

ALCOHOLISM DRUG ABUSE WEEKLY

News for policy and program decision-makers

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SAMHSA stops short of aligning 42 CFR Part 2 with HIPAA, but questions remain

The organizations that wanted 42 CFR Part 2 — the regulation protecting confidentiality of substance use disorder (SUD) treatment records and requiring patients to give written consent before their information is shared — lost their battle to align the regulation with the Health Insurance Portability and Accountability Act (HIPAA), the privacy law, last week. The final rule, issued on Jan. 3, on

the proposed supplemental rule issued a year ago left the consent provisions intact. But it did weaken restrictions on sharing information, once consent has been given, by broadening the scope of the people who can receive it to the vague category of “health care operations.”

The biggest problem is that patients won’t necessarily know what they are consenting to. Can their SUD treatment information end up in the hands of a divorce lawyer? Criminal justice? Child protective services? Their employer?

The final rule is a supplement to the first final rule, issued a year ago by the Substance Abuse and Mental

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Bottom Line...

The final rule on the supplemental proposed changes in 42 CFR Part 2 preserved consent, and did not, to the chagrin of the EHR community, turn the confidentiality rule into HIPAA.

Dr. Phil and Times reports come as NAATP focuses on revising ethics code

During the relatively slow news period between Christmas and New Year’s Day, explosive reports by *The New York Times* and *The Boston Globe*’s STAT investigative team had addiction treatment leaders on their heels as 2017 came to a close. The articles, detailing actions of newer profiteers in the treatment and recovery industry and questionable practices in the *Dr. Phil* show’s han-

dling of guests affected by addiction, left the executive director of the industry’s most prominent treatment center association asking basic questions about where the treatment community wants and needs to be.

Marvin Ventrell of the National Association of Addiction Treatment Providers (NAATP) told *ADAW* in regard to the STAT report’s references to claims that Phillip McGraw engages in televised exploitation of individuals at their most vulnerable time, “This begs us to ask, ‘Just how unique or not unique is our health care service compared to others?’” For in no other branch of health care, Ventrell explained, would a professional ever suggest that patients be put on tele-

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Bottom Line...

Prominent media reports of questionable ethical conduct in the treatment and recovery community could add momentum to some treatment leaders’ desire for a more activist stance against wrongdoing.

42 CFR PART 2 from page 1

Health Services Administration (SAMHSA), which promulgates 42 CFR Part 2. When the full final rule was issued then, SAMHSA also issued a supplemental proposed rule asking for public comment on changes to the consent provisions, as well as allowing information to be shared with contractors and subcontractors (see *ADAW*, Jan. 23, 2017).

Groups that wanted a HIPAA-like 42 CFR Part 2, with no consent requirement, still have hopes that changes can be made in the final rule on the supplemental changes.

Since 42 CFR Part 2's initial promulgation more than 30 years ago, the regulation has allowed information to be shared with insurance companies for the purposes of reimbursement. Now, however, under the electronic health record (EHR) system, everything goes into one big digital file. Starting about seven years ago, EHRs began fighting to get rid of 42 CFR Part 2 so they could more easily keep all patient information together.

Many treatment experts, including H. Westley Clark, M.D., J.D., who was at SAMHSA until he retired in the fall of 2014, believe weakening confidentiality and the patient's right to determine who gets his or her information will discourage people from seeking treatment. Unless

patients can pick and choose who gets their information, blanket consent forms giving consent for vague purposes such as "health care operations" could lead to dire consequences — losing your job, custody of your child or your freedom. "If proponents of eviscerating further 42 CFR Part 2 want the cooperation of patients, then they need to recognize the harm that society still imposes on those with SUDs," Clark told *ADAW* last week.

Payment/health care operations

"My preliminary reading is that the initial release requires consent but that the recipient can use that consent for any of the 17 or more payment and health care operations activities that it chooses," Clark told *ADAW* last week (see sidebar for the activities). "So, while consent is required, it is attenuated by the discretion of the recipient of the initial consent. The question is how specific does the signed consent have to be? Can the form simply say that consent is given for payment and health care operations activities?"

