A Life in the Community for Everyone

SAMHSA
Substance Abuse and Mental Health Services Administration
www.samhsa.gov • 1-877-SAMHSA-7

Behavioral Health is Essential To Health

Prevention Works

Treatment is Effective

People Recover

A Life in the Community for Everyone

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Future of Addictions Field and Workforce Development

H. Westley Clark, M.D., J.D., M.P.H., CAS, FASAM
Director
Center for Substance Abuse Treatment
Substance Abuse Mental Health Services Administration
U.S. Department of Health & Human Services

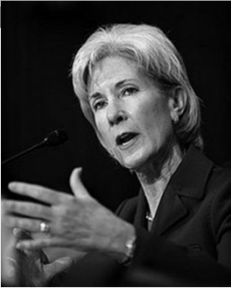**40th Kentucky School of Alcohol and Other Drug Studies**
Louisville, KY• July 22, 2013

"As we work to reduce substance abuse and the great damage it causes in our communities, we will make our country stronger and our people healthier and safer."

April 06, 2011

President Barack Obama

3

At its very core, our work today is about improving lives and ensuring peace of mind. It's about getting the right care to the right person at the right time -- each and every time.

October 4, 2010

Kathleen Sebelius
Secretary
U.S. Department of Health & Human Services

4

SAMHSA: Key Messages

➔ **Mission**: To reduce the impact of substance abuse and mental illness on America's communities

➔ **Roles**:
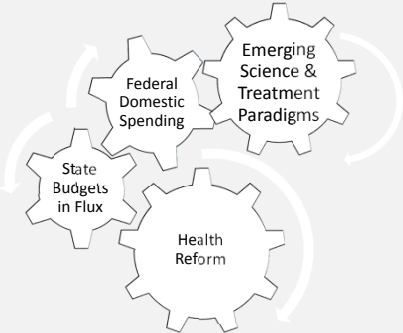 – Leadership and Voice
  – Funding - Service Capacity Development
  – Information/Communications
  – Regulation and Standard setting
  – Practice Improvement

Pamela S. Hyde, J.D.
Administrator
Substance Abuse and Mental Health Administration

5

"The Times, They Are a-Changin"

Emerging Science & Treatment Paradigms

Federal Domestic Spending

State Budgets in Flux

Health Reform

6

Improving the Nation's Health: SAMHSA's Role

➔ Behavioral health services improve health status and reduce health care and other costs to society.

➔ SAMHSA is charged with effectively targeting substance abuse and mental health services to the people most in need and to translate research in these areas more effectively and more rapidly into the general health care system.

➔ Continued improvement in the delivery and financing of prevention, treatment and recovery support services provides a cost effective opportunity to advance and protect the Nation's health.

➔ SAMHSA has identified strategic initiatives to guide us as we address emerging national trends.

7

SAMHSA STRATEGIC INITIATIVES

AIM: Improving the Nation's Behavioral Health (1-4)
AIM: Transforming Health Care in America (5-6)
AIM: Achieving Excellence in Operations (7-8)

| 1. Prevention | 2. Trauma and Justice | 3. Military Families | 4. Recovery Support | 5. Health Reform | 6. Health Information Technology | 7. Data, Outcomes & Quality | 8. Public Awareness & Support |

8

The Health Care Environment is "a-Changin"

➔ Integrated, coordinated, comprehensive care rather than disjointed, episodic, siloed care

➔ Prevention, wellness, and early intervention emphasized

➔ Expanded coverage and full access to care

➔ Parity for BH and physical health services

➔ Recovery services rather than simply acute and/or chronic care

➔ Moving towards person and family-centered home health and community-based models

➔ Reimbursement based on quality-of-care and health outcomes

➔ Role of States increasing

9

Emergent Patterns and Prognosticators

10

Overview: MH/SUDs in the U.S.

→ In 2011, an estimated 20.6 million persons were classified with substance abuse or dependence.

- 2.6 million of them were dependent upon or abused both alcohol and illicit drugs.

→ And, during that same year, there were an estimated 11.5 million adults (18 or older) in the U.S. – 5% of adults -- with serious mental illness in the past year.
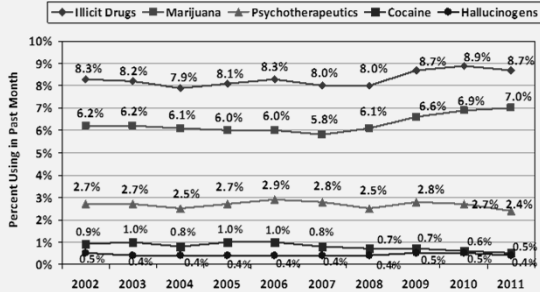
Source: 2011 NSDUH

