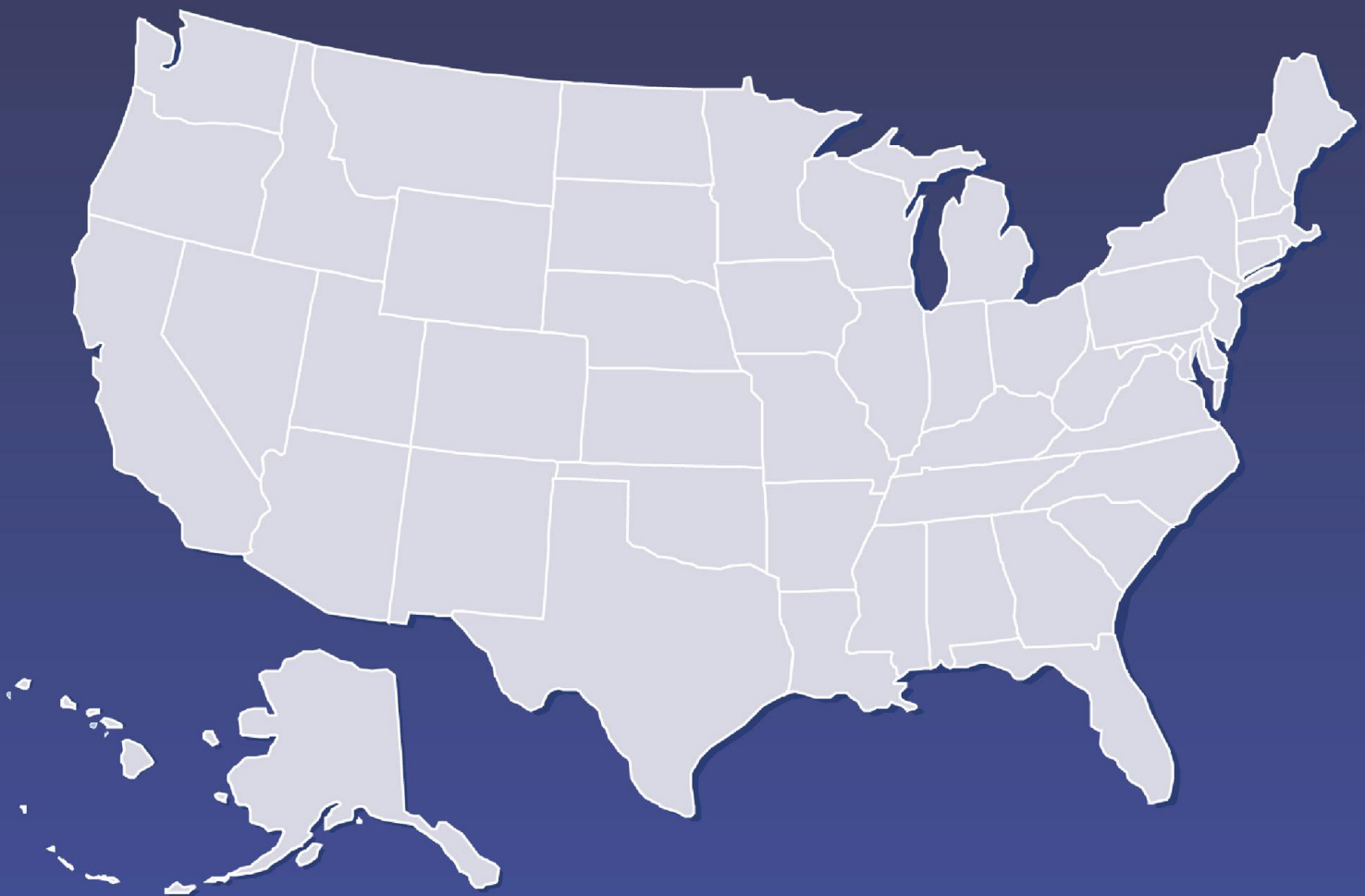


Report on State Responses to the FY 2011 Block Grant Addendum on Health Care Reform



U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
Center for Substance Abuse Treatment
Center for Substance Abuse Prevention
www.samhsa.gov

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Table of Contents

Executive Summary	1
Introduction and Methods	5
Coverage	6
Integration	8
Accountability	9
Provider Capacity	11
Involvement of Tribes	12
Evidence	13
Data and Reporting	16
Communication and Collaboration	17
TA and Other Resources	20
Health Information Technology	21
State Funding Distributions by Service Category	22
Conclusion	25

Executive Summary

The Affordable Care Act (ACA) presents a number of opportunities and challenges for States¹ in terms of systems changes that will be required to improve health care for individuals, families, and communities. To ensure appropriate consideration of behavioral health system needs and concerns, State behavioral health agencies will need to participate early and actively in their States' ACA planning and implementation processes. To determine whether behavioral health agencies are actively engaged, planning, and able to use available resources, the Substance Abuse and Mental Health Services Administration (SAMHSA) requested that States complete an addendum to the Fiscal Year 2011 Block Grant application to provide preliminary information on health care reform efforts. SAMHSA will use the information that States provide to determine State readiness and progress related to health care reform as well as to identify technical assistance (TA) and other resources that State behavioral health agencies will need to fully implement ACA requirements.

States submitted responses to each of the addendum's main categories: coverage, integration, accountability, provider capacity, involvement of Tribes, evidence, data and reporting, communication and collaboration, TA and other resources, health information technology (HIT), and State funding distributions by service category. Qualitative and quantitative analysis of the State responses was conducted, and the following themes across States were identified:

Coverage

- Nearly half the responding States (27) reported that their behavioral health agencies did not collect the data necessary to calculate the number of individuals currently in their behavioral health systems that are below 133 percent of the Federal Poverty Line.
- The most common capacity change anticipated by 20 States is in the types of services provided to better serve the incoming populations. Changes to the types of services include increases in care coordination, prevention, early intervention, health promotion, recovery support, primary care, services for specific populations, and specialty care services.
- Nearly half the responding States (27) reported that all publicly funded behavioral health service providers for substance abuse, mental health, or both are enrolled currently in Medicaid. Another 10 States reported that most providers were enrolled.

Integration

- All States except one are carrying out activities to integrate behavioral health care and primary care.
- Thirty-five States used formal partnership development such as fully integrated care sites, interagency agreements, partnerships between practices, and colocated services to integrate primary care and behavioral health care and to integrate and coordinate mental health and substance abuse services.

¹ For simplicity, we will use the term "State" within this document to refer to States, Territories, and the District of Columbia.

- The majority of State behavioral health agencies have not identified a preferred model of integration; 23 States have not developed a preferred model, and 10 reported that the flexibility of multiple models was preferred.
- Thirty State behavioral health agencies have identified content experts for the integration of behavioral health and primary care services.

Accountability

- To manage the needs of individuals with behavioral health and other chronic conditions, 10 States reported focusing on integrated treatment for persons with co-occurring disorders. Other approaches included health homes (6 States); Screening, Brief Intervention, and Referral to Treatment (SBIRT, 2 States); and use of the chronic care model (3 States).
- Services needed for individuals with behavioral health and other chronic conditions included wellness promotion and prevention services, including primary health care (19 States), care coordination and case management (18), recovery support services (12), health homes (7), integrated services for co-occurring disorders (7), and assisted housing (5).
- Forty-six States reported that they collaborate with the State Medicaid Authority and other partnering agencies to design protocols and develop approaches to meet the needs of those with behavioral health and chronic conditions. Twenty-one States reported that they perform in a leadership role for these collaboratives.

