U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administration

Center for Substance Abuse Treatment (CSAT)
Meeting of the CSAT National Advisory Council (NAC)

February 14, 2018
5600 Fishers Lane
Rockville, MD 20857

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Table of Contents

Council Members Present:

A. Kathryn Power, Chair
Tracy Goss, DFO
Bertrand Brown [on telephone]
Kristen Harper
Jason Howell
Sharon LeGore
Judith A. Martin
Eva Petoskey
Arthur Schut

Ex Officio Member:

Elinore F. McCance-Katz

Other Participants:

Allison F. Bauer
Christopher D. Carroll
Steve Daviss
Marla Hendriksson
Danielle Johnson Byrd
Art Kleinschmidt
Elizabeth Lopez
Onaje Salim
Pat Santora
Audra Stock
Mark Stringer

PROCEEDINGS

Agenda Item: Call Meeting to Order

MS. TRACY GOSS: Good morning, everybody. The 78th meeting of the Center of Substance Abuse National Advisory Council is hereby called to order, Kathryn Power, Chair, presiding.

Before we begin with a review, we will proceed with a council roll call. I'll start with those who are on the phone.

Bertrand Brown?

[No response.]

MS. TRACY GOSS: Terrance Range?

[No response.]

MS. TRACY GOSS: Okay, for those that are in the room, Kristen Harper?

MS. KRISTEN HARPER: Here.

MS. TRACY GOSS: Judith Martin?

DR. JUDITH A. MARTIN: Here.

MS. TRACY GOSS: Arthur Schut?

MR. ARTHUR SCHUT: Here.

MS. TRACY GOSS: Jason Howell?

MR. JASON HOWELL: Here.

MS. TRACY GOSS: Sharon LeGore?

MS. SHARON LEGORE: Here.

MS. TRACY GOSS: And Eva Petoskey?

MS. EVA PETOSKEY: Here.

MS. TRACY GOSS: Thank you.

Agenda Item: Welcome, Opening Remarks

MS. A. KATHRYN POWER: Thank you very much, Tracy. Can you all hear me all right? How come it's red and not green? It should be red?

MS. TRACY GOSS: [Inaudible.]

MS. A. KATHRYN POWER: It's okay?

MS. TRACY GOSS: Yeah.

MS. A. KATHRYN POWER: Can you hear me all right?

[Response.]

MS. A. KATHRYN POWER: Thanks, Tracy, very much. Good morning to everyone, and welcome to the members of the NAC and to all the staff that we don't have in front of you today.

As all of you may know, Dr. Kim Johnson has resigned. She is pursuing other opportunities, and Dr. Elinore McCance-Katz, our newest Secretary, has asked me to step into the role of Acting CSAT Director for the next 6 months while we search for a permanent CSAT Director. So we're going to begin that process immediately, and I've said 6 months and out. So I'm hoping that that will be the case that the Assistant Secretary will allow me to return to back to Boston.

That's my current job. I'm the regional administrator for Region 1 in Boston. I cover the six New England States. And I think that I'm going to be continuing in that role in some way during the time that I'm Acting CSAT Director, but I have a part-time administrative assistant in the Boston office. So I can stay connected with her. She can sort of act as the air traffic controller for me, and we'll have sort of weekly calls.

And I think the last thing in the world I wanted to have happened was have Region 1 think I abandoned them, you know? So, and it is important, I think, for SAMHSA to be in the regions. And many of you know that we've been in the regions now for 6 years. We were never in the regions before, and I think it's made a tremendous difference in terms of extending SAMHSA's message, SAMHSA's role, SAMHSA's Federal job in terms of supporting States and communities.

Because I used to be a commissioner in Rhode Island. I was commissioner for 10 years in Rhode Island. That's where the action is. You know, the action isn't at 5600 Fishers Lane. The action is at the State level. And then, in turn, the action is at a community level. So whatever we can do at the Federal level to support that, and I think that's even more true now, particularly after the

Affordable Care Act, and the States created different systems. It's more true now in terms of how those networking exchanges, Medicaid expansion, and all the things that happened after that, that States really are in the driver's seat about their own health reform and certainly around behavioral health.

I know that many of you also know that before I was a regional administrator, I served as the Director of the Center for Mental Health Services here at SAMHSA for 8 years. So, in total, I've been at SAMHSA for 15 years, and that's a good amount of time for me to feel comfortable. I also did a 6-month executive exchange at the Center for Substance Abuse Prevention. So I feel like I can talk with the people who work in this building and be able to sense that -- I know enough to be able to have a conversation.

Now I'll tell you it's very different now in this environment than it was when I was here 6 years ago, and that's a lot -- there are a lot of different reasons, I think, for that. But I think certainly the passage of CARA and the 21st Century Cures Act have really driven a lot of that change.

While I'm at CSAT, the things that I really am going to focus on are I want to make CSAT known as a Center of Excellence, and that Center of Excellence is going to be focused really on several areas. The first is we want to make sure that we excel in improving our impact and on the outcomes of our programs and working with States and having more impactful opportunities to influence them strategically, support them strategically, and be able to identify how and in what manner we can help them strategically.

And it's not just grants. I mean, grants are important. But there is also an opportunity, I think, to help with States, and you're going to hear from two States today that I think will give some examples about that in terms of the relationships that exist between Federal grant opportunities, Federal strategic and technical assistance, and how that aids those States in terms of moving forward. So I'd like to see us sort of I use the term "up our game," and I'm only using that because I'm a Patriot fan.

[Laughter.]

MS. A. KATHRYN POWER: So it's just a matter of kind of thinking, you know -- and of course, we're in the Olympics. So I think that's where my head is. So we're going to look at improving our impacts and outcomes as part of a Center of Excellence.

Secondarily, we're going to really look closely at customer service, at how are we interacting internally with each other, with our other internal customers not only across CSAT, but also in CMHS and CSAP and CBHSQ and OAS and all of the other agencies. And part of the reason we're going to do that is because, one, we need to do that in this environment. We need to be not staying in our own

little silos, but we need to be having conversations with people that cross the behavioral health threshold. But also because we expect that to also be replicated out in the regions and in States. We want that kind of conversation to be happening across the States and the communities.

So at the regional level, I'm interacting on a regular basis with all the other component parts of HHS. I'm not sure we do that enough here. You know, how often do we sit down and have a conversation with ACF, the Administration for Children and Families, who, by the way, have more money than anybody. Seriously, they have more money than anybody. And all of their money that works -- they work on substance abuse, child welfare, trauma, all large-end items. What are we doing to make sure that that's aligning in terms of effect and impact, particularly at the State and regional level?

So those are the kinds of things that I think I would like to work on in terms of making sure that our internal customers are -- we're responding to internal customers, and we're responding to external customers as well, including Federal external customers as well as States.

This is my first CSAT NAC, and I'm looking forward to getting to know all of you better, to hearing your ideas, and benefiting from your experiences and your perspectives. I think that your input will help us continue to improve our programs and services, and I ask you please to feel comfortable, to share your thoughts and ideas and comments and observations.

Agenda Item: Member Introductions and Updates

MS. A. KATHRYN POWER: And since some of you, I think, Tracy, you told me that some of them, some of the individuals today, this is your first NAC, and so we wanted to make sure that you introduce yourselves. We'd like you to use your mike so people can hear you and provide a short introduction.

And so I'm going to start I think alphabetically with Bertrand Brown, but we didn't hear him on the phone. Bertrand, are you there?

MR. BERTRAND BROWN: [on telephone] Yes, I'm here.

MS. A. KATHRYN POWER: Okay. Well, welcome. This is Bertrand Brown. Would you like to give us a short introduction and provide us a little background about yourself?

MR. BERTRAND BROWN: Sure. My name is Bertrand Brown. I'm a person in long-term recovery. So what that means is it's been 3 years and 9 months since I found the need to use [inaudible] and during my recovery, I get to work with the Georgia Council on Substance Abuse, giving hope to individuals and communities that didn't have hope before.

This is my first time being involved in any national advisory committee. So I'm very, very excited, and I look forward to working and giving input as needed and learning a lot from you guys.

MS. A. KATHRYN POWER: Thank you, Bertrand, very much.

Another new NAC council member is Jason Howell. Jason, you want to introduce yourself? You just have to hit the righthand side button. Yeah, there it is.

MR. JASON HOWELL: Good morning, everyone. My name is Jason Howell. I'm also a person in long-term recovery for both mental health and substance use issues. And recovery has enabled me to do things that I would have never been able to do stuck in my disease states, including be the director of a peer- and family-run organization called RecoveryPeople. That's -- RecoveryPeople really focuses in on training and technical assistance and advocacy, infrastructure development at the Texas level, I should say. I'm from Texas.

And then at the national level, I serve on the board of the National Alliance for Recovery Residences, or NARR. And NARR sets the standards for recovery housing and then provides certification programs at the State level. So I'm very happy to be here.

MS. A. KATHRYN POWER: Jason, where are you based?

MR. JASON HOWELL: Austin, Texas. But really, our programming is statewide.

MS. A. KATHRYN POWER: Oh, okay. Great. I was just in Austin for a wedding, and it was just a wonderful place. The music was fabulous.

MR. JASON HOWELL: Don't tell anybody because we have over 100 people moving there a day. We want to slow down things.

[Laughter.]

MS. A. KATHRYN POWER: The music was wonderful. All right.

Sharon LeGore? Sharon?

MS. SHARON LEGORE: Hi. I'm Sharon LeGore from the State of Pennsylvania. I am a family member. So I come with the experience of a mom dealing with losing a child to a heroin overdose, and I have a son that has a co-occurring disorder, and I have a son who was in a severe car crash that got addicted to opiates as a result.

As a result of losing my daughter, I started an organization called MOMSTELL, and we do advocacy work for our families, connecting them with resources and trying to help find treatment. I also co-direct the National Family Dialogue for families of youth with substance use disorders and have a history of working on legislation, things on legislation passed, including creating the first parent advisory council for substance abuse in the State of Pennsylvania and work as a consultant on issues regarding family engagement.

So I'm very, very excited to be here representing a family voice and to let you know, as you said, what is happening at the community level and what is so needed regarding treatment, housing, and other things that we need.

MS. A. KATHRYN POWER: Do you belong to some of the parent and family advocacy organizations that are statewide or regional or --

MS. SHARON LEGORE: We do statewide --

MS. A. KATHRYN POWER: Okay. Okay.

MS. SHARON LEGORE: -- and we do nationals. We work across the board with organizations like Faces and Voices of Recovery. We work with the Partnership --

MS. A. KATHRYN POWER: Right.

MS. SHARON LEGORE: -- for Drug-Free Kids, who also has a parent component that they're working on using CRAFT and doing parent coaching, which I was on the first group to be trained.

MS. A. KATHRYN POWER: Sure.

MS. SHARON LEGORE: And excellent program. So --

MS. A. KATHRYN POWER: Where in Pennsylvania are you?

MS. SHARON LEGORE: I am located in York, which is --

MS. A. KATHRYN POWER: In where? York?

MS. SHARON LEGORE: York, which is about 20 minutes from Harrisburg.

MS. A. KATHRYN POWER: Yeah, I lived in Harrisburg for 10 years.

MS. SHARON LEGORE: Oh, really?

MS. A. KATHRYN POWER: Yeah, both my children were born in Gettysburg.

MS. SHARON LEGORE: Oh, my goodness. Not that far.

MS. A. KATHRYN POWER: And believe it or not, yeah, I had -- for some reason. And so we lived right on Second Street on the Susquehanna River. Beautiful, beautiful old place. I loved Harrisburg. It was great.

MS. SHARON LEGORE: You were actually in Mount Wolf, which is around the corner from our Governor. He lives in Mount Wolf.

MS. A. KATHRYN POWER: Yeah. Yeah, that's great. I do want to also share with you, as we introduce yourselves, that if you haven't been connected with your regional administrator -- in your case, Sharon, it would be Jean Bennett for Pennsylvania -- I want to make sure that we follow up with you so that you know who your regional administrators are and make that connection.

Jason, for you, it would be Karen Hearod, and I think you know Karen?

MR. JASON HOWELL: Yes.

MS. A. KATHRYN POWER: Yes. So, and for all of you, I want to be sure that, Tracy, we follow up with that so that you know the person in your region that you can go to for anything all SAMHSA, and I think that would be really helpful. And they then know you, and you then have a link to them and you can bring them into things that you think would be important and keep them informed and involved.

So terrific. That would be great. Okay.

Eva Petoskey? Did I pronounced that correctly, Eva?

MS. EVA PETOSKEY: You know, it's -- yes. Well, yes, it's actually an Anishnaabek word, which is -- in this form is anglicized. It is "Bee-dos-kay."

MS. A. KATHRYN POWER: Oh, really?

MS. EVA PETOSKEY: And it means that the light, the light is coming or the sunrise.

MS. A. KATHRYN POWER: Oh, how wonderful.

MS. EVA PETOSKEY: So, but it's been kind of pronounced and I guess I would say anglicized for a couple of generations.

MS. A. KATHRYN POWER: Okay. It's beautiful.

MS. EVA PETOSKEY: But that is the origin of the word. Having said that, I'm going to introduce myself. Since this is my first meeting, it's always our custom to introduce ourselves in our language first. So --

[Speaking Native language.]

MS. EVA PETOSKEY: I won't do that every time. It's just our custom to -- to -- when we do that, we are expressing our spiritual self. And so when you start a new endeavor, it's always best to express your spiritual self first, and I think many of you can relate to that. But so now I'll talk about my professional stuff, which is part of me, but not all of me.

I am a -- well, first, I'll say also I am a person in long-term recovery. I have been -- in February, this month, I celebrate 40 years of sobriety.

MS. A. KATHRYN POWER: Congratulations.

MS. EVA PETOSKEY: And my work experience is about parallel to that. So as soon as I got sober, I also started working in the field. So I started working in primary prevention in 1978 in an organization called Great Lakes Intertribal Council. I went from graduate school to the basement of an old church on the Bad River Indian Reservation. So I've worked all of my professional career with tribal organizations and a few little stints in university and the State of Minnesota.

Worked in culturally based primary prevention, workforce development, evaluation, administration, and overall systems change supporting recovery, wellness, and healing from trauma, in particular intergenerational trauma, but all forms of trauma, very important part of our work here. I've worked for a variety of organizations, but for the last 23 years, I've worked for the Intertribal Council of Michigan, and in the last 10 years, I have -- well, 11 -- I've been the director of the Access to Recovery initiative that is a SAMHSA-funded initiative.

I think I'm probably -- that's all winding down now, but we're on a no-cost extension so I'm still working on that project.

MS. A. KATHRYN POWER: Right, right.

MS. EVA PETOSKEY: So we set up this awesome network through the Access to Recovery initiative within the 12 federally recognized tribes in the State of Michigan, and I'm probably the longest-standing ATR director.

MS. A. KATHRYN POWER: I think you are.

MS. EVA PETOSKEY: I started, and I finished. I never left. So I saw a lot of people come and go, but you know, I'm very committed to it. And it worked for us.

So, and as an example, as you said, impacts and outcomes, we set up this very response -- culturally responsive network, but we were also responsive to SAMHSA's requirements with the 12 tribes and one urban Indian organization in Detroit, American Indian Health and Family Services. And as the result of setting up that network, when the State of Michigan received the State targeted response funds for the opioid initiative, we are currently using -- we're a subcontractor for that initiative in Michigan, working with all 12 tribes, and we are using the network that we established through the Access to Recovery initiative for the treatment part of that.

MS. A. KATHRYN POWER: Great.

MS. EVA PETOSKEY: And then we have a network for the prevention, overdose prevention. I also have experience in tribal government. I served 6 years as -- on our tribal council, and I was the vice chairperson of our elected tribal council for the Grand Traverse Band of Ottawa and Chippewa Indians. So --

MS. A. KATHRYN POWER: Okay. Wonderful, thank you.

Eva, your regional administrator is Dr. Jeff Coady. Do you know Jeff?

MS. EVA PETOSKEY: Yes, I do know who he is. I know him real well.

MS. A. KATHRYN POWER: Okay, that's -- well, that's great. So he's -- he has the Midwestern States and a good connection for you to have. I know he's working hard to try to get services expanded into the tribes and --

MS. EVA PETOSKEY: Yeah, I'm actually on a panel with him --

MS. A. KATHRYN POWER: Okay. Wonderful.

MS. EVA PETOSKEY: -- next, I think, in May or something.

MS. A. KATHRYN POWER: Well, good. Well, tell him I said hi.

MS. EVA PETOSKEY: I will.

MS. A. KATHRYN POWER: Now I'd like to give a chance for the other members to introduce themselves and to update us on any new projects or concerns that they have. And we'll just sort of go around the table.

So, Arthur, I'm going to start with you. Use the mike.

MR. ARTHUR SCHUT: Thanks for reminding me.

MS. A. KATHRYN POWER: Sure.

MR. ARTHUR SCHUT: I've been in the field since alcohol was distilled.

[Laughter.]

MR. ARTHUR SCHUT: I've been in the field since 1969. I was around when Richard Nixon decided that he would fund community-based treatment out of Law Enforcement Assistance Administration money and divert that. I was in Iowa at the time. I was a street worker for the YMCA. I worked in the first drug program created by that money at that time, and I've been in the field ever since. Well, brief detour where I went to graduate school in clinical psychology and had an internship in a child mental health center in California.

But other than that, I've worked in the field for that period of time. And I've been a clinical director of a couple -- three different organizations. I was the CEO of two different organizations for a total of 30 years, both of which were comprehensive, including prevention and treatment services. And for the last few years, I've been consulting.

MS. A. KATHRYN POWER: You say you've been what, consulting?

MR. ARTHUR SCHUT: Consulting. Yeah, which is a little more relaxed effort than being a CEO.

MS. A. KATHRYN POWER: Good.

MR. ARTHUR SCHUT: I serve on a number of boards, including the board for the National Council for Behavioral Health.

MS. A. KATHRYN POWER: Sure.

MR. ARTHUR SCHUT: And NIATx, and I'm on the board of a managed care company that's a not-for-profit in Colorado that is capitated for mental health, Medicaid, and substance use disorders. So I have sort of a diverse background. I taught the master's program at the University of Iowa for 21 years at the same time I was working.

MS. A. KATHRYN POWER: Are you based in Iowa? Are you based in Iowa now?

MR. ARTHUR SCHUT: No, I'm based in Denver.

MS. A. KATHRYN POWER: Denver? That's right. You told me that. Okay. All right.

MR. ARTHUR SCHUT: Yeah, I should have gone -- I grew up in the east, went to graduate school there.

MS. A. KATHRYN POWER: All right. Well, you should be connected to both the regional administrators in Denver, Charlie Smith.

MR. ARTHUR SCHUT: Yes.

MS. A. KATHRYN POWER: And to the Midwest, Kim Nelson. So she has the Midwestern States and Iowa. So I mean that middle of America part.

MR. ARTHUR SCHUT: I live in Denver and work --

MS. A. KATHRYN POWER: Oh, there it is. All right. Sounds like you're very busy.

MR. ARTHUR SCHUT: Not as busy as I used to be, which is a good thing.

MS. A. KATHRYN POWER: Well, that's okay, though. That's a gift that you can give yourself, right?

MR. ARTHUR SCHUT: But I'm well. Yeah, I'm [inaudible] well.

MS. A. KATHRYN POWER: Right. Okay. Thank you very much, Arthur.

Dr. Martin?

DR. JUDITH A. MARTIN: Good morning. My name is Judy Martin, and I'm an addiction medicine physician specialist. And most of my work has been in the area of medication treatment for addiction, in particular opioid use disorder. And so I've worked in methadone clinics for 20-some years. And in 2012, I became the Medical Director for Substance Use Services in the City and County of San Francisco.

So in the Department of Public Health in San Francisco, which includes behavioral health services, I'm in charge of all the places where addiction shows up and addiction treatment happens. And I'm also the alcohol and drug administrator, which is a position that connects the county to the State, and almost all of the substance use services are sent down to the State from the county. So one of the efforts we're doing now in California is to turn all of the substance use treatment in all the counties into a managed care plan. It's called the 1115 waiver, which is a demonstration waiver.

And in California, we've always had those waivers to do new things, and this is an interesting new one in substance use. And it has the ability to raise the

professional level as well as expand services that are covered by Medicaid, and it fit right into the Medicaid expansion, which has disproportionately affected substance use patients who were able to get disability before. So just overnight in 2014, we saw hundreds of people who, all of a sudden, had insurance, and it was very useful to them and helpful and saved many lives.

California has many counties that have high overdose rates, in particular the higher rural counties. And so we have a statewide coalition sort of to help reduce overdose, and San Francisco has done that for many years, and so we provide some leadership about community naloxone access and as well as, of course, syringe access and how to make people safe enough that they can survive to get into treatment.

And yes, I am connected to Jon, our regional director for SAMHSA.

MS. A. KATHRYN POWER: Great.

DR. JUDITH A. MARTIN: And we're very -- I think his office is still in San Francisco.

MS. A. KATHRYN POWER: Oh, yes? Oh, yes. Yeah.

DR. JUDITH A. MARTIN: Yeah. So we're very close to each other.

MS. A. KATHRYN POWER: Right.

DR. JUDITH A. MARTIN: And he knows about the State effort and has been very supportive. One of the areas that I think throughout the country probably is important is the underutilization of medications for alcohol use disorder, and also there is a very obvious and well-documented racial disparity in deaths from alcohol. Even though white people drink more, black people proportionately die more from it.

MS. A. KATHRYN POWER: Right, right.

DR. JUDITH A. MARTIN: And so we want to be sure that the mistrust between the black community and medicine doesn't interfere with best practices for that community, and so it's one of the areas we're working on in the black and African-American health initiative in our city.

MS. A. KATHRYN POWER: That's wonderful. Jon and I always are in competition with each other because we have an east coast/west coast thing. So, you know, the west coast is always, you know, innovative and leading the way in California. The east coast is innovative and leading the way in Massachusetts. So we're always arm wrestling.

[Laughter.]

DR. JUDITH A. MARTIN: That's right. Yeah, including naloxone, right? Yeah.

MS. A. KATHRYN POWER: Okay. Who's doing the most here? You know, because we're plodding through the managed care thing in Massachusetts as well. And we've all got great schools. We all have smart people, and you know, it's just this great competition between John and I.

So, all right. Kristen?

MS. KRISTEN HARPER: Thank you, Jason.

Hi, Kristen Harper, and Jason just taught me how to use a microphone.

[Laughter.]

MS. KRISTEN HARPER: So I'm a person in long-term recovery. I entered recovery at 21 on a college campus. I currently am an independent contractor. I started a business back in the summer of last year called Recovery Cube, and we do technical assistance. We saw a vacuum for youth recovery technical assistance, and unfortunately, I've had a lot of business lately. So just heads-up to SAMHSA, you might want to look into that, but you know, put me out of business, I would love that.

So, currently, I'm right now working with Transforming Youth Recovery. They are a national nonprofit that awards seed grants to collegiate recovery communities. Right now, I have 160 colleges and universities that I provide technical assistance to. So I would actually love to jump on a regional call. Are you guys still all doing the calls like once a month or so?

MS. A. KATHRYN POWER: We do them every week.

MS. KRISTEN HARPER: That would be wonderful if I could essentially present on that call or --

MS. A. KATHRYN POWER: I think that makes sense.

MS. KRISTEN HARPER: Then I could connect all of our contacts to those -- to those regional coordinators.

MS. A. KATHRYN POWER: That's great.

MS. KRISTEN HARPER: Additionally, I also am a former executive director for the Association of Recovery Schools, which is recovery high schools, and that's a national organization as well.

MS. A. KATHRYN POWER: Right.

MS. KRISTEN HARPER: So I think it would be really good. So, yeah. So I'm honored. I love these meetings. I love coming, seeing some of my buddies. I can't wait for Andre to get here this afternoon, hopefully, [inaudible] so I'm honored to sit here.

I'm also a new mom. I have a 2-month-old at home.

MS. A. KATHRYN POWER: Congratulations.

MS. KRISTEN HARPER: So this is the first time I've been out in a while.

[Laughter.]

MS. A. KATHRYN POWER: I'm not sure this is where I would have chosen. You know, it's okay. It gets you out of the house.

MS. KRISTEN HARPER: Yeah, well, at least we get [inaudible]. So it's nice to be here and nice to --

MS. A. KATHRYN POWER: What's the name of your baby?

MS. KRISTEN HARPER: Sydney.

MS. A. KATHRYN POWER: Oh, lovely. That's wonderful. Well, Anne Herron is the person that we'll coordinate you with about getting on our weekly calls, and we'll look forward to that.

MS. KRISTEN HARPER: Great, thank you.

MS. A. KATHRYN POWER: All right. Okay. Let me just again welcome you.

Agenda Item: Consideration of the August 10, 2017, Minutes

MS. A. KATHRYN POWER: We're going to turn to business now. We need to vote on the August 20, 2017, minutes. Those were forwarded to you electronically and for your review and comment. I'm assuming if you had any comment, you were able to send that to Tracy. They have it back and certified in accordance with the Federal Advisory Committee Act regulations, and they did include your edits.

So we're ready to roll. I can entertain a motion to adopt the minutes.

DR. JUDITH A. MARTIN: I so move.

MS. A. KATHRYN POWER: Thank you, Dr. Martin. Is there any discussion on the minutes?

[No response.]

MS. A. KATHRYN POWER: Okay. I'd like to have a vote. All those in favor, signify -- is there a second to the motion?

MR. ARTHUR SCHUT: I second.

MS. A. KATHRYN POWER: Thank you, Arthur.

And we'll now vote to adopt the minutes as presented without any further corrections. All those in favor, signify by saying aye.

[A chorus of ayes.]

MS. A. KATHRYN POWER: No? Anyone, noes?

[No response.]

MS. A. KATHRYN POWER: Thank you. The minutes are adopted. I appreciate it.

Agenda Item: Director's Report

MS. A. KATHRYN POWER: Now we're going to move into my report, and obviously, this is not really "my report." This is the report of what has been going on at CSAT as I come in. I've been here 2 days, and I will talk to you a little bit about some of those issues that have been reported to me about the Director's work. And my -- what I'm going to report to you will reflect generally the areas where we have been engaged, and then you're going to hear from my leadership team about specific divisional work.

So I'm going to briskly do this in a way that, hopefully, you can move through the things that are important, and these CSAT activities are really only going to include the ones since the last report. And that means that I'm going to focus on some very specific areas rather than give you a whole list of ideas and issues and that we're working on.

So the first one is CSAT's response to the opioid crisis. Certainly, this is an ongoing issue, and SAMHSA is, of course, key in supporting the overarching Department, HHS's response to the opioid crisis through the programs on

prevention, on treatment, and on recovery. And as has already been mentioned by Eva that we have these State targeted response to opioid grants, or STR grants, funded under the 21st Century Cures Act. And we have the Medication-Assisted Prescription Drug and Opioid Addiction Program, or the MAT-PDOA as we call it, funded under the CARA, the Comprehensive Addiction and Recovery Act.

To assist the State opioid STR grantees, SAMHSA has recently awarded a technical assistance grant. So this is a new move for us. A technical assistance grant to a single entity, which will serve as the central coordinating point for ensuring that the requirements of the funding opportunity are met most efficiently. So we really want to bring the technical assistance to the moment, to the time, to the people, to the State when they need it. And that really, I think, is part of this issue about rapidly getting improved outcomes and more rapidly getting improved impact. If we could deliver that in ways that is effective for some of the State leaders that you'll be hearing from today.

So you'll be hearing from the single State authorities in certain States, and they need to be nimble. You know, they need to be moving quickly to really push that money out and put it where they need to put it. So we're going to make sure that we have a single technical assistant grant that can help them do that.

We're also increasing access to opioid use disorder treatment. That's the second area that we've been working on. In February of 2017, CSAT began accepting applications and providing DATA 2000 waivers to nurse practitioners and physician assistants, as well as physicians. But clearly, we're adding to the physician pool. We're adding nurse practitioners and physician assistants who meet the requirements under CARA to be able to prescribe buprenorphine for the treatment of opioid use disorder.