11

Past Month Alcohol Use - 2011

Any Use: **51.8% (133.4 million)**

Binge Use: **22.6% (58.3 million)**

Heavy Use: **6.2% (15.9 million)**

Source: NSDUH 2011

12

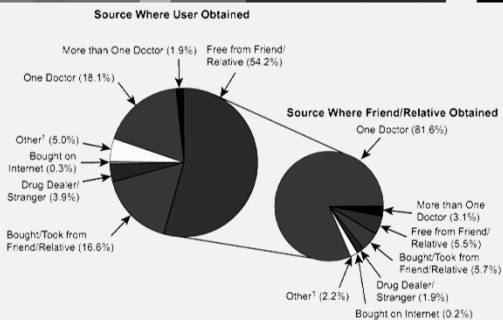**Past Month Use of Selected Illicit Drugs among Persons Aged 12 or Older: 2002-2011**

Legend: Illicit Drugs — Marijuana — Psychotherapeutics — Cocaine — Hallucinogens

Y-axis: Percent Using in Past Month

Illicit Drugs: 8.3% 8.2% 7.9% 8.1% 8.3% 8.0% 8.0% 8.7% 8.9% 8.7%
Marijuana: 6.2% 6.2% 6.1% 6.0% 6.0% 5.8% 6.1% 6.6% 6.9% 7.0%
Psychotherapeutics: 2.7% 2.7% 2.5% 2.7% 2.9% 2.8% 2.5% 2.8% 2.7% 2.4%
Cocaine: 0.9% 1.0% 0.8% 1.0% 1.0% 0.8% 0.7% 0.7% 0.6% 0.5%
Hallucinogens: 0.5% 0.4% 0.4% 0.4% 0.4% 0.4% 0.4% 0.5% 0.5% 0.4%

Years: 2002 2003 2004 2005 2006 2007 2008 2009 2010 2011

Source: 2011 NSDUH

13

Past Month Nonmedical Use of Prescription Drugs (Psychotherapeutics) among Persons 12+:2002-2011

Legend: Pain Relievers — Tranquilizers — Stimulants — Sedatives

Y-axis: Percent Using in Past Month

Pain Relievers: 1.9% 2.0% 1.8% 1.9% 2.1% 2.1% 1.9% 2.1% 2.0% 1.7%
Tranquilizers: 0.8% 0.8% 0.7% 0.7% 0.7% 0.7% 0.7% 0.8% 0.9% 0.7%
Stimulants: 0.6% 0.6% 0.5% 0.5% 0.6% 0.4% 0.4% 0.5% 0.4% 0.4%
Sedatives: 0.2% 0.1% 0.1% 0.1% 0.2% 0.1% 0.1% 0.1% 0.1% 0.1%

Years: 2002 2003 2004 2005 2006 2007 2008 2009 2010 2011
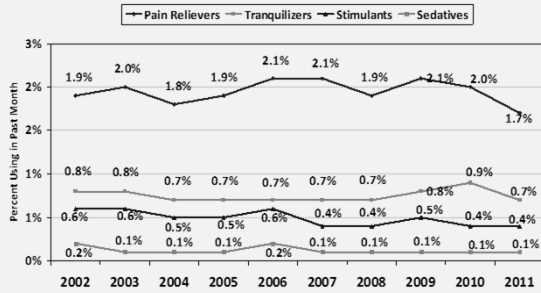
Source: 2011 NSDUH

14

Where Pain Relievers Were Obtained for Most Recent Nonmedical Use among Past Year Users Aged 12 or Older: 2010-2011

Source Where User Obtained

More than One Doctor (1.9%)
Free from Friend/Relative (54.2%)
One Doctor (18.1%)
Other[1] (5.0%)
Bought on Internet (0.3%)
Drug Dealer/Stranger (3.9%)
Bought/Took from Friend/Relative (16.6%)

Source Where Friend/Relative Obtained
One Doctor (81.6%)
More than One Doctor (3.1%)
Free from Friend/Relative (5.5%)
Bought/Took from Friend/Relative (5.7%)
Drug Dealer/Stranger (1.9%)
Bought on Internet (0.2%)
Other[1] (2.2%)

Source: 2011 NSDUH

15

Co-occurring SUD and Mental Illness (Adults 18 and older)

Percent Dependent or Abusing Substance

Serious Mental Illness (SMI)	22.6
Moderate Mental Illness	16.1
Low (Mild) Mental Illness	15.7
No Mental Illness	5.8