Provider Capacity

- States reported that their provider shortages were either statewide (17 States) or in rural areas (26). Twelve States reported a shortage of psychiatrists, and an additional eight reported shortages in child and adolescent psychiatrists and psychologists. Substance abuse programs in 10 States reported a dearth of substance abuse providers.
- To address these shortages, States have implemented a variety of workforce development strategies, including the development of competence standards as well as certification, licensure, and continuing education requirements.
- States need assistance to meet workforce training demands, including additional funding for evidence-based practice (EBP) trainings and assistance with the development of training plans.

Involvement of Tribes

Twenty-three of the responding States do not have any Federally recognized Tribes and therefore did not provide any information about Tribal involvement. Of the States who have Tribes, the following was found:

- Nineteen States include Tribes in the planning process by having at least one Tribal representative on the State workgroup.

- Information on Tribes is collected from Tribal liaisons in four States and reported as demographic data in the State data system. Sixteen States do not collect or report information on Tribes.
- Several States reported that they will begin or continue to conduct outreach to Tribes to ensure that they are involved in future efforts. Eleven States do not have plans to include Tribes in future needs assessment, planning, and service delivery efforts.

Evidence

- Thirty-two States were able to provide specific responses about the proportion of their mental health and substance abuse services that are evidence based.
- The most frequently cited resources for information on EBPs were SAMHSA's National Registry of Evidence-based Programs and Practices (13 States), other SAMHSA Web sites (9), universities and research institutes (9), SAMHSA's Treatment Improvement Protocols (8), and addiction technology transfer centers (7).
- Thirty-seven States also reported needing additional information related to EBPs, including measuring the implementation of and fidelity to EBPs, information about funding opportunities for developing and testing EBPs, and recommendations about gathering EBP outcomes and utilization data from providers.
- The vast majority of States are implementing a variety of EBPs, including supported employment (27 States), assertive community treatment (24), SBIRT (24), motivational interviewing (21), integrated dual disorders treatment (20), supportive housing (19), cognitive behavior therapy (17), and systems of care for children and youth (16).
- A sizeable number of States indicated that trauma screening is not provided as standard care (16 States) or that they are not implementing trauma-informed services across the age span (33).

Data and Reporting

- Most States are able to track Block Grant funding and identify individuals served and services provided through the Block Grant funds.
- Twenty-nine State Mental Health Authorities (SMHAs) and 22 Single State Agencies (SSAs) for substance abuse reported collecting data other than National Outcome Measures to obtain outcome and performance information. These States collect data related to client satisfaction, interpersonal relationships, medical and physical status, treatment engagement and retention, follow-up after hospitalization, access time to treatment, clinical progress as judged by clinician, and reason for termination.

Communication and Collaboration

- Fifty-four States reported collaborating with their State Medicaid agencies around the issue of health care reform, and the majority of States reported being involved in or initiating discussions regarding their State's Money Follows the Person program, the revised Medicaid 1915i waiver, and the concept of health homes.

- Forty-nine States reported some form of coordination with the National Guard, the Department of Veterans Affairs, and State and local authorities that are concerned with Guard, active duty, and reserves and behavioral health issues for them and their families.
- Forty-five States reported some form of collaboration with appropriate entities to ensure the integration into the health system of individuals reentering the community from correctional facilities.

TA and Other Resources

The most commonly cited TA and resource need areas were

- Workforce development and capacity (21 States)
- Services integration and linkages, especially related to the integration of behavioral health and primary care (16)
- Additional information and clarification of the provisions of ACA that will affect SMHAs and SSAs, specifically changes to Medicaid and the Substance Abuse Prevention and Treatment Block Grant requirements (15)
- Identification of funding resources to implement ACA-related requirements (13).

HIT

- Thirty States already have begun the process of developing HIT and electronic health record (EHR) infrastructure.
- Eighteen States indicated that provider training in EHR already had begun. Twenty-one States did not directly address the issue of provider readiness for HIT participation, and five indicated that they had no specific plans to ensure provider readiness.
- The most commonly cited TA and resource needs related to HIT were the identification of funding resources to support HIT development and implementation (16 States) and additional information on EHR development and requirements as they relate to ACA (6).

State Funding Distributions by Service Category

- States distributed funds across all of the mental health service categories, and most did not spend more than 25 percent of their total funds in any one area. States tended to distribute a higher percentage of their funds for outpatient, community and recovery support, and intensive support services.
- For most substance abuse services, States did not spend more than 25 percent of their total funds in any one category. The exceptions were outpatient services and out of home residential services.

As a result of addendum completion, SAMHSA has obtained needed information from States to assess their readiness to implement ACA as well as the areas in which State behavioral health agencies need assistance in order to fully realize the potential of ACA. SAMHSA assistance in these areas will help more States to comply with ACA requirements and to use the opportunity of health care reform to positively influence the provision of mental health and substance abuse prevention and treatment services.

Introduction

As implementation of the Affordable Care Act (ACA) progresses, State Mental Health Authorities (SMHAs) and Single State Agencies (SSAs) for substance abuse will need to prepare for significant changes in behavioral health systems and services. Although Fiscal Year (FY) 2014 is the time frame for most changes to State² systems, some provisions will take effect sooner (e.g., Money Follows the Person, Home Visiting, Medicaid 1915i). In addition, States will need to begin planning now for changes that will take effect in FY 2014. State responsibilities for implementing ACA will be enormous, and implementation across many levels of State government will be necessary. To ensure appropriate consideration of behavioral health system needs and concerns, SMHAs and SSAs will need to participate early and actively in their States' ACA planning and implementation processes.

The Substance Abuse and Mental Health Services Administration (SAMHSA) seeks to ensure that SMHAs and SSAs are actively engaged, planning, and able to use SAMHSA and other Department of Health and Human Services resources for ACA reform efforts. To this end, SAMHSA developed and requested that States complete an addendum to the FY 2011 Block Grant application to provide preliminary information on health care reform efforts. SAMHSA will use the information that States provide to determine State readiness and progress related to health care reform as well as to identify technical assistance (TA) and other resources that SMHAs and SSAs will need to fully implement ACA requirements.

This report describes the State responses to the addendum and the main activities that States are undertaking related to health care reform. The report is based on the qualitative analysis of State responses and is presented in accordance with the main categories of the addendum: coverage, integration, accountability, provider capacity, involvement of Tribes, evidence, data and reporting, communication and collaboration, TA and other resources, health information technology, and State funding distributions by service category. A brief methods discussion precedes the presentation of State responses and a conclusion summarizes the findings.

