

*Department of Health and Human Services
Substance Abuse and Mental Health Services Administration (SAMHSA)
Center for Substance Abuse Treatment (CSAT)
National Advisory Council (NAC)*

August 24, 2016

Open Session Minutes

*5600 Fishers Lane
Room 5E29
Rockville, Maryland 20857*

Open Session Minutes

Opening Remarks and Introduction

The Center for Substance Abuse Treatment (CSAT) National Advisory Council (NAC) Designated Federal Official (DFO), Tracy Goss, called the meeting to order at 9:30 a.m. and conducted a roll call. Dr. Kimberly Johnson, Chair, Center for Substance Abuse Treatment (CSAT), National Advisory Council (NAC), greeted the members, extending a warm welcome to the newest members, Ms. Kristen Harper, Dr. Judith Martin, and Mr. Lawrence Medina. Dr. Johnson also mentioned new member, Dr. Trenette Clark, who was not in attendance.

Dr. Johnson thanked the presenters in advance, and briefly reviewed the agenda for the day. She introduced Dr. Elizabeth Lopez, Acting Deputy Director, CSAT.

Consideration of the February 24, 2016, Minutes

Dr. Johnson called for a motion for approval of the February 24, 2016, minutes for the 74th meeting of the CSAT National Advisory Council. A motion was moved by OmiSade Ali and seconded by John Paul Malloy. The motion passed without objection or abstentions to the motion, and the February 24, 2016, minutes were then approved by the Council.

Council Member Introduction and Updates

Council Members in attendance were OmiSade Ali, M.A., CADDC, CCS; Kristin Harper, M.Ed., LCDC; Andre Johnson, M.A.; Judith Martin, M.D.; Lawrence Medina, M.B.A.; John Paul Molloy, J.D.; Indira Paharia, Psy.D, M.B.A., M.S., LCP; Arthur Schut, M.A.; and Lori Simon, M.D.

Dr. Johnson opened the floor for Council Member introductions and asked them to share a brief statement of their industry affiliation for the new members. Andre Johnson was not present for introductions.

Dr. Lori Simon, a psychiatrist in Northern New Jersey and the west side of Manhattan, introduced herself. She stated that her interest is the use of computers in healthcare and shared that she spent eight years working for a homeless shelter, providing psychiatric care to the homeless and underserved population.

Dr. Indira Paharia introduced herself, stating that she is a clinical psychologist by training with a background in integration, behavioral medicine, and managed care.

Ms. OmiSadé Ali introduced herself, stating that she has been in the field for 46 years. She stated that presently she works for Altarum Institute, which has the contract for training and technical assistance for ATR. She is also the President of First Nations, LLC, and has dedicated a good portion of her career assisting the Native American communities healing from the residential school experience for indigenous people on Turtle Island, United States and Canada.

Mr. Lawrence Medina stated that he was from Taos, New Mexico, and is with the first recovery community organization in New Mexico, called Recovery-Friendly Taos County. He stated that he has been involved in community organizing and community development issues. He noted that he is also with Southern Rockies Addiction Treatment Services, working on developing Opioid Treatment Programs (OTP) in northern New Mexico and southern Colorado.

Ms. Kristen Harper introduced herself as the Executive Director of the Association of Recovery Schools. Their primary mission is to help create, sustain, and accredit recovery high schools across the country. She stated that her passion is in integration of services between mental health and substance use disorder recovery, an issue seen in adolescents within schools.

Mr. John Paul Molloy introduced himself and stated that he is with Oxford House, a self-run, self-supported, recovery house. He stated that Oxford House has 2,087 facilities in 42 states, with about 17,000 beds, and today have 170 vacancies.

Mr. Arthur Schut introduced himself and stated that he's been in the field for 46 years. He stated that he has served in Safety Net treatment and prevention programs in a variety of places and taught in a Master's program in addiction counseling at the University of Iowa for a couple decades. He currently serves on the board of a managed care company, NIATx Foundation, and also the Board of the National Council for Behavioral Health.

