Alcohol Screening and Intervention in Trauma Centers: Confidentiality Concerns and Legal Considerations

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Recognizing the importance of identifying patients with alcohol problems, more and more trauma centers are implementing alcohol screening and intervention programs. Therefore, it is becoming increasingly important for trauma surgeons to be familiar with the applicability of federal laws and regulations governing the confidentiality of substance use records as they relate to their practice. These requirements are among the most protective confidentiality rules that exist in federal law. The purpose of this article is to review these statutes, discuss their potential impact on trauma centers and trauma patients, and provide recommendations to ensure compliance.

Alcohol Problems and Stigma

A recent nationwide survey documented that 83% of trauma surgeons believe that a trauma center is an appropriate place to address alcohol problems.[1] This represents a substantial change in attitudes toward alcohol screening in trauma centers over the past 5 years.[2] Societal attitudes have also changed, with fewer people regarding substance use disorders as a moral failure, greater recognition of medical, genetic, environmental, and social factors, and increasing emphasis on identification and treatment. Despite this progress, considerable stigma still exists, and patients and their families are legitimately concerned about the potential adverse consequences that may occur when a substance use disorder is inadvertently disclosed. These consequences include adverse insurance, employment, family, and legal problems.

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In the early 1970s, the federal government passed laws specifically intended to increase the willingness of patients to accept treatment by providing special protections that ensure the confidentiality of medical records related to alcohol and drug use disorders. Congress made clear that the confidentiality rules were designed to ensure that a person with a substance use disorder who admits his or her problem to a health care provider, or who enters treatment, is not made more vulnerable to adverse consequences than a person who avoids treatment.

Congress recognized that people who come forward for treatment of alcohol and drug use disorders are at significantly greater risk if the records of their health care are easily available because of the stigma and discrimination many face when they seek employment, insurance, and other necessities of life. Disclosures could also be detrimental to the interests of patients who are involved in divorce or custody proceedings, seeking to buy or rent a place to live, or many other activities. The federal confidentiality law was designed to assure people in need of care that they would not suffer these types of difficulties if they come forward for treatment.

Confidentiality of Alcohol and Drug Use Information

Regulations concerning the privacy of persons receiving alcohol and other drug prevention and treatment services are known as 42 CFR Part 2, *Confidentiality of Alcohol and Drug Abuse Patient Records*. They govern the management and disclosure of any information related to screening, identification, treatment, or referral to treatment of patients with an alcohol or drug use disorder at facilities that receive federal assistance, as virtually all trauma centers do. With only a few exceptions, 42 CFR Part 2 prohibits the disclosure of information that would identify someone as having an alcohol or drug use disorder unless the patient signs a special written release form. A standard hospital or insurance consent form is insufficient.

In several important respects, 42 CFR Part 2 requires a greater degree of confidentiality than is required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and its regulations. For example, whereas HIPAA allows disclosures to insurance companies, other payors, or

law enforcement officials without any written authorization from the patient, 42 CFR Part 2 requires the same special authorization form to be signed in those circumstances. Furthermore, although HIPAA allows disclosures without written authorization to other health care professionals within the same facility, 42 CFR Part 2 allows disclosures without consent only to other staff within the same facility that have a need for the information to perform their duties.

Absent the patient's written authorization, information about an alcohol or drug use disorder may be disclosed by a practitioner or organization in very limited circumstances, including if there is a medical emergency, research project or audit, the patient has committed a crime on program premises or against program personnel, or in situations in which state law requires the health professional to report suspected child abuse or neglect. Otherwise, without the patient's written authorization, information about an alcohol or drug use disorder can only be released by issuance of a court order. A subpoena is not sufficient. During any subsequent judicial hearing, the patient must be represented by an attorney (or be provided with an attorney if they cannot afford one); the hearing must take place in closed chambers; disclosure must document involvement in a crime that is 'extremely serious'; and there must be reasonable likelihood that disclosure will provide substantial value to the investigation.

Because of the importance of these issues, trauma centers have a strong legal and ethical obligation to ensure that information obtained for alcohol screening and intervention purposes will not be improperly disseminated.

