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NAADAC WEBINAR
ADVOCACY SERIES, SESSION IV:
CONFIDENTIALITY RULES CHANGES AND 42 CFR
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>> The broadcast is now starting. All attendees are in listen only mode.

>> JESSICA O'BRIEN: Hello, everyone, and welcome to today's webinar on confidentiality rule changes and 42 CFR, the fourth session in our advocacy series, presented by Dr. Westley Clark.

I'm so happy that you can be here with us today. My name is Jessie O'Brien and I'm the training and professional development content manager for NAADAC. I will be the organizer for this training experience.

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We're using go to webinar. You will see the panel. You can use that orange arrow anytime to minimize or maximize the control panel. If you have any questions for the presenter, just type them into the questions box. We're going to gather the questions and

give them to our presenter during the live Q and A towards the end of the webinar.

Any questions that we do not get to, we will collect directly from the presenter, and post the questions and answers on our website.

Lastly under the questions tab, you will see another tab that says handouts. You can download the Power Point slides from that handout tab and also user friendly instructional guide to access the CE quiz.

Please make sure to use the instructions in our handout tab when you're ready to take the quiz.

Without further ado, let me introduce you to today's presenter. Dr. Westley Clark is currently the dean's executive professor of public health at Santa Clara University in Santa Clara, California. He is formerly the director of the center for substance abuse treatment, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services, where he led the agency's effort to provide accessible treatment to all Americans with addictive disorders. He received a Bachelor of Arts degree from Wayne State University in Detroit. He also holds a medical doctorate degree and a master's degree in public health from the University of Michigan and a juris doctorate from Harvard University law school. Dr. Clark received his board certification from the American board of psychiatry in neurology and psychiatry. He is ABA certified in addiction medicine. He is licensed to practice medicine in California, Maryland, Massachusetts and Michigan. He is also a member of the Washington, D.C. bar.

So Dr. Clark, if you are ready, I will go ahead and turn this over to you.

>> DR. H. WESTLEY CLARK: I'm ready. Thank you. It's a pleasure to be invited to talk about this very important topic, 42 CFR part two.

I'm going to keep my image here because of bandwidth issues, but you can see me later. The most important thing right now is to use this time to go over the federal confidentiality rules.

As most of you know, one of the original reasons for having the confidential regulations was to encourage people to seek substance use treatment. We know that we treat less than 10 percent of people who have (indiscernible) issues, and the thought in 1970 when the rules were promulgated was that we needed to (indiscernible).

The other issue is that people in treatment, while they want to know if their privacy is going to be protected.

So I have no conflicts of interest to declare. I want to make that point clear on this issue. I am a bit of an advocate for patient's privacy issues because I think if we discourage people from coming into treatment, it prolongs the problems associated with substance use disorder.

So our objective is to discuss the 2020 final rule regarding 42

CFR part 2, which went into effect on August 14, and if we have the time, to describe the changes to 42 USC 290dd 2 B.

So what's the difference between 42 CFR and 290.

42 CFR are the regulations that have been promulgated under (indiscernible).

That law is changing, but not completely, and the 42 CFR part 2 regulation is based on the old law, which will be modified come March 27, 2021.

This was the revised rule timeline. As you can see, the final rule was promulgated as an NPRM in August 2019, and the rule took effect August 14, 2020, but in the meantime Congress passed the CARES Act which amended 42 USC 290dd and that doesn't go into effect until 2021. The key issue is that it changes part of the law and we will get to that subsequently.

Excuse me. One click ahead. Let me go back.

So these regulations have been in place since 1975, and they have undergone several modifications over the past years. But historically the key thing was we want patients to trust providers. We want patients to trust clinicians. We want patients to trust the treatment system.

So we need to be able to reassure them that the information they disclose to us as treatment providers will not be gratuitously made available at all.

Along the way, there came an interest in making sure that a network of entities had access to that information, and that included primary care providers, health care networks, and a number of other entities.

So as a result, several changes were promulgated. Most recently the new revised rule (indiscernible).

But I'd like to remind people as a lawyer, prior to this, the key issue for those who provide treatment is making sure people rely on us, trust us, if they have issues with us, so we can help them navigate their way to solutions to their substance use disorder that they may be experiencing.

42 CFR part 2, the new rule continues to apply to federally assisted SUD treatment programs, as soon as to prohibit law enforcement's use of SUD records in criminal prosecutions against patients absent a court record, and continues to restrict the disclosure of substance use disorder treatment records without patient consent except for bona fide medical emergency, scientific research, audit or program evaluation, appropriate court order, and there is a provision for child abuse and criminal act committed on the premises (indiscernible).

The new rule does not change the enforcement provision. Some of you may not be aware that while 42 CFR part 2 is a federal rule, it -- and SAMHSA has promulgated the regulation, the fact is SAMHSA does not have the authority under 42 USC 290dd to enforce 42 CFR part 2. Oddly enough (indiscernible) Department of Justice which has not recorded much in the way of enforcement over time, but

that's another discussion.

So what is a federally assisted program? What is a federally assisted substance use program?

This is a broad set of activities, including management by a federal office or agency, receipt of any federal funding, or the registration to dispense controlled substances related to the treatment of substance disorder.

So most nonprofit organizations that provide treatment are considered federally assisted, if a physician identifies herself as being a federally assisted substance use program because they have a large number of programs, then they might fall under this rule because of the fact that they use DEA registration, which is covered by the rule.

A program is an individual, entity, other than a general medical facility, or an identified unit in a general medical facility, that holds itself out as providing and provides diagnosis, treatment, or referral for treatment for a SUD. That includes medical personnel or other staff in a general facility who are identified as providers whose primary function is to provide diagnosis, treatment, or referral for treatment for a SUD program.

Holds itself out, means any activity that would lead one to reasonably conclude that the individual or entity provides substance use disorder diagnosis, treatment, or referral for treatment.

The key point is if you don't hold yourself out, if you don't meet the criteria, you don't fall under 42 CFR part 2 or 42 USC 290dd, and the determination of whether you're holding yourself out or that you meet these criteria would have to be made in litigation, traditional.

This is not a heavily -- this has not been a heavily litigated field, but it's a possibility.

Here are all the slides.

Good. Thank you.

So the changed provisions. This slide captures the provisions under the new federal rules that were changed. The definition of records, the applicability and redisclosure issues, notice of prohibition on redisclosure, disclosures permitted with written consent, disclosures by central recommending industries, disclosures to prescription drug monitoring programs, medical emergencies, research, audit and evaluation, court orders for undercover agents and informants, and SAMHSA (indiscernible) on employee's personal devices. That was one of the questions, the use of cell phones or email that is not attached to your employer or your business if you are self-employed.

