Substance Abuse and Mental Health Services Administration (SAMHSA): Confidentiality of Substance Use Disorder Patient Records Final Rule (42 CFR Part 2) Tribal Consultation July 31, 2018

Captain Chideha Ohuoha, MD, MPH, Director, Center for Substance Abuse Treatment: Good afternoon, and welcome to today's Confidentiality of Substance Use Disorder Patient Records Final Rule number 42 CFR Part 2 Tribal Consultation. I am Chideha Ohuoha, director of the Center for Substance Abuse Treatment [CSAT]. This is my first opportunity to speak with you since I joined SAMHSA in June. However, I'm looking forward to having the opportunity to interact with you in the future in my role as CSAT director. I hope that you find the information and discussions during this next hour and a half useful and enlightening. As CSAT director, I want to emphasize our center's commitment both to the effective implementation of Part 2 and full consultation with tribal entities about any substantial changes.

My role today in today's webinar is simple, but also one that I'm very pleased to fulfill, and that is to introduce to you Dr. Elinore McCance-Katz. Dr. McCance-Katz is leading SAMHSA as the first assistant secretary for mental health and substance use in the department of health and human services. In this role, she advises the HHS secretary on improving behavioral healthcare in America and leads to substance abuse and mental health services administration. She's a distinguished fellow of the American Academy of Addiction Psychiatry, with more than 25 years as a clinician, teacher, and a researcher. She has served as the chief medical officer for behavioral health in Rhode Island, is the state medical director for alcohol and drug programs in California, and was a professor of psychiatry at the University of California, San Francisco and at Brown University in Rhode Island.

Dr. McCance-Katz has published extensively in the areas of clinical pharmacology, medications developed for substance use disorders, drug-drug interactions, addiction psychology, and treatment of HIV infections in drug users. She served on the World Health Organization committee that developed guidelines on the treatment of drug users living with AIDS [Acquired Immune Deficiency Syndrome], and has been a national leader in addressing the overprescribing of opioid analgesics and on providing consultation on management of patients' chronic pain and opioid misuse. We are very fortunate to have Dr. McCance-Katz leading SAMHSA during this critical time when we face the challenges of opioid crisis and imagine the needs of behavioral health. Dr. McCance-Katz.

Elinore McCance-Katz, M.D., Ph.D., Assistant Secretary for Mental Health and Substance Use: Thanks very much. And in my role as the Assistant Secretary for Mental Health and Substance Use, I'm really committed to ensuring that the needs of American Indians and Alaskan natives are fully reflected in SAMHSA's programs and activities, and is understood among its staff and leadership. SAMHSA acknowledges tribal sovereignty and supports the unique government-to-government relationship that exists between federally recognized tribes and the federal government. In an effort to

strengthen our program's services, policies, and resources available for American Indians and Alaskan natives, SAMHSA will continue to consult and request input from tribal nations. We will also confer with urban Indian organizations on the unique issues the communities they serve face.

SAMHSA established the Office of Tribal Affairs Policy, led by Ms. Mirtha Beadle, to oversee tribal consultation and ensure that the priorities of the federally recognized tribes are fully reflected in SAMHSA's programming. SAMHSA's current tribal consultation policy demonstrates our commitment to reducing behavioral health issues for tribal communities by ensuring equal access to mental and substance use disorder prevention, treatment, and recovery support services. SAMHSA will consult whenever we plan to take actions that may affect tribal communities. Today's consultation is focused on how SAMHSA's confidentiality of substance use disorder patient record regulation, 42 CFR Part 2, impacts patient care, health outcomes, and patient privacy for tribal communities. Some of you may be aware that we held a listening session this past January for those interested in Part 2 to provide their input and ideas.

SAMHSA has scheduled a tribal consultation before the listening session, but it was canceled in response to a potential government shutdown, and it has taken us a bit of time to get this rescheduled. So we thank you for your patience with that. Please know that SAMHSA will fully consider the comments you provide during this consultation, those we received at the listening session, and those that will be provided to us in writing. Part 2 of the regulation and implement statutory provisions enacted in 1975 at a time when persons seeking treatment for substance use disorders faced significant consequence of even legal problems because they sought help. Since that time, Part 2 has ensured that persons who seek help for substance use disorders can be assured that their confidential information will be safeguarded and shared only for certain specific reasons with their permission and consent.

