A Life in the Community for Everyone

SAMHSA

Substance Abuse and Mental Health Services Administration

www.samhsa.gov • 1-877-SAMHSA-7

Key Issues in Substance Abuse

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8th Annual Training & Educational Symposium – California Opioid Maintenance Providers
Los Angeles, CA • September 15, 2011

President Barack Obama

"I am committed to restoring balance in our efforts to combat the drug problems that plague our communities. Drug use endangers the health and safety of every American, depletes financial and human resources, and deadens the spirit of many of our communities."

May 12, 2010

SAMHSA

Pamela S. Hyde, J.D.
Administrator, SAMHSA

"The non-medical use of prescription pain-relievers is now the second most prevalent form of illicit drug use in the nation, and its tragic consequences are seen in substance abuse treatment centers and hospital emergency departments throughout our nation."

July 15, 2010

SAMHSA's Role in Improving the Nation's Health

- Behavioral health services improve health status and reduce health care and other costs to society.
- SAMHSA is charged with effectively targeting substance abuse and mental health services to the people most in need and to translate research in these areas more effectively and more rapidly into the general health care system.
- Continued improvement in the delivery and financing of prevention, treatment and recovery support services provides a cost effective opportunity to advance and protect the Nation's health.

- Prevention of Substance Abuse and Mental Illness
- Trauma and Justice
- Military Families
- Recovery Support
- Health Reform
- Health Information Technology
- Data, Outcomes, and Quality
- Public Awareness and Support

Challenges

- In 2010, an estimated 22.1 million persons– 8.7% of the U.S. population aged 12 or older -- were classified with substance abuse or dependence.
  - 2.2 million reported past year dependence or abuse of psychotherapeutics (non-medical use) – 1.9 million of them for pain relievers
- 20.4% persons reported non-medical use of psychotherapeutics at sometime during their lifetime – 13.7% reporting non-medical use of pain relievers, and
- 2.0 million people (12 or older) initiated illicit use of pain relievers during 2010, second only to those who initiated marijuana use (2.4 million)

Source: 2010 NSDUH

Past Month Alcohol Use - 2010

Any Use: 51.8% (131.3 million)

Binge Use: 23.1% (58.6 million)

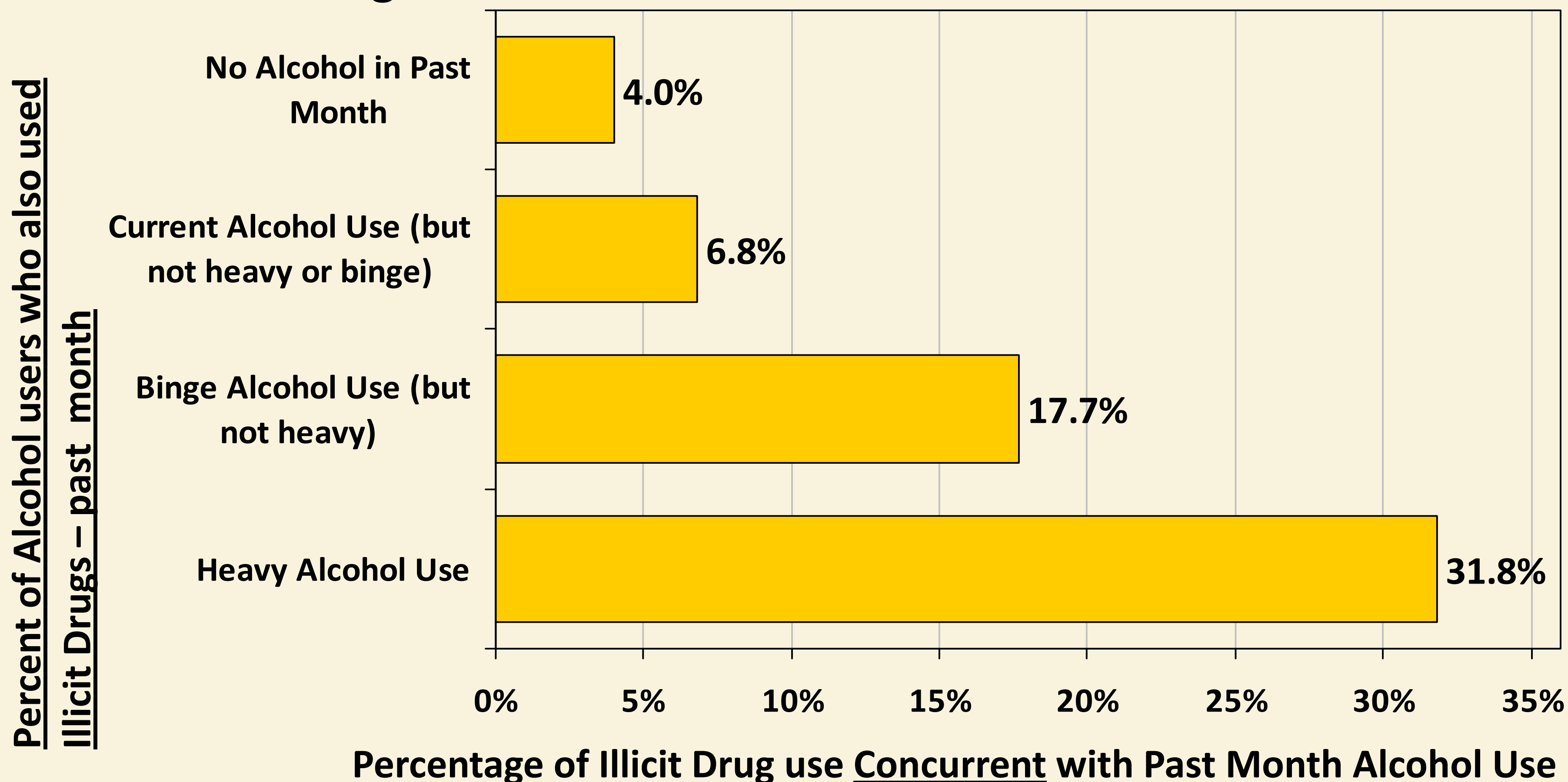
Heavy Use: 6.7% (16.9 million)

(Current, Binge, and Heavy Use estimates are similar to those in 2009)

Source: NSDUH 2010

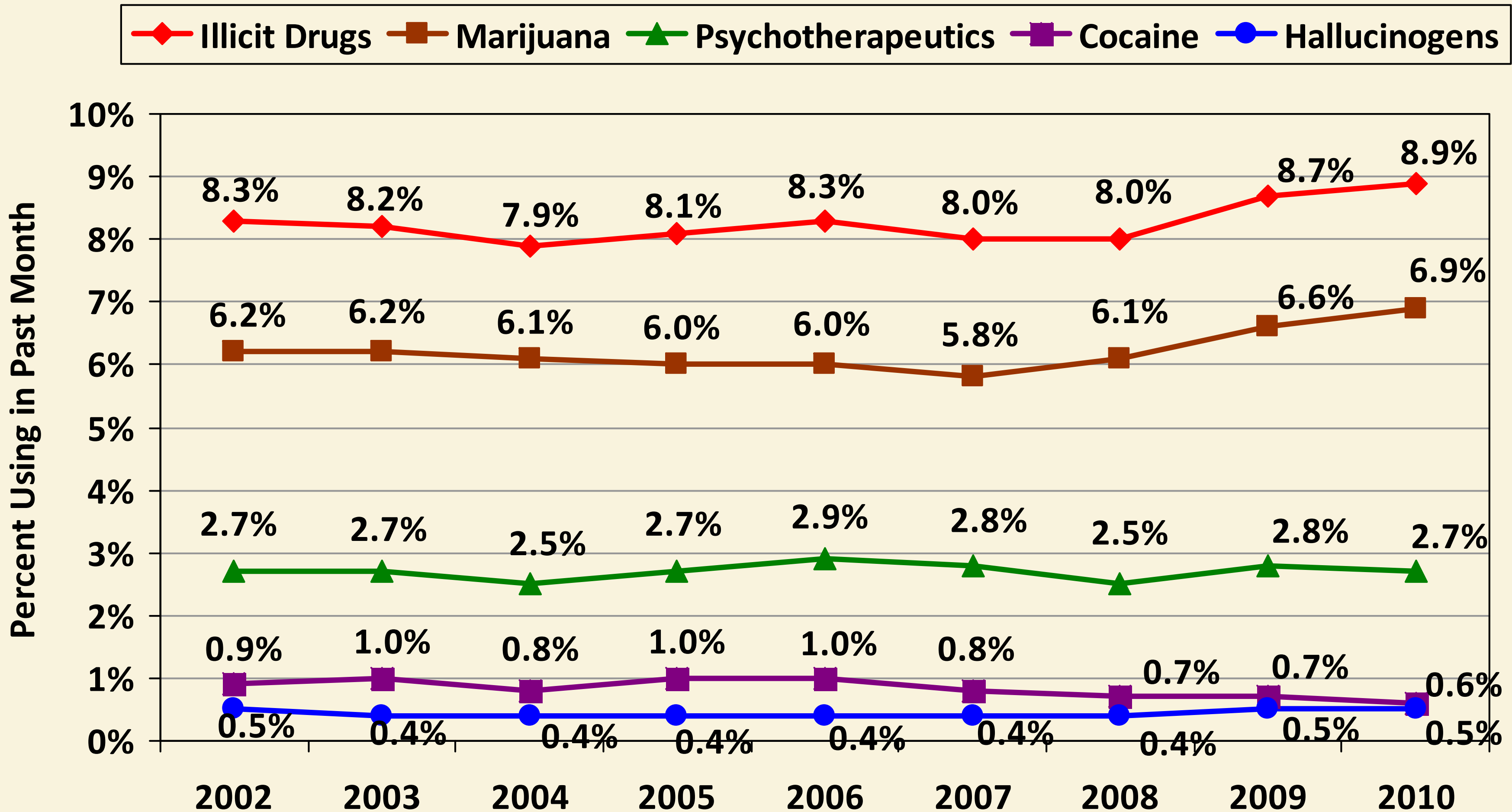
Concurrent Illicit Drug and Alcohol Use

Illicit Drug Use concurrent with Last Alcohol use among Past Month Alcohol Users aged 12+



