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Meeting of the CSAT National Advisory Council (NAC)

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Council Members Present:

Kimberly Johnson, Chair
Tracy Goss, DFO
Sade Ali
Trenette T. Clark Goings [on telephone]
Kristen Harper
Andre Johnson
Judith A. Martin
Lawrence Medina
John Paul Molloy
Indira Paharia
Arthur Schut
Lori Simon

Other Participants:
Brian Altman
Kana Enomoto
Laurie Krom
Jinhee Lee
Sarah Ndiangui
Dave Wanser
Wilson Washington

PROCEEDINGS

Agenda Item: Call Meeting to Order

OPERATOR: Welcome, and thank you for standing by. At this time, all participants are in a listen-only mode.

I'd now like to introduce your speakers for today's conference. Thank you. You may go ahead.

MS. TRACY GOSS: Good morning. The 76th meeting of the Center for Substance Abuse Treatment National Advisory Council is hereby called to order, Dr. Kimberly Johnson, Chair, presiding.

Agenda Item: Welcome, Opening Remarks

DR. KIMBERLY JOHNSON: Thanks, Tracy. Good morning, everyone, and welcome.

Do we have our new member here? Dr. Clark?

MS. TRACY GOSS: Nobody has called --

DR. KIMBERLY JOHNSON: Nobody is on? Well, I was going to welcome our newest member, but maybe I'll do that later.

I'd also like to recognize and thank all of our staff and guests who have agreed to participate in today's meeting, including Laurie Krom. Laurie, do you want to stand up and just wave at people? We're going to introduce you later, but --

[Laughter.]

DR. KIMBERLY JOHNSON: Who is the director of -- program director of The Collaborative for Excellence in Behavioral Health Research and Practice at the University of Missouri-Kansas -- this is really hard to say -- Kansas City's School of Nursing and Health Studies. How often do you have to say that?

[Laughter.]

DR. KIMBERLY JOHNSON: That's a hard one to spit out first thing in the morning. And Dr. Dave Wanser, co-director of JBS International Center for Sustainable Health and Care. And he's -- where is he? I saw him earlier. Oh, there you are.

I'd also like to thank Brian Altman, Director of the Division of Policy Innovation here. And from CSAT, Commander Jinhee Lee, Wilson Washington, and Sarah -- and I can never say Sarah's last name properly. Is she here yet? Do you know how to say her last name? I'm embarrassed that I can't say it. Ndiangui? Ndiangui?

MS. TRACY GOSS: Ndiangui.

DR. KIMBERLY JOHNSON: For contributing their expertise and knowledge to today's session. They'll be helping facilitate some conversations today.

And I want to acknowledge Dr. Elizabeth Lopez, who is upstairs dealing with a minor crisis and will be down here shortly. At our last meeting, I introduced her as CSAT's Acting Deputy Director. Oh, wow. That's true. I forgot. But today, I'm happy to introduce her as our permanent Deputy Director. I'm excited that Elizabeth has become a member of the CSAT team, and we're going to give her some time to say some words, but she will have to say those later, too.

Agenda Item: Consideration of the August 24, 2016, Minutes

DR. KIMBERLY JOHNSON: Our first item of business on this agenda is to vote on the August 24, 2016, minutes, which were forwarded to you electronically for your review and comment. They have been certified in accordance with the Federal Advisory Committee Act regulations and include your edits.

I will now entertain a motion to adopt the minutes.

MS. SADE ALI: So moved.

MR. ANDRE JOHNSON: Second.

DR. KIMBERLY JOHNSON: Are there any discussion of the minutes?

[No response.]

DR. KIMBERLY JOHNSON: Okay. May I get a vote to adopt the minutes as presented? All in favor?

[A chorus of ayes.]

DR. KIMBERLY JOHNSON: Are there any opposed?

[No response.]

DR. KIMBERLY JOHNSON: Any abstentions?

[No response.]

DR. KIMBERLY JOHNSON: Good morning. Okay, the minutes are adopted. Thank you.

Agenda Item: Member Introductions and Updates

DR. KIMBERLY JOHNSON: Why don't we just -- the script says I'd like to take a couple minutes to allow our new members to introduce themselves, but why don't we just go around and have everybody introduce themselves.

Sade, we'll start with you.

MS. SADE ALI: Okay. Good morning. [Speaking Native language.] My name is Sade Ali, and I am presently a government contractor with the ATR project with Altarum Institute. I'm also the executive director of First Nations, LLC, which is a Native-owned behavioral health program serving -- serving all of Turtle Island, United States and Canada. And I just have to say on next week, I believe, next week, I will celebrate 47 years in recovery --

DR. KIMBERLY JOHNSON: Congratulations.

MS. SADE ALI: -- and working in the field. So it's been a wonderful 47 years, and I hope to continue for a lot longer. Thank you.

MR. ANDRE JOHNSON: I fear I have to go behind you.

[Laughter.]

MR. ANDRE JOHNSON: Good morning, everyone. My name is Andre Johnson. I'm the president and chief executive officer of the Detroit Recovery Project, which is a peer-to-peer grant, peer-driven recovery community organization in the great City of Detroit. I'm also a person in long-term recovery. And what that means is I have not used no drugs and alcohol -- no slips, no dips, no weekend trips -- in, oh, wow, over 28 and 1/2 years.

DR. KIMBERLY JOHNSON: That's pretty impressive.

MS. KRISTEN HARPER: Hi. Good morning. My name is Kristen Harper. I am also a person in long-term recovery and have been since March 25th of 2001. And I am now the executive director for Recovery Communities in North Carolina. We're a recovery community organization that works with the Access to Recovery grant and also several other initiatives through block grant funding for the State of North Carolina.

And formerly I was with the Association of Recovery Schools, which was collegiate recovery and recovery high schools. So I'm grateful to be here to cover many facets of the recovery community.

Thank you.

DR. KIMBERLY JOHNSON: You can pass that one back.

[Laughter.]

MR. ARTHUR SCHUT: My name is Arthur Schut. I'm an independent consultant.

[Beeping.]

DR. KIMBERLY JOHNSON: Oh, we lost you there.

MR. ARTHUR SCHUT: I should have kept that one, huh?

DR. KIMBERLY JOHNSON: Go ahead.

MR. ARTHUR SCHUT: And prior to this, I had about 4 years as a clinical director and then an executive of several community-based drug and alcohol treatment organizations. And I have long-term interest in evidence-based practices and the implementation of those. I also taught in a master's program in addiction counseling for a little over 20 years at the University of Iowa, and I've been involved in ATTCs and what preceded them as well as a variety of other activities.

MR. JOHN PAUL MOLLOY: I'm Paul Molloy, and I'm involved with Oxford House and have been clean and sober for 42 years, a newcomer.

MS. SADE ALI: Keep coming.

[Laughter.]

DR. KIMBERLY JOHNSON: Over to you, yeah.

DR. LORI SIMON: I am Lori Simon. I have two passions. One is in psychiatry. I'm a psychiatrist in private practice in northern New Jersey and New York City. And in addition to doing that, I've worked in a bunch of different -- in psychiatric environments, including work with the homeless for 8 years, literally working in shelters in New York City. I'm very passionate about patient care and advocate for my patients a lot with insurance companies and all that stuff.

And the other passion is computer technology because prior to becoming a psychiatrist, I was in the computer field for about 18 years. And so I'm still involved through the American Psychiatric Association, and there's an organization called HL7, which is an international standards organization for computers in healthcare. So I'm active in that as well.

MR. LAWRENCE MEDINA: Good morning. Lawrence Medina from Taos, New Mexico. I am also in long-term recovery, over 25 years. I've been involved in recovery communities. Taos, New Mexico, is one of the first -- was the first RCO with Faces and Voices of Recovery in the State of New Mexico. So kind of spearheading a lot of in the rural and frontier areas where we're lost and falling through the cracks. So I get to do a lot of advocacy and be a little radical about, you know, people dying in rural and frontier areas. It's a big issue, and it seems to get worse.

But I'm an independent consultant with Zia Community Services. My last couple of projects I was sharing with methadone and suboxone clinics both in New Mexico and Colorado and also started a women's transitional living program that we integrated mental health and substance abuse treatment for women coming out of prison, pregnant women, and women with children. So a really fun project for that population.

It's good to be here. Thank you.

DR. JUDITH A. MARTIN: Good morning. My name is Judy Martin. I'm an addiction medicine specialist, and I worked for 28 years in methadone maintenance and buprenorphine treatment with -- mostly with heroin-using patients and their families.

Right now, I'm the substance use medical director for the City and County of San Francisco. So I'm involved in a lot of SAMHSA-funded things and also with administering the drug Medicaid part for our county because like the State block grants it to us. So I'm very interested in the system of care for substance use treatment and also in integrating medical care throughout all the paths to recovery.

DR. INDIRA PAHARIA: Indira Paharia, clinical psychologist, and I have a new role since the last time I was here. I'm the chief practice and performance officer for Hillside Family of Agencies. So that means I'm responsible for evidence-based practice, research, data analytics, and quality. And Hillside is a very large nonprofit human services organization that is -- has operations throughout New York State, Washington, D.C., and Maryland, and we serve about 13,000 children and families per year. And we're about 100 -- well, we're exactly 180 years old this year.

So the services include for child welfare, developmental disabilities, mental

health, substance abuse, and juvenile justice. So I'm very excited to be in this new role, and I'm also very excited to continue with SAMHSA in this role. So thank you.

DR. KIMBERLY JOHNSON: Yes, we should thank our members who are continuing on past the time they thought they were going to escape.

[Laughter.]

DR. KIMBERLY JOHNSON: We appreciate that. Operator, are any of the new members, any of the speakers, have they joined the line yet?

OPERATOR: At this time, I'm not showing anyone in the reader passcode. However, if you want to speak on today's call, please press *, then 0.

[Pause.]

DR. KIMBERLY JOHNSON: No? Okay. We'll move on. Thanks, everyone.

I'd like to direct your attention to the printed Director's report in your packet. It's quite long. The report includes all of the details. That's why it's long. Is that the operator? Hello?

MS. TRACY GOSS: Hello?

DR. TRENETTE T. CLARK GOINGS: [on telephone] Hi. I'm sorry. I was on the line a little before, but I was unable to talk because my line was muted. Can you hear me now?

DR. KIMBERLY JOHNSON: Yes, we can.

DR. TRENETTE T. CLARK GOINGS: I'm sorry. I just wanted to say I'm Trenette Clark Goings and that I'm on the line.

DR. KIMBERLY JOHNSON: So can you introduce yourself?

DR. TRENETTE T. CLARK GOINGS: Sure. I am, again, Trenette Clark Goings, an associate professor at the University of North Carolina at Chapel Hill in the School of Social Work. My research focuses on the epidemiology, etiology, prevention of substance use among adolescents and young adults.

I currently have a couple of studies funded by the NIH to examine substance use among adolescents who identify either as African American or biracial. I'm also very interested in binary interventions and evidence-based practice.

DR. KIMBERLY JOHNSON: Thank you so much, and thanks for joining us by

phone. It's sometimes hard to do that. So we really appreciate your willingness.

Is there anybody else we're expecting by phone?

MS. TRACY GOSS: Terrance Range.

DR. KIMBERLY JOHNSON: Right. Is Terrance on?

[No response.]

FEMALE SPEAKER: [on telephone] Hello?

DR. KIMBERLY JOHNSON: Hello.

FEMALE SPEAKER: Hi. This is [inaudible] calling.

DR. KIMBERLY JOHNSON: Oh, okay. Thanks. So we're only asking members of the advisory committee to speak.

[Background conversation.]

DR. KIMBERLY JOHNSON: Oh, okay. She's not hearing me. She's just listening. Oh, okay. Sorry.

Agenda Item: Director's Report

DR. KIMBERLY JOHNSON: So I'm getting the message. Welcome, and you should be in listen-only mode. So the current advisory committee members are the ones that are being introduced.

All right. So we're going to just keep plowing forward then. So the report that you have, that you received in your packet includes many details of the CSAT activities during the time period since our last report. I'm just going to cover a couple things now.

As you know, we're in the early days of a new administration. CSAT has been contributing to transition materials to ensure that the new leaders are aware not only of the great work that we all have done, but important areas to focus on the future.

Two pieces of legislation that passed during the previous -- actually, that passed in late in the previous administration have affected SAMHSA and CSAT in particular. The first is the Comprehensive Addiction Recovery Act, or CARA, as everyone calls it, was signed last July. As you may be aware, under CARA, nurse practitioners and physician assistants were given, among other things -- there were a lot of things CARA did. But one of the things that we had to

address pretty quickly was nurse practitioners and physician's assistants who were given the authority to apply for a waiver to prescribe buprenorphine for up to -- actually, it's not just up to 30 patients as part of the medication-assisted treatment program.

In October, the department hosted a public meeting to discuss what training should be required for new prescribers. So the law required 24 hours, and we had a meeting to talk about -- and it had a list of things that were required, but we had a meeting to talk about sort of how that would be organized, how we would make that work.

CSAT's Division of Pharmacological Therapies is working with SAMHSA's Provider Clinical Support System program to create a no-cost training for nurse practitioners and physician assistants. I also happen to know that I got a call from ASAM last week that their training is complete and ready to go. So there were a list of organizations that could provide that training in the statute, and so they're working on it.

Training -- so NPs and PAs will be able to start their required 24 hours of training. Actually, they could start some of it in November, and we hope to have them able to submit their applications this month. We've actually gotten some. Some people have sent in their 24 hours training already and said, okay, how do I apply? The application form was just approved by OMB last week. So we have the approval, and now it's just getting -- it's the process of getting it up on the Web site for people to use.

DPT staff worked really hard to put this effort into place in a very short period of time. As you know, one of my goals, one of SAMHSA's goals is to expand access to care, and giving prescribing authority to NPs and PAs is going to have a huge impact on that goal.

In December, we passed the -- "we," I'm not in Congress. Congress passed the 21st -- and the President signed the 21st Century Cures Act, which -- which had a lot of things in it, and a number of them affected SAMHSA. And Brian Altman will be joining us this afternoon to go over all the details of the Cures Act, but I wanted to just talk about one part of it that I think you're probably all interested in, which is the $1 billion to fund opioid grant program for the States, which we are managing. And it's kind of an interesting thing. The funding went to the department, not to SAMHSA. But the department is having us manage the funding.

MR. ANDRE JOHNSON: What department?

DR. KIMBERLY JOHNSON: Oh, HHS. The department we're in.

MR. ANDRE JOHNSON: Oh, okay.

DR. KIMBERLY JOHNSON: So we published the Funding Opportunity Announcement, the FOA, in December. I think it was less than a week after the bill was signed into law, and our staff, I just -- you know, that's not something that is normal practice. Normal process takes much longer than that. People worked really hard.

Is Crystal here? Did I see Crystal back there?

MS. TRACY GOSS: Yeah, she's here. She just ran upstairs.

DR. KIMBERLY JOHNSON: Of course, she left. But she -- Crystal and Linda worked really, really hard to get that out. I'm sure you had something to do with that, too, Tracy.

The applications are due in February. They're actually due the 17th. So coming right up. And if all goes as expected, we will be awarding the grants in April and expecting the States to start implementing in May.

This new grant program will provide needed funds to the States to enhance their activities to combat the opioid crisis and expand access to quality treatment and services. And as I said, I want to congratulate the CSAT team. They worked really, really hard, and they turned that thing around really quickly.

And quickly without lots of mistakes. Because sometimes you can do things quickly, and afterwards, you look at it and say "oops." But quickly, and they did a good job.

The other thing I want to update you on a little bit is the 42 CFR Part 2 because I'm sure people are interested in that as well. It has been a long process that started before I got here and took up a lot of my time and energy over the course of the past year. And you know, a lot of my time and energy means a lot more of other people's time and energy.

The Federal Register Notice was submitted on January 10th, and it was published on the -- I think it was the 17th. We also -- so what do I want to say about that? I guess what I want to say about that is it was supposed to be effective February 20 -- no, February 18th, I think. And because of the executive order, that is delayed to March 21st, I think, and we're publishing another Federal Register Notice to announce that it's going to be delayed until March 21st.

We also -- so how many people even looked at it and saw what we did? So it's actually quite different from what we proposed in the original Notice of Proposed Rulemaking. In addition to allowing for -- there are two things I think are major changes from the NPRM, and one is, is that we're allowing for a general consent in both the "to" and the "from" sections of the -- of the consent form, which really

basically allows for two-way communication throughout the healthcare system in an electronic health record if the patient chooses that.

And that we -- the other sort of big difference from the NPRM was that we allowed for more different types of databases to be linked to databases with Part 2 data for the purposes of research. There were other kind of minor tweaks. There were some things we didn't adopt, but those are the two kind of major differences from what we had proposed.

We also, at the same time, put out a Supplemental Notice of Proposed Rulemaking around the use of contractors to perform various functions within the healthcare system. That is different from the QSOA. So those of you that know the intricacies of this law. So that, that was a 30-day notice. So we're accepting comments for 30 days from publication, and that is in process.

So those are just a few highlights from the Director's report. There are many other programs and activities that we've been engaged in, as you know, and so do look at the -- people put a lot of work into the -- into that report, the written report. So do read it because it will -- you will know what we're doing once you've read that.

Agenda Item: SAMHSA/CSAT Budget Update

DR. KIMBERLY JOHNSON: So we're going to do a budget report, and Elizabeth isn't here yet. Should we just -- do you want me to do it? Does she have --

MS. TRACY GOSS: She didn't -- she was just going to talk about the budget. We could do that later.

DR. KIMBERLY JOHNSON: Do it later. Okay.

MS. TRACY GOSS: And then --

DR. KIMBERLY JOHNSON: So we'll just go to questions.

MS. TRACY GOSS: Right.

Agenda Item: Council Discussion

DR. KIMBERLY JOHNSON: So we'll do -- Elizabeth knows what she wants to say about the budget. So we'll wait until she gets here to do that.

So let's open the floor to any questions or comments that council members have pertaining to the Director's report or -- I guess we can't do the budget, but any thoughts, questions, comments? Judith?

DR. JUDITH A. MARTIN: So I really appreciate your leadership in moving the things along that you did, especially the prescribing for nurse practitioners because I think nurse practitioners in rural areas in particular will be able to help a lot of people who need it right now related to the opioid prescription drug epidemic.

I know that a decision was made that the first 8 hours could be the current courses, and then the second part, 16 hours I guess it is, after that should be from one specified organization. And I wondered whether any of the nursing professional societies are applying to become named organizations for doing the trainings?

DR. KIMBERLY JOHNSON: So there were a couple that were -- is this on? Yeah. There were a couple that were in the statute originally. And then I have -- we have gotten requests from at least one other, maybe two other organizations. And the way the statute is written, it gives the Secretary the authority to go ahead and name those, but we're in this transition process now.

DR. JUDITH A. MARTIN: Yes.

DR. KIMBERLY JOHNSON: And so, so it's on the agenda to have that conversation. But there is --

DR. JUDITH A. MARTIN: So it would have to be the HHS Secretary who agrees --

DR. KIMBERLY JOHNSON: The Secretary could --

DR. JUDITH A. MARTIN: Delegate to --

DR. KIMBERLY JOHNSON: Yes. Could -- but that has to happen because it's the Secretary in the statute. So, yes. So -- so we'll probably get there, but it's -- but we're in transition. So there are a lot of things that are just sort of on hold. Yeah.

DR. JUDITH A. MARTIN: And then on the rule, on the 42 CFR rule, I was wondering if any -- I know that the expanded ability to designate for whom the release consent is greatly expands the ability to do team care, integrated care, et cetera. However, the requirement to be able to give a list of people to whom it's been disclosed in the last 2 years could be a very difficult process for many integrated care organizations, and I wonder if any electronic record companies or if anybody can do that yet and what your speculation is about how long it's going to take before somebody can actually use that?

DR. KIMBERLY JOHNSON: Right. So that's a good question. I think -- and

there has been a lot of complaint about that, and that was, you know, a big debate for us is how do we, like given -- so this is Kim speaking personally. I mean, I think if people say anybody can access my data, you should know who did. So there are ways -- I mean, some -- and some systems do have the ability to do an audit, you know, whenever anyone accesses an electronic data system, right? So, you know, if you're accessing it, you're putting in your passcode or your user name or whatever it is, and so there's a way to do an audit for that.

Now translating that into something that is usable for a patient is another issue, right? So I think many systems can actually run an audit trail, but then the issue will be turning that into something that is actually usable for a patient. But you know, do you think that -- Lori, do you think that that's -- I mean, from a -- I don't think my -- and I'm not a programmer, but I don't think that that is technically a difficult thing to do.

DR. LORI SIMON: It just depends. It all depends on what they're capturing in the first place.

DR. KIMBERLY JOHNSON: Right.

DR. LORI SIMON: And down to what level of detail the vendors, you know, and the products are capturing, you know? So depending on that, once that data is there, yeah, it would not be difficult to come up with a user-friendly application. So the more important issue is what they're capturing in the first place.

DR. KIMBERLY JOHNSON: Right, right. Is it an individual? Is it organizational level? I mean, I think is it --

DR. JUDITH A. MARTIN: So --

DR. KIMBERLY JOHNSON: You know, I think that that's the --

DR. JUDITH A. MARTIN: -- I think our system now can tell us who touched the electronic record. It wouldn't be able to say who called you to discuss a case or, you know --

DR. KIMBERLY JOHNSON: Right. Right.

DR. LORI SIMON: Or what particular piece of data, you know?

DR. KIMBERLY JOHNSON: Right. Right. And I think the -- I think the thought was that so someone might not pull -- if it's in your record in a way that's not hidden. I mean, some records have the ability to hide that information, right? But if it's in a record in a way that's not hidden, I think our assumption, as in the people that were working on the rule, the assumption was then anyone that opens your record would have access to that data, and so it would just follow

that the simple thing to do would be to do the audit of who opened the record.

But you're right. That wouldn't necessarily capture anything that wasn't in the record. But I think the -- I mean, the way we were thinking about it when we wrote it was that the point of it was to capture who went into your record.

DR. JUDITH A. MARTIN: Good. Thanks.

DR. KIMBERLY JOHNSON: Other questions, comments, thoughts? There will be plenty of time to voice other thoughts, but about the Director's report in particular, either verbal or the one you read? No?

Is Elizabeth in here and hiding in the back? Not yet. Okay.

Is Jinhee here? I think we'll just -- Jinhee, do you want to come in? Here you are. Okay. So we'll jump to the Surgeon General's report.

Agenda Item: Surgeon General's Report

DR. KIMBERLY JOHNSON: As I'm -- this is my part, right? As I'm sure you know, the Surgeon General's report, how many of you have read it already? How many of you have downloaded it, and it's sitting in your pile?

[Laughter.]

DR. KIMBERLY JOHNSON: The Surgeon General's Report on Alcohol, Drugs, and Health was released in November. SAMHSA was a lead agency on developing the report, and CSAT staff played an integral role, particularly Jinhee. Oh, she's going to the other end.

Commander Jinhee Lee, senior public health adviser in CSAT's Division of Pharmacological Therapies -- I always say "pharmacological," and it's really "pharmacologic" therapies -- was one of the key participants. Jinhee is joining us today to give you a high-level look at the major areas of the report so that she entices you to read it.

[Laughter.]

CDR JINHEE LEE: I'll try my best. No guarantees. Don't hold me to that, please.

Sorry. I'm going to sit down just because I want to take a look -- I want to be able to see my slides. And if I'm over there, I won't be able to do so effectively, and I apologize to those who are -- who have my back, but hopefully, you are able to hear me.

Thank you for having me here. So I'm Jinhee Lee. I'm in the Center for Substance Abuse Treatment, and I've had the pleasure of being the managing editor for the Surgeon General's report. And I've been asked to provide a very high-level overview.

The report is over 400 pages, and there's no way to fit that into 15 minutes, and so just keep that in mind as I go through. It's very high level, okay? And as Kim had mentioned, you know, hopefully, it will entice you to look at the report if you haven't already done so.

So some of you might have been at the launch in October 2015 at the Unite to Face Addiction event in D.C., where the Surgeon General announced that he was going to do a report on addiction and that it would be ready one year out. I'm happy to announce that a few months ago, on November 17, 2016, he fulfilled this promise, and he released the first-ever Surgeon General's Report on Alcohol, Drugs, and Health in Los Angeles at a national summit in partnership with Facing Addiction, the same group that organized the Facing Addiction event in D.C. And that -- and he was joined by leadership from SAMHSA, from NIAAA, from NIDA, and other leading experts in the fields of prevention, treatment, and recovery.

At the same time, the report was also released to congressional staff and stakeholders, and we held a briefing the following week. And suffice to say, it was very well received.

As many of you know, this is a bipartisan issue and had the backing of everyone. But even still, we were all very nervous and walking on eggshells because we were asked to do this report in less than, well, I guess in about a year's timeframe. And for those of you who have worked on Surgeon General's reports before, you will know that these reports typically take at least 3 years. And so we had an accelerated timeline, and for those of us who were intimately involved in the report, we were all just kind of crossing our fingers and hoping that we would get green lights all the way through its clearance, and we did. And it launched, and we're all very happy and relieved.

And for those of you guys who have had a chance to read it, you know, I hope that you're pleased with the outcome of our hard work.

Just I wanted to share some metrics in terms of how it was received by the public. Within the first 4 days of the launch, we had 13,000 downloads of the full report. We had over 100,000 page views. All of our hard copy versions of the report were sold out within the first few hours of the launch, and I've been told that there are over 1,000 people on the wait list to receive the hard copy report.

For those of you who weren't able to snag a hard copy, it's also available online, and I'll give some more information towards the end of my presentation as to

where that can be found. And then secret amongst this group, we are working on printing out additional hard copy reports. And so I think that there's a way to go on the Web site and kind of get on that wait list. We're going to -- we're going to provide the reports for those people on the wait list first, and then for everybody else who requests it, hopefully, we'll be able to accommodate.

In terms of coverage, through December 2016, it showed that there were over 1,000 stories that reach an audience of almost 2 billion individuals. The report was also covered by all the major networks, you know, from CBS, NBC, ABC. The Surgeon General, suffice to say, was very busy on the day of the launch as well as in the weeks that went on, and you know, he's been doing a lot of interviews, and there's been a lot of articles on the report. And he's been filtering through requests from various stakeholder groups wanting him to speak about the report at their various conferences.

So I know I'm preaching to the choir here when they talk about the rationale for the report, but just wanted to hit on a couple of a bullets here. We know that drug and alcohol misuse and addiction are major public health challenges. The combined yearly economic impact of substance misuse is estimated around $442 billion, and we know that number is actually conservative because it comes from an article published in 2010.

The U.S. is also facing an unprecedented opioid crisis. We have nearly 20 million people in our country who had a substance use disorder involving prescription pain relievers in 2015. We had about 600,000 people who had a substance use disorder related to heroin.

Most Americans know someone with a substance use disorder or, you know, know someone who almost lost someone due to addiction, and you know, we also know from our data that substance use disorder treatment in the United States remains largely segregated from the rest of healthcare and serves only a fraction of those who need treatment. And in fact, our data shows that only 1 in 10 receives any type of treatment, and that means that 90 percent of people who need help are not getting it. And we know this is unacceptable, and we need to do more.

Our healthcare system has neglected to give the same level attention for substance use disorders as it has to other health conditions that affect similar numbers of people, and we need to -- which is why we need to change the conversation around substance use and substance use disorders, and which is why it's so significant that the Surgeon General has made this a priority and supported the development of this report.

