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In This Issue...

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Cover-up: No patient voices in SAMHSA 'summary' of 42 CFR Part 2 NPRM

Leaving out the organizations that opposed the federal government's proposal to eliminate the confidentiality protections of 42 CFR Part 2, MITRE, the company contracted to create a "summary" of public comments, has produced a slideshow that relies on two dozen "prominent" organizations. These organizations exclude those that oppose the changes in the Notice of Proposed Rulemaking (NPRM) released by the Substance Abuse and Mental Health Services Administration (SAMHSA) on Aug. 26, 2019 (see "SAMHSA proposes significant changes to 42 CFR Part 2," ADAW, Sept. 9, 2019, https://onlinelibrary.wiley.com/doi/10.1002/adaw.32473).

Key changes involve methadone patients losing confidentiality. Most treatment organizations, including the National Association of Addiction Treatment Programs and the American Society of Addiction Medicine, support the proposed changes. But opioid treatment programs (OTPs), patients (in OTPs and elsewhere) and the lead legal organization in the field want the protections kept.

Bottom Line...
The SAMHSA contractor has left out patient voices in summarizing the public comments on a proposed rulemaking on 42 CFR Part 2, making it look as if the field supports getting rid of confidentiality, especially for methadone patients.

See **Cover-up** page 2

Patients with alcoholic hepatitis benefit from timely AUD treatment

An analysis of outcomes associated with one of the most serious alcohol-related diseases starkly demonstrates the importance of establishing strong linkages between hospital-based care and specialty addiction treatment.

Published in the February 2020 issue of the journal *Clinical Gastroenterology and Hepatology*, the study involving two separate patient cohorts found that among patients with alcoholic hepatitis, alcohol treatment that was delivered within 30 days of a hospital discharge reduced the risk of alcohol relapse, hospital readmission and death. The alcohol treatment patients received varied in terms of level of intensity, and the researchers were not able to draw conclusions on what type of treatment might be most effective for these patients.

However, authors led by Thoetchai Peeraphatdit, M.D., an internist in the Department of Gastroenterology and Hepatology at the Mayo Clinic College of Medicine in Rochester, Minnesota, wrote in reference to their gastroenterology and hepatology colleagues that the study results "challenge us to do better as

Bottom Line...
Study results from two cohorts of patients with alcoholic hepatitis demonstrate the benefits of a rapid transition between hospital care and specialty alcohol treatment.

See **Hepatitis** page 6

Cover-up from page 1

Many patients have this as their first question when they enter treatment: Will it be confidential? These concerns were made clear in public comments to the SAMHSA proposals (see "Second 42 CFR Part 2 SAMHSA proposal comment deadline this week," ADAW, Oct. 21, 2019, https://onlinelibrary.wiley.com/doi/10.1002/adaw.32515). But the MITRE "summary" doesn't even mention them, and doesn't list the organizations representing them as "prominent." We read all of the comments, and the vast majority were opposed to the changes.

Where are the American Association for the Treatment of Opioid Dependence, Faces & Voices of Recovery, the Legal Action Center, the National Alliance for Medication Assisted Recovery — groups that are not listed once in the slideshow? Where is NAADAC, the Association for Addiction Professionals? Why are the organizations that were excluded from the "prominent" list those that do not support the SAMHSA proposal? (For the list, see the chart on p. 3.)

"We were disappointed that there were no voices of consumers included in the group of 'prominent' commenters. We hope that those voices are being seriously considered as SAMHSA works to finalize the rule."

Anita Marton

The key issue here is putting methadone into the prescription drug monitoring program (PDMP), currently not allowed by SAMHSA. That 2011 directive prohibiting OTPs from putting patient information into the PDMP would disappear under the SAMHSA proposal.

The comment period was confusing, because there were two NPRMs, one dealing with law enforcement (which is not even referred to in the MITRE summary), with two different deadlines, released on the same day. Was this confusion intentional?