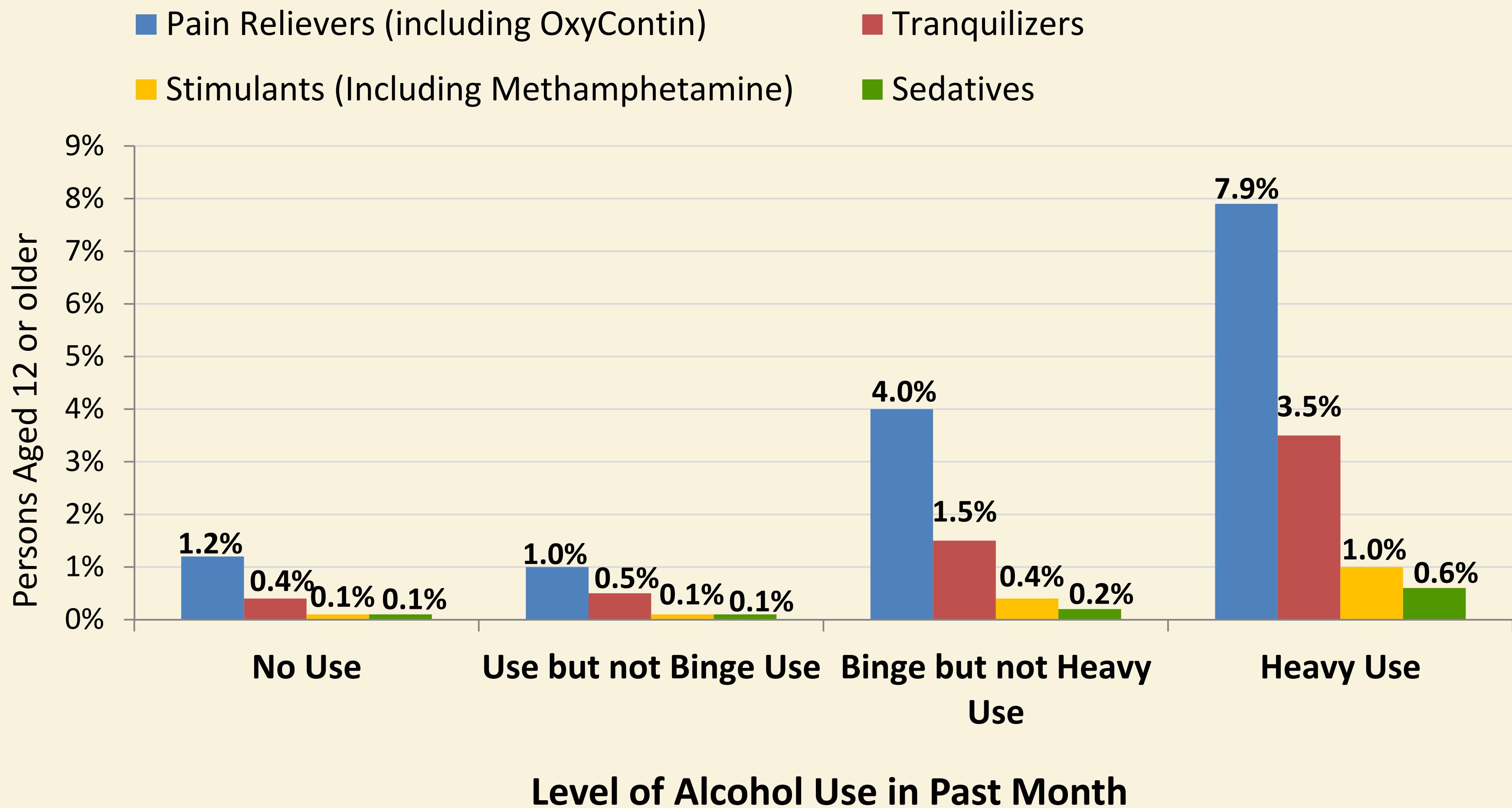
Source: NSDUH 2009

Past Month Use of Selected Illicit Drugs among Persons Aged 12 or Older: 2002-2009



Source: NSDUH, 2009

Alcohol and Prescription Drug Abuse



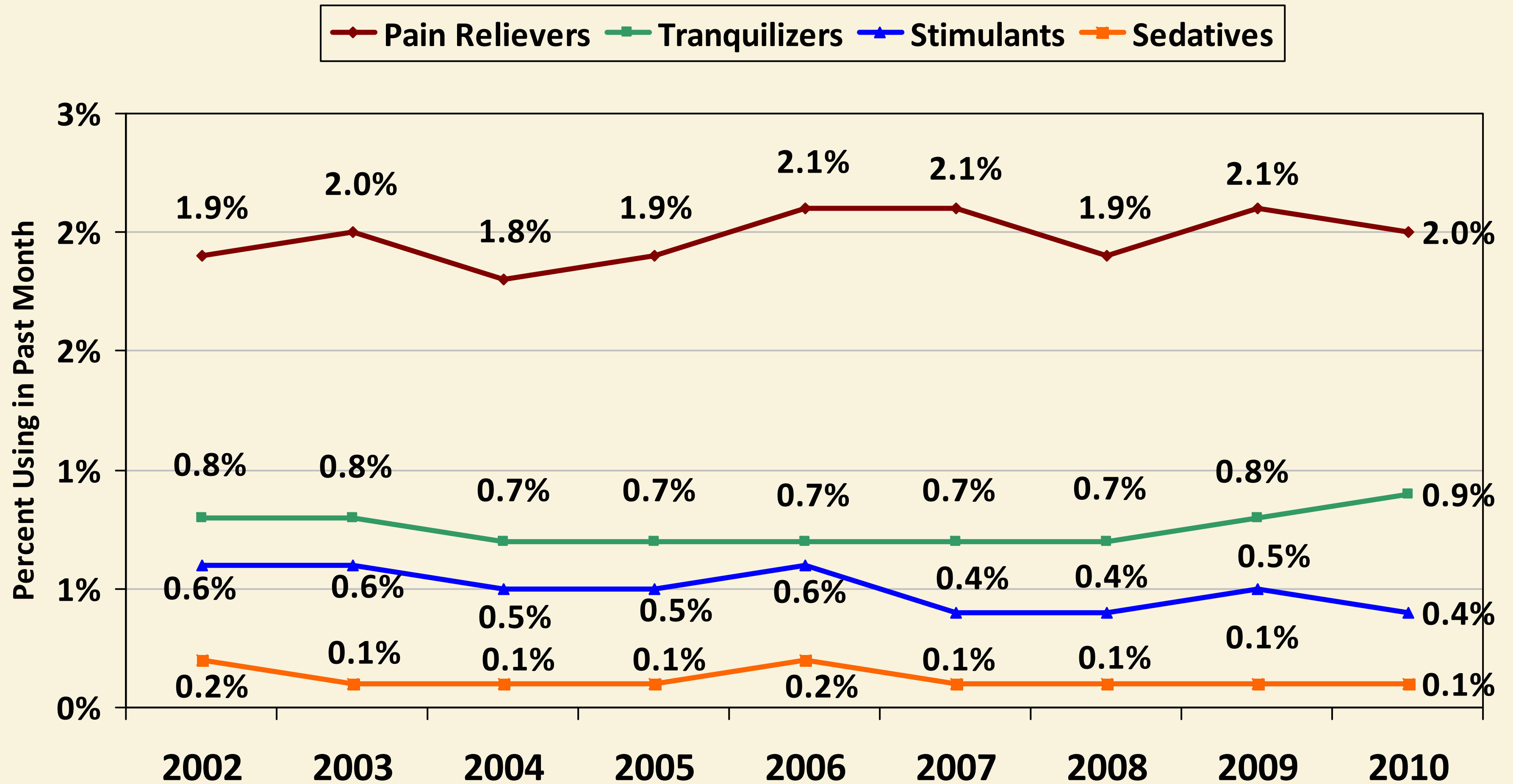
Source: NSDUH 2009

California State Indicators vs. National Average

Percent of clients reporting…	California	National Average
Binge Alcohol Use in Past Month	21.6%	23.15%
Any Illicit Drug Use in the Past Month	9.07%	8.14%
Alcohol or Drug Dependence or Abuse in Past Year	8.95%	9.1%
Needing, but not receiving treatment for illicit drug use	2.56%	2.5%
Needing, but not receiving treatment for alcohol use	7.22%	7.0%

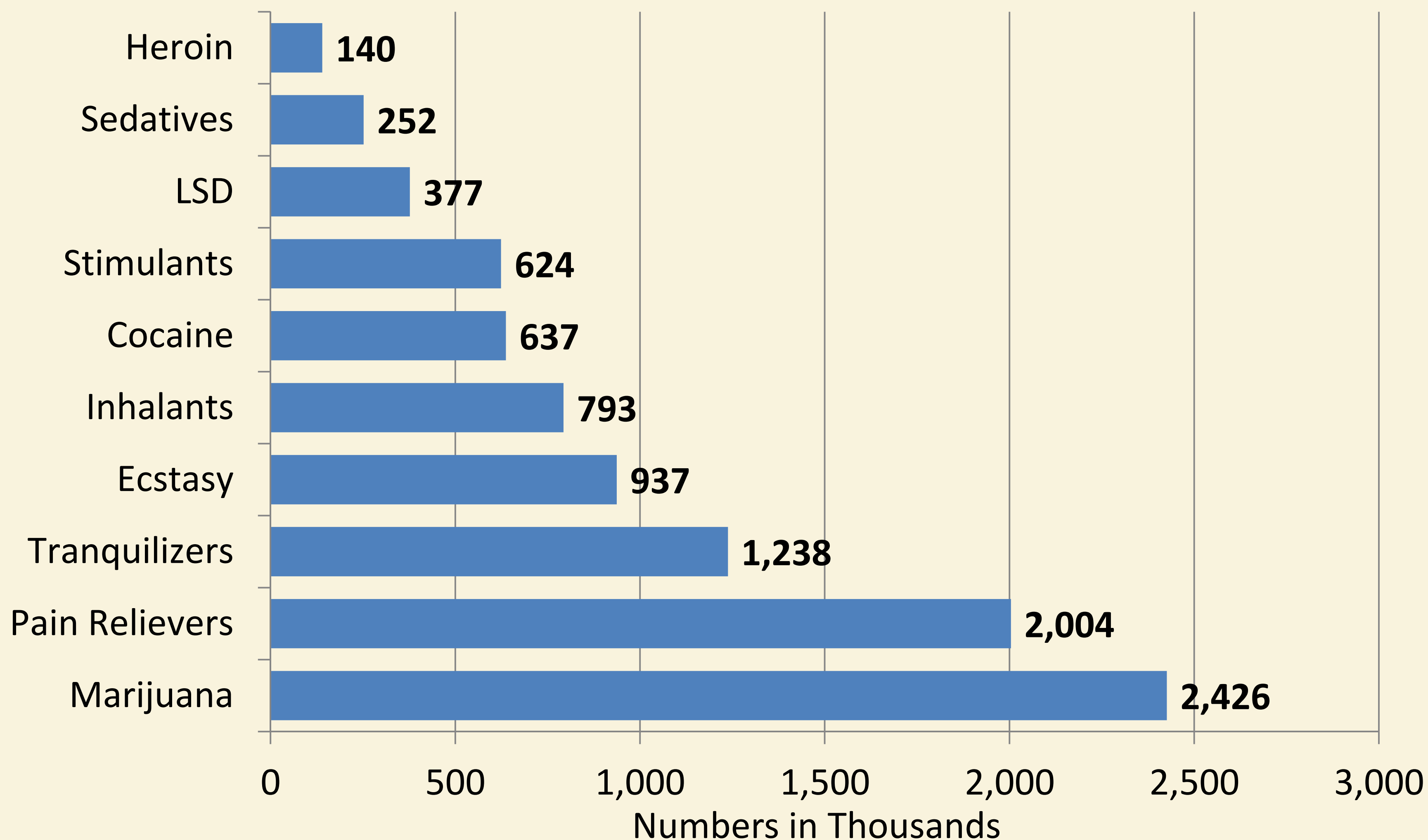
Source: NSDUH, 2007-2008 average

Past Month Nonmedical Use of Prescription Drugs (Psychotherapeutics) among Persons 12+:2002-20010



