and 80 percent physically assaulted.
  - Some form of violence is acceptable because the patient is ill.
  - Burn out related to workforce violence due to feelings of not being supported.
POTENTIAL VIOLENCE
Never wait for things to get worse

Identification of Patients for Potential Violence
- What is patient violence?
  - Threats of physical aggression and verbal assaults (name calling, swearing)
  - Past behavior is a good predictor of future behavior issues. PV designation in an electronic medical record. Utilizing visual cue on door (i.e. Gray Placard)
  - Ask questions on admission.
- 1 of every 3 patient violence events related to behavior health issue or substance abuse issue.

Code Gray - Aggressive Patient (P&P)
- Training is Key! NAPPI (Non-Abusive Psychological and Physical Intervention)
- Use of nonoffensive techniques (staying a safe distance from the agitated person, listening, showing empathy, posture)
- Having a team to respond that is trained to deescalate and/or restrain.
- Control by physical means will be last resort. Restraints should not be a consequence of a behavior if patient deescalates.
- Debrief: what caused the escalation? Empowerment of your team members.
GARRETT SECURITY WAND

GARRETT RESPONSIBILITY
- Security will have the primary responsibility for wanding of patients.
- The Intake Specialists will be the back up for the wanding procedure when Security is not available.

TRAINING
- The Intake Specialist will be trained by Security in the procedure for wanding including: technique, false positives and interference of outside materials.

INTAKE REQUIREMENT
- The team member will explain to the patient that the use of the Garrett Wand is for their safety, the safety of the other patients and for that of the unit. If a patient becomes aggressive and cannot be de-escalated by the team members in intake, please call a supervisor and ask for assistance in wanding the patient. Wanding is not optional. It is a requirement.

GARRETT SECURITY WAND

GARRETT WAND PROTOCOL
- The Intake Specialist will remain with the patient until they have been wanded.
- If a team member suspects that a family member may have passed contraband to the patient, the patient will be wanded again.
- Weapons and sharp items found during wanding will be confiscated and given to the appropriate supervisor.

SAFETY FIRST
- While it is tempting to play with the wand or wand other team members, please do not do this in front of the patients as it detracts from the seriousness of safety issues.
- The Garrett Wand will be kept in a secure designated place until it is necessary to wand a patient.

ESTABLISHED SAFETY MEASURES
The Garrett Wand is an additional safety measure and will not replace any established safety measure. The patient and their belongings will continue to be searched when they first enter intake when they are wanded per the protocols currently in place.
Florida Hospital System Boosts Security with Metal Detectors, Visitor Badges

June 21, 2019

The BayCare Health System has increased security measures by requiring identification, metal detector screenings, and a photo ID badge. Metal detectors will be installed at all public entrances, including the ED and ambulance entrances. BayCare also has a variety of other trainings that they are incorporating in the system to provide a safe and secure environment.

Violence in the Workplace

VIHA Weekly May 17, 2019

Occupational Safety and Health Act's (OSH Act) general duty clause requires employer's to protect employees from incidents of workplace violence. In Sec'y of Labor v. Integra Health Management, Inc., the Commission affirmed a citation issued to a social services provider after one of its employees was fatally stabbed by a mentally ill client.

The employee submitted reports to her supervisors in which she identified disturbing behavior from the member, and that she was "uncomfortable" being alone with him. During her visit, the member attacked the employee and fatally stabbed her nine times.

General duty clause states that "each employer...shall furnish to each of his employees employment and a place of employment which are free from recognized hazards that are causing or are likely to cause death or serious physical harm to his employees." To demonstrate a general duty clause violation, the agency must prove:

(a) The employer failed to keep the workplace free of a hazard to which employees were exposed.
(b) The hazard was recognized.
(c) The hazard was causing or was likely to cause death or serious physical harm; and
(d) There was a feasible and useful method to correct the hazard.

AHLA Weekly June 21, 2019

Violence in the Workplace

The employee submitted reports to her supervisors in which she identified disturbing behavior from the client, including an assault, headbutting, and threatening her with a knife. During her visit, the member attacked the employee and fatally stabbed her nine times.

General duty clause states that "each employer...shall furnish to each of his employees employment and a place of employment which are free from recognized hazards that are causing or are likely to cause death or serious physical harm to his employees." To demonstrate a general duty clause violation, the agency must prove:

(a) The employer failed to keep the workplace free of a hazard to which employees were exposed.
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(c) The hazard was causing or was likely to cause death or serious physical harm; and
(d) There was a feasible and useful method to correct the hazard.
Violence in the Workplace

**Best Practices**

- Reviewing safety policies and procedures and employee training programs to confirm they effectively reduce employees’ exposure to patient assaults.
- Health care employers should screen patients for violent tendencies, communicate any relevant information to employees.
- Debriefings after violent episodes.
- Simulation/role playing and conducting mock drills.
- Direct observation of the team's competency and communication.
- Mandatory training programs and refreshers (NAPPI).
- Dedicated modified rooms.
- Security presence 24/7.

Law Enforcement Concepts

- If there is an assault and battery of hospital personnel, will law enforcement automatically take that person to jail?
- The answer is no.
- What if there is an assault and battery of law enforcement personnel while in the hospital with the patient?

**Assault and Battery**: Section 784.07 Assault or Battery of Law Enforcement Officers. . . Emergency Care Providers — Specifically addresses an emergency care provider which includes physicians, employees, agents, or volunteers at hospitals who are employed, under contract or otherwise authorized by the hospital to perform duties directly associated for the care and treatment rendered by the hospital emergency department or the security thereof if assaulted or battered, have remedies. The person who has committed the assault or battery faces anywhere from a first degree misdemeanor to a first degree felony with severe penalties thereafter.
Escalating Workplace Violence Rocks Hospitals

- When you visit the Cleveland Clinic emergency department - whether as a patient family member or
to - a large sign directs you toward a metal detector.
- Cleveland Clinic has introduced other safety measures - such as wireless panic buttons incorporated
into ID badges and more safety cameras and plainclothes officers in ER's.
- According to the Occupational Safety and Health Administration, incidents of serious workplace
violence are four times more common in health care than in private industry.

Coordination Between Permitted Contractors,
Hospital Security and Law Enforcement

- Question: Chief would like your input on coordination between contract security and law
enforcement?
- Question: It's fine if metal detectors find guns, but what about all the ancillary equipment, i.e.,
knives and box cutters. How do we address them?

Care of the Patient at Risk for Potential
Violence P&P

- Electronic medical record notation of PV.
- Set expectation of appropriate behavior (i.e., behavioral contract).
- Utilization of de-escalation skills.
- Changing the culture - moving from reactionary to supportive.
- Whistles and/or personal safety devices.
- Activities.
- Violent patient Huddle Handoff.
- Struggle to differentiate impulsivity from predatory violence.
- A healthcare worker that feels protected will go the last mile for their
patient.
Self-Harm vs. Potentially violent is there a difference?

- Assessments for self harm are validated tools vs. tools to identify potentially violent patients.
- ENVIRONMENT, ENVIRONMENT, ENVIRONMENT.
- Remove items and cords.
- Locked cabinets.
- Duress alarms.

III. Behavioral Health Floor

- This is a locked unit!
- Ability to control visitors and contraband.
- Therapy in addition to medication stabilization.
- Provide consultation and support to Code Gray events.
Payment Sources

Tampa Bay Leaders Form Coalition To Address Mental Health Crisis

June 21, 2019
USF Public Media

- The coalition has already raised a little over $5 million toward their goal of $7.5 million that they need to cover operating costs for the first five years.
- BayCare is matching any donations given to the coalition. So far, companies like Advent Health, Florida Blue, and Tampa General Hospital have donated.

School Districts Developing Plans to Expand Mental Health Care for Students

- According to a 2016 report from the Florida Association of School Psychologists, there is ONE school psychologist for every 1,983 students in the State of Florida.
- In response to Parkland, Florida lawmakers are providing $69 million to enhance mental healthcare at public schools. The money will be divided among districts based on the number of students they have.
- Most school districts have Psychologists, Social Workers and School Counselors on staff but they are not always available at all schools.
- Psychologists are trained to help students deal with stress and trauma that is effecting their school performance
- Social Workers provide resources for families and try to figure out why students miss school
- School Counselors help students create schedules and meet academic goals

Julio Ochoa, Health News Florida, 05.24.18

Dedicated Psychiatric Unit or “DPU”

- See 42 C.F.R. Section 412.25.
- Focus is on patient types and length of stay.
- Reimbursement.
Readmissions

- Pathways was a coaching/navigation program for outpatient services. Privately funded.
- Today:
  - Focus is on recidivism.
  - If patient returns within 30 days team reviews what did not work and why and follows up with the patients.
  - EMRI transitions of care (the smart ROBO call).
    - Calls patients at intervals for 90 days post discharge. It is recorded voice and a report is generated every 24 hours. Depending on the patient’s responses to the questions, the responses may escalate to Pathway team prompting a “live” call to the patient.
  - Discharge planning: Would tele-psych help prevent readmissions from SNFs and ALFs.

Community Program with PAR/Discharge

- Operation PAR grant funded.
- Allows for a representative to be in the Emergency Room or on call.
- ED physician or Behavioral health team helps identify population.
- Typically identifying patients with opiate addiction/overdose.
- Representative tries to engage the patient in services as outpatient. Has expanded to substance abuse disorders inpatient/outpatient.
- Goal is to start early medication program to assist with withdrawal.

What’s Next?

Adult Mental Health System of Services:
- Three main elements - treatment, rehabilitation, support.

Treatment:
- Four main elements - medications, individual therapy, crisis intervention, and when necessary psychiatric hospitalization.

Rehabilitation:
- Aftercare services, comprehensive community service teams, DAY: Night services, educational services, Florida self directed care, supportive housing and employment, Mental health Club houses, and residential level 3.

Support:
- Case management, daycare services, drop-in/self help centers, incidental expense, information and referral, prevention, residential level 1, respite services, and meal and board with supervision levels 1 & 2.
Mental Health

Definition of Mental Illness

- Impairment of the mental or emotional processes:
  - That exercise conscious control of one's actions or of the ability to perceive or understand reality and
  - That substantially interferes with a person's ability to meet the ordinary demands of living regardless of
    etiology
  - Thought disorders may include schizophrenia, schizoaffective disorder, major depression, manic episode,
    bipolar disorder
- Excludes: developmental disabilities as defined in Chapter 393, intoxication or conditions
  manifested only by antisocial behavior or substance abuse.

Rights of persons with mental illnesses:

- Individual dignity
- Treatment
- Express and informed consent
- Quality of treatment
- Communication, abuse reporting, and visits
- Care and custody of personal effects
- Voting in public elections
- Habeas corpus
- Treatment and discharge planning
- Sexual misconduct prohibited
- Right to a representative
- Confidentiality
- Violation of rights
The Baker Act Florida Mental Health Act Fiscal Year 2017/2018 Annual Report

Report Highlights
- There were 205,781 involuntary (Baker Act) examinations in Fiscal Year 2017/2018.
- Involuntary examinations increased:
  - 2.92% from fiscal year 2016 to 2017
  - 16.26% from fiscal year 2013 to 2018
  - 53.98% from fiscal year 2008 to 2018.
- They have doubled 115.31% increase from fiscal year 2001 to 2017.
- From 2013 to 2018, statewide involuntary examinations increased:
  - 16.85% for children
  - 17.78% for youth adults (18-24)
  - 16.49% for older adults.
- Three-quarters (73.55%) of involuntary examinations in 2017 and 2018 were for adults 18 through 64 with 17.53% for children, and 7.41% for people 65 and older.
- 51.67% of involuntary examinations were initiated by law enforcement
- 46.31% initiated by professional certificate
- 2.02% initiated via ex parte order.
Psychiatric Presentations During All 4 Phases of the Lunar Cycle

- The study measured the number of psychiatric presentations for each group during the 4 NASA-defined phases of the lunar cycle, and the study was statistically powered to detect small effects.

- The study found that the lunar cycle did not have an effect on the incidence of psychiatric presentations or on the DSM-5 categories.

Francis OJ, Kopke BJ, Affatato AJ, Jarski RW
Summer 2017 Adv Mind Body Med. - NCBI

Law Enforcement discretion on transporting Baker Act - No Wrong Door
Transportation of persons for Involuntary Examination:

Highlights:
- Law Enforcement (LE) is responsible to transport the person to the appropriate facility within the designated receiving system pursuant to a transportation plan implemented by each county. §394.462
- LE has no responsibility to transport for voluntary admission
- LE may decline transport in certain circumstances
- The appropriate facility within the designated receiving system or the nearest receiving facility must accept persons brought by LE or EMS or private transport company authorized by the county for involuntary examination
- If LE believes that a person has an emergency medical condition, person may be first transported to a hospital for emergency treatment regardless of whether the hospital is a designated receiving facility.

TRANSPORTATION:

Question: Chief would like your input on transportation of persons for involuntary examination and what the police do.

Transportation to Receiving Facility

Part I: General Information

The circumstances, under which (Name of Person) was taken into custody are as follows:

Time: am pm Date:

Place or Facility Name:

Pick Up Address:

Family members or others present when person was taken into custody

Relationship

Phone Number

Next of Kin (if known)

Indicate personal knowledge by family members and others about the person's condition.

Delivered to (Nearest Receiving Facility):

Basis for Custody: (Check one)  Ex Parte Order  Certificate of Mental Health Professional  Report of Law Enforcement Officer

am pm

Signature of Law Enforcement Officer Date Time

Printed Name of Law Enforcement Officer Full Name of Law Enforcement Agency

Badge or ID Number Law Enforcement Case Number

CONTINUED OVER
Part II - Used When Law Enforcement Consigns Persons to Contract Transport or to Emergency Medical Personnel

If transport is used due to the medical condition of the person or due to a county-funded contract with a transport company, print the name of the company which will transport the person to the nearest emergency room in the case of a medical emergency or, if not a medical emergency, to the nearest designated receiving facility.

(specify facility to which person is to be taken)

The law enforcement agency and the transport service must agree that the continued presence of law enforcement personnel is not expected at the time of consignment to be necessary for the safety of the person or others.

I, of the Printed Name of Law Enforcement Officer Printed Name of Law Enforcement Agency

and I, of the Printed Name of Medical Transport Service Representative Printed Name of Medical Transport Service

agree that the continued presence of the law enforcement agency is not expected to be necessary for the safety of or others. By affixing my legal signature and date/time of signing below, I understand that continued transporting of the person named above to a receiving facility is no longer the responsibility of law enforcement agency. The responsibility is assumed by the medical transport service in accordance with s. 394.462 (1), F.S.

Signature of Law Enforcement Officer Date Signed Time Signed

Signature of Representative of Medical Transport Service Date Signed Time Signed

This form must be delivered with the person to the receiving facility for inclusion in the clinical record. A copy may be retained by the law enforcement agency and by the medical transport service.

By Authority of s. 394.462(18), 394.463, Florida Statutes

CF-MH 3100, Feb 05 (obsoletes previous editions) (Mandatory Form)

Resources & Research


DCF Mental Health Website: http://www.myflfamilies.com/service-programs/mental-health

The Baker Act - Florida Mental Health Act Fiscal Year 2017/2018 Annual Report

Prepared for the Florida Department of Children & Families


Hospitals Against Violence

The Joint Commission


Crisis Services - Baker Act - Forms


Best Practices - Integrating Security Officers Into the Clinical Team

Department of Health & Human Services - Center for Clinical Standards and Quality/Quality Teams & Councils Group July 2, 2019 Immunization Summary

May 21, 2019, Memo From Chief Anthony Holloway Regarding Hospital Procedures

Article: https://www.huffpost.com/entry/taylor-stry-great-hashtag-gn-g-n_5972440485870916888

1.48
MENTAL HEALTH AND SUBSTANCE ABUSE CARE IN THE ACADEMIC SETTING

By

Beverly Binner, Roanoke, VA
Daniel A. Jones, Boca Raton
I. INTRODUCTION
   A. Summary of Issue.
      1. Carilion Clinic ("Carilion"), a not-for-profit healthcare organization headquartered in Roanoke, Virginia, manages and operates several on-campus student health center clinics on behalf of the associated public and private colleges.
      2. In most cases, Carilion and its college clients have agreed that student health records created by Carilion are to be maintained in accordance with the Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA") (Public Law 104-191; 45 CFR Parts 160 and 164), as opposed to the Family Educational Rights and Privacy Act ("FERPA") (20 U.S.C § 1232g; 34 CFR 99).
      3. Carilion and its college clients have determined that there are advantages to maintaining records in accordance with HIPAA, including continuity of care and protection of patient privacy.
   B. Overview of Carilion Clinic.
      1. Carilion serves approximately 1 million residents throughout an approximately 20 county region in central and southwestern Virginia and western Virginia.
      2. Carilion has 225 practice sites across 75 specialties, over 700 employed physicians and over 13,000 employees.
      3. Carilion owns and operates seven hospitals, including the region’s only Level 1 trauma center.
      4. Carilion maintains its medical records in a single electronic medical record ("EMR") system in compliance with HIPAA and similar state privacy laws.

II. CHALLENGES
   A. Typically, colleges are not familiar with the similarities and differences between FERPA and HIPAA.
1. In some cases, education of the college-client concerning the differences in the laws and regulations was necessary, as well as education concerning the benefits of applying HIPAA to student health records.

2. Some colleges expressed concern that students may not want their health records to “follow” them past their college years.

B. Colleges are concerned about the risks of violating their obligations under FERPA.
   1. Confusion exists as to whether and under what circumstances colleges are required to ensure that student health records related to services rendered on campus are to be maintained in accordance with FERPA.
      a. FAQ 3: Does FERPA or HIPAA apply to elementary or secondary school student health records maintained by a health care provider that is not employed by a school?
      b. A: “If a person or entity acting on behalf of a school subject to FERPA, such as a school nurse that provides services to students under contract with or otherwise under the direct control of the school, maintains student health records, these records are education records under FERPA, just as they would be in the school maintained the records directly. This is the case regardless of whether the health care is provided to students on school grounds or off-site.” (emphasis added)

C. Maintaining FERPA records can be challenging and costly to a health care provider.
   1. Health care organizations already maintain records in accordance with HIPAA, and similar state laws.
   2. It can be difficult to fully integrate FERPA records into an electronic medical record system already set up for HIPAA compliance.
   3. Purchasing and maintaining a separate electronic medical record system to store FERPA treatment records can be costly and maintaining paper records is inefficient.

D. Requiring health care providers to determine whether a record is a FERPA record or a HIPAA record may increase the risk of using or disclosing student health records inappropriately and in violation of the applicable law.
   1. Health care providers already receive extensive education and training with respect to HIPAA compliance.
2. Requiring that health care providers receive FERPA training and determine when/whether a record should be used or disclosed in accordance with either FERPA or HIPAA has the potential for creating confusion, possibly resulting in a higher likelihood of inappropriate disclosures.

E. Maintaining records in accordance with FERPA could impede continuity of care.
   1. If a student health center maintains/stores FERPA treatment records, a determination must be made that the records are treatment records and not educational records requiring a student’s consent prior to disclosure, potentially causing a delay in the disclosure to a subsequent treatment provider.
   2. HIPAA records can generally be disclosed for treatment purposes without the patient’s consent/authorization.

III. SOLUTION:
   A. Carilion’s student health center arrangements provide for integration of student health records into Carilion’s EMR system.
      1. Health care providers with access to the EMR system are able to immediately access key medical information, including previous diagnosis, allergies and medications.
   B. Carilion’s student health center arrangements ensure that Carilion, not the college, has control over the health care services and the records.
      1. The student health centers are operated similar to how Carilion would operate any of its other ambulatory clinic sites except that the patient base is limited to students or college guests, such as camp attendees, and the space is provided by the college.
      2. Carilion employs clinical and administrative staff and is responsible for licensure/certification as appropriate, providing for ongoing training and education, supervision and disciplinary action and for maintaining professional liability insurance.
      3. Carilion determines what medical equipment or supplies are used.
      4. Space is typically provided by the college, but signage and advertisements are clear that Carilion Clinic is the service provider.
      5. Carilion provides students/patients with a notice of privacy practices as required by HIPAA and colleges are expected to notify students via their FERPA Notification that student health records are not subject to FERPA.
      6. Carilion handles referrals of students for follow up treatment, as appropriate.
   C. Support and buy-in from the Commonwealth of Virginia, Office of Attorney General’s office was needed and obtained.
      1. The OAG was involved in the review and approval of the student health services agreement for public colleges.
2. Factors that I believe influenced the OAG’s decision:
   a. The student health services arrangement established Carilion’s “control” over the records and student health services.
   b. Student health records would be subject to stringent security and privacy requirements under HIPAA.

3. OAG not willing to issue a formal opinion on the matter but reviewed and approved the college student health agreements that expressly provide for maintenance of student health records in accordance with HIPAA.

D. Benefits to students and colleges resulting from Carilion’s assumption of responsibility for records.
   1. Efficiencies created by Carilion.
      a. Carilion already owns and operates a comprehensive EMR systems that is available 24/7/365.
      b. Carilion personnel already receive extensive training on medical record privacy and compliance with HIPAA and other applicable federal and state privacy laws.
      c. Carilion already has a process for responding to requests for disclosures of or access to health record information.

   2. Risk avoidance.
      a. Not having to comply with two competing legal requirements (i.e., both HIPAA and FERPA) eliminates the need for and expense of extensive training of Carilion staff on FERPA and reduces the risk of confusion and potential for violations of applicable laws.

   3. Benefits to college.
      a. College no longer has the burden of deciding when a disclosure is appropriate.
      b. Carilion is responsible for determining when a disclosure is appropriate and thus, is liable for inappropriate disclosures.
      c. College does not have responsibility for maintaining records.
         i. College avoids the expense of having to purchase and maintain a stand-alone electronic medical record system.
         ii. College avoids risks associated with security and privacy.
         iii. College avoids the expense of having to ensure staff is available, even during breaks, and adequately trained to respond to requests for disclosures of medical records.
         iv. College avoids negative student health outcomes resulting from any delays in sharing student health information to subsequent treatment providers.

4. Benefit to student/patient.
   a. Improved continuity of care.
i. If a student treated at student health subsequently visits another Carilion provider, or other provider with access to Carilion’s EMR system, the student’s health records are immediately available for reference.

b. Patient privacy.

i. HIPAA is a more robust statute which includes stringent privacy standards.
Joint Guidance on the Application of the
Family Educational Rights and Privacy Act (FERPA)
And the Health Insurance Portability and
Accountability Act of 1996 (HIPAA)
To Student Health Records

November 2008
Contents

I. Introduction ........................................................................................................................ 1

II. Overview of FERPA ............................................................................................................. 1

III. Overview of HIPAA ............................................................................................................. 2

IV. Where FERPA and HIPAA May Intersect ............................................................................ 3

V. Frequently Asked Questions and Answers ............................................................................ 3

1. Does the HIPAA Privacy Rule apply to an elementary or secondary school?
2. How does FERPA apply to health records on students maintained by elementary or secondary schools?
3. Does FERPA or HIPAA apply to elementary or secondary school student health records maintained by a health care provider that is not employed by a school?
4. Are there circumstances in which the HIPAA Privacy Rule might apply to an elementary or secondary school?
5. Where the HIPAA Privacy Rule applies, does it allow a health care provider to disclose protected health information (PHI) about a troubled teen to the parents of the teen?
6. Where the HIPAA Privacy Rule applies, does it allow a health care provider to disclose protected health information (PHI) about a student to a school nurse or physician?
7. Does FERPA or HIPAA apply to records on students at health clinics run by postsecondary institutions?
8. Under FERPA, may an eligible student inspect and review his or her “treatment records”?
9. Under FERPA, may an eligible student’s treatment records be shared with parties other than treating professionals?
10. Under what circumstances does FERPA permit an eligible student’s treatment records to be disclosed to a third-party health care provider for treatment?
11. Are all student records maintained by a health clinic run by a postsecondary institution considered “treatment records” under FERPA?
12. Does FERPA or HIPAA apply to records on students who are patients at a university hospital?
13. Where the HIPAA Privacy Rule applies, does it permit a health care provider to disclose protected health information (PHI) about a patient to law enforcement, family members, or others if the provider believes the patient presents a serious danger to self or others?
14. Does FERPA permit a postsecondary institution to disclose a student’s treatment records or education records to law enforcement, the student’s parents, or others if the institution believes the student presents a serious danger to self or others?
15. Are the health records of an individual who is both a student and an employee of a university at which the person receives health care subject to the privacy provisions of FERPA or those of HIPAA?
16. Can a postsecondary institution be a “hybrid entity” under the HIPAA Privacy Rule?

VI. Conclusion ........................................................................................................................ 11
I. Introduction

The purpose of this guidance is to explain the relationship between the Family Educational Rights and Privacy Act (FERPA) and the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule, and to address apparent confusion on the part of school administrators, health care professionals, and others as to how these two laws apply to records maintained on students. It also addresses certain disclosures that are allowed without consent or authorization under both laws, especially those related to health and safety emergency situations. While this guidance seeks to answer many questions that school officials and others have had about the intersection of these federal laws, ongoing discussions may cause more issues to emerge. Contact information for submitting additional questions or suggestions for purposes of informing future guidance is provided at the end of this document. The Departments of Education and Health and Human Services are committed to a continuing dialogue with school officials and other professionals on these important matters affecting the safety and security of our nation’s schools.

II. Overview of FERPA

FERPA is a Federal law that protects the privacy of students’ “education records.” (See 20 U.S.C. § 1232g; 34 CFR Part 99). FERPA applies to educational agencies and institutions that receive funds under any program administered by the U.S. Department of Education. This includes virtually all public schools and school districts and most private and public postsecondary institutions, including medical and other professional schools. If an educational agency or institution receives funds under one or more of these programs, FERPA applies to the recipient as a whole, including each of its components, such as a department within a university. See 34 CFR § 99.1(d).

Private and religious schools at the elementary and secondary level generally do not receive funds from the Department of Education and are, therefore, not subject to FERPA. Note that a private school is not made subject to FERPA just because its students and teachers receive services from a local school district or State educational agency that receives funds from the Department. The school itself must receive funds from a program administered by the Department to be subject to FERPA. For example, if a school district places a student with a disability in a private school that is acting on behalf of the school district with regard to providing services to that student, the records of that student are subject to FERPA, but not the records of the other students in the private school. In such cases, the school district remains responsible for complying with FERPA with respect to the education records of the student placed at the private school.

An educational agency or institution subject to FERPA may not have a policy or practice of disclosing the education records of students, or personally identifiable information from education records, without a parent or eligible student’s written consent. See 34 CFR § 99.30. FERPA contains several exceptions to this general consent rule. See 34 CFR § 99.31. An “eligible student” is a student who is at least 18 years of age or who attends a postsecondary institution at any age. See 34 CFR §§ 99.3 and 99.5(a). Under FERPA, parents and eligible students have the right to inspect and review the student’s education records and to seek to have them amended in certain circumstances. See 34 CFR §§ 99.10 – 99.12 and §§ 99.20 – 99.22.

The term “education records” is broadly defined to mean those records that are: (1) directly related to a student, and (2) maintained by an educational agency or institution or by a party acting for the
agency or institution. See 34 CFR § 99.3. At the elementary or secondary level, a student’s health records, including immunization records, maintained by an educational agency or institution subject to FERPA, as well as records maintained by a school nurse, are “education records” subject to FERPA. In addition, records that schools maintain on special education students, including records on services provided to students under the Individuals with Disabilities Education Act (IDEA), are “education records” under FERPA. This is because these records are (1) directly related to a student, (2) maintained by the school or a party acting for the school, and (3) not excluded from the definition of “education records.”

At postsecondary institutions, medical and psychological treatment records of eligible students are excluded from the definition of “education records” if they are made, maintained, and used only in connection with treatment of the student and disclosed only to individuals providing the treatment. See 34 CFR § 99.3 “Education records.” These records are commonly called “treatment records.” An eligible student’s treatment records may be disclosed for purposes other than the student’s treatment, provided the records are disclosed under one of the exceptions to written consent under 34 CFR § 99.31(a) or with the student’s written consent under 34 CFR § 99.30. If a school discloses an eligible student’s treatment records for purposes other than treatment, the records are no longer excluded from the definition of “education records” and are subject to all other FERPA requirements.

The FERPA regulations and other helpful information can be found at: http://www.ed.gov/policy/gen/guid/fpco/index.html.

III. Overview of HIPAA

Congress enacted HIPAA in 1996 to, among other things, improve the efficiency and effectiveness of the health care system through the establishment of national standards and requirements for electronic health care transactions and to protect the privacy and security of individually identifiable health information. Collectively, these are known as HIPAA’s Administrative Simplification provisions, and the U.S. Department of Health and Human Services has issued a suite of rules, including a privacy rule, to implement these provisions. Entities subject to the HIPAA Administrative Simplification Rules (see 45 CFR Parts 160, 162, and 164), known as “covered entities,” are health plans, health care clearinghouses, and health care providers that transmit health information in electronic form in connection with covered transactions. See 45 CFR § 160.103. “Health care providers” include institutional providers of health or medical services, such as hospitals, as well as non-institutional providers, such as physicians, dentists, and other practitioners, along with any other person or organization that furnishes, bills, or is paid for health care in the normal course of business. Covered transactions are those for which the U.S. Department of Health and Human Services has adopted a standard, such as health care claims submitted to a health plan. See 45 CFR § 160.103 (definitions of “health care provider” and “transaction”) and 45 CFR Part 162, Subparts K–R.

The HIPAA Privacy Rule requires covered entities to protect individuals’ health records and other identifiable health information by requiring appropriate safeguards to protect privacy, and setting limits and conditions on the uses and disclosures that may be made of such information without patient authorization. The rule also gives patients rights over their health information, including rights to examine and obtain a copy of their health records, and to request corrections.
IV. Where FERPA and HIPAA May Intersect

When a school provides health care to students in the normal course of business, such as through its health clinic, it is also a “health care provider” as defined by HIPAA. If a school also conducts any covered transactions electronically in connection with that health care, it is then a covered entity under HIPAA. As a covered entity, the school must comply with the HIPAA Administrative Simplification Rules for Transactions and Code Sets and Identifiers with respect to its transactions. However, many schools, even those that are HIPAA covered entities, are not required to comply with the HIPAA Privacy Rule because the only health records maintained by the school are “education records” or “treatment records” of eligible students under FERPA, both of which are excluded from coverage under the HIPAA Privacy Rule. See the exception at paragraph (2)(i) and (2)(ii) to what is considered “protected health information” (PHI) at 45 CFR § 160.103. In addition, the exception for records covered by FERPA applies both to the HIPAA Privacy Rule, as well as to the HIPAA Security Rule, because the Security Rule applies to a subset of information covered by the Privacy Rule (i.e., electronic PHI). Information on the HIPAA Privacy Rule is available at: http://www.hhs.gov/ocr/hipaa/. Information on the other HIPAA Administrative Simplification Rules is available at: http://www.cms.hhs.gov/HIPAAGenInfo/.

V. Frequently Asked Questions and Answers

1. Does the HIPAA Privacy Rule apply to an elementary or secondary school?

Generally, no. In most cases, the HIPAA Privacy Rule does not apply to an elementary or secondary school because the school either: (1) is not a HIPAA covered entity or (2) is a HIPAA covered entity but maintains health information only on students in records that are by definition “education records” under FERPA and, therefore, is not subject to the HIPAA Privacy Rule.

- **The school is not a HIPAA covered entity.** The HIPAA Privacy Rule only applies to health plans, health care clearinghouses, and those health care providers that transmit health information electronically in connection with certain administrative and financial transactions (“covered transactions”). See 45 CFR § 160.102. Covered transactions are those for which the U.S. Department of Health and Human Services has adopted a standard, such as health care claims submitted to a health plan. See the definition of “transaction” at 45 CFR § 160.103 and 45 CFR Part 162, Subparts K–R. Thus, even though a school employs school nurses, physicians, psychologists, or other health care providers, the school is not generally a HIPAA covered entity because the providers do not engage in any of the covered transactions, such as billing a health plan electronically for their services. It is expected that most elementary and secondary schools fall into this category.

- **The school is a HIPAA covered entity but does not have “protected health information.”** Where a school does employ a health care provider that conducts one or more covered transactions electronically, such as electronically transmitting health care claims to a health plan for payment, the school is a HIPAA covered entity and must comply with the HIPAA Transactions and Code Sets and Identifier Rules with respect to such transactions. However, even in this case, many schools would not be required to comply with the HIPAA Privacy Rule because the school maintains health information only in student health records that are “education records” under FERPA and, thus, not “protected health information” under
HIPAA. Because student health information in education records is protected by FERPA, the HIPAA Privacy Rule excludes such information from its coverage. See the exception at paragraph (2)(i) to the definition of “protected health information” in the HIPAA Privacy Rule at 45 CFR § 160.103. For example, if a public high school employs a health care provider that bills Medicaid electronically for services provided to a student under the IDEA, the school is a HIPAA covered entity and would be subject to the HIPAA requirements concerning transactions. However, if the school’s provider maintains health information only in what are education records under FERPA, the school is not required to comply with the HIPAA Privacy Rule. Rather, the school would have to comply with FERPA’s privacy requirements with respect to its education records, including the requirement to obtain parental consent (34 CFR § 99.30) in order to disclose to Medicaid billing information about a service provided to a student.

2. **How does FERPA apply to health records on students maintained by elementary or secondary schools?**

At the elementary or secondary school level, students’ immunization and other health records that are maintained by a school district or individual school, including a school-operated health clinic, that receives funds under any program administered by the U.S. Department of Education are “education records” subject to FERPA, including health and medical records maintained by a school nurse who is employed by or under contract with a school or school district. Some schools may receive a grant from a foundation or government agency to hire a nurse. Notwithstanding the source of the funding, if the nurse is hired as a school official (or contractor), the records maintained by the nurse or clinic are “education records” subject to FERPA.

Parents have a right under FERPA to inspect and review these health and medical records because they are “education records” under FERPA. See 34 CFR §§ 99.10 – 99.12. In addition, these records may not be shared with third parties without written parental consent unless the disclosure meets one of the exceptions to FERPA’s general consent requirement. For instance, one of these exceptions allows schools to disclose a student’s health and medical information and other “education records” to teachers and other school officials, without written consent, if these school officials have “legitimate educational interests” in accordance with school policy. See 34 CFR § 99.31(a)(1). Another exception permits the disclosure of education records, without consent, to appropriate parties in connection with an emergency, if knowledge of the information is necessary to protect the health or safety of the student or other individuals. See 34 CFR §§ 99.31(a)(10) and 99.36.

3. **Does FERPA or HIPAA apply to elementary or secondary school student health records maintained by a health care provider that is not employed by a school?**

If a person or entity acting on behalf of a school subject to FERPA, such as a school nurse that provides services to students under contract with or otherwise under the direct control of the school, maintains student health records, these records are education records under FERPA, just as they would be if the school maintained the records directly. This is the case regardless of whether the health care is provided to students on school grounds or off-site. As education records, the information is protected under FERPA and not HIPAA.
Some outside parties provide services directly to students and are not employed by, under contract to, or otherwise acting on behalf of the school. In these circumstances, these records are not “education records” subject to FERPA, even if the services are provided on school grounds, because the party creating and maintaining the records is not acting on behalf of the school. For example, the records created by a public health nurse who provides immunization or other health services to students on school grounds or otherwise in connection with school activities but who is not acting on behalf of the school would not be “education records” under FERPA. In such situations, a school that wishes to disclose to this outside party health care provider any personally identifiable information from education records would have to comply with FERPA and obtain parental consent. See 34 CFR § 99.30.

With respect to HIPAA, even where student health records maintained by a health care provider are not education records protected by FERPA, the HIPAA Privacy Rule would apply to such records only if the provider conducts one or more of the HIPAA transactions electronically, e.g., billing a health plan electronically for his or her services, making the provider a HIPAA covered entity.

4. Are there circumstances in which the HIPAA Privacy Rule might apply to an elementary or secondary school?

There are some circumstances in which an elementary or secondary school would be subject to the HIPAA Privacy Rule, such as where the school is a HIPAA covered entity and is not subject to FERPA. As explained previously, most private schools at the elementary and secondary school levels typically do not receive funding from the U.S. Department of Education and, therefore, are not subject to FERPA.

A school that is not subject to FERPA and is a HIPAA covered entity must comply with the HIPAA Privacy Rule with respect to any individually identifiable health information it has about students and others to whom it provides health care. For example, if a private elementary school that is not subject to FERPA employs a physician who bills a health plan electronically for the care provided to students (making the school a HIPAA covered entity), the school is required to comply with the HIPAA Privacy Rule with respect to the individually identifiable health information of its patients. The only exception would be where the school, despite not being subject to FERPA, has education records on one or more students to whom it provides services on behalf of a school or school district that is subject to FERPA. In this exceptional case, the education records of only those publicly-placed students held by the private school would be subject to FERPA, while the remaining student health records would be subject to the HIPAA Privacy Rule.

5. Where the HIPAA Privacy Rule applies, does it allow a health care provider to disclose protected health information (PHI) about a troubled teen to the parents of the teen?

In most cases, yes. If the teen is a minor, the HIPAA Privacy Rule generally allows a covered entity to disclose PHI about the child to the child’s parent, as the minor child’s personal representative, when the disclosure is not inconsistent with state or other law. For more detailed information, see 45 CFR § 164.502(g) and the fact sheet regarding personal representatives at: http://www.hhs.gov/ocr/hipaa/guidelines/personalrepresentatives.pdf. In some cases, such as when a minor may receive treatment without a parent’s consent under applicable law, the parents are not treated as the minor’s personal representative. See 45 CFR § 164.502(g)(3). In such cases where
the parent is not the personal representative of the teen, other HIPAA Privacy Rule provisions may allow the disclosure of PHI about the teen to the parent. For example, if a provider believes the teen presents a serious danger to self or others, the HIPAA Privacy Rule permits a covered entity to disclose PHI to a parent or other person(s) if the covered entity has a good faith belief that: (1) the disclosure is necessary to prevent or lessen the threat and (2) the parent or other person(s) is reasonably able to prevent or lessen the threat. The disclosure also must be consistent with applicable law and standards of ethical conduct. See 45 CFR § 164.512(j)(1)(i).

In addition, the Privacy Rule permits covered entities to share information that is directly relevant to the involvement of a family member in the patient’s health care or payment for care if, when given the opportunity, the patient does not object to the disclosure. Even when the patient is not present or it is impracticable, because of emergency circumstances or the patient’s incapacity, for the covered entity to ask the patient about discussing his or her care or payment with a family member, a covered entity may share this information with the family member when, in exercising professional judgment, it determines that doing so would be in the best interest of the patient. See 45 CFR § 164.510(b).

6. Where the HIPAA Privacy Rule applies, does it allow a health care provider to disclose protected health information (PHI) about a student to a school nurse or physician?

Yes. The HIPAA Privacy Rule allows covered health care providers to disclose PHI about students to school nurses, physicians, or other health care providers for treatment purposes, without the authorization of the student or student’s parent. For example, a student’s primary care physician may discuss the student’s medication and other health care needs with a school nurse who will administer the student’s medication and provide care to the student while the student is at school.

7. Does FERPA or HIPAA apply to records on students at health clinics run by postsecondary institutions?

FERPA applies to most public and private postsecondary institutions and, thus, to the records on students at the campus health clinics of such institutions. These records will be either education records or treatment records under FERPA, both of which are excluded from coverage under the HIPAA Privacy Rule, even if the school is a HIPAA covered entity. See the exceptions at paragraphs (2)(i) and (2)(ii) to the definition of “protected health information” at 45 CFR § 160.103.

The term “education records” is broadly defined under FERPA to mean those records that are: (1) directly related to a student and (2) maintained by an educational agency or institution or by a party acting for the agency or institution. See 34 CFR § 99.3, “Education records.”

“Treatment records” under FERPA, as they are commonly called, are:

records on a student who is eighteen years of age or older, or is attending an institution of postsecondary education, which are made or maintained by a physician, psychiatrist, psychologist, or other recognized professional or paraprofessional acting in his professional or paraprofessional capacity, or assisting in that capacity, and which are made, maintained, or used only in connection with the provision of treatment to the student, and are not available to anyone other than persons providing such treatment, except that such records
can be personally reviewed by a physician or other appropriate professional of the student’s choice.

See 20 U.S.C. § 1232g(a)(4)(B)(iv); 34 CFR § 99.3, “Education records.” For example, treatment records would include health or medical records that a university psychologist maintains only in connection with the provision of treatment to an eligible student, and health or medical records that the campus health center or clinic maintains only in connection with the provision of treatment to an eligible student. (Treatment records also would include health or medical records on an eligible student in high school if the records otherwise meet the above definition.)

“Treatment records” are excluded from the definition of “education records” under FERPA. However, it is important to note, that a school may disclose an eligible student’s treatment records for purposes other than the student’s treatment provided that the records are disclosed under one of the exceptions to written consent under 34 CFR § 99.31(a) or with the student’s written consent under 34 CFR § 99.30. If a school discloses an eligible student’s treatment records for purposes other than treatment, the treatment records are no longer excluded from the definition of “education records” and are subject to all other FERPA requirements, including the right of the eligible student to inspect and review the records.

While the health records of students at postsecondary institutions may be subject to FERPA, if the institution is a HIPAA covered entity and provides health care to nonstudents, the individually identifiable health information of the clinic’s nonstudent patients is subject to the HIPAA Privacy Rule. Thus, for example, postsecondary institutions that are subject to both HIPAA and FERPA and that operate clinics open to staff, or the public, or both (including family members of students) are required to comply with FERPA with respect to the health records of their student patients, and with the HIPAA Privacy Rule with respect to the health records of their nonstudent patients.

8. Under FERPA, may an eligible student inspect and review his or her “treatment records”?

Under FERPA, treatment records, by definition, are not available to anyone other than professionals providing treatment to the student, or to physicians or other appropriate professionals of the student’s choice. However, this does not prevent an educational institution from allowing a student to inspect and review such records. If the institution chooses to do so, though, such records are no longer excluded from the definition of “education records” and are subject to all other FERPA requirements.

9. Under FERPA, may an eligible student’s treatment records be shared with parties other than treating professionals?

As explained previously, treatment records, by definition, are not available to anyone other than professionals providing treatment to the student, or to physicians or other appropriate professionals of the student’s choice. However, this does not prevent an educational institution from using or disclosing these records for other purposes or with other parties. If the institution chooses to do so, a disclosure may be made to any party with a prior written consent from the eligible student (see 34 CFR § 99.30) or under any of the disclosures permitted without consent in 34 CFR § 99.31 of FERPA.
For example, a university physician treating an eligible student might determine that treatment records should be disclosed to the student’s parents. This disclosure may be made if the eligible student is claimed as a dependent for federal income tax purposes (see 34 CFR § 99.31(a)(8)). If the eligible student is not claimed as a dependent, the disclosure may be made to parents, as well as other appropriate parties, if the disclosure is in connection with a health or safety emergency. See 34 CFR §§ 99.31(a)(10) and 99.36. Once the records are disclosed under one of the exceptions to FERPA’s general consent requirement, the treatment records are no longer excluded from the definition of “education records” and are subject to all other FERPA requirements as “education records” under FERPA.

10. **Under what circumstances does FERPA permit an eligible student’s treatment records to be disclosed to a third-party health care provider for treatment?**

An eligible student’s treatment records may be shared with health care professionals who are providing treatment to the student, including health care professionals who are not part of or not acting on behalf of the educational institution (i.e., third-party health care provider), as long as the information is being disclosed only for the purpose of providing treatment to the student. In addition, an eligible student’s treatment records may be disclosed to a third-party health care provider when the student has requested that his or her records be “reviewed by a physician or other appropriate professional of the student’s choice.” See 20 U.S.C. § 1232g(a)(4)(B)(iv). In either of these situations, if the treatment records are disclosed to a third-party health care provider that is a HIPAA covered entity, the records would become subject to the HIPAA Privacy Rule. The records at the educational institution continue to be treatment records under FERPA, so long as the records are only disclosed by the institution for treatment purposes to a health care provider or to the student’s physician or other appropriate professional requested by the student.

If the disclosure is for purposes other than treatment, an eligible student’s treatment record only may be disclosed to a third party as an “education record,” that is, with the prior written consent of the eligible student or if one of the exceptions to FERPA’s general consent requirement is met. See 34 CFR § 99.31. For example, if a university is served with a court order requiring the disclosure of the mental health records of a student maintained as treatment records at the campus clinic, the university may disclose the records to comply with the court order in accordance with the provisions of § 99.31(a)(9) of the FERPA regulations. However, the mental health records that the university disclosed for non-treatment purposes are no longer excluded from the definition of “education records” and are subject to all other FERPA requirements as “education records” under FERPA.

11. **Are all student records maintained by a health clinic run by a postsecondary institution considered “treatment records” under FERPA?**

Not all records on eligible students that are maintained by a college- or university-run health clinic are treatment records under FERPA because many such records are not made, maintained, or used only in connection with the treatment of a student. For example, billing records that a college- or university-run health clinic maintains on a student are “education records” under FERPA, the disclosure of which would require prior written consent from the eligible student unless an exception applies. See 34 CFR § 99.30. In addition, records relating to treatment that are shared with persons other than professionals providing treatment to the student are “education records” under FERPA. Thus, to the extent a health clinic has shared a student’s treatment information with
persons and for purposes other than for treatment, such information is an “education record,” not a treatment record under FERPA.

12. Does FERPA or HIPAA apply to records on students who are patients at a university hospital?

Patient records maintained by a hospital affiliated with a university that is subject to FERPA are not typically “education records” or “treatment records” under FERPA because university hospitals generally do not provide health care services to students on behalf of the educational institution. Rather, these hospitals provide such services without regard to the person’s status as a student and not on behalf of a university. Thus, assuming the hospital is a HIPAA covered entity, these records are subject to all of the HIPAA rules, including the HIPAA Privacy Rule. However, in a situation where a hospital does run the student health clinic on behalf of a university, the clinic records on students would be subject to FERPA, either as “education records” or “treatment records,” and not subject to the HIPAA Privacy Rule.

13. Where the HIPAA Privacy Rule applies, does it permit a health care provider to disclose protected health information (PHI) about a patient to law enforcement, family members, or others if the provider believes the patient presents a serious danger to self or others?

The HIPAA Privacy Rule permits a covered entity to disclose PHI, including psychotherapy notes, when the covered entity has a good faith belief that the disclosure: (1) is necessary to prevent or lessen a serious and imminent threat to the health or safety of the patient or others and (2) is to a person(s) reasonably able to prevent or lessen the threat. This may include, depending on the circumstances, disclosure to law enforcement, family members, the target of the threat, or others who the covered entity has a good faith belief can mitigate the threat. The disclosure also must be consistent with applicable law and standards of ethical conduct. See 45 CFR § 164.512(j)(1)(i).

For example, consistent with other law and ethical standards, a mental health provider whose teenage patient has made a credible threat to inflict serious and imminent bodily harm on one or more fellow students may alert law enforcement, a parent or other family member, school administrators or campus police, or others the provider believes may be able to prevent or lessen the chance of harm. In such cases, the covered entity is presumed to have acted in good faith where its belief is based upon the covered entity’s actual knowledge (i.e., based on the covered entity’s own interaction with the patient) or in reliance on a credible representation by a person with apparent knowledge or authority (i.e., based on a credible report from a family member or other person). See 45 CFR § 164.512(j)(4).

For threats or concerns that do not rise to the level of “serious and imminent,” other HIPAA Privacy Rule provisions may apply to permit the disclosure of PHI. For example, covered entities generally may disclose PHI about a minor child to the minor’s personal representative (e.g., a parent or legal guardian), consistent with state or other laws. See 45 CFR § 164.502(b).