Methods

Qualitative information in the 10 addendum categories and funding data by service category were requested by SAMHSA and provided by 55 States. All 50 States completed the addendum form; the five entities that did not submit forms were Territories and Pacific Jurisdictions. States were given the option of submitting an addendum that describes the mental health system, the substance abuse system, or both systems combined. The 55 States submitted 71 different addendum forms. Completed forms were saved as Microsoft Word documents or text files and uploaded to NVivo 9 qualitative software. Qualitative analysts coded State responses for each of the 10 categories and identified themes across States. In most cases, States that submitted separate addenda for their mental health and substance abuse systems provided similar answers within each category. In this case, the responses were counted once. In a few categories, two systems within one State provided contradictory responses; in this case, both of the responses were coded, and the State was counted twice for the question. For example, in the evidence category, States were asked to provide an estimate of the proportion of their services that are

² For simplicity, we will use the term "State" within this document to refer to States, Territories, and the District of Columbia.

evidence based. In a few cases, the substance abuse system was able to provide an estimate, but the mental health system was not, and vice versa. Both answers were coded for the State and are represented in the report. For this reason, the responses cannot be considered mutually exclusive and may add to greater than 55 States in some categories. Finally, in a few categories, responses from substance abuse and mental health systems are discussed separately when the information provided by States warranted the separation.

Coverage

ACA includes provisions that require health insurance coverage for more than 32 million of the estimated 45 million uninsured people in the United States. To plan for and meet the expected increase in demand for behavioral health services as ACA is implemented, States were asked to determine their current behavioral health system capacity to serve individuals in poverty, the needed system changes States anticipate to accommodate the newly insured under ACA, and the Medicaid participation status of their publicly funded providers.

Current System Capacity to Serve Individuals in Poverty

States were asked to report the number of individuals currently in their behavioral health systems that are below 133 percent of the Federal Poverty Level (FPL). Nearly half the States (27) reported that their behavioral health agencies did not collect the data necessary to calculate this number or that this figure was otherwise unavailable. A small group (8 States) cited other poverty measures such as Medicaid eligibility instead. Another 21 States did not provide a specific number for a response.

Thirteen States were able to provide estimates of individuals below 133 percent of the FPL but noted that they were restricted to counting individuals with reported incomes who participated in programs or services where income was measured.

- Five States provided estimates for combined behavioral health systems. Of these, one State estimated 78,000, and the other four States estimated between 45,000 and 55,000 individuals below 133 percent of the FPL.
- Five States provided estimates for mental health systems. These estimates included lower numbers of 4,500 and 14,000 to higher numbers of 254,000 and 451,000.
- Five States provided estimates for substance abuse systems. Of these States, one estimated 7,500, another 23,500, and the rest estimated serving between 44,000 and 67,000 individuals below 133 percent of the FPL.
- Two States provided estimates of children, youth, or young adults served by children's behavioral health systems; in both cases, the States estimated serving about 12,500 children in families below 133 percent of the FPL.

Capacity Changes Needed to Serve the Newly Insured

States were asked to describe how the capacity of their behavioral health systems will need to be changed to accommodate the newly insured. Twenty States are anticipating significant increases to their capacity needs; respondents estimated that the newly insured will increase their care population by at least 25 percent. Fourteen States do not anticipate significant changes or do not

know whether the changes would be significant. A small group (4 States) already is increasing capacity through demonstration projects, managed care programs, and State health care reform. The most common capacity change anticipated by 20 States is changing the types of services provided to better serve the incoming populations. Changes to the types of services included increases in

- Care coordination, especially between behavioral health and primary care providers, to help better utilize existing capacity (9 States)
- Prevention, early intervention, and health promotion services to promote healthy outcomes and reduce future pressure on system capacity (6)
- Recovery services due to anticipated increased demand for these services (4)
- Services for specific populations, including adults over age 21, adolescents, and older adults who may increase their demand for services (3)
- Specialty care services, particularly in substance abuse to treat severe cases (3)
- Primary care services and their capacity to work with behavioral health providers (2)
- Other services, including inpatient services, outpatient services, assessment and brief intervention, and other types of interventions (7).

Thirteen States foresee a need to expand the workforce to handle the new capacity. Specific provider and workforce needs are discussed in more depth in the Provider Capacity section. Other capacity changes cited by States included

- Expansion of the provider network to include providers currently underutilized, such as private practitioners and faith-based practitioners or to incorporate new provider types such as critical access behavioral health agencies and certified peer specialists (6 States)
- Changes to quality improvement, review, and assessment practices to reduce costs and improve efficiency (5)
- Changes in enrollment processes and service access points to reach out to the newly eligible (4)
- Technical changes such as implementation of telehealth and electronic health records to better utilize existing capacities (3)
- Other activities such as Medicaid billing changes, strategic model development, and seeking additional funding (7).

Twelve States did not describe their capacity needs specifically but noted in general that capacity will need to be expanded. Another 12 States did not provide a specific answer to the question.

Medicaid Enrollment of Providers

Nearly half the responding States (27) reported that all publicly funded behavioral health service providers for substance abuse, mental health, or both are enrolled currently in Medicaid. Another 10 States reported that most providers were enrolled. Sixteen States encourage enrollment in Medicaid, and six have an enrollment initiative underway. Only four States reported that providers were not enrolled or that enrollment efforts were not under way because Medicaid is not available (Territories) or because the State's Medicaid agency does not offer substance abuse benefits. Eleven States did not provide a specific answer to the question.

Integration

ACA includes provisions that emphasize a holistic perspective and approach to treatment and services as the standard to replace a currently siloed and fragmented delivery system, especially between primary care and behavioral health. States were asked to determine current integration with primary care, coordinated planning efforts with Medicaid agencies, the promotion of conversations and coordination between specialty system providers and primary care, and integration and coordination between mental health and substance abuse. Nearly all States reported efforts in each of these areas, particularly in integration with primary care and coordination between mental health and substance abuse.

Integration of Services

States described the efforts taking place to integrate behavioral health services with primary care, to promote conversations between specialty system providers and primary care, to integrate and coordinate substance abuse and mental health services, and to include Medicaid in integration activities. All States except one are carrying out activities to integrate behavioral health care and primary care, and only three States did not provide a specific answer to the question about integrating and coordinating mental health and substance abuse services. Thirteen States did not specifically answer the question about coordination with Medicaid.

Planning activities such as convening workgroups and holding discussions among stakeholders was a common activity in each integration area. Thirty-three States are undertaking some type of planning activity to integrate primary care and behavioral health care. Twenty-eight States are using planning activities to promote conversations between primary care and specialty system providers and to include Medicaid in integrated care planning and implementation. Twenty-two States are conducting these sorts of activities to integrate substance abuse and mental health services.

Practice reform measures such as provider training and TA, integrated care requirements in contracts, and changes to licensure also were fairly common. Twenty-nine States are using practice reform activities in integrating substance abuse and mental health services and integrating with primary care services. Sixteen States are making changes to Medicaid benefits to encourage integrated care, and 15 States are using practice reform activities to encourage conversations between primary care providers and specialty system providers.

Formal partnership development such as fully integrated care sites, interagency agreements, partnerships between practices, and co-located services was used by 35 States to integrate primary care and behavioral health care and to integrate and coordinate mental health and substance abuse services. In addition, 21 States have witnessed formal partnerships develop between specialty system providers and primary care providers such as Federally Qualified Health Centers and Community Health Centers.

Specific models and programs are being implemented in many States using grants and pilot projects. These models involve substance abuse, mental health, primary care, and Medicaid agencies in various combinations. The most common programs were Screening, Brief Intervention, and Referral to Treatment (SBIRT, 20 States), medical home programs (17), Co-occurring State Incentive Grants for Treatment of Persons with Co-occurring Substance-Related and Mental Disorders (8), and managed care programs (7).

