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June 24, 2008

Janice Staloski, Director
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Department of Health
132 Kline Plaza, Suite A
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RECEIVED
2008 JUL -2 AM 10:07
INDEPENDENT REGULATORY REVIEW COMMISSION

RE: Proposed Confidentiality Regulatory Changes (4 PA Code 255.5)

Dear Ms. Staloski:

I am writing to provide comment on draft proposed confidentiality regulation changes to 4 PA Code 255.5

It is gratifying to see the Pennsylvania Legislature address this need for revision and updating of the Commonwealth's Drug & Alcohol regulations. These regulations pertain to the confidentiality of protected health information of individual's seeking and receiving Drug & Alcohol treatment and services. These individuals face many hurdles on the road to recovery, and it is satisfying to see the legislature address some of these hurdles. However, as the Executive Director of a treatment provider delivering such services, I do have some concerns which I would like to express.

COMMENT #1:
§255.5 (b) Scope & Policy (1) "*This section applies to the record of a patient seeking, receiving or having received addiction treatment services from any program.*" Underline added.
This language has not changed and would still appear to suggest that any "patient seeking, receiving or having received addiction treatment services" from even a mental health project would be subject to the drug & alcohol regulations restrictions. In other words, (the definition of program not withstanding) it is conceivable that if the client discussed with their MH therapist their addictions issues as related to their mental health diagnosis, it could be interpreted that the client's MH record would come under the jurisdiction of the 255.5 regulations. Additionally, often D&A license auditors request to view MH records of which they should have not access. Such a restriction is unreasonable and further, would restrict care to the client. It is suggested that language be inserted that substitutes the phrase "drug & alcohol" in place of the word "any" to clarify this issue.

COMMENT #2:
§255.5 (b) Scope & Policy (5): "*Information from the patient record may not be used to initiate or substantiate criminal charges against the patient.*"
This language would appear to be unduly restrictive in nature. Naturally, projects should not release information potentially harmful to clients. However, projects

should be able to respond when clients commit criminal acts threatening the public safety. Additionally, how does this language relate to and function with the language found in §255.5 (d) (3) which states "*A program may disclose to law enforcement personnel information from a patient record, without the patient's consent, that is directly related to a patient's commission of a crime on the premises of the program or against program personnel or a threat to commit a crime. The information released under this paragraph shall be limited to the circumstances of the incident, including the patient status of the individual committing or threatening to commit the crime, that individual's name and address and that individual's last known whereabouts.* It would appear that this language would involve the initiation of criminal charges against a patient. Furth it could be interpreted as a conflict in the regulation language.

We originally addressed this language under a separate comment in our first letter. Because the language has been incorporated into this section, we address it here. This language would still appear to limit project responses to those incidents or threats occurring or threatened to occur solely on the project premises. This could potentially present risky limitations in the area of duty to warn, where the target of a threat is not on project premises nor is connected to the project through some form of contractual or other obligation. Additionally, if the incident or threat were off project premises or involved non-project personnel, then the project would be limited by this clause in what cooperation it could offer law enforcement personnel during a legitimate investigation. Further this lack of clarity could hamper a project's response under a duty to warn situation. Such lack of clarity could easily increase the risk presented in a duty to warn situation by confusing staff as to what legitimate actions they could take to ensure the safety of the target of a threat. This clearly could have a negative impact on public safety and welfare.

COMMENT #3:
§255.5 (c) (4) Consensual release of information from patient records
(4) "*With the patient's written consent, a program may disclose information from a patient record to the patient's probation or parole office if the following occur.*" Underline added.
This language would appear to address our earlier concerns of being to restrictive on project responses only to those probation officers or parole officers who are actually assigned to the individual client being served. This new language, by specifying the probation or parole office and not the individual officer, appears to take into account when the client may be served or monitored by other than their assigned probation officer or parole officer, such as during a vacation or other absence of the assigned probation officer or parole officer. This should prevent inadvertent impairment of coordination of treatment and the reporting of client progress to the court when a client's case may be heard during the absence of the assigned probation officer or parole officer.