Dr. Judith Martin introduced herself as an addiction medicine doctor, initially trained in family practice. She stated that in 1986 she began to work with heroin-addicted patients and their families, later becoming an addiction medicine specialist. She mentioned a demonstration waiver to bring the Drug Medi-Cal treatment up to parity. She stated integration is part of the waiver, so paying attention to the fractured funding streams and how to bring those things together is part of her job. Coincidentally, in light of the news about opiates throughout the country, she noted that she has also spent years training doctors about how to use buprenorphine and methadone.

Director's Report/SAMHSA Budget Update

Dr. Johnson shared the Director's Report with the Council Members. She stated that significant progress on updates to 42 CFR Part 2 regulations has been made. She informed the Council Members that the public comment period closed in April, and SAMHSA received 375 comments

from a variety of stakeholders. After reviewing the comments, the SAMHSA team created a Draft Final Rule, which is currently going through clearance. There is anticipation that the Final Rule will be published in the Federal Register sometime in October or early November.

Dr. Johnson reported that the new buprenorphine regulation to increase the cap on the number of patients qualified practitioners can treat with certain Schedule III, IV, and V maintenance and detoxification medications has been completed. She cited this as one of the priorities of the Secretary's opioid initiative. The Final Rule was published in the Federal Register on July 8th and went into effect on August 8th, raising the highest patient limit from 100 to 275.

Dr. Johnson also discussed the expansion of the PEPFAR work to Africa and East Europe. She explained that PEPFAR is the President's Emergency Plan for AIDS Relief. In support of the effort and also to attend the annual PEPFAR meeting in Durban, South Africa, Dr. Johnson, along with SAMHSA's Principal Deputy Administrator, Kana Enomoto, traveled to Tanzania, Zambia, and South Africa in July. Dr. Johnson discussed being particularly impressed with the international work around AIDS and how there were very clear goals like the 90-90-90 goals, which focus on the following: ninety percent of the people who are infected know that they're infected, ninety percent of those that know they are infected are in treatment, and ninety percent of those who are in treatment have viral load suppression.

Dr. Johnson also gave an update on the block grant conference that took place the week prior. She stated that there were 600 participants from across the country.

Lastly, Dr. Johnson mentioned a discussion meeting convening next week related to improving the quality of substance use disorder treatment. She stated that there would be a panel of state leaders and stakeholder representatives sharing their experiences and ideas. She also stated that the discussion from this conversation would be shared in hopes of developing strategic plans or work plans around quality issues.

Dr. Johnson introduced Ms. Stephanie Weaver, Director of Office of Program Analysis and Coordination, CSAT, to deliver the Budget Update report. Ms. Weaver stated that while there was not yet a 2017 budget, the Senate and House markups from the President's budget were proposed earlier in the year. She stated that the Senate Markup proposed an increase for the Medication-Assisted Treatment for Prescription Drug and Opioid Addiction, better known as MAT-PDOA; the suggested increase is from approximately \$10 million to \$60 million for that program for FY17.

Ms. Weaver also informed the members that a level funding with FY16 Enacted Budget for the Minority AIDS Initiative was also recommended to the Senate. The money was intended to support the mental health side, and services were combined into one funding line.

Ms. Weaver stated that the House recommended an increase from the President's suggested budget in FY17 for the criminal justice line for level funding with FY16 enacted budget, which is \$78 million for the drug courts and other criminal justice activities.

In closing, Ms. Weaver informed the members that the topics that were not recommended for funding in the Senate or House budgets included the Buprenorphine-Prescribing Authority Demonstration and the Cohort Monitoring and Evaluation and Medication Assisted Treatment Outcomes. The latter was somewhat related to the State-Targeted Response Cooperative Agreements, which was a request for mandatory funding of \$460 million. Neither the House nor the Senate recommended funding those activities.

Ms. Weaver opened the floor for questions or comments of which there were none.

Treatment Quality Issues

Dr. Johnson introduced Dr. Lisa Patton, the Director of the Division of Evaluation, Analysis and Quality for the Center for Behavioral Health Statistics and Quality (CBHSQ), and Dr. Patricia Santora, Public Health Analyst, Division of Services Improvement, CSAT.