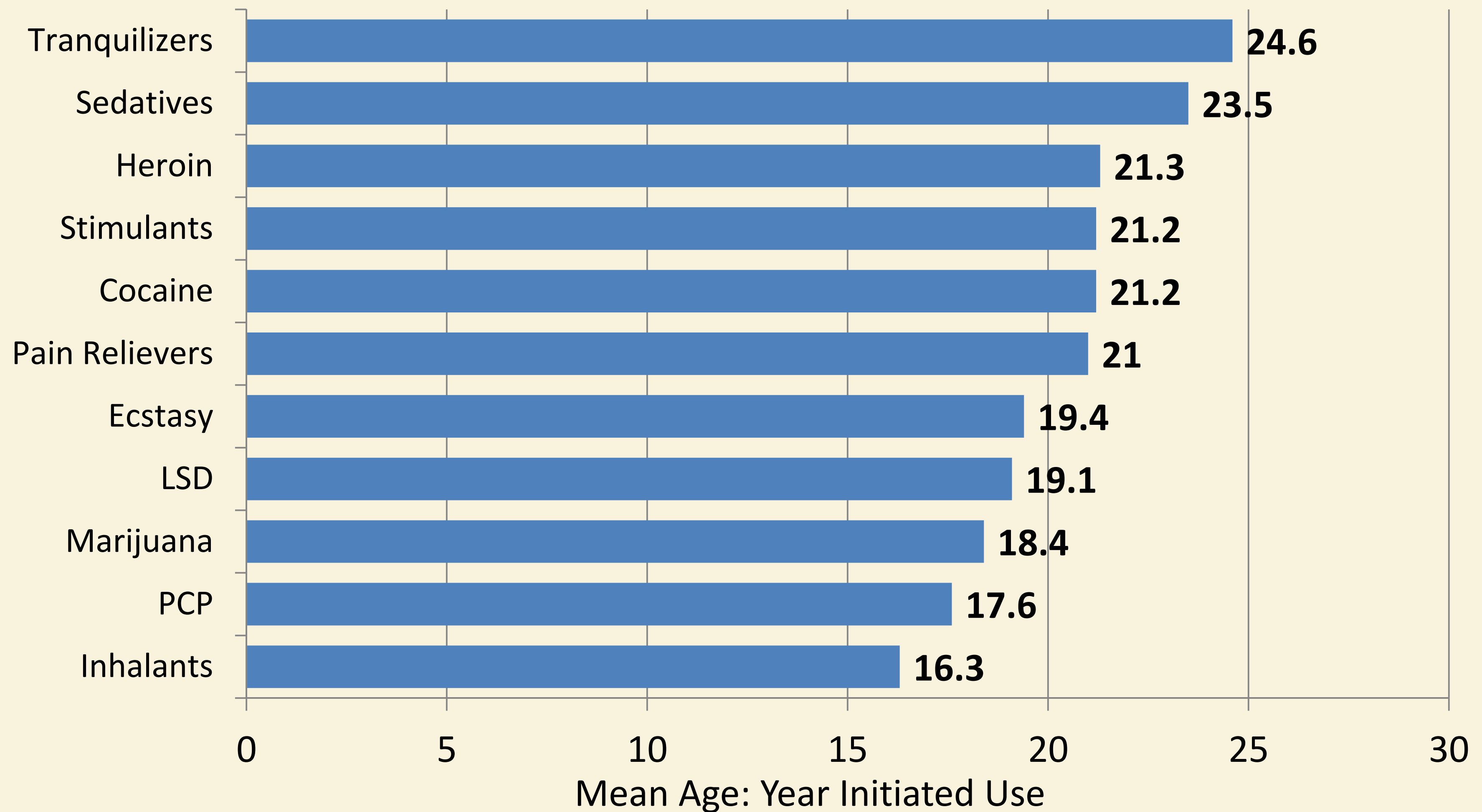
Source: NSDUH 2010

Past Year Initiates of Illicit Drugs – Persons 12 years and older



Source: NSDUH 2010

Mean Age at First Use – Past Year (aged 12-49)



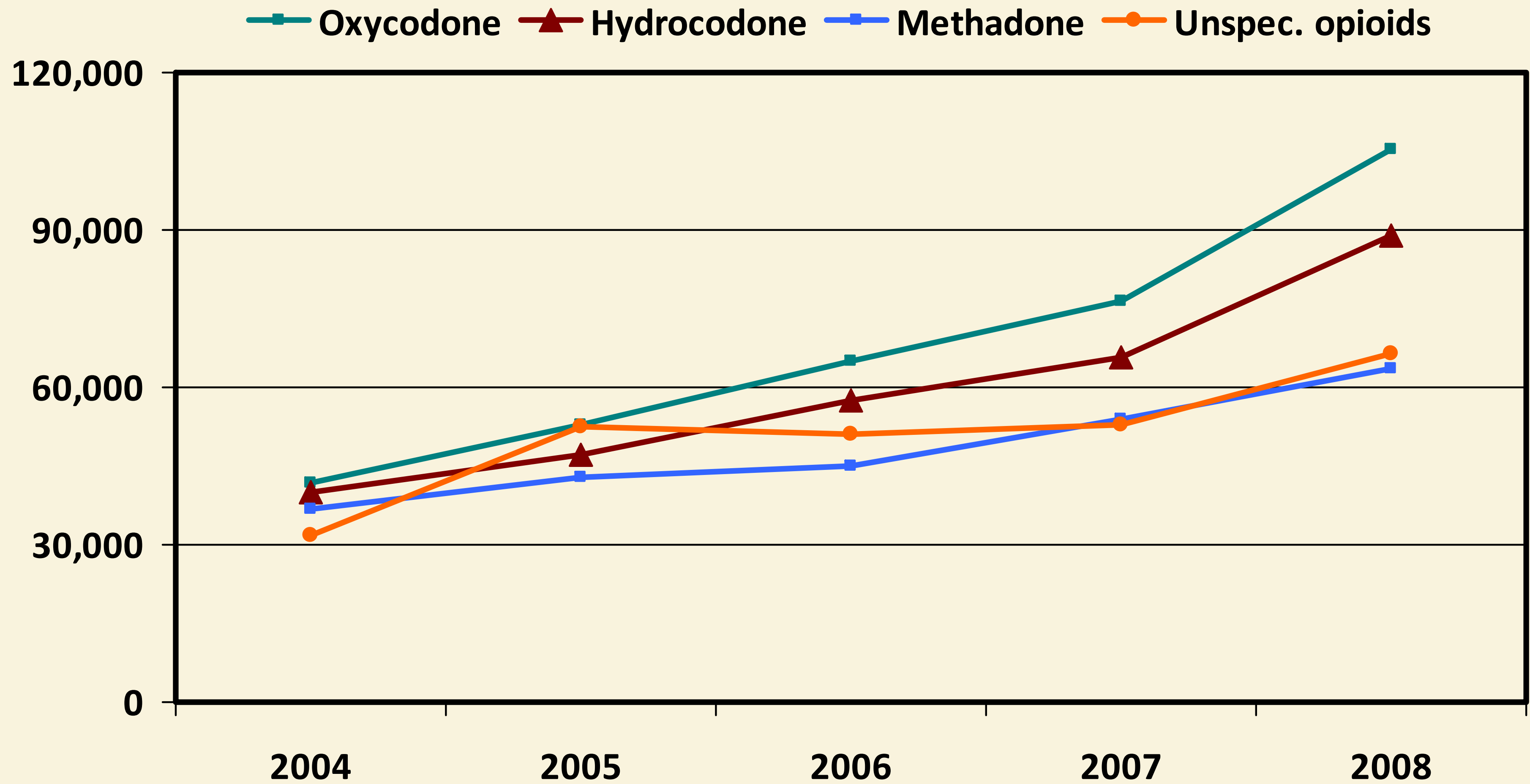
Source: NSDUH 2010

Prescription Drug Use Among Older U.S. Populations

- Recent studies have found that more than half of adults (57-85) rely on a combination of 5 or more prescription drugs, over-the-counter drugs and dietary supplements.
- Women are more likely to use prescription medications and dietary supplements, but men are more likely to suffer from an adverse drug interaction.
- Unfortunately, health professionals tend to overlook substance use disorders (SUD) in older adults, attributing symptoms to dementia/ Alzheimer's disease, depression or other problems.

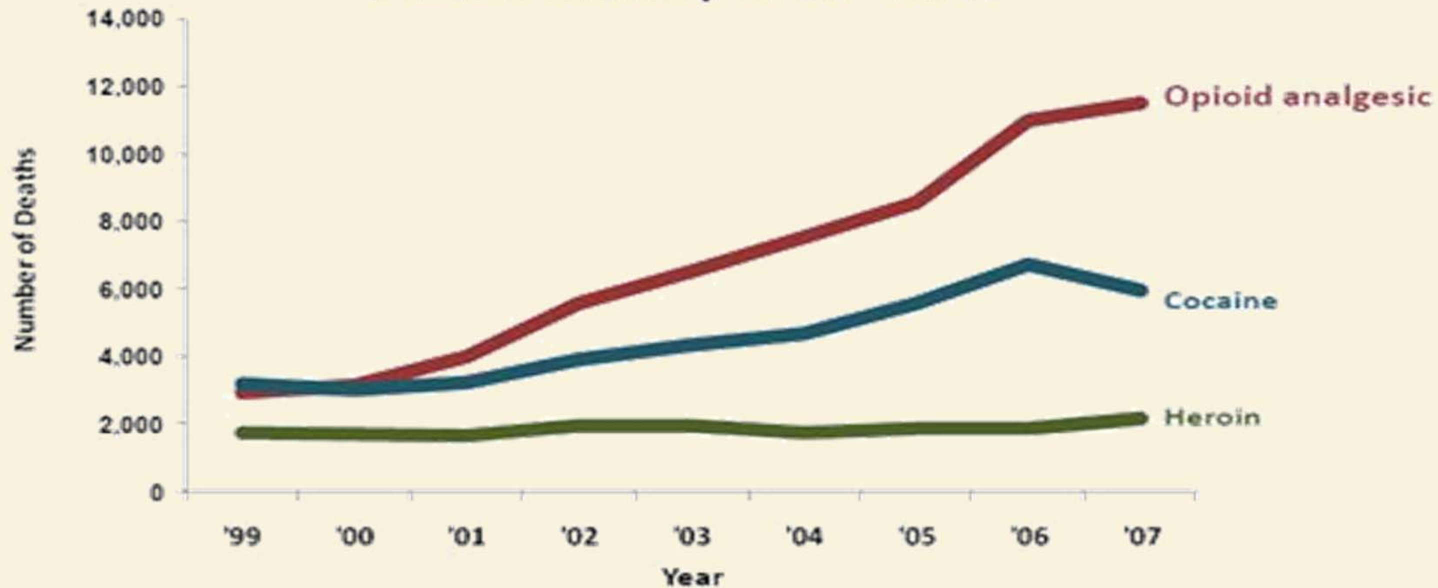
Source: Rabin, C (January 2009) Seniors mixing prescription and O.T.C drugs. Retrieved 1/9/09 from http://weblogdofraga.blogspot.com/2009/01/seniors-mixing-prescription-and-o.html & Han, B. Gfroerer, J. et al. (2009) Substance use disorder among older adults in the United States in 2020. Addiction 104.88-96.