14. Does FERPA permit a postsecondary institution to disclose a student’s treatment records or education records to law enforcement, the student’s parents, or others if the institution believes the student presents a serious danger to self or others?
An eligible student’s education records and treatment records (which are considered education records if used or made available for any purpose other than the eligible student’s treatment) may be disclosed, without consent, if the disclosure meets one of the exceptions to FERPA’s general consent rule. See 34 CFR § 99.31. One of the permitted disclosures is to appropriate parties, which may include law enforcement or parents of a student, in connection with an emergency if knowledge of the information is necessary to protect the health or safety of the student or other individuals. See 34 CFR §§ 99.31(a)(10) and 99.36.

There are other exceptions that apply to disclosing information to parents of eligible students that are discussed on the “Safe Schools & FERPA” Web page, as well as other information that should be helpful to school officials, at:

15. Are the health records of an individual who is both a student and an employee of a university at which the person receives health care subject to the privacy provisions of FERPA or those of HIPAA?

The individual’s health records would be considered “education records” protected under FERPA and, thus, excluded from coverage under the HIPAA Privacy Rule. FERPA defines “education records” as records that are directly related to a student and maintained by an educational agency or institution or by a party acting for the agency or institution. 34 CFR § 99.3 (“education records”). While FERPA excludes from this definition certain records relating to employees of the educational institution, to fall within this exclusion, such records must, among other things, relate exclusively to the individual in his or her capacity as an employee, such as records that were created in connection with health services that are available only to employees. Thus, the health or medical records that are maintained by a university as part of its provision of health care to a student who is also an employee of a university are covered by FERPA and not the HIPAA Privacy Rule.

16. Can a postsecondary institution be a “hybrid entity” under the HIPAA Privacy Rule?

Yes. A postsecondary institution that is a HIPAA covered entity may have health information to which the Privacy Rule may apply not only in the health records of nonstudents in the health clinic, but also in records maintained by other components of the institution that are not education records or treatment records under FERPA, such as in a law enforcement unit or research department. In such cases, the institution, as a HIPAA covered entity, has the option of becoming a “hybrid entity” and, thus, having the HIPAA Privacy Rule apply only to its health care unit. The school can achieve hybrid entity status by designating the health unit as its “health care component.” As a hybrid entity, any individually identifiable health information maintained by other components of the university (i.e., outside of the health care component), such as a law enforcement unit, or a research department, would not be subject to the HIPAA Privacy Rule, notwithstanding that these components of the institution might maintain records that are not “education records” or treatment records under FERPA.

To become a hybrid entity, the covered entity must designate and include in its health care component all components that would meet the definition of a covered entity if those components were separate legal entities. (A covered entity may have more than one health care component.) However, the hybrid entity is not permitted to include in its health care component other types of components that do not perform the covered functions of the covered entity or components that do
not perform support activities for the components performing covered functions. That is, components that do not perform health plan, health care provider, or health care clearinghouse functions and components that do not perform activities in support of these functions (as would a business associate of a separate legal entity) may not be included in a health care component. Within the hybrid entity, most of the HIPAA Privacy Rule requirements apply only to the health care component, although the hybrid entity retains certain oversight, compliance, and enforcement obligations. See 45 CFR § 164.105 of the Privacy Rule for more information.

VI. Conclusion

The HIPAA Privacy Rule specifically excludes from its coverage those records that are protected by FERPA. When making determinations as to whether personally identifiable information from student health records maintained by the educational agency or institution may be disclosed, school officials at institutions subject to FERPA should refer to FERPA and its requirements. While the educational agency or institution has the responsibility to make the initial, case-by-case determination of whether a disclosure meets the requirements of FERPA, the Department of Education’s Family Policy Compliance Office is available to offer technical assistance to school officials in making such determinations.

For quick, informal responses to routine questions about FERPA, school officials may e-mail the Department at FERPA@ed.gov. For more formal technical assistance on the information provided in this guidance in particular or FERPA in general, please contact the Family Policy Compliance Office at the following address:

Family Policy Compliance Office
U.S. Department of Education
400 Maryland Ave. S.W.
Washington, D.C. 20202-8520


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REPORT TO THE PRESIDENT

ON ISSUES RAISED BY THE VIRGINIA TECH TRagedy

June 13, 2007
“We reflect on what has been lost and comfort those enduring a profound grief. And somehow we know that a brighter morning will come. We know this because together Americans have overcome many evils and found strength through many storms.”

—President George W. Bush
June 13, 2007

The President
The White House
Washington, D.C. 20500

Dear Mr. President:

In the wake of the Virginia Tech tragedy, you charged us to travel to communities across our Nation to meet with a wide range of leaders on the broader issues raised by this tragedy, and to report back to you what we learned, together with our recommendations for how the Federal government can help avoid such tragedies in the future. The enclosed report summarizes our findings and provides our recommendations developed through discussions with educators, mental health experts, law enforcement and other key state and local officials from more than a dozen states.

We found great commonality in the themes that emerged from our meetings. Following the Virginia Tech tragedy and similar incidents of violence that have occurred in recent years, states and local communities are carefully considering whether they have properly addressed and balanced the fundamental interests of privacy and individual freedom, safety and security, and assisting those with mental health needs in getting appropriate care. Although state and local leaders recognized and underscored that these issues primarily must be resolved at the state and local level, these events make all of us ask whether there is more we can and should be doing.

As we note in our report, our recommendations are not a panacea. Rather, along with identifying steps that we can take, the report serves to focus our attention on the issues that must be part of the ongoing national dialogue as we continue to protect the freedoms we enjoy in our society, while appropriately minimizing risks to public safety.

We look forward to continuing our collaboration on the Federal level, as well as with states and localities, in our ongoing efforts to address these fundamental issues and take concrete steps to promote the well being and safety of all Americans.

Sincerely,

Michael O. Leavitt
Secretary
Department of Health and Human Services

Alberto R. Gonzales
Attorney General
Department of Justice

Margaret Spellings
Secretary
Department of Education

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**Table of Contents**

INTRODUCTION.............................................................................................................1

KEY FINDINGS..........................................................................................................2

CANVASSING THE NATION.....................................................................................3

COMMON THEMES AND OBSERVATIONS...............................................................5

FINDINGS AND RECOMMENDATIONS.................................................................6

  Critical Information Sharing Faces Substantial Obstacles.........................7

  Accurate and Complete Information on Individuals Prohibited from Possessing Firearms is Essential to Keep Guns Out of the Wrong Hands.................................10

  Improved Awareness and Communication are Key to Prevention............12

  It is Critical to Get People with Mental Illness Services They Need ......14

  Where We Know What to Do, We Have to be Better at Doing It............16

CONCLUSION ............................................................................................................19

ENDNOTES..............................................................................................................20
INTRODUCTION

On April 21, 2007, in response to the tragic shootings at Virginia Tech, President George W. Bush directed Secretaries Michael Leavitt and Margaret Spellings and Attorney General Alberto Gonzales to travel to communities across our nation and to meet with educators, mental health experts, law enforcement and state and local officials to discuss the broader issues raised by this tragedy. The President instructed Secretary Leavitt to summarize what they learned from these meetings and report back with recommendations about how the federal government can help avoid such tragedies in the future.

The Virginia Tech tragedy was deeply felt throughout America. People everywhere we traveled extended their hearts and prayers to the families and friends of the victims. The tragedy also raised issues with which our society has long grappled. Questions were raised about the proper balance between providing for the safety and security of our communities, while protecting privacy and liberty, and helping people with mental illness get the care they need. Our meetings and this report were not, and could not be, an attempt to resolve or reset the balance of all these interests. Nor did people with whom we met feel we could eliminate all risk, and at the same time maintain a free and open society. But there was a shared sense that we must not miss the opportunity to learn from this event and do what we can to make our communities safer.

This report does not seek to investigate the specifics of the Virginia Tech tragedy itself. That work is currently being done by the Virginia Tech Review Panel appointed by Governor Kaine. Instead, this report summarizes the major recurring themes we heard in our visits across the country. It includes critical steps state and local leaders identified to address school violence and mental illness at the community level.

The report includes recommended actions the federal government can take to support state and local communities and ensure that the federal government and federal law are not obstacles to achieving these goals. The recommended action items are not, individually or together, a panacea for the many complex issues our society confronts in trying to prevent another tragedy. Rather, they are an attempt to frame the issues and identify tangible steps we can take over time to help prevent events like the Virginia Tech tragedy.
KEY FINDINGS

- **Critical Information Sharing Faces Substantial Obstacles:** Education officials, healthcare providers, law enforcement personnel, and others are not fully informed about when they can share critical information on persons who are likely to be a danger to self or others, and the resulting confusion may chill legitimate information sharing.

- **Accurate and Complete Information on Individuals Prohibited from Possessing Firearms is Essential to Keep Guns Out of the Wrong Hands:** State laws and practices do not uniformly ensure that information on persons restricted from possessing firearms is appropriately captured and available to the National Instant Criminal Background Check System (NICS).

- **Improved Awareness and Communication are Key to Prevention:** It is important that parents, students, and teachers learn to recognize warning signs and encourage those who need help to seek it, so that people receive the care they need and our communities are safe.

- **It is Critical to Get People with Mental Illness the Services They Need:** Meeting the challenge of adequate and appropriate community integration of people with mental illness requires effective coordination of community service providers who are sensitive to the interests of safety, privacy, and provision of care.

- **Where We Know What to Do, We Have to be Better at Doing It:** For the many states and communities that have already adopted programs, including emergency preparedness and violence prevention plans, to address school and community violence, the challenge is fully implementing these programs through practice and effective communication.
CANVASSING THE NATION

To carry out the President’s charge promptly, Secretary Leavitt, Secretary Spellings and Attorney General Gonzales led federal delegations to meet with leaders in a dozen states between April 26, and May 4, 2007. Secretary Leavitt traveled to Colorado, Florida, Minnesota, Tennessee, Texas, Utah, and West Virginia; Secretary Spellings traveled to California and New Mexico, and Attorney General Gonzales traveled to Indiana, Oklahoma, and Mississippi. On May 16, 2007, the Secretaries and the Attorney General also participated in a phone conference with high-ranking Virginia officials convened by Governor Kaine. At each session, the Secretaries and the Attorney General were accompanied by high-ranking officials and experts from each of the other two federal Departments.

Governors and state officials responded quickly to our requests to convene key leadership. State and local leaders from a wide range of sectors actively participated and provided their individual input in each of the sessions. In most states, the Governors’ offices hosted the events, which were typically attended by senior state leadership, including Governors, Lieutenant Governors, Attorneys General, and state legislators. They were joined by state officials and experts from across the spectrum of the mental health, education, and law enforcement communities. The number of participants at each session ranged from 20 to 90. Sessions often included separate “breakout” discussions among mental health, education, and law enforcement experts, followed by a concluding plenary session to share and further discuss issues raised.

From the mental health community, participants typically included commissioners of state departments of health and/or mental health, counselors, psychiatrists, and other mental health professionals at schools and institutions of higher education, community mental health providers, and mental health advocates. From the education community, numerous college presidents participated, along with superintendents of public and higher education, school security officers, university officials, parents, and students. From the law enforcement community, the chiefs of numerous campus police forces participated, along with state and local law enforcement leaders, state departments of homeland security, local United States Attorneys, and representatives from the local Federal Bureau of Investigation (FBI), the United States Secret Service, and the Bureau of Alcohol, Tobacco, Firearms, and Explosives (ATF) offices.

The meetings took place at universities, community colleges, libraries, state capitols, state agencies, and other sites throughout the country. They focused on practices that have worked and obstacles that state and local leaders continue to face, as well as possible solutions to these obstacles. In each state, there were rich and informed discussions among educators, mental health professionals, law enforcement officials, and community representatives.
and advocates. In some instances, our visits complemented continuing statewide attention to these issues; in others, our visits served to launch state initiatives. For example, in Colorado, our visit coincided with a conference sponsored by the Colorado Attorney General’s Office and Governor Ritter on school safety; in Oklahoma, Governor Henry had already established a task force to evaluate similar issues; and in Florida, Governor Crist issued an executive order at the outset of our meeting establishing a workgroup to look at these issues, which issued a comprehensive report on May 24, 2007. In Virginia, Governor Kaine appointed a panel that is thoroughly reviewing the specific circumstances that occurred at Virginia Tech.
COMMON THEMES AND OBSERVATIONS

There was universal recognition that the issues are complex and that they represent critical, sensitive, and long-standing societal questions of balancing individual liberty and privacy with safety and security. All agreed that in a country of more than 300 million people, it is impossible to eliminate all risks. We can not maintain a free and open society and eliminate the possibility that violence in schools, offices, or malls will happen again. The focus of the meetings, therefore, was on how to minimize appropriately the possibility that these situations may occur in the future.

States, which have long sought to address the difficult balance among privacy, security and ensuring that people in need receive appropriate care, also report that they may be revisiting their approach in coming months, as tragic events such as Virginia Tech sharpen their focus on whether the balances that have been struck are correctly calibrated or whether there is a need to implement more effectively decisions that have already been made.

The meetings served to underscore that universal, “one-size-fits-all” solutions are unlikely to be helpful. Rather, appropriate responses to the issues must be tailored to a wide range of circumstances, depending, for example, on whether the context is a college or university, elementary or secondary school, whether the area is rural or urban, whether the setting is a single building, an expansive campus, or integrated in a city setting, or whether the threat being addressed is from a person who is familiar to the setting, or is a stranger to it. While most discussions focused on school violence, both at the K–12 and post-secondary level, there also were discussions about preventing violence in other public or community settings.

In each state, mental health experts were quick to point out that most people who are violent do not have a mental illness, and most people who have mental illness are not violent. Meeting participants expressed hope that the work being done at the federal and state levels continues to de-stigmatize mental illness, thereby normalizing requests for help.

Throughout these discussions, participants shared concerns about the increasing number of people with serious mental illness in schools, jails, and prisons. With respect to higher education, the perceived increase in students with mental illness was attributed to two factors: advances in treatment and supports enable more people with mental illness to attend college and many serious mental illnesses develop or manifest themselves at the age at which people typically enroll in and attend institutions of higher education. Many states are evaluating how their mental health systems provide services, including emergency services, to persons with mental illness, as they pursue the important goal of community integration.
FINDINGS AND RECOMMENDATIONS

Our meetings across the country produced comments on issues that spanned a wide range of topics from individuals from many disciplines and backgrounds. However, we heard and discussed several recurring and interconnected themes that are highlighted as key findings at the outset of this report:

- Critical Information Sharing Faces Substantial Obstacles
- Accurate and Complete Information on Individuals Prohibited from Possessing Firearms is Essential to Keep Guns Out of the Wrong Hands
- Improved Awareness and Communication are Key to Prevention
- It is Critical to Get People with Mental Illness the Services They Need
- Where We Know What to Do, We Have to be Better at Doing It

This report summarizes the recurring major themes that led to each finding, along with critical steps state and local leaders identified as being taken, or needing to be taken, to address school violence and mental illness. Though state and local leaders pointed out that these issues reside primarily with states and localities, we have concluded there are several things the federal government also can and should do to help. Thus, this report also identifies steps our three federal agencies can take to ensure federal law and activities support, rather than impede, state and local efforts to deal with the complex issues raised by the Virginia Tech tragedy. It adds to a significant array of efforts that the federal and state governments have already undertaken to address these types of issues.¹

In addition, participants also cited the important role that the U.S. Department of Homeland Security plays in assisting the states and localities in conducting threat assessments and risk preparedness. A number of the federal recommendations we identify in the report suggest opportunities for our agencies and Homeland Security to work together to better assist states and localities in these functions.
Critical Information Sharing Faces Substantial Obstacles

We repeatedly heard reports of “information silos” within educational institutions and among educational staff, mental health providers, and public safety officials that impede appropriate information sharing. These concerns are heightened by confusion about the laws that govern the sharing of information. Throughout our meetings and in every breakout session, we heard differing interpretations and confusion about legal restrictions on the ability to share information about a person who may be a threat to self or to others. In addition to federal laws that may affect information sharing practices, such as the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule and the Family Educational Rights and Privacy Act (FERPA), a broad patchwork of state laws and regulations also impact how information is shared on the state level. In some situations, these state laws and regulations are more restrictive than federal laws.

A consistent theme and broad perception in our meetings was that this confusion and differing interpretations about state and federal privacy laws and regulations impede appropriate information sharing. In some sessions, there were concerns and confusion about the potential liability of teachers, administrators, or institutions that could arise from sharing information, or from not sharing information, under privacy laws, as well as laws designed to protect individuals from discrimination on the basis of mental illness. It was almost universally observed that these fears and misunderstandings likely limit the transfer of information in more significant ways than is required by law. Particularly, although participants in each state meeting were aware of both HIPAA and FERPA, there was significant misunderstanding about the scope and application of these laws and their interrelation with state laws. In a number of discussions, participants reported circumstances in which they incorrectly believed that they were subject to liability or foreclosed from sharing information under federal law. Other participants were unsure whether and how HIPAA and FERPA actually limit or allow information to be shared and unaware of exceptions that could allow relevant information to be shared.

Of course, a predicate to sharing information is recognizing when individuals pose a threat to themselves or others, and when intervention to pre-empt the threat is appropriate. In this regard, participants flagged the need for effective, evidence-based, inter-disciplinary tools to conduct a reliable assessment of the degree, type, and immediacy of safety risk the individual poses.
State and Local Recommendations

- Increase information sharing and collaboration among state and local communities, educators, mental health officials, and law enforcement to better provide care and detect, intervene, and respond to potential incidents of violence in schools and other venues.

- Provide accurate information to help ensure that family members, educational administrators, mental health providers, and other appropriate persons understand when and how they are legally entitled to share and receive information about mental illness, and appropriately do so, particularly where college and school-age children and youth are involved, for the protection and well-being of the student and the community.

- Along with reviewing federal laws that may apply, clarify and promote wider understanding about how state law limits or allows the sharing of information about individuals who may pose a danger to themselves or others, and examine state law to determine if legislative or regulatory changes are needed to achieve the appropriate balance of privacy and security.

Recommended Federal Action

- The U.S. Departments of Health and Human Services and Education should develop additional guidance that clarifies how information can be shared legally under HIPAA and FERPA and disseminate it widely to the mental health, education, and law enforcement communities. The U.S. Department of Education should ensure that parents and school officials understand how and when post-secondary institutions can share information on college students with parents. In addition, the U.S. Departments of Education and Health and Human Services should consider whether further actions are needed to balance more appropriately the interests of safety, privacy, and treatment implicated by FERPA and HIPAA.

- The U.S. Department of Education should ensure that its emergency management grantees and state and local communities receiving training through the program have clear guidance on the sharing of information as it relates to educational records and FERPA.
• Federal agencies should continue to work together, and with states and appropriate partners, to improve, expand, coordinate, and disseminate information and best practices in behavioral analysis, threat assessments, and emergency preparedness, for colleges and universities.²

• The U.S. Department of Education, in collaboration with the U.S. Secret Service and the Department of Justice, should explore research of targeted violence in institutions of higher education³ and continue to share existing threat assessment methodology with interested institutions.⁴
Accurate and Complete Information on Individuals Prohibited from Possessing Firearms is Essential to Keep Guns Out of the Wrong Hands

At the majority of our meetings, participants focused on the imperative to ensure the effectiveness of existing federal firearms laws, and facilitate better cooperation and communication between states and the federal government to ensure that firearms background checks are thorough and complete.

At some of our sessions, participants also commented about other aspects of the enduring debate over gun control. For example, participants addressed the issue of firearms on campus, some in favor and some against. Campus law enforcement participants also discussed their enforcement practices and the need for education about existing campus policies on the possession of firearms on campus. But the focus of discussions related to gun policy was on increasing the effectiveness of current federal firearms regulation, which is limited by divergent state practice.

Only 23 states currently provide any information to the NICS on persons disqualified from possessing firearms under federal law for reasons related to mental health, and many of those that do provide information provide very few records. For the NICS to be maximally effective in keeping firearms out of the hands of persons prohibited by federal law, including those prohibited by virtue of reportable and qualifying mental health history, all states need to understand the full scope of the existing federal laws and submit, or make accessible, appropriate information to the NICS.

Some states reported that state privacy laws prevented them from sharing information with the NICS. Other concerns centered on limited resources to submit or make available required information. Many participants suggested the need to evaluate the existing approach in their state to sharing mental health information and how their state regulates access to firearms by persons with mental illness who are at risk of injury to themselves or others.

State and Local Recommendations

- Prioritize and address legal and financial barriers to submitting all relevant disqualifying information to the NICS and other crucial inter-agency information sharing systems to prevent individuals who are prohibited from possessing firearms by federal or state law from acquiring firearms from federally licensed firearms dealers.
Recommended Federal Action

• The U.S. Department of Justice, through the FBI and ATF, should reiterate the scope and requirements of federal firearms laws, including guidance on the federal firearms prohibitions in the Gun Control Act of 1968 and how to provide information to the NICS on persons whose receipt of a firearm would violate state or federal law.6

• The U.S. Department of Justice, through the FBI and ATF, should continue to encourage state and federal agencies to provide all appropriate information to the NICS so that required background checks are thorough and complete.7

• Some states may need to evaluate whether changes or modifications to state law are necessary to make more relevant information available to NICS. The U.S. Department of Justice should work with states to provide appropriate guidance on policies and procedures that would ensure that relevant and complete information is available for background checks.
**Improved Awareness and Communication are Key to Prevention**

Recognizing that there were warning signs that preceded many school violence incidents, participants in our meetings discussed ways to address school cultures, including tacit “codes of silence,” that may impede identifying and responding to those in crisis. Students may know of someone in need or someone who has made a threat, but frequently they do not share that information with individuals who can take appropriate action. Participants stressed the need to promote cultures of trust, respect, and open communication, to reduce student isolation, to normalize the act of seeking help by and for those who pose a threat to self or others, and to de-stigmatize mental illness. Underscoring the theme that information sharing is key, participants repeatedly identified the need for communication strategies that build bridges between education and mental health systems.

Participants in our meetings also focused on promoting prevention and early intervention for children with, or at risk for, mental illness through early detection, referral, and treatment. They additionally highlighted the importance of ensuring that parents, teachers and students understand and are sensitive to warning signs and know what to do if they encounter someone exhibiting these signs. Effective practices shared during our meetings included identifying responsible and appropriate individuals with whom to share concerns, and creating interdisciplinary teams to evaluate the information, assess the degree of threat, and intervene to pre-empt the threat. State practices vary from using toll-free call centers to “risk assessment” teams in schools to receive, evaluate, and act on threat information.

**State and Local Recommendations**

- **Develop cultures within schools and institutions of higher education that promote safety, trust, respect, and open communication.** Create environments conducive to seeking help and develop culturally appropriate messages to de-stigmatize mental illness and mental health treatment.

- **Educate and train parents, teachers, and students to recognize warning signs and known indicators of violence and mental illness and to alert those who can provide for safety and treatment.**

- **Establish and publicize widely a mechanism to report and respond to reported threats of violence.**
Recommended Federal Action

- The U.S. Department of Health and Human Services should work through the Centers for Disease Control and Prevention’s (CDC) 10 Academic Centers of Excellence on Youth Violence Prevention and collaborate with the U.S. Department of Education to identify opportunities to expand CDC’s “Choose Respect” initiative so that it includes efforts to develop healthy school climates and prevent violence in schools.8

- The U.S. Department of Health and Human Services should include a focus on college students in its mental health public education campaign to encourage young people to support their friends who are experiencing mental health problems.9

- The U.S. Departments of Education, Health and Human Services, and Justice should continue to work together and with states and local communities to improve and expand their collaboration on their “Safe Schools/Healthy Students” program.10
It is Critical to Get People with Mental Illness the Services They Need

In each state meeting, concerns were raised about the capacity of the state and local mental health delivery systems to meet the full range of mental health needs. Participants voiced concerns about the availability of resources to provide timely and appropriate treatment and services and an insufficient number of skilled mental health workers, which result in waiting lists for services. A number of participants also shared their perception of an increasing number of students with serious mental health issues and the lack of adequate services to support them, particularly at college and university settings. In some state meetings, issues were raised about the particular challenges of providing mental health services in rural and underserved areas. In this area, participants stressed the need to expand their use of telemedicine and other innovative technologies, including electronic health records. All agreed that greater emphasis is needed on creating a coordinated system of community mental health services.

Throughout our discussions, participants talked about the importance of community integration and federal efforts to work with states to facilitate transformation of their mental health systems, which are hallmarks of the President’s New Freedom Initiative. De-stigmatizing and raising awareness of mental illness and the need for services that are evidence-based, recovery focused, and consumer and family-driven were also common themes. In this regard, the importance of family-centered care and support were repeatedly mentioned, along with the need to gear services and treatments in ways that give consumers and families meaningful choices among treatment options.

Meeting the challenge of adequate and appropriate community integration of people with mental illness requires effective coordination of community service providers who are sensitive to the interests of safety, privacy, and provision of care. Many states are evaluating how their systems provide services to persons with mental illness, including emergency services and commitment procedures, as they pursue the important goal of community integration. Participants also recognized that to ensure that those individuals who need mental health services are receiving them, it is critical that states have adequate systems for monitoring and following up, particularly where a legal ruling mandates a course of treatment.

To maximize early detection and intervention to address mental health issues, participants discussed the importance of integration between primary care and mental health services and between primary and specialty care for persons with mental illnesses, including specialized services for children and young adults. In this area, training primary health care providers in basic detection techniques and ensuring they are connected with the mental health delivery system are key to getting support and help to those who are in need at an early stage.
State and Local Recommendations

- Evaluate state and local community mental health systems to ensure their adequacy in providing a full array and continuum of services, including mental health services for students, and in providing meaningful choices among treatment options.

- Integrate mental health screening, treatment, and referral with primary health care.

- Review emergency services and commitment laws to ensure the standards are clear, appropriate, and strike the proper balance among liberty and safety for the individual and the community, and appropriate treatment.

- Where a legal ruling mandates a course of treatment, make sure that systems are in place to ensure thorough follow-up.

Recommended Federal Action

- The U.S. Department of Health and Human Services should convene the directors of state mental health, substance abuse, and Medicaid agencies and constituent organizations to explore ways to expand and better coordinate delivery of evidence-based practices and community-based care to adults and children with mental and substance use disorders.

- The U.S. Department of Health and Human Services should examine current strategies for implementing innovative technologies in the mental health field to enhance service capacity, through such means as telemedicine, electronic health records, health information technology, and electronic decision support tools in health care.

- The interagency Federal Executive Steering Committee on Mental Health led by the U.S. Department of Health and Human Services should promote federal agency collaboration to support innovations in mental health services and supports for school aged children and young adults in primary care and specialty mental health settings using evidence-based programs and innovative technologies. The Committee should also examine ways of disseminating more widely state and local grant opportunities that focus on detecting and treating behavioral health and violence issues with children and youth.
Where We Know What to Do, We Have to be Better at Doing It

It is a sad fact that many states have had experiences with school violence; but as a result, many have already thought critically and extensively about the issue. State and local governments often have prevention and response plans and, in the aftermath of the Virginia Tech tragedy, many states have established task forces or are otherwise evaluating whether and how to adapt existing school violence strategies to the unique environment of higher education.

Many states reported that they have emergency management plans in place and that many schools, including institutions of higher education, have developed protocols and strategies for preventing and responding to emergencies. These plans and strategies are the product of previous experience with natural disasters and school violence, as well as more general emergency preparedness in a post-September 11th world. In some states, state and local community preparedness grants from the U.S. Departments of Homeland Security and Health and Human Services include emergency preparedness planning that extends beyond natural disasters and terrorist attacks to school violence and other violent episodes in public places. The U.S. Department of Justice similarly makes grants to states that can be used for such purposes. In other states, participants observed that existing plans might not contemplate evolving threats to public safety. Promising practices and examples of comprehensive emergency management planning efforts currently exist and are being used across the country, but participants acknowledged that more could be done to disseminate best practices.

The U.S. Department of Education has created guidance on emergency management planning for the K–12 school community, but institutions of higher education face some unique challenges, including the age of students, size of student body, and physical layout of campuses. Some participants noted that emergency preparedness plans crafted for the smaller and more contained environment of K-12 education might not be easily applied to more porous, larger, and diverse college campuses or other settings. Others observed that some K-12 policies may not apply to higher education, where the student population consists of young adults and adults. Some participants noted that having a plan was not a guarantee that it will be effective or used when needed. In this regard, many noted the importance of, and challenges to, practicing the plan and making sure that everyone in the relevant community (students, faculty, staff, and parents, as well as local law enforcement) is aware of appropriate steps to take in an emergency. Participants especially highlighted the need for continuous and ongoing education of students, given the constantly changing student body. Finally, many schools are using or evaluating new forms of technology to communicate with students in an emergency. However, they report that they often face challenges in establishing and maintaining these systems.
Campus police are often the first responders to campus violence, and may have the initial interactions with students or others whose behavior may indicate a potential for violence. Despite this, and perhaps because campuses are widely seen as safe environments, some campus law enforcement participants indicated that they are, in some cases, understaffed or lack resources for training, which may leave them less than ideally prepared for crisis incidents on campus. Some participants indicated that students, campus officials, and external law enforcement counterparts do not view campus police forces as full law enforcement officers. By contrast, some campus police forces reported that they work very effectively and cooperatively with local police forces, have agreements in place for joint assistance and training, and engage in such joint exercises. Whatever the local practice, joint training of first responders was seen as vital, as was increased resources. There was a consensus that campus police forces, which are on the front lines in keeping campuses safe, need adequate resources, training, and respect to do their jobs effectively.

State meeting participants who have experience with violence in schools and other public settings also discussed the importance of appropriately responding to victims and others impacted by the event, and that outsiders desiring to provide assistance must be sensitive to the particular needs of the local community. In addition, many participants stressed the need to provide longer-term follow up and mental health support to reduce the residual impact of tragic situations. States that have experienced violence in schools and other public settings further identified the importance of convening cross-cutting teams to evaluate the events and formulate and implement plans based on lessons learned.

**State and Local Recommendations**

- Integrate comprehensive all-hazards emergency management planning for schools into overall local and state emergency planning.

- Institute regular practice of emergency management response plans and revise them as issues arise and circumstances change.

- Communicate emergency management plans to all school officials, school service workers, parents, students, and first responders.

- Develop a clear communication plan and tools to communicate rapidly with students and parents to alert them when an emergency occurs. Utilize technology to improve notification, communication, and security systems.
• Ensure the actual and perceived effectiveness of campus law enforcement through enhanced professionalism of campus police forces and joint training with federal, state, and local law enforcement.

• Be prepared to provide both immediate and longer-term mental health support following an event, and evaluate events and the response to them in order to gather lessons learned and implement corrective measures.

Recommended Federal Action

• The U.S. Department of Education should review its information regarding emergency management planning\textsuperscript{12} to ensure it addresses the needs of institutions of higher education and then disseminate it widely.

• The U.S. Departments of Education, Homeland Security, and Justice should collaborate and be proactive in helping state, local, and campus law enforcement receive desired training and making them aware of federal resources on behavioral analysis, active shooter training, and other research and analysis relevant to preparedness and response\textsuperscript{13}.

• The U.S. Departments of Homeland Security and Justice, jointly and separately, and in collaboration with the U.S. Department of Education, should consider allowing existing grant programs to be used to facilitate joint training exercises for state, local, and campus law enforcement\textsuperscript{14}.

• The U.S. Departments of Health and Human Services and Homeland Security should examine their community preparedness grants to state and local communities, which include an emphasis on early detection of hazards through information sharing, to clarify the grants that are available for the prevention of and preparedness for violence in schools, offices, and public places.
CONCLUSION

The Virginia Tech tragedy and similar violent events that have occurred in recent years throughout our country raise deep-seated issues. They rightly make all of us ask whether the complex balancing of fundamental interests in our communities – interests of protecting privacy and civil liberties, ensuring that our communities are safe, and helping people get the care they need – is appropriately calibrated. Carrying out the President’s charge, we have met with Governors, legislators, state officials, and experts from the spectrum of mental health, education, and law enforcement communities, who have identified obstacles they face and steps they believe should be taken to address school violence and mental illness at the community level. Based on what we heard, we offer recommendations for actions the federal government can take in each of five major issue areas to address these concerns.

This report is not, and should not be, an attempt to answer these fundamental questions once and for all, or to set the balancing of these critical interests at the national level. Instead, along with identifying how the federal government can help, it serves to focus the issues that must be part of the ongoing dialogue – in communities, states, and at the federal level – that will continue to calibrate the balance of these important rights, as we protect our freedoms and provide for our safety.
ENDNOTES


2 In 2004, the U.S. Department of Justice’s Office of Community Oriented Policing (COPS) sponsored a national summit on campus safety issues which included campus law enforcement practitioners, local, state, and Federal government officials, and representatives from the International Association of Campus Law Enforcement Administrators (IACLEA) and other law enforcement and higher education organizations. The results of this summit are contained in a report entitled National Summit on Campus Public Safety: Strategies for Colleges and Universities in a Homeland Security Environment, which can be found at http://www.cops.usdoj.gov/files/ric/Publications/NationalSummitonCampusPublicSafety.pdf. The report’s primary recommendation was the creation of a National Center for Campus Law Enforcement that will develop and disseminate training, best practices, model policies, and other resources to enhance public safety on campus. To further this recommendation, the COPS Office provided funding to IACLEA to further explore the creation of a national center and more clearly define the campus public safety needs that a national center would seek to address. This project is on-going.


4 The FBI’s National Center for Analysis of Violent Crime Behavioral Analysis Unit-1 (BAU) (http://www.fbi.gov/hq/isd/cirg/ncavc.htm) provides federal, state, local, and foreign law enforcement agencies with various behavioral analysis services, with a specialty relating to issues involving threat assessment and school violence. The BAU works with requesting agencies in an attempt to provide a threat management strategy after gathering and evaluating all available information regarding various facets of the student’s life. The BAU also provides training programs on this topic to various law enforcement agencies, school administration personnel, and mental health professionals who are regularly tasked with responding to threatening situations in school environments.

5 The U.S. Department of Justice recently submitted a crime bill to Congress. Among other things, the proposed legislation recognizes the importance of state efforts to improve information about mental health records, and criminal dispositions in ensuring the effectiveness of federal firearms laws. The bill prioritizes NCHIP grant applications that aim to improve the quantity and quality of records included in the NICS.

6 The NICS Section of the FBI’s Criminal Justice Information Services (CJIS) Division has been working for the past eight years to promote the submission of information identifying all qualifying prohibited individuals to the NICS Index through a national outreach initiative focused on sharing information with stakeholders about the NICS’ operations. The NICS Section of CJIS has promoted the submission of mental health records and sought to further understanding of the scope of federal law and the need to make information available to the NICS through outreach to state and local officials. The NICS Section’s efforts have included a wide array of stakeholders, including law enforcement, mental health professionals, and court personnel. The NICS Section has previously sent letters to states reminding them of the scope of federal law and the need to make information available to the NICS. In addition, the ATF has been proactive in educating law enforcement and the firearms dealer community on federal firearms laws, and will continue to do so. After the Virginia Tech tragedy, ATF communicated to all state Attorneys General and federal firearms licensees explaining the federal firearms prohibition relating to “mental defectives” in the Gun Control Act of 1968 and encouraging states to make relevant information available to the NICS. These letters are available on the ATF’s website at http://www.atf.gov/press/2007press/050907open-letter-to-states-attorneys-general.htm and http://www.atf.gov/press/2007press/050907open-letter-to-ffls.htm.
7 By law, federal agencies are required to provide certain information to the NICS. Section 103(e) (1) of the 
Brady Act (Pub. L. 103-159) provides the Attorney General the authority to secure directly from any 
department or agency of the United States information on persons whose receipt of a firearm would violate 
federal or state law. The provision provides that the heads of such agencies shall provide the information to 
the NICS. To that end, the Department of Justice will continue its efforts to ensure that all federal agencies 
with relevant information forward that information to the NICS. Neither the Brady Act nor other federal laws 
require states to submit information on prohibited persons to the NICS, and thus to the extent that States 
submit information on prohibited persons to the NICS, they do so voluntarily. The Brady Act established the 
NCHIP Federal funding program, administered by BJS, as the primary means to improve the automation and 
accessibility of state criminal records at the national level. The President, through his FY 2008 budget, 
makes grant funding available, for which states can apply to improve the information provided to the NICS. 
In addition to providing funding to states, DOJ has been working to encourage the States to submit 
information on prohibited persons to the NICS. However, significant shortcomings remain in the 
completeness of the records in the system and the availability of relevant information for NICS checks.

8 CDC’s Academic Centers of Excellence on Youth Violence Prevention focus on assessing the problem of 
youth violence in targeted communities; mobilizing those communities to prevent youth violence; 
researching the development, evaluation, and dissemination of effective interventions; integrating the 
research and community mobilization components; and emphasizing interdisciplinary and participatory 

CDC’s Choose Respect initiative is a national effort to help youth form healthy relationships to prevent dating 
abuse before it starts. The initiative targets 11–14 year olds and the caring adults in their lives with the 
message that dating abuse is not just unacceptable, but also preventable by choosing respect. Based on 
social marketing principles and models of behavior change, the overall aim of the initiative is to move the 
target audience through the various stages of change by increasing knowledge and awareness; influencing 
beliefs; changing attitudes; and changing and sustaining behavior.

9 The U.S. Department of Health and Human Services, through its Substance Abuse and Mental Health 
Services Administration, recently launched the Mental Health National Anti Stigma Campaign to encourage 
young people between 18 and 25 to support their friends who are experiencing mental health problems. 
The prevalence of serious psychological distress in this age group is high, more than 50% higher than the 
general population, yet this age group is the least likely to receive treatment. The Web site for the program 
is http://www.stopstigma.samhsa.gov.

10 The Safe Schools/Healthy Students program provides grants to school districts for comprehensive, 
community-wide drug and violence prevention projects. School districts are required to partner with local 
law enforcement, public mental health, and juvenile justice agencies/entities. This program is jointly funded 
by the U.S. Departments of Education and Health and Human Services and jointly administered by the U.S. 
Departments of Education, Health and Human Services, and Justice. Information can be found at 

11 The inter-agency Federal Executive Steering Committee consists of high-level representatives from 
agencies within the U.S. Department of Health and Human Services and from nine other federal 
departments that serve children, adults, and older adults who have mental disorders. The Committee 
oversees implementation of the Interagency Federal Action Agenda on Mental Health under the President’s 
New Freedom Initiative. The Interagency Federal Action Agenda on Mental Health includes public education 
campaigns to de-stigmatize and raise awareness about mental illness and grants to states to transform their 
mental health system (including focused grants for children and adolescents) and foster the development of 
a mental health system that is evidence based, recovery focused, and consumer and family driven. 

12 In September 2004, the Department of Education published Practical Information on Crisis Planning: A 
Guide for Schools and Communities. The guide gives schools, districts, and communities the critical 
concepts and components of good crisis planning, stimulates thinking about the crisis preparedness process, 
and provides examples of promising practices. The guide can be found at: 

13 The U.S. Department of Justice, through the Bureau of Justice Assistance (BJA), has several relevant 
training courses that are available and currently scheduled for implementation across the country. Examples 
include the Advanced Law Enforcement Rapid Response Training (ALERRT) Program, developed in 
partnership with Texas State University. In addition, BJA has planned, in partnership with the International 
Association of Campus Law Enforcement Administrators (IACLEA) to facilitate a summit in the summer of 
2007 to invite federal agencies, law enforcement, security, and education executives for high level 
discussions on campus safety and security needs, resources, and promising practices. BJA’s Campus Crime 
Prevention Training Program covers relevant topics over several days, in partnership with the National Crime
Prevention Council and the IACLEA. The FBI and ATF also provide training courses as needed and desired. Specifically, as noted in footnote 4, above, the BAU is expert in behavioral analysis and works with state and local government to provide expertise and training.

14 The U.S. Department of Justice will continue to work with colleges and universities on training initiatives and will continue to make funds available to states. The Department of Justice urges states to consider how to make federal funds available to colleges and universities. In this regard, the Department of Justice should consider whether additional education and outreach to potentially eligible college and university participants, either directly or through state grant recipients, is warranted. Information about the grant program is located at http://www.ojp.usdoj.gov/BJA/grant/byrne.html.
Florida Atlantic University

Regulation 4.014 Involuntary Withdrawal

(1) PURPOSE

(A) This regulation sets forth the process for reviewing the continued enrollment or involuntary withdrawal of a student in any case where the student’s presence or continued presence on campus may constitute a direct threat to other individuals or the University Community, or in cases where the student poses a risk of substantial self-harm such that the student cannot safely continue participation in the University’s educational programs.

(B) The principles outlined in this regulation are applicable to all graduate and undergraduate students at the University. In the College of Medicine, however, the composition of the advisory group described in section (3) below will consist of the College of Medicine Medical Student Promotions and Professional Standards Committee (MSPPSC), and the procedures described in sections (6) and (7) below will be modified as necessary to comply with the relevant professional standards, policies, and procedures established by the College of Medicine. Those standards, policies, and procedures are incorporated herein by reference and available in the Medical Student Handbook.

(2) GENERAL PRINCIPLES

(A) Involuntary withdrawal is always a last resort, and should only be considered when a student is unwilling or unable to meet the minimum health or safety requirements to be qualified for enrollment, regardless of disability, and can no longer safely continue participating in the educational programs offered by the University.

(B) Prior to the consideration of involuntary withdrawal, the University must consider whether reasonable accommodations, including but not limited to individually tailored restrictions on activities, are available that would allow the student to remain enrolled.

(3) STUDENT INTERVENTION TEAM (SIT)

The SIT, chaired by the Dean of Students or designee, will advise and make recommendations regarding the continued enrollment or involuntary withdrawal of a student and will consist of the following persons:
(A) Director of Student Conduct;
(B) Director of Student Health Services or designee;
(C) Director of Counseling and Psychological Services (CAPS) or designee (in an ex-officio advisory capacity only);
(D) Director of Student Accessibility Services (SAS) or designee;
(E) Associate Provost or designee;
(F) Chief of University Police or designee;
(G) Office of the General Counsel (in an ex-officio advisory capacity only);
(H) Other campus administrators, as appropriate, at the invitation of the Dean of Students.

(4) BASIS FOR INVOLUNTARY WITHDRAWAL

(A) Cases involving a direct threat.

i. Involuntary withdrawal of a student may be appropriate in cases where the student’s presence or continued presence on campus may constitute a direct threat to other individuals or the University Community.

ii. In cases where a direct threat posed by a student is based on behavior that violates the Student Code of Conduct, an investigation conference letter or formal conduct charges may be issued by the Dean of Students Office in accordance with FAU Regulation 4.007. Code of Conduct procedures may be conducted in lieu of or contemporaneously with the procedures provided below.

iii. In all other cases, evaluation of whether a student’s presence or continued presence on campus may constitute a direct threat to other individuals or the University Community or whether the student poses a risk of substantial self-harm such that the student cannot safely continue participation in the University’s educational programs will follow the procedures outlined in this Regulation.

(B) Cases involving a risk of substantial self-harm.

Involuntary withdrawal of a student may be appropriate when, through an individualized assessment, the University determines, based on factors other than mere speculation, stereotypes, or generalizations about individuals with disabilities, that the student poses a risk of substantial self-harm in light of reasonable health and safety standards.

(5) FACTORS FOR CONSIDERATION
Except in emergency circumstances, in order to determine whether a student poses a direct threat or a risk of substantial self-harm that prevents the student from safely participating in the University’s educational programs, the University must conduct an individualized assessment and make a reasonable judgment based on multiple risk factors, current medical advice and records, and objective evidence of behavior. The risk factors to be considered include, but are not limited to:

(A) The nature and severity of the risk;
(B) The duration of the risk;
(C) The probability of substantial harm;
(D) Available options to mitigate risks; and/or
(E) The student’s impact on other individuals or other members of the University Community.

(6) PROCEDURES

(A) The following procedures shall apply to all cases of potential involuntary withdrawal under this Regulation except in cases where the Dean of Students or designee determines that a student poses a danger of imminent or serious physical harm to others at the University or where an emergency exists that may affect the health, safety or welfare of a student or the University community. In cases where the Dean of Students determines that such an emergency exists, deviation from these procedures shall be made only to the extent necessary to address the emergency, and may include interim measures as stated in Regulation 4.007.

(B) A student subject to involuntary withdrawal shall be notified in writing of the University’s concern and the process for involuntary withdrawal. The student will also be provided information about, and where appropriate the opportunity to request, an Exceptional Circumstances Withdrawal pursuant to Regulation 4.013.

(C) Following the issuance of a written notice of involuntary withdrawal, the Dean of Students may refer the student for an individual evaluation and assessment by a licensed psychiatrist or psychologist of the Dean’s choosing. If such a referral is made:

   i. The evaluation and assessment should include an analysis of the level of treatment clinically recommended to meaningfully reduce the risks to student safety.

   ii. The evaluation and assessment must be completed within fourteen (14) business days from the date of the referral, unless otherwise required by the Dean of Students, and the student must complete any release forms necessary to allow the psychiatrist or psychologist to
share the results of the evaluation and assessment with the Dean of Students and members of the SIT.

iii. Failure to complete the evaluation and assessment or provide the results of the evaluation and assessment may be considered in evaluating the nature and severity of the risk and whether options to mitigate those risks are available.

(D) The Dean of Students will call a meeting of the SIT. At least four SIT members (including ex-officio members) must be present, either in person or via conference call, to proceed with a meeting. The SIT will conduct an individualized risk assessment and make a reasonable judgement based on the risk factors identified in section (5) above.

(E) The student shall be provided a reasonable opportunity in advance of the meeting to submit relevant information for consideration in the risk assessment by the SIT, including written statements and medical information from the student’s preferred healthcare providers. The SIT shall consider any information provided by the student and shall give due weight to the records and opinions of the student’s preferred healthcare providers.

(F) Following the meeting, the SIT will make a recommendation on whether the student should remain enrolled or be involuntarily withdrawn, and in the case of involuntary withdrawal, any suggested conditions for return. The Dean of Students will make a final decision regarding the student’s status and notify the student in writing within five (5) business days after the recommendations issued by the SIT.

(G) A decision by the Dean of Students for involuntarily withdrawal shall take effect immediately.

   i. A student who is involuntarily withdrawn may no longer attend classes or participate in University programs, may not be an active member of a Registered Student Organization, must vacate University owned or affiliated housing, and may no longer use University facilities except to the extent permission is granted by the Dean of Students. A Student Affairs hold shall be placed on the student’s record, which will prevent the student’s reinstatement or readmission to the University until any conditions for return are completed.

   ii. A student who is involuntarily withdrawn after the published deadline for withdrawal will receive grades of WM in their course work for the semester.
(H) In lieu of involuntary withdrawal, a student may be subject to written conditions for continued enrollment that are specifically tailored to the individualized risk assessment conducted by the SIT. Failure to comply with the written conditions for continued enrollment will result in a subsequent notice of involuntary withdrawal consistent with the requirements set forth above.

(I) The student may appeal the decision of the Dean of Students. The appeal must be made in writing to the Vice President of Student Affairs and delivered within seven (7) calendar days after the date of the notification to the student of the Dean of Students’ decision. The Vice President of Student Affairs may, within a reasonable timeframe, approve, modify, or reject the original decision of the Dean of Students. The Vice President of Student Affairs’ decision will be considered final agency action.

(7) CONDITIONS FOR RETURN

(A) Students who have been involuntarily withdrawn are eligible for reinstatement of their enrollment for three consecutive semesters following the semester of involuntary withdrawal. In some cases, the Dean of Students may impose conditions to prepare the student for a successful return to the University. Those conditions may include, but are not limited to, the following:

i. Submission of evaluations by appropriate licensed medical or mental health professionals indicating that the student no longer poses a direct threat to others or a risk of substantial self-harm, and that the student is prepared to safely participate in the University’s educational programs.

ii. A signed authorization permitting the Dean of Students to discuss the student’s readiness to return to rigorous academic work and any reasonable accommodations that may be appropriate with the student’s medical providers.

iii. Other conditions based on an individualized assessment of the student, including consideration of current medical knowledge and the best available objective evidence. Careful consideration will be given to the opinions and recommendations of the student’s treating physician or mental health professional, if available.