Source: 2011 NSDUH

16

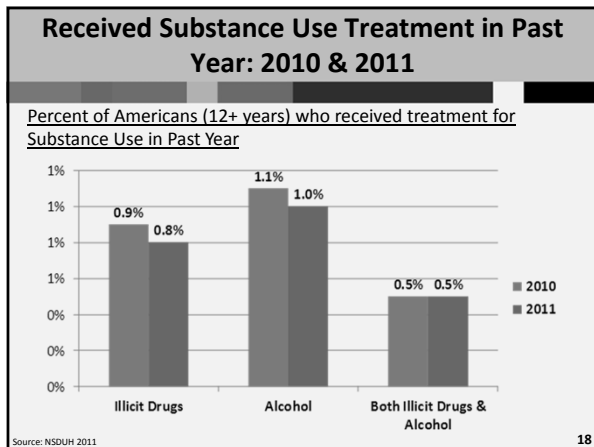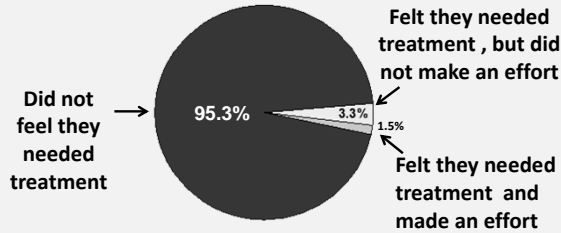## Tobacco and SUDs: A Smoking Gun?

➔ Smoking tobacco causes more deaths among clients in substance abuse treatment than the alcohol or drug use that brings them to treatment.

➔ A seminal 11-year retrospective cohort study of people who had been in addictions treatment found that 51% of deaths were the result of tobacco-related causes.

➔ This rate is 2X that found in the general population and nearly 1.5X the rate of death by other addiction-related causes.

➔ Despite these statistics, most substance abuse treatment programs do not address smoking cessation.

http://store.samhsa.gov/shin/content//SMA11-4636CLIN/SMA11-4636CLIN.pdf

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Received Substance Use Treatment in Past Year: 2010 & 2011

Percent of Americans (12+ years) who received treatment for Substance Use in Past Year

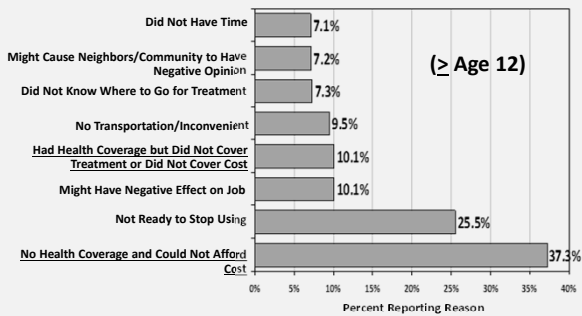|	2010	2011
Illicit Drugs	0.9%	0.8%
Alcohol	1.1%	1.0%
Both Illicit Drugs & Alcohol	0.5%	0.5%

Source: NSDUH 2011

18

Major Challenge: Unmet *and* Unrecognized Need for SUD Treatment (Persons 12 or Older)

19.3 Million Needing But Not Receiving Treatment for Illicit Drug or Alcohol Use

Did not feel they needed treatment → **95.3%**

Felt they needed treatment, but did not make an effort — 3.3%

1.5% — Felt they needed treatment and made an effort

Source: NSDUH 2011   NOTE: Percentages do not add to 100% due to rounding.

Reasons for Not Receiving SAT for Those Who Needed & Made the Effort to Get Treatment

(> Age 12)

Reason	Percent
Did Not Have Time	7.1%
Might Cause Neighbors/Community to Have Negative Opinion	7.2%
Did Not Know Where to Go for Treatment	7.3%
No Transportation/Inconvenient	9.5%
Had Health Coverage but Did Not Cover Treatment or Did Not Cover Cost	10.1%
Might Have Negative Effect on Job	10.1%
Not Ready to Stop Using	25.5%
No Health Coverage and Could Not Afford Cost	37.3%

Percent Reporting Reason

Source: NSDUH, 2008-2011 combined

20

Reasons for Not Receiving MH Services in the Past Year for those with Unmet Need for MH Care (2011)

(> Age 18)

Reason	Percent
Concerned about Confidentiality	5.9%
Health Ins. Didn't Cover Any Treatment	6.7%
Fear of Being Committed/Having to take Medicine	7.0%
Might Have Negative Effect on Job	7.0%
Did Not Want Others to Find Out	7.1%
Might Cause Neighbors/Community to Have Negative Opinion	8.0%
Health Ins. Didn't Cover Enough Treatment	8.3%
Did Not Feel Need for Treatment	8.5%
Treatment Would Not Help	10.4%
Did Not Have Time	15.1%
Didn't Know Where to Go for Services	16.2%
Could Handle Problem without Treatment	28.8%
Could not Afford Cost	50.1%

Percent among Adults Who Did Not Receive MH Care

Source: NSDUH, 2008-2011 combined

21

The Future of the Addictions Field

"A little less conversation, a little more action…"

➔ SAMHSA's health reform priorities

➔ The ACA and BH

22

SAMHSA's Health Reform Strategic Initiative

➔ Increase access to appropriate high quality prevention, treatment, and recovery services.

