



THE FUTURE OF BEHAVIORAL HEALTH IN NEW ENGLAND

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SAMHSA: A PUBLIC HEALTH AGENCY

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

➔ **Roles:**

- Leadership and Voice – Influencing Public Policy
- Data and Surveillance
- Public Education and Communications
- Regulation and Standard Setting
- Practice/Services Improvement and Financing
- Funding - Service Capacity/System Development (esp. to test new approaches)



Behavioral Health is Essential To Health



Prevention Works



Treatment is Effective



People Recover

Region I Profile

State	Capital	Population ¹	Pop. Density ²	Joint	SA Prevalence ³	SMI Prevalence ⁴	Suicide Rate ⁵
Connecticut	Hartford	3,574,097	738.1	Yes	10.01	4.39	8.6
Maine	Augusta	1,328,361	43.1	Yes	8.49	4.67	12.8
Massachusetts	Boston	6,547,629	839.4	No	9.88	4.19	7.5
New Hampshire	Concord	1,316,470	147	No	9.81	4.57	13.1
Rhode Island	Providence	1,052,567	1018.1	Yes	10.72	7.2	9.9
Vermont	Montpelier	625,741	67.9	No	9.57	4.69	14.0
<i>United States</i>	<i>Washington, DC</i>	<i>309,349,689</i>	<i>87.4</i>	<i>N/A</i>	<i>9.1</i>	<i>4.6</i>	<i>11.3</i>

¹U.S. Census 2010

²U.S. Census 2010

³SAMHSA, NSDUH 2008-2009, Table 19. Dependence on or Abuse of Illicit Drugs or Alcohol in Past Year among Persons Aged 18 or Older.

⁴SAMHSA, NSDUH 2008-2009, Table 22. Serious Mental Illness in Past Year among Persons Aged 18 or Older, by State.

⁵CDC, National Vital Statistics System-Mortality (NVSS-M) 2008, per 100,000

TODAY'S DISCUSSION

1 CHANGING HEALTH CARE ENVIRONMENT

2 BEHAVIORAL HEALTH AS PUBLIC HEALTH

3 SAMHSA'S STRATEGIC INITIATIVES

CHANGING HEALTH CARE ENVIRONMENT

6

- *Prevention/Wellness* Rather Than Illness
- *Behavioral Health is* Essential to *Health*
- *Quality* Rather Than Quantity – saving costs through better care rather than less care
- Inclusive – Everyone's *Eligible* for Something
- *Public Payers' Roles* Changing
- Implications for *State's Role*

WHY BEHAVIORAL HEALTH MATTERS TO PUBLIC HEALTH – 1

→ BH Affects Most Americans

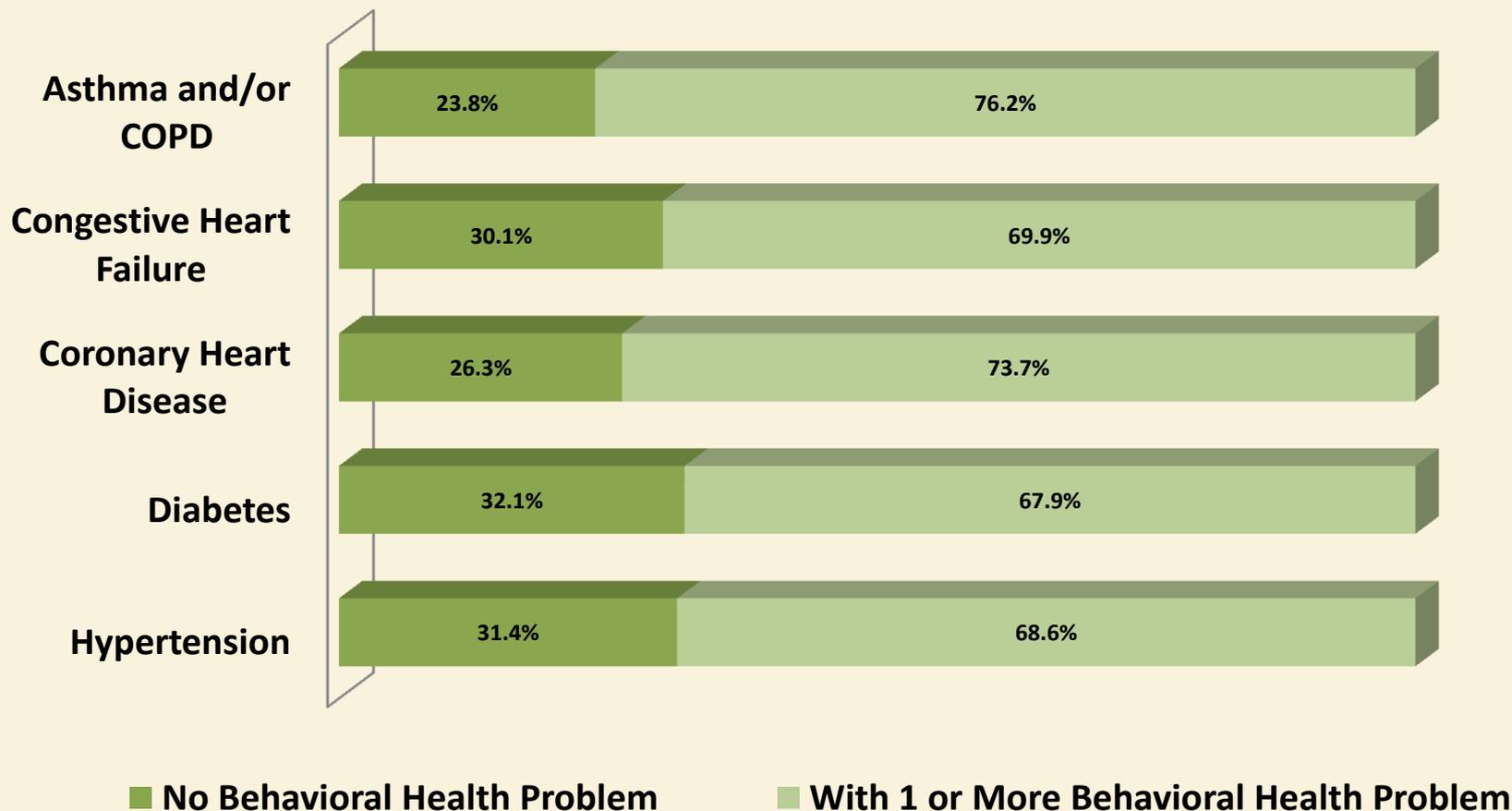
- Half will meet criteria for MI or substance abuse
- Half know someone in recovery from addiction (23 M +)
- One in four Americans will experience mental illness

