

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

February 1, 2017

Open Session Minutes

5600 Fishers Lane
Room 5 A503
Rockville, Maryland 20857

Open Session Minutes

Opening Remarks and Introduction

The Center for Substance Abuse Treatment (CSAT) National Advisory Council (NAC) Designated Federal Officer (DFO), Tracy Goss, called the meeting to order with Dr. Kimberly Johnson, Director of CSAT and NAC Chairperson, presiding. Dr. Johnson welcomed attendees and recognized and thanked staff and guests who agreed to participate in the meeting. She then introduced Dr. Elizabeth Lopez, Deputy Director of CSAT.

Consideration of the August 24, 2016, Minutes

Dr. Johnson called for a motion for approval of the August 24, 2016, minutes for the 75th meeting of the CSAT NAC. OmiSadé Ali moved to approve the minutes and Andre Johnson seconded the motion. The motion passed without objection or abstentions to the motion and the August 24, 2016 Minutes were then approved by the Council.

Council Member Introduction and Updates

Council Members in attendance were OmiSadé Ali, M.A., CADC, CCS; Trenette T. Clark Goings, Ph.D., LCSW; Kristen Harper, M.Ed., LCDC; Andre Johnson, M.A.; Judith A. 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.

Also in attendance were Brian Altman, Kana Enomoto, Laurie Krom, Jinhee Lee, Sarah Ndiangui, Dave Wanser, and Wilson Washington.

Dr. Johnson asked the Council Members to introduce themselves and provide information on their backgrounds.

Ms. OmiSadé introduced herself. Ms. Ali is affiliated with the Altarum Institute and is working on the Access To Recovery (ATR) training and technical assistance contract. She is executive director of First Nations, LLC, a Native-owned behavioral health program serving all of Turtle Island, United States, and Canada. She is celebrating 47 years in recovery and 47 years working in the field.

Mr. Andre Johnson introduced himself, stating that he is the president and chief executive officer of the Detroit Recovery Project, a peer-to-peer grant, peer-driven recovery community organization. Mr. Johnson noted that he is also a person in recovery for more than 28 years.

Ms. Kristen Harper introduced herself as the executive director for Recovery Communities in North Carolina, a recovery community organization that works with the ATR grant and other

initiatives through North Carolina block grant funding. She has been in long-term recovery since March 2001.

Mr. Arthur Schut stated that he is an independent consultant and was formerly a clinical director and then an executive of several community-based drug and alcohol treatment organizations. Mr. Schut noted that he has long-term interest in evidence-based practices and he has taught in a master's program in addiction counseling for more than 20 years at the University of Iowa.

Mr. John Paul Molloy introduced himself and said that he is involved with Oxford House in Silver Spring, Maryland. He also stated that he has been clean and sober for 42 years.

Dr. Lori Simon is a psychiatrist in private practice in New Jersey and New York City, and has worked in homeless shelters and other environments. She shared that she is passionate about patient care and is an advocate for her patients with insurance companies and elsewhere. Dr. Simon is interested in the application of computer technology in health care, and is involved through the American Psychiatric Association and HL7, an international standards organization.

Mr. Lawrence Medina introduced himself and noted his interest in treatment and recovery services in rural and frontier areas. From Taos, New Mexico, Mr. Medina is an independent consultant with Zia Community Services and was formerly affiliated with Faces and Voices of Recovery, one of the first recovery community organizations in the State of New Mexico. He stated that he has more than 25 years in recovery.

Dr. Judith A. Martin introduced herself. Dr. Martin is an addiction medicine specialist, and is currently the substance use medical director for the City and County of San Francisco. She is interested in the system of care for substance use treatment and in integrating medical care throughout the recovery process.

Dr. Indira Paharia stated that she is a clinical psychologist. Dr. Paharia is currently the chief practice and performance officer for Hillside Family of Agencies, a nonprofit human services organization that operates throughout New York State, Maryland, and Washington, D.C., and serves about 13,000 children and families each year.

Dr. Trenette T. Clark Goings introduced herself as an associate professor at the University of North Carolina at Chapel Hill in the School of Social Work. Her research focuses on epidemiology, etiology, and prevention of substance use among adolescents and young adults.

