ALCOHOLISM & DRUG ABUSE WEEKLY
News for policy and program decision-makers

Volume 27 Number 3
January 19, 2015
Print ISSN 1042-1394
Online ISSN 1556-7591

In This Issue...

CADCA Newsmaker Award
Alison Knopf, Editor

SIPAwards Third Place Winner
Spot News

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Patient SUD data quietly removed from Medicare, Medicaid, SCHIP research files

The Center for Medicare and Medicaid Services (CMS), at the request of the Substance Abuse and Mental Health Services Administration (SAMHSA), has quietly been scrubbing all Medicaid, Medicare and State Children's Health Insurance Program (SCHIP) files from any information that identified patients who had been treated for substance use disorders (SUDs). The scrubbing began in 2013, Aaron Albright, director of the CMS media relations group, told *ADAW* last week. This was done to protect patient confidentiality — the data files now had patient-identifying information such as names, addresses and Social Security numbers, and release of SUD treatment information without patient consent would violate 42 CFR Part 2, the federal regulation that protects the privacy of these records. According to CMS, researchers had been requesting the files and want-

See **42 CFR Part 2** page 2

Bottom Line...

There's a new wrinkle in the 42 CFR Part 2 controversy: patient SUD data has quietly been scrubbed from CMS research files, something SAMHSA requested in 2013.

The Business of Treatment

CEO: Paid referral offers abound, fueled by the field's own desires

BST

David Lisonbee, president and CEO of Twin Town Treatment Centers in Los Alamitos, Calif., says calls and email messages from entities that want to sell treatment leads to his facility are now coming in almost weekly. He most recently heard from a Huntington Beach, Calif., company called Lead Research Group, explaining to him in a phone message that one of its preferred products offers preverified individuals with private insurance who are willing to travel significant distances and are committed to pursuing their recovery.

Lisonbee replied that besides the fact that this company didn't do a great deal of homework on Twin Town (which is an in-network provider that specializes in outpatient and not residential services), he believes its method runs afoul of patient brokering laws. Yet he told *ADAW* that these entities, as well as many individuals and groups from within the addiction treatment community, justify their approach by saying they are single-mindedly fo-

See **Leads** page 6

Bottom Line...

An addiction treatment executive who has spoken out on organizational ethics believes that offers from outside entities to sell referrals to treatment centers are proliferating in part because of mixed messages about this practice from within the treatment community.

42 CFR Part 2 from page 1

ed patient-identifying information so that they could look at the same individuals across different databases.

"CMS is not permitted to disclose or allow the use of patient-identifying information on alcohol or drug abuse patients for research purposes without patient consent" under 42 CFR Part 2, said Albright in an email to *ADAW*. "Historically, CMS research files have not contained any patient-identifying information (e.g., name, address, Social Security number), and as a result, CMS did not redact information on drug or alcohol abuse treatments. More recently, researchers have started requesting patient-identifiable information to support linkages with other data sources. As the number of external data resources that could be used to re-identify a patient has grown, this has created concerns that CMS research data files could be used to identify a patient receiving treatment for alcohol or drug abuse. As a result, CMS received guidance from SAMHSA in 2013 that the agency should not release research data files that contain information on alcohol or drug abuse treatment without patient consent."

We asked Albright if the SAMHSA request was documented — he said it was made "verbally."

SAMHSA, through press officer Brad Stone, refused to be interviewed or to answer any questions about 42 CFR Part 2. As the removal was done in accord with regulation and in the interests of patients, the agency's refusal to discuss it is a mystery.

Bagley

The scrubbing was first brought to light in a blog, The Incidental Economist, written by Austin Frakt and Nicholas Bagley (a statement from CMS virtually identical to the one we received was printed in the blog last month). Eric Goplerud, Ph.D., who led the first charge against 42 CFR Part 2 five years ago (see *ADAW*, January 25, 2010), picked up on the message, and over the past few weeks any discussion of 42 CFR Part 2 has been dominated by the CMS records question. Frakt is a researcher and brought the matter to Bagley's attention.

Bagley, who is a professor at the University of Michigan Law School, said that researchers have relied on patient-identifying information in the past. "If you look at the [42 CFR Part 2] statute, it's quite clear that there's a research exception," said Bagley. Without the patient-identifying information, "a lot of research would be impossible to undertake," he said. "For example, if you're researching treatment options for AIDS patients, and substance use claims are scrubbed, you'll get a biased picture."