→ Increases Risks for/Co-Exists with Other Diseases, Yet is Preventable

- HIV/AIDS, STDs, diabetes, cardiovascular disease, obesity, asthma, hypertension
- More adverse childhood experiences (ACEs) = more health/BH conditions in adulthood
- Half of adult mental illness begins before age 14 and three-quarters before age 24

PREVALENCE OF BH CO-MORBIDITIES

(MEDICAID-ONLY BENEFICIARIES W/DISABILITIES)



Boyd, C., Clark, R., Leff, B., Richards, T., Weiss, C., Wolff, J. (2011, August). Clarifying Multimorbidity for Medicaid Programs to Improve Targeting and Delivering Clinical Services. Presented to SAMHSA, Rockville, MD.

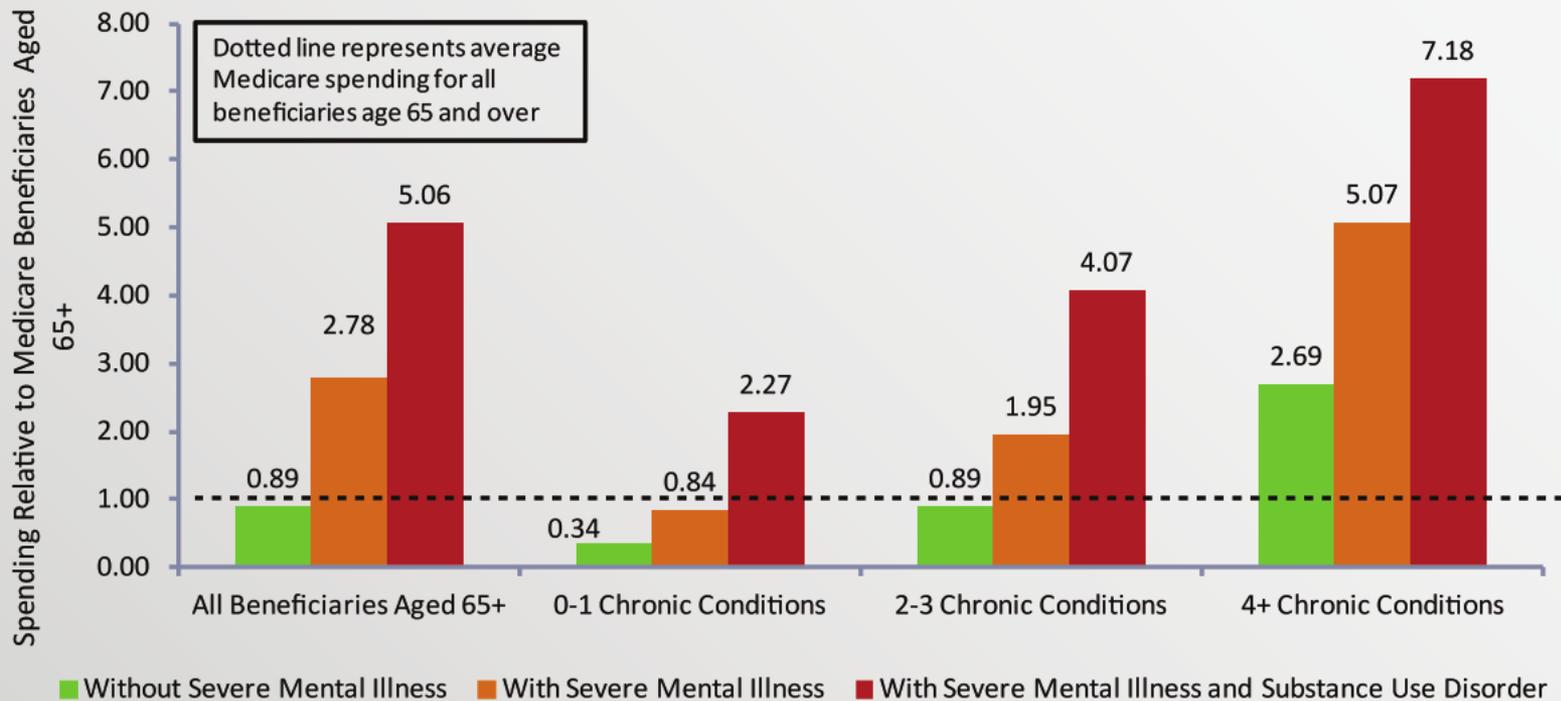
WHY BEHAVIORAL HEALTH MATTERS TO PUBLIC HEALTH - 2

→ High Impact on Health Systems – Practice and Costs

- ~ ¼ of pediatric visits and community hospital stays
- ~ 1/5 of ER visits involve illicit drugs (21 percent) or alcohol (19 percent)
- 2010: Medicare spent 5 x more on beneficiaries age 65+ w/SMI & SUDs than similar beneficiaries w/out these diagnoses
- 2010: Of Medicare beneficiaries w/out SMI, 17 percent were hospitalized; 46 percent of those w/SMI diagnosis; 88 percent of those with SMI/SUDs
- One of 5 top diagnoses in 30-day readmissions
 - 22 percent of Medicare beneficiaries age 65+ w/ SMI compared to 13 percent of those w/out SMI
 - Co-occurring SMI/SUDs – 34 percent rehospitalized w/in 30 days