Director's Report/SAMHSA CSAT Budget Update

Dr. Johnson shared the Director's Report with the Council Members, noting that she would discuss a couple of items among the many covered in the report. First, CSAT has been contributing to transition materials for the new administration to ensure that the new leaders are aware of CSAT's work and accomplishments and important areas of focus for the future.

Dr. Johnson stated that there are two pieces of legislation passed during the previous administration that affect SAMHSA and CSAT in particular. The first is the Comprehensive Addiction Recovery Act (CARA), signed in July 2016. CSAT had to quickly address the CARA provision that nurse practitioners and physician assistants had the authority to apply for a waiver to prescribe buprenorphine for patients as part of the medication-assisted treatment program. The Department of Health and Human Services (DHHS) hosted a public meeting in October 2016 to discuss training needs for new prescribers. Twenty-four hours of training are required under CARA. Currently, CSAT's Division of Pharmacological Therapies is working with the SAMHSA Provider Clinical Support System program to create no-cost training for nurse practitioners and physician assistants. Dr. Johnson noted that one of SAMHSA's goals is to expand access to care, and giving prescribing authority to nurse practitioners and physician assistants will have a huge impact on achieving that goal.

The second piece of legislation is the 21st Century Cures Act, passed in December 2016. One of the Act's provisions is \$1 billion to fund an opioid grant program for the states to enhance their activities to combat the opioid crisis and expand access to quality treatment and services. SAMHSA will manage the funding for DHHS. SAMHSA published the Funding Opportunity Announcement in December, less than a week after the bill was signed into law. Applications are due February 17, 2017, and grants should be awarded in April with implementation beginning in May.

Dr. Johnson also reported on updates to 42 CFR Part 2. She stated that the Federal Register Notice was submitted on January 10, 2017, and was published on January 17. The updates were originally to be effective in February 2017, but this date has been postponed to March 21 in response to an executive order.

Dr. Johnson stated that there are two major differences between the original Notice of Proposed Rulemaking and the final rule. The first is that SAMHSA is allowing for a general consent in both the "to" and "from" sections of the consent form, which allows for two-way communication throughout the health care system in an electronic health record (EHR). The second difference is that the rule allows for more types of databases to be linked to databases with Part 2 data for research purposes.

SAMHSA also published a Supplemental Notice of Proposed Rulemaking to cover contractors performing various functions within the health care system.

Dr. Johnson opened the floor for questions or comments on the Director's Report.

Dr. Martin commented that she appreciated CSAT's leadership in acting quickly, especially with regard to buprenorphine prescribing authority for nurse practitioners. She thinks nurse practitioners in rural areas will be able to help many people as a result. Dr. Martin asked if any of the nursing professional societies are applying to be able to conduct CARA training.

Dr. Johnson replied that there were a couple of associations in the original statute and SAMHSA has received requests from at least one association. The DHHS Secretary has the authority to name additional organizations who can conduct trainings.

Dr. Martin also asked if any EHR companies have addressed the 42 CFR Part 2 requirement that organizations be able to provide the list of people to whom release consent has been designated and who have received health record information.

Dr. Johnson noted that many systems can run an audit trail to derive that information. Dr. Simon added that, once the data is collected, it would not be difficult to develop a user-friendly application for reporting that data.

Presentation on the Surgeon General's Report

Dr. Johnson introduced Commander Jinhee Lee, who presented an overview of the Surgeon General's Report on Alcohol, Drugs, and Health, which was released in November 2016. She said that SAMHSA was a lead agency on the report and CSAT played an integral role in the development of the report.

CDR Lee served as the managing editor for the Surgeon General's report. The report was developed in 1 year after the Surgeon General announced that he was going to do a report on addiction that would be ready within that timeframe. These reports generally take around 3 years.

CDR Lee provided metrics related to the report. Within 4 days of the launch, there were 13,000 downloads of the full report and more than 100,000 page views. All of the hard copy versions sold out within the first few hours of the launch. More than 1,000 names are on a waitlist to receive the hard copy report. Media coverage through December 2016 was extensive with more than 1,000 stories reaching an audience of almost 2 billion.

CDR Lee noted that the United States is facing an opioid crisis; nearly 20 million people in the U.S. had a substance use disorder involving prescription painkillers in 2015. Around 600,000 had a substance use disorder related to heroin. She stated that only 10 percent of individuals with substance use disorders receive treatment, which is unacceptable. The Surgeon General has made this public health crisis a priority.