COMMENT #4:
§255.5 (c) (5) Consensual release of information from patient records
(5) "*With the patient's written consent, a program may disclose information form* (sic) *a patient record to judges who have imposed sentence on a particular client where such sentence is conditioned upon the entering a program.*" Underline added. Note typographical error: "form" should be from.

While minor changes in this language have been made, it would still appear to restrict programs in their responses only to those judges who have actually imposed the sentence prior on the patient. This language does not appear to take into account when the client may appear on the same issue before a different judge. A strict interpretation of this language may inadvertently impair coordination of treatment and the reporting of client progress to the court when a client's case may be heard by someone other then the issuing judge. An alteration in the language to allow judges access who have a legitimate need to know would be beneficial to Drug & Alcohol clients by enabling providers to respond.

While the proposed changes to Pa. 4 255.5 are focused upon the elements of confidentiality of patient records, I want to take this opportunity to comment on additional restrictive elements in the Drug and Alcohol regulations governing treatment of Drug and Alcohol consumers. There is a general consensus among a large portion of providers that the current drug and alcohol licensing regulations along with the interpretations of reviewers create barriers for clients to access services, add unnecessary cost to programs and impede efficient/effective program management. Of more concern is the occurrence of clients simply being regulated right out of service as a result of the obstacles to treatment that these regulations and interpretations create.

CASELOAD RATIO REQUIREMENTS

The current staff-to-client ratios are overly restrictive and create barriers to consumers entering into treatment; either delaying their entry or in some cases completely preventing entry at all. We believe this contradicts the federal standard of "any door" regarding D&A treatment. Delays of entering treatment for this population can result in entry to more expensive treatment settings and higher levels of care, such as emergency room visits or even incarceration. Such micromanaging places consumers at risk by not allowing providers to manage their own resources for the most effective treatment management. For providers such as our agency, the micromanaging staffing standards that are most problematical are the 35:1 for outpatient, the 1-10 for partial hospitalization and the supervisor to counselor ratio. These archaic and arbitrary ratios hinder provider responses to consumer needs, limit access to care and adversely influence overall clinical care.

TRAINING REQUIREMENTS

Training is an additional area where the standards of micromanagement interferes with the provision of quality clinical care. The current standards of training exceed all other licenses in Pennsylvania requiring 25-30 hours of training for counselors and assistants respectively. In contracts for example, to the PA State Boards of Nursing, Psychology and the Social Work, Marriage & Family Therapists and Professional Counselors that all require 30 hours biennially (15 hrs per year); with the Boards of Psychology & Social Work, Marriage & Family Therapists and Professional Counselors each requiring three hours in ethics. The State Board of Physical Therapy and the Pennsylvania State Board of Examiners in Speech-Language and Hearing require 20 hours biennially (10 hrs per year). The current D&A training requirements are out of line with other treatment disciplines and should be adjusted to be more reflective of other disciplines.

HIRING REQUIREMENTS

The current hiring requirements for counselors are too restrictive, preventing otherwise excellent candidates from hire. Degrees/majors such as teaching, divinity, and criminal justice neither meet the current requirements or interpretations of "other related field". In fact, even those with years of experience far exceeding the 2, 3 and 4 years requirements listed in regulation do not qualify for hire under the current requirements or interpretations. This current standard should be eliminated and standard reflective of other professional disciplines that ensures quality of hired staff should be adopted.

MEDICAL RECORDS REQUIREMENTS

The current regulation standards and interpretations have not kept pace with the developing technology of treatment or medical records management. Many providers in both behavioral health and medicine are now moving toward a full electronic medical record. The federal government has provided guidance through the HIPAA regulations for the management and implementation such systems. Yet the current regulation standards and interpretations actually work to hinder, and some cases penalize providers in creating more effective, state of the art medical record systems that would enable them to provide better and more coordinated care to D&A consumers. The current regulations need to be updated to more accurately reflect the level of technology in current practice.

Thank you for the opportunity to comment on these important proposed changes to confidentiality regulation 4 PA Code 255.5

Respectfully submitted,

Noreen Fredrick, MSN
Executive Director