Trends for Opioid Non-medical Use ED Visits – 2004 - 2008

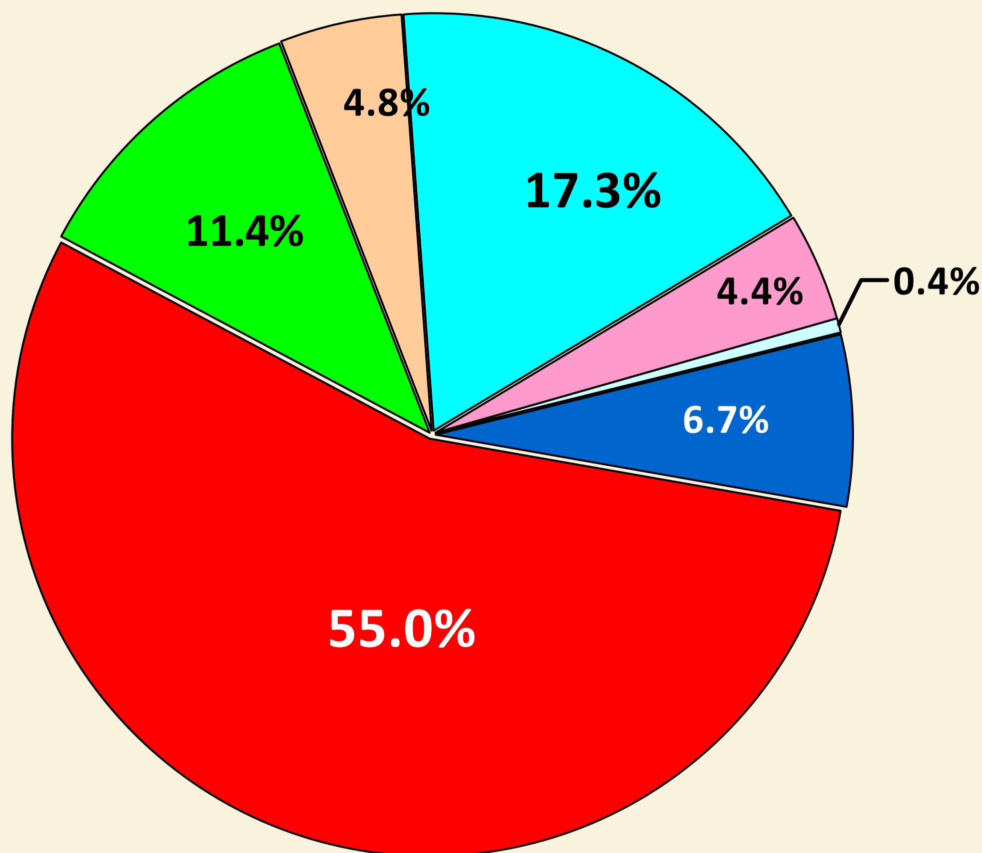


Source: DAWN Estimates, 2009

Unintentional Overdose Deaths

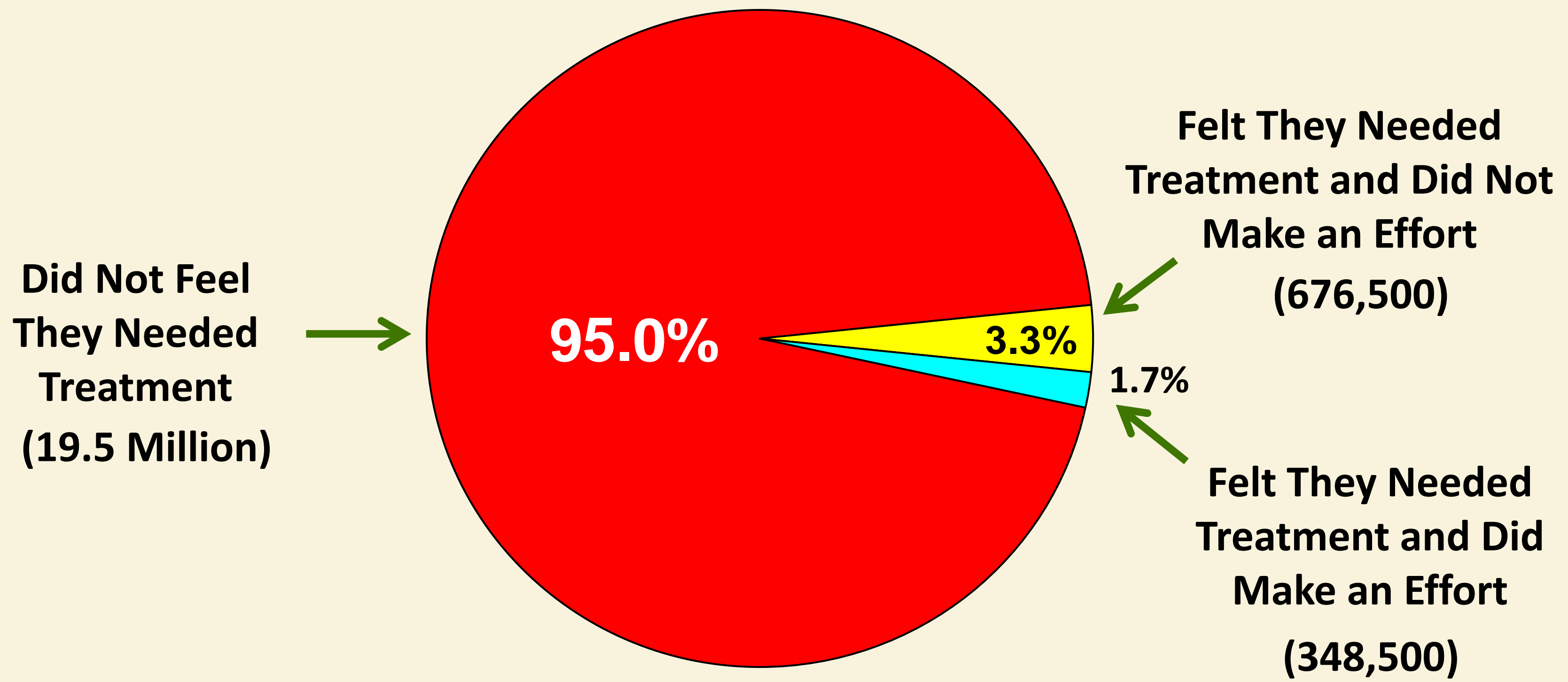


Source Where Pain Relievers Were Obtained for Most Recent Nonmedical Use among Past Year Users Aged 12 or Older: 2010



Source: NSDUH 2010

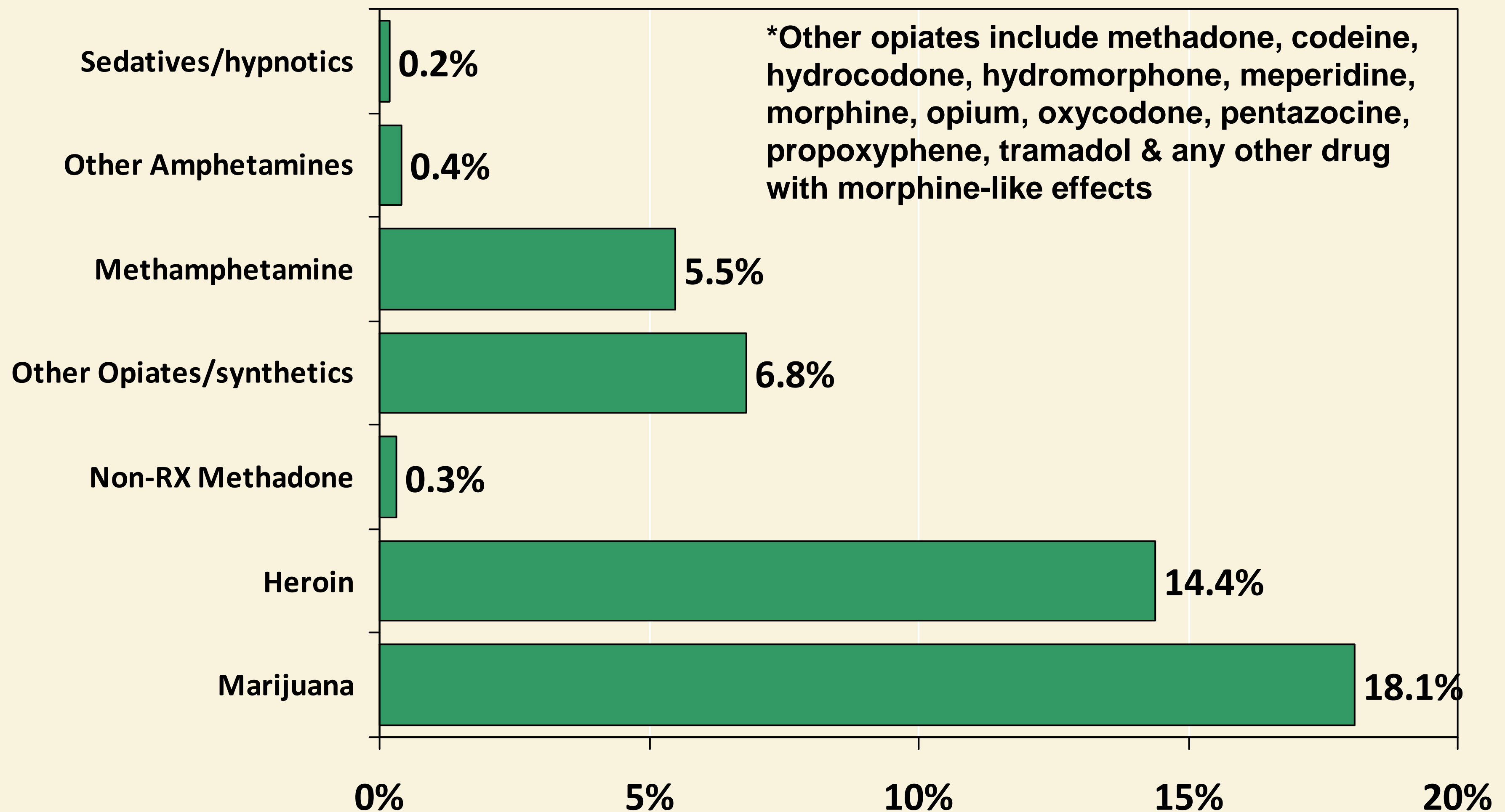
Past Year Perceived Need for and Effort Made to Receive Specialty Treatment among Persons Aged 12 or Older Needing But Not Receiving Treatment for Illicit Drug or Alcohol Use: 2009