So we will move forward with this.

So what's a record? Any information, whether recorded or not, created, received, or acquired by a part 2 program relating to a patient. That includes a diagnosis, treatment, and referral for treatment, information, billing information, emails, voice mails,

texts, provided.

However, if the information is conveyed orally by a part 2 program to a non-part 2 provider for treatment purposes with the consent of the patient, that doesn't become part of the record, subject to this part.

So people need to know about that.

Records otherwise transmitted by a part 2 program to a non-part 2 provider retain their characteristic as records in the hands of the non-part 2 provider, but may be segregated. So if the records are transmitted other than orally, then they retain their protection. But if you talk to somebody and they record that information in their records, then that information falls outside of 42 CFR part 2 according to SAMHSA, which means that you want to limit the opportunities that you have to talk to non-part 2 providers because that information then becomes part of the general record. And you can't assure the patient that that information is private.

Next slide, please.

Applicability and redisclosure. Treatment records created by non-part 2 providers are not covered by part 2 unless any substance use records previously received from a part 2 program are incorporated into those records.

So there is a requirement for segmentation or holding a part of any part 2 patient information previously received by the chief point that SAMHSA is making that they're relaxing the confidentiality records to allow non-part 2 providers to record any information they want about a patient who is taking substance use disorder treatment in their records, and that information is not protected currently under SAMHSA's view of 42 USC 290dd.

Next slide, please.

So we have (indiscernible) of disclosures were patient consent. The situation of the exceptions to the consent requirement (bad audio).

Next slide, please.

So the basic rule is that disclosures -- the patient can consent to the disclosure of their information. The clinical rule is in order for the patient to trust you, you should have their written consent, that they know what you're doing and why you're doing it. We want people to disclose a host of information, not just the fact that they have a methamphetamine issue or they have a heroin issue or they have a marijuana issue. So depending on your orientation as a psychotherapist, I always believe that there are a host of other issues that flow into someone's substance use problems, things like trauma and other things that the patient may want to disclose.

So getting the patient's written consent to share that information with other people, I think reinforces the trust that the patient has with the clinician.

But in any event, the basic rules to the consent form must

include certain information, including the parent's name, information about the recipient and source, what kind of SUS information will be shared and the purpose of the disclosure. Key thing. And that the patient is aware of that, so that the -- you maintain the trust relationship.

Next slide, please.

>> SAMSON TEKLEMARIAM: Hi, Dr. Clark, this is Samson, just a quick reminder. You can navigate to the next slide by clicking anywhere on the slide. You don't have to click on the arrows on the bottom. You can click on the arrows on your keyboard. It should work that way.

>> DR. H. WESTLEY CLARK: Let's see.

>> SAMSON TEKLEMARIAM: There you go.

>> DR. H. WESTLEY CLARK: All right. So a patient may consent to the part 2 records to an entity. So without naming a specific person. So one of the questions that some have asked. Well, what about the criminal justice system? Or what about housing or what about Social Security? You can say I need to disclose this information to the Social Security Administration. I need to disclose this information to the 15th district court drug treatment -- drug court program. You don't need to name a specific person as the recipient of the disclosure anymore.

So for those of you who were worried about the changes in the criminal justice system or any other helping system in which the person is involved or any system for which the person has to be accountable, they can name either a specific person or you can name a general person. Again you may want to clear that with the patient, but there's no regulatory requirement that you name a specific person.

(Indiscernible) now authorized disclosure to individual entity. You don't have to have a treatment provider relationship with the patient. So a community health center may be involved, drug court, local hospital. Very general.

Consent requirements are largely unchanged for entities that facilitate the exchange of information, like HIE, health information exchange. You may designate an entity participant in the HIE, even if that entity doesn't have a treating provider (indiscernible).

Patient consent is required before sharing part 2 records with providers outside of the part 2 program. If a patient consents, they may verbally disclose protected information to a primary care provider. The primary care provider may then enter that information into the patient record. But again that information loses its part 2 protection. Therefore, if you're concerned about the patient's trust, concerned about the patient's welfare, written records are the best way to retain part 2 protection.

Disclosures of part 2 records must be accompanied by a prohibition on redisclosure. This notice has a long and short version. The change, the new language for the long version, is in

section 232 A, and it clarifies the prohibition on redisclosure only applies to part 2 records, not the entire process. So the parcelling out that information. So it does represent a decrease in protections to the patient. The rationale is that the general health care system needs to know more information about the patient. Therefore, it doesn't require the patient's consent.

I'm of the belief that if you talk to people, they will -- they're operating in their own best interests and they will disclose that information, but there are a lot of people who declare that they potentially can't trust the patient, and as a result they don't want the patient to have to consent. You have to decide what your relationship is with the patient.

The disclosures for the purpose of payment and health care operations are now permitted with written consent in connection to they have almost 18 activities that are illustrated in the regulations that constitute payment and health care operations that are now specified under the regulatory provision.

And these things can be fairly broad. So when a patient authorizes disclosures for payment or health care operations, the recipient may redisclose the records to contractors, subcontractors, legal representatives to carry out the payment and health care operations. The new regulations contain that expanded view. That expanded view is of interest.

Here are some examples of the expanded view for the purpose of billing, clinical professional support services, patient safety activities, underwriting, third party liability coverage, fraud, waste, and/or abuse, medical review, business management, customer services, resolution of internal grievances, sale, transfer, or merger, eligibility determinations, risk adjustment, review of care medical necessity, care coordination, and accreditation.

If I had to explain this to a person, and they may get frightened. Don't explain this to a person and they may get angry when this gets out (indiscernible) in this provision which includes training opportunities even for non-clinical people. This is fairly broad and fairly wide.

The other thing that surfaces is disclosures to central registries, and this is particularly to OTP, opioid treatment programs. Opioid treatment programs in the previous rule were obligated to contact the central registry. The central registries were either maintained by a state or a third party vendor like lighthouse, to make sure that a person was not doubly enrolled. And this was an issue.

So there have been changes to this.

And then subject to patient's consent, OTPs are permitted to enroll in a state prescription drug monitoring program and permitted to report data into the PDMP when prescribing or dispensing medications on schedules 2 to 5 when consistent with applicable state law.

Stuck. Slide 27.

>> SAMSON TEKLEMARIAM: Oh, hey. Hey, Dr. Clark, yeah, it looks like you got it. Whenever it does get stuck you click on the slide with your mouse and it gives you back control, and then you can continue navigating using the arrows on your keyboard.

