

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

**57th Meeting
of the
SAMHSA National Advisory Council (NAC)**

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Sugarloaf Conference Room
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Council Members Present:

Pamela S. Hyde, SAMHSA Administrator and Chairperson
Holly Berilla, DFO
Eric B. Broderick
Henry Chung
Junius Gonzales
Megan Gregory
Kenneth J. Martinez
Charles Olson
Elizabeth A. Pattullo [on telephone]
Cassandra L. Price
Gail W. Stuart
Christopher R. Wilkins

Other Participants:

Sade Ali
Phillip Ames
Jerome "Brooks" Big John
Christopher D. Carroll
Patrick H. Conway
Sheila Cooper
Karen B. DeSalvo
Paolo del Vecchio
Kana Enomoto
Mary Fleming
Nevine Gahed
James Gallant [on telephone]
Joe Garcia
Fran Harding
Anne Herron
Leighton Y. Huey
Daryl Kade
Lori Simon
Rena Starks [on telephone]
Lisa Wade

PROCEEDINGS

Agenda Item: Call Meeting to Order

LCDR HOLLY BERILLA: Good morning. Operator?

OPERATOR: Yes, I'm standing by. How may I help you?

LCDR HOLLY BERILLA: Hi. We're going to go ahead and get started.

OPERATOR: All right. You may begin when you're ready.

LCDR HOLLY BERILLA: Okay, thank you.

Good morning. My name is Lieutenant Commander Holly Berilla. I'm the Designated Federal Officer for the SAMHSA National Advisory Council, and I'm the agency committee management officer.

And I'm calling the 57th meeting of SAMHSA's National Advisory Council to order, and Administrator Hyde is also the chair, and she is presiding.

Agenda Item: Welcome, Opening Remarks, and Consideration of Minutes from the August 2014 SAMHSA NAC Meeting

MS. PAMELA S. HYDE: Thank you, Holly.

And good morning, everyone. Special good morning to our NAC Council members. We have a couple more on the shuttle on their way. So we'll be joined by a couple more people.

We'll do a round of introductions here in a minute, but I also want to thank I see several of our other council members joining us today, and I'm really pleased about that because we have some really interesting conversation this morning. So thank you all for joining us.

We have a lot on the agenda this morning, including some guests. And before we do that, I want to acknowledge a couple of people who are not here today, but they're new members. We have had a longstanding member of this committee, ex officio from the Veterans Affairs Department, and that person recently retired. So we -- who had been with us for a very long time.

So now we have a new person who was not able to join us today, but his name is Harold Kudler. He is a psychiatrist who serves at the Department of Veterans

Affairs, chief consultant for mental health services. So he's got vast experience as a faculty member, trainer, educator, consultant, subject matter expert, leader, publisher, committee chair, and researcher and serves particularly as an expert in PTSD and was the founding chair of the PTSD Practice Guidelines Task Force of the International Society for Traumatic Stress Studies.

He authored the task force's Treatment Guidelines for Psychodynamic Treatment of PTSD and also co-chaired the Under Secretary for Veterans Affairs Special Committee on PTSD. So I think you can see that he brings lots of wisdom. We're excited and looking forward to having him be a part of our committee, our council.

And also I think most of you know that we do a significant amount of work on veterans and military families efforts. I want to thank Kathryn Power, who leads our efforts there, and also Stephanie Weaver, who was with us as a detailee from the National Guard until she retired from the National Guard. And when you see her, you'll know she's way too young to be a retiree, but nevertheless, once she retired from the National Guard, we brought her back on to SAMHSA to continue her work.

So Kathryn and Stephanie do a lot of great work on both veterans and military families issues. And I co-chair, on behalf of the Secretary, an interagency task force with DoD and VA on military and veterans mental and substance use issues.

So we're really pleased to have Dr. Kudler with us when he's able to join us.

The other person who you met yesterday but is not able to be here this morning is Victor Joseph. He is going to be on this council. He's a new member. He is the president and chairman of the Tanana Chiefs Conference from Alaska, an award-winning leader who's built a reputation for developing and implementing innovative strategies to address the healthcare needs of Alaska Native beneficiaries.

In his role as the president and chairman of TCC they call it, Mr. Joseph spent the past 20 years building the primary and behavioral healthcare services there. So he also -- I think you could tell from yesterday -- is going to be a great addition to our council.

I have to say that I have been here long enough. I've gone through several people turning over and new people coming on and serving their entire terms and leaving again. So it's starting to make me feel old, but nevertheless, it's great to have new people join us. These conversations are always really very rich because of it.

We have two other new people who are here. I'm going to let them introduce

themselves first and say just a word about yourself. First is Ken Martinez, an old colleague from New Mexico. Not old. A long-term colleague from New Mexico. Although, Ken, both of our hairs are getting a little grayer.

You want to introduce yourself and say a word or two about where you come from, what you're doing?

DR. KENNETH J. MARTINEZ: Sure. Thank you, and I appreciate being on the council.

I am from Albuquerque or Corrales, New Mexico, in particular. And been in the field for quite a few years, worked with Pam in State government in New Mexico, and currently, I work for the American Institutes for Research. And specifically working on Safe Schools/Healthy Students, a SAMHSA grant program, in the prevention bureau. And prior to that, I was in the children's mental health world in State government in New Mexico and with the University of New Mexico Department of Psychiatry, which I still hold an appointment in.

Thank you.

MS. PAMELA S. HYDE: Great, Ken. It's great to have you here.

Another new member of our team is Gail Stuart, who is also an old or long-term colleague of mine from ACMA, from the American -- or it's changed its name from ACMA. So, Gail, tell us a little bit about yourself.

DR. GAIL W. STUART: So my work has been in the psychiatric mental health field of nursing over the years doing a variety of clinical, administrative, research work. And I'm currently the dean of the College of Nursing at the Medical University of South Carolina in Charleston.

And I continue to be involved in a lot of interprofessional mental health organizations and groups, including the Annapolis Coalition for the Behavioral Health Workforce, and so I'm delighted to be joining all of you in this work as well.

Thank you.

MS. PAMELA S. HYDE: Thanks, Gail.

And I'm particularly pleased to have Gail here because she has been a constant and great advocate for having nursing involved, and I have some of my most wonderful and blessed colleagues and mentors are nurses. So I really appreciate her being here.

I noticed we've gotten two or three more nurses on, as you've come on. So

thanks. And you know now that Mary Wakefield, who comes out of nursing, is now our Deputy Secretary, or at least acting at the moment, and she has been a great partner for SAMHSA. So we're pleased about that.

All right. I think our two people that we were waiting on, Megan and who else were we waiting on? Cassandra, you guys were all on the same shuttle. So we've got you. So now we're going to do the rest of the introductions, and you guys don't need to say that much because we kind of know you a little bit, but if you just want to say where you're from and your role on the council.

So, Charlie, we'll let you start.

MR. CHARLES OLSON: Good morning. My name is Charlie Olson. I'm from Minnesota.

MR. CHRISTOPHER R. WILKINS: Good morning. I'm Chris Wilkins. I'm president emeritus of Loyola Recovery Foundation and a member of this council.

DR. JUNIUS GONZALES: Junius Gonzales, recently relocated from Texas to North Carolina. So I'm happy to be having less of a travel issue getting here. Member of the council.

MS. CASSANDRA L. PRICE: Cassandra Price from Georgia.

MR. PAOLO DEL VECCHIO: Good morning. I'm Paolo del Vecchio, Director of our Center for Mental Health Services.

MR. CHRISTOPHER D. CARROLL: Good morning, everybody. I'm Chris Carroll, Director of Healthcare Financing and Systems Integration.

MS. MARY FLAMING: Good morning, everybody. My name is Mary Fleming. I'm Director of the Office of Policy, Planning, and Innovation.

MS. FRAN HARDING: Good morning. I'm Fran Harding, Director for the Center for Substance Abuse Prevention here at SAMHSA.

DR. ERIC B. BRODERICK: Good morning. My name is Ric Broderick. I currently reside in Colorado and member of the council.

DR. HENRY CHUNG: Hi, Henry Chung from Montefiore Medical Center in New York City.

MS. MEGAN GREGORY: I'm Megan Gregory from Alaska.

MS. KANA ENOMOTO: Kana Enomoto, Deputy at SAMHSA.

MS. PAMELA S. HYDE: And this is Pam Hyde, the voice you've been hearing so far, is Administrator at SAMHSA.

Let's see. We have Nevine Gahed back there, who is Kana's special assistant, and also just assistant extraordinaire. And sitting next to her or walking in is Phillip Ames, who serves as my special assistant. And the two of them make sure our lives work. So it's great to have them.

Because we have council members from some of the other councils in the audience, I'm going to take 2 seconds and let you guys introduce yourself, which means we need somebody to take them a microphone.

Thanks, Anne.

MR. JEROME BIG JOHN: Happy to be here. My name is Jerome "Brooks" Big John. I'm from Lac du Flambeau, Wisconsin.

MR. JOE GARCIA: Good morning. Joe Garcia, head councilman for Ohkay Owingeh. I come from New Mexico.

DR. LEIGHTON Y. HUEY: Good morning. Leighton Huey, University of Connecticut and member of the Annapolis Coalition and member of the Center for Substance Abuse Treatment.

MS. SADE ALI: Good morning. Sade Ali, First Nations, LLC. I'm with the CSAT NAC.

DR. LORI SIMON: Lori Simon, psychiatrist from New York/New Jersey area. I'm with CSAT.

MS. PAMELA S. HYDE: Anybody else back there from any of our other councils? We have some other staff who are in the room, but staff will be coming in and out. So, staff, if you let me -- oh, we do have another. Lisa, yes?

MS. LISA WADE: Good morning. My name is Lisa Wade, and I am a council member, health, education, and social services director for Chickaloon Village in Alaska.

MS. PAMELA S. HYDE: Terrific. So thanks to the other council members for being here. And again, we have some great staff back there, but I know that some folks are going to be coming in and out.

So also know that Betsy, I believe, has joined us by phone. She's a member of this council. So, Betsy, are you on the line?

MS. ELIZABETH A. PATTULLO: [on telephone] Yes, I am, Pam. Good morning,

everybody. Sorry to be joining you from Boston on the phone.

MS. PAMELA S. HYDE: Operator, we can't hear the people on the phone. So Betsy should have an open line, able to join us for the conversation this morning.

MS. ELIZABETH A. PATTULLO: Can you hear me, Pam?

MS. PAMELA S. HYDE: Okay. Betsy, you and -- we're going to have you and the operator see if we can do something about your volume because we can't hear you. But know that Betsy is with us. She had to go do something else but was able to join us by phone. So appreciate her being here.

Before we get into the business of the morning, we have to adopt the minutes from the previous council meeting back in August. I hope you were able to look at those. They were sent out to you.

They were certified in accordance with the Federal Advisory Committees Act, or FACA, we call it, regulations. Members were given the opportunity to review and comment on the draft minutes, and members also received a copy of the certified minutes.

If you have any changes or additions, we can incorporate them in this meeting's minutes. And if not, I will take a motion to approve the minutes. So any motion?

[Motion.]

MS. PAMELA S. HYDE: Ric Broderick moves. Any second?

[Second.]

MS. PAMELA S. HYDE: Cassandra seconds. Any changes, comments, concerns about the minutes? Okay, any objection?

[No response.]

MS. PAMELA S. HYDE: Seeing none, we will approve the minutes as drafted, as certified.

Agenda Item: Reflections on the Joint National Advisory Council

MS. PAMELA S. HYDE: All right. So the first part of our meeting at this council is always to reflect a little bit about what we heard yesterday and what some of you may have participated in the individual councils. So I want to just start by opening the floor.

You heard a lot of information, as you always do when you come. But yesterday, as I said when we started and then ended up, Kana and I were trying to sort of speed update you on a jillion different things that SAMHSA is involved in just to give you a flavor of the breadth of our work because so many people relate to us on whatever it is they are interacting with us about. So we were trying to give you a flavor of that.

And then we tried to do some deep dive down into some of our thinking about treatment and particularly in various affinity groups we asked you all to split up in, and then in the work that Kana has been leading in one area to try to give you a sense of how we might do a little deeper dive into something, in the beginning of something that will clearly be multiyears in the making.

So, hopefully, you got a flavor of that. And to the extent that this week has been about what can SAMHSA do better, differently, to influence support, help with treatment, even though we don't fund a lot of it in the country, I'm interested in your reaction.

So Cassandra?

MS. CASSANDRA L. PRICE: She's calling on people today. I think I'm trying to wrap my head around yesterday. I think the areas were -- were okay the way they were defined.

I think there was some confusion about what had happened the day before and what the response was for the first panel. And then the time that we had together in the breakout group was a little bit shorter than probably would have liked. And maybe a little bit more of guidance with the breakout sessions to kind of guide the thoughts a little bit.

But I do think despite those challenges and the time frame, that there were a lot of people trying to come up with concrete ideas. I think that you kind of set that tone early when you were going, okay, well, that's great, but do you have an idea? And I think that's probably a good direction to push the councils because sometimes we get on I wouldn't call them tangents, but we get on the soap box of what we all agree upon and kind of general ideas or thoughts, but we never really cull it down to something very specific and something that's actionable.

So I think that's a really good direction. I just think if we'd have had a little more time we might have -- could have got to a little bit more solvency and some actionable items.

MS. PAMELA S. HYDE: Okay. Thanks for that input.

Other people have reactions to either the process of yesterday or to what you

heard? Henry?

DR. HENRY CHUNG: I thought -- I came late, but I was able to take a look at what Kana presented yesterday on the social norms. I have to say that's an important area. But the monies that SAMHSA has to actually influence that is very, very small, as Kana noted. It would be, I think, important to join with the national employer coalitions that are very, very involved in this whole arena of really trying to change the norms within their employee culture around access to mental health services.

It's really the number-one -- in some of the employer forums I've been involved in, it's really become the number-one issue among employers about adequacy of health plans, networks, and the willingness of their employees to really utilize the wellness-related prevention initiatives that obviously intersect with behavioral health, but also accessing treatment. So as much as we can work with the Fortune 500 companies through these national employers groups, like the Northeast Business Group on Health, Pacific Business Group on Health, the better.

MS. PAMELA S. HYDE: Thanks. Good comment. Yeah, Ric?

DR. ERIC B. BRODERICK: After our conference call, actually a little bit before it, I had been talking to a number of the providers. I live in a very small frontier community in southwest Colorado, and I talked to most of them.

And first of all, they hadn't heard of SAMHSA. These are on the ground providers who do either private practice or public sector mental health or substance abuse. And they get their money who they get it from, and ultimately from the State and ultimately from SAMHSA. And none of them, I mean none of them, have ever heard of SAMHSA, which is not surprising, given sort of what they do and where they live.

But I was thinking yesterday when we were talking, how important is that in terms of evolution of the standards of care? And the primary care providers for sure have never heard of SAMHSA. Some of them haven't even heard of SBIRT.

It's an interesting problem. And should you spend your time making sure they heard of SAMHSA or, you know, doing what needs to be done to make sure that when they ask a person if they drink, a nurse does at the local community health center, that she follows up with, if you say yes, the appropriate questions. And so, it's you probably could do both.

I mean, the branding issue is one of just putting SAMHSA's logo on stuff. But it -- I suspect if you had to choose, the latter would be more important than the former, and so I asked the questions differently than the three questions you posed to us about translating demand into need -- or need into demand, rather,

and how to address the standard of care and getting the mental health and the substance abuse people together with the primary care providers in this little community because they're not.

And so, they had a number of interesting sort of takes on it. They all thought it was a good idea, but it's not something that they're sort of actively working on. So there's a lot of work to be done, I guess.

MS. PAMELA S. HYDE: Yeah, those are interesting reflections. You remind me of a class I taught years and years and years ago and was for practitioners, but I was there as a public policy person. And I remember one of the first classes asking them if they knew where their salaries came from. You know, what was the payment source? And without exception, they had no idea.

So these were people doing clinical work, and now again, that was quite a long time ago, and I think financing is much more in the discussion these days. But at that time, people didn't know where their dollars came from. They just had concerns about the clients in front of them and what the constraints were about providing those services, et cetera. So it was kind of interesting.

DR. ERIC B. BRODERICK: Yeah, there is an awareness, as Henry said, about the importance and sort of this public health crisis that we talked about yesterday among those folks, among both the primary care folks and, well, the community at large, quite frankly. As is the case in many small towns, there's a whole page of the paper that's devoted to who got arrested and what it was for, and most of them are on drug-related, alcohol-related things.