The "summary" was presented at the SAMHSA Council meeting in January, and a copy was obtained by *ADAW* last week. After sharing it with the field, the response was immediate.

Responses

"I am deeply concerned about the review of Part 2 NPRM comments," said Bill Stauffer, speaking for Faces & Voices of Recovery. "How are 'prominent' organizations defined and who gets to define who makes that list? It is totally inappropriate to discount comments by 'nonprominent' commenters, like patients, people in recovery and recovery community organizations. The very people that these rules and the regulatory process are intended to protect are being excluded in this process. It is a bit demoralizing and deserves independent scrutiny."

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Alison Knopf, Editor
Alcoholism & Drug Abuse Weekly
111 River Street
Hoboken, NJ 07030-5774
Email: adawnewsletter@gmail.com

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And from Zachary C. Talbott, president of the National Alliance for Medication Assisted Recovery (and chief clinical officer of ReVIDA Recovery Centers): "Individuals in recovery and the providers who treat us clearly aren't 'prominent' according to their definition."

And H. Westley Clark, M.D., J.D., dean's executive professor at Santa Clara University and former director of SAMHSA's Center for Substance Abuse Treatment, said he was shocked at the absence of comments from consumers and individuals who will be most affected by these proposed changes.

"The presentation almost suggests that the purpose of 42 CFR Part 2 is to make matters convenient for providers, EHR [electronic health record] vendors and others with a financial interest in providing services to patients and people in recovery," said Clark. "This presentation is quite shocking, and I don't use the word *shocking* loosely."

In particular, he cited the slide referring to "prominent" organizations. "There is no similar slide capturing the interests of consumers," he said.

" This presentation is quite shocking, and I don't use the word shocking loosely.... I certainly hope that SAMHSA corrects this very narrow and heavily biased view of those who commented."

H. Westley Clark, M.D., J.D.

Clark, who signed the 2011 "Dear Colleague Letter" instructing OTPs not to report patient information to the PDMP, but rather to check it to see what medications their patients were getting from other doctors (see "CSAT advises OTPs on participation in PDMPs," ADAW, Oct. 24, 2011, https://onlinelibrary.wiley.com/doi/pdf/10.1002/adaw.20303), said it's not right to only count the comments of those with a financial interest in eliminating confidentiality. "It is one thing to acknowledge the enterprise interests in changing 42 CFR Part 2 — it is quite another to dismiss those who would be harmed by those changes," he said.

"I recognize that MITRE is simply the contractor, but you would think that the views of patients and people in recovery would matter," said Clark. "I certainly hope that SAMHSA corrects this very narrow and heavily biased view of those who commented."

"We were disappointed that there were no voices of consumers included in the group of 'prominent' commenters," said Anita Marton, deputy director and senior vice president of the Legal Action Center. "We hope that those voices are being seriously considered as SAMHSA works to finalize the rule."

We asked SAMHSA, the Department of Health and Human Services and MITRE how they defined "prominent" and why patient voices were left out of the presentation. They did not respond by press time. •

Public comment submissions on the NPRM included ~two dozen from prominent organizations

American Academy of Family Physicians	Cleveland Clinic
American College of Emergency Physicians	Drug & Alcohol Service Providers Organization
American Health Information Management Association (AHIMA)	Hazelden Betty Ford Foundation
American College of Obstetricians & Gynecologists (ACOG)	Health Level 7 (HL7) International
America's Health Insurance Plans (AHIP)	Healthcare Leadership Council
American Hospital Association (AHA)	MA Department of Public Health
American Medical Association (AMA)	Medicaid & CHIP Payment Access Commission (MaCPAC)
American Pharmacists Association	Medical Group Management Association
American Psychological Association	National Association of Community Health Centers
American Society of Addiction Medicine (ASAM)	National Association of State Controlled Substances Authorities
Amerihealth Caritas Family of Companies	Ostuka
Association of American Medical Colleges	Premier Healthcare Alliance
Cerner Corporation	Treatment Communities of America
Cigna	UnitedHealth Group

Source: MITRE