(B) Students requesting reinstatement should submit their request to the Dean of Students no later than thirty (30) calendar days prior to the beginning of the semester for which they are seeking reinstatement. The request should include documentation demonstrating the completion of any conditions for return.
(C) In cases where a student’s request for reinstatement is denied by the Dean of Students, the decision may be appealed in writing to the Vice President of Student Affairs within seven (7) calendar days after the date of the notification to the student of the Dean of Students’ decision. The Vice President of Student Affairs may, within a reasonable timeframe, approve, modify, or reject the original decision of the Dean of Students. The Vice President of Student Affairs’ decision will be considered final agency action.

(D) In cases where a student is not enrolled at the University for more than three (3) consecutive semesters, the student will be required to apply for readmission.

PRIVACY AND SAFETY
The Intersection of FERPA, HIPAA, the ADA, and Campus Safety

TODAY’S PRESENTERS

BEVERLY H. BINNER
Senior Associate General Counsel
Carilion Clinic

DANIEL A. JONES
Associate General Counsel
Florida Atlantic University

THREE DECADES OF SCHOOL SHOOTINGS

- The Wall Street Journal created a profile of all school shootings that took place between 1990 and 2018.
- The single common factor present in all shootings was that the shooter prepared for the shooting in advance.
- The second most frequently occurring factor was easy access to firearms owned by someone other than the shooter.
- The third most frequently occurring factor was the shooter told someone of his plans in advance.
- The fourth most frequently occurring factor was the shooter had displayed textbook suicidal behavior.
In 1974, there was growing public awareness and concern about the public dissemination by primary and secondary schools of information commonly considered private in nature, the withholding of "secret files" on students, and recordkeeping practices in general.

In very general terms, FERPA gives college students the rights to:
- Control the disclosure of their education records;
- Inspect and review their own records; and
- Request corrections.

-Steve McDonald

§ 99.3 defines Education Records as records that are:
- Directly related to a student; and
- Maintained by an educational agency or institution or by a party acting for the agency or institution.

Education Records do not include:
- Personal knowledge or observation
- Records kept in the sole possession of the maker, are used only as a personal memory aid, and are not accessible or revealed to any other person
- Employee records...unless the employee is employed as a result of his or her status as a student
- Law enforcement records
FAMILY EDUCATIONAL RIGHTS AND PRIVACY ACT (FERPA) 20 U.S.C § 1232g and 34 CFR 99

- Exceptions allowing disclosure:
  - Health or safety emergency
  - Certain disciplinary records
  - Judicial order or lawfully issued subpoena
  - Disclosure to those with a legitimate educational interest

Education Records do not include:
- Records on a student 18 years or older, attending a postsecondary institution, that are:
  - Made or maintained by a physician, psychiatrist, psychologist, or other recognized professional or paraprofessional acting in is or her professional capacity;
  - Made, maintained, or used only in connection with treatment of the student; and
  - Disclosed only to individuals providing the treatment.
- For purposes of this definition, “treatment” does not include remedial educational activities or activities that are part of the program of instruction at the agency or institution.

If a school discloses an eligible student’s treatment records for purposes other than treatment, the records are no longer excluded from the definition of “education records” and are subject to all other FERPA requirements (Joint Guidance, 2008).
HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA), 45 C.F.R PARTS 160 AND 164

- HIPAA is a federal law that protects the privacy and security of individually identifiable health information.
- Individually identifiable health information (45 CFR §160.103) means information that:
  - Is created or received by a health care provider, health plan, employer or health care clearinghouse; and
  - Relates to the past, present, or future physical or mental health, or condition of an individual; the provision of health care to an individual, or the past, present, or future payment for the provision of health care to an individual; and
  - Identifies the individual; or
  - With respect to which there is a reasonable basis to believe the information can be used to identify the individual.

FERPA v. HIPAA

- "Education records" and "treatment records" as such terms are defined under FERPA, are expressly excluded from coverage under HIPAA’s Privacy and Security Rules. (See subsection (2)(i) under definition of Protected Health Information, 45 C.F.R. 160.103).

FERPA v. HIPAA – Key Differences

- Disclosure of medical record for treatment purposes
  - HIPAA: Permissible without a patient’s authorization
  - FERPA:
    - If the record is considered an “educational record” then the student’s consent is required (unless an exception applies); but
    - If the record is a “treatment record” no consent from the student is required.
  - Required language in a HIPAA authorization for disclosure form is different than language required to be included in a FERPA consent to disclose form.
  - Notices: A HIPAA “Notice of Privacy Practices” is different than a FERPA “Notice of Rights”.

3.54
FERPA v. HIPAA - Confusion Exists

- Report to the President of the United States (June 13, 2007) Issued by the Department of Health and Human Services, Department of Education and Department of Justice, following Virginia Tech shooting tragedy in 2007, concluded that privacy laws, including HIPAA and FERPA, need amendment and clarification.

FERPA v. HIPAA - Guidance


FAQ 3: Does FERPA or HIPAA apply to elementary or secondary school student health records maintained by a health care provider that is not employed by a school?

A: “If a person or entity acting on behalf of a school subject to FERPA, such as a school nurse that provides services to students under contract with or otherwise under the direct control of the school, maintains student health records, these records are FERPA and HIPAA records under FERPA, just as they would be in the school if maintained by the school. This is the case regardless of whether the health care is provided to students on school grounds or offsite.” (emphasis added)

TREATMENT OF STUDENT HEALTH RECORDS IN VIRGINIA – APPROACHES VARY

- No single, uniform approach to maintaining records by Virginia academic institutions.
- HIPAA and/or FERPA notices are usually posted on college or student health center websites.
TREATMENT OF STUDENT HEALTH RECORDS IN VIRGINIA – APPROACHES VARY

- Factors to consider in determining whether to apply HIPAA v. FERPA standards:
  - How are student health records being maintained?
  - Is the Student Health Center a separate, stand-alone organization?
  - Does the Student Health Center bill payors for any services?
  - Who is performing services and maintaining records?
  - Where are student health services being performed?

A Case Study – Carilion Clinic’s approach to Student Health Records

- Carilion Clinic’s service area encompasses an approximately 20-county region in central and southwestern Virginia and southern West Virginia;
- Carilion Clinic owns/operates seven hospitals, including the region’s only adult and pediatric level 1 trauma center;
- 226 practice sites;
- Integrated electronic medical record system;
- Manages and operates the student health centers at several area colleges, both public and private;
- In most cases, Carilion maintains student health records in accordance with HIPAA.

- Contract clearly provides that student health records are owned by Carilion and maintained in accordance with HIPAA
- Student health records integrated into Carilion’s EMR system;
- However, enrollment forms, such as health history and immunization forms required to be obtained by the College, are maintained separately and owned by college.
- Health care services are provided on college campus in college-owned space
- Carilion has exclusive use of the space;
- Signage reflects that Carilion is the service provider.
A Case Study – Carilion Clinic’s approach to Student Health Records

- Carilion controls and is responsible for services and records
- Carilion employs all administrative and clinical staff;
- Carilion provides medical equipment and supplies;
- Carilion solely responsible for training of personnel, licensure/certifications, accreditation of facility, maintaining professional liability insurance, etc.

HIPAA - BENEFIT TO STUDENTS

- Single EMR system promotes continuity of care for students;
- Access to secure online patient portal through EMR system;
- Health care provider has responsibility for storage and maintenance of health records and for responding to requests for disclosures; and
- Health care provider has sole responsibility for determining what is or is not a permissible disclosure.

STUDENTS IN CRISIS – HIPAA ANALYSIS

- In Virginia, each public college or university is required to have in place policies and procedures for the prevention of violence on campus, including assessment and intervention with individuals who behavior poses a threat to the safety of campus community, and establish a specific threat assessment team to include members of law enforcement, mental health professionals, representatives of student affairs and human resources, and college/university counsel, responsible for implementing the assessment, intervention and action policies. (VA Code §23.9:210)
- Virginia’s Health Record Privacy law permits health care providers to disclose health records to the university’s threat assessment team. (VA Code §32.1-127.1/010.35)
- HIPAA does not permit this disclosure.
STUDENTS IN CRISIS – HIPAA ANALYSIS

- Mental Health Service Providers duty to protect third parties (VA Code §54.1-2400.1.B):
  - "A mental health service provider has a duty to take precautions to protect third parties from violent behavior or other serious harm only when the client has orally, in writing, or via sign language, communicated to the provider a specific and immediate threat to cause serious bodily injury or death to an identified or readily identifiable person or persons, if the provider reasonably believes, or should believe according to the standard of his profession, that the client has the intent and ability to carry out that threat immediately or imminently."

STUDENTS IN CRISIS – HIPAA ANALYSIS

- 45 CFR §164.512: Uses and disclosures for which an authorization or opportunity to agree or object is not required.
  - (j) Standard: Uses and Disclosures to avert a serious threat to health or safety.
  - (1) Permitted Disclosures. A covered entity may, consistent with applicable law and standards of ethical conduct, use or disclose protected health information, if the covered entity, in good faith, believes the use or disclosure:
    - (A) Is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public; and
    - (B) Is to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

FLORIDA STATUTES § 394.4615

- A clinical record shall be released when:
  - The patient authorizes the release
  - The patient is represented by counsel and the records are needed by counsel for adequate representation
  - Court Order
  - Patient is committed to the Department Corrections
- A clinical record may be released when:
  - A patient has declared an intention to harm other persons (may only release sufficient information to provide adequate warning)
  - Facility administrator or secretary of the department deems release necessary under administrative rule or treatment requirements
FLORIDA STATUTES § 490.0147

- Any communication between any person licensed under this chapter and her or his patient or client shall be confidential. This privilege may be waived under the following conditions:
  - When the person licensed under this chapter is a party defendant to a civil, criminal, or disciplinary action arising from a complaint filed by the patient or client, in which case the waiver shall be limited to that action.
  - When the patient or client agrees to the waiver, in writing, or when more than one person in a family is receiving therapy, when each family member agrees to the waiver, in writing.
  - When there is a clear and immediate probability of physical harm to the patient or client, to other individuals, or to society and the person licensed under this chapter communicates the information only to the potential victim, appropriate family member, or law enforcement or other appropriate authorities.

STUDENTS IN CRISIS AND THE ADA

- Title II of the ADA and Section 504 of the Rehabilitation Act prohibit discrimination against otherwise qualified individuals at post-secondary institutions who are suffering from mental or psychological disability.
- Universities may face legal liability for insisting that students who are disruptive or who engage in risky behavior withdraw from classes and leave campus until their conditions have stabilized.
  - Barbara A. Lee

STUDENTS IN CRISIS

- Does the student’s presence or continued presence on campus constitute a direct threat to other individuals or the University Community, or does the student pose a risk of substantial self-harm such that the student cannot safely continue participation in the University’s educational programs?
- Involuntary withdrawal is always a last resort, and should only be considered when a student is unwilling or unable to meet the minimum health or safety requirements to be qualified for enrollment, regardless of disability, and can no longer safely continue participating in the educational programs offered by the University.
- Prior to involuntary withdrawal, the University must consider whether reasonable accommodations, including but not limited to individually tailored restrictions on activities, are available that would allow the student to remain enrolled.
STUDENTS IN CRISIS

- Professional team must conduct an **INDIVIDUALIZED ASSESSMENT**, and make a reasonable judgment, based on current medical advice and records, and objective evidence or behavior. The risk factors to be considered should include:
  - The nature and severity of the risk;
  - The duration of the risk;
  - The probability of substantial harm;
  - Available options to mitigate risks, and/or
  - The student's impact on other individuals or other members of the University Community.

SEE/HEAR SOMETHING...**SAY SOMETHING**

- Educating student and faculty populations to common risk behaviors
- Partnering with community health resources and law enforcement
- Establishing multiple reporting options

HYPOTHETICAL

- Patient, a student on campus, discloses to a therapist in your on-campus Counseling Center that he's had thoughts about killing a female student at the University.
- What should the therapist do?
- If the therapist decides they can disclose the information, to whom does the therapist disclose?
- If the therapist discloses to the Dean of Students, what obligation does the University now have?
- The Dean of Students creates a record of her communication with the therapist, and the patient. Now the local police department has requested a copy of that disciplinary report. Can the Dean disclose?
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ACTIVE SHOOTER RESPONSE
AND PREPAREDNESS IN HEALTH CARE
Part II

By

Frank Harper, Phoenix, AZ
A DAY LIKE NO OTHER

A CASE STUDY OF THE LAS VEGAS MASS SHOOTING

Nevada Hospital Association
# Table of Contents

3  Disclaimer
3  Acknowledgments
5  Forward
5  Introduction
7  A Complex Incident
10 The Hospital Experience
15 Response
15  Triage
16  Safety and Security
18  Communications
21  Surge Plans
24  Mortuary Care Surge
25  Mental Health and Wellness
26 Recovery
33 Observations, Insights and Lessons
34  Observations
38  Insights
45  Lessons-to-be-learned
63 Conclusion

**Author:** Christopher K. Lake, PhD
The purpose of this special report is to provide supplemental hospital emergency management educational material via the case study of one of the worst mass-casualty incidents to occur in our nation's history: the shooting in Las Vegas, Nev., on Oct. 1, 2017. Every effort has been made to accurately capture the incident, actions and impressions of the hospitals and their staffs.

This report was prepared to further hospital, coalition and public health emergency management practices. The focus of the information is to foster discussion that may form the basis of future policy, procedures and exercises. Individual hospitals, agencies and responders are not attributed nor exposed within the text of this report.

The observations and lessons learned, as documented in this report, are in no way an indictment of any kind, nor should they be viewed as regrets about what could have been achieved better at the time of the incident. America has never seen an incident of this type or scale. This situation and subsequent response helped to identify areas where additional planning, exercises and assumptions are necessary based on the changing world and social environment in which we now live.

ACKNOWLEDGMENTS

The healthcare and first-responder community were called to work together in ways that have never been contemplated. Under extreme conditions — which included high stress, imminent danger, extraordinary patient volumes and acuity — these hospitals and individuals achieved amazing results. Each and every one of them contributed to saving hundreds of lives. They are all heroes.

Many responders and staff members still suffer from the events of that day. The emotional and psychological wounds, horrific memories and difficult humanitarian interactions with the injured and their families may never fully dissipate. Some responders incurred physical and debilitating injuries, and one made the ultimate sacrifice. The community, state, nation and world are indeed better places because of these selfless actions. Thank you to all of those affected.

This report would not be possible without the assistance and support of Nevada’s hospital, healthcare, first-responder communities, the Southern Nevada Health District, and emergency management teams. Thank you to the acute care hospitals who received the bulk of the self-transporting patients, including Sunrise Hospital and Medical Center, Desert Springs Hospital Medical Center, University Medical Center, Spring Valley Hospital Medical Center and Dignity Health St. Rose Dominica Siena. Thank you to the rest of the southern Nevada hospitals and systems who all contributed to patient care, received patients or transfers, shared equipment, supplies, pharmaceuticals, personnel, expertise and provided help and support in every imaginable way to support our community. These facilities are Centennial Hills Hospital Medical Center, Dignity Health Hospitals and Neighborhood Hospitals, Henderson Hospital, MountainView Hospital, North Vista Hospital, Southern Hills Hospital and Medical Center, Summerlin...
Hospital Medical Center, Valley Hospital Medical Center, AMG Specialty Hospital, Complex Care Hospital, Desert Parkway Behavioral Healthcare, Encompass Health (formerly HealthSouth), Horizon Specialty Hospitals, Infinity Hospice, Kindred Hospitals, Montevista Red Rock Behavioral Hospital, Mountain's Edge Hospital, Nathan Adelson Hospice, Seven Hills Hospital and Spring Mountain. A special thank you and acknowledgment goes out to the VA Southern Nevada Healthcare System, which provided endless hours of counseling and psychological first aid to the area's hospital staff and responders. Your dedication rescued the rescuers and provided much-needed emotional support.

To the people who shared their individual experiences, provided data, and helped organize multiple events, interviews, speaking engagements and InfoXChanges, thank you for being there and sharing what we know are difficult, emotional and sometimes painful memories. These people are (in no particular order) Karen Donnahie, Todd Sklamberg, Ryan Jensen, Dorita Sonereker, Christopher West, Mason VanHouweling, Todd Nicolson, Jeff Quinn, David Black, Christian Young, Stacey Helton, Brian Anderson, Daniel Llamas, Carolyn Hafen, Christina Conti, Glenn Simpson, Felix Acevedo Jr., John Fudenberg, Jodi Carl, Misty Richardson, Roger Brooks, Carissa Ray, Alan Keese, Robby Yoon, Tommy Urso, Antoinette Mullan, Vicki Gooss, Kelly Morrell, Mike Kelly, Tracy Szymanski, Ryan Hamblin, Branden Clarkson, Mark Kittelson, John Steinbeck, David Maclntyre, Caleb Cage, John Fildes, Lonnie Empey, Ryan Hudson, Donald Reisch, Marina Mkhitaryan and all the others who shared their insights and experiences during the site visits, hospital tours and round-table discussions.

To the subject-matter experts and peer reviewers who traveled from New York to exchange information, question our assumptions and challenge conclusions: Your professionalism, expertise and candor made our after-action review much more focused, detailed and meaningful. Thank you for taking the time out of your busy schedules to help us perform an honest and dispassionate review of our response. We extend our gratitude to, among others, Jenna Mandel-Ricci and the entire Greater New York Hospital Association, Patrick Meyers, Michael Moculski, Jared Shapiro, Lonnie Trotta, Tamer Hadi, Tim Styles, Nicholas Caglìuso, Mary Mahoney, Jerry DeStefano, Mark Marino, Kevin Chason, Eric Barton, Brad Kaufman, Katie Belfi, Brandy Ferguson, Nicholas Gavin, Scott Heller, Jay Brandt, Emily Carroll, Trevor Marshall, Jeff Bokser, Max Green, Elias Kontanis, TJ Kucera, James Vasswinkel, Andrew Durham, Michael Schon, Gray Aric, Thomas Boyle and Dennis Mazone.

A special thank you to Amy Shogren, Jenna Mandel-Ricci, Karen Donnahie, Daniel Llamas, Felix Acevedo Jr., Todd Nicolson, Christina Conti and Jeff Quinn for their help, support and for keeping the momentum of this project moving forward. The following people made this report better through their tireless review, edits and editorial comments. Jeff Quinn thank you again for your candid review and the significant effort you put in to making this document as comprehensive and accurate as it could be. Karen Donnahie,
Amy Shogren, Chris Crabtree, Christina Conti, and Annette (Matherly) Newman thank you for your reads, edits and impressions. Lindsey Gross thank you for the amazing layout and the design elements. I know this project took on a life of its own as more and more data became available and timelines continually were pushed back. Thank you for sticking through it.

The exclusion of anyone in this section is purely accidental and in no way lessens the gratitude we feel for contributions received.

FORWARD

This special report is not an after-action document, but instead a consolidated discussion of events, actions taken, lessons learned, observations and hospital experiences that resulted from the Las Vegas mass shooting. The information shared in this report was collected through interviews, facilitated discussions, field trips and the Nevada Healthcare Preparedness Partner’s InfoXChange program and is presented in a narrative. Individual patient care is not discussed as the focus of the report is on hospital emergency management. Likewise, family reunification and assistance outside of the hospital environment is not addressed within this report.

This report was supported by the Nevada State Division of Public and Behavioral Health through grant number 6NU90TP000534-05 from the Assistant Secretary for Preparedness and Response (ASPR). Its contents are solely the responsibility of the author and do not necessarily represent the official views of the Division or ASPR.

The recommended citation of this special report is:

Lake, C. A Day Like No Other: A Case Study of the Las Vegas Mass Shooting. Nevada Hospital Association. 2018

INTRODUCTION

Clark County, Nevada is approximately 83 square miles in size. Often, the term “Las Vegas” is used generically and interchangeably to describe the political subdivision that is Clark County. That holds true in this document as well. The Las Vegas Strip and Las Vegas McCarran International Airport are located within unincorporated Clark County. The county is commonly referred to as a land-locked island, as the next closest metropolitan area is San Bernardino, Calif., approximately 183 miles to the west.

Roughly three quarters of Nevada's population lives within Clark County. Las Vegas is the 30th largest city in the United States and is home to the world’s 26th busiest airport (8th busiest in the USA). A world-renown tourist destination, Clark County receives more than 43 million visitors every year.

No stranger to holding large events, Las Vegas is home to three of the world's 10 largest convention

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1 Nevada Healthcare Preparedness Partner’s InfoXChange program was conducted Jan. 31-Feb. 2, 2018. Subject-matter experts from New York (organized through the Greater New York Hospital Association) traveled to Las Vegas and took a tour of the event site and met with the hospital staff at most of the receiving facilities. The NY-SMEs could ask any questions of their Las Vegas peers related to how and why certain procedures or practices were applied. Physicians challenged physicians; coroners challenged coroners, etc. This discourse led to many of the lessons learned and highlighted within this report. SMEs included physicians, coroners, law enforcement, fire, EMS, nursing, public health officials, hospital CEOs and other hospital staff members.
centers and represents the largest hotel market in the USA. Large events include an annual New Year’s Eve celebration (attendance of 250,000+), “Super Bowl” parties (attendance 350,000+), the International Consumer Electronics Show (attendance 184,000+), the Electric Daisy Carnival (attendance 400,000+) and various concerts, NASCAR, Golden Knights and NCAA events.

The Route 91 Harvest Festival was a three-day country music concert event. The venue was an outdoor, flat lot approximating 15 acres in size with festival seating. The concert had 22,000 attendees. It was not considered a large-scale event by Las Vegas standards.

The event was well staffed with both security and first-aid personnel. Las Vegas Metropolitan Police Department (Metro) had 50 officers on duty at the concert, and Community Ambulance (a private ambulance service) had several paramedics, EMTs and a medical tent within the concert venue to provide first aid.

All attendees were issued Radio Frequency Identification Device (RFID) armbands that contained their concert ticket and credit card information. Because this was a three-day event, attendees required the ability to leave and re-enter the concert. RFID technology armbands afford concert-goers this flexibility. Additionally, this technology gives patrons the convenience of not needing to carry cash or credit cards with them, as they can wave their armband over a sensor at a vendor or food booth and automatically charge the credit card on file for whatever products they ordered. The unintended consequence of this technology is that by day three of the event, few people felt it necessary to carry their wallets — and hence their driver’s licenses or other forms of identification.

The hospital system in Clark County is predominantly private, with a mix of both for-profit and non-profit facilities. HCA Healthcare Inc. (HCA) operates three acute-care hospitals, including one trauma center. Universal Health Services (UHS) operates six acute-care hospitals. Dignity Health (non-profit) operates three acute-care facilities, including one trauma center, and partners with Emerus for the provision of four micro-hospitals. University Medical Center is a county-operated hospital and is the only Level I Trauma Center and burn center in the state of Nevada. Prime Healthcare operates one for-profit, acute-care hospital.
A COMPLEX INCIDENT

On the night of Oct. 1, 2017 at 10:05 p.m., shots were fired into the crowd of Harvest Festival attendees. More than 1,000 shots were fired over the course of approximately 15 minutes, many into the concert venue.

The shooter was perched in an elevated platform — shooting down from the 32nd floor of the Mandalay Bay Resort, located across the street from the concert venue and more than 350 yards away. Concert-goers initially didn’t realize what was happening and believed the noise to be firecrackers or part of the show.

Once it became apparent that people were being shot and killed, the crowd ran for their lives. Every exit, fence or other area of egress was quickly over-run. Survivors helped the wounded. Shirts, belts and other implements were used by these good Samaritans as make-shift tourniquets and compression bandages. Others picked up and carried the severely wounded away from the venue seeking shelter.

A total of 31 people were killed within the concert venue or died before reaching a hospital. More than 800 were injured, with the extent of these injuries ranging from minor to fatal. As the crowd ran away from the venue, they began taking refuge at area hotels, churches, convenience stores and airport facilities. Many of the injured self-transported or used ride-sharing services to get to the closest hospital. The incident location had spread from the contained 15-acre venue to more than four square miles of the densely populated city.
“A total of 31 people were killed within the concert venue or died before reaching a hospital.”
Hundreds of people broke through the McCarran Airport’s chain-link fence, which borders the venue, and ran down active runways. The Government Accountability Office would later declare that this resulted in the largest airport breach in history. Many of these individuals suffered from gunshot wounds or were hysterical. Allegiant Airlines sheltered more than 30 individuals at a maintenance facility, while another 130 people hid in Signature Flight Support hangers — many with life-threatening injuries. Others ran to any building on the airport grounds they could reach. A flight that was cleared for landing had to abandon the approach just before touching down, as a crowd of people were running down the landing strip, nearly creating another disaster. For the next several hours, flights were diverted to Phoenix or other cities.

The shooter used a bump-stock accessory on his rifle(s), which allowed the weapons to fire at near fully automatic (machine gun) speeds. Fire and EMS rescue crews could not make their way into the venue to treat the wounded, as gun shots were still ringing out. Additionally, these initial responding rescue crews had limited access to the people who ran toward the airport, because driving that direction placed them directly in the shooter’s line of fire. Units needed to either drive significant distances around the airport to other entrances or otherwise approach from the more rural county areas in the south.

Ultimately, the majority of the injured (approximately 800) found their own transportation to area hospitals or other medical care, using mapping applications on their smartphones to identify and route themselves. Paramedics were required to respond to more than 20 separate locations around the perimeter of the concert grounds to treat wounded people who initially fled on foot. Each of these locations had between three and 40 injured people.

In addition to the dilution of the wounded from the scene, law enforcement began getting multiple calls regarding additional active shooters. These calls came in from major resort casinos and from airport officials. These types of calls, referred to as “echo” calls, occur when victims run to another location and then collapse. The person who then finds the victim (whether a security guard or lay-person) calls 911 and reports that a person has been shot at their location. It’s a natural assumption, in the absence of any other facts, that the victim was
shot at or near the location in which they were found. In any case, all of these (approximately 20) echo calls were responded to by both law enforcement and paramedics just as if an active shooter were present. The result: Echo calls significantly contributed to scene confusion, additional service calls and responder anxiety.

Situational awareness in the initial phases of the response was challenging. Law enforcement and rescue crews had multiple reports of active shooters. Injured and deceased people were spread over four square miles throughout the city. The airport had been shut down. What sounded like machine-gun fire was witnessed by multiple fire and rescue crews. Law enforcement officers tried to engage the one known subject, and several were shot. And hundreds of injured patients, without any prior notification, began arriving at area hospitals.

THE HOSPITAL EXPERIENCE

Oct. 1, 2017, was a day like no other for Clark County hospitals. It was a relatively quiet Sunday night prior to the shooting. Many of the facilities had flexed-off excess staffing. The hospitals were at minimal Periodic Automatic Replenishment (PAR) values for supplies and pharmaceuticals, awaiting their Monday morning deliveries. And then it happened: Car load after car load of seriously wounded people started arriving without any notice.

Cars started pulling into the emergency room driveways and ambulance entrances. These cars were filled with as many people as could fit, many with life-threatening injuries, and some who exsanguinated and died on the short drive from the concert. The closest hospitals to the concert found themselves thrown into the midst of a mass-casualty incident, with no notice. The injured had no pre-hospital care. There was no field triage; minor injuries arrived in the same vehicles as patients who were critical. Non-trauma centers were receiving critical penetrating trauma. One hospital reported that a line of cars more than a quarter mile long was waiting to make entry into the hospital parking lot. The cars just kept coming, and the shooter was still shooting.

The hospital staff began receiving text messages and phone calls from co-workers, family and friends. Some people were offering to help, some communications were to check up on their status and some were offering additional information. The information flow was dynamic. Witness reports and victim statements were communicated via the network news and on social media. Most of the early information and witness accounts were absent of any actionable data or were false in their entirety. Reports of additional active shooters, gunmen spotted at various hospitals, and speculation about additional targets and motive all created an atmosphere of uncertainty — and in many cases, fear — within the first-responder community.

For the hospitals, the staff had to put all their fears and emotions to the side and keep on task. Triage, treatment and establishing some sense of organization were paramount in this situation. Initial tasks included extricating patients from vehicles as they arrived, triaging patients and providing life-saving treatments as fast as possible. Instituting a formal hospital incident command system had to wait until
additional staff could arrive, but “mobile command” and activating elements of multiple emergency plans took place at most facilities.

Almost uniformly, the emergency plans that were activated prior to the formal command centers being established included surge/triage plans, communications/staff call-back and lock down and security plans. The exact order of these plan activations varied based on the individual facilities’ situations; however, all hospitals stated that these plans were for the most part activated simultaneously.

The tempo remained steady for several hours, with patients arriving 10-15 at a time, one car after another, and later through the night, ambulances with multiple patients. Hospitals had no ability to estimate the total number of patients that they were going to receive, or the number of operational periods that this tempo would sustain. Based on limited information, echo calls and rumors/speculation being spread via social media, many people believed that Las Vegas was experiencing a coordinated complex attack like that which occurred in Paris, France2.

Doctors, nurses and hospital staff were quick to report back to work. Many simply showed up prior to being requested. This was both a blessing and a curse. It was a blessing because staff members in all disciplines were needed to effectively deal with the large numbers of patients that were arriving. It was also a curse because hospitals needed to ensure that they had enough staff depth to cover all positions and shifts the next day and thereafter.

2 Paris, France was the site of a series of coordinated attacks in November 2015. Attackers killed 130 people and injured another 413. Coordinated attacks took place at more than three locations and resulted in the deadliest occurrence of violence in France since WWII.
Because several reports had been received stating that gunmen had been seen at multiple hospitals, Metro deployed officers to help secure these medical facilities. At one facility specifically, Metro believed they had a credible sighting and created a multi-layered perimeter around the hospital while they began a search for the suspect. This activity made it difficult for several responding physicians and staff to get to their normal workplace. The staff that could not make it to their normal worksite drove to other facilities to help in any way they could.

One community hospital (non-trauma center) near the incident began receiving patients with major injuries. They activated their communications plans, calling in all available specialties and staff. Additionally, some people who were not able to get to their normal workplace showed up and augmented this hospital’s capability. Realizing that the trauma centers in the Las Vegas valley were all inundated, they functioned as though they were a trauma facility, with all specialties on-site throughout the night and all of the next day. ST elevation myocardial infarction (STEMI) alerts, unrelated motor vehicle traumas and other seriously injured patients were sent to this facility, load-balancing patients on a macro-scale during the healthcare system’s response phase to the shooting incident.

As the numbers of patients, tempo at which they arrived at area hospitals and acuity levels stayed steady, it was difficult to register everyone. Electronic health record (EHR) systems and registration clerks simply couldn't keep up. Patients needed immediate surgery. Other minor injury patients needed to be treated and released or transferred to outlying facilities. Much of this occurred without any patient registration taking place.

Hospitals began to run out of supplies and medications. Clean linens, endotracheal and chest tubes, as well as rapid sequence intubation medications stores were all quickly exhausted. Hospitals needed to share these items among themselves, borrowing from unaffected facilities such as the long-term acute care hospitals and those facilities that were more distant from the venue. At the same time and unrelated to the shooting, hospitals throughout America were experiencing critical shortages of IV fluids. This situation was exacerbated in Las Vegas by the sudden unanticipated need to start more than 1,000 IVs on one night. These added stressors disrupted normal workflows and projected a feeling of frustration that was felt by providers and staff throughout the healthcare system.

Blood was everywhere, and Environmental Service (EVS) crews became the unsung heroes at many hospitals — cleaning emergency rooms, waiting rooms and operating suites as fast as possible. Making room for the next patient was a critical task. And this task was never ending that night. Cleaning gurneys, equipment, floors and everything in between was required to eliminate cross-contamination, infection and other hazards related to bloodborne pathogens. Simple items that aren't thought of as mission critical or difficult to acquire during disasters suddenly were in short supply, as they became contaminated and needed to be discarded. These items included, but weren't limited to, ball point pens, dry erase markers, note pads and triage tags. Terminal cleaning and
Sterilization of surgical equipment was also an around-the-clock operation.

The next surge that hospitals experienced, occurring only minutes after the initial patient arrivals, was that of friends and families. It is estimated that for every patient seen, four to six others also came to the facilities. Waiting rooms designed for approximately 20 people were now crowded with literally hundreds of concerned family members. These people were starved for information. They wanted to know the status of their friends, when they could be seen, how long they were going to be in the hospital, what the long-term prognosis was — and they wanted that information immediately. Hospitals, on the other hand, couldn't initially provide any information. Many of these patients arrived without identification or were unconscious. It became difficult or impossible to confirm to families and friends if they were taking care of their loved ones.

Families and friends remained at hospitals. They used the restrooms, needed food and water, and they were constantly on their cell phones until the power was drained. This created additional logistical concerns in the early-morning hours: hospital cafeterias were generally closed at this hour, restrooms needed restocking, and having considerable numbers of people wandering the halls — looking for an available outlet to charge their phone — wasn't previously anticipated in most emergency operations plans. To make matters more difficult, these people were emotionally fragile. The following day county officials began coordinating with hospitals to redirect family and friends of those injured to the Family Assistance Center where they could get up-to-date information and a variety of social services. This helped to relieve these particular hospital stressors almost instantly.

Law enforcement, emergency operations centers and public health departments also were reaching out to hospitals in search of information. Phone calls, emails and in-person visits were relentless. These agencies all had valid needs to access the information requested, as family reunification, patient tracking, witness identification and casualty counts become impossible tasks without the necessary data. Some hospitals quickly shared information as it became available but, several hospitals didn't have immediate access to the information requested or felt they were prohibited from disclosing it.

Immediate access to the information was hampered for a multitude of reasons. First, many of the patients were unresponsive — either from their injuries or from anesthesia and pain medications administered during various medical procedures. Second, many patients had not been registered into the hospital system, as their injuries were so serious that the only priority was providing life-saving medical care. Third, some EHR systems don’t allow patient information to show up in queries until 24 hours post-registration. And lastly, some hospitals interpreted that federal law (Health Insurance Portability and Accountability Act, or HIPAA) prohibits the release of requested personal health information without either the patients’ informed consent or a court order.

The facilities that did provide patient information as soon as it was available interpreted HIPAA
Mortalities include: DOA, intra-operative, unsalvageable, and withdraw of care.

Mortalities were inevitable. Some patients were dead on arrival to area hospitals, and some patients were simply unsalvageable. In all, 26 individuals expired at area hospitals. Four facilities experienced between one and four deaths, while one hospital had 16 decedents, including a law-enforcement officer. Hospital mortuaries are generally small, holding one or two patients. Many of these facilities found themselves in a position requiring temporary additional mortuary surge space. In addition to this, at one point in time, a hospital was reportedly informed that they were to become the temporary mortuary for the 31 dead at the scene. This turned out to be rumor, but valuable resources and personnel time were required to straighten out this miscommunication to ensure bodies would not, in fact, start arriving.

The hospitals’ initial response phase lasted for approximately 24 hours. The patient acuity, volume of patients and workflow tempo took a noticeable toll on the hospital staff — both physically and emotionally. The wounds were described as horrific, and many reported that they felt as if they were working in a war zone. “People saw things nobody should ever have to see,” explained one charge nurse. Everyone — from the clinicians to administrators to EVS to volunteers — participated...
in the response and were likewise affected by the carnage and fear.

**RESPONSE**

The response phase included patient triage and stabilization, staff and visitor security, internal and external communications, visitor surge, ICS activation, and mortuary-care services. Within this phase of the incident, other challenges also became apparent, including issues with the electronic health record systems, HIPAA compliance and the simultaneous need to prepare for a follow-up attack or other disaster. We will discuss each of these challenges within this section, but lessons learned, and next steps will be presented in subsequent chapters.

**Triage**

Triage was imperative and constant. It was imperative because the numbers of critical patients requiring surgery, blood products or respiratory support immediately overwhelmed available resources at each of the involved hospitals. It was also a constant operation: Every minute, additional patients arrived, making it impossible to determine what the final patient counts and classifications (red, yellow, green, or black) would be in the end.

Hospitals approached both triage and most elements of the response differently, depending on the facility. Some hospitals teamed a physician with an emergency-room nurse and utilized Simple Triage And Rapid Treatment (START) Triage. This approach moved employees with a critical skill set away from the emergency department (where treatment was needed), adding to a human-resource shortage in the emergency department. Second, triage tags are designed for pre-hospital care, and therefore lack necessary elements for hospital-level treatments such as adequate space to document chest tube placement, ventilator settings and the use of blood products. Third, START Triage assumes that patients will be stratified across an acuity continuum (i.e., that not all patients will be red). However, based on the START protocol: All patients who are unconscious, or have respirations of more than 30 breaths per minute, or who have poor vascular perfusion, or who are unable to follow simple verbal commands are determined to be “red,” or critical, patients. This grouping contained a significant percentage of the patient population on this particular night — enough so that this group by itself was overwhelming to most facilities.

To overcome the issue of using emergency room staff to perform triage, one hospital decided to utilize ICU nurses to perform this function. While this concept was admirable, the ICU nurse generally doesn’t receive training regarding START Triage, and hence, misunderstandings related to how the tags worked resulted in some confusion. The confusion was related to the bottom of the triage tag, which is removable to quickly signify the color code of the patient. These untrained nurses thought the color code was based on whether the patient had been seen by a physician or was still waiting to be seen; this type of color code is frequently used in physician offices. The result was that some “red” patients were classified as “green” because they had been seen by a physician during the triage process. This confusion
did not result in any bad outcomes because it was quickly identified.

Other issues related specifically to START Triage included the predictable issues of inadequate available tags and cross-contamination. The issue of contamination was felt in many areas related to supplies and equipment. The amount of blood was unfathomable. “Everybody had an open wound, and hence everybody was bleeding,” one doctor explained. “The image that comes to mind would be that of a whaling in one of those Greenpeace ads,” said another hospital worker. This created a situation where somebody who wasn’t touching or treating patients had to act as the recorder: If you touched the patient and then reached for a triage tag, you stood the real risk of contaminating the entire stack of unused tags. Likewise, ball-point pens and other writing utensils were easily contaminated and needed to be disposed.

One facility handled triage in a novel way based on SWAT and military medicine teaching:

- All patients entered the emergency department and were seen by a trauma physician. A quick evaluation was performed. Patients needing respiratory support were intubated, patients needing blood products had an intraosseous line established (if IV access wasn’t immediately available), tourniquets were applied, and chest tubes were placed. This was essentially all treatments performed in the emergency room.

- Patients shot in the abdomen or hemorrhaging uncontrollably went immediately to surgery. These patients underwent procedures to stop the bleeding. The initial surgery had only this single mission. The patient was then moved to post-op with the wound being covered, but not closed. These patients would all return to surgery to complete all necessary procedures once operating rooms and surgeons were available to work at a more normal pace.

- Patients shot in the chest went to an ICU within the hospital where all cardio-thoracic specialties had been located. Head shots went to the trauma ICU, where all neuro resources were being staged. Isolated extremity wounds waited in chairs in a designated waiting room. These patients were evaluated by an orthopedic specialist and provided necessary wound cleaning, tetanus vaccination and splinting. Surgery, if needed, was scheduled for a later time.

This cohorting of patients, based on that patients’ sustained injuries, proved to be efficient and effective. One hospital alone treated 124 gunshot wounds in less than 24 hours.

**Safety and Security**

Safety and security was of paramount importance to all hospitals during the incident. Hospitals were being told that additional gunmen were seen on their campuses, and the rumors of multiple attacks made hospitals feel as though they could be the next soft target. The primary goal to combat this was to “harden” the facility.

Target hardening was achieved through a combination of methods — all of which were used to some extent at every hospital in the valley. These methods all included, to various degrees, an increased police presence at the hospitals,
contracted armed security reinforcements and access control.

Metro was quick to respond to several hospitals, providing security along the perimeter, directing traffic and screening vehicles. The quantity of officers that were available to each hospital, however, was limited by the factors related to the initial incident. Private security contracts were quickly activated. These contracts provided hospitals with additional security officers (both armed and unarmed).

Hospitals adopted a “Hot Zone” approach to security. This approach was easy to communicate to staff, as it was based on the principles of hazardous materials — a discipline that is taught routinely throughout the area. The outside grounds of the hospital were considered “hot,” meaning security could not be guaranteed. This area was patrolled by Metro, and in some cases, cleared by tactical teams. Emergency rooms, waiting rooms and other common areas in the hospitals (bathrooms, cafeterias, etc.) were considered “yellow.” This meant that these areas were relatively safe and secure, but employees must remain on guard and aware of what’s occurring in their immediate surroundings. Private armed security officers were frequently used to provide security and achieved a visual deterrent in these areas. The “green” zone was determined to be surgery as well as patient rooms on the various floors. Nobody (non-employees) could move from the “yellow” area of the hospital to a “green” area without a bona fide need. Many “green” areas also had a security presence, although several hospitals reported that unarmed security was provided in these areas as much to help provide information and customer service functions to visitors as for the purpose of “security.” The need to keep the press off patient floors was anticipated, although this type of intrusion wasn’t reported by any of the facilities.

Facility lock-down also helped harden the hospitals. Many facilities reported they established specific entrances for patients, a separate access point for visitors and yet a third for staff. For hospitals that reported establishing these access control points, the reviews were all positive. Patients accessed immediate triage and care, visitors were directed to people who could attempt to answer questions, provide reassurance and support, and employees could rapidly make it into the facility and to their areas of responsibility without getting caught in the crowds.

“Hospitals were being told that additional gunmen were seen on their campuses, and the rumors of multiple attacks made hospitals feel as though they could be the next target”
Communications

Communications proved to be a challenge at every level during this event. Communications challenges can be subdivided into groupings of phone trees, internal communications, external communications, technology issues, equipment shortages, personnel shortages and lexicon issues.

Phone trees proved to be effective in many instances. Many of the hospitals did not have any type of computer-generated call-trees, but instead required employees to make physical calls to other employees. Surgeons, nurses and medical practice groups worked diligently to call in the help they needed; additionally, many staff members self-dispatched and returned to work. This created a situation whereby at first, there wasn’t enough staff to handle all the injuries, and then almost as fast, hospitals found themselves with 1:1 staffing. Everyone wanted to help.

However, not every aspect of the phone-tree was without issues. Hospitals reported some phone lists weren’t current (numbers changed, people dropped their landline phones and only had cellular now, ex-employees remained on the list) or perhaps more importantly, the phone lists were missing key positions. Some key positions not included on the phone tree were EVS, pharmacy, central supply, radiology technicians and registration clerks, among others. It appears that many of the phone trees were clinically focused, and support staff were absent.

Internal communications, or the ability to effectively communicate with staff members throughout the facility, were hampered during the crisis. Reasons for this impediment ranged widely from employees being too busy in their respective tasks to read any form of distributed messages, to staff being too busy with emergency operations and response activities to develop meaningful or actionable insights. The pace, tempo and volume of all activities was by itself the largest impediment to effective internal communications.

But staff were hungry for information. They wanted to know if they were safe, if there was more than one shooter, why would somebody do this, and what the current situation was throughout the city and country. In the heat of the incident, nobody had all of these answers; but, in the absence of factual information, many turned to social media for updates. Social media was full of rumor and conjecture, which now found its way into the hospitals and in some instances, traveled like wildfire. This, reportedly, was most predominate in the very early hours of the response.

The internal communications piece that seemed to have the largest impact was communicating with individual nurses and other staff and telling them that they weren’t needed at the current time. Hospitals needed to keep some personnel available to cover the next shifts, and many staff members simply showed up to help without being called. “Emotional trauma” is how best to describe the feeling that many people described during interviews related to this communication. Staff had feelings of inadequacy or that they weren’t on the “A team.” Many reported feelings of being slighted or even angry when told to go home.
External communications were often described as the most difficult part of the response. Physicians repeatedly talked of how they were well prepared to repair trauma and deal with the medical cases as presented but dealing with families was something else altogether. The numbers of broken families and the emotionally drained friends all looking for answers took significant time to deal with appropriately. Among the descriptions: “I felt like I needed to be an emotional superhero for these people,” and, “It was difficult not to break down yourself and cry with each story being sadder or more heart-wrenching than the next.”

Chief Executive Officers or other high-level administrative staff often found themselves in the position of having to update family members. It was explained that managing expectations was very important when conducting family briefings. These expectations were managed by establishing set schedules for updates and explaining both what would be discussed and what wouldn’t be discussed at the update briefings. All information that was provided was aggregate and presented in as reassuring and positive a manner as was possible. Questions related to specific patients or situations were never answered in the group setting; instead, these needed to be addressed one on one.

Because there were so many unidentified patients, hospital staff and families spent considerable time at these briefings, trying to identify people and reunify them with their loved ones. Photos of tattoos, piercings and other body art were all used during the briefings to try to identify patients being treated. Once a patient was positively identified, the family and friends could be reunified, and, in many cases, could be bedside with their loved one shortly.

Information requests from law enforcement organizations (LEO), public health and emergency management agencies and the press were also challenging external communications situations. LEOs had multiple information needs, including identifying victims, witnesses and following up on missing persons’ reports. These requests for information weren’t organized through any single point of contact, and hospitals became frustrated with multiple requests from people within the same organizations. Public health and various emergency operations centers also needed information and were constantly calling the hospitals. Patient counts, patient names and level of injury severity were routinely requested to facilitate family reunification and the provision of various benefits or public assistance programs.

Technology issues also reportedly impacted some hospitals and their ability to effectively communicate. Hospitals in recent years have switched to Voice over Internet Protocol (VoIP) phone service from the legacy landline. This new technology basically uses the hospital internet connectivity for telephone services amongst all other uses. On normal days, this technology is problem-free. However, because of the volume of calls, emails, and the amount of medical data being transmitted each minute (radiology, EHR files, lab work, etc.), hospital systems had occasional difficulty.

Phone calls were coming into hospitals at an unimaginable pace. Hospitals reported that they
experienced dropped calls, temporary losses of service and an inability to get an outside line during the height of the incident. Many hospitals expressed that they wished they had dedicated, outgoing-only phone lines and isolated unpublished inbound phone lines for staff use.

Cell phones weren’t a complete solution either. Cell towers were saturated at times (although this was surprisingly limited). The biggest issue was poor coverage inside the hospital buildings. Staff were required to be in elevators, basements, radiology suites with lead walls and other areas within these large buildings where signal strength ranged from limited to non-existent. Some ingenious hospital staff members realized that while cellular connectivity was sketchy in these areas of the facility, the Wi-Fi signals were strong. These staff members quickly downloaded commercial-off-the-shelf (COTS) radio apps and installed these on their smartphones. Using these apps, staff members could create talk groups and stay in constant contact with the command center and other employees wherever they were located and despite intermittent loss of outside internet.

**Equipment shortages and personnel shortages** also contributed to communications issues. A shortage of radios and charging stations for both radios and cell phones was commonly experienced in the healthcare system. The lack of cell phone chargers was experienced by hospital staff and visitors alike. Several hospitals reported that they sent employees out to local retailers to purchase all the phone chargers they could find. However, people have different phones and take different chargers. Apple phones have multiple chargers themselves based on the version of phone that is being used, and similarly, Samsung also has multiple charger configurations within their brand. Thus, buying chargers did not prove to be a simple solution. Once the physical charger was made available, adequate electrical outlets to power the charging stations became the next issue. Communications equipment became a micro supply-chain puzzle all by itself.

Related to communications, personnel were also in short supply. There was no way to adequately staff phones. The incoming phone calls were immeasurable. “It does not matter if a facility has 100 incoming phone lines if there are only four people who can answer them,” one staff member stated. Staff members trained and qualified to register patients as they presented to the emergency
department were also in short supply. This human resource situation added to the difficult patient registration process, along with many other EHR-specific concerns that will be explored separately.

**Lexicons** — or a common set of terminologies used throughout the entire response continuum — would be useful in these high stress, high consequence situations. Hospitals throughout the Clark County area can provide status reports to each other and outside response agencies via an internet-based bulletin board system. The system currently in use isn’t described by most as “user friendly.” It has significant access controls in place and relies on a grouping of drop-down menus to explain what’s being experienced or the status of the hospital. As a further complication, the system is more than 10 years old and doesn’t lend itself to customization.