SAMHSA remains committed to ensuring privacy and confidentiality for persons seeking and receiving care for substance use disorders. However, there are many who believe that Part 2 has increasingly become a barrier to sharing information and coordinating care for persons with substance use disorders, and to adoption of electronic health records. Similarly, we understand the need for Part 2 to align with other health privacy laws such as the Health Insurance Portability and Accountability Act, or HIPAA, to help reduce burden on providers. Balancing these two imperatives, the need to share information to ensure coordinated, integrated care and proper treatment with the need to ensure patients seeking help for substance use disorders understand and approve when information is being shared about them, and with whom, is a key challenge for us, and we value your input and suggestions. Through today's consultation we want to understand how Part 2 is impacting patient outcomes, treatment and privacy in tribal communities. We also want to understand how we may better provide technical support, guidance, or training about Part 2. We appreciate you taking the time to join us today and look forward to your comments. Mirtha Beadle will now describe the process we will use today for our consultation. After she speaks, Suzette Brann and Mitchell

Berger will provide brief background about Part 2, and then we will hear your thoughts and questions. Thank you again for joining us today.

Mirtha Beadle, M.P.A., Director, Office of Tribal Affairs and Policy: Thank you, Dr. McCance-Katz. My name is Mirtha Beadle and I am the Director of the Office of Tribal Affairs and Policy. Today's consultation or meeting is actually happening in response to SAMHSA's consultation policy dated February 24, 2016, which specifically states that before any action is taken that will significantly affect Indian tribes, it is SAMHSA's policy that a consultation with Indian tribes will occur to the extent practicable and permitted by law. Sessions such as 42 CFR Part 2 that we're discussing today is an example of the type of effort that we consult with tribes about. There was a DTL or Dear Tribal Leader letter issued on June 15 advising of this consultation process, and also we want to make sure that you are aware that the consultation responsibility is the responsibility of all of SAMHSA, including each of its centers.

The consultation today is being done in partnership with SAMHSA's Center for Substance Abuse Treatment. For today, we will take a very specific process in order to receive comments from all of you. At the time of comment, we would like for Presidents, Chairs, or Governors of tribal nations to speak first, followed by Vice Presidents, Vice Chairs, or Lieutenant Governors, and then elected or traditionally appointed tribal officials. Following that time, we will receive comments from other tribal representatives on the line. If an individual is participating in response to a tribal leader and has consent, please identify the tribe or tribal leader that you are representing as you begin to make your comments. If there are any other questions about process, we can answer that during the consultation session, but we really appreciate your attendance and your participation with us today. Thank you so much.

Mitchell Berger, MPH, Public Health Advisor, Office of Policy, Planning and Innovation (OPPI): Thank you. My name is Mitchell Berger, and with my colleague, Suzette Brann, will be providing a brief overview of 42 CFR Part 2 and the topic of discussion today. Our colleague Chris Carroll sends his regrets that he was not able to be in. The confidentiality regulations are based on a statute that was developed in [the 1970s]. At that time, Congress noted that there was discrimination associated with substance use disorders and people were afraid of seeking treatment because of the fear that they could be subject to prosecution. At that time, in contrast with the growing trend today, most of the treatment was provided by specialty providers. The statute authorizing Part 2 was intended to respond to those concerns and ensure an individual's right to privacy and confidentiality. And it's important to note that even today people with substance use disorders continue to be subject to discrimination in such areas as employment, housing, education, and even in family matters and legal concerns.