And the availability of care is not real good, and it's sort of a microcosm of need versus demand versus access to care versus the workforce. I mean, all those issues are at play in this very small little town, and so I think Kana is on the right track.

DR. GAIL W. STUART: So kind of to follow up on that, I was thinking that if you wanted to raise social awareness of the work of this agency, why not jump into two of the major issues that are all over the news these days? And that's the police shooting involving a lot of mentally ill individuals, because it's now obviously rampant, and then rape on college campuses, et cetera.

And you know, if you could bring to the public's awareness here are the toolkits we have. Here are some things. It's almost using adverse events to -- to bring to greater public awareness the work of SAMHSA, the tools, the resources that you have, and perhaps to open more of a public dialogue. But to latch onto what the public is really riveting about, I think, is a good strategy possibly.

MS. PAMELA S. HYDE: Junius?

DR. JUNIUS GONZALES: So I actually was not going to comment, but Gail reminded me of something. And one of the real questions for the workgroup on the science of changing social norms is really what kinds of things allow positive change in attitudes and behaviors to regress, and what is the potency of events like the things that Gail is talking about? It had not been a studied question, actually. You know, you can say you just want to repeat the message.

That was not actually why I raised my hand. I wanted to ask about process, having been on other Federal councils and staffing. So one of the questions I was thinking about yesterday is so how do key and focal elements of the conversation and priority questions raised yesterday continue with each of the councils? Because there is sort of this gap to the next meeting.

As you well know, and I've talked about this with others in the agency, having worked with SAMHSA long ago, is some councils decide to either put together, and while no one wants more work, smaller workgroups not only of council members or of experts in the field to tackle something. But my main question is about the continuity of the conversation particularly around all the councils that you have.

MS. PAMELA S. HYDE: Thanks for both the process question and the content comments. Let me talk about the content stuff first. Interestingly enough, I would say, at least from my time here, which has been about 5 1/2 years now, there is pre Newtown and post Newtown.

Pre Newtown, we were doing sort of not too many people weren't paying attention to what we were doing. It was kind of inside the behavioral health field, and we were setting our directions and our strategic initiatives and working with our colleagues around HHS and doing good things and thinking about getting SAMHSA's name out there and getting more technical -- you know, the stuff that we do.

After Newtown, which happened in December of 2012, certainly my time has changed, and it's never really not gone back. I mean, it's never really gone back. And two or three things happened out of that time, Gail, which was a pretty clear interest in not putting SAMHSA in the middle of the conversation about violence and mental illness. That was not just SAMHSA. That was the White House. That was everybody else.

And if you remember what happened in January of 2013, when the Vice President and the President came out with the Now is the Time plan, the focus really was on going forward. And it was really getting up front. So if you look at a lot of the grant programs and the resources that we have received, the workforce initiatives out of that, it's really addressing young people because of the transition age youth and the recognition that a lot of both the perpetrators and certainly in the school situations, the victims in these situations are people in that

age group, under 25, basically.

So I think there was a great response at the Federal level, both in Congress because we got that passed -- that's one of the things that actually got passed -- has been to focus on the right things. On the other hand, as the events of life that include people with mental health or, in some cases, substance abuse issues have continued to unfold, they've all gotten national attention in ways that it didn't use to be. It used to be a local press issue. Now it's a national press issue every time it happens.

And so, this issue about how we talk about it, how we reflect about it, what the research is about gun violence and mental health, for example, about assisted outpatient treatment, all those things have come forward in ways that was really not on the top of everybody's mind before December of 2012. So we've done a significant number of different kinds of things, but that's also when the criticisms started.

And the criticisms didn't come as "You're not doing enough about your mission." The criticisms came about a very specific thing, that we're not doing enough about people with serious mental -- adults with serious mental illness. So that has been really the criticism. Frankly, Congress has been relatively supportive about all the other stuff that we do. If you look at our budget process, even in tight budget times, we've done fairly well.

And certainly, our colleagues in HHS have been very supportive in the workforce area, in CMS changes that they've worked with us on, on some of the research issues we've done, the grant programs, et cetera. I'm waxing on a bit here to say that I think now what we're trying to do is figure -- and now, as prescription drugs and substance abuse issues have come to be more at the fore, that also has emerged in ways that are very important and good, but they are led by cross-agency teams, not necessarily by SAMHSA.

We are a clear part of it, but we are not the leaders of it. So, so it's interesting to look at sort of where SAMHSA should stake its claim, and then I think part of what we were trying to show you yesterday -- because we have tried to get SAMHSA's name out there, not so much because we're just, you know, supporting SAMHSA. We are. But because we believe the country needs to know where to go about behavioral health issues.

On the other hand, and this is a personal reflection, I sometimes literally think about this at night about, well, you know, is it better that everybody is talking about behavioral health now? Because CDC is, FDA is, ACF is. I mean, you could go down the list. They all are. CMS is all over it. NAMD, the National Association of Medicaid Directors is all over behavioral health now and is reaching out to SAMHSA in different ways.

So all of a sudden, everybody cares about it, and maybe that's a really good thing. But it makes it very hard to herd the cats about what is evidence-based treatment? What should be the priorities? How can SAMHSA play the best role at leading the Nation in some of these areas? So it's been a challenge, and I think part of what we're putting back to you as advisers is helping us kind of think through that.

And out of that effort came this notion, which we'd been talking about before December of 2012, but we'd actually let go of because we didn't think we had the time, the resources, the capacity, the horses to ride to do a national dialogue about behavioral health or mental health. And after 2012, that came back.

And so, out of that is the work of the last couple of years that has resulted in Kana's leadership around the science of changing social norms. So, again, out of 9/11 came a lot of the maybe not exclusively, but certainly the trauma work, and out of this, I think, has come some real important science-based thinking about how do we change people's thinking about this? So I think we're in an interesting era.

I know Kana wants to jump in here, but I want to say one word about the process that Junius raised. We reach out sometimes to you as individuals in between a lot to get your expertise on particular things, and we've been trying to do more in between calls or in between meeting calls to get your advice or at least help you have the information you need to advise us the next time around. I think maybe we could do a little bit more conversation about your question of what's the best way to engage you?

Some of the center advisory committees have other work they are required to do by statute. So they do some other things in between as well. But it's a good question, and we probably should spend a little time thinking about it. Kana?

MS. KANA ENOMOTO: So speaking of the increasing interest in our issues, I apologize. I have to step out. We're having a briefing to prepare for the hearing that the Energy and Commerce Oversight Investigations Committee is going to have on medication-assisted treatment, and I'll be testifying for SAMHSA with others from the department.

I did want to address briefly, Junius, what you said. What are the setbacks, and how do you deal with things that can work against you with the positive messaging and the goals that you have?

I think it's harder to look at the empirical science, like the research science in the published literature. But one of the things that we're trying to tap into is what others use, which is pollsters and the science that they have developed over the years. And they do look at -- you know, because it's a little bit harder than, say, breast cancer. There's not some like really big adverse event that gets you to

like, wow, and now we don't like breast cancer survivors, right?

But, and polling for campaigns say you do have that. Right? You'll have a candidate. You have a referendum. You have an issue where there can be a negative news story that gets people to rethink the opinion that you've been trying to get them toward.

And so, I think by using polling science that will help us get closer at what do people respond to? How does an event, how does a message adversely affect their belief or their interest in your particular topic? So I think that'll be something that we can take advantage of, as well as the cognitive science around certain messaging and terms and how they appeal to people or galvanize them or don't galvanize them.

So thanks. And I will be back.

MS. PAMELA S. HYDE: Ken?

DR. KENNETH J. MARTINEZ: Thank you, Pam.

Being the new kid on the block, I'm just trying to figure out, you know, what our role is here, and looking at the agenda, it was a real packed agenda this morning. So thank you for time to reflect on yesterday because yesterday was jam-packed with lots of wonderful comments. And I was thinking about them last night about, you know, what rose to the top.

And for me, you know, with the issue about who is SAMHSA, what does SAMHSA do, does the public know about SAMHSA, you know, how much do we want the public to know about SAMHSA, all of that stuff. But you know, we want to craft the message in a positive way.

And lately, you know, SAMHSA has been under -- under fire, so to speak, and you know, given the negative press that has been out and given the committee that Kana just referred to, the House Energy and Commerce Subcommittee on Oversight Investigations that happened recently, the hearing that they had, the GAO report, you know? So there's a lot of things out there that are percolating, and it affects the perception of SAMHSA by the public because these -- some of these things have gotten kind of high profile.

So I'm wondering in terms of the role of this council, how can this council help you and help SAMHSA not only craft the message in a positive way, but be effective in that messaging? And you know, what can we do to support you and support the agency, which is a critical, vital agency, no matter how much it's not known, in the big field of behavioral health?

And I think several comments yesterday, you know, like does Congress or the

public understand what SAMHSA does? You know, Leighton made some comments asking those questions, and others have said it, too. So I think that's a front and center issue, and I think that's maybe one that this council might be able to help play a role in, in supporting that positive message. And you know, how can we kind of stem that tide of negativity to make this more of a positive thing so that we're not, you know, reacting all the time and as opposed -- we want to be proactive and not reactive.

So I think that's certainly a role that this council might be able to play. So I wondered what your thoughts were, and I'd also invite other council members to chime in about what your thoughts are regarding our role, you know, with this issue.

MS. PAMELA S. HYDE: Thanks for the question, Ken. Megan?

MS. MEGAN GREGORY: I actually have a few ideas. I serve on the Center for Native American Youth Board, and I'm sure you're familiar with the Champions for Change program. They've recently teamed up with the White House to create Generation Indigenous. And they just met with First Lady Michelle Obama at the White House, and she said folks in Indian Country didn't just wake up one day with addiction problems. These issues are the result of a long history of systematic discrimination and abuse.

And what they're doing is they're using young people to spread the message about suicide prevention and mental health issues. And they're taking a positive spin and, you know, getting a creative buzz going across the country among young people. And I feel like Charlie and I, I think this might be our last year here on the SAMHSA NAC, and it would be great if we could be your champions for change with this last year here.

What can we do to team up with the Center for Native American Youth to spread the message, whatever messages that you would like us to spread, as well as with the National Council of Young Leaders. I currently serve on that council as well, and we've recently teamed up with Starbucks. They actually had us meet at their headquarters in Seattle a month ago, and they're interested in putting 10,000, you know, opportunity youth back to work and sending kids back to school.

And I think that we need to look at ways to collaborate with them. You know, they have a lot of people that they could reach via a coffee cup, and I think that they would be willing to support what it is SAMHSA is saying to do. So I would encourage you to look at ways, since funding is limited, to reach out and connect with people in that way.

So I hope that, you know, with this last year together, there will be more outreach to get us involved because I could easily take a picture with you and talk about

the work that's being done and connect it with a hashtag. And it's going to be reaching so many people, and it's not going to cost you anything.

So thank you.

MS. PAMELA S. HYDE: Yeah, thanks for that, Megan.

Let me just make sure you know we have a new youth group called, Sheila, STyLE, STyLE. You want to come up to the table and just say two words about it? Because it is an effort to provide some youth input to our Tribal Technical Advisory Council.

We actually just held -- I think you know this, Megan. We just held the first-ever Native Youth Conference last November, brought in tons of Native youth. It was a great conference, interacting with the White House and a lot of agencies, including us. And then the White House is doing, they just did or is about to do another big Gen-I event. Can you say two words about that?

MS. SHEILA COOPER: Right, yeah.

MS. PAMELA S. HYDE: This is Sheila. She's our tribal liaison.

MS. SHEILA COOPER: Good morning. I'm Sheila Cooper.

The Office of Tribal Affairs and Policy has been involved with the Gen-I initiative from the White House. STyLE is SAMHSA's Tribal Youth Leaders. I say we got Indian STyLE going on in SAMHSA these days.

And so, it is an outgrowth, like Pam said, from our Native Youth Conference, and we haven't -- we're waiting somewhat in abeyance. The White House will be rolling out another national event for Native youth this summer. So we're coordinating our work with our youth with that initiative as well.

So I appreciate your comments and really are involved with Gen-I. So anytime you want to coordinate any of SAMHSA's efforts or want talking points, just contact our office.

Thank you.

MS. PAMELA S. HYDE: Follow-up?

MS. MEGAN GREGORY: I do, actually. I wanted to thank you. I was actually invited to participate, and because of my work schedule, I wasn't able to attend. But I'm excited to learn more, and Sheila, I have your email. So I'll be in touch.

Thank you.

MS. PAMELA S. HYDE: Great. Thanks.

I think this question or the comment maybe, Ken, come back to yours. But is with all this attention on behavioral health, so we're sort of talking somewhat about SAMHSA and somewhat about behavioral health, and they're related, but not the same. We didn't get any new staff to do this stuff. Poor Paolo has been trying to implement all the President's plan for Now is the Time, it's called, Project AWARE and Mental Health First Aid and a whole bunch of other stuff. Our HRSA relationships with much more workforce stuff, and Minority Fellowship Program has expanded.

And I don't know if we gave you one maybe more person that hasn't been filled yet or something like that. So they're all doing it with the same staff, and all of this attention is coming with the same Administrator and Deputy Administrator. So it's not like we have new people to do this. So we do struggle a little bit with what do we pay attention to? Because there's so much to do. I mean, there is just so much we could do.

And then also sometimes we're doing lots of stuff, but it's only this big because we only have this much resource. And sometimes even our best allies and friends don't know about it. So how do we -- how do we get that out there without -- we've actually added a fair amount of communications capacity. Marla has been very good at building that capacity, and we even added now recently an internal communications person because our own staff don't know what we're doing.

So I don't know if you saw the screen when you came in the door. We now have a screen that rolls all the time for our staff to see what we're working on because it's hard even for them to keep up with it. So your continuing advice, and Ken, I think your point is well taken, is how do we figure out how to make sure that the negativity that, you know, at any given time it's us. Two years ago, it was ARC. Some other day, it's going to be some other agency that's getting beat up.

So I don't think this is unique to SAMHSA. It just happens to be our time to get beat up at the moment, and there's a reason for that. So how do we focus on the reason without getting sucked into the negativity? Because it is easy to do that. It's easy to just into a defensive mode, and we don't want to do that. So answering your question will be important.

DR. HENRY CHUNG: You know, on this issue I think -- I also think a little bit about my time working with HRSA over the years when I was in the FQHC world. And I think part of it is back to Ric's question is, you know, how much importance is it to sort of know the agency versus how important is it that the agency's good work gets translated in a meaningful way?

HRSA, if you think about it, I mean, that's a very unsexy name. You know, HRSA? You know, what the heck is that? And it's very wide ranging in terms of its portfolio. It covers a heck of a lot. But really, the constituency that is the most active within HRSA is BPHC, right? If you think about it, people think of BPHC as being that direct service component, you know?

And the people who are in the FQHC world and the look-alike world are very passionate about the role of BPHC in HRSA. Partly it's because of the direct dollars that they get. So they kind of have that relationship with their project officers and so on.

And you know, if there were some aspect of SAMHSA that relates to that and building that sense of, you know, constituency where, you know, the champions of the agency are those who truly benefit from the dollars because they know how much good it's really making in their community, I think that's one aspect you can think about in your wide-ranging portfolio.

The other is if you think about the agencies like CDC and so on, again, these are broad, wide-ranging agencies. But they get known for certain specific items, and I think that when you look at SAMHSA's budget, you have a lot of priorities. But which priorities is it important to publicize your successes?

You know, the whole notion of access, as an example, is huge in this country. How do people get access to mental health and substance abuse treatment? Well, your PBHCI initiative is huge. Have we been able to quantify how many people have gotten access to mental health services as a result of that initiative? Quantification of those numbers would be very important in terms of, you know, putting out a positive statement.

I'm less enamored about, you know, worrying about the negative stuff. As you said, you know, those things come around and go around, depending on the politics of the day and whatever the issues are. It's more important, I think, to focus on what are the priorities of what you want the image of SAMHSA to be in terms of leading the way in this country, prioritizing what you want to talk about. You can't talk about everything because that does muddle the message.

And then how do you build that sort of internal constituency, you know, much of which is composed by a lot of the advisory board members that feel that very intense connection with SAMHSA, so that they feel close to it and are able to, if not speak on behalf of SAMHSA, represent the good that SAMHSA does on a day-to-day basis.