Acronyms and codes created additional confusion within hospitals that night. Outside agencies called hospitals requesting private and protected health information. Often it was stated “I’m with the MSAC,” “I’m with the JTTF” or “I’m with Fusion Center,” etc. Clearly, most hospital personnel weren’t familiar with these terms. In retrospect, several hospitals felt it would have been better if callers simply explained who the parent organization is that they were working for (I’m with public health, I’m with the FBI, I’m with Metro homicide, etc.).

**Surge Plans**

Surge plans or processes immediately went into effect at the most highly impacted hospitals. At one facility, Hospitalists were called in and tasked with evaluating all current inpatients and to identify those who could be discharged home, downgraded from the ICU to a hospital ward or transferred to another unaffected facility. All ICU rooms were changed from single to double occupancy. This increased the physical capacity of this facility significantly.

Hospitals reported that most existing patients, when they learned of the incident, wanted to help. Patients wanted to make room for those who were injured. They were more than cooperative to change into a double room or decide to go home (with outpatient follow-up care) or move to another unaffected hospital, more distant from their homes. This was just one example of many where the community members pulled together to make the recovery efforts go more smoothly.

Hospitals quickly learned that the imperative functions during this incident were throughput and not a surge percentage. For years, hospitals had been told and had based their plans on achieving a surge capacity of 20 percent above their licensed bed capacity. But in this event, surge capacity wasn’t as important as patient throughput. Critical patients were suffering from injuries requiring surgical interventions. Hence, the surge capability wasn’t measured in available rooms, but instead based on “turn times” and in “minutes to surgery.”

Having available patient rooms was not important if patients couldn’t get the hemorrhaging stopped within minutes. So instead of the previously determined matrices, hospitals needed to increase patient flow. This paradigm shift meant that surgeries needed to be performed in steps, equipment needed to be cleaned and immediately placed back into service and patient registration
processes needed to be streamlined. Every process or procedure needed to be reviewed based on necessity, function and the amount of time the process took. The minutes saved essentially equated to lives saved in surgery.

Surgical teams worked together in ways never tested. Pediatric trauma surgeons assisted in adult procedures and supervised residents. Anesthesiologists worked as transport team members when not in surgery. Specialty surgeons, who weren’t immediately needed in the initial response phase, worked as scrub nurses and assisted in whatever ways they could.

One trauma center reportedly sent an entire medical team to another facility to perform critical neurosurgeries when the patient was deemed too unstable for transport. This team was able to function as credentialed and privileged hospital members in part because of the long-standing Master Mutual Aid Agreement and an executive order that the Nevada Hospital Association crafted with the Governor’s office.

All elective surgeries in the area were canceled. This included not only hospitals, but also outpatient surgery centers. This was another area where the community pulled together. While obviously inconvenient, most patients realized that surgical supplies, blood, pharmaceuticals as well as the surgical talent (anesthesiologist, surgeons, surgical techs, nurses, sterilization personnel, etc.) all needed to be focused on the recovery efforts of the community. This decision was made voluntarily and early on during the response efforts. There was never a need to invoke any crisis standards of care or governmental edicts to get to this decision.

**Equipment and supplies** initially were in short supply. The fact that the incident occurred on a Sunday night — the day of the week and time in which hospitals in general have the lowest acceptable supply levels — contributed to these shortages, as did the sheer numbers of patients. “We ran out of everything,” stated one hospital emergency department director.

Linens were the first necessity that were noticeably in short supply. As patients were moved throughout the hospital to create surge capability and while hundreds of bleeding people simultaneously entered the facility, the need for clean sheets, pillow cases, blankets, etc. was apparent. Beds were changed 4-5 times per hour as the flow of patients continued.

Chest tubes, IVs, intraosseous needles and endotracheal tube supplies were also quickly depleted at those hospitals closest to the incident. One hospital reported that they needed to deploy and use more than 100 crash carts in the first hour of the response. Employees who were called into work were told to stop by other outlying hospitals and bring in additional supplies. Long-term, acute care hospitals (LTACs) were quick to offer critical supplies to the general hospitals. At one LTAC located across the street from one of the hardest hit general hospitals, employees literally ran across the street with boxes of supplies to meet the immediate needs of the emergency department. This sharing of supplies is not uncommon in Nevada. The Nevada Hospital Association has
“It simply wasn’t even imaginable – the warmth and outpouring of community members doing anything they could to help.”
developed a Master Mutual Aid Agreement (sharing agreement), which has been in place since 2006 just for these types of events.

Rapid sequence intubation medications as well as ventilators were close to being exhausted. Respiratory therapists at one facility worked on developing contingency plans that included having two patients, with similar ventilator settings and lung capacity, share one machine. This contingency, while developed and ready to be employed, luckily wasn’t needed.

Normal processes that included keeping supplies and medications in inventory-controlled lockers (e.g. PIXIS) or access-controlled machines needed to be modified. These lockers could not be restocked fast enough, and it was unrealistic to believe that staff could enter patient information for each medication or supply required. All supplies were set on carts or trays for immediate and easy access. Pharmacists and respiratory therapists worked together to build “kits” of needed supplies grouped together by procedure type. Examples of these kits included: chest tube insertion, rapid sequence intubation and vascular access and blood product administration kits.

Shortages were also created by access-control problems. Extra triage tags were described as “locked in someone’s office”. A further common issue shared by many staff members “We couldn’t access the supplies stored in the warehouse immediately because the warehouse is only staffed on weekdays.”

Ironically, while many politicians and newscasters reported on a significant blood shortage, this was never the case. Hospitals and local blood banks during the event did not indicate that blood or blood products were in immediate short supply. Robust systems are in place to ensure that blood products are always available and can be moved to whichever hospital needs these items.

*Family and friends* comprised the second surge that hospitals faced on Oct. 1, 2017, but unlike the patients, this surge came in many forms; they were physically at the facility, placing phone calls to the hospital and constantly monitoring and posting comments on social media. An average of four to six family members went to a hospital for every injured patient — and not necessarily the correct hospital. Additionally, these people would telephone hospitals multiple times a night looking for updates and information. Busy signals, confusion, lack of information and frustration all were reported and posted in real time to various social media websites. The situation created an environment where hospitals had to provide quality patient care at a rapid pace, provide outstanding customer service, and become a de facto community liaison office and deliver family assistance until the family assistance center could be opened. These people needed help finding their loved ones, guidance and emotional support. In some cases, they also needed assistance — assistance getting a hotel room, assistance with transportation, assistance with food provisions and assistance financially.

*Mortuary Care Surge*

Mortuary Care Surge is not something that is practiced at most hospitals. Prior to this event the Clark County Office of the Coroner and
Medical Examiner (CCOCME) and Southern Nevada Health District had spent considerable time working with area hospitals to help them develop plans and procedures to handle mass fatality events. Planning reportedly took place as far back as 2009. However, through attrition and facility remodels several hospitals either had plans that were no longer actionable or staff that was unfamiliar with these plans altogether. This created a situation at several facilities where mortuary surge was managed without the advantage of forethought or preparation.

One hospital experienced as many as 16 decedents from the incident, while other facilities managed a lessor number Some of these facilities already had corpses in their limited mortuary from other causes, and most of the affected hospitals only have room for two bodies at any time. Hospitals solved the storage problem in many ways. Some hospitals dedicated a patient room away from the emergency department to use as a temporary mortuary. One hospital converted the endoscopy suite to serve this function, knowing that the area could be secured, is on an isolated HVAC system and had resources that could be reasonably anticipated to be needed by the coroner should any field examination be required. It was imperative to quickly relocate these people away from the sight and general area of other patients. This effort was felt to help with patients’ emotional states and the morale of hospital staff.

Decedents from a crime or terrorism scene are possible sources of evidence. Therefore, hospitals were instructed by law enforcement to secure the bodies, not allow any viewings, and not allow loved ones to remove personal items or heirlooms such as jewelry, cell phones, etc. A chain of custody needed to be maintained. Additionally, many of the people killed were not immediately identified, so antemortem identifications needed to be performed by CCOCME.

**Mental Health and Wellness**

Mental health and wellness of hospital workers was an immediate concern during the incident. Staff was understandably shaken, sad and emotional. Healthcare facilities and the community as a whole did not have any actionable and exercised large-scale psychiatric first-aid plans. These emotional wellness concerns were not just for the clinicians, but every employee of every hospital. The scale of such an undertaking to many seemed overwhelming.

The VA healthcare system came to the immediate aid of these workers. Having unique expertise in dealing with people who experience emotional trauma, this group organized buses that housed private counseling rooms and trained personnel. These buses were deployed and spent weeks at area hospitals helping those in need. These counselors, who are accustomed to working with individuals returning from war zones, are not all psychologists or licensed counselors. It was pointed out, "Most of these affected people do not have any diagnosable disease or pathology; what they have is the normal human response to extreme stress, emotional pain and feelings ranging from hopelessness to exasperation. They don't need medications or treatment. They need support, a positive outlet for their feelings, and counseling
about signs and symptoms of withdraw, depression and the tendency to turn towards alcohol and the like.” For all practicality, the mobilization of this spontaneously developed task force, combined with the ingenuity of the personnel that recognized this capability, filled an enormous planning gap.

**RECOVERY**

In retrospect, it is difficult to determine when the response ended and when recovery efforts began. For many incident commanders, the four phases of emergency management (preparedness, response, recovery and mitigation) are neither linear nor a cycle as described in much of the hospital incident command trainings. Instead, the incident demanded that simultaneous, multifaceted, dynamic and complex actions be taken in each of the emergency management phases. Hospitals found themselves responding to the incident and providing patient care, while at the same time developing plans and preparing for a potential second or third wave (possibly from additional attacks) of patients and sustaining the heightened tempo for an unknown number of operational periods. Additionally, activities revolving around the electronic health record system, HIPAA legalities and other issues all required attention during what would have been the response and recovery phases.

The Hospital Incident Command System (HICS) was employed by most hospitals throughout the response and recovery phases to various degrees. This command system is designed to help hospitals organize resources to deal with a large-scale incident by arranging all administrative functions into four core disciplines under the commander.
These four functions include operations, logistics, planning and administration/finance.

Many hospitals described significant chaos and a lack of situational awareness during the initial hours of the incident. This created a situation whereby the hospitals focused more on calling in personnel instead of quickly establishing a formal command structure. Hospitals reported that in hindsight, they wished the HICS system was established earlier and maintained longer into the recovery phase. Areas where HICS organization could have been better managed were almost universally described as patient registration, staff assignments, donations management, the public information officer and time unit leader roles. All of these functions ultimately played a significant role in the recovery of the hospitals.

For the purpose of this case study, we will say that the recovery efforts began approximately 12 hours after the incident began. All patients had been seen by the emergency departments, undergone initial life-saving surgical procedures and were admitted to the hospital or treated and discharged. Many hospitals found that response and recovery phases had significant overlap.

Registering patients was one of the key elements of the hospital recovery process. Many patients had been seen, treated and admitted using a trauma alias or “John/Jane Doe” identifier. Once the patient’s name was discovered, entering that information as well as any treatment information was necessary to facilitate other recovery operations. These included victim assistance, family reunification and revenue cycle management, to name but a few.

This process was extensive. Due to the volume, tempo, anonymity and acuity of the patients, many people did not get registered during the response. Registration clerks and clinicians found the electronic health record system to be cumbersome and time consuming during the crisis. Clinicians, including surgeons, treated patients with urgency to stop bleeding and save lives. Documentation of procedures was minimal, and, in most cases, written on paper or triage tags instead of entered into an electronic system. These handwritten notes, which were often incomplete, would later need to be manually entered for each patient.

The Public Information Officer (PIO) role in HICS is defined as “the position responsible for coordinating information shared inside and outside the hospital. They serve as the conduit for information to internal personnel and external stakeholders, including other agencies.” However, most hospitals used this position primarily for responding to media inquiries. This limited application equated to multiple nurses, administrators and other staff being asked for information almost constantly by outside agencies. It has been identified by multiple emergency managers that greater hospital participation within the Medical Surge Area Command (MSAC) would have significantly limited the number of requests.

Time unit leaders are responsible for ensuring that hospitals have the correct numbers of staff, staffing the correct units and functions, and tracking the time each employee works. This job at many
hospitals was not implemented. Staff members were called in or showed up to work without a call and reported directly to their normal unit or floor. In the recovery phase, this created an inability to immediately determine the staff members who responded, staff hours and cost of responding to the incident. Additionally, if there was another disaster that occurred within the hospital, staff accountability and evacuation tracking would have been virtually impossible.

Donations management was ongoing for several days and weeks following the shooting. Hospitals received items ranging from food and clothing to large sums of cash. According to one physician, “Do you know how many FTEs it takes to manage 1,500 pizzas? It takes four.” Other hospitals reported that they didn’t have a plan to deal with the large numbers of people who showed up to donate items and cash. “It simply wasn’t even imaginable — the warmth and outpouring of community members doing anything they could to help.”

Donated food at one facility was placed in waiting rooms for families. Cafeteria workers were needed to maintain safe food-handling processes, monitor temperatures and maintain order. Public health personnel were also present to ensure adherence to good processes. Other hospitals had donated items like food moved to the family assistance center.

During the earliest portion of the recovery phase, hospitals found themselves needing to organize dignitary visits. These visits ranged from political representatives such as the Governor and President of the United States to celebrities. These visits were welcomed, but they disrupted normal
operations. Dignitaries want to tour the facilities and meet the families and injured. Heightened security and the extensive security processes are not just enacted for the limited time when the VIP is on site. Secret service advance teams visit and planning meetings take place prior to any high-level visitor reaching the hospital.

As a result of the initial response, elective surgeries were canceled for several days. Rescheduling all canceled surgeries became another logistical process during the recovery phase. One administrator compared rescheduling surgeries to the act of re-accommodating passengers on canceled flights, "The surgery suites are generally full, and yet now you need to accommodate another 2-3 days' worth of surgeries into the schedule."

Cleaning the entire hospital was required. It wasn't just the emergency departments and patient rooms; it was literally everything. During the event, those using the hospital facilities, waiting rooms, cafeterias, meeting spaces and offices included a surge of patients, hundreds of family members, law enforcement officials and double the typical staff.

Significant numbers of patient transfers also occurred during the recovery phase. Many of the injured were from out of state and wanted to return home for the rehabilitation phases of their care. This created another planning and logistical component that hospitals needed to complete. While none of the recovery tasks were by themselves overwhelming, the collection of unrelated tasks, needing to be completed almost simultaneously, was a service stressor. Those hospitals that maintained the HICS system throughout the recovery phase reported a seemingly more organized ability to systematically complete all tasks.

The scope and nature of this event impacted all hospitals and hospital systems within the region. Multi-Agency Coordinating Groups (MAC) were formed or activated to assist however they could.

These groups included the Medical Surge Area Command (MSAC), corporate offices of hospital systems, the Veterans Administration and the Nevada Hospital Association.

The MSAC is a standing committee of the Southern Nevada Healthcare Preparedness Coalition. The primary function of the MSAC was originally to manage medical supply requests and distribution during large-scale medical surge events. This
function is tested multiple times a year, and the MSAC is routinely activated as part of the county’s emergency operations center (EOC) during large events such as New Year’s Eve. On this night, the MSAC was also activated.

The MSAC is staffed during emergencies by sending a message to coalition members and asking them to respond to the EOC for an activation. During this event, the normal activation process was not utilized, but instead individual calls were made to members by the health district. This proved just as effective, as the MSAC was quickly staffed and operational. Members of the MSAC began working with other response agencies and unified command centers to piece together some situational awareness of the event. This information would be the first official information regarding the event provided to hospitals; it began to be disseminated more than an hour after the arrival of the first patients.

The MSAC’s primary mission wasn’t required during the shooting response. Hospitals and hospital systems were able to share among themselves using internal transfers and the Master Mutual Aid Agreement to quickly mitigate shortages. The MSAC, however, did step up to take on a critical new role: assisting with family reunification and patient tracking tasks. This would prove to be a frustrating assignment. Not only was this previously undefined (no policies, procedures or job action sheets), but also, several hospitals wouldn’t provide necessary information to this group.

Health systems activated their internal (national level) emergency plans and controls. Many of these systems had recent experiences with large-scale disasters, including wildfires in Nevada and California as well as hurricanes, flooding and evacuations in Texas. Because of these recent experiences, these health systems were quick to activate, and their staff were well trained. Health systems focused on ensuring they could provide additional personnel into their facilities if needed. This part of their corporate business continuity plan would ensure that if current Las Vegas-based personnel were exhausted, or if staff augmentation was required, entire teams could be deployed from other locations within their systems.

The VA system activated their mental health resources to assist hospital personnel. This activation included organizing hospital visits, transportation and use of the buses as well as other significant logistical issues. Compartmentalizing this mission into an internal MAC afforded an effective and efficient deployment, without the need to add any additional workload to the various hospitals or EOCs.

The Nevada Hospital Association (NHA) is not generally thought of as a response or recovery agency. As an industry association, the core mission of the NHA is to advocate for members. However, the association does maintain a community resilience program — which includes elements of hospital preparedness — and the association receives a sub-grant through the Nevada Division of Public and Behavioral Health to administer one of the state’s four coalitions in the rural areas.

On October 1, the NHA received many calls for assistance from various agencies, organizations
and members. Calls ranged from the MSAC advising NHA of the situation, ASPR officials trying to gather ground truth, politicians making inquiries, hospitals implementing the master mutual aid agreement and hospital corporations seeking information regarding total patient counts and aggregate injury types. It was obvious that there was a need for a central entity to collect, plan and disseminate information for hospital response and recovery purposes. The NHA was uniquely qualified and prepared to become this coordination body.

Concerns and issues included hospital corporations wanting to ensure they could deploy reinforcements in the form of complete surgical teams into the region, if necessary; area facilities and public health entities wanting to make sure hospitals weren’t experiencing any insurmountable shortages of equipment or supplies and to ensure high patient care standards could be maintained; and, politicians, emergency managers and resilience planners wanting to have plans in place to deal with either a simultaneous disaster or secondary attack.

The NHA worked on all of these issues with other partners. The community resilience office was the initial point of contact for all incoming calls, but the entire NHA office was dedicated to this cause. Issues were quickly prioritized into roughly the following categories: (a) direct requests for member assistance; (b) resilience and system sustainability concerns; (c) rumor control; (d) other information requests.

An example of a direct member request would be locating 50 ml bags of IV fluids for one hospital that was in extremely short supply after its considerable influx of surgical patients. An example of resilience and sustainability efforts included the NHA working with the Governor’s legal counsel to draft an executive order declaring a state of emergency and waiving licensing requirements. Once the executive order was signed by the Governor, the NHA worked directly with the boards of nursing, medicine and pharmacy to develop implementation policies.

Additionally, rumor control was time consuming but necessary. Rumors of blood shortages, additional shooters at hospitals, multiple attacks in different cities throughout Nevada, etc., all needed to be clarified, and accurate information disseminated. Other requests included questions from the press,

“Rumors of blood shortages, additional shooters at hospitals, multiple attacks in different cities throughout Nevada, all needed to be clarified.”
attempts to locate foreign nationals from various consulates and embassies, and offers from doctors, nurses and people of every walk of life wanting to donate their services and help. This activity was non-stop for approximately 48 hours post event, and then calmed down – but continued for another few days.

The Nevada Division of Emergency Management and the State Health Officer were in constant contact with the Nevada Hospital Association (NHA), as they were seeking hospital status updates and wanting to know if the NHA had brought in any providers from out of state. The healthcare system was in a vulnerable position. Doctors, nurses and the staffs of most Las Vegas hospitals had been working tirelessly around the clock. There was concern for these individuals, many wondering how long they could keep up the intense, punishing pace. There was concern for the citizens as well, with many wondering, “What if there was another disaster?” The resilience of the hospitals was stress-tested like never before. In the end, the hospital system was deemed more capable and robust than previously imagined. The teamwork and professionalism of the entire healthcare community, along with the breadth and resourcefulness of the various hospital corporations, demonstrated that Nevada can handle these sudden-impact catastrophes.

As recovery efforts continued, the NHA was called by the National Center for Victims of Crime to help administrators of the Las Vegas Victims' Fund (LVVF). This fund raised $31.4 million dollars from more than 90,000 individual donations. The administrators had developed a protocol that would distribute 100 percent of these funds to families and survivors of the shooting, but they needed a method to verify claims. The protocol required a physical injury for eligibility to receive funds, and disbursements were to be prioritized and apportioned based on the extent of the injury. Persons who suffered death, permanent brain damage and/or paralysis, and those requiring continuous home medical assistance, would receive the highest level of payment. Individuals requiring hospitalization would be paid the next highest amount, with a third category for those patients who had a physical injury but were either treated and released or handled on an outpatient basis.

Because the protocol was to distribute funds based on injury severity, hospitals would be required to confirm that each claimant was actually a patient within a specified date range; that they sustained injuries as a result of the shooting; and that they were either hospitalized or not hospitalized. If the claimant stated they suffered permanent brain damage or paralysis, then the hospital would need to verify this claim as well.

The NHA coordinated these efforts. For the protocol to work, all hospitals and their clinics, outpatient centers and urgent cares would need to fully participate. Additionally, all facilities would need to agree to use a single HIPAA compliant release and disclosure form. Multiple meetings were arranged with chief financial officers, hospital coding experts and legal teams. Hospitals were given about 45 days to complete the review for each claimant, and they would complete the review on a rolling basis, as claims were filed. Once again, the hospital sector came together to help the
community; 532 claims were paid by the fund, and approximately 700 medical charts were reviewed by the receiving hospitals.

The recovery and mitigation efforts are expected to continue for the next several years. Hospitals and their staffs are still dealing with the emotional trauma that resulted from the events of that night. Many policies and procedures are being refined based on lessons learned. New laws, regulations and the restructuring of state commissions are being proposed. First responders, emergency managers and community resiliency personnel are evaluating the best ways to utilize available resources during large-scale medical events or disasters, and new partnerships with community organizations and businesses are being developed.

**OBSERVATIONS, INSIGHTS AND LESSONS**

Many observations, insights and lessons-to-be-learned (OILs) resulted from this tragic event. In this section, many of these OILs are articulated and discussed. Understanding that there is no way to document and communicate all the OILs from the situation, an effort has been made to focus on knowledge points that could be easily learned and applied to other healthcare entities. Observations serve as the building blocks of future discussions and policy development. Insights provide an objective review of existing laws, regulations, policies and practices that were employed during the disaster response and
recovery. Lessons-to-be-learned are insights that have specific actions attached to them.

**Observations**

**Throughput.** All of the physicians and hospitals reported that it was the throughput of the patients within the hospital system that saved lives. Immediate bed availability or surge capacity was not a critical factor in this incident. The majority of patients with life-threatening injuries needed surgery. Therefore, it was the hospitals' ability to move the patient quickly through triage and the emergency department to surgery that was the main determinant of appropriate care. Steps should be taken to memorialize these processes and standard operating protocols created. It was observed that in disasters (mass shootings, earthquakes, fires) that create large numbers of traumatic injuries, throughput should be the focus of hospital preparedness, over all other forms of surge capacity.

**Non-traditional transportation methods (ride-sharing services, private auto, police vehicles and buses).** The hospitals received the overwhelming majority of patients related to this incident via non-traditional methods. While this is not an uncommon occurrence during sudden impact events, such as the Sarin gas attacks (Tokyo, 1995), this was a first for the Clark County healthcare system. Patients arrived without benefit of field triage, advanced casualty care, or pre-planned hospital destinations. Additionally, several hospitals received no advanced notice of the MCI.

It was observed that this no-notice, sudden impact event created a significant service disruption caused by, among other things, the use of non-traditional transportation. Hospitals should have an ability to issue system-wide alerts of their own initiative to other area hospitals. Additionally, policies and standard operating protocols should be incorporated into hospital disaster plans that detail who is responsible to extricate patients from non-traditional transportation, how alerts to other hospitals and first responders should be activated, and protocols defining both the method as well as who is responsible to organize mass casualty triage.

**Relationships.** Many individuals credited their personal and professional relationships with other hospitals, public health entities and first responders as one reason the event was managed so effectively — despite the lack of warning or immediate notice. The Southern Nevada Healthcare Preparedness Coalition (SNHPC) is a large planning group that, each month, brings together key emergency managers and preparedness personnel from the entire healthcare and emergency response continuum. It was observed by many that this coalition, while not having any direct response capability, helped the overall coordination through prior discussions, planning sessions and facilitated exercises and education. Additionally, because of the monthly meetings, agencies and responders know each other on a personal level, and they also understood the capabilities and available resources throughout the entire system.

**Patient Registration.** The function of registering patients during a mass casualty event can become overly burdensome. This burden was felt in multiple systems and across multiple agency types. Starting with ambulances, registering patients
and completing patient care records was limited. Hospitals also found themselves overwhelmed based on a number of elements including (a) sheer numbers of critical patients arriving at near simultaneous times; (b) a limited number of trained registration clerks staffing the emergency departments based on time of day and day of the week; (c) trauma patients arriving at non-trauma centers that didn’t have a trauma alias system in place; and (d) the normal process, by itself, is time-consuming. Additionally, hospitals needed to register these patients multiple times, in multiple systems, including the electronic health record system and the trauma registry system.

The registration process created downstream complications as well. Normally, HIPAA waivers and disclosures are completed during the registration process. Likewise, the registration process begins the medical chart that will follow the patient through their entire treatment process. This chart is then used for everything from legal documentation, mandatory reporting to the state health division or law enforcement, and revenue cycle management.

It was observed that these processes are rarely tested during drills and exercises. Hospitals should consider creating a “streamlined” or accelerated registration process that can be instituted during MCIs. One hospital’s observation is that they could cross-train other administrative personnel to perform the patient registration process, including human resource personnel and similar job classifications. This could then create a reserve force.

Finance issues were observed during the incident that included needing emergency services and contracts. Additional security, barriers, porta-potties, bottled water, telephone chargers, and the like were all purchased to help manage the incident. Several hospitals reported that these additional unplanned services and purchases exceeded $600,000 each.

It was observed and appreciated that the hospitals and healthcare organizations in Nevada represent a robust industry with a national reach and significant resources. These hospitals have the resources to back-fill personnel, move material and supplies, load-balance patients and specialty items such as blood as well as maintain a high-

“The function of registering patients during a mass casualty event can become overly burdensome.”
quality level of care. Hospitals should be viewed as a dynamic system — particularly those operated by large, publicly-traded corporations — instead of as single resources. With this new reality fully recognized, planners and legislators should work together to ensure personnel and patients alike can be easily moved or deployed across political boundaries.

**Hospital Environmental Services (EVS)** was observed to be one of the most critical support services within many hospitals. The copious amounts of blood that were involved in this traumatic incident required effective and efficient cleaning and decontamination of everything. Cross-contamination was a serious concern of physicians. EVS — not a department that generally speaking had surge plans — was forced to recall additional personnel. All hospitals reported that these workers were an integral part of the patient-care team, and many clinicians stated that they have a renewed appreciation for the tasks and work that this department completes. It was further observed that EVS was required to “triage” their workloads and tasks to best manage patient throughput. According to one EVS manager, “It isn’t enough to clean. We needed to disinfect the right equipment, rooms and areas of the hospitals so that the next patient didn’t have to wait.

**The 96-Hour Graph,** which most hospitals maintain to help determine operational sustainability during a disaster, was of limited use during this event. It was observed that these charts and graphs are created based on normal patient flows (admissions and discharges) and do not take into account the sudden need to change bed-linens throughout the hospital 4-6 times within hours, nor does it take into account that most admissions will require chest-tubes, etc. Hence, hospitals discovered that what they had believed to be a 96-hour supply of linens was in fact exhausted in less than 2-4 hours. It can be reasonably anticipated that in many sudden impact disasters, specific supply caches will be exhausted much faster than normal.

**Many commercial-off-the-shelf (COTS)** applications were observed to be beneficial to both rescuers and patients alike. Apps that let people use their smart phones as a walkie-talkie over Wi-Fi, as well as family locating apps, proved to be effective at a time when the numbers of available radios and cell signals seemed to be tapped out. Planners should evaluate which apps work across platforms (Apple and Android) and provide training to personnel on how these may be used during a disaster. Additionally, emergency managers should start encouraging families to install location detection apps on their smart phones as part of a personal accountability, individualized emergency reunification plan.

**Plan Familiarity** was an observed deficiency. Many individuals weren’t knowledgeable of existing plans and processes. This was observed throughout the responder continuum. Individual organizations, communities and coalitions should evaluate the implementation process of new and revised plans. Development of a formalized knowledge transfer protocol, that ensures personnel have access to institutional knowledge as well as new and revised policies, should be explored. After action reports and similar documents that don’t result in educational plans or teachable lessons are insufficient.
Human factors and ingenuity were observed from everyone involved. Many concert goers put themselves at great personal risk to save people they’d never met. People liberated vehicles and began operating an impromptu shuttle service to the hospitals. A respiratory therapist began researching methods to use a single ventilator to oxygenate multiple patients. In the hospital, patients self-discharged to make room for the critically injured. Security officers created different zones with varied levels of safety assurances. Doctors and nurses developed novel ways to triage hundreds of patients simultaneously. As planners and emergency managers, we need to develop a system to capture and memorialize all these invented solutions and test them to determine the most effective processes going forward.

Post-Traumatic Stress Disorder (PTSD) developing in rescuers, hospital staff and support personnel remains a concern. Many of these people helped victims who were experiencing devastating injuries or provided care to the family and loved ones of persons who were killed. Additionally, many rescuers directly knew someone who was injured or killed. This created an environment of heighten emotions in everyone affected. These emotions ranged from sadness to fear, with feelings of being overwhelmed and simultaneously having an overarching desire to do anything that could help. Mental health workers, life coaches, celebrities, therapy dogs and even Disney characters were all used to help relieve stress and help lighten the mood in the days following the event. By all accounts, all of these devices helped at the time. Human resource departments and organizational development professionals should continue to observe the individuals who worked during this event. It would be beneficial to the sector to understand if these traumatic occurrences manifest as PTSD in the individual at some future point or affect other areas of employee performance, such as employee retention or, conversely, employees who leave the field early. Once we understand the effects, hopefully we can develop countermeasures or training to protect our mental health following such tragedy. In the meantime, planning for the development and implementation of peer support teams should be considered.

System Saturation Plans: It was observed during this event that there remains a large window of opportunity to develop system saturation plans. These plans would fill the gap between what could be described as a normal functioning healthcare system and crisis standards of care. On October 1, the EMS system, trauma system and both fire and LEO were all operating above any anticipated maximum capacity. Any subsequent large-scale emergency could have tipped the scales and changed the outcomes for many patients. Through the ingenuity of many individuals, non-designated hospitals staffed and organized to provide trauma services, ride-sharing companies and drivers began providing emergency transportation, hotel security staff augmented LEO at many resorts, hospitals moved supplies and resources from non-affected facilities to the ones most in need, and hospital corporations were ready to move entire planes full of healthcare professionals into the region to augment medical personnel as needed. It was further observed that many of these resources
and ad hoc contingencies belonged to the private sector, not any governmental entity or unit. It is believed that the system would benefit if high-level future plans were developed, through state hospital associations or other non-governmental organizations, that memorialized the solutions developed during this crisis and simultaneously worked with the legislatures to remove bureaucratic barriers that limit the efficiencies of these plans. The hospital and healthcare sector should look to other sectors of the economy — such as electrical utilities or the transportation sector — and model their established processes to ensure continuity of services during major disruptions.

Release of Patient Information should be standardized throughout the community. This observation was recognized by multiple organizations at the local and state levels. Hospitals released a varied amount of information regarding the types or injuries being treated, patient names and the number of people being treated. Facilities interpreted HIPAA regulations differently, some personnel weren’t aware of the statutory mandate to report gunshot wound information to law enforcement and participation at the MSAC was limited. Standardization and agreements to share information bi-directionally would minimize response frustrations and may facilitate faster family reunification processes.

Insights

Triage. Several insights have been noted regarding triage and triage methods. The first insight was that while many hospitals did triage differently, all variations seemed to work equally effective (if the measurement of “effective” is the lack of otherwise salvageable people perishing from their wounds.) The key determinant or goal of triage in this case was to get the patients with uncontrolled hemorrhage into surgery first. This goal is obviously unique to trauma and perhaps easier to determine than when trying to triage pandemic patients who may need ventilation. Different triage methods may not be as effective as others in non-trauma situations.

The next insight was that triage doesn’t need to be overly complex. Based on the conclusion that each method used was equally effective — whether it was a trauma surgeon’s professional opinion after looking at a person or an algorithm that classified each patient — triage should be simplified as much as possible to minimize throughput times.
Regarding whom should be trained to perform triage, it was discovered that perhaps nurses, other than ED nurses, should be trained to perform this task at hospitals. ED nurses were needed to treat casualties, as were the physician staff at most facilities. Other nursing personnel in many cases were available, but untrained in emergency triage processes. During these mega-mass casualty incidents, it may be beneficial to have more people trained to perform initial triage from different disciplines.

**Security.** Injured people — along with their families and friends — all congregated at area hospitals en masse. People at facilities, meanwhile, reported seeing individuals with guns or reported hearing gunfire on or near their campuses during the event. And hospital staff were recalled and asked to report back to the hospital to work. This situation created many security vulnerabilities.

Insights that several hospitals have shared regarding security include:

- Taking proactive steps to harden their facilities before the next event.
- Dedicating employee entrances separate from patient or visitor entrances.
- Limiting the numbers of unlocked entry points during night-time hours.

To date, there have not been talks of installing metal detectors or having all visitors go through a security screening process, as has been discussed or employed by hospitals in other states. Based on the numbers of visitors and the recall of employees, this type of security screening may not have been efficient during this event.

It is outside the scope of this analysis to specify security methods employed by our hospitals during this event or on a daily basis. However, many security professionals with whom we talked did praise the “zone defense” strategy employed at one major hospital. This approach focused a police presence in the parking lots, driveways and entrances to the hospital. Inside the facility, contracted (armed) security officers were used to maintain order in the waiting rooms, registration areas and to perform access control functions. On the floors or otherwise secure areas such as surgery, non-armed hospital security was utilized to enforce access control and provide information and direction to approved visitors.

**Surge Capacity** insights were among the most prolific. For years, hospitals have been focusing on surge capacity measures as a percentage of beds that could be made available, above the number of licensed capacity. For example, hospitals were told to achieve a 20 percent surge capacity. The premise that these numbers would be adequate was proved wrong on several different levels during this mass shooting event.

First and foremost, the number of available beds within an individual hospital doesn’t equate to an ability to provide adequate patient care. In this instance, patients required surgery. The only treatment that would minimize death and suffering was surgery and administration of blood products to the most critical patients. Hence, surge capacity in the traditional sense meant nothing, and throughput was the more meaningful measure.
“Hospitals should understand that the number of patients they will receive will be proportional to the distance they are, in relation to other hospitals, from the incident.”
Second, the idea of 20 percent surge capacity is generally coupled with an assumption that EMS will be completing triage, medical transportation and load balancing the distribution of patients among all area hospitals. In this instance, patients self-transported to the closest hospitals. Many hospitals experienced an influx of patients equal to 30-50 percent of their regularly staffed bed capacity. In the new paradigm, hospitals should have plans and exercise simulations based on receiving the majority of patients via private auto. Hospitals should understand that the number of patients they will receive will be proportional to the distance they are, in relation to other hospitals, from the incident location.

**Master Mutual Aid Agreement (MMAA)** worked throughout the incident. Hospitals shared equipment, supplies and personnel. The major insight to the MMAA was that any system developed for the provision of emergency resources needs to be free of bureaucracy. This goes back to the patient throughput concept. Hospitals in crisis do not have the time or personnel to make multiple phone calls, fill-out requisition forms and wait for an EOC to fill an order.

During this incident, nursing supervisors were able to call other facilities directly and request needed items. They then sent a runner, often a nurse who had been recalled and was on their way into work, to stop by the other hospital to pick up the requested items. This worked effectively and efficiently. The order for requesting items, moving patients or augmenting personnel seemed to be in all cases internal stores first, then facilities within the same corporate structure, and then hospitals from competing organizations. We are unaware of any requests that went unmet during this event.

We have learned of one case where a non-trauma center requested a specialized neurosurgical-trauma team to assist in the surgery of an individual deemed too unstable to transfer. This request was also met, using the MMAA. Adding some further insight, it is evident that in some instances it may be safer, more efficient and prudent to mobilize surgical teams to the patients vs. the traditional model of immediate patient transport. More study needs to be completed regarding this assessment, but on the surface, cases where either an individual is too unstable for transport (i.e., bullet lodged in the spinal column), or where there is a significant quantity of critical trauma or burn patients at a non-trauma or non-burn center, specialized team mobilization may be a better option if it can be accomplished judiciously.

**Use of Clear Text.** The need for healthcare facilities to switch from various overhead paging “codes” to clearly stating what the issue is (clear text) was highlighted during this event. Hospitals found themselves full of multidisciplinary responders, including Metro, fire, EMS, FBI, contracted security personnel and others as well as a plethora of visitors and guests. Additionally, the healthcare workforce was augmented by professionals who generally work at different facilities, including competing hospitals, out-patient surgery centers, private practice offices, etc. If there was a secondary emergency within the facility — such as a fire, active shooter or an attempt to kidnap a newborn — announcing a “code” (i.e., Code Red in radiology) would mean nothing to a significant
portion of those occupying the facility. This event also provided insight that having standardized codes for all facilities within a geographic region is not the solution. For standardized codes to be effective, the assumption must be made that the majority of occupants work within the local hospital system. This case pointed out that many practitioners, non-healthcare personnel and if needed outside resources from other states, assist during these tragedies; thus, regional codes would also be less than effective.

**Hospital Incident Command System (HICS)** worked effectively once initiated, but trainings and exercises need to be conducted that focus on the transition from normal operations into HICS operations and the transition from one operational period to the next. Multiple hospitals stated that HICS should have been initiated immediately but wasn’t. Perhaps some of the hesitancy to institute the incident command system was based on the lack of situational awareness, as those inside overwhelmingly did not know the scope and scale of this incident. Additionally, based on the time and day of this incident, hospitals were at minimal staffing levels, and there is a natural tendency to focus all available resources toward treating patients vs. managing the incident. Once HICS was established, hospitals praised the system and stated that it remained in place for approximately a week as the facilities moved from response and treatment, ultimately migrating into recovery, reunification and managing dignitary and VIP visits.

Several other insights that were gained included a common statement from hospital staff that HICS is “slow to get going” as the command team organizes and determines what steps to take first; and the “time unit leader” position specifically wasn’t utilized to its full potential. To help with the issue that command is slow to get going, the Nevada Healthcare Preparedness Partners will be working to promulgate the “PENMAN” pneumonic. This pneumonic was originally created to teach paramedic students scene safety but has been modified by the NHA to help hospital command staff gain immediate situational awareness during crisis or disasters.

In the pneumonic, the “P” stands for Personal Safety and Personnel Safety. First and foremost, commanders are responsible for the safety of themselves and their staff, patients and visitors. On Oct. 1, the commanders realized that they had an immediate need to lock-down areas of the hospital, establish a perimeter, deal with the incoming traffic and respond to reports of other persons with guns on campus.

The “E” stands for Environment. This prompt for command is to quickly evaluate the state of the hospital’s current environment, which could include such things as damage assessments, environmental hazards, system status checks (radios, internet availability, critical infrastructure, etc.). In this event, the environment would also include the mood and demeanor of the crowd and staff. Both crowds resulting from this incident — those comprised of visitors and patients, the other comprised of staff members — reflected spirits of somber disbelief, sadness, fear and an urgency to help treat the injured patients. However, it could have just as easily been one of rage, hostility and vigilante tendencies with just a few minor changes
to the situation (example: if the shooter had been injured and transported to one of the area hospitals). Unanticipated changes to the hospital’s environment of care would be a service disrupter that command staff must immediately identify; this is why it’s the second most important priority.

“N” signifies the number of victims. This would include both external and internal victims. It is not important at this stage to have an exact number of patients, but instead a simple quantification such as 10-25, 26-50, 50-100 or more than 100. It is also useful at this early stage to gain an awareness of the tempo in which patients are arriving.

“M” is used to remind commanders to gain an understanding of the mechanism of injury and the types of injuries that are arriving to the facility. Likewise, in a pandemic or novel contagious disease, it is at this point in the initial phase that command should attempt to quantify the illness by both type and symptom.

The “A” serves to remind commanders to identify additional resources needed. Using the Oct. 1, 2017 scenario and the “PENMAN” pneumonic, commanders would easily have determined the need for additional law enforcement and security (P), need for additional radios, communications apps to be installed on smart phones, cell phone chargers (E), the need for additional staffing, supplies and equipment (N), and the awareness that this was going to be a surgical intensive event (meaning specialized personnel, equipment, services, blood products, etc. would all be in high demand) (M).

The last letter, “N” reminds commanders to evaluate the need to evacuate early in the HICS process. None of the facilities had a need to evacuate during this event.

Using the PENMAN pneumonic, hospitals can quickly start functioning within the HICS system. Commanders gain a quick and valuable assessment of the current conditions. The operations section chief has an understanding on the type of incident, tempo and number of patients. Immediate planning needs are identified. Logistical concerns and the need to activate contracts, mutual aid agreements or purchase additional goods or services can be quickly assessed; additionally, the administration/finance section can begin tracking costs, and if additional personnel are needed, fill the role of time unit leader immediately.

Time Unit Leaders were not used to their fullest capability during the incident. This functional position, located under the administration/finance section of HICS, has the primary mission of ensuring that the correct amount and type of personnel are requested based on the minimum staffing levels for each operational period, as determined by workload. The Time Unit Leader is the position that should be able to call in personnel based on needs (i.e., EVS, surgical staff, etc.) and should be able to track which personnel have reported to work and where within the hospital these individuals have been assigned. Renewing the

1 "PENMAN" pneumonic originally attributed to Crafton Hills College, Paramedic School in Yucaipa, California. 1987
**PERSONAL SAFETY / PERSONNEL SAFETY**

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
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<tbody>
<tr>
<td>Are we in a safe area?</td>
<td></td>
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<td>Are our staff and visitors safe?</td>
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**ENVIRONMENT**

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<tr>
<th>Question</th>
<th>Answer</th>
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<tr>
<td>What is the state of our current environment?</td>
<td>Damage assessment (interior/exterior)</td>
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<td></td>
<td>Environmental hazards (spills, fires, asbestos, live wires, oxygen-enriched environment, etc.)</td>
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<tr>
<td></td>
<td>System status checks (email, pager, cell, phone, internet, radio, TV/Cable, etc.)</td>
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**NUMBER OF VICTIMS**

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<th>Question</th>
<th>Answer</th>
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<tbody>
<tr>
<td>Internal and external</td>
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**MECHANISM OF INJURY**

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<th>Question</th>
<th>Answer</th>
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<tr>
<td>What caused the incident (earthquake, bomb, infectious disease, MCI, HazMat, etc.)?</td>
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**ADDITIONAL RESOURCES NEEDED IMMEDIATELY**

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<tr>
<th>Question</th>
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<td>Fire department, bomb squad, law enforcement, additional personnel or providers, etc.</td>
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**NEED FOR EVACUATION**

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<th>Question</th>
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<td>Loss of power, water or sewer</td>
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<tr>
<td>Structural integrity issues</td>
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interest in this position could serve hospitals better during disasters on several fronts.

- First, hospitals would meet requirements within the CMS Emergency Preparedness Conditions of Participation related to personnel accountability and tracking.
- Second, by recalling only the personnel needed, hospitals could ensure that they have available human resources for subsequent operational periods or should a secondary event take place.

**Lessons-to-be-learned**

The following lessons-to-be-learned are insights and observations that have specific action items for the NHA. Many actions have already been started within Nevada and are being advocated through the Nevada Healthcare Preparedness Partners and NHA Community Resilience programs. These items are not viewed as more important than any of the other OILs; however, these items could be described as more systemic or macro in nature, and therefore can't be achieved by any single facility or responder agency alone.

Electronic Health Records (EHRs) were problematic during the response, recovery and mitigation phases of this disaster. Additionally, without EHR vendors, hospitals and providers making changes, these difficulties can reasonably be anticipated to be repeated during subsequent disasters and MCI's.

In the response phase, the patient registration module proved very time- and labor-intensive, and many non-trauma centers didn't have an ability to automatically create trauma aliases (in the quantities required). This created significant difficulties down-stream with patient treatment. Due to a significant number of patients being non-registered prior to surgery, or in some cases treated and released, the EHRs were incomplete. Without the registration process taking place, items such as HIPAA waivers and informed consent weren't completed. Surgeons didn't have an EHR to record their patient interventions; lab and radiology didn't have an EHR to which to attach test results; and entering information on hundreds of patients retrospectively was inadequate to capture the entire treatment continuum. Conversely, for those patients who did have an EHR started, surgeons reported frustration about the number of mandatory fields that were required to be completed and an inability to modify these fields based on the situation.

Some EHRs were found to be unable to run reports until the patient was admitted for 24 hours; still other EHR systems did not have any data collection field that would connect the patient to a specific incident. This proved inadequate at several points during the response and recovery. Law enforcement officials needed complete lists of those persons involved in the incident as part of the crime investigation. Operations centers needed the names and patient counts being seen at area facilities to help with reunification, identification of foreign citizens (to advise consulates, etc.) and to facilitate planning section activities.

During the mitigation phase, hospitals found it difficult to identify all patients who were treated related to this event. This created a situation whereby Metro's Force Investigative Team was tasked with attempting to locate and
interview approximately 869 patients without the benefit of addresses, phone numbers or known location where the patients were staying (hotel). Additionally, based on Nevada Revised Statute, hospitals are required to report all gunshot wound (GSW) victims to law enforcement officials. On this night, 413 GSW victims were seen at area hospitals. Having a standardized batch report that could be initiated during mass-shooting events would have saved considerable time for both LEO and hospitals.

Hospital revenue cycles and invoicing for professional services were limited in many cases. The lack of complete EHRs and documentation of all services, treatment modalities and medications administered to individual patients made it impossible for many physicians to invoice insurance companies. As mitigation continued, hospitals were asked to verify each person's injury and classify by severity or type. This function was requested of the Las Vegas Fund administrators and also proved difficult and time consuming based on the earlier issues with patient registration and EHR processes.

The specific actions to be taken in regard to the electronic health records include:

1. The NHA conducted meetings and focus groups with first responder, emergency management and hospital organizations to determine what specific information is required of healthcare entities in the early stages of a mass casualty or terrorist event. The essential data points, based on input from law enforcement, public health, and emergency management, are:
a. Patient name
b. Contact information
c. Current location (hospital name or discharged)
d. Injury type (GSW, blast, blunt force trauma, etc.)
e. Acuity level (critical, serious, stable, minor, deceased)
f. Total number of patients seen as a result of the incident

2. The NHA conducted meetings with GoFundMe administrators and Las Vegas Victims Fund administrators to determine what information needs can reasonably be anticipated from hospitals following a disaster, school shooting or other MCI when a fund me page or fund of some type is established to benefit victims. The data points that are needed to validate benefit claims or eligibility were determined to be:
   a. Patient name
   b. Treating hospital name
   c. Dates of service
   d. Length of stay
   e. Statement, injury code or other evidence that the patient sustained a physical injury as a result of the incident
   f. If applicable, statement from treating physician or other evidence within the medical record that patient sustained permanent brain injury and/or permanent paralysis requiring continuous home medical assistance or long-term care

3. The NHA will be soliciting input from and conducting a virtual meeting with hospitals and prominent EHR companies to determine the best method of creating a simplified registration process as well as the creation of an “MCI toggle” that would either eliminate the mandatory fields function or create an express/lite version of the EHR. Developing canned reports that would collect the information required during the response phase, mandatory GSW reports and fund administration also will be explored.