The goal for this report was for it to be accessible to everyone, and not just geared toward the scientific community. While the report is more accessible, it still reviews the best available science and covers the entire spectrum from prevention, to treatment, to recovery supports.

According to CDR Lee, the report has chapters covering the neurobiological processes that turn casual substance use into a compulsive disorder; prevention of substance use disorders featuring descriptions of a range of programs and evidence-based policies; recovery-oriented services and systems; health care systems, including why integrating general health care with substance use disorder treatment can result in better outcomes; and legislation affecting treatment of substance

use disorders. The final chapter, “Vision for the Future: A Public Health Approach,” takes the more than 50 key findings from the previous chapters and summarizes them in five topline messages:

1. Both substance misuse and substance use disorders harm the health and wellbeing of individuals and communities. Addressing them requires implementation of effective strategies.
2. Highly effective community-based prevention programs and policies exist, and should be widely implemented.
3. Full integration of the continuum of services for substance use disorders with the rest of health care could significantly improve the quality, effectiveness, and safety of all health care.
4. Coordination and implementation of recent health reform and parity laws will help ensure increased access to services for people with substance use disorders.
5. A large body of research has clarified the biological, psychological, and social underpinnings of substance misuse and related disorders; and has described effective prevention, treatment, and recovery support services. Future research is needed to guide the new public health approach to substance misuse and substance use disorders.

The last chapter also contains recommendations for meeting attendees and other stakeholders to help change the culture, attitude, and practices around substance use. CDR Lee suggested next steps that align with the report’s findings and recommendations:

- Continue to work with community leaders and coalitions to expand the implementation of evidence-based treatment and recovery programs and policies.
- Use traditional and social media to inform the public, including parents and community leaders, about what is known about substance misuse and substance use disorders and effective programs and policies.
- Translate the science into messages appropriate for different audiences.
- Provide training to health care professionals to expand their knowledge and skills and enable them to improve the availability and quality of prevention, treatment services, and recovery support in all health settings.

CDR Lee concluded her presentation by describing the website that accompanies the report, <http://www.addiction.surgeongeneral.gov>. The website contains the full report, collateral materials, and fact sheets for specific audiences and on specific topics.

Council Discussion Topic: The 2016 Surgeon General’s Report on Alcohol, Drugs, and Health

The following points were raised and discussed during the Council’s discussion:

- Ms. Ali expressed her appreciation for the report's use of strength-based language, and lack of labeling. She also appreciated the honoring of people with lived experience, and the fact that the report notes that there are many roads to recovery, and not just one. CDR Lee pointed to the fact that SAMHSA had a very significant role in the development of the report. She said the working group felt it was important to highlight the recovery spectrum and promote the best available evidence.
- Mr. Johnson stated his appreciation for the Surgeon General's report and that the report was covered extensively on traditional and social media. He hoped that the synergy and relationships developed over the last couple of years can be sustained during the new administration.
- Ms. Harper said that the report provided validation to the evidence concluding that substance use disorder is a brain disease. She commented that the report has had a strong impact on the community and asked if there existed any integrated coalition of medical professionals and substance use experts working on updating and improving training around the issue. CDR Lee replied that CSAT has available training and developed partnerships with the Food and Drug Administration (FDA), National Institute on Drug Abuse (NIDA), and National Institute on Alcohol Abuse and Alcoholism (NIAAA) during development of the report. Dr. Johnson stated that Office of National Drug Control Policy (ONDCP) is working on medical education. Also, Centers for Disease Control and Prevention (CDC) is conducting massive outreach on their pain guidelines.
- Dr. Simon relayed that she was glad to see that the report includes the research that clarified the biological, psychological, and social underpinnings of substance misuse. In her experience, the majority of people who are abusing anything are self-medicating, or experiencing a comorbid mental illness and/or social service issue. She commented that patients are increasingly concerned about becoming addicted to mind-altering medications, even antidepressants. CDR Lee responded that the report does a good job of showing that treatment is not one-size-fits-all but rather is individualized.
- Mr. Medina asked what could be done to maintain momentum and continuity with the change in administration. Dr. Johnson stated that there has been no indication that there is going to be less concern about substance use disorders in the new administration. She also noted that both CARA and the Cures Act were congressional bills.
- Mr. Molloy said he was disappointed that the Surgeon General's report did not address television advertising of prescription drugs and the accompanying culture that says pills make people feel better. He also stressed the importance of evidence-based treatments and noted his opinion that the evidence base in the substance abuse field is not very good. He stated that more than 50 percent of people engaged in treatment in the U.S. are quacks. The field must face the fact that relapse does not have to, and should not, be part of the disease. Dr. Johnson responded that direct marketing of pharmaceuticals on TV

began in 1988 or 1989 based on interpretation of an FDA regulation. She also said that she was encouraged by discussion of measurements and outcomes at a recent conference.