MS. PAMELA S. HYDE: Yeah, interesting. We've just recently -- so this is a fact I'm telling you, not to undercut anything you just said. But just recently, our critics said the only people who support SAMHSA are people who get money from them, as if that somehow was a negative. It's like, and you know, obviously, you

just said, of course, people who are passionate about HRSA are people who get funded by HRSA. It's like, yeah, of course.

So I think our grantees are pretty supportive. You know, I they're -- it's not hard to get them to stand up and say thank you, SAMHSA. I think the issue again, and I want to make sure while it's okay to talk about this issue of SAMHSA's image, the issue really is what can we in this context keep, sort of like Ric said, keep focusing on what's the most important things to do.

I have noticed, and there's days when I go back and forth between that's a good thing and a bad thing. I have noticed that we can be the leaders on a particular issue, pick an issue, and it's hard to get any attention to it. And if Tom Frieden, who's a great colleague, from CDC says one statement about suicide prevention, for example, or about opioid overdose or about whatever, it's all of a sudden front page. It's on every radio station in the morning.

So he does have a platform. So having him use that platform for our issues is really critical, and we're really glad that CDC has embraced behavioral health issues. And yet at the same time, then we sort of go into the, okay, well, then you've got people in Congress say, well, fine let's save money by just getting rid of SAMHSA and letting CDC handle it. So, you know, we sort of struggle with that balance.

So, yes, Chris?

MR. CHRISTOPHER R. WILKINS: This is -- thanks for the question yesterday. I thought about this almost nonstop last evening.

It occurred to me that strident political rhetoric is most usually tactical and that it's meant, or at least it looks like it's meant, to discredit and marginalize the work that the agency has done. And then I got to thinking that what happens if that's successful?

What happens is that we litter the highway with facile or actions that are made to look facile, solutions that get put into place that fundamentally impede human progress. And that's what was disturbing me about the tenor of what you've been enduring. Let's marginalize and let us decide in the vacuum, and a lot of times, most times that's turned out very poorly for the person.

So I thought, okay, if SAMHSA's a person, what should SAMHSA walk into the room and say? And I thought it would be interesting if we tried to change the conversation with those values of civility and respect and say, look, we get it. We get that in the post ACA world health systems are hurdling together or hurdling apart to change their fundamental way of being in the community in ways that are really unprecedented, I think.

We get that big States with big Medicaid budgets are going to take a lot of definitive actions that are going to impact the way things happen for human beings. We get that risk-bearing payment models between third-party payers and managed payers are going to fundamentally shape that reality of service delivery as well.

We get that the proprietary sector is moving money and new financing models and service delivery cohorts into a world fundamentally owned by nonprofits for 75 years. You wouldn't have to look any further than the prison health movement, you know, to see that.

You know, we get that fields like behavioral economics are stepping up and saying, hey, you know all that money that you spend on behavioral health? Well, we understand the science of how human beings aggregate short-term and long-term incentives to make decisions about their lives, and we understand how to profile their personalities in 6 minutes through data, and we understand how to message them in ways that they're predicted to receive it and act upon it. And we can do that a lot more cheaply than all that behavioral health infrastructure.

So we get that. We, SAMHSA, get that. We understand the currents. We understand the big environment.

Here are four things we're going to do. First, we're going to find every single place in Federal policy and help States find it in State policy where anachronistic policies are fundamentally holding back the evolution of systems that are good for people. That's the first thing we're going to do.

And you know what? You're great at it. You know how to look at policy. You understand what holds people back. You don't have to go any further than the work you're doing with 42 CFR and a variety of other things to understand that.

Second thing we're going to do is we are going to point out relentlessly health disparities wherever they exist, especially when behavioral health is the primary or the secondary issue. And we are going to pound those things with data and understanding and stakeholders and coalitions, and we are going to make folks understand the problem. A lot of the way Mrs. Obama did in that statement, right?

Third thing we're going to do is we're going to look at these emerging new cohorts, right? And we're going to sort of set standards for them about how they should deliver care. That's the evidence-based care movement.

And finally, Pam, it occurred to me we, SAMHSA, are going to walk in and so insinuate and integrate ourselves into anything related to data that you couldn't get us out of it with a crowbar. You know, we have a history of having some of the best data around, and those datasets can be expanded. They can be

improved upon, and they can be integrated. And you're not going to get rid of us because we're a fundamental part about the data movement.

So that's it.

MS. PAMELA S. HYDE: Those are great and profound recommendations and thoughts. Thanks, Chris.

Say the third one again, the emerging new cohorts. Say a little bit more about what you meant about that.

MR. CHRISTOPHER R. WILKINS: Yeah. So let's take the proprietary prison health providers. I mean, they're ubiquitous at this point. We can educate them about how they do their work and how they include evidence-based practices in the way they do their work and how they build continuity to the community health systems.

MS. PAMELA S. HYDE: Okay, thanks.

That was really helpful. It was helpful in two ways. One has crystallized a little bit about some of the thinking, and I think it actually sets us up for a good conversation about the next set of things we're going to talk about. But it also, I think, says we have been paying attention to some of the right things because when we step back and say we can only fund this much of care, treatment, whatever, so how do we use that so that we actually change the field, not just pay for a grant? We really have been trying to move our grants in that way.

And then, secondly, we have paid a ton more attention to the who's making good or bad or stupid decisions, and what table do we need to be at? So we've sort of relentlessly been trying to do that.

And then we haven't done it for a while, but I know Larke has -- our head of our Office of Behavioral Health Equity has been with us a time or two in the past to talk about our fairly extensive disparities work, and we've gotten really good feedback about that. And I got for the first time, believe it or not, after 5 1/2 years, I actually got to go to one of the Network on Eliminating Disparities trainings that we do. We do them all the time, but I don't get to go to them all the time.

And it was really quite profound to see the people there and what they're getting out of that. And I actually got to sit through something I never get to do. I actually got to sit through a training about how to deal with young African-American male anger. And all that that places that that comes from -- racism and poverty and misunderstandings and fear and all that -- by an incredible trainer. So just I was really proud of SAMHSA when I got to sit through that and just see some of the work that we do that I don't always get to see.

So, so thank you for that, that frame. That's really helpful.

Other people have any further reactions on either what Chris said or what you heard yesterday? And Ken, I don't know if we actually answered your questions. Anybody have any reactions to Ken's questions?

DR. KENNETH J. MARTINEZ: I think, you know, one follow-up would be, you know, what -- what is your response to the GAO recommendations? What is SAMHSA going to do?

MS. PAMELA S. HYDE: The answer might be which GAO recommendations? There are several of them. We've been -- Paolo has been working on those. There was one GAO report that was the subject of the last hearing that I did, which was kind of an ugly hearing. But it was truly misunderstood.

There were two basic recommendations. One is that we bring back a Federal interagency work group that had gone defunct. And we basically said, no, that doesn't make any sense. That's kind of going backwards, and we've done a whole lot of stuff since then to coordinate in a much more complex way.

That was basically our response, and they just beat the heck out of us for, "What? You mean you don't want to coordinate?" And it's like, no, that's not what we said. So we've been struggling with that one ever since.

And then the second recommendation was you should evaluate your programs. And if you actually go look at the GAO report, SAMHSA does evaluate all its programs. The people who didn't evaluate their programs were the Veterans Administration and DoD, and they both said, "Yes, we agree. We need to evaluate our programs," and we're, in fact, working with them to do that.

And yet we got beat up pretty heavily in the hearing about not evaluating our programs, and that's not at all what the report said. So we sort of struggle with what people are finding, and there was absolutely nothing in that report to suggest that we'd done anything wrong, that any of our money was used inappropriately. Nothing like that. So what the -- what the committee used it for and what it actually said were two completely different things.

There's another GAO report cooking about the way we manage our grants, and we think we do have some ways that we could improve there. But again, no suggestion that anybody has used any money wrong or done anything about that. It's just we can do better oversight, and a lot of that is in Paolo's shop right now, but it has implications for the rest of our grant programs. And that one will be coming out soon, too.

And we're basically going to agree with a lot of those recommendations. But it

will be another opportunity to beat us about the head and shoulders. But we've already been doing some of those improvements about grant management processes even before this GAO report came out.

So we sort of struggle with the what's the politics of doing this? And I believe, and you know I'm saying this for the public, so I will say it. I believe there's a couple of things, two or three things driving the desire to do this. One is, I think, a true desire on the part of some people in Congress to improve behavioral health services for certain people that they perceive to be the priority. And they clearly are the priority in terms of treatment needs.

We think, actually, again, Paolo's shop has been doing more work on patient engagement and family engagement, and we have proposed for 2016, I think you saw that yesterday, a crisis pilot. Because we think that we ought to get up in front of these crises. We can't wait until people land in the emergency room, kids, young people with their families who have to sit for 15 hours. You can't wait until you get there and fix it. You've got to get upstream about it.

So we've proposed some ways to do that. But nevertheless, I think one -- one reason is people's true interest in making those things better for people. People just may have different assumptions about how to do that.

The second reason, I think, is that some people in Congress are interested in finding resources for things they would like to do that are not yet funded. More assisted outpatient treatment programs, that sort of thing. You got to find the money somewhere.

In this Congress, you can't come up with new programs. You got to get rid of something in order to fund something else. So they also -- they almost have to make some programs look bad in order to say, well, we can get rid of those so that we can fund these. And I think that is part of what's going on here.

And then the third thing I think that's going on here is the nature of a Congress that's ruled by one party and the White House that's ruled by another. And there's a little bit of that kind of "we're going to shoot at you," and we happen to be a convenient target for those other two reasons.

So I think those three -- those are the things that are moving us now. So I think we're really trying to focus on that first thing, which is how can we really improve services and treatment and not get too much caught up in the politics and this issue of we're going to have to get rid of that in order to fund this. So, so enough said about that. I don't know if that helps.

Any other comments? Or staff, any comments from you guys in terms of what we've been -- Paolo, you've been on the hot seat about some of this stuff for a while. Anything you want to say?

MR. PAOLO DEL VECCHIO: Just to acknowledge the incredible staff that we have here. In the past year, we've had many challenges, but lots of successes. And some of the really exciting work that we're doing, like the Section 223 work for certified clinical behavioral health clinics and like the work that we're doing with NIMH on the first episode serious mental illness, there has been 5 percent set-aside, which we really feel these kind of efforts are really going to make the longstanding change that we really need. And again, it's a testament in large part to the staff that we have here.

DR. HENRY CHUNG: I just think that's, Paolo, just such a huge importance in terms of bringing together again the notion of what SAMHSA does in influencing both policy and practice. The CCBH type movement, I think, is a huge opportunity to get those practice standards out there, and we really do as a field need to move beyond process standards. I think we have to be honest and say that our field really suffers from agreed-upon, robust outcome metrics of what we're expecting to see.

You know, things like how many people do we expect to improve by what period of time to this particular goal? How many people need to be on these types of medications or psychotherapies that have been shown to work, you know? We can't be sort of this wishy-washy, mushy, you know, we're providing treatment because there's a lot of stuff that's been shown to work, a lot of stuff's been shown, unfortunately, not to work. Or we just don't have evidence for.

And you know, I think that type of standardization, we have to be much more a part of leading that movement and not simply reacting to it. So if there's one thing I would urge, urge that. Use that as an opportunity.

MS. PAMELA S. HYDE: Yeah, Henry, that's a great point. And Pete has not been here today, but our Center for Behavior Health Statistics and Quality over the last several years has been working on a National Behavioral Health Quality Framework, which is actually on our Web site. But it's a living, breathing document because we've been doing a lot of work with NQF on validated measures.

Unfortunately, a lot of them are process measures. And so, as we do this 223 work, that Section 223, the pilot work that Paolo was talking about, we are working with CMS and ASPE on what measures, a lot of which what measures would drive quality payments, for example? So this is value-based payment.

And a lot of them are process payments or process measures, but we -- we don't exactly have the connection that maybe healthcare does. We have some sense that if a woman gets a mammogram every year during certain periods of their life, they are more likely to not die by cancer. So we have some of those relationships. So it's okay to use the process measure of did you get -- did the

women you're responsible for in your health plan get mammograms?

We don't quite have those connections yet, but I think we have begun to stick our toe in that water, and it goes back, Chris, to your issue about what our job is. And so, we thought about our data job much bigger than we have in the past and have moved our little Office of Applied Sciences to a much bigger Center for Behavioral Health Statistics and Quality that's looking at economics, that's looking at evaluation. It's looking at quality measures and all these things.

So, but maybe at some other time -- in fact, Paolo, at the break, I think Henry might really enjoy seeing just some of the measures we're looking at. Those are actually not out for the public yet, but you all are sometimes able to look at documents that are not considered public yet.

They will be out very quickly, though, and we are trying to finalize those, what measures would go into this program. So it'd be interesting to get your reaction.

All right. We're about -- Gail, one more comment.

DR. GAIL W. STUART: So I was just going to say I'm on the NQF panel to look at dual eligibles. That's largely our population. And the best we do is screen for something. We can get that in as a measure. Having a hard time getting continuity of care, and we know for our population that's enormous. So I'm happy to advocate for anything that you would like, but it's a tough struggle.

MS. PAMELA S. HYDE: So remember this conversation when we come back to the end of the day because I will ask you your opinion now about what things -- we use you as the sort of overarching group to say a little bit about what should we have our advisory councils pay attention to next time or in the media, in the middle or whatever.

So there's a jillion different things that have come up -- disparities, our policy work, our economic work, our financial mechanisms work, our work on quality measures. I mean, there's a jillion things -- our youth work. A jillion things that we could spend time on with you. So be thinking about that.

Agenda Item: Ecological Model of Integration

MS. PAMELA S. HYDE: All right. So let's move into the next topic, which is something we're calling -- we call it different things because we're -- it's an evolving construct. This is another one of those things that I have to laugh about because I am -- I am really known for and having again these lofty ideas that I have no way how to get to. So I have to ask the staff to help me figure out how to get to them.

And they're usually the right ideas and the right vision. I just need staff to help

with the roadmap. So this is one that a long time ago we were thinking more about how integration of care, which was primarily being discussed in terms of primary care. So integration, and it was being primarily discussed as putting behavioral health into primary care, and it was, frankly, being discussed often as just collocating a primary care provider in a behavioral health clinic or vice versa, a behavioral health professional in a primary care setting.

The concept of integration has gotten much more complex, and we've kind of stopped using the word "integration." We kind of flow in and out of using that word because it doesn't adequately capture what we've now been trying to think about, which is the way in which behavioral health truly is essential to health -- to community health, to individual health, to family health, to healthcare, to other human service systems, et cetera.

So we've been trying to think about that much more broadly. So we got into talking about it as an ecological model of health or, in this case, it's on the agenda as the ecological model of integration.

So Chris and Mary have been leading some of that thinking, and where we are is truly in the thinking stage about what it is and then what SAMHSA should do about it or what our role in it is. So the paper you got is not a paper that we've put out hugely publicly. It's just something our executive team has spent some time thinking about, and we're sort of at the, okay, now what do we do next with it?

We've had some conversation with some stakeholder groups and others. But Mary and Chris are going to talk you through the paper a little bit and how we're thinking about it and then try to get your reactions. So, Mary, I'll turn it over to you.

MS. MARY FLEMING: Thanks, Pam.

As Pam said, we were charged really about a little over a year ago with beginning to think through SAMHSA's approach or thoughts about integration, and we had a discussion I believe at the last time you were town or last April about integration. Since then, as Pam has suggested, our thinking has really evolved much beyond the concept of primary care and behavioral health integration into much more of sort of how do we operationalize one of our foundational pillars, which is behavioral health is essential to health.

So we began to look at what the data tells us, what we hear from the field, and how do we begin to move that conversation beyond that traditional thinking of integration with primary care? We've talked with our leadership team. We've worked with an internal staff group and gotten feedback from our regional administrators. So we're anxious to get some feedback from you all today. As Pam said, we have not really rolled this out very broadly.

We're really working from some core concepts that behavioral health is part of individual and community health, wellness, and prevention. So you cannot have a healthy community without behavioral health. That behavioral health has a clear relationship to health and the overall cost of healthcare as measured in several ways, both in terms of dollars and quality of life, looking at sort of several measures of health.

That healthcare interventions, both treatment and prevention, affect behaviors and outcomes. That there are certain social determinants of health that determine health and behavioral health outcomes, and we need to be thinking about those. Then also, and this really we have found as we've had this discussion, that the sort of intersection between our workforce work and the science of changing social norms is significant.

