Expanding Access to MAT in County Criminal Justice Settings

ALL-TEAM LEARNING COLLABORATIVE

DHCS California Department of HealthCareServices

HMA

September 23, 2020

WELCOME AND AGENDA OVERVIEW

- Energizing and Re-Activating Teams
- Project Updates
  - Jail MAT Treatment Data
  - Team Dashboards
- Buprenorphine: Issues From the Field
- Break
- Privacy Requirements for SUD Treatment Data
- "Teaser:" Stimulant Use
- Wrap-Up and Next Steps
- Slides and mini-recordings of individual sessions will be sent to all team members

Your Interaction

Use Chat freely to send questions and comments

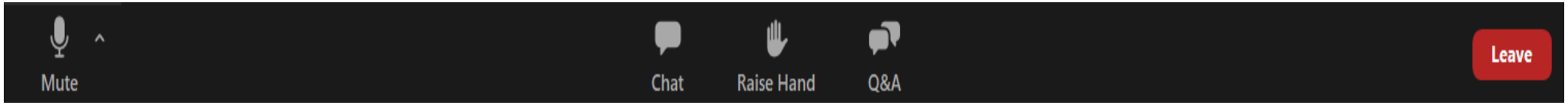
Provide input where requested to guide next steps

Provide real-time evaluation of topics as they are covered

Slides and video recordings of each session will be provided

ZOOM FEATURES

- You will join the meeting muted, however, this is an interactive meeting and lines will be unmuted during discussions
- The preferred audio is using “Phone Call” and enter your participant ID so that your name is associated with your phone number
- Use the “Chat” feature to type in a question or make a comment – there will be many Chat opportunities!
- Use the “Raise Your Hand” if you would like to speak
- Polling questions will be used – just click on the response you select
- Use Q&A to send questions you would like answered



Energizing and Re-Activating Teams

DHCS
California Department of HealthCareServices

HMA

Bren Manaugh | Coach
Deborah (Deb) Werner | Coach

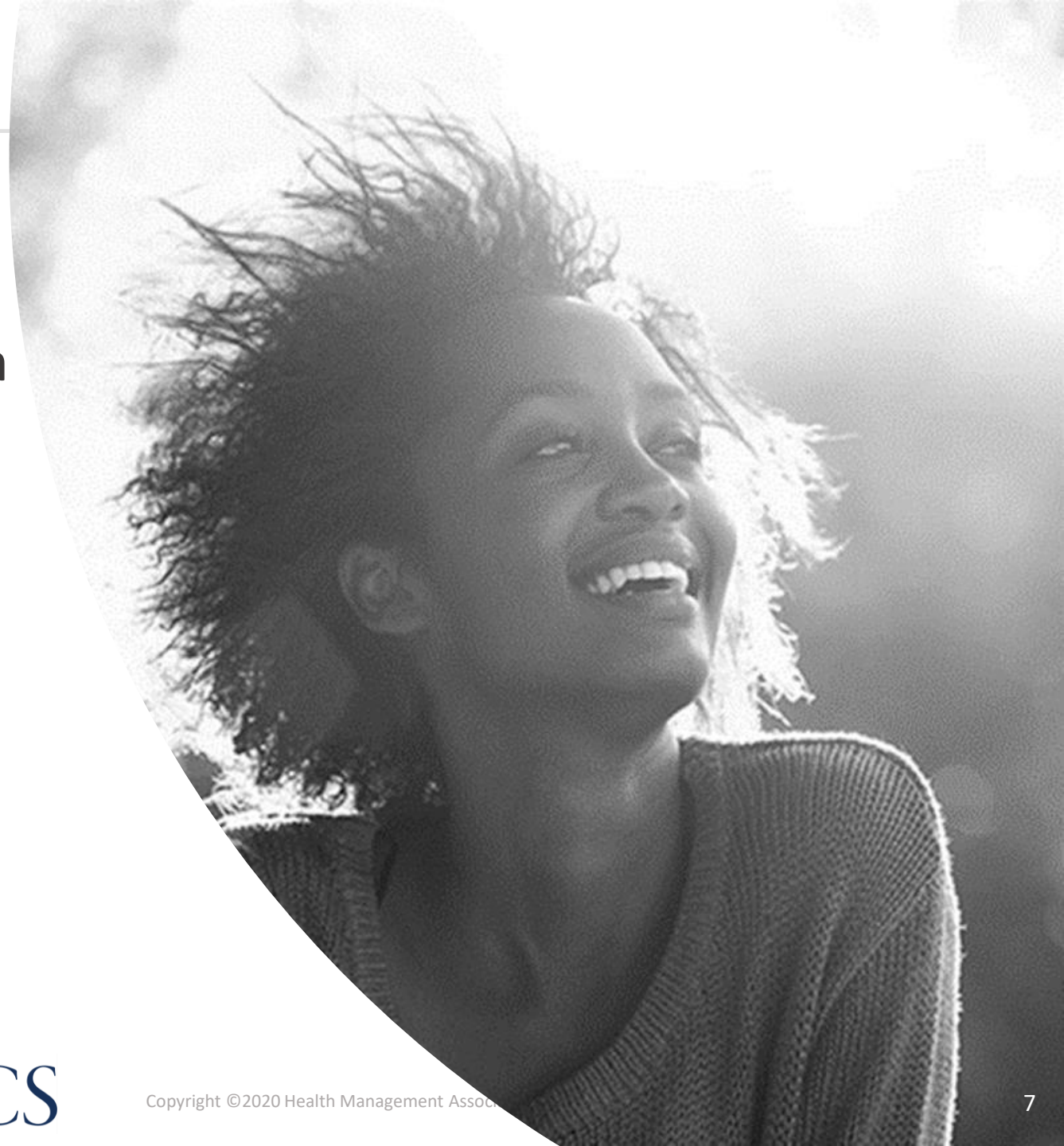
September 23, 2020

CHECKING IN: WHERE ARE WE?

WHEN THINGS AREN'T "NORMAL"

RESILIENCE

- About revitalizing – not just enduring
- Going through a difficult situation and finding a way to not only survive but thrive
- Drawing upon your personal strengths and coping skills
- Reorienting to your values and beliefs to find **meaning – what is your "why"?**
- **Hope and happiness** even in the midst of adversity



BUILDING RESILIENCE

NORMALIZING FEELINGS

MIND YOUR THOUGHTS

MANAGING REACTIONS

EMPATHY AND COMPASSION – OURSELVES

SELF CARE AND CALMING SKILLS

What is something that made you feel happy recently?

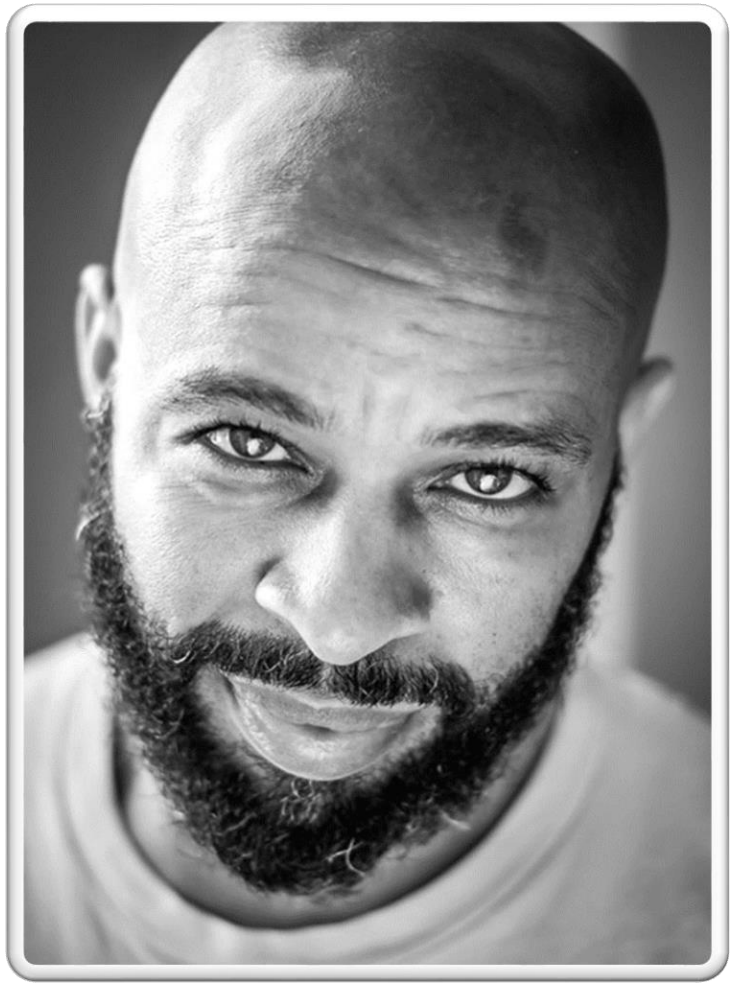
WHEN THINGS AREN'T "NORMAL"

- "Normal" is when you can reliably count on a choice or action leading to a certain outcome
- When we can't, feelings like apathy, anxiety, fear, anger --- are all understandable
- We can be the agents of change and action for our own life

MINDING OUR THOUGHTS

"There is so much going on that is hard. I don't know how I am going to manage it all!"

MINDING OUR THOUGHTS



"It's hard but I know I can do what I need to do to make it through"

Poll

What is your current personal energy level for the MAT learning collaborative ?

On a scale of 1 – 3 with

1 = just enough energy to hang in

2 = enough to participate

3 = energized and ready to go

My current energy level for the MAT learning collaborative is _____

HUMANS NEED FOUR SOURCES OF ENERGY

+ **PHYSICAL**
  quantity of your energy
+ **EMOTIONAL**
  quality of your energy
+ **MENTAL**
  focus of your energy
+ **HUMAN SPIRIT**
  energy derived from purpose – **your "why"**

https://theenergyproject.com/

WHAT IS YOUR *WHY*?

CHATTER-FALL

One word or short phrase that captures why you are involved in this learning collaborative…

Wait before you share it.

MOVING INTO ACTION

JOHN KOTTER'S 8 STEP PROCESS FOR LEADING CHANGE

- https://www.kotterinc.com/8-steps-process-for-leading-change/

WILLIAM BRIDGES – TRANSITIONS

Endings

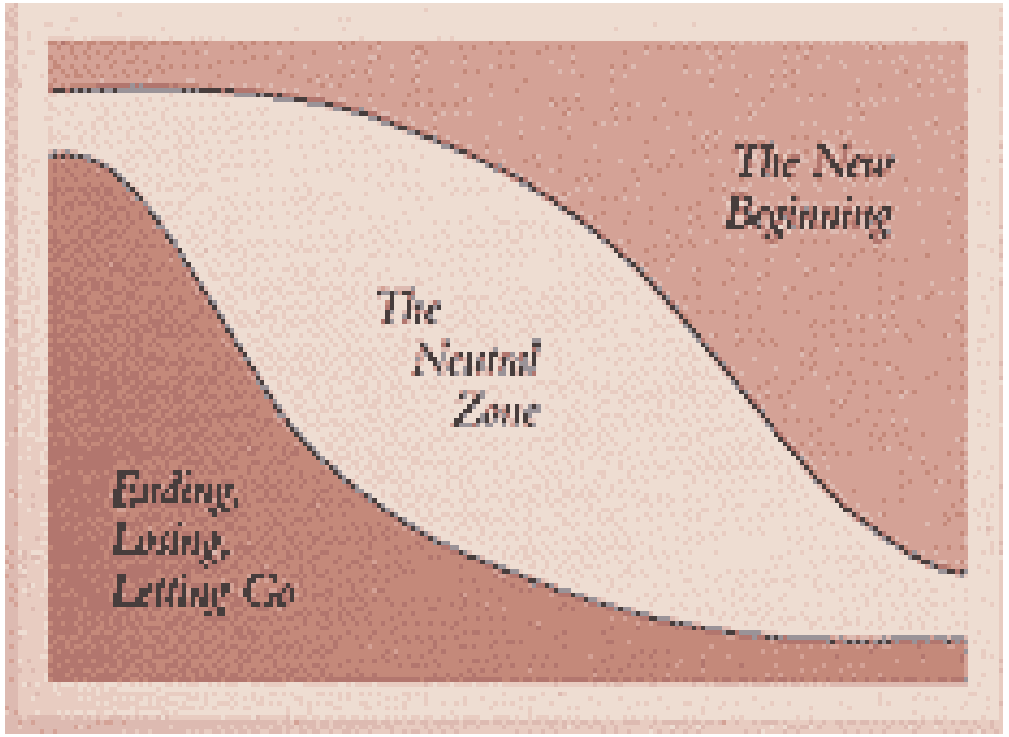
+ People holding onto the way things were
+ Mark the ending, let people grieve, let people bring something forward
+ Don't criticize past, call legacy built on

Neutral Zone

+ Uncertainty and increased anxiety
+ People feel over-loaded, communication, emotions, structure and small wins

New Beginnings

+ 4 Ps: leaders offer - **p**urpose, **p**icture, **p**lan, **p**art
+ Celebrate successes
+ Renew



Bridges, W. (1980). *Transitions: making sense of life's changes.* Reading, Mass.: Addison-Wesley.