➔ Reduce disparities that exist between the availability of services for MH/SUDs compared with the availability of services for other medical conditions.

➔ Support integrated, coordinated care, especially for people with behavioral health and co-occurring health conditions, such as HIV/AIDs.
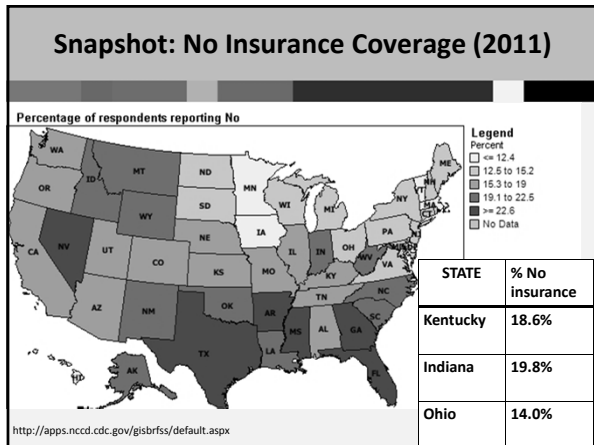
23

SAMHSA's Health Reform Goals

➔ Ensure that behavioral health is included in all aspects of health reform.

➔ Support Federal, State, Territorial, and Tribal efforts to develop and implement new Medicaid and Medicare provisions.

➔ Finalize and implement the parity provisions in the Mental Health Parity and Addiction Equity Act and the Affordable Care Act.

➔ Reconfigure SAMHSA Block Grants to support recovery and resilience.

➔ Foster integration of primary and behavioral health care.

24

The ACA and Health Reform

➔ More people will have insurance coverage

➔ Medicaid will play a bigger role in MH/SUD than ever before

➔ Focus on primary care and coordination with specialty care

➔ Major emphasis on home and community based services and less reliance on institutional care

➔ Preventing diseases and promoting wellness are huge themes

25

Snapshot: No Insurance Coverage (2011)

Percentage of respondents reporting No

Legend
Percent
☐ <= 12.4
☐ 12.5 to 15.2
☐ 15.3 to 19
☐ 19.1 to 22.5
■ >= 22.6
☐ No Data

STATE	% No insurance
Kentucky	18.6%
Indiana	19.8%
Ohio	14.0%

http://apps.nccd.cdc.gov/gisbrfss/default.aspx

ACA and Health Insurance Coverage

➔ Insurance Coverage Expands

➔ BH Parity

➔ Essential Health Benefits (EHBs)

➔ Individual Mandate Applies

➔ Subsidies For Those Under 400% FPL

➔ Medicaid Eligibility Set At 133% FPL

➔ Millions to obtain insurance through state exchanges

27

Medicaid Expansion: July 2013 Status

Expanding Not Expanding Debate Ongoing

| 24 expanding |
| 21 not expanding |
| 6 undecided |

SOURCE: URBAN INSTITUTE

Sources: http://www.urban.org/health_policy/health_care_reform/map.cfm;
http://kff.org/medicaid/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/

28

Prevalence of Behavioral Health Conditions Among Medicaid Expansion Populations

Uninsured Adults Ages 18-64 with Incomes ≤ 138% FPL (18 Million)

Percent with Condition

- 7.0% — Percent with a Serious Mental Illness (1,283,000) CI: 6.3%-7.7%
- 14.9% — Percent with Serious Psychological Distress (2,731,742) CI: 14.0%-15.9%
- 14.2% — Percent with a Substance Use Disorder (2,603,405) CI: 13.2%-15.2%

CI = Confidence Interval
Sources: 2008 – 2010 National Survey of Drug Use and Health
2010 American Community Survey

29

Prevalence of Behavioral Health Conditions Among Exchange Populations

Uninsured Adults Age 18-64 with Incomes between 133-399% FPL (19.9 Million)

Percent with Condition

- 6.0% — Percent with a Serious Mental Illness (1,195,600) CI: 5.5%-6.6%
- 13.3% — Percent with Serious Psychological Distress (2,650,247) CI: 12.4%-14.2%
- 14.6% — Percent with a Substance Use Disorder (2,909,294) CI: 13.7%-15.6%

CI = Confidence Interval
Sources: 2008 – 2010 National Survey of Drug Use and Health
2010 American Community Survey

30

SAMHSA/HHS Focus: Enrollment Activities

→Consumer Enrollment Assistance (thru BRSS TACS)
– Outreach/public education
– Enrollment/re-determination assistance
– Plan comparison and selection
– Grievance procedures
– Eligibility/enrollment communication materials

→Enrollment Assistance Best Practices TA – Toolkits

→Communication Strategy – Message Testing, Outreach to Stakeholder Groups, Webinars/Training Opportunities

→SOAR Changes to Address New Environment

→Data Work with ASPE and CMS

The Federal Web Destination for the Health Insurance Marketplace is HealthCare.gov

healthcare.gov

→ Consumer-focused website and a 24-hours-a-day consumer call center for the Health Insurance Marketplace.