Preferred Models of Primary Care and Behavioral Health Integration

The majority of State behavioral health agencies have not identified a preferred model of integration; 23 States have not developed a preferred model, and 10 reported that the flexibility of multiple models was preferred. Twenty-two State behavioral health agencies did not provide a specific answer. The preferred models that were identified were

- Four Quadrant Clinical Integration (3 States)
- Home Health (3)
- Bidirectional Integration (2)
- Integrated Co-Location of Services (2)
- Chronic Care (1)
- Safety Net Expansion (1).

Context Experts on Primary Care and Behavioral Health Integration

About half of State behavioral health agencies did not or could not answer this question; 19 declined to answer specifically, and 12 reported that content experts have not yet been identified. Thirty State behavioral health agencies have identified the following content experts:

- 17 content experts from integrated behavioral health agencies, including six Directors or Deputy or Assistant Directors, three Assistant or Deputy Commissioners, two Medical Directors, a Chief Clinical Officer, and a Chief Medical Officer
- 16 content experts from the State Mental Health Authorities, including five Medical Directors, four Directors or Associate Directors, and three Deputy or Associate Commissioners
- 14 content experts from the State Substance Abuse Authorities, including three Directors or Assistant Directors, two Administrators, a statistician, and a treatment coordinator
- 6 content experts from Medicaid, consisting of four Directors or Assistant Directors, a branch manager, and a business administrator
- 2 content experts from a Health and Human Services Department, consisting of a Deputy Director and a Department Chair
- 2 content experts from Children's Services, consisting of a services coordinator and a psychiatrist
- 3 other content experts, consisting of a Secretary of Health and a consultant from a private organization.

In general, content experts were selected for their support of health integration, expertise on specific models, experience leading integrated care projects, and a history of working with behavioral and primary care providers.

Accountability

States were asked to describe their efforts to implement the ACA provisions related to promoting better coordination of care, especially for people with chronic illnesses. Specifically related to accountability, States were asked to describe their plans to manage the needs of individuals with behavioral health and other chronic conditions. In addition, States were asked to identify the

types of services individuals with significant behavioral health and other chronic conditions need and the State's role in designing an approach to meet these needs.

Managing the Needs of Individuals with Behavioral Health and Chronic Conditions

States described the efforts under way to address the needs of individuals with behavioral health conditions and chronic illnesses. Eight States are currently in the process of developing a plan by collaborating with both publicly funded and other health care providers as well as the State Medicaid agency to determine how best to meet the needs of individuals with behavioral and chronic conditions. Seven states reported that they have efforts underway to move toward a recovery-oriented system of care for both mental and substance use disorders (SUDs). Ten States reported focusing on integrated treatment for persons with co-occurring conditions. The following models are being implemented in these States using different grants and pilot projects:

- Integrated treatment for co-occurring substance use and mental disorders (8 States)
- Health homes (6)
- SBIRT (2)
- A chronic care model (3).

Services Needed

States were asked to identify the types of services needed for individuals with behavioral health and other chronic conditions. Eighteen States identified care coordination and case management as much needed services. Twelve States reported needing recovery support services, and 19 reported a need for wellness promotion and prevention services (including primary health care). Twenty-five States did not provide a response to this question. Other common themes regarding services needed were

- Peer support (8 States)
- Health homes (7)
- Integrated services for co-occurring disorders (7)
- Assisted housing (5)
- Telehealth services (4)
- Family services such as home based therapies, family psychoeducation, and therapeutic foster care (4)
- Transportation (3)
- Intensive support services (3)
- Evidence based interventions (2)
- Supported employment (2)
- Wraparound services (2).

States' Roles

States were asked to identify their roles in designing approaches to meet the needs of individuals with behavioral health and chronic conditions. Forty-six States reported that they collaborate with the State Medicaid Authority and other partnering agencies to design protocols and develop approaches to meet the needs of those with behavioral health and chronic conditions. Twenty-

one State reported that they perform in a leadership role for these collaboratives. Of these States, four currently lead efforts to develop medical homes, three lead efforts to develop recovery-oriented systems of care, two lead efforts to implement patient-centered care models, and two ensure that mental health services are given proper consideration in health care reform efforts. Two SMHAs are part of the Governor's health care reform cabinet. Thirteen States either did not provide a response to this question or reported that the State's role had not been determined yet.

Provider Capacity

As discussed previously, ACA is expected to increase the number of people who will seek mental health and substance abuse services. Several States reported that this increased demand has the potential to add further strain to their mental health and addictions workforces that already are experiencing shortages. In this category, States described specific provider shortages, efforts to increase the number of professionals with basic competencies, and resources needed to expand the workforce.

Provider Shortages

States reported experiencing shortages according to location, service type, and discipline. States determined provider shortages using Federal provider shortage designations, State provider shortage designations, or provider ratios that exceeded commonly accepted standards. Geographically, States reported that their shortages were either statewide (17 States) or in rural areas (26). Consumers living in low population density areas may have to travel long distances to find a mental health or substance abuse provider, which limits their access to services. States also noted a limited ability to provide certain services due to the lack of qualified providers or organizations willing to provide the service. The services needing expansion included SBIRT, treatment for co-occurring disorders, child and adolescent services, case management, crisis management, outpatient services, detoxification, suboxone services, early intervention, medication assisted treatment, residential treatment, supportive housing, psychiatric services for adults and children, respite care, and trauma-informed services.

States characterized their manpower shortages in many disciplines as "widespread" or "severe." Many States are currently working with diminished capacity and will need to increase capacity if they are to satisfy their current needs in addition to the potential increased demand after ACA implementation. Twelve States reported a shortage of psychiatrists, and another eight reported shortages in child and adolescent psychiatrists and psychologists. Substance abuse programs in 10 States reported a dearth of substance abuse providers. Four States reported general shortages of qualified or certified providers and indicated a need for increased training and certification. Other disciplines with shortages reported by one or two States included marriage and family therapy, psychology, and social work.

Workforce Competency and Expansion Efforts

To address these shortages, States have implemented a variety of workforce development strategies, including the development of competence standards as well as certification, licensure, and continuing education requirements. Ten States described workforce development committee efforts. These committees are generally interagency teams tasked with developing

comprehensive plans to address workforce issues. Efforts are being led by the States, provider associations, or training institutes.

Sixteen States are developing or adopting competency standards for behavioral health and substance abuse providers with an emphasis on requirements for entry-level positions and clinical supervision. Universities are working with many of these States to develop competencies or infuse them into academic programs. Entry-level positions benefitting from competency development include peer support, family support, and recovery support specialists. These efforts enable States to develop training and certification programs that can attract more qualified people to the profession.

Thirty-five States reported using training to expand the number of qualified professionals in the workforce. Most of this training was focused on continuing education to increase or maintain the level of competence in the existing workforce. States also reported providing basic competency training opportunities for primary care, police, and emergency services. Fifteen States reported the training of providers in specific evidence-based practices (EBPs). Training was provided directly through the States or via contractual arrangements with universities, training centers, or provider associations. Although most trainings were conducted face-to-face, seven States provided distance learning opportunities.