Dr. Patton and Dr. Santora presented on treatment quality issues with a focus on the National Behavioral Health Quality Framework (NBHQF) and SAMHSA's Core Behavioral Health Measures. Dr. Patton also highlighted SAMHSA's collaborative work with ASPE on the development of performance measures on severe mental illness (SMI). This portfolio of eleven SMI measures emphasizes the need for care coordination and addressing physical health co-morbidities.

Dr. Patton discussed NBHQF's six goals:

- Promote the most effective prevention, treatment, and recovery practices for behavioral health disorders.
- Assure that behavioral health care is person-, family- and community-centered.
- Encourage effective coordination of behavioral health care with primary care, recovery and social support services.
- Assist communities to utilize best practices to enable healthy living.
- Make behavioral health care safer by reducing harm caused in the delivery of care.
- Foster affordable, high quality behavioral health care by advancing recovery-oriented systems of care.

The NBHQF also includes recommended measures across three target domains: payers, providers/practitioners, and patient/population. The majority of these recommended measures have been endorsed by the National Quality Forum (NQF).

Dr. Santora continued the presentation by discussing key measure gaps in behavioral health and SAMHSA's role in addressing these gaps. One significant area in need of improvement was alcohol screening and brief counseling. Dr. Santora discussed how CSAT collaborated with the American Medical Association to develop and support pilot testing of the alcohol screening and brief counseling measure for NQF endorsement that occurred in 2014. When quality performance measures are endorsed by NQF (considered the "gold standard" of care), health care practitioners are paid for their services. Thus, it was essential for CSAT to develop the alcohol screening measure and have it endorsed by NQF for providers to improve care in this key behavioral health area.

To further establish and expand alcohol screening and brief counseling as a permanent component of primary care services at the health plan level, Dr. Santora then discussed CSAT's current collaboration with the National Committee for Quality Assurance (NCQA) for additional testing of the alcohol screening and brief counseling measure to have it included in the Healthcare Effectiveness Data and Information Set (HEDIS), one of the most widely used sets of performance measures for health plans in the U.S. Health plans maintain responsibility to ensure that their members receive appropriate care. Valid and reliable behavioral health quality measures are essential for health care providers and program administrators to improve behavioral health care. Thus, having the alcohol screening and brief counseling measure included in HEDIS will build the foundation for a more comprehensive approach to measuring and improving the quality of alcohol treatment services and health outcomes for individuals with substance use disorders. The alcohol screening and brief counseling measure is on track to be included in HEDIS in July 2017.

Integrating behavioral health measures in primary care settings is critical for effective healthcare delivery since many symptoms that bring patients to primary care providers are related to behavioral health. Thus, identifying a core set of behavioral health measures is necessary for addressing behavioral conditions with high prevalence and healthcare costs. To that end, Dr. Santora also described a core set of three behavioral health measures that SAMHSA advocates for use in primary care. These measures are: unhealthy alcohol use: screening and brief counseling (NQF #2152; tobacco use: screening and cessation intervention (NQF #0028); and depression screening and follow-up plan (NQF #0418). This core set of measures has been endorsed by NQF and is recommended by the U.S. Preventive Services Task Force.

Drs. Santora and Patton concluded their presentation by acknowledging that although SAMHSA has accomplished much in addressing measure gaps and developing behavioral health measures,

additional measure challenges remain. Measure gaps identified for further investigation and development include screening for opioid use and treatment, and behavioral health measures that are outcome-based. SAMHSA is looking to the NAC for their help in addressing additional gaps in behavioral healthcare to improve quality of care and health outcomes for individuals with mental and substance use disorders.

Council Discussion Topic: What should SAMHSA do to ensure that patients receive quality treatment services?