MEDICARE BENEFICIARIES AGE 65+ WITH SMI AND SUD HAD SIGNIFICANTLY HIGHER MEDICARE SPENDING

Relative Per Capita Medicare Parts A and B Spending For Medicare Beneficiaries Aged 65+, By Number of Chronic Conditions and Severe Mental Illness Status¹, 2010

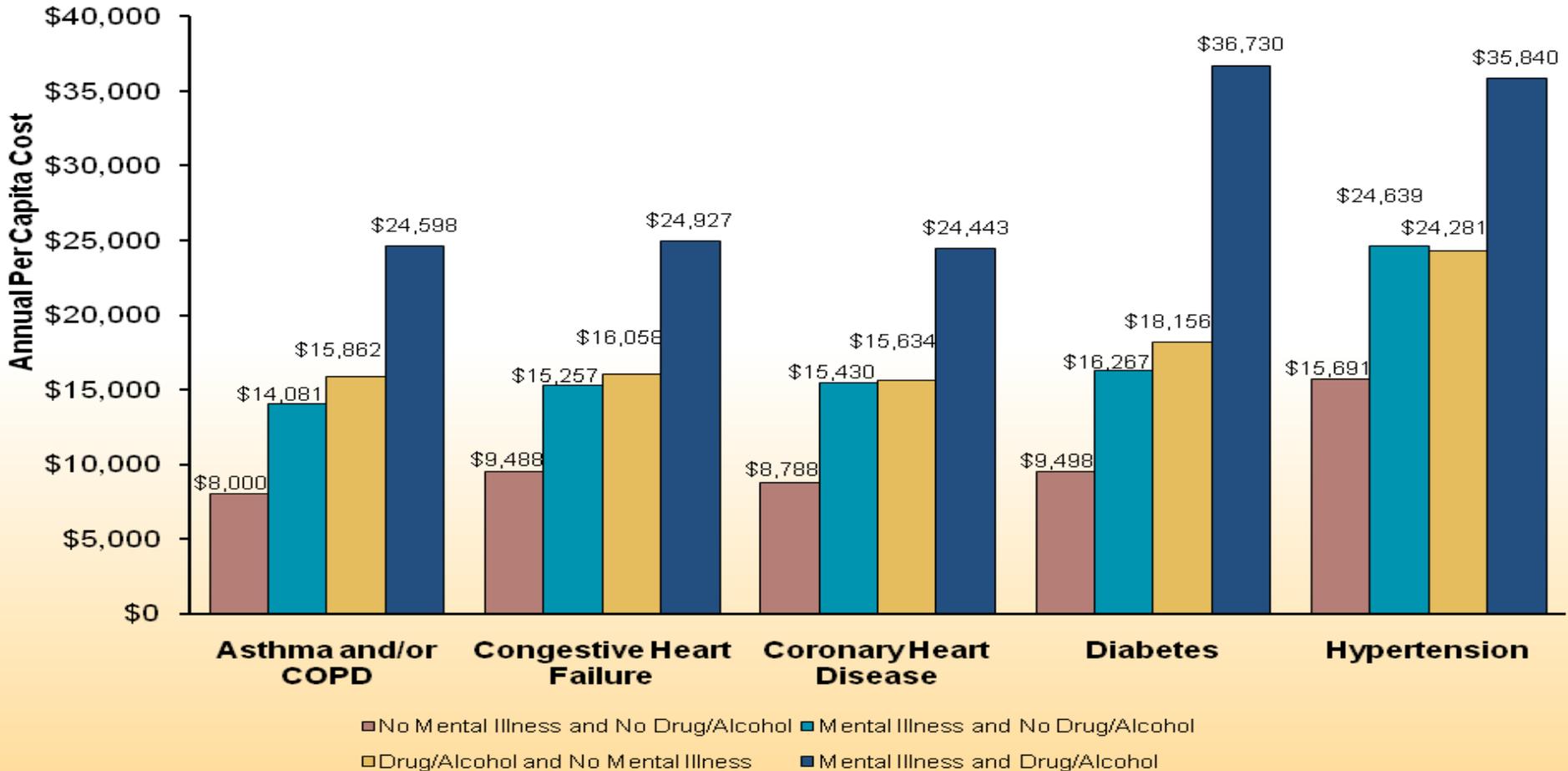


Note: Spending is expressed as a multiple of the average Medicare spending for all beneficiaries aged 65+ with and without severe mental illness (SMI). Medicare Part A and B spending includes inpatient and outpatient hospital services, physician visits, home health, skilled nursing facility, durable medical equipment, hospice, and misc. services.

¹ N = 22,166,860 Medicare beneficiaries age 65 and over without SMI, 1,356,980 with SMI, and 12,100 with both SMI and substance use disorder.

BH CO-MORBIDITIES: IMPACT ON COSTS

(MEDICAID-ONLY BENEFICIARIES W/ DISABILITIES)



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WHY BEHAVIORAL HEALTH MATTERS TO PUBLIC HEALTH - 3

12

→ High # BH-Related Premature Deaths/Preventable Illnesses

- Persons w/BH conditions die 8+ years younger, mostly from preventable health issues
- Half of all tobacco deaths occur among those w/BH conditions
- More deaths from suicide than HIV/AIDS and traffic accidents combined; plus breast cancer for all BH-related deaths

→ Study out of Germany using Composite International Diagnostic Interview and DSM-IV

- Much higher annualized death rates for women: 4.6-fold ↑ for females and 1.9-fold ↑ for males compared to age/gender-specific general pop
- Mean age of death 20 years ↓ for both genders
- Inpatient treatment had no impact on premature mortality

WHY BEHAVIORAL HEALTH MATTERS TO PUBLIC HEALTH - 4

13

- High Impact of Disparities (race, gender, ethnicity, LGBT, poverty) and Social Issues/Costs (homelessness, jails, child welfare)
- Most homeless and jailed individuals have BH needs; relatively few receive treatment; most are in or released to the community
 - LGBT population – elevated rates of tobacco use, certain cancers, depression and suicide deaths/attempts
 - Majority of foster children have drug-involved parents
 - Ethnic minorities more likely to be uninsured, have ↑ rates of certain disorders or incidence (e.g., suicide, drinking)
 - Persons with BH needs more likely to be uninsured and to “churn,” creating issues within the health delivery system.