20.5 Million Needing But Not Receiving Treatment for Illicit Drug or Alcohol Use

Source: NSDUH 2010

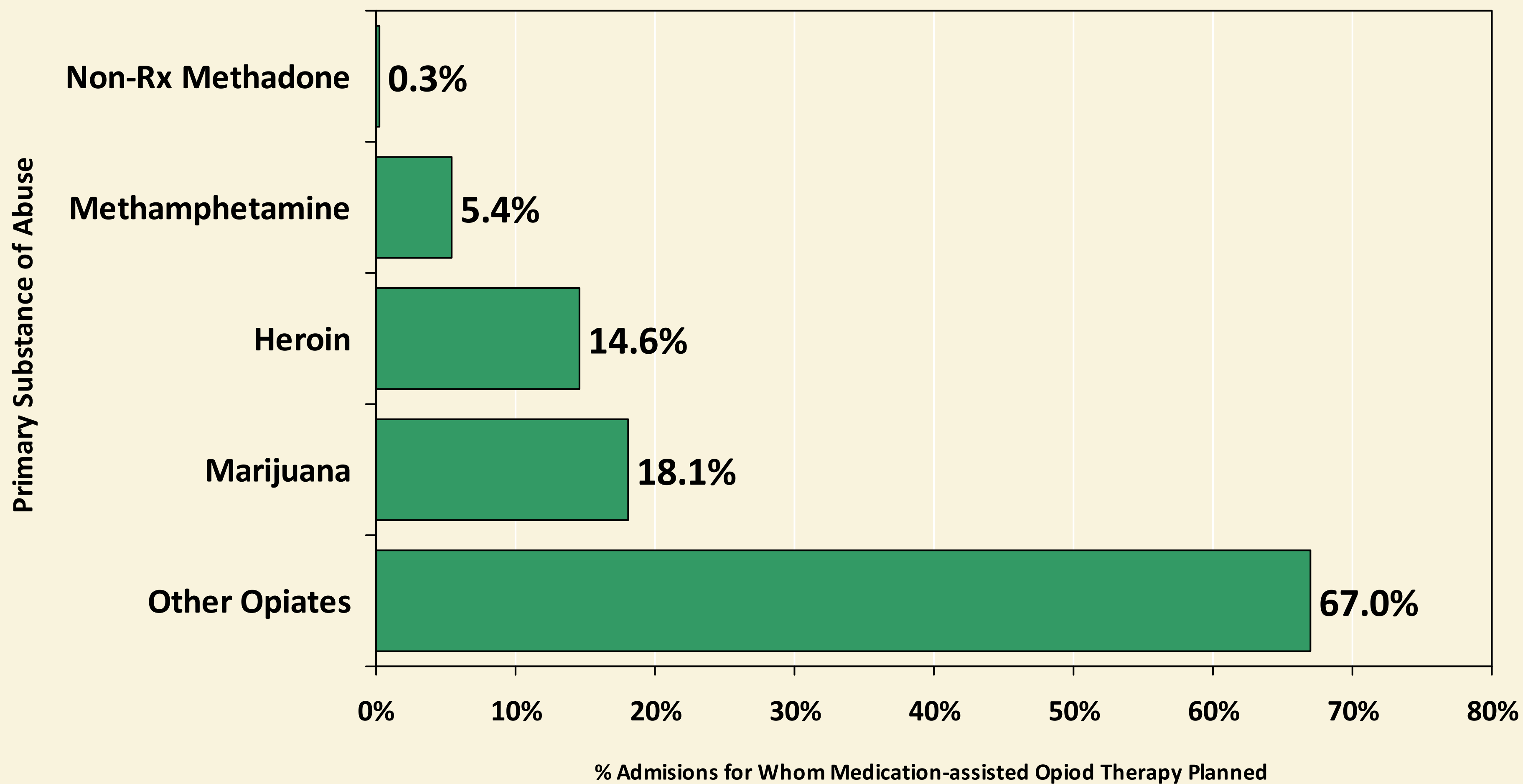
Treatment Admissions by Primary Substance of Abuse - 2009



Source: SAMHSA, TEDS 2009

Medication-Assisted Opioid Therapy – U.S. Treatment Admissions

Percent of Treatment Admissions for whom MAT was planned:



Source: SAMHSA, TEDS 2009

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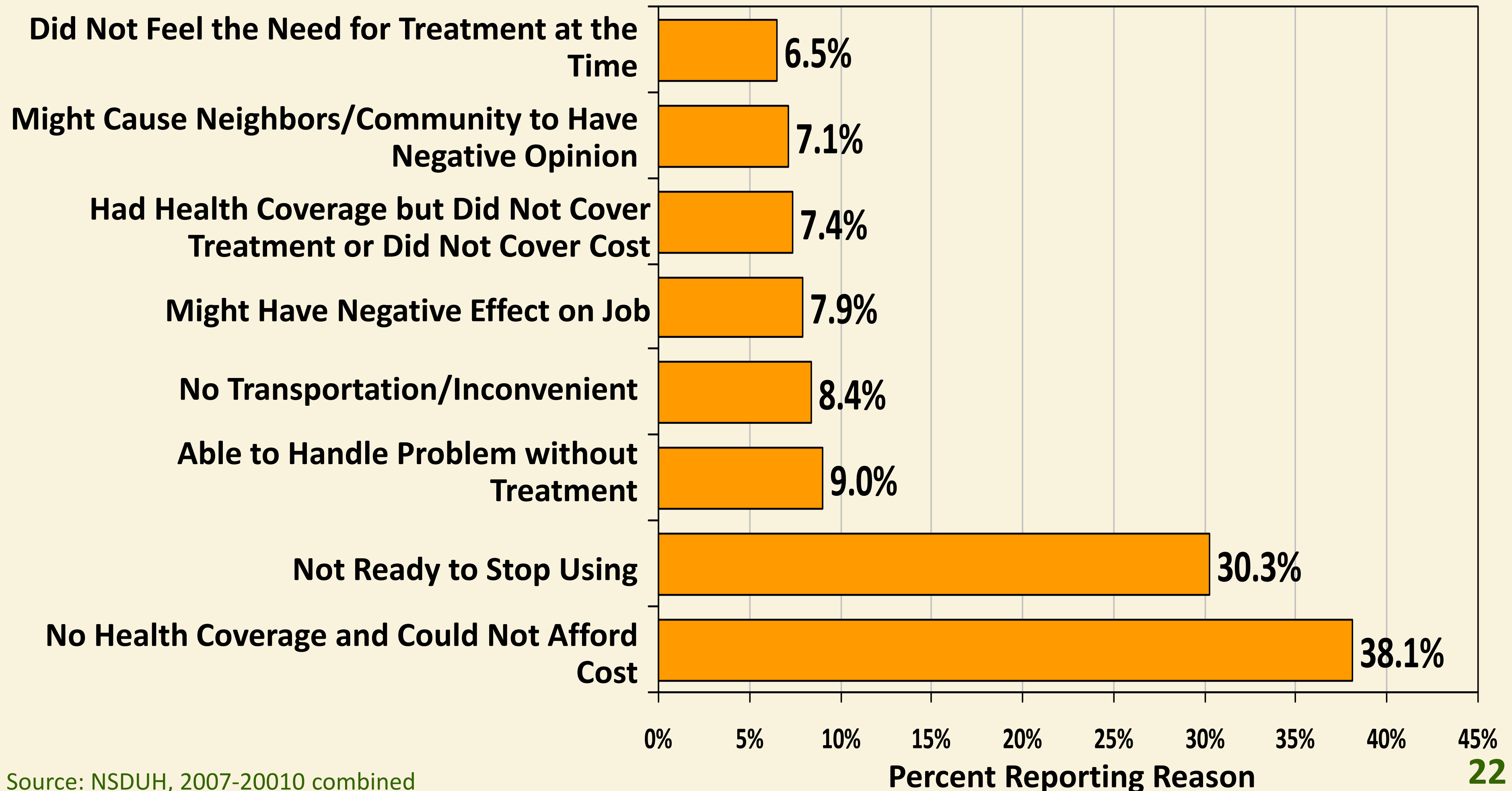
Reasons for Not Receiving Substance Use Treatment: Persons Aged 12+



Source: NSDUH, 2007-20010 combined

The Financial Toll of Prescription Drug Abuse

➔ In 2006, the estimated total cost in the United States of nonmedical use of prescription opioids was $53.4 billion

- 42 billion (79%) was attributable to lost productivity
- $8.2 billion (15%) to criminal justice costs,
- $2.2 billion (4%) to drug abuse treatment, and
- $944 million to medical complications (2%).

➔ Five drugs—OxyContin, oxycodone, hydrocodone, propoxyphene, and methadone—accounted for two-thirds of the total economic burden.

Source: *Clinical Journal of Pain*: March/April 2011 - Volume 27 - Issue 3 - p 194–202)

Prevalence

- The number of prescriptions dispensed by retail pharmacies between 2000 and 2009 increased by 48 percent, from 174 million to 257 million.
- Distribution of prescription drugs by drug companies grew from 96 mg/person in 1997 to 698 mg/person in 2007, enough for every American to take 5 mg Vicodin every 4 hrs for 3 weeks.

Source: CDC, 2011

Unique Factors of Prescription Drug Abuse

Low Perception of Risk

- Prescription drugs obtained from a medicine cabinet or pharmacy are perceived to be less addictive and not as dangerous as illegal drugs obtained from a drug dealer because they are manufactured by reputable pharmaceutical companies, prescribed by licensed clinicians, and dispensed by pharmacists.
- Teens' perception of the risks associated with abusing prescription drugs is relatively low, with less than half seeing "great risk" in trying prescription pain relievers such as Vicodin or OxyContin that a doctor did not prescribe for them.
- Low perception of risk, coupled with easy availability, is a recipe for an ongoing problem.

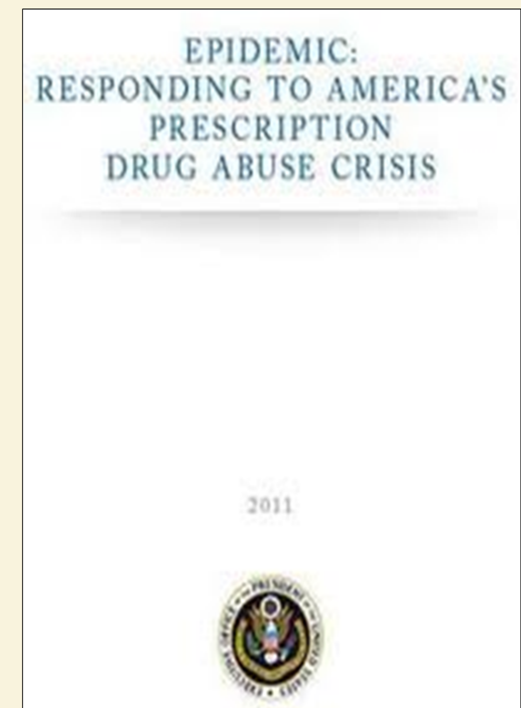
Source: The Partnership Attitude Tracking Study (PATS), sponsored by MetLife Foundation

Federal Strategy to Address the Problem of Prescription Drug Abuse

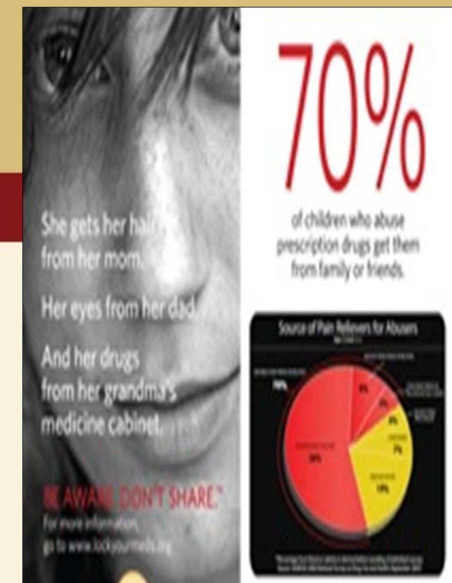
- The response to prescription drug abuse requires the collaboration between Departments of Justice, Health and Human Services, Veterans Affairs, Defense, and others.
- Prescription Drug Abuse Prevention Plan released by the White House in April, 2011 announces new Federal requirements that provide a national framework for reducing prescription drug abuse and the diversion of prescription drugs through education, tracking and monitoring, safe and appropriate disposal, and enforcement.