- Mr. Schut commented that medical and nursing schools and Physician Assistant programs should be incentivized to increase and enhance curricula related to addiction and substance use disorder.

Presentation on Translating Science to Service

Dr. Johnson introduced Laurie Krom, who delivered a presentation on the Addiction Technology Transfer Center (ATTC) Network and the science of technology transfer. Ms. Krom is at the University of Missouri-Kansas City and is the director of the ATTC Network office.

Ms. Krom stated that the ATTC is composed of a Network Coordinating Office, 10 domestic regional centers that align with the 10 HHS regions, 4 national focus area centers (Hispanic and Latino ATTC, Frontier and Rural ATTC, Native American and Alaska Native ATTC, and SBIRT ATTC). Two Centers of Excellence focus on young minority men who have sex with men and other LGBT populations and on pregnant and postpartum women and their families, respectively. There are also three PEPFAR-funded international centers: two in Vietnam and one in Thailand. Ms. Krom relayed that the ATTC Network will undergo reorganization in October 2017. There will no longer be any national focus area centers. Additionally, there will be two new international ATTCs: one in Ukraine and one in South Africa.

Ms. Krom reminded the attendees that the ATTC Network has been funded by SAMHSA since 1993. Its mission is to accelerate the adoption and implementation of evidence-based, and promising practices in recovery-oriented systems of care. The Network models its activities on the model of diffusion, the continuum of the diffusion of innovation.

Ms. Krom described and provided examples of diffusion of innovation. The earliest example she cited was from the 1930s when two Iowa State researchers studied why some farmers began using a new hybrid corn seed that increased yields by 20 percent but others were not. The pattern of adoption generally follows a curve that looks similar whether the innovation is new hybrid corn seed or a new technology or technique.

The field of implementation science looks at methods to promote the systematic uptake of research findings and other evidence-based practices. She noted that implementation science reveals what it takes to make lasting improvements—(effective intervention) X (effective and sufficient implementation) = consistent, sustainable outcomes). Ms. Krom cited sources of evidence of effective interventions, including SAMHSA's National Registry of Evidence-Based Programs and Practices (NREPP) and the Cochrane Collaboration.

Ms. Krom addressed the topic of ineffective and insufficient implementation, and discussed a model published in the Journal of the American Medical Association (JAMA) in 2015 that highlighted the external environment, characteristics of the organization, characteristics of the

innovation, and the implementation process itself. She then turned to the topic of factors involved in successful implementation using slides from a presentation by Kirchner, “What Is Implementation Science and Why Should You Care?” One of the facets, “facilitation,” is discussed as being key to successful implementation. She notes that people in the field have the skills required for basic facilitation. Professionals must learn how to translate it from the therapeutic situation into thinking about how those same skills can be applied in this context. Other subjects of interest are precision medicine and the learning health care system. She concluded that the substance use disorder field needs to look beyond its field to how other health professionals are looking to the future.

Council Discussion Topic: Technology Transfer

Ms. Ndiangui facilitated the discussion. The following points were raised and discussed during the Council’s discussion:

- Mr. Medina commented that, while he supports and believes in evidence-based programs, these programs are not always appropriate for rural and frontier areas or for communities of minority and color. Urban areas have access to more resources. He asked about the focus on rural and frontier areas. Ms. Krom replied that more research needs to be conducted on the needs of frontier and rural populations and that more research should be conducted by people of color and from frontier and rural populations. She also noted that the field may be unaware of some resources available in rural areas.
- Ms. Harper asked about community needs assessments, stating that she learned the importance of them while working on an SPF SIG project in rural Georgia. Ms. Krom responded that needs assessments can be resource intensive and it would be helpful to figure out how to do assessments that provide accurate data but would not use as many resources. She suggested possibilities such as partnering with local academic centers and universities. Dr. Johnson added that there is much more data available in huge national databases that allow for more granular data analysis, and said that she is encouraging the States to use SAMHSA as a resource for their needs assessments.
- Mr. Johnson asked about how to involve new grassroots RCOs in the ATTCs. He also noted the lack of best practice models that hone in on people of color, specifically African Americans. He further inquired about integrating behavioral health care with primary health care and how that relates to EHR systems and training. Ms. Krom agreed that relations between ATTCs and RCOs should be strengthened. She said that there must be practice-based research in addition to academic research. Dr. Johnson added that research can begin at a small scale within a health system and said that the Agency for Healthcare Research and Quality (AHRQ) has funded this type of work. She acknowledged the need for improving the evidence base regarding minority populations and health. However, the field is heading in that direction.

- Ms. Ali inquired whether the Native American and Alaska Native ATTC was being eliminated. Dr. Johnson replied that SAMHSA had made the decision to not fund the focus area ATTCs in the future; however, that does not mean that there will be no focus on special populations. ATTC will not be the vehicle and SAMHSA is currently looking at other vehicles for supporting this work.
- Dr. Simon commented that evidence-based studies and best practices are necessary, but are not sufficient when trying to apply them to some communities. The extent to which a program will strictly follow evidence-based practices should not be the sole criterion for evaluating a grant application. Building in evaluation is also important.
- Mr. Schut stated that, as well as best practices, the field also needs to state what practices are unacceptable. He commented that it would be good to have ways of measuring fidelity to best practices that are not time and resource intensive. Mr. Schut also discussed payment barriers with regard to evidence-based practices. Mr. Molloy added that these barriers should be documented in order to have the evidence to change policies.
- Dr. Paharia commented that funding was a challenge and gave the example of a State mandating use of evidence-based practices without providing adequate funding. Ms. Krom replied that ATTCs can help with implementation and can also provide information on other resources in a State or region.
- Dr. Johnson stated that NIDA was still a SAMHSA partner and the two agencies are reviewing ways to work together. Ms. Krom noted that ATTCs will always need to interface with NIDA and other NIH institutes.
- Dr. Johnson then asked if the group had any thoughts or advice for CSAT related to technology transfer:
 - Dr. Paharia said additional funding was needed as well as technical assistance, and guidance on implementing evidence-based practices within particular populations.
 - Dr. Martin commented that racial disparities in health care were a problem. Medical education must address implicit bias in various ways that “white health care” is delivered along with some communities’ suspicion of certain interventions that may prevent those populations from receiving the best health care.
 - Mr. Johnson asked about addressing recreational and medicinal use of marijuana. He has observed that young African American boys are not graduating from high school and that marijuana use is a huge norm in that community. Dr. Simon requested more health education from SAMHSA on marijuana for health care providers and the general public. Dr. Johnson mentioned the recent report on marijuana published by the National Academy of Medicine.

- Ms. Harper agreed with Ms. Krom that getting the community involved in research is crucial. She noted that this has occurred with some health issues such as obesity within minority communities but not with substance use disorder and recovery issues.

SAMHSA Leadership Discussion with CSAT Council Members

After the luncheon recess, Dr. Johnson introduced Kana Enomoto, SAMHSA's Acting Deputy Assistant Secretary for Mental Health and Substance Use and invited the Council members to comment or ask questions on issues of interest. Ms. Enomoto provided information on SAMHSA's activities.

Ms. Enomoto began the session by commending the CSAT leadership team and reviewing the successful passage of the Cures and CARA legislation. She is confident that there is a lot of positive interest in SAMHSA and its mission. She then asked the Council members to introduce themselves and discuss their concerns.

Mr. Schut described his concerns about implementation of evidence-based practices and that harmful practices are being continued. He was also concerned about States possibly reallocating funds based on assumed changes in Medicaid that may not come to pass. This reallocation could leave many people without the means of paying for needed treatment.

Ms. Harper stated that she could see that RCOs have access to populations that other treatment and recovery institutions historically have not had. She asked how to open up services to include underserved populations. She also asked how professionals with lived experience could contribute to improving training for health care professionals. She noted the importance of making sure that peers be involved in the conversation and process.