We asked SAMHSA these questions.

"A consent form probably would technically be in compliance with Part 2 if it sought the patient's written consent to disclose Part 2 informa-

tion for 'payment and health care operations activities' without further elaboration, as these activities are included for illustrative purposes," a SAMHSA spokesperson told *ADAW* last week. "However, it would probably be more helpful to specify on the form more precisely the types of payment and operations activities, such as billing, claims management or accreditation, for which consent is being sought disclose the patient's Part 2 information. However addressed on the consent form, it would also be necessary to ensure that disclosures are not made for treatment, diagnosis and referral for treatment, as such activities, including care coordination and case management, do not fall within the scope of payment and health care operations as defined in this final rule."

What happens if the patient just doesn't consent, period? "A patient is not compelled to give consent under Part 2 to share information for payment and health care operations activities or other purposes for which consent is being sought," according to SAMHSA. "However, in some cases, that may impact their ability to access services or the coordination of their treatment (e.g., the patient might be billed directly or denied services if their information is not shared for billing or claims management)."

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Discouraging patients from treatment

One of the first questions many patients want to know when they enter treatment is whether their information will be confidential. This is particularly true in the case of methadone treatment. Opioid treatment programs do not have to input information into the PDMP, so unlike buprenorphine, methadone can't be identified in that way. And while all SUDs are stigmatized, methadone is the most stigmatized type of treatment.

Mark Parrino, president of the American Association for the Treatment of Opioid Dependence (AA-TOD), is very concerned about “patients losing protections, which could get in the way of their seeking treatment or staying in treatment,” he told *ADAW* last week. During the entire debate on 42 CFR Part 2, Parrino has pointed out that during an opioid epidemic is not a good time to make patients fearful of going to treatment.

Yet some treatment organizations support getting rid of the consent provisions of 42 CFR Part 2 — and even getting rid of the entire regulation. The groups that called for aligning 42 CFR Part 2 with HIPAA expanded from the EHR field to treatment organizations last year: the American Society of Addiction Medicine and the Hazelden Betty Ford Foundation Center joined lawmakers in calling for the repeal of the regulation (see *ADAW*, Aug. 7, 2017). The Legal Action Center spearheaded a move by more than 100 treatment and recovery organizations to save 42 CFR Part 2 — and SUD patients — last fall (see *ADAW*, Oct. 2, 2017).

Possible legislative changes...

The Association for Behavioral Health and Wellness, a membership organization of insurance companies that cover SUD and mental illness, supported the final rule, in part because it will facilitate sharing of SUD information for health care

Payment and health care operations defined

Below are the payment and health care operations that could be included in the consent, according to the final rule on 42 CFR Part 2 issued by SAMHSA last week:

- Billing, claims management, collections activities, obtaining payment under a contract for reinsurance, claims filing and related health care data processing; Clinical professional support services (e.g., quality assessment and improvement initiatives; utilization review and management services);
- Patient safety activities;
- Activities pertaining to:
 - The training of student trainees and health care professionals;
 - The assessment of practitioner competencies;
 - The assessment of provider and/or health plan performance; and
 - Training of non-health care professionals;
- Accreditation, certification, licensing or credentialing activities;
- Underwriting, enrollment, premium rating and other activities related to the creation, renewal or replacement of a contract of health insurance or health benefits, and ceding, securing or placing a contract for reinsurance of risk relating to claims for health care;
- Third-party liability coverage;
- Activities related to addressing fraud, waste and abuse;
- Conducting or arranging for medical review, legal services and auditing functions;
- Business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating, including formulary development and administration, development or improvement of methods of payment or coverage policies;
- Business management and general administrative activities, including management activities relating to implementation of and compliance with the requirements of this or other statutes or regulations;
- Customer services, including the provision of data analyses for policy holders, plan sponsors or other customers;
- Resolution of internal grievances;
- The sale, transfer, merger, consolidation or dissolution of an organization;
- Determinations of eligibility or coverage (e.g., coordination of benefit services or the determination of cost-sharing amounts), and adjudication or subrogation of health benefit claims;
- Risk-adjusting amounts due based on enrollee health status and demographic characteristics; and
- Review of health care services with respect to medical necessity, coverage under a health plan, appropriateness of care or justification of charges.