And he's been a wonderful champion. If you had a chance to meet him or hear him speak, you know he's so articulate, so passionate and compassionate, and he's been a really great partner for this report and for everything else related to

the work that we do.

So the department had a very -- and the Surgeon General had a very specific vision in mind for this report in that they want it accessible to everyone. So if you've had a chance to read the report, you'll notice that the readability of the report, it deviates from previous Surgeon General's reports, and that was done on purpose. We didn't want it to be only geared towards a research or science community. We wanted it, the language to be more lay friendly so that everyone could read it.

The Surgeon General's report still reviews the best available science. It covers the entire spectrum from prevention, treatment, to recovery supports. So, you know, that has remained the same. It's just the language is a little bit different.

The report starts off with an introduction and overview of the report, which describes the extent of the substance use problem, the prevalence. It also describes the purpose, the focus, and the format of the report as well as some key terms and concepts and perspectives. And for the key terms, I mean, that was kind of important because I think that oftentimes a lot of things, like substance use, misuse, disorders are kind of described all over the place, and so we wanted -- there's actually a box in the introduction chapter that does a really good job of kind of explaining the terms that we use through the entire report.

So if you have a chance to look at that, I think it's a really good resource. The report then moves on to the neurobiology chapter, prevention, treatment, recovery, healthcare systems, and then finally lands on our final chapter, which is called the "Vision for the Future: A Public Health Approach" chapter, which takes, you know, the findings from the previous chapters and distills them into five top-line messages and then also provides a section for recommendations for various stakeholders as well.

So the neurobiology chapter reviews brain research on the neurobiological processes that turn casual substance use into a compulsive disorder. Over the last several decades, we've collected a substantial body of research on the effects of alcohol and drug use on the human brain. This research has shown that addiction is a chronic brain disease with a potential for recurrence and recovery.

The chapter reviews in detail the three main circuits in the brain involved in addiction and how substance use can hijack the normal function of these circuits. And this is all important to understanding why addiction is a health condition and not a result of a moral failing or a character flaw.

Now the prevention chapter describes a range of programs focused on preventing substance misuse, including universal prevention programs that target the whole community as well as programs that are tailored to high-risk

populations. It also describes population-level evidence-based policies that are effective for reducing underage drinking, drinking and driving, spread of infectious disease, and other consequences of alcohol and drug misuse.

There are over 60 prevention programs and policies that have been shown to prevent substance use problems. In regards to research, some of these are featured in the chapter, and the others are in table format in the appendices. These strategies can be implemented in schools and workplaces as well as communities.

Now many to most people who should get treatment for a substance use disorder don't end up doing so because they don't consider their use problematic or they don't know about the range and types of care that's available. And so the treatment chapter is really nice because it describes scientifically proven clinical activities that are used to screen, identify, and engage people who have a substance use disorder to treatment. It also describes a range of medications and behavioral treatments that can help people successfully address their substance use disorder.

Recovery. We know that recovery affects a huge number of people, but it's rarely discussed, and it's not always clear what it is depending on how you define it. But we know that it should be celebrated. This chapter describes what recovery is as well as the number of people in recovery. The chapter also reviews services and systems that provide recovery support and the many pathways that make recovery possible.

We know that while recovery-oriented services and systems have not been studied as much as prevention and treatment interventions, some research exists, and there is also an emerging social movement of recovery advocacy and services.

So the healthcare systems chapter, this is actually, I think, the longest chapter in the report. And you know, our poor section editor, Connie Weisner, had the joy of being the lead for this one because it kind of -- it takes in all the information from the previous chapter and then distills it down as to how it can impact prevention, treatment, and recovery.

But we know that the traditional separation of substance use disorder treatment and mental health services from mainstream healthcare has created obstacles to successful care coordination, making treatment of the whole person difficult and fragmented. This chapter explains why integrating general healthcare with specialty substance use disorder treatment can result in better outcomes.

The chapter also discusses recent legislation like the Affordable Care Act, the Mental Health Parity and Addiction Equity Act that requires healthcare plans to offer the same level of -- offer the same level of treatment as it does to other

health conditions.

Now then we move on to the final chapter, which is the "Vision for the Future" chapter, "A Public Health Approach." And again, you know, it takes the more than 50 key findings that we have in the previous chapters and distills them down to 5 general findings and top-line messages. The first one being that both substance misuse and substance use disorders harm the health and well-being of individuals and communities and that addressing them requires implementation of effective strategies.

So with this message, the Surgeon General is saying that substance misuse can have serious consequences like overdoses and suicides. We're also saying that substance use disorders are medical illnesses and that we need to expand access to evidence-based prevention and treatment services and recovery supports. The report describes advances made in prevention science. It notes that adolescence and young adulthood are major at-risk periods for substance use, misuse, and related harms. Although we also know that substance misuse and substance use disorders can occur across the entire lifespan.

Therefore, our second key message is that we need to implement and sustain evidence-based prevention programs and policies to reduce substance misuse and associated health and social problems.

The third key message is full integration of the continuum of services for substance use disorders with the rest of healthcare could significantly improve the quality, effectiveness, and safety of all healthcare. As I noted before, the separation of substance use disorder treatment from the rest of healthcare has contributed to a lack of understanding of substance use disorders as medical conditions and to individuals' lack of understanding that they may have a significant health problem.

It's also contributing to a slow adoption of scientifically supported medical treatments by providers. An implication of this finding for policy is that changes need to be made to incentivize treatment programs to offer the full continuum of care and coordinate with mainstream healthcare to integrate care. The workforce also needs to be cross-educated and trained, and professional education in medical schools, dental, nursing, pharmacy, et cetera, should require training on substance use and substance use disorders.

Now the Mental Health Parity and Addiction Equity Act and the ACA, the Affordable Care Act, have increased coverage for mental and substance use disorder treatment services for many Americans. Many more people are now able to access care. However, there still remains a great deal of uncertainty about the nature and the range of healthcare benefits that are available.

And so we need to increase the public understanding about individuals' right to

healthcare for treatment of substance use disorders. We also need to implement screening for substance misuse and substance use disorders within healthcare organizations.

And then, lastly, research over the last two decades has given us an understanding about the biological and psychological factors associated with substance misuse and disorders. We know more about substance use disorders than we knew about the effects of smoking when the Surgeon General's Report on Smoking and Health came out more than 50 years ago. However, additional research is needed, and future research needs to build upon this existing knowledge base.

And so this final chapter moves on to a section on the recommendation for stakeholders. In this section, the report calls on various stakeholder groups to help change the culture, attitude, and practices around substance use. This is not an exhaustive list. You know, unfortunately, we're kind of bound to a certain number of pages that we could make the report and so. But I think that the recommendations that we have for each of the stakeholder groups are general enough that they could be applied to everyone. And we know that, you know, it should be applied just because the problem impacts everyone, not just these people that are listed here.

This is not something that could be done alone, and so the Surgeon General and the department are asking that you continue to join us in changing the conversation around substance misuse and substance use disorders and taking a role in creating a society where communities are willing to invest in prevention services and where healthcare professionals treat substance use disorders with the same level of compassion as they would with any chronic disease. And then with everyone getting involved, the health and well-being of individuals and communities will be improved.

So in terms of next steps and what you can do, I wanted to conclude with these, and they align with the findings and recommendations of the Surgeon General's report. You could continue to work with community leaders and coalitions to expand the implementation of evidence-based treatment and recovery programs and policies. You can also use traditional and social media to inform the public, including parents and community leaders, about what we know about substance misuse and substance use disorders and effective programs and policies.

It's important to translate the science into messages appropriate for different audiences so that it's consumable. You can also provide training to healthcare professionals to expand their knowledge and skills and enable them to improve the availability and quality of prevention, treatment services, and recovery support in all health settings.

So, again, if you haven't already done so, we have this wonderful Web site,

www.addiction.surgeongeneral.gov. On there, you can find the full report, all the chapters broken out, in addition to, you know, the supplementary materials, the executive summary. And so it's quite nice.

The other thing that's very unique about this Web site is that it's responsive design. And what that means is that if you have a tablet or a smartphone, it's very easy to access the report using those means. And I've done that in meetings, too. Just wanted to look at a fact from the Surgeon General's report and being able to just use my phone and do it. So it's quite nice if you haven't already tried it.

Let's see here. We also have collateral materials, including a promotional video and flier and a toolkit that includes Web banners and images you can use for social media, sample articles and blog posts, and a short handout that provides highlights from the report.

And then there are also fact sheets for specific audiences as well as a general fact sheet that summarizes the main messages from the report. We also have in draft additional fact sheets targeted towards criminal justice, insurers/payers, as well as educator stakeholder groups. We also have topic-specific fact sheets that are in the works, specifically on medication-assisted treatment, addiction as a chronic brain disease, and then the last one is cost of substance use or misuse that will appear on the Web site in the coming months.

And I think with that, I think I've made the 15-minute mark. Thank you again for having me here and again stressing the fact that it's very high level and encourage you to access the report online until we have print copies available. And I think there's a little bit of time for questions, okay, if anyone has any.

Agenda Item: Council Discussion

MS. TRACY GOSS: So we'd like to open it up now for any questions that you have for Jinhee.

MS. SADE ALI: I have a comment. Can I use that microphone? Thank you.

First of all, thank you so much. I have two -- I have two things I want to say to you. Number one, please take back to your team that the attention to language, strength-based language is so -- I'm so thankful for that because I believe the way we talk about the work that we do and the people that we serve really changes the dynamic.

And I'm touched by the strength-based language I found here. I didn't see a label. I didn't see an addict or an alcoholic or labeling of people and families. And that's so appreciated.

The other thing is the honoring of people with lived experience. That's so important. And the fact that you state that in this report that recovery as a concept really needs to be explored a little bit more, and the fact that there are many roads to recovery and not just one, but there are many. I just have to say I really appreciate this.

Thank you so much.

CDR JINHEE LEE: Yeah. And you know, because even though this is the Surgeon General's report, SAMHSA had a very significant role in the report. And you know, I wanted to mention some of the colleagues that were part of the internal working group, including Tom Hill and Tom Coderre, who are very familiar with recovery. And you know, even though the scientific evidence in the recovery chapter isn't as strong as, let's say, the prevention or treatment chapter, we thought it was still very important to highlight the spectrum and just promote -- or to highlight the best available evidence.

So if you look at the introduction and how we lay out, how we're reviewing the science, there is a category of promising. So I think a lot of the evidence that we have in the recovery chapter falls in that category. But again, you know, we thought it was very important to include that, and that's why that's there. But thank you for those words.

MR. ANDRE JOHNSON: I certainly would echo my colleague as well. I thought the language was really great, and I also thought that the Surgeon General and the partnerships with CSAT and SAMHSA was absolutely amazing. I think this is probably one of the first times in our history of our country where a public health Surgeon General has really honed in on substance use disorders.

I remember after it aired on television and I just saw social media all over it. And folks were calling me. "Did you read the report?" And I remember thinking I was really, really grateful because these were individuals that are not necessarily in the field, and they began to say, gee, I didn't know that. You know, I learned this, that, and the other about the language.

So I'm hoping that in light of, you know, the new administration and everything that we can try to really sustain the synergy and the relationships that you all have created over the last couple years. I did have an opportunity to meet the Surgeon General here a couple years ago and one of the deputies, and I was just blown away, the knowledge, you know, that you all have had.

Because personally, I have felt that we don't talk about substance use disorder enough in the public health world. You know, I've attended many public health conferences and just feel like I'm on Gilligan's Island. All by myself.

[Laughter.]

MR. ANDRE JOHNSON: So I really, really think it would behoove us now to really maintain these partnerships and collaborations to really educate our country about some of the things we don't want to talk about. So, and I certainly applaud you, too, Director Johnson, just for lending yourself and making sure that as important as this is a national phenomenon and I think we got to talk amongst each other.

MS. KRISTEN HARPER: Yeah, to come after you two is like coming after some of our giants. So I just -- I also just want to second everything that was said and just share, as somebody living in long-term recovery, how validating this report was, to be able to come out of the shadows with evidence and with somebody at your level, at the Surgeon General's level saying, yep, it's a brain disease. That's what we've been saying.

So, and the impact that it's had on the community. I think the rollouts, there was so much passion and excitement. It wasn't just kind of a hidden report that scooted out, you know, at the end of the administration. And I just am very grateful that you gave us not even permission, but empowered us to really continue to keep stepping out into the light with this topic.

I do have a question related to the previous conversation that we were having about training medical professionals. I noticed that you suggest that we need to train our medical professionals differently, and we all have known that there's been some out-of-date curriculum out there. Is there any effort to kind of pinpoint what needs to be updated? Is there any sort of integrated coalition that you're aware about that has the medical professionals working with some of the folks that played a role in this particular report, maybe even with some lived experience?

I think that we all know that the medical community is lacking a little bit with some of the knowledge of how they treat patients, which is promoting some of the problem in the country. What do we do at this point about kind of, I don't know, rewriting curriculum? Or I don't know, it's a lofty goal, but what are you aware of?

CDR JINHEE LEE: So I know that, you know, like, for instance, for our CSAT portfolio, we have a number of training geared for the specific. I mean, we have PCSS, our PCSS program. So we have the PCSS-MAT as well as the PCSS-O.

You know, you mentioned partnerships. You know, throughout this whole painful, but rewarding process, we developed partnerships with our partners at CDC, the FDA -- oh, sorry -- FDA, NIDA, NIAAA. And I know that all of them have been looking at this report and trying to kind of incorporate them into their existing resources.

In terms of reaching out to various health professional like organizations and stakeholder groups, you know, that's above my pay grade, but I imagine that there have been some discussions with those stakeholder groups.

DR. KIMBERLY JOHNSON: Yeah. So, actually, ONDCP was working on something, and one of the things in my email box that I haven't read yet is a report of a meeting that they held a couple months ago around medical education. The other thing that is worth being aware of is the CDC with their pain guidelines is also doing a massive outreach in education around addressing pain. And so they are doing some overlap around pain and addiction as well.

So there are efforts going on. Some of them are in their infancy. Some of them, like PCSS-MAT and -O, have been going on for quite a while. And you know, that program has -- well, the MAT program has primarily focused on getting people waivered to prescribe buprenorphine. But there's a lot of other education opportunities that it's offering now that are to just basic addiction 101 for any kind of practitioner. And now, of course, we need to also think about not just physicians, but nurse practitioners, which we probably should have been thinking about anyway, but it's now a focus.

Lori?

CDR JINHEE LEE: Can I just add something to what Dr. Johnson had said? So we're also trying to expand and look at other healthcare professionals, not just physicians and prescribers, but pharmacists, you know, dentists, nurses, and such and, you know, trying to educate them on what MAT is or what substance use disorder is, what substance misuse is. So I know that there are concerted efforts to expand that audience group to others that we're exploring as well.

DR. LORI SIMON: Two comments. One, I was actually very glad to see that one of your bullets here was that a large body of research has clarified the biological, psychological, and social underpinnings of substance misuse because in my experience, the vast majority of people who are abusing anything are self-medicating or they're -- and that there's a comorbid mental illness, for example, depression, bipolar, or whatever, and -- and/or social service issues.

You know, if you're homeless, you know, if you don't treat -- get somebody housing, you know, it's going to be very difficult to deal with the addiction. So it has to be a multi-pronged attack, and I think that's like really important to make sure that that when there is treatment options, that that's included.

The second thing, it's very interesting what I'm starting to deal with -- and actually, increasingly -- and it's patients who take chronic medication for other things, like, for example, high blood pressure or high cholesterol. They're fine. You know, okay, got to take my Crestor or whatever, you know, I'm fine.

Anything that's mind related, okay, patients, because they're hearing the word "addiction," they're having -- I'm hearing increasing concerns about "Oh, my God. I can't take this." Even if it's an antidepressant, "I can't take this long term. I'm going to get addicted to it". So it's a very interesting outgrowth of, you know, the very important emphasis on this.

CDR JINHEE LEE: Yeah, what's nice is in the treatment chapter, because I think there are a lot of myths and misnomers about what treatment is and what it means to be in recovery. But I think the report does a really good job in showing that it's not a "one size fits all," and it's individualized. And so whether or not someone needs residential treatment, outpatient, you know, or all of the above or nothing at all, it's really based on the individual. But there's all this evidence that shows that all of those methods are effective.

MR. LAWRENCE MEDINA: Yes. Thank you for the presentation and the work. As others mentioned, you know, there's been a highlight on recovery and addiction, which is big. But with the big white elephant in the room about the new administration, so much work has been done, and I've seen this in States, Colorado being one, where certain administrations come and wipe out health and human services, and it's devastating when so much work and money was put into in seeing a reduction and seeing progress.

So what is, I mean -- and again, you know, with the administration who has power and control over that. But what could be done to maintain the continuity and the momentum that has been established in some great work, and is there concerns about major changes and going in a whole other direction?

DR. KIMBERLY JOHNSON: I'll do that one.

CDR JINHEE LEE: Okay, thank you.

[Laughter.]

CDR JINHEE LEE: Well, I was going to -- I was just going to say even when we were writing this report until the very end, we were thinking that because we didn't know who the new administration was going to be. We were like we're just going to go with the science. Just look at the science, and you know, this is all facts. So we're just going to put that down.

But to address your question, I'll it back over to Dr. Johnson.

[Laughter.]

DR. KIMBERLY JOHNSON: So we're only in the second week of the new administration. But we have had no indication that there is going to be less concern about this issue. I mean, actually, we have had the indication that

particularly with opioid use disorder, that there will be continued concern about the issue.

You also have to remember that it wasn't just the administration. Congress really put a big focus on. I mean, the Cures Act was not the administration's bill. CARA wasn't the administration's bill. Those were congressional bills. And so I don't think that -- I think that the concern, the problem is still there. The concern is still there, and we have been given a mandate by Congress as well as the administration, particularly with the Cures Act funding, that we need to fulfill.

And so, but it's the second week in the administration. So we're all still -- you know, they are figuring out, we're figuring out. We're all figuring out what the focus is.

MR. JOHN PAUL MOLLOY: Thank you for including Oxford House in the Surgeon General's report as an evidence-based program.

Two thoughts occurred to me. First of all, I'm probably the only one in the room who was around when the Surgeon General published the report on smoking, Surgeon General Terry. And it's interesting to note, I still smoke, of course. But apart from that, the rest of the country doesn't smoke as much. And the biggest reason the rest of the country doesn't smoke as much is that there's no advertising of cigarettes on television.

Now that I'm in the market for most medicines that are out there available, I sit and watch 60 Minutes or any other program, and I see that 80 percent of the revenue for the television networks comes from drug companies. I was disappointed that the Surgeon General's report didn't take head on the fact that we've created culture that says pills make us feel better. And as long as you have advertising on television and create that kind of culture, you're not going to get a great understanding.

Third point I want to make. Evidence-based is important. Evidence-based in this field is not very good. The reason it's not very good is it's very difficult to gather evidence when you deal with behavioral science. Beginning in 1987, we said here is a test tube, folks living in Oxford House. Plain, old human beings trying to change their behavior. Opened the door to all kinds of researchers.

Now some researchers have made a cottage industry out of studying us, like DePaul University. But those kinds of studies are needed. As I go from State to State, I'm ashamed of the fact that in our balkanized treatment industry, it is full of hustlers. We don't have Oxford Houses in Florida. I'm going to focus now on Florida. But Florida is one of the most difficult States because of so many hustlers.

If you read William White's book, Slaying the Dragon, the nice thing William

White has done is gathered evidence and history from over years and years and years. And if you -- it's about the same length as the Surgeon General's Report on Alcohol is. But as you go through it, you will find that folks have come up with all kinds of quick cures. And after a number of years, we're able to say some of them are quacks.

We have to face the fact that well over 50 percent of the folks engaged in treatment in this country are quacks. They don't have evidence as to what their outcome is. Their methodology is about the same as it was 40, 50, 60 years ago, and that is capture the person, remove them from the [inaudible] of sin by having intervention and detoxification. And everybody will detoxify from about every drug you can imagine in about a week and then release them again to be caught again, over and over and over.

Face up to the fact that the TEDS data, which is not mentioned much in the Surgeon General's report, suggested 15 percent of the people in treatment at any given time are on their fifth go-around in treatment. It is time this field face up to the fact that relapse does not have to and should not be part of the disease. It may happen. It shouldn't happen.

And until we get really hard on science and until we get really hard on public policy, might increase the tax on beer, although I notice Budweiser still sells -- now sells for less than Coca-Cola. But that last tax increase was in 1958. That will funnel a lot of money into the system.

Second, get the damn ads for every drug from constipation to whatever off the television. When you have mass propaganda convincing 200 or whatever the hell it is, 330 million people in the country that this is a way of life, it's kind of foolish to spend money on SAMHSA.

Now as probably the only Republican in the room, let me mention that this organization was formed by a Republican administration, as was HHS; as was EPA, if you want to throw a few more things in. And the reason Republicans form these organizations is they really want problems solved. And many Republicans -- we may have a crazy one in the White House right now, but many Republicans accept that decision-making is often burdened by lots of complications so that you end up never deciding anything.

However, the Surgeon General report, good step in the right direction. Should have had more pressure on evidence and the need for research. Should have faced up to the fact that with cigarette smoking, we cut it down by saying you can't advertise on television. And finally, the industry itself needs to be shaped up. No more hustlers.

DR. KIMBERLY JOHNSON: So I have two things to say to you that are not actually policy related. Well, they're policy related, but they're factual. So the

direct-to-consumer marketing of pharmaceuticals on TV started in 1988 or '89 -- I forget which year -- based on interpretation of an FDA regulation. So it was a change in interpretation or guidance, not even a change in regulation.

So that's where that happened, and that's how we landed here where we have so many ads now. So just that's a factual thing.

MR. JOHN PAUL MOLLOY: The lawyers couldn't advertise earlier either, but then an interpretation said, hey, let the lawyers hustle. Our profession itself said we'll advertise to sue everybody. Just call this number.

DR. KIMBERLY JOHNSON: The other thing that I think is -- is a good sign related to what you're talking about in terms of hustlers is so I was in Florida yesterday -- last night I came home -- at a conference where there were a lot of CEOs of treatment programs and recovery support programs as well. And the conversation there was all around measurement and outcomes. So not so much adopting specific evidence-based practices, but how are we going to know that we're doing a good job?

So I was encouraged because I think that that's -- that is important. I mean, so now I am going to make a policy statement is that I think we need to, as a field -- and "we" as CSAT need to, for our own selves as well, do a better job measuring our outcomes, whether it's treatment engagement or whether it's did you use or not? Did you get rehospitalized, come back into treatment? I think those are all things that we should be measuring at the program level and then bringing up to the national level and saying how are we doing as a nation with these issues.

So it was very encouraging to me that I'm not a voice in the wilderness talking about measurement. It's something that all of those CEOs were talking about and wanting clarity on what are the measures that we should be held accountable for so we can all start doing it?

MR. JOHN PAUL MOLLOY: Yeah. And you know one thing about, I guess we don't want to go so far as to have a chip in the ear to track people. However, well over 20 percent of the folks who get into treatment now get into treatment through the criminal justice system. And in the criminal justice system, you really can track if you want to.

But we need to face those hard terms and say how important is it that we come up with best practices in a short period of time, or do we kind of wait another 50 or 60 years to figure out -- you have a Bill Wilson and Dr. Bob who sit around and say, well, if you're going to leave the guy home, you better make sure the gas oven isn't able for him to take his life.

DR. KIMBERLY JOHNSON: So I don't think we need to wait 50 years. So Jinhee has to go on because she's doing this for everybody today. But Art has

been raising his hand, I hear, the whole time. So we're going to take one more question or comment from Art, and then I'm going to let her go.

MR. ARTHUR SCHUT: I just have one comment about incentivizing education, and it's both medical and nursing, et cetera. I think we really need to think through how to do this. We talk about incentivizing providers, but we really ought to incentivize medical schools and nursing schools and PA programs [inaudible], and there are several ways to do it. You know, one of those is to change board exams and add items to those routinely. Another would be to say to institutions of learning that you don't get any R01 grants unless you have curricula embedded in all your programs that relate to addiction and substance use disorder.

There needs -- the adoption of evidence-based practice is a very difficult thing, and having had a couple experiences in my life of trying to infuse curricula into programs, the medical education programs, is an extremely difficult thing to do. And I think that there need to be incentives that are loud and clear that say this is an extremely important thing to do. And if you don't do it, there are financial consequences for not doing it, and you need to do it to be able to practice.

It needs to be explicit and clear and --

DR. KIMBERLY JOHNSON: So you need to say that tomorrow when the research centers are here.

MR. ARTHUR SCHUT: I will do that as well.

DR. KIMBERLY JOHNSON: So, Jin, I'm sorry that Jinhee has to leave. Great discussion, but we can't let CSAP miss their opportunity to have this presentation, too.

CDR JINHEE LEE: Thank you for having me here.

DR. KIMBERLY JOHNSON: Thanks, Jinhee.

[Applause.]

DR. KIMBERLY JOHNSON: A break? How about a break?

[Recessed at 10:25 a.m.]
[Reconvened at 10:37 a.m.]

Agenda Item: TOPIC: Translating Science to Service

DR. KIMBERLY JOHNSON: I'm just going to start talking, and eventually, everyone will sit down. So we have a couple presentations today, and our theme

over the course of our NAC and the Joint NAC tomorrow is really the research to practice, practice to research cycle and trying to figure out this issue of how we -- how we provide good care based on what the research tells us.

So I'm really excited to have Laurie here. She's going to talk about how to effectively translate scientific advancements into practical service approaches. That's what my things say anyway, hopefully. I saw your slides. I know what you're talking about.

Later this month, some -- actually, a couple of people I think are going to be back for this other meeting later this month. CSAT and NIDA are hosting a meeting together, input from the scientific community and the practice community about how to -- it's a whole day meeting about this very topic, about how do we move forward with the science to service effort.

So, today, I have Laurie Krom, and I'm going to say your title again.

MS. LAURIE KROM: Just say --

DR. KIMBERLY JOHNSON: Just say the ATTC, Addiction Technology Transfer. She's the -- she is the -- is it still co-director of the -- she's the director of the Network Coordinating Office. See, I still want to say National Coordinating Office after all these years. Network Coordinating Office of the ATTC.

And Sarah, I'm sort of embarrassed. I mangled your last name earlier this morning. So moderating is Sarah --

MS. SARAH NDIANGUI: Ndiangui.

DR. KIMBERLY JOHNSON: See, yeah, see, I mangle it every time. Ndiangui. Who is a public health advisor in our Division of State and Community Assistance.

So, Laurie, take it away.

MS. LAURIE KROM: Hi, yes. My name is Laurie Krom, as Kim said. I know many of you here. I'm at the University of Missouri-Kansas City, and one of the hats I wear is the director of the -- I just like to say ATTC network office.

Right now, we're actually in an interesting period. The application -- ATTCs are competitive grant applications, cooperative agreements from SAMHSA, and our applications are actually due next week. So for the next 8 months approximately, the ATTC is comprised of my office, the Network Coordinating Office, 10 domestic regional centers that align with the 10 HHS regions, 4 national focus area ATTCs -- Hispanic -- but there are three that are population based, the Hispanic and Latino ATTC, Frontier and Rural ATTC, and Native

American and Alaska Native ATTC. And then one is on -- focuses solely on SBIRT, screening, brief intervention, referral to treatment.