The following points were raised/discussed during the Council's discussion:

- Dr. Paharia made a suggestion that when expanding core measures, anxiety should be considered as part of the list. Dr. Patton stated that a partnership was created with National Institute of Mental Health (NIMH) in 2011/2012 to try to look at Posttraumatic Stress Disorder (PTSD) and there is interest around developing trauma measures.
- Dr. Paharia also discussed a big problem with Electronic Health Record (EHR) adoption. She stated that behavioral health adoption is extremely low compared to the medical side and added that most solo behavioral health providers do not have resources for technology. Dr. Johnson pointed out that what has been noted, looking at grantees, is that when monies are allowed for the purchase of EHRs, there are higher adoption rates.
- Ms. Ali posed the question of how the voices of lived experience and supporters were included in the creation of the measures. She also asked if provisions were included for communities of color. Dr. Patton stated that the NBHQF was developed over a multiyear period and had at least two stakeholder panels that included researchers, clinicians, people who work in quality measurement, providers, consumers, and actual family members. She noted that after publishing the NBHQF, there was a public comment period in which 750 comments were received. She stated that there was a strong and diverse consumer component to those comments.
- Ms. Harper asked if there were any plans for youth assessment. Dr. Patton replied that a depression screen exists, and a number of the measures are specified for youth and have a youth and adolescent counterpart.
- Ms. Harper turned the focus on how data is collected. She mentioned a very small pilot program that was launched with apps. She stated that the adolescents and emerging adult population appear to participate more when they get to use their phones, thus apps have been very helpful in collecting data. Dr. Johnson mentioned that she would be interested in pursuing a conversation about better ways to collect data that do not require an EHR.

- Mr. Schut mentioned Medicaid in states where there is month-to-month eligibility the block grant pays in the interim. He stated that most block grant services are not claim-based services; therefore, when all payer claim databases are reviewed, mental health services are not present.

SAMHSA Acting Administrator's Discussion with Council Members

Ms. Amy Haseltine, Deputy Administrator for Operations for SAMHSA, and Tom Coderre, Chief of Staff for SAMHSA, joined the meeting after the luncheon recess to address and answer questions from the NAC Council Members.

Ms. Haseltine informed the members that since the last meeting, her focus has been on four buckets of activities: policies, processes, procedures, and systems. She stated that “the people make SAMHSA go,” and the focus has been on getting the right people with the right skill sets in the right spots. The second area of major focus for SAMHSA is on policy. One example is strengthening grant project officers cadre of employees, making sure that they understand what grant administration rules are, and making sure that they are comfortable operating in a grantor/grantee relationship. Another area of focus in the policy and procedural realm is in the area of transparency and accountability, both in terms of finances as well as ensuring that information is made available in and across SAMHSA.

Ms. Haseltine assured the Council that SAMHSA is well-positioned to get through the presidential transition. She stated that there is work at the federal level, departmental level, within SAMHSA to ensure continuity of operations and a smooth transition of power. A lot of SAMHSA’s work has opportunities to overlap, connect with or integrate with other organizations within SAMHSA. She stated that, from an operational standpoint, as an organization, SAMHSA is working to strengthen its partnerships via communication across centers.

Tom Coderre shared details about his role and position. In addition to representing SAMHSA with the Department, the White House, and other federal agencies, he is a member of the coordinating council for both the Interagency Coordinating Committee for the Prevention of Underage Drinking and the Behavioral Health Coordinating Council.

Mr. Coderre recapped that Congress has been immensely focused on both the substance use and the mental health side of the ledger this year. He stated that in the last nine months, SAMHSA testified at six congressional hearings, which is more than SAMHSA testified in the previous three years combined. The majority of the focus of these hearings was on opioids, but mental health and tribal issues have also been on the top of Congress's interest list, coming from a

diverse group of committees: The Judiciary Committee, the Oversight Committee, the Indian Affairs Committee, Energy and Commerce, Health and Education, Labor and Pensions, and Appropriations.

Mr. Coderre gave an update and explanation on the passage of the Comprehensive Addiction and Recovery Act, also known as CARA, which on July 22, 2016, the President signed into law. It was explained that there are six approaches in CARA: prevention; overdose reversal; treatment; recovery; law enforcement; and criminal justice. Specifically, CARA authorizes programs to increase public education and awareness regarding the misuse of prescription opioids and temporarily expand the range of providers who may furnish medication-assisted treatment for substance use disorders (e.g. authorizing qualified nurse practitioners and physician assistants to prescribe buprenorphine and certain other drugs used in such treatment through fiscal year 2020). CARA also reauthorizes and improves interoperability for grants to the states for Prescription Drug Monitoring Programs. In addition to signing CARA, the President is proposing a \$1.1 billion initiative to address the opioid crisis that our country is in the middle of and the overdose epidemic that we're experiencing.