The Trauma Center Exception

Trauma centers are required to provide only the level of confidentiality mandated by HIPAA in many, but not all, circumstances that involve alcohol and drug use. This is because in 1990, the Department of Health and Human Services (DHHS) amended 42 CFR Part 2 by providing an exemption to trauma centers and emergency departments under certain conditions. The reason for exempting trauma and emergency department medical records from 42 CFR confidentiality protections was the belief that disclosure of such records would not serve as a disincentive to patients seeking alcohol or drug treatment.[3] DHHS stated in its explanation of the rule change, 'we do not foresee that the elimination of hospital emergency rooms or surgical wards from coverage will act as a significant deterrent to patients seeking assistance for alcohol and drug abuse because patients are treated not because they have made a decision to seek alcohol and drug abuse treatment, but because they have suffered a trauma or have an acute condition with a primary diagnosis of other than alcohol or drug abuse.'[4]

The different standards of confidentiality occurred because confidentiality legislation was written in an era when screening for alcohol problems was done almost exclusively in alcohol treatment centers, and nearly all screening was performed by alcohol treatment specialists. The regulations did not anticipate that alcohol and drug counseling would some day be provided in trauma, primary care, obstetric, adolescent, emergency medicine, and other types of medical practices.

When Do Confidentiality Laws Apply to Trauma Centers?

The motivating reason for alcohol or drug screening determines the level of confidentiality of the resulting information.[4] A trauma surgeon who obtains a blood alcohol concentration (BAC) or drug toxicology screen to assist in managing the patient's injuries is not required to protect that information under 42 CFR Part 2, even if it identifies the individual as an alcohol or drug user. However, if the trauma center has staff whose primary purpose is to screen patients for a substance use disorder and to provide interventions, counseling, or referrals for counseling, then all information related to the substance use disorder is protected. According to the statute, 'these regulations would not apply, for example, to emergency room personnel who refer a patient to the intensive care unit for an apparent overdose, unless the primary function of such personnel is the provision of alcohol or drug abuse diagnosis, treatment, or referral and they are identified as providing such services or the emergency room has promoted itself to the community as a provider of such services.'[5]

A federal publication, *Alcohol and Other Drug Screening of Hospitalized Trauma Patients,* further clarifies this point: 'Although in general it is not necessary for emergency departments, trauma centers or hospitals to comply with federal confidentiality when treating patients with an alcohol or substance use disorder, it may become necessary if they go further and make a diagnosis of alcohol or substance abuse or addiction, conduct even a brief intervention, and/or refer the patient to treatment.'[4] Calling itself a prevention program does not excuse a program from adhering to the confidentiality rules. It is the kind of service provided, not the label, that determines whether the program must comply with the federal law.[6]

Implications for Trauma Care

If information protected by 42 CFR Part 2 is placed in the patient's hospital chart, no one is allowed access to the chart except 'personnel having a need for the information in connection with their duties that arise out of the provision of diagnosis, treatment, or referral for treatment of alcohol or drug use.'[7] The effect would be to prevent the trauma surgeons, orthopedists, neurosurgeons, physical therapists, and others not involved in providing substance use treatment from reviewing the chart, including the daily physician notes and other types of reports included in the medical record. Thus, compliance with 42 CFR Part 2, in effect, requires keeping information obtained for screening and intervention purposes in a separate chart with restricted access, or, if records are

computerized, access to that information covered under 42 CFR Part 2 must be password protected or otherwise limited to those who meet the test of needing the information to provide their alcohol- or drug-related counseling duties.

Confidentiality and Adolescent Trauma Patients

When federal regulations concerning privacy of information related to substance use were conceived in the 1970s, alcohol and drug use disorders were assumed to be health problems that primarily involved adults. Over the past two decades, the onset of abuse and addiction to opioids, stimulants, marijuana, and alcohol has been found increasingly among adolescents. Although this may reflect increasing efforts to diagnose these disorders among the young, the trends to earlier onset appear real and may continue.