4. Additional tasks and action steps can be anticipated following the meetings with EHR providers.

5. Once solutions are developed, the Nevada Healthcare Preparedness Partners will incorporate a patient registration surge component into our annual statewide exercise program. Mass patient registration processes had never been exercised to the extent seen as a result of this mass shooting.

*The Health Insurance Portability and Accountability Act (HIPAA)* created significant frustration for LEOs, emergency managers and hospitals alike. This federal regulation applies to all hospitals and healthcare providers who accept Medicaid and Medicare. Currently in Clark County, these regulations apply to all but one licensed hospital, and they also applied to all of the hospitals involved in resuscitations on Oct. 1, 2017. The frustrations centered on the bona fide needs of LEO and emergency management for patients' private healthcare information (PHI) and
the inability of hospitals to provide this without violating HIPAA.

The fact pattern of this incident, specific to HIPAA, was that hospitals were truly overwhelmed. There were not enough registration clerks to manually register everyone as fast as critical patients were arriving, and the EHR system could not keep up with the tempo. Because of this, normal registration processes were not adhered to, including informing patients of their rights under HIPAA, gaining verbal consent from patients to release information and the process of getting a signed HIPAA waiver. Additionally, the ability of all hospitals to create a list of patients being treated wasn’t possible in the first 12-24 hours of the incident.

Hospitals were unable to determine what type of information would be considered the minimum required, as required by HIPAA, when information requests were for all patients that had been seen. Every patient doesn’t require reunification, and victims who are not GSWs aren’t required to be reported to police. Additionally, some of the groups that were requesting information were pseudo-entities — calls from an emergency command center, for example. Some hospitals believed that for purposes of compliance and documentation, requests needed to be made in writing from a specific organization such as Metro or the FBI.

Exceptions to HIPAA are delineated in the regulation. These exceptions include 1135 waivers, court orders, subpoenas, administrative requests, activation of the national security act and to protect against an imminent threat to public health and safety. Under these exemptions the release of PHI is permissible, but not a requirement of the hospitals. None of these exceptions were applicable.

To compound the issue for hospitals further, the CMS Emergency Preparedness Conditions of Participation state explicitly, “HIPAA requirements are not suspended during a national or public health emergency.” Based on these concerns, some hospital privacy compliance personnel didn’t feel comfortable releasing PHI information. Retrospectively, the Nevada State Survey Agency agreed with the hospitals that providing this information may conflict with the current privacy laws.

In conclusion, hospitals wanted to provide the information as they received it and ultimately provided much of the information to the Southern Nevada Health District, which stepped up to assist with the disaster relief operations. The information was incomplete based on issues during the patient registration process and was slow to be transmitted. It would be more than 30 days before an accurate list of patient names could be generated.

The specific actions to be taken regarding HIPAA include:

1. The first action taken by the NHA Community Resilience Program was to conduct interviews with representatives from involved community partners to understand the issues and concerns related to HIPAA. This was an emotionally charged issue for many of the personalities involved, as everybody wanted to help the victims and also do what was right under the
2. Second, the NHA conducted multiple conference calls and asked many clarifying questions via email of our federal partners. CMS, ASPR and the FBI all participated and provided subject matter expertise. In some instances, confusion or inconsistencies existed even within the various branches of government. This event’s scope and scale made it unlike any circumstance envisioned. The number of patients far exceeded a typical MCI, when normal registration processes and HIPAA aren’t generally at issue. Yet, it didn’t raise to the level of a federally declared disaster either. It exposed a hole within HIPAA; all of the elements required during a large-scale disaster were present (nexus to terrorism, mass casualties, mass fatalities, need for family reunification, Presidential interest and requests for informational updates, international media, large population of injured from distant locations, the largest reunification operation of personal effects since 9/11, etc.), but for purposes of HIPAA it remained a status quo situation.

3. The NHA organized and hosted a symposium of HIPAA experts and Oct. 1 command staff to consider the issues exposed and develop solutions. This one-day symposium was held in Las Vegas, and HIPAA compliance experts attended from throughout the nation. CMS’ Office of Civil Rights attended with legal counsel and enforcement representatives. CMS Region IX sent personnel, and many other federal divisions including CMS’ Quality, Safety & Oversight Group and the HHS Assistant Secretary for Preparedness and Response (ASPR) had representatives attend via web conferencing. Local public health, fire, county legal counsels and hospital privacy officers, risk managers and lawyers also were in attendance.

The MCI was dissected, and all HIPAA concerns were identified during the first part of the symposium. During the second part of the symposium, possible solutions were identified.

CMS was forthright and explained that they were aware of the issues brought to light, but

“When does the right to individual privacy need to yield to a greater public good?”

The issue can best be summarized in the question, “When does the right to individual privacy need to yield to a greater public good?”
that there is no political appetite to change the current regulatory language. Additionally, the current interpretive guidance is believed to be complete. It was also explained that individuals can’t bring suit or legal actions directly against a hospital or provider for a suspected violation of HIPAA regulations. Unlike other areas of federal law such as the Americans with Disabilities Act (ADA), an individual’s sole remedy for a HIPAA violation is to report it and file a complaint with CMS’ Office of Civil Rights (OCR). Once a complaint is received, OCR investigates and determines if a violation occurred and what the extenuating circumstances were. Most cases are reportedly solved without fines, penalties or prosecution. OCR speculated that in this specific scenario, no findings would have been made against hospitals or any other covered entity.

Regarding releasing minimally required information, it was the consensus of the group that hospitals do not have the knowledge, skills or abilities to evaluate what would be the minimal information requirements for such things as a terrorism investigation, homicide or missing persons investigation, reunification process or epidemiological investigations. It was determined and agreed to by CMS’ OCR that if a verifiable request came in from a known governmental or disaster relief entity and the other requirements of HIPAA were met (patient authorization or one of the exemptions), then the information being requested should be viewed as the minimal required PHI. The PHI would then become permissible, but not required, to be released. The ultimate determination regarding the release of PHI still remains with the hospital unless there is a legal requirement for the release.

Blanket request for all patients being treated or seen remained problematic. HIPAA protects individual rights, not the rights of a class. Based on this, individual requests are one of the foundations of the regulations. Everyone understands that in this instance, and many more that are imaginable, individual requests would be disruptive to all organizations involved. Subject matter experts debated and worked to find the solution to this specific issue. One interim solution offered was to establish a business association between the hospitals and other emergency management organizations and then to use a standing letter to describe the minimum data elements that would be required during an MCI. This may work depending on how the relationship is established and the wording of the letter. However, it was pointed out that anyone who has a business relationship and receives PHI would then themselves be considered a covered entity subject to HIPAA regulations. This reality makes this solution more palatable for relationships between hospitals and public health entities and less desirable between hospitals and LEO (who are otherwise not covered entities). The final proposed solution was to develop a new Nevada Revised Statute (NRS). HIPAA allows covered entities to report PHI to law enforcement when required by law. The exact language was not determined; however, the recommended intent is to create an NRS requiring healthcare facilities to provide a minimum amount of PHI for each
person involved in a major MCI, when a local state of emergency or disaster is declared and when requested by a governmental entity. These facilities would then be required to report the information, for example, to the State Disaster Identification Team. Additionally, it was recommended that any individual or entity providing this information to the proper authority in good faith shall have immunity from any civil action related to the disclosure or consequential damages.

The issues of 1135 waivers and their ability to help with HIPAA regulations in these situations or even larger disasters was also discussed by the group. CMS explained that 1135 waivers “are not the panacea that they have been made out to be,” as they only provide an exemption for up to 72 hours and the exemption is extremely limited in scope. 1135 waivers do not exempt hospitals from all aspects of HIPAA regulations, and in this scenario, would not have been of any benefit. Additionally, both the President and the Secretary of Health and Human Services must declare an emergency or disaster and a public health emergency. Further, it was pointed out that 1135 waivers are not part of the HIPAA regulations; instead, they are contained in the Project BioShield Act of 2004 and were initially intended to assist in cases of pandemic or bioterrorism.

4. The NHA and its members will work with the Nevada Department of Emergency Management (DEM) to draft proposed and acceptable language for any bill draft request related to mandating release of PHI during MCIs. The NHA Community Resilience Program has already been having preliminary talks with DEM on this issue, and DEM has made a formal recommendation to the Governor’s Office and Homeland Security Commission through the Statewide Resilience Strategy, released July 1, 2018.

5. If a new NRS is developed, the application of this law will be incorporated into the NHPP’s annual statewide exercise and subsequently tested. Suggested changes to the application, administration or use of the new law will then be forwarded to DEM for the purpose of incorporating these lessons learned into the applicable administrative codes.

6. Currently under Nevada Revised Statutes, both GSW patients and burn patients are required to be reported to authorities by hospitals. Because this is delineated in law, no HIPAA violations can be assessed when hospitals provide PHI for these patients. On Oct. 1, 2017, this provision theoretically applied to 413 GSW patients, leaving 456 individuals who sustained injuries other than GSWs (at the event) for which hospitals were not covered by this particular HIPAA exemption. The law was never envisioned to be applied to an event such as the Harvest Festival. Instead, it was anticipated to help LEO become aware of suspects or other instances of gun violence that would have otherwise gone unreported. The unanticipated consequence of such a specific law was that hospitals were placed in a situation whereby only a portion of the victim count was reportable. If a new NRS is not introduced to cover MCI reporting, it may be beneficial to
modify the existing NRS language to include all patients who were involved in a shooting, burn or fire-related incident. This would have allowed for the reporting of all patients and would have significantly streamlined both requests for information and information gathering processes. Similarly, by including all patients related to a fire, LEO, fire marshals and arson investigators would have accurate patient counts following burn, fire and blast incidents that resulted in injuries — not necessarily just burns.

7. The NHA Community Resiliency Program will work with the Attorney General's Office and law enforcement agencies to develop a standardized information request form that can be quickly filled out and submitted to hospitals. This form will indicate the minimally necessary information and the applicable provision of NRS under which the request is being made or mandated. The form should be a check-box style one-pager that should be standardized across the state. The NHPP will then provide information and education to all hospitals and emergency departments regarding the law and the use of the form with the goal of clarifying the request process and the information that hospitals are compelled to provide in certain circumstances.

 Licensing and credentialing medical personnel from outside Nevada was a potential challenge. There was an immediate concern that Nevada was experiencing a complex coordinated attack. There was no situational awareness regarding the total number of patients, possible other imminent attacks or the possibility of another simultaneous disaster. The hospitals, physicians and support staff were all working at levels over the normal capacity of the system. The need to preplan and anticipate the requirement of medical reinforcements and to develop force multipliers was obvious.

Nevada has a plan to issue emergency licenses to medical providers. Unfortunately, the process is antiquated, time intensive and done on a case-by-case basis. During this situation, the current process seemed inadequate to meet the potential needs. The desired system would have a standardized process that would cover all provider types including those with licenses (physicians, nurses, pharmacists, etc.) and those with certifications (radiology techs, surgical techs, EMTs, etc.). Additionally, the desired system would prioritize the needs of hospitals.

The NHA began working with our hospital systems to identify potential needs as well as the ability of our hospital corporations to backfill personnel and other resources. We quickly discovered that our healthcare system is more robust, resourceful, reflective, and flexible than we had imagined. Many of our impacted hospitals are part of Fortune 100 corporations or large non-profit organizations. One system has more than 160 hospitals throughout the nation, while others operate between 30 and 70 additional facilities. These corporations reported having the ability to move complete trauma or other specialized surgical teams into their facilities. Many of these corporations have teams that all work together on a daily basis — teams that are trained in the corporate policies and procedures (HR, emergency preparedness, HAI,
special event reporting, etc.) as well as specific and proprietary systems such as the EHR, and medication ordering. Additionally, all personnel that would be temporarily reassigned have already been through the background, credentialing and privileging processes, employee orientations and are employees or providers in the specific hospital’s system. It was also found that these organizations have the scale and cash on hand to leverage service contracts, supplies, and even charter large aircraft to facilitate logistics between states.

To facilitate moving these personnel if needed, the NHA began working with the Governor’s office to develop a solution. Our hospitals had the capabilities, the resources and the personnel to backfill or augment their facilities, but we needed a method to quickly allow these people to practice in Nevada. We looked to how other states had handled similar situations and quickly determined we would craft an executive order, signed by the Governor, waiving licensing and certification requirements for all medical providers. There was some debate regarding if the Governor has the authority to waive these requirements. This added some time to the process. We modeled the executive order from a similar order signed by the Governor of Texas during the recent hurricanes and subsequent flooding; this added additional credence to the Governor’s authority. Ultimately, the order was crafted, walked through the approval processes and signed within 10 hours.

Following the issuance of this executive order, the NHA Community Resiliency Program began working directly with each of the licensing
boards, DEM and the State Division of Public and Behavioral Health to agree on a single process. The collaboration and level of teamwork was unprecedented. It was decided that if hospitals brought any personnel in from out-of-state, they would provide a list that included the name, license numbers, state of license, license type and contact phone number (cell phone). Additionally, whenever any of these provider’s temporary assignment was over, the boards would be notified. The NHA Community Resiliency Program agreed to facilitate this process and function as the intermediary between the licensing boards and the hospitals. The process was never activated. The shooter was a lone-wolf, no subsequent attacks took place and the local facilities were able to effectively manage the surge of patients without needing reinforcements.

The specific actions to be taken regarding licensing and credentialing include:

1. The NHA Community Resiliency Program presented an overview of our mutual aid agreement and proposed the following recommendation to the Nevada Intrastate Mutual Aid Committee:

   “In the event of a public health emergency or a disaster declared by the Nevada Governor, the Governor should have explicit authority to temporarily waive licensing requirements and to grant temporary reciprocity to all medical providers, allied health professions, and others who work within a licensed hospital system that currently operates within Nevada for the declared period of the incident. Out of state practitioners could also receive temporary waivers if their specialties or services are specifically requested by a licensed hospital system that currently operates within Nevada. In order to implement this recommendation, DEM, the Nevada Hospital Association and State Division of Public and Behavioral Health should work together to develop procedures for coordinating and processing out-of-state medical professionals listed above upon their arrival to and departure from the state to support the specific incident.”

   The Nevada Intrastate Mutual Aid Committee voted to approve this recommendation on March 28, 2018.

2. In the absence of any new authorities being granted to the Governor, the executive order that was drafted and issued shall serve as the template for any new executive order related to licensing during any disaster that requires medical reinforcements from other states. The NHA Community Resiliency Program will work with the State Division of Public and Behavioral Health to add this executive order’s language into the Crisis Standards of Care plan.

   GoFundMe or the establishment of other trust funds can reasonably be anticipated during the next disaster. Hospitals and state associations should prepare in advance of this eventuality.

   The Nevada Hospital Association and the affected hospitals did not participate in any of the GoFundMe planning. We were not included in determining the distribution protocols, nor were we part of the contracted administrative services of the victims’ fund. The funds were not
distributed as an insurance payment or to assist with medical reimbursements. Distributions were non-assignable and for all practicality amounted to a gift to those injured. This would later prove an important point, as receipt of fund monies for some, theoretically, could change their status if they are on public assistance, Medicaid or other similar programs. Some hospitals reported receiving requests from patients for financial guidance on these types of issues.

Shortly following the Las Vegas Victims’ Fund’s development of a draft protocol, it became apparent that hospitals would need to play an active role in validating claims. The draft protocol called for all payments to be prioritized and apportioned among the families of the decedents and most seriously injured. Injury was further delineated as a physical injury that needed medical treatment. Hospitals would need to evaluate every claim to the fund and determine: (1) if the claimant was in fact a patient during the set time frame (2) if the injuries being treated were a result of the Harvest Festival shooting (3) the extent of the injuries (4) the length of stay and dates of service.

To facilitate this process, the fund administrators developed a web-based portal and screening process. Claimants filled-out claim paperwork and signed a HIPAA waiver. They also attached any and all records or evidence of their injuries. The claim then was initially screened by an insurance company who volunteered their services. Claim forms were inspected for completeness and accuracy. Any discrepancy was rectified through direct contact with the claimant. Next, the FBI confirmed that the patient’s name was on the manifest of concert attendees. If it was not, the claimant would again be contacted by the insurance company and asked to provide evidence of attendance such as ticket stubs, photos, Facebook posts, casino host statements, etc. At this point, people were assumed to be in attendance if any attempt at providing evidence was made. The next step was for all claims that had been pre-verified to be reviewed by the hospitals and urgent care centers that provided treatment. This verification process was completed manually at each facility. Hospitals would receive an email each day telling them if they had claims to review, and then a designated person would open the virtual claim, review and print the HIPAA form, and then enter the necessary information.

The Nevada Hospital Association’s role was to get the buy-in and support of every hospital and urgent care center that treated patients. This was imperative if the protocol was to work. We arranged conference calls with all of the respective CFOs and fund administrators. Hospitals used this forum to hear the plan and ask questions.

Elements that all hospitals needed to unanimously agree upon included administrative policies previously never discussed in Nevada. All health-care facilities needed to accept a standardized HIPAA release form, in an electronic PDF format. The language of the release needed to be sent to all hospitals and urgent care centers and be approved by their respective legal departments. Hospitals would need to agree to validate all claims of permanent paralysis or brain injury and issue a certification statement to this effect. This statement would then need to be uploaded into the
system. All facilities would need to appoint a single point of contact who would be responsible to complete the claim verification process. For many hospitals, this was the Chief Financial Officer. One system designated the Director of the Corporate Central Billing Office to complete this task on behalf of the six hospitals within their system that received patients. Still others assigned this function to the Health Informatics Management Director. Lastly, all facilities had to agree that all claims would be completely validated within 30 days of the closing of the claim period. The NHA was able to get all facilities to unanimously agree to all the required terms and conditions.

There were some difficulties within this process. One facility had difficulties with the web-based software; some attachments weren’t making it through the virus scanning software. Another facility had issues being able to upload documents. Still other facilities received what may have been fraudulent claims. Claims where a person stated they had been admitted to a facility, yet no record of the person existed. Others tried to claim permanent brain injury as a result of the concert, when what they were diagnosed with was actually a psychogenic shock (absent any physical injury). In one case, a person with an extensive mental health history claimed the event compounded their illness. These claims were denied by the administrator based on the final protocol that stated only persons with physical injuries would be gifted money from the fund.

Whenever any issue related to the hospitals’ or urgent cares’ ability to use the software, meet timelines, or any other technical difficulties occurred, the NHA served as the intermediary between the facility and the Victims’ Fund Administrator. This intermediary role at times was time-consuming. Additionally, once outside organizations learned that the NHA was performing this intermediary role, requests for information from the Las Vegas Resiliency Center and Victims of Crime programs from multiple states began, with these entities then seeking help for their unique informational needs.

The specific actions to be taken regarding GoFundMe administration and support are as follows:

1. The data points that are needed to validate benefit claims or eligibility were determined to be:
   a. Patient name
   b. Treating hospital name
c. Dates of service

d. Length of stay

e. Statement, injury code or other evidence that the patient sustained a physical injury as a result of the incident

f. If applicable, statement from treating physician or other evidence within the medical record that patient sustained permanent brain injury and/or permanent paralysis requiring continuous home medical assistance or long-term care

The NHA will be recommending that hospitals create a check-box field within the electronic health record system to delineate patients from MCI's that sustained permanent paralysis and to delineate patients who sustained permanent brain injury. It was a common complaint from hospitals that the entire patient chart needed to be reviewed to determine if these claims were legitimate; in some of these cases, the treating physician had to be contacted and asked to provide the certification because it wasn’t clear in the hospital chart.

2. The NHA will be keeping the meeting minutes and other notes from this experience. We would be happy to assist other hospital associations that find themselves needing to recreate this process following a disaster.

*Fire and EMS resources and MCI dispatch protocols* should be evaluated based on this event. Since the development of paramedic programs, it has been the operational assumption that critical patients would arrive at hospitals via ambulance transportation. This was the assumption going into this MCI. However, the fire department responded en masse to the area of the shooting, only to be pinned back by gunfire. Likewise, ambulances from throughout the county were staged at a nearby fire station, committed to the incident and ready to transport patients. But many of the patients found their own transportation to area healthcare facilities.

The situation created was one where fire personnel and resources were sitting idle outside the area of immediate danger. Ambulances were staged and unavailable to perform interfacility transports or help load-balance affected hospitals. Hospitals found themselves having to extricate hundreds of patients out of incoming vehicles and performing triage in the ambulance bays outside the emergency room doors.

While it is outside the scope of this report to change any EMS policy, it is worth suggesting that a new deployment model should be explored. A model such as this may have improved throughput times and patient arrival-to-surgery times, if it were to dispatch a cadre of personnel to area hospitals to assist in the extrication, triage and even emergency procedures such as tourniquet placement, IV/IO line establishment and endotracheal intubation of patients. Additionally, using paramedic personnel to staff buses that could then move the walking-wounded to distant facilities instead of having paramedics stage at a fire station could have assisted with load-balancing, patient wait times and throughput.

The specific actions to be taken regarding fire and EMS deployment models are as follows:
“The shooter was perched in an elevated platform – shooting down from the 32nd floor of the Mandalay Bay Resort, located across the street from the concert and more than 350 yards away.”
1. The NHA Community Resiliency Program suggests large urban fire, EMS providers and the hospital community explore ways that fire and EMS resources could be best utilized.

2. If a deployment change is contemplated, the NHA will work with all parties and CMS officials to ensure any plan is compliant with the Emergency Medical Treatment and Active Labor (EMTALA) Act.

3. The Nevada Healthcare Preparedness Partners will incorporate any new procedural change into the statewide annual exercise so that personnel can become familiar with how any change in operations would work.

**Personal responsibility and accountability** can significantly alter the outcome of any tragic event. Whether it is having a personal evacuation plan, knowing first aid or CPR, or using modern technology to locate family members or the closest hospital, taking a direct personal role in the situation should be encouraged.

During this event, people used all available methods to quickly secure medical attention. Patients liberated vehicles, stole police cars, called Uber and ridesharing services or otherwise self-transported. Smartphones were instrumental in getting out-of-town visitors to the closest hospitals via mapping applications. These personal choices are all credited with decreasing the time from injury to surgery and saving many lives.

CPR and tourniquet application were also commonly used by laypersons. These techniques had limited effects (CPR isn’t effective on patients in hemorrhagic shock, and most of the tourniquets were applied incorrectly); however, these actions demonstrate that people are willing and able to initiate resuscitative measures under extreme circumstances.

Smartphones and various apps were utilized by many to help mitigate various issues. Aside from the obvious use of mapping apps, some people utilized family tracking apps to identify which hospital or other location their loved ones had fled to. Uber was used to summon transportation, and radio apps were used to keep groups of friends in contact with each other.

The specific actions to be taken in regard to personal responsibility and accountability are as follows:

1. The NHA Community Resilience Program will work with partner hospitals and others to develop multimedia educational materials related to tourniquet fabrication techniques (using readily available clothing and materials) as well as tourniquet application. All of the tourniquets applied during this event were non-commercial, make-shift devices that generally weren’t applied tight enough to stop arterial blood flow. It would be the desire of the Community Resilience Program to develop open-source, free educational materials that could be downloaded, adapted and taught in any school district or by any healthcare coalition to laypersons or life trustees.

2. The NHA Community Resilience Program will work to develop an individualized safety plan template that families and individuals could
use to create emergency plans. This template will focus on: (1) crowd safety and evacuation processes; (2) how to react to an active shooter or other sudden impact event; (3) establishment of predetermined reunification or meet-up locations if at an event and forced to evacuate; (4) use of various free smartphone apps to remain in contact with family and friends while attending large events; and (5) apps that track family and friends to facilitate reunification when separated. Hospitals, coalitions, fire department, public education programs and community groups will be able to download, adapt and utilize these materials to help build individual resilience within their communities.

3. The Community Resilience Program will evaluate apps that could be installed and utilized by healthcare entities, emergency operations centers and incident commanders, life trustees, and others during any major crisis. Apps will be evaluated based on cost (an emphasis will be placed on free apps), cross-platform interaction (Android and Apple OS), ease of use, band-width requirements, ability to work on both Wi-Fi or cellular networks. Additional comparisons may become evident during the evaluation process.

The type of apps that will be evaluated include:

- Walkie-talkie
- Personnel locator or tracking
- Social media monitoring and situational awareness
- Mapping that allow pins to be dropped to indicate various things, ability to look at the map based on a location typed vs geo-locating, ability to easily send map to printer, email or MMS to other responders
- First aid instructions

Master Mutual Aid Agreement (MMAA) expansion will be evaluated for feasibility. The MMAA worked exactly as intended during what was the first large-scale application of the agreement. Hospitals shared personnel, resources and supplies. They accepted patient transfers, and unaffected hospitals such as LTACs even went so far as to solicit affected acute care facilities to offer whatever help they could. The hospital community all pulled together to ensure there were no lapses in access to care, quality of care or patient safety.

Following this application of the MMAA, another major unrelated event occurred. Hospitals in Hawaii were at significant risk of running out of IV fluids. The healthcare system in Hawaii had apparently tried to get IV fluids via their regular suppliers but were unable due to the national shortage. They had reached out to state and federal emergency managers, attempting to get relief without success; and then they contacted the Hawaii Hospital and Healthcare Association, which put out a desperate plea via the AHA Emergency Readiness Group listserv.

The Nevada Hospital Association heard this plea for supply and logistical help, and the Community Resiliency Program activated the MMAA on behalf of Hawaii. The hospitals of Nevada immediately began developing a plan in coordination with the
Hawaii Hospital and Healthcare Association. One facility in Reno provided several pallets of solution via overnight air transport, immediately providing some short-term relief of the problem. Another facility referred the request to its corporate logistics and supply unit in Arizona, and soon thousands of bags were transported via air to the islands. But the help didn’t stop with shipping fluids to the island. The corporate logistic and supply unit was able to help Hawaii get an emergency contract with a pharmaceutical wholesaler in California. This was our first experience where one of our corporate hospital systems leveraged their buying power to assist an outside healthcare system. Once again, the system worked beautifully, and the industry solved the impending shortage crisis. All of the coordination, planning, logistics and contracts were provided by private sector organizations without the aid of any governmental entity or unit.

The lesson learned in the Hawaii example can’t be understated. Hospitals are no longer single resources confined by political or geographical borders. In this instance, hospitals in one state requested help and the NHA took the lead and instituted the MMAA, which resulted in fluids being supplied from both Nevada and Arizona. Additionally, an emergency contract was enacted with a supplier in yet a fourth state, California. This level of cooperation and interconnectivity among the healthcare sector was also being preplanned behind the scenes, as a contingency should a subsequent attack have occurred.

The specific actions to be taken regarding the MMAA are as follows:

1. The Nevada Hospital Association will contact the large hospital corporations and non-profit systems and determine if there is interest in entering into a MMAA at the system level. It is anticipated that an MMAA between the largest 40 hospital organizations would create a network of 1,270 acute-care hospitals that could share services, supplies and personnel in virtually every state.

2. The Nevada Hospital Association will contact the teaching hospitals throughout the nation and explore if we can facilitate an MMAA agreement between this subset of the hospital sector. It is estimated that approximately 78 percent of all burn beds, 60 percent of all pediatric ICUs, 80 percent of all Level I trauma centers and 40 percent of NICUs are found in

“Hospitals are no longer single resources confined by political or geographical borders.”
this subsector of the hospital community. This agreement would add an additional grouping of large hospitals, which could be as many as another 1,000 facilities.

3. If there is significant interest in MMAA expansion across the hospital sector, the NHA would begin discussions with leaders in other sectors to determine the best model of governance and administration. The NHA would work through the sector coordinating councils for the energy, transportation and rail sectors to identify subject matter experts, benchmarks and large-scale sample agreements that have had many activations.

4. Following the discussions with other sectors regarding their mutual aid agreements, a committee or board would be installed, an action plan would be developed and work on the program’s development would commence.

A hospital association emergency action plan and communications plan will need to be developed to preplan our response to any future disaster or major emergency. During the October incident, the entire Nevada Hospital Association was working issues on behalf of our members. We had the Community Resilience Program working on plans and operational issues. Our publications people were monitoring social media and helping to produce press releases and situational updates. Our president and CEO was in constant contact with high level political personnel and hospital executives. Everyone was busy, but we experienced overlap. Based on this experience, we believe we can organize ourselves to be more efficient during this type of event.

The plans should delineate what actions the association will undertake during a crisis, what the priorities will be, and who within the association is responsible for which actions. This will help create a more organized approach to the issues that can be anticipated and the communications that will need to occur.

The specific actions to be taken regarding emergency action plan and communications plan development are as follows:

1. Planning assumptions must be made during the plan’s development. Based on this incident, as well as others that have occurred in Nevada, we will be making the planning assumptions as follows:

   a. The event will occur after normal business hours. By making this assumption at the outset, we can plan for the worst case and develop communications routines that aren’t based on face-to-face interaction or the luxury of having administrative support.

   b. Only minimal information or situational awareness will be available for the first few hours.

   c. All news reports, EOC communications and intel received is, at best, an estimate of what’s happening and subject to change or further clarification.

   d. Hospitals will be overwhelmed and will need assistance.
e. Additional attacks, aftershocks or chaos will occur, and hospitals will need assistance developing contingency plans for these activities.

2. The plans must be made based on positions, not personalities. Certain individuals within the association have an institutional knowledge or other disaster response experiences from which they can draw to solve problems. The plan must try to capture this institutional knowledge and build job action sheets that could be used by anybody, regardless of disaster experience level.

3. The plan will be a living document, and appendixes and annexes that contain specific names, email addresses and phone numbers will require frequent updating.

4. The plan (excluding annexes) should be shared with association members so hospitals understand our capabilities and the services that can be offered during a crisis. Annexes will be transmitted to hospital command centers during the incident so that we can verify that the most current versions are being used by all facilities.

**CONCLUSION**

As this special report is written, we are still awaiting the results of the FBI’s Profiling Report. There currently is no known motive for why a person would cause so much death and destruction.

The healthcare system did learn that we have much to do regarding disaster management. This event is the closest thing to any large-scale disaster (such as an earthquake or other sudden-impact event) we have experienced in the times of modern healthcare and smart phones. More than 800 people were injured, 580+ needed emergency medical attention, and 58 people perished. Hospitals, EMS and law enforcement were stressed to levels never before seen in America.

We learned the human dynamics of experiencing such a disaster in the current time. Patients didn’t wait for help to arrive, paramedics didn’t have opportunity to provide field triage and treatments for many, and critical patients didn’t arrive evenly distributed to area facilities via ambulance. Instead, hospitals had limited notice of the event. Patients used smartphones with mapping software or ride-sharing apps to quickly get to the closest hospital. Trauma centers and community hospitals alike received major penetrating trauma; and these facilities needed to resuscitate and manage these patients in-house.

Situational awareness was absent. First responders learned about the system disruption that was caused by echo calls and the confusion with lexicons and codes. Law enforcement officers and paramedics were pinned down by gunfire, unable in many cases to get to the most critical of patients. We learned that the individuals attending the concert, while being shot at themselves, attempted to provide first aid and life-saving measures. These people who responded to the situation, before first responders could make entry, were the life trustees of the community.

Facilities experienced large numbers of patients swarming to their medical centers. Extricating the unconscious and unresponsive people from vehicles was physically laborious. Hundreds of
patients required triage, and the patient counts were constantly increasing. The goal of triage was to identify individuals requiring immediate surgery. All triage systems used proved equally effective to reach this goal.

Throughput was the most important principle. Surge capacity meant nothing if patients weren’t quickly rushed to surgery. Blood and blood products, rapid sequence intubation medications, compression bandages and endotracheal and chest tubes were the most needed items during the initial resuscitation phases.

Hospitals experienced internal problems with the patient registration process and EHR systems. Many of these problems stemmed from the sudden volume of patients, the sustained tempo in which patients were arriving and the staffing levels of registration personnel. We learned that specialized, computer-based programs that required individualized credentials and prior training (designed to provide updates and communication to various response agencies, EOCs and other hospitals) offered little value to the hospitals and took providers away from the bedside. These systems proved time intensive, redundant and restrictive. Managers, commanders and other key people would have been tied to a computer screen if these systems would have been utilized as designed.

Routine supplies ran low, including ball-point pens, triage tags and linens for the beds. Medical implements also were in short supply. Everything needed constant disinfecting, and cross-contamination was of the highest concern. EVS personnel proved to be an important part of the team and critical to the concept of throughput. We learned that extra EVS personnel need to be on the call-back list of every hospital, should a situation like this occur in the future.

Throughput was the most important principle.

The hospital incident command system (HICS) worked well for the operations management of the incident. Administrative functions were slow to be implemented and made various elements of staffing and information flow less efficient. Specifically, use of the public information officer as a single point of contact and a strong time-unit leader function would have improved administrative controls.

Mortuary surge plans must be updated and included as a component of any hospital’s
emergency plan. Additionally, job action sheets for the person(s) responsible for this operation must be developed. Hospitals also must realize that the person assigned to this function needs to be emotionally stable and one who is exhibiting good coping mechanisms based on the situation. Communication skills, empathy and leadership are all important characteristics of this position.

Mutual aid agreements between facilities that allow for the sharing of supplies, equipment, medications, personnel and the transfer of patients proved highly effective. These agreements did not require any paperwork nor other bureaucracy to activate or use. Throughput times were improved, and lives were saved because all hospitals worked together to ensure impacted facilities had everything they needed immediately.

Multi-Agency Coordination Groups (MAC), as defined in the National Incident Management System (NIMS), were imperative to managing the workload. The VA functioned as one MAC and managed the emotional support and staff support functions for area hospitals. The Nevada Hospital Association worked as another MAC and managed preplanning for possible additional attacks, provision of medical reinforcements and advocating for the needs of area hospitals. Neither of these MACs were preplanned or named during the event, but instead spontaneously developed to meet identified needs.

Lastly, we learned that communities should develop system saturation plans that address issues such as what to do when the trauma centers can’t take additional patients — and there are no available ambulances — and medical personnel, supplies and equipment are in severe short supply. These situations should not require long-term, diminished patient access to services or a degradation in the quality of medical care a community can provide.

Looking forward, this incident highlights the need for all response algorithms, plans and assumptions to be updated based on new technologies, societal norms and market forces. It will no longer be acceptable to maintain the same methodologies and mindsets emergency managers have held for generations.

Ambulance providers who don’t upgrade dispatch capabilities to match ridesharing apps currently available and used daily by the public will soon find that they are not the first choice of medical transport. People are now accustomed to being able to use a single rideshare app in every city and in most countries around the world. These apps allow the individual and driver to communicate directly with each other via both voice and text. Additionally, vehicle tracking is displayed, and the caller can choose to abandon the request if the unit is coming from too far away or alternative methods are better. Pricing is also displayed and transparent to the user. This is the new normal in transportation services and has already been embraced by several healthcare systems who have contracted with ridesharing services, over ambulances, for routine, non-emergency medical transportation.

First aid, CPR, Heimlich maneuvers, rescue breathing, tourniquet application and other easy-to-use, life-saving procedures should
be taught to everyone at an early age. These programs should be open-sourced, so that free training materials for standard procedures can be developed, and any community group can use them to educate their constituency. Phone apps that could provide additional detail and instructions similar to emergency medical dispatch instructions — and which could also simultaneously dispatch first responders — would be invaluable and are currently technologically feasible. This Just as we teach individuals how to install a car seat, we should teach people that these resources are available for free to download from the applicable app stores. Family reunification and voice contact even when cell signal is minimal would be much easier, and the need for complex, long-term operations to achieve reunification could be minimized.

The hospital sector is also going through dramatic transformations that will change all planning assumptions in the near future. Private healthcare assets, personnel and facilities currently account for approximately 18 percent of the nation’s gross national product. As the sector matures and consolidates, hospitals will strive to provide services in the most economical and efficient manner. This may equate to hospitals rightsizing the number of licensed beds they maintain in inventory, as more and more treatments and services are performed on an out-patient basis. The net effect may be lower healthcare cost, higher quality healthcare and higher patient satisfaction at the expense of surge capacity.

New coverage options and business models also are appearing within the healthcare sector. Several large employers have recently partnered to create an insurance option described as lowering cost and disrupting the status quo. Hospital groups also are experimenting with boutique facilities and hospitals that don’t take any insurance assignment. These hospitals are exempt from HIPAA, Emergency Medical Treatment & Labor Act and all CMS conditions of participation because they do not participate in the Medicare or Medicaid systems. Incorporating these facilities in any

“First aid, CPR, Heimlich maneuvers, rescue breathing, tourniquet application and other easy-to-use, life-saving procedures should be taught to everyone at an early age.”
organized community plan will be challenging if this business model flourishes.

Hospital consolidation has also afforded economies of scale in the area of emergency managers, risk managers and hospital preparedness personnel. Where there was once a dedicated person at each facility who held responsibilities for preparedness, large hospital systems are finding it a better alternative to maintain these personnel and functions at the corporate level. This consolidation allows standardized policies and procedures among all facilities in the brand as well as assured compliance with new emergency management regulatory requirements. There are pros and cons with this approach. It is definitely easier to allow personnel transfers between facilities or to bring to bear additional human resources from outside areas when disaster strikes, if everyone is trained to the same policies and procedures. Also, the new paradigm is to incorporate elements of emergency preparedness into everyone's job description, similar to how occupational safety and patient satisfaction initiatives have been done for years. This may result in more effective and efficient preparedness programs. The potential downside for community planners and public health: As more systems begin to internalize their emergency operations, less community-level flexibility exists, and coalitions' influence is diminished.

Changes in the technology, transportation and healthcare sectors is inevitable and occurring at a dizzying pace. Changes in any of these sectors often creates a dramatic shift in the type of care offered in new locations, new methods of getting either the patient to treatment or a treatment to the patient and requirements for either in-patient or out-of-hospital care. All of these sectors have proven to be interconnected. Changes in any one sector can provide a new service challenge to the others. We experienced this on a micro scale during this MCI. Patients used ridesharing services instead of ambulances. Patients traveled home to distant states, and only then sought medical care at an urgent care center. Patients who needed orthopedic surgery and would generally be a full trauma activation were able to be handled as outpatients. Patients came to area hospitals without any identification. These realities represent some of the new planning assumptions for emergency managers and hospitals.

There were many heroes that night. Their ingenuity, teamwork and hard work cannot be overstated. The human spirit was alive and well. Whenever the plan, policy or procedure failed, the people came together to solve the issue. Lives were saved, and the impacts of these horrific injuries were minimized by the individuals who came together to take life-saving action. Training, exercises and policy all help — but in the end, it's the people who make the difference.
ACTIVE SHOOTER: WHAT YOU CAN DO
FRANK HARPER, CEO, CRITICAL RESPONSE Technologies
FLAGSTAFF, ARIZONA

ARE YOU PREPARED?

COURSE OBJECTIVES

- Describe actions to take when confronted with an active shooter and responding law enforcement officials.
- Recognize potential violence indicators
- Describe actions to take to prevent and prepare for potential active shooter incidents.
- Describe how to manage the consequences of an active shooter incident.
WHAT IS THE PROBLEM

• Healthcare workers are at risk for violence.
• Patient stress is the most common cause of hospital violence.
• The person inflicting the violence is usually known to the agency.
• Your top priority when violence occurs is to protect yourself and your patients.

ACTIVE SHOOTER

• Actively engaged in killing or attempting to kill people in a confined and populated area
• One or more guns
• Intends to kill people not commit another crime

ACTIVE SHOOTER INCIDENTS

WHERE WE SHOP
EXERCISE FREE SPEECH
LEARN
WORK
SPORTING EVENTS
ENTERTAINMENT
DINE
ACTIVE SHOOTER EVENTS

• Unpredictable
• Dynamic
• May occur inside or outside a facility
• Usually short duration
• Require immediate action to reduce loss of life

ACTIVE SHOOTER EVENTS

<table>
<thead>
<tr>
<th>Location Categories</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency Room (ER)</td>
<td>29%</td>
</tr>
<tr>
<td>Parking lot</td>
<td>23%</td>
</tr>
<tr>
<td>Patient Rooms</td>
<td>23%</td>
</tr>
<tr>
<td>Office</td>
<td>4%</td>
</tr>
<tr>
<td>Other</td>
<td>20%</td>
</tr>
</tbody>
</table>

HOSPITAL BASED SHOOTING

Figure: Distribution of hospital-based shootings in the United States by year 2000-2011 (Kelen et al.)
ACTIVE SHOOTER “PROFILE”

- Male
- Personal association with victims
  - 32% estranged or current intimate relationship
  - 25% former or current patient
  - 5% employee
  - 13% no known association
- Motive-determined shooter with specific target
  - Grudge or revenge
  - Suicide
  - Euthanasia
  - Escape attempt
  - Societal violence

FBI BEHAVIORAL INDICATORS

- Personal grievance
- Inappropriate acquisition of multiple weapons
- Escalation of target practice and weapons training
- Inappropriate interest in explosives
- Intense interest with previous shootings and mass attacks
- Significant perceived or real personal loss
- Previous arrest for violent crime

SAMPLE PLANS

- Multiple plan examples: http://www.calhospitalprepare.org/active-shooter
- Multiple plan examples and resources: https://www.urmc.rochester.edu/emergency-preparedness/Preparedness-and-Response-Tools/Resources/Active-Shooter.aspx
How can you prepare for and prevent active shooter situations

HOW TO PREPARE

• Develop an Emergency Action Plan
• Conduct effective training
• Recognize indicators of potential workplace violence
NEW MEDICARE REQUIREMENTS

• On November 16th, 2017, the final CMS Emergency Preparedness rule added to the Conditions of Participation (CoPs) – 42 CFR Section 416.54 – went into effect for all Medicare and Medicaid hospitals. These revised regulations reflect both the traditional hazards hospital teams face (natural disasters, power outages, infectious disease, etc.) as well as newer threats (active shooter, cyberattacks, etc.).

• Like other CMS regulations, hospitals found non-compliant with the new CoPs are at risk of being removed as a Medicare and Medicaid provider.

NEW MEDICARE REQUIREMENTS

• The core elements of the regulation are ones most hospital emergency preparedness teams will recognize:
  • Build an emergency plan. Based on a risk assessment, develop an emergency plan using an all-hazards approach focusing on capacities and capabilities that are critical to preparedness for a full spectrum of emergencies or disasters specific to the location of a provider or supplier.
  • Develop policies and procedures. Develop and implement policies and procedures based on the plan and risk assessment.
  • Communication plan. Develop and maintain a communication plan that complies with both federal and state law. Patient care must be well-coordinated within the facility, across health care providers, and with State and local public health departments and emergency systems.
  • Training and testing program. Develop and maintain training and testing programs, including initial and annual trainings, and conduct drills and exercises or participate in an actual incident that tests the plan.

NEW MEDICARE REQUIREMENTS

• Some key highlights of the plan are:
  • Develop an emergency plan that includes specific actions to be taken.
    • for each hazard
    • identifies key staff for that hazard response
    • includes communication procedures to receive emergency warning alerts
    • communication with staff, families, individuals receiving care, before, during and after the emergency
    • plans should account for 3-10 days of an emergency
  • Develop both a shelter-in-place and evacuation plan (this may be specific to certain patient populations)
  • Develop a plan and system that includes the ability to track staff and patient locations during an emergency
  • Ensure back-up generators and communication systems with the expectation that power and land-line communication will be unavailable

NEW MEDICARE REQUIREMENTS
DEVELOPING AN EMERGENCY ACTION PLAN

Get input from:
• Human Resources
• Training Department
• Legal Department
• Facility owners/operators
• Property managers
• Local law enforcement
• Professional emergency management consultant

ELEMENTS OF PLAN

• Recognition of potential problem
• Reporting process
• Notification/Communication
• Emergency escape routes
• Evacuation procedures
• Lockdown procedures
• Integration with Incident Command, Unified Command, EOP
• Information concerning emergency response agencies/contacts

CONDUCT TRAINING

Employee training should include
• Identifying the sound of gunfire
• Reacting quickly
• Calling 911
• Reacting when law enforcement arrives
• Adopting a survival mindset during a crisis
MEET EVERYONE’S NEEDS

Ensure plans assess and provide for functional needs:

- Hearing or sight
- Mobility
- Limited or no English proficiency

HUMAN RESOURCES RESPONSIBILITIES

- Conduct effective background checks
- Create system for reporting violent behavior
- Make counseling available
- Assist in the development of an Emergency Action Plan

RESPOND
WHAT ACTIONS SHOULD YOU TAKE TO KEEP YOURSELF SAFE IN AN ACTIVE SHOOTER SITUATION?

"WHEN SECONDS COUNT, THE POLICE ARE ONLY MINUTES AWAY"

HOW TO RESPOND

• RUN
• HIDE
• FIGHT

RUN

• Move an escape route and plan in mind
• Leave your belongings behind
• Help other escape if possible
• Evacuate regardless of others
• Warn/prevent individuals from entering
• Do not attempt to move wounded people
• Keep your hands visible
• Follow police instructions
• Call 911 when safe to do so

Why do police need to see your hands?
SPECIAL CONSIDERATIONS

- Patients that cannot move easily
  - ICU, NICU, dialysis
- Emergency Department
  - EMTALA
- Surgical areas-OR
- Hazards or threats to first responders
  - MRI
  - Hazardous materials
  - Kitchen
- Regulatory
  - Pharmacy
- Off site clinics
- Hospital Code Team and Emergency Response

PATIENT CARE/EMTALA

- The need to continue to provide care was identified in early responses
- Hospital has obligation to continue to provide a screening exam for patients seeking care
- Explored options with partners
  - Fire department will set up triage outside of hospital grounds
  - Police can set up perimeter and direct to other location
- Identified alternate triage location and team
- Tested and revised with exercises

HIDE

YOUR HIDING SPOT SHOULD:

- Be out of the active shooter’s view
- Provide protection if shots are fired
- Not restrict options for movement
HIDE (CONT.)

To prevent an active shooter from entering a hiding place:

- Lock the door
- Blockade the door with heavy furniture
- Close, cover, and move away from any windows

KEEPING YOURSELF SAFE WHILE HIDING

If the shooter is nearby, take the following actions:

- Lock the door
- Hide behind a large item such as a desk or cabinet
- Silence your cell phone, including vibration
- Remain quiet

IMPORTANT INFORMATION

Provide law enforcement or 911 operators with:

- Location of shooter
- Number of shooters
- Physical descriptions
- Number and type of weapons being used
- Number of potential victims and locations
FIGHT

As an ABSOLUTE last resort:

- Act as aggressively as possible
- Throw items and use improvised weapons
- Work together to incapacitate the shooter
- Commit to your actions

ACTIVITY: WHAT WOULD YOU DO?

1. Look around the room. Consider what you would do in the event of an active shooter situation.
2. Think about both a HIDE and FIGHT scenario.
3. Develop a habit of creating this “situational awareness” everywhere you go.

What actions should you take when law enforcement arrives?
LAW ENFORCEMENT’S ROLE

IMMEDIATE PURPOSE:

• Stop the active shooter(s).
• Proceed to area where last shots heard.
• First priority is to eliminate the threat.