Mr. Coderre also informed the Council that on July 16th the House passed a substantially different version of Congressman Murphy's Helping Families in Mental Health Crisis Act of 2016. He stated that a version of the Mental Health Reform Act, version 2680 was passed, which has new provisions that were not in the previous version 2646. This bill elevates SAMHSA's impact by creating an Assistant Secretary for Mental Health and Substance Use Disorders to assume the role of the SAMHSA Administrator.

Mr. Coderre also recapped a few regulations that SAMHSA has been working on. One, commonly referred to as the "BUPE rule," was recently issued and would increase the patient limit for doctors who prescribe buprenorphine from 100 to 275. That rule has passed and it is complete.

Ms. Haseltine and Mr. Coderre opened the floor for questions or comments.

Mr. Lawrence Medina thanked Ms. Haseltine and Mr. Coderre for the overview. Mr. Medina then asked if there is a noticeable change in attitudes within Congress or the Hill. Mr. Coderre congratulated Mr. Medina on his 25 years of sobriety, and replied that we would have never seen activity on a bill like the Comprehensive Addiction Recovery Act if the times were not changing. Many of the resources exist on the criminal justice side and now CARA recognizes that. Mr. Coderre stated that we should see a more balanced approach in CARA, where there are programs that have been established or authorized at Department of Justice (DOJ), programs that have been authorized at HHS, and others established or authorized at Office of National Drug Control Policy (ONDCP) and some in other parts of the government. There is now a role to play for

everybody and SAMHSA is hopeful that we can get the funding necessary to actually carry out some of the programs that were authorized in that bill.

Dr. Judith Martin thanked SAMHSA leadership for attending all the committees and testifying. She inquired if the Murphy bill was still calling for the dissolving of SAMSHA and questioned if this request was still on the table. Mr. Coderre responded that the bill in question did start off with dismantling SAMHSA. However, the current bill elevates SAMHSA and recognizes that a strong SAMHSA is really what's needed in our country.

Ms. Kristen Harper asked Mr. Coderre to revisit the CARA bill and discuss from a policy standpoint how Recovery Support Services for youth, emerging adults, collegiate age population were addressed. Mr. Coderre responded that he was unable to speak on items that were not addressed in the bill. He reiterated SAMHSA's commitment to youth, confirming that the Administrator considers this a huge priority. He also noted that one of the challenges that SAMHSA faces is how SAMHSA "divvies" resources and how SAMHSA prioritizes due to having a limited number of them. He thanked members such as Ms. Harper for being on the Advisory Council to remind SAMHSA constantly that youth are important.

Ms. OmiSade Ali questioned how SAMHSA Leadership is encouraging our young people to come into the field. She also expressed concerns about what's going on across Native America, especially with the suicide clusters. Mr. Coderre acknowledged that he heard the same concern while visiting with the Tribal Technical Advisory Council earlier that day. Mr. Coderre stated that one of the challenges SAMHSA faces is that our authorities only allow SAMHSA to do what SAMHSA is allowed to do. Some of these decisions get made at the state level and some of them get made in Congress. He encouraged Ms. Ali to continue to be a vocal and strong advocate at the state level and in Congress. To address Ms. Ali's question about workforce, Mr. Coderre confirmed that SAMHSA has an entire strategic initiative at that is dedicated to workforce, led by Anne Herron.t. He also mentioned that Dr. Johnson has been providing good input into this initiative from her work not only as a provider, a former provider, and a former SSA, but from a research lens, as well.

Dr. Judith Martin inquired regarding SAMHSA's relationship with other federal organizations, specifically the relationship with CMS and what is being worked on. Mr. Coderre responded that the relationship with CMS is wonderful. He gave an example of how staff within the Office of Policy Planning and Innovation (OPPI), works very closely on a daily basis with CMS. Also through the Behavioral Health Coordinating Council, which has seven subcommittees that look at all aspects of behavioral health, whether it's serious mental illness, SAMHSA has a subcommittee on primary care and behavioral health integration. These meetings are held regularly, and CMS has staff members and principles that provide input.