>> DR. H. WESTLEY CLARK: Okay. I'm looking for control here. 28.

Now we're going to do slide 29.

So state central recommending industries. The OTPs may share and receive limited patient information in state central recommending industries to prevent multiple enrollments. Now, non-OTP providers may also query the information in central registries in order to prevent multiple enrollments, prevent duplicative prescriptions, inform prescriber decision making regarding prescribe opioid medications or prescribes other substances.

The issue here is once these registries are not set up for this purpose, so they will now have to accommodate this issue. The other issue is that the OPT does not have to seek the -- OTP does not have to seek the patient's consent -- the central registries does not have to seek this information to (indiscernible) so the OTP needs the patient consent to send the information to the central registries so (indiscernible) I'm concerned about double enrollment, so I want to accept you in my program. So in other words, the patient is almost forced to give the consent to share information to the central registries.

The problem is that now under the new rule, the central registry can give that information out to anybody who declares that they have a treatment provider relationship with a patient. That information that they hand out is limited to medication prescribing. But I've already seen one state where the state is saying, well, we want to share coordination, so they have taken the limited information that is in the regulations and expanded it (indiscernible) coordination using the central registry as a vehicle. That is part of the controversy. There really hasn't been much activity on central registries but you can expect if you're an OTP, to see that this will evolve and we'll see how many OTPs comply with the regulation.

Prescription drug monitoring programs. Some of you may be familiar with prescription drug monitoring programs. The prescription drug monitoring programs as you know record information for any scheduled, usually a two to four or -- schedule two or schedule four drug, and prescribers including pharmacists are required to access the prescription drug monitoring program. That means the prescription drug monitorings are regulated by law enforcement or the Department of Justice in their respective state, but the new rule under section 236 says a part 2 program or other lawful holder is permitted to (indiscernible) part 2 program to the applicable state prescription drug monitoring program if required by applicable state law.

A part 2 program or other lawful holder must obtain patient consent to a disclosure of records to the PDMP under section 231 prior to reporting such information.

Now, again this is another one of those modifications that may be somewhat confusing, because the federal law preempts the state law under 42 USC 290dd. Therefore, if the patient refuses to give their consent to provide this information to the PDMP, the treatment program cannot. So pay close attention to what's going on in your jurisdiction, because if you're an owner of a program, you may get a different opinion from the state authorities. If you're a treatment provider or counselor, (indiscernible) your boss may say, well you've got to disclose this information. Without patient consent, it's not legal.

So there are a number of issues of disclosures without patient consent. These have not been -- the ones in blue have not been changed. And if you will notice on this slide, the COEPHI.org, that's going to be a resource for you on 42 USC 290dd. (Indiscernible) protected health information, and they will be tracking some of these things. One of the historical limitations of this whole process under 42 CFR part 2, is nobody was tracking the complaints that were filed, the grievances that people suffered, and the problems. There are a host of court cases that have been put together subsequently, but they don't constitute the universe of these complaints.

If you look at the brown areas. These are the things that have been changed by the revised rules. The medical emergency, research, audit and evaluation, and court order.

To summarize the other things, the deidentified information can be disclosed without consent. So if state public health authorities wanted deidentified (indiscernible) they could get it. Internal communication, information shared within the program, you don't need patient consent.

Qualified service organizations, you don't need patient consent. Crimes on the premises (indiscernible) but you are restricted to a limited amount of information. Reporting suspected child abuse, you don't need patient consent.

Let's go over the areas that have been changed. Medical emergency, the basic rule under part 2 programs may share information with medical personnel to meet a bona fide medical emergency in which the patient's Briar informed consent cannot be obtained.

Part 2 program must document the disclosure in the patient's file and SAMHSA has issued additional guidance earlier this year for using the medical emergency exception when providing telehealth services during COVID-19 (indiscernible) to my knowledge no patient has ever complained that information was (indiscernible) to save their life but I may be wrong.

To meet a bona fide medical emergency in which a part 2 program is closed and unable to provide services or obtain the prior

written consent of the patient during a temporary state of emergency declared by a state or federal authority, you can share that information until such time that the part 2 program resumes operations. It's not a matter of being closed because it's the end of the day. It's not a matter of it being inconvenient because the patient is on vacation. You have to have a bona fide medical emergency.

The discussion of whether it's a bona fide medical emergency, things like floods, hurricanes, is often left up to the treatment program. And again most treatment programs will recognize that they're trying to work with the patient and keep the patient in a good situation.

Research. Disclosures for research under part 2 are permitted by a HIPAA covered entity or business associate to individuals and organizations who are neither HIPAA covered entities or subject to the common rule. The common rule is the HIPAA rules that govern research on human subjects. So the Office of Civil Rights handles that.

So part 2 programs and lawful holders may share information with entities regulated by HIPAA or the common rule if the deidentified information is recommended but not required. The revised rule added recipient may now be an entity subject to FDA regulations regarding protection of human subjects. If a part 2 program or lawful holder is a HIPAA covered entity, it may disclose data to any entity, so long as that disclosure complies with the HIPAA privacy rule. That's 45 CFR 164.512 and we're going to be visiting HIPAA soon, but right now unless you're involved in research, this won't be an issue for you, but some researchers may show up, the state may decide that they want to do some research in your site, and these are the rules that permit disclosure.

Audit and evaluation. SAMHSA says the new rules clarify specific situations that fall within the scope of permissible disclosures for audits and program evaluations.

Again they want to be able to make sure that the program is doing their job. So they want to make sure that those entities that are looking at whether the program is doing its job, are able to do it. So the basic rule was that the part 2 programs and lawful holders could share patient records with certain entities conducting audits and evaluations.

So -- and that these entities would have to agree to follow part 2 privacy and security. And information can only be used for the purpose of the audit and evaluation.

The revised rule, information may now be shared with federal, state, or local government for audit or evaluation. So CMS now has the authority to say if you are a program that gets Medicaid or Medicare funding, we want to audit your records. Or it could be a government contractor, a subcontractor, a legal representative. Patient identifying information may only be disclosed if the audit or evaluation cannot be carried out with deidentified information.

So that puts the burden on the treatment program to decide or to determine what that is, which may not be that easy if you're not familiar with audit or evaluation.

So key point though is that CMS will -- is now in a position to ask for information about what's going on in your treatment program. So we want to keep that in mind.