There are two Centers of Excellence, one on young minority men who have sex with men and other LGBT populations and one on pregnant and postpartum women and their families. And then we currently have three international centers that are funded by PEPFAR, the President's Emergency Plan for AIDS Relief. There are two sites in Vietnam, one in Hanoi, and the other in Ho Chi Minh City. And then we have our first international regional ATTC, the Southeast Asia Regional ATTC, which is headquartered in Chiang Mai, Thailand.

So beginning in October, we will have a little bit of a change to the structure of the network, continue to have the Network Coordinating Office and the 10 domestic regional centers. We will no longer have the national focus area centers. Because the Centers of Excellence are actually supplements to ATTC awards, we don't know yet, we won't know whether we have those. But the -- and then we will have five international ATTCs, one new one in the Ukraine and another new one in South Africa. So it'll be a big change for us moving forward.

I know many of you are familiar with the ATTC program, but just to remind you, we've been funded by SAMHSA since 1993. So we've been around quite a while, and our mission is to accelerate the adoption and implementation of evidence-based practices and promising practices in recovery-oriented systems of care. We heighten awareness and foster regional alliances, and I'll say a little bit more about how we do all of this in a bit.

So this conversation we were just having is very relevant. I was like, well, that makes a nice segue into what I'm about to say. So this is the model of how we -- and you really have to think of this model as a big picture, 30,000 feet above model of what it is the ATTCs are trying to do. We call this the model of the diffusion, the continuum of the diffusion of an innovation.

And it really aims to highlight what the role of technology transfer is in that diffusion and where different aspects of the life cycle of an innovation fit. Our goal in creating this model is to be better able to explain what it is that we do, what our expertise is in as ATTCs, and then also to help kind of people think about, well, what is it that needs to be done in order to truly implement with some success an evidence-based practice?

We often found -- one of the reasons we created the models, we've kind of found what this cartoon was expressing here. So you'll see on one side where there's lots of different arrows going around. This is the represents the innovation developed in research, kind of a very tends to be we have found very complicated process, very -- with very specific things.

Like we have tested this only on people who, you know, drink Miller Lite beer

three times a week. There's some very specific kind of not necessarily easily applicable to real-life situations practice. And then we give this to the field, give this to practitioners. A miracle occurs, and then they're all using it exactly how it was defined.

So we know this isn't what happens, and that's why there is this often talked about 17-year lag, and I think we've already discussed that a little bit this morning about how frustrating it is to really get science used throughout the field and try and limit the amount of, as you were saying, quacks out there.

So this idea of how you diffuse an innovation started in my current neck of the words, in the Midwest in Iowa. Ryan and Gross at Iowa State were looking at -- they noticed that some farmers, there was a new hybrid corn seed. And you know, this was Dust Bowl era '30s. And there were some farmers who were having more success than others. They were using this new hybrid corn seed that was hardier in drought situations and increased yields by 20 percent, and they wanted to know, well, if it's so great, why isn't everybody using it?

And so they looked at some of the characteristics of the farmers who had adopted this and found that those farms tended to be larger. They had higher income, more education, and had more trips to Des Moines. And one of the people who worked with them was Everett Rogers, and you probably have heard of him. He really published a lot about this idea of the S-shaped curve, with the idea that in -- do I have a little pointer? Oh, I do.

That if you're looking at time and the rate of adoption, early on, you'll have some people who will start to adopt an innovation, and over time, more and more people will catch on. And eventually, it will plateau, and you will still have some laggards out there adopting. But in general, this doesn't matter if you're talking about hybrid corn seed or the newest smartphone technology. This is the curve you will see in people using a new innovation.

So where are we now? As I was preparing this presentation, I went on our university journal -- our library's journal database and just typed in "implementation science." And from those early hybrid corn seed studies, there are now over 100,000 peer review journal articles published just in the past 12 months talking about implementation science. So you can see it's really in less than 100 years the explosion in interest, and I would say a lot of this even in the past 10 to 20 years.

The issue is, though, we have overlapping models and conflicting terms, and it's very unclear to folks, well, you know, exactly where do all these pieces fit in, and you know, we're still having a lag, and so we have maybe some good information, some theory, some frameworks for how to do this, but we're not necessarily making a huge dent on decreasing the gap between when an innovation is developed and when it's used in practice.

So I'd like to go back to this ATTC model and talk about it a little bit more in depth. So behind, you'll see underneath the model is this idea of diffusion, and in the ATTC framework, we think of diffusion as the spread of an innovation that happens regardless whether you're trying to get it to spread or not. So an innovation is created, our thought is that it will diffuse in some capacity or another over time.

The overlay on top of the model is technology transfer, which we define as accelerating the diffusion of an innovation. So while diffusion is in the background, the technology transfer is purposeful efforts to try and get that innovation into practice. Also you'll see that there is this bidirectional loop that runs throughout the model. That idea is to -- the reason that is there is to highlight the idea that it really takes continuous communication throughout the whole process between researchers and practitioners to -- when you're thinking about this model and how you diffuse an innovation.

So development is creating and initially evaluating the innovation. So in our case when we are talking about innovation, we're talking about a new practice, a medication, an intervention. So the product, the idea is we develop it. Then we need to translate it, and so this is explaining the essential elements and its relevance and then packaging it for dissemination.

And I just want to highlight this idea of explaining the essential elements of the innovation. I know this is something Kim has thought a lot about. I think it's something, a real opportunity for us to do better on is thinking about what are those essential elements that are successful that will be successful? And do we really need the whole practice as it was originally researched, or are there some nuggets of gold in there that we can pull out and use and have similar -- similar results?

So, and then -- so the idea behind this is this is lay language newsletters. We just heard from Jinhee about how the Surgeon General's report was purposefully put in lay language. And user-friendly tools, this is where we talk about the curricula, for example, that we were just discussing, talking about medical education, nursing education.

Once you translate it, then you disseminate it. So promoting awareness of the innovation, and I think this is -- at least in our experience as ATTCs, this is where we tend to get stuck is in dissemination. So we do a lot of awareness-raising events, presentations, "look at this great research." But we don't -- and so we get the word out there to some extent and we distribute materials and we give lots of checklists, but we don't necessarily go beyond that.

And so while -- and the ATTCs also have fallen into this, and I have lots of ideas about why that is, and we're hoping to transition over the next round of funding

into a slightly different model for ATTCs. But in general, this is why we have any day of the week, any hour of the day, you have at least 10 different webinars you can sign on and attend.

I think I forgot to put in one here highlighted. So before I talk about implementation, I just want to highlight adoption here. Adoption is we think of as a process of deciding whether or not to implement an innovation. So trying it on to see if it's the right fit. If we're thinking about a treatment agency, then doing some pilot studies, collecting some data, trying it out with a small group, does this fit in my context in my practice?

And in fact, I think one of the things that we sometimes get kind of caught up on here is that we think if we try it, then we automatically have to implement it. But in fact, what happens sometimes and what should happen is we try on a practice, and if we find out it's not working, and we're collecting the data and we're looking at it and we find that it's not working for us, we do not move on to implementation. We decide not to move forward and try something else that may work better for our particular population in the particular context where we are.

So then we look at -- okay, so that implementation then is we've decided this practice does work in our context. We want to really bring it to scale, for example, throughout our treatment agency. So, excuse me, how do we -- how do we incorporate it into the routine practice of our agency? And there, we really need to look at individual, organizational, and systemic characteristics. So what skills do we need? What do our job descriptions need to look like? What policy teams do we need to have?

And so you can look at this from a small, local perspective and then throughout the larger systems. So what are all of the things that need to adapt to being able to fully use this innovation with fidelity over time? So implementation science then is studying this part of the diffusion of an innovation, this particular aspect.

So what have implementation scientists taught us about what it takes to make lasting improvements? Well, we know we need to have an effective intervention. We've talked about that already today. We know we need to have the evidence. Ideally, if we have the evidence and then we have effective and sufficient implementation, then we should have consistent, sustainable outcomes.

Part of the problem is, is that we often -- this idea of people going to many different treatment episodes, and I think, you know, just thinking back to the earlier discussion you all had, one of the reasons, we would argue as ATTCs is that we don't necessarily see these consistent, sustainable outcomes is that we don't have effective and sufficient implementation.

So for an effective intervention, we have lots of places we can go to find

evidence of what are effective interventions, including SAMHSA's National Registry of Evidence-Based Programs and Practices. There are other places as well, the Cochrane Collaboration, other Federal resources. So, again, I'm not going to spend too much time here, but there are -- there are effective interventions.

Now we know, as we said, when we're looking at recovery supports and the recovery under the spectrum, evidence is not -- there isn't as many. There are promising practices, but there isn't as much evidence on that end. But certainly when we're talking about substance use disorder treatment, there is -- there are a number of effective interventions that we have evidence for.

So, again, going back to, okay, so then let's look at ineffective or insufficient implementation. What do we need to think about in implementation, and why is it that sometimes it's ineffective or many times it's ineffective and insufficient? So this cartoon says, "I'm back from training. I've got a binder. The training is already forgotten, but the binder will last forever. A living monument to temporary knowledge."

[Laughter.]

MS. LAURIE KROM: So thinking about what does it really take? What are the factors that we need to consider? What does it really take to get folks to do things differently than they have done through the past? Again, I mentioned earlier there are a lot of models, but there are -- there are consistencies across the models in the different factors that need to be considered when you are looking to adopt and implement an evidence-based practice.

This is a model that was published in JAMA just last year, highlighting the external environment, the characteristics of the organization, the characteristics of the innovation, the implementation process itself. So these four different factors, all something that need to be considered when you think about adopting an innovation -- and this was in healthcare delivery -- and then thinking about how that affects performance.

I like this one because I think it's pretty clear. Some models are very complex and difficult to understand, but I think this, for me at least, is, despite the multiple arrows, is pretty clear in highlighting what those factors are. I also really like this framework, which is even -- even a little -- even more simplified. So looking at the evidence, looking at the context, and looking at facilitation, facilitation in this case being what is it that you're doing to promote implementation?

So these slides are from Kirchner. What is implementation science, and why should you care? I thought she did a really nice job of laying out what kind of getting -- providing more detail about what those factors are that influence the implementation of innovation with fidelity.

So she argues first context. So what do we mean by that? Inner context of the organization that is working on implementation, what leadership support do you have? What's the culture of the organization? What are the priorities for the staff? What are the priorities of the clients, the patients? So what -- what is going on within the organization that is going to influence implementation?

And then also looking at the same time at the outer context. Where is the organization placed within the community? Are there local, State, Federal drivers for implementing this innovation? What other networks or who are the strategic partners of this group that they can work with that could either be a support or a detriment to implementing innovation with fidelity?

So taking both of those lenses, looking within and without, thinking about, okay, what are the factors that we need to consider?

We need to look at the innovation itself. I think we can do a better job at working with practitioners to help them understand what is the evidence? How do you -- how do you understand what kind of evidence a practice has? And then I think we can do a better job at the same time as well working with researchers to help them understand how you design a new intervention so that it can be used in practice rather than in this particular bubble that happens when you have a clinical trial.

And then we'll have to look at the recipient. So the people who are receiving the innovation. What are their motivations? What are their values and beliefs? We can't -- we can't look at if this is going to happen with success unless we also consider those factors as well.

I was a high school teacher for years, and to me, this always reminds me of how we -- just this is my Laurie's opinion here. We think teachers, public school teachers in particular, should solve all of the world's problems and put a lot of pressure, although not a lot of money, towards making sure that that happens. But we don't often look at, well, what is going on with the students? What are their lives like? How -- what is going on the classroom, and how does that affect them? So the same idea can be applied across many different innovations, including mental health.

So when you put all those things together, the inner and outer context, the innovation itself, thinking about the patient and the client, how do we then get to successful implementation? Kirchner argues that it is through facilitation, which is a multi-faceted process. Again, really just summarizing a lot of the models that exist when you think about how to get an implementation into practice.

I would recommend this book. It's called Version 1 Implementation Facilitation: A Training Manual. It says it's a training manual, but I think you don't have to

necessarily only use it for training. I find it actually really very good at looking at not just what are the factors that influence whether or not an innovation is adopted or implemented with fidelity, but how do you influence those factors? And what strategies, and she's drawing upon facilitation, just what are the -- listening, active listening. How do you build consensus? What are techniques to facilitate a discussion?

Basic facilitation, which, you know, as especially those in our field who have been counselors and working in therapy for a long time, that we have those skills. We can do that. We just have to learn how to translate it from the therapeutic situation into thinking about how those same skills can be applied in this context.

And then I just threw this in here because I think it is something to think about for the future. So this is also from JAMA, convergence of implementation science, precision medicine, and the learning healthcare system, a new model for biomedical research. So this is looking at research, but I do think, you know, we're still struggling with thinking about implementation, but other areas of medicine are moving on beyond that even.

And so while our field here is still thinking about this, other areas are thinking about precision medicine. So, for example, looking at how you make sure an individual gets the medication that specifically their system, based on their genetics, can be metabolized best to treat their disease, for example.

And then the learning healthcare system. How do we create a healthcare system where we're constant -- where there is a culture where we're constantly using data every day to make decisions about how we improve care? And -- and learn about what is working from what we're doing so that we have -- as practitioners take a responsibility with our patients to continue to improve care.

So that's -- that's where I think we're going. I think, you know, we're -- again, I think we need to do better here, but I don't think we can stay stuck here. I think we need to think about where other health professionals are also looking to the future. And there's my contact information.

Agenda Item: Council Discussion

MS. SARAH NDIANGUI: We'll go ahead and take questions.

MR. LAWRENCE MEDINA: Lawrence Medina here from New Mexico.

I, too, you know, support and believe in evidence-based programs, but I have found in rural and frontier areas and also communities of minority and color that we're forced with these evidence-based programs. We can't get an Oxford House in a rural area because it doesn't fit.

And some of these evidence-based programs don't fit, and I know a lot of times in communities -- here's a good example is that rural areas -- there's a lot of focus in urban and metropolitans. There's resources. There's a lot. And then you get into rural and frontier areas, you know, then the crumbs, you know, and whatever you're able to get.

And I think when it comes to information, the same thing happens, and a lot of money is put into urban and metropolitan areas, rightfully. That's where the numbers are. But I think there needs to be more focus, too, on rural and frontier areas, especially now with the opiate epidemic and seeing communities, it's just wiping out communities. It's just crazy. So the lacks that we have to deal with for Native American, Hispanos in creating programs that are culturally appropriate for these people in rural and frontiers, or even just, you know, for minorities.

So what focus, too, do you have on rural and frontier areas? And as they're looking at evidence-based programs for these, you know, geographic area and demographics so we're not forced with these -- you know, matrix model is a good example. That was built for a certain demographic, and we have to use it because that's the closest thing that we could use. But it really doesn't speak to the Hispanic or Native American.

But yet we're forced to use these evidence based, and then if we don't use it and it's culturally appropriate for that, we're considered we're not doing it right. So sometimes there is agendas behind that to sell something, but you know, we need to strive and work harder to address geographic areas such as rural and frontier and people of color that there's a better matchup. And I don't know, based on what you --

MS. LAURIE KROM: Well, I have -- well, I have a couple of things to say about that. One is that I agree with you. I think it gets back to this idea again that we really need to do a better job at thinking what are the essential elements of why this practice is working? So if you're looking at the matrix model, is it that you always need to use the whole package that can be very expensive all the time? Or are there pieces of it that are really the -- as I was saying before, the nuggets, are really what can drive change? And then how do you -- how can you use those?

And this is a little bit sacrilege what I'm saying here. So, but if I were to say this in the meeting tomorrow with the researchers, you know, some people might be waving their hands. So --

MR. LAWRENCE MEDINA: You're being recorded, too, by the way.

MS. LAURIE KROM: -- yes, I might be --

[Laughter.]

MS. LAURIE KROM: But you know, I think we need to do a better job at that. I think I would encourage you to talk about this tomorrow with the researchers in the room. I think there's lots of approaches we need to take to that, I know. We need more people of color and from frontier and rural populations who are the researchers, for certain, not just who are the recipients of the research.

I think that another thing I would say thinking about frontier and rural areas, I grew up in a very rural area, believe it or not, in New York State. Nobody thinks about New York as being rural. There are a lot of rural areas in New York.

[Laughter.]

MS. LAURIE KROM: And I think we need to think about resources in rural areas a bit differently. So, yes, while money is being funneled, and there are a lot of programs in urban areas, it's been my experience -- and this is not evidence-based, this is Laurie's experience -- that if you understand the particular community, there are a lot of resources there. We just haven't done as a field a good job of using them.

And so, for example, in the group that I grew up, the community I grew up in, which had a post office and one stop sign, our volunteer fire company was the center of the community. And so how -- if I were going into that community now and I didn't -- wasn't part of it, you would not necessarily know that, and you would think there weren't any resources, that there was nowhere anybody could go and that there wasn't a support system.

So I think we need to do a better job as a field at really looking at what are the resources we're talking about, and instead of necessarily always applying a new program or a new resource to a community, learning from people and thinking about, okay, well, how do we use what's already in place to -- to help us with our mission?

I don't have a good answer for what you said, but those are my two cents.

MS. SARAH NDIANGUI: I don't know who was first.

MS. KRISTEN HARPER: Thank you so much. That was really interesting, especially with the drilling going on behind your head. So you're doing a great job holding our attention.

So I worked on a SPF SIG project a couple of years ago in rural Georgia, and it was a southern county and really learned the importance of the first piece of the needs assessment process working in those communities. And so I was curious

if you have included any of those kind of aspects into what you're doing with your work as far as meeting the community where they're at?

If we're going to be patient centered, client centered, participant centered, individual centered, we also need to be community centered. And so, you know, what is your kind of take on the amount of time and resources that it takes to do a community needs assessment, but it's so beneficial as far as eventually getting the buy-in and implementation piece.

MS. LAURIE KROM: I think that none of us do needs assessments very well. I think that I can speak from ATTCs, every ATTC, it's written in the FOA, which I'm very familiar with at the moment -- the Funding Opportunity Announcement -- that you must do a needs assessment. So I think a lot of people tend to think of that as kind of a perfunctory thing that, okay, I need to do this so I can get on doing what I've decided is going to be therapy.

I think, as you kind of alluded to, it can be very resource intensive, and maybe we could do a better job at figuring out how to do needs assessments that would provide us with some accurate data but wouldn't necessarily take as much -- as many resources as -- as they tend to. How do we -- for example, how do we partner with local academic centers, local universities? If you're a community-based organization, how do you develop a relationship with someone who needs to do a master's thesis and can help you figure out your needs assessment? And then what are creative ways of doing those needs assessments?

I -- there was a gentleman who worked for the National Native American/Alaska Native ATTC who was a master's student working at the University of Iowa and happened to be also employed by the ATTC. And in his master's thesis, he wanted to -- now this is in Iowa. He wanted to find out some health information about the African immigrant communities. You can imagine that in Iowa that's not necessarily easy. There is no set database that he could, you know, sort of link up to.

So he -- and I'm just using this example because I really was impressed with his creative solution was to tap into some community organizations and organize a potluck picnic and kind of went out and did his own footwork advertising it. And then at the picnic, he was able to distribute his survey and collect some data.

So I think -- I don't know if I'm answering your question. I think we don't do a very good job of it. We can do a better job, but it takes creativity and probably some more work than we're comfortable doing because it's not what we've always done.

DR. KIMBERLY JOHNSON: Can I just throw in on top of that because there's also now we have huge national databases that allow us to do a lot more granular analysis than we used to do, and there are tools that we have. And one

of the things that like with this new grant that we have for the States, that I'm encouraging the States that if you don't have the resources to do your needs assessment, we have all the data. I mean, we can give it to you. I mean, we even like at the point of mapping, you know, where your service -- where your service deserts are versus where your service -- or where you have services versus where your needs are to help you figure out these kinds of things.

So I think between the two, right, between using the big national datasets and getting stuff from resources from the Feds because we have them, whether it's us or CDC or HRSA or whoever, I think that it isn't as hard as it maybe was 10 years ago.

MR. ANDRE JOHNSON: Hi.

MS. LAURIE KROM: Hi.

MR. ANDRE JOHNSON: Thank you for your presentation. Very, very thorough.

I did have just a couple questions about -- in fact, I'm a great admirer of the ATTC. I'm from Detroit, and so I've worked very closely with Great Lakes ATTC in Chicago, and they've been a great supporter of our RCO. And I don't think if it wasn't for that relationship, we wouldn't have been able to thrive over the years.

MS. LAURIE KROM: I did not pay him to say that.

[Laughter.]

MR. ANDRE JOHNSON: She really didn't, but you owe me.

But one of the things I'm noticing in the State of Michigan the last couple of years, because the synergy of advocacy, Faces of Addiction -- Faces of Addiction and Recovery movement, we've probably had at least 25 grassroot RCOs emerge. And I'm always a little concerned if they are being privy to the ATTC and how -- what type of systemic systems are in place to make sure that the new folks are being engaged?

Because I do believe we have this emerging work for us. Recovery not only in [inaudible] but recovery coaches that are now going to work in the field of hospital rooms, working in conjunction with police officers, working in conjunction with drug courts, working in conjunction with juvenile facilities, et cetera, et cetera. And have you all given some thought around best practice models that hone in on those specific areas?

And also some best practice models that hone in on people of color, specifically African Americans. Because I don't see a lot of best practice models that -- that -- that have where the time have really been taken in an African-American

community to really design a research-based program. And lastly, and I know I'm all over the place. I've got ADD, Laurie, so bear with me.

Lastly is, you know, this movement of integrated behavioral healthcare with primary healthcare, and what does that look like as it relates to electronic health record systems, that, you know, training around that area and best practice models around that area. And again, that focuses and targets on minority groups of people.

MS. LAURIE KROM: Those are big questions. I don't know if you're familiar with Faces and Voices of Recovery has some. I'm not exactly sure if SAMHSA funds it, but they do have an Association of Recovery Community Organizations, ARCO. And the ATTCs are -- I'm in a bit of an awkward position because I have -- because of where I am in my funding cycle, but --

DR. KIMBERLY JOHNSON: Oh, I'll just leave the room right now.

[Laughter.]

MS. LAURIE KROM: No. It's just -- I'll just say there are many of us who agree that there needs to be a strengthened relationship between ATTCs and RCOs, and certainly Great Lakes has forged the way for us there. And we hope that that will grow in the future, and I'd be happy to talk to you more about that after February 9th.

MR. ANDRE JOHNSON: We would, too.

MS. LAURIE KROM: I think, and in terms of developing best practice models for people of color, I really hope you bring that up again tomorrow. My other hat is in HIV prevention, and I do think that the HIV prevention world has done a better job at designing and researching strategies that are particularly focused on people of color. And I think there's something to learn from that.

I think -- I think, you know, it is hard. There are -- I haven't looked recently, and I don't know if you know, Kim, from an NREPP, but I think you can do some queries in NREPP, SAMHSA's registry on what populations a practice has been --

DR. KIMBERLY JOHNSON: Yeah, you can.

MS. LAURIE KROM: -- applied to. I don't know if you want to say more about that. But I can't really do more -- anything more than say, yes, you're right. And -- and I think that part of that conversation then goes back to those bidirectional arrows I was talking about, and that it can't only be, you know, academics designing new interventions. We also have to think about practice-based research. And so what do we know is working in communities, and then how do

we -- can we do a better job at connecting the communities? And maybe it's through the RCOs, but back to people who then can write the R01 to get the research done.

And the number of scientists in this country who are able to write and successfully receive R01 funding is not very high. It's a lot less than it used to be. So, you know, I really think we need to think about how we would do that in a strategic way.

DR. KIMBERLY JOHNSON: Can I just pop in about that? Because I think -- can you go back to your last, your next to the last slide? I think this concept of learning healthcare systems is really going to -- that's where we're going. And if we really think about what you can do sort of researching your own practices within your own health system, even before you think about feeding it up to a federally funded research program. I mean, there are ways of doing randomized studies on a small scale within a health system that is happening a lot, particularly in some of the FQHCs. AHRQ, our sister agency AHRQ has funded a lot of this kind of work.

And I think if we can get to that place, it addresses both the issue that Lawrence raised and the issue that you raised, Andre, is that, you know, when we do these randomized clinical trials with primarily white men is who the populations -- I mean, regardless of whether it's behavioral health or something else, that's -- it doesn't necessarily apply in other areas where this population is sparse. The intervention is complex, isn't necessarily culturally appropriate.

But we can learn from our practice, right? And if we set up our system in a way where we can learn from our practice that -- that really you can do that research in a way that is equally valid. It's not necessarily as scalable, right? But it's equally valid in terms of, and if we -- if we are measuring our outcomes, and that's what guides our practice, then to some extent these complex interventions become less important, right?

We pick out the nuggets. I mean, hopefully, we can do that in a scientific way, but if not, we pick out the nuggets in practice and we design our programs based on the data of the outcomes in your own program. And so I think that that's where we're really trying to lead things to so that -- so that we aren't spending the research dollars designing really complex interventions that have moderate effects, and we don't really know which parts of those complex interventions are creating that effect.

So I think, you know, that's where we want to head. We're on the path.

MS. SADE ALI: Yeah, thank you. I've been -- it's very fortuitous that you're here, number one, because I had a question that I was going to ask sometime in the next 2 days.

First of all, let me say -- and you didn't pay me to say this -- I am a huge fan of the ATTCs. I worked under three executive directors at ATTC New England for many years when ATTC New England was doing courses online. I presented on recovery-oriented systems of care when recovery-oriented systems of care was just a gleam in the eye of a couple people around the country and on person-directed and family-directed care. And that was a wonderful time for me. I also worked with Dick Spence at ATTC Gulf Coast, wonderful experiences.

I heard a rumor last week, as a matter of fact, that the ATTC that deals with Native -- the Native community is not going to be part of the organization anymore, and I need to find out if that's right. Because I love that we're global, but we've got challenges right here. And for me, that's a very personal thing for me because I know that the challenges that my communities are serving.

MS. LAURIE KROM: Yes, that's right. They're -- they're -- since about 2001, NIDA had a partnership with SAMHSA to create products based on NIDA research. It was called a blending initiative. Some of you may have heard of the blending initiative. We created what was called blending products like buprenorphine training for nonmedical professionals and motivational interviewing assessment, supervisory tools to enhance something. I can't remember anymore. But there were a number of products that were created, and that funding from NIDA helped supplement SAMHSA's budget for the ATTCs.

NIDA has decided to go in a different direction in this round of funding. And what I think SAMHSA realized and what we also, as ATTCs, know is that the heart of the work of the network comes from the regional centers. Although I think that's why we've been around since 1993. It's kind of unprecedented for a Federal program to stick around so long, and I think it's that we're able to have these centers that can operate somewhat independently and customize their programs to the particular needs of their region.

And the bulk of the work in the ATTCs happen at the regional level. And so SAMHSA -- SAMHSA, it's my understanding --

DR. KIMBERLY JOHNSON: Do you want me to answer this question?

MS. LAURIE KROM: Yeah. That would be --

DR. KIMBERLY JOHNSON: You're thinking, "Oh, Laurie is rescuing me," and I'm just letting her do it. It's unfair.

[Laughter.]

DR. KIMBERLY JOHNSON: So we made a -- we made a decision, given the

amount of funding that we had, to not fund the focus area ATTCs, which does not mean that we do not care about the populations that those focus areas were focused on. And so it's just that the ATTC is not going to be the vehicle, given the funding in this next cycle to do that.

