2018 NCSBN Scientific Symposium - Regulation: A Comparison of SUD Monitoring Programs Across the U.S. Video Transcript

Event
2018 NCSBN Scientific Symposium

More info: https://www.ncsbn.org/12009.htm

Presenter
Kent Gowen, MS, Senior Coordinator, Policy, Nursing Regulation Administration, NCSBN

So, this is a talk foundationally very similar to the talk that I gave at mid-year with some new information added on especially requests that I've gotten as this research has gone on. So, one thing I do want to say is that right now...

I can't speak for Richard, Richard Smiley, who is doing the other half of this project which is the statistical analysis of each state program's data, largely through their testing contractor, so Affinity Health, FirstSource Solutions, what have you. He is processing all the actual numbers that participants... and the participant data, and my role in this project is to read through all of the procedural documents and contracts that the programs have offered up to us.

So, when Richard is done, we're going to collect our data together and provide a written article about all the state programs, the differences, and then what might be most efficacious to a state program, and what may, hopefully, provide the most impact to a participant especially for success in overcoming whatever their substance use addiction is.

Okay so, for this presentation and my research, the main goal was to see how similar or dissimilar state monitoring programs are from each other across the country. Now, we say monitoring programs, previously we used to say alternative to discipline programs but monitoring programs were the most widely accepted term across all the state programs.

And then also, the other thing was what attributes are the core constituents of a program? What are the most unalterable attributes that are given to each participant? Because largely what we see is that these state programs are case-by-case.

They are left up to the treatment facility or the physician that provides the treatment participants, or it's left up to the case managers or the core committee in the states that use committees to make decisions.

So, what can we learn from this? So first, I do want to say that there was some methodology background to this which was reviewing the Substance Use Disorder and Nursing Appendix that NCSBN put out.

And we also collected program materials and this was just a solicitation to each of the state programs about, please offer up any policy or procedure documents, especially participant handbooks or manuals that they receive once they sign their contract or right before their contract, and then blank contracts because sometimes if a policy doesn't actually list, say, the testing frequency, sometimes the blank contracts will lay bare that there are options for those, so we can find if there's a case-by-case basis for an attribute or if it's actually mandated through all these documents.

And then finally, once we received all these documents, the goal was to just read all of them, which is very time-consuming. Only a few things could actually be word-searched through just a simple digital search process because every state uses different language and they're in different sections and sometimes it usually is implied only.

So it really does necessitate an entire reading of these documents. So for this presentation, I'll be presenting on 18 programs out of the 27 that we have information for, and here is the list of the ones we have. If you do not see your jurisdiction on this list, don't worry. We probably have your documents, but if not, feel free to contact me.

So... when we started, I got on the phone with some people from the IPN in Florida and walked through a bunch of attributes that I'd seen from different samples of procedural documents and policy manuals.

And ultimately, it narrowed down to about 9 broad categories and 160 attributes. This is a long list of things that can involve family involvement in peer support groups and if they do educational outreach, but it can also be more foundational elements such as the eligibility for a program, your intake evaluation.

And these are the nine categories that we consolidated all of these attributes into and they are... Of most important, it's entry to program, drug screening, violations, which we're going to cover a lot of, and restrictions, actions on licensure. So those are generally your non-compliance or relapse and then the consequences thereof.

So, the results of this analysis so far are that most of these programs have case-by-case stipulations, which on its face makes sense, you want to give your case managers, your practicing physicians, as much leeway to exercise their expertise, understanding, and then adapt a contract that is most efficacious for a given participant, not to say that that's the best way, it is the most common way.

So, some of the program policy and procedures do indicate variability in the requirement of a treatment program, and what kind of treatment program, the length of time in the program is very variable and we're going to see more of that later, and then the type of peer support groups, and so on. And some of the more interesting ones that we hope to put forward in this paper are workplace restrictions and how that may result in a better outcome for a participant.

And then again, most of these attributes are detailed in an individual's contract. So this is where we start to diverge from mid-year meeting presentation. I'm going to discuss static and dynamic attributes and because these are the ones that can most easily fit into a 25-minute presentation.