That healthcare and the behavioral health workforce is something that we have to deal with in terms of this model, that there are workforce shortages across the field, and there's also a need for increased competencies in both the behavioral health and the healthcare and social service workforce as relates to improving or implementing an ecological model.

I might add that I also think there is issues around adequate reimbursement mechanisms that will impact the workforce fairly significantly. And that what we're talking about is a sort of continuum or scope of services that runs from prevention, primary care, specialty care, emergency or crisis care, long-term care and recovery. That we really are thinking about this across the sort of healthcare and service delivery continuum.

And that wherever people show up, they need to be able to access the care that they require and the amount and the type of care that they need. So, and out of that, we began to look at various models. And Chris is going to talk about this a little bit, but the ecological model based on the IOM's model really seemed to resonate with how we were thinking about integration at this point, and I use that term reluctantly because we really are trying to move beyond the use of that term.

Chris, do you want to?

MR. CHRISTOPHER D. CARROLL: Yes, absolutely. So just to kind of continue to --

MS. PAMELA S. HYDE: I'm sorry, Chris. Can you introduce yourself? Mary did, and you gave a title, but if you could just say a little bit more about your role before you start?

MR. CHRISTOPHER D. CARROLL: Sure. Chris Carroll. Been at SAMHSA now

for 11 years serving in different capacities, starting in the block grant and then making my way I'm going to say over to the policy office, not up to the policy office.

Currently the Director of Healthcare Financing and Systems Integration and oversee the strategic initiative related to that. And it's good to see so many familiar faces and more familiar names, I guess.

So about a year ago, I think I actually introduced this topic to the National Advisory Council. We had done a memo to Secretary Burwell, which I think everybody got a copy of at that time. Since then there's been significant work ongoing. We did develop a model. We did have a number of conversations externally, more focused internally, I think.

I think what I would like to do is kind of give you a sense of what those conversations were. I know that we're going to pose some questions later to continue to help to frame the discussion, but just so you kind of know kind of where we've come over the past year I think would be helpful, too.

So general, generally, I think most people resonated with the graphical model there. It's kind of intuitive. But it definitely needs some work. I think it's maybe not as dynamic as it needs to be. It appears to be more transactional than flowing. So there is some significant work that needs to go into the model, which we continue to think about and do.

Integration as a buzz word distracts from the model was some of the feedback that we got, and it distracts from it from the broadness of the thinking about an ecological model. When you use the word "integration," it tends to focus people back towards this clinical model of integration.

Your request for data I believe went out to you prior to -- prior to the meeting. I don't know if we had a chance to discuss that, but that got us thinking also about the broadness of the issue that we're taking on. You can see from the data that referrals come from many places, that care is provided in many places. So that's also an interesting element.

I think there's a real need -- and building on that, I think there's a real need for us to develop a resource allocation model as well. You know, SAMHSA has a small percentage of investment in the behavioral health system. So I think we need to know where our investment is, what systems we're touching. But really, as we've just had a discussion, where is the money associated with the behavioral health system in the Nation? We have ideas about that, but I think to define that graphically would be of assistance as well.

And you know, I guess, finally, just building on that is we really hope this discussion today will continue to help our thinking evolve.

MS. MARY FLEMING: I think the issue, for example, of the use of proprietary businesses or companies in the providing jail services is a really good example of some of the things Chris and I have been talking about, really trying to capture as part of that resource allocation model not just where Medicaid and Medicare and insurers are paying, but where is the money in all of these pockets related to behavioral health, that that's really part of what we need to start thinking of.

So --

MR. CHRISTOPHER D. CARROLL: So I'll put out a few questions there, and then we'll just open it up for discussion. Three questions. No surprise there.

Does the model make sense to you, given what you've heard about SAMHSA's planning in the last few days? And we can tie that back to the science of changing social norms, our grants, our treatment issues, and data.

Is SAMHSA strategically positioned to have an influence over this issue, and should we be the one leading this task?

And what do you see -- this one is particularly critical, I think. What do you see is the best possible outcome for SAMHSA taking on this issue? What would happen?

MS. MARY FLEMING: So we'd like to just open it up for discussion.

DR. GAIL W. STUART: So I'm still trying to get my head around it because the ecological model --

MR. CHRISTOPHER D. CARROLL: We are -- we are, too.

DR. GAIL W. STUART: -- has been around for a long time, and I think it's really talking about healthy communities, and that's the level of analysis. Whereas, integrated care is a delivery system issue that focuses more on individuals and families and the way care is delivered. So these are two very different kind of ballparks that you're playing in. And I guess my question is what is the goal in this movement because the ecological model is huge, the complexity of it. You know, what would be the expected outcome that you would like to see from it?

MS. MARY FLEMING: I think it's how we've talked about being able to move the -- sort of move the needle on some key health indicators that you really, in fact, can't -- can't have a healthy community if it's not a behavioral healthy community.

So what we're, I think, trying to understand is, in fact, the scope of this too broad? Or how do we use the resources and tools, if you think about the listing of things that we had up yesterday, our seven or eight tools. Is there a way we can use or leverage those resources and tools to promote more of an ecological

approach to behavioral health?

So is there a way we align our grant-making, our policymaking in such a way so the outcome really is -- this really is the outcome, which is a healthy community that begins to move the needle on some of the key public health indicators, specifically related to behavioral health.

MS. PAMELA S. HYDE: So, Gail, the way you framed the question is exactly what we're trying to get at because every time we use the word, and I say "we" really broadly, the word "integration," we tend to mean behavioral health in primary care. And that, which is important, but it's a fairly narrow way to look at the role of behavioral health in healthy communities or healthy work.

And our -- SAMHSA's work is in prevention, it's in treatment, and it's in recovery. So recovery supports gets more at the social services, the community living, all of those kinds of -- housing, jails, I mean, all those kinds of things. So we're trying to think about, and then as Chris said, we have this huge set of work in disparities not only because we care about it, but because we're really clear that we are not going to get behavioral health issues dealt with if we don't deal with disparities.

And so, that's exactly what we're trying to do is how do we get our heads around not just primary behavioral health care integration, but this larger issue of where does behavioral health sit in the overall health delivery field? And health delivery doesn't mean just healthcare. It goes to prevention. It goes to everything else.

So that's exactly what we're struggling with, and you'll see it a little bit in the delivery system reform conversation, too, because that does focus on healthcare. But it has sort of a prevention interest, a healthy people kind of interest, as well as a, you know, not having people get deeper into a healthcare issue. So, anyway.

I think you had Cassandra and then Chris.

MS. CASSANDRA L. PRICE: I appreciated Gail's breaking it down for me because you helped me understand kind of the differences. I think the question that I would pose about this is even though we're talking about primary care integration from the delivery system, and we're talking about the larger scope here, I would wonder about the readiness of communities. And even the integrated healthcare system and the delivery system, its readiness to even go here.

Because I feel like that we don't even have a lot of primary care integration from direct service care, this happening that is the foundation of what you're talking about. So I would be very, very concerned about readiness for this to be implemented or for SAMHSA to take on such a large scope.

MS. PAMELA S. HYDE: That's a great question, too. And again, if I had them here, a lot of the PowerPoints that I use in my speeches has a picture of how moving from this, it changes the way we think about partnerships. So instead of just thinking about the doctor's office and making sure there's a behavioral health person in the doctor's office.

So once you do the SBIRT, then do you send them to the nurse to do education about alcohol use or whatever? And goes to more of maybe what Fran deals with, our goal is to try to prevent underage drinking.

But having been in lots of human service settings, you know this, it's the folks over there dealing with teen pregnancy who are clearer about the use of alcohol and its relationship to young people getting pregnant. And if we don't have those kind of partnerships, then we probably aren't going to be totally successful on underage drinking. So just to use one example.

So, but it is. It very quickly gets huge. So readiness is a great question.

Chris?

MR. CHRISTOPHER R. WILKINS: Mary, Chris, thanks a lot. That was good and a good discussion to start.

I got to fantasizing during the talk. Okay, I'm a community-based provider, and I'm going to come running to Dr. Chung at Montefiore, and we both are awake and we know the hundreds of interests we have to reconcile in trying to build a good service system. And I thought what would I really love to be able to log onto at the SAMHSA site and look at?

And you guys got me thinking that it would be sort of a thing called behavioral ecology economics and delivery system analytics. I mean, I think a way to get everything that you have --

MS. PAMELA S. HYDE: We'll make it a Web page. Grab that heading.

MR. CHRISTOPHER R. WILKINS: I think -- I think, you know, a way to get everything you have and your power to aggregate data from other Federal entities into a coherent framework where we can take it and decide to use an ecological approach locally or an economics approach locally or an integrated approach locally. Whatever, whatever we have to do tactically to make people be welcomed into healthcare, that -- that I could understand.

It's a big ocean, you know, the ecological model. They're all big oceans, and I heard you loud and clear yesterday. Three-point-six billion bucks, and 650 souls is not a big boat on a big ocean. So that analytic capacity is timely. It's germane,

and it captures one of your core capabilities.

MS. PAMELA S. HYDE: Ric and then Junius. And then Ken.

DR. ERIC B. BRODERICK: Chris, I'm kind of -- there's a lot of sort of stuff to sort of understand here, but I'm intrigued. Thank you. I'm sure Pete had a part in this, but thank you for this.

And I struggled in my time here to try to understand what the need was in terms from a public health perspective. And you need to know where the resources are and where they go and where the people who have the need are and how those two fit together, you know, in terms of geography and a lot of different things. So to be able to -- and I think this is what Chris was saying, to be able to understand, fundamentally understand where the resources in this -- not SAMHSA's resources, the resources in this country are and go to address behavioral health needs, it's fundamental.

It's akin -- different than what Henry was talking about, but akin to changing the expectations in terms of whether it's a process thing or an outcome thing. I mean, if you don't have that information, you're sharing an opinion, quite frankly. And so, thank you for undertaking that. I mean, Chris's comment about a big ocean and a little boat are very well taken, and you know, you talked about sort of what a choice to do something is a choice not to do something else.

I don't know what to tell you not to do, but I think it's a very fundamental piece of knowledge that nobody has and, quite frankly, we all need. I mean we, as a nation, need it. So it's -- it's good stuff.

MS. PAMELA S. HYDE: I think we were at Junius next and then Ken and then Henry.

DR. JUNIUS GONZALES: So I have several questions about this. You referred to looking at other models. So I'd be curious as to what those were and why those weren't sort of selected. That's question one.

The second one is that there are some limitations that are not structural, like the ones that you mention of using a fairly inert model. And so, while it can be helpful within which to do a rubric or matrix of your activities and kind of help organize and sort, my question would then be -- and this may be in the other models piece -- to get to where the agency wants to be, is it really about community change from a dynamics perspective?

So the goal is healthy community and making sure that behavioral health, you know, makes a contribution, and it certainly does. So I'm curious as to whether, I hate to call them second-order, next level down models can help if you do decide to think about repurposing the ecological model for behavioral health efforts sort

of at the agency.

I mean, there are lots of examples, which you know, even apart from the ones here, which, you know, really chunked out things to drive change, whether it's reducing dental caries in towns in Ireland where they got the milkmen involved and everybody involved to, you know, Marc Atkins' 1998 paper about school mental health using the ecological model. So it has been applied previously.

So that's a long-winded way of kind of getting at two questions really about other models and this issue of sort of the consideration of since it is so big and vast, et cetera, if SAMHSA had three priorities -- I'm making this up -- school mental health was one, what are you going to use? Because the ecological model probably won't help you, you know, to really get to where you want to be in terms of change.

I mean, there are system transformation models like Penny Foster-Fishman's terrific papers and that have actually some evidence behind them. So --

MS. PAMELA S. HYDE: Mary, do you want to -- do you have an answer to or do you want to say anything about the other models before we go on to the list?

MS. MARY FLEMING: The other models that we looked at may not have been as focused on sort of community transformation, and I think because we focused initially on sort of more of the integration issues. So we kept ending up at models that really continue to reflect a primary care behavioral health focus. So we were perhaps more narrow in our consideration of models.

So I appreciate your comments because I think that's very helpful. This, you know, we think about again as sort of the picture of the outcome, not in addition to sort of an organizing framework. So I guess part of my response may be that the models that you suggest may be a means of getting to the sort of concept of a healthy community.

So I appreciate your comments are helpful in terms of thinking through what some of the strategies might be to sort of getting us there. So that's very helpful.

MS. PAMELA S. HYDE: So Ken and then Henry.

DR. KENNETH J. MARTINEZ: I sort of wanted to go back to the beginning and what brought this up, and is this a reframing of what SAMHSA does within a new context of, you know, what's been called integration of primary care and behavioral health to extend to a much broader type of integration? Because in the paper, it says does this entail a major paradigm shift, or is it just a logical next step in leveraging the scope, scale, and impact of current behavioral health strategies?

You know, and Gail talked about this being a model that's been around. 1979, Urie Bronfenbrenner, you know, wrote about this, and prior to that, I would say the "ecological model" is really an indigenous model. You know, this goes back millennia. So this is nothing new and has been the basis of good health in general for peoples -- indigenous people across time.

You know, all the structural issues, the contextual issues, the community, the self-care, the spiritual, you know, it's all part of that. So I'm just wondering why now, and is this marking a shift in direction? I'm trying to understand the bigger context before we get into the details of it all.

MS. PAMELA S. HYDE: Probably the simple answer to that is we've been thinking about it for some time. So it's not new in that sense that what's new about it in the last year is trying to put pen to paper about it because it's so easy to get kind of in the clouds about it, and I don't mean the IT cloud. I mean, it's just so easy to sort of get your head into the big, yeah, it'd be great if communities were healthy. So it's sort of our attempt to start to say what does -- what does thinking that way have implications for our work or what we pay attention to?

And I will come back in a minute with some examples about that, but I think that's the why now. It's not like it started yesterday. It just -- it's sort of an evolution for us under my leadership. I'll take some responsibility or credit, depending on how you want to give it to me, for sort of forcing us to try to start writing it down, and what does that mean for our work? And again, I'll give an example or two in a second.

DR. HENRY CHUNG: You know, I think the ecological model is very helpful in reminding us about all of the different factors that impact good behavioral health and healthy communities. The problem with the ecological model, at least from a clinician's perspective, is that you look at this and you say I'm only a tiny piece of this whole thing. So tell me what I need to do to be a part of making a difference.

And I think to go back to your early point, Chris, about this model, at least in the way it's drawn, looks terribly static. It doesn't inform us about what we need to do. So if I were to think about this from a clinician standpoint and 5 years from now say that we employed the ecological model to make a difference, what would I try to do?

Well, I'd try to describe the priorities. I'd say I want to reduce hospitalization rates and injuries due to alcohol. I would like to reduce and improve outcomes for serious mental illness as reflected by decreased hospital admissions and better employment and more stable housing, let's say. And I'd like to reduce suicide by making sure that that depression treatment is available everywhere.

So now I employ the ecological model, and I say, okay, if I want to tackle those

three priorities, how do I draw it so that primary care is involved, specialty care is involved, social service is involved, schools are involved, and play it all out? And I think that's -- that, to me, is the fundamental issue here, and it goes back to, you know, Chris Wilkins' point that we need data because there's no way that we can point at this and say we actually had an impact unless we know what outcome we're going to go for. And so, what databases do we need to link together to understand the scope of the problem?

And then to your point, Pam, about, you know, you can't do one thing without taking away something from something else. I mean, that's your job and the agency's job, quite frankly, because that is what you need to do.

I mean, I just have to tell you that that's what we're doing day-to-day in our delivery system reform. We are taking away money in one area to do in another area because we believe that by doing those things we're going to generate savings and that generating those savings will hopefully keep us whole as we make this transformation.

And I think the agency is going to be under the same pressure. You're going to have to somehow argue that if we employ the ecological model, we're not giving up all the good stuff we're doing in the community. But instead, we're sort of repurposing those funds to get people all on the same page to accomplish one type of goal.

And it's not about, again, I'm skeptical about this notion of keeping people healthy, even though it's in all the World Health Organization stuff. It's awfully difficult to measure, and it's awfully difficult to pay for. It is easier to pay for I'm reducing disease. I'm reducing, you know, recidivism. I'm reducing those kind -- and those things will translate, which we should measure, try to measure.

But that's the way I kind of think about it because every time I see this type of diagram, even though I respect it and understand what it's about, it really doesn't motivate me to do anything about my work, my daily work.

