

# ALCOHOLISM DRUG ABUSE WEEKLY

News for policy and program decision-makers

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## IN THIS ISSUE...

This issue features coverage from what will be the first in a long series of steps in which confidentiality rules for patient records may change. At issue is patient consent to release their alcohol and drug abuse treatment records. The confidentiality regulations are governed by the Substance Abuse and Mental Health Services Administration, which is seeking a balance between privacy and technology.

... See top story, this page

Teens with first manic episode have high risk of SUDs  
... See page 5



Study says patient attitudes changing about HCV treatment  
... See page 8



Alison Knopf, Editor,  
winner of CADCA  
Newsmaker Award

ADAW wins SIPA award for 'Housing First' exclusive  
... See page 8

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## SAMHSA opens door to weakening 42 CFR Part 2

The confidentiality regulations governing medical records for the treatment of substance use disorders (SUDs), in force for more than 40 years, are being called into question by almost everyone in health care except for patient rights advocates. And based on the number of commenters at a daylong June 11 "listening session" held by the Substance Abuse and Mental Health Services Administration (SAMHSA), the patients are losing in the battle.

It's become a battle, despite the long history of uncontested primacy of the regulations, known as 42 CFR Part 2, because of electronic medical records. Under 42 CFR Part 2, a pa-

### Bottom Line...

*The long process of changing — or not — the confidentiality regulations took the first step in years last week.*

tient must give explicit, written consent each time SUD treatment records are released; the consent must include to whom the records are released, and be for one time only. Redis closure is not permitted without patient consent, and again, the consent must be specific for the individual receiver. This was not a problem with paper records, but with electronic medical records, Health

See **SAMHSA** page 2

## The Business of Treatment

### Facilities must be proactive to find referral sources in SBIRT



The last two letters in the acronym "SBIRT" seem like an afterthought to some observers in the addiction treatment community, as few providers seem to trust that broad Screening, Brief Intervention and Referral to Treatment initiatives in primary care will lead many patients to specialty providers' front door. In fact, the "RT" part of SBIRT is not well understood by the referrers themselves, who often don't know to whom to refer these patients.

Yet one specialty provider reports a surge in components of its business as a result of screening in primary care says addiction treatment providers can capture referrals if they make an aggressive case to

### Bottom Line...

*A Kansas specialty treatment provider got aggressive in pursuing screening for substance use disorders with general medical providers and has seen a spike in insurance business as a direct result.*

general medical entities. It works because the provider uses its own staff to do the screening in hospitals.

The nonprofit Central Kansas Foundation currently has five formal SBIRT-related agreements with Salina Regional Health Center (an acute-care hospital), Salina Family Healthcare (a community health center/Federally Qualified Health Center)

See **SBIRT** page 6

### SAMHSA from page 1

Information Exchanges (HIEs), insurance companies, health care providers (including many SUD health care providers), and vendors of information technology and electronic medical records systems all oppose it in the digital age. It's too difficult to "segment" the specific consent, they claim. At the June 11 session, these speakers were overwhelmingly in favor of replacing 42 CFR Part 2 with a much weaker privacy standard like the 1996 Health Insurance Portability and Accountability Act (HIPAA), revising 42 CFR Part 2 to weaken its consent provisions, or repealing 42 CFR Part 2 altogether.

Whether SAMHSA is actually entertaining weakening the consent provisions is unclear. Four years ago, SAMHSA unequivocally said it wouldn't change them (see *ADAW*, June 21, 2010). In an August 4 public meeting on 42 CFR Part 2 that same year, Pamela Hyde, administrator of SAMHSA, and H. Westley Clark, M.D., director of SAMHSA's Center for Substance Abuse Treatment, reiterated that 42 CFR Part 2 would not be revised in any way (see *ADAW*, August 9, 2010). Since then, there have been indications that all is not well with SAMHSA and the confidentiality regulations; for example, Hyde said, "It's getting in our way" last fall at a workforce

meeting, referring to 42 CFR Part 2 (see *ADAW*, September 23, 2013).

Still, 42 CFR Part 2 is a regulation implementing a statute. Only Congress can change the confidentiality law itself — 42 U.S.C. Section 290-dd-2 is the citation — by amending it, for example. But the federal agency charged with implementing the law's provisions, which is SAMHSA/the Department of Health and Human Services (HHS), and which implements the law by issuing regulations like 42 CFR Part 2, has the authority to amend the regulations themselves. That is what SAMHSA is considering whether to do now. However, it cannot change the basic requirements of the statute itself, which includes the requirement that the patient's written consent must be obtained before disclosures can be made.