I'm going to discuss monitoring contract length, drug screen frequency as dynamic attributes. These are the ones that can change for a participant. So, if they have a case-by-case tailored contract, these may vary. It also may vary chronologically. So, as a participant goes into a second, third, fourth year, their drug screen frequency will change or their contract length may be renegotiated.

And then, the static program attributes, on average, these are attributes that do not change for participants, and these are definitions largely of noncompliance, relapse, and medication-assisted therapy. The reason I put medication-assisted therapy as a static attribute is in the policy documents that we have, medication-assisted therapy is largely given as a definition and is left up for a physician to choose, but that definition remains the same for all participants.

So, monitoring contract length, this is one thing that we're very interested in and most of the state programs are interested in talking about. One thing I do want to say is that programs that in private conversation have attested that they have a three-year program in their policy documents, they have more wiggle room than that.

And this is not a statement for all programs, but some of them usually have a... There are possibilities for extension or there may be circumstances where they would have it shortened. So, anytime you do hear a program say, "three-year, five-year, two-year contract," realize that that may be a median, not always, but it may be, and there may be some plus or minuses to that.

So generally, and I'm only going to present on the minimum length because there's a lot of variability, so largely you see that 3 years among the 18 programs is the most common minimum for a substance use disorder contract. For these three categories, the 6 months, 1 year, and 2 year-minimums, those are the minimum contract lengths listed in their documents.

But among those five programs, they have scales so it may be... So one of the programs has a 1 year minimum but they also have options for 2 years, 5 years, and more. And then the 6-month program, for example, has six months as the minimum and that's not just isolated to mental health diagnosis.

So six-month minimum but then additional contracts for two-year, four-year, five-year, and five years max, is a very common phrase for these higher contract lengths. And then, "Other," at the bottom, are policy documents that are either explicitly case-by-case and they don't have a max or minimum for their contracts in their document procedures.

Or it's not available in the documents that we have, or there's actually conflicting documents... Sorry, conflicting information in the documents. And for that example, the contract will state that you can have a variety of contract lengths, but then in the procedure documents, they'll say explicitly, five-year program.

And again, these are not set in stone. Whatever the practices on the ground for these programs, may be more dynamic, they may be different from the materials that we have. My scope is only for the

documents on-hand. And so, further surveys and discussions with these programs will elucidate what actually is happening on the ground.

Another big topic for a lot of people and a big question that I get about these programs are the drug screen frequency. And as I mentioned, Richard Smiley is actually looking at all of the testing provider information, and this is one of the big categories where you can actually tease out how long a participant has been in a program compared to how often they're screened.

And so, again, these are minimum tests per month. There's usually a wide range. Only one program I ever saw has a maximum number of tests and that was, you can only test 365 times in a year which, you know, I guess, being safe... So largely, what we see across these programs is that the minimum tests are typically one to two per month, or four, and case-by-case, which is really interesting, and a lot of these programs also...

These minimums are only in place for the first year of the contract and that with continued employment, good behavior, no diagnosis of relapse or noncompliance, will result in a lowering. But they're usually mandated lowering so they have another scale that they would go down to. Also, I want to say that all of these are listed as minimum tests per month.

Not all documents say minimum tests per month, sometimes it's minimum tests per year, so sometimes it would be 36 tests in a year and I've just rounded it to the tests per month and I've truncated any remainder. Oh, thank you. You're so kind. The not available and case-by-case, in this instance, are a little more self-explanatory.

So, the case-by-case for drug tests would mean in their policy documents it would be as needed, or as the testing provider dictates. So those procedural documents will say that...

Sorry, excuse me. So, those procedural documents will say that a participant will call into the testing center or testing provider and if they are called for a test, they must test within the same, like, four-hour, eight-hour window. So that would be a case-by-case. It's not in their documents but their provider may have some sort of minimum agreement.

So medication-assisted therapy, I've actually gotten a lot of emails about this directly, so I thought to present it right now. It is a little vaguer than I would like to present on, but this happily is one element that is easily searched through all documents using just digital search terms.