→ Helps Americans prepare for enrollment now; and to sign up for private health insurance starting October 1, 2013 for coverage in 2014.

→ New tools explain choices and help identify coverage best suited for individuals, families, and small business owners.

32

Other Important information on the ACA and Health Reform is at HHS.gov/HealthCare

hhs.gov/healthcare

→ Important information and resources about provisions in the Affordable Care Act law:
• Prevention and wellness
• Pre-existing conditions
• Prescription discounts for seniors
• Young adult coverage
• Lifetime limits
• Federal and State level information
• And more…

33

State Leadership Example

kynect
Kentucky's Healthcare Connection

http://kynect.ky.gov/

ABOUT   INDIVIDUALS & FAMILIES   SMALL BUSINESSES   INSURANCE AGENTS   kynectors   FAQ

A new day has arrived.
Introducing kynect: Kentucky's Healthcare Connection.
Quality healthcare coverage. For every Kentuckian.

kynect: Kentucky's Healthcare Connection

If this video will not play, please click here for more information on kynect

34

ACA and 10 Essential Health Benefits

1) Ambulatory patient services
2) Emergency services
3) Hospitalization
4) Maternity and newborn care
5) *Mental health and substance use disorder services, including behavioral health treatment*

6) Prescription drugs
7) Rehabilitative and habilitative services and devices
8) Laboratory services
9) Preventive and wellness services and chronic disease management
10) Pediatric services, including oral and vision care

35

ACA and Preventive Services

➔ The Affordable Care Act requires health plans to cover a number of preventive services related to behavioral health without cost sharing (for plans effective on or after 09/23/10)

➔ **Adults**

● Alcohol misuse screening and counseling

● Tobacco use screening & cessation interventions

● Depression screening

● HIV screening for those at higher risk

● Obesity screening and counseling

36

ACA and Preventive Services (cont.)

➔ **Pregnant Women**
- Special, pregnancy-tailored counseling for tobacco cessation and avoiding alcohol use

➔ **Children**
- HIV screening for those at higher risk
- Sexually transmitted infection prevention and counseling for adolescents at higher risk
- Alcohol and drug use assessments and screening for depression for adolescents
- Behavioral assessments for children of all ages
- Developmental screening (under age 3) and surveillance (throughout childhood)
- Autism screening for children at 18 and 24 months
- Obesity screening and counseling

37

ACA and Integrated Health Care Services

➔ Focus on holistic health, including prevention and recovery

➔ Cross-disciplinary knowledge and understanding

➔ Shared priorities/initiatives

➔ Improved management and continuity of care

➔ Coordinated and/or co-located service delivery

➔ Consolidated reporting of client outcomes

➔ Braided/blended funding streams

➔ Linkage of health records

38

Business Case for Integrated Care

➔ Research has found that individuals with co-occurring substance abuse/mental health disorders randomized into integrated care had significantly lower total medical costs than those in independent care.[1]

➔ By integrating substance abuse treatment and mental health services into primary care, the quality of health care available to these populations will improve – along with their health status.

[1] Parthasarathy, S. et al. (2001) *J Stud Alcohol*. 62(1): 89-97 [2] Parthasarathy, S. et al. (2003) Med Care. 41(3): 357-367

39

ACA and Integrated Care: FQHCs, CHCs, ACOs & Health Homes

ACA programs focus on person and family-centered coordinated care:

➔MH/SUD services in primary care through Federally-Qualified Health Centers (FQHCs)

➔Primary care in MH/SUD settings through community health centers (CHCs) & other agencies

• Services and technical assistance

➔Accountable Care Organizations (ACOs) and Health Homes

40

Integrated Care: Screening, Brief Intervention & Referral to Treatment (SBIRT)

➔Embedding screening, brief intervention, referral & treatment of substance abuse problems within primary care settings such as emergency centers, community health care clinics, and trauma centers helps to:

• Identify patients who don't perceive a need for treatment,

• Provide them with a solid strategy to reduce or eliminate substance abuse, and

• Move them into appropriate services.

41 41

Barriers to Integrated Care

➔Delivery System Design
• Physical separation of services, fragmented communication, language differences between systems

➔Financing
• Siloed payment & reporting systems, competition for scarce resources

➔Legal/Regulatory
• HIPAA and confidentiality rules, conflicting mandates at federal, state & local levels, categorical program requirements

Source: *Report of the California Primary Care, Mental Health, and Substance Use Services Integration Policy Initiative* (2009, October 22) [PowerPoint Slides] Retrieved from http://www.ibhp.org/index.php?section=news&subsection=show_news_details&news_id=80

42

Barriers to Integrated Care (cont.)