The 42 CFR Part 2 regulations were first issued in 1975, and were last amended in 1987.

Clark, who for six months in 2012 was detailed to be head of information technology at SAMHSA (see *ADAW*, December 19, 2011) wasn't even at the SAMHSA listening session. He was listening in via webinar as his schedule allowed, according to the SAMHSA press office, which did not make him available for an interview. Instead, the session, which was announced in the *Federal Register* May 12 (see *ADAW*,

May 19), was facilitated by Maureen Boyle, whose SAMHSA titles are health IT team lead and public health advisor (until June 16, when she moves to the National Institute on Drug Abuse), and Kate Tipping, public health advisor at SAMHSA.

### Technology vs. privacy

Boyle opened the session by referring to possible changes. "We believe there are ways of updating the regulations that will help technology vendors and health care providers comply while also protecting privacy," she said. This set the tone for the day, as many commenters talked about how 42 CFR Part 2 adversely affects them. Unlike four years ago, there are many more people clearly taking sides on the issue, although the same few are still supporting keeping the regulations as is.

One common thread among the commenters who favor changing the regulations is that they promote stigma, a position taken most frequently by providers of "behavioral" (mental health and SUD) treatment services. Ronald Manderscheid, Ph.D., executive director of the National Association of County Behavioral Health and Developmental Disability Directors, said 42 CFR Part 2 "promotes stigma and separateness for people with substance use conditions." He recommended that changes be made so

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# WILEY

that records are not available to the police. But they should be shared via electronic health records, he said. And a veteran Washington insider, Manderscheid suggested avoiding statutory and regulatory changes. “We think workarounds need to be developed because legislation and regulatory change takes time,” he said, recommending that HHS develop a “digital health technology office.”

Kurt J. Brower, M.D., an addiction psychiatrist at the University of Michigan, said that “addiction is a disease of secrets, such as getting controlled substances from doctors,” he said. “Most patients have never heard of 42 CFR until they do seek treatment, and they are more likely to use 42 CFR to hide information from people who would help them.”

There were suggestions that payers may not be able to offer SUD treatment if they can't freely share records. Sarah Dobbin, assistant general counsel at the Massachusetts Office of Health and Human Services, which administers MassHealth, the state's Medicaid program, said it's essential to amend the regulations to allow a third-party payer to disclose SUD information. “Like all data we receive, we need to use and disclose this in order to function as a public insurer,” she said. Some functions are outsourced, and these parties need access to the information, she said. “If we can't take advantage of a QSO [Qualified Service Organization] exemption, we would be limited from outsourcing anything that has to do with substance abuse information,” she said. “That could limit our ability to give benefits in the first place to people who otherwise would not be able to afford substance abuse treatment.”

Others in favor of revising the regulations are Richard Rosenthal, M.D., from the American Academy of Addiction Psychiatry; Mark Jones of SmartNet in Oklahoma; Eric Goplerud, Ph.D.; Al Guida of Netsmart; Oregon Behavioral Health; Maine-Health; Renee Popovits; many IT vendors; and more.

## Civil rights

Advocates for keeping 42 CFR Part 2 as is argued that the consent provision keeps the SUD treatment information from being used to incarcerate patients, take their children away, be denied insurance or employment, and more.

Many people who want the regulations changed refer to patient safety, saying that they need to know a patient's SUD status in order to treat them. But James C. Pyles, principal with the Washington, D.C.-based law firm Powers Pyles Sutter & Verville, said that under the law, patients can't be treated without their consent. “It is a battery,” he

**‘We believe there are ways of updating the regulations that will help technology vendors and health care providers comply while also protecting privacy.’**

Maureen Boyle

said. “What is more patient-centered than putting a patient in charge of their health information?”

And Deborah Peel, M.D., founder of Patient Privacy Rights, based in Austin, Texas, said that lack of privacy causes bad treatment, with research conducted for the Institute of Medicine showing that 5 to 6 million people a year delay or avoid treatment because they are afraid the information can be used against them in some way. In an emergency situation, such as to save a life, of course disclosure without consent is necessary, she said. “The people in the ER should be able to make that call,” she said.