And actually, the numbers are growing. I think it was a difficult start. We've had difficulty even in my States, trying to get physicians, nurse practitioners, and physician assistants to step up and say "I want to do this." But we're, I think, surely and steadily growing.

As of February 3rd, 4,432 nurse practitioners and 1,184 physician assistants are able now to treat up to 30 patients. And then SAMHSA expects to receive requests for waivers to treat up to 100 patients beginning in early March, which I hope will be an opportunity, as it were, to really get, as Dr. Martin has indicated, MAT out for a whole range of substitution disorders. I hope, actually, Dr. Martin, that's going to be one of the effects here is that we can spread the news about MAT for a whole range of disorders, not just opioids.

And so I think I'm looking forward to that because, you know, we underused medication for alcohol. We've underused MAT for adolescents. You know, there's a whole range of populations that we really need to look at very carefully.

So I'm hoping that this notion about increasing the number of patients that people can have from 30 to 100 will help bring growth to that area. Those providers are in addition to the over 40,000 physicians who have now been waivered to prescribe.

And finally, SAMHSA is working with stakeholders to refine the DATA waiver 2000 training to better prepare practitioners to provide care and enhancing newly DATA waivered mentoring programs to provide immediate and ongoing support to healthcare providers who are working with patients with opioid use disorder. It's one thing to be waivered. It's another thing to be clinically adept at knowing how to proceed with that medication-assisted treatment.

And there is the gap. You know, therein you've got to make sure that individual clinicians feel comfortable, practiced, and confident, I think is the word, to make sure that they are doing what is appropriate for the interventions.

And the third area we've been working on, and I'm sure you've all been involved in some of these discussions is 42 CFR Part 2.

MR. BERTRAND BROWN: Hello again. This is Bertrand --

MS. A. KATHRYN POWER: I'm sorry? I can't hear him. He's not speaking to us? Okay. Okay.

42 CFR Part 2. In January of 2016, SAMHSA enacted revisions to 42 CFR Part 2 to modernize and ease the communication between providers of substance use disorder treatment and other healthcare services via electronic means. Currently, SAMHSA issued a Supplemental Notice of Proposed Rulemaking to address issues raised by commentators, but not directly addressed in the original Notice of Proposed Rulemaking regarding the use of contractors for payment of healthcare operations activities.

That final rule was published in January of this year. So on January 2nd, it was published. And on January 31st, SAMHSA held a listening session to learn about the effects of the new rules. Were any of you able to call into that listening session? Okay. So that listening session, Dr. Johnson hosted that listening session, and we asked people to tell us about their opinions about the effects of the new rules to identify additional changes that might be necessary.

And so staff copiously took down notes during that listening session. It was recorded so that we have an opportunity now to look carefully at those comments and begin the next phase of this revision. So a quick review of some of those comments, let me just touch on them really quickly. I don't want to bore you to tears, but there are three areas that we heard.

The first was the prohibitions against redisclosure of information under Section

2.32 seemed to some of the listeners to be at odds with healthcare providers' increasing use of electronic records management systems in an integrated healthcare setting. So that was the first issue.

The second issue was with the changes made to Section 2.31, which now requires that the name and title of the individual or the name of the organization to which disclosure is to be made, presents significant challenges to criminal justice and other social service agencies that may not know the name of the provider, or the name of the provider may change, or the name of the provider may change frequently.

And then the third comment, cluster of comments, that was important is that there was clear indication from the listening public that said we need -- SAMHSA must develop some regulatory guidance to provide training and to develop educational materials, to develop model forms, to develop model practices as indicated in the preamble of the 2017 final rule to ensure that there is consistent implementation.

And I think that these were just a few, but these are the highlights of what occurred in the listening session, and we are going to continue to refine that and begin to further bring clarity and finality to this. This has been going on for 25 years, and we are inching our way to come to some resolution, and we are very open to hearing what the concerns are. And we, in fact, want to make sure that we are responding to those concerns and that we need to put in play the appropriate subregulatory guidance that will be understood by everyone and that will protect people, but that will also acknowledge the new environment that we have in integrated care and electronic health records.

So any comments or questions for me on that? Dr. Martin?

DR. JUDITH A. MARTIN: Thank you for summarizing so well the report and picking the highlights. I appreciate that.

And I can testify that in our State, the Federal grant regarding opiates has been really effective in training new clinicians.

MS. A. KATHRYN POWER: Oh, good. Okay.

DR. JUDITH A. MARTIN: And it's been applied as a hub-and-spoke model, where the hub is people who know about opiates and who treat people --

MS. A. KATHRYN POWER: Right.

DR. JUDITH A. MARTIN: -- and then the spokes tend to be FQHCs.

MS. A. KATHRYN POWER: Right.

DR. JUDITH A. MARTIN: And I think that's a good model. Also we've brought in our professional organization, the California Society of Addiction Medicine, to provide mentorship.

MS. A. KATHRYN POWER: Excellent.

DR. JUDITH A. MARTIN: And so I was thinking we should tap into the local physician organizations that treat addiction --

MS. A. KATHRYN POWER: Okay.

DR. JUDITH A. MARTIN: -- addiction psychiatry, addiction medicine, who might be good mentors. I know the PCSS already does that with SAMHSA.

MS. A. KATHRYN POWER: Right, right.

DR. JUDITH A. MARTIN: But a more local focus, maybe people who might know each other.

MS. A. KATHRYN POWER: Okay.

DR. JUDITH A. MARTIN: And also I don't know if there's any effort to enhance the current fellowships in addiction medicine because that's where our leaders are going to come from who can then be more mentors.

MS. A. KATHRYN POWER: Okay.

DR. JUDITH A. MARTIN: I think those things would be helpful. In terms of 42 CFR, those points are very eloquent that people brought up in their talking points. I think in our current efforts to integrate care, it's one of the main barriers.

MS. A. KATHRYN POWER: It is.

DR. JUDITH A. MARTIN: And the other one is the -- in mental health, the medical necessity is one.

MS. A. KATHRYN POWER: Right, right.

DR. JUDITH A. MARTIN: Those two things are really stumbling blocks in terms of integration, even though we try and try.

MS. A. KATHRYN POWER: Yeah, yeah. Well, I know that Dr. Elinore McCance-Katz feels very strongly about making sure that people get the care they need when they need it and doesn't want to see a lot of barriers for that. And I think that that's got to be the driver, but at the same time, we want to make

sure that both individuals with these use disorders are protected to the extent of the law and that we will also protect the practicing physicians in terms of the exchange of information and confidentiality.

I think the other issue that you've raised about sort of connecting more local providers in support, I think that's where she's headed. I think she really wants to see, you know, that scope of technical assistance that is not just what SAMHSA can provide, but that we have some bona fide technical assistance, clinical expertise at the local level that can be sharing and working together to make sure that there is this clinical confidence around the delivery of services.

So I think -- I think both of your comments are what I've heard her speak about, which is great. So you must have talked to her. Yeah?

DR. JUDITH A. MARTIN: Yes. We used to be almost neighbors. She was in California.

MS. A. KATHRYN POWER: That's right. I know she was. I know she was. That's great. Then, of course, she went to Rhode Island, which tells you something, right? My little State.

[Laughter.]

MS. A. KATHRYN POWER: Okay. Any other -- oh, I'm sorry. Arthur, go ahead.

MR. ARTHUR SCHUT: No, that's fine. I'm very concerned about the enforcement around misuse of information that will be released basically to everyone going forward.

MS. A. KATHRYN POWER: Okay.

MR. ARTHUR SCHUT: I mean, HIPAA, frankly, is a sieve when it comes to where all the information goes.

MS. A. KATHRYN POWER: Right.

MR. ARTHUR SCHUT: And defaulting to that, I have concerns with the impact of that. And having lived through folks accessing information, using information, putting informants in -- the law enforcement agencies putting informants in groups so they can find out who to track in terms of patients and finding the people who are doing drugs, all those kinds of things impede access to treatment when the word gets out that that's what happening.

And it, frankly, impedes access by people of means. People who are in the criminal justice system are accustomed to not having any rights, basically. And many people who are poor, frankly, are accustomed to that, unfortunately. But

what it really does is impede access by lawyers and physicians and health professionals and business folks that if you think you're going to go to a treatment center, and it's going to be released, and you're not going to be able to consent explicitly to that, people tend to avoid treatment.

And so I think robust enforcement needs to be part of this. Otherwise, we default to the way it was before the law was passed back in whenever.

My second concern is about medication-assisted treatment and having SAMHSA take a position on access to the medication. There are a variety of ways that if you actually try to do medication-assisted treatment, what you run up against is who's paying for the medication, and can you get access to that medication?

And even if the medication is on a formulary, in some instances, it's a buy-and-bill medication. So the provider has to buy it and then bill for it. Sometimes you don't get paid for that, right? And if you're playing with something like Vivitrol that has a fairly hefty pricing to it, even if you get it through the wholesale pharmacy, if you're a small organization, and you have to buy it, but then you have no guarantee when you bill you're going to get paid, and you're buying it at a level that is economical in terms of dose, which is 25 doses or more at a time, you end up in a position of maybe getting stuck for 2 or 3 doses, which ends up being $2,000 or $3,000, for example.

And there is a hesitance to buy-and-bill to make that available. And I think if there could be a way to have a conversation with CMS around State Medicaid reimbursements and that, in fact, buy-and-bill is unacceptable or anything that impedes prescriber access to reimbursement for those medication-assisted treatments is --

MS. A. KATHRYN POWER: Good. We'll put it on the list.

MR. ARTHUR SCHUT: -- essential because you can have all the training in the world and all of the enthusiasm and --

MS. A. KATHRYN POWER: Right.

MR. ARTHUR SCHUT: -- in point of fact, be unable to get the drug realistically to prescribe it.

MS. A. KATHRYN POWER: Well, I think there is some ongoing conversation between SAMHSA and CMS relative to those issues. The reality is that the name of the process rests with the State Medicaid plan, and the State Medicaid plan being either supported by CMS in terms of whatever they have in their State Medicaid plan. And that's the place where, you know -- and some of our States may want to talk about that today in terms of what has worked well in terms of trying to get some those reimbursement issues addressed within State Medicaid

plans. So I think that's really the way to go.

Other comments? Yes?

MR. JASON HOWELL: Yes, thank you.

So to medication-assisted treatment, I do think it's fantastic. One of the barriers has been that we haven't had enough physicians to be able to prescribe and really know how to prescribe. So I'm glad that there are efforts that are addressing that. But really, the goal is recovery, and I've advocated that maybe we should reframe this as "medication-assisted recovery" because too often when we say MAT, many people are thinking about the medication, the pill.

MS. A. KATHRYN POWER: Right.

MR. JASON HOWELL: When really from an evidence-based practice standpoint, it's giving people access to the medication, but then also into counseling or recovery coaching or -- we're talking about recovery. So how do we get individuals in those recovery support services?

I've heard from various States that some communications that they receive from SAMHSA seem to really emphasize the medication piece, but then also look how can we be also building out the recovery support services and kind of bridging that?

And then the other thing is also understanding this is about choice. I think that there is some fear around this becoming mandated treatment.

MS. A. KATHRYN POWER: Yes, right.

MR. JASON HOWELL: And there are individuals who definitely have the right and have valid reasons not to be on medication-assisted treatment.

MS. A. KATHRYN POWER: Right, right. Thank you very much, Jason.

Actually, I've heard -- it must be the Denver -- it must be the Denver elevation because I've heard Charlie Smith preach to us and say, "You should not be calling this MAT. You should be calling this medication-assisted recovery." So you must all be thinking about it the same way there.

Other comments? Yes, Sharon?

MS. SHARON LEGORE: Coming from the family perspective, there is such a gap in between looking at medicated-assisted treatment and abstinence. And we have arguments, you know, at the levels ourselves because some parents feel abstinence is the only way.

MS. A. KATHRYN POWER: Yep.

MS. SHARON LEGORE: And others want to look at medicated-assisted treatment, but not really understanding what it is. So getting information out there to the families as well is important because there are some families that are included and looked at for those supports, to be a support system. So if you're coming in and they're saying, well, we'd like to use medicated-assisted treatment, but the family members are scared to death, you know, it puts the person, you know, in a sort of a limbo.

So that education piece to get out there what it is, and if you're looking at a disease model concept, you know, to get families to understand that this is not the end all --

MS. A. KATHRYN POWER: Right.

MS. SHARON LEGORE: -- but this could be an area that might save your child's life.

MS. A. KATHRYN POWER: Okay, okay. Thank you.

I'm going to toss that back to my senior staff and say, all right, are there some opportunities for us to figure out a way to create some fact sheets, some tools, some handy things that people can have to say, you know, when you go talk to a family member or somebody is in an emergency room and say, "Well, what do you mean, you're going to give my son, you know, Suboxone. Tell me what that is. Tell me what the -- explain that to me." I think that's a hugely important issue.

And I think you're right. I think, you know, I'm telling you that America does not know a lot about opioids, and they do not know a lot about medication. And I think one of the biggest problems we have is trying to get out that information to everyone and say, you know, we look at the FDA's list of over 100 opioids. I'll bet most Americans couldn't tell you what's on that list.

They might have heard of Percocet. They might have heard of OxyContin, but not a whole lot. So, you know -- and then on the other side, what does Vivitrol do, you know? I mean, so I think that all of that notion is really one of the things we have to build a higher level of awareness for just the very reasons that you talked about.

MS. SHARON LEGORE: And it's also for the physicians.

MS. A. KATHRYN POWER: Right. Correct.

MS. SHARON LEGORE: They need to be educated as well.

MS. A. KATHRYN POWER: Absolutely. Absolutely. Okay. Yes, Dr. Martin?

DR. JUDITH A. MARTIN: So I'd like to underline what Sharon just said. I mean, that's one of the main questions that our patients have, the adult patients, you know? Who come in, even when they walk into a methadone clinic, they say, "What's better about your medicine than my drug? You know, what's the difference, doc? Why are you giving me this stuff?"

And that's what I'm trying to -- you know?

MS. A. KATHRYN POWER: Right.

DR. JUDITH A. MARTIN: And it takes -- it takes some explaining because --

MS. A. KATHRYN POWER: It does.

DR. JUDITH A. MARTIN: -- the medication we use is treatment, and it stabilizes their brain, and they can be abstinent, if you define abstinent as doing what you're supposed to do and not using drugs. And so we've even had Methadone Anonymous groups in our methadone clinics. It doesn't mean that people can't do the 12 steps or whatever. It stabilizes them to the point where they're not out of control with the drugs.

MS. SHARON LEGORE: Right. It's not just about the medicine.

DR. JUDITH A. MARTIN: Exactly.

MS. SHARON LEGORE: It's about learning about your disease as well.

MS. A. KATHRYN POWER: Okay. Thank you, Dr. Martin. Kristen?

MS. KRISTEN HARPER: Go ahead.

MS. A. KATHRYN POWER: Oh, I'm sorry. Eva?

MS. EVA PETOSKEY: Well, yeah, I just -- okay, okay. I have a loud voice, but I agree with many of the things that have already been said. So I won't repeat those, but I would also add that targeting rural areas.

For example, in Michigan, there is no methadone treatment available in the Upper Peninsula. It sort of cuts off at the -- there's plenty available in the southern part of the State. You get into rural and remote areas, there is nothing.

MS. A. KATHRYN POWER: Right.

MS. EVA PETOSKEY: As well as MAT in general. There are very few physicians in the Upper Peninsula of Michigan. I'm just giving this as an example. I'm sure this is probably true in other rural or remote areas of the country. And an even higher need for education of the community. So that's an issue, targeting rural communities with this training and with the training of physicians, nurse practitioners, as well as those physician assistants.

The other thing I would add, we did a survey of the treatment programs in our network, our ATR network, trying to find out the readiness for doing -- working with medication-assisted treatment. And we still have a culture of pushback in a lot of treatment programs because they're saying this is just a replacement of one drug with another. So, again, that's an education. It's a huge educational undertaking.

We are -- our network, we are believers in MAT, but whenever I explain it, I say here is the -- here is recovery. Here is the circle of recovery. Here is medication-assisted treatment. It's a slice of that circle. It is not the solution alone. And then also emphasizing the use of integrated care and really building those partnerships between physicians for referral and collaboration back and forth with behavioral health. It's so critical, and it doesn't happen.

MS. A. KATHRYN POWER: Right.

MS. EVA PETOSKEY: It doesn't happen. I could go on because we have quite a bit of experience with MAT challenges, people with Suboxone especially engaging drug-seeking behaviors, or Suboxone-seeking behaviors. Quite a bit of behavior around that. So I don't want to focus on the negative, but some of the challenges.

And also diverting of the drugs. And then the legal consequences of drug diversion are significant with Suboxone. In Michigan, it's up to a 7-year -- it's a felony for diverting one pill of Suboxone. It's a felony punishable by 7 years in prison if the judge wants to be -- we just experienced this with two clients, where they diverted a small number of pills, and now they're facing, together, up to 42 years in prison. I don't think it'll go that way, but it could.

So I think that's another -- that's educational thing. I think people need to be informed, "If you divert this pill, you know, you're in trouble." I don't know that people really go into it getting that. You know, there's a lot of education. So I just wanted to give a few examples.

MS. A. KATHRYN POWER: Right. And let me add that if any of you use any particular kind of information or handout or something that you personally think has been helpful in that educative process, send it our way. You know, we could take a look at it, and Marla can kind of look at it and say, wow, this might be

something that we could adapt for larger audiences.

Because you're obviously doing it, you know, and so I always like to think that if at the local and community level that you're doing it, we don't have reinvent the wheel at every level. You know, we can take some of that information and package it in a way that would be useful. So thank you, Eva.

Okay. Kristen?

MS. KRISTEN HARPER: I just wanted to make a pitch for there to be some education including the doctors, as Judith mentioned. I really impress upon SAMHSA to focus on pediatricians, OB-GYNs, college health centers, counseling centers at the college level, high school counseling organizations to get into that youth PT and to the adolescent PT. If you're going to talk to the families, you're going to also --

MS. A. KATHRYN POWER: Right. Okay.

MS. KRISTEN HARPER: -- encounter the youth piece as well. And so, you know, one of the nice things that we do have several networks now available to help with that. So there is the Collegiate Recovery Network. There is a high school network. There's a lot of different ways to get information out. So it's not as difficult as it was maybe 10 years ago.

And then, separately, I am hopeful that we're going to talk about the evidence-based piece that got tabled --

MS. A. KATHRYN POWER: Great.

MS. KRISTEN HARPER: I'd love to hear what's going on with that.

MS. A. KATHRYN POWER: Okay. All right. Thank you.

Other comments? Arthur?

MR. ARTHUR SCHUT: It's an editorial.

MS. A. KATHRYN POWER: An editorial?

MR. ARTHUR SCHUT: An editorial.

MS. A. KATHRYN POWER: Okay.

MR. ARTHUR SCHUT: I've had it with providers who are philosophically opposed to medication, and I'm over with it. And I think that there is an obligation to provide patients a choice to every available evidence-based practice

and including -- that includes medication-assisted treatment. And that should it be philosophically opposed to this and not provided to patients is malpractice. And I think we need to state that position. If you're denying -- if you're in healthcare and you're philosophically opposed to providing an effective treatment, and you don't make that available to patients, you're engaged in malpractice.

And we ought to take a position as an organization, as a field, that this is not acceptable behavior, and if you are philosophically opposed to it, you can go do something else in life. But being in substance use disorder treatment is an inappropriate place for you to be if that's how you treat the people that you serve in that way.

MS. A. KATHRYN POWER: Thank you. I think that, you know, in our region, we've talked a lot with medical associations -- thank you. We talk to a lot of medical associations, et cetera, and I always start those comments with, you know, if we really believe in first doing no harm, let's start from that premise. And from that, you build that kind of argument, and I think that we have a long way to go to convince some people about that.

So, all right. What I'd like to do -- thank you all for your comments. We're going to move to -- well, go back one, Tracy. All right.

Agenda Item: CSAT Division/Office Director's Update

MS. A. KATHRYN POWER: I think this is here because they want you to see what we look like now in terms of the SAMHSA organization. Just to reorient you that we're kind of shifting things, and change is continuously going on. But right now, we have four centers -- CSAT, CSAP, CMHS, and CBHSQ. We have three offices -- Policy, Planning, and Innovation, which is undergoing its own change; the Office of Financial Resources; and the Office of Management, Technology, and Operations. And then from the Office of the Assistant Secretary, we have various offices that are specifically focused on particular issues or particular populations. So the Office of Tribal Affairs and Policy, the Office of Behavioral Health Equity, and the Office of Communications.

This is going to change, I think, over time. I think there's going to be some movement. I think that you have also an Office of the Chief Medical Officer now, and that has medical staff that are sitting in the centers but also report up to the Chief Medical Officer, Dr. Anita Everett. So there's going to be a lot of changes, but this -- right now, this is what this looks like.

Okay, Tracy, let's go. Okay. So this is what the CSAT organization looks like. I am very fortunate to have senior staff that is comprised of division directors and an Office of Program Analysis, OPAC, and an Office of the Director for Consumer Affairs. So you're going to hear from my senior staff, and I've asked

the senior leadership at CSAT to provide short updates, whatever that means and however -- whatever time you need or whatever Tracy has told you -- on the current programs in your divisions and your offices.

And we're -- you know, again, this is just meant to give you a quick snapshot, and obviously, they're here to answer your questions or interact with you. But they're going to give you a little picture. Audra Stock is the Director of the Division of Services Improvement. Welcome, Audra. Thank you for being here.

MS. AUDRA STOCK: Thank you. Hello, everyone. It's nice to see a lot of you again and also meet a few of you for the first time.

I've chosen to highlight three areas on DSI today. And the first ones are pregnant and postpartum women grant pilots. You may have heard about this last year. As a result of CARA, we were given the opportunity to grant three awards to States to expand the continuum of pregnant and postpartum women treatment.

For those of us who practice in the field, we are glad that this is finally here, that we were given an appropriation we could expand into outpatient and other types of services. Previously, it had only been residential.

So there were three awards made -- Massachusetts, Virginia, and New York. And they're about 6 months in operation, and they've phased in their kind of programming and planning, and they're about ready to launch their services. We're really excited to see their proposals and hoping to see how this expands the continuum of care. But some of the themes that they've talked about is really targeting the opioid crisis and targeting areas where we've seen a lot of overdose rates of pregnant and postpartum women.

They're incorporating systems that have more MAT availability. They're partnering more with OB-GYN, pediatricians, and other systems that naturally see pregnant and postpartum women as a population that may not have integrated behavioral health components. We're also really trying to focus on expanding the family services, like what you mentioned, and how to really engage the whole family unit, not just the mother and the child.

As a result of CARA, our partners in CBHSQ are also required to do an evaluation on this program, and so we're looking forward to working with them to determine early and long-term results.

MS. A. KATHRYN POWER: All right. Thank you, Audra. Oh, you're going to keep on going? Okay.

MS. AUDRA STOCK: I have three.

MS. A. KATHRYN POWER: I'm sorry. There was a pause.

MS. AUDRA STOCK: I'll go through them quickly. The one I think everyone is going to want to hear about, too. I'll quickly cover SBIRT because SBIRT has been in the news a lot, and even though we've had a reduction in some of that funding, SBIRT has become kind of the go-to kind of adaptable model to use in response to a lot of public health issues, but especially the opioid crisis.

And we have a lot of our grantees doing wonderful, innovative practices to incorporate SBIRT and used to train a variety of providers from across the medical providers, nurses, behavioral health counselors, wellness coaches, and even developing videos and opioid overdose reversal kits. And we have some tribal pain council integration. We've had our SBIRT coordinators working with tribes to work around how to work with pain and tribal councils. And so a lot of great things are happening with SBIRT, which I can show to you all later when we have more time.

But finally and most exciting, and which hits some of the points that you all mentioned today, tomorrow SAMHSA is releasing TIP No. 63. This is very exciting for a number of reasons. CSAT owns the KAP contract, the Knowledge Application Program contract that's been responsible for working with our contractors and subject matter experts in the field to update in a really aggressive timeline TIP 63, which is around medications for opioid use disorder.

And I say medications, but I also want to emphasize that there is five modules in this. Some are for our physicians so that they can understand the three FDA-approved medications used to treat opioid use disorder. One is for family members, and so individuals who are either nonmedical or nonclinical, but certainly care about this issue or have been trained to help. And also professionals in the field that are not medical but want to work around recovery supports or other elements to help treat opioid use disorder.

So that's launching tomorrow right after we deliver it to Congress. So very exciting. Those are my updates. Thank you.

MS. A. KATHRYN POWER: Thanks. Thanks, Audra. I'm going to ask folks to just hold questions or comments until all the division directors have summarized, and then we'll be having that period of time, and then we'll take a break. So let me just move through the senior leadership here.

Thank you again, Audra. And now, next, Onaje Salim, Director of the Division of State and Community Assistance, will update us on his activities. Welcome.

DR. ONAJE SALIM: Thank you.

Good morning, everyone. The Division of State and Community Assistance is

subdivided into three branches -- a Performance Partnership Grant Branch that manages the large substance abuse prevention and treatment block grant. That's not up there, but I wanted you to be aware of how we're structured. We also have the Performance Measurement Branch that handles the grantee data and health information technology. And our third branch is the Co-Occurring and Homeless Activities Branch that manages grants and contracts to work with the homeless and substance abusing population.

Three highlights that we have, two of them have already been very well covered. I'll just add that the State STR, what we call the State Targeted Response grant program is administratively housed in DSCA. However, it is truly a SAMHSA program, a SAMHSA-wide program, led from the top by our Assistant Secretary Dr. McCance-Katz, who receives reports directly from our project officers, giving us direct feedback and leadership on how we should implement the program. It's a rather large program, as you know. Therefore, it's funded by appropriations in 2016, the 21st Century Cures Act, and there were 57 grants to 50 States and territories.

And I think as you have been articulating, the States are where the innovation is happening. Each State received their award in April 2017, began the work in May, and developed strategic plans, which we received. And we've also received some mid -- mid term, mid year reports indicating that thousands of people have already been served. We're expanding treatment with STR.

And of course, there has been a focus on medication-assisted treatment because of the stigma against it. But we're articulating a public health approach, a comprehensive approach that improves prevention, all forms of treatment, including medications and recovery supports. That's what our project officers are focused upon. We're collaborating very closely with our prevention colleagues, and in fact, it's kind of like a duo, a team of two, with each State having a prevention project officer and a treatment project officer for STR. I'm really happy to talk more about that and also to receive your input as to how we can improve that implementation.

I won't say anything more about 42 CFR Part 2. I don't think I could improve upon what we've already heard from Director Power, except maybe to ask Suzette Brann to raise her hand. She's the lead in our division for that activity, and of course, although the rule has been finalized, we are continuing to deal with it.

Last thing I would update you on is our recovery housing activities. I've worked with Jason and others around the country. We have our internal workgroup, and of course, some of this is stimulated by some of the publicity and bad actors and things that have been occurring around the country in terms of the exploitation of people who are trying to receive recovery and the unclear regulatory environment.

SAMHSA, I don't think, will be establishing new regulations, but we are going to work on guidance, clear definitions, better funding streams, better collaboration with Housing and Urban Development, and hopefully promote higher-quality recovery housing throughout the country as a part of an overall recovery support services framework.

So thank you very much.

MS. A. KATHRYN POWER: Thanks, Onaje.

Danielle Johnson Byrd has recently accepted the post of Director, Division of Pharmacologic Therapies after having served as its Acting Director for the past month. Danielle, thank you for taking on the responsibility, and welcome.

MS. DANIELLE JOHNSON BYRD: Thank you.

The Division of Pharmacologic Therapies is responsible for providing day-to-day regulatory oversight of medication-assisted treatment on two key activities. The first is supporting the accreditation and certification of the over 1,500 opioid treatment programs throughout the country who serve more than 300,000 patients annually. And we also are responsible for implementing the DATA 2000 waiver, which certifies qualified physicians, nurse practitioners, and physician assistants to provide office-based opioid treatment.

As Ms. Power mentioned, there are over 40,000 waivered physicians and upwards of 5,600 nurse practitioners and physician assistants who have also received waivers. We also manage the Providers' Clinical Support System grant that provides training and mentoring to individuals who are interested in becoming DATA waivered or who are currently DATA waivered.