Adolescents have privacy concerns that are similar to those of adults. Both minors and their parents may be concerned about the potential for a lifetime of stigma and discrimination that may result from the diagnosis of a substance use disorder in the child, which may have a lasting effect on future opportunities in education, employment, insurance coverage, and other areas.

When state law allows a minor to give consent for his or her own substance use treatment, 42 CFR Part 2 prohibits release of any information without the minor's consent.[8,9] When state law requires parental consent to treat the minor, the law prohibits disclosure of any information without the permission of both the minor and the parent. Nevertheless, the minor's consent is required before any information may be shared with the parent. In all cases, therefore, the minor's consent is required for disclosure.[10,11]

Confidentiality and Pregnant Trauma Patients

Alcohol or drug intoxication may be present in pregnant trauma patients. For social and legal reasons, there are many pressures on pregnant women to hide an alcohol or drug use problem. This may result in undertreatment and potential worsening of their substance use disorder, with adverse consequences to both the mother and the fetus.

Federal concerns about child abuse emerged with the passage of two landmark pieces of legislation: the 1974 Child Abuse Prevention and Treatment Act and the Adoption Assistance and Child Welfare Act of 1980. These two specific pieces of legislation establish financial incentives for states to mandate reporting of suspected child abuse or neglect and of infants affected by illegal substance use or withdrawal. All states have enacted such laws to varying extents, and some of those laws require maternal alcohol or drug use to be reported to authorities. Both 42 CFR Part 2 and HIPAA allow those disclosures when mandated by state reporting laws, so trauma centers must make them. Thus, pregnant trauma patients with an alcohol or drug use disorder may have a substantial incentive to deny the existence of a problem, sometimes making it difficult to diagnose these conditions without an objective test such as a BAC or urine toxicology screen.[12]

Confidentiality and Drunk Driving

Forty states have passed legislation mandating BAC testing for drivers who survive an automobile crash.[13] Mandatory testing means that the driver must comply with a request from a law enforcement official for a BAC measurement. It does not mandate testing by medical personnel. Therefore, there are no direct implications for trauma care.

However, six states (Hawaii, Illinois, Indiana, Oregon, Pennsylvania, and Utah) have adopted a hospital BAC reporting statute. These are laws that require or authorize hospital personnel to report BAC results of drivers involved in crashes to local law enforcement authorities where the results are available as a result of medical treatment. These statutes do not require physicians to perform a BAC or urine toxicology screen for purposes of screening for drunk driving. However, neither 42 CFR Part 2 nor HIPAA prohibit physicians from reporting BAC or urine toxicology screens to the police if they are not obtained as part of a screening and intervention program.

Most physicians believe that it is contrary to the traditions of the doctor-patient relationship to perform procedures to initiate possible criminal sanctions against a patient who is seeking their help with a medical condition. There is also concern that reporting could be arbitrary, with physicians more likely, in a spirit of retribution, to report certain types of patients.[14] For these reasons and others, the American College of Emergency Physicians has adopted a policy that opposes permissive and mandatory reporting of drunk driving to legal authorities.[15]

In most cases, the patient with an alcohol or drug use disorder does not represent a threat to the public. However, impaired drivers represent a clear risk that is all too familiar to the trauma surgeon. Patient confidentiality is not an absolute right. Exceptions that have been accepted by the public include cases where failing to reveal certain information would result in serious bodily harm to the patient or to others. Trauma surgeons have a professional duty to maintain confidentiality as a fundamental condition for acquiring their patient's trust. However, there are compelling arguments for developing means of reporting drunk driving.

Forty-eight states currently have statutes that mandate reporting of gunshot wounds to legal authorities.[16] Suspected child abuse and certain infectious diseases are also covered by mandatory reporting laws. These mandates are widely accepted by trauma surgeons. However, the trauma physician or nurse is not charged with the task of reporting. Hospital administrators and security staff typically perform this function. Trauma surgeons are interested in public safety and injury prevention and would likely also support some type of drunk driving legal intervention in trauma centers, provided that it does not require them to act as agents of the police.