operations and payment purposes with patient consent, and it permits a shortened notice to the patient that redisclosure is prohibited. However, Rebecca Murow Klein, director of government relations, said the group had hoped for complete

alignment with HIPAA. “While the rule does help to promote the appropriate sharing of SUD information for health care payment and operations purposes, more needs to be done to allow for the sharing of

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SUD records for treatment and care coordination,” she said Jan. 3. “We will continue to actively pursue legislative changes that will allow for disclosures for treatment and care coordination purposes, as the final regulation falls short of full alignment with HIPAA.”

Indeed, Bill Stauffer, executive director of the Pennsylvania Recovery Organizations Alliance (PRO-A), wrote a letter on Dec. 21, 2017, to the HELP committee, which is apparently interested in further weakening 42 CFR Part 2, as the EHR industry would like. He shared the letter with *ADAW*. Faces & Voices of Recovery, which PRO-A belongs to, also strongly supports keeping 42 CFR Part 2 as it is.

...or subregulatory guidance

The Legal Action Center is calling for SAMHSA to provide subregulatory guidance to clarify the following:

- That protected substance use disorder information shared pursuant to the final rule’s provisions cannot be used to limit or deny insurance coverage or limit access to health care, or otherwise limit patients’ rights or opportunities in any way.
- That protected substance use disorder information shared pursuant to the final rule’s provisions cannot be shared with criminal justice agencies, criminal or civil courts, child welfare agencies or patients’ employers.
- That contractors, subcontractors and legal representatives who receive protected substance use disorder information pursuant to the final rule must, if necessary, resist in judicial proceedings any efforts to obtain access to the information except as permitted by Part 2. “SAMHSA balanced the need to

better integrate addiction care into mainstream medical practices with the need to protect substance use patients against the many harms that could arise from unconsented disclosure,” the Legal Action Center wrote in an email to *ADAW* Jan. 3. “We are pleased that Part 2’s consent requirements remain intact — as this requirement is a core protection of the statute and a critically important patient right.” However, the Legal Action Center is still concerned that “loosening restrictions around the sharing of patient information without their knowledge will have significant consequences — both for patients who might be harmed by these disclosures and to those who might be deterred from seeking the treatment that they need to get and stay well.” •

For the final rule, go to <https://www.gpo.gov/fdsys/pkg/FR-2018-01-03/pdf/2017-28400.pdf>.

More best and worst of 2017, and hopes and fears for 2018

There wasn’t room in the Preview Issue (ADAW, Jan. 1) to run all of the important reflections from stakeholders in the addiction field on the highs and lows of 2017 and the challenges they face in 2018; the additional comments are included here. (Note: Inclusion here doesn’t signify that these comments are any less important than those in the Jan. 1 issue.)

Best of 2017: The Affordable Care Act’s (ACA’s) requirements on mental health and substance use disorders (SUDs) as essential health benefits at parity and Medicaid expansion were preserved; Cures money got out to states (but regretting more was not done to require expenditures on evidence-based strategies and recovery supports, and some states have sat on their money); there was greater availability of naloxone at the ground level; federal agencies gave clearer guidance on disclosure and nonquantitative treatment limita-

tions on the Mental Health Parity and Addiction Equity Act (MHPAEA); Rich Baum from the Office of National Drug Control Policy (ONDCP) became a vocal champion of recovery; the Surgeon General’s Report was used to help frame addiction policy and advocacy; a whole new team of players in a new administration got education on addiction; and quality care initiatives were advanced by organizations like the American Society of Addiction Medicine, Facing Addiction and Shatterproof.