Four Major Areas of the 2011 Prescription Drug Abuse Prevention Plan

- Educating patients and health care providers
- Increasing use of prescription monitoring programs (PMPs)
- Implementing and promoting use of prescription drug disposal programs
- Supporting law enforcement efforts against illegal prescribing



Education



- Prescribers and Dispensers
  - Mandatory training
  - Development of educational materials (REMS)
  - Required education curricula in health professional schools
  - Evidence-based clinical guidelines
- Parents, Youth, and Patients
  - Evidence-based public education and media
  - campaigns
  - Awareness of dangers and prevalence of prescription drug abuse, safe use, proper storage, and disposal

REMS for Opioids

- ➔ In response to Congressional mandate, FDA has begun development of REMS for Opioids.
- ➔ Although REMS are directed at manufacturers, concerns have been raised about possible impact on pharmacists, physicians, clinicians, and patients, including:
  - Changes in regulations for prescribing
  - Required provider and public education
  - Increased monitoring
  - Restricted access to effective pain medications for cancer patients or patients with chronic pain.

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Consideration Points: REMS

- The feedback loop for REMS must allow continuous improvement – why did a patient failure occur, rather than merely documenting that failure. What metrics should be used to capture success or failure?
- Are controls on distributors necessary – can they be efficiently provided without being unduly burdensome on the health care system?
  - Opioid distribution already has monitoring systems in place. Are additional restrictions necessary?
- Should innovators and generic sponsors use a single, shared system to provide a REMS?
- Excessive regulation at all levels will limit critical patient access – how much is too much?

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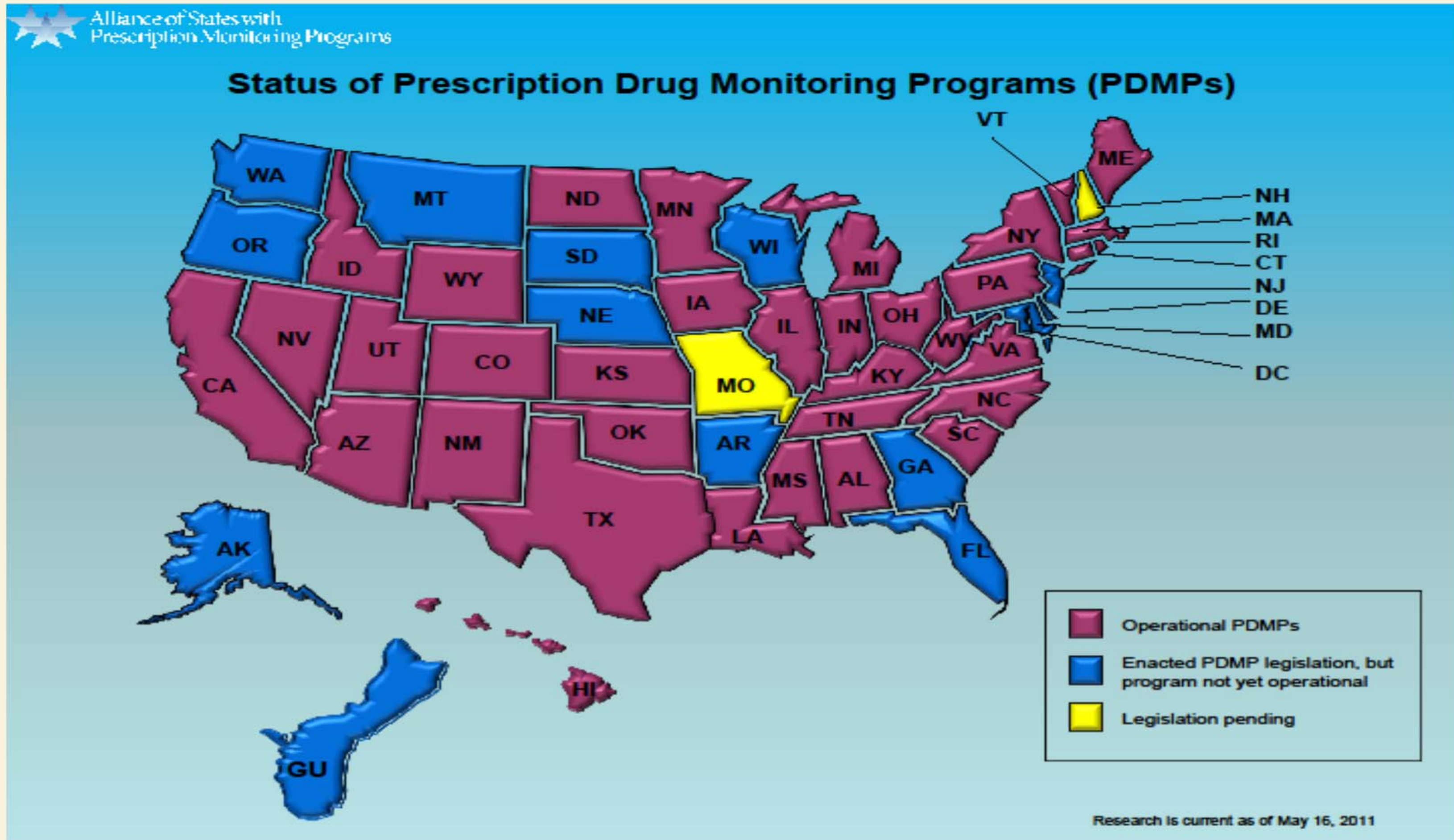
Tracking and Monitoring



SAMHSA's "Dear Colleague" Letter

- ➔ Planned "Dear Colleague" letter to provide guidance for OTPs and the CURES system regarding Prescription Drug Monitoring Programs.
- ➔ Two messages:
  - Programs cannot report (due to confidentiality)
  - Programs should access CURES

PMPs Are Only Part of the Solution

- PMPs cannot solve the prescription drug abuse and misuse problem alone.
- Other tools need to be in the mix, including:
  - Doctor shopping laws
  - Pain Clinic regulation at the state level
  - Integration of electronic prescribing, electronic health records – Health IT

Disposal

- ➔ DEA-led National Take-Back Day initiatives in September 2010 and April 2011 resulted in the collection of more than 300 tons of unused medicine for safe and proper disposal.
- ➔ Creation of new federal rules that will make disposal of prescription drugs more convenient and accessible

Prescription Drop Off Programs

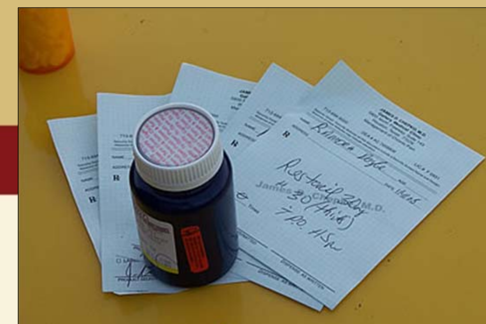
- At least 20 states now have collection programs for unused medications – a total of approximately 90 take-back programs across the country.
- Several states saw record hauls in 2009.
- A mail-in program in Maine has collected 2,000 pounds of medications since 2007.
- A 6-county program in Washington state – involving pharmacies and clinics – has collected 35,000 pounds over 3 years.
- Three collection sites in Palo Alto, CA. received more than 5,400 pounds dropped off in 2009.
- In Utah, police station collection bins have netted approximately 5,000 pounds since 2007.

Source: Stark, M. (19 January, 2010) More states took in expired meds in 2009. Retrieved 03/03/10 from http://66.240.200.85/news/ap/finance_business/2010/Jan/19/more_states_took_in_expired_meds_in_2009.html

Prescription Drop Off Programs (cont'd)

- ➔ Prescription Drop Off programs encourage people to responsibly dispose of unused medications.
- ➔ Programs are generally a collaboration between law enforcement, public health departments, and community organizations/businesses.
- ➔ Any prescription drop off program should:
  - Record the name, strength, and quantity of the medications turned in.
  - Be sensitive to environmental issues regarding medication disposal – particularly the impact on water supply quality.

Enforcement



- ➔ Continue aggressive enforcement actions against pain clinics and doctor shoppers.
- ➔ Train law enforcement and prosecutors.
- ➔ Write and disseminate model regulations and laws for pain clinics.
- ➔ Support High-Intensity Drug Trafficking Areas (HIDTAs).

Questions?

Patient Protection and Affordable Care Act (ACA)

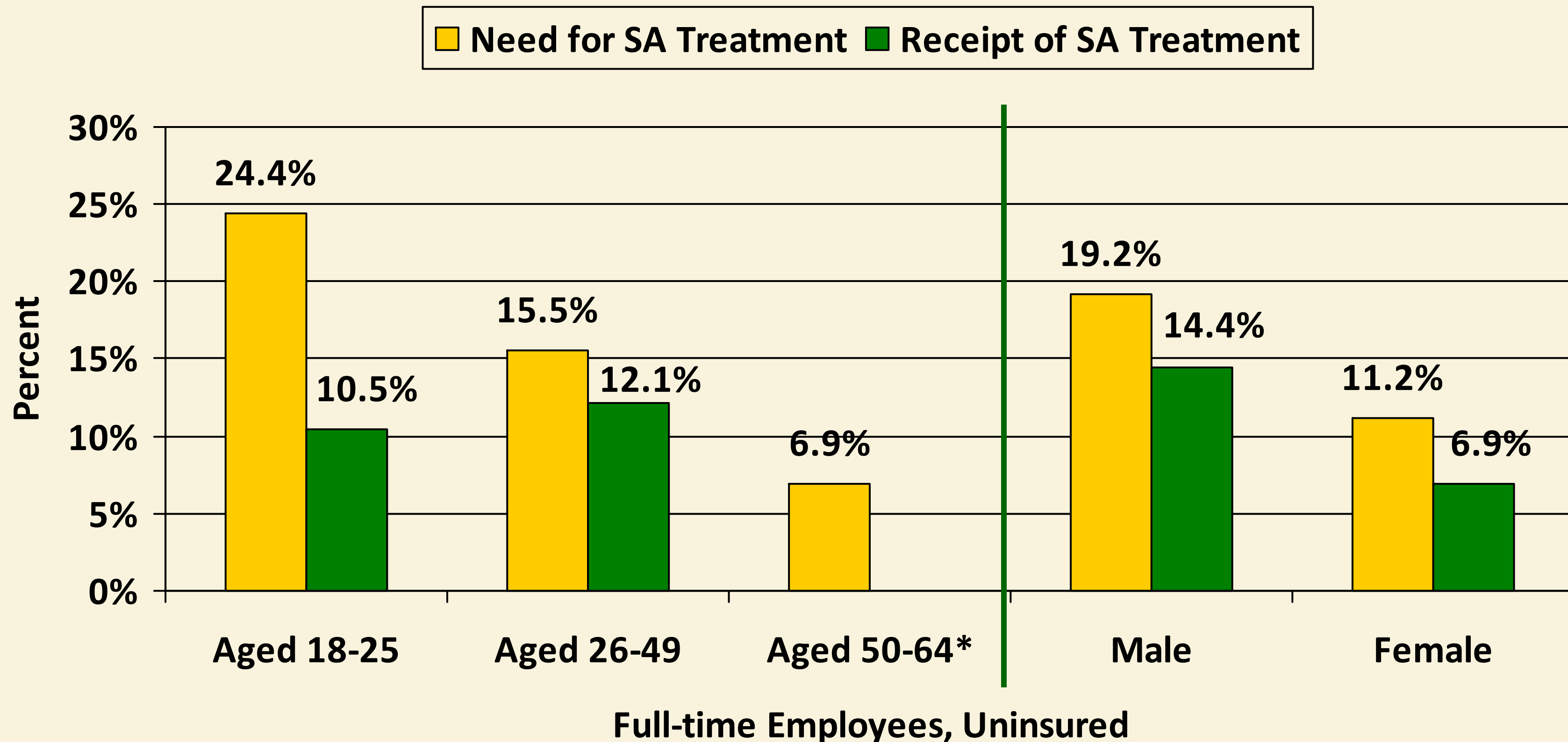
- ➔ 38.1% of those needing substance abuse treatment did not receive it because they did not have health insurance coverage or couldn’t afford the cost.
- ➔ Another 7.4% had health insurance, but it didn’t cover the cost of treatment.
- ➔ The Affordable Care Act (ACA) Does Several Things:
  - Expands Insurance Coverage
  - Institutes Insurance Reforms
  - Builds Infrastructure To Provide Improved Health Outcomes
  - Puts In Motion Structural Changes To How Healthcare Delivery Is Structured & Financed