So we have naltrexone, Vivitrol, buprenorphine, all the brand names but only Vivitrol was the only brand name that came up. So across all 27 programs that we have documents for, only 6 programs mentioned naltrexone, 6 programs mention buprenorphine, and 5 programs mentioned both of them. All the language used by these programs again put the responsibility on a physician to dictate whether it is efficacious for a participant to utilize MAT.

Even though the language may have shalls, mays, in its phrasing, often the entire framework of the passage will be giving a responsibility to a physician. So, a little more on this. For the naltrexone,Vivitrol in documents across the programs, usually what is mentioned is that there's clinical evidence for efficacy for lowering relapse rate and that is usually for CRNAs and anesthetists in general.

And then, the next most common attribute to be discussed about in these documents are about how it is required for high-risk participants. High-risk is determined case-by-case, and in that case, it is required for one to two years. And then, the other most common attribute is that it is actually...

Can be used as a substitute for key restrictions or narcotic restrictions. One of those documents only said Vivitrol even though they had previously said naltrexone. So I'd want to ask them more about that. And then, if appropriate, will be required again for one to two years, and then case-by-case. Buprenorphine actually has fewer mentions.

Usually, they're just in the list of substances that must be cleared with a case manager or substances that will be tested for and the "will be tested for" is not on the screen. Oh, sorry. It is for "mentioned only," but no discernible policy for it. And then this again the most common phrasing around buprenorphine was that it would result in increased meetings and contract changes.

What I'm not presenting here on this slide but may be interesting about this is that, they increase the amount of self-reports that you must give if you're on medication-assisted therapy, self-administration, of course, is not allowed, and it's isolated to the oral formulation of this.

Okay, and then we've updated the noncompliance definitions and relapse definitions to give you a breakdown of how these programs define relapse and noncompliance which are fairly important for a participant to know what their definitions are, so that they can know what are violations, what would immediately rise to noncompliance and therefore action, and what would be considered relapse.

So I've broken down some of these categories into charts such as drug test, attendance, other drug violation, and other consequences, and we're going to go through this one by one, so don't worry about that. So, drug test violation, that is considered noncompliance, failure to submit a test and positive test are the most common ones.

These are across six programs roughly. Some programs like program Q right here will have positive test but won't mention failed or missed test as a noncompliance. And then, substituted, altered tests, and unauthorized use. Now, with this asterisk on Q here, Q interestingly, and this is unique among the programs that I have looked at, defines an unwitnessed collection as noncompliance and is determined an invalid sample.

And that's the only program I've ever seen that definition for. And then other drug violations across these programs. This is much narrower range. It never rises beyond three programs, but some of these programs will list failure to obey restrictions, diversion, ingestion, failed abstinence, even arrests in their documents, and these are the only ones that explicitly mention them as violations that will be considered noncompliance.

And then, also, on the admitted, confirmed, and diagnosed relapse, right here, the second row down, of these three programs, only one of them does not define relapse. So you have two programs that do define relapse, but then one of them won't define relapse but then will say that confirmed and diagnosed relapse will rise to noncompliance.

Whether that causes a problem for the program or participants is unclear, again, further surveys and discussions will reveal that. So other violations that are considered noncompliance is a much longer list and this is actually an exhaustive list. There's nothing left out from this. So, you have failure to notify at the bottom, license lapsed...

But then, one thing I do want to point out is where the last column was largely two programs that explicitly lay out noncompliant drug violations. With this list, you have a lot more variability among the programs. So, whether there is an institutional history where they felt that it was important to put, say, failure to pay fees as noncompliance in their documents, is an interesting thing to follow up with.

I would like to know more about that. So, late report... The most common one though is refusal or failure to respond. And that's among the four programs. So, program noncompliance, the two most common violations are very broad and those are attendance and violation of contract or law, and these are necessarily broad for a program so that they could say that, "Listen, you signed this contract and you are out of the terms of this contract, so you are in noncompliance."

So that gives them a much bigger catchall. That may mean that they would then belong to all the other violations of, if you are arrested, if you are violating your access restrictions. And then, attendance is another broad category and that applies to meetings with case managers, peer reports or peer meetings, and then even work and work site meetings.

And then, some programs don't explicitly list noncompliance but they do indicate the consequences for noncompliance. Even though they lack a definition. So, a little bit of a breakdown about what may be considered as noncompliance and then some programs where a certain thing is the only consideration for noncompliance.