Confidentiality and Health Insurance

In 36 states it is possible for an insurer to withhold payment to the hospital and to the treating physicians if

information suggests that the patient was intoxicated at the time of his or her injury.[17] These states enacted their versions of the Uniform Accident and Sickness Policy Provision Law (UPPL), a model law that allows insurance carriers to exclude coverage for alcohol and drug-related injuries. The model states, 'Intoxicants and Narcotics–The insurer shall not be liable for any loss sustained or contracted in consequence of the insured's being intoxicated or under the influence of any narcotic unless administered on the advice of a physician.'[18]

Trauma surgeons may choose not to measure BAC or to screen for substance use disorders if this information can be used as a reason to refuse to pay them for their services. No particular BAC threshold is required for an insurer to deny payment, nor must a causal relationship between the intoxication and the injury be established.[19] Thus, if the invoice submitted to the insurer contains a bill for a BAC measurement or urine toxicology screen, the insurer may demand to see the result and withhold payment until the trauma center complies.

Even in situations where the BAC or urine toxicology screens are conducted in the course of alcohol and drug treatment services that are covered by 42 CFR Part 2, those confidentiality rules ordinarily do not provide patients much protection from disclosure to insurance companies, because patients typically sign consent forms authorizing the release of this and other medical information to the insurer to obtain payment.

Screening with questionnaires rather than BAC or urine toxicology tests and keeping the results separate from the chart is one means of reducing the risk of UPPL-related denials. However, clinical care for the injuries may be compromised if the clinician is prevented from obtaining a BAC or urine toxicology screen. When screening for substance use disorders, a combination of objective markers and self-report questionnaires increases diagnostic accuracy and sensitivity. It is also difficult to counsel patients not to drink and drive when language in the patient's insurance contract prevents the physician from determining if the driver was, in fact, intoxicated. Additionally, increasing trauma patients' motivation to change their drinking habits usually involves exploring the relationship between their alcohol use, admitting BAC, and the injury sustained.

Computerized Medical Records and Alcohol and Drug Use Histories

Many of the unnecessary deaths caused by medical errors documented by the Institute of Medicine (IOM) were attributed to communication problems among health care providers, and the report urged improved fluidity and fidelity of communications by use of computerized medical records.[20] Insurers, however, may also desire computerized medical records with other purposes in mind. The possibility of a 'national health card' computerized throughout the country, with potentially sensitive patient information available from the card, exponentially increases the dangers of recording information that stigmatizes the patient. Maintaining a separate, parallel medical chart within a computer system to comply with 42 CFR Part 2 can be complicated but has been done successfully in many instances.

Recommendations to Ensure Confidentiality

To ensure compliance with federal confidentiality concerns and legal protections, current hospital 'consent to care' forms could be changed so that blanket permission would not be given to release all information to outside agencies, such as insurance companies. For records covered under 42 CFR Part 2, this is compulsory, because the special and more limiting consent form required by the regulations must be used. This might also reduce the risk of insurance denials for the patient who was intoxicated at the time of injury, a common and significant discriminatory practice.[21]

Having staff whose primary function is alcohol screening and intervention and segregating information so that it is not in the medical record and available to third parties is the best available policy in trauma centers. Psychiatrists often maintain separate medical records out of concerns with sharing sensitive information with the large number of individuals who review a typical medical record. Such an approach affords the greatest amount of confidentiality protection. Individuals designated to perform screening and interventions could serve as 'gatekeepers' who are familiar with 42 CFR Part 2 and state confidentiality issues and make decisions about the release of sensitive information.

As an alternative to maintaining a separate, locked file, the intervention staff could place alcohol- and drug-related information in a separate section of the chart that is designated as confidential. This portion of the chart could be shared by those who provide the screening and intervention without being viewed by everyone involved in the patient's care. The confidential portion of the chart would be separated from the main record when the patient is discharged. The physical separation of protected information, even though it remains in the patient's own medical chart, would remind clinicians of the importance of maintaining confidentiality and ensuring compliance with 42 CFR Part 2.