Twenty-two States are using Federal and State financial incentive programs to increase the number of practitioners in provider shortage areas. Fourteen States reported offering loan repayment for those who work in provider shortage areas. Eight States participate with the National Health Service Corp Program, which offers a financial incentive for providers who commit to work in provider shortage areas.

Needed Resources

States would like increased support to continue and expand workforce development efforts. In particular, 17 States need assistance to meet training demands, including additional funding for EBP trainings and assistance with the development of training plans. Four States cited the need for access to loan repayment programs such as the National Health Service Corp to expand the workforce in underserved areas. Assistance with provider recruitment, including marketing to encourage individuals to enter the behavioral health field, is of interest to four States.

Involvement of Tribes

As ACA is implemented, SAMHSA will require States to have more Tribal involvement in needs assessment, planning, and service delivery processes. States were asked to describe how Tribes are currently included in their planning processes; how Tribal needs were assessed and addressed in last year's service plans; how specific information about Tribes is collected and reported; and what the State's plans are to consult with each Tribe in the State to ensure involvement in needs assessment, planning, and service delivery processes.

Twenty-three of the responding States do not have any Federally recognized Tribes and therefore did not provide any information about Tribal involvement. Of the States who have Tribes, the following was found:

- Nineteen States include Tribes in the planning process by having at least one Tribal representative on the State workgroup. Other States have less formal arrangements and

meet with Tribes on an as-needed basis. Six States have formalized consultation policies with Tribes that describe how State agencies will engage with Tribes on planning and other relevant issues. Two States also mentioned that they are required to notify Tribes of changes to Medicaid. Nine do not include Tribes in planning, and four did not answer the planning question.

- Four States noted that assessment is a part of the planning process, and two States conducted a separate needs assessment process for Tribes. Tribal liaisons are responsible for assessing Tribal needs in four States. Tribal liaisons maintain close contact with Tribal representatives and typically are able to share information about the Tribe. Eight States did not assess or address Tribal needs in last year's State plan, and 13 others did not answer this question.
- Information on Tribes is collected from Tribal liaisons in four States and is reported as demographic data in the State data system. Sixteen States do not collect or report information on Tribes, and three did not answer this question.
- Several States reported that they will begin or continue to conduct outreach to Tribes to ensure that they are involved in future efforts. States plan to include tribes through coalitions, workgroups, and Medicaid planning efforts. To a lesser extent, Tribes will be able to access State resources through consultation or technical assistance. Eleven States do not have plans for including Tribes in future needs assessment, planning, and service delivery efforts, and one State did not answer this question.

Evidence

For the past several years, SAMHSA has prioritized the development and implementation of EBPs in mental health and substance abuse prevention and treatment service delivery. ACA also includes provisions that promote the adoption and use of EBPs; therefore, States are encouraged to maintain or increase EBP development and implementation. In this area, States reported on the proportion of their purchased services that are evidence-based, the information that States have and still need on EBPs, how States are implementing services that are “good and modern,” and how trauma screening and trauma-informed services are incorporated into standard care.

Proportion of Purchased Services That Are Evidence Based

Thirty-two of the 55 responding States provided specific responses about the proportion of their services that are evidence-based. Seven States were able to provide specific numbers related to the total proportion of both mental health and substance abuse services that are evidence based. Of these States, one reported that 85 percent of its services are EBPs, four reported 40–60 percent, one reported 35 percent, and one reported 15 percent.

Seventeen States provided proportions for their substance abuse systems only, and most provided information on their prevention systems only. Of these States, 10 reported that 100 percent of their prevention services are EBPs, three reported 85–95 percent, and one reported 70 percent. One State reported that 100 percent of both its substance abuse prevention and treatment services are EBPs, one reported 40 percent, and one reported 20–25 percent.

Eight States were able to provide the proportion of mental health services that are evidence based. Of these States, one reported that 100 percent of mental health services are EBPs, and two reported 20–25 percent. The remaining five States reported that less than 10 percent of their

mental health services are EBPs. States that did not have the data available to provide specific proportions of services that are evidence based typically stated that their funds are mixed with funds from other agencies such as Medicaid and then funneled to providers for services. These States do not track the funds once they are blended with funds from other agencies and could not provide a specific response about proportions of purchased services.

Information on EBPs

Most of the 45 States reporting in this area provided information about the types of organizations and other resources from which they have received information on EBPs. The most frequently cited resources for information on EBPs were

- SAMHSA’s National Registry of Evidence-based Programs and Practices (13 States)
- Other SAMHSA Web sites, including SAMHSA’s main site and Treatment Improvement Exchange Web site (9)
- Universities and research institutes (9)
- SAMHSA’s Treatment Improvement Protocols (8)
- Addiction Technology Transfer Centers (7)
- Websites, libraries, or clearinghouses maintained by individual States (5)
- SAMHSA’s TA publications (3)
- Experts on specific EBPs (3).

In addition, six States gained information from provider trainings on implementing specific EBPs, another six received information from a State-sponsored EBP collaborative, and five reported receiving information on EBPs as a result of participation in EBP research studies and demonstration projects. Thirteen States also collect information from providers on the extent of EBP implementation.

Thirty-seven States also reported needing additional information related to EBP development and implementation. Eighteen States would like to have information related to measuring the implementation of and fidelity to EBPs, including valid tools for assessing fidelity. Five States would like information about grant and other funding opportunities for developing and testing EBPs. Six States would like recommendations about gathering EBP outcomes and utilization data from providers. Other needs cited by one or two States each included adapting EBPs for specific cultures, cost-effective EBPs for youth, available EBP training, information on new and emerging EBPs, and results of research studies for specific EBPs.

Implementing “Good and Modern” Services

All 55 States provided information about the ways in which they are implementing services that are good and modern according to SAMHSA’s definition and examples that were provided to States with the addendum form. The vast majority of States responded to this question by describing the types of EBPs that they are currently implementing. The most often cited EBPs that States are implementing are

- Supported employment (27 States)
- Assertive community treatment (24)
- SBIRT (24)
- Motivational interviewing (21)

- Integrated dual disorders treatment (20)
- Supportive housing (19)
- Cognitive behavior therapy (17)
- Systems of care for children and youth (16)
- Seeking Safety (a trauma-informed model, 13)
- Wraparound services (13)
- Peer or family support services (11)
- Trauma-focused cognitive behavior therapy (11)
- A matrix model (10)
- Multisystemic therapy (for youth; 10).

States also responded to the question of how they were implementing good and modern services and how they planned to develop increased capability to provide EBPs. The most often cited strategies for developing and maintaining a good and modern system of care included

- Training providers to use EBPs (30 States)
- Collecting and reviewing fidelity data for EBPs (9)
- Using a SAMHSA grant to develop a system of care for children and youth (8)
- Establishing a committee to assess and improve the quality of services (8)
- Actively seeking input from consumers about services improvement (6)
- Transforming the State system to a recovery-oriented system of care (5).

Seven States reported that they required their providers to use EBPs. Most States reported that they encouraged their providers to use EBPs by offering training and materials and reinforcing the importance of EBPs at the Federal level; however, they did not require that a specific proportion of services be evidence based.

