23 May 2016

MEMORANDUM

From: Health Law Attorney, Navy Medicine East

To: NME AOR Attorneys and Legal Officers

Subj: ADVISORY MEMORANDUM: HEALTHCARE PROVIDER REPORTING OF ACTIVE DUTY PATIENT MISCONDUCT DISCOVERED DURING THE COURSE OF HEALTH CARE TREATMENT

Ref:
(a) DoD 6025.18-R, "DoD Health Information Privacy Regulation"
(b) DHA, Privacy and Civil Liberties Office, "The Military Command Exception and Disclosing PHI of Armed Forces Personnel"
(c) U.S. Navy Regulations, Article 1137, "Obligation to Report Offenses"
(d) U.S. Navy Regulations, Article 1123, "Adverse Entries in Medical and Dental Records"
(e) Manual of the Medical Department, Article 16-38, "Entries by Health Care Professionals"
(f) Manual of the Medical Department, Article 16-15, "Documentation in the Medical Record"
(g) MILPERSMAN 1910-146, "Separation by Reason of Misconduct – Drug Abuse"
(h) DoD Instruction 6490.08, "Command Notification Requirements to Dispel Stigma in Providing Mental Health Care to Service Members"
(i) OPNAVINST 1752.2B, "Family Advocacy Program (FAP)
(j) 42 USC 13031, "Child Abuse Reporting"
(k) DoD Directive 2311.01E, "DoD Law of War Program"
(l) DoD Directive 5240.06, "Counterintelligence Awareness and Reporting (CIAR)"
(m) Military Rule of Evidence 513

1. Purpose. There is understandable confusion about what providers can and cannot do with patient misconduct information discovered during the course of health care treatment of active duty members. This advisory opinion is intended to address some of the more prominent laws, regulations and instructions that affect required, authorized, and prohibited disclosure/reporting of misconduct specific to the patient and, as an advisory memorandum, is not binding interpretation of the references.

2. Discussion.

a. Reference (a) is based on federal law regarding uses and disclosures of Protected Health Information (PHI). In general, the PHI of individuals shall not be used or disclosed except for specifically permitted purposes (C1.2.1.). For purposes of this discussion, some of

those permitted purposes include uses and disclosures: required by law (C7.1.); about victims of abuse, neglect or domestic violence (C7.3); to avert a serious threat to health or safety (C7.10); and for activities deemed necessary by appropriate military command authorities to assure the proper execution of the military mission (C7.11.1.1.), see also, reference (b). Uses and disclosures for such purposes are authorized, not required, by reference (a), i.e. a covered entity may use and disclose PHI for the permitted purpose. In effect, reference (a) prohibits disclosure of PHI, except in certain circumstances when disclosure of PHI is authorized.

b. Reference (c) requires reporting, to superior authority, of all UCMJ offenses that come under the observation of persons in the naval service. Cases involving persons prosecuted for failure to report an offense of another have contemplated the witness being physically present and observing the offense occurring. See generally, *U.S. v Bland, 39 M.J. 921.* Accordingly, being told about an offense after the fact is not observation of an offense and does not require reporting under reference (a).

c. References (d) and (e) require a medical officer to inform a patient's commanding officer whenever an entry is made in the patient's medical record that indicates the patient's use of marijuana, narcotic substances, or other controlled substances. The question is whether providers are required to enter indications of drug abuse in the medical record which would then require reporting.

(1) Reference (f) identifies what documentation should be entered in the medical record, including:
   (a) chief complaint or purpose of visit;
   (b) diagnosis;
   (c) studies ordered and results, e.g. toxicology screenings; and
   (d) disposition.

   Reference (f) does not require particular medical record documentation. Rather, it provides guidance to medical department personnel regarding the same.

(2) The National Committee for Quality Assurance (NCQA) is one of many entities addressing standards of care. Regarding medical record documentation, NCQA promotes consistent, current and complete documentation in the treatment record as an essential component of quality patient care.

(3) While compliance with reference (f) may not be mandatory, failure to enter consistent and complete documentation in the medical record may be a failure of the standard of care.

At a minimum, providers should endeavor to satisfy the standard of care for medical record documentation by entering into the medical record indications of drug abuse (e.g. observation, labs, statement, etc.) that relate to any of the recommended medical record entries listed in reference (f), e.g. purpose of visit, diagnosis, etc. If the provider does not document indications of drug abuse in the medical record, the provider is not required to report. However, when there is a positive urinalysis or blood test (tox screen), providers are encouraged, not required, to immediately notify the patient's commanding officer pursuant to reference (g).

d. Mental Health Care, and Drug and Alcohol Abuse Education. Reference (h) provides additional protections from disclosure for patients seeking mental health care or drug and alcohol abuse education (as distinguished from substance abuse treatment). If a patient is seeking either of these, the health care provider shall follow a presumption against notifying the patient's commanding officer. This presumption may be overcome only if one or more of nine notification standards is/are present. When at least one of the nine notification standards is present, reporting is required.