And so we are looking at other vehicles that we have, and that's about as much as I can say because it's not in a budget document at this point. But know that we do care about all of the populations that we're cutting. I mean, it was somewhat random who wound up getting those particular ATTCs, which were only in this last funding cycle. So we're looking at other ways of supporting specialized technical assistance and training, and I guess that's probably all I can say about it at this point.

MS. LAURIE KROM: The only thing I would add is that particular ATTC, as Kim said, has only been around since 2012. Prior to that, we didn't have these national focus areas, and it was all regional work and network work as a collaboration among regional ATTCs. And I think we contributed quite a lot to Native communities before that focus area existed. So I'm hopeful. I mean, I don't -- I don't even know if I'll be refunded. But I'm hopeful that whoever use the 11 new ATTC grants can continue that in conjunction with whatever the new mechanism will be.

It was a surprise to all of us, and I think, you know -- but I think that the commitment in whomever is funded, hopefully, there will be some incumbents that are funded and the commitment level won't diminish.

DR. LORI SIMON: One of the things that I think is hugely important is I think evidence-based studies, best practices, are they absolutely necessary? Absolutely. You know, there's so much that can be learned from them. But I don't think they're sufficient because the sufficient part is how do you take what you learned from these studies and then apply it to whether it's a particular community, whether it's Native Americans, whether it's rural, whether it's an individual, because everybody is different.

And even with funding for grants, I mean, if you're going to base your sole evaluation of an application for somebody submitting that solely onto what extent they're following evidence-based or best practices, to me, I don't think it's enough. And it's extremely important, and I run into this all the time. I'm going to give you one example. I mean, I'm a psychiatrist. I'm in private practice.

And if I was to follow, you know, the strict Freudian, okay, this is what you're supposed to do, this is what you're not supposed to do, first of all, I can't practice that way, and every patient is different. And I'll give you one example. Recently, I had a patient who is bipolar. She has been homeless for about 15 years -- now she's in supportive housing -- because her bipolar disorder was not treated. Horrible family history. I mean, you know, a lot of stuff. And things are more

stable now partly because she is in the supportive housing where she has some social work support.

She also has me, and some of what I do is not pure psychiatry. And so, recently, what's come up, she's also had some orthopedic problems. And I was talking to her recently, and she's telling me how depressed she is and how hopeless she feels. Well, so should I just say, okay, let's adjust your medication, you know? Well, the reason why she's depressed and feels hopeless is because the care I think she's getting for the orthopedic problems, I have a feeling because she has a psychiatric history that things are falling through the cracks.

And so I could just sort of ignore that, but I can't. And so what I'm doing is now advocating for her, and I put in a call to the doctor's office who's -- and that one's easy because I haven't gotten a call back, and I'm waiting. I'm trying to get the radiology reports and stuff to advocate for her to get the care she needs. So the reason why she's depressed and hopeless, it's not -- you know, it's not one stop, one size fits all. And I think that's so important when we try to come up with, you know, any of these plans for treatment.

MS. LAURIE KROM: Yeah, I think you're -- is that on? I think you're right. I think it is about improving quality of care overall. I think the tricky part is when we get -- is this intersection between using the evidence and using research-based practices, but not in isolation. What's the -- how do we promote that so that we don't have folks who are doing everything by feeling, what they think feels right and what their intuition is telling them?

So it is about striking the balance. I think there's a lot of Kim was talking about AHRQ's practice-based research network. I think there is a lot of information about person-centered care. I think that is a lot of what goes into when we're thinking about redesigning systems to be recovery oriented, and I'm looking over here because I know Detroit has done a lot of work on that. But the tricky part is some people hear that, and they -- and they thought -- they kind of go more towards the, well, what feels right? What -- you know, oh, I just think that -- so we need to -- how do we balance?

DR. LORI SIMON: Right. And I totally agree with you, and so I think the trick is when you're developing funding is you want to see both.

MS. LAURIE KROM: I'm not developing funding. You might want to look at --

[Laughter.]

DR. LORI SIMON: No, I'm saying in general I think what you want to do is when you develop a funding, you know, a particular grant, you want to make sure that, yes, whatever the applicant is providing in their application is, yes, they are basing, you know, what they're coming up with on the evidence base and the

thing. But there's enough latitude that it's not like, okay, I have to follow steps one through five, and that's it. And then you also want to build an evaluation. So if there are -- so if there is some latitude for them to kind of, you know, expand a bit, there needs to be an evaluation of, okay, let's see, you know, if this actually works.

MS. LAURIE KROM: Art was next.

MR. ARTHUR SCHUT: So I have lots of opinions about this, and I will spare you most of it.

[Laughter.]

MS. LAURIE KROM: We're not surprised.

MR. ARTHUR SCHUT: So there are some things that I really think we need to -- in terms of adoption and implementation, we really need to say what's an unacceptable practice. There are a lot of unacceptable practices, and we really don't clearly state those practices that are [inaudible].

You know, I'm philosophically opposed to the use of medication. No, you're not. You're practicing now. That's malpractice. If there's an appropriate treatment and you're not using it, that's malpractice. You shouldn't be doing it. So it's not only best practices, but it's also unacceptable practices and taking a stand about this.

I think it would be nice to have ways to measure fidelity to best practices that doesn't take twice as long as providing the intervention. And so part of what happens in implementation is you start losing fidelity over time, and there's no quick -- there's no good way to measure fidelity, and I'd like to see if we can look at that.

And you already talked about clinical trials and having been part of clinical trials. By the time we get done eliminating everybody on probation, parole, who uses multiple substances, et cetera, you know, I have something totally -- well, it's useful for a very specific group of people who don't -- who comprise a minority of the folks that I see.

And then the other thing really is in terms of barriers, what are the payment barriers? And they fall in two categories for me. One is payers deciding that they want -- including single State authorities, that they want this evidence-based practice instituted in its entirety, right? And so you're supposed to do that, sort of one size fits all with this evidence-based practice, and it drives me nuts. And it's also extremely expensive to do an appropriate intervention.

The other part of it is that the payers, and you know, we've had this historic

bifurcation into poor and folks without insurance, and insurance pushed more and more people into the poor, you know, and this is the interesting piece. Now we have the expansion, maybe we have the expansion of Medicare. But we've had it, and that deals with -- really provides some robust access to people who are below where we are, the 138 percent of poverty. But the people above that now have high deductible, high co-pay policy. They can't pay for anything.

And there's certain evidence-based practices like the medication-assisted treatment, that you actually need to be able to have somebody pay for the medication. And if you can't, you can't live on that, right? I mean, it's -- and I have many examples of that kind of thing. But it's resources do get in the way and enter requirements, or absence thereof, get in the way of implementation. So --

MR. JOHN PAUL MOLLOY: That's the sort of thing that needs to be documented, by the way. It is -- it is documented more by anecdote than statistics.

MR. ARTHUR SCHUT: Well, even if you had documented it, it doesn't change it.

MR. JOHN PAUL MOLLOY: So with the documentation, it's easier to get it changed, you know? I'm socializing cost for medicines and so on. This is an idea that's been around a long time.

DR. KIMBERLY JOHNSON: Push your button.

MR. JOHN PAUL MOLLOY: It's very close to being achieved, and I don't think anyone in the present climate should give up on the idea that you socialize a lot of these costs and you really do have universal healthcare. One of the advantages of the person you now have in the White House, while it makes us all nervous every day, 24 hours a day, is he's not an ideologue. He doesn't give a damn about which side does. He says what works? How do you build a building so it doesn't fall down?

And I would bet that you're going to get universal healthcare, particularly with respect to drugs, within the next 9 months. And so you need to think about it, and you need to talk about it. But you need to quantify it. What are the needs?

MS. LAURIE KROM: Thank you. I think Indira?

DR. INDIRA PAHARIA: Yeah, thanks. This presentation was terrific. I really appreciate it because my organization does a lot of this. We have a whole research arm and an evidence-based practice arm and data analytics to measure outcomes, measure fidelity to implementing evidence-based practice. And we treat children, adolescents, and families residential, outpatient, day treatment, school-based interventions, juvenile justice, developmental

disabilities, a whole array.

What I want to echo from folks that I'm hearing is the challenge with funding. So we have a lot of university partnerships that we've cultivated over time, but -- and so some of those universities are willing to pay for helping us to implement evidence-based practice. But in general, that money we have to go into philanthropy for, right? I mean, where do we -- or grants or other.

There's just no -- and so, to Arthur's point, when a State, in New York State, where we're predominantly located, is mandating all of these evidence-based practices, no one is paying for us to implement them. So this is the biggest challenge that we're having, in addition to staff who don't want to have to deal with evidence-based practice because they don't really understand yet how it will value them in the long term.

But anything that can be done to help with the funding for -- you know, we're a nonprofit, human services, community services-based organization, and so that's the biggest challenge. And we have the most vulnerable people that we're serving who deserve to have access to evidence-based care.

Thank you.

MS. LAURIE KROM: Have you -- are you familiar with the ATTC in your region?

DR. INDIRA PAHARIA: You know, I'm not. And --

MS. LAURIE KROM: So maybe something for you to look into.

DR. INDIRA PAHARIA: Yeah, I think so. I just moved to New York. So I'm not that familiar with everything up there.

MS. LAURIE KROM: And are you familiar with this literature on learning healthcare systems?

DR. INDIRA PAHARIA: Somewhat.

MS. LAURIE KROM: It sounds like you have a system that's set up nicely already.

DR. INDIRA PAHARIA: It is. We put a huge strategic investment into this. That's why I'm there.

MS. LAURIE KROM: Yeah. Well, so I think, you know, it sounds like you're in the right place, and maybe -- I can't speak to the funding, obviously. But I can think of a couple of partners that might be useful.

DR. INDIRA PAHARIA: Could I talk to you afterwards?

MS. LAURIE KROM: Yeah.

DR. INDIRA PAHARIA: That would be terrific.

MS. LAURIE KROM: So I think that's one of the benefits to the ATTC that often is untapped is we can help with implementation, but we also often are very familiar with who else in the State or region can help. So, you know, I would just -- this is kind of an aside from our presentation, but I think -- I think that we need to do a better job at letting people know that they should always talk to their ATTC. And even if the ATTC can't help, they usually can figure out who can help.

DR. INDIRA PAHARIA: Thank you.

DR. JUDITH A. MARTIN: I was going to say that somehow thinking of an ATTC as something other than a collaboration between SAMHSA and NIDA sort of redefines what it is in my brain because I've always thought it as a nice collaboration between the two organizations. So it will be interesting to see what comes out of the loan from the SAMHSA side.

One of the things that I think is really useful in even single practices to improve care is to use the small test of change PDSA learning and then to be part of a learning collaborative. And that is shared across medicine with primary care and hospitals. So especially with this opiate use crisis, many of our health plans are using that model and incentivizing healthcare improvement in the area of prescription of opiates practices as well incorporating opiate treatment into primary care for the primary care involved in various health plans.

So I think that's an area of convergence that may be very important.

MS. LAURIE KROM: Yes, I would agree. And I know Kim would agree. We have thought a lot about that, and I think if you were to peruse the new ATTC funding announcement, you will notice that there is an emphasis on performance improvement and using those kind of change practices. I think it falls into -- sorry, let me get back to the model here.

I think it falls into both the area of adoption. We actually have thought a lot about how do you use PDSA cycles, for example, to try on a practice and collect some quick data and decide whether or not this is right for you? Certainly falls into implementation. It's another tool in the toolbox. So it's another method we can use.

DR. JUDITH A. MARTIN: Certainly to test feasibility.

MS. LAURIE KROM: Right, right. Yeah. So I think, yes, and I don't know that, you know, while it may be common practice in medical arenas, I don't know that it always is in treatment agencies. NIATx certainly has done a lot of work in that area, but I think we still have some lifting to do there. I don't know, Kim, if you want to say more about that, that's your prerogative.

DR. KIMBERLY JOHNSON: I don't think I need to say more about that specifically. I mean, we -- you know, we rewrote the funding announcement to better reflect where we are in the world now than where we were 5 years ago or 6 years ago. And so, hopefully, hopefully, we'll get back applications that reflect where we are.

I want to say, you know, we aren't abandoning our partnership with NIDA. I think that that's just as I was saying we aren't abandoning the populations that we focused on in the national focus areas, we aren't abandoning our partnership with NIDA. I mean, we really are trying to figure out what's next because we felt like the blending project had reached the end of its lifespan. The way that that was working, the kinds of products that it was producing weren't necessarily the right things for what we know now about technology transfer and particularly around implementation.

But we haven't got an answer for what comes next. So that's partly why we're having this conversation. I mean, that's why they're here tomorrow, to have this conversation. That's why we have this other meeting that is scheduled in 3 weeks or so that's bringing in researchers. So it's tomorrow, you know, the Joint NAC, we'll all have -- so all of you will have the opportunity to talk with the senior leadership at NIDA, NIAAA, and NIMH, and there are actually other institutes that also do work in our arena that aren't going to be here, but those are the three big ones.

MS. LAURIE KROM: And Kim?

DR. KIMBERLY JOHNSON: Yeah.

MS. LAURIE KROM: Can I just add that I think that that initiative, the blending initiative formalized our relationship between the ATTCs and NIDA. But by the very mission of what we do, ATTCs will always need to interface with researchers, NIDA and NIMH -- you know what I'm trying to say. Other NIH institutes.

One other thing I think, you know, you could argue that was a challenge when we had the blending initiative is that because we had to focus so much on NIDA that it limited our ability as ATTCs to focus on research coming out of the other institutes. So it's not like this is done in a vacuum. ATTCs also have felt like the blending initiative is kind of stagnated, and we needed to refresh.

I'm not saying of us wanted the money taken away. Of course not. But I think, ultimately, speaking for my colleagues in the ATTCs, we would agree with SAMHSA that it can be used in a better, new, and fresh way, and because we're all about change, we should be promoting change in how we work as well.

DR. INDIRA PAHARIA: Can we get your slides electronically?

MS. TRACY GOSS: Yeah, I can send them to you.

DR. INDIRA PAHARIA: You can send them? Great. Thank you.

DR. KIMBERLY JOHNSON: So we have just a couple minutes before we go to lunch, and I'm just curious, given the discussion, do you all have thoughts -- I mean, we talked a little bit about the blending project. But do you have other thoughts or advice for CSAT? Now is your chance. Around -- just around this particular issue in terms of technology transfer and what our role is and what we need to do more of better, differently?

DR. INDIRA PAHARIA: Funding. Funding -- sorry, funding would be my only advice and technical assistance in helping, you know, because where the rubber meets the road in community organizations, it's really tough to do this.

And maybe some guidance on looking at the EBPs and what populations, and you may already be doing this. I know you have a whole huge EBP repository, but looking at which populations, even if they weren't necessarily normed on a particular population, how might they be applicable to others I think would be helpful. Because we have that resource internally at my organization where we can do that kind of vetting, but that's unusual to have. So that's --

DR. KIMBERLY JOHNSON: Okay.

DR. JUDITH A. MARTIN: I was going to say there is some information now in medical education about how to address in the educational system racial disparities in healthcare, and in our field, it's a really bad problem. And the harms from the drugs that are used are often higher in black and African-American communities and in poor communities.

So it has to address things like implicit bias in various ways that we deliver white healthcare and also the community's suspicion of certain interventions that get in the way of actually those populations getting the best that we have in medicine. And I don't know how to incorporate it in this, but I think it's a key element.

DR. KIMBERLY JOHNSON: Yeah. And I think that's so we -- because me either, I guess. But thinking about how do we incorporate what we're learning in other parts of the health system is important regardless, right?

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

DR. KIMBERLY JOHNSON: And doing that in how we address disparities is doubly important because we have so few resources to devote to -- to the research and to trying to figure out what works best for whom. But we can learn that elsewhere and apply it.

DR. JUDITH A. MARTIN: Yeah.

DR. KIMBERLY JOHNSON: So, yeah, we have to figure that out.

DR. JUDITH A. MARTIN: Here's an example that I'm struggling with right now. The death rates from alcohol in our city show a really huge racial disparity. Black men die from alcohol at much higher rates than white men, even though more white men drink. But so we did -- and alcohol treatment medications are way underutilized in general care and in addiction treatment.

So we did a performance improvement in 2012 that involved an intervention that was education for prescribing providers throughout the mental health system and behavioral health system. And we were able to increase the prescribing numbers, the numbers of active prescriptions in our electronic prescribing system. But there was still a racial disparity. Black people and black men got fewer prescriptions.

And so then we did another think of it. Of course went back to the table and said so why is this? And we're in the process of looking at that, and there are various things about our system that just aren't welcoming.

And that -- and the places that do well, looking at what the clinics that do well and the clinics that don't, I mean, typically, they have people who recommend the medications more often, like, say, the pharmacists are conscious of it. They have black clinic directors who know the role of alcohol in the black community, and so they carry that in mind when they talk to clients. And also the front desk even is more -- you know, has a black face, is more welcoming.

So I think that there's more than just putting a best practice of giving alcohol treatment medications into the pipeline. But it has -- we have to pay attention to so many other contextual things, as the slide says, and racial disparities is a huge one that we really have to work on.

DR. KIMBERLY JOHNSON: You know, oh, go ahead, Andre. I'll --

MR. ANDRE JOHNSON: I just wanted to kind of look at one area in specific, which is really discussing how we can address the marijuana issue. We're in the city where it's recreational and medicinal purposes, and it's a huge norm in the black community. And we also know that young black boys are not graduating

from high school, and it's really sad. It's not normal.

You know, it's normal to walk down the street in the city of Detroit and see a kid rolling up a blunt, and it's also normal to see over 200 dispensaries in the city of Detroit. We had some that was open 24/7, just a drive-through like it's a McDonald's or something. And so I really would like to see more best practice models that tie in marijuana usage for young kids and how it pretty much cuts them out of their place in the educational system and just being successful individuals. And I'm not really sure how that looks, you know, if we can get some town hall meetings and really target urban communities.

DR. KIMBERLY JOHNSON: So you know what you guys are making me think of is, I mean, and we should continue this conversation tomorrow with the research centers because, right, they fund. But what we, "we" at CSAT can do is with our resources is not necessarily fund RCTs because that's not what we do, but we can gather evidence that's out there from practice. So where is -- where is -- where are the organizations or where are the communities that are doing a good job, right?

And it kind of gets to the -- it's the same thing for what you're saying, Judith, is that if you have found some solutions, I mean, we can use our resources to identify -- whether it's you or whether it's some other organizations to say what are some promising, and you used that language, promising practices, practice-based evidence that we can document and then get to whether it's the ATTC or whether it's another vehicle that we're disseminating that.

So that's something that we could, you know, because I think of, well, okay, what are my vehicles, what are my resources to address these issues? And we have contracts that we can -- you know, we can have people do this kind of not -- it's research, but it's not the kind -- you know, it's not an RCT research, but it's research. It's gathering the evidence and saying so who's doing something? What is the problem, and who's doing something well about it? If that makes sense, and I don't know.

MS. KRISTEN HARPER: Yeah, and I think that Lori's point to the minimum amount of researchers that are actually able to get funding at the R01 level is so key in this conversation because the community organizations that are trying to do the work, that are seeing anecdotal outcomes don't have access to those types of researchers. So being able to connect the dots with, hey, there is maybe something happening in Detroit. We're seeing some pretty positive, you know, things happening locally. Is there a way that SAMHSA could or CSAT could jump in and kind of help us connect with some funding and with that human capital within the research world?

I also think, another point, everything you said, first of all. If you ever want to hire me, I would work for you in a heartbeat because that was --

[Laughter.]

MS. KRISTEN HARPER: That was one of the best presentations I've ever seen.

MS. LAURIE KROM: Thank you.

MS. KRISTEN HARPER: Because your point on getting the community involved in the research I think is going to be really key. So it would be cool if we could get, and that is an official word, "cool," if we could get some kind of, I don't know, leadership, cohorts, or something within pockets of these subcommunities where we could potentially raise up or bring up junior community participatory researchers that could -- we've seen it with obesity within the minority communities. We've seen these really cool grants come out that it helped get especially women involved in the research.

But we haven't really seen that yet within the recovery population or substance use disorder. So if there is a way for us to do that under, you know, your guidance, and I think we'd have a lot of interest in that.

DR. LORI SIMON: I think to follow up on Andre's point about marijuana, there is already information that's out there, and I think I agree. It's just become so mainstream now because it's being more and more States are declaring it legal, both recreational use and medical use. And I think the more education that SAMHSA can put out there, both for healthcare providers as well as the general public, to say, hey, it's not all great.

DR. KIMBERLY JOHNSON: Well, so we have a great resource that just came out, what, a week or two ago, the formerly the National -- no, National? What is it called now? The former IOM, Institute of Medicine, and they have a new name under the National Academies of Science. So maybe it's just National Academy of Medicine? I forget.

But anyway, they just came out with a report within the past 2 weeks. They published a report on the science around marijuana. It's a great report that just it basically says what it -- you know, what it does medically, what it doesn't do medically, what we really don't know. And it does the same around marijuana use disorder, what we -- you know, what we know, what we don't know. So it's a great -- so it's a tool that we can absolutely use because it's the latest science on that particular drug.

MS. LAURIE KROM: Can I?

DR. KIMBERLY JOHNSON: Yeah.

MS. LAURIE KROM: So two things. Art and I are part of a team that the ATTCs

are working with National Council for Behavioral Health and Advocates for Human Potential to have a national cannabis policy summit in August in Denver. The idea is that this is a science-based conference, not a pro or con. It's, look, this is -- this is what we know, and then what are some policies, not just governmental policies, but organizational as well, policies that we can think about putting into place that will help you deal with whatever your State or your locality has enacted.

So that may be something to think about. But the second thing I wanted to say is I think we're starting to do a better job, especially with the Surgeon General's report, at talking about addiction as a brain disease. I think I would argue, and I think we could do a better job of helping people understand that addiction tends to also be a pediatric disease and starting in adolescence, and so connecting those dots -- or younger.

Connecting those dots of whether you are for or against marijuana legalization, but just thinking in general about how using substances at an early age affect developing brain and what repercussions those have I think is really important. And you know, certainly I think the ATTCs speak about that, but we can do a better job at really helping people understand the, as I said, that addiction is a pediatric disease.

DR. KIMBERLY JOHNSON: I think that is the perfect place to end.

[Laughter.]

DR. KIMBERLY JOHNSON: So thanks, everybody. I think it was a great discussion. Once again, I wish we had more time, but it's time for lunch, and we need to be back here at 1:00 p.m. because that's when Kana is coming. Kana is coming to talk with us at 1:00 p.m. So think of the things you want to ask Kana about at 1:00 p.m.

Thanks, everyone.

[Recessed at 12:03 p.m.]
[Reconvened at 1:05 p.m.]

Agenda Item: SAMHSA Leadership Discussion with CSAT Council Members

DR. KIMBERLY JOHNSON: Welcome back, everyone. As you can see, we are joined by Kana Enomoto, who is SAMHSA's -- new title -- Acting Deputy Assistant Secretary for Mental Health and Substance Use. This is your chance to ask questions or discuss anything you'd like to bring to Kana's attention.

Kana, I don't know if you wanted to say some things before people started assaulting you with questions or --

MS. KANA ENOMOTO: I get confused that it turns green, then red.

DR. KIMBERLY JOHNSON: Yeah, red is on.

MS. KANA ENOMOTO: Red is on. I know most of you. It's good to see you again. But I would -- it would be great to go around and just to have you guys introduce yourselves, where you're from, and then kind of what's top of mind for you and what you might like to discuss. It's not an assault. It's really a conversation.

But before you do that, I do want to acknowledge that we have -- really had a great year. I sent up the FY '16 accomplishments, and SAMHSA really did, I think, have a banner year. And we overcame many, many challenges, including not having a Director for part of the year, and then not having a Deputy Director for part of the year in CSAT. And I want to commend our new leadership team in CSAT. You really do have the best of the best.

Really skilled, consummate professionals and experts, and they -- so I appreciate having both Kim and Elizabeth at the helm of CSAT. And a really fantastically dedicated and strong team. You know, with the Cures Act being signed in December and SAMHSA being able to post that funding announcement the very next day really was an example of Government at its best, as Deepa would say, not Government at its normal.

[Laughter.]

MS. KANA ENOMOTO: At its best. So we can't come to expect that every time, but I have to say that our team really pulled together working with the department, working with the White House to make sure that those funds that Congress identified and the President ratified as being so important to the Nation are going to get out as soon as possible.

And we took, with Cures passing overwhelmingly in the House and the Senate in a bipartisan way, that there is a mandate and not just support for SAMHSA, but really an enthusiasm for SAMHSA and what it does and what it has to offer the country. And so we're -- you know, I know there may be questions about transition and what's happening. There are lots of questions. There's lots of change happening. That goes without saying.

But for SAMHSA, we're feeling, I think, very positive, very confident that the Nation has spoken very loudly about how important these issues are, and we're here at the right time and the right place to make good on the promises that we've made in Cures and CARA.

So, with that, if we could just go around and people could share kind of what you're thinking about and what you're curious about or advice that you have, then we can just have a conversation from there.

DR. KIMBERLY JOHNSON: Paul, you get to go first.

MR. JOHN PAUL MOLLOY: I've got to bite my tongue because I was sitting here thinking, my God, we have to be grateful for the opioid, you know, crisis because without the opioid crisis, probably Congress wouldn't have paid any attention.

MS. KANA ENOMOTO: Very true.

MR. JOHN PAUL MOLLOY: Bad thought.

MR. ARTHUR SCHUT: It's cynicism. Well, just in general, I have concerns --

DR. KIMBERLY JOHNSON: Put on the mic, Art. So we can --

MR. ARTHUR SCHUT: Sorry.

DR. KIMBERLY JOHNSON: So people on the phone can hear you.

MR. ARTHUR SCHUT: Yeah, in general, I have concerns of which we've talked about previously here, but about implementation of evidence-based practices. And I have concerns also in that context of being concerned about what's not an evidence-based practice and, in fact, what is harmful and should not be done, and there are a variety of those things. But if people continue to do things that are ill-advised and not appropriate and harmful, then I think we need to be explicit.

So, and then a good, nice, shorthand way to test -- when we test for fidelity when you implement something that is an evidence-based practice as opposed to current methods for fidelity testing, coming to that movement.

And then I do have a general concern about what States have been doing in part around the assumption -- many of them made changes in or anticipating reallocations, started reallocating funds on the assumption that Medicare would pay for all treatment, and clearly, that might not be the case. And Medicare also doesn't pay for people, the people who are 138 percent above poverty, 139 percent above.

So you end up with people who have high deductibles and high co-pays, and that's very difficult. So some -- some looking at how States are using block grant dollars, and now that there are plans to have Medicaid take over all that, if

there's a reversal of the expansion States or there is not expansion in other States, how the block grant is available for treatment.

MS. KRISTEN HARPER: First of all, thank you so much for your effort last year with the reports, the Surgeon General, the Cures. It's just a common thank you probably. It does not hold the weight of appreciation from us. So all I can offer is that. So --

I -- Kris Harper, I'm now at the RCO in North Carolina. I'm the executive director for Recovery Communities of North Carolina. And I -- coming up through the collegiate recovery world and youth recovery support, recovery high schools was incredibly helpful for me to identify what populations were able to get access to resources and to treatment and what populations are not.