PUBLIC PERCEPTION OF VALUE

- ➔ Public Willing to Pay 40 percent LESS . . .
 - To avoid mental illnesses (MI) compared to avoiding medical illness, even when MI (including SUDs) are recognized as burdensome*

- ➔ Mental Illnesses Account for 15.4 Percent of Total Burden of Disease**
 - Yet MH expenditures in U.S. account for only 6.2 percent of total health expenditures
 - SA expenditures account for only about 1 percent

* Source: NICHD, 2011

** Source: World Health Organization

WHY DOES IT MATTER?

- ➔ Public sees social consequences of behavioral health rather than health consequences
 - Homelessness, gangs, jails, tragedies (e.g., mass casualty shootings), disability, lost productivity, high government costs
- ➔ M/SUDs seen as matter of will instead of diseases or conditions to be prevented, treated and recovered from
 - Compare diabetes – not just about eating choices
- ➔ Universal Knowledge of First Aid for Health Conditions; Don't Teach or Know Signs, Symptoms, How to Get Help for MH or SA Issues

BH AS A SOCIAL PROBLEM LEADS TO INSUFFICIENT RESPONSES

Increased Security & Police Protection

Tightened Background Checks & Access to Weapons

Legal Control of Perpetrators & Their Treatment

More Jail Cells, Shelters, Juvenile Justice Facilities

Institutional System & Provider Oversight

SAMHSA'S 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

STRATEGIC INITIATIVE: PREVENTION

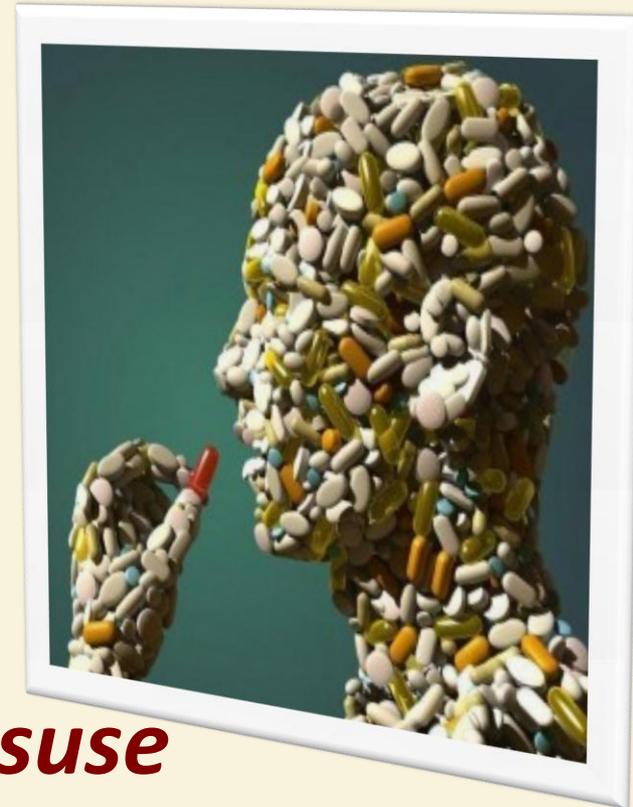
18

→ Substance Abuse and Mental Illness; Build Emotional & Behavioral Health

→ *Suicide Prevention*

→ Prevent Underage Drinking

→ *Prescription Drug Abuse/Misuse*



SUICIDE AND MENTAL ILLNESS: TOUGH REALITIES

19

19

50 Percent of Those Who Die By Suicide Had Major Depression – Suicide rate of people with major depression is 8 times that of the general population

90 Percent of Individuals Who Die By Suicide Had a Mental Disorder

MISSED OPPORTUNITIES = LIVES LOST

20

77 percent of individuals who die by suicide had visited their primary care doctor within the year

45 percent had visited their primary care doctor within the month

18 percent of elderly patients visited their primary care doctor on same day as their suicide