Dr. Judith Martin asked if a goal date was established for payment reform in the treatment field. Mr. Coderre encouraged Dr. Martin to meet with him in the morning to be introduced to Chris Carroll, who would be able to give more information about what the trajectory looks like. Ms. Haseltine also mentioned that there was a President's task force regarding this as well. Mr. Coderre agreed and let Dr. Martin know that SAMHSA is very engaged in the Parity Task Force that the President established back in March. Mr. Coderre noted that the final report is going to be due to the President at the end of October. Ms. Haseltine reinforced that this President's task force is a multiagency project.

Reimbursement Strategies for Peer Services

Dr. Johnson introduced Patty McCarthy Metcalf, Executive Director of Faces and Voices of Recovery. The discussion was moderated by Tom Hill, Senior Advisor on Addiction and Recovery, CSAT.

Ms. McCarthy Metcalf opened with background information, reporting that Faces and Voices is a national advocacy organization based in Washington D.C. She stated that there were two different programs, the first being Association of Recovery Community Organizations (ARCO), as well as about 100 organizations around the country that are delivering peer services and doing advocacy work and public awareness. The second is a separate LLC that was created called the Council on Accreditation of Peer Recovery Support Services (CAPRSS).

Ms. McCarthy stated that her opinion is that there is prevention and there is treatment, but SAMHSA has not yet moved to re-dedicating resources internally to create guidance and training for the recovery workforce.

Ms. McCarthy stated that there is federal funding through block grants such as SAMHSA's TCE-Peer-to-Peer Grant and the Access to Recovery grant. She also stated that there were different ways that Regional Care Organizations (RCOs) and peer services are being funded. She expressed hopes of looking at other federal sources of funding through the Department of Justice, Department of Education and other departments as addiction touches lives in every department.

Ms. McCarthy Metcalf continued by saying that a lot of states have county-based funding, which allows the county to decide whether or not to provide Recovery Support Services. She stated that this can be a challenge as well as an opportunity.

Ms. McCarthy Metcalf expressed that in her opinion, moving towards the CAPRSS accreditation system will make it easier across the board to sustain the services that they have been building,

as it requires equal attention the structure or the quality, as well as the demonstration of their effectiveness.

Ms. McCarthy Metcalf stated that Medicaid reimbursement is rare for addiction peer support services; however, it is dominant in mental health peer services. She continued saying that there are 30 states that are reimbursing through Medicaid for mental health peer services whereas there are maybe six that are reimbursing for addiction. Resources are being circulated in the communities and states to try to change this. She cited this as an area of focus that stakeholders could help with regarding policy issues on the federal level.

Ms. McCarthy Metcalf continued by saying that there is a difference between accreditation and certification. She stated that accrediting an organization means that they've met standards to demonstrate that they are efficient enough to provide peer services. She stated that they have certified RCOs as well as peer programs within larger organizations within behavioral health agencies. She stated that organizations that are providing peer services within a treatment agency are encouraged to seek accreditation. She further explained that the preference would be to accredit treatment agencies that have a separate body or program within their agency that is peer-run, peer-driven and delivering peer services.

Ms. McCarthy Metcalf stated that Faces and Voices of Recovery is working with 11 organizations to become accredited, and there is one state that is a statewide model. She shared that in New Hampshire there was legislation stating that RCOs should be accredited by CAPRSS in order to receive state funding. She stated that accreditation is now a nationwide scope and there is a lot of interest from the mental health peer community to use the accreditation system to accredit peer-run organizations.

Lastly, coordinated and comprehensive work is being done with statewide models. She stated that it ensures that states are delivering quality services. She noted that some states believe that accreditation will be an expectation to receive state funding.

Council Discussion

The following points were raised/discussed during the Council's discussion:

- Mr. Medina thanked Faces and Voices of Recovery and stated that this was a good example of helping with capacity building and awareness at a very grassroots level.
- Dr. Johnson asked the members to think about what SAMHSA and CSAT could do going forward to address the Medicaid disparity.