➜ Workforce
- Feared loss of identity and priority
- Lack of cross-training
- Shortage of providers, need for cultural competence/linguistic capacity

➜ Health Information Technology
- Lack of common IT systems, electronic health records (EHRs) often unable to support multi-system information

Source: *Report of the California Primary Care, Mental Health, and Substance Use Services Integration Policy Initiative* (2009, October 22) [PowerPoint Slides] Retrieved from http://www.ibhp.org/index.php?section=news&subsection=show_news_details&news_id=80   43

ACA Emphasis on Evidence-Based Practices

➜ Evidence-Based Practices (EBPs) provide scientifically-validated evidence that the program is effectively meeting goals.

➜ Why use EPBs?
– When services are informed by the best available evidence, the quality of care is improved.

– Using EBPs increases the likelihood that desired outcomes will be obtained.

– By employing these practices, available resources are often used more efficiently.

44

SAMHSA's National Registry of Evidence-based Programs and Practices (NREPP)

➜ The National Registry of Evidence-based Programs and Practices (NREPP) is a searchable online registry of mental health and substance abuse interventions that have been reviewed and rated by independent reviewers.

➜ The NREPP website helps states, territories, community-based organizations, and others to identify service models that may address your particular regional and cultural needs, and match your specific resource capacity.

➜ Search feature allows users to identify NREPP interventions that have been evaluated in comparative effectiveness research studies.

➜ http://www.nrepp.samhsa.gov/

ACA and Health Reform Implications For States & Providers

→ Need For Infrastructure To Work With Insurance

→ Grant Funds Reconceptualized To Not Duplicate Insured Benefits

→ Medicaid Changes and State Insurance Mandates

→ Integration of MH/SU with Primary Care

→ Health Homes and Accountable Care Organizations

→ Electronic Health Records

→ Payment Reform Pilot Programs

→ Evidence Based Practices

→ Licensure and Credentialing Standards

46

ACA and HIT: Tools for Change

21st Century Health Information Technology

47

SAMHSA's HIT Objectives

→ Increase the involvement of behavioral health organizations in state Health information Exchange (HIE) pilot activities

→ Increase the number of behavioral health organizations meeting meaningful use activities

→ Address the issues of privacy and security associated with mental illness and substance use disorder treatment

→ Develop working relationships with Medicaid, Mental Health and Substance Use Authorities

48

ACA and HIT

➜ ACA requires implementation of uniform standards for electronic exchange of health information.

➜ HIT will provide many public health benefits, including:
- Early detection of infectious disease outbreaks around the country,
- Improved tracking of chronic disease management, and
- Evaluation of health care based on value -- enabled by the collection of de-identified price and quality information that can be compared.

49

HIT and BH Providers

➜ HIT is an important part of providing integrated treatment by linking between programs, services, and providers.

➜ HIT can help behavioral health providers:
- Communicate and collaborate between providers and other programs
- Track the progress of those who leave a program and monitor when and if additional services are needed
- Reduce redundancy between programs and providers
- Increase the quality of care
- Increase access to services and support

50

Challenges for Behavioral Health Care

➜ Clarifying how 42 CFR Part 2 is impacted by Health IT.
- Without a guarantee of confidentiality, many individuals with substance abuse problems would be reluctant to participate fully in treatment programs.

➜ Establishing trust between providers and patients.
- Electronic exchange efforts must establish trust relationships with all participants, including patients.

➜ Acquiring and Training Adequate Resources:
- Most mental health providers and the majority of substance use treatment providers are not Eligible Providers or Meaningful Users under the HITECH Act and are thus not eligible for financial incentives to modernize either the acquisition or use of EHR.

Sources: STATE of Florida v CENTER FOR DRUG-FREE LIVING, INC, 842 So.2d 177 (2003) at 181. Melissa M. Goldstein, JD et al, 2010   51

Behavioral Health IT

➔ Behavioral health is unique

- More stringent privacy requirements
- Subjective diagnoses
- Majority Non-pharmacological treatments
- Less emphasis on labs & imaging
- Need for strong and continued patient engagement
- Role of the family and social support structure