Worst of 2017: Despite all efforts in D.C. and the states, the death rate from opioids continued to skyrocket, and some policymakers seem numb to it and out of touch with the devastation it causes individuals, families and communities, as evidenced by an \$81 billion disaster relief package for hurricanes and wildfires at the end of the year and no supplemental or emergency package for the opioid epidemic despite it being declared a

public health emergency and the death rate being significantly higher (of course, disaster relief is necessary as well). Also, the Drug Enforcement Administration’s (DEA’s) authority to go after unlawful distribution of opioids was weakened; there were efforts to slash the budget at the ONDCP, and no director was named; and there were tax breaks for the alcohol industry in the tax package despite alcohol killing more people than any other drug.

Hopes for 2018: greater requirements for evidence-based care and ethical delivery of care; clarification that same-day assessment is not same-day treatment and more transparency on waiting lists for treatment; additional funding for recovery supports; greater state and federal enforcement of the MHPAEA; more funding of research on what SUD interventions work best for which patients; lawsuits against the unlawful actors in the opioid pharma and dis-

tribution industry begin to change unlawful marketing and distribution practices; and unity is restored among all addiction advocates.

Fears for 2018: short-term funding rather than sustained decade-long funding to combat the opioid epidemic, ONDCP staffing and funding reduced; and the Marino bill doesn't get overturned and Congress and the administration allow those players that drove the opioid crisis to not be required to help fix it.

— *Carol McDaid, principal, Capitol Decisions*

Best of 2017:

- NAADAC celebrated 45 years of building the addiction profession, setting standards, achievement in leadership, advocacy and education.
- We had over 1,000 addiction professionals at our 2017 annual conference in Denver, Colorado, this past September. And over 100,000 professionals have taken our webinar courses over the past few years.
- We expanded the NAADAC Minority Fellowship Program to provide resources for behavior health professionals focusing on addiction.
- In February, NAADAC launched its redesign of over 500 website pages at www.naadac.org.
- With the Association for the Treatment of Tobacco Use and Dependence and the Council for Tobacco Treatment Training Programs, we launched a new national certificate program in October 2017.
- We worked with other addiction organizations to defeat several renditions of the national health care bill that would destroy the work that the Affordable Care Act started in the Obama administration. This showed a united front that is a positive model for other public policy initiatives.
- We expanded the National Certification Commission for

Addiction Professionals testing in four states across the nation and added distance proctoring to the testing resources on demand.

Worst of 2017:

- We worked so hard to defeat the overhaul of the Affordable Care Act this summer only to lose to the ACA's individual mandate in the tax bill. We are so disappointed and concerned about future access to SUD prevention, treatment and recovery support services, and for those who will lose their health insurance or be priced out of affordable insurance due to these changes.
- We are disappointed that the surgeon general's report on addiction in the United States has not been a key resource by the current administration and used as a tool to fight the growing epidemics of alcohol, marijuana and opioids.
- We are disappointed that the president's commission and opioids announcement did not reflect the concern of that commission by supporting more funding for opioid prevention treatment and prescription suppression. We know that it's going to take much more education and training in monitoring systems to prevent further opioid abuse and dependence.

— *Cynthia Moreno Tuohy, executive director, NAADAC, the Association for Addiction Professionals*

I recall at this time last year focusing on a number of external influences that impacted addiction treatment: the Cures Act, the Comprehensive Addiction and Recovery Act, the White House Parity Task Force Report and the Surgeon General's Report. The political climate in Washington changed dramatically this year, although we did see some policy direction, including the White House Commission on Combating

Drug Addiction and the Opioid Crisis, with its 53 recommendations for us. I think, however, that the recent hearing on the problems *within* the delivery of addiction services held by the House Committee on Energy and Commerce in December are particularly noteworthy.

My dominant thoughts this year, therefore, are less about external influences than they are about internal action. What matters to NAATP at this point is very much about what *we do internally* about the adequacy of the delivery of addiction treatment.

That adequacy of care is dominated by two conditions: (1) omnipresent problems with the conduct of addiction treatment providers and the poor public perception they create; and, paradoxically, (2) the greatest opportunity we have ever had to deliver good care because we have better clinical tools than ever before, and because we have solid public and policymaker recognition of addiction as a primary and chronic disease. With those realities in mind, NAATP launched its internally focused Quality Assurance Initiative (QAI) this year designed to clean up our own side of the street and model best practices. The QAI is scheduled to release its first products in January 2018, beginning with a revised NAATP Code of Ethics that will define and prohibit key problematic business practices, including service misrepresentation, patient brokering, leads buying and selling, deceptive web presence, deceptive directory call aggregation, insurance billing abuse, payment kickbacks, and licensing and accreditation misrepresentations. The January release will also include a consumer protection resource regarding discernment of quality care.