THE QUESTION OF SUICIDE WAS SELDOM RAISED

MISSED OPPORTUNITIES = LIVES LOST

21

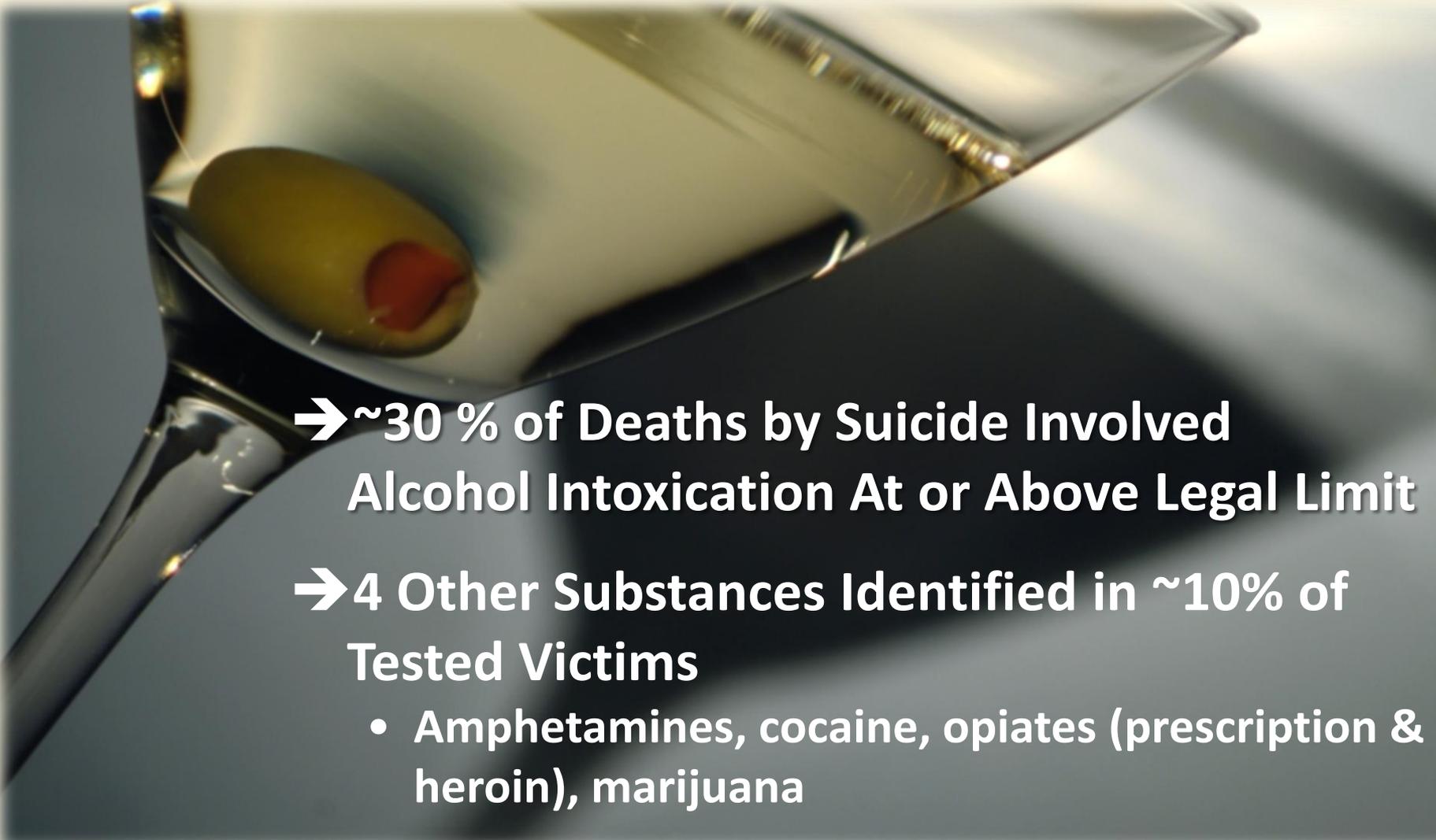
→ Individuals Discharged from An Inpatient Unit or Emergency Room Continue to Be at Risk for Suicide

- ~10 percent of individuals who died by suicide had been discharged from an ED within previous 60 days
- ~ 8.6 percent hospitalized for suicidality are predicted to eventually die by suicide

SUICIDE AND SUBSTANCE ABUSE: TOUGH REALITIES

22

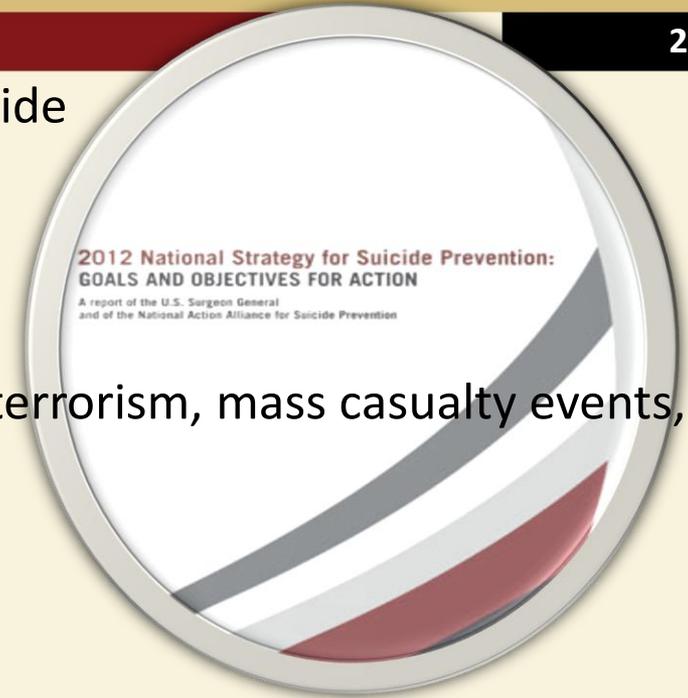
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- 
- ~30 % of Deaths by Suicide Involved Alcohol Intoxication At or Above Legal Limit
 - 4 Other Substances Identified in ~10% of Tested Victims
 - Amphetamines, cocaine, opiates (prescription & heroin), marijuana

SURGEON GENERAL'S NATIONAL STRATEGY FOR SUICIDE PREVENTION (NSSP)

23

- ➔ Annually, 11 M+ Americans Seriously Consider Suicide
 - 8 M make a plan
 - 2.5 M > 14 years attempt
- ➔ America Loses ~100 People/24 Hrs
 - 38,000 in 2010 – not to battles of war, acts of terrorism, mass casualty events, or natural disasters
 - Half w/ firearms; many w/prescription drugs
 - America lost more service members to suicide (349) than to combat (229) in 2011
- ➔ NSSP – Public/Private Partnership
 - Survivors, practitioners, funders, advocates, standard setters
 - Released 9/10/12 – World Suicide Prevention Day
 - Data, standards, screening, high impact models, awareness, high need populations, payment policies
 - SAMHSA's Garrett Lee Smith Suicide Prevention Grants



PRESCRIPTION DRUGS

→ Most Prevalent Illicit Drug Problem After Marijuana

- ~**22 M** persons initiated nonmedical pain reliever use since 2002
- ~1 in 22 (**4.6 percent**) reported misuse/abuse of prescription pain relievers (2010 & 2011)
- US represents 4.5 percent of world's population, yet consumes **99 percent** of world's hydrocodone (International Narcotics Control Board)

→ Emergency Room Visits

- Non-medical use of ADHD stimulant medications **nearly tripled** from 5,212 to 15,585 visits; (2005 – 2010)

→ SU Treatment Admissions

- Benzodiazepine and narcotic pain reliever abuse **↑ 569.7 percent** (2000 to 2010)