Major Drivers in the ACA

- More people will have insurance coverage
- Medicaid will play a bigger role in MH/SUD than ever before
- Emphasis on primary care and coordination with specialty care
- Encourages home and community based services and less reliance on institutional care
- Preventing diseases and promoting wellness is a huge theme
- Outcomes: improving the experience of care, improving the health of the population and reducing costs

The Uninsured – U.S.

➔ More than 18.4 million full-time employees (18-64) had no health insurance coverage -- 54.5% of the Nation's uninsured adults.



*Receipt of treatment data for the 50-64 age group were suppressed because of low precision.
Source: 2007 & 2008 SAMHSA NSDUHs

SAMHSA’s Health Care Reform Strategic Initiative

➔ SAMHSA’s Health Care Reform strategic initiative seeks to

- broaden health coverage to increase access to appropriate quality care, and
- reduce disparities that currently exist between the availability of services for substance abuse, mental disorders, and other medical conditions.

SAMHSA's Health Care Reform Strategic Initiative - Goals

→ SAMHSA's Health Care Reform strategic initiative goals:

- Assure behavioral health is included in all aspects of Health Care Reform (HCR) implementation.
- Support Federal, State, and Territorial efforts to develop and implement new provisions under Medicaid/Medicare.
- Finalize and implement the parity provisions in Mental Health Parity and Addictions Equity Act and the Affordable Care Act.
- Develop changes in SAMHSA Block Grants to support recovery and resilience.
- Foster the integration of primary and behavioral health care.

What Coverage Expansion under ACA Mean for those with Mental and Substance Use Disorders?

Impact on Coverage: Many uninsured individuals will be covered in 2014 —most likely by the expansion in Medicaid

- ➔ Of the 35 Million uninsured that will be covered, 16 million will become newly eligible under Medicaid.
- ➔ An estimated 1.8 million uninsured have a serious addiction and 3.3 million uninsured have a mental illness
- ➔ 39% of the individuals served by Mental Health Authorities have no insurance
- ➔ Nationally, served under programs funded by State Substance Abuse Authorities:
  - 61% of the individuals served have no insurance;
  - 87% of these are estimated under 133% FPL

How Will These Changes Affect Behavioral Health Providers?

- Traditionally, individuals presenting with co-occurring disorders were “downstream.”
  - Providers could expect that symptoms reflected more acute conditions.
- Individuals entering treatment as a result of early screening and brief intervention will more likely be “upstream.”
  - Providers need to be flexible and not assume that these individuals have co-occurring conditions.

What Do We Know About the Newly Covered?

➔ Individuals Near the Federal Poverty Level—More diverse group than we think

- 40% under the age of 29
- 56% are employed or living with their families
- Conditions are more acute when they present
- Care is more costly

	>100% FPL	>100 – 200% FPL	>200% FPL
Poor or fair physical health	25%	18%	11%
Poor or fair mental health	16%	11%	6%

Source: Center on Budget and Policy Priorities

The Need to Re-Thinking Coverage

- Massachusetts study: although 95% have health insurance, only 84% of those coming to SA facilities have insurance
  - Beyond enrolling: Churning on and off Medicaid from MA experience
- To engage the young “Invincibles” does substance abuse treatment need to appeal to the young?
- Is there enough capacity in SUD treatment for an additional 4 million?
- Are SA facilities Medicaid ready?
  - According to 2008 NSSATS: only 58% of SA facilities said they accepted Medicaid
- Medicaid does not pay for non-medical residential SA treatment

ACA Promotes Primary Care Coordination

➔ ACA Focus on primary care and specialty care coordination:

- Significant enhancements to primary care
  - Incentives for Accountable Care Organizations (ACOs)
  - Dual Medicare and Medicaid Eligibles
- Bi-directional Integration
  - MH/SUD in primary care
  - Primary care in MH/SUD settings
- Challenges in collaborating and meeting requirements of 42CFR Part II

Federally Qualified Health Centers

- Many of the newly insured will utilize Federally Qualified Health Centers (FQHC).
- In 2007, 1080 Community Health Centers (CHC) reported seeing 17 million patients.
- Mental health services were provided to 677,213, and substance abuse services to 92,406 – approximately 4% of total patients receiving services.
- 2.8% of CHC staff are mental health personnel; 0.7% are substance abuse treatment professionals.
- A few CHC's also engage in medication-assisted treatment.
- SAMSHA is currently conducting a survey of OTPs that asks if they have a formal agreement for medical referrals from CHCs.

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FQHCs and MAT

- At this time, a small number of Federally Qualified Health Centers engage in medication-assisted treatment.
- SAMSHA is currently conducting a survey of OTPs that asks if they have a formal agreement for medical referrals from CHCs. The results will be published later this year.
- With the increase in individuals using FQHC services it is important that OTPs begin to build and enhance linkages with them.

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Section 2703: Health Homes Under Medicaid at State's Option

- Effective January 1, 2011, Section 2703 adds section 1945 to the Social Security Act to allow States to elect this option under the Medicaid State Plan Amendment (SPA).
- SAMSHA is to consult with states on prevention and treatment of those with MH and SUD conditions; but separate from the formal SPA process

Section 2703: Health Homes Under Medicaid at State's Option

- The provision offers States additional Federal support to enhance the integration and coordination of primary, acute, behavioral health, and long-term care services and supports for Medicaid enrollees with chronic conditions.
- Planning opportunities: States can access Title XIX funding using their pre-Recovery act FMAP rate methodology to engage in planning activities aimed at developing and submitting a State plan amendment.

Accountable Care Organizations (ACO)

- Group of providers with shared governance that manages and coordinates the total spectrum of care for defined populations
- Primary care is the foundation but also responsible for preventive, specialty, ER, acute and post-acute
- ACA requires CMS to develop new payment models to support ACOs, such as withholds that are rewards for good outcomes
- Medicare ACO's require a service population of at least 5,000 Medicare patients, with specific quality and cost measures reporting;
- Hospitals and large MD practices most likely 1st adapters
- How do OTPs fit in the ACO model?

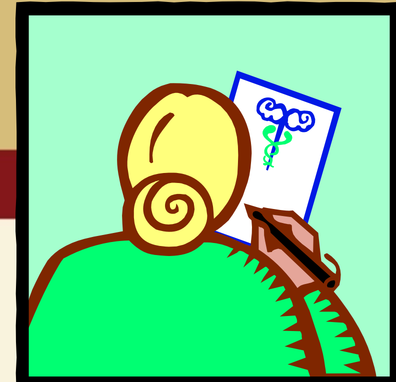
Compliance and Payment

- ➔ Providers and managed care organizations must report/repay any overpayment from Medicare or Medicaid within 60 days .
- ➔ More rigorous screening procedures for providers seeking Medicare's approval to bill
- ➔ Require providers as a condition of participation in Medicare, to adopt compliance programs that meet federal
- ➔ Soon all claims submitted online
- ➔ Bundling should not be mechanism to "hide" the services rendered

Evaluating Your Position: What Do You Have to Offer?

- How close are alternatives?
- Alliances to organizations, for referrals and collaboration, especially if small agency.
- What specialty niche?
- Your longevity and reputation?
- So who do you know—Medicaid, SSA, MDs, etc?
- Market/relationships to primary care? school health centers?

Your Clinicians



- ➔ Professionals eligible-- and for what services?
  - SA counselor my not be eligible for independent billing, but clinic arrangement with MD oversight OK under Medicaid
  - For co-occurring clients, some providers may bill the MH service
  - If not recognized SA Counselors, may recognize other professional credential, I.e., MSW, CMFT, etc Very diverse laws
  - Intensive Outpatient Svc, not usually but could be eligible if have Medicaid Rehab Option

More Provider Issues

- ➔ The state's licensing of professionals and providers
- ➔ Managed care organization's credentialing
- ➔ Open and closed panels; even if on network with contract, not guaranteed referrals
- ➔ Understand "medical necessity" and other utilization requirements so that can bill for services; get prior authorization if a costly service

Build the Infrastructure

- ➔ Personnel to determine eligibility quickly
- ➔ Understand billing rules
- ➔ May "unbundle" or take program services and bill separately
- ➔ Under managed care, may need to credential and bill staff individually
- ➔ Follow up on unfavorable utilization determinations; Medicaid have strong appeal rights
- ➔ Market early and often

Questions?

Integrating Health Information Technology

- ➔ As part of Health Reform, OTP providers will be required to integrate Health IT into their systems.
- ➔ Under Health IT, quality initiatives will measure performance and drive quality-based competition in the industry.
- ➔ Toolkit materials should reflect the expanding use of electronic health records, interoperable health information, and the challenge of ensuring confidentiality within the new systems.

- Purpose: Ensure the behavioral health provider network, including prevention specialists and consumer providers, fully participates with the general health care delivery system in the adoption of health information technology.
- Primary role of SAMHSA's HIT effort is to support the behavioral health aspects of the electronic health record based on the standards and systems promoted by the Office of the National Coordinator for Health IT.

SAMHSA Health IT Strategic Initiative Goals

- ➔ Develop the infrastructure for interoperable Electronic Health Records, including privacy, confidentiality, and data standards.
- ➔ Provide incentives and create tools to facilitate the adoption of Health IT and EHRs with behavioral health functionality in general and specialty healthcare settings.
- ➔ Deliver technical assistance to State Health IT leaders, behavioral health and health providers, patients/consumers, and others to increase adoption of EHRs and Health IT with behavioral health functionality.
- ➔ Enhance capacity for the exchange and analysis of EHR data to assess quality of care and improve patient outcomes.

Benefits of Health IT for OTPs

➔ The adoption of consistent Health IT platforms has the capability of reducing morbidity and mortality among OTPs.

- More accurate client data will be available.
- Deaths and related data will be able to be tracked and analyzed throughout the interoperable system.
- Standard information for OTPs will allow programs to cross reference and validate patient information.

More Accurate Client Data

- ➔ Clinical standards and quality measures will be developed, including standard and consistent information available across OTPs.
  - Result: A standard record that will accurately report who presents for treatment, what they present with, and what happens to them during and after treatment.