Entities that have direct administrative control over part 2 programs may conduct audits and evaluations and they give examples of audits and evaluations. These activities include audits and evaluations under this section, includes activities undertaken by federal, state, or local government authorities, third party payer entities, in order do identify actions the agency or third party payer entity (indiscernible) basically to make sure that there's no fraud, waste, and abuse to establish more efficient care, to ensure resources to manage effectively or patients to determine the need for (indiscernible) payment policies and to review appropriateness of medical care, medical necessity and utilization of services.

Now, why treatment programs wanted to agree to this, I don't know, but they did, so I expect to see more treatment programs being investigated by the OIG because of problems found in their Medicaid billing and their Medicare billing or other third party entities. So stay tuned. We'll see how that works out.

Undercover agents and informants. Court ordered placement of an undercover agent or informant, so an informant can be a patient in your program. An undercover agent can also be a patient in your program. But the part 2 program is extended to a period ever 12 months and courts are authorized to further extend it through a new court order.

So the basic rule historically was you could only do it for six months and the information obtained by agents or an informant could only be used -- could not be used to criminally prosecute or investigate a patient. The revised rule did not change that, but they can order placement of an undercover agent or informant for up to 12 months instead of six. Again the idea is that you're investigating the program, you're investigating the program staff, you're investigating the counselors, you're investigating everybody but the patient. The problem with that, of course, is that if the informant discovers information about the patient's activities outside of the treatment program, and individuals that the patient knows about but not the patient, those individuals probably can be prosecuted, and if those individuals think that that information came from the patient, that's a problem. But this is the new rule.

Disposition of records. When a patient sends -- this has popped up with telehealth. It's popped up with (audio difficulties).

It's popped up with new information. It's popped up with all these new technologies.

Okay. So if the patient uses your phone, you're not supposed to -- you should not be using your own cell phone, your own personal email, but you can (indiscernible) this process by

deleting the message.

So this is under the technical and practical guidance, using personal devices for employees, volunteers and trainees. So they're trying to cover the landscape.

Personal devices should not be used to communicate with the patient. If a patient contacts an employee, volunteer or trainee on their personal device, they should immediately delete the information from their personal account, not the employee, volunteer or trainee, and only respond via an authorized channel provided by the part 2 program. So your program should not be expecting you to use your own personal cell phone to contact patients. Obviously it may happen. So what the agency is doing is giving you permission to receive this information, but not to maintain a contact, or you should terminate the conversation as quickly as possible and use an authorized approach to -- an authorized channel to provide that information.

Data segmentation, non-part 2 programs that regularly receive part 2 protected information can use data segmentation, label or flag the information from the general health care record so that that information is protected.

Whether EHR systems can accommodate that, I don't know. Hopefully SAMHSA will explore that with the EHR vendors, like epic or other vendors. Whatever vendor you use, you may want to ask if it has a relationship with the local hospital, if you're part of a larger system, you may want to know about it, because that is an interesting and important issue.

These are resources that you can access dealing with the final rule, and those resources include a new consent authorized (indiscernible) you can get that from the CLE people, the center for excellence in (indiscernible) health information. That is a useful form. You can (indiscernible) your own form. But if you're concerned about the accuracy of your new form, basically you can just adopt their form and throw your logo on it and move forward with it.

All of these organizations, including SAMHSA, will declare that these are -- meant not necessarily legally competent. They'll have to wait until the courts decide.

But I have reviewed over 150 court cases and very rarely has the consent form been raised at the level of district courts or federal district courts or appeal courts.

By and large most patients under the previous rules tell you where they want the information to go. It's in their own best interest. They're interested in their hypertension, diabetes, whatever medical problems they might have. HIV, hepatitis, and they don't want to (indiscernible) so they don't want to share information. But the new approach basically that we're going to balance the needs of the clinicians and the clinics and the health care delivery system and the vendors against the privacy rights of the patient. My concern is you fully disclose to the patients the

limits of their confidentiality so they don't get angry, they don't feel that you violated their trust and they don't feel that they need to abandon.

In addition to this, the CARES Act. So even more changes are coming to substance use confidentiality. I was surprised that they went through with these new regulations, despite the fact -- because of 42 USC 290dd changes.

Under the CARES Act, it removes the longstanding privacy section where information is shared for treatment, payment and health care operations. And weakens the prohibition against the use of protected records in criminal investigations and prosecutions.

Unlike prior legislative proposals, (indiscernible) voluntary, written patient consent still required before any initial disclosure of substance use disorder records can be made for treatment, payment, or health care operations purposes, and the patient who sign these consent forms still has the right to revoke their consent to prohibit future redisclosures. The question is does the patient know that?

Consent, currently written consent required prior to sharing information included for treatment, payment, or health care operations. That information is prohibited from being redisclosed. But the health care -- the health insurance portability and accountability act, otherwise known as HIPAA allows information to be shared for this purpose. So we now know that the revised rule also allows this information, but the HIPAA rule is a little broader.

Health care operations. This is what the new law says. Quality assessment and improvement activities, reviewing the competence or qualifications of health care professionals. Et cetera. Some of the same things that are in the revised rule. Very broad things. The information goes very broad.

Business planning and development. This is conducting cost management, planning analysis. Business management and general management activities. Customer service. These are all things that are in HIPAA and that are now in the revised rules, but again it will go further, because now it's in 42 USC 290dd 2 D.

Written consent is required before you acquire that information, but if the patient is not going to get paid, then -- if the provider is not going to get paid if they can't provide the treatment.

Information may be disclosed to any health care provider, even those who do not have any treating provider relationship (indiscernible) provision of health care, such as fund-raising on behalf of the health care entity, provider, underwriting, legal services, fund-raising. I don't know. But that's what the 42 USC 290dd will permit. Hopefully that doesn't happen.

So this slide has the phrase perpetual consent. It shall be permissible for a patient's prior written consent to be given once for all such future uses or disclosures for purposes of treatment,

payment, and health care operations, until such time as the patient revokes such consent in writing. That means patients in treatment with you, if the treatment is successful, the patient leaves, five months later somebody wants to know about them, five years later somebody wants to know about them and since you don't have a patient revocation of consent, the program can release that information.

If they're required -- if they require a new approach when you're terminating care with a patient, you may want to ask if they're terminating their consent, such that if these things happen five months later or five years later, the program is not in an awkward situation of having to disclose information unbeknownst to the patient. The key issue is the laws have been required.

Patients will have the right to revoke the consent for future uses but that information is already disclosed, it's no longer protected. So once the horse is out of the barn, then you can't retrieve it. The patient has given the consent and left treatment, the right to revoke is meaningless until it's employed at the time of discharge.