“Most people can't even get a copy of their own records,” said Peel, who is a psychiatrist. In 2002, HHS stripped the right of consent for disclosure from the HIPAA rule, she said, adding that the entire health IT system is now “designed for surveillance.” In the era of data, people's health records have become a commodity, with consent a barrier.

## Discrimination against SUDs

The privacy protections of 42 CFR Part 2 “are as critical today as they were when they were first enacted more than 40 years ago,” said Katie O'Neill, senior vice president of the Legal Action Center. “HIPAA will not protect people with substance use disorders.” This consent should also be required for payment purposes, she said. “Stigma and discrimination are real consequences” of SUDs, she said. Today, pregnant women face criminal and civil penalties just for seeking treatment, she noted. The Legal Action Center gets frequent requests for help from treatment centers whose records are sought by law enforcement with no consent, she said, adding that police interrogate patients coming out of opioid treatment programs.

Carol McDaid, representing Faces and Voices of Recovery, identified herself as a woman in long-term recovery, and urged SAMHSA to maintain 42 CFR Part 2 privacy. Surveys of members of Faces and Voices show that there is still employment discrimination, child custody loss and insurance denials due to SUD records disclosures, she said. “I lost insurance as a result of inappropriate release of my treatment records,” she said. The best way to preserve privacy is to require the individualized patient consent for release of records, as is provided in 42 CFR Part 2, she said. “A patient's medical record is their property,” she said.

## Other conditions

Karla Lopez of the Legal Action  
[Continues on next page](#)

Continued from previous page

Center noted that electronic health records and health information exchanges already have to comply with regulations in order to be HIPAA-compliant. In addition, there are already many state regulations regarding HIV/AIDS, domestic violence, mental health and other conditions calling for privacy. “Even if 42 CFR Part 2 did not exist,” she said, these other regulations would have to be accommodated.

There are still questions, as there were four years ago, about who is covered under 42 CFR Part 2 — is it only a specialty SUD provider, or does it extend to a primary care provider conducting screening and brief intervention? “The Legal Action Center agrees with SAMHSA that who is covered has been the source of some confusion, and we welcome clarification,” said Lopez.

## ‘The stigma isn’t because methadone patients’ health records are separate.’

Joycelyn Woods

“Substance abuse still carries as much stigma as ever,” said Victor Kogler, executive director of the Alcohol and Drug Policy Institute in California. He said that Qualified Service Organization Agreements (QSOAs), in which an SUD treatment provider can sign up to provide care and enter into information sharing, should not eliminate the consent required for 42 CFR Part 2. “I’ve seen these provisions interpreted and applied too broadly as a way of bypassing 42 CFR Part 2,” he said, citing a countywide probation program that was determined to be a QSO and thus to be provided access to all patient records. “In any revision of 42 CFR, the QSO provision should be framed so it is clear what is and what is not a QSO,” he said.

Then, Kogler recommended that SAMHSA set aside an entire day for

patient comments. “This entire process will lack integrity if the voice of patients isn’t heard,” he said. “These are their records.”

### Methadone

Joycelyn Woods, executive director of the National Alliance for Medication-Assisted Recovery, spoke on behalf of methadone and buprenorphine patients. Revising 42 CFR Part 2 would create a barrier to patients to entering treatment, she said. Patients who tell their health care providers they are on methadone are told they should get off it, she said. “Once information gets into a big database, there’s no protection anywhere,” she said.

Mark W. Parrino, president of the American Association for the Treatment of Opioid Dependence, which represents opioid treatment programs, said the protections af-

forded by 42 CFR Part 2 are critical. “We still live in an age of employment discrimination. We still live in an age where police cruisers park in front of drug treatment facilities.” And many law enforcement agencies want to use prescription monitoring programs “to cross-match patient records against any outstanding warrants,” he said.

Woods called the patient safety issue a “red herring,” saying that most patients on methadone are stable and employed, and when they go to the doctor, they don’t say they’re on methadone, because of stigma. “The stigma isn’t because methadone patients’ health records are separate,” she said.