- Ms. Harper mentioned more training is needed within community colleges for peer recovery support, taking trained peer recovery support specialists into medical schools to teach medical students. She mentioned prevention involvement, using RCOs to facilitate prevention activities within schools or middle schools.
- Ms. Ali asked about the accreditation of native organizations. Ms. McCarthy Metcalf stated that this is something that they would love to work on. Ms. Ali suggested she work with Eva Petoskey from the Inter-Tribal Council of Michigan.
- Ms. Ali also mentioned data collection is less about the quantitative than the qualitative. She pointed out the importance of stories and anecdotes that people share that have changed their lives. Ms. McCarthy Metcalf mentioned that a cloud-based data collection system for Recovery Support Services is in development. She stated that they are meeting with all of the RCOs with interest in the workgroup to determine which data points should be collected. She stated that the data platform will be available to everyone within the next year.
- Ms. Ali questioned the cost of accreditation. Ms. McCarthy Metcalf stated that there was a \$1000 accreditation fee to get into the system and the other fees are paid when the facility is ready for the site visit.
- Dr. Paharia also explained a business case for expanding Medicaid coverage, thus expanding MCOs. She stated that there are possibly several years of claims data now in various MCOs. She noted that if a study could be funded to look at those members who received peer support services, versus those who did not, they could look at the effectiveness of the treatment itself and the medical cost offset of ER utilization and medical admissions as well as readmits on both sides, behavioral health and medical. Dr. Johnson stated that there was a vehicle that could potentially support this effort.
- Ms. Harper asked about phases or stages of the development of RCO and if emerging communities have been looked at; for instance, more established communities versus startups. Ms. McCarthy Metcalf stated that there is a RCO toolkit that was developed to help new and emerging RCOs based on the ones that have been around longer with more experience.

Public Comment

Dr. Johnson opened the floor for public comments. There were no public comments.

RECAP: Putting it all Together

Dr. Johnson closed the meeting by asking for general comments from the members on the meeting format, content, and discussion. She also asked the members to identify one thing that could be improved upon.

Mr. Schut stated that he appreciated having the reading materials prior to the meeting. He stated that he would like to have an opportunity to talk about the significant issues faced within the field.

Dr. Paharia stated that she appreciated how often Dr. Johnson encouraged everyone to speak up and be involved.

Dr. Simon stated that it would be nice if there was a way that the NAC could potentially play a role in the development of the grants; for example, the wording and what would be helpful to include.

Ms. Ali stated that the short presentations with sections for a response and questions were very helpful.

Mr. Medina stated that a short orientation for new members would be helpful. He stated that he liked the agenda.

Ms. Harper mentioned that it would have been helpful to have the recovery instrument that was mentioned in one of the presentations prior to the meeting.

Mr. Molloy felt that the format of the meeting went well.

Dr. Martin stated that she really enjoyed the meeting and Dr. Johnson's leadership style, and enjoyed her knowledge of performance improvement technology as that is useful to the field. She stated that she would be curious as to what the hot topics are and where input is needed.

Dr. Johnson thanked the members for participating in the CSAT National Advisory Council Meeting and called for a motion to adjourn the meeting. The motion was moved by Ms. OmiSade Ali and seconded by Mr. John Paul Molloy. The motion passed without objections or abstentions.

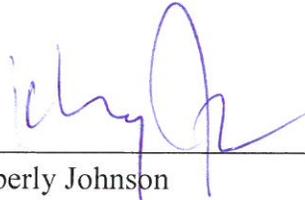
Adjournment

At the conclusion of the presentations and the recap, Dr. Kimberly Johnson moved for a motion to adjourn. At 3:45 p.m., a motion was moved by Ms. OmiSade Ali to adjourn the meeting and seconded by Mr. John Paul Molloy. Motion was passed and meeting was adjourned.

I certify that to the best of my knowledge, the foregoing minutes are accurate and complete.

11/17/17

Date



Dr. Kimberly Johnson

Director, Center for Substance Abuse Treatment