We're also excited about several products that we've been working on. The Clinical Guidance for Treating Pregnant and Parenting Women with Opioid Use Disorder and Their Infants was released on February 7th, and it's available at the SAMHSA store. And we are also working on several fact sheets as companion documents to that product. And we are working on the opioid overdose prevention and response curriculum, which is expected to be released in March of this year.

MS. A. KATHRYN POWER: Thank you, Danielle.

As many of you know, Ivette Torres retired at the end of December after having led the Office of Consumer Affairs in CSAT for many, many years, and we are very fortunate to have Marla Hendriksson join CSAT as the Acting Director for the Office of Consumer Affairs. Marla has been at SAMHSA for many years and knows the communications business.

Marla, welcome, and thank you.

MS. MARLA HENDRIKSSON: Thank you. This is my first NAC here with CSAT, but I have seen you in the other capacities, my other capacity before. So it's nice to see you again in this new role.

First, I wanted to again acknowledge the long work that Ivette had provided for recovery for so many years. She poured her heart and soul into it, and she has touched so many communities around the country. So I would like to build on that work and also expand upon it.

So up here on the slide here, there are a number of things. I'm not going to go through them. They're in the Director's summary. But as I learn more, I really want to immerse in the role. I want to get to know all of you, and in doing so, one of the things I'd like to do when I say expansion is to expand the portfolio into more work with families, with caregivers, schools, communities, and health providers. I love the conversation so far. I've been taking lots of notes, and from the projects we have here right now, hopefully, I'll get to know you more and talk more about them.

There are three that I'd like to highlight right now, and the rest are, again, in the Director's summary. The first being the project called Understanding Treatment and Recovery Services. And for this one, we are doing an environmental scan and talking with stakeholders to understand and evaluate the current materials out there pertaining to substance use disorders and treatment and recovery, that what is available to consumers right now?

How -- do they work? What messaging actually resonates with them? And you know, are they able to access this information? From what I'm hearing now, there are pockets where they are not. So trying to improve on that. You know, what -- do they know the choices for treatment?

And again, it goes back to more patient education, more provider education, and looking for ways to promote that higher level of awareness that we are talking about here. We're also using it to develop and promote the new materials that provide more beneficial and accurate information. The field continues to change, and so the materials have to be upgraded as well. And making sure that they're in the right formats and sent out to the right media and they have not only the consumer voice, but that sensitivity as well.

The second one I wanted to highlight is in the portfolio what I'd like to characterize as workforce development. There is one on education and information, and for this one, it's about working with college freshmen and sophomores as they are starting in their student careers using a campus-based platform to help them choose that career in behavioral health. We are focusing

on four States right now around the country, and those are Indiana, Minnesota, Mississippi, and New Mexico. And this is still in a very early stage, but we are working with those universities to host full-day forums, and each State is still in that planning process.

And finally, we're working on some capacity building with peer mentors in the Criminal Justice Involved Youth project. And for this one, we are developing a curriculum for a 2-day training on basic and intermediate skills for peer mentoring, and this is for people who work with, again, the youth and young adults who are at risk or who have been in the criminal justice system. We have a training scheduled for Pennsylvania in mid to late March. Again, it's in the Director's report.

So, again, I wanted to highlight the fact that I want to build on the work so far, expand on it, and in doing so, it has -- I would like to work more closely with my colleagues to integrate the work of the Office of Consumer Affairs and making sure that we have that consumer voice.

And this goes to not only my fellow division directors here, but also with the other centers, with the rest of SAMHSA, and the regions as well. And my ask to all of you, as I get to know you, is I want to learn more about where that action is and where our work can be more infused with yours. The whole added dimension of medicated-assisted recovery, I love that, and the abstinence component as well. I'm taking notes on that fact sheet that we need for family members and hope to get to know you more.

MS. A. KATHRYN POWER: Thank you, Marla, very much.

Any comments or questions for the senior staff? I know they touched on a lot of areas, and they're going to be here, and you can talk to them. But if you have any comments or questions or observations for them for the moment?

MR. ARTHUR SCHUT: I just have a quick comment.

MS. A. KATHRYN POWER: Arthur?

MR. ARTHUR SCHUT: I'll talk to Marla offline. But if you Google for treatment and typically treatment of adolescents, you get a lot of bad actors, and it would be nice if we could figure out a way to redirect people to --

MS. A. KATHRYN POWER: Okay.

MR. ARTHUR SCHUT: -- the SAMHSA website. But there are real problems with that.

MS. A. KATHRYN POWER: Okay.

MR. ARTHUR SCHUT: They're usually places that don't have an address in your Internet search.

MS. A. KATHRYN POWER: Oh, that's scary.

MR. ARTHUR SCHUT: And they all funnel. A whole bunch of them have been put out of business or at least are being better regulated for it, but it's a problem.

MS. A. KATHRYN POWER: Great. Thank you.

MS. KRISTEN HARPER: If I could just add real quick to that, we just launched yesterday the Recovery Resource app through Facing Addiction and Transforming Youth Recovery. Have you seen it?

FEMALE SPEAKER: Not yet.

MS. A. KATHRYN POWER: I just saw that yesterday. Yeah, yeah, I just saw that.

MS. KRISTEN HARPER: Yeah. We've been studying about 5 years to try to figure out a good vetting process. There are still holes in it, but it really has improved.

MS. A. KATHRYN POWER: Okay.

MS. KRISTEN HARPER: So we can go on now, and local family groups, anybody can go in there and enter a resource on there, and then it gets kicked back to staff who will vet it. But I think that, hopefully, that will expand.

MS. A. KATHRYN POWER: Great.

MS. KRISTEN HARPER: And we'll have more resources --

MS. A. KATHRYN POWER: All right. Okay. I want to thank everyone. I know we're a little bit over, too, for a break. So I have to use the bathroom. So I'm going to give you about 12 minutes so that you can start here at 10:30 a.m., and Elizabeth will give us a quick budget update, and then we'll move to Chris Carroll.

And I really -- mostly we want to stay on time in terms of giving you a good lunch break from 12:00 p.m. to 1:00 p.m., and then being ready and available when the Assistant Secretary comes down at 1:00 p.m.

So 12 minutes, we'll see you back here. Thank you.

[Recessed at 10:19 a.m.]
[Reconvened at 10:33 a.m.]

Agenda Item: SAMHSA/CSAT Budget Update

DR. ELIZABETH LOPEZ: -- discussion that happens especially in each of the houses, as you know, and the next process is to reconcile those numbers, right? They're pretty close, as you can see, which is always really good news. They also kind of are unanimously supporting additional resources for us, which is also sometimes good news. So we also don't like the number to go in the opposite direction.

So you've been witnessing over the last couple of months, through the last couple of continuing resolution discussions, exactly where we are in terms of discussion about conferencing, if you will, is what we call it, and coming to an agreement about what these final numbers will be. So at this point, we're still operating at what we call a continuing resolution or an annualized continuing resolution for FY '17. So the numbers that we are operating under are our final '17 budget numbers because that's what we're committed to do.

Just last week, as you know, we were issued another continuing resolution that while there's been a 2-year budget large deal passed, we don't have our final bill, you know, our budget for FY '18 yet, and our CR takes us now to March 23rd, where we hope that there will be a conference on these sets of numbers as a feedback on the '18 budget, or the President's proposed, and we'll have a final budget for FY '18.

So I think I'll stop there and ask if anybody has any questions.

MS. A. KATHRYN POWER: Okay. Questions? Dr. Martin?

DR. JUDITH A. MARTIN: So this has been a really confusing time in terms of who gets money and who doesn't. One of the areas that really affects a lot of our especially pregnant and postpartum women is the visiting nurse effort in maternal/child health. And I wasn't sure if that had got funded. Do you know?

DR. ELIZABETH LOPEZ: Well, I don't -- they're in the same situation as we are in terms of the budget action for the final fiscal year here in FY '18. So there hasn't been a final budget action, I believe, for any of the other operating divisions in HHS. So they should be operating at the continuing resolution level from FY '17, but we can -- I can find out from our contacts over there to see what the status is and get that information back to you.

DR. JUDITH A. MARTIN: I think it was in question for a while in the CR. Thank you.

MS. A. KATHRYN POWER: Other questions? Other comments?

[No response.]

MS. A. KATHRYN POWER: Okay, great. Well, it's going to be a continuing process --

DR. JUDITH A. MARTIN: Yes.

MS. A. KATHRYN POWER: -- to track this, to follow Congress and to see what happens with the continuing resolutions as well as the next year's budget. So thank you very much, Dr. Lopez.

I just want to take a break here for a second and introduce Dr. Steve Daviss. Steve is a newcomer to SAMHSA, and he is a part of Dr. Anita Everett's Office of the Chief Medical Officer team. And as I mentioned earlier this morning, folks who are part of that professional group are actually deployed in some shape or fashion into the center. So we are very fortunate that Dr. Daviss is a part of the CSAT environment, but he also reports and works directly with Dr. Anita Everett as our Chief Medical Officer.

So, Dr. Daviss, I just thought I'd give you a chance to introduce yourself to the group.

DR. STEVE DAVISS: Oh, thank you very much. I appreciate it.

Good morning, everyone. So I just want to thank you all for volunteering your time to do this work here. So I'm just going to give you like a minute or so about who I am and where I came from and what I do.

So I'm a psychiatrist. I've been in practice for about 20 years. I've worked in all sorts of different settings -- outpatient, group practice, nursing home, hospital. Spent 10 years as the chair of psychiatry for one of the University of Maryland hospitals. I've run addiction programs before.

And so I started here at SAMHSA about 5 months ago in September after Dr. Anita Everett, our CMO, who I know well because we both live in Maryland, and she told me about this opportunity and the great work that SAMHSA is doing as far as building the clinical experience and medical leadership here. So I'm really thrilled to be here.

I started off just working in the Office of the Chief Medical Officer, really focused on the opioid crisis quite a bit. Other things, too -- 42 CFR and telemedicine and so forth. But with Dr. Campopiano, who had been the senior medical advisor for CSAT for, I guess, maybe 4 years or so --

MS. A. KATHRYN POWER: Yeah, several.

DR. STEVE DAVISS: -- left in December, and so I'm now filling in that position as well, and I'm really happy to be here. I am available. So feel free to reach out to me if I can be of any help to any of you.

Thank you.

MS. A. KATHRYN POWER: Thanks, Dr. Daviss, very much. Appreciate you saying something. Great.

Agenda Item: TOPIC: Behavioral Health Spending and Use Accounts

MS. A. KATHRYN POWER: What I'd like to do now is go on to the topic of the day that is -- we understand that the council had some interest in talking about, Behavioral Health Spending and Use Accounts. And we're very fortunate to have Chris Carroll, who is the Director of Healthcare Financing and Systems Integration, join us today to talk about SAMHSA's Behavioral Health Spending and Use Accounts and our initiative in that area.

Chris is a part of the Office of the Assistant Secretary and leads all of SAMHSA's health financing activities. And SAMHSA for many years was not involved in discussions really about financing or health spending, and so we're very fortunate to have someone of Chris's caliber here, focusing on programs and resources to ensure that behavioral healthcare services are more accessible and connected to the broader healthcare system.

Chris has over 25 years of experience in behavioral health, with a background in mental health and substance use services administration and financing, public health program implementation, organizational management, and behavioral health systems operation. My one claim to fame is that I hired him.

[Laughter.]

MS. A. KATHRYN POWER: While at SAMHSA, he has worked to maintain and manage relationships and programs with the Department of Health and Human Services officials across all sectors of that Department, with members of Congress, with executives of other Federal and State agencies, with professional associations and organizations, international and nongovernmental organizations, and engagement with various constituency groups.

The Behavioral Health Spending and Use Accounts initiative was really created to provide policymakers with essential information on expenditures for and utilization of mental health and substance use disorder treatment services,

sources of financing around those, the allocation of treatment spending by providers, and what are some of those trends over time. So it gets to some of the issues that have already been raised here about, you know, areas that you have in terms of observations or questions.

To do that, the initiative allows us to provide comparisons of spending and financing sources between behavioral health and all health treatment, and you know, this gives us a window on things that we might not have had in the past but that we now have that window. So I'm going to turn it over to Chris. We have basically until lunch time, right, Tracy?

Okay. So we have a little chunk of time that Chris is going to do a presentation. My name is up there, but I don't think I'm going to have any role in the presentation because I'm not that smart. But Chris is going to do the smart part, and then we're going to facilitate some conversation and discussion.

So, Chris, welcome, and thank you.

MR. CHRISTOPHER D. CARROLL: Thank you. It's nice to be here and meet all of you, too.

Before I start, I know that this is a time of change, and having worked for Kathryn for 6 years, I know that you are in the most capable of hands, that is for sure.

So as Kathryn said, this is, you know, it's a longstanding report. We've been doing it for about 25 years, and what it does is provide us and you and State policymakers the opportunity to look at different changes in healthcare financing -- who's utilizing services, who's not utilizing services. The ACA created some interesting dynamics about who pays for services.

One of the interesting things, and this has been hard for me to change saying, is we got so used to saying Medicaid is the largest payer of behavioral health services in the United States. Maybe not so much anymore. The advent of the ACA created the opportunity for the private sector to move in, and within mental health, the private sector actually pays for 28 percent of all mental health services. Medicaid only pays for 25 percent now. So Medicaid is not the largest payer of mental health services in the United States anymore.

Now if you look at, and I'm going to read you some facts that we pulled out of the -- out of the report, which we consider very interesting. If you look at public spending, the public spending is greater than private spending across behavioral health because then you combine Medicaid and Medicare, and it's a greater payment than the private sector, you know, with out-of-pocket cost and different things like that, that whole input as well.

Before moving on -- or let's go ahead and move on to the next slide, please.

You know, this is a report that comes out of a large-scale technical assistance center called the Center for Finance Reform and Innovation. That is run by our -- one of our contractors on that TA center is Truven IBM. So I would be remiss if I didn't thank Amy Windham and her team, and Amy is probably on the line, and I should get an email if I flub anything, I think. But you know, they have done a fantastic job.

So, yeah, for more than 20 years, it does provide policymakers -- begins to answer a few questions. What the nation spends on mental health and SUD treatment, which payment sources fund treatment, who delivers treatment, and how expenditures and use have changed over time.

Next slide, please.

These are an example of the previous reports that we've done.

Next slide.

We are scheduled for an hour and 45 minutes. You probably feel about now I'm not going to make an hour and 45 minutes, but so I'm hoping that we have the opportunity to have some discussion about some of the emerging trends that you guys are seeing and what you're interested in and where we could move the next iteration of the report and better meet your needs.

Right now, we're updating the spending estimates through 2015, streamlining production, updating to a consistent and more efficient methodology to improve the accuracy of the provider and setting splits within the payer estimate, examine trends in behavioral health access, utilization patterns, and prices in addition to spending.

Next slide.

So some of the methods. It is interesting that what we do is we focus the spending estimates on expenditures for treatment as opposed to disease burden, right? So they include only the spending on direct treatment for mental health and substance use disorders and exclude other comorbid conditions. That's a consistency issue. I mean, I think there are other reports or analysis that begin to do some of that, but this is kind of a straight-ahead report.

Now you'll see, if we can go to the next slide. Well, okay. Payer stratification. Private/public, we talked a little bit about that at the onset. Diagnosis group, mental disorders and SUDs. So it's a pretty straight forward report.

Can we go to the next slide?

These are the settings that we begin to look at. All hospitals, general hospitals, freestanding home health, retail prescription drugs. We look at drug costs over time and how that's influencing care. Other professionals, psychologists, psychiatrists. Psychiatrist physician, nursing homes.

Next slide.

Here's where it gets interesting, right, is it's a pretty straightforward report, but look at the plethora of data sources that is used to generate this report. We also have some expertise in the room. I just looked back and saw Pat Santora back there. So thank you, Pat, for being here. And if you have anything to add, feel free to step up.

DR. PAT SANTORA: Okay. I will.

MR. CHRISTOPHER D. CARROLL: Significant amounts of data get poured into this report. What comes out of it is some pretty enlightening data. Feel free to ask questions anytime you want.

Next slide.

DR. JUDITH A. MARTIN: So just to --

MR. CHRISTOPHER D. CARROLL: Yes, ma'am?

DR. JUDITH A. MARTIN: So I'm not necessarily a budget or finance person. So say that a physician provides buprenorphine as part of their primary care in an FQHC, would that show up on these?

MR. CHRISTOPHER D. CARROLL: So some of the claims data would if billed against Medicaid or other insurance --

DR. JUDITH A. MARTIN: So it depends on the ICD-10 code?

MR. CHRISTOPHER D. CARROLL: It would depend upon the CPT code and the ICD code.

DR. JUDITH A. MARTIN: So if a mental health provider does dual diagnosis treatment, but they don't necessarily put that as their primary diagnosis because they're primarily treating mental health, would it show up here?

MR. CHRISTOPHER D. CARROLL: Well, in some of the prescription data, I think it would. I think it would show up. As we get a look at national trends and national expenditures, I think the granularity of what you're looking for gets lost in kind of a larger --

DR. JUDITH A. MARTIN: So the social work wouldn't be, but the medication would?

MR. CHRISTOPHER D. CARROLL: The social work?

DR. JUDITH A. MARTIN: I mean the therapy.

MR. CHRISTOPHER D. CARROLL: No, therapies are included. Those are captured as well. Spending on therapies is captured. So that's in that other providers.

MR. JASON HOWELL: Speaking of other providers, does this include nonclinical services like recovery support services?

MR. CHRISTOPHER D. CARROLL: I do not -- well, it may. It may. I'll have to go in and look and see specifically what it does. We do, you know, through [inaudible] reformulation. And Pat, if you know, please chime in. We do other reports based on State Medicaid data, which collects some of the different types of services that are provided through peers.

MS. A. KATHRYN POWER: Arthur, did you have a question?

MR. ARTHUR SCHUT: Do you collect information from the Federal block grant that goes to States that work with substance use block grant? Because it really doesn't create -- one of the problems with it is it doesn't create claims.

MR. CHRISTOPHER D. CARROLL: That's right.

MR. ARTHUR SCHUT: And so it tends to be underrepresented. And I'm wondering if that shows up someplace?

MR. CHRISTOPHER D. CARROLL: I believe -- I believe it does. I'll check and make sure. So I have two "to dos" here.

MR. ARTHUR SCHUT: I mean, part of what -- my observation is that the Medicaid data as a claims data is a problem, too, because if you have month-to-month eligibility, lots of times the block grant kicks in and provides continuous service. But in the Medicaid claims data, you don't see that.

MR. CHRISTOPHER D. CARROLL: That is correct, and as I was thinking here, yes, it is in the data as other payer sources. So we do collect other State and local payer sources. So it is included in the overall [inaudible].

MS. A. KATHRYN POWER: Okay, Chris?

MR. CHRISTOPHER D. CARROLL: Results. Next slide.

MS. A. KATHRYN POWER: Go ahead. Yep.

MR. CHRISTOPHER D. CARROLL: In 2014, mental health and substance abuse spending totaled $220 billion, up from $42 billion in 1986. That's a pretty amazing increase. Yes, we know that it's not enough. You can see that in 1986, there was $32 billion, spending 78 percent on mental health and only $9 billion, 22 percent on substance use disorder. Move that over to 2014, $220 billion, you have $186 billion spent on mental health and $34 billion spent on substance use disorders.

MR. JASON HOWELL: Has that been adjusted for population or inflation at all?

MR. CHRISTOPHER D. CARROLL: I will certainly find out. I would imagine, though.

Next slide, please.

MS. SHARON LEGORE: And does that look at to how many are post substance abuse problems coming into mental health because there just seems to be such a gap in funding so much more for mental health?

MR. CHRISTOPHER D. CARROLL: So it is --

MS. SHARON LEGORE: But a lot have to come in through the door of mental health to get substance abuse treatment.

MR. CHRISTOPHER D. CARROLL: Right. So since it is a spending estimate, it is what is generated and where were the expenses allocated. So some of that mental health and substance use service provision and expenditure could be for one person. It could be split like that, but does that answer your question?

MS. SHARON LEGORE: I was just looking at the difference is --

MR. CHRISTOPHER D. CARROLL: Yeah.

MS. SHARON LEGORE: -- so great. And I know with working with some grantees that that was an issue in their States, even just with funding issues where substance abuse isn't allotted as much because people aren't entering the door through mental health. So that's -- they get difference in funding --

MR. CHRISTOPHER D. CARROLL: I may turn that over to our colleagues. No, it's a very good question.

DR. ELIZABETH LOPEZ: No, it's a good question. I think -- I think what you're really seeing is the difference, as Kathryn noted earlier, in the recent passages of

not only CARA and ACA and Cures, but also parity and kind of the slow -- and we've been talking about that here internally and we were speaking about this yesterday -- the slow uptake of parity in terms of reimbursement.

There is -- there has been a gap certainly in Federal funding, but substance abuse, as you know, has been really catching up with more reimbursement rates in terms of public health funded programming. So I think that's what this dip and then slow incline, it's coming together, and I think that's what this reflects. And I mean, Pat, if you wanted to add anything to that?

DR. PAT SANTORA: Well, Chris, we also have -- in addition to the spending and the expenditures report, we also have SAMHSA's projections that they're from 2014 to 2020, and that's where you really see the increase based on these two new laws.

DR. ELIZABETH LOPEZ: Yes.

DR. PAT SANTORA: And so if you don't have a copy of that report, that's readily available from our website, and that's extremely encouraging when you look at the numbers particularly around substance abuse treatment.

MS. A. KATHRYN POWER: I think also that the -- you know, for me, this reflects the mission of SAMHSA. I mean, we're supposed to be putting a message out that behavioral health is essential to health. We've gotten better about that message I think over time, at least within the last 10 to 15 years that I've been here. That we've gotten CMS to be more responsive about that across 1115 waivers, across State plans, across all their innovation grants. We've gotten the Affordable Care Act to be out in front saying that mental health and substance use are essential health benefits for the first time in our nation's history.

I mean, I think all that is playing a role. I mean, I'm not in Congress. But it certainly looks like those are the pressures that are being brought to bear, and we're finally, I think, also turning the corner about saying, well, we don't know whether mental health and substance use disorder services work so we're not going to value it the same way we value other physical healthcare or primary healthcare interventions. I think we're finally turning the curve on that. And I think that means, hopefully, that people will invoke or will seek or will try to access behavioral health treatment in ways that they didn't do before.

So, Chris, those are just some of my observations.

MR. CHRISTOPHER D. CARROLL: So I also think mental health may have been a little bit ahead of -- been ahead of this, right? Because I think treatment-seeking behavior in mental health has improved to the point where people are more comfortable in seeking treatment. There is more access and less stigma around that. Substance use disorder and seeking treatment is still heavily

stigmatized. So I think people are less willing to seek treatment.

MS. KRISTEN HARPER: Yeah, just to second that, I agree with the stigma piece of it. But also until we address insurance as well, I think that that's another piece of it, too. Because they really dictated a lot of what -- how we define it.

MR. CHRISTOPHER D. CARROLL: [Inaudible.]

MS. KRISTEN HARPER: Yeah, exactly.

MR. CHRISTOPHER D. CARROLL: And disabilities.

DR. JUDITH A. MARTIN: So the ACA expansion happened in 2014. So I would expect the following year would probably show the fact that many people with substance use became beneficiaries that year and maybe had access to treatment?

MR. CHRISTOPHER D. CARROLL: Well, what we do know is that it did, the ACA did improve the coverage of individuals. I don't know if it improved access. Spending almost remained flat --

DR. JUDITH A. MARTIN: Really? Wow.

MR. CHRISTOPHER D. CARROLL: -- during that time. So --

DR. JUDITH A. MARTIN: That's horrible.

MR. CHRISTOPHER D. CARROLL: I mean, there are narrow networks. There's all kinds of things that -- the stigma that come into play around whether people will seek treatment or not. And as a result of that, it gets generated and captured as expenditures when we could reflect here about what we're seeing, as you can see, here is the percent growth in spending on SUD as compared to all health, slightly higher than all health. So that's -- you know, I think that's a good sign. It's not much of an increase, 0.3 percent. So --

MS. A. KATHRYN POWER: Chris, I'm just making a note that it's interesting that the expenditures on SUD went down significantly at the beginning of the opioid epidemic and the rise of pharma, which is basically seen as the window between 1995 going forward, which I think is a fascinating graphic.

MR. CHRISTOPHER D. CARROLL: Yeah, and I'm not sure of the timeline of the availability of medications to treat --

MS. A. KATHRYN POWER: Exactly, yeah.

MR. CHRISTOPHER D. CARROLL: -- source but that was some of the cost of

the increased cost in substance use disorders related to the provision of medication-assisted treatment and was generated through pharmacy claims, those expenditures are being captured there. Next slide.

Compared with all health, SUD treatment depended more on public spending. You can see public spending previously, 34 for -- well, not previously, but significantly out there, here's where you get your block grant and Medicare/Medicaid. Private spending still not where it needs to be.

We are interested in subsequent reports to kind of understand. You know, it's interesting, I get a phone call about once a month from some treatment consulting that says, "Hello, and thank you for your interest in seeking substance use treatment. Please stay on the line, and I'll connect you with a therapist." I'm like, "You got the Government." I mean, this is -- you know, click, they just hang up.

But you know, these are -- so these things are popping up over and over. I heard you say this.

MR. ARTHUR SCHUT: Those are the bad actors. I could just say they're brokers.

MR. CHRISTOPHER D. CARROLL: Yeah.

MS. A. KATHRYN POWER: That's amazing.

MR. CHRISTOPHER D. CARROLL: So we were particularly interested in that residential piece as it relates to, as you know, kind of the sober housing/residential pieces that tend to be popping up. As well as, and Kathryn alluded to this earlier, the 1115 waiver process and allowing INDs to deliver essential services. We're working with CMS right now, and I understand you just can't open up a product line and say, okay, everything is going to be better now.

And you'll hear probably Dr. McCance-Katz later today as she has particular concerns about, you know, siloed piece of care, residential treatment, about, what is it, 4 months after? That is not a continuum of care. So I think you'll hear from her a little bit later.

But we're working with CMS now to say, you know, can we really understand what's going on? Okay, so you allow States to do this. What's really going on there? And who's popping up? Where are mom and pops? And whose -- what health systems are saying, all right, we got another product lab, so let's open the doors up.

Some of this spending, you know, as we look at this -- and we will get on the front of this, too. But on the back end of this, we can see where States and other

insurers began to spend their money. I know. I've run a psychiatric health system. If you give somebody an opportunity for a product line, you'll open it. And if you provide good reimbursement, we'll find the patients that we need to fill that.

So, yes, ma'am?

DR. JUDITH A. MARTIN: So in our State, along with that --

MR. CHRISTOPHER D. CARROLL: What State are you in?

DR. JUDITH A. MARTIN: California.

MR. CHRISTOPHER D. CARROLL: California.

DR. JUDITH A. MARTIN: Along -- yeah. Along with the removal of the IND part, what went along with that was restriction of length of time in treatment and requirement for a level of care central authorization based on the ASAM.

MR. CHRISTOPHER D. CARROLL: Basing criterion.

DR. JUDITH A. MARTIN: So the professionalization of it went up. And so in my city, there are a lot of homeless people who basically had for years instead of recovery homes been put in residential treatment for a year, and now they have to be reauthorized every month. So what we really need is the residential stepdown where they can be in outpatient treatment and have a safe living situation.

MR. CHRISTOPHER D. CARROLL: You can see all health spending is basically split at 49/51 percent between private and public sources.

Next slide.

So this is what I alluded to earlier about, you know, who pays for what? And you can see the private insurance. I'm color blind. So I'm going to have to have some help with this. I believe that's the middle bar there. You can see in 2014, it's 21 percent of SUD spending was private interests. Is that right?

MS. A. KATHRYN POWER: No, that's Medicaid.

DR. ELIZABETH LOPEZ: No. The 21 percent in '14 is the Medicaid.

MR. CHRISTOPHER D. CARROLL: Oh, I see, 18. It's 18 percent. Okay. So it corresponds to the list.