(1) Harm to self. Provider believes there is a serious risk of self-harm.
(2) Harm to others. Provider believes there is a serious risk of harm to others.
(3) Harm to mission. Provider believes there is a serious risk of harm to a specific military operational mission. Serious risk may include disorders that significantly impact impulsivity, insight, reliability, and judgment.
(4) Special personnel. Patient is in a program, e.g. PRP, of such sensitivity that normal notification standards would significantly risk mission accomplishment.
(5) Inpatient care. Patient is admitted or discharged from any inpatient mental health or substance abuse treatment facility.
(6) Acute medical conditions interfering with duty.
(7) Substance abuse treatment program. Patient has entered into, or is being discharged from, a formal out- or inpatient treatment program for treatment of substance abuse/dependency.

(8) Command-directed mental health evaluation.

(9) Other special circumstances. Proper execution of the military mission outweighs the interests served by avoiding notification. This is determined on a case-by-case basis by a health care provider at the O-6 or equivalent level or above or a commanding officer at the O-6 level or above.

Reference (h) is a DoD instruction and takes precedence over references (c) through (e) - Navy instruction/regulation. Accordingly, if a provider sees a patient for mental health care or drug and alcohol abuse education, and documents indications of drug abuse in the medical record, as outlined in paragraph c. above, the provider shall not report or disclose that information to the patient's commanding officer unless one or more of the nine notification standards is present.

Note 1: Providers must make a reporting determination using the facts and circumstances of each case. Where there is a risk of harm, the provider must determine if the risk is serious. The provider must use sound judgement, consult peers or supervisors, etc. and be prepared to justify the decision to report or not report. Willful or negligent failure to report a serious risk of harm could have negative implications for the provider. On the other hand, reporting a risk of harm that is not serious, could also have negative implications for the provider, e.g. complaint to licensing authority.

Note 2: If required to disclose, providers may only disclose the minimum amount of information necessary to satisfy the purpose of the disclosure. Generally, this will include diagnosis, treatment prescribed or planned, applicable duty limitations, and implications for the safety of the patient or others.

e. Federal and/or State Reporting Requirements.

(1) Child abuse/neglect. References (i) and (j), and all states and territories require some level of mandatory reporting of known or suspected child abuse/neglect/exploitation (including child pornography). Such mandatory reporting is compatible with both references (a) and (h), as the former authorizes disclosures as required by law and/or to avert a serious threat to health or safety, and the latter mandates disclosure to prevent harm to others.

(2) Domestic abuse/neglect. Some states may require reporting. Reference (i) requires reporting to law enforcement in the case of major physical injury or indication of a

propensity or intent by the alleged offender to inflict major physical injury. Such mandatory reporting is compatible with both references (a) and (h), as the former generally authorizes disclosures of domestic violence, to avert a serious threat to health or safety or as required by law, and the latter mandates disclosure to prevent harm to others.

(3) Reporting of certain types of wounds, use of dangerous weapons, elder abuse, war crimes, etc. Depending on the jurisdiction, there may be other circumstances requiring reporting. It is incumbent on the provider to know or seek legal counsel on mandatory reporting requirements, disclosure authorizations and other applicable laws and directives.

3. Scenarios.

a. During a routine appointment, a provider, making small talk, asks a patient what he did over the weekend. The patient, who is not seeking mental health care or drug and alcohol abuse education, tells the provider that he went to a party and smoked marijuana.
Q: Is the provider required to report this misconduct?
A: Yes, if the provider enters the information into the health record. References (d) and (e).
Q: May the provider report the misconduct, even if not required to report it?
A: Yes. Reference (a), section C7.11.1.1. I would recommend the provider report.

b. During a mental health appointment, a patient reports that she can't sleep since returning from deployment. In order to fall asleep, the patient states that she takes her husband's controlled prescription medications.
Q: Is the provider required to report this misconduct?
A: No, unless one of the nine notification standards listed in reference (h) is present.
Q: What notification standards could apply here?
A: The provider must make that determination. Possibilities include:
(1) If the provider believes there is a serious risk of harm to a specific military operational mission. Must be a *serious risk* and a *specific operational mission.* The provider may want to inquire about what the patient does, e.g. administrative job vs. aircraft mechanic.
(2) If an O-6 provider determines that the proper execution of the military mission outweighs the interests served by avoiding notification. **Note**: this exception appears

to be a "catch all" – does not require "serious risk" or "specific operational mission" – and that's probably why it requires a decision at the O-6 level.