Another comment was filed in writing by Robert G. Newman, M.D., president emeritus of Beth Israel Medical Center, who was sued by

the government — and won — when law enforcement tried to get records of his patients in opioid treatment programs in New York City in the 1970s. “Misunderstanding of addiction, of addicts and of addiction treatment is near-universal in our society and — sadly — is widely evident among healthcare workers, hospitals, clinics, insurers, etc.,” he wrote. “Accordingly, while the broadest possible knowledge of a patient’s history can be helpful in reaching a diagnosis and deciding on the optimal therapeutic course, knowledge of an addiction history is far more likely to result in negative consequences for the patient.”

### Whose record?

Newman stressed that an individual’s desire to disclose personal information should be that individual’s. If they want to authorize the release of that information, they should be free to, he said, “but such authorization must not be coerced, and must not be a sine qua non for the provision of treatment.”

“One thing I’ve learned in 25 years of practice is there is no end to the number of people who need to have access to your personal health information without your consent,” said Pyles, who was attending the meeting on behalf of the American Psychoanalytic Association. “No matter what you do you’ll never satisfy them.” What has changed in recent years, he said, is that there are “new health care models on the scene.” But what hasn’t changed is the expectation of patients that they will have privacy, he said. He cautioned SAMHSA not to waver. “Corporations and associations are like adolescent boys — they want to know who’s the boss and what are the rules,” he said. “SAMHSA’s role is to keep the rules.” The confidentiality rules are even more important with current health information technology, because now privacy can be breached “from anywhere in the world,” he said. “Once privacy is breached electronically, it can never



be recovered.” If SAMHSA falters in this, he said, the new models of records release will be “on the street tomorrow.”

There were 115 people present in the SAMHSA room, with more than 2,000 registered to attend via

phone (as we did) or Web. The comments made via phone or in person on June 11 don't necessarily represent the actual comments, many of which will be sent in writing, and some of which (like Newman's) we obtained for this story. •

Go to [www.samhsa.gov/health-privacy](http://www.samhsa.gov/health-privacy) for instructions on filing a comment. Comments are due by June 25 and will be posted at the URL by mid-July.

We will be following this story closely in the coming weeks.

## Teens with first manic episode have high risk of SUDs

While it is known that adolescents with bipolar disorder have a greater chance than adolescents without psychiatric disorders of developing substance use disorders (SUDs), little is known about the risk and protective factors involved. The first study to look at risk factors prospectively is now in press at the *Journal of the American Academy of Child & Adolescent Psychiatry*.

Lead author Jacob R. Stephens and colleagues undertook a prospective study looking specifically at bipolar disorder (BD) subjects, who have a particularly high risk for an SUD that persists even when controlled for other psychiatric disorders.

Adolescents with comorbid SUD and bipolar disorder have increased suicide attempts, poor medication adherence, rapid cycling and poorer functioning; in addition, the combined problems are associated with high rates of legal problems, unwanted pregnancies and HIV infection.

It would be valuable to be able to identify adolescents with bipolar disorder who are most susceptible to developing SUDs, the researchers said.

The study looked at clinical and demographic traits connected with SUDs in adolescents with bipolar disorder, focusing on possible risk and resilience factors for developing an SUD following hospitalization for a first manic episode. They hypothesized that male, older, white adolescents with a family history of SUDs were all characteristics that would predispose the patient to have an SUD. In addition, they also hypothesized that adolescents with BD and a comorbid psychiatric dis-

**‘Future directions include examining specific relationships between substance use and clinical characteristics in our sample (e.g., cannabis use and psychosis), as well as a propensity model to further explore the relationship between stimulants and SUDs.’**

Jacob R. Stephens, et al.

order would be more likely to have an SUD. Finally, they hypothesized that adolescents with these demographic and clinical characteristics, even if they did not have an SUD coming into the study, would be more likely to develop one during follow-up.

### Study details

There were 103 adolescents aged 12–20 who had been hospitalized for the first time for a manic or mixed episode; all were diagnosed with bipolar disorder. The participants had been recruited as part of

the University of Cincinnati First-Episode Mania Study between 1999 and 2005, and had already participated in studies of alcohol and cannabis abuse following a first manic episode.

The age of bipolar disorder onset was the age at which the adolescent first met *DSM-IV* criteria for an episode of depression, mania or hypomania; a mixed episode was one that met criteria for both a manic and a major depressive episode for at least a week; and psychosis was defined as having delusions or hallucinations. Adolescents and primary caregivers were interviewed to determine diagnoses.