DR. ELIZABETH LOPEZ: It's 18, 18 --

MR. CHRISTOPHER D. CARROLL: Okay. Gotcha. Out-of-pocket 9 percent. That's a significant amount of dollars.

Yes, ma'am. Go ahead.

MS. A. KATHRYN POWER: I was just remembering how we met, were pointing out colors.

MR. CHRISTOPHER D. CARROLL: Yes.

[Laughter.]

MR. CHRISTOPHER D. CARROLL: I've worked through my disability. I figured out that it follows the list. So you can see for that's the distribution of SUD spending across payers. Did you have -- go ahead.

MS. EVA PETOSKEY: Well, I was just saying that, you know -- sorry. You have a multi-step thing here.

That in Michigan, we have some pilot programs going on about privatization of SUD and mental health services. And originally, the Governor wanted to just kind of do it, bam, and kind of got talked back into a pilot, some pilot programs.

And I find this interesting, though. If the trend in the past in terms of spending by private insurance has been so disproportionately low for SUD, am I understanding this right? So then we want to turn the whole thing over to privatize it, and I guess there would have to be some -- that doesn't look too good to me in terms of a future trend. Will we really be able to get services for people with an SUD if we privatize?

I guess that's just what I was kind of going, wow, you know? That was interesting to me.

MR. ARTHUR SCHUT: I think '86 to 2004 --

MR. CHRISTOPHER D. CARROLL: Was a greater share.

MR. ARTHUR SCHUT: -- was about managed care, and basically, there were a lot of hospital-based inpatient units that closed because it was no longer a profit center, a cost center. And I think that's part of what happened. So you ultimately had the vast majority of people in publicly funded treatment, and you also had insurance companies who have had to call providers together and say we're not going to pay for this anymore. We're going to send them to you, the publicly funded sector.

So I do have concerns about the accurately reporting costs. And for example, in Colorado, detox is paid for by -- in Medicaid with four outpatient codes that really have not a lot to do with substance use disorder. I don't know how they show up in the data.

Then you have commercial payers that will pay intensive outpatient rates and for residential and insist that the --

MR. CHRISTOPHER D. CARROLL: Because it's a higher rate.

MR. ARTHUR SCHUT: -- patient pays the "room and board" cost. So that there's this sort of --

MR. CHRISTOPHER D. CARROLL: It's a gaming of the system.

MR. ARTHUR SCHUT: Yeah, and I don't know where the gaming shows up in the --

MR. CHRISTOPHER D. CARROLL: Yeah.

MR. ARTHUR SCHUT: But it's all directed toward let's spend less money on it.

MR. CHRISTOPHER D. CARROLL: Right.

MR. ARTHUR SCHUT: Or underpay.

MR. CHRISTOPHER D. CARROLL: Yeah?

MR. JASON HOWELL: The other thing that was kind of going through my mind, I know for research, we know that the changes in the '80s and '90s, when third parties started paying for more services, they got to restrict what -- you know, what types of service were individuals getting. And so we moved more and more to a clinical model. And individuals that wanted recovery support services or wanted to access services that looked more at social model are having to pay out-of-pocket, and I don't see a way that your research could even capture that.

So I think that that there's other services out there that are just not beginning to be captured.

MR. CHRISTOPHER D. CARROLL: So this is the same part of this conversation is what do you not see here, what do you want to see here, and what should we be looking at? That type of thing. Ultimately, we want to get that in the hands of decision-makers, right? And where should they be spending their scarce resources.

Interesting about detox, just as a side note, and I've been working on some of

this with Art Kleinschmidt back there. I guess you'll meet him in a little bit. We've been looking at, especially within Medicaid, detox services. So we did a small, little analytical project that looked at, just by CPT codes, the frequency of detox services over the course of a 2-year period in the Medicaid populations and then commercial populations.

And you really start to see detox as kind of a treatment failure because there's nothing to go to or it's used inappropriately. But there are Medicaid recipients that are getting detoxed four, five, six, seven times every year, and that's significantly higher than the private sector as well. So I don't know if there's more utilization than we knew in the private sector or what. Or I don't know what it is. But what we know right now is that detox doesn't seem to be -- used, again, in a silo doesn't seem to be an effective course of treatment for many people that continue to use it.

MR. ARTHUR SCHUT: I have lots of opinions.

[Laughter.]

MR. ARTHUR SCHUT: So for a while, I operated three out of the four social detoxes in metropolitan Denver. We transported people out of the EDs who were unsafe to discharge out of 20 hospitals, which freed beds in the hospitals and saved money on that end, and then engaged people with case management that then attempted to follow them. But that population is a very difficult, distinct population, and there is no recognition on the physical medicine side of all the savings that occur in hospital systems in ED.

So what you have, in fact, is this huge decrease in emergency room costs that are not measured and an increase in the difficult to treat. Many people who have problems with diabetes and blood sugars and hypertension and all those kinds of things and require medical care, but really don't get it. So there is this cost share, and there are ways to do that, though. Some of that is not compensated, particularly in terms of the competence of case management and following people and linking people. And people have to work -- there has to be professionals that work with those folks under bridges and out in the community and actually try to engage them.

MS. KRISTEN HARPER: One of the ways that we found when I was in North Carolina, I was ED for a recovery community organization that was statewide, is we actually had a training program for peers to come in, become trained, go into the emergency departments. So if they didn't have access to funding for case workers, we were using the peers for some of that transportation and also immediately getting them plugged into the continuum of recovery support services.

So that reimbursement came from a grant. But I think that would also be

something that we want to figure in is how do you track that recovery support service cost?

MR. CHRISTOPHER D. CARROLL: Okay. Next slide. So this is -- this is the distribution of spending by provider type, and a large portion of SUD spending, 37 percent, went to specialty mental health and substance use treatment centers. This may have gotten to your question a little bit earlier about that one person that may get the services from both and how mental health -- the State dynamics of how spending is distributed.

Hospital care, retail prescription drugs. That's something that we think will increase over time. Long-term care, office space, professionals. I always find the insurance administration piece to be interesting. Eight billion dollars is a lot of money that's not particularly in treatment related -- or I'm sorry, $3 billion, 8 percent. Just it's kind of interesting.

MS. EVA PETOSKEY: What is that cost exactly? What would be something --

MR. CHRISTOPHER D. CARROLL: It's kind of the overhead of doing business.

MS. EVA PETOSKEY: Yeah.

DR. JUDITH A. MARTIN: So, so the hospital cost is people who go in voluntarily for substance use treatment, or is it people who go in for cirrhosis and --

MR. CHRISTOPHER D. CARROLL: No, those are excluded. Those other comorbid conditions are excluded, and so it would be for prior diagnosis of some sort of SUD.

DR. JUDITH A. MARTIN: Our primary care hospital, you know, regular hospital sees a really high percentage of people admitted for surgery and for medical problems who then require an alcohol detox or require ongoing opiate therapy.

MR. CHRISTOPHER D. CARROLL: Right. And that would be captured, but the initiating hospitalization --

DR. JUDITH A. MARTIN: And would that count, though -- if that were captured, would count as hospital care here?

MR. CHRISTOPHER D. CARROLL: The physical?

DR. JUDITH A. MARTIN: On this, would that be purple cost?

MR. CHRISTOPHER D. CARROLL: It would -- I assume it would be purple, purple cost.

DR. JUDITH A. MARTIN: Thank you.

MR. CHRISTOPHER D. CARROLL: Yes. Next slide. From 2002 to 2014, growth in SUD treatment spending on prescription medications, this is new-to-market medications, increased substantially. Spending on medications to treat opioid use disorder represented the majority of prescription spending. You can see where the spending is over on the righthand side. Look at that steep incline there. That accounts for a lot of the increase.

And you know, that's probably consistent with what we saw in mental health years ago with primary care beginning to prescribe [inaudible] medications in their office settings.

DR. JUDITH A. MARTIN: Right.

MR. CHRISTOPHER D. CARROLL: So for me, this has always been an interesting piece of medicine. It's kind of that transactional piece. It is not involvement in the life of the person and following them over time. It's what can I do -- what script can I write to see the next person? And that's a rough generalization from me, but that's -- it's script writing.

Next slide.

Specialty providers received the majority of SUD spending paid to providers. Distribution of SUD spending by specialty and nonspecialty providers. So specialty providers are getting -- they are the ones billing. They are the ones getting the majority of the reimbursement. You can see an increase over time of nonspecialty providers, and this, you know, kind of goes to that point I was just making before is in primary care started providing prescriptions in quasi-mental healthcare and primary care settings because it became easier for them.

What you're seeing, I think, is some of the nonspecialty care providers finding it easier to --

MS. A. KATHRYN POWER: Tell me the definition between, the difference between specialty and nonspecialty.

MR. CHRISTOPHER D. CARROLL: So specialty --

MS. A. KATHRYN POWER: Because I'm confused about the fact that, remember, one of the things that we were watching very carefully was the prescription of psychotropic medications in the primary care world and then not being able to track that and understand that and get ahead of that. So I just was curious about the definition.

MR. CHRISTOPHER D. CARROLL: Yeah. I'll have to track that one down real

quick for you here. Specialty care would be those primarily engaged in the treatment of SUD and --

MS. A. KATHRYN POWER: Oh, okay. All right.

MR. CHRISTOPHER D. CARROLL: Nonspecialty care, I think, probably contains a broader range of different type of providers that happen to be treating somebody with substance use disorder.

MS. A. KATHRYN POWER: Okay. All right.

MR. CHRISTOPHER D. CARROLL: But I'm absolutely sure that's fine within the report. We can make sure of getting everybody the report on this as well.

MS. A. KATHRYN POWER: Right. Okay. Right.

MR. CHRISTOPHER D. CARROLL: Yes, ma'am?

DR. JUDITH A. MARTIN: So I have a question about the prior slide on medications. Do you have any breakdown in the medications by who pays for it, private -- the slide before this one? Whether some of it is Medicaid or, in particular, Medicare Part D, where I've had patients relapse just because they become 65 because Medicare Part D is such a morass. So I'd be interested to know who's paying -- which insurance is paying for that.

MR. CHRISTOPHER D. CARROLL: So that's not captured here, but if we want to look at that, we could also look at that. We are also in the final stages of clearing the financing of medication-assisted treatment analytical report, in which we look at all the States and who covers what. And this would be Medicaid, what requires prior authorization, what has limits on it. So this is -- it lists all the States, and we do look at some Medicare Advantage plans in there as well.

So, but if that is something that you're interested in, then we --

DR. JUDITH A. MARTIN: Thank you.

MR. CHRISTOPHER D. CARROLL: Next slide. '86 to 2014 share of SUD outpatient treatment and medication expenditures increased. The share of inpatient treatment decreased, which kind of makes sense. All right? Inpatient is the more expensive. I think over time what we'll see is residential treatment through 2014 decreasing down to 27 percent. As we've talked about earlier, the random phone calls and the 1115 waiver process, we may see the residential treatment go up.

Next slide.

MR. JASON HOWELL: So on that slide there, so there's inpatient and residential. So inpatient is like detox and hospitalization versus residential, which is residential treatment?

MR. CHRISTOPHER D. CARROLL: Correct.

MR. JASON HOWELL: Okay, thanks.

MR. CHRISTOPHER D. CARROLL: From 2009 to 2014, private insurance spending, and that's excluding prescription drugs for behavioral health treatment, increased more than Medicare because of greater increases in the number of enrollees and higher services costs. So total spending, 13.6 percent. Number of enrollees, you can see that's where that increased significantly.

Percentage using behavioral health services. So we're still not seeing kind of the utilization or treatment-seeking behavior there. Number of encounters per person went down, and the cost per unit of service went down significantly or compared -- I'm sorry, the private, and Medicare is down significantly compared to private insurance, which, you know, that's interesting. So -- yes, ma'am?

DR. JUDITH A. MARTIN: So Medicare, I believe, was excluded from Wellstone-Domenici in 2008, the parity bill.

MR. CHRISTOPHER D. CARROLL: It was.

DR. JUDITH A. MARTIN: So does Medicare here include Medicaid?

MR. CHRISTOPHER D. CARROLL: No.

DR. JUDITH A. MARTIN: So I'm not surprised.

MS. A. KATHRYN POWER: Chris, I'm not sure that I remember most of the sources. SSDI is one of the sources that they look at?

MR. CHRISTOPHER D. CARROLL: I believe --

MS. A. KATHRYN POWER: Because I remember there was something that came across this year about how many mental illnesses and substance use disorders were now receiving SSDI for their behavioral health conditions. So I was just curious about whether that's one of the sources. So I'm just raising the question.

MR. CHRISTOPHER D. CARROLL: So, I mean, we -- I'll look into it here as we're talking here.

MS. A. KATHRYN POWER: So it definitely has been -- this came to my

attention because somebody said look at the increase over the past several years in the numbers of SUDs and mental illnesses who now have applied for SSDI.

MR. CHRISTOPHER D. CARROLL: I think that was me, actually, that said that, and this was at one of your regional administrator meetings. Because we didn't look at and because substance use disorders aren't qualifying disability, we looked at mental health and where the outlay of money across the Federal Government is.

MS. A. KATHRYN POWER: Right.

MR. CHRISTOPHER D. CARROLL: It's twice -- they spend – SS -- the Social Security Administrations spends almost twice as much as CMS on the payment --

MS. A. KATHRYN POWER: Right, right.

MR. CHRISTOPHER D. CARROLL: -- and you could probably --

MS. A. KATHRYN POWER: Somebody was saying they were becoming even a bigger payer than in some cases Medicare and Medicaid. So I was --

MR. CHRISTOPHER D. CARROLL: Yes, yes.

MS. A. KATHRYN POWER: All right.

MR. CHRISTOPHER D. CARROLL: That's broadly, broadly defined.

MS. A. KATHRYN POWER: Yeah.

MR. CHRISTOPHER D. CARROLL: And you can imagine then if substance use disorders were a qualifying disability, we are dumping people in the deep end of ocean.

MS. A. KATHRYN POWER: Absolutely. Absolutely.

MR. ARTHUR SCHUT: They were until the Reagan administration. The Reagan administration ruled that it was no longer a disability. So --

DR. JUDITH A. MARTIN: I remember that time. About 75 percent --

MR. ARTHUR SCHUT: I do, too.

DR. JUDITH A. MARTIN: About 75 percent of my patients were able to qualify on mental health at that time, but a lot of people lost insurance.

MS. A. KATHRYN POWER: Right. Yep, absolutely.

MR. CHRISTOPHER D. CARROLL: Next slide, please. So, conclusions. From '86 to 2009, growth in SUD spending typically lagged behind all health spending. But after 2009, growth in SUD spending exceeded all health spending. So increase there. Share of SUD treatment spending in specialty SUD treatments declined since 1992. From '86 to 2014, spending on prescription drugs increased from $3 million to $1.8 billion, driven overwhelmingly by increased use of buprenorphine and naloxone. In 2014, however, retail prescription drugs accounted for only 5 percent of total SUD spending.

Next slide.

The acceleration of SUD treatment since 2009 suggests that access and integration into the overall medical system may be improving as the result of parity and the ACA. Incorporation of administrative claims data allows us to understand the drivers for spending. For example, for private insurance, the percentage of enrollees using services increased. Spending increases were driven mostly by cost per unit of service.

Next slide.

There we go. So, I mean, I think the opportunity that you guys have and some of what we've done in the past is through our analytical capabilities that we have in SAMHSA is we've really said -- and we have these major reports, and we want to keep doing these major reports because I think it's important that we're able to provide decision-makers some of the trends and what's happening. But we also drill down in some of these reports.

We are -- right now, as part of this, we're trying to focus on residential spending, what's happening with that over time because of what we talked about earlier. We think we need to keep an eye on that. But if there are other things that we need to be looking at or that are of interest to you or you think are important to the nation that we could do, you all are the vehicles to take this report and go away with the [inaudible]. Because they're important, important pieces of it.

Agenda Item: Council Discussion

DR. JUDITH A. MARTIN: One of the -- one of the presentations at our last meeting was about using the cascade model from HIV to monitor how we're doing. Can you -- do you think this is enough information to say how many people with a diagnosis of moderate to severe opiate use disorder are getting long-term medication?

MR. CHRISTOPHER D. CARROLL: So this is, I think, one of the -- I think one of

the quandaries, right? Is, and it's, to some extent, our own fault. Another anecdote. We got called by the Chief Medical Officer of OPM, and they oversee the Federal employees insurance over there, and they said we have -- we're concerned because we have less than a 1 percent utilization rate in medication-assisted treatment in our Federal employee insurance programs. Is that right?

And well, we don't know if it's right. We can tell you what we find, but we don't know that's the right rate. So I think the answer to your question is I think we can tell you what we find. Whether that's what it needs to be or not --

DR. JUDITH A. MARTIN: No, I mean, to set a baseline, then we can talk about goals. If the methadone is missing, right, it wouldn't count as a prescription. But maybe we could get that from TEDS? I don't know.

MR. CHRISTOPHER D. CARROLL: Yes. Yes, you can. We've taken a look at some of the settings and blood types of draws that were prescribed as all our trends. So, yeah. I mean, our opportunity here is because we work so closely with our colleagues from CBHSQ and because we have an amazing set of data sources that we can start to cross over and coalesce is that we can start to ask some of these questions that pair different datasets and start to answer some of the questions that you guys need.

MR. JASON HOWELL: Yeah. So I could write a whole page. So one of the things that -- I love databases.

[Laughter.]

MS. A. KATHRYN POWER: Go, Jason, go.

MR. JASON HOWELL: I love data. So thank you for this. I really enjoyed this. One of the things that was going on in my head. It's great seeing, all right, so from a dollar perspective where are we at. But just because we spend more dollars, we don't know so what are the outcomes.

MR. CHRISTOPHER D. CARROLL: Right.

MR. JASON HOWELL: And so being able to pull that data in somehow, and I realize that that means that we have to define what recovery outcomes look like and have a consistent way of talking about that in order to do that analysis.

The other thing that was popping in my mind and I kind of referred to it earlier is, you know, we -- of the persons with substance use disorder that could benefit from treatment, only 10 percent of those are accessing treatment. And then if we look at so how are we defining treatments and what people are accessing, a lot of what they're accessing is not clinical treatment. And so there is that kind of the blind spot, I'm afraid, is around all of those recovery support services that

individuals are accessing. Some maybe are being paid through block grants. I think a lot of it is just being paid out-of-pocket, more through nonprofits. They're just really off the radar.

One way that we could capture it is fund it. And so then we get into the place of what -- what dollars are going to be spent to help build up infrastructure so recovery support service providers can interface with payment systems that would be captured?

And my other comment was it's also great that we're seeing more dollars. Unfortunately, there are corrupt individuals out in the world that come in and find ways to exploit. You kind of referred to it earlier with some of the ways that outpatient treatment is interfacing with some sober livings and creating a corrupt model that we saw kind of contained in Florida, and now we're seeing it really widespread.

So as we increase the dollars, then looking at ways that we can ensure that to minimize corruption or really kind of make sure that individuals are getting quality care.

MR. CHRISTOPHER D. CARROLL: I -- you should have a conversation with Art over there. He's chomping at the bit to talk to you about the sober living. Yeah, he said he did a lot of work on that.

MS. A. KATHRYN POWER: Other suggestions, comments for Chris?

MR. ARTHUR SCHUT: I have -- and I don't know if this is possible. I have an interest in the cost offset in physical medicine. And one of the challenges is most private payers silo their behavioral health business from their physical health business.

MR. CHRISTOPHER D. CARROLL: So you can only see behavioral --

MR. ARTHUR SCHUT: So they look at, you know, premium in and expense out there, but they don't -- they never look at the physical as an offset that occurs when a user providers a continuum of care and you have recovery supports. So some of that stuff they don't pay for because they don't see it as a value.

And I had this fantasy that when we begin to integrate care, we're actually going to integrate payment systems. But most commercial providers can't give you that information because it's siloed, and they at some level have no interest in it, which is interesting to me. And I don't know if there's a way for us to begin to collect data that relate to that in some way that we can make that point.

MR. CHRISTOPHER D. CARROLL: So we are doing that. We've begun the analysis on that. What we're finding is so if we take a whole person -- believe it

or not, we're going to take a whole person and --

[Laughter.]

MR. CHRISTOPHER D. CARROLL: -- over time, you're going to look at physical health costs and their substance use costs, and this is kind of from initiation of treatment, right? So there may be some ER visits that constitute some of the substance use treatment costs, but most of the physical health costs. And then you can look at engagement of treatment over 30 days, 60 days, 90 days, 180 days plus. And what you see is increase in spending on substance use services, decrease on spending on physical health services, but a general decrease in all costs over time.

And I think that's the piece where you're not going to get insurers to say, "Okay, we believe you. We'll do it," right? You're going to have to demonstrate that investment in SUD services will actually decrease your overall health expenditures for your beneficiary. And I think that's what we need. That's what we need to do. So I can share something with you just for your confidential feedback.

MS. A. KATHRYN POWER: Chris, is the next -- the next window for this estimate is the next what stamp?

MR. CHRISTOPHER D. CARROLL: Are we including HHS clearance or not in that?

MS. A. KATHRYN POWER: Yes.

MR. CHRISTOPHER D. CARROLL: 2027, I don't --

[Laughter.]

[Crosstalk.]

MS. A. KATHRYN POWER: The reason I was asking is because I think that would help people think about --

MR. CHRISTOPHER D. CARROLL: Yeah, yeah.

MS. A. KATHRYN POWER: -- what would be those suggestions for next steps. Given the trends that you see, you know, what else should we be thinking about in terms of value, impact, patient outcomes, et cetera, that we could -- we could tweak the estimates in some way to begin to look at with a different lens?

MR. CHRISTOPHER D. CARROLL: Right. I mean, so in some ways, it's dependent on the data that you receive, right? And so I think that most of this is

2018, the most current data we have on this is 40-ish.

MS. A. KATHRYN POWER: Okay.

MR. CHRISTOPHER D. CARROLL: But if we had to look at like what's happening now, I think it's safe to say that we're looking to some devolved decision-making to the States and how funds get to them and how they decide to institute their largest healthcare programs. I think that's going to have an influence over what we see in the future, and we should maybe pose some of those questions now because that's the data that we'll be seeing in probably a year. So you will probably see a new report in 18 months or so.

MS. A. KATHRYN POWER: Okay.

MS. SHARON LEGORE: I'm just curious to ask. With the rise in buprenorphine and naloxone especially at 85 percent, does that take -- is that going to take into effect or are you looking at the rising cost, you know, that has just skyrocketed because of, you know, okay, it's a money maker.

MR. CHRISTOPHER D. CARROLL: Right. Right.

MS. SHARON LEGORE: And would that make that make line just skyrocket in the next couple years since we've heard so much about price gouging on these medications?

MR. CHRISTOPHER D. CARROLL: So, yeah. I think what you're seeing there is that -- that's the cost. That's a cost-based pie chart and not a utilization. So I think what you'll see is more spending, but that does not necessarily mean increased utilization.

MS. SHARON LEGORE: Right.

MR. CHRISTOPHER D. CARROLL: So I think if prices go up, you'll see -- you'll see more spending. Access, I think we're still back to where we are at the beginning of this conversation is limited funding for limited -- stigma and different ability to access treatment, I think, is still persistent. But it's going to go up.

MS. SHARON LEGORE: Because it makes -- yeah, then it makes it harder to access when it's increased, and I know especially with families who are trying to subsidize the payment for these medications --

MR. CHRISTOPHER D. CARROLL: Right. Right.

MS. SHARON LEGORE: -- and as well , you know, all the naloxone kits that are going out, and not having the follow-up needed afterwards, reviving someone, and there's no follow-up, you know, a warm handoff to be able to keep them

from just coming right back. And then they get caught up in these statistics again.

MR. CHRISTOPHER D. CARROLL: Right, right. Right.

MS. A. KATHRYN POWER: Other questions. Oh, Dr. Martin?

DR. JUDITH A. MARTIN: So I have a question about could you look at, since you're looking at all the different kinds of substance use treatment, can you see if each of those offers, which of those offer medication? Because one of the things we're working on is to make sure that wherever the person lands for treatment or chooses or is qualified to get treatment, that they have access to the medications they need.

MR. CHRISTOPHER D. CARROLL: Yes, we can. And maybe not through this, but we have a way to do that. In fact, we work with CBHSQ to look at the TEDS data and to get facilities and prescription upon discharge of the medication-assisted treatments, you know, generally. You know, whether that relates to access or culture of the organization, I don't know. But it is -- it is low, and I think that's concerning because it's an evidenced good practice.

It goes to your point earlier is why aren't we providing people the best care that we know works? Yes, ma'am?

MS. A. KATHRYN POWER: Kristen?

MS. KRISTEN HARPER: Yeah, as somebody on the ground in these communities, I would love to see just infographics of some of this information.

MR. CHRISTOPHER D. CARROLL: Okay.

MS. KRISTEN HARPER: I think that that would be really helpful to just flyer the communities with some of these numbers. And as you have new information coming out, I think that would be really exciting.

MR. CHRISTOPHER D. CARROLL: Okay. That's great. That's a very good suggestion.

MS. A. KATHRYN POWER: Any other comments or questions for Chris?

[No response.]

MS. A. KATHRYN POWER: Thank you, Chris.

MR. CHRISTOPHER D. CARROLL: Well, thank you all.

[Crosstalk.]

MS. A. KATHRYN POWER: It was wonderful. Nice to have an economist in the room.

[Applause.]

MS. A. KATHRYN POWER: What I'd like to do now is for a few minutes is invite Art Kleinschmidt to join us at the table, and I'm going to introduce Art, and he just -- I'm just going to ask him to introduce himself to you. Art is a new senior advisor on substance use at SAMHSA. And he has been -- he's working with us at CSAT. So we're very lucky to have him.

And Art, you're going to use the mike, and I want people to see who you are and know a little bit about your background and say hello.

DR. ART KLEINSCHMIDT: Well, thank you for the introduction. I wasn't expecting to get a seat at the table. Much appreciated.

Yeah, I started SAMHSA in August. I've been working in the substance abuse field since 2002. I actually came to this field via my own experience. I got over 16 years clean and sober, and that's what led me into the treatment field.

And as far as like some of your questions, we have -- I don't want to say developing like a new model, but we are advocating, we're going to convene an expert panel with -- Dr. Steve Daviss is working with me on this one, too -- where we're going to look at a sober house model and start to see if we can combine that with MAT and make that more readily available.

When you look at a treatment like that, I'm assuming the efficacy will be pretty high and at a lower sort of cost because it will bring in the social constructs plus the, you know, biomedicals for a portion of it. So I was in Colorado working at like an extended care, worked in multiple levels of care, but most recently like a long-term residential program and worked with rather chronic users that were, for the most part, in that transitional sort of age.

So I appreciate everybody being here.

MS. A. KATHRYN POWER: Any comments or questions for Art? We're going to start to look at some projects across the other agencies at HHS, and Art is going to be connecting with some of the ACF work and some of the substance use disorder, child trauma, economic workforce issues related to that population. So we're very excited to have Art onboard.

So, all right, so any questions or comments for Art? Dr. Martin?

DR. JUDITH A. MARTIN: So one of the things we struggle with in perinatal treatment is a lot of the sort of residential, acute residential treatment have room for the mother and an infant, but there might be three or four kids at home that aren't there and not having a mother. So in your talk about housing and sober housing and so on, we would be -- I would encourage you to think about whole families.

DR. ART KLEINSCHMIDT: I already started communicating with the Office of Violence Against Women, and we started looking at like the multi-family sort of complexes.

DR. JUDITH A. MARTIN: Right.

DR. ART KLEINSCHMIDT: And I spoke to -- also in our planning because you're looking at like the rural areas, too, that are hard hit by the opioid crisis, and they have a multi-family unit in there as well. So kind of one of the things that I was looking like when the woman goes to treatment or sober living or something like that, seeing like establishing where they could actually have their children with them, right? Because when you break up -- I mean, that's like a two-parter, not just for the person in treatment, but also their kids are separated from home, right? And then they don't have the bonding sort of experience, and they're almost like -- there's like a lot of shame involved.

Like even if they cognitively understand that, yeah, my mom has this ailment, she has to go do this, they still feel like abandoned, right? And that becomes like a whole other issue of itself. So I've been talking to people about sort of combining those two and letting them remain together while they do treatment, and they can do family treatment together.

