APPENDIX E
CONFIDENTIALITY AND PARENTAL INVOLVEMENT

Protecting an appropriate level of confidentiality for adolescents' health care information is an essential determinant of whether this population will access care, answer questions honestly, and develop and maintain a therapeutic alliance with their doctor. Fear that clinicians will reveal private information can cause concern and lead adolescents to answer screening questions inaccurately. It is essential that providers understand confidentiality laws and how to navigate discussions with patients and parents so that they are able to screen and intervene as needed. Although privacy and minor consent laws vary by state, providers will need to make a clinical judgment as to whether the circumstances for referral warrant parental involvement. In most states, confidentiality cannot be breached unless clinical judgment suggests the patient or another individual is in imminent danger because of risky behavior.

> "All of the major medical organizations and numerous current laws support the ability of clinicians to provide confidential health care, within established guidelines, for adolescents who use alcohol" (NIAAA, 2011).

REGULATORY CONSIDERATIONS: WHICH LAWS APPLY TO YOU?

Numerous federal and state laws protect the privacy of health care information. According to the American Academy of Pediatrics, there are at least four types of laws that affect a health care professional's ability to share information about a patient in their care:

- Federal medical privacy rules issued under the federal Health Insurance Portability and Accountability Act (HIPAA)
- State privacy laws
- State minor consent laws
- Family Educational Rights and Privacy Act (FERPA)

There is also federal confidentiality legislation (42 USC § 290dd-2) that governs facilities deemed to be federal alcohol and drug abuse treatment programs under 42 Code of Federal Regulations (CFR) Part 2.

Each type of privacy or confidentiality regulation can change over time, so we recommend regular examination of applicable federal and state laws in coordination with legal counsel to ensure service delivery compliance.

More information on HIPAA, state privacy laws, and state minor consent laws can be found in the **American Academy of Pediatrics**, **Confidentiality Laws Tip Sheet** and the Legal Action Center's **training resources** (Legal Action Center).

HIPAA

While HIPAA rules permit sharing information between providers, there are unique considerations for minors who have legally consented to care. In general, HIPAA allows a parent to have access to the medical records for his or her minor child, when the access is consistent with state or other law. Providers should inform parents that they have the right to access their child's medical records but encourage them to speak directly with their child instead to avoid hindering the effectiveness of treatment.

The HIPAA Privacy Rule does not apply when:

- A minor has consented for care and parental is not required by state or other applicable law.
- A minor obtains care at the direction of a court.
- A parent agrees that a health care provider and minor may have a confidential relationship.
- It is inconsistent with state privacy laws.

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STATE PRIVACY LAWS

A parent's ability to access their minor child's health information is dependent upon state privacy laws. Examine state laws or seek advice from legal counsel to determine whether they specifically address the confidentiality of a minor's health information. If this issue is not addressed in state law, professionals can typically determine whether or not to grant access.

STATE MINOR CONSENT LAWS

State minor consent laws govern whether minors can give their own consent for health care (i.e., care obtained without the consent of a parent or guardian). Every state has enacted these laws, which fall into two categories:

1. Laws that are based on the status of the minor (minors who are emancipated, living apart from parents, married, pregnant and/or parenting)
2. Laws that are based on the type of care that is sought (emergency, family planning, drug/alcohol, and mental health)

Nearly all states have enacted a law that allows minors to consent for care related to drug and alcohol use **(AAP Tip Sheet)**.

FERPA

FERPA (20 U.S.C. § 1232g; 34 CFR Part 99) protects the privacy of student education records at all schools that receive funds under an applicable program of the U.S. Department of Education. This law applies to non-high school students, mainly students attending a program in higher education. This law gives parents certain rights with respect to their children's education records – rights transferred to the student when he or she reaches the age of 18 or attends a school beyond the high school level. The U.S. Department of Education **website** (U.S. Department of Education, 2018) provides additional details on the law.

42 CFR PART 2

In general, federally subsidized substance use treatment programs must abide by Part 2 and cannot disclose health information for treatment, payment and health care operations without prior written consent and authorization.