MS. PAMELA S. HYDE: Well, so that's a great segue maybe to some examples. And welcome back to Kana. I know she has -- will have some things to say about this. Let me use a general comment or general example first, and then I'll go into some more specific behavioral health examples, and some of the staff have heard me use these. But here is where my head goes.

So it's like we can spend the next 20 years giving grants out to fund food banks, or we can start to shift that money into taking on hunger. And if we take on hunger, then we're going to have to do something different than just give out sacks of groceries. We're going to have to teach the people who come for the sacks of groceries how to do community gardens. We're going to maybe have to divert some of that money into actually buying -- buying stuff for gardens, hoses,

and other things that don't look like food stuff.

So it's not going to look like what people think it should look like in terms of the way we spend our money if we're called a food organization or a hunger organization or whatever. That's the general example.

Some of the specific examples I think that we struggle with as SAMHSA is -- and we get both criticism and support for, which is which do we spend our money on? Teaching parents how to be better parents and how not to traumatize their children inadvertently or how to deal with young people and their families when they experience trauma or bullying at school or whatever. Do we spend our money on that?

Or do we spend our money treating people with serious mental illness who may have that serious mental illness in part because of genetics and in part because of other things, but in part because of their traumatic experiences as children? So where's the right balance in our doing that? When we spend money on parenting support and those kinds of things, we get told it's not behavioral health.

We just got creamed about a Web site that we have that was parenting support that was substance abuse prevention based on some science, but it hadn't been updated in a while. So we had to take it down for a while, while we were updating it for the science. So the criticism is rational in that sense. But in the sense of we shouldn't be paying for that stuff. It's a ridiculous waste of money, which is basically what we were told, and we don't really think that.

We think that there is something to parenting and early childhood development that has an impact on substance use and issues going forward. Let me give you a few other examples. Do we pay for diversion to try to keep people out of justice systems, or do we pay for reentry after they're already in? And God knows, they need help enrolling in care and getting all kinds of support not to bounce back in. But what's the right balance between more diversion, less reentry?

Do we do more violence prevention or response to disasters? Because a lot of the disasters and tragedies are weather, but a lot of them these days are violence related. Bombings in Boston, you know, shootings in Aurora, and those kinds of things. So what's the right balance in those things?

Frankly, do we do PTSD work with veterans and military families, or do we do more work at peace and conflict resolution? That is a uniquely behavioral health issue, and yet people don't see SAMHSA's role as doing peace and conflict resolution. And I can assure you if we started spending money there, we would get creamed on not paying for this other thing.

Should we spend more money on assisted outpatient treatment and literally get

people into treatment by force, or should we spend more time and money paying for how do we engage patients in treatment and care and keep them in it? How do we engage families to support their family members in care?

We can do, which we are, doing opioid overdose-related death prevention or prevention of opioid related -- opioid overdose-related deaths. We want to prevent that, clearly. So should we spend money on that, or should we spend money preventing the use of opioids? So what's that balance? And obviously, we're doing some of both.

So I could go on, but it is these are concrete examples that we have to face every day with our limited \$3.6 billion and our 650 people. And I think our effort to do this ecological model is saying what's the right balance, even in the face of the criticisms, even in the face of being beaten up for doing this. Because we have some people who are on the side of you should be doing AOT, and you should be doing reentry, and you should be doing PTSD, and you should be doing -- I mean, I could go on.

So I think that is sort of the concrete why, and yet it's obviously much more glorious in some way than that as well.

DR. HENRY CHUNG: Just a quick response because I think that that is, in some ways, reflective of the -- of the tension. But I guess sort of my own view about it is that it's not an either/or. So, in other words, if we take the opioid example, Pam, and we say that, you know, we want to reduce opioid-related deaths using the ecological model. Then the question is in this framework of the ecological model, where does the SAMHSA and SAMHSA-funded agencies take the lead, and where do the social service agencies and the primary care agencies take the lead?

So that the outcome is in that community we're going to reduce opioid-related deaths by 40 percent, and the way we're going to get at it is that we're going to provide, you know, treatment, but we're also going to do the prevention work. But everyone is going to have a role to play, and we're going to have to draw that out so that it's not just SAMHSA.

And the question is, you know, in which cases does SAMHSA lead in those types of examples? In which case is SAMHSA really a contributor to that effort? And I think that's the part that needs to be teased out. I appreciate what you're saying, though.

MS. PAMELA S. HYDE: Yeah, absolutely. And in fact, we have had a tendency to be a little over inclusive of using place-based approaches to things because sometimes that's just, you know, the answer to everything, and it's not that simple. But the suicide prevention people that we've been supporting for the last 4 or 5 years have done a lot of work now in thinking about the zero suicide

approach in health systems, healthcare delivery systems. And the faith-based approach to supporting people to prevent suicide and the survivor, survivor -- either family member survivor or survivor attempt groups, and there's whole bunch of different aspects of these things. They've been pulling them all together, and now the question is, well, if we put them all in one place, could we actually make a community that had less suicide?

So there is a way in which -- because it's not all SAMHSA. There is no way. I mean, we don't generally fund churches and synagogues and mosques to do this stuff. But we do sometimes provide the information, provide the training, provide the support, et cetera.

So these are sort of the struggles. And where do we want to think -- the model is trying to force us to think about where do we want to influence the way these communities think or the way these communities embrace behavioral health so that their community health -- there's no perfect healthy community, and there's no perfect healthy individual or family probably.

But anyway, yeah, Gail?

DR. GAIL W. STUART: So to follow up on your comments, when we have difficult curriculum, we do what we call content mapping, which is just what you're saying. If you took that model and you mapped where the programs who's doing what, SAMHSA or other people, I would start with evidence, though. I would pick a topic that has your strongest evidence because there's lots of topics out there, as you said.

And I would also look at what people are doing that if we could just get them to stop doing, we would advance the field. A lot of clinical care it is doing things we should not be doing, not just doing the better things, but stop doing what doesn't work. And if you took one topical area that you had good evidence for prevention, treatment, recovery, those three areas, and then did a map, I think that would be very powerful.

MS. PAMELA S. HYDE: Megan?

MS. MEGAN GREGORY: Yeah, I was involved with United Way of Anchorage on their collective impact increasing the graduation rate to 90 percent by 2020, and I feel like, you know, they're doing that across the Nation with United Way and working with Strive out of Cincinnati, Ohio. And I feel like they could help figure out this model and create more of a framework so that you could see where the backbone teams are and where people fit so that people feel like they do have a stake and they are included.

So I just wanted to share that.

MS. PAMELA S. HYDE: That's great. We might get some names of connections from you so we can talk to some folks who are doing this.

Yeah, Chris?

MR. CHRISTOPHER R. WILKINS: The opioid example just helped me come back to this. So in the opioid epidemic, Fran has got a terrific curriculum to empower parents to understand signs and symptoms. I'm saying this is SAMHSA at the party, right? SAMHSA is doing this stuff. Fran has got a terrific curriculum to empower parents to know what they're looking at.

I think one of the most heartbreaking things I heard at a Long Island hearing on opioid dependence was a father say, "I unwittingly helped kill my kid, a heroin addict, because I didn't know what to do." Chris and Mary have data on the number of people who overdose and die within 72 hours of being released from a correctional facility because their tolerance is so low. They also have the data on how many people got a dose of Narcan on an emergency basis in the field and didn't get engaged in any kind of care thereafter.

And the prevention, great prevention, great data and analytics, and great investments in innovation become what SAMHSA is. We'll worry about whether or not it's an ecological model or an integrated model or a whatever model. But you become the indispensable resource in building a frame around a problem when we're going through a Medicaid reform or something else.

MS. PAMELA S. HYDE: So if I hear you right, that one of the things you're suggesting is that we continue or grow our effort not to try to fix all this or do all this, but rather to have the resources that people who might be trying to play in these various places can come to and look to?

MR. CHRISTOPHER R. WILKINS: Yeah, great data and analytics. I promise I won't say it again.

MS. PAMELA S. HYDE: Oh, we're data and analytics people. We're trying to grow our capacity.

MR. CHRISTOPHER R. WILKINS: And then being able to have practice standards that support people once they understand that data and analytics, that's great.

MS. PAMELA S. HYDE: And I will say for our tribal folks who are here, we are also -- while we're very supportive of data approaches and scientific and evidence-based approaches, we are very cognizant of the fact that data issues are different in tribal communities and that evidence is different in tribal communities. We're also very committed, as you all know, I think, to practice-based evidence, which is a little harder to sell to some people who want the hard

science. But sometimes that's our role is to test out something, make sure, see if it works in real life or see if there's something we can learn from practice that then can move it either into research or move it into wide-scale use.

Yeah, Junius?

DR. JUNIUS GONZALES: A tangential question. So many communities, like Tampa and El Paso where I was, funded by very large health foundation are subscribing to or purchasing these living, fairly living health dashboards, particularly out of a group at Berkeley. And so, we -- there was no disagreement that there had to be some behavioral health, which was great indicators there.

So I don't know how much you've seen those and whether the communities who have taken them up -- because the business seemed to be doing well for these faculty at Berkeley -- are putting in right at the start some behavioral health indicators and outcomes.

MS. PAMELA S. HYDE: Want to address that, Chris? Are you --

MR. CHRISTOPHER D. CARROLL: Well, I think we did do -- we looked at a lot of data around healthy communities. There's not a lot of behavioral health addressed through the healthy communities. But I do think there are behavioral health barometers and some other measures that we're -- or systems that we're developing here. We're starting to get that. It's having that wider influence and maybe this is one of those mechanisms to do that.

MS. PAMELA S. HYDE: So I think your question raises for me is our issue on metrics and how do we know if we made a difference and where -- and actually, Henry raised this, too, a little bit. But one of my bugaboos about things in terms of measures at the moment and the dashboards is some of our things, suicide being a great example, is you almost do better if the person does, in fact, leave your system because they died. I mean, I hate to say it that way, but from a metric point of view, it sometimes is.

So if you're measuring readmissions and the person leaves your emergency room or leaves your inpatient care and goes out and commits suicide, which we know the higher proportion of those who do, it doesn't show up in your readmission metric. And if there are certain other -- I mean, I could give you other examples.

So we've been really, frankly, beaten on our CMS partners and others who -- in fact, Patrick Conway will be here, and he's been a part of this. You're welcome to ask him. He knows about it. We beat him up all the time in a great way. He's a good guy.

And, but we've been trying to think about how do we get metrics into these value-

based purchasing approaches that actually tell us what we want to know and that people actually have some incentive for getting better in our metrics? So sometimes it's not always great to do SBIRT and identify somebody who has an alcohol or a potential alcohol use problem because then you got to do something about it.

And so, trying to figure out what the metric is that captures the incentive in the right way is a challenge. And so, we've been struggling with that.

On the other hand, we've been doing things that like our colleagues at CDC who are doing Million Hearts. We know all the data about how much higher cardiac issues, tobacco use, hypertension, those kinds of things are among the populations we care about. So we have been one of the pace setters in adopting hypertension guidelines for some of our behavioral health programs so that they know what the guidelines are to address people with hypertension.

So we've been kind of in these funny fields, and yet, to be honest, because we had the conversation a little bit earlier about why we get criticism, we sometimes get criticism for, as Henry said, you can only -- you have to take some money away from one place to do another thing. So we have been trying to figure out what's the right balance and where do we play the right roles in that?

Ken?

DR. KENNETH J. MARTINEZ: Just to thank you for your comment a little earlier about SAMHSA's commitment to practice-based evidence. So I'm glad to hear that. Your examples, you know, about the opioid and others, I'm not dichotomist necessarily. I mean, it's not either/or, like Henry was saying. I see them as developmental. So it's a developmental process, and some of it may be based on philosophy about which you believe in more or politics or whatever the reason is that you feel more strongly about one side or the other.

But it would seem like SAMHSA would be in a position, and you are, by default, in that position of balancing the pressures, the needs, the science, you're weighing all of that to see what is best. And eventually, you know, we're going to be moving in one direction or the other for societal reasons, for based on the new science that's coming out on either/or.

But I understand the dilemma you're in, in terms of trying to balance the two sides. So instead of looking at it as either/or, you know, how are you going to advance the field by the science that you help support and the best thinking internally and the best advice you get from other people to say this is where we're going to be heading.

And we don't necessarily know where we're going to end up in 5 years or even in 3 years on this particular issue, but it's dynamic, and we're going to be kind of

taking in all the information that we can to land where we hand. And I think that's sort of, you know, kind of an approach that I would think would be helpful because sometimes, you know, sending down your decision ahead of time and saying we're not going to do that or we are going to do that may be dangerous in that because new information may come to light about something, whether in the science field or whatever, that is going to influence ultimately where we end up, you know, as a field and as an agency.

So I just see it as a dynamic developmental process of evolution of science, of philosophy, and all of that that we're going to -- that's going to inform us.

MS. PAMELA S. HYDE: Henry, I think you had your hand up.

DR. HENRY CHUNG: I couldn't help myself, but as you were talking about this whole notion of the metrics and the value-based arrangements and how do you begin to sort of look at how people game and look a little better in order to have this event happen and the issue of suicide. So as you know, you guys have -- SAMHSA has had a very positive impact on value-based arrangements and the fact that, you know, the ACOs of which daily are growing throughout this country, the Medicare shared savings and a pioneer ACO where Montefiore is involved, you know, CMS made a bold statement by saying that we're going to ask everyone to do depression screening.

And that was, as you know, not yet a HEDIS measure, not yet an AQF measure, and they said, no, we want to see this happen for all Medicare recipients. That's kudos to SAMHSA for pushing that through. Now they've taken that in this next year in another measure, which is with depression remission.

Now I have a problem with remission in general kind of as the next step. I like to look at response first. I like to look at how the diabetes community really got diabetes improved because they began to look at how process translates to outcome, but that's just sort of, you know, parsing it very finely. The notion is that now that you screen it, you've got to now report on how you're going to improve it, right?

So that's another challenge to our ACO, right? Which is a great challenge. We're ready to step up for it.

And then you have to think about, okay, well, now we're talking about suicide, let's say. So suicide, depending on which community you're in, can be very, very difficult to measure, you know, because it's for many communities a low base reading. But perhaps in tribal communities very, very high. So just depends on which community that you're in.

Certainly one could look at, as an example, you know, suicide attempts, if one could, you know, believe that that's a reasonable measure. And so, sort of a

higher order measure might be, okay, well, you're decreasing -- you're improving people with depression. You're screening for it more. Are suicide attempts decreasing, you know, or hospitalizations or ER visits due to suicide attempts decreasing?

That might be a good way of thinking about how we begin to impact, you know, this number and get to where I think we all want to get to.

MS. PAMELA S. HYDE: Thank you for saying that because I've been sort of beating up our suicide folks, suicide prevention folks on tracking the attempts and not just the deaths. I think we're a little clearer, though, about the relationship between you do X, you prevent a death. We're not quite as clear about you do X, you prevent an attempt. It's not quite as straight a line.

So we're still struggling with that, but obviously, I think what you're hearing is we're trying to think of our work a little more complexly and where it has the broadest impact. And again, back to both of these comments, I guess I would put maybe to a very specific advice kind of question. Right at the moment, whether people hear it publicly or not, we've said it 50 hundred times. Our mental health dollars, three-quarters of them, go to people with serious mental illness.

Now we don't necessarily control what's done with those dollars because a bunch of it is done by the States through the block grant that they get to make choices about. They get to make choices about whether it goes to adults or whether it goes to children with serious emotional disturbances.

They get to make some decisions about what kind of services they do. We have some general guidelines, but by law, we aren't allowed to say, Oklahoma, you do this. Ohio, you do that. Iowa, you do this. Wisconsin, you do that. Minnesota, you do this. We can't tell them that way.

But about three-quarters of our money goes to both adults with serious mental illness and young people with serious emotional disturbance. The other 25 percent goes to this combination of early intervention, prevention, emotional health development, school-based services, and a number of other things. Paolo could list them out easier and better than I could. And so, part of the question, I guess, is that kind of the general right balance? Or do you think we should be doing more or less?

And then we also get, and I've alluded to it several times because it's one of the criticisms that's going about us at the moment. We get told that because we don't fund or don't spend all of our money or a lot of our money on requiring things like assisted outpatient treatment that somehow we must not agree with it.