So, if you really want to get a good start with understanding the parts of the statute, the regulation, the best place to do that is by starting with the statute, 42 U.S.C. § 290dd–2. And this statute is the basis for the regulation of 42 CFR Part 2. In the statute, states that records of the identity, diagnosis, prognosis, or treatment of any patient maintaining a connection with the performance of any program or activity relating to substance

abuse education, prevention, training, treatment, rehabilitation, or research conducted, regulated, or directly or indirectly assisted by any department or agency of the United States shall be confidential. So think about how potentially broad that is. That refers not only to treatment, but identity, diagnosis, and prognosis. It talks about activities that are conducted, regulated, or directly or indirectly assisted by any department or agency of the United States. Now, the statute does provide for certain exemptions to that general statement. It says you can disclose records as permitted by patient written consent. And it also provides for certain specific exemptions to the consent requirement, including for medical emergencies, to qualified personnel for audit and evaluation purposes and research purposes with the caveat that you cannot identify individual patients in any report. And it even says, going back to Congress's concern in enacting the statute, that you can disclose to criminally investigate or charge a patient, but to do that you're going to need a court order and you're going to have to show good cause, including the need to avert a substantial risk of death or serious bodily harm. And there's some other factors noted in the statute that the court is supposed to consider. Except as authorized by that court order, a record cannot be used to initiate or substantiate criminal charges against a patient or to conduct a criminal investigation of a patient.

Now, some statutes may say the secretary may issue regulations, but this particular statute that instructed HHS to issue regulations further implementing this statute. And these regulations are now called back to their location in the court of the Federal Register, 42 CFR Part 2. So, the regulations were first issued in 1975 and were last substantively updated prior to the changes we made recently in 1987. So, why did we update the rule in 2017 and 2018? Well, there have been a lot of changes over the past 30 years. We now have new models of integrated care that rely on information sharing. We have an entire electronic infrastructure for information exchange that did not exist in 1987. We have health information exchanges, electronic health records, multi-tier claims databases. We have a new emphasis on performance management, delivery system changes, value-based payment. And increasing substance use disorder is being offered not only by specialty health centers, but often within the primary care system and with other providers that are also providing other types of health services, not just substance use disorder.

As many of you may know, the process for rulemaking is a lengthy process and we started our process in 2014 when we held a listening session to get input on specific changes to Part 2. That in turn led to a notice of proposed rulemaking we were making in 2016. We received many comments to that rule and we published a final notice in January 2017. At the same time, because there were some changes we wanted to make in 2017 that were not discussed in the 2016 notice, we issued a supplemental notice of proposed rulemaking at the same time. And we finalized that rule based on the supplemental notice in 2018. So, as far as tribal comments we received, there were fairly few comments that we got specifically from tribal nations and entities. We did get a handful though, and we did get some comments that referenced tribal entities along with other types of agencies or stakeholders, such as state and local governments. And the concerns that these comments expressed were things like the need to align with

Part 2 with the Health Insurance Portability and Accountability Act, the need to assure adequate tribal accommodations, these comments emphasize the important of privacy and getting patient consent, and they said SAMHSA needs to do more in terms of providing technical assistance and training.

I'm not going to read through these comments, but they're included in the slide and they're just representative of the types of comments we received. This one stating the importance of aligning with HIPAA. And this one suggesting that SAMHSA did a good job striking a balance between protecting privacy and facilitating information sharing. So, in January 2017, we finalized, as I said, the 2017 rule, and we did strive hard to strike that balance between patient protection and sharing information. And time doesn't permit us to go through all of the changes, but we made numerous alterations to the regulation to hit areas like consent requirement, redisclosure, medical emergencies, we align further with HIPAA for the research provisions, and evaluation sections we changed, and one general theme is we did a lot of updates recognizing the fact that more and more information exchange was conducted electronically.

That was obviously not the case in 1987. Now we allow electronic signatures, we refer to electronic records, and we've done a lot to update the rule in that regard. The 2018 rule was a little bit more, and the 2017 supplemental notice was a little bit more limited in scope. As we were finalizing the 2017 rule, we got a lot of comments from people about lawful holders. People like emergency rooms, treatment providers, people conducting researchers, those conducting audit and evaluation, those are lawful holders. They said we often need to share information with contractors, subcontractors, and legal representatives pertaining to operations of those activities. And so we looked to the HIPAA privacy rule and we made a change that basically said, if you get the patient's initial consent for these payment and operations activities, things like billing, claims management, patient safety, training, clinical professional support services, you can then share with a contractor or a subcontractor or a legal representative without having to go back each and every time and re-consent the patient. We also permitted similar changes for audit and evaluation, and we included an abbreviated notice of the prohibition on re-disclosure that accompanies the disclosure of patient identifying information, for instance, when the patient consents to share information with a primary care provider. We now allow an abbreviated notice [of prohibition on re-disclosure].