Bagley pointed out that CMS never informed researchers that the data would be scrubbed, and that the policy change wasn't even mentioned at the 42 CFR Part 2 "listening session" held last spring (see *ADAW*, June 16).

Bagley also pointed out that "bona fide researchers" are subject to Institutional Review Board rules to protect subjects.

'Big data'

Goplerud, who is senior vice president at NORC at the University of Chicago, first heard about the scrubbing from participants in a Research Data Assistance Center (ResDAC) meeting in Washington last fall, he told *ADAW*. ResDAC provides free assistance to academic and nonprofit researchers interested in using Medicare, Medicaid, SCHIP and Medicare Current Beneficiary Survey (MCBS) data for research; primary funding comes from a CMS research contract. CMS itself charges for research data files.

"The result will be shutting down research into Medicaid and

ALCOHOLISM & DRUG ABUSE WEEKLY
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Alcoholism & Drug Abuse Weekly (Print ISSN 1042-1394; Online ISSN 1556-7591) is an independent newsletter meeting the information needs of all alcoholism and drug abuse professionals, providing timely reports on national trends and developments in funding, policy, prevention, treatment and research in alcohol and drug abuse, and also covering issues on certification, reimbursement and other news of importance to public, private nonprofit and for-profit treatment agencies. Published every week except for the first Mondays in July and September and the last Mondays in November and December. The yearly subscription rates for **Alcoholism & Drug Abuse Weekly** are: Print only: $695 (individual, U.S./Can./Mex.), $839 (individual, rest of world), $6135 (institutional, U.S.), $6279 (institutional, Can./Mex.), $6327 (institutional, rest of world); Print & electronic: $765 (individual, U.S./Can./Mex.), $909 (individual, rest of the world), $7362 (institutional, U.S.), $7506 (institutional, Can./Mex.), $7554 (institutional, rest of the world); Electronic only: $555 (individual, worldwide), $6135 (institutional, worldwide). **Alcoholism & Drug Abuse Weekly** accepts no advertising and is supported solely by its readers. For address changes or new subscriptions, contact Subscription Distribution US, c/o John Wiley & Sons, Inc., 111 River Street, Hoboken, NJ 07030-5774; (201) 748-6645; e-mail: subinfo@wiley.com.

Alcoholism & Drug Abuse Weekly is indexed in: Academic Search (EBSCO), Academic Search Elite (EBSCO), Academic Search Premier (EBSCO), Current Abstracts (EBSCO), EBSCO Masterfile Elite (EBSCO), EBSCO MasterFILE Select (EBSCO), Expanded Academic ASAP (Thomson Gale), Health Source Nursing/Academic, InfoTrac, Proquest 5000 (ProQuest), Proquest Discovery (ProQuest), ProQuest Health & Medical, Complete (ProQuest), Proquest Platinum (ProQuest), Proquest Research Library (ProQuest), Student Resource Center College, Student Resource Center Gold and Student Resource Center Silver.

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WILEY

Medicare data, shutting off predictive analytics, 'big data' disease and treatment modeling, economic and pharmaco-economic modeling of disease and treatments," said Goplerud. CMS is redacting all substance use diagnoses and procedure codes from all providers, because it cannot determine if the information might be derived from providers covered by the regulation, said Goplerud.

"This is really pernicious," he said. "If this decision is a harbinger, we should be mobilizing the medical and research communities," said Goplerud, adding that he briefed the Coalition for Whole Health on this issue earlier this month.

For patients

"You should know that SAMHSA and CMS have been working closely with their legal teams to approach the issue of confidentiality carefully," said H. Westley Clark, M.D., former director of SAMHSA's Center for Substance Abuse Treatment, where he spearheaded discussions about 42 CFR Part 2 and, as a lawyer, was also the resident expert. Now, however, he can't comment on — because he doesn't know — how 42 CFR Part 2 might be revised.

But he can comment on the controversy. And while he appreciates concerns about research, he said that policies that permit the disclosure of names are "not only an issue for patients who were assured confidentiality but for programs that promised confidentiality," he told *ADAW* in an email. "Researchers play an important third-party part in this discussion. However, while SAMHSA has stated publicly that it wants to promote research access to data, it must do so carefully, given the old adage of throwing the baby out with the bath water."

Clark also pointed out that "who has access to what information under 42 CFR Part 2 derives from the federal law promulgated by Congress." The law gives people access to research information with the program director's involvement — the program director being the treatment provider. "What many are asking for is to have access to research information without the program director's involvement," said Clark.