The Legal Action Center has created a **decision tree (Legal Action Center, 2018)** and **fact sheet (Legal Action Center, 2016)** to help you determine if Part 2 applies to you or your agency. SAMHSA also provides fact sheets and frequently asked questions on their **website** (SAMHSA, 2019) to further explain Part 2's confidentiality regulations.

Even SBIRT providers who are not subject to Part 2 should have a basic understanding of Part 2's requirements to facilitate communication and engagement with Part 2 programs. Furthermore, funding streams are moving in the direction of aligning with Part 2's requirements, so it is prudent for all providers to understand what the requirements.

42 CFR Part 2 and HIPAA: Follow both laws, if possible. If 42 CFR Part 2 is more restrictive, then its provisions apply.

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DISCUSSING CONFIDENTIALITY WITH PATIENTS AND PARENTS

Introduce confidentiality practices.

Confidentiality provisions should be introduced and defined during the initial visit for adolescents new to a practice and prior to the first time the adolescent is interviewed without a parent present. Explain the confidentiality policy — including the limits of confidentiality — to the patient and parent(s) simultaneously. By doing so, the clinician can reassure parents that they will receive any information involving the immediate safety of their child, while also reassuring the adolescent that details discussed will remain confidential. The American Academy of Pediatrics' (AAP) **Information for Teens: What You Need to Know About Privacy** (American Academy of Pediatrics, 2010) can help adolescents understand their privacy rights, what to expect from interactions with their provider around drugs and alcohol and additional information regarding parental involvement.

Example messaging to introduce parents to confidential information gathering:

- Starting at age (x) all patients are seen for at least a portion of their visit without parents so they can start having opportunities to take ownership of their health.
- Our goal is to have a trusted relationship with you and your child where accurate information is shared so we can provide the best care possible. When confidentiality is not upheld, young people are less likely to talk about potentially sensitive and important information, which means they are less likely to get the care they need.
- As your teen's health care provider, it's important that I build a relationship of trust with him/her. While sometimes teens tell their doctor things that they won't tell their parents, I want you to trust that I will bring you in on any serious health problems or issues of personal safety.

LESSONS FROM THE PILOT

Create a safe space for confidential discussions.

Parents may not be aware of their child's substance use and the adolescent may not disclose their use history to a provider in front of their parent. During the FaCES learning collaborative, many of the FQHCs piloting adolescent SBIRT implementation experienced this tension and developed solutions that allow the parent to be comfortable while giving the patient room to discuss their substance use with a provider. Some best practices that emerged from their innovative solutions are:

- **Present the screening tool away from parents** — Venice Family Clinic in Venice, Calif., created a laminated, self-administered S2BI score card for patients in need of being screened. This has helped with confidentiality, as the patient can take the time privately to write down their answers to the screening questions, rather than be prompted to discuss it verbally.
- **Treat S2BI screening as a vital sign** — Vista Community Clinic in Vista, Calif., established a workflow where a medical assistant takes the patient's vitals (e.g., body temperature, blood pressure) and delivers the self-administered screening tool, during which parents are asked to wait in the lobby.
- **Make private visits the standard once children reach a designated age** — Several clinics made this an expectation and standard part of entering adolescence at their clinic. Some have a pre-distributed policy that parents stay in the waiting room during well visits for patients over a certain age, therefore eliminating the need to ask parents if it is okay to meet with the patient alone. At Health Services, Inc. in Montgomery, Ala., providers ask that patients come in alone to the visit so they can practice answering questions about their own health instead of looking to their parents, therefore giving them more ownership over their own health.

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DISCUSSING CONFIDENTIALITY WITH PATIENTS AND PARENTS

Maintain confidentiality unless there is imminent risk.

We recommend maintaining an adolescent's confidentiality unless their health or safety, or the health or safety of another individual, is acutely in danger. Older adolescents generally may be afforded more confidentiality than younger teens, who are at higher risk for both the acute and chronic consequences of substance use. Decisions about breaching confidentiality should be discussed with supervisors when a provider is unsure of whether to disclose information. In cases that warrant parental involvement, the clinician should focus discussions with the patient on allowing the parent to be included in their substance use and treatment discussions.