REACTING TO LAW ENFORCEMENT

• Remain Calm
• Put down any items
• Raise hands and spread fingers
• Avoid quick movements
• Avoid pointing, screaming or yelling
• Proceed in directions from which officers are entering
• Do what you are told, even if you feel like you are being treated as a criminal

SAFE LOCATION/ASSEMBLY POINT

Area controlled by law enforcement until:

• The situation is under control
• All witnesses are interviewed
• Everyone is accounted for
RECOVERY

- Triage and treatment of victims
- Notification, line of duty death
- Accounting for staff, patients, visitors
- Evidence Recovery
- Legal Proceedings
- Memorial

Psychological Support
- Psychological First Aid
  - http://www.nctsn.org/content/psychological-first-aid
- PsyStart- psychological triage
- CISD

MANAGING THE CONSEQUENCES

- Determine who is missing or injured
- Determine a method for notifying families
- Assess psychological state of individuals
- Identify and fill critical personnel or operational gaps
LESSONS LEARNED

- Document response activities
- Identify successes
- Provide analysis of existing plan and effectiveness
- Describe plans for improvements

INTEGRATED PLANNING

- Share your plans
- Preposition maps, access badges, master keys
- Plan together
- Exercise together
- Provide blueprints, facility plans
- Equipment cache

- Integrating into the care/security teams
- Transport or treat at the facility decisions
- Visiting LE duties/OFF duty officer duties (SD)
LEGISLATIVE AGENDA AND GOVERNMENT RESPONSE TO LEGALIZED MARIJUANA AND THE OPIOID CRISIS

By TBD
AN UPDATE ON 42 CFR PART 2

By

Gina Bertolini, Raleigh, NC
I. INTRODUCTION TO 42 C.F.R. PART 2 (“PART 2”)

As many health care practitioners, health information management professionals, and health lawyers know, balancing patients’ privacy interests with the need to access accurate, up-to-date medical information can be challenging. Over the decade and a half since the implementation of HIPAA’s Privacy Rule, though, most have learned to maneuver within the mandates of the Privacy Rule while navigating its intersection with more restrictive state laws. Health care providers have implemented policies and procedures that safeguard patients’ health information—in compliance with federal and state requirements—while ensuring appropriate and timely access to medical records for permissible purposes, such as treatment, payment, peer review, quality, public health, and law enforcement. Substance use disorder (“SUD”) records, however, are subject to more restrictive federal requirements related to disclosure and have remained particularly vexing to access and incorporate into today’s modern health care environment. This is especially true as health care providers have sought to improve and enhance the interoperability of electronic health records, not only in response to the Affordable Care Act’s meaningful use and health information exchange (“HIE”) mandates, but also in response to the development of alternative payor models, innovative and collaborative care programs, and provider consolidation.

The federal rule that protects SUD records, commonly referred to as “Part 2,” is located at 42 C.F.R. Part 2. In recognition of the stigma imposed upon patients referred to or receiving SUD treatment, Part 2 provides more stringent federal protections for SUD records, as compared to other health privacy laws, such as the Privacy Rule. Part 2 protects the confidentiality of records pertaining to the identity, diagnosis, prognosis, or treatment of any patient maintained

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1 The author would like to acknowledge and thank Steven Pine and Leah Richardson for their assistance with this paper.

2 “HIPAA” refers to the Health Insurance Portability and Accountability Act of 1996, and the “Privacy Rule” refers to HIPAA’s implementing regulations at 45 C.F.R. part 160 and part 164, subparts A and E.

3 Pursuant to the 2017 Final Rule promulgated by the Substance Abuse and Mental Health Service Agency (SAMHSA), further described herein, the terms “alcohol abuse” and “drug abuse” were replaced throughout the Part 2 implementing regulations and are now collectively referred to as “substance use disorder,” or “SUD.” See Confidentiality of Substance Use Disorder Patient Records; Final Rule, 82 Fed. Reg. 6052, 6062 (January 18, 2017); see also 42 C.F.R. § 2.11.

in connection with a “federally assisted” program or activity (as defined by the rule)\(^5\) relating to SUD education, prevention, training, treatment, rehabilitation, or research. Written out of “great concern” that the misuse of SUD records could lead to a host of negative consequences such as loss of employment, housing, custody, and discrimination in the delivery of health care and public services,\(^6\) the regulations generally allow disclosure of such records only with the individual’s express written consent, with very few exceptions.\(^7\) In particular, the exceptions to Part 2 do not include disclosures without consent for payment or treatment purposes.\(^8\)

With regulations promulgated in 1975,\(^9\) and amended in 1987\(^10\) and 1995,\(^11\) Part 2 predates the Privacy Rule and the proliferation of interoperable electronic health records. Part 2 also predates the movement among health care providers, payors, and the federal government to develop new models of integrated health care, such as continuing care organizations (“CCOs”) and accountable care organizations (“ACOs”), as well as the technological capabilities to meaningfully and timely exchange health information in a way that facilitates such integration.

A. Brief description of Part 2 regulations

Part 2 imposes restrictions upon the disclosure and use of SUD patient records maintained in connection with the performance of any Part 2 program. Unless certain circumstances exist, disclosure is prohibited: “If any circumstance exists under which disclosure is permitted, that circumstance acts to remove the prohibition on disclosure but does not compel disclosure.”\(^12\)

A Part 2 “program” is any of the following that is considered to be federally assisted: (a) an individual or entity (other than a general medical facility) that holds itself out as providing, and provides, SUD diagnosis, treatment, or referral for treatment; or (b) an identified unit within a general medical facility that holds itself out as providing, and provides, SUD diagnosis, treatment, or referral for treatment; or (c) medical personnel or other staff in a general medical facility whose primary function is the provision of SUD diagnosis, treatment, or referral for treatment and who are identified as such providers.\(^13\) A program is “federally assisted” if it is, among other things, conducted in whole or in part by any U.S. department or agency; carried out under a license, certification, registration, or other authorization granted by any U.S. department.

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\(^5\) See 42 C.F.R. § 2.12(b).
\(^7\) See 42 C.F.R. § 2.51.
\(^8\) Id.
\(^9\) 40 Fed. Reg. 27,802 (July 1, 1975).
\(^10\) 52 Fed. Reg. 21,798 (June 9, 1987).
\(^12\) 42 C.F.R. § 2.2(b).
\(^13\) 42 C.F.R. § 2.11.
or agency, including a participating provider in the Medicare program and registration to dispense a substance under the Controlled Substances Act (to the extent the controlled substance is used in the treatment of substance use disorders); or assisted by the Internal Revenue Service through the allowance of income tax deductions for contributions to the program or through the granting of tax exempt status to the program.\textsuperscript{14}

The restrictions on disclosure apply to any information, whether recorded or not, that would identify a patient as having or having had a SUD and is drug or alcohol abuse information obtained by a federally assisted program for the purpose of treating a SUD, making a diagnosis for that treatment, or making a referral for that treatment.\textsuperscript{15} Part 2 generally prohibits programs from disclosing information without patient consent, except in the following circumstances: (1) medical emergencies; (2) cases involving child abuse or neglect where reporting is required by state law; (3) related to a crime on the program’s premises or against program personnel; (4) in relation to a qualified audit or evaluation of the program; (5) in relation to research; (6) pursuant to “Qualified Service Organization” agreements; and (7) in response to court orders.\textsuperscript{16} Generally, in all other circumstances, disclosure requires patient consent, including a high level of specificity regarding which program is permitted to make the disclosure, how much and what kind of information may be disclosed, and some level of detail regarding the entity or individual to whom disclosure may be made.\textsuperscript{17} Part 2 also generally prohibits re-disclosure by an individual who is a lawful holder of Part 2 information, and requires that a warning notice accompany any disclosure.\textsuperscript{18}


In 1970, Congress passed the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act, and in 1972, the Drug Abuse Office and Treatment Act (collectively, “the Acts”)\textsuperscript{19}. Together, these laws prohibited disclosure of “[r]ecords of the identity, diagnosis, prognosis, or treatment of any patient” maintained in connection with alcoholism or alcohol abuse education, training, treatment, rehabilitation, or research or any

\begin{itemize}
\item \textsuperscript{14} 42 C.F.R. § 2.12(b).
\item \textsuperscript{15} 42 C.F.R. § 2.12(a).
\item \textsuperscript{16} See generally 42 C.F.R. Part 2, Subparts B, D, and E.
\item \textsuperscript{17} 42 C.F.R. § 2.31.
\item \textsuperscript{18} 42 C.F.R. § 2.32.
\end{itemize}
drug abuse prevention functions, where such activities were conducted, regulated, or assisted by any U.S. department or agency.\textsuperscript{20} Except in certain limited circumstances, such records could not be disclosed without the prior written consent of the patient. The Acts required the Secretary of Health, Education, and Welfare (the predecessor agency to Health and Human Services) to promulgate implementing regulations.\textsuperscript{21} The Secretary, in the first regulations implementing the Acts, referred to the difficult balance that exists between the policy interests associated with the Acts, foreshadowing challenges to come:

The purpose of the regulations set forth in this part is to implement the authorizing legislation in a manner that, to the extent practicable, takes into account two streams of legal thought and social policy. One has to do with enhancing the quality and attractiveness of treatment systems. The other is concerned with the interests of patients as citizens, most particularly in regard to protecting their rights of privacy. Within each stream there are cross-currents, and it should come as no surprise that areas of turbulence are to be found at their confluence.\textsuperscript{22}

In the early 1970s, when Congress passed the Acts, it was concerned that discrimination associated with SUD treatment, along with a fear of prosecution, deterred people from seeking treatment.\textsuperscript{23} The purpose of the regulations was to “ensure that a patient receiving treatment for a substance use disorder in a part 2 program is not made more vulnerable by reason of the availability of their patient record than an individual with a substance use disorder who does not seek treatment.”\textsuperscript{24} At the time, patient records were primarily, if not entirely, paper. Indeed, the security precautions at section 2.17 of the initial Part 2 regulations adopted in 1975 required that “[r]ecords containing any information pertaining to patients shall be kept in a secure room, or in a locked file cabinet, safe, or other similar container, when not in use.”\textsuperscript{25}

As federal regulators, legislators, health care providers, and most industry experts would agree, since 1975 the use of data and information in conjunction with technology has and continues to transform our nation’s health care system, enabling care coordination, enhanced

\textsuperscript{20} Confidentiality of Alcohol and Drug Abuse Patient Records; Final Rule, 40 Fed. Reg. 27,802, 27,803 (July 01, 1975).
\textsuperscript{21} The Drug Abuse Office and Treatment Act of 1972, infra. note 11. Originally, the Act required the Director of the Special Action Office for Drug Abuse Prevention to promulgate regulations, but in 1975, the Act was amended to replace the Director with the Secretary of Health, Education, and Welfare. See 40 Fed. Reg. at 27,803.
\textsuperscript{22} 40 Fed. Reg. at 27,804.
\textsuperscript{24} 81 Fed. Reg. at 6989.
\textsuperscript{25} 40 Fed. Reg. at 27,808 (codified at 42 C.F.R. § 2.17).
treatment options, and improved quality, while furthering research and development in materially beneficial ways.\textsuperscript{26} Indeed, driven by the model of a national health information infrastructure, HIPAA created the standards for information exchange, privacy and security. Furthered by the Affordable Care Act and the Health Information Technology for Economic and Clinical Health Act (“HITECH”), government initiatives have encouraged the adoption of interoperable electronic health records, the development of health information exchanges (“HIEs”) and patient data registries, and the use of data for clinical, quality, research, operations, and public health purposes.\textsuperscript{27} As stated by the Secretary in a 2016 proposed rule seeking to modernize Part 2, these initiatives “served the objective of ensuring patient health information is secure, private, accurate, and available where and when needed.”\textsuperscript{28}

Against this backdrop, however, is a nation that continues to face challenges in addressing the prevention and treatment of SUDs and the rehabilitation of individuals with SUDs. Never has the need to remove impediments to treatment and rehabilitation – whether they be physical, financial, emotional, or otherwise – been more crucial than now. Every day, more than 130 people in the United States die due to an opioid overdose.\textsuperscript{29} Despite this crisis, many behavioral health and SUD treatment program advocates are opposed to expanding or changing Part 2’s restrictive approach to disclosure, some claiming that the proposed weakening or elimination of the patient’s right to consent for almost every disclosure, even in relation to treatment, is in fact prompted by the desire by some behavioral health providers to avoid investment in EHR technology that will adequately preserve patients’ privacy rights.\textsuperscript{30} Given the “unprecedented health information privacy breach epidemic”\textsuperscript{31} happening in the United States and the vulnerability of large, integrated health systems and HIEs, these advocates encourage the Substance Abuse and Mental Health Services Administration (“SAMHSA”)\textsuperscript{32} to require behavioral health treatment providers “to invest in technology that accommodates the privacy rights of the patients they serve,” rather than diminishing their patients’ privacy rights to accommodate

\begin{footnotesize}
\begin{enumerate}
\item 81 Fed. Reg. at 6991-92.
\item 81 Fed. Reg. at 6992.
\item National Institute on Drug Abuse, Opioid Overdose Crisis, revised January 2019, located at https://www.drugabuse.gov/drugs-abuse/opioids/opioid-overdose-crisis.
\item Id.
\item SAMHSA is the federal agency that implements and enforces Part 2; see https://www.samhsa.gov/.
\end{enumerate}
\end{footnotesize}
“current technological inadequacies.” Advocates further reiterate that the same concerns prompting this legislation in 1970 still exist: loss of employment, loss of housing, loss of child custody, discrimination by health care providers and insurers, arrest, incarceration, as well as disruption to family relationships and career and even suicide. This landscape, according to many behavioral health advocates, discourages individuals struggling with SUDs to seek treatment, and makes those who do more vulnerable to these negative consequences.

Other behavioral health providers, however, argue that Part 2 is paternalistic and perpetuates the stigma of SUDs, as compared to other chronic illnesses. As stated in comments presented by the Hazelden Betty Ford Foundation, the largest nonprofit provider of SUDs in the United States and abroad, in response to a 2017 proposed rule to update Part 2:

> By not evolving with [the dramatic and progressive changes in the way health care is delivered], the Part 2 regulations are inadvertently perpetuating the stigma of SUD, restricting access to its treatment by isolating this single chronic health condition from integrated physical and mental healthcare, and limiting the evidence-based and patient safety tools [available] to SUDs providers.

These providers argue that Part 2 confuses patients, who “routinely express frustration with the Part 2 barriers,” and generally support the harmonization of HIPAA and Part 2 into a single set of standards applicable to all protected health information (PHI), including that generated through SUD treatment, prevention, and education.

II. RECENT REGULATORY CHANGES TO PART 2

A. 2016 Proposed Rule

On February 9, 2016, SAMHSA published a proposed rule ("the 2016 Proposed Rule") that seeks to modernize the Part 2 regulations “to increase opportunities for individuals with substance abuse disorders to participate in new and emerging health and health care models and

34 Id.
36 Id.
health information technology (IT),” while retaining important privacy protections. According to SAMHSA,

[t]his modernization is necessary because behavioral health, including substance use disorder treatment, is essential to overall health; the costs of untreated substance use disorders, both personal and societal, are substantial; and there continues to be a need for confidentiality protections that encourage patients to seek treatment without fear of compromising their privacy.38

The 2016 Proposed Rule is the result, at least in part, of general comments and feedback about Part 2 solicited by SAMHSA through written comments and through a public Listening Session held in 2014. In addition to inviting general comments, SAMHSA sought feedback on six key provisions—applicability, consent requirements, re-disclosure, medical emergency, Qualified Service Organizations (“QSOs”), and research. Approximately 1,800 individuals participated in the Listening Session, resulting in 112 oral and 635 written submissions.39 Comments ranged from those who expressed concern that continued segregation of SUD records within increasingly integrated health systems was not only unwarranted in the age of HIPAA but also dangerous to patient health and safety, to those who argued that their ability to treat patients struggling with addiction was heavily dependent on the enhanced security provided by Part 2, which, in their opinion, should not be compromised.40

In commentary to the 2016 Proposed Rule, SAMHSA emphasized its desire to facilitate the electronic exchange of SUD information for treatment and “other legitimate health care purposes.” However, SAMHSA also emphasized that it must balance the promotion of information exchange within new and emerging integrated care models against the privacy concerns of SUD patients receiving treatment. Moreover, it must operate within the parameters of the authorizing legislation and its statutory intent, which is to protect the confidentiality of SUD records such that individuals receiving treatment are no more vulnerable to discrimination, harm to their reputations and relationships, and civil and criminal consequences than those who do not seek treatment.41

37 81 Fed. Reg. at 6990.
38 Id. at 6993.
40 Id.
41 81 Fed. Reg. at 6993.
Major proposed revisions in the 2016 Proposed Rule included:

- revising the definition of “Program” to include “general medical practices” under certain conditions;
- expanding the consent form to include a general designation of “to whom” a patient’s records may be disclosed;
- adding a requirement that patients, upon request, must be provided a list of entities to which their records have been disclosed pursuant to the general “to whom” designation;
- adding security requirements for both paper and electronic records;
- allowing the notice to patients of federal confidentiality requirements to be provided in either paper or electronic form;
- clarifying that the prohibition on redisclosure only applies to information that would directly or indirectly identify an individual as having been diagnosed, treated, or referred for treatment of a SUD, and would not prohibit other health-related information shared by a Part 2 Program to be disclosed (if permissible under other applicable laws);
- revising the medical emergencies section to give providers more discretion regarding what constitutes a “bona fide medical emergency,” and
- revising the research exception to allow Part 2 data to be disclosed to “qualified personnel” for research purposes, contingent upon documentation that the researcher would meet certain requirements related to human research protections.  

In response to the 2016 Proposed Rule, SAMHSA received 376 “detailed [and] thoughtful” public comments, “reflective of the complex issues addressed and balanced in the part 2 regulations.” Many commenters were concerned, in particular, about SAMHSA’s proposed expansion of the consent to allow a general designation, and expressed concern that the provision requiring the entity to whom records were disclosed to provide a list of all entities to whom it further disclosed records was insufficient. Some commenters expressed frustration with SAMHSA’s stated intent of facilitating information sharing and modernizing the regulations at the expense of patient privacy, particularly in light of the significant expansion of electronic health records and the number of breaches of personal information occurring in the United States annually. Some SUD therapists and behavioral health providers feared the proposed revisions to the consent requirements would disincentive patients from receiving treatment and force therapists to rely more heavily on “psychotherapy notes,” essentially driving information even more deeply underground. One rural health provider explained that pregnant women often forego prenatal care due to the fear of imprisonment and loss of child custody, and encouraged

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42 81 Fed. Reg. at 6990.
43 82 Fed. Reg. at 6056.
a “cautious, step-wise approach to making substance use treatment records more integrated with general medical records.”

Others, however, opined that the existing disparate treatment of SUD records is overprotective and further stigmatizes individuals with SUDs, while limiting opportunities for coordinated care among a diverse team of medical and behavioral health providers. As one comment pointed out, the revised term “substance use disorder” in lieu of “drug abuse” and “alcohol abuse” reflects “increased recognition of substance use disorder as a disease as evidenced by its inclusion in the Diagnostic and Statistical Manual of Mental Disorders: IV.” In addition, a number of commenters urged SAMHSA to include care coordination and case management as a permissible disclosure, especially given the complex patchwork of mental health and SUD delivery systems and the needs of patients, who typically are frequent users of multiple health systems. Some commenters urged full alignment with HIPAA.

B. 2017 Final Rule

SAMHSA published its final rule January 13, 2017 (“the 2017 Final Rule”). In the 2017 Final Rule, SAMHSA reiterated the changes that have occurred within the U.S. health care system not envisioned by the current (1987) regulations:

new models of integrated care that are built on a foundation of information sharing to support coordination of patient care, the development of an electronic infrastructure for managing and exchanging patient information, and a new focus on performance measurement within the health care systems.

SAMHSA categorized the “significant technology changes” impacting the delivery of health care in the United States, including:

- the creation of the Office of the National Coordinator for Health Information Technology (ONC), which was established in 2004 as an office within HHS;

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47 Id.
• the HITECH Act, part of the American Recovery and Reinvestment Act of 2009 (ARRA), which, among other things, included the expansion of ONC's authority and the provision of federal funds for ONC's activities consistent with the development of a nationwide health IT infrastructure;

• the certification of health IT by ONC and the authorization of CMS' Electronic Health Record (EHR) Incentive Program, which included payments to eligible providers for the adoption and meaningful use of certified EHR technology; and

• many other federal programs, “all of which served the objective of ensuring patient health information is secure, private, accurate, and available where and when needed.”

SAMHSA also outlined its role in encouraging the use of health IT by SUD and mental health providers, including collaborating with ONC to develop two sets of Frequently Asked Questions and convening a number of stakeholder meetings to provide guidance on the application of Part 2 to HIE models; creating a one-year pilot project with five state HIEs to support the exchange of health information among behavioral health and physical health providers; and facilitating the Data Segmentation for Privacy (DS4P) initiative within ONC's Standards and Interoperability (S&I) Framework, which, among other things, helped develop standards to improve the interoperability of EHRs containing sensitive Part 2 information and developed the branded “Consent2Share,” an open-source health IT solution that assists in consent management and data segmentation. SAMHSA acknowledged, however, that despite these efforts, some stakeholders continued to request modernization of Part 2 based on the belief that Part 2 “continues to be a barrier to the integration of substance use disorder treatment and physical health care.”

SAMHSA stated that its objective in implementing the 2017 Final Rule, in particular by easing the consent process for the disclosure of SUD records to treating providers, was to ensure that patients with SUDs can participate in and benefit from these improvements, while providing “appropriate privacy safeguards.” SAMHSA reiterated its observation made in the 2016 Proposed Rule, which is that it is required to operate within the statutory framework of the enabling statute. Thus, to the extent allowable, SAMHSA permitted “disclosure and use to increase access to treatment and improve treatment services,” while recognizing that, due to the sensitivity of these records, there is a “specific need for strong privacy protections.”

A detailed analysis of major revisions pursuant to the 2017 Final Rule follows.

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49 82 Fed. Reg. at 6055.
50 Id. at 6053.
51 Id. at 6061.
1. Revised or newly defined terms

SAMHSA finalized several revised or newly defined terms, including the new term “substance use disorder” in place of “alcohol abuse and drug abuse,” in recognition of classification manuals, current diagnostic lexicon, and commonly used terminology. “Substance use disorder” includes disorders associated with altered mental status that have the potential to lead to risky and/or socially prohibited behaviors, including alcohol, cannabis, hallucinogens, inhalants, opioids, sedatives, hypnotics, anxiolytics, and stimulants, excluding tobacco and caffeine.52

SAMHSA revised the definition of “records” by adding “created by,” such that “records” means “any information, whether recorded or not, created by, received, or acquired by a part 2 program relating to a patient (e.g., diagnosis, treatment and referral for treatment information, billing information, emails, voice mails, and texts).” The revised definition also makes clear that “records” refers to both paper and electronic records. A “lawful holder” of such records, or of patient identifying information, is an “individual or entity who has received such information as the result of a part 2-compliant patient consent (with a prohibition on re-disclosure notice) or as a result of one of the exceptions to the consent requirements in the statute or implementing regulations,” and therefore is bound by Part 2.53 Several provisions in the 2017 Final Rule are updated to apply the new term “lawful holders.”

SAMHSA finalized a revision to the definition of “Qualified Service Organization,” or “QSO,” to include population health management in the list of examples of services a QSO may provide. Additionally, “to emphasize that [QSO Agreements] should not be used to avoid obtaining patient consent,” SAMHSA revised the term “medical services” in the list of examples of services offered by a QSO to “medical staffing services.”55

2. “Program” revisions

The 2016 Proposed Rule would have revised “Program” to make clear that an individual or entity holding itself out as providing, and that does provide, SUD diagnosis, treatment, or referral does not apply to a general medical facility or general medical practice that, on occasion, provides SUD treatment services incident to the provision of general health care. This proposed revision, according to SAMHSA, was in recognition that more SUD treatment services are

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52 Id. at 6062, codified at 42 C.F.R. § 2.11.
54 Id. at 6054.
55 Id. at 6066.
occurring in general health care and integrated care settings, including general medical practices (i.e., not just general medical facilities), and would have limited the applicability of Part 2 to specialized programs within general medical practices. Excluding health care providers who work in general medical practices but only provide incidental SUD treatment services (secondary to the provision of other health care services) would have been consistent with SAMHSA’s original approach, which was to assure confidentiality protections and access to specialized programs “while not unnecessarily imposing requirements on general medical facilities or practices in an overly broad manner.”

Based on the number and type of comments regarding revising the definition of “Program,” SAMHSA concluded that most commenters misunderstood this portion of the 2016 Proposed Rule and believed instead “that SAMHSA was expanding the definition of program to include individuals and entities that had not previously been covered.” Accordingly, SAMHSA concluded that “separating out general medical practices from general medical facilities was more confusing than clarifying,” and did not make the proposed changes to the definition of “Program.” SAMHSA provided a few clarifications illustrating application of the term “Program,” and referenced its FAQs for further guidance.

3. Part 2 consent form

The most significant changes proposed by the 2016 Proposed Rule related to patient consent for the disclosure of health information for care coordination, treatment, and payment. As an initial matter, it may be helpful to articulate what SAMHSA did not do (in either the proposed or final rule): it did not create a general exception to the patient consent requirement for release of Part 2 records for treatment or payment purposes. SAMHSA did, however, propose to move away from its “one-size-fits-all” approach and closer to flexible consent form requirements that would vary, to a certain degree, depending on the relationship between the recipient of the information and the patient.

Under the pre-2017 regulations, a Part 2 consent form had to specifically identify the name or title of the individual or organization to which a Part 2 Program may disclose records. This specificity requirement assured that patients identify, at the point of consent, “exactly who they are authorizing to receive their information.” However, commenters noted that the

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58 42 C.F.R. § 2.31.; see also 81 Fed. Reg. at 7000.
59 81 Fed. Reg. at 7000. For disclosures to treating providers and third-party payors that require information for treatment or reimbursement purposes, in addition to naming a specific individual, the consent form could name the entity as the recipient of the information, e.g., “Hospital Name,” or “Medicare.”
specifi city requirement imposed unwieldy consent management burdens on Accountable Care Organizations (“ACOs”), Continuing Care Organizations (“CCOs”), and Health Information Exchanges (“HIEs”), since new treating providers may join these organizations as participants on a rolling basis. Because of the onerous consent requirements and the difficulty of naming treating providers with specificity, many of these organizations did not include SUD treatment information in their systems, handicapping care coordination efforts and raising patient safety concerns.

In response, and in recognition that effective SUD treatment depends on collaboration among mental health, SUD and addiction specialists, general health, and other service providers, SAMHSA proposed to allow a general designation for disclosure to treating providers through an entity that does not have a treating provider relationship with the patient, “such as an entity that facilitates the exchange of health information or a research institution.”60 For example, where a patient authorizes disclosure to a specifically named ACO, the patient also may generally designate a re-disclosure by the ACO to a “class of participants” that has a treating provider relationship with the patient.61 To assure that patient identifying information is disclosed only to those individuals and entities on the health care team with a need to know, the general designation would be limited to individuals and entities with a treating provider relationship.62

In creating a distinction between individuals and entities that have a treating provider relationship and those that do not, the revised consent requirements compelled the need to define “treating provider relationship.” SAMHSA’s proposed definition of “treating provider relationship” did not require an actual in-person encounter. Rather, a “treating provider relationship” is “clearly established”63 when an individual seeks diagnosis, evaluation, and/or treatment for any condition from an individual or entity, and such individual or entity agrees to undertake those services.64 Such relationship can be established by a health care provider or another member of a health care team, and the term “agree” does not imply a formal, written agreement; rather, an agreement may be evidenced by, for example, making an appointment or a telephone consultation.65 An entity will have a treating provider relationship if the entity

60 Id.
61 Id.
62 But note, a patient may designate the name of an individual participant, such as Jane Doe, MD, or John Doe, without requiring a treating provider relationship. See id. at 7000; see also id. at 7019 (to be codified at 42 C.F.R. § 2.31(a)(4)(iv)(A)). See id. at 7001 for a chart that provides an overview of permissible options when completing the “To Whom” designation section of the proposed consent form.
63 Id. at 6994.
64 Id.
65 Id. at 6994, 7000.
employs or privileges one or more individuals who have a treating provider relationship with the patient.66

The 2017 Final Rule finalized the consent requirements, with very minor modifications. With regard to the “To Whom” requirement, SAMHSA acknowledged in the Preamble to the 2017 Final Rule that it received several comments regarding its proposed revisions. Those supporting the updated consent requirements cited various reasons for their support: increased facilitation of informed patient decisions; increased patient choice regarding the protection of their health information; and increased sharing of medical records between and among providers. Other commenters felt the changes did not go far enough, stating that even with these revisions, the consent process would place unnecessary burdens on providers, such as increased staff training, obstacles to information sharing and integrated care, and a lack of significant impact on the ability of HIEs to share Part 2 information.67 Supporters also reiterated that current consent requirements were overprotective of SUD patients and further stigmatized them, while those opposed cited the significant risks to patients seeking SUD treatment, such as loss of jobs, prosecution, damage to reputation, and the detrimental impact on child custody proceedings.68

Many commenters, both for and against the changes, cited the technical challenges to the proposed consent requirements, including issues related to data segregation. For example,

66 Id. at 7000, 7002.

67 Id.


Why should a person who has received SUD treatment not have the same right to make independent decisions regarding the nature, extent, and duration of disclosure as someone receiving any other health care service? Why would SAMHSA deny a person who has received SUD treatment the right to decide that they want any and all information regarding their SUD treatment shared with any and all of their health care providers indefinitely as needed for coordination of care? Not allowing persons who have received SUD treatment to decide that they want their SUD treatment information shared in the same manner as all their other healthcare information is paternalistic, condescending, and discriminatory.


Data show that active substance abusers discount the future, so their ability to discern the longer-term consequences of providing a general consent may be impaired at entry into treatment. Having a standard procedure in place for specific releases of information with their PCP (which substance use disordered patients often do not have) or other specialist would still provide the communication needed with less risk of loss of privacy. It would be helpful to have data where having separate records has impaired or undermined the healthcare of substance use disordered patients. At the same time, there are already data showing how criminalization of substance use, particularly among pregnant women, has negatively impacted these individuals in terms of seeking prenatal care, due to the risks of imprisonment and loss of child custody. Making the treatment records more accessible to other providers will likely exacerbate the situation, with individuals not seeking prenatal care or treatment for their substance use disorder.
commenters stated that few EHR systems and HIEs have the capability to segregate SUD patient information in a way that assures compliance with the proposed revisions, meaning they would have to expend significant amounts of funds to create a compliant system, or “simply exclude substance use disorder patient data from their systems, thus adversely impacting system integration and patient care.”69 One commenter stressed that SUD patients’ privacy should not be compromised due to poorly designed EHRs.70 In response, SAMHSA acknowledged the concerns regarding technical challenges to the consent requirements, including data segregation. SAMHSA reiterated the “significant role” it has played in encouraging and developing health IT by behavioral health providers “and towards minimizing technical burdens through a variety of activities.”71 SAMHSA specifically referenced the DS4P initiative within ONC’s Standards and Interoperability Framework, which aims to develop standards to improve EHR interoperability in relation to sensitive information that is protected to a higher standard due to Part 2 and similar state laws. SAMHSA also referenced the development of Consent2Share, an open-source health IT solution based on DS4P standards, “which assists in consent management and data segmentation and is currently being used by the Prince Georges County (Maryland) Health Department to manage patient consent directives while sharing substance use disorder information with an HIE.”72

Ultimately, in the 2017 Final Rule,73 SAMHSA finalized its proposal that allows a general designation for individuals and entities that have a treating provider relationship with the patient, including through intermediary entities that do not have a treating provider relationship, such as ACOs or HIEs.74 The patient may designate by name one or more individuals on their health care team with whom they have a treating provider relationship, or they may generally designate treating providers as “past,” “current,” and/or “future.”75 SAMHSA adopted the definition of “treating provider” that was proposed in the 2016 Proposed Rule, stating it “respectfully declines to provide more specificity in the final rule.”76 Acknowledging that the “arrangements between treating providers and other entities evolve too rapidly to be comprehensively addressed in regulations,” SAMHSA stated that the inquiry is fact-specific, and it encouraged “innovative

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69 82 Fed. Reg. at 6078.
70 Id.
71 Id.
72 Id.
73 SAMHSA relocated the “To Whom” provision from section 2.31(a)(2) to section 2.31(a)(4). See 82 Fed. Reg. at 6080; see also 42 C.F.R. § 2.31(a)(4).
74 82 Fed. Reg. at 6077.
75 Id. at 6080. For an updated Table regarding designating individuals and organizations in the “To Whom” section of the consent form, see 82 Fed. Reg. at 6080.
76 Id. at 6082.
solutions to implement this provision.”\textsuperscript{77} It also indicated it might issue subregulatory guidance if further clarification is needed in the future.\textsuperscript{78} SAMHSA further reiterated that the consent form must contain an explicit description of the amount and kind of substance-use disorder treatment information that may be disclosed.\textsuperscript{79}

In response to comments regarding the effectiveness of the general designation and attendant risks to privacy, SAMHSA explicitly stated that the patient retains the ability to name specific individuals or entities to whom information may be disclosed.\textsuperscript{80} In addition, SAMHSA made clear that, if a general designation such as “to my current and future treating providers” is used, the entity must have a mechanism in place to determine whether a treating provider relationship exists between the patient and the provider to whom the information is being disclosed, such as an attestation.\textsuperscript{81} As further protection, the prohibition on redisclosure notice must be provided with the disclosure pursuant to a general designation, as well as a copy of the Part 2-compliant consent form (or the pertinent information on the consent form that allows the treating provider to comply).\textsuperscript{82}

SAMHSA clarified that more than one HIE or other intermediary can be listed on the consent form. Responding to requests for a sample consent form, SAMHSA suggested that it might issue subregulatory guidance that includes a sample consent form.\textsuperscript{83}

4. Part 2 list of disclosures

To balance privacy protections related to SAMHSA’s revisions to the general consent form, the 2017 Final Rule requires Part 2 programs to provide to patients who have agreed to the general designation, upon such patient’s request, a list of entities to which their information has been disclosed pursuant to the general designation (a “List of Disclosures”), going back two years. The Final Rule modified this provision from what was proposed by adding a paragraph that

\textsuperscript{77} Id.

\textsuperscript{78} Id. During the SAMHSA 2018 Listening Session, one speaker commented that “SAMHSA recognized ambiguities in the 2017 rule and promised subregulatory guidance on 27 items.” See SAMHSA 2018 Listening Session Transcript, p. 15 (Comments of Renee Popovits, read by Eric Okelbud, Popovits Law Group). In May of 2018, SAMHSA published two guidance documents addressing Part 2, which appear to be the first and only subregulatory guidance published since the 2017 and 2018 Final Rules. Those documents are “Disclosure of Substance Use Disorder Patient Records: Does Part 2 Apply to Me?” and “Disclosure of Substance Use Disorder Patient Records: How Do I Exchange Part 2 Data?”, available at https://www.samhsa.gov/about-us/who-we-are/laws-regulations/confidentiality-regulations-faqs.

\textsuperscript{79} 82 Fed. Reg. at 6077; 42 C.F.R. § 2.31(a)(4).

\textsuperscript{80} Id. at 6081.

\textsuperscript{81} Id. at 6080, 6081.

\textsuperscript{82} Id. at 6081.

\textsuperscript{83} Id. at 6079.
clarifies that the Part 2 Program is not responsible for complying with the List of Disclosures; rather, the entity named on the consent form that disclosed information pursuant to a patient’s general designation (the entity that serves as an “intermediary,” as described in the revised regulation) is responsible for such compliance within thirty days or less of receipt of the written request. In response to several comments that urged the List of Disclosures requirement to be effective simultaneous with changes to the consent form, SAMHSA removed the proposed two-year delayed implementation, and compliance was required as of the Final Rule effective date.

SAMHSA indicated that it plans to issue subregulatory guidance that clarifies how the patient can request a List of Disclosures pursuant to this new provision.

5. Security of records

SAMHSA finalized its proposed rule regarding security of records, with only minor changes. Accordingly, section 2.16 clarifies that the requirement to have formal policies and procedures in place addressing the security of Part 2 records, including maintenance, sanitation, and destruction, applies to both Part 2 programs and other lawful holders of Part 2 patient identifying information. In response to comments regarding the burden this will place on private citizens, SAMHSA responded that a patient who has obtained his or her records and family members or private citizens who received records from a patient are not “lawful holders of patient identifying information,” and further that lawful holders are generally familiar with Part 2. SAMHSA also updated section 2.16 to address both paper and electronic records.

SAMHSA specifically declined to adopt some commenters’ suggestions that compliance with HIPAA’s Security Rule would satisfy Part 2 requirements, stating that some entities subject to Part 2 are not subject to HIPAA, but indicated that it “may provide” subregulatory guidance on the extent to which compliance with HIPAA security requirements would satisfy section 2.16. SAMHSA also reiterated what it stated in the 2016 Proposed Rule, which is that the Office for Civil Rights and the National Institute of Standards and Technology have helpful resources related to the development of formal policies and procedures. However, SAMHSA revised the proposed

84 Id. at 6072; 42 C.F.R. § 2.13(d).
85 Id. at 6056. Many commenters expressed concern regarding the two-year lag time between revisions to the general consent and the requirement to provide a list of disclosures, and questioned SAMHSA’s commitment to patient privacy. Id. at 6071-72.
86 Id. at 6072. See infra., note 78, regarding SAMHSA’s issuance of subregulatory guidance.
87 82 Fed. Reg. at 6075.
88 Id.
89 Id., codified at 42 C.F.R. § 2.16.
90 Id. at 6075. See infra., note 78, regarding SAMHSA’s issuance of subregulatory guidance.
91 82 Fed. Reg. at 6075.
regulatory language with respect to the contents of security policies related to electronic records from “copying, downloading, forwarding, transferring, and removing such records” to “creating, receiving, maintaining, and transmitting such records” to more closely align with the HIPAA Security Rule.\textsuperscript{92}

6. Research

Part 2 programs or other lawful holders of Part 2 patient information are permitted to disclose such information to qualified personnel for the purpose of conducting scientific research if the researcher provides documentation of meeting certain requirements, including those related to HIPAA and existing protections for human research, as applicable.\textsuperscript{93} Similar to the current rule, researchers may include Part 2 patient information in research reports only in aggregate form in which the information cannot be re-identified and serve as an authorized means to directly or indirectly identify a patient as having or having had a substance-use disorder.\textsuperscript{94}

Recognizing that the process of linking data streams presents research opportunities as well as risks to privacy and security, SAMHSA proposed to permit researchers to request to link data sets that include patient identifying information disclosed by a Part 2 Program, limited to circumstances where: (1) the data links to data from a federal data repository; and (2) the request, including a data protection plan, is reviewed and approved by an Institutional Review Board registered with the Office for Human Research Protections (“IRB”) in accordance with 45 C.F.R. part 46.\textsuperscript{95} In response to public comments regarding the limitation of disclosure to only federal data repositories, SAMHSA expanded the data linkages provision to permit researchers to link to federal and nonfederal data repositories, provided the request is reviewed by the IRB, as stated above, and patient identifying information is not provided to law enforcement agencies or officials.\textsuperscript{96} Where identifying information obtained from a Part 2 Program is linked to a data repository, the repository is “fully bound” by the provisions of Part 2 and, after providing the researcher with the linked data, must take steps to destroy or delete the linked data to render the patient identifying information non-retrievable.\textsuperscript{97}

7. Audit and evaluations

\textsuperscript{92} Id.
\textsuperscript{93} 42 C.F.R. § 2.52(a)–(b).
\textsuperscript{94} 42 C.F.R. § 2.52(b)(3).
\textsuperscript{95} 81 Fed. Reg. at 7020–21.
\textsuperscript{96} 82 Fed. Reg. at 6100–01; 42 C.F.R. § 2.52(c).
\textsuperscript{97} 42 C.F.R. § 2.52(c).
The Final Rule’s Part 2 revisions permit an audit or evaluation necessary to meet the requirements of a CMS-regulated ACO or similar CMS-regulated organization (including a CMS-regulated Qualified Entity), under certain conditions. The Final Rule also requires ACOs or similar CMS-regulated entities to meet certain criteria, such as having in place administrative and/or clinical systems, and having a signed Participation Agreement with CMS or similar documentation that demonstrates that the organization and its auditors or evaluators must conduct the audit and evaluation activities in full compliance with all applicable provisions of 42 U.S.C. 290dd–2 and Part 2 regulations.98

C. 2017 Supplemental Notice of Proposed Rulemaking

In addition to issuing the 2017 Final Rule, SAMHSA issued a Supplemental Notice of Proposed Rulemaking (“SNPRM”) “to propose additional clarifications to the part 2 regulations as amended by the concurrently issued final rule.”99 SAMHSA indicated that, in relation to the 2016 Proposed Rule, questions were raised regarding Part 2 restrictions, dating back to 1987, on lawful holders and their contractors’ and subcontractors’ use and disclosure of Part 2 patient identifying information for payment, health care operations, and other health care related activities. In particular, SAMHSA noted that some comments to the 2016 Proposed Rule urged SAMHSA to clarify the scope of permitted disclosures of Part 2 information by third party payors.100 Another commenter asserted that Part 2 does not require handling third party payors any differently than other payors. “These comments,” SAMHSA stated, “have prompted SAMHSA to propose additional clarification and modifications to the Part 2 rules to clarify the scope of permissible disclosures.”101

Specifically, SAMHSA sought further comments regarding whether a lawful holder could disclose the minimum information necessary for payment and health care operations. SAMHSA also sought comments related to an abbreviated notice regarding the prohibition on re-disclosure “in certain circumstances” where such shorter notice would be warranted. Lastly, SAMHSA sought comments regarding disclosures by lawful holders and their contractors and subcontractors to carry out audit or evaluations beyond Medicare, Medicaid, and CHIP, in response to comments regarding the “critical importance of audits and evaluations” for entities that may not be CMS-regulated and may involve private payors.102

98 42 C.F.R. § 2.53.
100 Id. at 5486.
101 Id.
102 Id. at 5485, 5487-88.
D. 2018 Final Rule

SAMHSA received 57 comments in response to the SNPRM, and on January 03, 2018, issued a Final Rule in furtherance of the SNPRM (“the 2018 Final Rule”), effective February 02, 2018.\(^\text{103}\) In the Preamble to the 2018 Final Rule, SAMHSA clarified that, consistent with its purpose in revising the 2017 Final Rule, SAMHSA intended these revisions to better align Part 2 with advances in the delivery of health care in the United States, while retaining important privacy protections for SUD patients.\(^\text{104}\) SAMHSA specifically identified the development of integrated health care models and the use of electronic exchange of patient information as advancements.\(^\text{105}\)

SAMHSA first commented on the number of commenters who requested that SAMHSA align Part 2 with HIPAA, for a number of reasons, including promoting the flow of information between and among providers; facilitating EHR interoperability; improving compliance; promoting innovative care models, including integrated and coordinated care and value-based and population-based models; and improving patient care and reducing stigma and potential harm to patients, among others.\(^\text{106}\) SAMHSA responded that it “has attempted to align this final rule with HIPAA, the HITECH Act, and their implementing regulations to the extent feasible, based on the proposed revisions in the SNPRM, the public comments received, and the limitations on SAMHSA’s authority in the governing statute.”\(^\text{107}\) On this latter point, SAMHSA reiterated that Part 2 and its authorizing statute are “separate and distinct” from HIPAA and HITECH and provide more stringent protections than other federal privacy laws, in recognition that SUD patients often face discrimination and legal recourse if their information is impermissibly disclosed.\(^\text{108}\) SAMHSA foreshadowed future regulatory activity, stating, “To the extent feasible given these restrictions, SAMHSA continues to review these issues, plans to explore additional alignment with HIPAA, and may consider additional rulemaking.”\(^\text{109}\)

1. Disclosures permitted for payment and health care operations

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\(^\text{103}\) 83 Fed. Reg. 239 (January 03, 2018). Note that the Federal Register states that 55 comments were received, whereas the SNPRM Docket Folder at regulations.gov states that 57 comments were received. The Docket Folder includes total submissions received to date, and may include submissions received after the comment period closed, or may include certain submissions that SAMHSA otherwise determined were duplicate or near duplicate results of a mass-mail campaign. Apparently, there can be discrepancies between what is posted in the Docket Folder and the number the agency reports. See, e.g., https://www.regulations.gov/document?D=HHS-OS-2016-0005-0378.

\(^\text{104}\) 83 Fed. Reg. at 239.

\(^\text{105}\) Id.

\(^\text{106}\) Id. at 240.

\(^\text{107}\) Id.

\(^\text{108}\) Id.

\(^\text{109}\) Id.
In the SNPRM, SAMHSA prefaced its proposed revisions regarding disclosures for payment and health care operations by acknowledging the “integral role” in the management, delivery, and payment of health care services that contractors, subcontractors, and legal representatives play.\textsuperscript{110} However, “limits should be placed on disclosures of (part 2) patient identifying information to such entities to carry out these activities.”\textsuperscript{111} To strike this balance, SAMHSA proposed to list in the regulations at section 2.33 specific types of activities for which any lawful holder of patient identifying information could further disclose the minimal information necessary for payment and/or health care operations activities.\textsuperscript{112} That list included (in part):

- billing, claims management, and collections activities
- clinical professional support services (e.g., quality assessment and improvement, utilization review);
- patient safety activities
- the training of health care professionals (“HCPs”) and students, and the training of non-HCPs
- assessment of provider and/or health plan performance
- accreditation, certification, credentialing, and licensing activities
- activities related to a contract for health insurance or health benefits
- activities related to addressing fraud, waste, or abuse
- arranging for medical review and legal and auditing functions
- business planning and development
- business management and general administrative activities
- customer service
- sale, transfer, merger, or dissolution of an organization
- resolution of internal grievances
- determination of eligibility for coverage.

The use of the terms “payment” and “health care operations,” though similar to HIPAA’s Privacy Rule, is not identical, and specifically does not include activities considered to be related to the patient’s diagnosis, treatment, or referral for treatment. Moreover, because “SAMHSA believes it is important to maintain patient choice in disclosing information to health care providers with whom [patients] will have contact,” SAMHSA clarified that the proposed provision would not cover care coordination or case management, despite comments requesting such

\textsuperscript{110} 82 Fed. Reg. at 5487.
\textsuperscript{111} Id.
\textsuperscript{112} Id.
disclosures, and disclosures to contractor, subcontractors, or legal representatives to carry out other functions would be strictly prohibited.\textsuperscript{113}

SAMHSA also stated in its SNPRM that disclosures would be limited to only the information necessary to carry out the purpose of the disclosure, and the contractors, subcontractors, and legal representatives would become lawful holders upon receipt of Part 2 data and thus would be subject to Part 2 requirements.\textsuperscript{114} SAMHSA proposed to include a new provision requiring all lawful holders that engage contractors or subcontractors for payment or health care operations, for which disclosure of Part 2 information is required, to include specific contract (and subcontract) terms to comply with Part 2, as relevant.