"Computerized records have created a new opportunity to access data and to process that data," said Clark. "Such records have also created a new opportunity for breaches and abuse of that very data. Both SAMHSA and CMS are committed to researchers having appropriate access to patient information, but the process that must be followed must conform to the law. What our friends Bagley and Goplerud are saying is that if the accretion of existing policies oozed outside of the existing law, that's okay. I don't think that is appropriate."

'Hopefully those knowledgeable about the ways of 'Big Data' will help with the promulgation of the new 42 CFR Part 2, so that both research and privacy can coexist.'

H. Westley Clark, M.D.

Researchers must recognize that confidentiality was not set up to protect them, but to protect patients, said Clark. "People present to substance use disorder treatment programs with conditions that can deprive them of income, employment and personal freedom," he said.

Once the notice of proposed rulemaking (NPRM) on 42 CFR Part 2 is out, researchers and everyone else will be able to weigh in, said Clark. "Hopefully those knowledgeable about the ways of 'Big Data' will help with the promulgation of the new 42 CFR Part 2, so that both research and privacy can coexist," he said.

Waiting for the NPRM

Indeed, that is exactly what is happening, with Goplerud leading the fray. Goplerud thinks that 42 CFR Part 2 inhibits information sharing anyway, and that it is not in the best interests of patients under "integrated" care. "The NPRM will come out in in 2015, and we should be prepared to comment on the rule when it comes out," he told *ADAW*.

Meanwhile, the Legal Action Center, one of the strongest supporters of 42 CFR Part 2, did not return multiple emails and phone calls for this article. Faces & Voices of Recovery supports it; others have heard from Goplerud and said that they have not decided where they stand yet.

Chuck Ingoglia of the National Council for Behavioral Health, which did not comment on the listening session (neither did NASADAD), had this comment: "42 CFR is a complex and challenging law. The question of how or whether to change the law has stymied policymakers, and there is not a national consensus in the addiction field on what needs to be done. The National Council is committed to protecting the rights of people living with substance use disorders, and we recognize the role of 42 CFR in that regard. We have also heard from various stakeholders that the 42 CFR requirements can be perceived as presenting a barrier to integrated care. Given that 42 CFR is currently the law of the land, we are working with members to help them understand the law's requirements and how they can effectively implement integrated care models that work within the context of 42 CFR." •

New Faces & Voices director vows to rebuild financial stability

The top priority of Faces & Voices of Recovery under the new executive director is to "focus on public policy and recovery support services," said Patty McCarthy Metcalf in an interview with *ADAW* last week. To do this, Metcalf, who was named executive director last month (see *ADAW*, Dec. 22, 2014), said that the organization will also have to work on funding sources so it can "advocate with the government and states and the recovery community to assist them in building capacity."

Until this month, McCarthy Metcalf was deputy director of the Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TACS) at the Substance Abuse and Mental Health Services Administration (SAMHSA). Before that, she was director of Friends of Recovery-Vermont.

"My goal is to regain our financial stability that we enjoyed for a long time, as we were growing," said McCarthy Metcalf of Faces & Voices. "Over the past year, we have had to strategically look at how to raise unrestricted and restricted funding."

There are several Faces & Voices initiatives that are ongoing, she said: the most active is the Association of Recovery Community Organizations (ARCO), which last year grew to more than 100 members. There are three contracts that bring in monthly revenue, said McCarthy Metcalf, all acquired in October. One, funded directly by SAMHSA, is for housing and homelessness in the recovery community. Another, on developing peer intervention, is from the Center for Social Innovations through the Hilton Foundation, which also has the BRSS TACS contract. Faces & Voices has for years had a subcontract with SAMHSA's BRSS TACS to deliver technical assistance, and this is the third revenue source; this contract will be on health care reform education in the recovery community. "We want to look at whether or not the people who get enrolled in health care are able to receive treatment and recovery services," she said.

Last year was a troubling one for Faces & Voices, with longtime executive director Pat Taylor's sudden and still mysterious retirement (see *ADAW*, March 3, 2014) followed by 10 months without an executive director. There was also a much vaunted planned merger with Young People in Recovery (YPR; see *ADAW*, Oct. 6, 2014), which dissolved for reasons that are still unclear in early December (see *ADAW*, Dec. 22, 2014) at about the same time that McCarthy Metcalf's appointment by the board was announced.