TEAM DEVELOPMENT (AND RE-DEVELOPMENT)

+ Forming
+ Storming
+ Norming
+ Performing
+ (Adjourning)

Tuckman, B. W. (1965). Developmental sequence in small groups. *Psychological Bulletin, 63*(6), 384–399. https://doi.org/10.1037/h0022100

Poll

What developmental stage do you think your team is at?

1 = forming or reforming

2 = storming

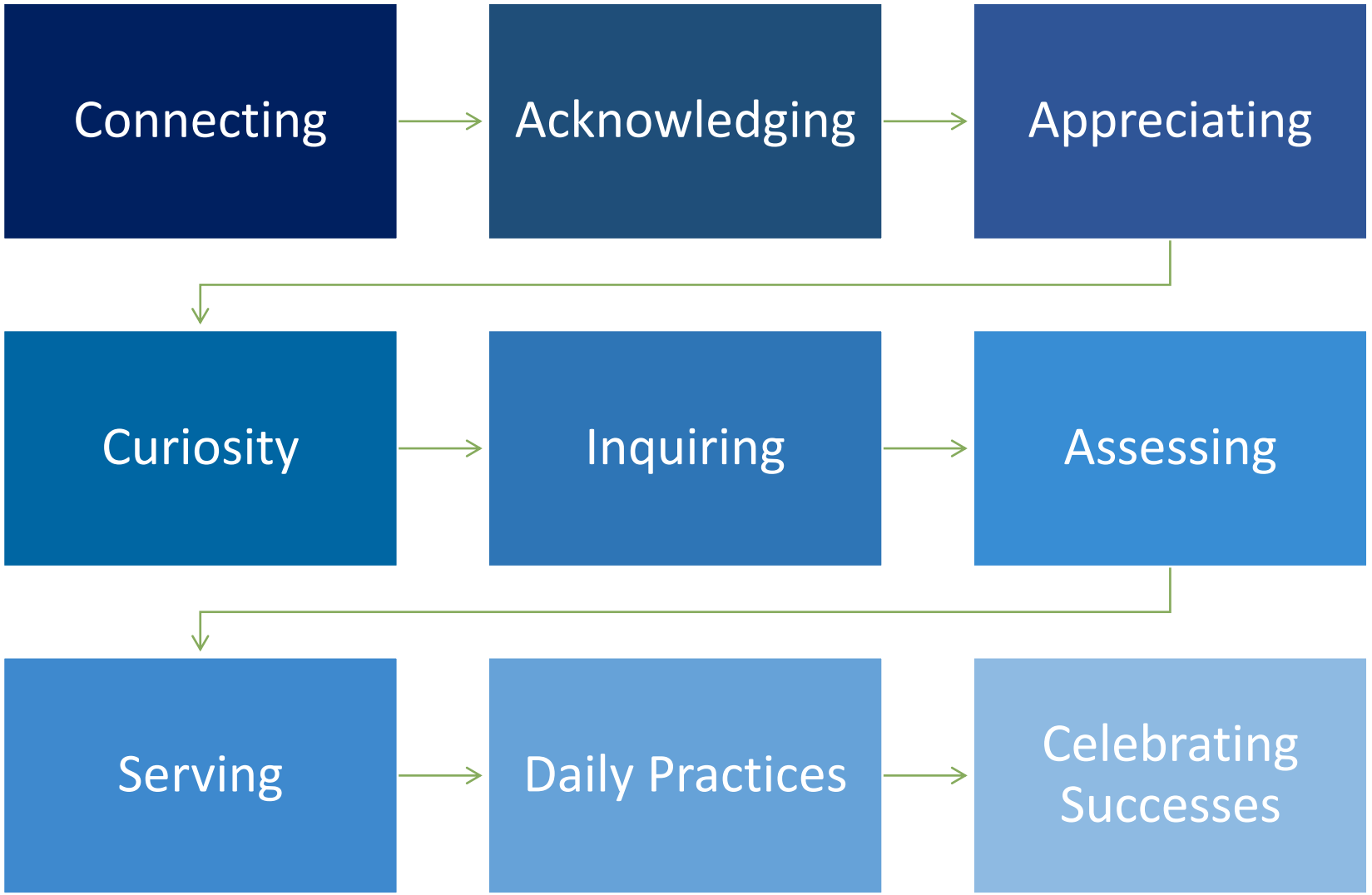
3 = norming

4 = performing

5 = adjourning

My team's current stage for the MAT learning collaborative is _____

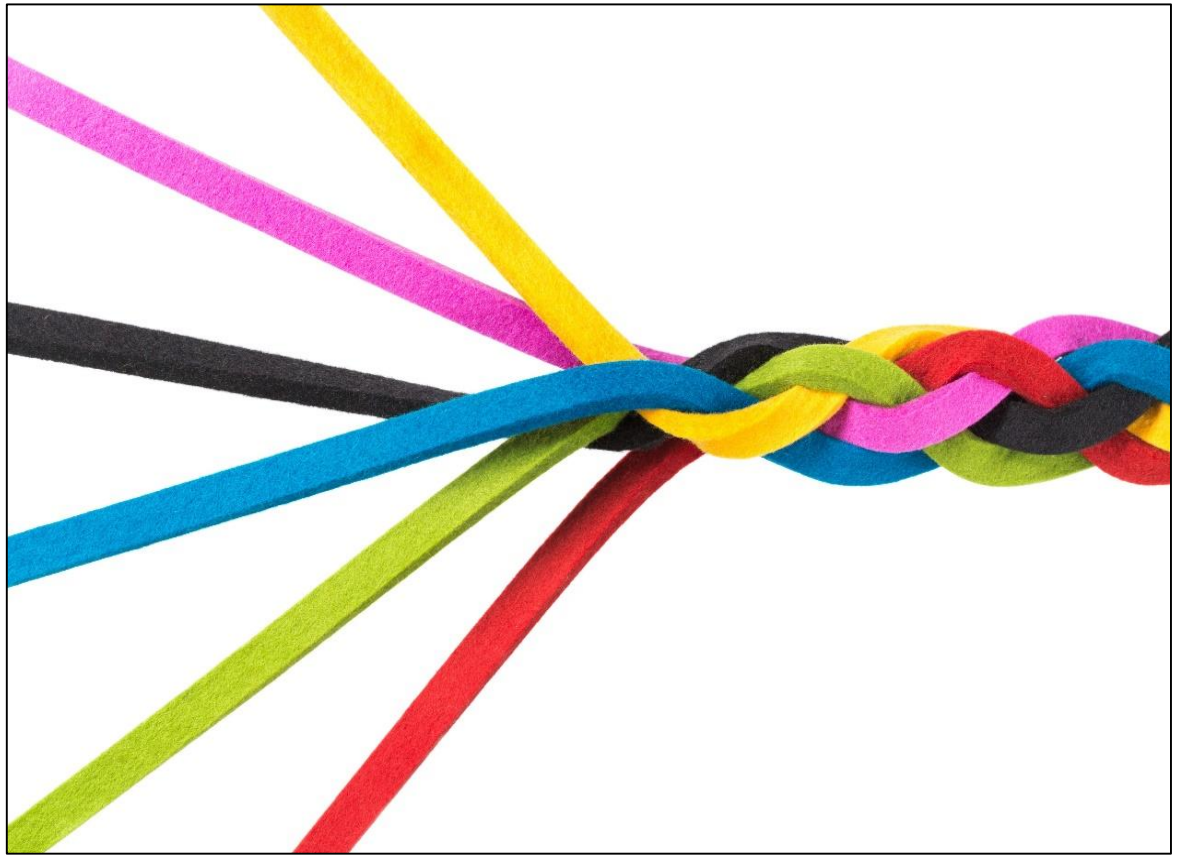
Re-energizing Teams!



CHATTER-FALL

One action I will take in the next 48 hours to re-energize and move this work forward

Wait before you share it.



ALONE WE CAN DO SO LITTLE; TOGETHER WE CAN DO SO MUCH.

Helen Keller

CONTACT US

FOR ANY QUESTIONS OR COMMENTS

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Bmanaugh@healthmanagement.com

DEBORAH (DEB) WERNER, MA, PMP

dwerner@ahpnet.com

HEALTH MANAGEMENT ASSOCIATES

HEALTH MANAGEMENT ASSOCIATES

DHCS

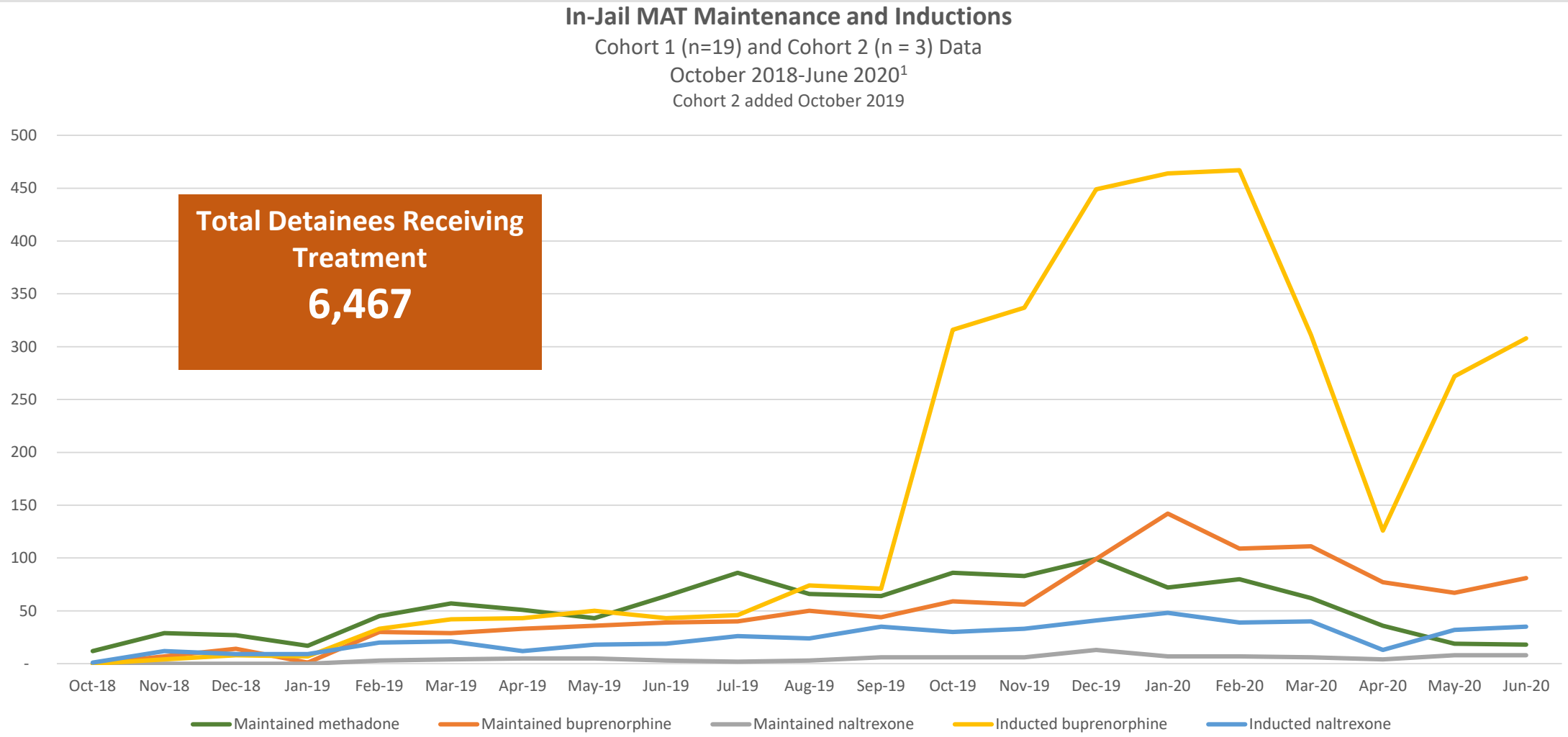
This session on Energizing and Re-Activating Teams was:

+ Very useful
+ Somewhat useful
+ Not very useful
+ Not useful at all

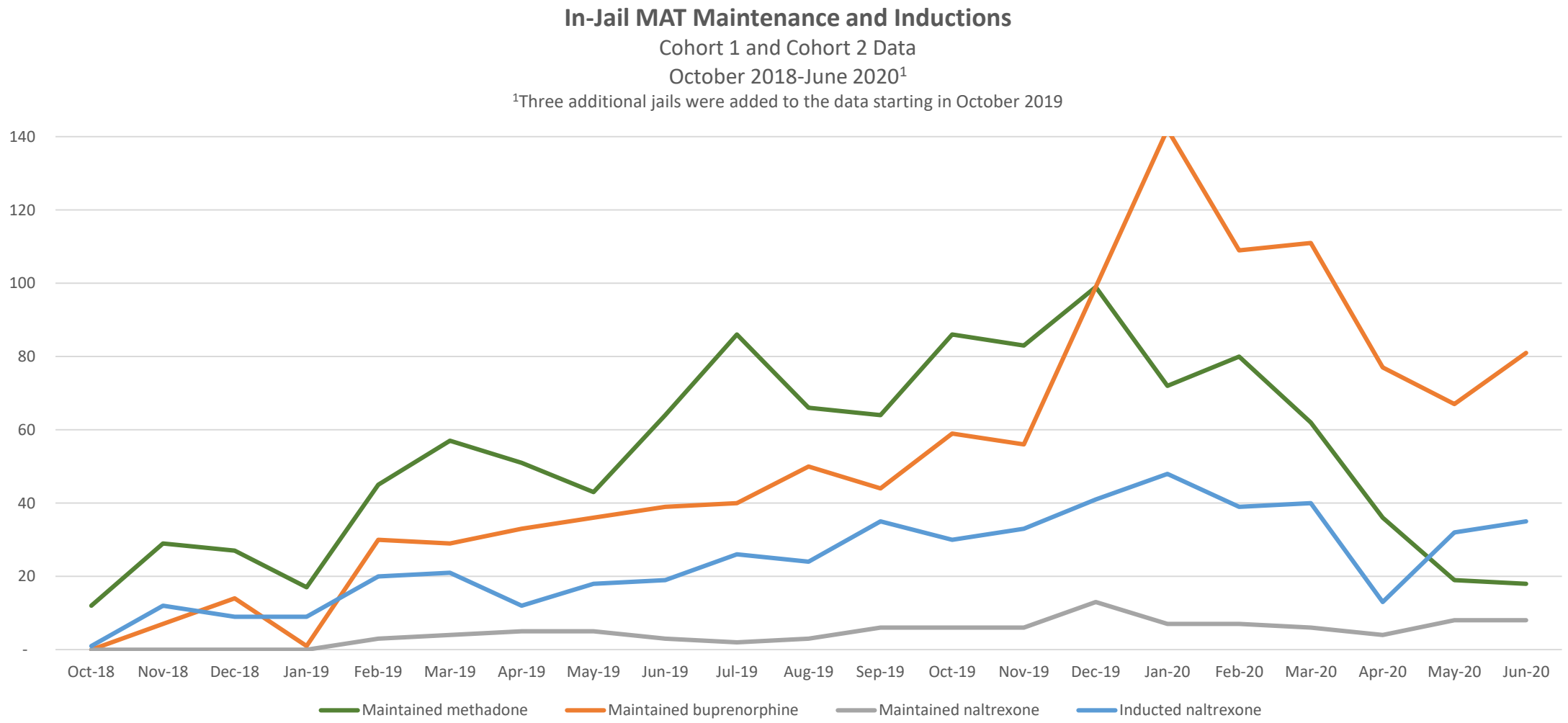
After entering your response, please provide CHAT input on anything you especially liked or didn't like, and anything you'd like to know more about

PROJECT UPDATES

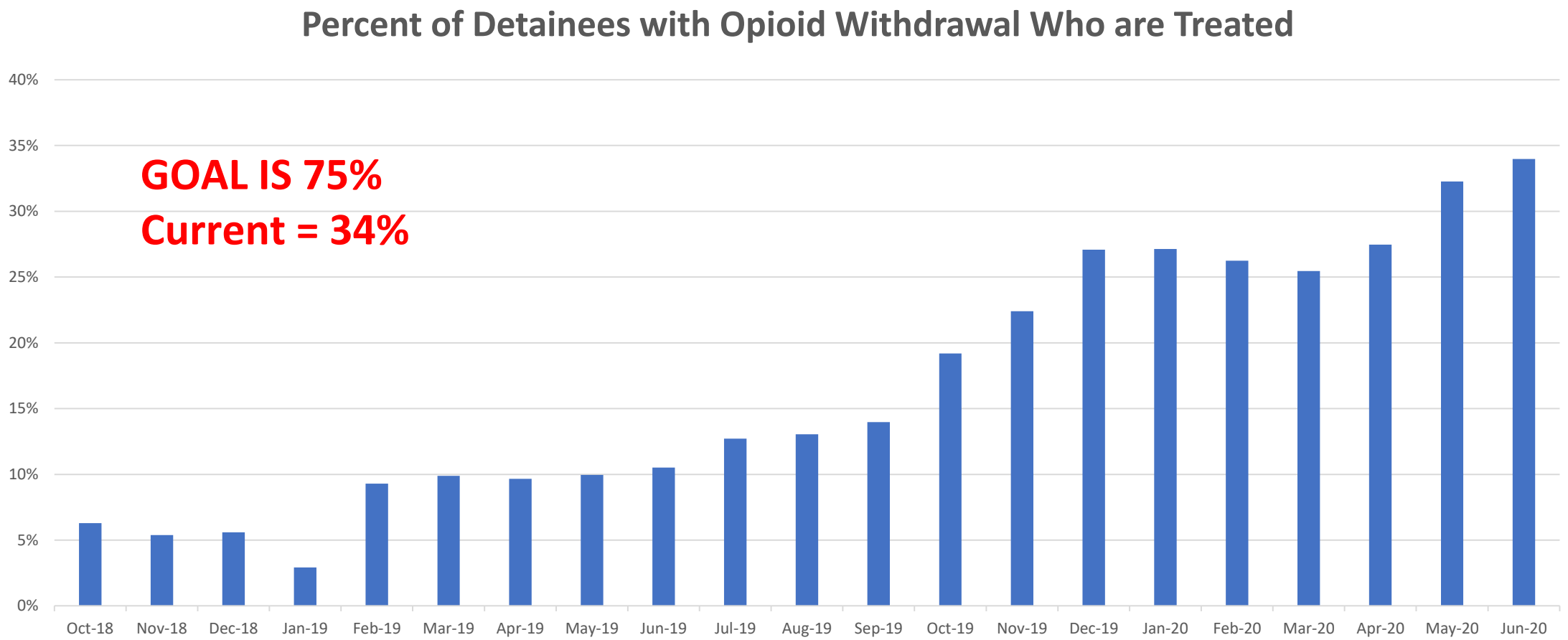
JAIL MAT TREATMENT DATA



JAIL MAT TREATMENT DATA – BUPRENORPHINE INDUCTIONS REMOVED



JAIL MAT TREATMENT DATA – PERCENT IN WITHDRAWAL RECEIVING MAT



PROJECT DATA TAKE-AWAYS

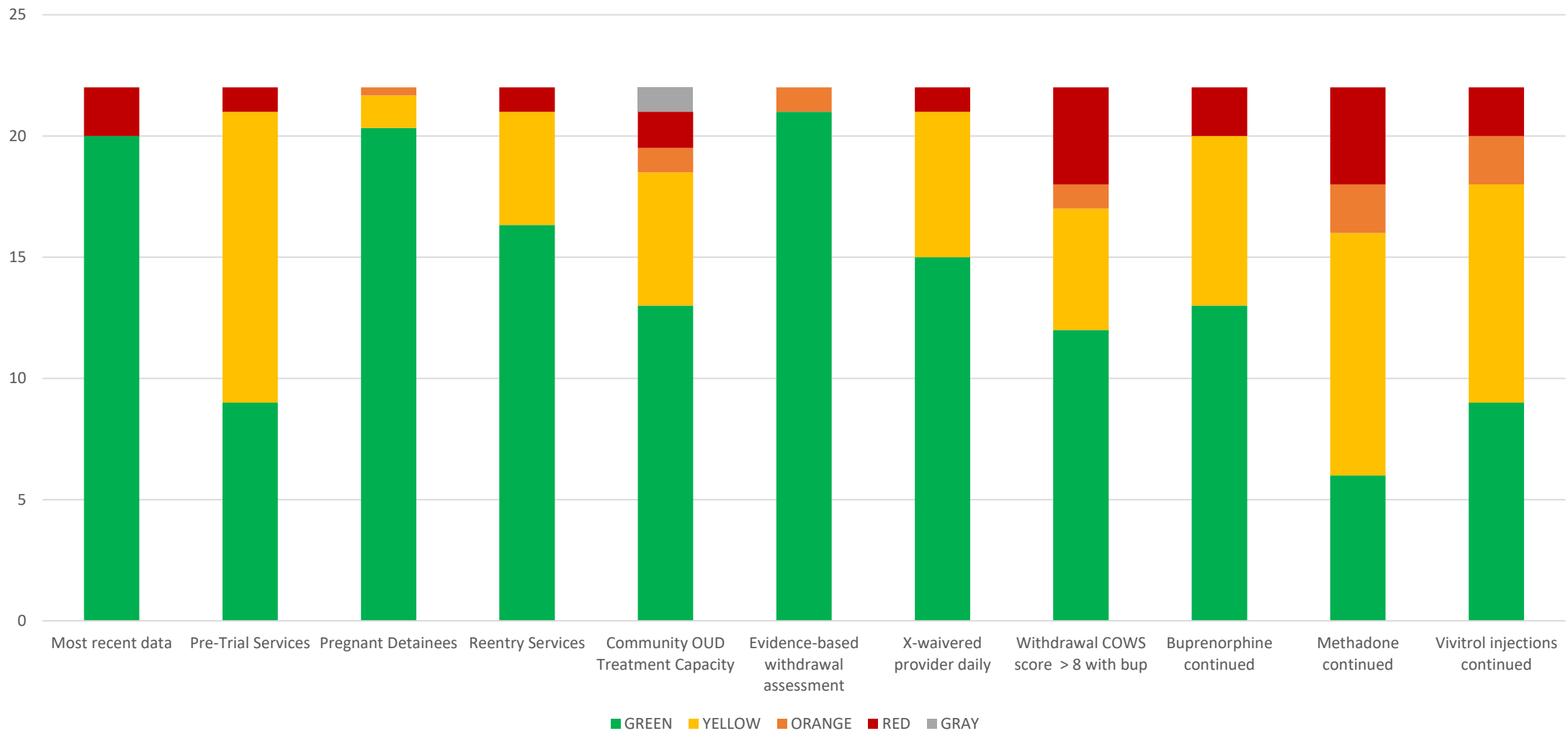
Treatment numbers continue to rise, especially with move to using buprenorphine for withdrawal management

Teams should review own data regularly

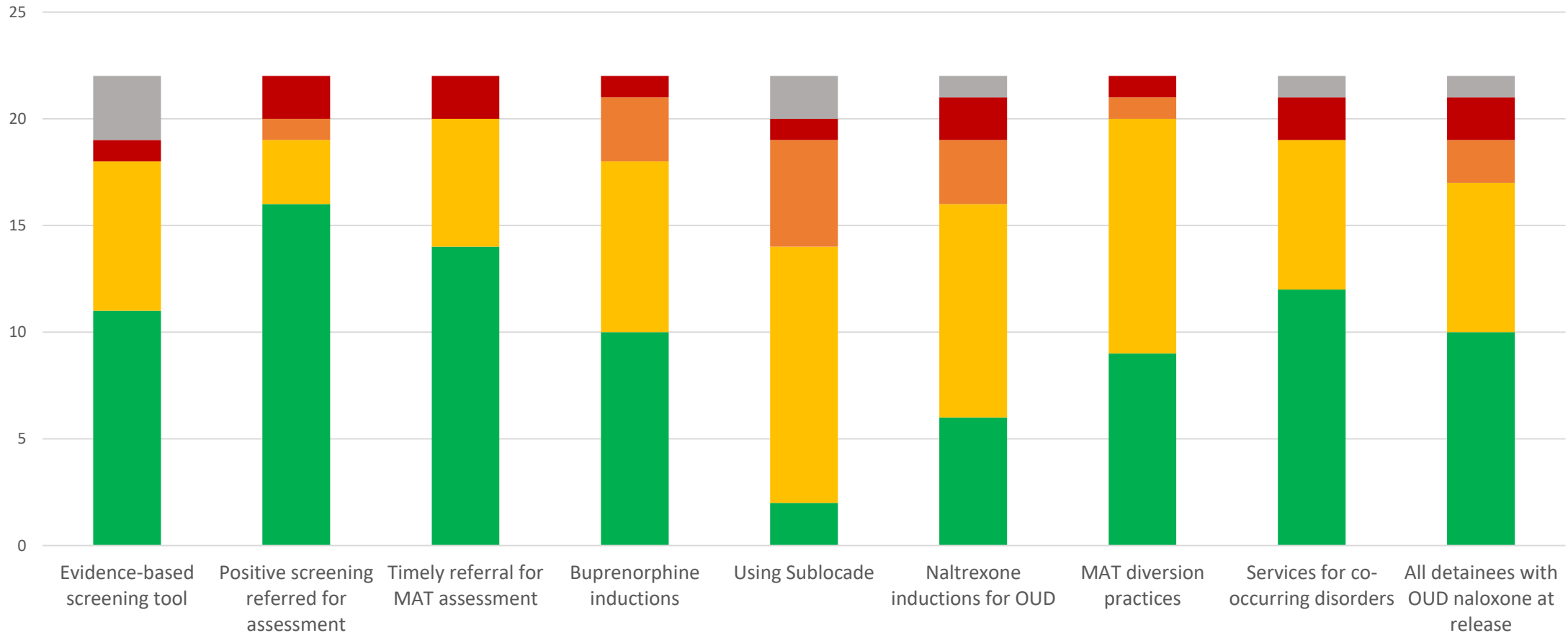
Add consideration of:

- How many people were assessed for MAT
- How many people were denied MAT
  - We see many denials for “presence of heroin,” “tested positive for meth
- Look for differences in providers, gaps in time of day/day of week
- How many have you terminated and why
- How many have refused treatment and who they are
  - Disparities, gang issues