Incorporating Trauma-Informed Services Into Standard Care

The topic of trauma-informed services consisted of two main questions: how trauma screening is incorporated into standard care and how States are implementing trauma-informed services across the age span. A sizable number of States indicated that trauma screening is not provided as standard care (16 States) or that they are not implementing trauma-informed services across the age span (33). In addition, 12 States did not answer the screening question, and eight did not address trauma services across the age span. Of the States that did respond, the most often cited strategies for incorporating trauma screening into standard care were

- Training clinicians to gather information related to trauma (21 States)
- Requiring the administration of a specific screening or assessment tool that contains a section on trauma (11)
- Requiring trauma screening for women's services (7)
- Requiring trauma screening in State hospitals (3).

Thirteen States responded that they were implementing trauma-informed services across the age span by offering an array of trauma-informed services for different age groups and populations, including children and youth (13 States), women (7), veterans (2), individuals who have been incarcerated (2), American Indians (2), and older adults (2). Another 14 States reported providing evidence-based services for children and youth but not addressing other age groups,

and four responded that the only trauma-informed services provided statewide are for women. Eleven States reported that they are attempting to expand their capabilities in the provision of trauma-informed services by offering additional trauma training for providers.

Data and Reporting

The States were asked to describe their ability to provide specific information on services and individuals that are funded through the Block Grants and to provide outcome or performance information other than the National Outcome Measures (NOMs). Most States are able to track Block Grant funding and identify individuals served and services provided through the Block Grant funds because of unique client identifiers that allow for their treatment episodes to be linked over time and across agencies.

Block Grant Data (Mental Health)

A total of 15 States can provide information on individuals served using Mental Health Block Grant funds. Another 15 States are able to provide information on services provided and programs funded through the Mental Health Block Grant. Six States can provide fiscal tracking information; however, eight States are unable to track Block Grant funds because no codes are applied to services funded using Mental Health Block Grant dollars at the service or the individual level. One Territory is in the process of purchasing a data system to collect specific information about services funded through the Block Grant, and two States did not provide an answer to the question.

Data Other Than NOMs (Mental Health)

Twenty-nine States reported collecting data other than NOMs to obtain outcome and performance information. Of these States, 11 collect a variety of outcome and performance data such as client satisfaction, change in interpersonal relationships, change in medical or physical status, engagement, retention, follow-up after hospitalization, and treatment completion. Four States are able to collect data for outcomes monitoring systems for adults and children. Four States use the Web Infrastructure for Treatment Services (WITS) electronic health record (EHR) system to collect their outcomes data. Ten States are in the process of developing, purchasing, or expanding their data systems in order to collect data other than NOMs. Two States are unable to provide outcomes data for the Block Grant other than NOMs. Four States did not provide a specific answer to this question.

Block Grant Data (Substance Abuse)

A total of 18 States reported being able to provide information on individuals served using Substance Abuse Prevention and Treatment (SAPT) Block Grant funds. Through their participation in data collection for the Treatment Episode Data Set (TEDS), these States assign unique client identifiers that allow for client treatment episodes to be linked over time and across agencies. Services also are reported using unique codes and can be linked to the client, the clinician providing the service, and the funding source. Ten States are able to provide information on services provided through the SAPT Block Grant. Five States reported using the WITS EHR system to collect TEDS information; results of screening assessments; and data on the number, type, frequency, modality, and cost of services provided. Nine States are unable to

distinguish the clients funded or partially funded through the Block Grant from clients whose services are funded through other sources.

Data Other Than NOMs (Substance Abuse)

States were asked about their ability to provide information about outcome and performance data other than NOMs. Twenty-two States reported that they are able to provide data other than the NOMs. Of these States, seven collect a variety of outcomes and performance information such as legislatively mandated data and data specific to national, State, or local grants and partnerships. Two States require their providers to conduct a follow-up assessment with clients 60–90 days after discharge. The purpose of this follow-up interview is to assess the standard NOM areas of alcohol or drug use, criminal involvement, employment and education, housing status, and social support of recovery. Three States collect their non-NOMs outcome measures using a Web-based system. Four States are in the process of purchasing or developing a Web-based system to collect data other than the NOMs. Five States did not provide an answer to this question.

Non-NOMs outcome measures collected by States include

- Access time to treatment (length of time between interview and admission)
- Clinical progress as judged by clinician (e.g., significant progress, some progress)
- Reason for termination (e.g., completed treatment, referred elsewhere)
- Numbers of clients that drop out of treatment prematurely (e.g., within the first week)
- Number of discrete treatment episodes
- Numbers of patients that refuse additional recommended treatment services
- Reasons for treatment interruption (e.g., patient moved, patient was incarcerated, natural disaster).

Communication and Collaboration

ACA includes provisions that require collaboration among consumer, provider, payer, and government stakeholders. States were asked to report on their involvement in planning for health care reform, in their State’s “Money Follows the Person” efforts and their revised Medicaid 1915i waiver (if applicable), and in any discussions regarding the health home concept as it relates to individuals with serious mental illness (SMI), children with serious emotional disturbances (SED), individuals with SUDs, and individuals with co-occurring disorders. States also were asked to describe their collaborative involvement, if any, with the military regarding behavioral health issues of Guard members, active duty, reserves, and their families, as well as their coordination with the appropriate entities to ensure integration into the health system of those reentering the community from correctional facilities.

Planning for Health Care Reform with the Medicaid Agency

Almost all State behavioral health agencies (54) reported being engaged with their Medicaid agencies on the issue of health care reform. Five agencies did not answer the question, and one indicated that the question was not applicable as these agencies do not exist in the Territory. Of those indicating that they are collaborating with the Medicaid agency, 24 reported participating in a planning committee or task force convened to address health care reform. Seven indicated that their agency is under the same organizational umbrella as the Medicaid agency, thus making collaboration an ongoing feature of their relationship, and three noted that they have signed or

will sign an interagency Memorandum of Agreement or Cooperative Agreement to solidify their partnership in planning for health care reform. One entity reported creating a strategic plan with the Medicaid agency, and another hosted a symposium to discuss the issues.

Money Follows the Person

The majority of State behavioral health agencies (38) support their State's consideration, planning, and implementation of the Money Follows the Person program. Of the agencies responding that they were involved in the consideration of the program, five stated that their State ultimately decided not to apply, and four indicated that their State has applied for or received an expansion of the program. Twenty-two agencies did not directly answer the question, two reported that they are not involved in their State's Money Follows the Person efforts, one indicated that the question is not applicable as these agencies do not exist in the Territory, and one indicated that their State is not pursuing a Money Follows the Person grant but did not indicate whether they had been involved in the consideration of the opportunity.

Revised Medicaid 1915i Program

Approximately half of the State behavioral health agencies (28) responding in this area indicated that they have initiated or are currently engaged in discussions regarding the revised Medicaid 1915i program. Twenty-three agencies did not directly answer the question. Four agencies indicated that there has not been any discussion regarding the program or that a discussion has not been initiated. Four agencies reported that their State is not pursuing a revised 1915i but did not indicate what type of discussions occurred prior to this decision, one agency reported that it is not involved in the State's discussions regarding the program, and one indicated that the question is not applicable as these agencies do not exist in the Territory. Of those agencies indicating that they are involved in their State's discussions regarding the revised 1915i program, 10 reported that their State is definitely pursuing a waiver, and the remainder indicated that they are in the various stages of consideration of the opportunity and planning for a proposal. One agency noted that its State currently has a waiver for individuals with SMI.