And it's not that I think -- both Paolo and I have had this conversation. We've said it publicly. It's not that we don't think it's necessary sometimes, but to think

that that is sort of the place we should be spending a significant portion of our dollars has not been what we've proposed to Congress. We haven't proposed that.

We have said publicly -- they haven't taken us up on it yet. But we have said if they want to fund a program that we could fund States to do assisted outpatient treatment that we would do it and evaluate it. It needs more research, needs more evidence. Let's do that and see what works. Again, what works in Oklahoma may not be what works in Minnesota. What works in California is not going to be what works in New York. And so, what are the differences there?

So we are more than happen to do other things if Congress wants to give us those dollars. So the question is do you think we're in the right ballpark in this area? And I know that's a little far afield from the ecological model. But it is related to the criticism of the day.

So I'm going to put that on the table and just give Kana a heads-up that I'm going to give her a minute to say anything if she wants to because she's done a lot of thinking about this, but I always put her on the spot. So I'm giving her 5 minutes to think about it.

DR. KENNETH J. MARTINEZ: Just on that particular issue of assisted outpatients, you know, there is tremendous pressure on SAMHSA on that. So I'm wondering if SAMHSA could again take a proactive approach and say, well, we will craft a model AOT, sort of taking into consideration all of the issues that people are concerned about and see. You know, let's try it out in one location or another. And, but without someone else taking the reins and doing it for SAMHSA and dictating what an AOT -- you know, what Congress is going to pay for in terms of an AOT type of program.

Would it make sense to take that proactive approach? I don't know.

MS. PAMELA S. HYDE: Well, it's a good question, and actually, Paolo's shop is doing an analysis of what States are doing in this area, and then ASPE is also doing some work that will come after that about sort of the -- what the research says what the pros and cons are about it.

One of the things that has been difficult is some of our critics wanted to do a Federal standard for what AOT looked like. And of course, that's something every single State does differently. Every State has their own laws and their own language about what the priorities are, which is why we think this is a place where a grant program might make a lot of sense.

Let's see how it works differently with different language in different States. But so we're sort of dipping our toe in that water a little bit. I think we're far from being able to say here's the right standard. Here's what it should look like

because we're not quite there.

The New York approach is one approach, but the North Carolina approach is a different approach, and there's really only been about three major studies on it so far, which is in three different places -- well, two in the same place. And they came out with completely different results.

So it is something we're sort of toying with about what's our role in that. Anybody else want to make any other comments about this before I let Kana?

DR. HENRY CHUNG: Just on this issue of SMI. I mean, I think the whole AOT thing is again pushed because there's this perception that folks with SMI have the potential to be violent. Therefore, you know, if they're noncompliant, they must be pushed into AOT. That's really what's fueling it.

Because AOT programs, even in New York or wherever, they touch a very, very tiny number of the number of people that truly need help and assistance. It's not going to be -- you know, AOT is not going to be -- it's important for a tiny number of people, but it's not going to be the difference maker in terms of looking at the outcomes that all of us want, you know, whatever political party you're in.

Really it's about engaging people and keeping them continuously in care. That's the issue. And so, what dimensions are missing, you know? How do we support that? Obviously, family engagement is a big one. And whatever SAMHSA can do to be on that side of the fence that says that we support this, balancing individual rights. But also the fact that families are so engaged and they're the ones picking up the pieces, I think that's an important piece.

And the other is, you know, access to evidence-based treatment, which we've had discussions about in other places. You know, we know there's tremendous under utilization of long-acting medications for SMI populations. We know that there's tremendous under utilization of clozapine. These are not simply because patients or consumers don't like them. It's not that. It's that our delivery system is wholly unprepared to deliver those advances.

You know, if you're at a community mental health center that doesn't have great access to primary care, and you're hearing clozapine, it's scary because every 2 weeks, you're getting a blood draw. Well, automatically you're thinking how many of my consumers are going to be on this because I don't know that they're going to go get this 2 week blood draw that's required. And yet that's a tremendously advanced lifesaving type of medication.

So I think it's focusing on that aspect of it. To me, that's more consonant with what I think SAMHSA should be doing.

MS. PAMELA S. HYDE: Yeah, I think you're right, and I think that's why some

kind of a grant program that would let us test those things and test if there's a way to do engagement. And I think we've really embraced the family issue because every -- almost every one of these situations has a family who's either given up or who's actively engaged and struggling through the issue.

So, Kana, do you want to -- not necessarily about AOT, but the larger. Whatever, however you want to --

MS. KANA ENOMOTO: Okay. Thanks.

So I think we do have a grant program on the table that does allow us or would allow us to test or allow communities to demonstrate how best to take the different pieces of the puzzle that are necessary to create safe, crisis-informed communities for people with SMI, kids with SED.

And AOT could be a part of that, but we know that AOT is not the only part. And you read about the New York Times Magazine article that just came out, or was it Huff Post? But the very long story about the Rikers Island and the unfortunate tale. So there's -- AOT is a part of that picture, but obviously, it wasn't the complete solution, and you need more.

And so, our crisis systems proposal, which goes across mental health and substance abuse, would emphasize the family engagement, the individual engagement, the what do you need to do in respect with law enforcement and the court system and community treatment and so forth? So, I mean, I think that's what we want to test out. What is the best way to array these services that communities can achieve the kinds of outcomes that consumers and families really want and that the rest of us really want?

But, and so AOT is a part of that, but we want to emphasize the balance, and again, the emphasis is on the outcomes, the outcomes for people, the outcomes for families, the outcomes for communities, and putting the right pieces and paying for them. How do we pay for them? How do we sustain them?

So we can give you half a million dollars for a grant, and that will fill in all the blanks for 3 or 4 years, but what is the other policy work that needs to get done to sustain? How do you pay for family engagement? How do you pay for the outreach, the very persistent and consistent outreach that you need to do if someone is not chronically homeless?

We have chronically homeless outreach dollars, but there are people who are living in a home but need more outreach to get engaged. And possibly not by professionals, but by peers because, in fact, that's what's going to be the hook to get someone into services and support. So we do have a program like that that we've conceptualized and we've put forward, and we're hoping to get it funded and get it grown.

With respect to the integrated model, the ecological model, I'm sorry that I missed the presentation. But you know, when we -- I think when this first came up, people were talking about integration, integration, integration, and some people meant mental health and substance abuse. Some people were behavioral health and primary care. And Pam is like, no, it's bigger than that. It's bigger than that.

And I think the reason why she says it, I mean, right here we had it. It's behavioral health is essential to health. But in fact, behavioral health is also essential to education. Behavioral health is essential to employment. Behavioral health is essential to stable housing, to staying out of the criminal justice system. Behavioral health is essential to a lot of things, and we don't necessarily have a clean model that demonstrates that. It doesn't share our value proposition to others.

We manifest it, actually, in most of our grant programs. Most of our grant programs say you have to have like 72 different partners at the table. SAMHSA knows that. Behavioral health lives that. I don't know that we've articulated it really clearly. Who are those other partners that we should have consistently? Because, for many years, we were like Sisyphus, you know, cursed, eternal damnation of rolling the boulder up the hill, and then it falls back down the hill.

And a lot of that is because Sisyphus was rolling that rock by himself. And so, behavioral health service said, hey, we can't just do this by ourselves. So maybe mental health should partner with substance abuse. But that, you know, we rolled the rock up the hill. It goes up a little farther, but it still falls back down. So then we say, okay, we're going to partner with criminal justice. Now we're going to partner with housing. Now we need to partner with businesses.

And I think that's the thought here of documenting in some way who are all the partners that Sisyphus needs to roll this boulder up the hill and get it to stay there? And I guess it's not necessarily in order to motivate somebody to approach their treatment at the clinical level so differently. But I do feel like sometimes we have clinicians who are very disheartened that, wow, I spent a lot of time with this child. I spent a lot of time with this individual, with this family. And then they lost their apartment, and everything fell apart, right?

I invested a lot of time with this person, and then they got arrested, and I lost contact with them. So it is acknowledging something that all of our providers already know. They, in fact, are a tiny part of that individual's or that family's life. And so, while they can have a huge impact, all the other parts need to be working together in order to have the optimal impact that gets sustained.

And so, I think that's the point of trying to get a model and whether, I mean, certainly I think graphically we could display it better. I think we could think about

it better. But at the end of the day, it's just to sort of solidify our thinking because we tend to be -- we in general think this way, but because it's not documented really clearly in a way that we have consensus and we can all see it and touch it, it gets manifest in our programs differently every time.

So in this program, you have to have child welfare, but in that program, you don't have to have child welfare, you need to have MCH. And in this program, you need to have juvenile justice, but in that one, you need the schools. And I think we just need sort of a heuristic that every time we can look at a problem and we can say, okay, prescription drug abuse. Who would be the -- we have our map, and so let's pick through, let's look at the data. Where are there little betas that would say this is a predictor of this outcome? And then we can use that map to say then these are the logical partners for this program, but we should start from the same base every time.

And we don't quite do that right now. Right now it's a little bit more our own instinct, our own experience, what the field is telling us. But it's variable, and it's really easy to leave somebody out that way, like, oh, wow, no one brought them up at that first meeting, and so now this has sort of gone the way it's gone. And people say, hey, how come you left us out?

So I think this is the opportunity to set the frame, and then from this consistent frame, we can set a direction as we go in the future. And I think we can also take the frame to those other systems and say that not only are you important to us, we're important to you. And we can talk to you about how that happens.

MS. PAMELA S. HYDE: Thanks, Kana. Cassandra?

MS. CASSANDRA L. PRICE: I think -- I think, conceptually, we all agree. I think where I'm having probably the biggest challenge or thinking through the challenge of this is through implementation and how important it is to be at people's tables, and vice versa. But that's a challenge at the national level, and it's a challenge at the State level.

And so, how to carry this forth into a community and have all those partners at the table, to me, is very overwhelming to think about. So that's kind of where I think from a structural standpoint. I don't think anybody disagrees, but I think it always comes back to, well, how do you implement something of this magnitude? So that's a challenge.

DR. KENNETH J. MARTINEZ: Could I respond? You know, I've been involved in two major SAMHSA grant programs, and one is Systems of Care Children's Mental Health Initiative and now Safe Schools. And in both of those programs, like you said, you know, you have required partners.

So SAMHSA already does this, you know, in certain grant programs, and it is a

major challenge, as you're saying. We've had challenges in getting one partner or another to the table, for whatever reason, historical reasons that they didn't play together before and there are some bad feelings, or whatever the issue is. But you know, the pressure, the push is, well, keep trying. Keep trying. Do whatever you can to get them there.

And for the most part, it works, you know, eventually, to getting those partners. So your explanation was very helpful because I had asked the question earlier why? You know, why are we thinking about it this way? It makes total sense, but why is a model sort of being applied to all of this now like an overlay? And it is, you know, like you're saying, to have something to work from a little bit more consistently across grant programs to be able to bring people together.

And the GPO, the Government Project Officer, who says, well, you need to have child welfare at the table, but we don't play with child welfare. They don't like us. They say, well, keep trying. Keep trying. So, you know, eventually, things tend to happen and work, and sometimes that relationship is turned around.

So I appreciate the fact that, you know, you want to make this happen, and sometimes it is through the enforcement of a Government Project Officer and a contingency to the grant that you require it that it does make it happen.

MS. PAMELA S. HYDE: Both of you have asked questions, and Kana, you may want to respond to, about sort of implementation. It's like bigger than a breadbox. So how to get my head around it, and then your question about why now? What are you trying to get at? And I think we've tried to sort of say that in a couple of ways, but I want to say it in a third way.

So part of it is the set of sort of options that Henry and I were talking about. You could do this, or you could do that. So part of it is where does SAMHSA spend its money, or where does it decide the right balance is? The bigger picture or the direct grant process, et cetera? So that's one reason for doing it.

The other reason, which Kana articulated very well, is the sort of the how we do it, what we do. So what we require of our grantees, how we ask them to do their business, why we make them bring these partners to the table, what's the impact, et cetera. So, but that's all SAMHSA centric.

In some ways, the third piece is, well, maybe it's not even really about SAMHSA and what behavioral health does. Maybe it's really more about influencing that larger field. So, and some of you raised it. What do we get criminal justice to do? What do we get primary care practitioners to do? What do we get, frankly, specialists in diabetes care to do? What do we get preventionists who don't have anything to do with behavioral health, at least that's not on their minds, they're trying to do something with young people, and somehow it hasn't come up or they haven't thought about what the implications are about bringing behavioral

health to the table.

So sometimes it's also helping other places and other systems understand the importance that behavioral health is to their outcomes or to their overall mission and goal. And again, trying to figure out where that balance is, where do we spend time influencing other systems, where do we spend time influencing our grants, where do we spend time thinking about what kind of grants we do because we have a whole other thing that we've been working on about the theory of change, which Kana mentioned yesterday some.

So all of these are reasons why we're trying to look at this picture bigger, and we think as a Federal Government agency, we have some responsibility to think at that bigger, higher level and keep questioning ourselves about are we spending our dollars and using our human resources in the right ways and the right places?

DR. KENNETH J. MARTINEZ: I just have a concrete example of that. You know, there's three SAMHSA grant programs in one State that I'm working in, and they are using the same State management team for all three. Now that's revolutionary in a way because, you know, it's the same people, but it's different grant programs related to children. And, but it's coordinated now because all the child-serving agencies and parents and everything are in one group hearing all of the different requirements from the grant programs, but actually collaborating, integrating, coordinating because of that one State management team for all of them.

MS. PAMELA S. HYDE: That's a great example because just this week, we did our 223 demonstration RFA, and we shifted it, the language, from saying create a steering committee for this to either develop or expand or utilize or adjust or whatever, enhance a steering committee you already have. So we've been, even just in our own minds, in fairly simple ways trying to think about how we aren't re-creating wheels all the time for certain things.

We need to get to a break here before our guests get here. Mary or Chris, do you have any final comments you want to make?

MS. MARY FLEMING: Well, I wanted to thank everybody for the discussion. It was really very helpful. I think one of the things that would be useful for Chris and I to think about doing is really, Junius, the comments you made about the use of barometers in various communities through foundations. I'd really like to spend some time sort of looking at what communities are doing around their own measurement of health and where the intersection of behavioral health is in that context. I think that would be useful for us.

And apart from that, there's lots of food for thought about where this intersects with our use of the theory of change and how we move our portfolios along and I

think the issue of also setting some clear priorities and maybe selecting one or two areas where we really try to see if there's a way we begin to put some legs to this and think through its implementation would be helpful. So I appreciate all your comments. It's great.

Thanks.

MS. PAMELA S. HYDE: So Kana has another comment.

MS. KANA ENOMOTO: I just wanted to respond to what Cassandra was saying in terms of it could be overwhelming to think about having to have all of these partners at the table. And I want to just say I don't think that's necessarily the purpose to say we're going to start requiring all 35 partners in every program every time.

I think some ways I'm really big on sort of the way we have approached disparities impact statement. You could tell me all the different kinds of people you're serving, but if I don't know who's in your community, I don't know if there's a disparity, right?

So you may be serving 3 or 4 different language groups, but there are 16 language groups in your community, right, you're falling short. But three or four seemed like a lot when I just looked at it on paper, and I think that's what this is for. It's to say, you know, there are really 35 different agencies or dimensions to this problem. Five of them the data show have a really big impact. You've already got four of them at the table. You know, it seems like you need to focus on bringing that fifth one in.

But without knowing that, without having a model to start with, you're thinking those four partners are pretty great, right? Or you're going to spend time going and get an 8th, a 9th, and a 10th one that don't have a huge valence here. And so, I think that's more. It's to guide our work efficiently, not to say in a cookie cutter way everyone has to have, you know, a steering committee of 35 every time.

MS. PAMELA S. HYDE: Okay. So let's move into the break by going back to the issue that Junius raised about process, which is we have some requirements about what we have to do when we bring you all together. But we can talk to you individually all we want. So if you have -- if this stimulates your thinking, I am very big on the fact that these conversations stimulate your thinking and ours.

If you have follow-up thoughts or things you'd like to just say more about or ask more about, please give Mary or Carol -- or Chris a call and -- we have lots of Chrises in the department or in the agency so I sometimes have to think about the last name first. So give one of them a call and feel free to talk with them, send them an email, whatever. And they may reach out to some of you based on

some of your comments today as well. So know that we will continue to call on you a little bit in that way.

So let's take a break. We are waiting for Patrick and Karen to arrive. They are on their way, we think.

Elizabeth, are you still on the phone, Pattullo?