Ability to Track Mortality Data

- ➔ Currently, mortality data related to misuse of methadone is not consistent or reliable.
- ➔ Health IT will result in the ability to more accurately track deaths by client, including related data to assist in the analysis of deaths.
  - Result: the ability to more accurately track, analyze, and report on the effectiveness of OTPs and assess the standard of care provided.

Data Available Across Systems

➔ Interoperable IT systems as part of Health IT will allow OTPs to access toxicology reports and concurrent medications from client’s other physicians.

- The result: less danger of drug overdoses or adverse reactions.
- Better synergism within the client’s entire treatment program.

- Health IT may provide OTPs with the most powerful tool to address the increased morbidity and mortality available to them.
- The challenge is to be ready to use that tool.
- A small percentage of behavioral health providers have the capability to create and use the interoperable systems required by Health IT.
- Even if the systems are in place, many do not have the personnel trained to effectively use them.

HIT Activities within SAMHSA

SAMHSA regulates:

→ 1230 opioid treatment programs that dispense methadone and buprenorphine treatment to 288,824 patients nationwide.

- Interactive online "Extranet" allows providers to extract patient health information from medical records and submit an electronic form that is evaluated concurrently by Federal and State regulatory authorities.
- The system addresses exemptions and stores the completed exception form data electronically so it can be reviewed periodically.
- The online system processes over 30,000 patient exemptions per year.

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HIT Activities within SAMHSA (cont'd.)

SAMHSA is working with (cont'd.):

- Several State behavioral health and Medicaid agencies to develop open source EHRs and health information exchange (HIE) services that integrate behavioral health within community-based health homes and State Health and Human Service programs.
- The treatment field to develop a web-based system that would provide digital access to methadone, including selected patient health information and dose levels, that can be securely accessed by providers nationwide. This system is being developed to address the need for continued care of opioid-dependent patients displaced by various disasters.

PDMPs and Electronic Health Records (EHRs)

- ➔ SAMHSA is working with the Office of National Coordinator (ONC) for Health Information Technology to develop a strategy for using electronic health record systems (EHRs) with prescription monitoring programs.
- ➔ SAMHSA has also presented to the Alliance of States with Prescription Drug Monitoring Programs (PDMPs) an analysis of an assessment of the States' ability to push information from PDMPs into EHRs, as it relates to unsolicited notifications.

Joplin, MO

- ➔ The recent disaster in Joplin, Missouri, demonstrated the benefit of interoperable electronic health record (EHR) system for OTPs.
- ➔ The OTP in Joplin was completely destroyed by the recent tornado.
- ➔ Continuity of care was facilitated by the ability to connect with the EHR system at a program 200 miles away.
- ➔ Patients' complete records were uploaded from a remote server, allowing them to access services at the alternate location.

Electronic Health Records & Confidentiality

➔ "Evolving health information technology (HIT) is dragging healthcare providers into a world in which confidentiality rules, designed when patient records were maintained almost universally in paper charts, either do not apply or are in serious practical conflict with electronic information exchange."

Source: Connors, B. MSW, Leipold, J. DBA, MBA (2009 July/August) The 42 CFR Part 2 and NHIN conundrum *Behavioral Healthcare* 29(7):52-53

Ensuring Confidentiality and Trust

- Increased accessibility to health records raises the question of how to ensure patient confidentiality and trust.
- In order to achieve any level of systemic durability and success, electronic exchange efforts must establish trusting relationships with all participants, including patients. *(Melissa M. Goldstein, JD et al, 2010)*

Critical Health IT Questions

- Who needs what information when?
- Who determines who needs what Information when?
- How should psychotherapy notes be treated – as part of the patient record?

Treating the Chart vs. Treating the Patient

- The trusting relationship between physician and patient must be maintained.
- The increased accessibility to more patient information should not shift the focus from the patient to the patient's chart.
- The chart is not the patient.
- The additional information that health information technology makes available should enhance the trusting doctor-patient relationship, not replace it.

42 USC 290dd-2 & 42 CFR Part 2

- The purpose of the statute and regulations prohibiting disclosure of records relating to substance abuse treatment, except with the patient's consent or a court order after good cause is shown, is to encourage patients to seek substance abuse treatment without fear that by doing so their privacy will be compromised.

Source: STATE of Florida v CENTER FOR DRUG-FREE LIVING, INC, 842 So.2d 177 (2003) at 181.

Primary Care Providers

- Primary care providers who work in a general medical facility and do not hold themselves as providing alcohol or drug abuse diagnosis, treatment, or referral to treatment (DTRT) are not affected by 42 CFR Part 2.

Non-applicability of Restrictions on Disclosure of 42 CFR Part 2

- The restrictions on disclosure in these regulations do not apply to communications between a program and a qualified service organization of information needed by the organization to provide services to the program.

Source: 42 CFR § 2.12 (c)(4)

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Clarifying 42 CFR Part 2

- Some believe that under the current statutory and regulatory framework physicians and case managers cannot access any information about an individual's substance use.
- Others believe that substance use disorder information regarding treatment covered by 42 USC 290dd and 42 CFR Part 2 is unnecessarily withheld from physicians, payers, health information exchanges, and health plans.

Clarifying 42 CFR Part 2 (cont'd.)

- Still others believe that the extra protections of 42 CFR Part 2 are critical to protecting the rights of persons with a history of substance abuse or substance use disorders who might otherwise face discrimination in the workplace or community due to that history or current treatment.

42 CFR Part 2 FAQs

- To help providers in the behavioral health field better understand privacy issues related to Health IT, SAMHSA, in collaboration with ONC has created a set of Frequently Asked Questions (FAQs).
- These FAQs can be accessed at: http://www.samhsa.gov/healthprivacy/docs/EHR-FAQs.pdf
- SAMHSA is currently creating a second set of 42 CFR Part 2 FAQs as a result of input received from stakeholders that expands the existing FAQs to include additional confidentiality areas and situations.
- Both documents are developed by the Legal Action Center.

Questions?

“Combating the Silent Epidemic of Viral Hepatitis” -- HHS Action Plan

- ➔ An estimated 3.5–5.3 million persons are living with viral hepatitis in the United States.
- ➔ Because viral hepatitis can persist for decades without symptoms, 65%–75% of infected Americans remain unaware of their infection status and are not receiving care and treatment.
- ➔ On May 12, 2011, the U.S. Department of Health & Human Services launched its action plan to prevent & treat viral hepatitis.

Focus of the HHS Action Plan

The HHS Action Plan is organized into 6 topic areas:

- ➔ Educate providers and communities to reduce health disparities;
- ➔ Improve testing, care, and treatment to prevent liver disease and cancer;
- ➔ Strengthen surveillance to detect viral hepatitis transmission and disease;
- ➔ Eliminate transmission of vaccine-preventable viral hepatitis;
- ➔ Reduce viral hepatitis caused by drug-use behaviors; and
- ➔ Protect patients and workers from health-care-associated viral hepatitis.

What This Means for OTPs

- The HHS Hepatitis Plan indicates that OTPs are not taking advantage of the opportunity to vaccinate their high risk populations.
- Because an estimated 60-70% of OTP patients are infected with Hepatitis C Virus (HCV), they are at increased risk for Hepatitis A and B.
  - Therefore, vaccinating for Hepatitis A (HAV) and Hepatitis B (HBV) is important from a public health standpoint.
- SAMHSA is encouraging OTPs to increase their efforts to educate patients regarding hepatitis and provide them with the opportunity to be vaccinated.

SAMHSA Hepatitis Prevention Project

- In 2005, SAMHSA initiated the Hepatitis Prevention Project to educate OTP staff on hepatitis and liver disease.
- In 2007, SAMHSA received funding from the DHHS Minority AIDS Initiative (MAI) to assess the feasibility of providing SAMHSA HIV grantees and OTPs with Hepatitis B vaccine and Hepatitis C testing.
- In 2010, SAMHSA plans to integrate the vaccine project with an educational component.

SAMHSA Activities: NIATx Demonstration Project

- FY 2010, SAMHSA supported a demonstration project through which NIATx assisted a group of OTPs with process improvement strategies.
- Goal was to reduce or eliminate barriers to and delays in patients' access to care.
- Based on positive results, a second phase was funded for NIATx to work with a larger, more representative group of OTPs during FY 2011.
- 43 programs applied for Phase II, based on State agency directors' recommendations.

SAMHSA Activities: Physician Education

➔ CSAT has programs in place or in development to educate physicians and other health care professionals regarding Medication-Assisted Treatment:

- Publication of CSAT Treatment Improvement Protocol
- CSAT-sponsored workshops and symposium on methadone
- CSAT-hosted summit meetings for opioid treatment programs
- Development of computerized patient intake questionnaire
- Development of CME course on the use of methadone to treat pain

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CME Course: Prescribing Opioids for Chronic Pain (3-6 Hours)

- ➔ CSAT's *Prescribing Opioids for Chronic Pain* curriculum.
- ➔ Educational objectives:
  - Identify clinical situations in which opioids are indicated and contraindicated for the treatment of chronic pain
  - Select patients who are appropriate candidates for long-term therapy with opioids, including methadone
  - Educate patients about methadone's unique pharmacologic properties, such as its long duration of action and absence of euphoric effect (lack of knowledge of these characteristics on the part of physicians and patients has contributed to inadvertent overdoses and fatalities)

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- To date in FY 2011, approximately 550 physicians have participated in live CME courses.
- An additional 400 physicians viewed the online recordings of the live courses.
- SAMHSA estimates that another 500-600 physicians will be reached trough the live courses scheduled through the rest of FY 2011.

The Physician Clinical Support System - Buprenorphine (PCSS-B)

PCSS for buprenorphine (PCSS-B) provides additional support to all physicians – but is particularly valuable to practitioners new to providing care to those who abused or are dependent on opioids.

- PCSS-B is a program of the American Academy of Addiction Psychiatry (AAAP) and its partners, the American Osteopathic Academy of Addiction Medicine (AOAAM) and the American Psychiatric Association (APA). Web site: www.pcssb.org.
- The PCSS is a free, national service staffed by 45 trained physician mentors, a PCSS medical director and 5 physicians, who are national experts in the use of buprenorphine.
- Physicians who prescribe or dispense buprenorphine can contact the PCSS for support via telephone, email, and/or at the place of clinical practice.

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PCSS for Appropriate Use of Methadone (PCSS-M)

- The Physician Clinical Support System for Methadone (PCSS-M) is a free, nationwide program through which health care providers needing information and mentoring on methadone treatment for opioid addiction and/or pain can connect with experts in the field.
- PCCS Mentors come from across the country and work in licensed opioid treatment programs, pain clinics, primary care, and other practice settings.
- The PCSS-M is coordinated by the American Society of Addiction Medicine (ASAM) in conjunction with other leading medical societies.
- Website: http://pcssmethadone.org/

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PCSS- Opioids

- FY 2011 Cooperative Agreement to:
  - develop a free national mentoring network that will provide clinical support (e.g., clinical updates, consultations, evidence-based outcomes and training) to physicians, dentists and other medical professionals in the appropriate use of opioids for the treatment of chronic pain and opioid-related addiction.
- The target population for this initiative includes prescribers (physicians, dentists) and other health professionals working in SAMHSA-certified OTPs as well as those prescribers using opiate-based therapy for chronic pain.

Thank you.