And now having this new experience in an RCO, I see that RCOs cast a wider net. They really have access to minority populations, larger, other sort of populations that just are not being seen in collegiate recovery, recovery high schools, or really adolescent treatment. So that's one of my concerns is how do we open up services to include populations that are not being seen right now? So underserved rural populations, minority populations.

My other kind of --

MS. KANA ENOMOTO: I think I asked you guys that question. When we talked to the youth recovery people, I asked that. So, good. I'm glad.

MS. KRISTEN HARPER: Yeah. So we -- also with the earlier conversations, training for healthcare professionals, that is something else that seems to have been kind of coming out of the conversations today. It's, you know, how do we identify what needs to be tweaked for training? How can we as folks with lived experience play a part in that?

And then also my last kind of thought for the room is how do we get peers more involved in the conversation, in this process? Either you know, creating opportunities to participate in research or to be a key piece in the continuum of care that's happening. We'd like to have an important voice, and again, you've always heard our voices. So we just want to make sure that continues.

[Beeping.]

MR. ANDRE JOHNSON: Hey, Kana. How are you?

MS. KANA ENOMOTO: It's the famous Andre Johnson.

[Laughter.]

MR. ANDRE JOHNSON: I was thinking about when I saw you speak at the Unite addiction event in D.C. a couple years ago, and you were like a rock star when you came out there.

DR. KIMBERLY JOHNSON: She even had a leather coat on, remember?

MR. ANDRE JOHNSON: Oh, wow. I didn't know --

[Laughter.]

MS. KANA ENOMOTO: I was copying Nora Volkow.

MR. ANDRE JOHNSON: But I did want to, you know, take a moment and just let you know that we appreciate you. At least I appreciate the fact that, you know, we had some phenomenal leaders worked with you over the years and having Tom Coderre and Tom Hill, and you know, ONDCP Director Mike Botticelli and Peter come on. And really, for me being a person in long-term recovery, I like to think they really contributed heavily to the recovery movement nationally. And I would like to think that the needle has been moved in this country, and this is a direct result, really a shift, in you being mindful of the recovery, the importance of recovery.

And I'm just hoping, and I said this earlier that I'm hoping we can keep that synergy and keep moving the needle and making sure that we have people in leadership positions in this country, and people who are in long-term recovery bring a certain amount of I'd like to think passion, compassion, empathy, and experience and education. And so I'm just hoping you keep that going.

I just wrote down a few items that I brought out earlier. There's one -- some of the things that I would like to see on a local level. Because we've had a lot of good success on the national level, but how does that filter down into the local communities that have major issues as relates to their struggles?

Being a person in a major urban city like Detroit, we get the crux of everything. Meaning that, you know, our Michigan Department of Corrections budget is $3 billion. We house 50,000 inmates in the State of Michigan, and 80 percent of those people are returning back to the city of Detroit after 15-, 25-year bits, for lack of words, and a lot of them had SUD and mental health related issues that never necessarily got treated.

And prison and the county jail system has become more a holding -- holding grounds for people with mental health disorders, especially with the close of psychiatric hospitals. And there's a lot of conversation about co-occurring, integrating mental health and substance use disorder funding streams together, and what I've seen in our region, in our Wayne County area, it's a $1 billion budget. And that budget, 95 percent of that budget is for mental health. And

substance use providers tend to struggle with that little pot of money. You know what I mean? And just really making sure we have a solid integration of those programs obviously in conjunction with primary healthcare.

Then I would really hope to see SAMHSA, CSAT, you know, really take the lead in saying, hey, we're going to push it African American. I mean, this is Black History Month, you know? Let's celebrate Black History Month, you know, in this country. I mean, it's something we all should be talking about, and we should have a little thing around recovery and African American, you know, whatever.

I'm not -- I don't have anything specific, but I'm just trying to be as creative as possible to capitalize off of the times, capitalize off of where we are right now. In Detroit, marijuana usage is heavy. We have over 200 and some medical marijuana dispensaries, and black kids smoke marijuana like I drink water, and I drink a lot of water.

Opioid, you know, I think our country, and you guys, everybody really capitalized off of -- I don't want to -- maybe "capitalized" is not the right word, but this opioid epidemic is not new in the urban community. So for every white suburban girl that may have died in our area, there were 10 overdoses of poor black people. And so I really hope that at some point we can articulate some of the real realities that exist around addiction, you know?

Yeah, we know this opioid is a crisis, but it's just not -- it didn't just become an epidemic last year or the year before. There's been an epidemic since the '60s in our area. But I really want to just, you know, applaud you for all the progress you guys have made in these, you know, transition times. And I hope you stay in that position because you've got a wealth of experience.

Thank you.

MS. SADE ALI: Good afternoon, Kana. Anybody who has met me even once knows what my passion is and my reason for -- one of my reasons for being here because it's certainly not the only one. I, too, am a person in long-term recovery, and I shared with this group that next week will be 47 years that since I used heroin and cocaine.

And I so agree with you, and I know you heard me saying "amen" when you were talking about this. There's always been an epidemic in some of our communities. It's not -- so thank you for bringing that out.

I also want to say to you that I want to share with you a comment I made this morning to -- please tell me her name, Jinlee?

DR. KIMBERLY JOHNSON: Jinhee.

MS. SADE ALI: Jinhee. Jinhee, when she presented about the Surgeon General's report, as when I was Deputy Commissioner for the Department of Behavioral Health in Philly, my staff, which was 685 people, nicknamed me the language police. And I think it was done with love, and I got a mug and a badge and all of that.

But I heard nothing but strength-based language in that report. That really gladdened my heart. That was so wonderful. And the attention to those of us who have made -- are making this journey to recovery and that there are many roads to that recovery and those need to be explored more, I really appreciate that, and I need to say that to you as well.

My -- of course, my passion is around my community, the indigenous people of Turtle Island. So the United States and where my reservation is in Canada. We have a -- we're in a crisis. We're in a crisis like never before. There have been multiple acts of genocide against our people since contact, and they're still happening.

I went to the Dakota Access Pipeline at Standing Rock, Oceti Sakowin camp, and I stayed there, and I led prayers as an elder because I'm an elder in my community. When you reach 65, you're an elder. I'm 70. And I led prayer circles, and the only weapons we had were prayers.

And I walked around, being a person who is heavily involved and has been, I've been in the field as long as I've been in recovery, with the behavioral health of our people, and I saw the post traumatic stress disorder of people who were coming back from the front lines. They didn't allow me to go to the front lines because I can't move as fast as I used to, and there were a lot of attacks on our people.

But I saw the PTSD in those camps, and it broke my heart because I know that this is just another one of those genocidal tactics. And not to take anything from Flint really, not to take anything from Flint, but those things have been happening on our reservations for a long time. Some of the pueblos, they have undrinkable water in New Mexico and in Arizona. People, you need water for life.

The things that our people are enduring make it even more, even more relevant that we provide the best behavioral healthcare, that we understand the challenges that it's not just about the use of alcohol and other drugs or the mental health challenge, that we need to look at what's going on in here, not what's wrong with you or what happened to you. And to do that in a cultural context by people who are -- not just trained, but who are of the people. And we're out there.

So that's always going to be my -- my passion. And also recently some of our grantees and myself were on a call around the development of recovery

community organizations in response to the money coming out of CARA, and the ITC Michigan, the director of the ATR program that was on that call with me -- and she's going to be sitting here. This is somebody I love a lot, and she's wonderful, Eva Petoskey, and you're going to love her, working with her, right?

MR. ANDRE JOHNSON: Eva is --

MS. SADE ALI: She is wonderful. And we decided that we were going to do something trying to create something that's culturally resonant with indigenous thought, using medicine. And I saw the agenda for the TTAC, and how do they start out with a prayer? I would love to do that. I know it's not appropriate in this group, but that's who I am. So I did it before I came in here. But that's culturally resonant. They're running their group as Native people.

So we decided we were going to call our things "healing circles." So we're in the process of actually creating something that's going to be resonant across Native America, not only in tribal nations, but in urban settings as well with Native health centers, with Native community centers so that we can actually be able to say to recovery community organization structure, yes, we're doing the same thing. We're people in long-term recovery helping each other onto the red road of recovery and doing it in a cultural context.

And we've actually started that up in the ITC Michigan with Dana Neubrest, and that name, I know that name is very popular, and she's very well known. And we brought her in, and we did this unbelievable elders women -- elder women healing circle in Michigan in a snow storm, and it was -- yeah. But it was beautiful, and it's a start of actually responding to those things. I'm asking you, please, don't take your mind off it. It might seem to you like a lot is going on, but more needs to happen.

Our children are dying, you know? We need to stop that cycle. We need to uplift the people in a way that's resonant with us, that we can hear it and that we can respond to it with people who look like us and people who are of us. There are certainly enough of us.

Thank you.

MS. KANA ENOMOTO: Thank you.

DR. INDIRA PAHARIA: Hi, it's so nice to see you. I have a different role now, and I'm with a large nonprofit human services organization. My focus is research, evidence-based practice, quality, and data analytics. And so a lot of the conversations we've been having this morning have been really relevant to work. We predominantly serve children and adolescents as well as families, including -- the services are developmental disabilities, juvenile justice, mental health, substance abuse, child welfare.

And you know, one of the things that I'm wondering about having, as you know, having a background in managed care, we're -- the organization I'm with, Hillside Family of Agencies, we're predominantly throughout New York State and then some operations in D.C. and Maryland. But as you might know, New York State was planning to move a lot of vulnerable children into managed care, and now we're not sure what's going on. And I know this is something that the whole country is wondering about, as different States are focused on this.

So if you have any insights on that, and Medicaid, I'm sure everybody would love to know, but that's something we're struggling with trying to read the tea leaves, and everything just keeps getting delayed and delayed and delayed. And in some ways I don't have a problem with that because I think some of these populations really shouldn't be in managed care, having worked on that side of it and knowing what that's like.

But on the other hand, if we are going in that direction, there's a lot of planning that has to happen for services like residential treatment, day treatment, and outpatient for kids. So, so thank you.

MS. KANA ENOMOTO: Congratulations on the move.

DR. INDIRA PAHARIA: Oh, thank you.

DR. JUDITH A. MARTIN: Good afternoon. Thanks for hearing us today.

My name is Judy Martin. I'm from San Francisco, and I've been involved in an interesting activity, implementing the 1115 waiver that turns drug Medi-Cal into a managed care plan within the county. And in doing that, I realized how -- what a step up from implementing a SATP grant that is. In other words, there is a lot that -- much raised accountability as well as professionalization and including an evidence-based level-of-care placement tool.

And so, you know, I realize that we may be losing that soon because a lot of it is even though 1115 waivers way predated ACA, of course, but if the expansion is eliminated, many of the people who would benefit from it would not because the expansion disproportionately affects substance-using adults.

I don't know if that results in any kind of request to you, but -- but one thing I would say that this waiver pushes that I think is a really good idea that's been primary for me for a long time as an addiction doctor, and also treat in primary care, is the integration of care in areas that where the funding streams have been fractured since we've been alive. And sometimes the integration of those funding streams, it's sort of like is their old pilot study maybe never happened, and it's sort of turf issue kind of stuff.

So it's a difficult thing, but I think that in view of promoting the health of our patients, if -- if primary care were more able to offer substance use treatment onsite, I think that would be huge.

MR. LAWRENCE MEDINA: Good afternoon. I'm Lawrence Medina from New Mexico, a new kid on the block here, but it's good to be connected with some wonderful people.

And you know, New Mexico, we have our challenges, and like other States are well advanced and moving along, and you know, you look at smaller States or poorer States like New Mexico, that we have -- we tend to stumble over ourselves. You know, 15 providers shut down, claim fraud or Medicaid fraud. They were all by the Attorney General cleared, but it's just this collective insanity that is quite embarrassing, you know, but due to the politics and the dysfunction that is kind of like I'm in long-term recovery, and we say I'm trying to fix a broken thinker with a broken thinker. You know what I mean?

And it's just New Mexico, based on the issues that we're faced with, but our systems of care. You know, so any support or nudging that we need to continue to move along to address the issues that we're faced with as a State is deeply appreciated.

A couple of areas, you know, rural and frontier areas fall into the cracks. That's always an issue that we were talking earlier about evidence-based practices in metropolitan and urban, great. But what about people of color, you know, that -- you know, just that there is still some focus, and what SAMHSA provides in terms of resources is great. You know, that we were talking with somebody who has some apps and all the free resources that SAMHSA provides is big, big in training and so forth. So thank you.

What we're finding out that a new model, that crisis stabilization units, that a lot of the State cannot afford to start opening up these detox. Medicaid doesn't pay for it, but looking at cost-effective ways of and looking for resources for, you know, kind of these ambulatory detox or crisis stabilization units that don't need to be in a hospital that we see that could be beneficial in small communities.

I think another thing in New Mexico that according to Dr. Wayne Lindstrom with the Behavioral Health Services Division, you know, said we possibly may be headed in a perfect storm with the shortage of clinicians, and you know, and the pay, and there are so many factors. But what can we do to address that?

And lastly is for States that how can SAMHSA or would SAMHSA consider to increase block grant funds for States that really need it? You know, and understanding that there's always limited funding, but you know, consideration that these grants that are competitive, that we compete against, respectfully, the big cities, that we don't have a chance at.

You know, we don't have the contents in those grant proposals to even compete. And it takes 80 to 100 hours to write it, and plus, to even get to that point, but to look at some of these States and how SAMHSA could increase block grant money to help us with these areas that we so need. So thank you.

DR. LORI SIMON: Welcome. I'm going to talk about two things because I wear two hats. So the first is my clinician hat, and one of the things that I've been running into is the huge problems with insurance. Now I'm not -- I'm not of the ilk of, oh, let's get rid of Obamacare, you know? Because that's very simplistic because I think there are some very good things that Obamacare did. I mean, certainly, there's a lot more people who have been insured who didn't have any insurance at all.

And so, but there are also significant problems, and I run into it almost on a weekly basis. With me, because I do outpatient work, it's a lot of trying to get medications for patients. I mean, I can give you one example that's coming up now. A patient of mine who needs the brand name of an antidepressant because the generic doesn't work for her. The insurance company, they -- it's kind of you play Whack-a-Mole with them.

So another thing is, okay, they'll approve it, but it's going to cost the patient literally like $500 she doesn't have. She's on Medicare. She doesn't have that money. And so she was able to get into a program but has not gotten that medication yet. And so she's literally prescribing like 7 days at a time. I mean, it's insane.

And at one point, she said to me, well, I'm just not going to take it, you know? No, you can't do that. You know? So I mean, I could go on and on and on. I mean, literally, I got delayed 45 minutes yesterday driving down here from my office in New York because I was on the phone screaming at an insurance company about some insane, insane medication issue.

So, anyway, so what I think --

MS. KANA ENOMOTO: I'd hate to be on the other end of that.

DR. LORI SIMON: What?

MS. KANA ENOMOTO: I said I'd hate to be the insurance company on the other end of that.

[Laughter.]

DR. LORI SIMON: You can only imagine. It's horrible. It's horrible. So the -- I think what SAMHSA can do is -- is, you know, one of the things that needs to be

done is there needs to be an intelligent discussion around insurance. And the way you do that is you talk to both the patients and you talk to the providers, and you find out what -- where are the problems. Because that, and you know what, if you do that for behavioral health, it needs to be done for every specialty.

But if you guys do that for behavioral health and substance use, you know, you're setting a very good, you know, lead for -- for that because it has to be done, and that's the only way there's going to be an intelligent discussion about where the problems are and what needs to be done. So I just encourage you to do that.

The second, the other thing is with Medicare because Medicare keeps coming up with all these different ways because they're trying to get data from doctors. They're also trying to encourage them to use computers. But they go about it in such a -- and now we have the newest version of MACRA, but everything is up at 76,000 feet. And so the result of that is that at least in the New York metropolitan area, more and more doctors are just getting out of Medicare. It's not just -- it's not psychiatry.

I'm one of the few doctors that takes psychiatry -- I'm one of the few psychiatrists that takes Medicare, but I'm talking in all specialties just because they don't want to deal with it anymore. So that's not good. So that's one issue.

The second thing is, is my other hat, which is the computer side of things. And I really think that SAMHSA, I mean -- and they have. You know, I know it's one of your focal focuses is health information technology, and I know you've done some really good projects. I would like to see more of a lead taken at SAMHSA.

I've actually tried working with the American Psychiatric Association a bit, but I'm starting to see that there's limitations there, and I think SAMHSA, which represents all of mental health and substance abuse, can really take a leadership role even more than they're doing now. And so what I'm doing is I'm organizing a bit of a meeting at the end of February with Kim and Anita Everett because she spans both worlds, the APA and here, obviously.

And two of the techie guys here, Jim Kretz and Ken Salyards, and we'd love it if you could join us. So to just start a conversation and to see where we go.

MS. KANA ENOMOTO: I love the techie guys.

DR. LORI SIMON: You're invited.

MS. KANA ENOMOTO: I'm just curious, but when you say you think that SAMHSA could take a bigger role in the HIT space, in what way or --

DR. LORI SIMON: There's -- I mean, I'll give you just one example of a project

that I've been trying to get going because I'm actually now active in HL7, yeah. And that's what I mentioned to Kim.

So, for example, there is a big -- there's a big disconnect on what gets created in terms of software for providers and what they need. And healthcare is very unique in that way because in every -- and this is what I was talking about with the insurance of asking the people. When I used to develop software before I got into healthcare, I would go to the departments that wanted the software and find out what they needed and work with them. Doesn't happen in healthcare very much.

So just one project, what I'd like to propose is to develop a database of requirements that providers need not only for -- in all aspects, not just psychiatry, all aspects of behavioral health. And then have to be used by two groups of people. One are the vendors. Okay, so the vendors can see, okay, this is what a social worker can use who's in a mental health clinic. This is what a psychiatrist needs in an outpatient setting, for example.

And so that they see what's needed, and then they can also in their database say, okay, this is the products I have. This is what I support or don't support either partially, fully, planning on supporting it, whatever. And then the other is for the providers to say, okay, this is what I need in a software tool. Let me see which products the vendors have support my needs.

And so I tried to get that going in the APA, but there was some limitations there. And I'd like to get HL7 involved in doing that, but there's funding issues. And so that's just one product, one product idea, but there's others, too. So --

MS. KANA ENOMOTO: So helping to support innovations or analyses that --

DR. LORI SIMON: Yeah, understanding what's needed in technology. Kind of really taking a lead in that.

MS. KANA ENOMOTO: Well, you guys are good. Kim has her hands full.

[Laughter.]

MS. SADE ALI: Yes, she does.

DR. JUDITH A. MARTIN: We talk to her even more.

MS. KANA ENOMOTO: I bet. But it's great, and it's exactly why you guys were selected to be on this council because you have good ideas, strong ideas, clear vision, and you're not afraid to say what you think, and that helps us. And we can only be stronger by having you guys share your diversity, coming from very different perspectives, which is excellent for us.

You know, and I want to go back to actually what Paul said in the beginning about, you know, that it took something so tragic as the opioid crisis to bring -- to bring attention to our issues and spotlight on is I think I would pair that with some of the tragic events that happened that brought about the Helping Families in Mental Health Crisis Act and its origins and getting a lot of fuel from Newtown and other types of events that occurred.

And so it's true that there were a number of tragedies, personal and national, that fed into the movement and the energy behind Cures, behind CARA, behind Helping Families in Mental Health Crisis, and it's too bad. You know, I think that it's interesting when sometimes I was talking to Paul Hinds from NIMH, and we were talking about how researchers -- well, many researchers still think if we just produce the data, then people will act.

And both had our data for a long time. We've had the clinical data. We've had the economic data, you know? We've had population-level data, and people weren't acting. And so it is -- it is too bad that it took, you know, people -- people dying.

And this isn't the first time that people died from behavioral health conditions, but it was people dying that were a lot -- that looked a lot like the people who make these decisions. That's what -- that's what moved the needle, and while all of it makes me quite sad, I think we do have a huge responsibility based on that, that this is progress born out of tragedy that we really have to make good on it so we don't have to do this again. But I did want to acknowledge that point.

And it does -- you know, Andre, you know, you don't want to exploit the misfortunes of others, but I think what we do want to do is honor it, and then it's true that the opioid crisis is not, it's not necessarily a new crisis to everyone. Where you come up with the term of "epidemic," it's the -- it's the exponential growth in a certain population, the incidence of the problem so that it has grown faster in certain populations than others, but it has also doubled in communities of color. It has quadrupled in Indian Country.

So it's not -- it's not isolated to any one community, and it has had longstanding history across multiple communities, particularly urban and other of our service communities. So we can't take our eye off the ball. I think we are -- amidst all the change that's going on here, I think we really should give a lot of credit to the staff, who are so laser-focused on our mission and on what they're here to do, which is to advance the issues of prevention, treatment, recovery for people across America.

And they're great. I think our -- you know, people, you know, amidst lots of ups and downs and people have feelings about what's happening in the country one way or the other, but I commend our staff because they've been able to stay

focused, and we've been meeting our expenses, we're getting our stuff out. We're getting our work done. We're doing stuff that's of, I think, the highest quality that we've ever achieved in terms of how we're doing our budgets, getting our FOAs out, being on time, doing our audits, getting our records straight, getting our grant files straight.

And getting out incredibly important policy documents like the [inaudible] and the 42 and the SGR and 223. I mean, we have so much to celebrate, and people are so productive and that's amidst considerable HR challenges and operational challenges and things like that. And that includes us thinking about issues of recovery communities that are harder to serve. The need for innovation when we have a workforce that doesn't come near to meeting the demand for services, and not just the demand for services, but the undemanded need for services that we know exists.

So we have to be creative. And you guys didn't really ask about transition, which kudos to you.

[Laughter.]

MS. KANA ENOMOTO: But it is -- it is out there. The last council, someone said, "No one seems to be talking about all of this stress and, you know, change," and blah, blah, blah. It's like I want to live where you live, where no one is talking about that because where I live people talk about it all the time.

But you know, I think regardless of where it goes or how things unfold, you know, we can't -- we're not going to put -- we're not going to be able to put recovery back in the box, right? We're not going to be able to put integration back in the box, and it's not just because SAMHSA has done such a good job of getting the word out or because the SG has done a good job of getting the word out or anybody else. But because, you know, we had a West Virginia community health center system come in, saying we need help on behavioral health because we're doing great on our quality metrics all the way up until, you know, we need to be managing the behavioral health issues.

So we're doing -- we're getting up to, you know, 90 percent of where we want to be on diabetes, but if I want to get that one step further, I've got to help people manage their depression. I've got to help people manage their substance use disorder. Same on cardiovascular disease, same with cancer, same with everything else. They know that they need to address our issues well if they're going to really get top marks for addressing everything else that they're responsible for.

And I think that's true -- it's increasingly true in workplaces and increasingly true at colleges and universities and high schools. People, that they want their kids to be school ready, to be school successful and to graduate. That, you know,

our populations have the highest dropout rates, you know? Our populations have the highest unemployment rates.

So for every -- I think other domains, you know, child welfare, juvenile justice. You know, the juvenile justice folks are our best friends. They love SAMHSA. ACF, not making a political statement, but at the end of, you know, January 20th, we were trying to put stuff out around, you know, to the child welfare system. Not to circumvent anything, but because those folks understand how important behavioral health issues are to the human services world.

And so all of that is to say that no matter what happens in the policy landscape with the Affordable Care Act or beyond, I think it's going to be our job collectively to help the system navigate bringing behavioral health into the mix of healthcare, into the mix of human services, into the mix of education because it's just -- it's gotten past politics. It's just people are becoming aware that this is -- this is in their lives. This is in their families. This is in their communities.

And so whatever system, whatever political context, we're going to have to deal with it. And it's all our jobs kind of in the -- in a neutral fashion or in an aligned fashion to figure out how do we thread that needle? Whatever this context is of this situation, this institution, this set of issues or conditions, how do we -- how do we help them address what we know are the challenges of mental illness, substance use? How do we advance prevention, treatment, and recovery?

How do we incentivize care for the people who need it the most? And I think that's the opportunity that we have ahead of us, and you know, the Medi-Cal 1115 waiver, I think we're going to be looking to California to see how that plays out. And very hopeful. I know people are very excited about it. I think there is great opportunity there, and we can learn and take that learning.

And again, I have the sense that -- and people aren't saying let's provide bad healthcare. People are saying there are some challenges with the way this one system was structured. We need to fix that and make it better. But I think the idea is to make it better, not to make it worse. And so I think let's look at what is happening in California, what happens with the 1115 waiver, how is that relevant to others, how can we capitalize on it, how can we spread it, how can we make it better?

And what -- you know, what does it mean? And ultimately, are we getting better outcomes for people? That's, I think, what everybody wants.

In terms of the block grant funds and poorer States, there is a piece, and Brian will talk about Cures. There is a piece in there that talks about looking at the formula, but it is not -- that's why it's a formula grant and not a discretionary grant. We don't get to decide we're going to give some States more money and other States less. There is a formula that gets run every year, and funds are

allocated accordingly. We may be putting that formula out for comment and having a look at that formula, but I thought it would be a bigger consensus, public-ish process.

Talking about evidence-based practices and warning against harmful programs, I mean, that's very interesting that you bring that up, and I think that's something, you know, I encourage you to talk to Anita, the Office of the CMO, as well as our Center for Behavioral Health Statistics and Quality. We have -- and you guys have heard about NREPP 9 million times because we talk about it. At like every other council meeting, someone wants to talk about it.

But you know, the folks in CBHSQ have been very excited and really doing a nice job of building out that learning center, the place where we would talk about innovations, about things where we don't have lots of data. We don't have a randomized controlled trial, but it's something that people need to know about. And I've talked to some guilds and others that are realizing the need, you know, where we're a little bit short on having that full-scale trial that would go into a journal, but that could be beneficial for others to know about. And then eventually, we scaffold off of that learning and do that.

We're also in the process of doing re-reviews. So, you know, it's not necessarily warnings against harmful practices, but we are looking at the practices that are in NREPP, saying are there some of these that we want to take a look-see if they are still kind of would meet the criteria that we think in this day and age they should be meeting in order for it to have an endorsement through the NREPP, and how effective do we really think we are? And at the same time, we changed our ratings in NREPP so that we would be able to document when something doesn't have strong evidence and that we would say so.

Because in the past, the model developer could choose to not have their model included, but now that's not -- that's no longer an option so that you would have something in there that says there is -- evidence is not demonstrated for this particular model. So it's not going all the way to where you're saying, but it does go in a direction.

And the Surgeon General's language, I want to commend the team for that. You know, Director Botticelli and ONDCP also put out a guide around language. But we had been working on the report for some time before that guide came out even, and it does represent very strong leadership on behalf of some of our strong and wonderful leaders that we had with us through the development of the report. Tom Coderre was a great leader there.

We had originally gotten -- but it also signifies great partnership with our colleagues in the research community. So in the neurobiology chapter in particular. It started out with the definition of addiction as a chronic disease of the brain, susceptible to relapse or sort of -- oh, it was a chronic relapsing

condition of the brain. And that was the definition of it, and we were like, well, that's so it just sounds like relapse is inevitable, that it is a relapsing condition and everyone relapses.

And so we actually worked with them to come up with a different definition. It was a chronic condition of the brain with the potential for recovery and recurrence and that we would talk about it as we talk about other conditions. Because "relapse" really places the responsibility on the individual versus "recurrence," which places the -- puts the action on the condition. And but that, so, yes, we pushed it. But the institutes, Nora and George both accepted it, right?