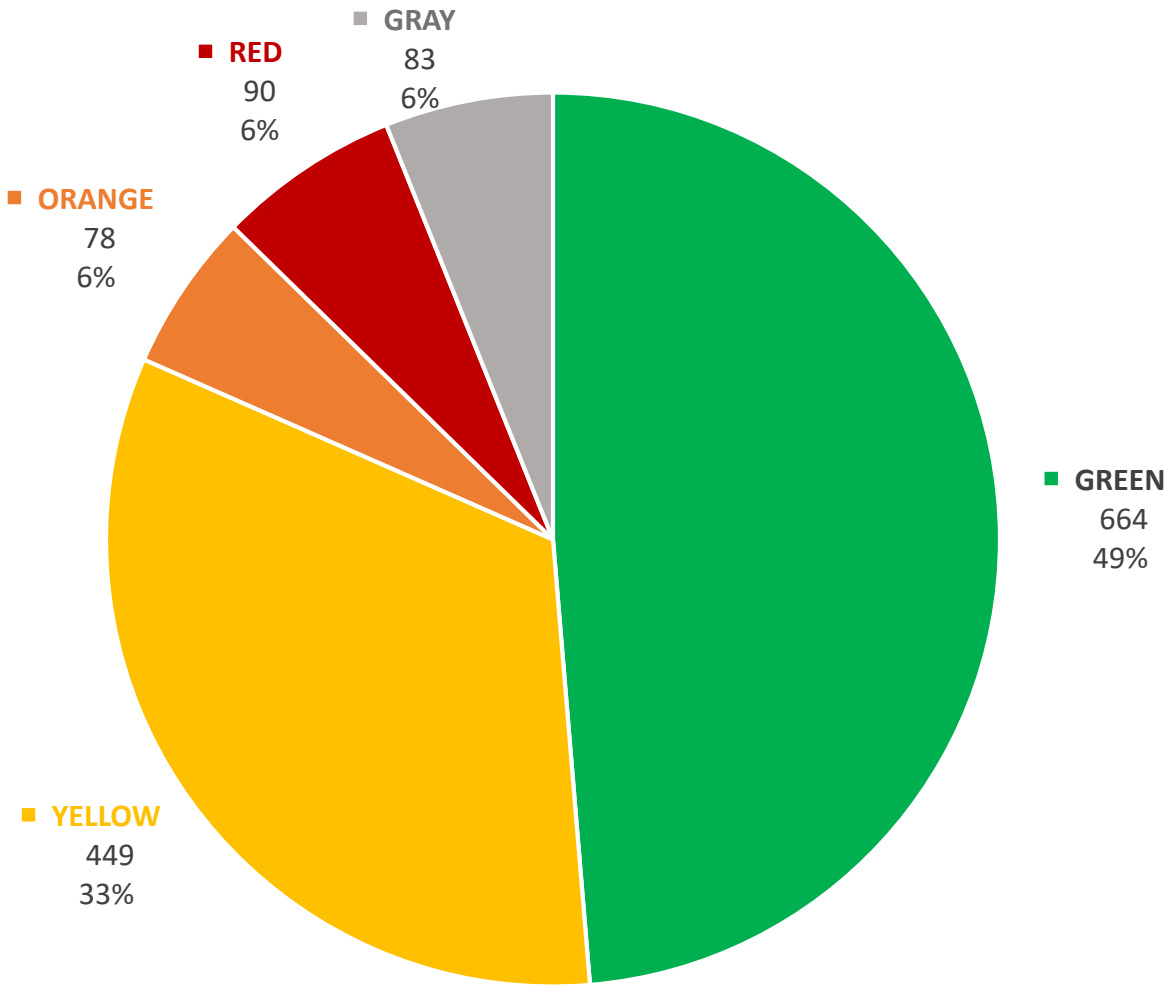
SUMMARY: TEAM STATUS BY INDICATOR (1 OF 2) SEPTEMBER 2020 (N=22)



SUMMARY: TEAM STATUS BY INDICATOR (2 OF 2) SEPTEMBER 2020 (N=22))



DASHBOARDS ALL RESPONSES SUMMARY (N=22 JAILS; 1364 RESPONSES)



CURRENT PROJECT CALENDAR

SESSION	DATE	START	END
Re-Entry Webinar	9/9/2020	10:00 am	11:30 am
Re-Entry Follow Up Discussion	9/11/2020	10:00 am	11:00 am
Learning Collaborative #1	9/23/2020	9:00 am	12:00 pm
ASAM Updates Webinar	9/29/2020	9:00 am	10:00 am
Stimulant Use Webinar	10/7/2020	10:00 am	11:00 am
Sublocade Webinar/Workgroup	10/13/2020	10:00 am	11:00 am
Methadone Webinar	11/11/2020	9:00 am	10:00 am
Opioid Withdrawal Management – COWS Training Webinar	12/3/2020	10:00 am	11:00 am
Learning Collaborative #2	12/16/2020	1:00 pm	4:00 pm
Co-Occurring Disorders Webinar	1/21/2021	10:00 am	11:00 am
Pretrial Services Webinar	2/23/2021	10:00 am	11:00 am
Alcohol Withdrawal Management Webinar	Feb. 2021	TBD	TBD
Learning Collaborative #3	3/25/2021	9:00 am	12:00 pm
Outcomes Tracking Webinar	April 2021	TBD	TBD

POLLING QUESTIONS

1. The MAT Treatment Data was:
+ Very useful
+ Somewhat useful
+ Not very useful
+ Not useful at all

2. The Project Dashboard Treatment Data was:
+ Very useful
+ Somewhat useful
+ Not very useful
+ Not useful at all

After entering your response, please provide CHAT input on anything you especially like or didn't like, and anything you'd like to know more about

ISSUES FROM THE FIELD: A CONVERSATION ABOUT BUPRENORPHINE

Use CHAT to send questions
Written guidance will follow….

Carol Clancy, PsyD.
Shannon Robinson, MD

BUPRENORPHINE ISSUES RAISED BY PROVIDERS WITHIN THE CRIMINAL JUSTICE SYSTEM

Buprenorphine:

+ Withdrawal management with buprenorphine
+ Stopping and restarting buprenorphine before release
+ Buprenorphine use and use of other drugs
+ Therapeutic range of buprenorphine
+ P&P for MAT
+ Healthcare staffing

Upcoming webinars to address these issues in more detail:

+ ASAM Updates 9/29/20
+ Injectable Buprenorphine 10/13/20
+ Opioid Withdrawal Management 12/3/20

POLLING QUESTION

This discussion of buprenorphine issues was:

+ Very useful
+ Somewhat useful
+ Not very useful
+ Not useful at all

After entering your response, please provide CHAT input on anything you'd like to know more about buprenorphine and suggestions on how to get the info

BREAK

PRIVACY REQUIREMENTS FOR SUBSTANCE USE DISORDER TREATMENT:
Impact of Recent Changes to 42CFR and HIPPA for Justice Settings and Health Care Providers

HMA

Shelly Virva, LCSW, FNAP
Donna Strugar-Fritsch, BSN, MPA, CCHP

September 23, 2020

LEARNING OBJECTIVES

- Health care participants will understand how 42CFR applies to justice settings
- Justice system participants will understand how 42CRF applies to health care settings
- All participants will understand:
  - Why there are recent changes to 42CFR
  - The changes to 42CFR and how they impact justice-involved clients
  - How HIPAA applies to correctional settings
  - How HIPAA and 42CFR intersect
  - Recent changes to HIPAA related to COVID-19

AGENDA

I. 42CFR

- + History of federal rule
- + California version
- + What 42CFR covers
- + 42 CFR and courts
- + 42 CFR and overdoses
- + Recent changes to 42CFR
  - ○ Why
  - ○ What

II. HIPAA

- + History of HIPAA
- + HIPAA and jails
- + HIPAA during COVID

III. Alignment of 42CFR and HIPAA

IV. CARES ACT Changes for COVID-19

V. Resources

42CFR PART 2 HISTORY

- Congress passed the legislation in the 1970s to encourage people to enter SUD treatment (20 years before HIPAA)
- The regulations implementing the law are at 42 Code of Federal Regulations, Part 2 and are commonly referred to as “Part 2.”
- Protects confidentiality for people in SUD treatment in order to protect against discrimination in arrest and prosecution, housing, child custody, employment, insurance coverage, public benefits, and other matters.
- Requires patient knowledge of and consent to release of SUD treatment information
- Protects patient records by requiring BOTH a specialized, detailed court order AND a subpoena or similar legal mandate before turning over treatment documents.

42CFR PART 2 HISTORY

Part 2 regulations revised in 2017 and 2018

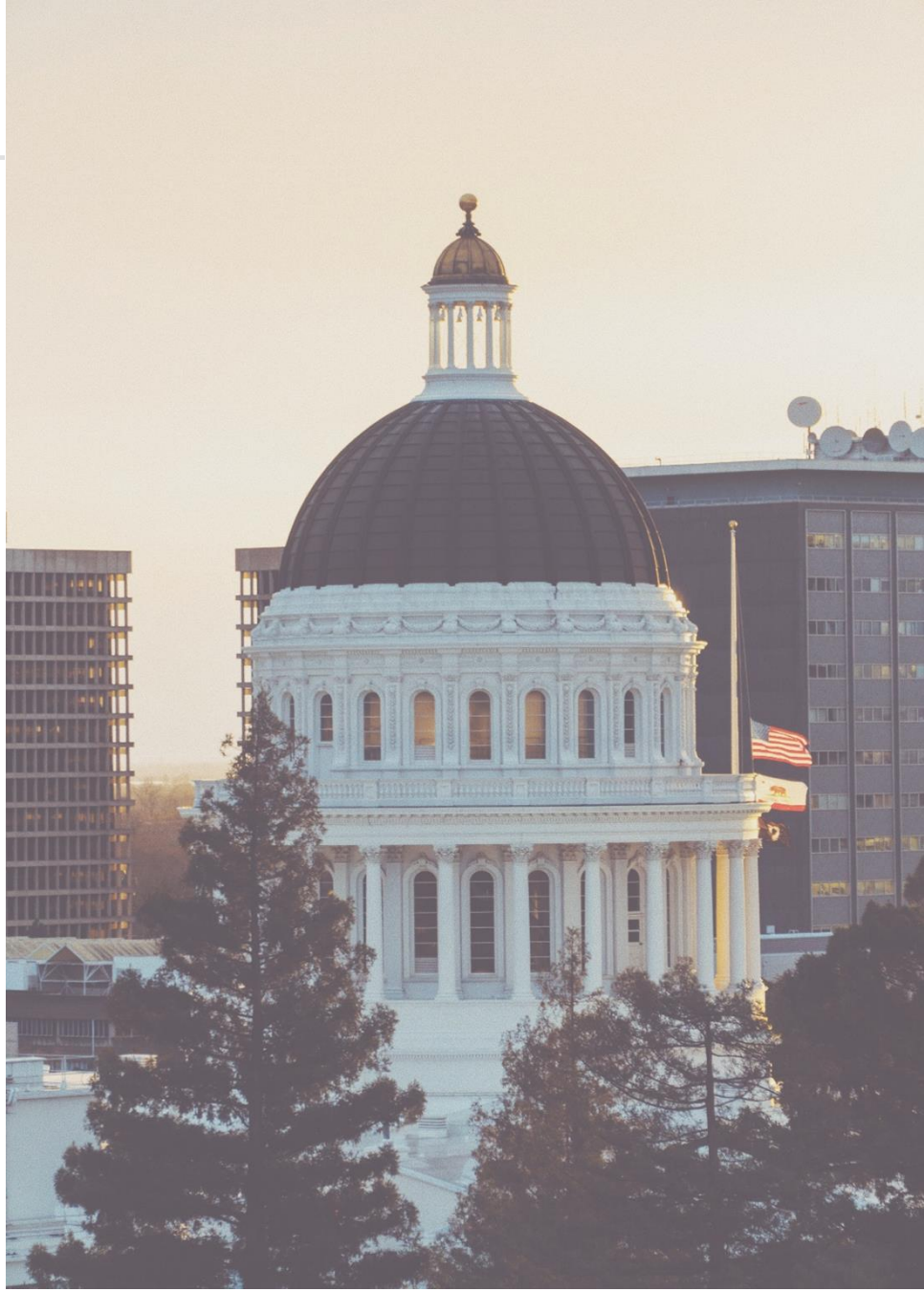
2018 revisions enacted in July 2020

Applies only to Federally Assisted SUD programs

Revised changes in place until revisions to HIPAA are enacted

42 CFR AND STATE PRIVACY LAW

- Under Part 2, no state law may either authorize or compel any disclosure prohibited by the regulations in this part. Thus, if both state law and Part 2 are applicable, a provider must comply with the stricter requirements of Part 2.
- California's Confidentiality of Medical Information Act (CMIA) mirrors HIPAA in most respects
- Section 11845.5 of California Health and Safety Code regulates the confidentiality of SUD information in the state, and closely follows 42CFR
- California SUD regulation states that providers must abide by the privacy protections set forth at 42 CFR Part 2.39 Thus, it appears that the state views state law as being coextensive with Part 2 and not imposing any restrictions that go beyond what is required under federal law.



WHAT DOES PART 2 42CFR COVER?