42 CFR [part 2] prohibits unauthorized disclosure of these records. And we hope that that abbreviated notice can help accommodate electronic health records a little bit easier. So, as Doctor McCance-Katz said, we did hold a listening session in January 2018. We had planned to hold this consultation first, but we had to change that because of the government shutdown. Hopefully, many people on this call were able to participate in that listening session or able to access the information online where we have the slides, the transcript, the audio recording, and the summary of the comments. We held this meeting because we were instructed to do so by Congress as part of the 21st Century Cures Act, and specifically we were asked to get input on patient care, health outcomes, and patient privacy. And we had about 86 people in person and 1200 participating via phone or web conference. And the comments were similar to what we

received in a large sense to the proposed rules. They said you needed to do more to align Part 2 and HIPAA. They asked for more sub- regulatory guidance and technical assistance. They noted the importance of electronic health records [EHRs] and the difficulty of consent in an EHR environment. And at the same time that we also heard from some patients and providers who said please be careful with your changes, because they were concerned about the continuing stigma and discrimination that additional information sharing could potentially facilitate. So, as far as today's meeting, you're obviously free to comment on any aspect of Part 2 that you wish to, but some questions for consideration include, how does 42 CFR impact patient care outcomes and privacy in tribal communities? What specific changes, if any, should we consider to the regulatory text of Part 2 that would benefit AI/AN [American Indian/Alaska Native] populations and tribal entities? What kind of sub regulatory guidance or technical assistance would be helpful to tribal entities and communities? And delving into the details, what kind of changes should we make to the regulation to align further Part 2 further with hippo or other privacy laws or regulations? Again, understanding the overall statutory framework of 42 U.S. Code § 290dd–2. So, with that background, I think we're very happy to turn to your questions and comments and address them as best we can.

Female: Are there elected or appointed tribal leaders on the call? We'll pause for just a moment until everyone can organize themselves, and then we'll call for the next order of comments. We'll open up the floor than on the call to other comments, please. State your name, your tribal position or affiliation before providing your comment.

Dr.Jennifer Drew: My name is Dr. Jennifer Drew. I'm medical epidemiologist for the Great Plains Tribal Chairman's Health Board. And my comment is related to when 42 CFR Part 2 is violated and there is a break in the federal regulations such as using information from a patient while they're in treatment to prosecute them for substance abuse that was investigated while they are in treatment. So both a violation of like going into the treatment center and asking them questions and then using that information for prosecution without the special court order, that the recourse is through the US Attorney. In South Dakota, there's less than 800,000 individuals and the State's Attorney worked in the US Attorney's office for years. And so, if the US Attorney decides they're not going to enforce a certain section of 42 CFR Part 2, such as special court orders to go in and do investigations, or the use of that data, not using data from treatment to prosecute, I don't know of any other recourse that tribes have. And where this is happening in South Dakota, it's happening at the treatment center in Pennington County where it serves predominantly American Indians who live in poverty and don't have a voice. And there's a plea-bargaining kind of fast track, right from that. If somebody violates any kind of what they're calling a crime on the premises, it's not, but what it is, like say they have a Tylenol [no.] 3 on them, and they don't have a prescription for it but it's in their pocket, or 24 hours after they've been in a treatment center their luggage is searched, which even though they had already been admitted, it hadn't been searched yet, and they found an empty syringe. Any contraband they're considering a crime on the premises and they're immediately going in and investigating and taking pictures of urine because we are in ingestion by possession state. Then they use two felonies and then they just basically plea-bargain them and fast track them

into the criminal justice system, even if they have no prior history at all of criminal [inaudible due to background noise 23:31]. And so, if the US Attorney is the only recourse, and it's pretty much, I just call it a white status regime of men who have been working together and play, have dinners together, their kids played together, and they're not going to uphold the state's attorney from using that information, the US Attorney isn't. Then where are the tribes left? What recourse are they left when there are individuals that are like 60 to 80 percent of the people served by this treatment center are being prosecuted. And that's what concerns me.