As 2018 progresses (the 40th anniversary year for NAATP), the QAI will produce more material intended to deter bad practice and promote good practice. Much of this will come out at the NAATP 2018 national conference, and these resources

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will ultimately be collected in a NAATP Addiction Treatment Operations Guidebook.

I would be remiss if I didn't add one more factor to this reflection. While we focus our attention internally (which progress will go a long way), it is also true that without payer parity, treatment will remain out of reach for many people. We saw in two recent reports, the Milliman Report and the Mark Report, that parity violations for addiction treatment payment are significant and common. We are going to have to redouble our efforts here to fill in this piece of the puzzle.

My final thought or wish for 2018 is that the field develops better internal discernment. We need to get better at recognizing both the cheaters and the substandard practitioners, and avoid factionalizing what should be a concerted effort. The bad guys and pretenders not only do not ID themselves as such, they often tell you that they are the ethics authorities and even hold events to say so. Worst of all, many of us at-

tend them. As for the substandard care piece, we should continue to make progress to further professionalize our field. "I'm sober now" is not a professional qualification.

—*Marvin Ventrell, executive director, National Association of Addiction Treatment Providers*

Hopes: My hope is some serious funding for addiction treatment, prevention and recovery. Not just a billion here or a token piece of legislation there, but a comprehensive funding package worthy of a public health emergency.

Fears: Several. First, it is an election year, and the legislative process always grinds to a halt, especially after August recess. Second, there is the funding. Congressional leadership, especially in the House, has made it clear that Medicare and Medicaid are vulnerable, and these programs are responsible for billions of dollars in substance abuse treatment. Third, there is a leadership vacuum on the subject of addiction at the White House, as we still have no permanent director at the ONDCP or

DEA. The interim directors are knowledgeable professionals doing a fine job, but their influence is undercut merely by their "interim" title. Fourth, all public health is under siege, as we are seeing cuts to the Public Health and Prevention fund, and very little sequester relief.

— *Andrew Kessler, principal, Slingshot Solutions*

My fear is that 42 CFR Part 2 will be eviscerated to the point that treatment programs will no longer be able to reassure those with substance use disorders seeking treatment that their privacy will be respected and that their confidentiality will be protected. I fear that once substance use disorder treatment programs explain the large number of entities that can have unconsented access to a patient's records under the Health Insurance Portability and Accountability Act and a revised 42 CFR Part 2, those in need of treatment will delay or refuse treatment.

— *H. Westley Clark, M.D., J.D., Dean's Executive Professor, Santa Clara University* •

Ethics from page 1

vision when they are in the throes of a crisis. "Does this really make sense?" Ventrell asked. "My answer is no, it does not."

The publication of these articles comes at a potentially impactful time, as NAATP leadership is about to deliver a revised code of ethics to members and has recently indicated that it will take its most active stance yet against questionable business practices within its ranks.

It is clear that at least some NAATP member facilities have benefited in the past from the types of practices that are now being much more closely scrutinized by regulators and in the media. And while the association is not ready to impose any disciplinary actions based specifically on the latest news reports, it is trying to communicate that centers need to be more careful about

examining the nature of their business relationships.

"The appearance of impropriety matters," Ventrell said. "If it's a close call, it's in one's best interest to steer clear."

Details of reports

The New York Times' "Addiction Inc." series, published Dec. 27, chronicles how relatively lax government regulation and an absence of consensus standards for clinical care have helped give rise to a profit-dominated mindset, amid the despair of addiction and overdose death. Most of the news in the *Times'* report was not new: the abuses have been detailed over the years in *ADAW* and in some other news outlets.