Health Homes

Approximately half of the State behavioral health agencies (28) have had discussions regarding the concept of a health home as it relates to individuals with SMI or children with SED, individuals with SUDs, and individuals with co-occurring disorders. Twenty-seven agencies did not directly answer the question, one agency indicated that it had not yet initiated discussion, one reported that it is not involved in the State's discussions of the health home concept, one noted that the question is not applicable as these agencies do not exist in the Territory, and four reported that their State has not had any discussions regarding the concept of a health home. Of those agencies indicating that they have participated in discussions regarding the concept of a health home, four reported that their State is already implementing health homes for adults with SMI or children with SED. Four agencies reported that their State has received a grant to implement the health home concept, and another four agencies reported that a State committee has been discussing the concept of health homes as it relates to individuals with SMI or children with SED, individuals with SUDs, and individuals with co-occurring disorders.

Coordination with Entities that are Concerned with Guard, Active Duty, and Reserves and Behavioral Health Issues for Them and Their Families

Almost all (49) responding State behavioral health agencies reported some form of coordination with the National Guard, the Department of Veterans Affairs (VA), and State and local authorities that are concerned with Guard, active duty, and reserves and behavioral health issues for them and their families. Six agencies did not answer the question, one indicated that there is no coordination in the State, and one reported that the question is not applicable because these entities do not exist in the Territory. One agency indicated that coordination is planned but not yet implemented, and another noted that it had made initial contact with the appropriate entities.

Of those agencies that reported coordination with regard to military behavioral health, a wide variety of activities and coordinating agencies were identified. The most frequently mentioned activity was training of health care providers, military personnel, civilians, and family members regarding the mental health issues and challenges that veterans may face when returning from combat, as well as other special issues such as suicide prevention, stress, and traumatic brain injury (20 agencies). The second most frequently mentioned activity was the coordination of services for military personnel through the Access to Recovery grant program, for which 15 agencies have identified veterans as a priority population. Twelve agencies reported some form of outreach to local health care providers, other State and local agencies, military families, and the general public regarding mental health issues that active duty and returning veterans may face, as well as resources and supports available to them and their families. Other activities mentioned by fewer agencies were participation on a task force or workgroup related to veterans' mental health (9), suicide prevention programs (6), jail diversion programs (5), and the creation of a referral network (5). The most frequently cited agencies with whom the agencies collaborate on these issues were the National Guard (35 agencies), the VA (29), and local providers (15).

Coordination with Entities to Ensure Integration into the Health System of Those Reentering the Community from Correctional Facilities

The overwhelming majority of State behavioral health agencies (45) reported some form of collaboration with appropriate entities to ensure the integration into the health system of individuals reentering the community from correctional facilities. Nine agencies did not answer the question. Two agencies described plans to collaborate in the future, one agency noted that it does not have plans to collaborate, and one noted that the question is not applicable as these agencies do not exist in the Territory. Of those agencies reporting collaboration, a wide variety of activities and partner agencies were described. The most frequently cited collaborative activity was participation in an interagency or interdisciplinary team or workgroup (16 agencies), followed closely by discharge planning, care coordination, and case management for releasees (14). Other frequently cited activities included coordination of services across systems (13) and jail diversion programs (11). Eight agencies reported that individuals reentering the community from correctional facilities are identified as a priority population in their Access to Recovery grant program. The most frequently mentioned partners in these activities were the Department of Corrections (40 agencies), juvenile justice (12), probation and parole (9), and the court system (7).

Technical Assistance and Other Resources

SAMHSA is seeking to assist States now with their planning and implementation efforts for health care reform. To ensure the most effective and efficient use of our resources, SAMHSA asked the States to provide information on TA needed to address all of the other categories in the addendum form, suggestions regarding opportunities for exchanging information and ideas with other States, and other resources that would be helpful for States' planning and TA efforts. States communicated a number of TA and other resources needed to plan for and implement health care reform as well as ideas for collaboration with other States.

TA and Other Resources

A primary concern of grantees was a need for additional information and clarification of the provisions of ACA that will affect them, more specifically changes to Medicaid and the SAPT Block Grant requirements. Fifteen States cited this as a TA need and recommended a number of mediums for communicating this information, including regular and advanced training for agency staff, synthesized presentations by Federal officials, status and implementation information provided by SAMHSA, and onsite briefings. The other most commonly cited TA and resource need areas were

- Workforce development and capacity, including addressing provider shortages, recruiting and retaining behavioral health professionals, building professional competencies and certification, and identifying workforce training resources and resources for capacity measurement and evaluation (21 States)
- Research models and best practices for integrating behavioral health and primary care as part of a wraparound system of care (17)
- Services integration and linkages, especially related to the integration of behavioral health and primary care (16)
- Identification of funding resources to implement ACA-related requirements, including developing health information technology (HIT) infrastructure and emergency crisis systems, integrating services, blending funds, building recovery infrastructure, and funding EBPs (13)
- EBPs for services integration, prevention and treatment, and promoting positive mental health outcomes (12)
- Information on grants available through SAMHSA and other Federal agencies (7)
- SUD training for primary care providers (6).

Other TA and resource needs cited by only one or two States each included billing for services, analysis of benefits, identification of subject matter experts, establishment of health care homes, State needs assessments and gap analysis, and improving the inclusion of Tribes in the planning and implementation of health care reform. A number of States also indicated a need for information and clarification on the ACA requirements for EHRs, which is discussed in more detail in the HIT section.

State Collaboration and Information Exchange

States identified a number of ideas for information exchange with other States. Nine States suggested that SAMHSA provide support and resources for State-to-State collaboration. In addition, 12 States suggested that a new Web site for collaboration be developed or that SAMHSA's existing Web site be used for this purpose. Other suggested mechanisms for aiding collaboration included an email list serve for periodic updates and information sharing, an online resources database, a regional TA center, and an updated list of State contact information.

Fifteen States suggested that SAMHSA facilitate periodic regional conference calls for States to discuss, share, and pose any questions they have regarding ACA implementation. Fifteen States also recommended regional or national conferences for States to discuss health care reform. A number of these States recommended incorporating an opportunity for this discussion into the annual Mental Health and SAPT Block Grant meetings.

Thirteen States recommended periodic Webinars as a medium for sharing information and best practices among States and providing training related to HIT, EHR, and health care reform. These States preferred Webinars because they are relatively inexpensive to implement, able to reach relatively large numbers of people, and minimize the need to travel to trainings and meetings.

HIT

Over the next few years, as ACA is implemented, behavioral health care providers will need to be increasingly linked to the HIT system being developed by the Department of Health and Human Services Office of the National Coordinator of HIT as well as any HIT systems currently being developed or implemented in their States. In this category, States provided information about the HIT progress within their State, efforts to ensure provider readiness for HIT participation, and HIT-related TA and resources needed.

State HIT Progress to Date

Thirty States already have begun the process of developing HIT and EHR infrastructure. Thirteen of these States indicated that their State committees are currently meeting to develop HIT infrastructure and strategy, and 17 indicated that standards have been developed or proposed standards have been submitted for State approval. Strategies highlighted by one or two States to develop HIT infrastructure included adopting one region's successful model as the statewide model, developing an open-source electronic medical records system, and using the VA and SAMHSA's EHR interface. Four States reported receiving Federal grants to support HIT infrastructure development.