Female: Thank you. That's my comment.

Mitchell Berger, MPH, Public Health Advisor, OPPI: I think the response to that, and others, you are free to jump in, is as stated in the regulation, reports of violations have to be addressed to the US Attorney in which the district where the violation occurred, and because SAMHSA does not directly enforce Part 2, we do not bring criminal charges on behalf of the federal government. Only DOJ [the U.S. Department of Justice] can do that. You're talking about the potential, and we don't want to comment on any specific situations obviously, but you are talking about a situation where maybe there's contact between the State's Attorney that is potentially investigating crimes on the premises of a Part 2 program and the US Attorney's office that would drive enforcement and make sure that Part 2 was followed. One thing, the program can contact the US Attorney and express their concern about what's going on. Another thing to point out is that the information that is obtained from a Part 2 program, that should be subject to a court order that is obtained without a court order when it goes to court is likely going to be excluded because it was not properly obtained. Now there is an exception to Part 2 regulations for crimes committed on the premises, but that is typically referencing crimes committed by a patient such as threats, violence against a Part 2 program, and… I'm sorry.

Dr. Jennifer Drew: Yep. But I guess the point that you just said that I think you're missing is, when there's a conflict of interest, when the prosecuting State's Attorney's office and the US Attorney office are best friends and you have a conflict of interest, then where do you go next with that? And then the other thing is, when something is excluded, you're assuming there's no plea bargain, and that's not what's happening here. Everybody is getting multiple charges and they're basically plea bargaining them down to one felony. And when you plea-bargain, you don't get an opportunity to say this is inadmissible. And so there's a system, and I would call it institutional racism. There's a system that has developed over decades here that is very effective in putting… American Indians make up 10 percent of the population but we make, specifically Wendy and, we make up over 50 percent of the women in the South Dakota women's prison, and over 60 percent of those are drug related. And these practices contribute to that.

Mitchell Berger, MPH, Public Health Advisor, OPPI: Ma'am, we definitely respect and acknowledge that comment, but we want… And you can follow up with us. You know our email address where you can contact us for further information as we

conclude the call. Bye for now, I think we've said what we can state on that question. We like to make sure everybody gets a fair chance to ask questions. So, if anybody else has questions, and like I said, we'll give you the address where you can follow-up.

Dr. Jennifer Drew: Good, than I'm not just asking --

Mitchell Berger, MPH, Public Health Advisor, OPPI: And we appreciate the comment.

Dr. Jennifer Drew: Yeah, I'm basically, saying that there needs to be a more fair process than just one US Attorney that you can go to.

Mitchell Berger, MPH, Public Health Advisor, OPPI: Okay. We absolutely respect that. Thank you. Do we have any other questions?

Mark Withers: Yes, hi, this is Mark Withers with United South and Eastern Tribes. I wasn't part of the original webinar, so I probably have some beginner type question for you. This particular 42 CFR Part 2, I guess, was created to provide extra protections for people that are seeking behavioral health, correct?

Mitchell Berger, MPH, Public Health Advisor, OPPI: Yes, the purpose of 42 CFR Part 2 basically, there's a complex procedural history, but there were statutes in the 1970s that were consolidated into what's now title 42 section § 290dd–2 of the US code, and that information is on our website. Like I said, there will be information including a link with further information. But that statute in term is the basis for 42 CFR Part 2, the regulation that's basically a regulation that implements a governing statute and kind of the statute provides a big picture and the regulation fleshes it out a little bit. So, the intent of 42 CFR is to implement the statute, which is aimed at ensuring that persons who seek substance use diagnosis treatment or referral for treatment are not subject to, in particular, criminal prosecution and investigation, but also ensuring that they have control over how their information is being used.

Mark Withers: So if this is intended to be kind of an extension, I guess, of the HIPAA section then? That's kind of how I'm seeing it. I just don't know if that's correct.