> **'We can't survive on contracts alone.'**
>
> Patty McCarthy Metcalf

"There wasn't one big thing that happened," to cause the problems last year, said McCarthy Metcalf. "We had experienced a lot of growth without a clear financial plan to sustain it," she said. Articulating a common problem for associations that depend on contracts, she explained that staff had been hired under funding that had no clear sustainability. "We can't survive on contracts alone," she said. "My goal as an executive director is to rebuild our unrestricted funding from foundations."

For example, there is a Peter G. Dodge grant for an ARCO executive leadership academy, she said. "It's very small" but it's a start; it can also be used for public policy such as supporting the Comprehensive Addiction and Recovery Act. "There's an interest in having Faces & Voices at the forefront of discussions about health care reform," McCarthy Metcalf said.

Taylor, merger

We asked McCarthy Metcalf if Faces & Voices could be more specific about the reasons for Taylor's resignation, and the breakdown of the merger. "Those are two issues we presented," she said. "Pat Taylor resigned; there's no back story to expand on — she moved on to other work." Last spring, a strategic planning retreat resulted in a decision to collaborate, and that's why the merger was explored, she said. "When you approach a merger, it takes a period of time to do the dating process before you can get married, and in that time, we discovered or came to realize that the boards explored different options in terms of what the organizational structure would look like," she said. "A merger consultant working with a small group from each board determined that we had organizational problems." The main problem on the Faces & Voices side was that there was no executive director, she said. "The issue of who would take executive leadership of the merged organization was a point of contention," she said. "The conversation about the merger with the merger consultant is privileged information," she said, adding, "No company is going to discuss publicly the details of a merger." Faces & Voices has "strong intentions to continue to work together with YPR and revisit the option," she said. However, there are "no plans for opening up merger talks again."

"I'd like to heal the wound with Pat Taylor," said John de Miranda, former board member with Faces & Voices. "I took over an agency many years ago in San Diego that had been down the same road, and there were hurt feelings five years later. We had an event to honor her, and this helped bring people back in." If

 Alcoholism & Drug Abuse Weekly DOI: 10.1002/adaw

it's possible, said de Miranda, he hopes something similar can be done for Taylor. Meanwhile, he said it's a "good sign" that McCarthy Metcalf has taken over as executive director.

Faces & Voices does plan to do something to honor Taylor, said McCarthy Metcalf. "We've been considering how to do that in the most appropriate way," she said. "Part of that has to do with what Pat's availability and interest is at this point, but I do want to acknowledge and appreciate the tremendous amount of work that Pat has done."

Although her home office is in Vermont, McCarthy Metcalf plans to spend at least a week every month in Washington, D.C., where the Faces & Voices office is managed by Jerry Gillen, director of operations. In long-term recovery herself, McCarthy Metcalf will be in Washington this week for the recovery events hosted by the Office of National Drug Control Policy, as will de Miranda. •

N.H. adds new substance misuse position in governor's office

Gov. Maggie Hassan of New Hampshire announced January 9 that her office has a new position, Senior Director for Substance Misuse and Behavioral Health. The position, funded by a grant from the New Hampshire Charitable Foundation, will be held by John G. "Jack" Wozmak of Walpole.

Among Wozmak's tasks will be working with the Governor's Commission on Alcohol and Drug Abuse Prevention, Treatment, and Recovery and the other state agencies to coordinate the state's substance use and related behavioral health policies, William Hinkle, Hassan's spokesman, told *ADAW*. The Governor's Commission is headed by Joe Harding, who is the director of the state's Bureau of Drug and Alcohol Services and the state's SSA in charge of the Substance Abuse Prevention and Treatment block grant.

"Substance misuse, which frequently co-occurs with mental illness, is one of the most pressing public health and safety challenges facing New Hampshire, straining our families, hurting the productivity of our workers and undermining the safety of our communities," Hassan said in announcing the appointment. "The public-private partnership with the New Hampshire Charitable Foundation to create this position is another important step in our ongoing efforts to address our substance misuse challenge, including our expanded behavioral health efforts, the substance use disorder benefit that is part of our bipartisan health care expansion plan, the launch of our prescription drug monitoring program, the increase in the safe and effective use of Narcan for emergency responders, and our regional strategy with my fellow New England governors."

'We want individuals struggling with alcohol and drug problems and their families to know that, although addiction is a challenging health issue, treatment is available and recovery is possible.'