- Information obtained by a federally assisted SUDT program identifying someone with SUD
  - Personally Identifiable Information
    - Information which can be used to identify an individual
  - Protected Health Information (PHI)
    - Individual health information
- Part 2 requires explicit patient consent for all of the above

Part 2 generally prohibits treatment programs and certain third-party recipients from disclosing patient identities or records without patient consent, except I the following circumstances:

- Medical emergencies, 42 CFR § 2.51
- Child abuse or neglect reports required by state law, 42 CFR § 2.12(c)(6)
- Reporting a patient's crime on program premises or against program personnel, 42 CFR § 2.12(c)(5)
- Qualified audit or evaluation of the program, 42 CFR § 2.53
- Research requests, 42 CFR § 2.52
- Qualified Service Organization Agreements, 42 CFR § 2.12(c)(4)
- Court orders authorizing disclosure and use of the patient records, 42 CFR §§ 2.61-2.67

WHO DOES 42 CFR APPLY TO?

Two major requirements to determine whether data sharing for an individual is subject to Part 2 restrictions:

+ **Federally "assisted"** services **AND**
+ Agency/individual delivering services must **"hold itself out"** as being a substance use disorder treatment provider

https://www.hhs.gov/about/news/2019/08/22/hhs-42-cfr-part-2-proposed-rule-fact-sheet.html

FEDERALLY "ASSISTED"

Direct funding for services	• Medi-Cal (Medicaid), Medicare, or grant funding via SAMHSA
Program Oversight/Certification	• SAMHSA-certified Opioid Treatment Program
Provider Oversight/Certification	• Individual treatment providers registered with the DEA to prescribe controlled substances as part of MAT

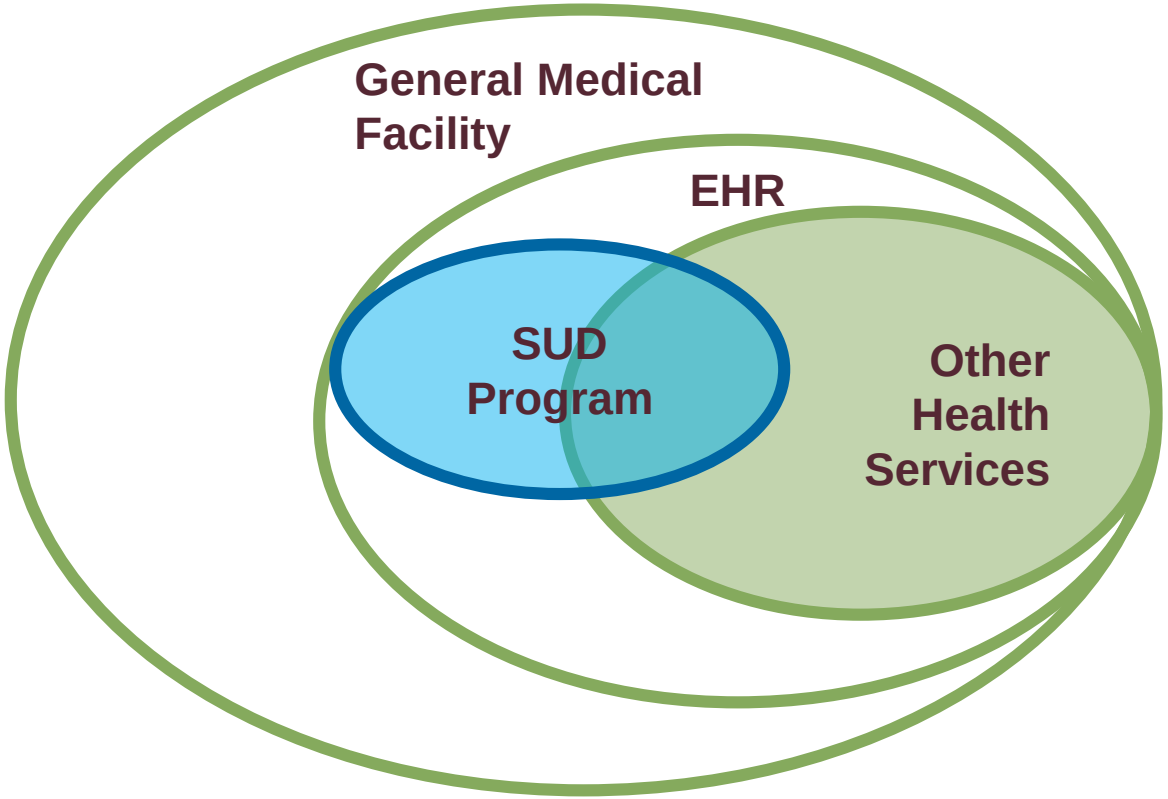
"HOLDING ITSELF OUT"

- Facility:
  - Advertising itself as treating SUD
  - Freestanding program
- Individual program/provider:
  - The primary function is the diagnosis, treatment, or referral for treatment of patients with SUD
  - Inpatient/outpatient treatment/detox program
  - Addiction specialist, even in a facility or program that is not addiction-related

PRIMARY CARE PROVIDERS THAT TREAT SUD

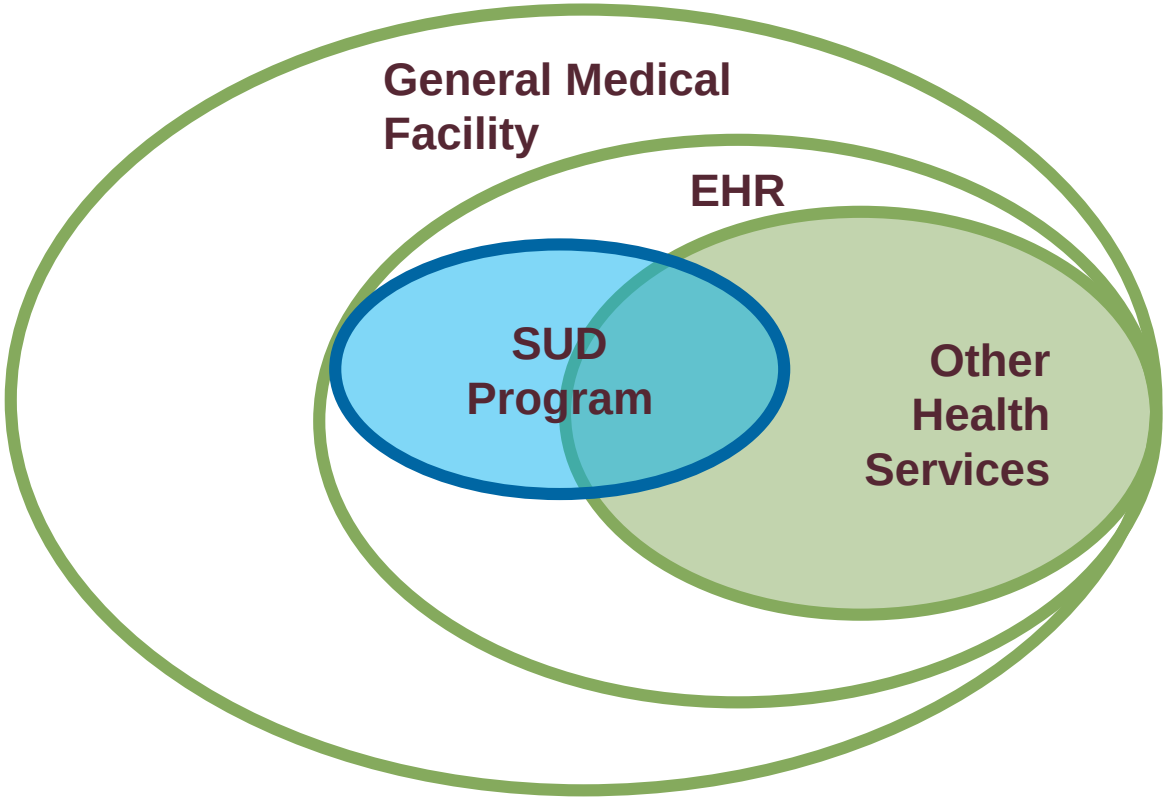
- Some primary care practices delivering SUD care may be able to avoid regulation under Part 2 by limiting the scope and active promotion of their SUD services.
- Avoiding Part 2 regulation simplifies data sharing among practitioners serving patients with SUDs.
- Primary care practices that operate Part 2 programs can best integrate care if they utilize a single electronic health record (EHR) system that segregates Part 2 records from other records.
- This system could potentially rely on technical safeguards such as firewalls, or administrative safeguards such as access control policies coupled with audits.

SUD PROGRAM IN A GENERAL MEDICAL FACILITY: "HELD OUT"



- Only the Part 2 program/provider is subject to Part 2 restrictions
- Other services are subject to HIPAA
- Many agencies revert to highest standard (part 2) for all data, but jeopardize patient continuity of care

SUD PROGRAM IN A GENERAL MEDICAL FACILITY: "HELD OUT



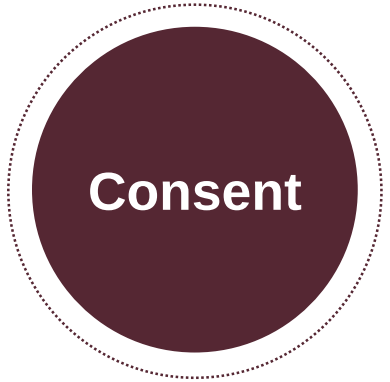
Part 2 program data can be shared:

- Without consent:
  - Within a part 2 program
  - Outside the program (within the facility) for purposes related to SUD services
    - Billing, administration, etc.
- With consent:
  - To coordinate care with other healthcare providers outside the program (even if inside the facility)
  - Could also include non-part 2 data

Practices seeking to share data with other providers have several options to do so.

Almost all data can be shared, during an emergency

Institutional Solution= Qualified Service Organization Agreement (organization to organization), but NOT for tx purposes; Good for most data types; restrictions for SUD data & often BH



Retail solution that requires patient & provider involvement

42CFR AND COURTS/JUSTICE SETTINGS

- Courts, attorneys, and probation are not covered by 42CFR, but the treatment information they seek is.
- Courts must provide advisement and procure a valid consent in compliance with 42CFR Part 2 in order to obtain treatment information **from a provider organization covered by 42CFR**.
- National Drug Court Institute enumerates 9 best practices for confidentiality which, if followed, can greatly reduce the potential of a sanction
- Resources: County Privacy Officer, Privacy Officer at AOD Agency

Questions for chat: Do your courts and probation have adequate 42CFR-compliant Release of Information forms and related policies and procedures?

- *If yes, are you willing to share them?*
- *If no, what information or technical assistance would you like?*

1. Changes related to Public Health Emergency – Will continue until the current COVID related public health emergency ends
2. Changes from SAMHSA rulemaking
   - Started by SAMHSA in August, 2019
   - New rules published July 15,2020
   - Effective August 14, 2020
3. Changes from CARES Act
   - Signed March 27,2020
   - Provided emergency funding AND modified 42 CFR Part 2
   - HHS will implement additional changes in 42 CFR Part 2 over the next year
   - These changes will take effect March 27,2021

WHAT CHANGED?

- Treatment records created by non-Part 2 providers based on their own patient encounter(s) are explicitly not covered by Part 2, unless any SUD records previously received from a Part 2 program are incorporated into such records. Segmentation or holding a part of any Part 2 patient record previously received can be used to ensure that new records created by non-Part 2 providers will not become subject to Part 2

WHY?

- To facilitate coordination of care activities by non-part-2 provider

WHAT CHANGED?

- When an SUD patient sends an incidental message to the personal device of an employee of a Part 2 program, the employee will be able to fulfill the Part 2 requirement for “sanitizing” the device by deleting that message.

WHY?

- To ensure that the personal devices of employees will not need to be confiscated or destroyed, in order to sanitize in compliance with Part 2.

WHAT CHANGED?

- An SUD patient may consent to disclosure of the patient's Part 2 treatment records to an entity (e.g., the Social Security Administration), without naming a specific person as the recipient for the disclosure.

WHY?

- To allow patients to apply for benefits and resources more easily, for example, when using online applications that do not identify a specific person as the recipient for a disclosure of Part 2 records.

DETAILS ON RELEASE OF INFORMATION FOR SUD RECORDS

Written consent from the patient is the best way to legally disclose information to other care providers. Part 2 consent must have nine elements:

- Patient Name
- Name of the part 2 provider or entity
- A description of how much information and what kind of information may be disclosed, including a description of the SUD
- The name(s) of the individual(s) or entity to whom disclosure is made
- Ability to revoke consent
- Date on which, or condition, which will cause consent to expire
- Patient signature
- Date

Model consent documents: **Legal Action Center**

4. DISCLOSURES PERMITTED W/ WRITTEN CONSENT

WHAT CHANGED?

- Disclosures for the purpose of "payment and health care operations" are permitted with written consent, in connection with an illustrative list of 18 activities that constitute payment and health care operations now specified under the regulatory provision.

WHY?

- In order to resolve lingering confusion under Part 2 about what activities count as "payment and health care operations," the list of examples has been moved into the regulation text from the preamble, and expanded to include care coordination and case management activities

5. DISCLOSURES TO CENTRAL REGISTRIES AND PDMPS

WHAT CHANGED?

- Non-OTP (opioid treatment program) and non-central registry treating providers are now eligible to query a central registry, in order to determine whether their patients are already receiving opioid treatment through a member program.

  OTPs are permitted to enroll in a state prescription drug monitoring program (PDMP), and permitted to report data into the PDMP when prescribing or dispensing medications on Schedules II to V, consistent with applicable state law.

WHY?

- To prevent duplicative enrollments in SUD care, duplicative prescriptions for SUD treatment, and adverse drug events related to SUD treatment.