Several commenters responded to SAMHSA’s proposed list of explicitly permitted payment and health care operations activities. Several expressly supported the list, with one commenter observing that these activities “represent significant progress toward SAMHSA’s stated goal of modernizing 42 CFR part 2 to increase opportunities for individuals with substance use disorders to participate in new and emerging health care models and health information technology.”\textsuperscript{115} Several commenters requested that care coordination and case management be added to the list of activities, while others requested that they be explicitly excluded.\textsuperscript{116} Some commenters requested that the list be restricted or narrowed, while two observed that, in light of “the rapid changes occurring in the health care payment and delivery system,” any list of permitted activities would be quickly outdated.\textsuperscript{117}

In reviewing the comments submitted in response to SAMHSA’s proposed revisions in the SNPRM, SAMHSA stressed that it seeks balance between protecting the confidentiality of SUD patient records and ensuring that the regulations do not pose a barrier to SUD patients who seek to benefit from emerging models of health care that promote integrated care and patient safety. Additionally, SAMHSA reiterated that lawful holders of Part 2 protected data have “legitimate needs” to disclose information to their contractors, subcontractors, and legal representatives for payment and operations purposes.\textsuperscript{118} Accordingly, in the 2018 Final Rule, SAMHSA finalized its revisions to section 2.33 as proposed in the SNPRM, with the exception of the list of 17 specific types of payment and health care operations activities. Instead, SAMHSA included the list of activities in the preamble to the 2018 Final Rule, substantively unchanged from what was

\begin{itemize}
\item \textsuperscript{113} Id.
\item \textsuperscript{114} Id.
\item \textsuperscript{115} 83 Fed. Reg. at 242.
\item \textsuperscript{116} Id.
\item \textsuperscript{117} Id. at 243.
\item \textsuperscript{118} id. at 241-42.
\end{itemize}
proposed, “to make clear that it is an illustrative rather than exhaustive list of the types of payments and health care operations activities that would be acceptable to SAMHSA.”\textsuperscript{119} SAMHSA explicitly stated that it intends to permit other payment and health care operations activities under section 2.33 “as the health care system continues to evolve.”\textsuperscript{120} SAMHSA reiterated, however, that these activities do not encompass SUD diagnosis, treatment, or referral for treatment, since patient choice with regard to those disclosures is essential, and the text of section 2.33(b) would state as such.\textsuperscript{121} For this reason, SAMHSA stated, the list of activities does not encompass care coordination or case management, a position that, SAMHSA acknowledged, differs from HIPAA’s Privacy Rule, pursuant to which “health care operations” encompasses case management and care coordination.\textsuperscript{122}

Some commenters expressed disdain that lawful holders would, under the proposed rule, have more latitude in sharing patient identifying information with other entities than is afforded the patients themselves, who under the 2017 Final Rule can only disclose Part 2 protected data to entities with whom they do not have a treating provider relationship if they specifically designate an individual participant within that entity.\textsuperscript{123} SAMHSA acknowledged the concern and indicated that it would convene a stakeholder meeting, as required by the 21\textsuperscript{st} Century Cures Act, to address this issue.\textsuperscript{124} Similarly, with regard to commenters’ mixed recommendations regarding coordination of care and case management, SAMHSA stated that the 21\textsuperscript{st} Century Cures Act stakeholder meeting would address the effects of Part 2 on patient care and health outcomes, among other things, and would provide stakeholders the opportunity to offer further input on implementation of part 2, including changes adopted in the 2018 Final Rule.\textsuperscript{125}

SAMHSA also finalized the proposed new regulatory text requiring lawful holders that engage contractors and subcontractors to carry out payment and health care operations that require the use of Part 2 protected data to include specific contractual language requiring compliance with Part 2.\textsuperscript{126} SAMHSA did not, however, require the contract to specify the permitted uses of Part 2 protected data, and makes some allowances for relationships with legal

\begin{footnotesize}
\begin{enumerate}
\item \textit{id.} at 241.
\item \textit{id.}
\item \textit{id.} at 243.
\item \textit{id.}
\item \textit{id.} at 241.
\item \textit{id.} at 242.
\item \textit{id.} at 244.
\item \textit{id.} In particular, SAMHSA states that contractual language requiring general compliance with applicable federal laws is not sufficient to meet this requirement, since “[r]eferring Part 2 in contracts will help to underscore the importance of compliance with part 2 provisions.” \textit{id.}
\end{enumerate}
\end{footnotesize}
representatives.127 Recognizing the administrative burden of bringing contracts into compliance, SAMHSA allows lawful holders until February 02, 2020 (two years from the effective date of the 2018 Final Rule), to bring their contracts with contractors and subcontractors into compliance.128

2. Abbreviated Notice

In addition to proposed revisions to the scope of disclosures, SAMHSA proposed in the SNPRM to allow an abbreviated notice for the purposes of complying with Part 2’s notice requirement regarding re-disclosure. Specifically, Section 2.32 of the regulations requires that each disclosure made with the patient’s written consent be accompanied by a written statement informing the recipient that the records are protected by federal confidentiality rules. SAMHSA proposed adding an abbreviated statement “to be used in certain circumstances (e.g., for particular types of disclosures or technical systems) where a shorter notice may be warranted.”129 The purpose of this proposal was, at least in part, to comply with the text box limitations imposed by many EHR systems. SAMHSA suggested, as an example of an abbreviated notice, “Data is subject to 42 CFR part 2. Use/disclose in conformance with part 2.”

Several commenters were supportive of SAMHSA’s proposal, though expressed the importance of developing technical solutions for conveying the prohibition on redisclosure, including codes, flags, pop-ups, and other signifiers – solutions that are not yet technically feasible.130 Commenters who opposed expressed concern that the abbreviated notice would confuse patients and health care providers and fail to adequately safeguard against unauthorized disclosure. Others commented that the notice is insufficient where electronic systems do not exist to “tag” SUD information so that the notice is automatically attached.131

SAMHSA reiterated in commentary to the 2018 Final Rule that its proposal for an abbreviated notice was “due to concerns about character limits in free-text fields within electronic health record systems,” many of which have a standard maximum character limit of 80 characters in free text space.132 SAMHSA further indicated that it recognizes that there are

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127 Id. at 244-45. SAMHSA acknowledged that Part 2 does not require consent forms to be passed to contractors and subcontractors, so revised the regulatory text to remove the reference to patient consent in relation to the requirement to state specific uses of patient identifying information by the contractor, subcontractor, or legal representative. SAMHSA stated, however, that “part 2 programs and other lawful holders should ensure that the purpose section of the consent form is consistent with the role of or services provided by the contractor or subcontractor.” Id. at 245.
128 Id. at 244.
129 82 Fed. Reg. at 5487.
130 83 Fed. Reg. at 240.
131 Id.
132 Id.
technical issues to be resolved, but on balance, concluded that an abbreviated notice as an option to comply with section 2.32 would be beneficial. However, “because even commenters supporting inclusion of an abbreviated notice had differing views about the circumstances under which an abbreviated notice should be used,” SAMHSA decided it would allow the abbreviated notice in any instance in which notice is required. SAMHSA also modified the language in response to comments that the proposed abbreviated notice did not adequately warn against potential misuse of patient identifying information. The final abbreviated notice is as follows: “Federal law/42 CFR part 2 prohibits unauthorized disclosure of these records.”

3. Audit and Evaluation

SAMHSA finalized its proposed rule to clarify that audits and evaluations may be performed on behalf of federal, state, and local governments providing financial assistance to, or regulating the activities of, lawful holders as well as Part 2 programs, and that such disclosures may be made to contractors, subcontractors, or legal representatives to carry out such audit or evaluation. This is in recognition that federal, state, and local governments often need to access all of the records, including Part 2 program records, held by entities they regulate to evaluate compliance with applicable laws, rules, and policies. As examples, SAMHSA stated that Accountable Care Organizations (ACOs) or similar CMS-regulated health care models may wish to evaluate the impact of integrated care on several participating behavioral health programs’ quality of care, “or a state may wish to do an audit to see how many individuals who leave state-supported correctional facilities subsequently receive substance use disorder treatment.”

E. The 2018 SAMHSA Listening Session

As required by the 21st Century Cures Act (Pub. Law 114-255), and as referenced in the 2018 Final Rule, SAMHSA held a public listening session on January 31, 2018, to elicit information regarding Part 2. As stated by SAMHSA, the listening session “was an opportunity for the public to provide input to SAMHSA concerning the effect of part 2 on patient care, health outcomes, and patient privacy as well as potential regulatory changes and future subregulatory guidance.” The event was held live, and participants included in-person commenters as well as individuals who submitted comments through the teleconference and/or webcast. The proceedings were recorded and a transcription is now available online.

133 *id.* at 246.
In her opening remarks, Dr. McCance-Katz, HHS Assistant Secretary for Mental Health and Substance Use, indicated that this topic is a priority for HHS. She further reiterated what SAMHSA has previously stated in recent rulemaking, which is that much has changed since 1975, and SUD treatment should be brought “into the mainstream of medical care” as a medical disorder no different than other medical disorders such as cancer and heart disease. While Dr. McCance-Katz assured that appropriate protections need to be in place to prevent misuse of SUD information, she stated that increased access to care requires modification of Part 2.135

The Listening Session yielded wide support for aligning Part 2 with HIPAA across multiple stakeholder groups, with many arguing that Part 2 is a barrier to coordinated care, holistic treatment of SUD patients, and maximum use of electronic health records.136 While some behavioral health advocates argued that the continued existence of Part 2 perpetuates a negative stigma toward SUDs, others expressed concern that loosening Part 2’s restrictions on disclosure would put SUD patients at risk of exposure and that societal stigmas are still rampant.137 Some expressed interest in shifting the confidentiality of SUD records to HIPAA, but modifying HIPAA’s regulatory rules to better address these highly sensitive records.138

SAMHSA closed the Listening Session by stating it would consider all oral and written comments submitted, but did not specifically outline next steps.

III. CONCLUSION AND NEXT STEPS FOR PART 2

While recent changes to the Part 2 regulations take a number of steps closer toward coordination of care for a particularly vulnerable patient population, in the end there remains a significant gap between permissible data sharing for SUD patients and what is otherwise allowed under HIPAA and other state and federal laws. This is particularly pronounced in the area of data sharing for treatment purposes. While the recent Part 2 changes outlined above provide some additional flexibility in developing more generalized consent options for sharing data, Part 2 still requires that every SUD patient consent for his/her information to be shared for treatment purposes, except in the case of medical emergencies.

On the one hand, it is difficult to deny that there is still some degree of personal and professional stigma associated with SUDs, and unintentional exposure of a SUD referral,

135 Id. at p. 5-6.
diagnosis, or treatment can have a detrimental effect on an individual’s personal and professional relationships – some argue that this warrants a trade-off in data sharing. On the other hand, particularly in a society facing significant health, law enforcement, and public policy crises associated with the rise of opioid-abuse and other SUDs, real patient harm can result when health providers make medical decisions without the benefit of the full picture of a patient’s condition. In addition, as health care providers increasingly offer integrated care models, there is some resultant uncertainty regarding the degree of SUD-related services these providers can offer as part of their care model without becoming subject to these data sharing restrictions.

Recognizing that privacy regulations and laws are complex, create confusion for practitioners and patients, and often are interpreted too stringently, in 2019 SAMHSA awarded a grant for the Center for Excellence for Protected Health Information (CoE-PHI).\footnote{“Center of Excellence for Protected Health Information Related to Mental and Substance Use Disorders” Grant Announcement, FOA Number TI-18-021, July 18, 2018, available at \url{https://www.samhsa.gov/grants/grant-announcements/ti-18-021}.} The purpose of the CoE-PHI is to “establish one National Center of Excellence to develop and disseminate training, technical assistance, and educational resources for healthcare practitioners, families, individuals, states, and communities on various privacy laws and regulations as they relate to information about mental and substance use disorders.”\footnote{Id.} According to the awardee, a recent survey conducted by SAMHSA found that concerns about privacy among individuals with behavioral health needs is a primary reason for not receiving treatment. The CoE-PHI’s goal is to clarify privacy protections and promote communication of patient records to improve access to and quality of care.\footnote{Id.}

In the end, while SAMHSA is certainly aware of these conflicting ethical drives, it also recognizes that it remains constrained in further rulemaking given the existing statutory language that establishes SAMHSA’s Part 2 guardrails.\footnote{See, e.g., 83 Fed. Reg. at 240, 242; 82 Fed. Reg. at 6060, 6061.} Thus, while additional rulemaking on Part 2 regulations is anticipated in 2019 or 2020, moving to a system of robust care coordination and data sharing for SUD patients likely will require Congressional action. While Part 2 legislative changes did not make it into the 2018 Support Act, the current Administration’s focus on a “regulatory sprint” towards care coordination, particularly in the arena of fighting opioid-

abuse, indicates there is potential for bipartisan support in exploring legislative options moving forward. Indeed, in April of 2019, a bipartisan group of lawmakers reintroduced bills in the House and Senate that would amend Part 2 to align it with HIPAA. Identical bills introduced in previous sessions of Congress failed to pass due to opposition by advocacy groups and some legislators, and most recently, the Overdose Prevention and Patient Safety Act passed in the House but later died in the Senate. Whether a concerted drive toward coordinated care within the midst of costly and devastating complications tied to a national drug epidemic can create a groundswell of support for significant change remains to be seen.

144 On December 12, 2018, HHS released a request for information ("RFI") on improving care coordination and reducing the regulatory burden of HIPAA's regulatory rules, part of the "Regulatory Sprint to Coordinated Care," led by Deputy Secretary Eric Hargan. See HHS Press Release, available at https://www.hhs.gov/about/news/2018/12/12/hhs-seeks-public-input-improving-care-coordination-and-reducing-regulatory-burdens-hipaa-rules.html. The RFI sought responses to comments regarding modifying "provisions of the HIPAA Rules which present barriers that limit or discourage coordinated care and case management (including care coordination challenges arising from the opioid crisis) . . . or otherwise impose regulatory burdens that may impede the transformation to value-based health care without providing commensurate privacy or security protections."

See Summary, available at https://www.regulations.gov/docket?D=HHS-OCR-2018-0028. HHS posed 54 questions across five broad topics, including promoting information sharing for care coordination and promoting parental and caregiver involvement in the treatment and recovery of substance use disorders and serious mental illness. One question specifically sought comments regarding how a general requirement for health care providers to share PHI when requested by another health care provider would interact with other laws, such as 42 CFR part 2. HHS received 1,337 comments. While a comprehensive review of comments is beyond the scope of this paper, it is worthwhile to note that several comments include arguments for and against full alignment of Part 2 with HIPAA. Comments are available at https://www.regulations.gov/docketBrowser?rpp=25&so=DESC&sb=commentDueDate&po=0&D=HHS-OCR-2018-0028.

INTRO TO 42 C.F.R. PART 2

- Federal rule that protects substance use disorder ("SUD") records is located at 42 C.F.R. Part 2, and is commonly referred to as "Part 2"
- In recognition of the stigma imposed upon patients who are referred to or receive SUD treatment, Part 2 provides more stringent protections for SUD records, as compared to other health privacy laws, such as HIPAA's Privacy Rule
- Part 2 protects the confidentiality of records pertaining to the identity, diagnosis, prognosis, or treatment of any patient maintained in connection with a "federally assisted" program or activity relating to SUD diagnosis, treatment, or referral for treatment
- No disclosure without written consent of the patient (except in limited circumstances)
- Prohibits redisclosure by a "Lawful Holder" of Part 2 information
- Requires that a warning notice accompany every disclosure

HIPAA, PART 2, AND STATE LAWS

- Part 2 is more restrictive than HIPAA
  - No Treatment exception
  - Payment and limited operations with consent
- SUD patient records may be subject to HIPAA, Part 2, and state laws concurrently
- Other laws may apply in some settings (e.g. Family Educational Rights and Privacy Act – "FERPA")
- Follow the law that is more restrictive
HIPAA, PART 2, AND STATE LAWS

State laws and Substance Use Disorder Records – Disclosure with Patient Consent

INTRO TO 42 C.F.R. PART 2

- Early 1970s: Congress was concerned that the misuse of SUD records could lead to a host of negative consequences such as loss of employment, housing, custody, and discrimination in the delivery of health care and public services and that this would deter people from seeking treatment.
- Purpose was to "ensure that a patient receiving treatment for a substance use disorder in a part 2 program is not made more vulnerable by reason of the availability of their patient record than an individual with a substance use disorder who does not seek treatment."
- 42 U.S.C. § 290dd-2 is the implementing statute.
- Imposes criminal penalties.
- Substance Abuse and Mental Health Services Administration (SAMHSA) enforces.

INITIAL PART 2 REGULATIONS ADOPTED IN 1975

"The purpose of the regulations set forth in this part is to implement the authorizing legislation in a manner that, to the extent practicable, takes into account two streams of legal thought and social policy. One has to do with enhancing the quality and attractiveness of treatment systems. The other is concerned with the interests of patients as citizens, most particularly in regard to protecting their rights of privacy. Within each stream there are cross-currents, and it should come as no surprise that areas of turbulence are to be found at their confluence."

40 Fed. Reg. 27,802, 27,804 (July 1, 1975)
PART 2 IS OLD!

- Regulations promulgated in 1975, amended in 1987 and 1995
- Part 2 Predates:
  - HIPAA's Privacy Rule and the proliferation of electronic health records
  - The movement among health care providers, payors, and the federal government to develop new models of integrated health care as a means of improving patient care and reducing costs (e.g., CCOs and ACOs)
  - The technological capabilities to meaningfully and timely exchange health information in a way that facilitates integrated care

FAST FORWARD TO 2000 AND BEYOND

- HIPAA created the standards for information exchange, privacy and security and established the model of a national health information infrastructure
- The proliferation of patient data as a result of advanced technology has and continues to create opportunities that are transforming our nation’s health care system
- Public and private initiatives have encouraged:
  - the adoption of interoperable electronic health records
  - the development of health information exchanges (“HIEs”) and patient data registries
  - the use of data for clinical, quality, health care operations, research, and public health purposes

Over the past 5 years, SAMHSA has taken steps to modernize Part 2, in recognition that:
- SUD treatment is “essential to overall health”
- SUD treatment continues to require enhanced confidentiality protections
- Individuals with SUDs require increased opportunities to participate in new and emerging healthcare models and to benefit from advancements in health information technology
SAMHSA'S EFFORTS TO MODERNIZE
PART 2

- Since 2014:
  - 2 Listening Sessions (2014 and 2018)
  - 2 Final Rules (2017 and 2018)
  - Approximately 1,100 written comments submitted
  - Approximately 200 pages in the Federal Register (Commentary and Proposed and Final Rules)

- Every day, more than 130 people in the United States die due to an opioid overdose
- Many behavioral health and SUD treatment program advocates are opposed to expanding or changing Part 2's restrictive approach to disclosure
- Given the "unprecedented health information privacy breach epidemic" in the U.S. and the vulnerability of large integrated health systems and HIEs, these advocates encourage SAMHSA to require behavioral health treatment providers "to invest in technology that accommodates the privacy rights of the patients they serve"
- The same concerns prompting this legislation in 1970 still exist: loss of employment, loss of housing, loss of child custody, discrimination by health care providers and insurers, arrest, incarceration, as well as disruption to family relationships and career, and suicide

- Other behavioral health providers argue that Part 2 is paternalistic and perpetuates the stigma of SUDs, as compared to other chronic illnesses
- Part 2 restricts access to treatment by preventing integrated physical and mental health care
- Part 2 limits evidence-based and patient safety tools available to SUDs providers
- Part 2 confuses patients, who "routinely express frustration with the Part 2 barriers"
- Many advocates support the harmonization of HIPAA and Part 2 into a single set of standards applicable to all PHI, including SUD diagnosis treatment and records
H.R. 3545, OVERDOSE PREVENTION AND PATIENT SAFETY ACT

Hearing on “Improving the Coordination and Quality of Substance Use Disorder Treatment,” Subcommittee on Health (May 8, 2018)
Legislation to amend the Public Health Service Act to protect the confidentiality of substance use disorder patient records
Date: Tuesday, May 8, 2018; 1:00pm
Location: 2123 Rayburn House Office Building
Subcommittees: Health (115th Congress)

THE 2017 REVISIONS
Numerous changes to the Rule
- Entire Rule updated to apply to electronic, as well as paper, exchange of Part 2 records
- Several definitions updated or added, including “lawful holder,” “substance use disorder,” “medical staffing services”
- Consent requirements (§ 2.31)
- List of Disclosures (§ 2.13)
- Medical Emergencies (§ 2.51)
- Research (§ 2.52)
- Audit and evaluation (§ 2.53)

THE 2018 REVISIONS
- Disclosures for Payment and Healthcare Operations List of Disclosures (§ 2.33)
- Abbreviated Notice (§ 2.32)
- Audit and Evaluation (§ 2.53)
APPLYING PART 2 - THE “NEW” RULE

- Does Part 2 Apply? Is information protected by Part 2 (§§2.11-2.23)?
- Are There Any Exceptions? If information is subject to Part 2, does it fall under one of the exceptions to consent/exclusions (§2.12, §2.23, §§2.51-2.53)?
- Will the Patient Consent to Disclosure? Does the patient consent in writing to disclosure? (§§2.13, 2.31-2.35)
- Does a Court Order Apply? If no exception/exclusion to Part 2 applies and the patient does not consent to disclosure, can a court order be obtained? (§§2.61-2.67)


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APPLYING PART 2 - THE “NEW” RULE

Does Part 2 Apply? Are the records protected by Part 2 (Subpart B, §§2.11-2.23)?

- Purpose: Part 2 imposes restrictions on the disclosure of substance use disorder patient records maintained in connection with the performance of any Part 2 Program (§2.2)
- “Substance use disorder” is a new definition, replacing alcohol abuse and drug abuse - consistent with recognized classification manuals, current diagnostic lexicon and commonly used terminology (§2.11)
  - “A cluster of cognitive, behavioral, and physiological symptoms indicating that the individual continues using the substance despite significant substance-related problems such as impaired control, social impairment, risky use, and pharmacological tolerance and withdrawal, [but] . . . does not include tobacco or caffeine use.”

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APPLYING PART 2 - THE “NEW” RULE

Determination of “Program” is fact specific:

- An individual or entity (other than a general medical facility) that holds itself out as providing, and provides, SUD diagnosis, treatment, or referral for treatment; or
- An identified unit within a general medical facility that holds itself out as providing, and provides, SUD diagnosis, treatment, or referral for treatment; or
- Medical personnel or other staff in a general medical facility whose primary function is the provision of SUD diagnosis, treatment, or referral for treatment and who are identified as such providers
- A practice composed of primary care providers could be considered a “general medical facility”
- “Holds itself out” means any activity that would lead one to reasonably conclude that the individual or entity provides SUD diagnosis, treatment, or referral (helpful guidance in the 2017 Preamble and in previously published FAQs)
APPLYING PART 2 - THE “NEW” RULE

The definition of “Program” did not change in 2017 or 2018

- SAMHSA considered revising this term to make clear that a general medical facility or general medical practice that on occasion provides SUD treatment services incident to the provision of general health care is not a “Program”
- SAMHSA recognizes that more SUD treatment services are occurring in general health care and integrated care settings, including general medical practices (i.e., not just general medical facilities)
- Intent of Part 2 was to limit its applicability to specialized programs, not to impose requirements on general medical facilities or practices “in an overly broad manner”
- Based on comments, SAMHSA concluded that many commenters misunderstood the intent of the proposed revisions, and further that separating general medical practices from general medical facilities was confusing, so did not revise the definition as proposed

“Program” must be federally assisted

- No changes in 2017 or 2018
- Carried out under license, certification, registration, or other authorization by federal department or agency (Medicare/Medicaid, registration under Controlled Substances Act to dispense controlled substances – DEA number – if used for SUD treatment)
- Conducted in whole or in part by any department or agency of the U.S., directly or by contract or otherwise (not including the VA or the Armed Forces)
- Supported by funds provided by any department or agency of the federal government (federal financial assistance in any form, tax exemption, conducted by a state or local government unit that receives federal funds that could be used, but are not necessarily, for SUD programs)

Restrictions on disclosure apply to any information (whether recorded or not) that:

- “would identify a patient as having or having had a SUD either directly, by reference to publicly available information, or through verification of such identification by another person.” (§ 2.12)

What Is a Disclosure? (§2.11)

- Sharing written records outside the Part 2 Program
- Sharing patient identifying information in a way that re-identifies the patient
- Verbal discussions with staff or others outside the Part 2 Program
- Submitting claims information to a payor (e.g., Medicare)

No changes in 2017 or 2018 [other than updating terminology]
APPLYING PART 2 - THE “NEW” RULE

Applies regardless of whether information has been recorded (§2.12(a))

Disclosure must be limited to only that information necessary to carry out the purpose of the disclosure (§2.13)

Generally requires data segmentation

Are There Any Exceptions?

Section 2.12, Applicability, specifically exempts the following, when specific conditions and requirements exist:

Communications between a Part 2 facility and an entity having direct administrative control over that Part 2 Program (where certain conditions exist)

Communications between a Part 2 Program and a “Qualified Service Organization” for information relevant to services performed by the QSO

Reports of suspected child abuse and neglect pursuant to state law (but not in relation to civil or criminal proceedings that arise in relation to child abuse or neglect)

Subpart D, Disclosures Without Patient Consent, outlines three exceptions (covered in next slide)

Subpart E, Court Orders Authorizing Disclosure and Use, outlines disclosure pursuant to court orders

Are There Any Exceptions?

Subpart D, Disclosures Without Patient Consent, outlines three exceptions

Updated in 2017/2018

Medical Emergencies (§2.51) Allows disclosure of patient identifying information to medical personnel to meet a bona fide medical emergency where patient’s informed consent cannot be obtained

Pre-2017 Rule said disclosure was for the purpose of treating a condition that poses an immediate threat to the health of any individual and requires immediate medical intervention

2017 Rule gives health care providers more discretion

Revised language aligns with the statute

Consent “cannot be obtained” means the patient is incapable of providing consent, not that he/she refuses

Requires documentation of the disclosure by the Part 2 program
Are There Any Exceptions?

- **Subpart D, Disclosures Without Patient Consent**, outlines three exceptions.
- **Updated in 2017/2018**
- **Research (§2.52):** Allows disclosure of patient identifying information by the Part 2 Program or any Lawful Holder of such information.
  - Pre-2017 Rule said only Part 2 Program Directors could disclose for research purposes.
  - Allows disclosure to qualified personnel if the researcher provides documentation of meeting certain requirements regarding other existing protections for human research subjects (HIPAA, Common Rule).
  - Enables researchers holding Part 2 data to link to data sets from federal and non-federal data repositories when certain conditions are met.
    - Part 2 data must be in aggregate form, so it is non-identifiable.
- **Audits & Evaluations (§2.53):** Allows disclosure of patient identifying information by the Part 2 Program or an Lawful Holder in the course of an on-site audit.
  - Pre-2017 Rule said only Part 2 Program Directors could determine who is qualified to conduct an audit or evaluation.
  - Requires recipient to agree to restrictions on re-disclosure.
  - Clarifies that Medicare and Medicaid audit or evaluation section includes CHIP (Children’s Health Insurance Program) and disclosures can be made to contractors, subcontractors, or legal representatives carrying out such audit.
  - Permits an audit or evaluation necessary to meet the requirements of a CMS-regulated ACO or similar CMS-regulated organization, under certain conditions.
  - Allows audits or evaluations performed on behalf of federal, state, or local governments providing financial assistance to or regulating the activities of a Part 2 Program or to a Lawful Holder (e.g., a CMS-regulated ACO evaluates the impact of integrated care on several behavioral health participants; a state audits to determine how many individuals who leave state-supported correctional facilities receive SUD treatment).
  - Allows contractors, subcontractors, and legal representatives to perform audits for third-party payors or quality improvement organizations.

Will the Patient Consent to Disclosure?

- Does the patient consent in writing to disclosure? (§§2.13, 2.31-2.35)
- Consent must be in writing (paper or electronic versions acceptable) and must include nine elements:
  1. **Name of patient**
  2. **“From Whom”** – name or general designation of Part 2 Program, entity, or individual permitted to make the disclosure (proposed change removing the general designation not implemented).
  3. **Amount and Kind of Information to be Disclosed** – must include an “explicit description” of the SUD information to be disclosed; “all of my SUD information” or “all of my records” not acceptable, must have “sufficient specificity to allow the disclosing program or other entity to comply with the request” [new in 2017].
APPLYING PART 2 - THE “NEW” RULE

- Will the Patient Consent to Disclosure? Does the patient consent in writing to disclosure? (§§2.13, 2.31-2.35)

  4. “To Whom”: Name of individual(s) to whom disclosure is to be made or name of entity (if treating provider relationship exists) (see next slide)

  5. Purpose of Disclosure (e.g., “treatment”)

  6. Revocation - notice that consent can be revoked (except to extent Part 2 Program or Lawful Holder has relied on it)

  7. Duration - Date, event or condition upon which consent will expire; must ensure consent will last no longer than necessary to serve purpose for which it is provided

  8. Signature - Patient signature; if consent is on behalf of minor or incompetent person, should be signed by individual authorized to consent (§§2.14, 2.15)

  9. Date – Date patient (or authorized representative) signed form

- General designation acceptable for individuals & entities that have a treating provider relationship with the patient, including through intermediary entities like ACOs or HIEs

  - For example, patient may designate “past,” “current,” or “future” treating providers or may generally designate entity by name

  - Patient also may designate by name one or more individuals on health care team with whom patient has a treating provider relationship

- If using a general designation, statement must be included on the consent form that the patient confirms his/her understanding that, upon the patient’s request, he/she must be provided a list of entities to which his/her information has been disclosed pursuant to the general designation; limited to 2 years (§§ 2.31, 2.13(d))
APPLYING PART 2 - THE “NEW” RULE

Disclosures for Payment and Health Care Operations (§2.33)

- If a patient consents to disclosure for Payment or Health Care Operations Activities, a Lawful Holder may further disclose to contractors, subcontractors, and legal representatives in furtherance of those activities
  - Must be limited to that information necessary to carry out the stated purpose
  - Lawful Holders must have contracts in place with the recipient stating the recipient is bound by Part 2
  - Recipients must receive a notice with the disclosure
  - Recipients must be required to report any unauthorized uses, disclosures, or breaches
- Disclosures for other purposes, such as SUD diagnosis, referral, or treatment are not permitted

SAMHSA did not finalize the list of Health Care Operations activities in the Proposed Rule, but included the list in the Preamble as illustrative of the types of Payment and Health Care Operations activities that are acceptable

- SAMHSA intends for other Payment and Health Care Operations activities to be permitted “as the health care system continues to evolve”
- Care coordination and case management explicitly prohibited
- Lawful Holders have until February of 2020 to bring contracts into compliance

Abbreviated Notice

“Federal law/42 CFR part 2 prohibits unauthorized disclosure of these records.”
JESSIE’S LAW

Jessie Grubb was a 30-year old woman from West Virginia with a history of a heroin addiction. After successfully completing addiction treatment, Jessie had hip surgery at a hospital in Michigan. Even though her parents told hospital staff that she had a history of addiction, such information was not conveyed to her physician. She was discharged with 50 oxycodone pills. Within 24 hours of her discharge, she overdosed and died.


“Jessie’s Law” was enacted as part of House Bill No. 6, which became known as the SUPPORT for Patients and Communities Act (“Support Act”). Jessie’s Law was not part of the original form of House Bill No. 6 introduced in June 2018, but was later added to the final version of House Bill No. 6 in October 2018. Specifically, Section 7052 provides that DHHS will “develop best practices for health care providers and state agencies regarding the display of a patient’s history of opioid addiction in the patient’s medical records” and Section 7053 provides that the Centers for Medicare and Medicaid Services (“CMS”) and the Health Resources and Services Administration (“HRSA”) will provide notice on an annual basis to health care providers about health information that may be disclosed under federal privacy laws to families, caregivers, and health care providers during emergencies, including overdoses.


“Jessie’s Law” was first introduced in the 2015-2016 legislative session as Senate Bill No. 2866 and House Bill No. 5142 and proposed sweeping amendments to Part 2. These bills never became law, but in April of 2019, a bipartisan group of lawmakers reintroduced bills in the House and Senate that would align Part 2 with HIPAA. See https://www.congress.gov/bill/116th-congress/senate-bill/1012/history

Questions?

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TELEMEDICINE - ISSUES AND CHALLENGES IN PROVIDING MENTAL HEALTH SERVICES AND COMBATING THE OPIOID EPIDEMIC

By

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I. WHAT IS TELEMEDICINE?

The terms telehealth and telemedicine are sometimes used interchangeably, but historically, the term “telemedicine” has focused more narrowly on the provision of clinical services while the term “telehealth” encompasses a broader range of services that address health care needs.

The official definition depends on who is asking. For example, Sec. 1834(m) [42 U.S.C. 1395m] & 42 CFR § 410.78 (Medicare) defines “telehealth services” to include office visits and consultations that are provided using an interactive 2-way telecommunications system (with real-time audio and video) by a doctor or certain other health care provider who isn’t at your location. Under Medicaid, “telehealth” (or Telemonitoring) is the use of telecommunications and information technology to provide access to health assessment, diagnosis, intervention, consultation, supervision and information across distance. In Florida, 59G-1.057, F.A.C. defines it as the practice of health care delivery by a practitioner who is located at a site other than the site where a recipient is located for the purposes of evaluation, diagnosis, or treatment. Under 64B15-14.0081, F.A.C., “telemedicine” means the practice of medicine by a licensed Florida physician or physician assistant where patient care, treatment, or services are provided through the use of medical information exchanged from one site to another via electronic communications. Telemedicine shall not include the provision of health care services only through an audio only telephone, email messages, text messages, facsimile transmission, U.S. Mail or other parcel service, or any combination thereof.

The modalities of both telemedicine and telehealth include use of smart phones, medical devices, tablets, computers, audio and video imaging equipment. These allow patients to engage with providers, often specialists not available in their communities, in real time. They also allow provider to provider consultation. Of note, broadband internet access is usually required to enable interaction or transmission of images and medical data for evaluation.

II. GUIDELINES FOR REIMBURSEMENT

A. Medicare

1. Only for specific services provided at a doctor's office, hospital, critical access hospital (CAH), rural health clinic, federally qualified health center, hospital-based or critical access hospital-based dialysis facility, skilled nursing facility, or community mental health center

2. “Originating site” must be located in either:
   a. A county outside a Metropolitan Statistical Area (MSA); or
   b. A rural Health Professional Shortage Area (HPSA) in a rural census tract
      i. HPSAs are designated by the HRSA as having shortages of primary care physicians, dental health providers, and/or mental health
providers. It may be geographic, by population, or by number of facilities.

3. Expansion of Medicare Reimbursement
   a. The AMA advocated for—and the Centers for Medicare & Medicaid Services has accepted—five new Current Procedural Terminology (CPT®) codes for 2019 that will allow physicians to be paid for their delivery of health care services using virtual technologies including remote patient monitoring (RPM) and e-consults.
      i. 99453 Remote monitoring of physiologic parameter(s), (for example, weight, blood pressure, pulse oximetry, respiratory flow rate) initial; setup and patient education on equipment use.
      ii. 99454 Device(s) supply with daily recording(s) or programmed alert(s) transmission, each 30 days.
      iii. 99457 Remote physiologic monitoring treatment management services, 20 minutes or more of clinical staff/physician/other qualified health care professional time in a calendar month requiring interactive communication with the patient/caregiver during the month.
      iv. 99451 Interprofessional telephone/internet/electronic health record assessment and management service provided by a consultative physician, including a written report to the patient’s treating/requesting physician or other qualified health care professional, 5 minutes or more of medical consultative time.
      v. 99452 Interprofessional telephone/internet/electronic health record referral service(s) provided by a treating/requesting physician or other qualified health care professional, 30 minutes.
   b. Bipartisan Budget Act:
      i. Beginning January 1, 2019, the Bipartisan Budget Act of 2018 (BBA) removed the originating site geographic conditions and added eligible originating sites to diagnose, evaluate, or treat symptoms of an acute stroke.
   c. SUPPORT
      i. Beginning July 1, 2019, the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act removed the originating site geographic conditions and added an individual’s home as a permissible originating telehealth services site for treatment of a substance use disorder or a co-occurring mental health disorder.
      ii. It also mandates the use of electronic prescribing of controlled substances (EPCS) for all controlled substances under Medicare Part D by January 2021.
d. Mental Health Telemedicine Expansion Act, HR 1301
   i. In February, H.R. 1301, the Mental Health Telemedicine Expansion Act, was introduced to Congress. The bill would amend section 1834(m) of the Social Security Act (42 U.S.C. 1395m(m)) which covers payment for telehealth services and list specific requirements for the use of telehealth for Medicare providers. In addition to current reimbursement codes, psychotherapy services, as identified by current procedural terminology (CPT) codes 90834 and 90837, would become reimbursable when delivered via telehealth.
   ii. The Mental Health Telemedicine Expansion Act would also add specific requirements for providers using telehealth to deliver services using those codes. Providers would need to conduct an in-person assessment of the patient’s need for the service, prior to providing mental health telehealth services and subsequently reassess those needs at a frequency that is specified by the Secretary of Health and Human Services. However, the geographical limitations that telehealth services in Medicare currently face would not apply to these services. The patient’s home would be considered an eligible originating site in the delivery of these services, however there will be no facility fee available for the patient’s home or any other originating site that is not described in the original telehealth statute.

e. Updates to the Medicare Advantage Program
   i. CMS issued a final rule on April 5, 2019 implementing several provisions from the BBA including updating the Medicare Advantage program by allowing MA plans to include “additional telehealth benefits” as part of the Medicare basic benefits.
   ii. As a result, starting in plan year 2020, MA plans will be able to include such “additional telehealth benefits” (i.e., telehealth benefits beyond what original Medicare allows) in their bids for the basic Medicare benefits.
   1. “Additional telehealth benefits” are defined as services i) available under Medicare Part B, but not payable under the original Medicare telehealth benefit and ii) identified by the MA plan as clinically appropriate to furnish through electronic exchange when the physician or practitioner providing the services is not in the same location as the enrollee. See 42 CFR 422.135(a); 42 CFR 410.78. CMS broadly defines “electronic exchange” as electronic information and telecommunications technology and permits MA plans to furnish such “additional telehealth benefits” provided the plan meets the following requirements:
      a. the plan provides in-person access to the specified Part B services(s) at the election of the enrollee;
      b. the plan advises each enrollee that he/she may receive the specified Part B services through an in-person visit or through electronic exchange;
c. the plan complies with the Medicare provider selection and credentialing requirements and, when providing additional telehealth benefits, ensures through its contract with the provider that the provider meets and complies with applicable state licensing requirements and other applicable laws for the state in which the enrollee is located and receiving the services; and
d. the plan makes information about coverage of additional telehealth benefits available to CMS upon request, including but not limited to statistics on use or cost, manner or method of electronic exchange, evaluation or effectiveness, and demonstration of regulatory compliance. See 42 CFR 422.135(c).

2. CMS has required that for every MA additional telehealth benefit, the MA plan also must provide access to the same service via an in-person visit, thereby giving the MA plan enrollee the ultimate choice in how to access such services. CMS has chosen not to define which services will be considered “clinically appropriate” to offer in this manner, instead extending to the provision of such additional telehealth benefits the existing requirement at Section 422.504(a)(3)(iii) that the MA organization to agree to provide all benefits covered by Medicare “in a manner consistent with professionally recognized standards of health care.” CMS will defer to MA plans to independently determine, for each plan year, which services are clinically appropriate to furnish using electronic information and telecommunications technology.

f. ET3
   i. Another recent trend is introduction of legislation among states to adopt interstate licensure compacts which allow special licensure to exceptions to state licensing requirements for specific health care providers to practice across state lines in other states that have adopted the same compact as long as certain requirements are met. Main one is Recognition of EMS Personnel Licensure Interstate Compact (REPLICA) which allows EMS personnel to respond to calls and transport patients across state lines. (To date, Florida is not a member)
   ii. Health and Human Services recently announced ET3, which will begin in early 2020 and provides a voluntary payment model will reimburse EMS personnel for transporting a Medicare patient to a site other than an emergency room or for the delivery of treatment on the scene or via telehealth. The model aims to ensure Medicare beneficiaries receive the most appropriate care and to provide more efficient, broader access to emergency care.
B. Medicaid

1. Federal policy does not place many restrictions on state Medicaid programs in terms of adopting or designing telehealth coverage but it also offers little guidance or information about implementation.
   a. The federal Medicaid statute does not identify telehealth as a specific service.
   b. Broad CMS guidelines require providers to practice within the scope of their state practice law and to comply with pertinent state licensing rules.
   c. Payment for telehealth must satisfy federal Medicaid requirements for efficiency, economy, and quality of care.

2. Thus, state Medicaid coverage of telehealth varies across multiple dimensions, such as the telehealth modality, specialties and services, providers authorized to deliver services through telehealth, and sites of service.

3. The general Medicaid requirements of comparability, state wideness and freedom of choice do not apply with regard to telemedicine services. However, states limiting telehealth to certain providers or regions must assure access to and cover face-to-face visits in regions where telehealth is not available.

4. Key modalities typically covered:
   a. Live video (synchronous telehealth). Ex: Web cams
   b. Store-and-forward (asynchronous telehealth). Ex: X-rays

5. Modalities less likely to be covered:
   a. Mobile Health (mHealth). Ex: Smartphone apps
   b. Electronic Consults (e-consults). Ex: Provider-to-provider

C. Florida

1. Section 59G-1.057 of the Florida Administrative Code
   a. (4) Coverage. Florida Medicaid reimburses for telemedicine services using interactive telecommunications equipment that includes, at a minimum audio and video equipment permitting two-way, real time, interactive communication between a recipient and a practitioner.
   b. (5) Exclusion. Florida Medicaid does not reimburse for:
      i. (a) Telephone conversations, chart review(s), electronic mail messages, or facsimile transmissions.
      ii. (b) Equipment required to provide telemedicine services.
   c. (6) Reimbursement. The following applies to practitioners rendering services in the fee-for-service delivery system:
      i. (a) Florida Medicaid reimburses the practitioner who is providing the evaluation, diagnosis, or treatment recommendation located at a site other than where the recipient is located.
      ii. (b) Providers must include modifier GT on the CMS-1500 claim form, incorporated by reference in Rule 59G-4.001, F.A.C.

2. Live video telehealth is covered under Medicaid fee-for-service plans, and is optional for managed care plans. The state’s model contract for managed care plans explicitly notes this and, for plans choosing to use telehealth, the contract describes the conditions for payment.
D. Private Insurance

1. Currently, 29 states plus the District of Columbia have telehealth commercial insurance laws requiring commercial health insurance companies cover services provided via telehealth to the same extent those services are covered if provided in-person. Continued expansions in reimbursement mean providers can enhance telehealth offerings, both for the immediate cost savings and growing opportunities for revenue generation, to say nothing of patient quality and satisfaction.

2. In 2016, Florida HB 7087: The bill authorized the Agency for Health Care Administration (AHCA), the Department of Health (DOH) and the Office of Insurance Regulation (OIR) to survey health care facilities, health care practitioners, insurers, and health maintenance organizations, regarding the use of telehealth. Report submitted helped pave the way for the most recent Telehealth Law passed on April 29, 2019.

E. House Bill 23

1. A recent telehealth bill in Florida could have expanded telehealth adoption by providing a tax credit to health insurers and health maintenance organizations (HMO) that cover services provided via telehealth. HB 23 would have established the telehealth tax credit, beginning on January 1, 2020. The credit would amount to one tenth of one percent (0.1%) of total insurance premiums received and may be applied against the corporate income tax or insurance premium tax. If unused, the credit would carry over each year for a period not exceeding five years.

2. HB 23 also includes certain provisions for defining telehealth and establishes both practice standards and restrictions regarding its use. (Florida does not currently define telehealth in statute). The new provisions would also permit out-of-state telehealth providers to provide health care services to patients located in Florida if such a provider registers with the applicable board or department.

III. MENTAL HEALTH & THE OPIOID CRISIS

While the “opioid crisis” may be well known, what is not very well-known is that use of these drugs can lead to Opioid Use Disorder, which is a psychiatric illness that was introduced for the first time in the 5th ed. of the DSM. (2013). This is a chronic lifelong disorder, with serious potential consequences including disability, relapses, and death. Opioid use is also tied to the development of depression, dysthymia, generalized anxiety disorder, and panic disorder. According to a recent article in a journal of internal medicine:

Very high rates of mental health disorders co-exist among patients with opioid use disorders as well as among patients with chronic pain conditions leading to increased risk for suicide. The 2017 National Survey on Drug Use and Health found, however, that 92 percent, or 19.7 million people, with a substance use disorder receive no treatment, and 57 percent, or 46.6 million people, with a mental illness receive no treatment.
A. **Barriers to Care**  
1. Substantial medical literature documents the clinical effectiveness of MAT for opioid addiction. MAT is medication-assisted treatment, involves the use of medication along with counseling and behavioral therapies. 3 FDA medications used to treat opioid addiction are Methadone, Buprenorphine, and Naltrexone. The purpose is to prevent withdrawal symptoms and block the euphoric effects of the opioid.  
2. The problem is implementing that treatment and getting it to the patients who need it. As explained by the CEO of the AMA in a letter to Congress addressing the opioid crisis, one of the reasons MAT is so underutilized is because of problems with the current reimbursement scheme. Despite this evidence and the worsening epidemic, MAT, particularly using buprenorphine, is significantly underutilized. One reason for its underutilization is that traditional physician payment systems provide little or no support for nonface-to-face services such as phone calls and email consultations with patients, collaboration between addiction specialists and other physicians, as well as between outpatient treatment programs and other health care providers such as emergency departments, and coordination of the behavioral, social and other support services that patients being treated for opioid use disorder need in addition to their medication.  
3. Other barriers to care include fragmented delivery systems, insufficient supply and geographic maldistribution of behavioral health providers, and patient concerns about confidentiality and fear of stigma attached to acknowledging the need for and seeking treatment.  

B. **Combatting the Opioid Crisis**  
1. In a 2015 press release, Secretary of Agriculture Tom Vilsak explained how opioid and other substance misuse disproportionately affect rural areas, and telemedicine is proving to be an effective tool for treating patients when experts otherwise would be unavailable. Hospitals, schools and training centers across the country are successfully using telecommunications to deliver specialized care to area residents.  
2. As a result, many organizations, including the AMA have advocated for greater utilization of telemedicine. Last year, the AMA sent a letter to Congress emphasizing the need for increased access to treatment for these patients.  
3. The Florida Legislature seems to agree – part of the legislative intent found under 394.453 “The Florida Mental Health Act” or “The Baker Act” states:  

   “The Legislature further finds the need for additional psychiatrists to be of critical state concern and recommends the establishment of an additional psychiatry program to be offered by one of Florida’s schools of medicine currently not offering psychiatry. The program shall seek to integrate primary care and psychiatry and other evolving models of care for persons with mental health and
substance use disorders. Additionally, the Legislature finds that the use of telemedicine for patient evaluation, case management, and ongoing care will improve management of patient care and reduce costs of transportation.”

C. Using Telemedicine to Treat Substance Use Disorders
1. The primary ways telemedicine is used to treat SUDs, as well as other mental health disorders, is through videoconferencing for delivering psychotherapy and counseling as well as assessment and medication management, as well as provider consultation and collaboration.
2. The HRSA provides some other examples of how telemedicine can be used to treat Substance Use Disorders, including developing programs for underserved communities, provider to provider consultation resources, and focusing on developing prescribing guidelines for pain management and related behavioral health services on its website: https://www.hrsa.gov/opioids.
3. Using telemedicine to treat mental health patients is not an entirely novel idea; AMA researchers found that specialists using telemedicine the most to interact with patients are: Radiologists at 39.5 percent, Psychiatrists at 27.8 percent, and Cardiologists at 24.1 percent. Further, videoconferencing is employed by the practices of 31.6 percent of emergency physicians and about 25 percent of psychiatrists’ and pathologists’ practices. Cardiologists and nephrologists are the biggest remote patient monitoring users, while radiologists and pathologists are the biggest users of telemedicine’s data storing-and-forwarding function.
4. The good news, is we are making progress. AMA’s Opioid Task Force’s 2019 Progress Report shows physicians have significantly lowered the number of opioid prescriptions they write and there are rising numbers of doctors registering with and using their state prescription-drug monitoring program (PDMP), getting certified to provide in-office buprenorphine, and prescribing naloxone for at-risk patients. More providers are also utilizing the CDC’s Guideline for Prescribing Opioids for Chronic Pain.
5. Unfortunately, according to AMA President-elect Susan R. Bailey, M.D.: “This progress, however, has not led to an overall reduction in mortality or a measurable increase in positive patient outcomes.” Progress has also been stalled by barriers to evidence-based treatment. These include:
   a. Payer practices that delay or deny care.
   b. Reluctance to use MAT.
   c. Stigma.
   d. Lack of sufficient treatment facilities and addiction medicine specialists.
   e. But, most of all, there is a lack of financial support.

IV. FEDERAL AND STATE LIMITATIONS
For purposes of our presentation, we’re going to focus on the federal and state limitations on the delivery of telemedicine services for certain medication prescriptions. These limitations were enacted to address patient safety concerns related to prescribing certain medications via telehealth, specifically, concerns re whether the interaction is enough to ensure that providers have
sufficient medical history or information to safely prescribe a medication. For example, psychiatrists are trained to pick up on little things like micro-expressions which can reveal hidden emotions. These may be more difficult to notice over even a high-definition video transmission. Joe Navaro, a former FBI agent who is trained in deception, espionage and interrogation, said in an article in *Psychology Today* that it’s not just micro-expressions via teleconferencing that can be missed if caregivers are not properly trained. Certain facial expressions are so small, like the twitch beneath the eye, and rapid - they pass in 1/15th to 1/25th of a second - that they are extremely difficult to observe.