So my question to you is will the patient recall the right to revoke before harm occurs? And that's something you should deal with.

There is under 42 USC 290dd 2 b a self-pay rule, and this is what I call perpetuating health disparities. While the CARES Act amendments to 42 USC 290dd 2 b weaken the privacy rules, (indiscernible) what that means is if I pay in full, out-of-pocket, I can request that my substance use disorder treatment record not be disclosed, not disclose that information. So if I got enough money to pay for treatment, then my records are protected. If I don't have enough money to pay for treatment, then I'm going to have to go with -- hope that God will take care of me, for those of you who believe in God. If you don't believe in God, (audio difficulties) make sure no harm occurs to you.

So I think this creates a disparity.

Now, there are (audio difficulties) so they would be -- they would have no obligation to disclose. And some OTPs that only take cash, so they are in a different situation. If the patient says I'm paying in full out-of-pocket and I (indiscernible) and not disclose, the provider cannot disclose it.

Use of records. Court law prohibits the use of the SUD records in criminal proceedings against the patient unless authorized by can a court order or patient request. The new law extends this prohibition to civil, criminal, administrative or legislative proceedings conducted by any federal, state or local authority. It includes law enforcement investigations, it includes the application for a warrant, it includes any proceeding before a federal, state or local agency, it includes any criminal prosecution or civil action before a federal or state court. This is a good thing because what it does is allows a lot more

protection to the patient, so you can't be prosecuted. Now again, justice will have to figure this out.

It also has an anti-discrimination provision. SUD current law does not contain this. Under the new CARES Act amendment, this prohibits discrimination based on information in the SUD records, no matter how the information was disclosed. That's going to be tricky given the new 42 CFR part 2 revised rule, which allows disclosures or redisclosures. But the anti-discrimination protections will extend to a range of activities, federally funded activities, admission, access to, or treatment for health care, employment, receipt of workers' comp, housing, access to federal, state or local courts, access to, approval of or maintenance of social services and benefits provided by or funded by federal, state or local governments.

This is also very positive thing, and again these don't take effect until March 27 of 2021. The new law requires that regulations be promulgated by HHS. Before then, but the law takes effect regardless of whether these new regulations are promulgated or not.

Under the revised rule, took effect on August 14, SAMHSA promised that as these new regulations would be forthcoming, so we'll just have to wait and see.

Information to public health authorities. So deidentified information, that's nothing new. This section (indiscernible) require substance use programs to report patient specific information as long as they use deidentified information.

What the burden is on the OTP or the providers is to be sure that deidentified information is being used on the part of the public health authorities. So you can disclose the patient's information, including the patient's name, but the public health authority has to use deidentified information, so we'll see how that worked out.

Enforcement. Currently violations of SUD confidentiality law are subject to criminal monetary penalties, but they're rarely enforced. There's no requirement to notify patients of a breach.

Under 42 -- under the 42 CFR part 2, the Department of Justice, using their local district attorneys, justice attorneys, will be responsible for enforcement, and as I pointed out, I can't find any records where they have done a decent job of that.

Under the amendments, civil penalties will apply, including the imposition of penalties for wrongful disclosure of protected information and it will extend HIPAA's breach notification requirements to SUD requirements. Meaning if someone steals your computer or accesses patient information on your cell phone, you will have to notify the patient of the breach, and so -- and you also have to notify HHS of the breach.

So this is also a positive thing.

It imposes a breach notification administrative program on SUD programs and other covered entities. A covered entity that

accesses, maintains, retains, modifies, records, stores, destroys or otherwise holds, uses, or discloses unsecured protected health information shall in case of a breach provide notification, notify each individual whose unsecured information has been or is reasonably believed by the covered entity that has been breached or acquired or disclosed.

Key issue, this is a new role for SUD treatment programs, including OTPs and individual providers who are covered by 42 USC 290dd.

Once you notify people of the breach, they're more inclined to go to their local attorney that they see on the billboards and say I'm (indiscernible) so there's a definition of a breach. This slide carries that definition of a breach. There is a good faith exception to the definition of a breach. The covered entity or business associate has a good faith belief that the unauthorized person to whom the impermissible disclosure was made would not have been able to retain that information.

Again you won't know until the patient is informed that their privacy has been violated, at which point you got a different situation. Nevertheless, this is soft, but it is a burden, and I look at the OIG, the office of the inspector general, who handles the HIPAA notifications, and the Office of Civil Rights, what they do is show that people have been fined substantially for breach notifications.

So the issue is who will be in charge of the new rule once March 27, 2021, comes along? We'll have to wait and see what HHS decides. Historically as I've said before, SAMHSA's promulgated changes to 42 CFR part 2, whereas the Department of Justice was supposed to prosecute those violations. Historically the Office of Civil Rights administers HIPAA. And it has an administrative structure to do that. We don't know who's going to be the agency that is responsible for the new hybrid final rule. It has to be promulgated under 42 USC 290dd 2 B.

So these are common HIPAA violations you should be aware of. Snooping on health care records. Failure to perform -- some of you are familiar with people who have looked -- snooped into the records of movie stars, politicians, and other people. And those are all HIPAA violations, and some programs have been fined for that.

Under the current 42 USC 290dd, you have to sue independently, and actually under both 42 CFR part 2, the substance use records and HIPAA records, you don't have what's called a private right of action you're going to have to rely on the federal government to sue on your behalf. Now, there are some jurisdictions that are allowing this private right of action, but under the existing law, the Department of Justice is supposed to protect your confidentiality. They haven't done much in that area. Office of Civil Rights does a much better job of it, but it may not be sufficient if you've been substantially aggrieved. But these are

the kinds of HIPAA violations that occur, and so -- and you should be familiar with this, but you won't have to deal with these until March 27, unless you're otherwise covered by HIPAA, and many programs have dual coverage, covered by 42 USC 290dd and HIPAA. So if you're already a HIPAA covered entity, it's an issue that you probably should (indiscernible).

There is the issue of court orders. There's this NPRM which is not -- which has not been finally addressed. SAMHSA has delayed responding to it. When they promulgated the first NPRM for the broader rule, they wanted to be able to also include a new 263 confidential communications to disclose information. They wanted to be able to disclose information to law enforcement for drug trafficking and the current rule does not include drug trafficking, but they haven't acted on this, so we'll have to wait and see if they're going to act on this. If they act on this, drug trafficking can be anything because it's often decided by the arresting officials, it has racial (indiscernible) do they have 20 pills or a person using for personal use because they have 20 pills, that will become an issue.