DR. JUDITH A. MARTIN: That's right.

DR. ART KLEINSCHMIDT: And they could start to kind of move on from there, right? So that's sort of what I've been looking at at that issue as well.

MR. JASON HOWELL: I just would like to offer myself as a resource. Recovery housing has been part of -- a big part of my recovery journey, and it is something that I really focus on and I'm really interested in looking at. So how do we actually operationalize some of these concepts? I really, you know, looking at individuals who've chosen to be on MAT and move into recovery housing. So how do we actually facilitate that? You know, families in recovery housing. Great concepts, but then how do we actually, you know, operationalize that with fidelity?

DR. ART KLEINSCHMIDT: Yeah, we're right there with you trying to hammer these things out. We were on a conference call the other day. You're with NARR? So we had Dave Sheridan on the phone. So we're in the process of

looking and trying to hammer out and come up with some guidelines. I think NARR is going to put some out here shortly. So we're looking forward to seeing that.

And also I know somebody brought up about like the nefarious sort of treatment, sort of racket and the patient brokering. So we're looking through NARR as well like some of the certification processes involved with that. So --

MS. A. KATHRYN POWER: Okay. Thank you very much, Art. We appreciate you joining us.

I think at this point unless anyone has any burning issues that they want to raise before we take a break, I will allow that if you have any burning issues you want to raise before we take a break. I think that there was some, a little bit of time here for any further council discussion, if you wanted to add anything relative to what Chris talked about on spending estimates. But I think we were able to get through I think most of those observations during Chris's presentation.

So thank you again, Chris. Thank you, Art.

I'm going to give you a little extra time for lunch, okay? I would ask that you're back here about 5 minutes to 1:00 p.m. so that we can anticipate and be in place when the Assistant Secretary joins us at 1:00 p.m., if that's okay?

So enjoy yourself. Tracy, you want to give folks any good words about the break?

MS. TRACY GOSS: Sure. The cafeteria is right across the atrium. Please feel free to leave your bags here. I will be in here. You're more than welcome to come and have lunch in here. But that's just about all I have.

MS. A. KATHRYN POWER: Okay. Any other questions?

[No response.]

MS. A. KATHRYN POWER: Enjoy your lunch. Thank you very much.

[Recessed at 11:55 a.m.]
[Reconvened at 1:01 p.m.]

Agenda Item: SAMHSA Leadership Discussion with CSAT Council Members

MS. A. KATHRYN POWER: Okay. We'll start the afternoon. Thanks again this morning for a very good discussion. It was wonderful to hear everyone so

engaged, frankly, on the economic discussion and some of the other areas, and people feel very comfortable about telling us their editorials and their opinions. And that's really -- I want to encourage that, even as we go to the afternoon.

I want to welcome you back, and I'm very pleased to introduce Dr. Elinore McCance-Katz. Dr. McCance-Katz was recently appointed as the first-ever Assistant Secretary for Mental Health and Substance Use in the Department of Health and Human Services. In this role, she advises the HHS Secretary on improving behavioral healthcare in America, and she leads the Substance Abuse and Mental Health Services Administration.

She's a distinguished fellow of the American Academy of Addiction Psychiatry, with more than 25 years as a clinician, as a teacher, and as a clinical researcher. She has served as the Chief Medical Officer for Behavioral Healthcare in Rhode Island. She has served as the State Medical Director for Alcohol and Drug Programs in California and was professor of psychiatry at the University of California-San Francisco and at Brown University in Rhode Island.

Dr. McCance-Katz has published extensively in the areas of clinical pharmacology, medications development for substance use disorder, drug-drug interactions, addiction psychiatry, and treatment of HIV infections in drug users. We are very fortunate to have Dr. McCance-Katz leading SAMHSA during what I consider one of the most critical times in our history and never mind in our world today when we are facing the challenges of the opioid crisis and the emerging needs of behavioral health, with a tremendously renewed emphasis on serious mental illnesses, serious emotional disturbances, and substance use disorders.

So thank you, Dr. Katz, for joining us, and welcome.

You got it right. That's it. That's it.

DR. ELINORE F. MCCANCE-KATZ: When it's red? Okay.

Well, thank you. Nice to be here. Maybe we could go around and do introductions?

MS. SHARON LEGORE: Hi, I'm Sharon LeGore, and I'm representing the family voice.

MS. A. KATHRYN POWER: Don't forget your mikes. Don't forget your mikes.

MS. SHARON LEGORE: Sorry. I'm representing the family voice, and I come from Pennsylvania and working with families directly and help them get services and do advocacy work, policy work, legislative.

DR. JUDITH A. MARTIN: I know we've met before. I'm Judy Martin, medical

director of substance use treatment in San Francisco and addiction medicine physician.

MR. ARTHUR SCHUT: I'm Arthur Schut from Denver, Colorado, and I represent providers.

MS. KRISTEN HARPER: Kristen Harper, and I represent collegiate recovery, recovery high schools, and youth voice, currently working with 160 universities and colleges -- Brown is one of them -- to provide recovery support services to students.

MS. EVA PETOSKEY: I'm Eva Petoskey. I work with the Intertribal Council of Michigan. I work with all 12 federally recognized tribes doing treatment and recovery support services, and we also are collaborating with the State of Michigan on the State targeted response.

MR. JASON HOWELL: Hi, I'm Jason Howell. I'm a person in long-term recovery from both mental health and substance use issues. I live in Texas, and there, I'm executive director of a nonprofit called RecoveryPeople. RecoveryPeople focuses on technical assistance, training around workforce development and also infrastructure development, as well as advocacy. And at the national level, I am on the board of the National Alliance for Recovery Residences. So I do a lot around recovery housing.

MS. A. KATHRYN POWER: We have someone on the phone. Bertrand, are you there on the phone?

MR. BERTRAND BROWN: Yes, I'm here. Bertrand Brown, Georgia Council on Substance Abuse. I'm a person in long-term recovery, and also I'm a certified peer specialist in the State of Georgia.

MS. A. KATHRYN POWER: Thank you. Thank you.

DR. ELINORE F. MCCANCE-KATZ: All right. Thank you. Thank you. Nice to meet all of you.

So I thought what I'd do is just give a few remarks about basically the direction SAMHSA will take as to substance use treatment, the opioid crisis, and then let you ask me questions. And I think that would be the most productive way to spend our time together.

You know, I'll start by just saying that Congress, through the Cures Act, created my position, the Assistant Secretary position, and I think they did this because they are very concerned about the issues facing this nation in terms of mental and substance use disorders. So the position itself is meant to bring that -- that perspective, that concern that they have to the higher levels of Government to

make sure that there is a voice and that the Federal Government better addresses the needs of people with these kinds of conditions.

And so, and so the position that I have is different than that of the previous SAMHSA Administrator position in that I spend probably about, I'm going to guesstimate, at least 40 percent of my time down at HHS. So I have my office here, but I have an office at HHS, and I spend a fair amount of time working with other agencies, other departments, other divisions within HHS around issues related to behavioral health. And I also do provide the leadership for SAMHSA as well.

So it's kind of a different -- a different role than for previous Administrators and actually puts some substantial constraints on time. So, so I try very hard to talk with people, meet with people. I find it challenging, and so I'm going to be doing regular calls with stakeholders. I should start, I believe, the first -- it might be like March 1st or 2nd. There will be invitations going out. I wanted to make you all aware of that. Because I am very interested in hearing from the field, but it is hard to do on an individual basis, and that's just a constraint of the kind of position that it is. I assure you it is not because I don't want to hear from you.

So, so the Assistant Secretary role has some pretty specific components to it that have all been delineated by Congress. One of them is to maintain a system to disseminate research findings and evidence-based practices to service providers to improve prevention and treatment services. And so I wanted to mention to you that we will -- we are in the process right now of reformulating how we do that from the role of SAMHSA.

We -- you probably know this, but in case you don't, we will no longer have the what was previously called the NREPP program, the National Registry of Evidence-Based Programs and Practices. But instead, we have our policy laboratory, again created by the 21st Century Cures Act, whose role it is to be engaged in not only whatever research activity SAMHSA undertakes, but also in promulgating evidence-based programs and practices. And they are in the process right now of building a new part of our website. I'm told that's going to go up pretty quickly here.

Which brings -- and it's going to be very different than NREPP, and what I mean by that is that it's not going to be -- for the most part, there may be some -- but it will not focus on single types of programs or practices. But it will focus on spectrums of care that are needed to make sure that people get all of the evidence-based clinically informed programs and practices that are needed to help somebody with their recovery.

SAMHSA actually has lots of treatment improvement protocols, expert panel white papers, and we are also looking to the field for evidence-based programs and practices that have been widely accepted. So -- so, for example, the ASAM

document that outlines medication-assisted treatment for opioid use disorder, that will go on the site. Why? Because it is widely accepted that this is an organization that is a recognized expert in the practice of addiction medicine and widely accepted around medication-assisted treatment.

And we'll be looking at a lot of -- a lot of stakeholder groups, national organizations that also are looked to by third-party payers, that are looked to by Government agencies for input around what are the evidence-based programs and practices. And that is what SAMHSA will be -- will be putting on its website through the policy laboratory.

I should also tell you that one of -- one of my big concerns with NREPP, just to be very blunt with you, is that if you look at what's on NREPP, I haven't looked at all 462, I believe, offerings on that site, which, by the way, is still available, if people want to look at it. But the ones I've looked at all have price lists, and I believe that that's a barrier to use of evidence-based practices because I think that many programs, many organizations don't have a lot of extra money to pay somebody to come in and provide a half a day or a day training that they're then told they have to keep doing when they get new staff and to update and to pay for travel. That's very, very costly.

In fact, I had some of the staff at SAMHSA just cost out a few of those programs, and I can tell you that I got ranges from a low, a low of about $1,600 to a high over $80,000 in the first year. So, you know, that's -- and everything in between. So that's prohibitive. Prohibitive, I would say for many of our [inaudible].

And what we want to do at SAMHSA is look at our technical assistance and training programs very differently than has been the case up until now. I want as much as possible things to be made available at no cost, and everything that we put on our website, which would be evidence-based, there won't be cost for these things, but you may wonder, well, how do we implement them?

And how we're going to do that is through the development of an entirely new system of training and technical assistance, which will be coming out over time, but you've seen some of it already. We will have some national training and technical assistance programs. We have, for example, the Providers' Clinical Support System for Medication-Assisted Treatment, which also addresses still safe opioid prescribing.

We have the newly awarded STR technical assistance and training program. That is the largest technical assistance and training program ever put out by SAMHSA. And that is to be a national -- a national program that will provide on-the-ground, localized training depending on the needs of communities, and we'll be watching that very closely because that is a new initiative and a sizable initiative for SAMHSA. So if that program doesn't work the way I'm planning for it to work, we will be making adjustments to it. So, so stay tuned for that.

We also -- you may or may not know this. We have a funding announcement out right now to develop a clinical support system for serious mental illness, and that is going to be a national program that will provide expert technical assistance and training related to serious mental illness. Some of the requirements is it will have to develop a Center of Excellence for psychopharmacology, including the use of clozapine, the treatment for [inaudible]. It will also develop a course to help States and communities establish assisted outpatient treatment programs, using the most up-to-date evidence-based practices.

We also have -- and you notice because you're on the CSAT NAC, we had a lot of success with our Addiction Technology Transfer Centers. I personally think that's a really good program that SAMHSA has. What we do is we have -- HHS has divided the country into 10 regions, and so we have 10 ATTCs, and we have 2 specialty ATTCs that we believe focus on areas of special needs, and one of those -- one of those is the Native American ATTC, and the other will be the Hispanic/Latino ATTC.

But then the 10 regions will each have an ATTC, and we will be working to do the same thing for prevention and for mental illness. And as that happens, the idea is all of these -- all of these technical assistance centers will be required to work together, and they will be required to do on-the-ground training. So no longer will SAMHSA only serve its grantees. SAMHSA will serve the nation, and anyone can get those resources because we will fund them by regions, like I say, with the national oversight centers, and we will monitor this closely. But we hope that this will provide a great deal of resource to communities that has not been previously available from local experts.

You know, coming from the States, I believe that every community is different, every State is different, and so it's really important to have local people deliver the training and technical assistance because they know best what's going on in their communities. And probably easier to identify with, easier to communicate with over time.

So that's where we're going with training and technical assistance. This, I will just tell you, is part of the President's approach to addressing the opioid crisis has been making more training and technical assistance available to the communities. It doesn't do a whole lot of good to throw billions of dollars at communities that don't have a workforce, don't have -- don't have providers that are trained. We really have to take that very seriously and do a good job of that, and we are doing this in a very methodical, logical way. So I'm happy to tell you that that is -- that what I'm telling you is supported by this administration.

Having said all of that, I'll just mention a couple of other things. Have you had Chris Jones here yet? Has Chris come in?

DR. ELIZABETH LOPEZ: Chris Jones? No.

DR. ELINORE F. MCCANCE-KATZ: Is he going to come and speak?

DR. ELIZABETH LOPEZ: No, no.

DR. ELINORE F. MCCANCE-KATZ: He's not going to be at this one? Oh, okay. Well, then I'll mention. So we have -- but the Cures Act requires that we set up the National Mental Health and Substance Use Policy Laboratory. We have done that, and we've hired a Director, Chris Jones, who has a lot of experience in particularly addiction medicine research, but also research practices within behavioral health. I think he'll do a great job towards focusing the policy laboratory on important issues.

I can tell you that a couple of the issues that we're looking at right now is one of the -- one of the questions that I think everyone asks, but certainly get asked within HHS is how do we know that what we do for opiate addiction works? How do we know medication-assisted treatment works? We do actually have research-based evidence for that, but we are doing even more with that because we're going to look at some of our existing grant programs and go into the communities and start to look at what the outcomes have been based on what States and communities are doing with the grant dollars they've been given.

And we'll be reporting back to the Secretary about that. He's quite interested in knowing whether the money that we are putting into the communities is actually making a difference. So that's a research area for the policy laboratory.

We also are looking at doing another survey around practitioners who have the waiver to prescribe buprenorphine products or offers this treatment of opioid use disorders, and I think that will be pursued as well. We've already -- already reached out to two of the main DATA waiver provider groups, and they have responded positively to the idea of a survey, where we will look not only at physician practice, but also physician assistants and nurse practitioners who since the enactment of CARA have been able to get the waiver as well.

And then we will also be taking on some research topics in serious mental illness, one of which I think could be applicable to both substance use disorders and mental illness, and that is we're looking at the possibility of some research on the effectiveness of peer recovery group in 10 communities because we so often get this question of, well, how do you know it works? I mean, those of us who provide care to people know how important it is, but we want to try and find something that we can look at and say here's the evidence. Here is the actual evidence. It's not anecdotal. It's real.

So, so Chris will be looking at how we might do that -- and his staff. I will say this

will take some time because we just hired Chris in January. And while he has a few SAMHSA staff that are working with him, there are other positions that we'll need to fill over time. So that will take a little while to do.

So what else? I'll just mention to you briefly, just for the sake of completeness, that we also have something called the Interdepartmental Serious Mental Illness Coordinating Committee. We call it the ISMICC. This is a public-Federal partnership around serious mental illness also mandated by the 21st Century Cures Act. The public members did a really, really a fantastic job of providing a document to Congress that really lays out a blueprint, if you will, for what the issues are around serious mental illness and what we need to be doing federally and at the State and local levels as to how we can better serve people and their families with serious mental illness.

I think I will stop there, and I'm happy to talk to you more.

Agenda Item: Council Discussion

MS. A. KATHRYN POWER: Judith?

DR. JUDITH A. MARTIN: So thank you for --

MS. A. KATHRYN POWER: Dr. Martin, can you put the microphone closer so we can hear you?

DR. JUDITH A. MARTIN: Closer?

MS. A. KATHRYN POWER: Okay. Thank you.

DR. JUDITH A. MARTIN: Thank you for tackling such difficult and important things. I appreciate you being here.

One of the things that we're finding, especially in California, in implementing evidence-based practices and also in doing evidence-based placement with the ASAM criteria is that nobody knows how to monitor compliance or fidelity to those things. So our compliance department and probably our State monitors need some help there. And also our providers how to document properly, if that's going to be used.

And then another question that I had was I think in the ATTC last grant iteration, performance improvement technology was included as part of their services, and I wondered how that's going and whether that's part of the TA that's being done is the performance improvement projects. How to take something that's a best practice and put it in effect in a particular setting in small sets of changes?

DR. ELINORE F. MCCANCE-KATZ: Yeah. So it's a big question. So the

ATTCs were awarded this year. We don't have any reports from them as yet, but we probably can follow up and find out. It's a very good question.

You know, the issue of really what you're describing is -- are quality of care issues, right? So and that is quite variable by provider. There -- that requires us to just offer more training and work with States around what the best practices are and try -- so when we give money to a State, they subcontract it out. So really, the key here is to work with our States around what constitutes evidence-based practices and how to evaluate and make sure that people get to the care and services they need.

Now SAMHSA does collect data, but one of the things that I've learned that is more challenging is some of the data collection issues around our block grants. And we are still waiting for data on the STR program. We will be very diligent around working with the States. As it so happens, some of our project officers are here from some of these programs, and I work directly with them. So I know that they're trying to work very hard with the States around these issues.

In terms of the provision of technical assistance, for the STR, technical assistance and training is required that the States receive assistance in those areas, and so we will be monitoring that to see whether that's happening and how that's being accepted by the States. I think that coming from a State like Rhode Island, where we were doing things that I know aren't being done pretty much, maybe in Massachusetts, and maybe in a couple of the Northeastern States, but not so much anywhere else, I know that all the States agreed to monitor. And so I'm not sure how much it's going to take to get people to do what you're describing, but we do have that as a requirement of the grant. So we'll have to see how that works out.

And I would also say, Judy, that since I suspect you're still strongly involved with ASAM and --

DR. JUDITH A. MARTIN: Mm-hmm. And CSAM.

DR. ELINORE F. MCCANCE-KATZ: -- CSAM, of course. It would be good to connect with the grantee and make sure that the kinds of fidelity principles that we think need to be taught are part of what's offered in the program. I would certainly support that.

DR. JUDITH A. MARTIN: Yeah, our State Cures grant does include CSAM in a mentorship program for primary care physicians --

DR. ELINORE F. MCCANCE-KATZ: Okay. Okay.

DR. JUDITH A. MARTIN: -- to provide buprenorphine. And it's a little bit more intensive and local in that the --

DR. ELINORE F. MCCANCE-KATZ: Yes, yes.

DR. JUDITH A. MARTIN: And I think it's going to be great.

DR. ELINORE F. MCCANCE-KATZ: I think that's really good to hear, but it doesn't really get to the issue that you talked about, which is the fidelity. So I would still say that it would be good to try to enact because the more -- the more evidence-based types of trainings that we can get to people, the more likely it is that there will be some uptake given that, you know, didactics are not that effective so we have to do it over and over.

MR. JASON HOWELL: Thank you so much for talking about recovery outcomes. Because oftentimes we get in policy discussions, and it's like what are we measuring? And so you figuring out, you know, what those recovery outcomes are important. I think the other thing I was really happy to hear is the interest in recovery support services. Prevention and treatment is fantastic, and we need those, but also how do we support individuals in long-term recovery?

The ATTCs are a huge resource, but then their core competencies really are more around prevention and treatment, and so being able to link them with individuals and organizations that have been doing the work around recovery support services to understand what best practices are I think would be important.

DR. ELINORE F. MCCANCE-KATZ: So, so do you work with your ATTC at all?

MR. JASON HOWELL: Yeah, I'm in Texas, and so that's going to be the South by Southwest.

DR. ELINORE F. MCCANCE-KATZ: Right.

MR. JASON HOWELL: And I've given -- at the regional meeting, they announced this, and I gave them some of the same feedback. You know, and if it was recovery high schools, then we've got the Association of -- I'm going to get it wrong.

MS. KRISTEN HARPER: Recovery schools? Oh, Association for Recovery in Higher Education.

MR. JASON HOWELL: Right. So there's I think each kind of domain, whether we're talking about recovery housing, there's, you know, the National Alliance for Recovery Residences, recovery high schools. There have been a lot of folks working around that. Collegiate programs, another group. And then recovery community centers. And so I think a lot of really great work has been done, and so it's about tapping into that body of knowledge.

DR. ELINORE F. MCCANCE-KATZ: Right, right. That's why I'm asking. And I think that would be really important, and the ATTC certainly would be a place where it would be important because the ATTCs, and also, by the way, the Providers' Clinical Support System. There should be trainings. There should be information available. And I say this as a physician who was a residency trainer for a long time. We really didn't focus at all on the community resources. Community resources, arguably -- I think easily arguably -- are as important as the medical treatment.

And so when we don't train our health practitioners on what the resources are in communities, how to access those resources, what should they be looking for when they go to another community, this is -- this is, I think, a big gap in training healthcare practitioners. And so the ATTCs focus, they tend to focus on non-M.D.s for the most part. The Providers' Clinical Support System has been, for many years, M.D.s, and now more other trainers, other professions as well because of the prescribing privileges that are changing over time.

And so I think it would be a good thing to start to work information in because it really needs to be -- really needs to be part of the solution.

MS. KRISTEN HARPER: Thank you for saying that. Thank you, Jason, for pointing it out.

You know, one of the struggles of recovery research, which is an emergent new research field, that we had is actually finding people that are in recovery because we don't really have so many pockets. But we have seen some pockets or datasets come out, emerge from recovery community organizations, collegiate recovery or recovery high schools. GPRA, I think, has also been in the past, you know, as much as being somebody that has facilitated an ATR grant, it could be a little bit of a pain in the neck, but it will yield some information that I think will help.

I also want to point out that professional assistance programs that pilots doctors, nurses, these programs where we have professionals that are going to treatment, that are seeking long-term recovery, they are tracked for almost 5 years, which in our population is almost unheard of for a longitudinal study. So having up to 5 years to track these same people, we're seeing some really great outcomes from that.

Same with collegiate recovery because most of the students stay engaged with the program for an average of 3 to 4 years. So we've got some groundwork for looking at some of those populations because we are a tricky population to follow, to track.

John Kelly out of Harvard, he's got some really great information, and I just --

while I have you captively, I'm trying to just let you know there are some really great studies that are coming out. But we need more. We absolutely need more, and I think it's refreshing to hear you say that it's being done at a local level, and every community is different. You're absolutely right, you know?

And then the youth piece as well. I think we're being -- we're not doing what we need to do for the youth piece. Because if you talk about prevention, recovery is a type of prevention. It's not primary prevention, but it is prevention. If we can get in early, then we can change the trajectory of those kids' lives and actually save a lot of money.

So I just wanted to get all that out. I had a list in my head. So thank you for listening. I appreciate it.

DR. ELINORE F. MCCANCE-KATZ: Well, and I agree with everything you said. You know, it's -- it may seem like a subtle difference, but it's a different way of looking at things, right? It's different than what the traditional way has been, but you know, I think that if one -- if one has the opportunity to be in communities and work in communities -- and so one of the things, one of the real resources that I had in some of my positions was that, you know, I'm a physician, but I also was in government, which meant I went to communities. And so I got a chance to work with people and to see these services right up close and personal, which most practitioners don't get to see, and it made a huge impression on me.

And one of the things I can remember doing when -- so I wanted to -- I wanted to see what was happening in Rhode Island with overdoses that were coming into the emergency department. I just wanted to see how that went and how we had peers coming into the EDs, and they were having not a lot of luck with getting people to go into care. And I was able to watch that and to see how that worked, and it makes a huge impression. And you don't have to do it a lot of times. You know, I wasn't there all the time, believe me. But I only had to go see a few of these cases, and I could see what they were up against.

And one of the things we did in Rhode Island was we made a change to how the peers were working with people in the EDs so that while a lot of people, you know, when they've been reversed with naloxone, they're not really ready to talk to somebody. But you get them to sign a consent form so that you can follow up with them, and that's what they started to do. I mean, we're still waiting to hear, but I will tell you that Rhode Island is doing a lot of things, and we had a 9 percent drop in our overdose death rate in the first half of 2017, and I think these kinds of interventions have really been the keys.

So it's -- that's not a research study. That's my own anecdotal experience. But it just -- I think it helps to shape how I think we should be doing things on a national level, and it's not going to be just us. It's got to be -- it's got to be community resources and medical professionals that all work together. We have

to find a way to do that more efficiently, more effectively, which is why we need to be talking with the training programs to make sure that those resources get to clinicians and they start to understand these things. And then they can work for those resources in their communities.

But I used to say to my residents when I was training them that emergency department, that's [inaudible]. But I would say know your dispositions. Know your dispositions. And what that means is know the medical professionals you're going to send people to. At that time, it never occurred to me about nurses and other types of community resources. Now I know.

And so I say know your dispositions. I'm talking about a lot more than just who's the next practitioner you're going to refer that patient to.

MS. SHARON LEGORE: One of the things that we have done in working with the families, and I've lost a daughter to an overdose, and I have a son who was in a car crash, and I also have another son. It sounds like I'm a poster child here. But another son with co-occurring disorders, bipolar, schizophrenia. And one of the things in finding resources that I felt was really helpful was working with our system of care in our political county, where they have all the players at the table from the different systems and looking at some of the barriers that are out there to accessing services and all beginning to work on those.

And we have found that extremely helpful to get services out, what is available to the families as well. So, and again, I'm saying everything everybody else said, but I really appreciate this approach as opposed to "same old, same old," to really look at holistically the whole person and how we can work to not only do treatment, but then to recovery and include the families in that, too. So we've been doing peer-to-peer work as well with families that, you know, we don't have the evidence base, but we know it's working.

So I just appreciate what was said.

DR. ELINORE F. MCCANCE-KATZ: Thank you. Thank you for your comment. And I'll also say that, you know, at the level of the Federal Government, it's hard for us to really do anything that will touch an individual, right? I mean, it's we're kind of up here just kind of seeing what's going on nationally, and we hope that the things that we think through and put into programs locally will work.

But one thing I will tell you is that this administration is very interested in communication with families around medical issues. We have already put out guidance around -- around HIPAA and around issues related to people who may come in to EDs who have had an opiate overdose or some emergency related to a drug toxicity or just a drug-related incident that requires emergency care. There has been a lot of misunderstanding on the part of healthcare professionals and, frankly, the lawyers that advise the hospitals and other care systems.

When someone comes in, this is not -- it's certainly not 42 CFR protected, and we're about to put that out, but also under HIPAA, you can communicate with families when it's important, it is a medical emergency.

And so we put out guidance, and we've circulated that to practitioners and to healthcare organizations and we will be working very hard to make medical communications more available to family members.

MS. SHARON LEGORE: Yeah, I appreciate that. That is also a barrier to deal with, especially when you're dealing with an adult child or a transitioning youth, which families across this country are experiencing. And so I mentioned the system of care, it's just another way, you know, to be able to work with other programs that are out there that are working at local levels to get that information out to families.

DR. ELINORE F. MCCANCE-KATZ: Yes, it's very challenging. One of the other things that we did was we just put out this information sheet for families on how to select a substance abuse treatment program. You know, too often if you Google, you know -- well, whatever search engine you use -- and you put in "addiction treatment" or "opiate addiction," or you can get a lot of programs that may not be quality types of programs. And so we have put something out to give families some guidance around what they should be looking for in terms of what constitutes a good evidence-based treatment program.

MS. SHARON LEGORE: And that would be great to get that information out, you know, in all our networking.

DR. ELINORE F. MCCANCE-KATZ: Yeah. Marielle, where is that? Where is the one-pager for families?

FEMALE SPEAKER: That's on SAMHSA's website. I can send Kathryn --

[Crosstalk.]

DR. ELINORE F. MCCANCE-KATZ: We should really get that out.

MS. SHARON LEGORE: That would be great. We could post that, you know, and send it out to other organizations.

DR. ELINORE F. MCCANCE-KATZ: Oh, we would be happy to have you do that. So please make sure you talk with Elizabeth to make sure that happens.

MS. A. KATHRYN POWER: Okay. We'll make sure. That would be great. That would be great. Thank you.