A. **Florida Standards for Telemedicine Practice; F.A.C. 64B15-14.0081 & 64B8-9.0141**
   1. (2) The standard of care, as defined in Section 456.50(1)(e), F.S., shall remain the same regardless of whether a Florida licensed physician or physician assistant provides health care services in person or by telemedicine.
   2. (5) Prescribing medications based solely on an electronic medical questionnaire constitutes the failure to practice medicine with that level of care, skill, and treatment which is recognized by reasonably prudent physicians as being acceptable under similar conditions and circumstances, as well as prescribing legend drugs other than in the course of a physician’s professional practice.
   3. (6) Physicians and physician assistants shall not provide treatment recommendations, including issuing a prescription, via electronic or other means, unless the following elements have been met:
      a. (a) A documented patient evaluation, including history and physical examination to establish the diagnosis for which any legend drug is prescribed.
      b. (b) Discussion between the physician or the physician assistant and the patient regarding treatment options and the risks and benefits of treatment.
      c. (c) Maintenance of contemporaneous medical records meeting the requirements of Rule 64B15-15.004, F.A.C.
   4. (7) The practice of medicine by telemedicine does not alter any obligation of the physician or the physician assistant regarding patient confidentiality or recordkeeping.
   5. (8) A physician-patient relationship may be established through telemedicine.
      a. (Telemedicine shall not include the provision of health care services only through an audio only telephone, email messages, text messages, facsimile transmission, U.S. Mail or other parcel service, or any combination thereof).

B. **Controlled Substances – Florida**
   1. Drugs and other substances that are considered controlled substances under the Controlled Substances Act (CSA) are divided into five schedules. An updated and complete list of the schedules is published annually in Title 21 Code of Federal Regulations (C.F.R.) §§ 1308.11 through 1308.15. A list is also found in Fla. Stat. 893.03. Substances are placed in their respective schedules based on whether they have a currently accepted medical use in treatment in the United States, their relative abuse potential, and likelihood of causing dependence when abused.
a. Schedule I: No accepted medical use, lack of accepted safety for use under medical supervision, and a high potential for abuse. Ex: heroin, LSD, marijuana, etc.
b. Schedule II/IIIN: High potential for abuse which may lead to severe psychological or physical dependence. Ex: Narcotics: Hydromorphone (Dilaudid), Dolophine, Demerol, Oxycontin/Percocet, Fentanyl, Morphine, Codeine, Opium, Hydrocodone [opioids]. Ex: Stimulants: Adderall, Ritalin
c. Schedule III/IIIN. Ex: Tylenol with Codeine, Suboxone
d. Schedule IV. Ex: Xanax, Klonopin, Valium, Ativan, Versed
e. Schedule V. Ex: Robitussin (< 200 mg codeine)

2. Treating Acute Pain; F.A.C. 64B15-14.005(2) & 64B8-9.013
a. Florida has limitations on prescribing controlled substances, and they depend on whether the treatment is for chronic pain or acute pain. The general standard for prescribing controlled substances for treatment of acute pain includes an evaluation of the patient, which includes a physical examination, a written treatment plan, informed consent, periodic review and reevaluation of the patient’s status, consultations with other specialists as needed, and medical record keeping.

3. Treating Chronic Pain; Fla. Stat. § 456.44(3)
a. Standards for treatment of chronic pain are listed in Fla. Stat. § 456.44(3). Requirements similar to treatment of acute pain, although the periodic review is required to be no more than 3 months. (g) also requires immediate referral of patients with signs or symptoms of substance abuse to a board-certified pain management physician, an addiction medicine specialist, or a mental health addiction facility as it pertains to drug abuse or addiction unless the registrant is a physician who is board-certified or board-eligible in pain management.

4. House Bill 21
a. In 2018, HB 21 was presented and signed by the governor and became law (chapter 2018-13). It added section 456.0301, “Requirement for instructions on controlled substance prescribing” – includes, among other things, continuing education requirement, emphasizing standard for prescribing opiates.
   i. Each person registered with the DEA and authorized to prescribe controlled substances must complete a board-approved 2-hour CE course on prescribing controlled substances.
   ii. “The course must include information on the current standards for prescribing controlled substances, particularly opiates; alternatives to these standards; nonpharmacological therapies; prescribing emergency opioid antagonists; and the risks of opioid addiction following all stages of treatment in the management of acute pain.”

b. It also amended 456.072 authorizing disciplinary action against practitioners for violating specified provisions relating to controlled substances.
It also amended 456.44 to define “acute pain,” also states a patient can only use 1 physician to obtain controlled substances, and contains robust documentation requirements as to the medical justification for continued treatment with controlled substances and those steps taken to ensure medically appropriate use of controlled substances by the patient.

It also amended 465.0276 to limit a dispensing practitioner to a 3-day supply of opioids for treatment of acute pain, or a 7-day supply if: 1. The prescriber, in his or her professional judgment, believes that more than a 3-day supply of such an opioid is medically necessary to treat the patient’s pain as an acute medical condition; 2. The prescriber indicates “ACUTE PAIN EXCEPTION” on the prescription; and 3. The prescriber adequately documents in the patient’s medical records the acute medical condition and lack of alternative treatment options that justify deviation from the 3-day supply limit established in this subsection.

5. F.A.C. 64B15-14.0081
   a. Florida also limits the prescription of controlled substances via telemedicine.
   b. The Code originally stated simply that “[c]ontrolled substances shall not be prescribed through the use of telemedicine.”
   c. In 2014, the section was amended to add the phrase: “This provision does not preclude physicians from ordering controlled substances through the use of telemedicine for patients hospitalized in a facility licensed pursuant to Chapter 395, F.S.”
   d. Finally, in 2016, the exception for treatment of psychiatric disorders was added. The current code reads: “[c]ontrolled substances shall not be prescribed through the use of telemedicine except for the treatment of psychiatric disorders. This provision does not preclude physicians or physician assistants from ordering controlled substances through the use of telemedicine for patients hospitalized in a facility licensed pursuant to Chapter 395, F.S.”

6. House Bill 23 – remember, this would codify into statute provisions regarding prescribing controlled substances via telehealth, and includes two additional circumstances under which a physician may use telehealth to prescribe a controlled substance.

C. Controlled Substances – Federal
   1. It is important to note that with respect to prescribing controlled substances for treatment of acute pain, the FAC requires providers comply with both Florida and Federal laws. But generally, providers should always be aware of potential preemption issues, especially with respect to the practice of telemedicine.
   2. In the case of controlled substances, there is a federal floor for requirements and limitations established by the Ryan Haight Online Pharmacy Consumer Protection Act of 2008. This Act was enacted on October 15, 2008 as a result of the death of a California high school honors student and athlete who died from an overdose of controlled substances he had purchased from a rogue online pharmacy. It amended
the Controlled Substances Act (CSA) (21 USC 829 & 21 USC 802) and Controlled Substances Import and Export Act (CSIEA) by adding various provisions to prevent the illegal distribution and dispensing of controlled substances by means of the internet, although there is still a fundamental perquisite that a prescription must be issued for a legitimate medical purpose by a practitioner acting in the usual course of professional practice. It generally prohibits prescribing of controlled substances through the Internet without a “valid prescription,” which requires the prescriber to have conducted at least one in-person medical evaluation of the patient. It exempts telehealth providers from this requirement under a limited set of circumstances.

3. Federal law also allows practitioners to prescribe controlled substances if they meet one of seven “practice of telemedicine” exceptions.
   a. Section 802(54) of Title 21, U.S.C., defines the practice of telemedicine as “the practice of medicine in accordance with applicable [f]ederal and [s]tate laws by a practitioner (other than a pharmacist) who is at a location remote from the patient and is communicating with the patient, or health care professional who is treating the patient, using a telecommunication system referred to in section 1395m(m) of title 42, [U.S.C.].”
   b. The “practice of telemedicine” exceptions are very narrow. They created an unintended barrier for legitimate practitioners seeking to use telemedicine to address practitioner shortages and deliver clinically-appropriate medical care to patients located in settings such as homes, schools, and rural areas (all common “originating sites” in contemporary direct-to-patient telemedicine service models). One of the exceptions – the special registration exception – was designed to allow telemedicine prescribing in these other settings without an in-person exam. However, for nearly ten years, the DEA never activated that special registration.

4. Special Registration for Telemedicine Act of 2018
   a. In response, President Trump signed into law the Special Registration for Telemedicine Act on Oct. 24, 2018. This was added to Title III, Subtitle B, Chapter 4 of the larger legislation titled the “SUPPORT for Patients and Communities Act” which we discussed early in this presentation. This Act requires the DEA to activate a special registration allowing physicians and NPs to prescribe controlled substances via telemedicine without an in-person exam. The DEA has no more than one year to complete the task. The law affords DEA ample time to issue proposed regulations, allow a 60 or 90-day period for the public to submit comments, consider and respond to those comments, and then publish the final regulations. Interested providers and telemedicine advocates should watch for the proposed regulations, submit comments, and make their voices heard on this important issue.
   b. Until then, it is best practice to have an in-person visit with a patient before prescribing them controlled substances virtually. That way, providers can capitalize on telehealth opportunities while maintaining compliance with applicable laws.
V. **ENFORCEMENT ACTIVITIES**

As mentioned earlier, the last few years have seen an explosive growth of telemedicine. Some estimates peg the global telemedicine technologies market, including hardware, software, and services, at nearly $40 billion in 2018. Incredibly, this market is projected to grow by 18% annually over the next six years, reaching $103 billion in 2024. Given the increased utilization of telemedicine, federal prosecutors and regulators are beginning to take note. The note chronicles some recent trends by prosecutors and offers practical advice.

VI. **Legal Developments**

The first development in the telemedicine enforcement space came in April of last year when the Department of Health and Human Services, Office of Inspector General (HHS/OIG) issued a report entitled “CMS Paid Practitioners for Telehealth Services that did not Meet Medicare Requirements.” As its title suggests, the report took issue with telemedicine providers and noted that upwards of one third of all telemedicine claims were improper.

On the heels of that report, the Department of Justice announced an indictment in Tennessee linked to a “billion-dollar telemedicine fraud conspiracy.” According to the indictment, the defendants set up an elaborate telemedicine scheme in which a telemedicine company “fraudulently solicited insurance coverage information and prescriptions from consumers across the country.”

And, finally, in December, the US Attorney’s Office in Utah announced a multimillion False Claims Act settlement. The United States alleged that the company violated Medicare’s prohibition against telephone solicitation of covered products to beneficiaries.

**Best Practices**

In light of this enhanced enforcement scrutiny, providers interested in telemedicine would be well-served by erring on the side of caution as the regulatory landscape is still being developed. We outline a few practical recommendations that are best practices.

**Ensure Patients Are Telemedicine Eligible.** Medicare only reimburses for care in the telemedicine setting when the patients receiving care are in rural settings (or otherwise meet other specific criteria). When developing your telemedicine program, make sure that the patients receiving these services are actually eligible. To that end, carefully scrutinize your patients’ demographics and current location. Only bill for those services that meet eligibility requirements.

**Make Sure the Patient is Receiving Telemedicine Services at a Qualified Site.** Telehealth services must be furnished to a beneficiary at an eligible originating site, which is one of the following: the office of a practitioner, a hospital, a critical access hospital (CAH), a rural health clinic, a federally qualified health center, a hospital-based or CAH-based renal dialysis center, a skilled nursing facility, or a community mental health center. Thus, before billing for telemedicine claims, make sure the patient is actually located at a facility that is eligible.

**Make Sure You’re Using Approved Communications Equipment.** In general, practitioners must provide telehealth services using an interactive telecommunications system. Generally, interactive telecommunications systems do not include telephone, fax, or email. These interactive
communication systems must allow real-time communication with both audio and video between the beneficiary and the practitioner.

**Make Sure You’re Only Providing Covered Services.** The CMS website lists allowable telehealth services and corresponding HCPCS codes. Make sure that you only provide services that are actually covered by telemedicine. Note that the list changes annually so practitioners would be well-served by reviewing the list of services covered.

**Make Sure the Telemedicine Provider is Located in the United States.** In general, Medicare payment is not allowed for services provided outside the United States. The Medicare Benefit Policy Manual states that the professional services of a physician are covered if provided within the United States. This has historically been an audit focus for CMS. Accordingly, make sure your telemedicine providers are located in the United States.

**Be Mindful of Medicare’s Anti-Solicitation Provisions.** In general, Medicare bans unsolicited calls to Medicare beneficiaries (or potential beneficiaries). Therefore, make sure you are calling only on those that have opted-in to receive telemedicine calls. While there has been some loosening restrictions—e.g., agents may now send unsolicited emails to potential beneficiaries if there is an opt-out option—these loosening restrictions do not apply to telephone calls. Therefore, obtaining—and documenting—patient consent is critical.

**Adopt a Whistleblower Hotline.** As the cases in Utah demonstrate, a leading cause of potential healthcare fraud investigations originate with whistleblowers filing suit under the False Claims Act. Therefore, a best practice in telemedicine—or any setting—is to adopt an internal whistleblower hotline where complaints can be raised internally. Ensuring that employees know about the hotline, trust the hotline, and use the hotline is critical to any hotline’s ultimate success.

**Remain Vigilant with AKS.** The government’s prosecutions to date have taken issue with improper financial relationships between telemedicine companies and the companies who make/supply Durable Medical Equipment/prescriptions. The government has scrutiny these relationships under the Anti-Kickback Statute. Therefore, as in any healthcare practice, carefully scrutinize the arrangement between the telemedicine company and any other vendors, ensuring that all arrangements pass regulatory muster.

**Document, Document, Document (and Record)!** Most healthcare practitioners know by now that files need to be documented thoroughly to withstand audits and scrutiny. So too in the telemedicine context. A best practice is to invest in recording of phone calls. This is often a telemedicine company’s best line of defense in rebutting patient complaints and other allegations.

**Mine Your Own Telemedicine Data.** A best practice for all healthcare practitioners, particularly high-volume practices, is to carefully review and mine your own billing and prescribing data. Of most importance, look at the top prescribed products and the top referrals. The government will likely look at this data, so it is best to review this same data set. For patients receiving anomalously high number of referrals/products, be sure that the medical files document the need for these referrals/products.
Ultimately, no suggestion will inoculate a telemedicine provider from scrutiny. As the government spends more and more money on telemedicine, increased enforcement is likely to be the norm. As the old adage goes, an ounce of prevention is worth a pound of cure. Nowhere is this adage truer in the evolving world of telemedicine.
Telemedicine Issues Associated with Behavioral Health and the Opioid Crisis

JASON MEHTA & ASHLEY MAKRIS

Presentation Overview

- What is Telemedicine?
- Guidelines for Reimbursement
- Mental Health & the Opioid Crisis
- Federal and State Limitations
- Enforcement Activities

The terms telehealth and telemedicine are sometimes used interchangeably, but historically, the term telemedicine has focused more narrowly on the provision of clinical services while the term telehealth encompasses a broader range of services that address health care needs.
Modalities
- Patient - provider
- Provider-provider
- Includes use of smart phones, medical devices, tablets, computers, audio and video imaging equipment, etc.
- Usually requires broadband internet access to enable interaction or transmission of images and medical data for evaluation.

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Medicare
- Only for specific services provided at specific locations.
- "Originating site" must be located in either:
  - A county outside a Metropolitan Statistical Area (MSA); or
  - A rural Health Professional Shortage Area (HPSA) in a rural census tract
HPSAs – designated by HRSA as having shortages of PCP, dental health, & mental health. May be geographic, by population, or facilities.

Expansion of services delivered via telehealth

- Bipartisan Budget Act of 2018 (BBA)
  - "additional telehealth benefits"
- Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act

Medicaid

- Limited restrictions
- Limited guidance
- The general Medicaid requirements of comparability, statewideness, and freedom of choice do not apply with regard to telemedicine services.
Medicaid cont...

- Key modalities typically covered:
  - Live video (synchronous telehealth)
  - Store-and-forward (asynchronous telehealth)
  - Remote Patient Monitoring (RPM)
- Modalities less likely to be covered:
  - Mobile Health (mHealth)
  - Electronic Consults (e-consults)

Florida

- Section 59G-1.057 of the Florida Administrative Code
- (4) Coverage. Florida Medicaid reimburses for telemedicine services using interactive telecommunications equipment that includes at a minimum, audio and video equipment permitting two-way, real-time, interactive communication between a recipient and a practitioner.
- (5) Exclusion. Florida Medicaid does not reimburse for:
  - (a) Telephone conversations, chat reviews, electronic mail messages, or facsimile transmissions.
  - (b) Equipment required to provide telemedicine services.

HB 23

- Tax credit?
- Provisions for defining telehealth and establishes both practice standards and restrictions regarding its use. (Florida does not currently define telehealth in statute). The new provisions would also permit out-of-state telehealth providers to provide health care services to patients located in Florida if such a provider registers with the applicable board or department.
- April 29th, ordered engrossed, then enrolled.
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"Of the almost 20 million individuals with a substance use disorder in 2017, more than 2 million qualified as having an opioid addiction," according to research published in the Journal of the American Medical Association (JAMA).
Opioid use tied to development of...

- Depression
- Dysthymia (Persistent Depressive Disorder)
- Generalized Anxiety Disorder
- Panic Disorder

“Very high rates of mental health disorders co-exist among patients with opioid use disorders as well as among patients with chronic pain conditions leading to increased risk for suicide. The 2017 National Survey on Drug Use and Health found, however, that 92 percent, or 19.7 million people, with a substance use disorder receive no treatment, and 57 percent, or 46.6 million people, with a mental illness receive no treatment.”

Barriers to Care

- Fragmented delivery systems
- Insufficient supply and geographic maldistribution of behavioral health providers
- Patient concerns about confidentiality and fear of stigma attached to acknowledging the need for and seeking treatment
Telemedicine is proving to be an effective tool for treating patients when experts otherwise would be unavailable.

Fla. Stat. § 394

"...the Legislature finds that the use of telemedicine for patient evaluation, case management and ongoing care will improve management of patient care and reduce costs of transportation."

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Standards for Telemedicine Practice

- Standard of Care
- Prerequisites to providing treatment recommendations/issuing prescriptions
- Confidentiality/bookkeeping
- A physician-patient relationship may be established through telemedicine.

Controlled Substances

- Schedule I
- Schedule II
- Schedule III
- Schedule IV
- Schedule V
Acute Pain

- (a) Evaluation of the Patient.
- (b) Treatment Plan.
- (c) Informed Consent and Agreement for Treatment.
- (d) Periodic Review.
- (e) Consultation.
- (f) Medical Records.

Chronic Pain

- (a) Evaluation of the Patient.
- (b) Treatment Plan.
- (c) Informed Consent.
- (d) Periodic Review.
- (e) Consultation.
- (f) Medical Records.
- (g) Referral to Pain Management Specialist.

Fla. Stat. § 456.0301
Fla. Stat. § 456.072
Fla. Stat. § 456.44
Fla. Stat. § 465.0276

Fla. Admin. Code. 64B15-14.0081(4)

- “[c]ontrolled substances shall not be prescribed through the use of telemedicine.”
- “This provision does not preclude physicians from ordering controlled substances through the use of telemedicine for patients hospitalized in a facility licensed pursuant to Chapter 395, F.S.”
- “[c]ontrolled substances shall not be prescribed through the use of telemedicine except for the treatment of psychiatric disorders. This provision does not preclude physicians or physician assistants from ordering controlled substances through the use of telemedicine for patients hospitalized in a facility licensed pursuant to Chapter 395, F.S.”
Fla. Stat. § 456.47 & 627.42396 (again)

HB 23 proposed provisions:

House Bill 23 proposed that a controlled substance provider may not use telehealth to prescribe a controlled substance unless the controlled substance is
prescribed for the following:
1. Treatment of a psychiatric disorder
2. Treatment at a hospital licensed under chapter 395
3. The treatment of a patient receiving hospital services
   or defined in § 409.004(16)
4. The treatment of a resident of a nursing home facility
   or defined in § 409.004(16)

April 29th: ordered engrossed, then enrolled

Controlled Substances

Ryan Haight Act:
"valid prescription"
at least one in-person medical evaluation OR practice of telemedicine
“Special Registration for Telemedicine Act of 2018”

Section 311(h)(2) of the Controlled Substances Act (21 U.S.C. 831(h)(2)) is amended to read as follows:

“(2) REGULATIONS.—Not later than 1 year after the date of enactment of the SUPPORT for Patients and Communities Act, in consultation with the Secretary, the Attorney General shall promulgate final regulations specifying—

(A) the limited circumstances in which a special registration under this subsection may be issued; and

(B) the procedure for obtaining a special registration under this subsection.”

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Telemedicine and Medicare

- Given the growth of telemedicine, regulators and prosecutors have started taking note.
- In April 2018, HHS/OIG found that roughly 31% of telemedicine claims were improper.
- HHS/OIG specifically recommended an action plan CMS regulators to use to address improper use of telemedicine.
Telemedicine Risks

- In October 2018, DOJ announced an indictment in Tennessee linked to a “billion-dollar telemedicine fraud conspiracy.”
- According to the indictment, the defendants set up an elaborate telemedicine scheme in which a telemedicine company “fraudulently solicited insurance coverage information and prescriptions from consumers across the country.”

More Prosecutions from DOJ Related to Telemedicine

- In December 2018, the US Attorney’s Office in Utah announced a multi-million False Claims Act settlement.
- The United States alleged that the company violated Medicare’s prohibition against telephone solicitation of covered products to beneficiaries.

Take-Aways from Government’s Enforcement Actions

- While there have been a dearth of public cases as far, a few salient points can be gleaned from the government actions to date.
- Of course, each case is unique and is judged on its own merits.
- Nonetheless, these data points are illustrative for healthcare providers interested in pursuing telemedicine.
Key Warning Signs from Tennessee Indictment

- In the Tennessee case, some of the relevant considerations giving rise to the criminal indictment included:
  - Soliciting insurance information from patients across the country;
  - Selling products at increased, marked-up prices;
  - “Concocting” information about the efficacy of products;
  - Creating an “intentionally deficient customer service designed to stall consumer complaints”, and
  - Marketing weight-loss and cannabis products but actually selling different reimbursable products once patients picked up the phone calls.

Key Warning Signs from Utah FCA Case

- In the Utah case, some of the relevant considerations giving rise to the civil settlement included:
  - The company violated Medicare’s prohibition against telephone solicitation of covered products to beneficiaries;
  - The company indiscriminately sold multiple Durable Medical Equipment products to all beneficiaries on the same phone call and
  - The company created prescriptions that were then sent to prescribing physicians to prescribe services (as opposed to the physicians creating the prescriptions).

Key Warning Signs from CMS Report

- CMS identified the following problematic features of telemedicine claims:
  - Claims where the beneficiaries received services at nonrural originating sites;
  - Claims billed by ineligible institutional providers;
  - Claims for services provided by an allowable means of communication;
  - Claims were for a noncovered service; and
  - Claims were for services provided by a physician located outside the United States.
Compliance Strategies

Providers interested in telemedicine would be well-served by erring on the side of caution as the regulatory landscape is still being developed.

Nonetheless, we outline ten practical suggestions for helping to develop a compliant telemedicine program that will survive scrutiny.

We caution that, ultimately, no solution will ensure that a regulator won’t ask questions. But, the more that can be done on the front end to ensure compliance, the better the prospects on the back end.

Strategy #1: Ensure Patients Are Telemedicine Eligible

Medicare only reimburses for care in the telemedicine setting when the patients receiving care are in rural settings (or otherwise meet other specific criteria).

When developing your telemedicine program, make sure that the patients receiving these services are actually eligible.

To that end, carefully scrutinize your patients' demographics and current location. Only bill for those services that meet eligibility requirements.

Strategy #2: Make Sure the Patient is Receiving Telemedicine Services at a Qualified Site

Telehealth services must be furnished to a beneficiary at an eligible originating site, which is one of the following: the office or a practitioner, a hospital, a critical access hospital (CAH), a rural health clinic, a federally qualified health center, a hospital-based or CAH-based renal dialysis center, a skilled nursing facility, or a community mental health center (42 CFR § 410.78(b)(3)).

Independent renal dialysis facilities are not eligible originating sites.

Before billing for telemedicine claims, make sure the patient is actually located at a facility that is eligible. Be sure to document this.
Strategy #3: Make Sure You’re Using Approved Communications Equipment

- In general, practitioners must provide telehealth services using an interactive telecommunications system (42 CFR § 410.78(b)).
- Generally, interactive telecommunications systems do not include telephone, fax, or email (42 CFR § 410.78(a)(3)) (with modest exceptions for patients in Alaska or Hawaii).
- These interactive communication systems must allow real-time communication with both audio and video between the beneficiary and the practitioner.

Strategy #4: Make Sure You’re Only Providing Covered Services

- The CMS website lists allowable telehealth services and corresponding HCPCS codes.
- Make sure that you only provide services that are actually covered by telemedicine.
- Note that the list changes annually so practitioners would be well-served by reviewing the list of services covered.

Strategy #5: Make Sure the Telemedicine Provider is Located in the United States

- In general, Medicare payment is not allowed for services provided outside the United States.
- The Medicare Benefit Policy Manual states that the professional services of a physician are covered if provided within the United States.
- This has historically been an audit focus for CMS. Accordingly, make sure your telemedicine providers are located in the United States.
Strategy #6: Be Mindful of Medicare’s Anti-Solicitation Provisions

- In general, Medicare bans unsolicited calls to Medicare beneficiaries or potential beneficiaries. Therefore, make sure you are calling only on those that have opted-in to receive telemedicine calls.
- While there has been some loosening restrictions—e.g., agents may now send unsolicited emails to potential beneficiaries if there is an opt-out option—these loosening restrictions do not apply to telephone calls.
- Therefore, obtaining—and documenting—patient consent is critical.

Strategy #7: Adopt a Whistleblower Hotline

- As the cases in Utah demonstrate, a leading cause of potential healthcare fraud investigations originate with whistleblowers filing suit under the False Claims Act.
- Therefore, a best practice in telemedicine—or any setting—is to adopt an internal whistleblower hotline where complaints can be raised internally.
- Ensuring that employees know about the hotline, trust the hotline, and use the hotline is critical to any hotline’s ultimate success.

Strategy #8: Remain Vigilant with AKS

- The government’s prosecutions to date have taken issue with improper financial relationships between telemedicine companies and the companies who make/supply Durable Medical Equipment/prescriptions.
- Therefore, as in any healthcare practice, carefully scrutinize these relationships under the Anti-Kickback Statute.
- The government has scrutinized these relationships between the telemedicine company and any other vendors ensuring that all arrangements pass regulatory muster.
Strategy #9: Document, Document, Document (and Record)!

- Most healthcare practitioners know by now that files need to be documented thoroughly to withstand audits and scrutiny. So too in the telemedicine context.
- A best practice is to invest in recording of phone calls. This is often a telemedicine company's best line of defense in rebutting patient complaints and other allegations.
- With the rapidly decreasing costs associated with this technology, recording of calls will likely be the new baseline expectation.

Strategy #10: Mine Your Own Telemedicine Data

- A best practice for all healthcare practitioners, particularly high-volume practices, is to carefully review and mine your own billing and prescribing data.
- Of most importance, look at the top prescribed products and the top referred products in your practice. Look at the data, as it's best to review this same data set.
- For patients receiving a nomially high number of referrals/products, be sure that the medical files document the need for these referrals/products.
FLORIDA'S LAWYER
ASSISTANCE PROGRAM FOR
ATTORNEYS WITH MENTAL
HEALTH AND/OR SUBSTANCE
ABUSE ISSUES

By

John Lesko, Pompano Beach
History of Florida Lawyers Assistance

In 1976, the Florida Supreme Court specifically recognized the disease concept of alcoholism and ruled that the presence of the illness could be taken into consideration when determining sanctions to be imposed on an attorney. Following this decision, the Court in 1979 mandated the Florida Bar to establish a commission on alcohol and drug abuse, charging the commission with assisting and monitoring chemically dependent attorneys during and after the grievance process. The Court also expressed its hope that the commission would be able to identify and assist affected lawyers prior to disciplinary proceedings being filed. The commission eventually evolved into the Florida Bar Special Committee on Alcohol and Drug Abuse (the Committee).

In 1981, the Committee issued a report containing the following recommendations:

1. Establishment of a statewide, toll-free hotline through which chemically dependent attorneys could obtain help.
2. Establishment of an independent Alcohol Advisory Committee to assist the Court and the Bar in disciplinary cases where chemical dependency was involved.
3. Establishment of an educational program, including speakers to appear at local bar meetings, to inform attorneys of the problem and to let chemically dependent attorneys know that help was available.

In 1985, the rules regulating the Florida Bar were amended to provide that the Bar was to create or fund a program for the identification of its members who are addicted to or dependent upon chemicals and the assistance of those members in overcoming such addictions or dependencies. The rationale for implementing the rule was the Court’s determination that a program designed to intervene before a chemically dependent attorney entered the disciplinary system could result in substantial savings of funds, client harm, and devastated lives, as well as acting as a resource to grievance committees in cases where alcohol or drugs were involved. In that same year, the Bar was, for the first time, given the responsibility of monitoring the probation of an attorney disciplined by the Court.
Both the Bar and the Committee perceived that a major impediment to the objective of reaching attorneys before they became involved in discipline was the issue of confidentiality of information provided by lawyers voluntarily seeking help. In order to provide the necessary safeguards, 25 active members of the Florida Bar petitioned the Court for a further amendment to the Rules providing for such confidentiality. In 1985 the Court authorized Rule 3-7.1(o) [now 3-7.1(j)] providing that an attorney has voluntarily sought, received, or accepted treatment for alcoholism or alcohol or drug abuse shall be confidential and shall not be admitted as evidence in disciplinary proceedings under these rules unless agreed to by the attorney who sought the treatment. In carrying out the Court’s mandate to create or fund a lawyer assistance program (LAP), it was decided that in order to assure confidentiality and provide maximum separation between the Bar and the LAP, a new corporation independent of the Bar should be created. This led to the formation of Florida Lawyers Assistance, Inc. in February 1986.

Other Impairments

Shortly after the creation of the LAP, it became apparent that conditions other than chemical dependency can also adversely affect an attorney’s ability to practice law. Such other conditions may include depression, stress, bi-polar disorders, personality disorders, financial and family problems, and other addictions such as gambling, sex, or food. Failure to address and treat these conditions can result in consequences just as severe as drug addiction or alcoholism. In recognition of this fact, the Court in 1998 expanded Rule 2-9.11 to provide that the program of assistance for addicted and chemically dependent members would also include those suffering psychological problems affecting their professional performance.

The Various Roles of FLA

Although FLA was originally created pursuant to this Court’s 1986 mandate as a voluntary, lawyers-helping-lawyers organization (which remains its core mission), it has evolved based on the needs of the Supreme Court, the Florida Bar, and the Florida Board of Bar Examiners to serve various functions. The role played by FLA in each of these cases depends on the category of client dealt with. Below is a description of each of the FLA client categories and FLA’s duties for each.
Voluntary Clients: These are individuals who contact FLA on their own or are referred by colleagues, judges, or family members, and have no Florida Bar or Bar Examiner involvement. In most cases, these clients are not placed under an FLA monitoring contract, but are referred to a local FLA contact in their area and informed of the closest FLA attorney support meeting. These services, as well as FLA’s education and prevention efforts, are funded by an allocation from the Florida Bar and the clients pay no fee.

Pre-Admission Clients: These are law students or out of state attorneys who have become aware through FLA or Bar Examiner outreach efforts (or fellow students) that issues in their history may require proof of rehabilitation in order to gain admission to the Florida Bar. They generally contact FLA directly (hopefully, early in their law school career) and enter into a monitoring contract which calls for meeting attendance, meetings with an attorney-monitor, and random urinalysis testing. It is the applicant’s decision whether to notify the Bar Examiners about entering into the contract. If they do, the Bar Examiners will normally request they execute a release allowing FLA to share the information in the client’s file and, if that release is provided, FLA will furnish the Bar Examiners with the information upon the Bar Examiners’ request. Other applicants may be sent to FLA by the Board after a review of the application or an investigatory hearing, with the requirement that the applicant enter into an FLA contract and document a period of sobriety, after which they will granted conditional admission. Pre-admission clients pay FLA a monthly fee of $25.00 as an administrative fee for maintaining their file.

Conditional Admission, Diversion, and Probation Cases: These are monitored clients who are subject to a formal order of this Court: 1) granting them conditional admission for a specified period; 2) granting them the non-disciplinary option of diversion; or 3) placing them on probation, either upon reinstatement or in conjunction with an admonishment or similar sanction. Very often the terms of monitoring are set by the Board of Bar Examiners (in conditional admission cases), by a referee (in disciplinary and reinstatement cases), or by consent agreement with the Florida Bar, and many of these clients are already under contract with FLA. In an event of non-compliance, FLA will consult with the Legal Division of the Florida Bar regarding the seriousness of the violation and suggest measures which may benefit the client therapeutically, but any final decision on sanctions is left to the Florida Bar and this Court. Clients in these
categories do not pay any fee to FLA, but do pay a monthly fee of $75.00 (conditional admittees) or $100.00 (diversion or probation) to the Florida Bar, which in turn pays a corresponding administrative fee to FLA, rendering the process financially neutral to the Bar.

Reinstatement and Readmission Cases: Clients in these cases are similar to pre-admission cases, in which information is compiled towards the end of submitting the record at any reinstatement or readmission hearing. There are rare cases where this Court has ordered ongoing monitoring and reporting of suspended attorneys, but unless the suspension is 90 days or less, the usual rule is that it is the attorney’s choice whether to enter into a monitoring contract with FLA (although it is obviously to their advantage to do so). Previously, an attorney seeking reinstatement could block FLA from testifying if their compliance was less than adequate, but this changed several years ago with the Court’s adoption of Bar Rule 3-7.10(f)(3)(g)(5) which requires a waiver of confidentiality if the lawyer has sought or received treatment or counseling for chemical or alcohol dependency or for other medical reasons that relate to the petitioner's fitness to practice law.

FLA CURRENTLY

The primary programs we offer are still: 1) weekly attorney support groups 2) evaluations and recommendations to The Florida Bar and 3) monitoring of students and preadmissions, lawyer discipline cases and conditional admissions. In addition, we provide monitoring for employers, court requirements and anytime substance abuse and mental health compliance requires documentation.

A comparison of the FY 2018 breakdown of our cases, with prior years, shows minimal changes in the percentage types of clients we monitor. Alcohol remains the most typical participant with slight increases in mental health cases. There has, however, been a decline in the numbers of Florida Bar and Board of Bar Examiner referrals. We have endeavored to identify the reasons for the declining referral rate and believe there are a number of factors: 1) more robust criminal diversion and probation programs for alcohol and drug cases often completed before the individual comes to FLA; 2) fewer DUI cases due to Uber and other ridesharing programs, and 3) lower law school admission rates than in past years.
That said, we have experienced an increase in voluntary contacts which usually do not require formal monitoring. Almost every day, we receive a call from a lawyer, judge, student, colleague or family member looking for assistance with a substance abuse or mental health problem. Again, around 55% of these calls involve substance abuse, 35% mental health, and the rest concern aging, financial, anger management, law office management, suicide concerns and a few others. Some of the calls result in referrals outside of FLA, but many of them state that it has been extremely helpful to have an understanding attorney or clinician to speak with. Only a small number of them require the documentation and accountability provided by monitoring.

We have also partnered with the Florida Council of Circuit Judges to create and administer the Florida Judicial Wellness Program (FJWP). This group provides support and resources for jurists seeking help for themselves or other judges. FLA is charged with answering the FJWP Confidential Hotline and connecting the judge with a volunteer judge or a clinician. Through our work with the judges, including involvement in their events, we have had the opportunity to educate judges about helping lawyers who appear to have problems.

Law school involvement has increased as we learn how best to work with each law school and provide services not otherwise available for students. We are delighted to be invited by one of our local law schools to have “Office Hours” twice a month. Our goal is to initiate a similar program in every school, likely utilizing some of our volunteers.

Outreach is also an integral part of FLA’s mission. FLA staff conducts programs at local bar associations, large law firms, Inns of Court, government agencies, Florida Bar programming and law school classes. More than 3,000 lawyers, students, and judges have heard us this past year alone and it is our hope that they are more aware of the availability of help, either at FLA or through private programs or counseling.

Summary

In conclusion, FLA has reached thousands of attorneys, judges and law students since its beginning and it is clear that our services continue to be crucial to our profession. The legal profession has known for some time that many of its members are struggling with mental health and/or substance use disorders. Recent studies conducted show just how prevalent these issues continue to be and illustrate that we still cannot ignore the problem. In 2016, the American Bar
Association (ABA) Commission on Lawyer Assistance Programs and Hazelden Betty Ford Foundation published their study of nearly 13,000 currently practicing lawyers. It found that between 21 and 36 percent qualify as problem drinkers, and that approximately 28 percent, 19 percent, and 23 percent are struggling with some level of depression, anxiety, and stress, respectively.

We would welcome the opportunity to meet with the members of this honorable Court to further describe the important support that FLA provides to our profession.

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ii. Rule 2-9.11


iv. Rule 3-7.1(j)

v. 1 P. R. Krill, R. Johnson, & L. Albert, The Prevalence of Substance Use and Other Mental Health Concerns Among American Attorneys, 10 J. ADDICTION MED. 46 (2016)
Stress, Chemical Dependency, and Attorney Satisfaction

Molly J. Paris, Esq.
Assistant Director, Florida Lawyers Assistance

Overcoming Stress, Anxiety, and Substance Abuse in the Legal Community

Presentation Developed by:
Molly Paris, Esquire
Director, Florida Lawyers Assistance

About Today’s Presenter

- John Lesko, JD, CAP, CCJAP
- Lawyer (1994 - 2007) and clinician (2010 - present)
- UF Health / FL Recovery Center (2011-2017)
- BoardPrep Recovery Center (2017-2018)
- Clinical care, and legal and licensing concerns, for attorneys and other professionals
I. Mental Health in the Legal Community
   • Scope of the Problem
   • Warning Signs of Suicide

II. Substance Abuse in the Legal Community
   • Scope of the Problem
   • What is Alcoholism?
   • Warning Signs

III. Florida Lawyers Assistance
   • What is FLA
   • FLA’s Role in the Legal Community

IV. Managing Workplace Stress
   • Suggestions for Employees
   • Suggestions for Employers

What we know about Legal Careers, Mental Health, and Addiction

During your first trial, you’ll remember you once thought law school was stressful, and you’ll get a good laugh.
Stress of Practicing

- Adversarial process
- Client’s most important interests
- Financial stress (contingent fee, expenses, “client” accounts)
- Long hours, deadlines, billing
- High expectations (superiors and clients)
- Nobody is happy
- Career investment/cmobile (feel trapped)

Effects of Stress

- Depression, anxiety, burnout
- Damage to immune, circulatory, digestive systems
- Substance abuse
- Unprofessional behavior
- Suicide

Mental Health and the Legal Profession

Stats

- Highest rates of suicide and depression of any occupational category
- Lawyers are 3.6 times more likely to suffer from depression than nonlawyers
- 28% of lawyers suffer from depression
- 19% of lawyers show symptoms of anxiety

A 2014 CNN article, “Why are Lawyers Killing Themselves” – 4th highest

2016, lawyers have highest suicide rate

Annual suicide rate, per capita:
- General pop = 14 per 100,000
- Attorneys = 69.3 per 100,000
Study by the ABA-Hazelden Betty Ford Foundation:

- N = 15K
- 20% v. 10%
- 33% of lawyers are problem drinkers
- 29% of lawyers in their first decade of practice report problem drinking

Lawyer disciplinary and malpractice cases:

- 40% to 70% involve alcohol/drug abuse or MDD disorder
- 80% of Client Protection Fund cases involve chemical dependency or a gambling component

Lawyers’ Mental Health and Substance Use Disorders Reported

Lawyer Steals Mortgages to Pay for his Oxy Habit

$800,000 worth of grand larceny against his ex-wife. John Rodia doesn’t have any money or any job.

It’s rarely common to hear about addicts resorting to burglary in order to ensure their next hit, but

John M. Rodia, a lawyer from Connecticut who

was also a state trooper at one time, stole more

than $800,000 from eleven of his own clients.

It’s a terrifying: the housing market has gone

haywire. He apologized in court, saying: I know I’ve hurt a lot of people. But I just manne...
Ervin Gonzalez, Esquire

On June 9, 2017, The Miami Herald reported that Mr. Ervin Gonzalez took his own life.

Speaking from the bench following his death, Federal Judge Federico Moreno stated, “He was a friend of judges and lawyers, but more importantly, of this community.”

Law firm: “he had been quietly battling mental illness.”

Mental Health and Substance Disorders

Organic and stress-related

Genetic Component
“Best predictor of MH D/O or suicide...”

Can be described as “situational”

MH and SUDs LOOK just the same...
Mental Health and Substance Disorders

A scientifically proven biomedical, social, and psychological disease (AMA: ’56, ’87) – ancient problem – primary and progressive

Not a matter of faith, religious doctrine, or moral failure
Not a matter of willpower or a "weakness"
Doesn’t matter what people “think” about it

Addiction Diagnosed by Behaviors

- Compulsive use / Inability to consistently abstain
- Craving and impaired control over drug use & behaviors
- Legal problems
- Unpredictable use patterns and outcomes
- Relapse is a feature
- Continued use despite increasing consequences

Why use substances

- Self-medication– they “work”
- Experimentation– curiosity, social
- Fun– they “work”

**AND** “unfortunately,” we’re programmed to survive… (See Darwin)
Brains Like “Drugs”

- Genetic, environmental, and social factors affect use.
- Psychoactive drugs (and behaviors) “reward” the brain.
- Brain developed in layers, heavy on survival...
- Repetitive and frequent use of substances or behaviors causes long-lasting changes in the brain structure, chemistry and pathway processes.

Other Addictions

- Gambling
- Internet Addiction
- Sex Addiction
- Eating Disorders
- Shoplifting Addiction
- Compulsive Shopping

Substance Use and the Legal Profession
Addiction: an illness for lawyers?

- “Genetically-based, stress-induced disorder” (Kevin McCauley, MD)
- i.e., illness ACTIVATED by stress
- “Stress” chemical in brain that occurs in addiction

“Good” Traits and Susceptibility

- Intelligent
- Detail-oriented (good MPs)
- Dedicated/ hard workers
- Socially conscious/ sense of justice
- Competitive
- Confident (arrogant)
- Driven to succeed/ scorekeepers/ wins/ $
Help is Available

WE CAN Help

Neuroplasticity

- Exercise brain into new habits; good and bad
- Cells can regenerate and grow
- New association networks form
- Synaptic changes (neurotransmitters, receptors and transporters)
- Addiction and Mental Health
  - Contingency Management Care

Safe Haven Programs (e.g., LAP)

- LAP (Lawyers’ Assistance Programs)...
- Modeled on Pilots’ and Physicians’ Programs
- **HIGH success rates**
- Participants elect participation and monitoring
- LAP guides recovery and verifies compliance
- “safe harbor” protection; FLA is *completely confidential* (for voluntary participants)
Who is Florida Lawyers Assistance, Inc.

FLA History and Regulation

30 attorney support groups/400 volunteers – MH & SUD
Comprehensive help— MH & SUD— psychologist on staff

NOT a Bar agency, but funded by and cooperative
with FL Bar

Formed non-profit in 1986, with Bar rule to ensure confidentiality

About Florida Lawyers Assistance, Inc.

FLA is a non-profit corporation formed in 1986 in response to the Florida Supreme Court’s mandate that a program be created to identify and offer assistance to bar members who suffer from substance abuse, mental health, or other disorders which negatively affect their lives and careers (Bar Rule 2-9.11).

FLA’s primary purpose is to assist the impaired attorney in his or her recovery. Florida Lawyers Assistance takes the firm position that substance abuse, compulsive behavior, and psychological problems are treatable illnesses rather than moral issues.
Confidentiality is paramount and in voluntary cases, it is protected by a written contract with The Florida Bar which guarantees the confidentiality of FLA records, as well as by Bar Rule 3-7.1(j), Chap. 397.482-486, F.S.

Judges, attorneys, and law students who seek the assistance of FLA need not worry that FLA will report them to the Bar, the Board of Bar Examiners, or their employer (unless a specific waiver is executed).

What Should We Do?

What Can We Do?

Why?

Warning signs of suicidal thoughts

- Withdrawing from friends and family.
- Loss of interest in usual activities.
- Showing signs of current depression, irritability.
- Changes in appetite, sleep, level of activity or sleep patterns.
- Negative self statements.
- Recurring suicidal thoughts or fantasies.
- Talking, writing or hinting about suicide.

- Best predictor: family hx
- Previous attempts.
- Feelings of hopelessness and helplessness.
- Purposefully managing personal affairs - eg, giving away possessions, making personal wills or life insurance, “cleaning up” personal affairs.
- Sudden change from extreme depression to “at peace” (may indicate decision to attempt).
Warning Signs of Alcohol and Drug Abuse

Psychological Signs
- Withdrawing from colleagues
- Irritability
- Inattentiveness
- Outbursts
- Mood Swings
- Paranoia
- Lack of Motivation

Physical Signs
- Slurred Speech
- Blood Shot Eyes
- Unkempt Hygiene and Appearance
- Sudden Weight Loss or Gain
- Odors on Breath, Body, or Clothing
- Decreased Performance
- Excessive Absenteeism

Who is Florida Lawyers Assistance, Inc.

Overcoming Workplace Stress: What You Can Do
General Tips for Managing Stress

- Regular exercise is a great way to reduce the effects of stress.
- Lead a healthy lifestyle—proper nutrition makes a big difference.
- Take one thing at a time.
- Be realistic in what you can accomplish compared to what you want to accomplish.
- Shed the “superman/superwoman” urge—realize that no one’s perfect, you will make mistakes.
- Partake in Resilience Training and Workshops

People who develop RESILIENCE

- Synonymous to: self-care, stress management, etc.
- Better understand and get along with others
- Rational actors who can put their own emotions aside
- Less frustrated when things do not go as planned
- Make better decisions relative to impact on others
- More able to adapt to change, emotional resilience

Effective Recovery

- Stress management
  - Ability to rest
  - Ability to process
  - Ability to feel safe
- Personal Support
- Professional Support
- Lawyer Assistance Program
Understanding and Overcoming Workplace Stress: An Employer’s Role

Role of Well-Being Committee
- Appoint a Wellness Advocate
- Provide Training and Education on Well-Being, Including During New Lawyer Orientation
- Encourage Feedback and Provide Feedback
- Provide Resilience Workshops and Training
- Implement and Emphasize a Service-Centered Mission

The Role of Well-Being Committee
- Establish Policies and Practices to Support Lawyer Well-Being
- Monitor For Signs of Work Addiction and Poor Self-Care
- Actively Combat Social Isolation and Encourage Interconnectivity
Understanding and Overcoming Workplace Stress: Why it Matters

It is Good for Business

"Better" Lawyers \(\rightarrow\) Better Representation \(\rightarrow\) Greater Success

- Decreases Turnover and Absenteeism
- Increases Employee Engagement and Loyalty
- Improves Competence and Productivity
- Increases Client Satisfaction and Loyalty
- Improves Profitability

It is the Right Thing to do

Lawyers spend **A LOT OF TIME Working**

- Lawyers prioritize self-sufficiency, but work culture affects us all
- Enjoy work and life
- We chose "care-giving" profession for a reason
- We can save lives
If You REMEMBER ONE SLIDE

- Don’t do nothing... that’s the ONLY WRONG THING...
- Lean on science
- Remember: professional protection as well as humanitarian help
- What you do EVERY DAY as a lawyer...

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