A diagnostic assessment was completed at the time of hospitalization. The participants were assessed one month after discharge, and at four-month intervals from then on. Symptoms of SUDs and mood disorders were reviewed, week by week.

### Cannabis most common

Almost half (48 percent) of the adolescents had either a comorbid SUD before their first hospitalization for mania, or developed one during follow-up. The most common substance was cannabis (84 percent). Of the 49 adolescents who developed an SUD, 32 were diagnosed before or at the hospitalization.

The researchers found that unlike the studies they cited, there was no difference in race/ethnicity, sex and socioeconomic status in participants with and without SUDs. Likewise, having an SUD didn't predict co-occurring ADHD, anxiety disorders or PTSD. However, a later age

[Continues on next page](#)

## Continued from previous page

of onset of bipolar disorder, psychotic symptoms (hallucinations or delusions) at baseline, a history of a manic (not mixed) mood episode at baseline and a history of physical or sexual abuse were associated with comorbid SUDs. Treatment with stimulants was associated with not having an SUD.

Only psychosis and physical or sexual abuse were significant predictors of a SUD diagnosis, with psychosis a borderline predictor and physical or sexual abuse a significant predictor.

Of 71 participants, 17 (24 percent) developed an SUD during follow-up, with a median time of 40 weeks after hospitalization. In 9 of the 17, cannabis abuse or dependence was the first SUD to develop, but the most common SUD was alcohol abuse or dependence, which occurred in 13 of the 17 participants (76 percent), followed by cannabis abuse or dependence (12 participants, or 71 percent).

Psychosis at baseline, comorbid disruptive behavior disorders and PTSD were significantly associated with developing an SUD during follow-up.

The strongest predictor of developing an SUD was baseline psychosis, followed by PTSD, with bipolar disorder remaining a significant predictor.

The rate of SUD in this bipolar disorder sample (47.6 percent) is higher than rates previously reported in other studies, probably due to the fact that the participants were inpatients with their first episode of bipolar disorder mania.

An earlier retrospective study found that adolescent-onset (not childhood), oppositional defiant dis-

order, and anxiety disorders (including PTSD) predicted development of an SUD. What makes this study unique is that the patients had not been diagnosed with bipolar disorder prior to hospitalization, allowing the researchers to prospectively track the subsequent development of SUDs.

## Self-medication?

The researchers didn't look for possible reasons for the SUDs, but they speculate that young people could have used substances to self-medicate bipolar disorder. Earlier studies have supported this hypothesis in patients with psychosis and PTSD as well. Other studies report that patients with bipolar disorder say they use substances for their mood-altering effects, lending further credence to the self-medication hypothesis.

It's also possible that mania-associated impulsivity may contribute to using substances, the researchers said, adding that additional studies are needed to find out what is causing the SUDs in individuals with bipolar disorder, in particular those with psychosis or comorbid PTSD. The study shows that treatment with psychostimulants before the first manic or mixed episode could protect adolescents with BD from subsequent SUDs. This could be because the patients actually had ADHD, and it has been argued that treatment of ADHD with stimulants does protect against SUDs. In this study sample, both patients with (49 percent) and without (29 percent) ADHD had been given stimulants. This was a naturalistic study, with researcher physicians not involved in treatment, so the researchers didn't know why children without

ADHD were given stimulants. They may have been misdiagnosed by primary care physicians, the researchers said, adding that the symptoms were actually characteristic of mania and not ADHD. Stimulants could protect against SUDs by sustaining increased levels of dopamine, preventing the dopamine spike associated with drug administration. Another explanation is that patients with risk factors for developing an SUD may have actually been less likely to receive a prescription for stimulants due to concerns about abuse, they said.

The researchers concluded that additional studies of the relationship between stimulant treatment and prevention of SUDs in teens with bipolar disorder are necessary, particularly in light of limitations of the small sample group in this study.

The strengths of the study — prospective design, length of follow-up, comprehensive symptom assessment and naturalistic approach — provide helpful information about SUD development, the researchers said. “Future directions include examining specific relationships between substance use and clinical characteristics in our sample (e.g., cannabis use and psychosis), as well as a propensity model to further explore the relationship between stimulants and SUDs,” they write. “Further empirical data to identify a broader range of clinical and biological risk and protective factors for developing SUDs in adolescents with BD are needed.”