So I think that there's progress all around, and we have such good partners, and everyone, you know, is -- has heard, I think, from the field that this is the way that the field wants to go. So it wasn't a fight, I guess, is my point. But that they were like "Sure, great. We get it." And we were sort of prepared for like more argument.

[Laughter.]

MS. KANA ENOMOTO: It was like a series of three emails, and we're like, oh, hey, we've got a new definition. That was really easy.

So I think it is strengths-based, strengths-oriented language and it's a credit to our team, but also a credit to all the folks across the department and our scientists who all cleared it and approved it and believed in it. And a lot of that is with the Surgeon General's really wonderful leadership because he embraces our issues, and he is such a strengths-oriented person himself, and so he brought that, I think, feel to the report overall.

But with that, I will let you guys go. Thank you very much. It was a good conversation. And keep it up. Keep it coming.

DR. KIMBERLY JOHNSON: Thanks, Kana.

[Applause.]

Agenda Item: The 21st Century Cures Act

DR. KIMBERLY JOHNSON: So next we have Brian Altman, who is the Division -- Director, Division of Policy Innovation. Is that actually your title? What's your -- you're a Division Director, but it doesn't say what you're a Division Director --

MR. BRIAN ALTMAN: Yeah. So I'm the Director of the Division of Policy Innovation within OPPI, as well as the Acting Director of the Office of Legislation.

DR. KIMBERLY JOHNSON: Thank you. So he's going to talk about the Cures Act. Take it away.

MR. BRIAN ALTMAN: I'll just take a personal point of privilege since I heard the question. We actually have put out one guidance document, a report on something you should never do, would be wrong, which is conversion therapy. So in October of 2015, we published the report, which I call our "unscience" report. It goes through 20 to 30 pages worth of how unscientific that is and how it should never be done. And then the other half is what you can actually do to support -- you know, for LGBTQ. So I have a third hat, LGBT policy lead, as you know.

But for the Cures Act. So for those of you who haven't followed that quite as closely, it was about a 4-year process on the mental health side at least, which you know for Congress is actually pretty quick. So in 2013, Congressman Tim Murphy, who was a child psychologist, had introduced the Helping Families in Crisis Act. And it was an interesting bill, to say the least.

But as we sort of, I think, told people, both on the outside and our particular staff, that bills change over time and sausage gets made and committees have hearings and don't -- don't look at the original product as what will likely be the end.

So at the end of the day in the House, the bill did look very different than the start, and it passed the Energy and Commerce Committee by a wide bipartisan measure. And in the Senate, there have been two bills. Essentially, a chairman's bill, Chairman Alexander and Ranking Member Murray, there's sort of a small mental health bill that reauthorized some of our programs.

And then Senator Bill Cassidy from Louisiana and Chris Murphy from Connecticut have a Tim Murphy-like bill, and they changed the title. It was no longer the Helping Families in Mental Health Crisis Act. They put a sort of less crisis, you know, spin on it, which we appreciated, and sort of didn't include some of the more -- provisions that were more controversial.

And so --

DR. JUDITH A. MARTIN: [Inaudible.]

MR. BRIAN ALTMAN: Well, yeah. And so, at the end of the day then, again the House bill that had passed the Energy and Commerce Committee and the House floor was sort of the base, but there was negotiations that went on between the House and Senate, and we provided technical assistance along the whole way.

And then the other part of the Cures Act that relates to SAMHSA is the opioid

grant program. Hopefully, you know we had proposed that as a budget proposal in FY '17, and then they sort of took that budget proposal and put it into law in the Cures Act.

So it was enacted on December 13, 2016. I don't know if Kana mentioned that she and I and Tom Coderre were able to go to the White House for the signing ceremony. So I think that just shows not only the importance of that part of the bill -- because it was a much broader bill -- and the importance of SAMHSA and the behavioral health field that there was this broad, bipartisan, final sort of signing ceremony in the White House that we were able to attend.

And at the end of the day, it sort of also moved from sort of a mental health bill to what eventually is essentially a SAMHSA reauthorization bill. So those of you who have been around a while, the last time we were reauthorized as an agency was in 2000. So it was 16 years since our last full reauthorization. It essentially reauthorizes the agency, for the most part.

So key issues, I would point out here -- if you didn't know, I'm doing this five times today. So I like to point out the key areas for each of the different advisory committees. So the opioid grant program, obviously. This actual advisory committee, the statute requires that it says NIDA and the other one said NIAAA, but it was actually both for both. So both the NIDA and NIAAA Directors are ex officio members of these -- of this advisory committee and that at least half of the appointed members of this advisory committee have to have one of these degrees or experiences.

But suffice it to say that we did some research before this became enacted, and so we were very -- relatively very confident that no makeup would have be changed. We wouldn't have to kick somebody off because this was going to become law, and looking at packages before, we were relatively sure that we wouldn't have to like tell somebody they couldn't join because they don't meet this criteria with that 50 percent balance.

It requires that within one year of finalizing the Part 2 rule, which hopefully Kim has already told you got posted on January 18th, we have to have a stakeholder meeting, see how it's going. And then as Kana quickly alluded to, it requires a study and report on the block grant formula.

I'm guessing I probably -- do I still need to do a slide, or you talked about the opioid grant program?

DR. KIMBERLY JOHNSON: We did, but I don't think it would be a bad thing to -- just because I -- you know, I had a sentence about it.

MR. BRIAN ALTMAN: Okay. So, yeah. So the way it worked is like this really weird process because normally like you create a program, and then you fund it.

It turned out because of all the way the bills are moving at the weird times, we actually got the funding like a couple days or like a week before we got the authority to do the grant program.

But suffice it to say by December 13th, we had the authority to do a $1 billion program over 2 years, and they had released the first $500 million for FY '17 so we could put out the Funding Opportunity Announcement, which came out the day after the bill became law.

DR. KIMBERLY JOHNSON: Which I have told everybody that over and over.

MR. BRIAN ALTMAN: Right. Because it was all -- because the staff was incredible. And so that it was included in the CR. So, normally, a CR just carries over, as you know, the funding from the previous year. So it added this $500 million to our overall appropriations.

And the FOA itself, the Funding Opportunity Announcement line is a non-exhaustive list of allowable uses of the funding, and it requires the States to report on the uses. The grantee is essentially the SSA, and there is an appendix with a formula so that each State knows how much they would get if they applied with their successful application.

And then it's sort of like what we call here in Washington a "know your funding account," that the billion dollars went into. So you could sort of carry over funds for a longer period of time than normal under the statute.

So the rest of the bill is sort of it's about eight titles that relate to behavioral health in general. Six through X are sort of very specific to SAMHSA or a couple of programs here and there with our public health partners at HRSA or CDC. And then XI, XII, and XIII are issues that we work with other parts of HHS or other departments on that we have a huge stake in, but we are not the responsible party for the most part.

So I'll quickly go through those. So, hopefully, you might know by now that we don't have an Administrator anymore. We have an Assistant Secretary for Mental Health and Substance Use. And rather than a Principal Deputy Administrator, we have a Deputy Assistant Secretary. We think it elevates the head because I think in the non-Beltway or even in the Beltway, sometimes people assume or understand or think that Assistant Secretary has more power or influence or greater responsibility than an Administrator.

So to the extent that that perception is improved, there is a new title. That's great. I think it also sort of throws the perception that behavioral health is more important. We have an Assistant Secretary. I think that's great. But day-to-day operationally, the Assistant Secretary, just like the former Administrator, is presidentially appointed, Senate confirmed, reports directly to the Secretary.

As I said, sort of generally reauthorizes SAMHSA overall with some focus, you know, from the original bill on serious mental illness, homelessness, and veterans. And then there are parts of the bill, both operationally and programmatically, that we have been doing at SAMHSA for quite a while but were not actually in statute or codified or authorized.

So, for example, former Administrator Hyde created the Center for Behavioral Health Statistics and Quality, but subject to the whim of the next now Assistant Secretary or whatever, somebody else could have decided, well, we don't really need a CBHSQ or it should look like this or that parts of it should be moved here or there. And so this codifies the fact that we do have a Center for Behavioral Health Statistics and Quality. And also former Administrator Hyde established the position of chief medical officer, and that is now in the statute as well. Somebody can't come in and just decide we don't have a chief medical officer.

Lays out some overall planning and reporting requirements. We've already got to do a new strategic plan in 2018. So that's not a big change. We talked about the advisory council parts. The peer review requirements were specific to mental health grants. So there's no change in the peer review process for CSAT grants.

It tasks the Assistant Secretary with planning and evaluation, with creating an evaluation plan for department wide. So, essentially, they would look at all parts of HHS and sort of gives some planning and guidance on which operating and staff divisions might want to evaluate which programs for emphasis now or in a couple of years. And then it might outline which evaluations they're going to do versus which ones we should do here at SAMHSA or with our partners at NIDA, et cetera.

For those of you who know what the PAIMI, Protection and Advocacy for Individuals with Mental Illness Program, there's a GAO study, and it also creates an interdepartmental serious mental illness coordinating committee.

So Title VII is -- the titles are really interesting because they're sort of a throwback to the original bill, but what got implemented is a little bit different. So they really want to ensure that mental health and substance use disorder prevention, treatment, and recovery programs keep pace with science and technology.

So I sit in the Office of Policy, Planning, and Innovation. We gave it a new name also. We are now the National Mental Health and Substance Use Policy Laboratory. All things that happen in OPPI can be moved into the policy lab. And then it does sort of like give a greater sense of some issues or coordinating roles that we can do. But for all intents and purposes, it's OPPI renamed.

We obviously -- as Kana was just saying, we've had NREPP for a while, but it

wasn't in statute. So it codifies NREPP. And then as somebody might know, a lot of the programming in CSAT that's not the block grant is funded through what we call the programs of regional and national significance line. So it reauthorized that funding line, which allows some of our FOAs to go out with a cap at that level.

Title VIII is the block grant title. So there's a few new reporting requirements on both sides. It sort of like codifies that you can do the joint application, but it doesn't require that you do. So that's not really new. And then the two main things I would say are the maintenance of effort requirement allows for an alternative penalty. So I don't know how -- I got a question from the prevention people because I think how they relate to their SSA and having to file all the paperwork to get an exception may not be the same as the folks over here.

But for those of you who are aware, we've been running up against maintenance of effort requirement issues for a number of years now, especially on the SABG side because as more and more substance use disorder treatment is funded in areas of the State that's not the SSA, it's harder and harder for the SSA to meet the MOE requirement. And the penalty has traditionally been quite harsh in terms of the amount of funding that the State would lose. So this allows us to negotiate a different alternative penalty.

And then as Kana said, it requires us to study the block grant distribution formula. And so we would sort of convene a study, put it out for public comment, and then all the SSAs and mental health program directors can figure out who's going to win and lose and comment and complaint or praise us, which is -- that's for you.

MR. ARTHUR SCHUT: Is this the formula used by Congress to --

MR. BRIAN ALTMAN: Yeah. So they didn't change the statutory formula, but they said we may want to change the statutory formula later. You should go study like how they think we should do that. That wasn't something we encouraged.

DR. KIMBERLY JOHNSON: Art remembers the last -- yeah. I remember the last time, yeah.

MR. ARTHUR SCHUT: It was. It was, well --

DR. KIMBERLY JOHNSON: I asked the people when we were talking about this internally, I said, "Does anyone remember?" And yes, Civil War.

MR. ARTHUR SCHUT: Yeah, it was.

MR. BRIAN ALTMAN: It wasn't like those other provisions. This is not one of

those preventions -- provisions where we went to the Hill and said you know what would be a really great idea? Yeah.

DR. KIMBERLY JOHNSON: We just go study it.

MR. BRIAN ALTMAN: So we're going to study it, and you can comment.

DR. JUDITH A. MARTIN: But it says to report. What does that mean?

MR. BRIAN ALTMAN: So we have to send a report to Congress that says like, hey, we studied it. Here was the public comment. Here is how we think it should be changed. We don't think it should be changed. Yada, yada, yada.

They're guessing some sentence in there eventually will be there does not seem to be consensus on -- et cetera.

DR. KIMBERLY JOHNSON: Right. What are the options that were discussed? These are the comments on those options. Yeah.

MR. BRIAN ALTMAN: So Title IX is basically about the grants, and so they put it in three buckets of topics of individuals and families, workforce, and then college campus. I put it more in like operational buckets in the sense that this title is really broken up into sort of programs that we had. They were in the statute. They reauthorized them.

Programs we had because we got funded to do them. They weren't in the statute. Now they're in the statute. And then a third category is programs we never had. Now we have them, except that we don't have any funding for them. So we don't have them. The newly authorized programs, shall we say.

So, for example, it reauthorized our, you know, homeless grants, jail diversion, primary and behavioral healthcare integration, Garrett Lee Smith suicide prevention, and it established treatment and Sober Truth on Underaged Drinking. Of those that they reauthorized, there's only two that really fundamentally changed. The primary and behavioral healthcare integration grant, for those of you who know, it was a grant to community mental health centers to bring primary care into community mental health centers for adults with SMI. Now it's essentially bidirectional for anyone with a behavioral health condition, and the grant goes to the State.

The Garrett Lee Smith Campus Program is essentially changed from a suicide prevention specific program to a broader behavioral health on campus grant program, and you can use funds in a different way, including hiring staff. So programs that we have been doing a long time but were not specifically in statute, our National Suicide Prevention Lifeline and our treatment locator and helpline. Now they're in the statute. We have to do those.

And then it authorized, the new programs are adult suicide prevention, assertive community treatment, and crisis response. And then it didn't create a program on older adults. So there's still no older adult grant program at SAMHSA, but one of my -- my fourth hat is aging policy lead because we don't, I'll be honest, do a lot on aging. But we should be doing more, according to this, in terms of at least TA and information sharing. So anyone going to prevention, they can watch my panel.

DR. LORI SIMON: I have a quick question. Just going back to Title VII, it mentions science and technology. But then when you look at the individual bullets, I don't see anything about technology.

MR. BRIAN ALTMAN: Well, it's keeping pace with technology. So I think, you know, when you were talking about like programs that we could do or should look at, like you could put them in the NREPP queue or something. But there was no sort of like -- there's no specific authorization or funding or language that says like you should do this thing.

There are within the OPPI/policy lab, they authorize innovation grants. So we could look at technology and how it's used through those innovation grants if Congress were to give us money for innovation grants. But even those innovation grants, they're not specific to like technology grants.

DR. KIMBERLY JOHNSON: There is a bunch of language that really ONC winds up being responsible for around technology in Cures, but it's not ours. I mean, it will impact us and we will be involved in those efforts, but it's really -- it's ONC winds up being responsible.

DR. LORI SIMON: Okay.

MR. WILSON WASHINGTON: I wanted to just add, the National Registry is a component technology piece. It says that -- it's talking about it under VII. You can go back to VII. But it is talked about under VII.

DR. KIMBERLY JOHNSON: The technology section of NREPP.

MR. WILSON WASHINGTON: Reauthorization of the National Registry, NREPP.

MR. BRIAN ALTMAN: Right. So the Title IX, then there's the strengthening healthcare workforce piece. So there's a program we've been working with HRSA on for a number of years, the mental and behavioral health education training grants that are authorized as a new program at HRSA focused on sort of medical residents and fellows, health service psychologists, and social workers and working with academic programs to get them out in the field.

For those of you who are familiar with the Minority Fellowship Program, you may not know that it's been in operation since 1972 between NIMH, ADAMHA, and SAMHSA. It was never actually authorized in statute. We just kept getting money year after year. So now it's in statute.

And then as Kana also alluded to regarding the need for a greater, larger workforce, there are reports that we will have to do on the state of the mental health workforce.

The campus section, in addition to the Garrett Lee Smith Campus Program that sort of has new uses, it also establishes an interagency working group on mental health on college campuses and a public awareness campaign to focus on behavioral health on campuses.

So Title X is the women, children, and adolescents. So, again, so it reauthorizes programs like our Joint Mental Health Initiative, National Child Traumatic Stress Initiative. And then it creates new programs, oh, and the SUD for adolescents program that's run out of CSAT. And it establishes new programs on maternal depression and sort of like a zero to 12 mental health promotion and sort of looking at the early signs for SUD grant program.

And so then the other key highlights of this thing, there is these other titles that we here at SAMHSA would not necessarily be responsible for, but we worked on for a long time and we're going to have partners on. So in addition to the meeting on Part 2, which I had mentioned earlier, this title also has various provisions related to HIPAA. If you followed the bill from the beginning, they wanted to carve out a section of HIPAA, which would allow providers greater latitude to tell family members and others what's going on with their loved one, family member, friend, and their mental health condition.

That would have been the only condition that would have been carved out of HIPAA, and so that was not in the final bill. Instead, what was in there was some language that other members of Congress had been pushing around clarifying what HIPAA really -- what you can and can't do under HIPAA and just getting the information out there. So it creates like a grant program for the Office of Civil Rights to train people on the connection between HIPAA and individuals with mental illness and what you can and can't say or listen to or do.

And then Title XII is the Medicaid mental health coverage provision. Got to step in this because I had stepped in it twice already, and it went well once and it didn't the other. It did not include the repealing of the IMD exclusion. That was, as I say, both controversial and costly. So what it does instead is that it requires two reports, one on the original Medicaid psych demo related to IMD from the Affordable Care Act as well as a report on the Medicaid managed care rule that CMS put out a while ago providing some latitude under waivers for IMD

exclusion and the 16-bed issue. But it doesn't like repeal it for either a mental health or the SUD side.

And then it does clarify that Medicaid does not prohibit separate payment for mental health, and you should have like -- you know, a lot of times the bill just uses mental health because that's the way it started. But I mean, the same issue goes forward. So we would also say that doesn't prohibit separate payment for a substance use disorder treatment and primary care service on the same day. It's a same-day billing issue.

And then Title XIII is the parity one. So it doesn't change the underlying Mental Health Parity and Addiction Equity Act statute at all. But again, it talks about sort of doing more reporting on enforcement and clarity on how people can file claims and find out, you know, what the plans cover or don't cover. It also asks for a convening within 6 months of a public meeting to produce an action plan. Some of you might remember the previous President put out a mental health parity report last October. It appears as though we'll be meeting some more and having another report based on the statute.

And then the last piece of parity that I don't have a bullet on, but it was in there is that, again, it doesn't change the underlying MHPAEA statute, but it also clarifies that eating disorders coverage should be at parity, and in particular, the inpatient treatment for eating disorders should be looked at just like inpatient treatment for medical/surgical because I know the eating disorder community has had a rough go, shall we say, of getting parity applied to inpatient treatment for eating disorders.

And Q&A.

Agenda Item: Council Discussion

DR. JUDITH A. MARTIN: You mentioned that some of the programs are now in statute that you're doing and others aren't. Is that good for them to be in statute? I mean, does that give you more security that they're not going to be eliminated? Or are they just -- it's a theory in your business of choosing initiatives?

MR. BRIAN ALTMAN: I think it's a coin flip. There's pros and cons to both. How's that for a tease or a lawyer-y answer?

DR. KIMBERLY JOHNSON: It's yes and yes.

MR. BRIAN ALTMAN: Yeah. So I'll give you an example, my personal opinion, shall we say. My personal opinion, as the LGBT policy lead, is that the Minority Fellowship Program has traditionally and always been focused on racial and ethnic minorities as a population. There have been conversations both with the, you know, grantee community as well as people here at SAMHSA at one point of

like would we want to potentially in the future include sexual and gender minorities as a population of focus under MFP? You know, could we get more money so that nobody loses out, but like have that flexibility to look at other minority populations?

That was sort of more of a possibility when we were not specifically authorized in a statute that says racial and ethnic minorities is the population of focus under the statute. On the other hand, like with the -- I, again, on a sort of personal note from previous jobs, had long been an advocate of authorizing the National Suicide Prevention Lifeline because it's just too important to not know that it's going to be there and that it's not sort of subject to some, you know, individual or, you know, sort of change.

So I think it can go both ways.

MR. ANDRE JOHNSON: Yeah, I've got a -- hi, Brian. I'm Andre Johnson.

You know, when you talk about the racial and ethnic specialty grants, you know, our agency had received a couple. And just real quickly, we wrote a grant to test men being released from prison for HIV, and it was very interesting that we ended up finding a lot of young men coming home from prison who were HIV positive, and they wasn't positive when they entered the prison system.

And so I think those specialty grants can do a lot of benefit in our communities. But I wanted to ask you a question --

MR. BRIAN ALTMAN: Could I just clarify for a second, though? So the Minority AIDS Initiative Grant Program is wholly separate from the Minority Fellowship Program. The Minority Fellowship Training Program is a training program that trains people essentially in various disciplines to, you know, learn how to best treat culturally competently the population of focus.

MR. ANDRE JOHNSON: Okay.

MR. BRIAN ALTMAN: So that, and then the Minority AIDS Initiative Grants are totally separate, more like services or prevention grants.

MR. ANDRE JOHNSON: Well, thank you for that clarification.

MR. BRIAN ALTMAN: Sure.

MR. ANDRE JOHNSON: I think they're still important, too. But I just want to ask a question. What's the thought behind the whole review of the block grant formula? What's the -- can you give me a personal or --

MR. BRIAN ALTMAN: Go ask NASADAD or NASMHPD. All I can say is, you

know, like that wasn't one of those where we ran to the Hill and be like "You should do this." So, clearly, either there were individual members who wanted that with that or the associations themselves thought it was time. I don't know.

DR. KIMBERLY JOHNSON: And the thought is always it comes from a State or a group of States that feel like that the distribution is unfair, and so now we're going to look at the distribution. I mean, every time it comes up, that's what initiates it.

MR. ANDRE JOHNSON: And you know, quite nicely, we've had that issue in our State. So, you know, obviously Detroit is the largest city in the State of Michigan, and the rest of the State say why does Detroit get the lion's share of block grant dollars? Because we have the lion's share of the problem. You know what I mean?

And so it's -- it really pisses me off personally because I have to fight with communities that are well off financially versus our community not necessarily.

MR. BRIAN ALTMAN: We'll see where it lands. I think you're next.

DR. KIMBERLY JOHNSON: Before -- what time do you have to get out of here? When is your next one?

MR. BRIAN ALTMAN: So this is -- you're like my last one.

DR. KIMBERLY JOHNSON: Oh, okay. Okay.

MR. BRIAN ALTMAN: Ultimate.

DR. KIMBERLY JOHNSON: All right. So we can do this based on our schedule, not yours.

MR. BRIAN ALTMAN: I have like a 2:30 p.m., a public meeting, but they want me to come down for discussion.

MR. LAWRENCE MEDINA: Hello. Lawrence Medina from New Mexico. Just kind of a basic question when it comes to policy. With a lot of, you know, maybe some changes coming down the pipeline with the new administration, they always say there's power in numbers, you know, to make change. But I think when it comes to policy, what suggestions or recommendations from at a State level or local level have influence on policy to keep -- you know, to keep this going, you know?

And is the voice seen and really count, and is there power in numbers in support of these policies that are vital to communities around the country?

MR. BRIAN ALTMAN: Yeah. I mean, I think clearly there are -- is a focus, generally speaking, from you know individuals who help lead Congress and the White House right now that, you know, the States know and understand what works best. And so the role and influence, I think, of Governor --

[Beeping.]

FEMALE SPEAKER: Sorry. I'm just going to turn it off.

MR. BRIAN ALTMAN: Of Governors will be important. I think that, yeah, that -- you know, I think that's why certain groups are targeting, you know, Governors who have either expanded Medicaid or, you know, seen the value of certain policies and programs and don't want them changed or in a certain way. So, I mean, I think the best I could say is that I think the current climate really relies on the notion that States know best.

MR. LAWRENCE MEDINA: You gave us the politically correct answer. I'm just kidding.

MR. BRIAN ALTMAN: I'm a lawyer.

[Laughter.]

MR. BRIAN ALTMAN: And I've been here 5 1/2 years. So I got practice.

MS. KRISTEN HARPER: I just -- I wanted to share that I'm on one of the review committees for the Minority Fellowship Program, and I have thoroughly enjoyed reading the applications. And a lot of them have, at least this go around right now, have been LGBTQ. So it's been really interesting to see -- hear their stories, the personal statements of the applicants, that they are represented. It's just you're right. It has been not --

MR. BRIAN ALTMAN: Yeah. I mean, I think that like certainly there's nothing in the program that says like the person who gets the fellowship --

MS. KRISTEN HARPER: Right.

MR. BRIAN ALTMAN: -- can't be LGBT.

MS. KRISTEN HARPER: Right.

MR. BRIAN ALTMAN: It's just the focus isn't for them to get trained on LGBT cultural competency. But hopefully, you know, that would come personally from their individual life experience.

MS. SADE ALI: I just wanted to give you a little funny anecdote from the Minority

Fellowship focus used to be much different, and I know that because I was chosen in 1974. But at that time, you had to come to Washington for 3 months and stay in Washington. And I had two little kids, and I couldn't do that. So Willie Colon took my place and -- yeah.

Yeah, so at that time, the fellowship was designed to bring people of color into Government service. So they were training us to take positions in our SSAs and in the Government. So it was very different.

DR. KIMBERLY JOHNSON: No other questions?

[No response.]

DR. KIMBERLY JOHNSON: Thank you, Brian, for coming.

MR. BRIAN ALTMAN: Sure. I assume you're going to take all the Part 2 questions?

DR. KIMBERLY JOHNSON: Hmm?

MR. BRIAN ALTMAN: I said I assume you're going to take all the Part 2 questions, too.

DR. KIMBERLY JOHNSON: Oh, did they come up while I excused myself?

MR. BRIAN ALTMAN: No, no, no, no. I'm just teasing.

[Laughter.]

MR. BRIAN ALTMAN: I've got to get out of here before people start asking --

DR. KIMBERLY JOHNSON: I have been. I have been as the day has gone by.

MR. BRIAN ALTMAN: Okay.

DR. KIMBERLY JOHNSON: So I think now is a good time to take a break. If we can maybe take 10 minutes instead of our whatever we scheduled, then we'll be back on track.

Thank you.

[Recessed at 2:26 p.m.]
[Reconvened at 2:36 p.m.]

DR. KIMBERLY JOHNSON: We'll go ahead and get started. I'm sure Art and Andre will be right back.

Let me get back to my script, see what we said. Oh, there you are.

MR. ARTHUR SCHUT: I was just hiding.

Agenda Item: TOPIC: Technology Assisted Care

DR. KIMBERLY JOHNSON: Oh. So the next topic, we're going to have this presentation and a conversation about technology assisted care, and it just seemed like the right thing, in my mind anyway, the right conversation to have after the conversation we had this morning because if we were thinking about how we're going to increase access and quality of care, particularly in underserved areas or rural parts of the country, then technology is going to be a key component of how we do that.

So Dr. Dave Wanser, who is the co-director of JBS International Center for Sustainable Health and Care, is going to share his expertise with us today on this topic, and moderating our discussion will be Wilson Washington, who is the public health adviser in CSAT's Division of State and Community Assistance.

So I will turn it over to you.

MR. WILSON WASHINGTON: Okay. Before Dave gets started, I'll read you this myself again. As Dr. Johnson said, I'm Wilson Washington. I've actually been with the Technology Assisted Care Program since 2010, and a lot has happened since 2010. One thing that I'm comfortable with is the fact that Dave Wanser has been there since day one. We've kind of left each other, then came back together. And so we've had three cohorts that are finished with target capacity expansion, technology assisted care, and we are on our fourth cohort of grantees.