SOME FAMILY AND FRIENDS AREN'T HELPING

25

- ➔ Marijuana: ~ 70 percent of 523,000 teens aged 12-14 **received the drug for free** the last time they used
 - Over half (55.6-percent) received **from friends**
 - Over 10 percent received from someone in **their family**
- ➔ Prescription Pain Relievers: 54 percent of persons 12 and ↑ who used non-medically received them **from a friend or relative for free**
- ➔ Alcohol: ~20 percent of the time, parents, guardians, or other **adult family members provided** alcohol for underage drinkers

SAMHSA's WORK – WITH PARTNERS

- ➔ W/ Office of National Drug Control Policy (ONDCP) – Prescription Drug Prevention Plan
- ➔ W/ ASPE and CMS – Data Analysis
- ➔ W/ FDA, DEA, NIDA – Prescriber Training, Report to Congress, Public Awareness
- ➔ W/ ASTHO – Opioid Overdose Prevention Toolkit
- ➔ W/ ONC and DOJ – Grants to States for Prescription Drug Monitoring Programs (PDMPs) Interoperability with Health Information Exchanges (HIEs) and between States
- ➔ W/ States – Grants for Prevention of Prescription Drug Abuse and Underage Drinking

STRATEGIC INITIATIVE: TRAUMA AND JUSTICE

27

- ➔ Trauma-Informed Care; Trauma-Specific Screening and Services
 - Common definitions, principles, data
 - Consolidated technical assistance approach
- ➔ Childhood trauma in Juvenile Justice/Child Welfare
- ➔ ***Grants for Adult Trauma Screening Brief Interventions – GATSBI***
 - New services research grant program proposed to test new brief intervention (BI) models for women
 - Screen for trauma and interpersonal violence in emergency rooms, primary care offices, OB/GYN offices; provide BI
- ➔ Court Collaboratives/Early Diversion to Prevent Penetration into Corrections or Judicial Systems
- ➔ ***BH Impact of Disasters/Tragedies***

TRAGEDIES

Grand Rapids, MI
2011 – 8 Lost



Aurora, CO
2012 - 12 Lost



Nickel Mines, PA
2007 – 6 Lost

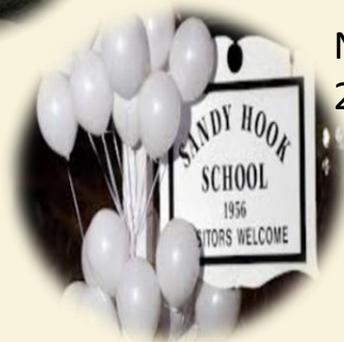


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Tucson, AZ
2011 – 6 Lost



Newtown, CT
2012 – 26 Lost



Asher Brown
2010 – 1 Lost
13 yrs old



Boston, MA
2013 – 3 Lost



Virginia Tech, VA
2007 - 33 Lost



Red Lake Band of Chippewa,
MN, 2005 – 10 Lost



Columbine High School
Littleton, CO
1999 - 15 Lost



SAMHSA's DISASTER TECHNICAL ASSISTANCE CENTER (DTAC): NATURAL AND HUMAN-CAUSED DISASTERS

29



Disaster Training and Technical Assistance

Supporting all-hazards disaster behavioral health preparedness, response, and recovery through informed, targeted technical assistance

- ➔ Technical Assistance, Training, and Expert Consultation
 - Review state/local all-hazards disaster BH plans
- ➔ Disaster BH Resources
 - >1,800 tip sheets, publications, studies, and articles
- ➔ Information Exchange and Knowledge Brokering
 - Connects those seeking technical assistance w/peers and experts in BH field

www.samhsa.gov/dtac

ADDITIONAL SAMHSA RESOURCES & WORK

30

SUICIDE PREVENTION
LIFELINE
1-800-273-TALK (8255)



24/7 Treatment
Referral Line
1-800-662-HELP (4357)

 **Disaster Distress Helpline**
1-800-985-5990
Text **TalkWithUs** to 66746

→ www.samhsa.gov

→ www.suicidepreventionlifeline.org

→ www.samhsa.gov/treatment

→ www.disasterdistress.gov

→ Research efforts with Assistant Secretary for Preparedness and Response (ASPR) and NIH

THE PRESIDENT'S PLAN: MENTAL HEALTH AS A PUBLIC HEALTH ISSUE

31



- ➔ **Less than half of people w/BH conditions receive the care they need**
- ➔ 23 Executive Actions to Reduce Access to Guns and Increase Mental Health Services
- ➔ FY 2014 Budget Mental Health Proposals -- \$235 M
- ➔ National Dialogue on Mental Health – to be launched this Spring

“We are going to need to work on making access to mental health care as easy as access to a gun.”

--President Obama

PRESIDENT'S EXECUTIVE ACTIONS ON GUN VIOLENCE – MAJOR IMPLICATIONS FOR BH

→ Among the 23 Executive Actions

- No. 17: "Release a letter to health care providers clarifying that no federal law prohibits them from reporting threats of violence to law enforcement authorities."
 - **January 16: Letter issued by Secretary Sebelius**
- No. 2: "Address unnecessary legal barriers, particularly relating to the Health Insurance Portability and Accountability Act, that may prevent states from making information available to the background check system." – ***Advance Notice of Proposed Rule-Making (ANPRM)***
 - ANPRM available for review at: <https://federalregister.gov/a/2013-01073>
 - Comments can be submitted to: <http://www.regulations.gov/>
 - Comments due **June 7, 2013**

STRATEGIC INITIATIVE: MILITARY FAMILIES

→ Access to Community-Based BH Care

- ***President's Executive Order – VA pilots; peers; suicide prevention; quality measures; National Research Action Plan (PTSD, TBI, suicide prevention)***
- TRICARE – credentialing and service package for current military personnel
- State policy academies – 30 + states/territories and DC – National Guard, Reservists, families not otherwise covered