So, you see a lot of variability with the programs that will consider failed drug test as noncompliance, but those same programs... So program A considers a failed drug test as noncompliance, but it will also consider other program violations as noncompliance. B is fairly represented across this table as is D.

D is actually in all of these. So D will consider all of these violations as noncompliance, whereas program O will only list in their documents violation of law or contract as a noncompliance violation. So this is more of an interesting analysis of the catchall phrases that are used in the instance of violation of contract or law, and then the much more specific explicit laying out.

And again, this may be institutional reasoning behind this, there may be some historical precedent, but we'll have to discuss with those programs why they put these in there and what efficacy is shown with the participants. Sorry, I keep saying efficacy. It is the most efficacious word in this... So, responses to noncompliance, again, we have a wide variety of definitions of noncompliance in these documents, but what are the responses across the programs?

And this is another narrow column where it's usually about two to three programs represented in this list. The one figure that I do want to show you is that 14 of the programs, which is the majority of the ones that we've analyzed at this point, do not define their response to noncompliance, which for a certain program makes sense.

You may think that they want to have more leeway about what they're going to respond with, and then other ones felt the need to have clear mandated options such as increased drug frequency, increased contract length. Some of these will just go to a reevaluation for SUD which would, in that case, re-trigger an increase in contract length or a new contract.

And so, for the consequences... Sorry, the response to noncompliance, it goes on... This previous list was, these may be required or considered, and then this is the list of what is absolutely required response to noncompliance. And again, this is a much smaller list.

This is program D, has a referral to discipline as required, and then increase contract length for program E is absolutely required for noncompliance. A lot of programs vaguely mention written warnings where they have scales for noncompliance. So if you are a Level 1 noncompliance, then you would get a written warning. But if you rose to Level 2 noncompliance, you would get further actions.

But again, none of those were required. They all used "may" language instead of "shall" or "will" or "is required." So that's noncompliance, very quick overview. I do want to cover in the remaining few minutes the definition of relapse across these programs.

The most... So unlike the other ones which were ordered according to the number of programs in a descending order, this one is in a descending order or increasing order of more stipulations for what relapse is. So it'll start with just a positive screen.

And so, this is, for lack of a better word, the most simple definition, and then the one with more stipulations are something like return to drug and alcohol prescription, or admitted use after a period of abstinence. So there you have three new definitions for relapse. The majority of programs have return to signs and symptoms after apparent recovery.

Again, this is a very broad definition of relapse. And then, you have six don't define relapse. Again, this is for the 13 programs. This is not for the full 27. No program has multiple definitions across these for what relapse is. So there's no confliction or conflicting accounts across the documents. So the response to relapse is varied across programs.

Down here, when it says case-by-case, that's a program that leaves details up to case managers, again, and it doesn't use "shall" or "will" language. And these are similar to the noncompliance, you would cease practice, evaluation for SUD, increase contract length, but the other unique ones are impose access restrictions, and support meetings.

The programs that do not define their responses to relapse, one of them has a definition of relapse but doesn't list responses to relapse. So it's an uncommon thing to have a program define relapse and then not define their responses for it. So to recap, which I understand was a very quick presentation that moved through a lot of slides.

These slides are available and I'm also available for further questions after this. But for a quick recap, the attributes across programs are individualized to participants, largely on a case-by-case basis and sometimes this is determined by the severity of SUD, and that's determined by evaluator recommendations or a committee will use DSM-5 SUD levels.

And then noncompliance definitions vary across the programs. Relapse definitions are generally defined as a return to substance use in seven programs and it is determined by an evaluation in one program, and then not defined at all for five. And so, further study, as I said, Richard Smiley and I are going to coalesce this into a larger article with figures and explanations that extend beyond what can be presented very simply in 20 minutes.

So, there's nine remaining state programs to analyze their documents for. Richard just got a larger batch of testing data that we need to pool together. And then really walk through which policies put into practice by each program results in a better result for participants and for the program, and may be even more cost-effective.

Again, thank you very much. Sorry to rush through this. Thank you for your time.