Joe Harding

Since 1998, Wozmak has served as the county administrator for Cheshire County, where he has worked to develop drug and mental health courts. Prior to that, he was administrator at Beech Hill Hospital, a substance use disorder treatment facility.

"Combating substance misuse and related behavioral health challenges is not only critical to the health and safety of our communities, it is critical for workforce development and economic growth, and I thank Governor Hassan for choosing me for this important position," Wozmak said. "I look forward to working with state agencies and all other stakeholders to coordinate our substance misuse policies."

Wozmak's position was approved by the Joint Legislative Fiscal Committee on Nov. 24, 2014, and the grant was approved by the Executive Council on Dec. 3, 2014.

Treatment locator

In related news from New Hampshire, Harding announced the launching of a treatment locator website for substance use disorders. The site, www.nhtreatment.org, was developed to help New Hampshire citizens in need of substance use disorder treatment find available service providers.

"This website is a valuable tool and provides a much needed service. It will help individuals who are in need of treatment find help and aid healthcare providers in locating available services for individuals in their care," Harding said in announcing the website January 5. "It also will enable providers who provide treatment to easily register to list their services on this website. We want individuals struggling with alcohol and drug problems and their families to know that, although addiction is a challenging health issue, treatment is available and recovery

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is possible."

According to New Hampshire's Medical Examiner's Office, the number of heroin-related deaths rose substantially between 2010 and 2013 — from 13 to 70. Additionally, emergency room visits related to heroin use more than doubled between 2012 and 2013. Consequently, the number of individuals seeking treatment has also risen. In the last 10 years, the number of people admitted to state-funded treatment programs rose by 90 percent for heroin use and by 500 percent for prescription opiate abuse.

"The misuse of drugs in New Hampshire has been an ongoing challenge," said Harding. "Not only with prescription opiate and heroin use, but also with youth and young adult substance use. Although the rates of misuse among youth and young adults have gone down, New Hampshire still ranks in the top ten of all states for alcohol use, binge drinking, marijuana use, prescription pain reliever abuse, and alcohol or drug dependence. The good news is that there are concerted and effective efforts under way to prevent alcohol and drug problems and to dramatically expand the capacity for substance use disorders treatment services in New Hampshire." •

Corrections TC to close in Indiana due to budget cuts

Kelley House in Fort Wayne, Indiana, a minimum-security treatment facility for people with substance use disorders and mental illness, will close its doors at the end of this month due to budget cuts, according to the agency that operates it, Allen County Community Corrections. A "modified therapeutic community," Kelley House is for individuals with co-occurring mental health and substance use disorders.

The closure will mean 14 current residents, all men, will be displaced. In addition, eight full-time employee positions will be eliminated. Four additional employees will be reassigned to other positions within Community Corrections.

"The Kelley House was a one-of-a-kind program that imparted life-changing influences for those it served in its four years of operation," said Kim Churchward, executive director of Allen County Community Corrections, in a statement. "We will lose eight highly professional employees, whose work helped to build the culture of positivity and integrity for that program."

Kelley House was named in honor of Jim Kelley, a founder of the original Washington House, which was a detoxification facility. Since opening more than six years ago, it has served 137 offenders. Currently, there are 33 participants — the 14 who are in residence and the 19 living on their own but coming for aftercare services. Offenders are referred by the Allen Circuit and Superior Courts.

The annual operating budget of Kelley House was $1.3 million, most of which came from the Indiana Department of Correction in the form of grants. There were also some proceeds from Restoration Works Woodworking, an enterprise that is run by offenders in the program that creates wood products for sale. Overall, the annual budget for Allen County Community Corrections is $5.5 million.

According to Allen County Community Corrections, Kelley House focused on "right living" — improved decision-making, problem-solving skills and increased ability to socialize in the community.

Allen Superior Court Judge John Surbeck, chair of the Allen County Community Corrections Advisory Board, said that Community Corrections worked hard to find resources to sustain the Kelley House, including cutting equipment and service costs and eliminating positions through attrition.

"Our duty to be fiscally responsible ultimately forced us to make this difficult decision," Surbeck said. "We are committed to a smooth transition for the offenders and for our employees who have been displaced as a result of the Kelley House closure."

Allen County Community Corrections officials assured reporters that the displaced residents would "never be homeless." •

LEADS from page 1
cused on saving addicts' lives.