c. Patient is brought to the emergency room by friends. The patient is delirious. The friends report that the patient tried to commit suicide. The provider runs some diagnostic labs. The labs indicate the presence of cocaine.
Q: Is the provider required to report this misconduct?
A: Yes, if the provider enters the information into the health record. It is my opinion that the provider should enter this information into the health record to meet the documentation standard of care.
Q: If the patient is involuntarily admitted for inpatient mental health treatment and the intake paperwork references attempted suicide by drug overdose. Is the provider required to report this misconduct?
A: Possibly. The provider is required to report inpatient care and harm to self, but only the minimum necessary amount of information. Whether the method of attempted suicide (cocaine overdose) is necessary to report may depend on whether the patient is a regular user or whether this was a one-time use solely for the purpose of attempting suicide, i.e. is the drug use relevant to the diagnosis, the treatment plan, etc. The provider is also required to report harm to mission, but again, if the patient only used one time, is the drug use a serious risk to a specific operational mission, or does the proper execution of the military mission outweighs the interests served by avoiding notification? The answers to these questions are fact dependent and require critical analysis by the provider.

d. A mental health provider is informed by his patient who recently returned from deployment that he participated in the rape and torture of an Iraqi civilian with fellow Soldiers.
Q: Is the provider required to report this misconduct?
A: Possibly. References (k), Section 6.3, requires that all military and U.S. civilian employees, contractor personnel, and subcontractors assigned to or accompanying a DoD Component report reportable incidents through their chain of command. A reportable incident is defined as a possible, suspected, or alleged violation of the law of war, for which there is credible information, or conduct during military operations other than war that would constitute a violation of the law of war if it occurred during an armed conflict. The Law of War, also called the "law of armed conflict" is that part of international law that regulates the conduct of armed hostilities. The law of war encompasses all international law for the conduct of hostilities binding on the United States or its individual

citizens, including treaties and international agreements to which the United States is a party, and applicable customary international law. The Geneva Conventions are a source listing reportable incidents, e.g. POW torture; murder, torture, or brutality of civilians in areas of armed conflict and occupied territories. Arguably, a patient disclosure or admission of having engaged in possible war crimes is "credible information" that would trigger the mandatory reporting requirement.

As indicated above, reference (h) prohibits reporting except in certain circumstances. Since reference (h) is a slightly more recent DoD directive than is reference (k), it may be argued that the prohibitions against reporting take precedence over the requirement to report, unless one of the exceptions apply. Perhaps the most likely exception applicable in this scenario, absent additional facts, is the "other special circumstances" exception. Something the deciding O-6 must consider is whether the execution of the military mission may be affected by an incident that occurred in the past, and if so, whether such execution outweighs the interests in avoiding notification, e.g. potential successful treatment.

e. A mental health provider is informed by her patient of an interest in joining a known international terrorist group.
Q: Is the provider required to report?
A: Probably not. Reference (l) requires the reporting of contacts, activities, indicators, and behaviors as potential threats against the DoD, its personnel, information, materiel, facilities, and activities, or against U.S. national security. First, reference (h) is a more recent directive than reference (l), and arguably takes precedence. Second, whether an "interest" is reportable depends on the facts of the disclosure and the level of activity of the patient. If the patient has taken any affirmative action, e.g. advocating violence, contacting the group, etc., then the "interest" may be reportable depending on whether one or more of the exceptions in reference (h) are met.

Note: Repeated browsing or visiting known or suspected international terrorist websites that promote or advocate violence directed against the United States or U.S. forces, or that promote international terrorism or terrorist themes, without official sanction in the performance of duty is reportable, but failure to report this activity may not alone serve as the basis for punitive action under Article 92, UCMJ (orders violation).

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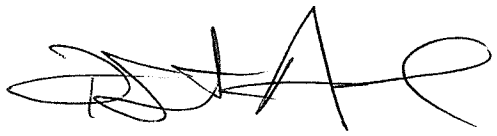
Q: Upon further discussions with the patient, the provider learns that the patient isn't just interested, but intends to join an organized named terrorist group. Is the provider required to report?

A: Possibly. The intent to join a terrorist group suggests more prohibited activity than mere interest, e.g. expression of an obligation to engage in violence in support of a known terrorist group, association or connection (online, email, social networking) to a known terrorist group, etc. Such activity certainly should be considered by the provider in determining reporting requirements, e.g. harm to others, harm to mission, and/or other special circumstances.

Note: Reference (m) makes confidential communications, between patient and psychotherapist, for the purposes of facilitating diagnosis or treatment, privileged/protected. However, reference (m) does not apply when there is a duty to report under federal or state law, or service regulations.

4. This truly is a complicated issue, particularly when it comes to mental health. There is a thin line between deciding to report and risk violating privacy and other laws and applicable service regulations like references (a) and (h), and deciding not to report and risk violating the mandatory reporting service regulations, or worse, failing to prevent harm to others or the military mission. Providers must consider the facts and circumstances of each case when making reporting decisions, and legal advisors should be ready to assist providers in making the best decision.



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