Mitchell Berger, MPH, Public Health Advisor, OPPI: Yes. HIPAA, the Health Insurance Portability and Accountability Act was enacted in 1996, which was actually many years after the Part 2 statute and regulation. HIPAA tends to govern all information, all health information, and HIPAA reaches a much wider net of providers; health plans, clearinghouses, others that electronically submit claims for transactions. With the Part 2 program, it's a much more limited subset of that, because you have to meet the definition of Part 2 program, which is first you have to be federally assisted. So going back to that statute, which mentions activities conducted are regulated directly or indirectly by any part of the United States, that's things like participating in Medicare or Medicaid, it's things such as getting federal funds, being tax exempt or getting tax-exempt donations, and then, not only that, you have to meet the definition of program,

which means you have to hold yourself out as providing and provide substance use diagnosis treatment or referral, or if you're in a general medical facility such as a federally qualified health center, a hospital, or trauma center, you either hold yourself out or you have an identified unit where your primary function is to provide substance use diagnosis, So, HIPAA is a different regulation from Part 2 in the sense that, in HIPAA, the exemptions and other things also are very different from Part 2. So, prevention, or treatment. Part 2 governs only a very limited number of programs and subjects substance use disorder information from those programs to some additional standards that extend beyond HIPAA.

Mark Withers: It seems to be a focus on the 42 CFR from detecting people seeking behavioral health treatment from multiple sources [?]. Is that one of the intended purposes, [inaudible due to audio distortion 31:38] speaking?

Mitchell Berger, MPH, Public Health Advisor, OPPI: I'm sorry, I didn't hear all of that question. Could you please read it again?

Mark Withers: Yes, it seems as if the 42 CFR, seems at least today, it seems to be more focused on police investigations or investigations at some point of people that are either in a behavioral health center to keep them from being investigated while they're there or during the course of the program. That's just kind of a curious as to how that plays out.

Mitchell Berger, MPH, Public Health Advisor, OPPI: Well, Part 2, first, it can apply, the regulation and statute can apply to both current and former patients. You don't lose your Part 2 protection just because you are no longer a patient. And secondly, it's important to note that when you say behavioral health, Part 2 is focused solely on substance use disorders. If it's mental health information, mental health information may be reached by HIPAA. There are many state laws that impact patient privacy. But Part 2 is only limited to what's defined as a substance use disorder and the regulation basically finds that a person is having trouble with a substance, they can't stop using it, if they're having adverse effects on their lives, in accordance with what's stated in the diagnostic and statistical manual for mental health and for behavioral health professionals, and it only applies to substance abuse information that shows somebody has or has had a substance use disorder. So, mental health information, which is obviously a big piece of behavioral health by itself, is not reached by Part 2. I guess we're ready for our next question.

Fran Arseneau: Hello. My name is Fran Arseneau and I'm calling from Southcentral Foundation, a tribal health organization in Anchorage, Alaska. And would it be possible for the presenters today to provide us some summary of the changes in the final rule?

Mitchell Berger, MPH, Public Health Advisor, OPPI: Yes, we would absolutely be able to do that. We've done many slide presentations and we have done that separate documents. So, if you contact us through the email box that we'll share at the

conclusion of this presentation, we can share that information with you. Yes. Any additional comments?

Martha: Hello. My name is Martha. I'm calling from Plymouth Tribal Health and Family Services, and we have a question related to 42 CFR Part 2 and it's applicability in behavioral health integration into primary care.

Female: Martha, please go ahead and proceed.

Martha: Thank you. Specifically in how providers can work with one another for continuity of care. And accessing the client record.

Mitchell Berger, MPH, Public Health Advisor, OPPI: That's a very good question, one we've had a lot of discussion about. I think a couple things, and again I'll invite my colleagues to state anything that I may miss, but a couple things that I would point to his first, we emphasize the importance of patient consent. If you get patient consent, 90, 95 percent of the things you want to do under Part 2 you're able to do in terms of making sure that the patient's treatment providers are informed of how they're being treated. So that is one thing that we would always point to. So, looking beyond that, because if a patient doesn't consent, you can look at whether one of the exceptions applies and does it fall within one of the various exceptions, but the best way to ensure continuity of care and ensure the patient is able to continue to maintain control over the flow of their information is to get patient consent, and you can do that by including the nine elements that are listed in section 2.31 of the regulation and having a patient essentially then have a discussion with the patient about what you're asking from them and how their information is going to be shared. And we believe in many cases most patients will be willing to consent to that, although we understand that people have different experiences.