Mr. Johnson expressed concern that successes on the national level filter down to the local level, and presented information about Detroit as an example. He said that many former inmates return to Detroit with mental health issues and substance use disorders and funding is not adequate for treatment and recovery. He stressed the need for integration of those programs in conjunction with primary health care.

Ms. Ali reiterated her earlier appreciation for the strength-based language used in the Surgeon General's report. She said that Native populations in the U.S. are in crisis with many Native Americans suffering from post-traumatic stress disorder. There is a strong need for behavioral health care that is presented within the appropriate cultural context and that includes members of the population as care providers. Ms. Ali described "healing circles," programs, and recovery supports that resonate with Native populations across the country and in different environments.

Dr. Paharia described her new position focusing on research, quality, and data analytics within a large, nonprofit, human services organization. She asked about Medicaid changes and how they might affect provision of treatment, specifically with regard to managed care.

Dr. Martin relayed that she has been working on implementing a 1115 waiver in San Francisco that turns drug Medi-Cal into a managed care plan within the county. She commented that having primary health care be able to offer substance use treatment onsite would be a huge benefit.

Mr. Medina described challenges in providing substance use treatment in smaller or poorer States such as New Mexico. He mentioned crisis stabilization units as being a model that could be helpful in New Mexico but that funding is difficult. He also discussed a potential shortage of clinicians and queried whether block grant funds could be increased for States that have shortfalls or increased needs.

Dr. Simon described issues that she has experienced with getting approval from insurers for the correct medications for patients, including people on Medicare. She suggested that SAMHSA can get involved in discussions about insurance and medications. She discussed the data that Medicare requires doctors to provide and said that more and more doctors are getting out of Medicare because of these demands. Dr. Simon also encouraged SAMHSA to be more of a leader in health information technology. She said that there is often a disconnect between what software developers create for health care providers and what those providers actually need.

Ms. Enomoto responded to many of the issues brought up by the Council members. She said that SAMHSA is operating at a high level and at the highest quality. She believes that, with legislation such as Cures and CARA and policy documents such as the Surgeon General's report, substance use disorder has a high profile and is getting necessary attention. She wants to help people manage substance use disorder and mental health issues similar to the way other conditions and diseases are managed. SAMHSA has an important role to play in helping the system navigate bringing behavioral health into the mix of health care, human services, and education.

Ms. Enomoto discussed the need to determine how to incentivize care for the people who need it the most. Other issues she commented on include the fact that block grants are awarded according to a formula and are not discretionary and that the Center for Behavioral Health Statistics and Quality is building out a learning center where innovations and research needs can be discussed. Also, Ms. Enomoto mentioned that SAMHSA is conducting "re-reviews" of some of the practices in NREPP to see if they still meet the criteria for promising practices. She commended the team for the language used in the Surgeon General's report.

Presentation on the 21st Century Cures Act

Dr. Johnson introduced Brian Altman, who is the Director of the Division of Policy Innovation within SAMHSA's Office of Policy, Planning and Innovation and the Acting Director of the Office of Legislation. Mr. Altman delivered a presentation on the background and provisions of the 21st Century Cures Act.

Mr. Altman stated that the mental health sections of the act were originally part of the Helping Families in Crisis bill which was introduced by Rep. Tim Murphy, a child psychologist, in 2013. A similar bill was introduced in the Senate. The opioid funding sections derive from the FY17 federal budget proposal. The two were combined into the 21st Century Cures Act enacted on December 13, 2016.

The bill includes requirements for the composition of SAMHSA's advisory committees. For the CSAT Advisory Council, it requires that both the NIDA and NIAAA directors be ex officio members and that at least half of the appointed members have specific degrees or experience. Other requirements include having a stakeholder meeting within 1 year of finalizing the 42 CFR Part 2 rule and studying and reporting on the block grant formula.

Mr. Altman relayed that the opioid grant program was actually funded before the agency was authorized to conduct the grant program. SAMHSA has authority to do a \$1 billion program over 2 years with \$500 million released for FY17. SAMHSA issued the FOA the day after the bill became law.