52

ACA and National Aggregate Data

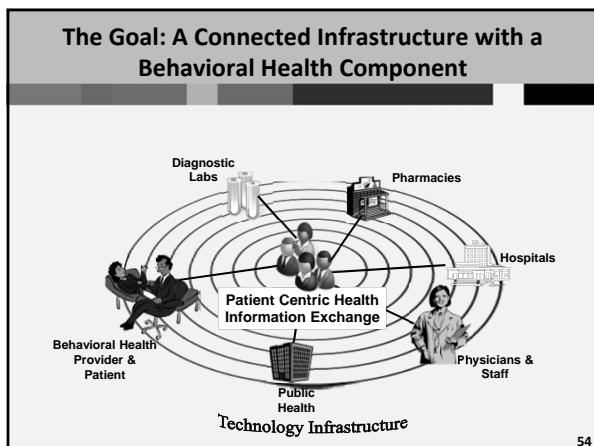➔ Under the Affordable Care Act, a large pool of aggregate national data will be available.
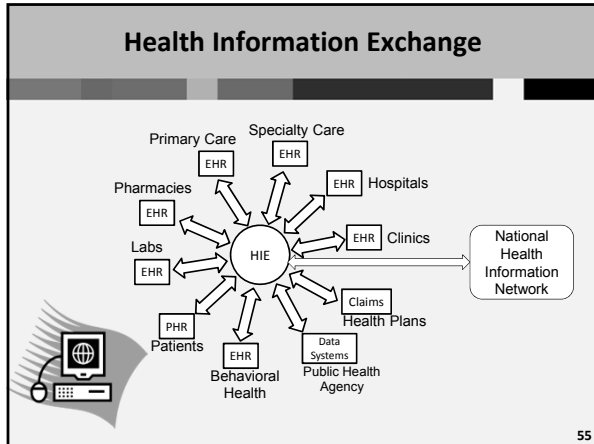➔ Benefits:
- Low frequency conditions (such as schizophrenia) will be able to be tracked.
- The ability to have a better sense of who presents for treatment
➔ Challenges:
- Who gets what?
- Ensuring quality with increased quantity

53

The Goal: A Connected Infrastructure with a Behavioral Health Component

54

Health Information Exchange

Primary Care — EHR
Specialty Care — EHR
Pharmacies — EHR
Hospitals — EHR
Labs — EHR
Clinics — EHR
HIE
National Health Information Network
Claims — Health Plans
PHR — Patients
Data Systems — Public Health Agency
EHR — Behavioral Health

55

Privacy, Confidentiality, and Trust

➔ Increased accessibility to health records raises the question of how to ensure patient confidentiality and trust.

➔ To be sustainable, electronic exchange efforts must establish trusting relationships with all participants, including patients.

Trust Me, I'm a Doctor

Melissa M. Goldstein, JD et al, 2010

56

42 CFR Part 2 and Title 38

➔ The purpose of the statute and regulations prohibiting disclosure of records relating to substance abuse treatment, except with the patient's consent or a court order after good cause is shown, is <u>to encourage patients to seek substance abuse treatment without fear that by doing so their privacy will be compromised</u>.

Source: State of Florida Center for Drug-Free Living , Inc.,842 So.2d 177 (2003) at 181.

57

42 CFR Part 2

➔ Limited exceptions for disclosure without consent :
- Medical emergencies
- Child abuse reporting
- Crimes on program premises or against program personnel
- Communications with a qualified service organization of information needed by the organization to provide services to the program
- Public Health research
- Court order
- Audits and evaluations

Source: 42 CFR Part 2   58

The Role of States

➔ 42 CFR Part 2 set a minimum standard for protecting and security protected health information (PHI). If the state law is more restrictive then the state law governs.

➔ For example, mandatory child abuse reporting laws in each state are unaffected by 42 CFR Part 2.

➔ A local, county, or state counsel can advise whether state law or federal law is more restrictive in a given area.

59

Critical Privacy Questions

➔ Federal and state regulations provide the ground rules. Careful analysis determines how the rules are applied to ensure effective treatment of substance use and mental health disorders.

- Who needs what information when?
- Who determines who needs what Information when?
- How should psychotherapy notes be treated – as part of the patient record?
- How should HIT systems be designed to control disclosure and re-disclosure of sensitive information

60

42 CFR Part 2 FAQs

➔ To help providers in the behavioral health field better understand privacy issues related to Health IT, SAMHSA, in collaboration with ONC has created two sets of Frequently Asked Questions (FAQs).

➔ These FAQs can be accessed at: http://www.samhsa.gov/healthprivacy/docs/EHR-FAQs.pdf and

➔ http://www.samhsa.gov/about/laws/SAMHSA_42CFRPART2F AQII_Revised.pdf

➔ Series of webinars by the Legal Action Center on 42 CFR Part 2 http://www.lac.org/index.php/lac/webinar_archive

61

Solutions for Privacy

➔ SAMHSA is working with the VA on the ONC Standards and Interoperability Initiative for Data Segmentation for Privacy

• Will support compliance with 42 CFR Part 2, Title 38, and state mental health privacy laws

• Open source tool that can be integrated into existing EHR platforms

• Successful demo at HIMSS 2013 in March

• Currently working on production level development leading to real-world testing

62

Solutions for Privacy (cont.)

➔ SAMHSA/HRSA Health Information Exchange Pilot

• To develop infrastructure supporting the exchange of health information among behavioral health and physical health providers

• Development or adaptation of electronic health information exchange (HIE) systems to support the exchange

• Work through the challenges of exchanging 42 CFR data and implement a process to do so

• 5 states (KY, OK, RI, ME, IL)

63

Change Agents: Building the BH Workforce

64

SAMHSA's BH Workforce Priorities

➔ SAMHSA's WF Report (January 2013):

- An adequate supply of a well-trained workforce is the foundation for an effective service delivery system.