MS. SHARON LEGORE: Because like you said, there is so much bad

information out there, trying to get the good information to families has been difficult.

DR. ELINORE F. MCCANCE-KATZ: It's very difficult.

MS. SHARON LEGORE: And a lot of times even in working with it, you don't know what's out there that has been developed. So this is great. Thank you.

MS. KRISTEN HARPER: I will share, too, that we just recently -- there was a few representatives from the recovery -- national recovery organizations that were called in to Google to have this conversation about the search engine. Because Google shut down all their advertising for treatment centers recently, and so they called in people to find out how are we supposed to vet, how are we supposed to figure this out?

So I don't know what came of that meeting, but I do know that we had some folks there, and there were a couple of other people. So they're working on it.

DR. ELINORE F. MCCANCE-KATZ: Great.

MS. A. KATHRYN POWER: Other questions, comments for the Assistant Secretary?

MS. EVA PETOSKEY: I have to take this opportunity, and my head is sort of spinning because there are so many things I could ask or could maybe draw your attention to, but I think I'll focus on tribal issues. And in Michigan, for example, we are part of the State targeted response initiative.

I work for an organization called the Intertribal Council of Michigan, which is a coalition of the 12 federally recognized tribes in the State. So we have a partnership or a subcontract with the State targeted response initiative at the statehouse, and so we are working, working the treatment part of that with our existing infrastructure that we've created through a 10-year Access to Recovery initiative that we had funded from SAMHSA.

So we created a pretty amazing treatment and recovery support infrastructure, with the goal being to increase the array of services so that we don't only provide treatment or good care, but we're also providing recovery support. So we also have a lot of innovative, culturally based services that are part of our system of care that we created through the Access to Recovery.

So, and we have done outcome studies because we used the GPRA extensively, and we were successful in -- of course, these are -- you know, they're outcome studies. They're not research. But we were successful in doing follow-ups on at least 80 percent of our population. So we have data on over 10,000 people, with an 80 percent follow-up rate.

And so I didn't bring the fact sheets along today. I intended to, but I forgot. So another time. But we have quite a bit of data and good outcomes and looking at, if we have resources, I think we could do a remarkable study. Because one of the things that the Access to Recovery initiative did was it took units of care down to, you know, a quarter of an hour. So we have data on dosage and duration of service that other than through insurance or maybe Medicaid has that kind of data. But I don't know if SAMHSA ever had an initiative like that where we collected that level of data about the actual services that people receive.

So we have both data that we could do an outcome analysis and then integrate actual dosage and duration of service. But we don't have the resources right now to do that, but I'm just saying that I hope that as the STR goes forward, that we will -- "we," I mean that SAMHSA will. Obviously, you have this newly awarded TA contract that I'm assuming part of that will be data and evaluation. I don't know if that's a valid assumption or not --

DR. ELINORE F. MCCANCE-KATZ: Okay. So that's only as it relates directly to the services that they are providing.

MS. EVA PETOSKEY: Yes, yes, yes.

DR. ELINORE F. MCCANCE-KATZ: We want to know what they're doing, but not what you're talking about.

MS. EVA PETOSKEY: Well, that maybe I misspoke then because I am talking about the direct services. Yeah, yeah.

DR. ELINORE F. MCCANCE-KATZ: Oh, okay.

MS. EVA PETOSKEY: I kind of slid over into another topic. But I guess I wanted to say, going back to the tribal issues, that I would encourage SAMHSA to continue to partnership -- in partnership with tribes. And you know that some tribes feel very strongly about having a direct relationship to SAMHSA versus having that relationship defined through the State. And others, here in Michigan, we've been able to work out our interests with the State that work pretty effectively.

But it's taken a lot of effort. It isn't always a natural partnership at the State level between the tribes and the State. Typically, when we've talked about government-to-government, it's been more of tribal government to Federal Government or to SAMHSA. But if you can develop good State consultation arrangements with the tribes, it is a workable system.

But I don't want to advocate for that. I just know that in Michigan, we've made that work. Other tribes may and tribal organizations may have other opinions.

So --

DR. ELINORE F. MCCANCE-KATZ: Well, we certainly know that particularly our tribal lands are very, very heavily affected.

MS. EVA PETOSKEY: Absolutely. In Michigan, we do know that we have twice the overdose death rate right now. So that is part of why we and the State prioritized working with the tribes. And if you can take that down to the family level, in the community that I live in, I live on a small reservation community in northern Michigan. And over the holiday, over the Thanksgiving holiday, we had three overdoses in the community. It's a very small community, only about 900 people on the reservation. So we had three overdoses in the same house.

Two of them were revived with naloxone. Fortunately, we have first response that carried that, and then the third individual, when the autopsy came back, it was strictly fentanyl, not heroin. So we also have that problem going on with the fentanyl and the difficulty in doing that, you know, turning that around in the community on the spot. We're doing some of this work.

So it gets very challenging when you have these small rural communities, especially everyone is related, it adds another layer of challenge to talk about families, very large, extended families. I try to focus on the solution because sometimes when I get too hard, down too deep into the problem, I can hear my voice cracking. So anyway, I'll turn that over.

Thank you, though, for listening.

MS. A. KATHRYN POWER: Other questions or comments for the Assistant Secretary? Dr. Martin?

DR. JUDITH A. MARTIN: One of the presentations we had last meeting in August was about a kind of provocative discussion about comparing the AIDS epidemic and the overdose epidemic, and a suggestion of possibly using the cascade model to address the opiate use disorder problem. And I wonder what you think about that because I know you know both diseases, having worked in HIV and substance use.

DR. ELINORE F. MCCANCE-KATZ: Right, right. So that is true that, as for those of you who don't know, I have a Ph.D. in infectious disease epidemiology, and so for many years, I worked at the interface of opiate addiction and HIV. So that's what I'll tell you.

Opiate addiction is not an infectious disease, and what I don't want to do is spend a lot of time developing models that I don't think fit simply because a model had some success with one disorder. And by the way, we didn't have the cascade when we got HAART, right? The highly active antiretroviral therapy.

That came along afterwards, actually quite late afterwards.

And while it does have some utility in terms of pointing us in the direction of how successful we are in identification and getting people in treatment and retaining them in treatment, it's not -- I don't believe it's the same thing for any substance. I see substance use as chronic, as a chronic illness. I think that there is no one test that we could use to quickly get this information, and frankly, we don't -- we don't have the means by which to match treatments to patients, which was so important for HIV.

So with HIV, you know, you had an infectious agent. You often had people who were injection drug users, and we had -- we knew a few things. One, we over time were able to get a simple blood sample and find out what medications were they resistant to so that we could tailor -- tailor pharmacotherapy for the infection. We don't have that. We don't have anything even close to that for the opioid epidemic.

And we also knew that there were likely to be with certain medications drug interactions that could on the one hand present some toxicity issues, but on the other hand present adherence issues. So we had that information. We had all that information available. That's been tremendously important to the management of HIV. We don't -- we're not there with opiate addiction.

DR. JUDITH A. MARTIN: We need those handheld pencils.

DR. ELINORE F. MCCANCE-KATZ: We need something. We need something. But you know, I mean, as you were saying about -- about evidence-based treatment, which includes assessment, too often we aren't even identifying who it is that should be in that cascade, right? So, so I just -- I don't see it as the same kind of model because we lack so many things, and that model, it took us years with HIV to get to the point where we could develop the cascade. And now we can, and it's a useful tool.

And so maybe we'll get there with opiate addiction. I hope we do. But right now, I don't know how we would reliably identify. I don't think we have a great way right now of matching treatments to patients. I think we know some things that are going to be really important. I'll say one of them here. I'm not a big fan of detox, especially detox where people are put out on the street with no tolerance. We know there's better than 80 percent -- that's one thing we do know, that they're likely to relapse.

And when they do, a lot of the fentanyl overdose, they're going to die. So, to me, that gets not only to a medical care issue, it's an ethical issue. So we need to be talking about how we treat this illness effectively, what works. If somebody wants to be -- I'm not saying that people can't be detoxed. There are people who want that, and we do need to honor people's wishes. But they deserve to

know all the facts, and they should -- I -- at this point, I wouldn't be willing to detox somebody who wasn't willing to take a dose of naltrexone before they left.

So, so we know things like that. But other than that, we don't know how to match somebody to methadone or buprenorphine if they're new. I mean, we could -- you and I, we've treated a lot of patients in opiate treatment programs. But unless we have that history, if they're newly coming in, it's very difficult to know what we should do. Whereas, with HIV, a couple blood tests, and you do know what to do, and you do know how to judge what the interactions are going to be. And you can work with people around that.

It's hard to really inform people when we don't have that kind of information. So I don't see it as the same model right now. I hope we'll get there, but we're not there yet. And I don't want to -- I don't want to waste time trying to come up with a model when what I really want is to give people lifesaving care.

MS. A. KATHRYN POWER: Other comments, suggestions? I knew you were going to offer an editorial. I knew that.

[Laughter.]

MR. ARTHUR SCHUT: I'm not going to go through my list.

MS. A. KATHRYN POWER: Oh, you're not?

MR. ARTHUR SCHUT: I'm assuming you're going to chat about that. I think it's important, too, for SAMHSA to encourage a continuum of care, and there are lots of standalone entities. There are standalone detoxes. There are standalone residential. And I don't think it serves people well. And I think detox, when it is the front door for a continuum of care, and that continuum of care at the point of detox improves comprehensive case management, there are advantages to that to the community and to the individuals.

I also think it takes a long time sometimes to engage people in treatment, and so they may come back repetitively, but detox and discharge is not a good model. But detox and the assignment of a comprehensive case manager that follows through with somebody and maybe with other community resources -- oops, my mike went out. Is it time?

MS. A. KATHRYN POWER: That's all right.

[Laughter.]

MR. ARTHUR SCHUT: So I think there are things that really work well, but there's just a point at which you know I'm going to have standalone entities, but you have them integrated. And not only integrated with themselves, but then

integrated with healthcare and primary care and those systems.

DR. ELINORE F. MCCANCE-KATZ: So, of course, I couldn't agree with you more, and we have to require those things.

MR. ARTHUR SCHUT: Yes.

DR. ELINORE F. MCCANCE-KATZ: Again, so too often, the model is you go to some residential or inpatient level of care that's someplace, but it's not in your community. And they don't know who to refer you to when you're leaving, and so too often, that kind of falls to the wayside. So we have to -- and I will tell you that those are the kinds of things that SAMHSA is working with CMS on to try to get those kinds of requirements in place so that we can make sure that people don't fall by the wayside and become vulnerable to overdose and death.

If somebody is going to be detoxed, I really believe they have to have naltrexone at this point. And they have to have what you're talking about. They have to have the case management. They have to have the psychosocial services. They have to have the community recovery supports. That's our obligation. It is not okay to send somebody to a program that doesn't have those connections.

We shouldn't be paying for that. We shouldn't be telling families that they should put their loved ones there, and we can do better. And I will tell you that that is something that we are concerned about in this administration, and we are trying to take that on. It's not easy to do. It's not easy to do because these for-profit places are powerful. They're powerful. But I promise you, the message does get communicated.

MS. A. KATHRYN POWER: On that remarkably exhortative ending, thank you, Dr. McCance-Katz. I am told that you need to have another audience. So join me in thanking Dr. McCance-Katz.

[Applause.]

MS. A. KATHRYN POWER: Thanks. I really appreciate all of your comments and suggestions and observations. I know that she appreciates it as well. It's very important.

We're going to take a 15-minute break now. And please be back at 2:15 p.m. We've got what I consider to be one of the highlights of the day, and that will be the discussion with our State leadership. So please come back at 2:15 p.m.

Thank you.

[Recessed at 1:58 p.m.]
[Reconvened at 2:15 p.m.]

Agenda Item: TOPIC: Massachusetts Response to the Opioid Crisis

MS. A. KATHRYN POWER: All right, folks. Welcome back. I said that, for me, this is one of the most important and strong pieces on the agenda today because we are going to hear from the State leadership, and I am delighted to reorient ourselves to the fact that the Department received funding under the 21st Century Cures Act to create the opioid STR grants. The grants are currently in their second year with funding distributed to 50 States, the District of Columbia, and 6 territories.

This next segment includes presentations from two opioid STR grantees about how they are using the funds to combat the particular challenges their States face regarding opioids. We're going to hold the discussion until the end of both presentations, and then they will join us at the table for Q&A and conversation.

The first to present is Allison Bauer, Director of the Bureau of Substance Addiction Services, what we call affectionately as BSAS, of the Massachusetts Department of Public Health. Prior to joining BSAS, Allison served as the senior director of the Boston Foundation, leading the Boston Foundation's health and wellness strategy, and as the staff director, chief counsel for the Joint Committee on Mental Health and Substance Use in the Massachusetts House of Representatives.

In 2010, she was selected to the inaugural class of the Terrance Keenan Institute on Emerging Leaders in Health Philanthropy fellow by the Grantmakers in Health organization. Currently, she's an adjunct professor at Boston College Graduate School of Social Work. She also taught at the Simmons College School of Social Work and was an assistant professor at Virginia Commonwealth University School of Social Work, where she earned her master's degree in social work.

She has an undergraduate degree from the University of Rochester, and she holds a J.D. from the University of Pennsylvania Law School. Allison currently serves on the advisory board of Playworks New England and acts as a strategic adviser to Positive Tracks, whose mission is to help youth turn sweat into civic action.

Let me just make a couple of personal comments about Allison. I've been in the region for 6 years. I've been in -- well, I lived in the region for 35 years. So I've worked with a lot of State directors in the New England States, most notably the larger boss of Allison is Secretary Marylou Sudders, who was the head of the Department of Mental Health in Massachusetts when I was commissioner in Rhode Island. So we have a long and deep history between myself and the New

England States, and in particular, I worked with several BSAS directors in the time that I've been there. And I cannot tell you how -- what a pleasure it is to work with Allison, what a leader she is, and I'm really delighted that we have two great States here.

Not just about STR, not just about STR, but about the whole way in which you think about substance use disorders and the way in which you think about the values and philosophy of substance use disorders. And it's interesting because in Massachusetts, unlike in Rhode Island, there are two authorities. There is the mental health authority is in one department. The public health and BSAS single State authority is in another department. So that makes kind of an interesting conversation, and I think she has worked really brilliantly to balance that.

So, Allison, welcome, and thank you very much.

MS. ALLISON F. BAUER: Well, thank you, Kathryn, and thank you to everybody. I hope I can live up to that introduction. So I appreciate that.

I also wanted to note, to acknowledge and thank everybody who's serving on the advisory council, particularly those people who've either identified that they're people in long-term recovery is something that I'm not, but my brother is. And so I've had that experience in a family setting. So I can identify both with family members as well as with those individuals. And I just want to acknowledge you and thank you for everything you're doing to contribute to the dialogue here.

I think that, you know, Kathryn noted this, but to say that the leadership in Massachusetts is particularly strong on this would probably be an understatement. I came into the role with a Governor who is incredibly supportive of this work, was tapped by the Federal administration to be on a Federal advisory body on this issue. Convened a working group when he took office under the leadership of the Secretary, Secretary Sudders, and then also my direct boss, who is the commissioner in the Department of Public Health, Commissioner Bharel, comes to this with a great passion not just leading the whole of the department, but having served for many years as the medical director of Boston Healthcare for the Homeless and herself being someone who treated many people with substance use disorder.

So I have a very strong leadership on this issue. The other piece, which I will note, is I also have a really strong team and bench, and the depth of knowledge of the people that I work with at and have the privilege to lead at the Bureau of Substance Addiction Services is kind of unparalleled, I will say.

So what I'm going to do -- let's see if I can make this work. There we go. So what I'm going to do is what you see up on the screen is the agenda. I'm going to talk a little bit about the epidemic in Massachusetts. I'm then going to kind of provide a little bit of an overview of our grant, our STR grant, the specific projects

that we're working on.

The Assistant Secretary spoke very much about wanting to have results and data, and I think that we will, in fact, have that. But as you know, given the timeframe of the grant and when it came out, the work really started in the early fall, and so we've got more process and outcomes, you know, outputs, more the numbers of people we touched versus the actual outcomes of the work themselves. But I will actually be able to talk a little bit about what it is we're going to be measuring. So you could have a sense of that as well.

So let's just go ahead. So just as a quick reminder, just because every State got a different amount, I know this is a formula funding grant. I don't necessarily know how the Feds do their formulas, but I would imagine it has something to do with the numbers of people affected, and our State is -- while a very small one is very, very highly affected by this particular epidemic, the opioid epidemic.

I've been asked many times why I think that is, and I actually think it is one of the -- this is me unofficially saying this. No government has sanctioned what I'm about to say right now. But what I will say we can boast a really extensive and very robust healthcare system in the State of Massachusetts. We are often noted in the State as being a State, certainly the City of Boston and a State of eds and meds, lots of great docs and lots of great academics.

And I think that robust health system meant that there were a lot of people who really have great access to care. And when access to care included the idea of pain as a vital sign and the access to and prescriptions -- access to prescriptions for a host of opioids, those that people can't recognize, things like Percocet or oxycodone or others, there was what was then created in Massachusetts I think was a really a depth of an epidemic that was started in that space.

I don't have this listed in this slide, though it's in other presentations I have. We have a very, very high-functioning prescription drug monitoring program now, and what I can say is that there has been a precipitous drop in prescription drugs as being the drug of choice now for individuals, which is great. However, many of those people who had started on those prescription drugs, of course, have since transitioned to heroin. And I think now what we're seeing and what is more scary is fentanyl.

So that by way of some background. But I was saying that the annual worth that Massachusetts gets under this Cures Act funding, the STR grant, is about $11.7 million a year for each year for the 2 years. So upwards of $23 million is a large amount of money, but we are putting it to very good use. The grant period, as you can see, was from the time of the notice of the awards in April. The idea was to start working in May.

It takes a few months before contracts are in place, but that's our grant period,

and then you can see the breakdown on the grant areas of what we have done or how we've presented our work. The bulk of the work had to be directed towards treatment and recovery. We do -- we are doing some prevention, and you'll see that. And then we utilized some money for the admin and infrastructure, and that was because, as you may know, State hiring systems can be lengthy, and this had a quick startup.

And so what this allowed us to do was to actually bring in staff specifically paid through the grant system that were not part of the State system, but function like State employees so we were able to function very quickly. We have a project manager for this particular grant. We have a prevention coordinator. We have a treatment and recovery coordinator, and we've actually hired a data person specifically for this grant. So we have staff specifically targeting on this grant.

So just to, again, to do -- we're going to do a couple of quick slides here that -- actually, they get swallowed up in that? Yeah, that's what I'm doing.

So just quickly, these are slides that a staff person made for me last night because I said how come we go right into the data? We don't do this grant overview. And I have to really talk with my staff. They put too many words on the slides. So don't worry so much about reading these. I'm certainly not going to read them to you. But this just gives you a quick scan of the prevention activities that we're doing, and you should note that -- I'm going to put these on so I can actually see what you're reading -- that the pharmacy workgroup and practice guidance is actually an unfunded part of this. But I'll talk a little bit about it, notwithstanding.

Then the treatment and recovery work that we're doing is laid out here, and I'm going to get into each of these things in more detail when I talk to you. The other thing that I will note is when I get there that we do have training and technical assistance rolled into this as well, and I will mention that to you. So that's the overview of what it is we're doing.

So let's just talk briefly about the epidemic in Massachusetts. So it is a pretty powerful one. What I'm going to do is I'm going to take you through some visuals here. So this is 2001 to 2005. Pay attention to the dark blue. 2006 to 2010, and the most recent one that I have, 2011 through 2015. That's the parts that don't -- that either have the sort of black and blue, I can tell you, if you don't know Massachusetts, also lack a lot of people. So it's a part of the State where you're not really going to see a lot of folks, and even in that -- even in that far west part of the State, we refer to that area as the Berkshires, you can still see some dark blue.

Obviously, you see some very intense dark blue in a slight spine down the middle of the State, and then the southeast and the cape is particularly heavy hit, as well as the northeast. There is also some areas that are hit in the City of

Boston. Again, if I had a really cool pointer, I could point it out to you, but the very dark areas that are to the far right along the water, that little nook, that's the City of Boston.

So, obviously, the State, we were asked to determine which areas in the State have the greatest -- you know, which would you consider high-risk areas so that we can put some things in place around pharmacy access, and we said the State is the high-risk area. So that's the way we think about the work in Massachusetts.

So the good news -- and there is good news, and in fact, I have even more good news, which I will share -- is that we just recently have seen some decrease in overdose deaths. Now the reason why it's red and not gray is that they're more predictive numbers as opposed to actual numbers, and so we want to be cautious. But I specifically brought my iPad out, not to show you how many pieces of technology I can use at the same time, but because earlier today, while we were here, a press release was issued by the Department of Public Health that said, "Opioid-related overdose deaths in 2017 fell by more than 8 percent."

So the slide you're seeing doesn't have the fourth quarterly numbers on it, and basically, it declined in 2017 by an estimated 8.3 percent, compared to 2016, which calculates out to dipping under 2,000 deaths, again estimated and confirmed a total of under 2,000, or 178 fewer deaths. We've only seen increases -- from 2015 and 2016 was a 22 percent increase. Prior to that was a 30 percent increase. Prior to that was a 39 percent increase. So this is not just a leveling off, but actually, the curve is starting to bend in the other direction.

I will say that there are quotes in this press release both by my boss, the commissioner, as well the big boss, the Secretary, both saying welcome development, but there is much more work to do. We don't want to rest on it.

And as something that I also want to lift up because I believe the Assistant Secretary mentioned it as well, we particularly want to note that where we saw an increase was in the Latino community. So you'll see the data that I'm going to show you is showing very high preponderance of white individuals being part of the epidemic in Massachusetts and, in fact, those who are seeking services. And we do note those seeking services match those who are struggling or if those seeking services were seeking those services because we were not reaching populations of color that needed to be reached.

So it's an issue that I think we're going to be doubling down on specifically with the Latino communities in Massachusetts. So I wanted to just to lift that up. Again, it's encouraging, but I don't think we're going to be resting on our laurels.

So the initial grant roles that we have were, as we laid them out in our materials, to serve over 10,000 individuals during the 2-year period, to increase the access

to treatment as well as to reduce the opioid misuse and abuse and prevent overdose deaths. So I'm going to now talk in more detail about each of the different initiatives.

Just we have pretty charts, pretty maps, and our staff put this together. Every -- the key on there, every dot represents one of the programs of the grant, and it shows you the sort of scope of trying to reach across the State with all of the different programs on the grant. If I overlaid this on the deep blue that you saw, you would probably note that it matched up pretty well with the deep blues. Some of it also has to do with where service providers are. In that central region, those are the regions that are RDPH regions in the State. In that central region, you'll note that there is a cluster of services in one area, even though the dark blue is other places.

One, it's a really small State. So it's actually not too far to get places. And two, that's the City of Worcester, which is also one of the three largest cities in the State, and therefore, it's where the services are. So that central region tends to be served more from that city, though you can see that there's definitely an attempt to reach across the whole State with the work for this grant.

So the actual work that we're doing, for our prevention initiatives, our Overdose Education and Narcan Distribution program, or the OEND expansion, is an opportunity for us to be able to put Narcan out into more communities. The work here has been in collaboration with one of my partner bureaus, the Bureau for Infectious Disease. They have managed syringe access sites, safe syringe access sites, and we've been partnering the OEND and Narcan, not surprisingly, with the syringe access sites as a way to leverage the relationships that have already been developed in the community as well as to target those individuals who are coming in for safe syringes probably are the ones who are going to need the Narcan. So we're trying to do a partnering relationship there.

We are working with seven different agencies across the State. Medical centers, they include community health centers and include a number of other agencies. So that's one piece of our work.

What I wanted to note, Sharon, you said earlier that the use of naloxone needed to be -- have a follow-up to it. When somebody overdosed, there needed to be follow-up. So what I'm really pleased to tell you about is the second piece of work that we have in our grant is the post overdose intervention. I think we changed the name from Knock and Talk because I think people thought that sounded too police-like.

But the post overdose intervention is a pilot. We're doing three communities where we're taking what were three existing community-based first responder overdose programs and building those out. So they're in the communities of Boston and Fall River and then in a collaboration of communities north of

Boston. We're partnering the outreach worker, the recovery worker, the person who works as a treatment provider with the first responders. And when there has been a reported overdose, there is, in fact, direct follow-up.

Not -- there's a model out there that people may have heard of, a party model where people were coming into police office locations. This is going out into the community, going to the home where there'd been an overdose, and saying in that sort of Chinese -- the Chinese have a symbol that means both crisis and opportunity. "In that moment of crisis, there is often opportunity." And the idea is how do we, post overdose, immediately follow up and say, "Look, this just happened. Can we help you right now?"

So, again, it's only in three sites, but we're looking forward to seeing what kind of data we get from that -- from that project.

And here, this map is just a distribution of those two programs, the post overdose follow-up, along with the Narcan. So, again, we've got much more of the OEND out there than the post overdose. We've only got a couple of -- I said it's a couple of pilots, but you can see that they're collocated around where the distribution is for the Narcan.

So -- and this, again, echoing the Assistant Secretary, training and technical assistance are obviously key to being able to do the work. So having overdose prevention training and technical assistance for the human service providers to be able to lift up the needs that they're identifying to be able to help to do the work, to be able to have more people trained, we're working, and this, I will say, this needs assessment in training is being done, conducted and done by one of our partners, Health Resources in Action, which is a wonderful national organization that we utilize. It's only one piece of the kind of training and technical assistance we do, but I wanted to just highlight it because it's so important, as the Assistant Secretary noted.

And then, finally, as I mentioned, we have kind of an unfunded piece. So this is something that we think rolls into the work that we're doing. We're not using specific STR funds for it, but we are linking the work, which is convening a workgroup to be able to help drive official practice around how we get more naloxone out into the community. The workgroup's role is going to be to define and address the systemic barriers to accessing naloxone, with the idea of development of a guidance document.

The workgroup has already held a formal meeting, and they have had two phone calls to follow up. So what we're trying to do is make sure that we're driving -- to driving progressive policy change to accompany the work.

So I want to move on and talk a little about our treatment and recovery support initiatives. So here, the work that we're doing to expand the OBOT, so the office-

based opioid treatment, we focused, as well as provide training and TA to the sites to be able to have expanded service, as you can see, for at least 700 individuals.

So we've started the grant. Boston Medical Center, which is the home of not only one of the best -- it's one of the safety net hospitals, I think, in the country, certainly in the Northeast. There is a new Center for Addiction Medicine that's housed there, the Grayken Center. You may be familiar with the person who's run the Grayken Center. I was hoping that Kathryn wasn't going to say I was the best person to ever serve in my role because, clearly, I wasn't. I'm not. Michael Botticelli, who had the -- had the seat that I'm in for many years before I did and then went on to a significant role in the Federal Government in the last administration, is back running the Grayken Center and bringing his expertise there.

And so we're leveraging the Boston Medical Center's expertise for an awful lot of training. And they've delivered already 36 trainings to OBOT centers and staff since the grant began. We're also using the opioid ECHO telehealth approach to employ videoconferencing technology so that healthcare teams can continue to learn from a distance. I know somebody was talking about the rural areas, and I did mention there are parts of the State that, in fact, don't have that many people, but they do have people -- they do have people being helped. And the utilization of the telehealth allows really strong resources to get out to those health centers where they may not have as much expertise as those in the -- in more of the urban core.

So we do have health centers throughout the State that are -- that we've been expanding our OBOT program. This is one that I'm actually particularly excited about, and it's also going to bring me back to today's press release. Our MAT-RI program, Medication-Assisted Treatment-Reentry Initiative, is targeting individuals who are reentering the community from houses of corrections.

We in Massachusetts have passed through legislation something called Chapter 55, which brought together originally 10, now 20 different databases of information so that they could actually talk to each other, and then that would allow us to produce information that would give us the most up-to-date data on who was being affected by this epidemic. I would direct you to check out our Chapter 55 website. You can literally play with it. It's an interactive site.