Mr. Altman described other provisions of the Cures Act:

- Elevates the head of SAMHSA to the position of Assistant Secretary for Mental Health and Substance Use;
- Reauthorizes SAMHSA with some focus on serious mental illness, homelessness, and veterans;
- Codifies the Center for Behavioral Health Statistics and Quality and establishes the position of Chief Medical Officer;
- Tasks the Assistant Secretary with planning and evaluation and creating a department-wide evaluation plan;
- Creates an Interdepartmental Serious Mental Illness Coordinating Committee;
- Changes the name of the Office of Policy, Planning and Innovation to the National Mental Health and Substance Use Policy Laboratory;
- Codifies the National Registry of Evidence-based Programs and Practices;
- Requires HHS to study and report on the block grant distribution formula;
- Reauthorizes numerous SAMHSA programs at FY16 funding levels;

- Changes the focus on some programs such as the Garrett Lee Smith Campus Program, which changed from a suicide prevention-specific program to a broader behavioral health on-campus grant program;
- Authorizes new programs on adult suicide prevention, assertive community treatment, and crisis response;
- Clarifies that Medicaid does not prohibit separate payment for mental health and primary care services provided to an individual on the same day;
- Requires more reporting on enforcement of the Mental Health Parity and Addiction Equity Act and clarifies how people file claims and find out what plans cover and do not cover; and
- Clarifies that eating disorders coverage should be at parity, particularly for inpatient treatment for eating disorders.

Council Discussion Topic: The 21st Century Cures Act

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

- Dr. Martin asked if it was an advantage for programs to be in statute. Does it provide more security for programs to be in statute? Mr. Altman replied that there were pros and cons. He noted that not being under statute could provide more flexibility but that being specifically authorized was a means of protecting important programs.
- Mr. Johnson asked about the thinking behind the review of the block grant formula. Mr. Altman and Dr. Johnson replied that these requests could be initiated by associations or States that think the distribution formula is unfair.
- Mr. Medina asked for suggestions for influencing policy to favor continuing focus on vital behavioral health issues. Mr. Altman responded that he thinks the current climate relies on the notion that States know best.
- Ms. Harper commented that she is one of the reviewers for the Minority Fellowship Program and has enjoyed reading the applications. Many of the applications have been LGBTQ.
- Ms. Ali noted that she had been selected for a Minority Fellowship in 1974 when the fellowship was designed to bring people of color in government service.

Presentation on Technology-Assisted Care

Dr. Johnson introduced Dr. Dave Wanser who delivered a presentation on technology-assisted care. Dr. Wanser is the co-director of the JBS International Center for Sustainable Health and Care. Wilson Washington, the public health adviser in CSAT's Division of State and Community Assistance, moderated the discussion.

Dr. Wanser began by stating that the presentation would cover where technology-assisted care is going, how to deal with the rapid pace of technology development coupled with the slow pace of research and lack of evidence, and the implementation issues. He stated that the Institute of Medicine called for health care systems to be centered on the provision of continuous, comprehensive, coordinated, and accessible care in 1994. The Cures Act speaks to the issue of what integration and care coordination models should look like. Care coordination, integration, payment, and technology are inextricably linked, which has far-reaching ramifications for providers and patients.

Dr. Wanser said that there are essential core competencies for behavioral health providers, and this has been challenging for many organizations. Health care is struggling with how data may be generated, used, reused, and shared. The reality is that real-time, continuous, anticipatory data is “front and center” in making sure that the health care system works. Reporting and information exchange must be bidirectional, especially as the system moves toward value-based payment models.

Dr. Wanser discussed the proliferation of health and behavioral health apps, noting that there are an estimated 43,700 health-related apps and more than 3,000 behavioral health apps. Although there is evidence for the effectiveness of some of these apps, this is not the case for most. He also stated that patient portals have been helpful and that some of these are interactive with discussion boards and searchable resources.

Dr. Wanser said that the next stage is wearables such as Fitbit that integrate with apps and portals. He discussed prescriptive analytics and noted that, as technology improves, big data and data analytics can be useful at the individual level. The social determinants of health are the data points that allow for fine-tuning and isolating an intervention that can be highly predictive of future behavior and that allows the physician to take proactive action. Dr. Wanser described how this type of data analysis might be applied to substance abuse treatment; for example, to predict relapse or the likelihood of staying engaged in a treatment program.