WHAT CHANGED?

- Declared emergencies resulting from natural disasters (e.g., hurricanes) that disrupt treatment facilities and services are considered a “bona fide medical emergency,” for the purpose of disclosing SUD records without patient consent under Part 2.

WHY?

- To ensure clinically appropriate communications and access to SUD care, in the context of declared emergencies resulting from natural disasters.

WHAT CHANGED?

- Disclosures for research under Part 2 are permitted by a HIPAA-covered entity or business associate to individuals and organizations who are neither HIPAA covered entities, nor subject to the Common Rule (re: Research on Human Subjects).

WHY?

- To facilitate appropriate disclosures for research, by streamlining overlapping requirements under Part 2, the HIPAA Privacy Rule and the Common Rule.

WHAT CHANGED?

- Clarifies specific situations that fall within the scope of permissible disclosures for audits and/or program evaluation purposes

WHY?

- To resolve current ambiguity under Part 2 about what activities are covered by the audit and evaluation provision.

WHAT CHANGED?

- Court-ordered placement of an undercover agent or informant within a Part 2 program is extended to a period of 12 months, and courts are authorized to further extend the period of placement through a new court order.

WHY?

- To address law enforcement concerns that the current policy is overly restrictive to some ongoing investigations of Part 2 programs.

CHATTER-FALL INSTRUCTIONS

- We will have two Chatter-Fall questions
- We will walk through each question as a group
- You will take a minute to type your response in the Zoom Group Chat, but **don't click enter.**
- When instructed, you will click enter.

CHATTER-FALL #1

JS has an OUD and is maintained on Suboxone by his primary care provider (PCP) who is not covered by Part 2.

JS also attends Intensive Outpatient Program at a local county SUD program, which is covered by Part 2.

JS has signed a Release of Information at for the PCP to obtain his SUD records which are now incorporated into his medical record at the primary care office.

Does this make JS's medical record at the PCP office subject to Part 2?

Type your response and

don't click enter.

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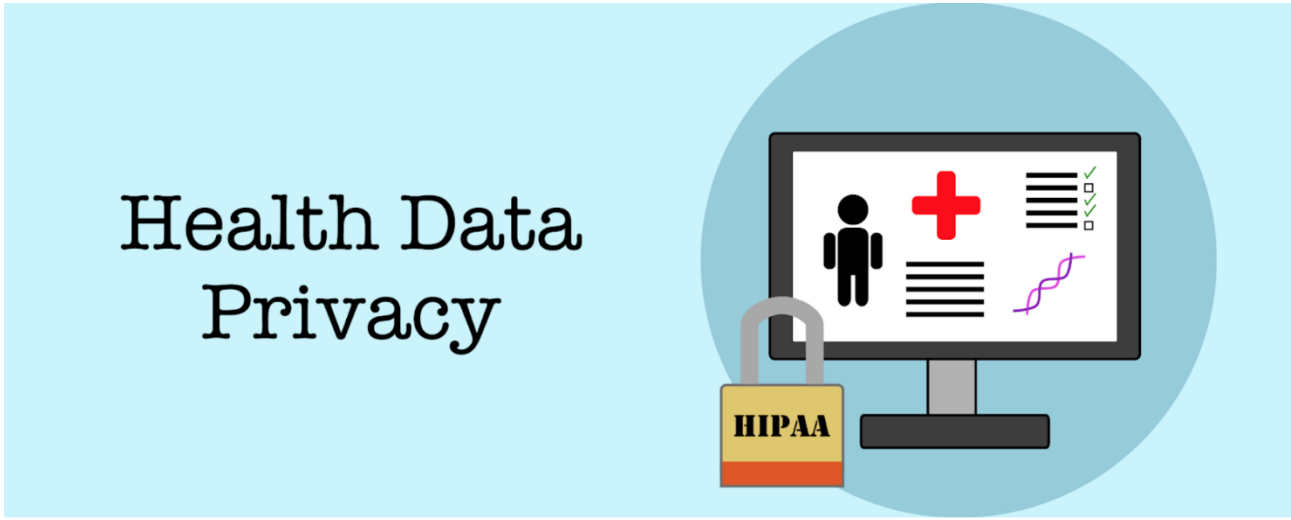
Does this make JS's medical record at the PCP office subject to Part 2?

Go ahead and **Click Enter**

- Health Insurance Portability and Privacy Act enacted into law in 1996
- Protects patient health information from being disclosed without consent or knowledge
- HIPAA Privacy Rule sets standards for use and disclosure of PHI by "covered entities"
- Covered Entities:
  - Health Plan
  - Health care provider that perform electronic standard transactions (billing)
  - Health care clearinghouse



WHAT ARE THE ENFORCEMENT CHANGES ANNOUNCED BY THE OFFICE OF CIVIL RIGHTS REGARDING COVID-19?

They will NOT enforce rules regarding HIPAA compliance of communication platforms during the public health emergency. Use of FaceTime, Facebook Messenger, Google Hangouts, and Skype are all called out as acceptable options during the emergency.

Sources:
https://www.hhs.gov/hipaa/for-professionals/special-topics/emergency-preparedness/notification-enforcement-discretion-telehealth/index.html
https://www.samhsa.gov/sites/default/files/covid-19-42-cfr-part-2-guidance-03192020.pdf

- Written consent from the patient is the best and many clinics have telehealth consents as part of standard consent package for new patients
  - May not be able to obtain written consent during a pandemic
  - Verbal consent for telehealth should be documented in note
  - Other good things to document:

Location of patient

- ☐ For emergency reasons
- ☐ Post pandemic possibly for billing reasons

Procedures for technical problems

- ☐ Discuss with each visit
- ☐ Provide information in your FAQs for telehealth

If patient is alone or not alone during visit

- ☐ Provide information in your FAQs for telehealth
- ☐ Safety and comprehensiveness of assessment

- Jails are usually *not* covered entities under HIPAA
  - Not a health plan
  - Not a health care clearing house
  - Provides health care but *usually* does not electronically submit encounter data, health care authorization requests, billings, or other covered transactions
- Depending on many factors, when a jail contracts with a vendor to provide health care, that vendor may fall under HIPAA if it electronically bills for its services
- Inmates have patient privacy protections under HIPAA, but they differ from privacy rights of non-incarcerated persons
  - Correctional institution is not required to provide Notice of Privacy Practices
  - Access to medical records differs

HIPAA AND COURTS/ATTORNEYS/PROBATION

- Courts, Attorneys, and Probation are not covered entities, *but* treatment providers under contract to them may be.
- HIPAA prohibits any program from conditioning treatment on a patient signing a consent, but
- The judge, probation/parole, child welfare can condition participation in the drug court program on the defendant signing the consent form.

Questions for chat: Do your courts and probation have adequate HIPAA-compliant Release of Information forms and related policies and procedures?

- *If yes, are you willing to share them?*
- *If no, what information or technical assistance would you like?*

CORONAVIRUS AID RELIEF AND ECONOMIC SECURITIES ACT (CARES)

- CARES Act signed into law March 27, 2020
- Significant resources and allowances for telehealth
- Ensure SUD patients can continue to get the care and treatment(s) needed
- Aligns with HIPAA
- Mandates HHS make revisions to Part 2 regulations to implement and enforce the statutory changes.
- The deadline for this is 3/27/21

WHAT ARE THE CHANGES TO CONSENT FOR SUD INFORMATION ANNOUNCED IN THE CARES ACT AND WHEN WILL THEY GO INTO EFFECT?

- The CARES Act intends to set regulations of 42 CFR to be consistent with HIPAA
- 12- month timeframe for HHS to implement from 3/27/20
  - Source: https://www.congress.gov/bill/116th-congress/house-bill/748
- What about if the public health emergency ends and we have not reached 3/27/21?

or

- What about if there is a legal challenge to the 42 CFR section of the CARES Act?
  - We will revert to the requirements for 42 CFR part 2 Revised Rule

REFERENCES

+ Gates, K & L What Comes Next for Part 2? The CARES Act's Surprising Overhaul of the Controversial Law Protecting the Confidentiality of Substance Use Disorder Records https://www.jdsupra.com/legalnews/what-comes-next-for-part-2-the-cares-70074/
+ https://www.samhsa.gov/newsroom/press-announcements/202007131330
+ https://www.lac.org/resource/the-fundamentals-of-42-cfr-part-2
+ https://www.chcf.org/wp-content/uploads/2018/07/OvercomingDataSharingChallengesOpioid.pdf
+ https://www.chcf.org/wp-content/uploads/2017/12/PDF-FinePrintExchangingBehavioral.pdf
+ https://www.samhsa.gov/about-us/who-we-are/laws-regulations/confidentiality-regulations-faqs

REFERENCES AND RESOURCES

+ https://www.chcf.org/wp-content/uploads/2018/07/OvercomingDataSharingChallengesOpioid.pdf
+ https://www.chcf.org/wp-content/uploads/2017/12/PDF-FinePrintExchangingBehavioral.pdf
+ https://www.samhsa.gov/about-us/who-we-are/laws-regulations/confidentiality-regulations-faqs
+ https://www.ndci.org/sites/default/files/nadcp/14146_NDCI_Benchbook_v6.pdf

This session on 42CFR and HIPAA issues was:

+ Very useful
+ Somewhat useful
+ Not very useful
+ Not useful at all

After entering your response, please provide CHAT input on anything you'd like to know more about buprenorphine and suggestions on how to get the info

POLLING QUESTION

This session on 42CFR and HIPAA issues was:

+ Very useful
+ Somewhat useful
+ Not very useful
+ Not useful at all

After entering your response, please provide CHAT input on anything you'd like to know more about buprenorphine and suggestions on how to get the info

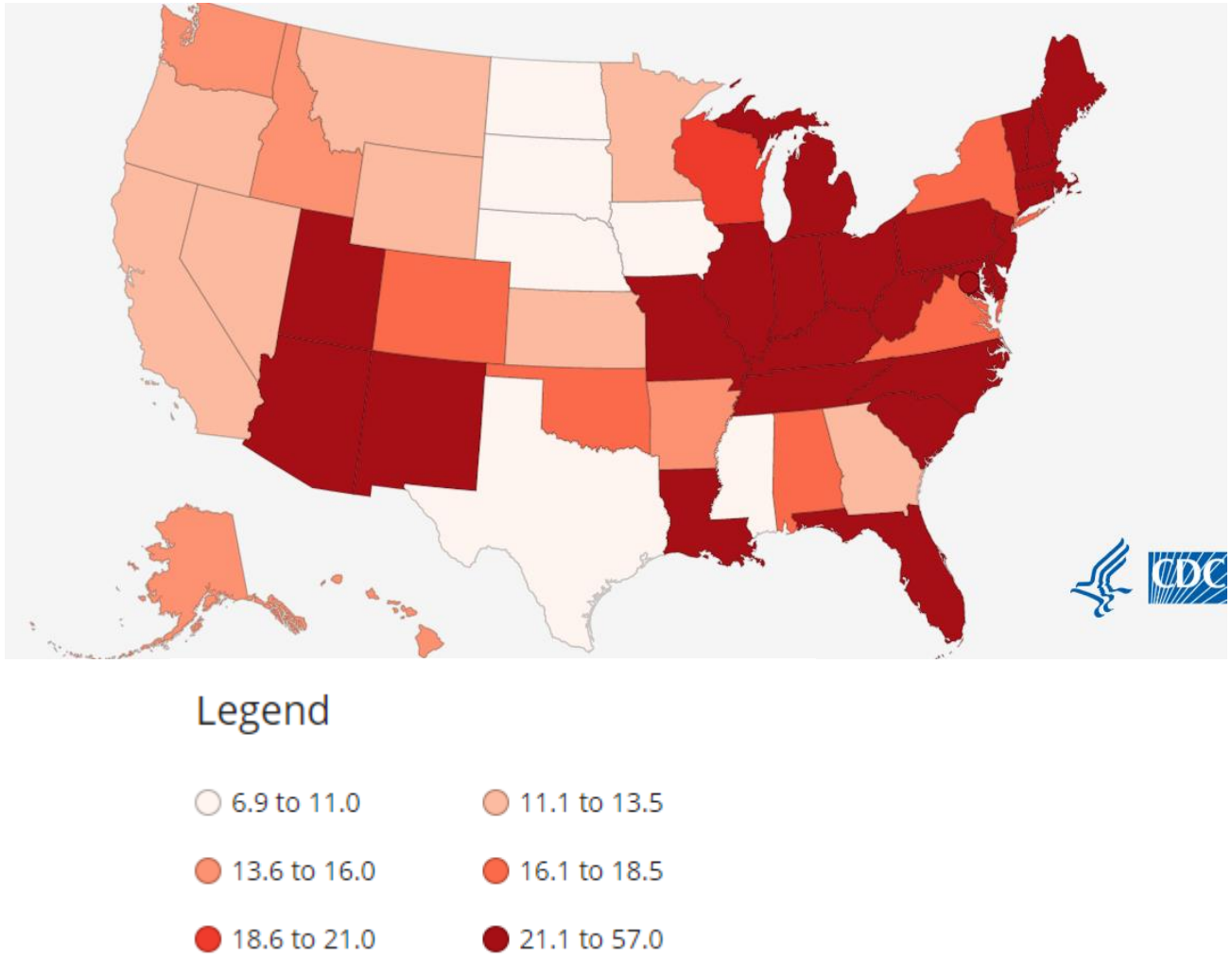
Stimulant Use Disorders

Shannon Robinson, MD
Fellow American Society of Addiction Medicine

September 23rd, 2020

IMPORTANCE: OVERDOSE DEATHS NATIONALLY AND LOCALLY

Overdose deaths



2018:

Age adjusted OD death rate

Nationally 21/100,000

California 13/100,000

West Virginia 52/ 100,000 (highest rate)

South Dakota 6.9/100,000 (lowest rate)

Number of ODs

Nationally 67,367 ODs

California 5,348 ODs (highest #)

Florida 4,698 ODs (second highest #)

Opioid involved ODs

Nationally 70%

California 45%

Cocaine involved OD death rate

Nationally 4.5

California 1.9

Psychostimulants involved OD death rate

Nationally 3.9

California 6.6

STIMULANT OVERDOSE DEATHS CONTINUE TO RISE NATIONALLY & LOCALLY
HTTPS://WWW.CDC.GOV/NCHS/NVSS/VSRR/DRUG-OVERDOSE-DATA.HTM#DASHBOARD

Figure 2. 12 Month-ending Provisional Number of Drug Overdose Deaths by Drug or Drug Class: United States

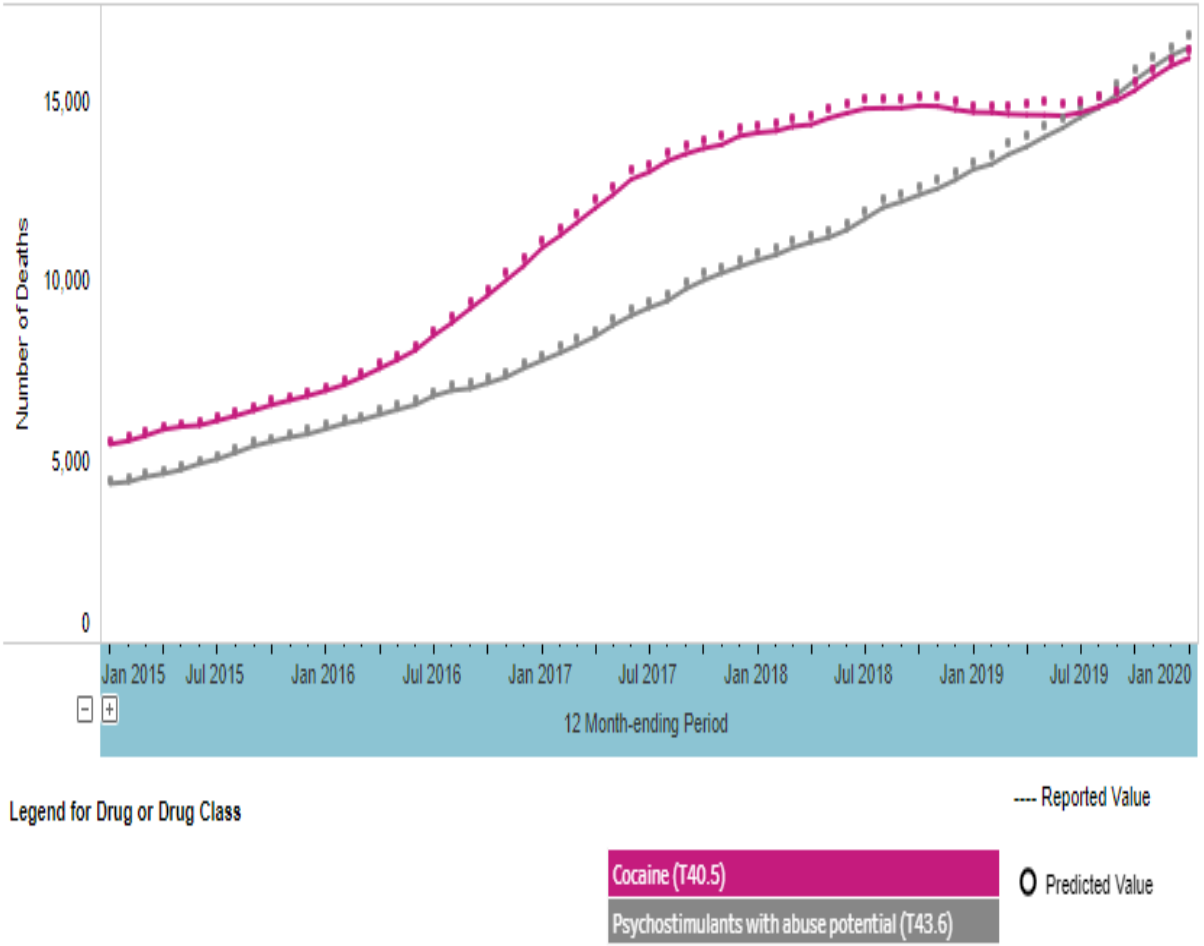
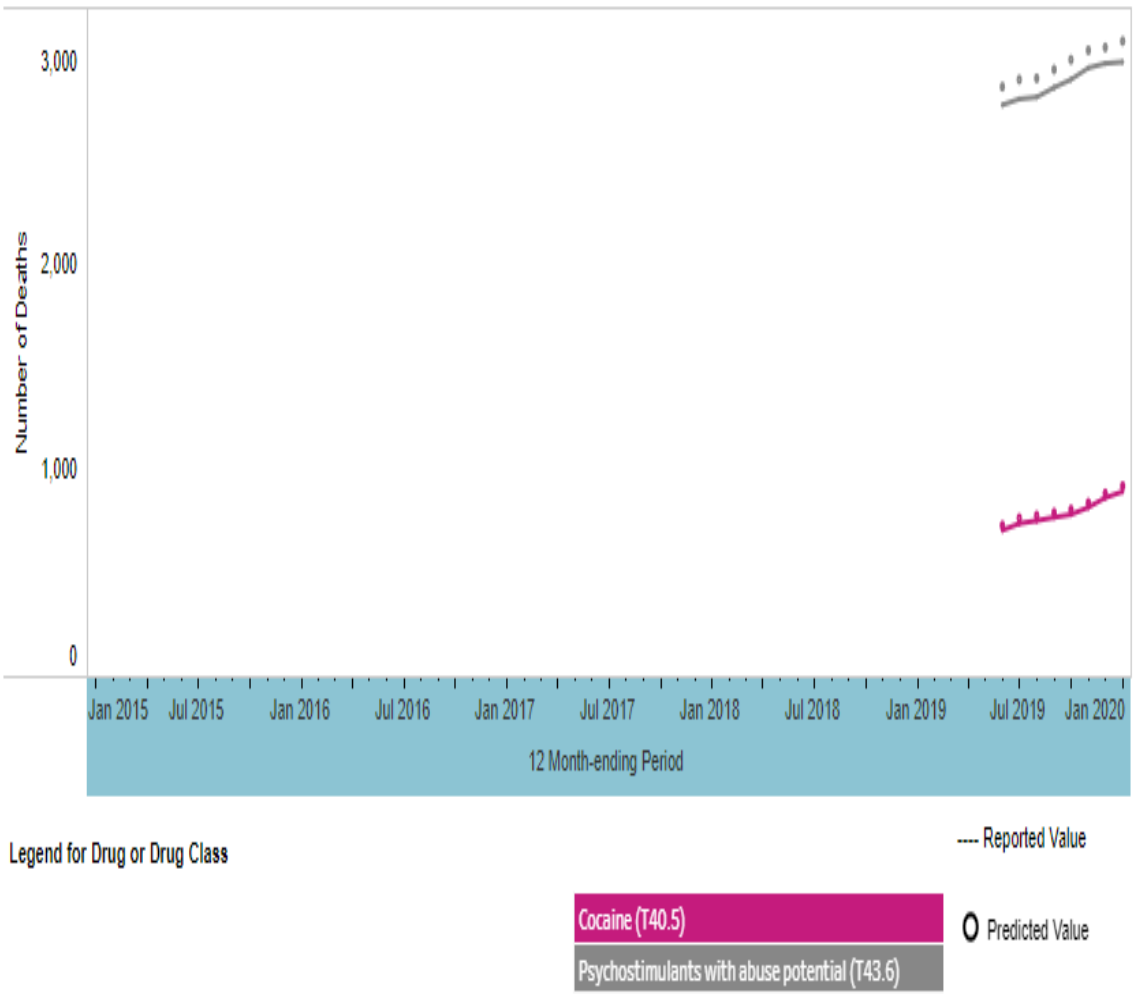


Figure 2. 12 Month-ending Provisional Number of Drug Overdose Deaths by Drug or Drug Class: California



WHAT ARE STIMULANTS?

- Cocaine (paste, powder, free base)
- "Psychostimulants with abuse potential"
  - Khat & Ephedra
  - Amphetamine from mahuang
    - Methamphetamine
    - MDMA/ecstasy = Molly = methylenedioxy-methamphetamine
    - Dextroamphetamine
    - Levoamphetamine
    - Methylphenidate = Ritalin
  - Methylxanthines
    - Caffeine (coffee)
    - Theophyline (tea)
    - Theobromide (chocolate)
  - Cathinone (bath salts)
  - Methcathinone
  - Cathine (norpseudoepherdrine)


Coca plant

Powder cocaine/ methamphetamines


Free Base Cocaine


Khat


Ephedra


Mahuang

Bath Salts


Bath Salts

Bath Salts

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DHCS

IMPORTANCE: ETHNICITY DATA

+ 2019 California OD rate/ 100,000

Race/ Ethnicity	Psychostimulants	Cocaine
Native American	19.8	3.0
African American	11.8	9.2
Caucasian	9.6	2.1
Hispanic	4.8	1.2
Asian/ Pacific Islander	1.6	.5
California	6.6	1.9

+ Demographic data should influence education efforts

SOME CONSEQUENCES ARE DEPENDENT UPON MODE OF CONSUMPTION

- Smoking
  - Burned lips
  - Throat problems
  - Lung problems- acute (50% of those who smoke cocaine) and chronic
- Injection
  - Skin & heart infections
  - Hepatitis or HIV
- Snorting
  - Sinus infections
  - Holes in nasal septum
  - Nosebleeds
  - Hoarseness

Among those who consume drugs by smoking:

- **1 of 6 users will become dependent on cocaine**
- **1 of 9 users will become dependent on amphetamines**

NOTE:
There is cross tolerance from one class of stimulants to another

EFFECTS ARE DEPENDENT UPON MODE OF CONSUMPTION AND HALF LIFE

Onset of Action

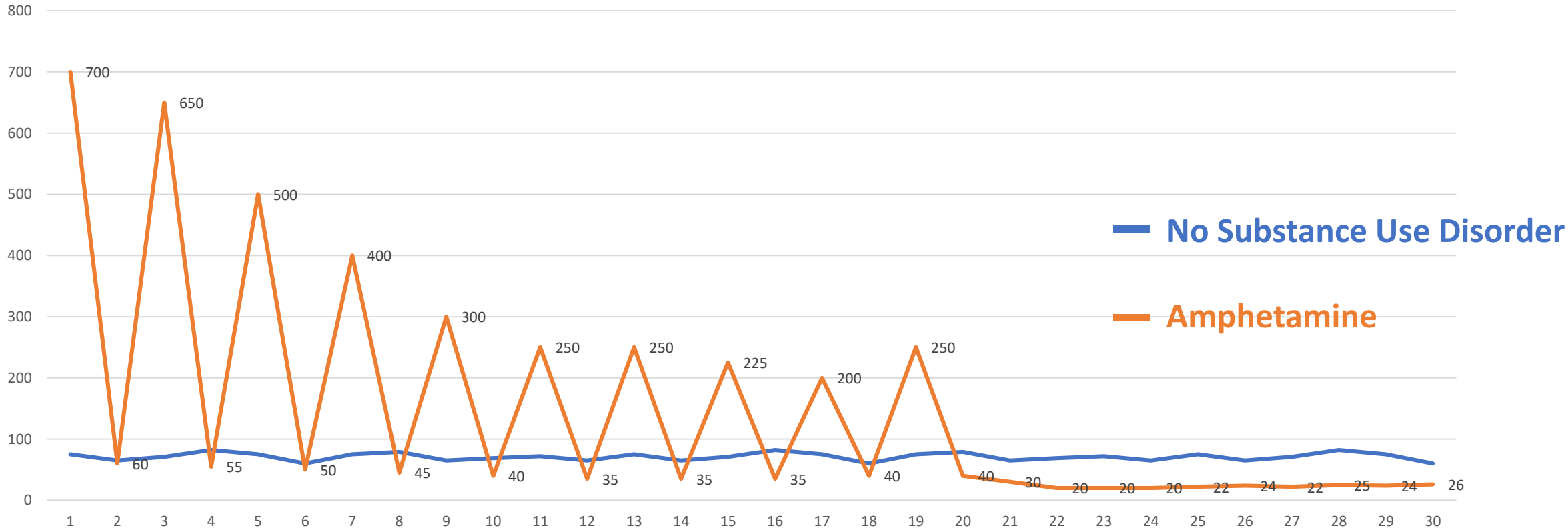
+ Smoking- drug reaches brain within seconds
+ Injection- drugs reaches brain within 5 minutes
+ Snorting- drugs reaches brain within 15 minutes
+ Oral-drugs reaches brain within 45 minutes