But what we learned from that was that there are certain priority populations who are more at risk than others, and those people who are being released from corrections, whether they be houses of corrections or the DOC, so either the jails or the prisons, were at much higher risk of fatal overdose. Those being released, the original data, those people being released from prison, the longer stays, were about 55 times more likely to overdose. Those being released from houses of corrections were over 200 times more likely to overdose upon release,

which makes sense if you are in let's call it an unintentional detox, and then you are released, your ability to navigate what happens if you use upon release was -- is obviously problematic.

So we are using some of our STR funds to do an initiative that would help connect these individuals being released with MAT, starting, well, pre-release so that they could then be -- have a safe transition out. And it says five county houses of corrections, but I'm happy to say in the press release that went out today, we've added a sixth. So we're working with Hampden County, Franklin, Worcester, Middlesex, Bristol, and we've added Suffolk, which is the county that Boston sits in.

Every one of the sites is using the injectable naltrexone. Some are actually providing buprenorphine, and a couple have indicated that they would like to use the injectable buprenorphine once it's ready. So we're really excited about that initiative and, again, showing you that we have some really good State coverage for both the OBOTs and the MAT-RI around the State.

This piece I think is a really important one because I've heard now a number of people -- and I think, Jason, you said it a few times -- the idea of recovery and that such an important piece is recovery. I have staff at the department who said that we really need to change our language to talking about a recovery-oriented system of care and to use that lens. They've impressed that upon me, and it didn't take a lot of work to get me to agree, but I do think these next two pieces of our grant are pieces that will demonstrate that we've put that into action.

So the ATR, the Access to Recovery program, obviously, we started it with two sites in Boston and Springfield, our two largest cities. We're going to be implementing and expanding, expanding in the current two sites where existed and then adding two new sites. Those four cities make up a good percentage of our population and certainly house a number, a great number of the people who are -- more people are beginning to relocate and living after they come out of treatment. But these individuals will be through the ATR program getting that post treatment continued support for all of those different pieces that I think it almost sounds funny for me to stand up here and explain this to you. So I'm not going to. But that you know are necessary for people to stay in recovery.

So we're really thrilled about that particular initiative, and then I would note that we also have the Families Recover project, and I know that that came up as well, expanding support services for pregnant and parenting women in the six recovery support centers that we already have. I will note that some of our Chapter 55 data also lifted up the fact that one of the most dangerous times for women is after they've given birth. And it's interesting, people seemed to think that this was an unusual thing, right? Wouldn't having a new baby keep you safe?

So, interestingly -- so I have kids. I have 15-year-old twins, which makes my home job almost as difficult as my day job. But I will note that I think if for anyone who has children, you know, it's interesting, when women are pregnant, I think on the whole, they try to abstain from things that they think are going to be bad for the pregnancy. For someone who doesn't have a substance use disorder, it may be that they don't drink or maybe they avoid sushi, or whatever it is, you know, unpasteurized cheeses.

But what's interesting is immediately upon giving birth, you almost always think, "Oh, my God, where's the sushi? I'm ready to have it now because I just," you know? And I think that, you know, I joke a little bit when I say that, but for people with a substance use disorder, we have data that specifically shows a precipitous drop in the risk of overdose, particularly in the second, third trimester. There's real attentiveness to caring for that pregnancy.

There is then an unbelievable increase in overdose risk immediately after giving birth, up to one full year. It is dramatic. And in fact, the risk of overdose is higher than before the pregnancy. So wanting to make sure that we have programs in place to help address that is part of the grant. Again, we used our State data to make sure that this was happening.

Again, they were really into the mouse today, this time. So I want to just make sure that I'm -- I think I'm pretty good on time. The evaluation framework. So as I said, we don't necessarily have the data yet, but just to give you a sense of how we're thinking about evaluating the work, how many people we're serving, how many new people did we bring in? The success rate in recruiting and retaining the population, which of the services have the greatest impact, and then is there a dosage component?

So this is the way we're thinking about it, and I was told I have to be very -- I have to tell you a little bit more about that in a second. But so that's our frame. What I can give you is our current demographics. This is as of October 31st. So it was right off the bat.

It gives you a sense of the age of the clients as well as the sex, which should not be surprising. Also the race and the ethnicity. And then here are the key outcome measures we're going to look at, and one of the things that I was -- our data person wanted to make clear is that the variables are not consistent against all individual programs. So meaning that we're not going to collect each of these variables for every program I discussed.

For some programs like the OEND, it may be just the overdose and the drug use. But for the ATR, it's going to be every single one. So there are going to be different data points for each of these different programs as they match up to the program. I did say that we did have some outputs already. So some of the touches, if not the outcomes.

So just through the collection period that you'll see noted on the far right, here are some of the numbers for our OEND. I think about the fact that I just read you a report that said, you know, we had 178 fewer deaths in calendar 2017 than '16, you know? And then you look at the number of reverses that we had just in that 6-month period. I think but for Narcan, I mean, it has really been tremendous and perhaps one of the greatest reasons why, though we know people for whom Narcan is used often overdose again. But we're able to use this to -- I call Narcan the drug that keeps people alive until they're ready to go into treatment.

It is the thing that keeps people alive until they're ready to be in full-time treatment and hopefully -- and keep them back on that playing field if they have -- I don't like calling it relapses, I call them recurrences. In no other illness do we call it a relapse. Nobody has a second asthma attack. "Oh, my God, they relapsed on their asthma." Like I think all illnesses have recurrences, you know? Nobody's second heart attack is called a relapse. I just -- I don't get it.

But you can see the post overdose intervention, 89 of those encounters just in that short period of really connecting with someone after they've overdosed. We've had 177 clients enrolled in the OBOTs, 35 already in the MAT-RI program, and let's see, here we go, over 1,300 clients already enrolled in the ATR. And then 18 clients, which are families and their kids, in the Families Recover project.

So my next slide is just this. Obviously, we're not going to do that right now. We'll do that after my colleague speaks, but just to give you just my contact information as well as information about our help line. We do have a substance addiction help line that has the number as well as a website, where people can go online and find information immediately, whether it's someone seeking treatment or a family member.

So, with that, I will step away.

MS. A. KATHRYN POWER: Thank you very much, Allison. Really well put.

[Applause.]

MS. A. KATHRYN POWER: I asked the -- I asked Tracy how we ended up having Allison from Massachusetts and Mark from Missouri, whether we're into the M's or something? I'm not quite sure why. And the response I got was that because the actual folks working the STR grants who sit in CSAT and CSAP recommended these two people. And there is clear evidence why they recommended these two people. Because these two States, first of all, are well known. Leadership is well known and established.

And I think that I will tell you my other observation about these two States is that

Massachusetts sits in Region 1, the first region really to work on very effectively and dramatically the emergence of the opioid epidemic. Governor Shumlin in Vermont was the first Governor to ever announce a public health emergency.

And Missouri sits in Region 5, which is one of the most heavily affected regions and had enormous issues related to HIV infection and several other emerging issues. And so I think it's interesting that we have the two regions that I saw as really the first regions that really began to get very serious about this issue and have obviously made your mark in terms of things happening.

Agenda Item: TOPIC: Missouri Response to the Opioid Crisis

MS. A. KATHRYN POWER: So I want to now introduce Mark Stringer, who serves as the Director of the Missouri Department of Mental Health. Mark is a licensed professional counselor and nationally certified counselor with over 30 years of experience in the substance use disorder and mental health fields. After graduating magna cum laude from Westminster College -- is that the one in Maryland?

MR. MARK STRINGER: That's the one in Missouri.

MS. A. KATHRYN POWER: Oh, okay. There's another Westminster College in Maryland, which I went to. Mark served in the U.S. Army as an officer with the 101st Airborne Division before moving into the behavioral health field. Thank you for your service, Mark.

Since then, he has directed adult and adolescent addiction treatment programs, a psychiatric hospital intake unit, an outpatient clinic, and an inpatient geriatric psychiatry unit. Along the way, he earned his master's degree in counseling from Truman University.

In State government service at the Department of Mental Health, he was the Behavioral Health Division Director before becoming the department director in July 2015, and Mark also serves as the immediate past president of the Board of Directors of the National Association of State Alcohol and Drug Abuse Directors, known as NASADAD.

Welcome, Mark. Thank you very much for being here.

MR. MARK STRINGER: Thank you, Kathryn. I'm sorry I haven't had the chance to say hello yet. We met years and years ago. But I've met many of them.

MS. A. KATHRYN POWER: Okay.

MR. MARK STRINGER: Good afternoon. You'll find that my information is not dissimilar from Allison's. This, the STR grant and other grants that have come down have done some tremendous things in Missouri. They've really helped us transform our system in a way that would not have been possible without those funds. And the rapidity with which they came, it seemed to all have come at once, and we had very short timeframes, and I'll talk about that all in a minute.

First of all, I can't get control of this damn thing.

[Laughter.]

MR. MARK STRINGER: Well, let's just try this. First of all, I have to tell you that -- that's okay. We'll figure it out. I have to confess that Missouri remains the only State in the country without a prescription drug monitoring program.

So every -- yeah, every year, we have an annual NASADAD meeting, which is a fairly large gathering of 300 or 400 people, and I was president for a while, now immediate past president. And every damn year at the NASADAD meeting, somebody flashes a map of the United States up on the board, and all the States are green, except for one white blob right in the middle of the country. And as soon as people that white blob, the whole 300, as if on cue, turn and look at me.

[Laughter.]

MR. MARK STRINGER: So, and that's all because of one senator who has threatened to filibuster or who has filibustered every year. And he -- a couple of years ago, he made a comment on the floor at about 2:00 in the morning that maybe not having a PDMP will help "to cleanse the gene pool" was the quote, and that was in the St. Louis Post-Dispatch.

So, and ironically, this senator is a physician. So, anyway, his term is coming close to an end here, and so we're hopeful that we can get a real PDMP eventually. That would certainly make things better in Missouri.

This is -- and I'll get back on track in a minute. This is Missouri's legislative session, which I never look forward to. Some of the questions we get, some of the recent questions, for example, came from the house was, one of them was, "How many people in Missouri last year chose to become addicted to meth?" Well, the answer to this, zero, right? Nobody chooses meth.

And we went on a full tour of our new Fulton State Hospital, and one of the representatives said, "How many of these people can you store here?" Ooh. Yeah, they're not all like that by any means, but we've got some -- we've got some winners.

So, anyway, that was completely off topic. I'm sorry. Okay. One more off topic thing.

[Laughter.]

MR. MARK STRINGER: I really appreciate -- I really appreciate the language that has been used here today. I think people have been very careful to talk about "people with substance use disorders" and not "addicts." And to avoid things like, you know, "clean," "dirty," and those kinds of things that really cast a bad light on people with substance use disorders and on the field.

And so we've -- I know in Missouri we've been working really hard to clean up our language, and again, I just appreciate the type of language that's been used here today, and I want to thank you for that.

Okay. We have got a lot going on in Missouri.

[Pause.]

MR. MARK STRINGER: So we've got a lot going on in Missouri, and I'm going to try to avoid acronyms, but one thing we have going on right now is we're also one of eight demonstration States for the Certified Community Behavioral Health Project, which is interesting, but incredibly complicated. So that's going on right now. That, too, is a 2-year project.

A couple of other things, just to, again, get the acronyms out of the way. We have another large grant that we call MO-HOPE. It's Missouri Heroin Overdose Prevention grant, 5 years, for $5 million from SAMHSA. And the focus here is on what Allison talked about, OEND, Overdose Education and Naloxone Distribution. We really are trying with this grant to get funds or the naloxone out in the hands of people that need it and to provide a tremendous amount of training.

This last year, for example, our Governor, who's pretty new, got the cabinet together and said that he wanted the entire cabinet -- there are 16 of us. I'm the oldest. But there are 16 of us on the cabinet, and he charged every member of the cabinet to come up with something to help with the opiate crisis in Missouri. And I looked at some of my colleagues. You know, for me, it was easy. For our director of the Department of Health, it was easy.

I looked at the director of the Department of Natural Resources, who was sort of scratching her head and thinking, "What the hell?" Well, it didn't take long for her to realize that she has park rangers out in the field who encounter people in State parks who have overdosed. So wouldn't it be good to get all of her park rangers trained? So one day, it was on a Thursday, I believe it was, the Governor and I and a crew went to a State park and trained 38 of Missouri's 44

park rangers.

The other departments have chipped in similarly with very creative ways to be involved in this. So I certainly applaud our Governor for having that sort of a focus and investment in the services. So, anyway, that was done under the MO-HOPE grant.

We have the MAT-PDOA grant, Medication-Assisted Treatment-Prescription Drug and Opioid Addiction grant. That's the Federal grant, $3 million for 3 years, and we're contracting with two providers, two of our most experienced and creative providers to come up with a different treatment model, a different strategy that I'll talk to you about here in a minute.

We are using as part of our STR grant, we're using Project ECHO. Is everybody familiar with ECHO? Got that? Okay. So we have ECHO, we have two flavors of ECHO. One is for chronic pain management, and the other is for treatment of opioid use disorder. And so those -- and those are essentially coaching models. They're not telehealth, per se, but they're coaching models so that you can coach people in remote areas about how to deal with chronic conditions.

Last, we have what we call what PCSS waiver trainings. That's Providers' Clinical Support System for Medication-Assisted Treatment. It's a national model that we're doing in collaboration with the American Academy for Addiction Psychiatry, and it's providing a tremendous amount of training for physicians in how to treat opiate use disorders with medication, except they've gone beyond opiate use disorder. They're including alcohol, other addictions.

So those are some of the things we've got going on right now. Okay. Okay, like -- I'm sorry. Like Allison, I'm going to sort of organize this into prevention, treatment, and recovery areas. In terms of prevention, these are some of the things we've got going on under our various grants and particularly the STR grant. GenerationRx you may have heard of. That's a school-based program that teaches kids responsible use of prescription medications.

We have, as I said, a chronic pain management ECHO for primary care teams, and then we have OEND project. And when we're focusing, we're doing it on a broad basis, but we're focusing in particular on criminal justice settings and community pharmacies, working with the Missouri Pharmacy Association, and then in peer recovery services.

I like Allison's quote about naloxone, you know, mine is the only thing that naloxone enables is breathing. That's -- those are two things that just -- the two things that drive me nuts are, one, that you use medication for treating addiction, you're just switching one addiction for another. That's the worst one. And then the second one is that naloxone is simply an enabling device. It doesn't make any sense.

In terms of treatment, we did change our approach to treatment with these grants. Feel that these grants are generally fairly short period. STR we just have 2 years. Now that's punishing for the staff to throw something together in 2 years and to get providers trained up and so on. On the other hand, it forces you not to waste any time. And we have people all over the country who are dying from this condition, and so we looked hard at our treatment model where, and before, people were doing a lot of detox for opioids. There was a lot of residential and group therapy.

We approached -- in Missouri, like in the rest of the country, the tendency is to approach opioid use disorders as an acute care problem or as an academic deficit, where what you need is a 30-day educational program, right? That's the history in Missouri and elsewhere. And then medications were -- uh-oh, I've lost my -- medications were used -- medications like buprenorphine were used as a last resort.

Okay. We had to scrap a lot of that. We were finding that people and have found a couple of differences with people who have opiate use disorders. One is that a lot more of those folks come to us voluntarily than people in the past. Normally, and the norm is for people to be coerced into treatment in some way, and that's okay. That works.

But with this population we found more coming voluntarily for treatment services, and we found that if we didn't get started right away with medication for people for whom it's appropriate -- and that's a lot of those folks. If we don't get started with medication almost immediately, we were losing them. And so we developed a Medication First model where you may see a physician and get started on medication within 24 hours or sooner. Now that's in contrast to in the past, you might have to go through weeks of assessment and various groups and things like that, and then again, you might be told, well, do you want to try this medication? And if somebody says no, well, that's fine.

We don't take that approach for people with severe mental illness. You probably have, too. I've worked with people with schizophrenia. And if I'm working with someone with pretty severe schizophrenia who says, "I really don't want that medication," I may not be able to force them to take it, but by God, I'm not going to take no for an answer either, if this medication will save their life.

So we switched to a model where we do a very quick sort of an assessment and get the appointment with the doc, get them in to see the doc, get started on medication almost immediately, and it does these things, of course. That's what it's supposed to do. What this does is, as I see it, it simply cools down the brain so that people can focus on the things we want them to. They can focus on learning about addiction. They can focus on individual counseling, group therapy, and so on instead of just being eaten alive by this active addiction that

will -- that will in many cases pull them away from the treatment that could save their lives.

So we found this Medication First model to be very effective, and I'll have some numbers to show you next time around. But certainly, anecdotally, we're hearing great things. This, we're seeing people who are staying engaged in treatment longer and being successful.

We have -- we've trained a number -- in fact, I've got some outcome stuff I'll show you here in a second. We've trained quite a few providers to prescribe medications, Suboxone and naltrexone in particular. In Missouri, we have about 501 physicians who are waivered now to prescribe Suboxone and buprenorphine products. Do you know what the modal number of patients is? The modal number of patients for that 500 doctors is 1.

So most of the docs, so we're getting docs trained. We are seeing growing interest, but the modal number of patients that those doctors have is 1. Now, of course, there are some that have a lot more than that, and we're seeing the numbers growing. But that's been a frustration that we've had, that we have not picked up speed faster. There's a lot of reasons for that, as I'm sure you can imagine.

We have been working with the Missouri Primary Care Association, Missouri Hospital Association, as I said, the Pharmacy Association, we're really bringing in a lot of nontraditional partners in these efforts and establishing some good, long-lasting relationships.

We've encountered, as I said, some problems. One is physicians and other prescribers that are willing to pick up the speed with regard to treating people with opioid use disorders. We ran right into some rules that were problematic. One of those was in our Medicaid pharmacy program, there was a mandatory taper. So after 6 months, you had to start tapering down if someone was on Suboxone. It's a credit, I think, to my folks and our relationship with our State Medicaid agency that they changed that rule. So that rule no longer exists.

We also, as I said, we don't have enough prescribers. We have in Missouri something called assistant physicians. Ever hear of that? Is that a unique? Now it's not a physician assistant. It's an assistant physician. So in Missouri, we have a really bright representative who's a physician named Dr. Keith Frederick, who got legislation passed a couple years ago that gives certain privileges to assistant physicians.

Assistant physicians are people, they're doctors, people who have graduated from medical school but can't find a match, as they call it, in terms of residency. There's a lot more graduates of medical school than there are residency slots. So in many cases, these folks would go get a Ph.D. degree or a master's degree

in something while they're waiting for a residency slot.

Well ,this actually gives assistant physicians certain practicing abilities, one of which would be getting waivered and prescribing Suboxone, which would be an interesting way of expanding our workforce, particularly out in the rural areas where it's such a difficult -- where it's so difficult to get prescribers.

The other barrier that we run across is something called the Ryan Haight Act. Do you remember that, the Ryan Haight Act? The Ryan Haight Act was a very well-intentioned piece of legislation designed to rein in online pharmacies, but there is a provision in the Ryan Haight Act that says that physicians who prescribe controlled substances have to see the patient first, face to face. You've got to see the patient person to person, face to face first, then you can prescribe the medication.

Well, you know, if you're a physician doing telehealth, and you've got somebody up in Park, Missouri, which is the far northeast corner, you're not going to drive up there. There may not even be a physician anywhere in that county. And so it's really posing a barrier to telehealth prescribing of medication-assisted treatment.

So our own Senator McCaskill and a couple of other Senators have written a letter to the DEA that simply requires the DEA to -- can craft some sort of a registry. You get on the registry, then you can do it that way. And we're also pushing for a change in the law that would remove that provision that may have been useful before but really is harmful now, we think.

In terms of recovery services, we've got four recovery community centers. We're really stepping up with regard to our recovery housing, and we are requiring the NARR certification as part of doing business with the State. Training a lot of peers. We have just a general workforce shortage in Missouri, and we see better and smarter use of peers as one of the key solutions to that problem.

These are just some of the things that we have that we offer to our providers or clinicians. We have a website that you can go to. We have a listserv that's particularly interesting. In fact, the last few months, we've had physicians engaging with other physicians on our listserv and talking about individual cases -- no names and all that -- but those individual cases talking about practice, how they set up their practices, things like that. It's really -- it's been more helpful than I had ever imagined. We've got two ECHO sites, as I said, telehealth equipment, statewide office hours, trainings, and so on.

On this website, on this Missouri Opioid STR website, there is a health literate patient brochure. It's under "Resources," and we talked earlier about I think resources for families. It's -- I think it's fairly easy to read, fairly easy and straightforward to read. I think that's something that you could print out and

trifold and hand to somebody who was struggling and wanted to know about medication-assisted treatment.

Elsewhere on the website, we also have a more elaborate implementation guide for the medical treatment of opioid use disorders. That has been very popular.

We've developed some unusual partners for this, and this is the part that probably to me, aside from saving lives, this has been the most fun is establishing relationships, again with people who we haven't historically worked with.

Okay. That concludes my presentation. Thank you.

MS. A. KATHRYN POWER: Thank you very much, Mark.

[Applause.]

MR. MARK STRINGER: There is over here, the committee members have these, and they're over here, too. They are just a one-page thing of handouts similar to what Allison had in terms of being process things. We won't have the outcome things for a while.

So thank you.

Agenda Item: Council Discussion

MS. A. KATHRYN POWER: Thank you very much, Mark.

Okay. So Allison and Mark are going to join us at the table, and we have an opportunity to interact with them in terms of the description about their STR grants, but certainly they are both single State authorities in their States, and so they cover a huge variety of resources relative to substance use disorder, opioids, mental illnesses, et cetera. And so, you know, whatever your questions may be in terms of STR, you know, keep in mind that they control a whole host of resources relative to how the STR complements the block grant, complements other kinds of resources and State resources, frankly, which I think is an important message.

It's interesting that both Missouri and Massachusetts have just about the same amount of money, which I was intrigued by. And I didn't realize that you had -- I don't know what your population base is. But the formula that Congress used was to take a look at the variety of, you know, population criteria, other opioid factors in terms of how they created that distinction. So my first question is, what is your population base, Allison?

MS. ALLISON F. BAUER: We just -- it's about the same.

MS. A. KATHRYN POWER: That's what I thought.

MS. ALLISON F. BAUER: We're both in the vicinity of 6 million.

MS. A. KATHRYN POWER: Okay. All right.

MS. ALLISON F. BAUER: Okay? Just north of 6 million.

MS. A. KATHRYN POWER: Okay. Yeah, so that's helpful.

MS. ALLISON F. BAUER: We're just more compacted.

MS. A. KATHRYN POWER: I get that, but I think that's interesting. Because, again, you were two States that really had high levels of engagement in the opioid epidemic, and your populations are similar and your money is similar. So from the STR grant perspective.

So I'm going to open it up to the council. Take advantage. You've got two really smart people here, and let's go to that.

MS. KRISTEN HARPER: Yeah, I have a question. First of all, thank you so much for your presentations. It was -- you guys are funny as well informative. So appreciate that.

MS. ALLISON F. BAUER: I know. He got the big laughs. I'm like I normally get the bigger laughs. So there you go. You put him in the room with me, set it up.

MS. KRISTEN HARPER: And to you, Allison, I want to say thank you for supporting the adolescent treatment programs, recovery high schools.

MS. ALLISON F. BAUER: We do have recovery high schools.

MS. KRISTEN HARPER: Massachusetts is --

MS. ALLISON F. BAUER: And interestingly, I want to note, because you bring them up, in this most recent budget, which is not passed yet in our State, the money and funding for recovery high schools is actually moving from us to the Department of Elementary and Secondary Education.

MS. KRISTEN HARPER: Really?

MS. ALLISON F. BAUER: It's moving into education.

MS. KRISTEN HARPER: Wow.

MS. ALLISON F. BAUER: Which some people might be nervous about. We think it's great. One, we have a safe and supportive schools working group that was also mandated by the legislation. I sit on that, along with my prevention team and my youth and young adult director, along with folks from education.

But the idea is that the schools will actually get more support for their students by being seen as schools, as opposed to --

MS. KRISTEN HARPER: It makes us more legitimate.

MS. ALLISON F. BAUER: Right. It makes you more legitimate. We can still be there and help at making sure programmatically things are in place. But now one of the biggest issues we have is transportation. If they're a school under DESE, our acronym, they need to be able to transport. So I just wanted to highlight that because you mentioned recovery high schools.

MS. KRISTEN HARPER: Thank you for telling us.

MS. ALLISON F. BAUER: This just is happening, literally as we speak.

MS. KRISTEN HARPER: That's very exciting. We want to share that with the rest of the schools for sure.

My question to you both is coming from the recovery high school world, collegiate recovery, recovery community organizations, having experience working in all of those systems, there seems to be a real stronghold in the recovery community organization as far as advocacy efforts go with single State agencies. What's lacking is the communication between collegiate recovery, which now we have over 210, I think, now across the country.

You have a Missouri coalition of collegiate recovery communities. Boston, that whole entire area is kind of --

MS. ALLISON F. BAUER: We're replete with colleges.

MS. KRISTEN HARPER: Yes, yes. So what do you guys want to hear from representatives as far as getting your attention, what kind of information would be helpful, informing you, you know, what kind of students you have, how much is the cost, you know, where do they live? But those types of things, is that interesting as single State agencies? Do you want to hear those kind of things? What would be attention-getting, I guess, so I could tell my folks?

MR. MARK STRINGER: Well, I mean, all of that would be interesting to me. I told you earlier I know almost nothing about our group. I've never been approached by them. I'd love to just have some facetime with them --

MS. KRISTEN HARPER: Sure.

MR. MARK STRINGER: -- to find out what they're doing, what they look like, and what their needs are.

MS. ALLISON F. BAUER: I would echo that exactly. You know, what do we need to hear? Anything about it because I don't think that, again, given the breadth of population, like I think we have, you know, 6 million, and then we have like another million of students in Massachusetts pretty much. I mean, it's unbelievable. I don't know that I've ever even heard the term "collegiate recovery" until today.

MS. KRISTEN HARPER: Wow.

MS. ALLISON F. BAUER: Believe it or not. And obviously, very deeply embedded in we have A-CRA, we have youth-based programs, we have recovery high school. I mean, I have a youth and young adult unit within my department. Collegiate recovery as a term has never even come up for me.

MS. KRISTEN HARPER: We're edgy now.

MS. ALLISON F. BAUER: So, yeah, so really hearing anything would be good.

MS. A. KATHRYN POWER: And another key way, to connect to your regional administrators. So Jeff Coady, me, Rebecca --

MS. ALLISON F. BAUER: Yeah, and I would say articulating what they mean because they start to help someone without -- you know, that's their -- I flip back-and-forth between my two degrees. That's where the social work comes out, like start where your client is. I wouldn't even know where they were in terms of needs. So that would be an important piece.

MS. KRISTEN HARPER: Great. Thank you.

MR. MARK STRINGER: Our recovery support providers, not this group, but our recovery support providers have -- under the Access to Recovery grant have pulled together and been trying for years, years to get -- we've had an ATR grant since 2004. They tried for years to get State funding. This year, finally, the Governor put something like $3 million in his budget for recovery support services, which was a real victory for them.

But they've been working with us. We've been coaching them. So I'd love to have a similar relationship with that group.

MS. A. KATHRYN POWER: Jason?

MR. JASON HOWELL: First of all, thank you so much. Both of you all's States are doing a lot around recovery support services, peer recovery coaches, and recovery housing.

Mark, I've got to be honest. My blood started boiling, as a person in long-term recovery, when you described the, what did you call it, Medication First and then framed it as mandated treatment. That's a patient right issue. You said that you wouldn't take no for an answer. I took great offense because it's really about empowering people's choices.

And I understand that you and physicians and maybe even SAMHSA have an opinion about what the individual's care should be, but ultimately, it should be the individual's choice. And I hope that SAMHSA doesn't ever take a position around that, and I hope that you understand that's why the recovery community is -- one of the reasons why the recovery community is so sensitive around the medication-assisted treatment campaign and educating. Because in some cases, it's being framed as kind of mandated treatment.

And so I just hope that we -- that we all understand that and be sensitive to it.

MR. MARK STRINGER: Yeah, I appreciate that. And that was clumsy of me. When I said "take no for an answer," it means as a clinician, that it doesn't mean that I could mandate it. But it does mean if in the core of my being, if I have somebody sitting in front of me who has 13 drunk driving arrests, has never been on naltrexone or Vivitrol, I think I owe it to that person to do what I can through motivational interviewing -- you know, whatever appropriate techniques there are -- to get them to do it. I really believe that.