Using screening questionnaires, rather than laboratory tests that are routinely placed in the medical record, can reduce the risk of UPPL-related insurance problems. Saliva alcohol testing strips are an alternative option to blood alcohol testing and may reduce the risk of problems with insurance denials because they do not provide durable results.

One key disadvantage of separate medical records is that it perpetuates the notion that substance use disorders are not part of mainstream medical care, and it implies that the patient's own treating physician, in this case a trauma surgeon, should not be aware of the patient's problem or be part of the intervention team. In some cases, information about the patient's alcohol or drug problem is vital for managing the presenting injuries or for identifying patients who may have adverse drug reactions or develop withdrawal syndromes.

An additional disadvantage resulting from the need to segregate information is the contradiction between this practice and the 'no wrong door to treatment' practice recommended by public health experts and federal agencies, where all patients admitted to hospitals are screened for an underlying alcohol or drug use disorder as part of mainstream health care. If this approach were adopted, and obtaining information about alcohol use was an integral part of the history taking for all patients, the medical record of every patient with a positive screen would have to be treated in accordance with 42 CFR Part 2, and written permission would be required when it is necessary for health care providers other than substance abuse treatment staff to have access to the chart.

CONCLUSION

Trauma surgeons have an ethical and legal obligation to ensure that information related to alcohol and drug use disorders is not disseminated to those who do not have a right to know. Any effort to modify federal privacy regulations must be done cautiously so as not to diminish their invaluable aspects and cause new problems. However, one problem that must be considered is whether or not confidentiality laws perpetuate the stigmatization they were designed to prevent.

Whereas the arguments for protecting privacy in the current environment are strong, it is clear that we would be far better off if we were to move toward an era in which substance use disorders and addiction are no more stigmatized or hidden than other diseases, including those that frequently result from the substance use problem. The benefits to those afflicted, and to the public health in general, of treating epilepsy, depression, and other once strongly stigmatized disorders are obvious. Stigmatization creates barriers to treatment and perpetuates substance use disorders, injuries, family violence, school dropouts, crime, injuries, the spread of infectious diseases, and robs patients and their families of the hope of recovery.[21]

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EDITORIAL COMMENT

Trauma surgeons recognize the high prevalence of alcohol problems among their patients and that it is important to address these problems.[1] Research consistently demonstrates that screening and brief intervention (SBI) for alcohol use

disorders decrease alcohol use, recurrent use of health care resources, and recurrent driving under the influence[2–5] Insurance barriers,[6] lack of knowledge about SBIs,[1,7] and potential harm caused by identifying a patient's substance use disorder have all been barriers to implementing hospital-based SBI programs. This article helps trauma centers meet the new Committee on Trauma requirement to screen for and provide alcohol interventions. While trauma centers and surgeons make this journey to help patients with their alcohol disorders, they must be aware of the protection mechanisms that help maintain confidentiality to avoid legal, insurance, and employment implications.

Surgeons should also seriously consider why they obtain a blood alcohol concentration (BAC). If the BAC is obtained for purposes other than screening for alcohol problems, it may force some hospitals and physicians into the role of law enforcement officers rather than medical care providers. Moreover, in states with insurance laws that allow withholding payment if a patient is intoxicated, the BAC provides information directly to insurers. Screening patients for alcohol disorders with standardized screening instruments such as the Alcohol Use Disorders Identification Test,[8] and not the BAC, allows the patient to be screened, treated, and protected while also allowing the physician and hospital to be reimbursed.

This article helps clarify the current legal climate in the United States. Surgeons are now aware that the release of substance use information is prohibited if it is obtained specifically for the purpose of screening and providing interventions. Under these circumstances, the information cannot be released without specific written patient consent. Surgeons facilitating the adoption of SBIs should ensure that their hospitals restrict access to alcohol use information. This restricted access helps avoid improper dissemination of substance use information to attorneys, insurance companies, and law enforcement agencies. This important article helps surgeons overcome another barrier to SBI and helps trauma centers more actively participate in recurrent injury prevention efforts.

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