Linda: Hi, this is Brenda Fare from Alaska, the Tlingit Tribe. I have a question. So, for integrated care, we have a psychiatrist that will be contracting with and will be using two different electronic health records. How does she share pertinent information to our medical providers if they don't have access to our EHR while still falling within 42 CFR?

Mitchell Berger, MPH, Public Health Advisor, OPPI: I would advise, again, if the patient consents to share their information, whether it's from an electronic health record or a patient record, the provider would be able to access the record. As far as EHR systems not being compatible, that's where the question is coming from, that's not something SAMHSA directly controls as far as different EHR systems not being interoperable. If it's from the sharing of the information from a part to legal perspective, that if the patient consents, the information should be able to be broadly shared.

Linda: I also have another question, if that's okay. Here in Alaska, what we've been told is, when Office of Children's Services opens up a case, and it's a custody case, all records, they can view all records including substance use records of the parents

involved in the custody case. And that's concerning to me. I mean, I understand why they say that, but it's still concerning that nothing is private.

Mitchell Berger, MPH, Public Health Advisor, OPPI: There is a provision in the statute and within Part 2 reports of suspected child abuse and neglect can be made by Part 2 programs. That's an exception to the general consent requirements. I'm not quite sure of the situation you're referring to. I'm a little bit unclear about -- but again, like I said, we'll have an address at the end of the call if you want to provide us further details. We can look at that and try to provide you a response.

Linda: Okay, thank you.

[Long Pause]

Mitchell Berger, MPH, Public Health Advisor, OPPI: Okay, hearing no additional comments, we'll go through some of our concluding slides, and also, explain how you can provide further information to us or further comments, or ask further questions about these issues. So, in 2018, patient privacy remains a critical concern, however, equally important is we understand that the need for providers to be able to share information to improve substance use disorder patient treatment, for patients to be able to benefit from integrated care, for the overall health system patients and providers to be able to use health information exchanges, electronic health records, and multi-payer claims databases. And we have also stated in the 2018 rule that we plan to explore additional alignment with HIPAA and we're considering additional rulemaking. So, as far as the next steps, considering the need for additional webinars and other presentations and outreach materials responding to some of the comments we've gotten about the need for more technical assistance.

And, I can also, add that SAMHSA recently released a funding announcement for a privacy center of excellence that also will be able to help with some of this, and that's on our website. We're updating sub regulatory guidance. And we welcome written comments on all provisions of Part 2 in some of the priorities and issues addressed today. So, importantly, how you submit written comments, the address is tribalconsultation@SAMHSA.hhs.gov, if you want to submit them electronically.

If you'd rather send any of the comments by mail, you can address them to the address that's noted, Sharece Tyer, public health analyst, in our OPPI office at 5600 Fishers Lane. We do note that we may not be able to acknowledge each and every comment we get do to depending on the volume of comments that we've received. Also, we want to note that for further information about Part 2 we have a Part 2 website that lists documents from our listening session, our various guidances, links to the final rules we were just discussing, and other information, and that is also noted above. And if you have other questions about tribal issues relating to tribes, to tribal entities, the email address is noted. So, we want to think everybody very much.

Female: The closing period for comments is September.

Mitchell Berger, MPH, Public Health Advisor, OPPI: Oh yes, and the closing period for comments about in relation to this webinar is one month, is it September, as noted in the invitation letter that you received. So, with that said, Mirtha, do you want to make any closing?

Mirtha Beadle, M.P.A., Director, Office of Tribal Affairs and Policy: No. We appreciate the time that you've taken to hear information about 42 CFR, the regulation itself, and we look forward to any comments or questions that you have and appreciate your joining us today.

[End]