LESSON FROM THE PILOT

During the first week of screening at one of the sites of Family First Health in South Central Pennsylvania, a 16-year-old patient came in with her parent for an acute visit. She completed the S2BI on paper while her parent sat next to her. The S2BI was then reviewed by the clinician. When her parent left the room, she disclosed regular substance use and risky sexual behavior, which she did not initially indicate during screening. Through a brief intervention conversation, the patient expressed appreciation for the chance to discuss these issues, which would not have happened with her parent in the room. This patient's experience is not unique. Since then, multiple patients have disclosed substance use when a parent left the room, allowing providers to briefly intervene and educate the patient.

Examples of instances when confidentiality may need to be broken include, but are not limited to:

- The patient discloses thoughts and/or attempts of suicide — "I've been thinking a lot about death and I wish I were dead."
- The patient discusses thoughts or desires to harm another person — "I was so angry that he was making fun of me that I wanted to kill him."
- The patient is at high risk for an overdose based on the severity of reported use.

Encourage parental involvement whenever possible. Even in situations where there is not an acute safety risk, adolescents may benefit from parental support in accessing recommended services. As many clinicians who provide care for adolescents can attest, teens are unlikely to follow through with referrals without the support of an adult—even more so if they are being referred for treatment of a diagnosis that they may not agree with, such as a substance use disorder. Parental participation in the health care of their adolescents should usually be encouraged but should not be mandated (Schizer et al., 2015).

Even when sensitive information such as suicidal or homicidal thoughts or ideation needs to be discussed with parents or family, the clinician should first discuss with the adolescent what and how information will be presented to parents. By strategizing with the adolescent ahead of time, a clinician can transmit necessary information to parents while simultaneously protecting the provider-patient bond.

In many cases, by the time an adolescent has developed a substance use disorder, parents are already aware of their use, though they may underestimate the seriousness of the problem. We recommend that clinicians ask adolescents whether their parents are aware of their substance use and encourage them to invite their parents into the conversation. This can be a rewarding experience for the adolescent if the clinician focuses on points of mutual agreement.

APPENDIX F
SBIRT DATA COLLECTION GUIDE

This guide is intended to help your team build a sustainable data collection process in an EHR. Each row is a data field accompanied by a recommended answer format and options, a data description and analysis questions to consider in order to get the most out of the information you collect. Following these fields from top to bottom will take a provider through the SBIRT process of data collection and analysis. Here are some general recommendations to guide your EHR development/modification process:

- It is likely that you are already collecting many of these data points; therefore, **we recommend adding 19 SBIRT-specific data points to your EHR** that are critical to understanding your patient population and quality improvement needs. If resources and capabilities allow, an additional seven data points will further enhance your quality improvement capabilities.
- **Use a drop-down menu of options whenever possible and avoid using freeform text boxes**. This will improve data quality by reducing provider variability and making it as easy as possible to enter data. Drop down options below are suggestions, but do not represent an exhaustive list of options.
- Judicious use of EHR hard stops or a programmable process by which a response is required before a user can move forward with a task. Research shows that hard stops are associated with higher performance on both process and outcomes measures (Powers et. al, 2018). Consider potential unintended consequences including avoidance of hard-stopped workflow, increased alert frequency and delay to care.
- Enable best practice alerts that instruct provider to deliver the appropriate intervention based on the screening results (e.g., if patient screens lowest risk, provide anticipatory guidance).

KEY

Critical SBIRT Data Points (19)
Additional Recommended SBIRT Data Points (7)
Data Points Likely to Be Available Already (15)

- Bold analysis questions should be prioritized.
- Analysis questions with benchmarks are measures that relate to outcomes mentioned in this document.

Data Field (EHR Name)	Answer Options	Data Description	Analysis Questions
Client and Clinic Identification			
Patient ID Number (Datatable.PatientID)	Numerical entry	Unique client ID used to track throughout the SBIRT data process.	**Overall, did adolescents with multiple screening results show decreased risk over time?** Did programs more consistently provide completed screening data over time? Did programs more consistently match the intervention with the screening results over time?
Encounter Date (Encounter.Date)	MM/DD/YYYY	The data of the earliest encounter provided.	
Name of Clinic (Clinic.Name)	Drop Down: Populate this field with clinic names if applicable	Name of clinic where patient is seen.	