"The thought is, 'If we're getting people the help they need, we will use any means possible,'" Lisonbee said of what he sees as an increasingly prevalent mind-set. But these "leads" are desperate individuals and family members looking for help — they don't know that they are being "sold," not just referred.

Part of what disturbs Lisonbee about the practice of paying for referrals is that it is not just being fueled by outside interests. He says a number of field professionals ranging from interventionists to sober coaches to treatment centers that operate their own patient call centers are also engaging in this behavior, which has been one of the targeted trends among groups such as the National Association of Addiction Treatment Providers (NAATP) that have been making organizational ethics a priority topic of discussion in recent months.

"Unfortunately we have a different standard in the addiction world," Lisonbee said. "I can't think of anywhere else in medicine where this would be considered accepted practice."

Processing the call

Lisonbee, who last year discussed with *ADAW* a pitch he received to broaden his organization's revenue stream through a blended ownership model with drug toxicology labs (see *ADAW*, March 17, 2014), says he generally decides to respond directly to such inquiries with some words of caution.

"We tell them that we post our ethical standards on our website, which include that we refuse to pay for referrals," he said. "This also gives them the message that what they're doing isn't generally accepted."

Yet he adds that he doesn't know if other treatment centers offer similar reactions when they are contacted. "There are some who don't think this is unethical, as long as it's not using government dollars," he said.

When Lisonbee returned the cold call from Lead Research Group (www.leadresearchgroup.com), he learned from the staff member who oversees addiction-related calls that the company also generates leads for entities ranging from medical equipment suppliers to life insurance underwriters to mortgage loan companies. The company website describes Lead Research Group as a "direct marketing agency with a primary focus on lead generation and client acquisition."

Lisonbee said he learned that the marketing agency will offer either screened or unscreened calls, depending on its arrangement with a client. It will charge a treatment provider a per-call fee for a prospective patient for whom it has inquired about insurance status. Or it will charge a lower per-call fee to the provider if it is simply forwarding a caller unscreened to the facility, he said. The provider remains responsible for authorizing treatment and arranging transportation to the facility.

ADAW attempted to reach a representative of Lead Research Group and spoke briefly with a staff member who fielded our request for an interview, but no one contacted us back by press time last week.

Lisonbee said he receives a variety of reactions when he engages a company on the ethical implications of paid referral strategies. "Most are somewhat embarrassed when I bring up ethics. They'll often hang up," he said. "Others are somewhat apologetic. Others will say this is a gray area."

But he believes attitudes within the field that have fueled tactics such as deceptive Internet marketing of facilities to consumers end up creating much of the concern. "There's so much money out there," he said. "It blinds providers."

Role of insurance

Lisonbee believes that insurance companies ultimately may hold the key to slowing these arrangements, which depend largely on preferred provider organization (PPO) benefit structures that allow for out-of-network payments (in-network providers would be in direct violation of the terms of their insurance contracts by paying for referrals).

He thinks what will evolve in the insurance industry is a phasing-out of the PPO arrangement in favor of an "exclusive provider organization" structure that acts as a hybrid between a PPO and a health maintenance organization (HMO), allowing plan members to see a specialist without a primary care referral but requiring that the specialist be listed as a panel provider. "We'll see PPOs priced out of the market," Lisonbee said. •

Editor's note: Lisonbee is not alone in his concerns. Ken Gregoire, chairman of the board of the National Association of Addiction Treatment Providers; Bob Ferguson, head of the NAATP's ethics committee; Beth Ann Middlebrook of The Watershed; Florida attorney Jeffrey Lynne; and Jerry Rhodes, CEO of CRC Health Group, have spoken to *ADAW* frequently on concerns about ethics, Internet marketing and patient brokering (see *ADAW*, January 12; November 17, 2014; November 3, 2014; September 29, 2014; November 5, 2012).

'There are some who don't think this is unethical, as long as it's not using government dollars.'

David Lisonbee

Briefly Noted

CDC: 6 alcohol poisoning deaths a day in the U.S.