Now that's not mandating, but it's not giving up either. So does that make sense? I mean, does that make it any more palatable? I realize at the end of the day, it's choice. Unless some -- well, it is choice, unless you're committed to a State hospital or something.

MS. ALLISON F. BAUER: So I would -- I was going to say I'll let you answer, and then I'll talk. Go ahead. I don't know if you want to --

MR. JASON HOWELL: Yeah, you asked if it was more palatable? I think, you know, motivational interviewing is a way that you can -- doing MI is really empowering people, having them, you know, look at ambivalence and maybe moving in a particular direction. Bad MI is manipulating them into somebody, a person of power's agenda. And I think that's where we have to be very sensitive around because, ultimately, it's about empowering their decision.

MR. MARK STRINGER: I agree. I agree.

MS. A. KATHRYN POWER: I can just add, Jason, that having been at SAMHSA

for a number of years, I think there is no way that we would ever take a different position, other than saying consumer choice is, first and foremost, the value that we believe in. And that means, no matter what your health condition is, you have the right to make choices about the way in which you want to access care, the kind of care you want to access. But we're trying to influence the clinician community to participate more fully in understanding how to offer MAT as one of the continuum of care that is available.

And to me, that's where the struggle is. That we're having trouble convincing enough professionals and clinicians to engage with individuals with these behavioral health conditions. Having worked on advocacy and client rights for a lot of my career, there is no way that we would not promote client choice and consumer choice in all of our services. So just from SAMHSA's perspective.

Allison?

MS. ALLISON F. BAUER: Yeah. No, I just wanted to note a couple of things. So you talked about the peer recovery model, and I think that, again, we have legislation the Governor has proposed and that there is a commission that's being headed up by our Secretary that's going to be looking at more standardized credentialing for that peer recovery population in terms of the staffing of coaches so that we could aim towards more reimbursement for this population by showing some standardized training.

So I wanted to lift that up because I do think it's a pretty unique model. I think there's a national, some international body that does credentialing, but this is actually literally something that will be set at the State level so that we could aim towards that.

On the medication thing, I would say we have within the State, it's mandated that you offer the opportunity and that you cannot keep somebody from admission to a program for any medication whatsoever. I recently sent out reminders in the fall with a posting for the complaint line so that our clients could call and complain if, for some reason, they were kept from a program. And that's because of any medication.

Unlike, you know, Mark, I don't oversee mental health. I think Kathryn explained we have sort of a unique split in the State. There is a commissioner of mental health. There is a commissioner of public health. And I work with it as the bureau director for the substance addiction within the public health. So we have to work across, and I'm at a different level than the commissioner of mental health. So it can be a little confusing.

But we are very clear to make sure that we talk a lot about co-occurring disorders, and we speak about that pretty extensively because over 75 percent of our population is dually diagnosed. So we, obviously, have to deal with it. But

any medication. So whether it's psychotropic medication, you can't be denied getting into a program or not being taken. So that's the piece that, you know, when I'm like drawing that bright-line distinction, that's the bright line that we think about in our State.

MS. A. KATHRYN POWER: Okay. Thank you both for that. Other questions, other comments? Eva?

MS. EVA PETOSKEY: I have a question, yeah. Okay. So, yes. So both of you have had ATR projects in your State. So talk a little more detail, in a little more detail about how the STR has worked with the ATR and how they're working together.

MS. ALLISON F. BAUER: So, for us, it's really I would say every STR project that we have done, with the exception of the houses of correction work, the reentry, was using the STR money to grow something that had either a small or nascent effort that we were trying to expand. ATR had been in place in the State, and I'm sorry that, oh, she left. But -- what?

MS. A. KATHRYN POWER: A long time.

MS. ALLISON F. BAUER: Yeah, but we've had ATR for quite some time, but this allowed us to have it be much more robust and to bring in some new partners. We have a big program called NECAP, which is an interesting model that we brought in. It's a training program, and it really focuses on training people, particularly in culinary. Well, culinary is a great space to work in if you have either queries or you have, you know, records. It allows you to be able to do work in a lot of places. And so we've been able to have this great partnership.

I think a lot, for me, ATR -- so as you heard from my bio, I spent a lot of time in philanthropy, almost 10 years, in the Boston Foundation. And the foundation had a big project called Street Safe, which was alternatives for gang members to gang violence. The language was very much like "a way out, a way up." Like part of the reason why people wound up in gangs -- and please understand I'm drawing a parallel not between people who have an illness and gang members, but programmatically similarities. That they often wound up that way because they didn't see another way.

And so having workforce training programs, having options for people showed them that there was a different way to go. And again, not making a comparison in terms of the population, but programmatically, I think about ATR as providing all of those opportunities for somebody who might otherwise be blunted from opportunity. So it is are they getting the transit pass that they needed to be able to transfer? Are they being able to get the training? Are they then getting connected to workforce?

Are they getting -- because, really, I think of it as that wraparound service to help people find their way in recovery and continue down the path and provide, as it's -- I spent a long time working around obesity prevention and social determinants of health. And it's not -- it's often not the thing. It's this unexpected thing that creates the barrier. You can tell people all you want about how to eat right, but if there isn't healthy food in their neighborhood, they're going to have a hard time eating right.

You can tell somebody to stay in recovery. You know, to stay in recovery, you really need to work. You really need to have it, but like unless you provide some resource. So what we're doing with our ATR is just we contract with Advocates for Human Potential and IHR, two contractors -- AHP, IHR -- and they have just been able to lift up the work and make it more robust in all of those support pieces. That's the -- I mean, I probably have a really good one-pager somewhere I can find, but that's the way we've done it.

MR. MARK STRINGER: Yeah, we have --

MS. A. KATHRYN POWER: Microphone, Mark.

MR. MARK STRINGER: In Missouri, we have -- we have too much variance in terms of our relationships between our recovery support providers and our treatment providers. There are some parts of the State where they work together just beautifully. Then there are other parts of the State where they don't look at each other, and STR has been an opportunity to bring those worlds a little closer together.

It has provided some extra funding for one of the best pieces of advice that I gave was to our -- we have a recovery support coalition. I said, listen, I know that you guys are dealing with more than opiates, but when you talk to the government, talk about opiates. That's what people are interested in these days. It doesn't preclude you from talking about other things, but talk about opiates. Well, that caused somebody's fear over there, and so because of that, again, they will, I hope, have this $3 million investment in recovery support services that will bring them even closer to our treatment system.

But I completely agree with Allison. I mean, we have -- some days, we have 2,500 people waiting to get in for traditional treatment services in Missouri. We've got to create as many paths to recovery as we can, you know? So our recovery support providers will either support people who are in treatment, coming through treatment, or some people simply find themselves there. That's okay. I think people often find the right place to go. Does that make sense?

MS. EVA PETOSKEY: Yeah.

MS. ALLISON F. BAUER: So I want to be able to give you more detail. I don't know if you want to ask your follow-up question, and then I can -- I found it. I could give you some more detail.

So within our ATR program, over two cycles of the ATR grant that we've had, which is predecessor to our STR, over 15,000 individuals in Boston/Springfield were served. Those were our initial sites. The participants had a 30 percent increase in employment or school enrollment, 13 percent increase in stable housing. They had a sustained low health, behavioral health, their social consequences related to substance abuse, lower rates of new arrests. So we've again had a drop there. And participants in one or more of the 20 employment training programs that we've had, increased enrollment in either -- in school after participation was 42 percent.

So, again, we're taking we took that success and translated with the STR to build out two new cities based on that, that work. So --

MS. EVA PETOSKEY: The only limitation I think that the STR has now with looking at those outcomes is the STR is not required to collect the same type of data that was required in ATR. So I don't know how that's --

MS. ALLISON F. BAUER: It's not required to. It doesn't mean that we are not collecting it.

MS. EVA PETOSKEY: Yeah, well, that's kind of what I wanted to --

MS. ALLISON F. BAUER: I think because we've got it, yeah. Because we've got the data in place already.

MS. EVA PETOSKEY: Right.

MS. ALLISON F. BAUER: And you know, as I was saying, these are simple things. This is like a medical copay or eyeglasses so that you can -- or dental care. I mean, it's really simple, and it's almost ironic that we don't -- that it would not be considered a viable part of work.

MS. EVA PETOSKEY: Well, I think what you both described is a good example of how the treatment can work with the whole recovery continuum and how it's so necessary. I worry about the States and jurisdictions that don't have something like an Access to Recovery. You know, is there something else available? Because a lot of us have brought this issue up. And so you can't just treat people in isolation with MAT.

So, anyway, I'm just putting that out there, just as a reminder. It's why I asked, part of why I asked the question. But because we've had a tribal Access to Recovery, and not a State Access to Recovery, and so the State often looks to

us to say, wow, how did you do that? Well, you know, so --

MS. A. KATHRYN POWER: Thanks, Eva. Other questions?

MS. KRISTEN HARPER: I'll just follow this --

MS. A. KATHRYN POWER: Oh, sure.

MS. KRISTEN HARPER: -- just really quickly. Coming from North Carolina, where we had the Access to Recovery grant, to move to Georgia, where we don't have it, has been a stark comparison. What they were able to do in Georgia several years ago is change some of the Medicaid reimbursement around peer recovery support. So they were able to add code for reimbursement, and I think that was some way to try to compensate not having ATR.

MS. A. KATHRYN POWER: Jason?

MR. JASON HOWELL: Yeah, my question was going to be or maybe it's asking some advice. I come from the State of Texas. I think Texas got the largest STR amount of money. But I don't know if we have the capacity to quickly be able to, you know, get out contracts and really stand a lot of programs up. And I think that a lot of States have had the same difficulty. It sounds like that you all were able to figure out ways to kind of get programs out and stand things up in a timely manner, and I would love to take any jewels of wisdom back to Texas.

MR. MARK STRINGER: You know, we -- there have been -- in the first ATR, 2004, there was a tremendous amount of pressure from SAMHSA and others to get these things up and running, tremendous amount of pressure. We were fortunate at the time to have a large faith-based organization in St. Louis that had already gathered a lot of faith-based organizations together, and many of them were doing the kind of work that we were looking for.

So we were lucky, Jason, as we had that group, and they could branch out. In fact, they did branch out across the State. So for me, it was just dumb luck, frankly. And then once they -- and they helped with training. They helped with regional presentations, all that kind of stuff. But it was finding that existing sort of a core group around which the others can coalesce, that was our best way to do it.

MS. ALLISON F. BAUER: And I think I mentioned this in my presentation, but I went back. I actually have some draft language from our -- the language from our continuation application, and we had to in the continuation application talk about what were the challenges that you faced. And our first barrier to accomplishment that we listed was the timeline for startup. And it said, you know, that was by far our biggest challenge. But the way that we tried to address that was to work with hiring, as I said, these outside staff.

So we literally brought on a program manager, a prevention coordinator, a treatment and recovery coordinator, and an STR-specific epidemiologist so that we could not have to wait for the State hiring process, which would have literally made us incapable of doing anything. We also looked to expand on where you had it wasn't standing up new programs. It was finding the kernel of a program that was functioning and then blowing that out versus starting from something new. And I think that that made a difference. And once it got running, then you could look to do expanded sites or other locations.

And then we are, like, for example, we're slowly getting our IRBs approved for some of the data. But you know, data collection challenge and coordination and collaboration across sectors again, and then but we listed how we dealt with them. But I think in terms of the quick response, starting from a place that you have something and bringing in, if you can, with the money additional outside staff that can start right away. For us, we know we certainly have a fair number of external contracted vendors that we work with who can help us get things running right away.

MS. A. KATHRYN POWER: Well, and I think the other thing that I would mention is that, at least in Region 1 -- and I'm not sure about Mark's region -- every single Governor has an opioid working task force, and that was in play long before STR ever showed up. So that really gave the framework for a consolidated like everybody in the cabinet, Mark, talking to each other.

Or the Governor saying, oh, no, no, no. I want you all, guys, opioids, opioids, opioids. And then that helps propel the kind of change that you want. Because the Governor's opioid task force had, you know, 67 recommendations. Guess what? STR could slide right into some of those recommendations.

MS. ALLISON F. BAUER: That's true, and I would note, I think Mark did this. But we also have a MAT-PDOA grant, but from CDC. We also, as I think you heard earlier today from one of your staff, we're one of the three States with the PPW pilot for the wraparound services. So you know, getting this money, we had so many needs identified and we had so much mapped out that we didn't necessarily have resources for, that it was about taking resources and sliding it right in, as Kathryn said, to things that, you know, one, it fit with pieces we already had in place. The PPW pilot came after. But we already had a lot of things working. So that also helped.

MR. MARK STRINGER: Then the last thing we did, too, to take some of those, we had -- we found that we had to simplify everything that we could just simply because a lot of the providers that we're dealing with didn't have the resources to do these big thick State contracts and things like that. So we somehow managed to get permission to really streamline things so that they wouldn't be overburdened with the paperwork involved.

MS. A. KATHRYN POWER: Other questions for our guests? Dr. Martin?

DR. JUDITH A. MARTIN: Yeah. I was really interested, Allison, in your description of using the grant money to -- for people in corrections, and that sort of interface. So do you put your staff as field service in corrections, or do you pay jail health to take care of them, or how do you do that?

MS. ALLISON F. BAUER: So, so the way that substance services are delivered in Massachusetts, we are a procurer of services. So we don't put our staff -- which actually distinguishes it. The Department of Mental Health has front-line staff that actually provide services. None of our staff are service providers in that sense. We are procurers of services. We do training. We contract. We are contract managers.

But the money goes to the -- there are contracted service providers. I think with our MAT-RI, the Medication-Assisted Treatment in Re-entry is the Spectrum Health Services and the Gavin Foundation are two community-based providers that then partner with the houses of corrections. Because unlike -- so you're talking about correctional health. So correctional health typically is in the prisons, in the DOCs. But in the HOCs, the house of corrections, the jails, they don't typically have extensive health staff, but we utilize community providers who then partner with the houses to provide the service.

DR. JUDITH A. MARTIN: So they actually go into the houses?

MS. ALLISON F. BAUER: They do. That was kind of the whole point for this was to try to create the connection. For those people may or may not know, I know HIV came up earlier for some folks. But now retired, but Michael Ashe was the longtime sheriff of Hampden County, which is a county out in the west, was one of the preeminent pioneers in creating connections between health and corrections around the HIV service.

And I know it sounds so funny I would know this, but when I was doing my graduate work in D.C., we brought -- interestingly, put on a conference on health in corrections and brought Michael Ashe from Hampden to speak in D.C., to talk to the D.C. area about how -- how to make these connections. I focused on HIV/AIDS in my graduate degree, and it was, you know, because you wound up with drug-resistant strains of HIV TB and people were getting treatment -- oddly, they would get treatment for HIV in prison and in jail, and then they get released, and they didn't have a good continuation of care. So he had created that in Massachusetts around HIV.

In some ways, this is sort of built off of his model that was started ages ago at this -- literally ages ago at this small house of corrections in western Mass to say, well, if we start the treatment before the release, then it creates a seamlessness.

And the seamlessness around, I mean, in HIV, it was drug-resistant strains. Here, the seamlessness is keeping people from overdosing the minute they walk out the door. So --

DR. JUDITH A. MARTIN: And then if they are in treatment in the community, are you able to continue the treatment when the person --

MS. ALLISON F. BAUER: So the idea, the idea is that because there are community providers, these providers are doing the connection that they wind up transitioning into I would call it the sort of patient-centered medical home. But in the continuation of care with those providers.

DR. JUDITH A. MARTIN: I meant like, say, somebody gets arrested who's already on buprenorphine.

MS. ALLISON F. BAUER: Oh. So if they get arrested, and they wind up going back into the -- if they get rearrested?

DR. JUDITH A. MARTIN: Yes.

MS. ALLISON F. BAUER: That's a -- I would have to get back to you on how that's handled. That's next stage, but yeah. I mean, I imagine they're continuing to get -- most of the most of the jails are much more comfortable with Vivitrol than naltrexone because of the shot and the --

DR. JUDITH A. MARTIN: Because of the pharma?

MS. ALLISON F. BAUER: The pharma. Because of the fact that it's also -- I mean, I think diversion is raised a lot. Diversion and concern is a big issue. I know --

DR. JUDITH A. MARTIN: Yes. And if you're in prison, I mean, aspirin is diverted. Everything --

MS. ALLISON F. BAUER: Everything is diverted. And so there's the idea -- that's why a couple of our shops, while they're interested in buprenorphine, they're only interested once the injectable is available. But of course, you have to start with the noninjectable. We're trying to work through that with them because there is just a lot of diversion concerns. But anyway, that's the way we do it.

DR. JUDITH A. MARTIN: We do have jail starts in San Francisco and also continuation of buprenorphine or methadone, but not in the prisons.

MS. ALLISON F. BAUER: So, again, for us, it's the jails that we're working with versus the prisons. So I make the distinction in Massachusetts that HOC, the

houses of corrections, which are the community-based jails, versus the DOC, which is our State prison system. We did not break into the State prison system.

But good news is the data drove us more to the need being greater in terms of overdoses coming out of the houses of correction. So while it's easier for us to partner there, it also was matched up from a data perspective on where we should be in terms of the greatest need.

MS. A. KATHRYN POWER: Okay. Mark, I'm a little concerned. I know that you had a travel arrangement set up at 3:45 p.m. Are you all set?

MR. MARK STRINGER: I'm all set. In fact, I think I've got to go at 4:00 p.m.

MS. A. KATHRYN POWER: Oh, you're going to go at 4:00 p.m. Okay. So just -- so I just wanted to let people know that I know Kristen had to leave, I think, and so other questions for Allison or Mark?

[No response.]

MS. A. KATHRYN POWER: Well, I didn't mean to stifle everybody.

[Laughter.]

MS. A. KATHRYN POWER: Okay. Well, first of all, let's thank our terrific presenters, Allison and Mark.

[Applause.]

MS. A. KATHRYN POWER: I'm delighted. Allison and I were trying to get lunch for the last 4 months, and we meet in Rockville. I tell you, it's amazing.

MS. ALLISON F. BAUER: You keep canceling lunch on me, but you know, let's just meet here.

MS. A. KATHRYN POWER: It's just amazing. So thank you both for your excellent work.

MR. MARK STRINGER: Thank you.

MS. A. KATHRYN POWER: And we are so proud of what you do.

MR. MARK STRINGER: You're very gracious. Thank you.

MS. ALLISON F. BAUER: Thank you. You're terrific to work with, and Region 1 is not being ignored, in case anyone is concerned.

MS. A. KATHRYN POWER: I'll be back. I'll be back.

MR. MARK STRINGER: Okay. Thank you.

MS. A. KATHRYN POWER: Okay. Thank you both.

Agenda Item: Public Comment

MS. A. KATHRYN POWER: We have not received, I think, Tracy, no written submission from the public. So what that means is we don't have any written submission to consider, and I'm to ask if there are any members of the public -- wow. Are there any members of the public who would like to address the council? I don't think there are.

Agenda Item: RECAP: Putting It All Together

MS. A. KATHRYN POWER: So that's great. So I want to -- I'm evidently supposed to do some kind of recap, and I really don't think you need a recap. You've been here. You know what we did.

And I really just want to get a real quick round robin, sort of a one-sentence reaction from all of you on what worked, you know, what was expected today, what did you -- what would you like to see included the next time? Just some feedback about the meeting today because I think that will help us.

So I'm going to start with you, Arthur.

MR. ARTHUR SCHUT: I think my concern is that when I first joined, there was a lot of briefing material --

MS. A. KATHRYN POWER: Yep.

MR. ARTHUR SCHUT: -- but very little interest in having advice.

MS. A. KATHRYN POWER: Okay.

MR. ARTHUR SCHUT: And that has changed in the last couple of years.

MS. A. KATHRYN POWER: Okay.

MR. ARTHUR SCHUT: Where, in fact, there's an emphasis on getting input from us as regards, rather than it was -- I won't call it a dog and pony show, but it was basically this entire briefing all the time and really no opportunity to provide input.

MS. A. KATHRYN POWER: Got it, right.

MR. ARTHUR SCHUT: And there's been plenty of opportunity to provide input today, and I think that's our value.

MS. A. KATHRYN POWER: Absolutely.

MR. ARTHUR SCHUT: And most of us would not be here if we couldn't do that, if that makes sense?

MS. A. KATHRYN POWER: Well, and we thank you for --

MR. ARTHUR SCHUT: Well, I'm very pleased about that. It's great.

MS. A. KATHRYN POWER: Good. Thank you, Arthur. Dr. Martin, any comment?

DR. JUDITH A. MARTIN: I enjoyed myself.

MS. A. KATHRYN POWER: Good.

DR. JUDITH A. MARTIN: Yes. And I think that some of the support for medical treatment for opiate use disorder comes through, and I think that's going to save a lot of lives.

MS. A. KATHRYN POWER: Okay.

DR. JUDITH A. MARTIN: So I definitely support that. And so I'm trying to think if there is any suggestion about format. I really like the discussion about what SAMHSA sees in terms of finance and the numbers. That was really interesting.

MS. A. KATHRYN POWER: Good.

DR. JUDITH A. MARTIN: And not my expertise, but --

MS. A. KATHRYN POWER: Good. Well, we had heard that's what you wanted. So I think that's why Tracy planned it that way. You know, we had heard.

So, and it actually does open up another set of windows of opportunity about hearing back from people about the concerns about financing. And so, I mean, I would like to see it sort of as an ongoing piece of the work that we talk about because you're experiencing those issues with the insurance companies, you know, at the State level, at the provider level, et cetera. So I think that's a good theme for us to think about over the next cycle.

DR. JUDITH A. MARTIN: I think the discussion in the room shows that there is

kind of a need for more integration and, as Jason was saying, more choice for the patient to have wherever they are to be able to continue the relationship --

MS. A. KATHRYN POWER: Right.

DR. JUDITH A. MARTIN: -- with their own providers and still have every option, including medication or without medication.

MS. A. KATHRYN POWER: Got it. Okay. Okay, thank you. Sharon?

MS. SHARON LEGORE: First, I want to say since this was my first experience, I've sat on different councils and more been the token person. So I want to thank you especially and to all the colleagues here for being very welcoming and not making me like that whatsoever. I really felt that, you know, my voice could be heard and being engaged in the conversations. So for that experience, this has been great.

Hearing some of the things, because I've been getting online such negative things that are happening, like with NREPP --

MS. A. KATHRYN POWER: Right.

MS. SHARON LEGORE: Hearing what's really happening was extremely exciting for me.

MS. A. KATHRYN POWER: Good.

MS. SHARON LEGORE: And you know, for me, a suggestion might be to get that information out to people who are just thinking, oh, my gosh, evidence-based treatment is gone, and that's the end of it. Without saying, wait a minute, we want to look at the whole person.

MS. A. KATHRYN POWER: Right.

MS. SHARON LEGORE: And treat the whole person. So that, to me, would be just a suggestion.

MS. A. KATHRYN POWER: Great.

MS. SHARON LEGORE: To get out there to stop all this negative that's out there because we really need to work together to build. We need to move on because this is what we have and how do we build it and how do we tackle this crisis?

MS. A. KATHRYN POWER: And instilling hope in people. I mean, I think that's also the driver. We know there's problems. We know people have difficulty, but

we don't want you to take no for an answer. We want to stay with you and keep on moving forward and stay hopeful about this. So I think that's great.

MS. SHARON LEGORE: And just one of the things that I'd like to hear, too, the financing was extremely helpful as well.

MS. A. KATHRYN POWER: Good.

MS. SHARON LEGORE: But for me, research and how can we work with researchers as well of being families to be able to come up with ways to prove what we're doing works.

MS. A. KATHRYN POWER: Well, I think, actually, Elizabeth and I were talking a little bit about research at lunchtime, and probably when the Assistant Secretary said something about Chris Jones, we'll probably the next time do something around the research/scientific piece as well as a look back into how the policy lab is being formulated.

So I think that would be kind of a nice -- you know, financing is a part of that, and then you have sort of the research and science side. Because we're getting much more involved in having a conversation about research and scientific inquiry that, frankly, under the law we were not allowed to do for many years because services and research were split. And now we're becoming much more adept at talking about that. So we'll put that on the agenda and figure that out.

Thank you. Jason?

MR. JASON HOWELL: I wanted to say that the content and speakers were great. I sit on many advisory panels, and that's not always true. So that's greatly appreciated. I'm glad to hear from Art that the culture has changed, that our voices are valued because I tend to use my voice quite a bit. So I'm glad it's appreciated.

I value today very much. I did not value yesterday's training very much.

MS. A. KATHRYN POWER: Okay. Thank you. And Eva?

MS. EVA PETOSKEY: Oh --

MS. A. KATHRYN POWER: You want to turn on your mike?

MS. EVA PETOSKEY: Oh, yeah. I have a loud voice, but that helps. I have enjoyed today. I enjoyed a lot of the ideas. I thought it stimulating, interesting. I've learned some things. I also really appreciated the clarification on NREPP because a lot of people have -- I happened to be one of the people that was involved with a re-review, and I got this really abrupt letter saying -- well, I don't

know if it was really -- the tone of it wasn't abrupt. I was just left wondering what's going on. So I --

MS. A. KATHRYN POWER: You were not alone.

MS. EVA PETOSKEY: I appreciate that. And so I want to continue the dialogue, and some of the things that are kind of top priority for me is how to really take MAT into the community effectively. That's really a top priority. I want to see that work. I want to see it work on the continuum of care.

I also -- and I want to get down into the details, but I see so many challenges. I would love to have another conversation with you sometime about your practice because I just see so many challenges that happen, and I know there are solutions to them all.

MS. A. KATHRYN POWER: Sure.

MS. EVA PETOSKEY: And there are probably people have found them. So this was a good place for this. It's hopeful to see that we're moving forward in a good way. So --

MS. A. KATHRYN POWER: Okay. Thanks, Eva, very much.

I want to, first of all, ask Tracy if she has any final words for the group?

MS. TRACY GOSS: No.

MS. A. KATHRYN POWER: Well, let's first of all -- I'm sorry? Bertrand, I'm sorry. Would you like to --

MR. BERTRAND BROWN: Yes.

MS. A. KATHRYN POWER: Okay.

MR. BERTRAND BROWN: So this has been -- for me, it was very, very helpful to know there is a lot of work being done across the country. You know, I'm here in Georgia, and I don't hear much about what's going on and the different things. So I loved today. It was very informative and very eye-opening for me. And I really appreciate the experience.

MS. A. KATHRYN POWER: Okay, thank you, Bertrand, we appreciate it. I know it's hard work to stay on the phone all day. I do it a lot sitting in my Boston office, and it's hard. So we appreciate the stamina it took for you to stay with us all day today.

Tracy, anything else?

MS. TRACY GOSS: No.

MS. A. KATHRYN POWER: Okay. We want to thank Tracy, who is responsible for all of this. She puts together the entire package, everything in front of you. She makes sure we're all wired for this. So thank you, Tracy, very much. You did an excellent job.

[Applause.]

MS. A. KATHRYN POWER: I want to thank all of you. I hope you all have a safe trip home. Don't forget to reconnect with your regional administrator. And I want to reconnect with -- Kristen has asked me to do a little follow-up networking with her. I'm happy to do that with any of you.

So, you know, please, I'm only here for a short time, but I'm -- I am working here full time for the short time that I'm here. So that's part of what I want to do. I know that we're going to continue to value your insights and your experience and to share that with us. And when's the next meeting?

MS. TRACY GOSS: We have not been told yet.

Agenda Item: Adjourn Open Meeting

MS. A. KATHRYN POWER: You have not been told yet. Okay. I'm going to ask for a motion to adjourn the meeting.

[Motion.]

MS. A. KATHRYN POWER: So moved. Is there is a second?

[Second.]

MS. A. KATHRYN POWER: All right. We have moved and seconded. All those in favor?

[A chorus of ayes.]

MS. A. KATHRYN POWER: We are now adjourned. Thank you all very, very much.

[Whereupon, at 3:56 p.m., the meeting was adjourned.]