The beneficiaries have included fast-growing treatment chains such as American Addiction Centers, drug testing companies that have billed

insurance for millions, and "Florida model" outpatient and sober living organizations that overran the once-quiet community of Prescott, Arizona. Ventrell characterized the *Times'* series of articles as solid reporting, but not necessarily anything that would surprise a seasoned addiction professional who has been aware of questionable practices for some time. He does think it's a good thing that the industry is being scrutinized in the mainstream press.

The Boston Globe's two-part report on *Dr. Phil*, which opens with former guest Todd Herzog's claim that he was exposed to vodka in his dressing room and was given a dose of Xanax before the taping of a show in which he had to be carried onto the set, brings to the fore some clearer-cut issues, Ventrell believes.

"You don't take someone to television when they're dying," Ventrell

said. “You take them to the hospital.”

Certainly, questionable portrayals of addiction on television are not limited to the daytime talk format. The A&E series *Intervention* has long been the target of criticism for presentations in which the educational value of portraying an intervention is significantly overshadowed by the sensationalistic images of individuals’ behavior in their active addiction.

“The reason Dr. Phil has a show is twofold: income and entertainment,” Ventrell said. Using an individual’s image during any stage of their course of treatment, including during an intervention, would be conduct specifically prohibited in NAATP’s ethics code, he said.

But that doesn’t mean a NAATP member cannot have any tie to McGraw’s work, Ventrell explained. If a patient who has appeared on the show is eventually referred to a treatment program, and there is no remuneration involved in the referral, the facility can treat the patient, he said.

Also, on the surface there would not appear to be any clear ethical violations with NAATP members’ use of Dr. Phil’s Path to Recovery, a virtual reality program that allows a treatment center’s patients to have a virtual conversation with McGraw and to complete follow-up workbook activities. The website www.drphil.rehab lists centers that have purchased the Dr. Phil materials, including NAATP members such as Benchmark

Transitions in California and Transformations Treatment Center in Florida.

“If it lists a provider because it thinks it’s a good center, that’s fine,” Ventrell said. But centers must carefully evaluate whether any such arrangement serves to exploit patients, he said.

A representative for McGraw said in the STAT article that the show uses several treatment centers as a resource. One that has become so closely linked to the show that some have called it “the company that Dr. Phil built,” according to the article, is Origins Behavioral HealthCare.

‘You don’t take someone to television when they’re dying. You take them to the hospital.’

Marvin Ventrell

But according to the STAT report, by the time guests on *Dr. Phil* might make it to Origins or another treatment center, they probably have endured a period of struggle during which they were offered little or no medical supervision.

The report also might leave readers to wonder why a treatment organization would choose to be closely associated with a show whose representative is quoted as saying about the medical supervision issue, “Addicts are notorious for lying, deflecting and trivializing. But, if they are at risk when they arrive, then they were at risk before they arrived. The only change is they are one step closer to getting help, typically help they could not have even come close to affording.”

Reaction from members

Ventrell said that the newspaper coverage of recent weeks resulted in some positive engagement among NAATP members on social media. Members have appeared to grow increasingly supportive of barring from the association any entities found to be breaching ethical standards.

While Ventrell acknowledges that there is less clarity and consensus in the addiction field on best practices than there is in other branches of health care, “That should not mean that we should not know what they are. Successful centers have clear practices that are supported by evidence.” While NAATP will not be in the business of issuing clinical practice guidelines, steps that could be taken elsewhere, such as more rigorous accreditation standards, could help to reinforce quality across the field, Ventrell said. •

Addiction Policy Forum gets PhRMA funding for new programs

You’re going to be hearing a lot more from the Addiction Policy Forum, which last month announced a “significant” financial commitment from the Pharmaceutical Research and Manufacturers of America (PhRMA). This will enable the Washington, D.C.–based Addiction Policy Forum to do more with the programs it is launching.

“We hear all too often that families and community leaders don’t know where to turn for services that

can help loved ones who are in crisis — or prevent the crisis from happening in the first place,” said Jessica Hulsey Nickel, president and chief executive officer of the Addiction Policy Forum, in announcing the initiatives. “By working closely to families and experts in the field, we’re creating localized resources and evidence-based tools that will make a real difference in addressing substance use disorders. We are grateful to all of our partner organizations

for their ongoing commitment to this important issue.”