MS. ELIZABETH A. PATTULLO: I am on the phone, Pam. I don't know if you can hear me. This is Betsy.

MS. PAMELA S. HYDE: Barely. Can you speak up, and you get the final comment before we break here.

MS. ELIZABETH A. PATTULLO: Sorry. Say that one more time?

MS. PAMELA S. HYDE: I'm sorry, Betsy, we're having a hard time hearing you. I think we're going to have to keep working on the sound because we're not able to hear you. So we're going to go ahead and take a break. Betsy, we'll keep working on it, and we'll try to get to you in the next part.

All right. We'll be starting up again at 11:00 a.m.

[Off the record at 10:50 a.m.]

[On the record at 11:00 a.m.]

Agenda Item: Health Information Technology and Delivery System Reform

MS. PAMELA S. HYDE: Why don't we get our advisory committee members back to the table? And folks on the phone, just know that we are getting reorganized here and getting ready to start our next topic.

I want to welcome Patrick and Karen. Good to see both of you. They both know that I'm not always real big on the Dr. DeSalvo and Dr. Conway stuff. So it's Patrick and Karen to me. So thank you for being here.

We know that it's a huge haul to get up here to Rockville, and you guys are very, very busy. So we really appreciate your being here.

We have been very excited about you coming. I'm going to have our advisory committee members say hello to you real quickly and tell you who they are around the table. Just so you know, we have other advisory committee members that -- because we have seven advisory committees. For a small agency, we have a lot. Some of them have stayed over from meetings yesterday and today

just to hear you guys and interact with you. So they are in the audience or we also have a lot of people on the phone.

And at some point, I will ask you guys about how many people we have listening. So you'll be able to tell. So these are broadcast all over the country, and sometimes we have a few people, and sometimes we have hundreds of people. Just depends on the day and the moment.

So why don't we do a quick round of introductions? And I want to thank Holly. She's our advisory council officer who helps us make sure we stay organized. So you met Holly coming in. And Charlie, why don't you introduce yourself?

MR. CHARLES OLSON: I'm Charlie Olson. I'm from Minnesota, and I'm a youth advocate.

DR. GAIL W. STUART: Hi, I'm Gail Stuart, psychiatric nurse and dean of the College of Nursing at the Medical University of South Carolina in Charleston.

MR. CHRISTOPHER R. WILKINS: I'm Chris Wilkins, member of the National Advisory Council and from Rochester, New York.

MR. PAOLO DEL VECCHIO: Hi. I'm Paolo del Vecchio. I'm the Director of SAMHSA's Center for Mental Health Services.

MS. PAMELA S. HYDE: Cassandra, can we get you to introduce yourself?

MS. CASSANDRA L. PRICE: Absolutely. Cassandra Price. I am a member of the council and from the State of Georgia.

MS. PAMELA S. HYDE: And the substance abuse?

MS. CASSANDRA L. PRICE: The SSA for Georgia.

MS. PAMELA S. HYDE: The single State agency, substance abuse director. Chris?

MR. CHRISTOPHER D. CARROLL: Chris Carroll, Director of Healthcare Financing and Systems Integration.

MS. DARYL KADE: Hi, I'm Daryl Kade, Acting Director of the Center for Substance Abuse Treatment.

MS. FRAN HARDING: Good morning. Fran Harding, the center Director for Substance Abuse Prevention.

DR. ERIC B. BRODERICK: Hi. I'm Ric Broderick. I'm a member of the national

council, formerly the Deputy Administrator here a number of years ago.

MS. PAMELA S. HYDE: And a former Commissioned Corps officer.

DR. HENRY CHUNG: I'm Henry Chung. I'm chief medical officer from Montefiore's care management organization, one of the pioneer ACOs. Also a Wave II grantee for integration of behavioral health in primary care.

MS. MEGAN GREGORY: Hello. I'm Megan Gregory. I'm from Alaska and also a youth advocate on the SAMHSA National Advisory Council.

DR. KENNETH J. MARTINEZ: Hi. I'm Ken Martinez, and I'm from Corrales, New Mexico, on the National Advisory Council. Work for American Institutes of Research.

MS. PAMELA S. HYDE: And we have -- oh, Mary, you want to introduce yourself?

MS. MARY FLEMING: Hi. I'm Mary Fleming, Director of the Office of Policy, Planning, and Innovation. Hello.

MS. PAMELA S. HYDE: Yeah. I don't know if we're going to be able to hear Betsy. We have one other council member who's really critical, but she's on the phone. Betsy, can you try one more time to see if we can hear you introduce yourself?

MS. ELIZABETH A. PATTULLO: Yes. Betsy Pattullo, chair of Beacon Health Options, a managed care company in Boston.

MS. PAMELA S. HYDE: I don't know if you could -- yeah, Boston. She is the chairman and founder of Beacon Health Options. They just did some merging. So bigger company. So she's certainly a financier and payer.

And then, Junius, you want to introduce yourself?

DR. JUNIUS GONZALES: Junius Gonzales, University of North Carolina.

MS. PAMELA S. HYDE: So lots of other great people, but that's who you have to hear you today, among other people around the country. So welcome, and thank you for being here. We're really excited about your presentation and the conversation.

DR. KAREN B. DESALVO: Well, thank you all for -- there we go. Well, good morning, and thanks to everybody for giving us the chance to come and dialogue about the work that we're doing in the department, and it's increasingly administration wide, to advance better care.

We have some slides, and I think you -- we'll do our best to stick to them. The truth is Patrick and I might be a little bit off script sometimes. So forgive us if we do that.

What we want to talk about today is to give you an overview of the delivery system reform effort, to share with you a snapshot of some of the recent announcements in the work of delivery system reform to give you a flavor of the kinds of large-scale and bold initiatives that we're undertaking, to share with you some of the early results upon which we've been building this work, and a snapshot of what we think is coming up soon with respect to good progress.

And then where we really want to be able to have some good dialogue is talking about scaling and partnership. The work that -- let me get into telling you how things were shaped and then sort of how we're growing it with scale and partnership.

So just as a snapshot, the tagline for this work is about "better, smarter, healthier." The goal there is that we want to improve the care system by really touching on not just the incentives in the system or the delivery models themselves, but also the information model that's available.

And that the history of this really is that under Secretary Burwell's leadership, the call to action around moving beyond coverage. So saying that everyone having coverage to an affordable insurance product was necessary, but not sufficient to getting to better care and particularly better health over the long run.

But a really important next step was going to be that we had as a top priority this delivery system reform initiative to see that once people got into the system with their coverage or people who already were in the system, that they were accessing one that allowed them to have better care from a quality and efficiency and effectiveness standpoint, to have the information necessary to spend their money more wisely, increasingly important as copays and deductibles are part of packages. But also this is the case for States and for employers and others who are payers in the system. And then how could we turn our attention to thinking about the defining as clearly as possible what health for people in communities would look like over time?

I'm going to talk you through in a little bit on the way that we've organized this effort, but I wanted to say in particular that Secretary Burwell was really great about helping the department leadership, all of us, including Pam, really sit down and think about, well, we want to do everything. But we can't boil the ocean. We've got to be focused on how will we make the most impact in the shortest run to see that we can start to not even start, to keep the cost curve bent and the progress in quality and safety going. That will give us over time an opportunity to reinvest and to continue to expand upon that foundation.

I'm not sure it's necessary to tell you why it matters to have a higher-performing healthcare system, but we leave in this slide just so that you have it in case you want. For those of you on the phone -- do they have the slides, Pam? They should. We're on the slide that's called "Why it matters," which is slide 5.

You know, I think at the end of the day, this is really for all of us about finding a way that we can create a care system that is very person centered, that is supportive of everyone in the country in a way that gives them not only access, but access to something that is coordinated, that is culturally appropriate, that is considering their longitudinal healthcare experience, but also considering the nonmedical determinants of health. Really being able to take a fulsome picture of a person and partner with them to advance their care and their health.

There was quite a lot of ongoing success in seeing that we're doing a better job at healthcare costs. Certainly Patrick is going to talk more about what we've been seeing in the last few years in the smarter spending realm of some of the work that we've been doing at HHS, some work that States are doing, private payers are doing on a large scale to change the way that the spending curve has been in the past and really see that we're bending it in such a way that we're not going to have the kinds of concerns about the solvency of Medicare, but also of Medicaid programs.

And frankly, what it kind of comes back to is the individual, the fact that people want to make -- they want to have information available so they know what they're buying with their money, that they know what kind of choices that they have to make. And we hear that from not only consumers, but also from business.

And then, you know, I think the last piece I've mentioned a couple times, but this is sort of my favorite area, and that is that it's not just about care. This is about -- it's not just that care episode. It's about your long-term health, whether you have chronic disease or none at all, and how we can make sure that we're leveraging all the appropriate resources for you, not just the care system, but everything in the community, it's going to matter to keep people healthier for a lifetime.

Here's our approach. So those are all lofty ideals and ways that we want to see the world evolve. What we settled on were three critical pathways that in order to get to a place where we could have better care, smarter spending, and healthier people in communities, we need to change the way we pay providers, deliver care, and distribute information.

This means that we need a better business model. We need to support better care models and have the information model that's supported, all of that, and leverage technology to really innovate care delivery as well.

We've put most of our emphasis on the incentive piece, on paying providers on moving away from fee-for-service and moving towards alternative payment models. Why? Because we're a major payer. We're HHS. We feel that we have a responsibility to lead in the area. We know that providers in many cases are just waiting for us to declare and to move away from the kind of system that causes practices to have to see -- to do more instead of doing better.

The fee-for-service model has long been a frustration for primary care, which is where I come from, and for population health, it's really a challenge. So the faster we could move with clarity was something that was a request that we heard over and over again. And we're going to share with you in a bit the clear goals that we've laid out in that area and how we're defining changing to value-based or alternative payment models.

The second area is really encouraging the integration and coordination of clinical care services with an eye on not only improving individual, but also population health and seeing that we have a way that we can really engage patients in shared decision-making. This is a space also where there is so much evidence about what works.

Somebody was mentioning over here, I think it was you, Henry, the work in integrating mental health in primary care as an example. There's good models of this. There's good evidence that it works. Sometimes we just haven't done enough to really support and advance it in all kinds of ways -- licensure, payment models, information availability, and a whole host of other challenges. So whatever we can do through our technical assistance, through the Medicaid Innovation Accelerator, through our SIM State programs and beyond, are ways that we, HHS, want to see that we're really helping support better care delivery models.

And then in the final space about distributing information, we won't be able to bring care models or payment models to scale unless we have the data that we need, and we can't get that data from chart abstraction. It's going to have to be something that is seamlessly abstracted but was entered as part of the normal workflow.

The tremendous success in the adoption of electronic health records in the meaningful use space in the past 5 years has given us a taste of what it feels like in some environments to have really good data that's granular enough to allow us to do quality measurement, quality improvement, population health and individual health. That data is often locked in silos and not following the patient across the care continuum, and I'm preaching to the choir here, but it's not following patients across the entire care continuum because of the structure of meaningful use.

Not all types of the care system were eligible for that program, and so there is gaps in the availability of information in behavioral health, as well as in other

areas like long-term post acute care. So we still have an intense amount of work to see that we're digitizing the care experience, that information with consent is moving where it needs to be, where it matters most, and then that we can use that data for purposes of advancing care and health.

In this space also is work around transparency on cost and quality of information and making sure that the data we have is out and available and that it is consumer friendly and that it is something that is useful, along with the information from private pay and Medicaid.

Having the structure of what it looks like for success and how we want to get there, I just want this slide is to remind us to be really clear that we did this work over the last year by convening stakeholders mostly here in Washington, but a series of listening sessions in the information space that I've had the chance to do across the country. Patrick has done that in the payment and delivery space.

So we've tried to get out of the beltway, listen to and hear from providers. We also want to make sure that we're incentivizing the right things, and so learning from the evidence and making sure that we're aligned with payers in particular because we think that's one of the biggest or early efforts of work that needs to happen because the wrong payment model can really get in the way.

And then finally to make sure that we're partnering with States so that the population served by Medicaid have the opportunities that Medicare and some of the private pay have as well.

I want to turn it over to Patrick, and he's going to talk about some of the announcements that we've made in the areas that will give you a flavor of the kinds of work that we're doing to advance these efforts.

DR. PATRICK H. CONWAY: Hi, thanks for having me. I'm Patrick Conway. I'm a pediatrician by training and practice on weekends, mainly taking care of children with multiple chronic conditions, including substance abuse and mental health issues.

Been chief medical officer at CMS for 4 years or so now. If I make it another year, I'll be the longest-serving chief medical officer in CMS history. So that's my goal.

[Laughter.]

DR. PATRICK H. CONWAY: And then a Deputy Administrator and now Acting Principal Deputy, but I run our Innovation Center and our center focused on quality essentially. So I'm going to go quickly because I do want to make sure we have plenty of time for discussion.

As Karen shared the frame, we announced some goals. The Secretary specifically announced these goals at the end of January in terms of the payment or incentive reform piece. Goal number one, that 30 percent of payments are in alternative payment models. These are payment models where the provider is accountable for the total cost of care and the quality for a population or at least an episode of care. And I'll show you some numbers that we're at about 20 percent in Medicare right now.

The announcement was for Medicare, but we really want Medicaid, States, providers, purchasers, others to move in the same direction, and we announced this Healthcare Payment and Learning and Action Network in March with the President and the Secretary and had, for example, 7 of the 10 largest private payers in the country join the effort. Many of them announcing goals aligned with these goals, had States including representatives there that were announcing similar goals. New York, Delaware, many States joining the network and many of them announcing very similar goals and focusing on their whole State's population, really aligned with other work we're doing in State innovation and Medicaid innovation, which we can talk about in the Q&A portion.

Goal number two is just that 85 percent of payments by 2016 have at least some link to quality and cost, and 90 percent by 2018. For those of you who've been in Government before, it's not incredibly common to set very time-bound, specific goals. So I think this was a big step for our health system to set these goals.

And as Karen said, the main point is not just shifting the payments. The point is better healthcare for people across the Nation. This framework I won't go through. It's the taxonomy, the definitions we're using for the previous slide. Happy to take questions on this if you want.

This just shows graphically where Medicare is, where we have the most robust data. So 2011, we had zero -- the dark blue is alternative payment models. 2011, we had zero percent of payments in alternative payment models. By the end of 2014, approximately 20 percent, and then you can see the goals of 30 and 50 for 2016 and '18. So a lot of progress in the last 3 years.

And then the light blue is fee-for-service with a link to quality. We were about two-thirds of payments in 2011. We're now at 80 plus percent of payments with a link to quality and cost. I don't -- I think we have a slide later on on some of the effects -- for example, in readmissions -- when we link payment to care delivery.

This is in the care delivery bucket. We have a hypothesis that we need to support clinicians and physicians in this transformation. So, for example, in the hospital setting, we made major investments in patient safety that resulted in a 17 percent reduction in patient harm in this country. That's approximately 50,000 lives saved, 1.3 million injuries and adverse events and infections avoided, approximately \$12 billion in cost savings. And Art worked with us on this work

and did actually chart review because we didn't have the electronic health information in terms of the baseline.

So this investment, Transforming Clinical Practice Initiative, the argument is we need to invest in the outpatient setting as well. So major investment of up to \$800 million supporting, hopefully, 150,000 clinicians and physicians. So they really learn how to think about their whole population. How do you manage that? How do you stratify populations? How do you manage them outside of the office visit, et cetera?

And there are stages that they would go through, and we would fund networks. So organizations that have relationships either at the State, regional, or national level with clinicians and physicians who can help them in this transformation. So major investment in the clinician side.

Before I turn it over to Karen, we're also investing in States. So both through State innovation models out of the Innovation Center and something called the Medicaid Innovation Accelerator, really working with States around how do you improve population health.

Many of these States are working on the integration of behavioral health and substance abuse issues, for example, in primary care, in health homes, in Medicaid. So, you know, this is our first out of the gate, out of Medicaid Innovation Accelerator topic identified by States for substance abuse disorders. So we now have a network of States working on substance abuse disorders and improvement of the care delivery system in those States.

So we do think this assistance in care delivery and improvement is critical. With that, I'll turn it over to Karen.

DR. KAREN B. DESALVO: And I'll just be quick. This is the outline of one of the major announcements we made in the information space so that the two Patrick was talking about was where we decided we wanted to go with payment, and there is underneath that quite a lot of work to see that we can get there and the various rules that we put out and the way we encourage the other payers.