There are six alcohol poisoning deaths a day in the United States, according to the Centers for Disease Control and Prevention (CDC). In its January 6 issue of the *Morbidity and Mortality Weekly Report*, the CDC notes that binge drinking can cause alcohol poisoning. During the 2010–2012 period, there was an average of 2,221 deaths from alcohol poisoning a year among people ages 15 years and over in the United States. Of these, three-quarters occurred in adults ages 35 to 64, and three-quarters involved men. The highest age-adjusted death rate was among American Indians and Alaskan Natives. The state with the highest rate of alcohol poisoning deaths was Alaska. Binge drinking is defined as consuming four or more drinks for women or five or more drinks for

Continues on next page

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Continued from previous page
men, on one occasion. Signs and symptoms are progressive, beginning with minimal impairment and ranging through decreased judgment, slurred speech, reduced coordination, vomiting, stupor, and ultimately for many, coma and death. Alcohol poisoning depends on various factors, including the tolerance of the drinker to alcohol. Adults who binge drink consume about eight drinks per binge, according to the CDC. For the full report, go to www.cdc.gov/mmwr/preview/mmwrhtml/mm63e0106a1.htm?s_cid=mm63e0106a1_w.

State News

Rosecrance partners with recovering family to provide prevention in Wisconsin

Your Choice, a drug education program founded by the Lybert family, is partnering with Rosecrance to provide prevention education in the area. The Lyberts — Sandi, Rick, Ashleigh and Tyler — speak at schools and give presentations about their own experiences with substance abuse. The Lyberts developed their prevention program to help other families cope with the problems that they faced. They speak at conferences as well. Tyler started using drugs in sixth grade as a way to make friends and fit in. He was overweight, and other students teased him about it. He was in and out of jail, using alcohol, then marijuana and finally heroin. Ashleigh, his sister, talks about the pressure her brother's addiction caused; Rick, the father, talks about his anger; and Sandi, the mother, talks about her enabling behavior. Tyler is now 27 and has been sober for six years. Rosecrance gave Your Choice a grant for prevention education for 2015. "Your Choice is well-established in Wisconsin and has reached thousands of children, teens and families through presentations and outreach," Kelly Dinsmore, Rosecrance director of business development, told *ADAW*. Rosecrance, based in Chicago, has two offices in Wisconsin, she said, "so we were familiar with the Lyberts initially through those channels." In addition, Rosecrance participated in a prevention education event with Your Choice last year called Stairway to Heroin, she said. The third such event — Stairway to Heroin 3: Bridge to Action — takes place February 17 in Hartland, Wisconsin. Asked how the partnership benefits Rosecrance, Dinsmore said the program is so "well-established" that "it just makes sense to partner with them to strengthen and spread the message about the dangers of abusing drugs and alcohol." Your Choice does get paid small stipends for speaking engagements, but the Rosecrance grant will help fund travel expenses, event fees, printing costs for educational materials and other speakers within the Your Choice network, said Dinsmore. Your Choice also sells drug-test kits and offers $150 classes for young people who are threatened with expulsion, according to the Your Choice website.

Coming up...

The **Community Anti-Drug Coalitions of America National Leadership Forum** will be held **February 2–5** in **National Harbor, Maryland**. For more information, go to **http://forum.cadca.org**.

The **Evolution of Addiction Treatment** will hold its conference **February 5–8** in **Los Angeles, California**. Go to **www.theevolutionofaddictiontreatment.com** for more information.

The **Addiction Executives Industry Summit** will be held **February 8–11** in **Naples, Florida**. For more information, go to **www.axissummit.com**.

In case you haven't heard...

A former bartender at a country club frequented by Rep. John Boehner (R-Ohio) has been arrested for threatening to kill the politician, claiming that Boehner was the devil and the bartender was Jesus Christ. The bartender, Michael Robert Hoyt, had served Representative Boehner many times over the course of the five years he worked at the country club but was fired last fall. His claims — which anyone in the mental health field would call hallucinations — landed him in jail, with the focus on the fact that he said there were many times that he could have poisoned the congressman's wine but didn't. Last fall, after he was fired, Hoyt called 911 and blamed Boehner, saying that "he had a loaded Beretta .380 automatic and he was going to shoot Boehner and take off," according to United States Capitol Police Special Agent Christopher M. Desrosiers. He even e-mailed Boehner's wife, seeking to get help to get his job back. Although the loaded gun — which was retrieved by police from his home after the 911 call last fall, at which time he was also hospitalized on a 72-hour hold — seems like more of a concern than the poisoning, which Hoyt said he could have done if he had really wanted to hurt Boehner, the news articles only focused on possible poisoning. In the meantime, Hoyt, who had stopped taking the medicine that had been prescribed last fall, is now in jail, with the entire focus on the possibility that a bartender could poison someone, and nobody is very worried about guns.