So Dave is going to talk with you today about some things that have happened, some lessons learned, and then we'll open it up for questions. So, Dave?

DR. DAVE WANSER: Thank you, Wilson.

So when I got invited to come here, and I'm really happy to be here. I'm looking forward to visiting with you all and especially your questions because I know from having sat here the earlier part of the day, you will have some.

[Laughter.]

DR. DAVE WANSER: Always better than none. So this is basically the charge is where are we going with technology-assisted care, and how do you deal with technology when it changes so fast and with lack of evidence? And then what are the implementation issues? And those are really good questions, and so I

will do my best to try to answer some of them.

DR. KIMBERLY JOHNSON: Oh, you know what I forgot, Dave? I'm sorry. I'm interrupting you in the middle because I forgot I have to ask -- because it's the afternoon and I don't want anyone to not pay attention. We need a volunteer who is willing to do like a 5-minute, I think, presentation tomorrow at the Joint NAC on what we discussed here today.

So before -- I want to make sure they're listening to you.

[Laughter.]

DR. DAVE WANSER: So this is a test.

MALE SPEAKER: Can we appoint somebody?

DR. KIMBERLY JOHNSON: Yes, but it can't be me. That won't be 5 minutes.

MS. KRISTEN HARPER: I'll do it.

DR. KIMBERLY JOHNSON: Okay, great. Yeah, we got a volunteer. Okay.

MS. KRISTEN HARPER: If we need a vote, I'm happy to do that.

DR. KIMBERLY JOHNSON: Oh, do we need a vote?

FEMALE SPEAKER: No, go for it.

DR. KIMBERLY JOHNSON: We've had the one volunteer accept. Sorry, Dave. I'm so sorry.

DR. DAVE WANSER: That's okay. That's all right.

So, you know, technology is now our present, but if we think about this pathway that got us here, it goes back to something that was published by the Institute, the formerly known as Institute of Medicine. It's now the National Academies of Medicine. But back in '94, they said this is what health systems ought to do, and you know, then you fast forward 20-plus years. And now the 21st Century Cures Act says, hey, this is what we ought to do, and it's essentially the same thing.

And it speaks to this issue of what integration needs to look like, what care coordination models need to look like, and how, as we understand that, it's inextricably linked to the use of technology. So it's care coordination, integration, payment, technology. You cannot separate those four things any longer. And it has some pretty far-reaching ramifications not only for provider systems, but for people who need to access any kind of health or behavioral healthcare.

So what that means is that if you're a behavioral health provider, there are some core competencies that now are essential, and this has been very challenging for many organizations. In my experience of working in almost all of the States, there's been a pretty uneven uptake of this, that, you know, you have to know that you can share and reuse and use data that's generated by your clients. And that is something that all of healthcare is struggling with. And I'll mention kind of parenthetically the handout you got has some slides that aren't in this presentation because Kim said it's a great presentation, just shorten it by half.

[Laughter.]

DR. DAVE WANSER: So, so there are some -- you know, there are some things there that kind of play back and reference some of this, but the reality now is that the need for real time, continuous anticipatory data is really front and center in making sure that works. And you know, as a provider previously, as a State director, as somebody that worked at a university, I know that oftentimes data is unidirectional and people think about reporting. And reporting doesn't imply that you get anything out of that except -- you know, I had a provider say to me once, "I give you data. You give me money." And that was the relationship.

So the essence of bidirectional information exchange, whether it's bidirectional between payers and clinicians and providers or bidirectional between clients and providers, that is an essential ingredient of this. And as we move toward the value-based payment models, it gets to be even more critical to be able to look outside of something that is primarily focused on symptom remediation to are we providing increased access? Are we providing increased engagement? Are we activating people to change their behavior? And are we retaining them in treatment long enough for it to make a difference, and are we using data to inform all of that? And oftentimes, we're not.

So one of the things that comes up often enough is that, you know, is there proof? Do we know this stuff works? And as you can see here, there are an estimated 43,700 health-related apps, and 3,000-plus behavioral health apps. Probably while we're sitting here today, there will be 3,005 because they're coming out so quickly.

And what we know is that those apps are out there. We've had some that have been in widespread use for some of our TAC grantees. HS is one of those. myStrength is another. Those are the two that probably are the best known products right now, and they both are starting to amass an evidence base that these things work. They're helpful in a number of ways with engagement, with retention, with behavioral activation.

We also know that patient portals have done a good job, and what we've seen in the portals that our TAC providers have implemented is they're really a lot better

than a lot of the portals you see primary care practitioners implementing, which are oftentimes just Word documents, and they're linked very much to their electronic health records. Many of the portals that we've seen for our TAC grantees have been interactive. They've got discussion boards. They have searchable resources. They've done things to help you answer questions and get assistance, and they're available 24/7.

You know, where we're headed next, as anybody that's got a Fitbit can tell you, is wearables, things that integrate with apps and portals. And you know, while I said predictive analytics and artificial intelligence, as we were talking about at lunch, it's they've changed the terminology now to prescriptive analytics. And what that means is that we've been able to predict things for very widespread, broad population bases. As we get better and better at big data and analytics, it starts to be able to be individualized.

So, you know, in this whole discussion of population health, when you think about populations, what's embedded in that are social determinants of health. And the social determinants of health are the data points that allow us to really fine tune and isolate an intervention to the point where I was reading on my way here, actually, on the plane yesterday about an oncology study where there is analytics now that can predict where a lung cancer patient is likely to go into an emergency room or a hospitalization in the next 30 days.

And the physician gets a notice and says this individual, according to the algorithm, is likely to be hospitalized in the next 30 days. You need to do these things. We know that these things are effective to prevent hospitalization.

So you think about how that might play out for substance abuse treatment. You know, how can you predict when somebody is going to relapse? How can you predict, when somebody walks in the door, their likelihood of staying engaged in your program? And in my experience, that's been an area, independent of technology, where we've not as a field done as good of a job of focusing on that in everything we do. And you know, NIATx certainly helped some folks kind of refocus them on access and engagement and streamlining workflow so that people get in the door.

The way these models are headed, it's going to be somebody doing that. It may not be traditional providers, but somebody is going to be doing it. And if you don't do those things and use technology to improve those processes, then you're going to be left out. If I were to recommend two things that absolutely everybody should be using, it's telehealth and texting. I've got one example up there from New York Medical Center that was using texting for high-risk patients.

We've had so many examples with our TAC grantees of texting being a high-payoff, low-cost, easy lift to get people to keep appointments, stay engaged, get engaged in the first place. One of the first grantees, first cohort of grantees we

had, I did a focus group with a bunch of men who had -- who were veterans, and they'd just been released from prison. And all the organization was doing was texting them a motivational message every morning.

And I, frankly, was skeptical that that made any difference at all, and we did the focus group, the first thing out of their mouths was, "This is my lifeline. I don't know what I would do if I didn't get this message every day." And come to find out folks were, you know, writing them down, putting them up on the refrigerator, on the mirror in the bathroom. They were taking them to their AA/NA groups and reading them out loud. This was their connection, and they knew that if they had that connection every morning that there was somebody at that organization they could talk to if they needed to.

So hard-to-engage group, simple tool, and the finding was that it helped them stay engaged.

Telehealth has proven highly effective, and in fact, some of the best research that's come out has been around people with behavioral health conditions, and it works. And there's a couple of slides in the longer presentation about that having captured the attention of the big telehealth companies. And so now American Well and Teladoc, the two biggest ones, have a specific product line for behavioral health. And they're implementing that in Walgreens and CVS.

So if I'm a traditional substance abuse provider and I'm not using these things, and I'm a person on the street with an opioid problem and I can go to Walgreens or I can just call somebody up and I can do a -- you know, have a counseling session over the phone versus trying to call a treatment organization and being told there's a waiting list, what am I going to do? You know, as we all know, the concept of waiting to address your addiction makes no sense.

I was involved on a project last year with Office of National Coordinator for Health IT around helping encourage behavioral health providers to adopt technology, and the next few slides with the blue heading are things that we put into training slides for behavioral health providers. But this one reflects kind of this difference between provider-centered organizations and patient-centered. And with the notion being that the client is really part of the care team, and if the client is part of the care team and you ask people how do you want your care delivered, they would say I want it to be proactive.

And I want it -- I want to have information shared across my care team. I don't want to have to tell everybody my story. And that change is reflected in the changes in payment models that we're now seeing, you know, in statutory language, in MACRA and elsewhere.

Here's some of our examples from our TAC grantees, and you know, the one, Fountain House is in New York City, right in the middle of Manhattan.

Centerstone in Indiana. There's another Centerstone in Tennessee. They're in very rural areas. River Edge is in Macon, Georgia. It covers a third of the State.

MS. KRISTEN HARPER: That's my hometown.

DR. DAVE WANSER: All right. So you know those guys.

MS. KRISTEN HARPER: We don't have a lot of [inaudible].

DR. DAVE WANSER: Heartview is in Bismarck, but they cover pretty much a third of the State, which is all rural. You know, all these folks have implemented different kinds of technologies, thanks to the technology assisted care grant. And in every case, they've really found these to be highly effective engagement tools. They've increased the use of these tools, and in the case of Heartview, they found that just if they isolate on people who used their social network, their portal, and looked at where they were looking back at the period of time before they got into the program and started using the technology. Then if they looked after they use the technology. Their outpatient cost went up, which meant they were keeping their appointments, and their use of inpatient and emergency departments went down.

And I think it's that kind of cost benefit and return on investment that we need to be sharpening the focus on because these are -- these are all really effective tools. And there's a lot of things coming in the pipeline right now, and I'll talk about that in a second. But essentially, what we're seeing technology do is create alternatives to brick and mortar. So you don't need a place. You don't need a building in order to effectively deliver behavioral healthcare or recovery supports.

And recovery supports have been of all the different things that our TAC grantees have done, using peers and using recovery support via technology has been the most widely embraced and by far the most popular. And so we're seeing things now like Big White Wall, Silver Cloud, Sober Grid. These are all models that are out there that are patient-engagement based tools, and they're all demonstrating that there's a value proposition here for engagement, recovery support.

DR. JUDITH A. MARTIN: So this particular slide, I had a question about it. So it looks like one of the things that's happening here is that people engaged in outpatient treatment, after 6 months, it looks like they're going over to physical care? Is that like a graduation to primary care for recovery support?

DR. DAVE WANSER: It means that they're getting access in part. And so recovery support is ongoing, and what they've found with this particular program is, you know, and I don't know where you particularly stand on this, but I've always had a hard time with this concept of graduation from treatment. What

they've found is if they leave the door open with this portal so that you can keep using the portal as long as you want to. You might have been in treatment. You might have had a successful treatment episode. You feel like you're okay. But you still have the portal.

And what they've found was even after breaks of 6 months, 9 months, 12 months, that if people started to feel they were slipping, they would get on the portal. They would say "I need to talk to somebody." And the program could reach out to them and head off a relapse. And in doing that, the people started to pay more attention to wellness overall, and that's been -- that's been another theme that we've seen is that attention to my overall wellness being more -- kind of more than my addiction.

MR. ARTHUR SCHUT: I also have a question about that. Do they provide that the inpatient, is that a behavioral health inpatient?

DR. DAVE WANSER: No.

MR. ARTHUR SCHUT: Or is that, that's just general inpatient?

DR. DAVE WANSER: That's general inpatient. They got -- they got datasets --

MR. ARTHUR SCHUT: So that's in a hospital bed or in a hospital system or --

DR. DAVE WANSER: This is a freestanding substance abuse treatment program. What they did was they got all the claims data for the State.

MR. ARTHUR SCHUT: Got it.

DR. DAVE WANSER: And analyzed the claims data and matched that --

MR. ARTHUR SCHUT: So nobody gave them that part of the savings?

DR. DAVE WANSER: No. So they were having -- they were having that conversation --

MR. ARTHUR SCHUT: This is not a good business model.

DR. DAVE WANSER: Right. They were having that conversation with the legislature last time I was there.

People have learned -- had some struggles getting started on these projects, and this is kind of the list of the things that they've wrestled with. And in my experience working with people on startups of health IT-related products years before I started working on this project, this is -- this is kind of a common experience. You know, things -- you do a bad job of selecting, you're not going

to be happy with your product. Staff grumble about it. They try to resist it.

Things don't work the way they were promised. You know, I can't tell you how many times I've told program people when the vendor tells you something works this way, tell them to prove it. Staff buy-in. It's been surprising with the TAC grantees how many staff have felt threatened by a client getting engaged with technology, getting engaged with a smartphone app, with even telehealth has been a threat.

So, you know, hiring project staff. One of the things that from one of our programs, rural FQHC was doing telehealth, and they're doing telehealth, and they said we've been advertising for the staff person for 6 months, and we can't get anybody to apply to come to this little town in Oklahoma that had the only restaurant was an A&W Root Beer. And I said you've got every urban center in the State. You've got two medical schools. Surely you can find somebody. They just don't have to live here. And it didn't compute.

So that's been an issue. You know, a lot of times when people apply for grants, they say, you know, hey, do you want to go in on this grant with me? We're going to get $180,000 a year. People go, "Yeah." And then you get the grant, and you say, okay, let's do it. And they go, uh, wait a minute. I don't think so. That's been an issue for a number of them.

And then, you know, people are -- there's an accountability side to these grants that oftentimes runs counter to people's implementation timelines. And so I know with our first couple of cohorts people really rushed to get up and running and then made some really bad purchasing decisions at the front end. We have advocated for, and Wilson has been very receptive to, this notion of doing implementation site visits early on and then doing sustainability site visits toward the end because people make bad decisions at the front end, and they don't really think about sustainability in ways other than, well, I'll just get another grant.

DR. LORI SIMON: Two things. Have you done studies as to what happened when the grant money runs out?

DR. DAVE WANSER: Yes.

DR. LORI SIMON: Are they able to sustain this?

DR. DAVE WANSER: More often than not. Yes, more often than not. I'm going to talk to you what that -- what that means.

I think one of the things that they've learned that is certainly generalizable to any other setting is that if executive leadership is not engaged from the get-go, you will not be successful. That's an absolute. In every single case where executive leadership was, you know, disinterested in this, they struggled throughout the

entire period of the grant, and their ability to sustain it was extremely constrained.

Having implementation being something that you actively manage with a written, formal process has been another one. People have all kinds of assumptions about how things are going to work, whether it's what staff do or workflows or the technology. You have to continually go back and test that and make sure you've got data that supports it.

And then the data collection plan has been another key issue. GPRA has never been conducive to collecting electronically. And what happens in these organizations, and one example, one of our first grantees was a large national organization with a national footprint. And they had their own corporate assessment tool they used. They had the State reporting assessment tool. Then they had GPRA.

And so getting somebody in the door took about 4 hours. And the thing, it looked like it was created by the "department of redundancy department."

[Laughter.]

DR. DAVE WANSER: I mean, it was just, you know, where clients would say, "You've asked me that five times already". And so streamlining and using technology to capture this information has been something that a number of our grantees have done, even though it's technically been against the rules for how you collect GPRA. They've had online portals where you can go in and just do the first half of the GPRA online and, you know, then do the rest.

DR. KIMBERLY JOHNSON: That's against the rules?

DR. DAVE WANSER: You're supposed to ask people the questions, write them down in the first session, all the way through.

FEMALE SPEAKER: Yeah. That takes about 2 hours.

DR. DAVE WANSER: Yeah, it's not gone well for -- it could be -- so it's like do you want a lot of data, or do you want some good data?

DR. LORI SIMON: Are you actually using software that's canned software and not finding it, or are these grantees actually developing their own software?

DR. DAVE WANSER: For the most part, they've had to develop their own portal for collecting it. And people have been very nervous about it because they've been told this is what you do. I'm probably talking out of school here.

DR. KIMBERLY JOHNSON: Didn't we last year -- didn't we last year --

DR. DAVE WANSER: You started to flex that, yes.

DR. KIMBERLY JOHNSON: Flex that.

DR. DAVE WANSER: Yes, yes. But it's been an issue in terms of how -- and it gets to this whole issue that the larger healthcare system is wrestling with around this patient-generated health data, you know? And people want to share, you know? Ninety percent of people say I would really like to share more data about my health status with my provider, and 90 percent of providers say I don't want to see that data. It's too much for me to incorporate and know what to do.

And the move toward prescriptive analytics is making that a lot more streamlined and a lot more valuable.

So to generalize this across any SAMHSA grantee, I would suggest that everybody needs to be adopting this range of health IT tools. It's inescapable if you're going to be participating in any payment model at all, and thinking that you could survive on SAPT grants from the State is getting to be a fainter and fainter reality.

Going forward, as more States have provided Medicaid benefits for substance abuse treatment, as people are more inclined to be in large networks regardless of their health plan, as more people have health insurance, all those things have really made the adoption of health IT tools essential. Getting feedback from clients about how they like the technology and how it's working for them and making adjustments is critical. People have -- one of the programs we went to early on had their IT guy training clients how to use technology, which meant that the IT guy wasn't doing things like making the technology work. He was focused on doing classes for how to use the technology.

And we said do a video, you know? How do the rest of us learn how to, you know, fix a broken part in your car, change your oil, learn how to rollerskate? You do a YouTube. You know, you search YouTube. So people started creating videos because they had a lot of -- a lot of the clients that have participated in this program, particularly those with criminal justice histories, didn't know a thing about turning on a computer.

And so, and what we found is the most effective trainers for using technology were peers. Peers who had said, yeah, I was there, too. I didn't know how to do this either. It's easy. Let me show you.

So, you know, using an ongoing feedback means how is the technology working is really important. And every agency staff person really needs to have some basic education of what's going on in health IT. There's a lot of -- there's a lot of movement, and it's connected to payment reform. Everybody's got to be tuned

into that.

And then, you know, one of the things that have certainly been important is a number of our grantees have done is to collaborate with other folks to share in purchasing technology, you know? Go into it collaboratively to get some economies of scale.

So, but the things that we've worked with the leadership of these organizations on, and it's there again critical to success, is that health IT projects are really about policy and practice. They're not about technology. And I've literally had directors when I call and say I want to talk to you about this health IT thing, and they go let me transfer you to my IT person. And I said, no, this is a policy conversation.

We've really advocated for organizations to create an information strategic plan. Where are you going with technology? Because these things are all integrated, and to think about, well, I'm just going to buy this, and then I'm going to buy this over here, and then I'm going to buy this. Everything now is a computer. So if you don't have the ability to have those things interact, you're suboptimizing what you're doing.

One of our grantee's organizations bought a new phone system, and their IT person pointed out to their executive team the phone system isn't a phone system, it's a computer. And you can make this computer interact with our electronic health record and interact with our texting app so your secretarial staff and your case managers don't have to call people and remind them there is an appointment.

They can look at the calendar. They can figure out who is assigned to what client. They can text the client, "You've got an appointment tomorrow, 2:00 p.m. If you can't make it, respond." All done without hands on.

Vendor contract management has been a challenge. People sign these contracts, and then they are unhappy, and they don't negotiate or renegotiate. And oftentimes, it's because they did a really poor job in the first place in what they've bought. I've had executive directors for organizations, when I said, well, how did you select this piece of technology? They said, well, I went to a conference, and they had a bunch of exhibitors. I really liked these people.

And so they bought something, and their marketing people were really good, the technology not so much.

The single biggest thing that has been a challenge in every one of our grantee organizations is culture change. And anybody I talked to that does similar things, regardless of their area -- whether it's changing in practice patterns, whether it's doing integrated care, whether it's adopting new risk-based payment models --

the fundamental barrier is culture change in the organization, getting staff to think differently. And it's ironic to me that the area of behavioral health where our charge is to help people change is populated by people who have a terribly hard time with changing themselves.

And you know, this whole idea that you've got to spend money on this stuff. It's not cheap. But you've got to spend it to save money, and that's hard to get people's arms around. So, you know, as we move to value-based care, what you're really having to also think about is accommodating the needs of payers and health systems as almost everybody is going to be connected to large payers and large health systems. So you've got to pay attention to what -- the way they think and what their needs are and figure out how your culture can fit into their culture.

One thing that we've really focused on from the get-go on our technology assisted care grants -- and as Wilson said, has used the words "scalability" and "sustainability" hundreds and thousands of times since we've started with all the grantees -- is that, you know, you've got to sustain this, and you've got to scale it. And scaling it oftentimes is the key to sustaining it because if you start, if you buy, if you invest in a piece of technology for your organization and you say, well, our GPRA requirement is we're going to serve 100 people, then you scale it for 100 people.

If you say the requirement should be that you make everybody in your organization use this because it's more efficient, then you've helped sustain it. And we've had some real gaps there. People have really been stuck where they'll train three people to do telehealth and -- or one person to do telehealth. And you say, well, what happens if 100 people want to receive their services with telehealth? Well, then it won't work. Well, design -- design for a scalability solution.

This whole issue of health IT and evidence-based practice, people were asking questions earlier about evidence-based practice and NREPP. And you know, and I think we've got to think about technology-enhanced settings being the new normal. So there are ways of us re-imagining how we do evidence-based practice and fidelity modeling, but we also have to recognize that there are some things that have made that transition. There's good CBT tools, MBT tools out there that are technology based. There's starting to be some evidence around that.

Not all evidence-based practices would necessarily be transferrable immediately to technology, but we need to think about technology as an enhancement for those. But then there's also now evidence that using these technologies achieves effective clinical outcomes. So telehealth, Project Echo model, texting appointment reminders, we know that these things work. So there is that other side of the equation, and I don't know where NREPP goes if they start to list

telehealth as one of the evidence-based practices. But there is starting to be that out there.

So I think that there needs to be a comprehensive agency strategy for any organization that asks for or receives money from SAMHSA. State level, local level, that they should have strategies in place. They should develop that with assistance as needed, that they should be anticipating the need to have interoperable shared data. That there needs to be some plan for how you're going to have a suite of technology tools. That those expectations are clearly laid out in FOAs and that the things that people all need to do are health information exchange, telehealth, text, and data analytics.

And you know, the thing that is a part of that is that there are now something like 213 behavioral health technology startup companies that have come online in the last 24 months. So there's a lot of action.

People are out there seeing that there's ways that they can make money on doing health IT focused on behavioral health populations. And the things they're focusing on are screening and identification of clients, ways of streamlining that, care coordination and disease management, and measuring efficacy of interventions at the granular level. So those kinds of things are out there. There's a market now for this to be happening.

So I think I've covered most of this that really data -- having data to prove up that what you're doing is working. So, to close, the thinking about this for kind of the SAMHSA strategic plan, and as you all know, health IT has been a part of the strategic priorities for many years now. Where do you go from here? I think you take this technology and transfer it, the knowledge we've gained, transfer it to everything else that SAMHSA is doing.

There's plenty of room for the lessons that we've seen and the success stories we've seen to be a part of every funding opportunity that comes out of SAMHSA. There should be minimum requirements for the ways that organizations have to capture the social determinants of health, that they've got to have tools to manage behavior change that are technology-enhanced, that they've got to have analytic capabilities, and they need to participate in health information exchanges of some kind or the other, even if it's point-to-point using secure messaging.

And recognizing that there is great unevenness across the provider systems across the States, and there should be more of a focus on targeting the most in need. Rural areas, small providers that haven't got the wherewithal to make these things happen I think have a dim future ahead of them.

And then State agencies need to step up and play more of a leadership role. There have been State directors that have been onboard with this. There's

others that could be -- that couldn't be any less interested. And block grants have the opportunity to say that you've got to have some role in your State of supporting health IT adoption in your provider system. So I think all of those things are relevant to the future.

So I'll take questions.

Agenda Item: Council Discussion

DR. KIMBERLY JOHNSON: We have some questions.

DR. LORI SIMON: Two comments. Number one, the texting --

DR. KIMBERLY JOHNSON: Lori, can you get the mic so they can hear you on the phone?

DR. LORI SIMON: I'm sorry. Two comments. First one, the texting. Texting can be great for certain functions, and you've identified some of them. But you have to be careful about how you use texting because when you start using texting to have a clinical conversation, that actually can be very detrimental.

And so -- I'm actually a psychiatrist. And so when patients are doing that, I mean, it's great for appointments. It's great for some of the things that you mentioned. When you start trying to have a clinical conversation, you have to be really careful about that because it could be very easily misconstrued. The patient is not seeing you, isn't hearing your voice. There is no body emotion, et cetera.

So that's just -- you know, it's not a -- it's not for everything, but it's for --

DR. DAVE WANSER: Absolutely. Absolutely.

DR. LORI SIMON: Yes. You know, one of the things I think would be great is for when there has been technology successfully used, for example, through the TAC grants, to have some kind of resource somewhere -- maybe it's in SAMHSA, maybe there is a conference you guys put together that kind of shows other respective community organizations, you know, hey, this is what can be done and to give them ideas as to, you know, how things have been successfully implemented in other locations. So I think sharing more of those success stories would be great.

DR. DAVE WANSER: I couldn't agree more, and one of the things we've done with DSI is we've created what's called the "ideas exchange." And so the different DSI portfolios -- adolescent, pregnant and parenting women, SBIRT, criminal justice -- all of those grantees have access to all the things we've posted on the technology assisted care site. So there's a lot of resource sharing that

can go on that way, still constrained to those DSI grantees.

DR. LORI SIMON: Yes.

DR. DAVE WANSER: But I agree. There needs to be more.

DR. LORI SIMON: Now here are some of the problems. The grants primarily -- first of all, SAMHSA's grants are great, but they're limited. There's only a certain amount that they have, obviously. So number one, and they primarily focus on community mental health centers. I mean, that's the focus.

There's an awful lot of outpatient, a lot of major healthcare that gets done in other settings, and you mentioned like small practices. There's a lot more of that in behavioral health than in other specialties, and that is a huge problem. There is not much out there. I have an EHR, but I'm one of the few that does. People -- members of the American Psychiatric Association call all the time, ask "What should I use?" The meaningful use program, which I affectionately call the "meaningless use" program, been terrible. Doesn't address specialties.

The -- now they have MACRA, which I haven't read in depth, but I'm not very confident it's going to be a whole lot --

DR. DAVE WANSER: It's only 1,200 pages.

DR. LORI SIMON: Yeah, oh, okay. Well, it's not -- I don't have a whole lot of hope -- I could be wrong -- that it's going to be much better.

And so there is an awful lot of behavioral health providers that are not -- don't have the resources, don't have the time, don't have anything to get involved in behavioral health. And what's happening -- I mentioned this at an earlier session -- is, at least I'm from the New York metropolitan area, the whole -- well, I think the combination of the computer requirements and those quality reporting requirements, which also have to be used from providers, have become so onerous to clinicians that they are dropping out of Medicare.

And I'm not even talking about psychiatry. I'm talking about other specialties.

DR. DAVE WANSER: Right.

DR. LORI SIMON: Because they don't want to deal with it. And I'm convinced it's not the fact that Medicare pays less because Medicare has always paid less. They just don't want to deal with this anymore. And in psychiatry, I'm one of the few psychiatrists in my area that takes Medicare, and I would love to be able to incent some of my colleagues just to take a few patients, but things are so onerous that I don't even have anything to say to them that's positive.

So, so the point I'm making is that this is great, but there's a lot of the behavioral health treatment sector that's missing.

DR. DAVE WANSER: I agree with you. And but I do think, if I'm trying to be optimistic about this, that there's been -- that the message from providers around too much and that more isn't better has been heard by Health and Human Services. And there's greater alignment and a sharpening of focus on the tools.