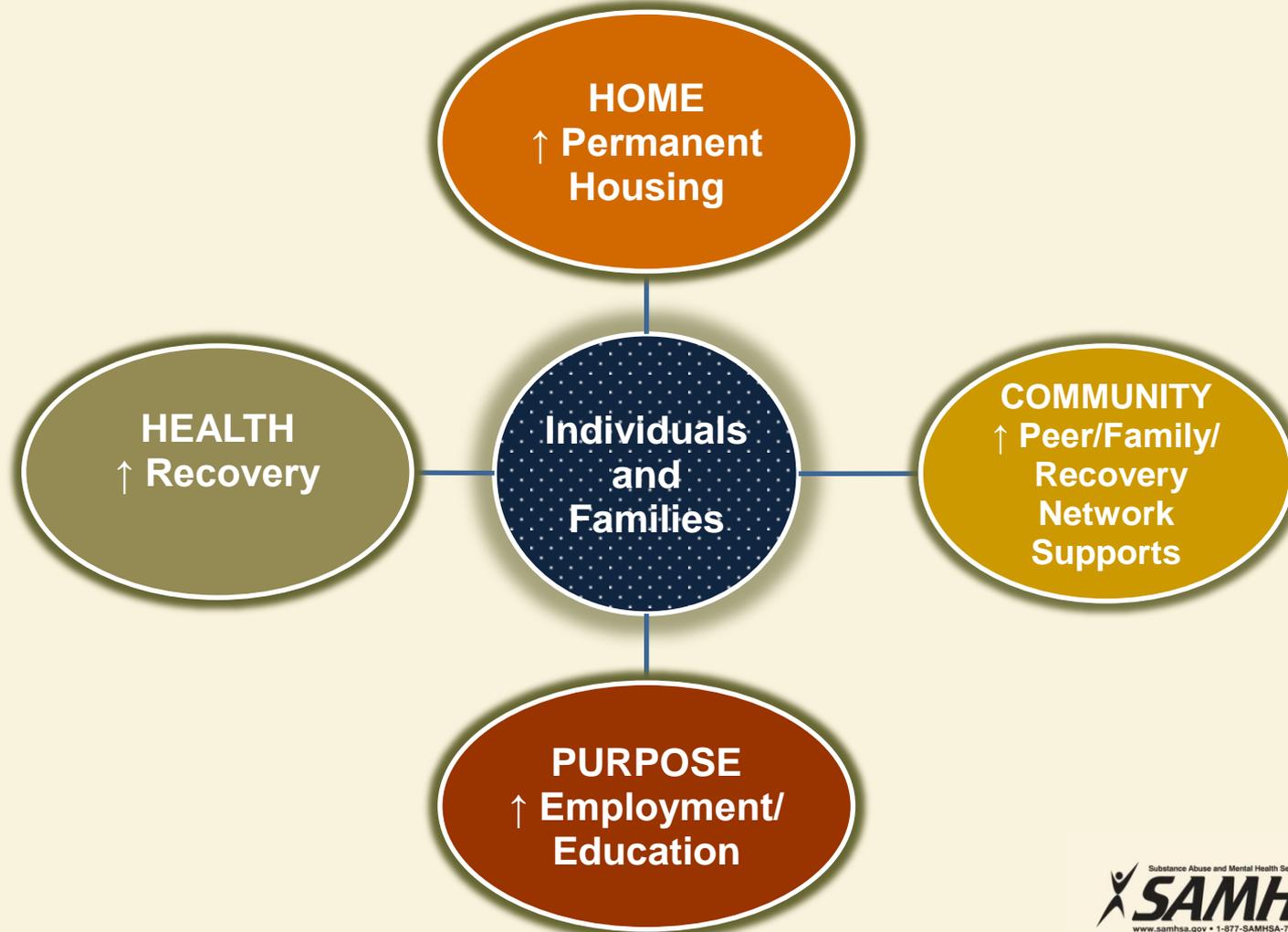
→ Military Culture Training

- With HRSA and private partners – National Council/SAAS

→ Promote Emotional Health/Resilience of Veterans, Services Personnel, and Military Families

- Programs & evidence-based practices in HHS programs

STRATEGIC INITIATIVE: RECOVERY SUPPORT



STRATEGIC INITIATIVE: HEALTH REFORM

35

- ➔ *Essential Health Benefits (EHBs) – Parity*
- ➔ *Enrollment and Eligibility – Qualified Health Plans (QHPs)*
- ➔ Uniform Block Grant Application – TA to States
- ➔ Services, Payment Policies, Quality/Measures
 - Medicaid (health homes, rules/regs, good & modern services, screening, prevention)
 - Medicare (duals, partial hospitalization, same day billing)
- ➔ *Primary/Behavioral Health Care Integration (PBHCI)*
- ➔ HIV/AIDS Prevention and Mental Health Treatment

ESSENTIAL HEALTH BENEFITS (EHB)

10 BENEFIT CATEGORIES

36

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

PARITY/ACA: PROJECTED REACH

	Individuals who will gain MH, SUD, or both benefits under the ACA including federal parity protections	Individuals with existing MH and SUD benefits who will benefit from federal parity protections	Total individuals who will benefit from federal parity protections as a result of the ACA
Individuals currently in individual plans	3.9 million	7.1 million	11 million
Individuals currently in small group plans	1.2 million	23.3 million	24.5 million
Individuals currently uninsured	27 million	n/a	27 million
<u>Total</u>	<u>32.1 million</u>	<u>30.4 million</u>	<u>62.5 million</u>

NOTE: These estimates include individuals and families who are currently enrolled in grandfathered coverage

IN 2014: MILLIONS MORE AMERICANS WILL HAVE HEALTH COVERAGE OPPORTUNITIES

38

- Currently, 37.9 Million Are Uninsured <400% FPL*
- 18.0 M – Medicaid expansion eligible
 - 19.9 M – ACA exchange eligible**
 - ***11.019 M (29%) – Have BH condition(s)***
 - <http://www.samhsa.gov/healthreform/enrollment.aspx>