So just recognize that this may become an issue. It is not affected by the provisions of the CARES Act and SAMHSA hasn't done anything with this. This was requested by the Department of Justice because they basically wanted greater access to outpatient records.

(Indiscernible) some of you may recall the story of Willie Sutton, which is why do you rob banks? The answer was because that's where the money is. Why do you want information from drug treatment programs? Because that's where the drug treatment people are.

With that, I want to thank you. We can open this up for questions.

>> JESSICA O'BRIEN: All right. Well, no surprise, thank you so much, Dr. Clark. This was excellent training, and a great update on confidentiality. And 42 CFR. We have a lot of questions.

So I'm going to get to them so that you can share more of your expertise.

The first is David from the state of Washington asks what violations of client confidentiality are most common with the move to telehealth?

>> DR. H. WESTLEY CLARK: That hasn't been documented, but people are asking a lot of questions. Telehealth under COVID-19 has been very liberal, and so what you want to keep in mind is that people have tolerated some flexibility.

(Indiscernible) downloaded or stored in unsecured mobile device is one violation. Log in to your telehealth software is shared by (indiscernible) part of a larger system and people can access your telehealth information. If you have no (indiscernible). If you haven't secured enough data privacy policy with the patient. If you don't let them know about the privacy policy. If you're

messaging patients outside of a secure portal. That's an issue. And if you don't have business associates (indiscernible) in your telehealth activity. These are the six most common violations to telehealth at this point in time.

Now, we know about hacking and we know about other things (indiscernible) we can anticipate those possibilities. But again COVID-19 has created the very (audio difficulties). HHS, Office of Civil Rights is very tolerant of (audio difficulties) the objective is to protect patients and to protect the providers.

Next question.

>> JESSICA O'BRIEN: All right. Great. Thank you.

Evan from Nevada asks what special considerations do court mandated clients have regarding 42 CFR?

>> DR. H. WESTLEY CLARK: Well, if you're mandated to treatment, you have to agree to release your information to the court. This is not -- this has not changed. This is an old provision in 42 CFR part 2.

If you agree to release your information to the drug board, or to the courts or to the probation officer, you cannot rescind that until your (indiscernible) under that authority has expired, so if you have a six month probation, you can't rescind it for six months (indiscernible) you cannot rescind it. But the courts (indiscernible) notice they go to court without the patient's consent. On the other hand (audio difficulties) you're remanded to incarceration. The patient doesn't have much options unfortunately. Unless they're willing to go down to protect their personal information. They can do that.

Next question.

>> JESSICA O'BRIEN: All right. Daniel from California asks what is the link to comment on the new rules? Have the deadline for comment already passed?

>> DR. H. WESTLEY CLARK: Oh, yeah. This is the final rule. The comments were due in December of 2019. They got a host of comments. A lot they got from vendors, electronic health records vendors, some organizations like treatment providers, (indiscernible) and they're waiting to get sued to discover it wasn't such a great idea but they have to wait. They may not get sued. Maybe they're overly cautious so we'll have to wait and see.

Next.

>> JESSICA O'BRIEN: All right. Guy from Texas asks are private pay providers who do not receive federal funds for their services obligated to follow these new rules?

>> DR. H. WESTLEY CLARK: Nope. But they do have HIPAA. They may be covered by HIPAA. But if you are a private pay provider, and -- it depends on the scope of your services. You can be a private pay provider (audio difficulties) you are covered by 42 CFR part 2.

Now, from March 27 -- come March 27, if you're a self-pay patient then you're exempt. March 27 of 2021.

So if your private pay provider is providing psychotherapy, group therapy, you're not covered. If you're a private pay provider providing any controlled substance, (indiscernible) methadone (indiscernible) you're covered. If you're a private pay provider who only provides (indiscernible) or even Narcan, then you're not covered (indiscernible).

>> JESSICA O'BRIEN: So many nuances, thank you.

So Karen from Minnesota asks what exactly is the exception related to child abuse/neglect?

>> DR. H. WESTLEY CLARK: What's a good exception? You should disclose this to your patients up front. I've been in that situation. You let patients know what the disclosures are. If you report anything that I suspect is child abuse, most state laws have a fairly clear and expansive definition of what they think child abuse is. Your program should provide you that, and if you don't have a program, you can access the state's law in your jurisdiction.

So the exception is I don't need the patient's consent. I'm obligated to report and I just need to follow the rules that state has for reporting child abuse and neglect.

>> JESSICA O'BRIEN: Okay. So Kaylen from Idaho asks can a patient consent for treatment/payment/health care operations in a single consent form, or do they need separate consents for each entity that will receive records related to treatments?

>> DR. H. WESTLEY CLARK: Well, remember the entity -- it can be very broad, so if the entity serves those broad purposes, they don't need (audio difficulties) because you're disclosing it, but you're disclosing it to those entities. See what I mean? So if you've got multiple entities, I've got Blue Cross on the left, I've got Aetna on the right and I've got CMS in the middle. So I can disclose to Blue Cross for a wide range of conditions including health care operations, but I need to put in the consent form that I'm disclosing (indiscernible). I don't have to put in the consent form that I'm disclosing (indiscernible) in the administrative section or Miss Jones in the other administrative section. I can use the generic, I'm disclosing to Blue Cross on the left, and on the right CMS in the middle.

>> JESSICA O'BRIEN: Got you. Okay.

Christine from South Carolina asks I am confused on the issue related to non-member, parentheses, treating provider, access to the central registry. I'm under the impression that access is allowable without obtaining consent if for the express coordination for providing --

>> DR. H. WESTLEY CLARK: Go ahead.

>> JESSICA O'BRIEN: Oh, I submitted a TA request to center of excellence for protected health information that stated consent would be required for the disclosure by the registry to the treating provider. And then she gives a quote that says the consent is necessary so that the state's central registry can

disclose part 2 protected information to the non-member treating provider, even if a non-member treating provider -- go ahead.

>> DR. H. WESTLEY CLARK: If you read the regulation, the consent is required to disclose to the central registry but once the central registry gets the information, there is no subsequent requirement for redisclosure. There's no consent required. So let's say lighthouse. That's one of the central registries (indiscernible). I'm the OTP. I check in with lighthouse. I give them the patient's name, the (indiscernible).