The study, “Risk and Protective Factors Associated with Substance Use Disorders in Adolescents with First-Episode Mania,” was funded by the National Institute of Mental Health. •

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## SBIRT from page 1

and primary care physician groups. It did not acquire these passively. “We were proactive — we were the one coming to them with data,” Central Kansas Foundation CEO Les

Sperling told *ADAW*. Sperling explained that his organization's interest in linking with general medicine intensified as health reform began to dominate policy discussions several years ago. “The Affordable Care Act

was coming on board, and we were listening to what the leaders in Washington were saying about how substance abuse providers would benefit," he said.

### Overcoming odds

Addiction treatment facilities need to remember that SBIRT initiatives are not designed mainly to capture individuals needing intensive levels of care. According to data from SBIRT grantees provided by the Substance Abuse and Mental Health Services Administration (SAMHSA), only 1.2 percent of patients who are screened in SBIRT programs end up being referred to specialty treatment. One of the common reactions on the part of busy physicians is that this is such a small number, why go through the extra — and unreimbursed — effort of trying to get them into treatment.

"So few people identified by screening have severe enough problems to warrant referral," Richard Saitz, M.D., M.P.H., a faculty member of the Clinical Addiction Research and Education Unit at the Boston University School of Medicine, told *ADAW*. "And then of them, a minuscule number ever seek and receive treatment. I am not aware of an agency that could say they successfully receive referrals."

In the case of the Central Kansas Foundation, no federal grant money is involved in the screening initiatives that have yielded business for the center, said Sperling. Commercial and Medicaid billing codes for SBIRT activities in Kansas constitute the main revenue source, he said.

He added that full-time staffers in his organization are largely the individuals conducting the screening in the primary care settings where the Central Kansas Foundation has a presence. "We have full-time staff on the medical/surgical units of acute-care hospitals," he said.

According to Sperling, it is not a primary care lack of understanding of the impact of untreated substance use problems that impedes integrat-

ed care efforts, but rather the logistics of the busy general medical setting that poses challenges.

"Most health care professionals recognize that unhealthy substance use impacts patients, but there are significant issues around workflow," he said. "You have to work to ensure that you don't make things more cumbersome for them."

Therefore, it behooves specialty providers that want to assist patients identified through screening to cast themselves as willing and nimble problem-solvers for general medical professionals, Sperling believes. "You have to be prepared to be the administrative go-to person," he said. "You have to be able to do the research and the legwork that medical professionals can't do; this could

**'We have full-time staff on the medical/surgical units of acute-care hospitals.'**

Les Sperling

include researching billing codes."

He added, "It's better if you tell the medical leadership going in, 'We'll take care of the problems that come up.'"

Sperling said that since his organization has become involved in SBIRT-related activity, its commercial insurance business is up 300 percent and its detox services have grown by 238 percent. He expects more agreements to be reached in the near future. The Central Kansas Foundation also operates residential, outpatient and medication-assisted treatment services.

He advises providers that want to be available to primary care entities in their community to choose their participating staff wisely. "It is important to have very competent

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staff," he said. "You have to prioritize picking staff with the skills to work in a fast-paced environment."

### Diverse arrangements

Sperling said there are some differences in the terms of the arrangements the Central Kansas Foundation has with the various primary care entities with which it does business. In some, the specialty provider has a straight contract with the organization to provide certain services, while in others there is a revenue-sharing arrangement.

Terms of the Central Kansas Foundation's various memoranda of understanding also vary a bit from agreement to agreement. "The agreements with acute care are somewhat more detailed," said Sperling. "There are credentialing issues that are more important in hospitals. The external constraints on hospitals are a little more robust."

He explained that the various partners in these arrangements also might articulate slightly different goals in terms of the outcomes they want to generate. "The outcomes that we look for are effective patient engagement on unhealthy use," he said. "By having this be part of medical practice, patients have a heightened level of engagement. We can help them access the resources they need to make proper decisions around substance use."

As for the primary care entities, they have somewhat different priorities. "At the acute-care hospital level, they are looking for a reduction in the use of emergency services," Sperling said.