Dr. Wanser stated that everyone should be using telehealth and texting. He discussed one New York City program that used texting for high-risk patients. He conducted a focus group of participants who received a motivational message each morning. The focus group members considered the message to be critical to their success in the program. Dr. Wanser said that telehealth has proven to be highly effective with some of the best research providing evidence for its effectiveness with behavioral health conditions. Telehealth can also contribute to patient-centered care. Dr. Wanser provided information on how technology can reduce costs and improve return on investment and aid in recovery support. He also said that grant-funded technology projects have generally been sustainable.

As he concluded the presentation, Dr. Wanser said that several factors, such as States providing Medicaid benefits for substance use disorder treatment and more people having health insurance,

have made the adoption of health technology tools essential. Technology is expensive, can be difficult to implement, and requires planning and engagement at the highest levels of the organization.

Council Discussion Topic: Technology-Assisted Care

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

- Dr. Simon commented that texting can be great for certain functions but could be detrimental for others such as clinical conversations. She said it would be helpful to have a resource on technology-assisted care that shares success stories and provides ideas that community organizations can implement. Dr. Wanser replied that DSI grantees have access to "ideas exchange" resources on the technology-assisted care site. However, there needs to be more information sharing.
- Dr. Simon also stated that SAMHSA grants primarily focus on community mental health centers, leaving out other settings that provide behavioral health care. The combination of computer requirements and quality reporting requirements has become so onerous to clinicians that they are dropping out of Medicare. Dr. Wanser agreed and said that HHS is trying to address these concerns.
- Dr. Paharia said that the importance of technology cannot be overstated; however, she noted that lack of interoperability of systems between different agencies is a major challenge. Implementing an EHR system can increase work for staff. Dr. Wanser responded that ONC is attuned to the notion that everybody does not need a full-scale EHR. Additionally, data elements should be aligned and prioritized across systems and records. Dr. Johnson added that the learning health system model was desirable but that the current system was opposite that model. She wants everyone to think about what needs to be done differently to improve use of technology in behavioral health care.
- Mr. Medina discussed the costs of implementing technology, especially for smaller organizations that cannot afford the costs. How can small communities begin to implement technology to be efficient and effective? Dr. Wanser said that States must take some leadership position. He noted that the State has to help because of the great economies of scale there.
- Mr. Schut also discussed the costs and difficulty for smaller organizations of collecting numerous data elements. He said that because people were accustomed to collecting information on forms, the EHR was developed to look similar to a form, which is not the best design. Dr. Martin added that local systems and State-level systems are often not compatible. Dr. Wanser stated that vendors and developers need to be open to customers telling them what they need and how they need it to work. Dr. Simon

agreed, saying that the fact that developers are not consulting with end users is one of the biggest issues in health care.

- Mr. Schut asked why CMS does not require but only encourages collection of behavioral health data. Dr. Wanser responded that CMS will not tell Medicaid agencies what to do because Medicaid is a State program. However, their “Dear State Medicaid Director” letters are articulations of policy and may have leverage.
- Mr. Washington recommended that organizations develop relationships with Federally Qualified Community Health Centers because they have behavioral health resources and have experience implementing an integrated health care delivery model. He stated that SAMHSA is focusing on scalability and sustainability because resources are scarce.
- Dr. Simon reiterated that she thinks the two biggest issues are usability and interoperability. She thinks SAMHSA can have a central role in leading improvement of technology in health care. Mr. Medina added that organizations or agencies may have to choose among numerous technologies without necessarily having the experience to make an informed choice. Dr. Wanser listed three guiding principles for developing an EHR that a clinician came up with that he has found to be a useful framework. They are: 1) a provider should never have to enter a data element more than once; 2) there is not a single thing that the State or federal government requires that should not be part of good clinical care; and 3) the system should make providers smarter. Mr. Washington added a fourth principle: the system should free up more clinical time for the provider.

Public Comment

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

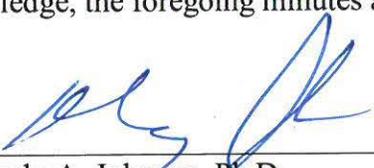
Adjournment

Dr. Johnson thanked the Advisory Council members for a rich discussion. She stated that she hoped to bring the Council members’ thoughts into the conversation with the researchers and that they must keep the conversation going. Dr. Johnson called for motion to adjourn the meeting. At 4:10 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.

Date

4/28/17



Kimberly A. Johnson, Ph.D.

Director, Center for Substance Abuse Treatment