Source: 2010 NSDUH

**Eligible for premium tax credits and not eligible for Medicaid

ACA: HHS

ENROLLMENT ASSISTANCE ACTIVITIES

→ Consumer Assistance Grants

- Employed directly by Medicaid agency or Exchange entity
- Support state development of appeals assistance services and claims dispute processes

→ Marketplace Assisters

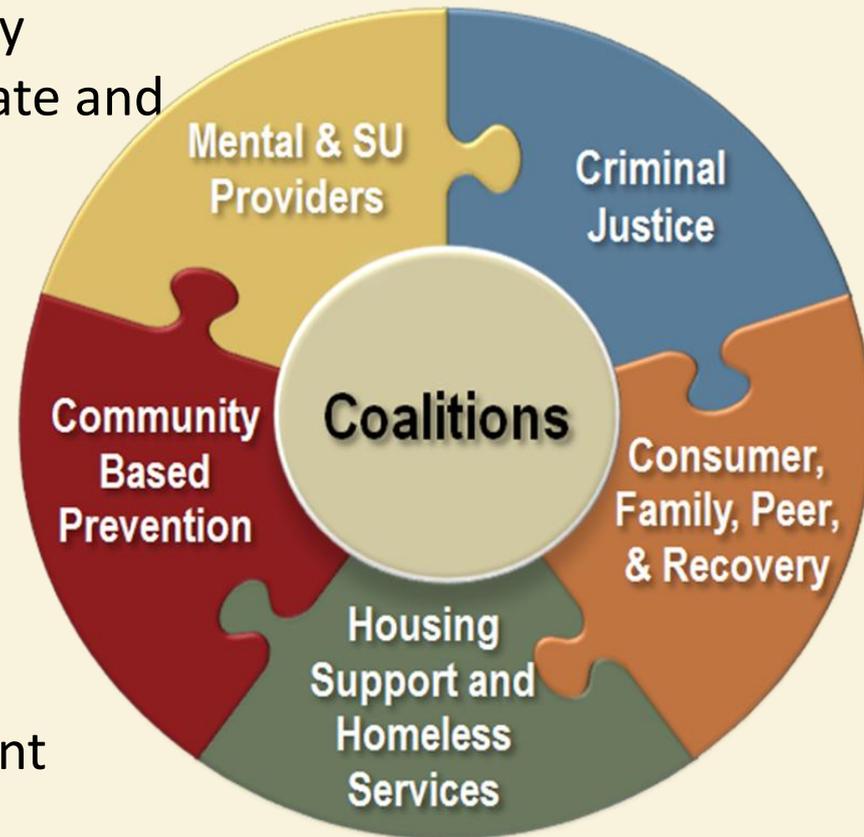
- Employed directly by Medicaid agency or Exchange entity, or funded by grant or contract to fulfill additional non-navigator assistance requirement

→ Navigator Program (2014)

- Include at least one consumer-focused non-profit
- Required for and financed by each Exchange
- At least 13 States engaged in public planning work
AR, WA, WV, CA, CO, CT, DC, HI, MN, NV, OR, VT

SAMHSA ENROLLMENT STRATEGY

- Collaborate w/national organizations whose members/constituents interact regularly w/individuals who have M/SUDs to create and implement enrollment communication campaigns
- Promote and encourage use of CMS marketing materials
- Provide T/TA in developing enrollment communication campaigns using these materials
- Provide training to design and implement enrollment assistance activities
- Channel feedback and evaluate success



BH AND PRIMARY CARE INTEGRATION: SAMHSA, HRSA, AHRQ, CMS

41

- Joint or Coordinated Products, TA, Grants
- Models of Integrated Care
 - Primary – SBIRT approach; integrated care approach
 - Specialty – Before, After or AS primary care
- Clinical Practice Issues
 - Capacity
 - Workforce competencies
 - System issues
 - Office flow issues
- Payment – Financing – Cost Issues
- Metrics re Value (Quality and Cost)

SAMHSA/HRSA – CENTER FOR INTEGRATED HEALTH SOLUTIONS (CIHS)

42

→ **Goal:** Promote planning and development of integrated PC and BH care for those w/SMI and/or addiction disorders, whether seen in specialty or PC settings (bi-directional)



→ **Purpose:** Serve as a national training and technical assistance center on bi-directional integration of PC and BH care and related workforce development needs

SAMHSA's WORK WITH OTHER FEDERAL PROGRAMS

43

- **AHRQ Center for Integration Models:** Developing models of integrated BH care in primary care settings
- **CMS/CMMI Innovative Financing Models for Integration:** Grants to test models
- **SAMHSA'S Primary/BH Integration (PBHCI) Grants:** Physical health of adults w/ SMI and TA for bi-directional integration
- **HRSA FQHCs:** Integrating BH screening, brief intervention and treatment
- **Medicare Accountable Care Organizations:** Payment for integrated care and outcomes
- **CMS Health Homes:** Whole person care for persons with specific characteristics or health conditions
- **CMS Partnership for Patients:** Reducing hospital readmissions; increasing quality

SAMHSA's NATIONAL BEHAVIORAL HEALTH *Barometer* - HIT

44

→ Annual Snapshot of BH in the Nation

- By nation, region, and state
- Key indicators from SAMHSA's population and treatment facility data sets, other HHS key surveillance data, and state-identified indicators
- Point-in-time data reflecting current status
- Trend over time to paint a picture of progress or emerging issues

INNOVATIVE USE OF TECHNOLOGY

Single, cloud-based platform to manage functions currently handled separately in three different systems – ***Common Data Platform (CDP)***



Community Early Warning and Monitoring System (C-EMS) - web-based framework for communities to respond quickly to emerging issues using targeted interventions

Data Portal to a secure, remote access system that allows approved researchers access to restricted-use BH data while protecting confidentiality



SAMHSA'S VISION

→ A Nation that Acts on the Knowledge that:

- Behavioral health is essential to health
- Prevention works
- Treatment is effective
- People recover



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