- Workforce issues, which have been of concern for decades, have taken on a greater sense of urgency with the passage of recent parity and health reform legislation.

http://store.samhsa.gov/product/Report-to-Congress-on-the-Nation-s-Substance-Abuse-and-Mental-Health-Workforce-Issues/PEP13-RTC-BHWORK

65

SAMHSA's BH Workforce Priorities

➔ SAMHSA has embedded workforce elements in each of the eight Strategic Initiatives. Examples:

- **Prevention of Substance Abuse and Mental Illness:** Educate the behavioral health field about successful interventions, such as screening, brief intervention, and referral to treatment (SBIRT); and develop and implement training around suicide prevention and prescription drug abuse.

- **Health Reform**: Work with partners and stakeholders to develop a new generation of providers, promote innovation of service delivery through primary care and behavioral health care integration, and increase quality and reduce health care costs through health insurance exchanges and the essential and benchmark benefit plans.

66

Workforce Challenges of Health Reform

➔ Health reform offers many potential benefits, but relies on the ability of the health care field to meet the challenges resulting from its implementation:
- Influx of millions of new clients into the behavioral health care system.
- Need to implement Health IT
- Greater emphasis on evidence-based practices and outcomes
- Increased emphasis on credentials and education for behavioral health workforce
- Emphasis on early intervention and integrated care (primary and behavioral health)

67

ACA Focus on Workforce Development

Training and Research

➔ Increased patient-centered health research

➔ Training grants for behavioral health workforce

➔ Training on MH/SUD for primary care extender

Support for Workforce Development

➔ Funding for residencies for behavioral health included with other disciplines (HRSA)

➔ Loan repayment programs

➔ Push towards more national certification standards and re-licensure/re-certification

➔ Primary care/behavioral health integration -- bidirectional

68

BH Workforce Challenges Contribute to Treatment Gap

➔ Mal-distribution of workforce -- 55% of U.S. counties -- all rural -- have no practicing psychiatrists, psychologists, or social workers.

➔ Inadequate compensation

➔ Aging workforce

➔ Growing demand for workers but difficulties recruiting people to field -- especially from minority communities

➔ Potential impact of the Affordable Care Act, including training, education and credentialing

➔ Poorly articulated career pathways

➔ Increased emphasis health information technology and integration of primary and behavioral health care
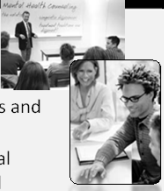
69

SAMHSA Response:
Minority Fellowship Program (MFP)

➔ SAMHSA program supported by three centers.

➔ Purpose: to facilitate the entry of ethnic minority students into mental health careers and

- increase the number of psychologists, psychiatric nurses, psychiatrists, and social workers trained to teach, administer, and provide direct mental health and substance abuse services to ethnic minority groups.

➔ In his 2014 budget, the President includes $50 million in funds to train masters-level mental health specialists, which would expand the program to include nurses, counselors who work in the schools, and others.

70

The Role of Peer Support

➔ Self-help and peer support groups play a large role in treatment programs and can play a large role in reducing the treatment gap.

➔ Thus, the field is faced with the challenge of how to balance the increased emphasis on credentials and education with the important contribution that is made by "lived experience."

➔ "Lived experience" is important, but it is not a substitute for competence or ethics.

71

Training and Education Needs

To effectively use integrated care to help close the treatment gap efforts need to:

➔ Train BH providers in team competencies and the primary care culture

➔ Train primary care providers on SBIRT including brief interventions and brief treatment

➔ Increase care coordination

➔ Provide cross-training in co-occurring disorders

➔ Pre-service and in-service education needs to foster adoption of evidenced-based practices

72

"The Only Thing Constant is Change"

Change is a process, not an event.

Image: http://addictivebehaviors.wordpress.com/2011/05/05/how-to-make-real-change-and-transform-your-life/ 73

"The Only Thing Constant is Change"

➔ Emergent Shifts in the MH/SUD Health Landscape include:
- Returning Veterans
- Aging Baby Boomers
- Evolving Racial and Ethnic Demographics
- Synthetic Drugs
- Prescription Drug Abuse

CHANGE AHEAD

74

The Future of the Addictions Field: Final Thoughts

➔ Health Reform is a Key Driver for Meaningful Change in MH/SUD services
➔ Change Is Complex and Imperfect – It Takes Time
➔ New Partnerships and Ways of Doing Business Will Be Needed
➔ We Who Serve Others Will Need To Keep Up With The Changes – Millions Depend on Us
➔ We Need To Embrace Change

be the change

75

THANK YOU

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76