Lead agencies responsible for developing a statewide HIT strategy varied. Nineteen States identified interagency steering committees as being responsible for the statewide HIT strategy. Within these committees, lead agencies varied and included State departments of health, community health, public health, mental health, and IT. Ten States identified the Governor's office as the lead agency, four identified the State Medicaid agency, and five States identified private organizations or contractors as the lead HIT entity.

Of the States that responded the questions relating to HIT progress to date, 26 noted that the SMHA or SSA was not a direct member of the steering committee or HIT strategy development

group; however, they received regular updates and in some instances participated in meetings or votes on the final HIT strategy. Only seven States reported that the SMHA or SSA was not involved at all in developing the State's HIT strategy.

Efforts to Ensure Provider Readiness for HIT Participation

State efforts to ensure provider readiness for HIT system participation were less clearly identified. Twenty-one States did not directly answer this question. Efforts identified by the States that did address the question included accessing grants and other funding sources and assessing current funding resources for training. Eighteen States indicated that provider training in EHR already had begun. Five States indicated that they had no specific plans to ensure provider readiness for HIT participation.

HIT-Related TA and Resources Needed

States identified a number of HIT and EHR related TA needs, which overlapped considerably with their overall TA needs discussed in the previous section. The most commonly cited TA and resource needs related to HIT were the identification of funding resources to support HIT development and implementation (16 States) and additional information on EHR development and requirements as they relate to ACA (6). TA and information needs reported by one or two States each included information about Federal expectations, standards, policies, system requirements, compliance, and infrastructure development for HIT and EHRs and how HIT can be used to support Medicaid and other third-party billing as well as statewide data collection. Suggested mechanisms for providing this information included SAMHSA's dissemination of best practices, identification of subject matter experts, and trainings on HIT topics. Webinars again were cited as the preferred medium for trainings.

State Funding Distributions by Service Category

SAMHSA also requested that States complete a table to provide data on State funding distributed in different service categories. SAMHSA requested that States complete two tables, one for mental health services and one for substance abuse services. Thirty-eight States completed a funding distribution table for mental health services, and 48 completed a table for substance abuse services. For some service categories, States responded that the category was not applicable, and this column was added to the table. Tables 1 and 2 present the distribution of State funds for various service categories in mental health and substance abuse, respectively. The numbers in the tables represent the number of States that reported spending the indicated percentage of funds for the particular service category.

Table 1. State Funding Distributions by Service Category – Mental Health (N=38)

Category	Service Examples	Estimated Percent of Funds Distributed					
		Less than 10	10–25	26–50	51–75	Over 75	Not Applicable
Healthcare Home/Physical Health	SBIRT, acute primary care, general health screens, tests, and immunizations	20	5	0	0	0	13
Prevention and Wellness	Prevention and wellness, including smoking cessation	22	6	0	0	0	10
Engagement Services	Engagement services, including assessment, specialized evaluations, service planning (including crisis planning), consumer/family education), and outreach	19	14	1	1	0	3
Outpatient	Outpatient and medication services, including individual evidence-based therapies, family therapy, medication management, and consultation	7	11	10	3	1	6
Community and Recovery Support	Community and recovery support (rehabilitative), including peer support, recovery support services, case management, skill building, supported employment, supportive housing, and behavioral management	6	19	8	2	2	1
Other Supports	Other supports (habilitative), including personal care, homemaker, respite, transportation, assisted living, and trained behavioral health interpreters	24	5	2	1	0	6
Intensive Support Services	Intensive support services, including intensive outpatient, partial hospitalization, assertive community treatment, intensive home-based treatment, and multi-systemic therapy	16	11	3	0	0	8
Out of Home Residential	Out-of-home residential services, including crisis stabilization, residential services, and supports for children in foster care	16	8	3	0	0	11
Acute Services	Acute intensive services, including mobile crisis services, urgent care, psychiatric inpatient, and medical detoxification services	15	8	1	2	0	12

As shown in Table 1, States distributed funds across all of the service categories, and most did not spend more than 25 percent of their total funds in any one area. States tended to distribute a higher percentage of their funds for outpatient, community and recovery support, and intensive support services.

Table 2. State Funding Distributions by Service Category – Substance Abuse (N=48)

Category	Service Examples	Estimated Percent of Funds Distributed					
		Less than 10	10–25	26–50	51–75	Over 75	Not Applicable
Healthcare Home/Physical Health	SBIRT, acute primary care, general health screens, tests, and immunizations	37	0	0	0	0	11
Prevention and Wellness	Prevention and wellness, including smoking cessation	5	34	5	0	0	4
Engagement Services	Engagement services, including assessment, specialized evaluations, service planning (including crisis planning), consumer/family education), and outreach	31	8	1	1	1	6
Outpatient	Outpatient and medication services, including individual evidence-based therapies, family therapy, medication management, and consultation	7	16	17	3	1	4
Community and Recovery Support	Community and recovery support (rehabilitative), including peer support, recovery support services, case management, skill building, supported employment, supportive housing, and behavioral management	27	12	2	1	0	6
Other Supports	Other supports (habilitative), including personal care, homemaker, respite, transportation, assisted living, and trained behavioral health interpreters	32	2	1	1	0	12
Intensive Support Services	Intensive support services, including intensive outpatient, partial hospitalization, assertive community treatment, intensive home-based treatment, and multi-systemic therapy	22	16	3	1	0	6
Out of Home Residential	Out-of-home residential services, including crisis stabilization, residential services, and supports for children in foster care	8	10	19	3	0	8
Acute Services	Acute intensive services, including mobile crisis services, urgent care, psychiatric inpatient, and medical detoxification services	33	5	1	1	0	8

For most substance abuse services, States did not spend more than 25 percent of their total funds in any one area (Table 2). The exceptions were outpatient services, for which 21 States distributed 26 percent or more of their total funds, and out of home residential services, for which 22 States distributed 26 percent or more.

Conclusion

States provided a wealth of information through completion of the FY 2011 Block Grant application addendum about their efforts related to health care reform planning and implementation. The purpose of the addendum was to inform SAMHSA about potential areas in which States will need TA and resources in order to realize the full potential of ACA to reform health care. States reported strong planning and implementation efforts under way in some of the addendum areas, including the integration of behavioral health and primary health care, identification of provider shortages, expansion of the behavioral health workforce, provision of EBPs, Block Grant data reporting, planning for health care reform with State Medicaid agencies, coordination with the military to provide needed services, coordination with corrections facilities to ensure integration of releasees, and the development of HIT and EHR infrastructure. States reported needing assistance and funding to make progress in a number of other areas, including estimation of coverage rates and anticipating increases in demand for services as a result of ACA, addressing of provider shortages, identification and management of the needs of individuals with behavioral health and other chronic conditions, inclusion of Tribes in services planning and delivery, incorporation of trauma-informed services into standard care, establishment of behavioral health homes, and assurance of provider readiness for HIT system participation. SAMHSA's assistance in these areas will prepare more States to respond effectively to the changes required by ACA and to use the opportunities of health care reform to expand and improve behavioral health services for adults, children, and families throughout the Nation.