And certainly, one of the key components for the merit-based payment program and the alternative payment models is that care coordination is one of your measures of success, which really opens the door to behavioral health. But behavioral health has to be receptive to that door being opened. And so, yeah, I think there's ways of solving all those problems, and I think HHS has been tuned into it.

Yes?

DR. INDIRA PAHARIA: So the importance of technology, I mean, I don't think we can overstate, especially with EMR or EHR as we're trying to capture data for analytics that go way beyond just reporting, as you were talking about for value-based payment, et cetera. But I think one of the big challenges we have in behavioral health and human services is that it's not typical to necessarily have an EHR, right? So now the interoperability is a problem because you're working with agencies -- county, State, Federal -- and you can't receive documents electronically.

So where you think an EMR, an EHR is going to reduce work for staff, it actually ends up increasing work for staff. And so we've experienced this in my organization where we now have staff who literally spend half of their time scanning and attaching documents because the populations we serve, we serve children and families who are mainly on Medicaid. These are incredibly vulnerable people who are involved with multiple county, State, and Federal agencies and multiple providers.

So I'm all for this, but I mean, this is a huge challenge. And if you have any insights on this, I'd love to hear because we're really struggling to figure this one out.

DR. DAVE WANSER: It was one of the interesting points of conversation in our project with ONC last year, and they're very attuned to the notion that everybody doesn't need a full-scale EHR. And where meaningful use has gone, if there's a bright side, is that we've gone from just saying, well, yes, we've done this to is what you've done been effective? And MACRA is the continuation of meaningful use. That's -- they've embedded and connected technology and payment in MACRA, which makes it important.

So what's happened is in those earlier iterations, the first -- stage one meaningful use certified products, all you had to do is send a PDF, and you've met the requirement. What needs to happen now, and technology has made this possible, is that you can embed, you can send those -- that data directly into an EHR. So nobody has got to scan stuff. Nobody reads the scanned stuff anyway.

But what it requires us to all do differently is to think about data elements instead of forms, and this has been, you know, after I heard it --

DR. KIMBERLY JOHNSON: You and I have been talking about this for how many years?

DR. DAVE WANSER: Yes. But it's one of those things where you've got to hear it at least 12 times before it starts to resonate because everybody thinks forms. We've all -- you know, that's how we all were brought up with paper records. They're data elements. There's a finite number of them. That's the good news.

And there should be alignment of them. There should be prioritization of them. And for most of these data elements there are data standards so that an apple is still an apple when it goes from point A to point B. So the technology has caught up. It's another place where executive leadership engagement is so absolutely critical because they need to know that.

What they tend to know, in my experience of talking to them, is this doesn't work, it pisses off all of our providers, and it costs too much. They know that much. What they don't know is where it's headed, the value proposition for it, the ways you can streamline and modularize it so that you're not buying everything that you don't need but only things you do need, and how you then use health information exchanges or direct secure messaging tools to make that happen.

And they don't know that if you're a State director, that Medicaid will help you pay for it if you reach out to them and develop a plan for them to help pay for my provider system to participate in the health information exchange. There's such a lack of awareness around what is available and the potential benefits of that, and I think that's been one of the fundamental challenges, is why I recommended the block grants need to put State directors on the line for helping support their provider system's continued existence. Because otherwise, I think the traditional providers are at risk.

DR. KIMBERLY JOHNSON: You know, can I just -- I guess because I'm sitting here I get to just interrupt everybody. I mean, when I think about the kinds of the place we want to be, right, where Lori was talking about the learning health system and how we could potentially get data from patients on an ongoing basis that feeds into algorithms that tells us how they're doing, right? And that we get in a format that makes sense for the provider, and we can adapt care to the

patient's needs and that we can manage population health by aggregating that up and managing our systems in that way.

And where we are really is the exact opposite of that, right? It's a top-down -- it's exactly what we were talking about at lunch. You feed us data, and we give you money. And we aren't really actually -- and so one of the questions I have and I don't want to -- you all have things to say, and you all have questions. So you don't have to respond to this right now. I want you to say what you want to say.

But what I want us to think about is what do we need to do differently because I feel like we have this program that's doing amazing things on a very small scale. And we need to -- and we need to start thinking about how -- and I've talked to Wilson about this, we need to think about how we start scaling this up.

DR. DAVE WANSER: Exactly.

DR. KIMBERLY JOHNSON: So that's a thought that I want us to discuss, but I don't want -- like five people raised their hands, and I don't want to stop that.

DR. DAVE WANSER: Yeah, Lawrence?

MR. LAWRENCE MEDINA: Thank you. I was just thinking about was that the Bionic Man, we have the technology, the intelligence, and sometimes you say but we just don't have the money, you know, for -- and you look at budgets, if you look at target or entities and you segment it of budgets under $750,000. And you look at the human factor that we've been doing this for the last 100 years, you know, on paper. And I think a lot of these providers are falling through the cracks.

Because you either -- it's either, you know, we're in a society that, you know, you either, you know, sink or swim. You know, you know, you know, lift yourself up by the bootstraps. And if you can't do that, you can't play. And I think that's the reality is in small communities where providers don't have the funding to do this.

To give you an example, New Mexico, the State was paying for an ASI system where we didn't have to pay. And it was great because you could do your assessment, and that was a mandate for Medicaid or to get your funding, and so you just put the person in front of the computer, they did their thing, and you print it out, and that was it. I mean, you know, and it was like, well, what is this?

I mean, it kind of went through the motion, but the data collection wasn't effective because they weren't proper -- staff weren't properly trained and to maximize this ASI system the way it should be used. And they winded up doing away with it, but it was like we felt that it was a waste of money because it wasn't rolled out properly to maximize the usage of it.

But smaller organizations, let's just say $750,000 and smaller, sometimes you have to start to crawl before you can walk with this stuff that don't have the hardware, don't have the setup. But I can see the effectiveness if how block grant or funding from a State entity to help smaller providers get going with the electronic health record, telehealth.

For example, in IOP when you have and you're in a rural area, and you're struggling with Johnny because he has multiple relapses. But you know what, nobody has ever done a psych eval on this person. One, there's shortage of doctors to get a psych eval because they're just -- they're limited in that area. But having access to telehealth could get Johnny this psych eval to say, okay, let's try to do something different than patting him on the back, and we're going to say we're going to send you to IOP for the fourth time. And there's limited residential and there's no mental health to send him, you know?

But I just see in small communities how do we start to crawl, begin to crawl so we can start walking with this? Because we really needed to get with the times and be efficient and effective.

DR. DAVE WANSER: And I think that's where I come down on the State's role of taking some leadership position on this. And I say that having been the State substance abuse director and then, subsequently, the mental health and substance abuse director in Texas. And as a substance abuse director, we created a statewide electronic health record that every single one of our providers use, treatment and prevention. And it was free.

We built it. They used it. I had providers that after, you know, 4 or 5 years of this thing being in place, didn't know the concept of State reporting. They hadn't ever had to do it because they just -- they had an electronic health record, and it gave them information, and they used it, and it was easy to use. And they never knew that we were collecting all the data that we were reporting to SAMHSA. They never knew that.

And everybody else in the world knows what that's like. So, yeah, and it was agnostic to the size and scale of your organization. So the small guys have the same tools as the big guys, and I think so that's a part of it. The State has to help because there are great economies of scale there.

And then appreciating that if you are struggling to use systems that are collecting a lot of data that you're not going to use, then it won't be an effective tool. And Tom McLellan, who, you know, was instrumental in creating the ASI and was very firm believer of fidelity for a while, finally got to the point where he said I don't care about fidelity. If you're going to collect information, use the information.

So less is more. If you're going to collect it, use it. And that's oftentimes not

been the priority.

DR. LORI SIMON: When you developed the EHR in Texas, was that available to, say, a private solo practitioner or only for more community --

DR. DAVE WANSER: People we funded.

DR. LORI SIMON: Okay. Not the private folks?

DR. DAVE WANSER: Some of them were private. Yes?

MR. ARTHUR SCHUT: So my experience is that there are a lot of States that are behind providers in terms of technology.

DR. DAVE WANSER: Yes.

MR. ARTHUR SCHUT: And I don't know if there's a way that we can collectively, you know, "we" as in CSAT, can get that to change. But you know what I think about TEDS. But --

DR. KIMBERLY JOHNSON: You know what I think about TEDS.

MR. ARTHUR SCHUT: Yeah, and the States added to this. I mean, the State I'm in I think has 90 or 100 items in TEDS that are add-ons that really nobody uses, right? We just collect.

I think we get to a point where we say to a State you can collect 5 data elements and you have to do it accurately, or 10. And I also don't -- I think if you're a $750,000 a year organization, you can't do it. I think it's hard for a $10 million organization, frankly, to do this well and correctly.

And I think my other sort of comment about this, other than figuring out a way to incentivize States to have accurate data systems that have limited numbers of elements in them. We need to help people understand that it's not -- we never used paper records to do this, right? I mean, there are a lot of places that the paper record was completed at the time at which it had to go to the archive.

DR. DAVE WANSER: Yeah. You know, and Friday was -- you didn't see anybody on Fridays because it was paperwork day.

[Laughter.]

MR. ARTHUR SCHUT: That just happened last week. And so there was no -- there's just no urgency to document records in our field, right? I mean, this was what happened. So now we're at, you know, real-time data. And we believe that the electronic health record should look like a paper record, which is the downfall

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DR. DAVE WANSER: Right. Because we think about forms.

MR. ARTHUR SCHUT: Yeah. Because those forms, we've been pulling forms and tech fields -- text fields or compare them. So part of it is just educating the workforce about whether it's really a data system. It's really not a paper record or a health record. I mean, it has data about your health. So it's a health record, but so this is sort of my thoughts about like I think it's there are very few States I think that are ahead of the most innovative providers.

DR. DAVE WANSER: Yes.

MR. ARTHUR SCHUT: And I don't know how to fix that.

DR. DAVE WANSER: Well, and you know, when you think about data systems and technology, the vast majority of the public, if you say "data systems," they think it's got something to do with math. And if you say "technology," they think it's got something to do with science. And most people don't do very well in math and science. So "information" I think is a better term for both those things because everybody is interested in information.

DR. JUDITH A. MARTIN: So I have some experience for San Francisco. In 2010, the city and county bought or set up an electronic record system for behavioral health that included substance use and mental health and required that the billing or the payment was based on what you put in there. So the billing definitely had to be uploaded in there, plus in California, there's a required CalOMS.

DR. DAVE WANSER: Right.

DR. JUDITH A. MARTIN: Which is outcome measures on admission, discharge, and if it's a long treatment, yearly. And so the contracts of the providers that the county makes include yearly revisions of performance measures that are taken out of the CalOMS. You know, like some of it is data quality that you have to fill in, and other parts of it have to do with improvement and progress in treatment at 60 days, that kind of thing.

So that the providers see that it's being used, but the whole system that we have is not very compatible with HIE because we're stuck with it, with a kind of old-fashioned technology in order to be compatible with the State's Medicaid billing. So the State hasn't improved their Medicaid billing system. So we're stuck with not being able to -- I mean, on our screen, we can't even do Explorer uploads, you know, like upgrades. Otherwise, it would -- we'd not be able to use the electronic record.

And in substance use in particular, I think the mental health has come further with patient portal now, but substance use is still siloed, each program, because of the privacy issue. So, theoretically, if it weren't -- I mean, if everybody signed a release for 42 CFR now, I guess we could have the patient portal for some patients.

DR. KIMBERLY JOHNSON: In March. In March, when the bills are actually in effect.

[Laughter.]

DR. JUDITH A. MARTIN: Right. But, but -- but it would be hard to keep track of who signed and who didn't because if you turn it on, you turn it on for everybody, right? So to harvest the diagnosis out of the diagnosis page makes a problem out of it. Or that collects appointments from everywhere so that if a person shows up one place, we can remind them of their further appointments in other places, and let alone connect to primary care.

So we are a kind of safety net ACO, and which is San Francisco Health Network that the county -- is the county health plan, DPH really, Department of Public Health. And they are shopping for an enterprise-wide system, and they kind of leave us out because there is no big company that can handle this, especially the billing part at this stage.

DR. DAVE WANSER: Yeah, there are, in fact. There are companies that can handle it. But the critical fault is leaving you out, and that's -- you know, I've said it several times. If I'm a clinician in a program and I want my clients to use technology, I've got to ask them how this technology is working for them and what they want it to do and how they need it to work for it to be successful.

If I'm a vendor selling something, I need to be open to my customers telling me this is how I need it to work. This is what it needs to do differently. If I'm a payer and demanding that people use technology, then my network has to be able to effectively use that technology, and it needs to keep up with changing practice patterns.

So I would encourage you and all of your like-minded organizations to say to the county we need this to function better. And the fact is CMS has money available for you to make it function better, and the fact is every State Medicaid agency has to do a health information technology plan, and every State Medicaid agency has been encouraged by CMS to incorporate behavioral health in their health information technology plan.

So I would say, county, State, show us Medi-Cal, how have you addressed behavioral health being integrated through your required health information plan?

Yes?

DR. LORI SIMON: I think what you just said is one of the biggest issues in healthcare, is that the vast, vast amount of time is the vendors or whoever is developing is not talking to people who are using the system.

DR. DAVE WANSER: That's because the people that are using the system aren't demanding it from their vendors.

DR. LORI SIMON: There's -- well, we can go back and forth about that because I actually have an IT background, and I started out in banking, okay? And in banking, you know, it was the users ran the system. And the users signed off, and they used to joke don't get into his code, you know? And that has not happened in healthcare, and that has been the biggest issue.

And vendors are controlling because they swooped in and they care about making money, and they want to appeal to the biggest audience. And so, for a variety of reasons, I'll not go into them all now, that has not happened. And to say that, well, they need to demand it, they don't even know that they need to demand it.

And so when Arthur, when you talked about how data looks, you know, and that's one element of it. But the data flow is a huge problem. And you know, providers will say this isn't how I do my work, and it's costing me more time, and I'm losing productivity.

DR. DAVE WANSER: We had three of our TAC grantees fire their vendor last year, and they were scared about doing it. But they were all very much happier after they did it. They got something that was so much better. But it's very frightening, and the vendors will bend over backwards to offer you deals not to leave or threaten you not to get your data back if you fire them.

But you know, we all change technology all the time in our personal lives. We just don't have that same mindset when it comes to things we've bought for our organizations.

MR. ARTHUR SCHUT: If I understood you correctly, you said that CMS encourages behavioral health data --

DR. DAVE WANSER: Yes.

MR. ARTHUR SCHUT: So why don't they just require it, right? That's the problem is if you encourage it, then if they require it, people would do it. And then the other problem that we have, I think, is if you're a technology company producing software, you want to produce it for an industry like banking, where all the transactions are. But the user wants all those kinds of transactions. There is

some consistency in terms of the kinds of things that go on in banking.

In behavioral health, we all want ours customized because A organization does things this way and B organization does it this way and C organization does it this way. And if there's not enough volume between those, no vendor wants to produce that unless you're going to customize it and pay them a great deal of money.

DR. DAVE WANSER: It's --

MR. ARTHUR SCHUT: So that's --

DR. DAVE WANSER: Yes, two things. One is that CMS won't tell Medicaid agencies what to do because Medicaid is a State program. But their "Dear State Medicaid Director" letters are articulations of policy, and oftentimes, you can find leverage there. But the nail you hit on the head was, you know, we're all unique just like everybody else. And so everybody wants to change it just for me.

And one of the States I helped with implementing electronic health record wisely said we're going to take this, we bought something that other States have used. We're going to take what they're using, and nobody can change anything for 6 months. And after 6 months, the number of things they wanted to change was miniscule.

If they'd have said up front "What should we change?" Well, we want it to be this way. Most of which would have been people backward engineering it to the forms they were familiar with on paper. Yeah.

MR. WILSON WASHINGTON: I would -- I would add, and as I listened, this is a very, very good conversation. I'm actually looking at this from two different perspectives, actually from two different worlds. My primary experience is from the HRSA side of the world with the FQHCs, who had quite a bit of money to implement technology.

So my first recommendation is if you're within a zone of a Federally Qualified Community Health Center, please develop a collaborative relationship with them because in many cases, they have behavioral health resources within the FQHCs, and they've already tried to implement, and in many cases very effectively, an integrated healthcare delivery model.

The other challenge where we talked about why do CMS not make the States, require the States to do certain things, what we learned in the beginning when we started technology assisted care program, all the States are different, and it's driven by the Governors and who is actually in leadership, whether the leadership supports technology or not, whether or not -- Dave mentioned the health information technology or the strategic plan for the State for health

information technology. Our push was -- in the beginning with the National Governors Association was to try to get behavioral health written in the fabric of that plan because a lot of States were planning -- because there was such an issue around privacy and security and 42 CFR-type issues and sharing information, a lot of States were planning their entire HIT infrastructure absent any behavioral health at the table.

And so a lot of States have a strategic health information technology plan that has no -- nothing to do with behavioral health. So what we were pushing for was that the States actually write behavioral health into the fabric of the plan, get some of the CEOs from behavioral health-like organizations, i.e., mental health and substance abuse organizations, to be part of the infrastructure or the governance of the State plans. That worked in some cases. It didn't work in other cases, and it changed with the leadership for the State, whether the States was supportive of the Affordable Care Act and the movement in the direction of the Affordable Care Act or not.

So as a result, we ended up with two different worlds, one that was moving forward and implementing technology that worked, that could share information, and the other that was kind of left behind. Behavioral health kind of got left behind, and SAMHSA tried, with everything we had within our programs, to put technology assisted care projects out in the field to see how they could work. We were always working with very little resources and a huge task.

So therein lies why we focus around scalability and sustainability because we wanted to try to find those technologies that could work in our industry, that could help bring us up to speed with not enough resources, but with very limited or scarce resources. And once we found the technology that we could leverage -- and we're in that phase right now. If we found something and we can find something that works, then we want to scale it, and we want to just show and prove that we can sustain it.

So we're dealing with a very complex issue from a funding standpoint and from a policy standpoint. And certainly, it is welcoming to hear you talk about some of the complications because I think that's really going to drive our discussions moving forward on how we can address this huge problem.

DR. KIMBERLY JOHNSON: You know, Wilson, it's interesting to me because a lot of the conversation has been around frustrations about the technology itself. So if you think about the whole adoption thing that we talked about this morning, the technology transfer process, and if you go back to the diffusion of innovations, I mean, having a technology that's diffusible is kind of the first step.

And so one of the things it makes me think about is what we need to be doing at CSAT is continue to maybe expand, and this is probably what you're trying to get this meeting together about is our work with HL7 in terms of standards. Because

what I learned, which shocked me when Ken was telling me -- Ken, one of our staff folks who has been working on standards.

MR. WILSON WASHINGTON: Is he back there?

DR. KIMBERLY JOHNSON: There he is.

[Laughter.]

DR. KIMBERLY JOHNSON: Is that like so we have just completed work on semantics, right? So having the same -- having -- meaning the same thing when we talk about terms, but we haven't talked about syntax. So we don't have standardized. So you can't have interoperable systems if the data elements don't mean the same things, and they're -- just they aren't formatted in the same way.

So it's fascinating to me that we aren't there. I mean, it just wasn't mine. I mean, pharmacy has had that forever. If you talk about billing, I mean, the payment system has those clear standards. So that part of it, but when we talk about the health record portion of an EHR, we don't have those clear standards.

So, so I think when I hear this conversation about the frustrations, it's so much the technology itself. Then clearly, we need to continue to do some work. I mean, we -- you know, we have this debate here, and I'm always harassing Ken and others. They come to me with ideas, and I say, well, why isn't industry doing that? We shouldn't be -- you know, we shouldn't be in this, doing this work.

But there are clearly things that we should be doing to help improve the technology so that it's worth adopting because we are never going to get to where we want to be. I mean, we haven't had any conversation really about patient-facing tools, and people are -- people are using those whether -- whatever we do, right?

But if they're using them, and we aren't capturing that data to support their care, I mean, it's a huge lost opportunity. And we haven't talked about privacy at all, but I'm going to just let that one go.

DR. LORI SIMON: I think that the two biggest issues are the usability and then the interoperability. And Arthur, what you were saying about banking, what I was actually trying to say is it isn't any different. Because I worked for a bank in the personal trust division. I don't know anything about personal trust, but I developed a system for the personal trust division. You know, I saw their reports, and I saw.

Now the personal trust division of that bank, it could be very different from the personal trust of another bank. But the difference was that bank was a large

bank. They had the money to have their own dedicated IT staff, and so they developed software to fit them.

The problem in healthcare is, with few exceptions -- say, like large hospitals or something -- those resources haven't been there. And so the vendors have sort of filled -- you know, have sort of filled in the gap there, and that's not working. And so I actually have thought that maybe professional organizations that represent providers because an individual provider doesn't have the money. They don't have the resources. They don't have anything, you know?

MR. ARTHUR SCHUT: You have no clout.

DR. LORI SIMON: No. Exactly. And so the professional organizations do, and so I thought maybe that might a way. But I think SAMHSA, because this is such -- this is behavioral health, and this is a Federal organization, and what better place to have a central role in leading what we need?

MR. LAWRENCE MEDINA: Yes, and I think some States should have to reinvent the wheel like Texas. New Mexico could learn so much from Texas, you know? I used to do IT plans for consultation for different counties, and for example, we did have one county with 16 departments when we did this IT plan. And it was complicated, and I had to bring an IT specialist to help me write the plan.

But there was the assessment, and each department is different. And then when you get into the implementation plan, I mean, there's a whole process. It's humongous that even a county, it's taken 5 years to get to the point to spend $1 million to purchase the software, pick the right commercial vendor, make sure that what is the -- because their last vendor, their tech support was terrible.

So, you know, you got this major learning curve, and then you're out there on the Internet, and you said there's hundreds out there that say "eenie, meanie, miney, mo, now which one?" And it's a gamble and say I hope I get the right one. And I have all these hundred pieces I need to manage that I've never managed.

So I think, again, that what can we learn from Texas and other States that developed the software, provided it, and in a sense mandated but provided the support to do it. If you want to build with us, then you have to use this technology. Here is the training. Here is the support.

Because I don't know, it's complex. But thank you.

DR. DAVE WANSER: I know I'm running late.

DR. KIMBERLY JOHNSON: No, we still have a couple more minutes.

DR. DAVE WANSER: But my -- when we decided to build an electronic health record, it started off as kind of a case management system for one city in the State. And my clinical director, a physician, said, you know, we could just stretch this a little bit further and have an electronic health record. And --

[Laughter.]

DR. DAVE WANSER: And I said, okay, you're in charge of it. And he wasn't an IT guy. He was a physician. And what he developed, he said there's three guiding principles. And he came to me with this. He said there's three guiding principles, and I want us to all agree that we will focus on achieving these three guiding principles. And I'll run it, but I just want you to be onboard with it.

So the first one was that a provider should never, ever have to enter a data element more than once.

MALE SPEAKER: God bless you.

[Laughter.]

DR. DAVE WANSER: The second was -- the second was that there is not a single thing that the State or Federal Government needs that shouldn't be part of good clinical care. And the third one was the system should make providers smarter.

And that was the most wise and useful framework for us because we stuck with it, and there were times when there were -- battles would, you know, break out with people and say, well, I want to add all this new requirements for data. And he would say what's that got to do with direct clinical care? How is it going to make the provider smarter? And why do we need it? And that argued against making the system something where everybody kept throwing more stuff into.

And again, it was -- it was that there was somebody who was clinically focused articulating the requirements, holding people to the requirements. And at any given time, we had a hundred things on the list that people wanted for improvements, at any given time for 4 years. And we actively worked the list, and we prioritized and we got feedback from people, and not everything got approved.

And some things, we obviously had to weigh time, money, resources, and value. And very few organizations or States have managed projects that actively. It's one of the things we worked with the grantees on because you don't just buy the stuff and plug it in and hope for the best. You actively manage it. And if you're doing a good job of collecting feedback from the end-users, they will give you things that they need to see improved.

And the organizations that have done that, again, symbolized by their executive buy-in and leadership, have really found that the level of adoption has gone up, the ease of use has improved, clinician buy-in has been improved, and they're seeing outcomes in terms of like those cost offsets I shared.

DR. KIMBERLY JOHNSON: So thank you. That was a great discussion.

MR. WILSON WASHINGTON: I'll just add one more thing to that list of three, which is what I evaluate, and I've evaluated hundreds of EHR systems. The fourth thing is the EHR, the automation should free up more clinical time for the provider. Because if your electronic system gives -- I call it hourglass time. If you're spending so much time trying to negotiate an automated system, then that's the wrong system to have. It should be giving you more clinical time with your client.

DR. LORI SIMON: And that's the biggest problem that I hear doctors say.

DR. DAVE WANSER: And if you've got tools that allow clients to input their own data, everybody -- everybody wins.

MR. ARTHUR SCHUT: Unless it's not allowed-- well, sorry.

[Laughter.]

DR. DAVE WANSER: Thank you all so much. This has really been a great conversation. I appreciate it.

[Applause.]

Agenda Item: Public Comment

DR. KIMBERLY JOHNSON: Okay. So public comment? So now is the time for public comment. Do we have any members of the public that are here today that are sitting behind me -- I guess I have to turn around -- that would like to address the Council?

[No response.]

DR. KIMBERLY JOHNSON: Okay. Then what about on the phone? Are there any members of the public that are on the phone that would like to address the Council?

OPERATOR: If you have any questions from the phone, press * and 1, and then record your name. Again, * and 1 if you have any comments. One moment.

[Pause.]

OPERATOR: We have no comments.

DR. KIMBERLY JOHNSON: Thank you.

Well, thank you, everyone, for coming. The agenda says that I have to do a recap, but I don't think there's much to recap.

I do want -- Kristen, just remember that tomorrow you have like --

MS. KRISTEN HARPER: Yes.

DR. KIMBERLY JOHNSON: -- I think it's 5 minutes they're giving you to recap what we did today.

So thank you, everybody, for this rich discussion. I hope that we can bring some of the thoughts that came to you today tomorrow into the conversation with the research folks, and it's just another one of those things. We have to figure out how to keep talking about it. But thanks a lot.

Anything else we have to do? Oh, this is the end of the open meeting. But then we have a closed meeting. No closed meeting today?

Agenda Item: Adjourn Open Meeting

MS. TRACY GOSS: So we need a motion to close.

DR. KIMBERLY JOHNSON: If I'd read my notes before I just -- so is there a motion to close the meeting?

[Motion.]

[Second.]

DR. KIMBERLY JOHNSON: All in favor?

[A chorus of ayes.]

DR. KIMBERLY JOHNSON: Any opposed?

[No response.]

DR. KIMBERLY JOHNSON: Okay. Thank you. We'll see --

DR. JUDITH A. MARTIN: Is the date set for August?

MS. TRACY GOSS: Not that I have been told. As soon as -- I haven't been told.

DR. KIMBERLY JOHNSON: No date set yet.

MS. TRACY GOSS: But as soon as I know, I'll forward that along.

DR. KIMBERLY JOHNSON: Thanks, everyone.

MS. TRACY GOSS: If I could have everybody put their nametag into their binders, tomorrow -- you don't have to take them to the hotel. I'll go ahead and put them in the room for tomorrow.

[Whereupon, at 4:01 p.m., the meeting was adjourned.]