Below are the new programs from the Addiction Policy Forum:

- *The Addiction Resource Center*: This online portal will be a comprehensive resource to assist patients and their loved ones with substance use disorders. The new platform, with support from the Chris and Vicky Cornell Foundation,

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will guide patients through a validated self-assessment tool; help them develop a proposed treatment plan; and provide a guide to reliable, evidence-based information about resources in their local area. Initially, the Forum will host a database of local resources in Ohio, Maryland and Minnesota. Over the coming months, new states will be added so that more and more Americans suffering with substance use disorder will have a place to turn for help.

- **Prevention Initiative:** Community Anti-Drug Coalitions of America (CADCA) and the Addiction Policy Forum will create and distribute educational kits and essential resources on prevention, as well as prescription drug disposal and misuse. With more than 5,000 community coalitions throughout the country and a track record of helping create drug-free communities globally, CADCA is uniquely positioned to disseminate evidence-based prevention resources to scope and scale nationally.
- **Emergency Medicine Initiative:** The Addiction Policy Forum will work with hospitals to develop tools to support effective post-overdose interventions. This project will ensure that health systems have the necessary protocols, assessment tools and linkages between care and follow-up to turn an overdose into an opportunity for intervention and connection with treatment and recovery. Pilots underway with Mercy Health Systems and Berger Hospital in Ohio will produce open-source tools and protocols necessary to support emergency departments across the country in implementing interventions to help patients

Coming up...

The 28th National Leadership Forum of **Community Anti-Drug Coalitions of America** and the **Substance Abuse and Mental Health Services Administration** 14th Prevention Day will be held **Feb. 5–8** in **National Harbor, Maryland**. For more information, go to www.cadca.org/events/forum2018.

The **American Society of Addiction Medicine** will hold its annual conference **April 12–15** in **San Diego**. Go to <https://www.asam.org/education/live-online-cme/the-asam-annual-conference> for more information.

who overdose.

- **Research to Find a Cure:** Together with their partners such as Faces & Voices of Recovery, the Addiction Policy Forum will launch the Addiction Science Initiative: Advancing Treatment and Recovery. This initiative will raise funds to support research by the National Institute on Drug Abuse on treatment and recovery from substance use disorders, including opioid use disorder.
- **Recovery Initiative:** The Forum will work with national partner Faces & Voices of Recovery to support the growth of statewide recovery community organizations across all 50 states and to enhance recovery support throughout the nation.

“Taken together, the programs and partnerships announced today by the Addiction Policy Forum represent the most comprehensive, direct approach to the opioid crisis in America to date,” said Gen. Barry McCaffrey, advisory board chair for the Addiction Policy Forum and for-

mer director of the Office of National Drug Control Policy. “The 21 million Americans who are living with the disease of addiction need our help urgently — there is simply no more time to waste. By welcoming all stakeholders to the table and focusing on action over rhetoric, we can have a lasting impact on this crisis.”

We asked Nickel if there were any conflicts of interest in her organization accepting money from PhRMA. “Absolutely not,” she said. “Patients and families come first, period. This funding provides support for our vision and will help scale these programs nationwide so communities have resources they desperately need. It’s important to keep in mind that every disease that has made advancements in treatment has done so with industry and scientists at the table. Addiction is no different.” •

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In case you haven't heard...

The main fallout from the move by Attorney General Jeff Sessions to rescind the policy allowing legalized marijuana to go forward in states without federal intervention is going to be on the cannabis industry, observers predict. U.S. attorneys will be able to decide whether to aggressively enforce federal law, under which marijuana is illegal. The move is likely to drive away investors. Whether it will also result in police going after people who are using marijuana recreationally in states where it is legal is unclear, but large growing operations may be targeted. States that enjoyed tax revenues from the industry are likely to fight it as well. The Associated Press broke the news Jan. 4. Sessions has blamed marijuana for violence.