Dr. Smith knows that the patient is on (indiscernible), contacts the central registry and the rule actually doesn't say (indiscernible) so the doctor says contact the central registries and is Jane Jones a patient. The central registries gets to say yes. Dr. Jones doesn't need the release of information. The central registry doesn't need (indiscernible) as I read it, as they articulate it. The only people -- the only time that there's a consent that is required is the (indiscernible) to PDMP which you keep in mind that if you upload the information to PDMP, all of those people that access that information, they don't need the written consent. You don't need the patient's consent to consult the central registry. But you do -- you need the patient's consent to disclose to the central registry. But that's generally handled on admissions. Because you're trying to avoid duplicate registration. Once that information is in the central registry, they don't need the consent from the patient. And the treatment program no longer has control of that information anyway. The central registry does.

>> JESSICA O'BRIEN: Okay. Kelly from North Carolina asks do we know if substance use therapy on college campuses and collegiate recovery communities are qualified organizations?

>> DR. H. WESTLEY CLARK: They may very well be. So you want to first of all universities and colleges often have their own confidentiality rules anyway. But if they're totally private, places like Harvard, they get a lot of information (indiscernible) if they follow the (indiscernible) program, they're covered.

>> JESSICA O'BRIEN: Okay. Linda from New Hampshire asks how does this interact with wits program in New Hampshire? Wits is web information technology system.

>> DR. H. WESTLEY CLARK: What do they use their wits for? Is that state (indiscernible) entity?

>> JESSICA O'BRIEN: I'm not sure.

>> DR. H. WESTLEY CLARK: Yeah. I'm not sure what they're using their wits system for. If it's a state entity, so they upload treatment information to the state. The state is the public health authority, so public health authority can get the patient information.

>> JESSICA O'BRIEN: Okay.

>> DR. H. WESTLEY CLARK: We covered that. Yeah. Yeah. The

new rule allows public health authorities to get that information, (indiscernible) CARES Act. CARES Act, it doesn't even have to be deidentified. The new rule says they can get (audio difficulties).

>> JESSICA O'BRIEN: Great.

Maurice from New York asks what if you send information to an unauthorized party or entity by mistake through a wrong fax number or email?

>> DR. H. WESTLEY CLARK: Then under the existing rules, you try to retrieve that as soon as possible. What people have sort of done is actually destroy it, but it doesn't guarantee that it's destroyed. It depends on how far away it is, you can call and ask them to destroy it. With Zoom, you retrieve that information. Under the new HIPAA rules, you'll have to disclose it's a breach and then the question is in good faith, can that person use that information. So let's say you send it to the garbage authority of fax machines because it's next door to somebody's health clinic and their fax machine broke down or they didn't have a fax machine. So they probably don't have much use for that information, so you in good faith to ask them to destroy it, and you would not have to notify anybody, because you in good faith said that they couldn't use the information. But if it turns out it was used -- a lot of these things it will depend on whether there's a case, whether there's a complaint, whether there's an issue. So if someone is harmed, (indiscernible) if the patient is harmed by some of these things, then it's a whole given ball of wax, because now (indiscernible) information could be used and if it turns out that the waste disposal company was run by the father of the patient or the relative of the patient, and then they used this to harm the patient, (audio difficulties). These are all hypotheticals (audio difficulties) is no longer a hypothetical.

>> JESSICA O'BRIEN: That's why your expertise is so valuable because you can give us a sense of how to think through it.

Thank you very much.

So Julie from North Dakota asks wondering if when -- wondering if when we can't figure out a situation, if we can call NAADAC or who do we call to sort it out? I find the agencies will not allow us to talk today attorneys or say, quote, we are not going to call the attorney, but I don't want to be involved in any legal problems with confidentiality. Are sober living houses (indiscernible).

>> DR. H. WESTLEY CLARK: I would imagine it depends on the jurisdiction. Some sober living homes don't fall under (audio difficulties) under 42 USC 290dd. Some states may define them as substance treatment programs because they require (audio difficulties) so you have to ask how are sober living (audio difficulties) and then you go.

>> JESSICA O'BRIEN: Okay. Rainie from Minnesota asks how strong do you think enforcement of a HIPAA violation is?

>> DR. H. WESTLEY CLARK: Some argue it's mediocre, but they do enforce it. They collect data. They report on violations. They

charge people money and people have to pay them money. So it's much stronger than the enforcement of -- the current 42 CFR part 2. So again since there's no private right of action, theoretically I cannot sue under HIPAA, just as I can't sue under 42 USC 290dd (audio difficulties) bring the heat, and they get a backlog.

With regard to the (audio difficulties) SAMHSA does sponsor this center of excellence. You can try to touch base with them.

In the end, everybody will say you have to (audio difficulties) in the end the most important thing is to be fully transparent with your patient. This is about transparency. This is about (audio difficulties). This is about letting the patient know what the (audio difficulties). If the patient can't trust you, they can sue you. If they can't trust you, they get angry at you. (Audio difficulties) as most of us do. Remember the last time you felt you were stymied as every twist and turn and how well you handled it. So think about that.

The key point is trust, transparency, communication.

>> JESSICA O'BRIEN: All right. Jessica from Nebraska asks oftentimes a client is assigned a probation officer and at some point the probation officer changes. We have found ourselves in a bind when we attempt to communicate with the client's probation officer and find they have been reassigned, thus invalidating our specific named probation officer on the release, is it better to write a generic release or is it best to specify a name.

>> DR. H. WESTLEY CLARK: (Audio difficulties) probation. It doesn't have to designate a specific person. The new (audio difficulties) made to accommodate that kind of thing (audio difficulties). If a person under your care for a time period, then you want to make sure that you're able to communicate to benefit the patient.

>> JESSICA O'BRIEN: Yeah. I think that's a great change.

>> DR. H. WESTLEY CLARK: Remember they can always revoke, but most people don't, because if they revoke, then the probation (audio difficulties) revoke them too.

>> JESSICA O'BRIEN: Right.

>> DR. H. WESTLEY CLARK: It's not a good bargaining position for the patient. So (audio difficulties) so write Lancaster county probation.

>> JESSICA O'BRIEN: To clarify the change in the CARES Act -- okay, so to clarify, the changes in the CARES Act have already been passed or could be passed?

>> DR. H. WESTLEY CLARK: They're already passed. They go into effect March 27, 2021. For those of you who want to remember the specific date, April fool's, 2021.

(Laughter.)

>> JESSICA O'BRIEN: Interesting coincidence.

>> DR. H. WESTLEY CLARK: Well, that's what I say too.

>> JESSICA O'BRIEN: Yeah. Right. And also for those of you in the handout section of the webinar menu, you can find a copy of the

CARES Act, so be sure to check that out.