Half Life

+ Cocaine roughly 1h
+ Bath Salts roughly 3 hours
+ Amphetamine roughly 7 hours
+ Methamphetamines roughly 12 hours

NEUROBIOLOGY OF ADDICTION

https://www.youtube.com/watch?v=bwZcPwlRRcc&feature=youtube



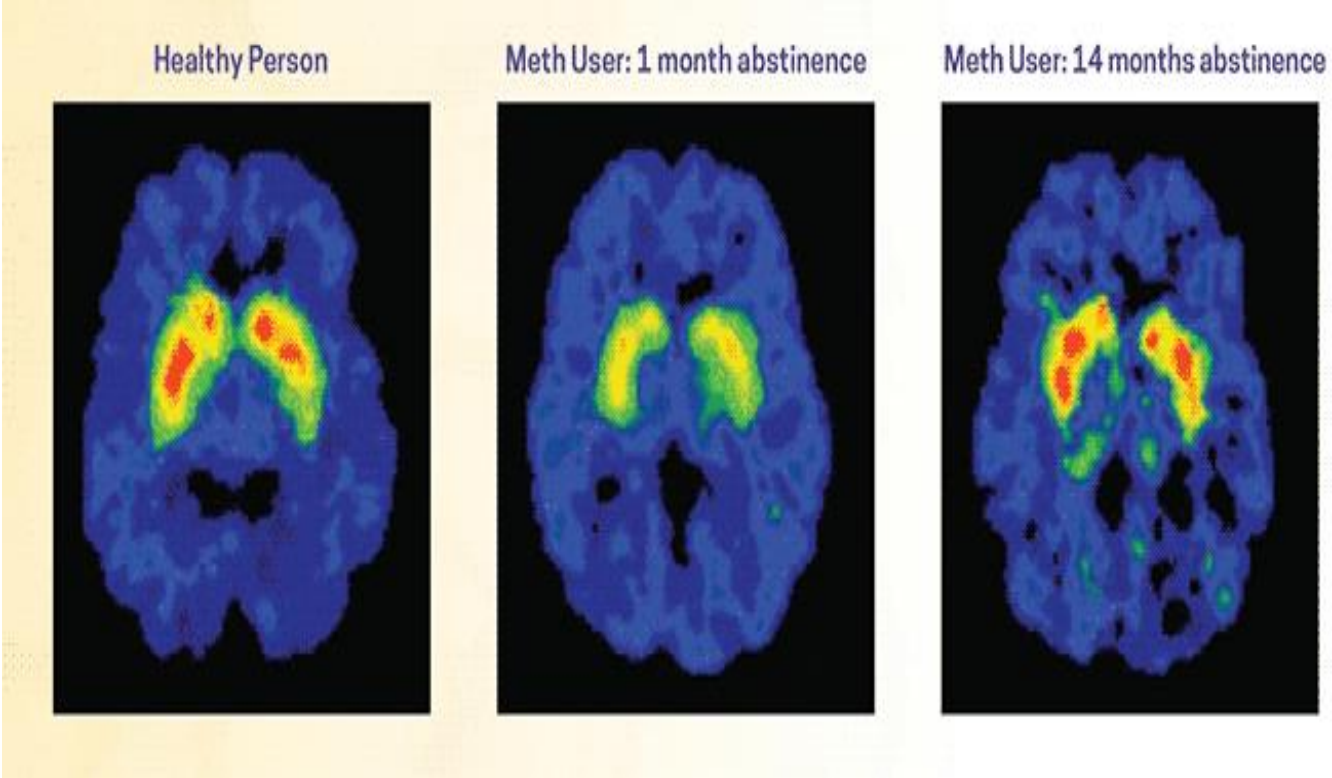
Dopamine levels vs. Episodes of amphetamine use

Source: Volkow (2015) Cell, 162 (4), 712-25.

Please note this an HMA proprietary slide.

NEUROBIOLOGY OF ADDICTION RECOVERY TAKES TIME

- Prolonged drug use changes the brain in long lasting ways
- Changes are both functional and structural
- Return to normal takes over 1 year



These images showing the density of dopamine transporters in the brain illustrate the brain's remarkable ability to recover, at least in part, after a long abstinence from drugs—in this case, methamphetamine. [51]

Source: The Journal of Neuroscience, 21(23):9414-9418. 2001

NEUROTRANSMITTERS

- Dopamine- reward and motivation system
- Norepinephrine- fight or flight
- Serotonin- mood, cognition

ACUTE EFFECTS OF STIMULANT INTOXICATION IS RELATED TO DOPAMINE, NOREPINEPHRINE & SEROTONIN

- Increased
  - alertness/ vigilance, concentration, mental acuity
  - energy, locomotion
  - sensory awareness & sexual desire
  - self confidence, grandiosity, anxiety, irritability, paranoia
  - heart rate & blood pressure, irregular heartbeat, vasoconstriction
  - breathing rate, temperature, pupil size & blood sugar
  - electrical activity, seizures
- Euphoria
- Toxic effects on muscles
- Abnormal movements
  - Dystonia, tremors, streotypy
- Decreased
  - brain blood flow & glucose metabolism
  - appetite & sleep
  - judgment & complex multi-tasking
  - defecation and urination

EFFECTS OF STIMULANT INTOXICATION IS RELATED TO DOPAMINE, NOREPINEPHRINE & SEROTONIN

Severe agitation may require intramuscular injections of medications to calm patient; however, there are no reversal agents

Overdose:

+ Hypertensive (HTN) crisis
+ Cardiac arrythmia
+ Myocardial infarction (MI)
+ Cerebrovascular Accident (CVA)
+ Psychosis

Treatment of Intoxication:

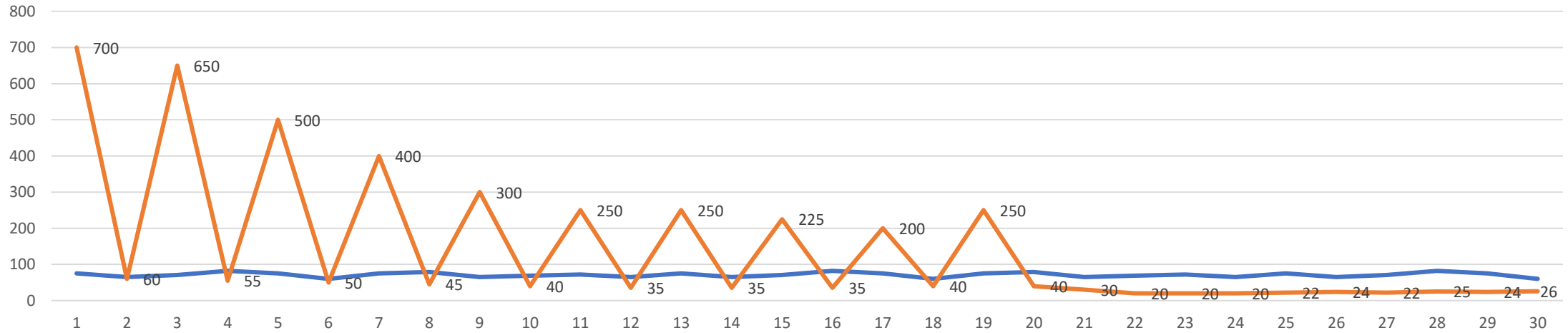
+ Talk down the client in a calm environment

Treatment of Overdose

+ Treat HTN with alpha and/ or beta blockers
+ Treat arrythmias with anti-arrhythmics
+ Treat vasoconstriction causing (MI) with nitroglycerin
+ Treat agitation with benzodiazepines
+ Treat psychosis with antipsychotics

LONG TERM PSYCHOLOGICAL EFFECTS OF CONTINUAL USE OF ILLICIT STIMULANTS

+ Tolerance to euphoria and appetite suppression
+ Loss of ability to concentrate & severe memory loss*
+ Loss of ability to feel pleasure without drug



+ Paranoia and psychosis (hallucinations & delusions)
+ Insomnia and fatigue
+ Irritable and angry
+ Depression (suicidal ideation)
+ Impulsive, reckless sexual behavior

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LONG TERM PHYSICAL EFFECTS OF CONTINUAL USE OF STIMULANTS

- Dry mouth, severe dental decay & gum problems
- Bruxism
- Weight loss
- Increased sweating; oily skin
- Skin lesions from injection & formication (leading to skin picking)
- Headaches
- Seizures
- Strokes & heart attacks
- Irregular heart beats
- Kidney & liver failure
- Damaged brain cells
- Neonatal effects

STIMULANTS AND PREGNANCY

+ Maternal death- pregnancy may increase risk of cardiovascular events
+ Preterm labor
+ Earlier gestational age at delivery
+ Low birth rate
+ Small for gestational age

+ Secreted in breast milk

Child:
Dysregulated behavior, growth, inhibitory control, attention and abstract reasoning, but these effects appear to be related to gestational age at delivery, psychiatric disorders, other prenatal exposures and quality of postnatal environment

Source: Smid, M. C., Metz, T. D., & Gordon, A. J. (2019). Stimulant Use in Pregnancy: An Under-recognized Epidemic Among Pregnant Women. *Clinical obstetrics and gynecology*, *62*(1), 168–184. https://doi.org/10.1097/GRF.0000000000000418

CESSATION FROM STIMULANTS

- Acute withdrawal: 4 days (no medication intervention recommended)
  - Increased appetite
  - Increased sleep & dreaming
  - Decreased activity & energy
  - Depression & anhedonia
  - Decreased concentration
  - Craving
- Protracted withdrawal up to 10 weeks
- Lingering effects on the brain; may be permanent
  - Executive dysfunction (Baicy, K. 2007)
  - Memory problems
  - Psychosis
  - Movement Disorders

MEDICATIONS HAVE NOT BEEN FOUND TO BE EFFECTIVE;
VACCINE TRIALS AND OTHER PHARMACOTHERAPY TRIALS ARE UNDERWAY

- Motivational Interviewing (MI)
  - Decreased days of stimulant use & amount of stimulant used/ day
- Cognitive Behavior Therapy (CBT)
  - Decreased quantity of stimulant use & frequency/ week
  - Decreased risky sexual behaviors
- Community Reinforcement Approach- see next slide
- Contingency Management- see next slide

STRONG EVIDENCE FOR THESE AS INDIVIDUAL INTERVENTIONS OR IN COMBINATION APPROACHES

- Community Reinforcement Approach (CRA)
  - Decreased addiction severity
  - Decreased drug use (weeks of use, frequency/week, $/week)
  - Increased cocaine abstinence
- Contingency Management (CM)
  - Decreased days of stimulant use
  - Decreased stimulant cravings
  - Decreased HIV risk behaviors
  - Studies:
    - 50% of vets completed 14 sessions in 12 weeks compared to 42% completing 2 sessions in 1 year
    - 2 VA studies: 92% of almost 28,00 tox screens negative & of >69,000 tox screens negative

Poll Question:

The routine urine toxicology test used at the clinic/ facility where I work is a…

a. preliminary test.
b. confirmatory test.
c. preliminary test that is reflexively confirmed.
d. I am unsure if the test is a preliminary or a confirmatory.

Stay Healthy

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HMA | HEALTH MANAGEMENT ASSOCIATES

This session on Stimulant Use was:

+ Very useful
+ Somewhat useful
+ Not very useful
+ Not useful at all

After entering your response, please provide CHAT input on anything you'd like to know more about stimulants and your client work

WRAP UP AND NEXT STEPS

NEXT STEPS

Keep up the great work!
Meet with your coach.
Report your data.
Dig deep on barriers to treatment.

Send in your MOU amendments and amended project budgets

NEW PROJECT FUNDING ANNOUNCEMENT COMING FOR 2021

Working Webinars: ASAM Changes, Methadone, Reducing MAT Diversion, Stimulants, Sublocade, Withdrawal Management/COWs

NEXT STEPS SOR 2 COUNTY TOUCHPOINTS

USE THE 9 TRAINING MODULES

https://addictionfreeca.org/California-MAT-Expansion-Project/County-Touchpoints-in-Access-to-MAT-for-Justice-Involved-Populations/Training-Site

NEW LEARNING COLLBORATIVE

Effective Child Welfare and Justice Systems for Families Impacted by Opioid and Stimulant Use

NEW LEARNING COLLABORATIVE

Addressing Special Populations with OUD/Stimulant Use in County Justice Systems (not in custody)

1. **Persons with co-occurring SMI and addiction**
2. **Early Interception and Deflection of People with Problem Substance Use**

NEW LEARNING COLLABORATIVES

- Modelled on successful aspects of this Jail MAT collaborative
- Program description and applications out in October
- Applications and selection in December
- Teams start work in January through August 2022
- Both collaboratives will accept up to 12 county-based teams
- Opportunity to integrate, align, and optimize the many disparate activities and funding streams to address gaps and sustainability and create effective, seamless, person-centered services for your most challenging populations

FINAL POLLING QUESTIONS

1. Overall, today's Learning Collaborative was:
+ Very useful
+ Somewhat useful
+ Not very useful
+ Not useful at all

After entering your responses, please provide CHAT input on any suggestions you have for a more productive Virtual Learning Collaborative and/or for specific content you would appreciate

2. The material presented today was
+ At the right level
+ Too basic
+ Too detailed

THANK YOU FOR BEING PART OF THIS IMPORTANT WORK;

YOU ARE SAVING LIVES!