Yet he said that in all the settings where the Central Kansas Foundation has a presence, "The model has been very accepted. The medical professionals appreciate the expertise we bring." •

## BRIEFLY NOTED

### Study says patient attitudes changing about HCV treatment

Injecting drug users enrolled in methadone treatment want treatment for hepatitis C, according to a recent study published in the *Journal of Addiction Medicine*. Injection drug use is a responsible for a high prevalence of HCV infection, the researchers said. "One of the most important findings of this work is that people who inject drugs do want to be educated about the disease and that education is associated with willingness to be treated," says senior author Andrew H. Talal, MD, professor of medicine in the Division of Gastroenterology, Hepatology and Nutrition at University of Buffalo (UB) and adjunct associate professor of medicine at Weill Cornell Medical College. First author is Marija Zeremski, PhD, senior research associate in medicine at Weill Cornell Medical College and research assistant professor of medicine at UB. "These new findings support the premise that addiction-treatment facilities can help provide sustained HCV treatment for this population," Talal says. "These facilities have the added advantage of being able to link HCV care to drug treatment, allowing for closer patient evaluation, which will likely lead to improved adherence to treatment regimens." While HCV infection is often asymptomatic, 75 to 80 percent people who are infected will have infections that progress to liver cirrhosis and/or liver cancer. The study was based on 320 patients in an opioid treatment program (OTP), being treated with methadone. More than three quarters wanted to get treatment for HCV. "People who inject drugs have always wanted to be treated for hepatitis C, but there have been a variety of barriers at the patient, provider and institutional levels," said Talal. "Most importantly, there has been a lack of education about the disease, a fear of side effects of interferon,

## Coming up...

The **National Conference on Addiction Disorders** will be held **August 22–26** in **St. Louis, Missouri**. For more information, go to [www.addictionpro.com/ncad-conference/national-conference-addiction-disorders](http://www.addictionpro.com/ncad-conference/national-conference-addiction-disorders).

The **Cape Cod Symposium on Addictive Disorders** will be held **September 11–14** in **Hyannis, Massachusetts**. Go to [www.ccsad.com](http://www.ccsad.com) for more information.

discomfort in conventional health care venues and a lack of awareness of the status of the infection." Interferon, the standard treatment, is avoided by many patients due to fears of side effects, including fatigue, fever, nausea, anorexia, muscle pain and hair loss, to insomnia, depression and irritability. "A major change in the attitudes of people who use drugs is due to knowledge about greatly improved treatment efficacy and the ability to provide HCV treatment at the same site as the substance abuse treatment," said Talal.

### ADAW wins SIPA award for 'Housing First' exclusive

*Alcoholism & Drug Abuse Weekly* won a Specialized Information Publishers Association (SIPA) award for spot news. The awards were announced June 6. *ADAW* won third place for the article "HUD advisory pits landlord concerns against 'Housing First'" published in the August 12, 2013 issue.

SIPA, a division of the Software

### *Alcoholism & Drug Abuse Weekly*

welcomes letters to the editor from its readers on any topic in the addiction field. Letters no longer than 350 words should be submitted to:

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Letters may be edited for space or style.

and Information Industry Association (SIIA), is "the international trade association dedicated to advancing the interests of publishers and media companies serving the needs of niche communities."

For the winning article, go to [www.alcoholismdrugabuseweekly.com/Article-Detail/hud-allowing-landlords-to-discriminate-against-homeless-people-with-suds-despite-federal-housing-first-policy.aspx](http://www.alcoholismdrugabuseweekly.com/Article-Detail/hud-allowing-landlords-to-discriminate-against-homeless-people-with-suds-despite-federal-housing-first-policy.aspx).

## In case you haven't heard...

A Tennessee woman was put in jail last month for doctor-shopping, according to a press release from the Office of the Inspector General in the Department of Finance and Administration, which pursued the case because she used TennCare, the state Medicaid program, to pay for the visits in which she obtained oxycodone. "The battle to stop doctor shopping in TennCare is one that we continue to fight, with help from our partners across the state," Inspector General Deborah Faulkner said in the May 30 press release. "We are sending out a message that the citizens of Tennessee have set forth a zero tolerance policy for TennCare fraud and abuse, and we're aggressively enforcing it." Defrauding TennCare is punishable by up to two years in prison, and obtaining a controlled substance by fraud is punishable by two to four years in prison. The OIG relies on a "Cash for Tips" program that gives Tennesseans cash rewards for tips on TennCare fraud that lead to convictions. The press release doesn't say how much it will cost the state to incarcerate the young woman who was charged.