Dawn -- we have time for some more, Dawn asks with the growth of collaborative law enforcement/(indiscernible) should all treatment information be kept confidential from law enforcement?

>> DR. H. WESTLEY CLARK: For me the issue is transparency, trust, and communication. Transparency, communication, and trust. Let the patient know what the deal is. If the patient is under the influence or has some cognitive compromise, can't process the information at this time, reiterate this issue. So that the patient knows. The patient is the entity whose welfare we're trying to protect so we want to respect their autonomy and their own independent decision making ability (audio difficulties) I should hold back the information. If I don't think that decision making capable is compromised then the patient should be able to make the decision and ask me for advice about the extent of the disclosure, because as you know, these collaborative relationships sometimes operate to the detriment of the patient, sometimes operate to the benefit of the patient. We don't want to be in the position of (audio difficulties).

>> JESSICA O'BRIEN: Yeah, that's true.

Carmen from Washington, D.C. asks can you elaborate more on being required by an organization to use a personal device to contact and communicate with a client? Many of us are required to have our EHR app on our personal device and receive client contact from our personal device.

>> DR. H. WESTLEY CLARK: Well, HHS's position is it's a bad idea. Because if it's on a personal device, somebody else accesses it, then you will have (audio difficulties). That is less of an issue right now, but come March 27, it becomes an issue. Because under HIPAA, the personal information -- such information is protected health information, and it could be a breach. So again a lot of providers, organizations decided that this is a wonderful idea, so now they got to cough up the resources for this administrative function. And they may be able to give you an iPad, which are expensive these days, so that information can be uploaded there. But if you're using your own personal phone, our significant other, your spouse, your child, your friend, your relative, a person on the street has access to it, then it's not a good idea. If it's encrypted, maybe you can argue the encrypted that it prevents other people from accessing it, but it's not a good idea.

>> JESSICA O'BRIEN: It's not recommended.

>> DR. H. WESTLEY CLARK: Not recommended.

>> JESSICA O'BRIEN: Not recommended.

Okay. So Brian from Alaska asks what impact do all of these changes have on faith -- on faith based substance use treatment programs?

>> DR. H. WESTLEY CLARK: It depends whether you are a substance use treatment program under the law. If you are, then you're

controlled by it. If you're not, then you're not. So I have seen one faith based program that advertised we don't -- we're not a program under 42 CFR part 2. We're not controlled by this and all your information is confidential. They can make that assertion. If they're not, they don't (audio difficulties) opioids or alcohol or (audio difficulties), they fall under the rule. Because that activity is regulated, not the program (audio difficulties) so that activity falls under the rule. But the program (audio difficulties) they didn't prescribe controlled substances, macro biotics, vitamins, whatever, so they didn't fall under it.

>> JESSICA O'BRIEN: Kevin from forest hills, New York, asks CFR 42 stated that the expiration date or condition had to be specified in the release. Does the new proposed rule state that that is no longer required or effective?

>> DR. H. WESTLEY CLARK: It's no longer effective. In perpetuity, once that information is (audio difficulties). So key point is the rules that say the information can be disclosed in perpetuity, unless the patient revokes the consent. The patient has to actively revoke the content. That's how I read it. So we'll see how that is interpreted over time. But again we may -- this is September, so September, October, November, December, so we have four months this year, and January, February, March, three years next year. So seven months. We've got a new ball game.

So keep the expiration date. Be mindful that it may not be controlling under the new CARES Act provision.

>> JESSICA O'BRIEN: Okay, well, I think that's with all the time we -- about all the time we have for questions. This was fabulous and we have quite a few people here today and I know they valued your expertise in getting their questions answered, as this will impact all of us in the field. So thank you so much. I really appreciate it.

>> DR. H. WESTLEY CLARK: And I would appreciate them notifying NAADAC if they encounter some of these problems with patients and patient complaints about breach of confidentiality. So we do need to have a better understanding of what the conditions are. They are on the frontlines, they're in the situations where they have all the information, and we can all help them and their patients if creating a repository (audio difficulties).

>> JESSICA O'BRIEN: Right. Absolutely. Good feedback. It's good feedback to NAADAC.

Thank you so much.

>> DR. H. WESTLEY CLARK: All right.

>> JESSICA O'BRIEN: Wonderful.

So just a reminder that everything you need to know about this webinar is housed on its own designated web page, so right after this event, you can go back to this website and find the CE quiz and get to work on getting your CEs. It's housed at NAADAC.org advocacy - confidential - 42 CFR - webinar.

Check out our schedule for our upcoming webinars on September 9

we are going to be wrapping up our cultural hue hilt series with social responsibility in the addiction profession.

The annual NAADAC conference is going to virtual in year and it's literally right around the corner. We are in September right now, you can earn up to 28 CEs, if you haven't registered, we hope you will. For more information visit the conference website, [NAADAC.org/annual conference](http://NAADAC.org/annual%20conference).

Bookmark this page shown here on slides. You can stay up-to-date on the latest in this new series, our cultural humility series which I mentioned is wrapping up next week, Wednesday, September 9, hopefully you can all be there. All of these presentations are available on demand, so check them out at your convenience.

We also have our COVID-19 resources page. There are six excellent free webinars covering top concerns in the addiction profession. And presented by leading experts in the field.

Currently NAADAC is also offering two specialty online training series. The first is our clinical supervision in the addiction profession, which you can find more information about -- find more information about, the web page at the bottom of the screen. The web address. We also have a second series, addiction treatment in military and veteran culture, so you can visit the web page that you see at the bottom of this slide.

Just a reminder that as a NAADAC member, here's a quick review of the benefits of being a member. By joining NAADAC, you'll have immediate access to over 145 CEs which are included as a NAADAC benefit. This is huge, guys. Lots of CEs. We all need them. You'll have NAADAC's magazine, face-to-face seminars and as I mentioned, our conference is coming up in September. So check it out. Consider joining NAADAC if you're not already a member.

So please take note that a short survey will pop up at the end of this webinar. Please take the time to give us your feedback. Share any notes for the presenter, tell us how we can improve. Your feedback is very important as we continue to improve your learning experience.

Thank you again for participating in this webinar. Thank you, Dr. Clark, for your valuable expertise, leadership, and support in the field. I encourage all of you to take some time to browse our website to learn how NAADAC helps others, and stay connected with us on LinkedIn, Facebook and Twitter. Hope you all have a wonderful day. Take care, everyone.

>> DR. H. WESTLEY CLARK: Thank you. Bye-bye.
(End of webinar.)

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