The second was to support care delivery evolution, and the third is to support the information space. We put out in January an interoperability roadmap and actually a companion piece, which was a standards advisory that defined how we would get in the short, intermediate, and long term to a place where the data was connected. Where we unlock that information so it's useful and available to consumers and others who need it. Identifying that standards and a good trust environment and the right incentives will make a difference to move us forward.

DR. PATRICK H. CONWAY: So I'll talk quickly through some early results. So cost growth, lowest cost growth in the last 4 years in more than 50 years. So

very positive healthcare cost trend.

Our own actuary and external experts saying that a portion of this is due to delivery system reform. Very, very difficult to assign that exact proportion. There are studies that have tried to and are getting in the hundreds of billions of dollars estimates, but low cost growth.

Readmissions. I still remember 4 years ago before implementing this program and being told by hospitals and clinicians, at least a portion of them, there is no possible way to decrease readmissions. Why would you tie incentives and technical assistance to it? We're now seeing at a national scale we've decreased readmissions.

It was 19 to 20 percent for years. We're now at 18 percent or below. That's 150,000 Medicare beneficiaries staying home and healthy every year instead of being readmitted, and I can tell you, and you know this, you know this better than I. Mental health and substance abuse issues, a major risk factor for readmissions. And we're seeing providers, as they improve, thinking about how they deliver effective care in those arenas to prevent readmission.

So point here, I think when we tie incentives and support, providers are able to improve on behalf of patients.

Accountable care organizations. We do have a pioneer ACO representative in the room, and actually, just to call this out, Montefiore, you know, is doing some incredible things, which -- like building housing, et cetera. So really thinking about that integration of the whole person care. One of our most successful ACOs in terms of both on the cost and quality side, and we've got other examples.

You know, the ACOs, broadly I can tell you as they work to coordinate care, mental health and substance abuse issues are a major foci, both for the health systems and the physician groups. Our Comprehensive Primary Care Initiative, which I don't believe I have a slide on, you know, one of the areas they identified very early on -- so these are primary care medical practices where they're responsible for quality and total cost of care -- was how do we integrate -- how do we integrate and care for people with mental health disorders?

And so, some excellent work in some of our models in these arenas and happy to take questions on that. I won't -- sorry, I already shared the safety results. But contribution of partnership for patients, quality improvement organizations and providers across the country delivering safer care to patients. And I'll do the next couple slides and then turn it back over to Karen.

You know, some principles. We really are focused on improving mental health and reducing substance abuse as critical components of health system

transformation. I can tell you Pam and SAMHSA broadly have been incredible partners in this work, have taught us a lot around this area.

Certainly, I think more we can do. There's always -- in my heart, I used to be a quality improvement person in a health system. We can always improve. So I think there is certainly opportunity for improvement, but I think SAMHSA is certainly helping CMS move, I think, in the right direction.

We are focused on prevention and population health. We actually have a whole population health group in the Innovation Center, led by Darshak Sanghavi. We think there's this underlying principle of eliminating health disparities and health equity and really focusing on underserved populations. So major focus of our Medicaid work, of our Innovation Center work, et cetera, and then this issue of integration of healthcare with social services and supports, which you obviously know.

We actually have a model in development called accountable health communities, where we -- our hypothesis is if we put an investment into a community like a county or a geographic area, and we say we want you to have a lead entity that coordinates your care delivery system with what I'll call your social service and support systems, that we could address some of these social determinants of health.

And actually, there are some communities that have done this, like Hennepin County and other examples, that really drive lower healthcare delivery spend because they're investing in population health and prevention and social service support. So happy to take questions on that, but that model is in development.

Our Healthcare Innovation Awards, behavioral health was a major focus. It always depends how you count, but at least over \$66 million out of our Healthcare Innovation Awards went to projects related to behavioral health, both in round one and round two. Things like medication management, crisis management services, prevention in the pediatric population of suicide, et cetera.

And with that, I will turn it over to Karen.

DR. KAREN B. DESALVO: Thanks, Patrick.

So as an example in the information space, this is ONC specific, but there is other work happening in the department. Just back to this nod about thinking broadly about population health and accountable health communities, this week we announced the release of \$1 million in grant monies basically for 10 nearing \$100,000 sort of challenge-type grants around the country to spur innovation in creating platforms that weren't just about exchanging between traditional healthcare or meaningful use providers, the physical health providers, basically, but encouraging new models of data movement and data use that would really

support the non-MU eligible providers. So behavioral health, long-term care.

What we're hoping to see is innovation that is inclusive of the social determinants. There are some nice examples of that happening in the country, in places like Dallas and Miami and San Diego and Austin, that you want to sort of spur that kind of thinking to get ahead of what kind of data needs will we have in the future, as we have a broader payment opportunity that allows that flexibility.

Within our recent Notice of Proposed Rulemaking for certification of electronic health records, because of the push by Pam and SAMHSA over the last few years to really bring the behavioral health community to the table, the team at ONC has been working on what would a certification for a behavioral health product look like. We actually have some of that specified in the Notice of Proposed Rulemaking, again so that when providers want to do uptake they know what they're getting, and it'll meet some of the expectations that would be outlined around interoperability and service.

In our interoperability roadmap, which, if you haven't seen, I hope that you will take a look. We've been getting really positive feedback. It's been out now for a couple of months, and we're executing on it, such a negative word, isn't it? We're acting on it. And you'll, I hope, see in there that we have pushed the envelope to say this is a lot more than about physical health. It's even more than healthcare.

We really need to begin to create a technology and policy framework that supports, again, a more fulsome picture of people and communities because that's where -- that's the direction that we want to go, and we see the community going. We have supports in partnership with CMS and CMMI called the Health IT Resource Center. So SIM States can tap into technical resource at HHS, led by ONC, that can help them know what is the right data model that's going to help us not only meet the alternative payment models, but really innovate care delivery.

We have set up within our own FACA an advanced health models group that's looking at the, you know, more integrated community-focused, person-centered models of care, again getting away from episodic healthcare, which is how our ONC FACA was thinking as we were standing it up, but really broadening the vision. And then there's other work that we've been doing with opioid initiative that we can take questions on later.

I think what Patrick and I maybe want to convey and not -- finish going through some of these other category slides and kind of get to this end piece so we can take questions. Before I talk about the scaling thing, I want to talk about the scaling of the project piece, which is to say there's been so much great work that's happened as we inventoried that across HHS. But as the Secretary asked us to get really focused on creating a foundation, a structure for this work, what are the ways that we, HHS, could make the most difference most effectively in

the shortest period of time?

It was about changing the way we pay for care to set a model and leave so that other payers would go along. Because as Patrick showed, when you move to alternative payment models and give more flexibility to providers and give them the right supports and the right data to make good decisions in partnership with communities and patients, really great things emerge. Better quality, better safety, more person-centered, better experience for everybody on the ground.

And so, we really wanted to push that. We want to support folks who are doing good work in care delivery, but also help share best practices in whatever ways we can. And very similarly in the technology space, how can we continue to advance the march and successful adoption of electronic health records, the sharing of that information with appropriate consent that would expand that universe. Make sure that we digitize the care and the health experience of people in this country, and so that the information is there for everyone to make the kinds of decisions that they want to make on the front lines.

And now that we have this core piece done, this is such a great -- you know, Chris has been participating in our conversations, the CDC and others, as we start to think through what is the right relationships and partnerships that are going to actually make the real difference for the consumers on the ground? How do we weave together the work that's happening already on the front lines in SAMHSA-funded grantees and programs to see that nothing is duplicated, but that everything is leveraged that's going to make the most difference.

And as Patrick and I have said a lot to Pam, make sure that we're not -- we do not want to leave anyone behind. We want to make sure that this is inclusive of everyone and that the future models that we're working on, that we're developing are thoughtful about creating a world in which the kind of care that is the best practice models that we're familiar with or that we all want to get ourselves and our families to is the kinds of things that we're allowing for with payment and support and the technology.

So maybe we'll stop there and just take questions.

Agenda Item: Council Discussion

MS. PAMELA S. HYDE: Thank you, guys. This is a lot of stuff, and I know we're pushing you in a short period of time.

So for the advisory council members, you got a flavor of why we talked about the ecological model and what we were thinking about in SAMHSA before hearing from Karen and Patrick.

So you all jump in. I know I think Ric and Ken and a couple of other people

already indicated you had questions. So I don't know if one of you want to start?

DR. ERIC B. BRODERICK: Sure. I would be happy to. Ric Broderick.

First of all, I want to thank you both. I'm a satisfied beneficiary.

[Laughter.]

DR. KAREN B. DESALVO: Do you have a patient portal that you're using?

DR. ERIC B. BRODERICK: We can talk later about that. Anyway, I look back to my parents' experience with Medicare and mine, and it's vastly different. So I appreciate it. Thank you.

I got so many questions I kind of don't know where to start. But, so I kind of harken back to that old axiom that what gets measured gets done, and what gets paid for gets done. And so, and as you talk about incentives and sort of helping people, helping providers and helping the system sort of do the right stuff, I sort of harken back also to sort of how the standard of care evolves, and what are your thoughts about that?

How are you thinking about the role that you play in the development of the standards of care so that it doesn't become a choice anymore, really. I mean, there is not a choice as to whether or not you take somebody's blood pressure. You just do it, and you don't even think about it.

And so, how does that become, in terms of the issues around behavioral health, how does that become a standard of care for providers? Because it's not now and should be.

DR. PATRICK H. CONWAY: Maybe I'll start. Karen will add more. On the standards of care, you know, I think about sort of a structure, what are our levels to push quality and standards. So the first one that I oversee is literally the clinical standards in the survey and certification process.

So, and we've done the first major update to home health in more than 25 years. We've said publicly we're working on long-term care, nursing home regulations. There is a reason those haven't been updated for 30 years. They're really complex. That's in our process. We hope to get that out soon.

I get a report every morning that is the hardest thing I read every morning, which has an official name. I call it bad things that happen in America the day before. So it's a report from survey agencies of events that occurred. So I don't want us to lose sight of this. You know, there is a stream of performance, and there is, unfortunately, a tail of performance that is really problematic. And that enforcement realm is important there.

So, you know, the next is this measurement issue, where we've done some work with SAMHSA. I think I don't think any of us would say we've got the perfect set of measures yet in these arenas. So I think it gets everything from measure development to processes with the National Quality Forum to, you know, processes with States. We're actually doing some work with States on what should be the measures for Medicaid health homes, and could we align on sets of measures?

And as you heard in my remarks, I think mental health and substance abuse issues are key in that sort of core set of measures. We're doing a lot of measure alignment work with private payers, both on the Medicare side, Medicaid, and commercial payers. You know, but I do think we've got to challenge to develop and implement more meaningful measures, and we've done some work, I think, that lays a foundation to get there, but we're still probably not there yet.

And then the last piece I'd call out, which is really this spreading of best practices. And when I talk about these networks, this is not CMS teaching them to do this. You know, comprehensive primary care initiative, it's one primary care practice teaching the others, or one ACO teaching the others. And I think we have to set up that truly continuous learning system, that T3 and T4 of health system transformation so you're accelerating those changes and spreading those best practices as fast as possible.

DR. KAREN B. DESALVO: Three things maybe. When, in a former life, I was running primary care with integrated mental health in New Orleans, and for us, we had the luxury of being an alternative payment model, being able to build our teams on the ground at those health centers. And because of the challenge that our community was facing with PTSD and anxiety and situational depression, we chose to build in screeners in our electronic health record that just made it universal that everybody got checked.

And then if they were flagged, they got further evaluated and had a warm handoff in the clinic to somebody who was trained and skilled and ready to help them that day and figure out what's the next care pathway. And those are the kinds of flexible things that you get to do in the care environment when you don't have to be worried about having someone come back for an assessment or not having a lot of pieces of paper that are going to track everything.

So as we're thinking about the care delivery piece, it's letting people innovate within, you know, obviously reason, but that's what people want it to do. They want it to happen. So that's -- that's the one. It's back to the sharing best practices. How do we help people know what works for others?

The second would be about the importance of work that has to do with privacy. So when you do advance that kind of model, you want to make sure that not

everybody on the care team has access to all the information, and there is some really important technical and policy challenges around data segmentation for privacy.

This is work that has been going on for a long time and is not going to end, but you'll find it throughout the work that ONC is doing. But it's bigger than that. It's departmental level efforts that have to be solved.

But I want to just talk about the measurement piece because the behavioral health council, we raised this issue that we don't have great measures for quality in the space of behavioral health. I know that from the ground also that as we were -- you know, back to this cost and transparency, this cost and quality transparency thing, I think about the behavioral health resource guide, Pam, that you helped us make in New Orleans.

And I could list everybody. It was a great step forward. Here are all the resources that are available. I can't really tell you what the quality is.

I can tell you if they're accredited. I can tell you many other things. So there's steps that we really need help on -- we, the community; we, HHS -- to know that not only can we define a measure of quality, what kind of report carding can we put out to the world to let folks know what choices they're making about the quality of the providers that they're choosing. And then from the data standpoint what is it that we could make sure we're incorporating in the electronic health records and beyond to see that that's more seamlessly captured and available for folks.

MS. PAMELA S. HYDE: Henry? Ken, next? Henry?

DR. HENRY CHUNG: First of all, I just want to say that the both of you are extremely well positioned because you guys came from the practice world to lead this effort and very much appreciate your leadership on both arenas. I think, you know, there's lots of things I could ask. But really the impact issue that, Patrick, you asked, which is what in the short term can both of you do that will accelerate, if you will, the impact for the community, the behavioral health community and the constituencies that we serve?

I think one is the success of the ACOs. I mean, there's just no question that, you know, the ACOs are moving. They're moving fast. There's more and more growing. Mental health professionals are not currently on the preferred attribution list. That's a mistake. It's a serious mistake because the data shows that particularly for SMI, but also other populations, the frequency of visits to behavioral health providers is huge.

And people have said, well, you know, you can always include psychiatrists and psychologists in your ACOs. But ACOs don't do that unless it's clear how they

can attribute these patients for responsibility purposes. So one of the things that, you know, we've asked you to do, and I'm asking you again, is to basically change the attribution formula so that if we include mental health professionals in our ACOs, they actually -- we can see what the activity level is and begin to align responsibility.

Because that will accelerate the value-based payment uptake and the creativity that I think our mental health professionals need to encourage them to accept fee-for-service Medicare patients. Because as you know, access for fee-for-service Medicare, huge issue. Huge issue. So that's number one.

Number two is I hate to do this, but go back to 42 CFR. New England Journal of Medicine had another piece, somewhat unfair in the way that it characterized the issues vis-à-vis SAMHSA and HHS. But the bottom line is there is still massive confusion in the field about this. And at an ACO level, there is no question that we're hindered by data suppression, by this suppression of alcohol-related, drug-related claim, mental health-related claims.

The fact that we cannot look at which patients are being readmitted who have a secondary diagnosis of alcohol, when clearly we -- well, I won't say clearly. But most of that treatment is not in the 42 CFR environment, you know, is a problem. And I know that there is problems with regards to the cleanliness of the data, but we've got to overcome that if we really want to make a meaningful differences.

So those would be the two, I think, higher impact arenas that I think would accelerate your agenda in terms of what HHS is trying to provide.

MS. PAMELA S. HYDE: Do you guys want to answer the first part, and then I'll jump in on the 42 CFR?

DR. KAREN B. DESALVO: Oh, good. Because I was going to punt it to you.

MS. PAMELA S. HYDE: Yeah. Go ahead.

DR. PATRICK H. CONWAY: The first one, I think it's a great point, and I think we should look at that. As you know, we're sort of in the process of updating our ACO rules, which is one of the big programs, and we have more flexibility in the pioneer and next-generation ACO environments. So it's a great point. And would be happy to follow up more.

On the second, we'll defer to Pam.

MS. PAMELA S. HYDE: Punt to me. I saw the New England Journal of Medicine. We're trying to respond to it the way we responded to similar kind of criticism from another reporter not too long ago. It's not quite appropriate, as you indicated, to say that somehow we told CMS they had to do this. There is a law.

It's an old law, and we're having to live with it.

And that law, it would take Congress to change it, and I think most of us have determined that probably now is not the time to try to get Congress to change that. But we are working on the regs, which are also about 25 years old. And as some people know but don't necessarily appreciate, it takes a long time to get regs changed in the Federal Government.

But this issue of access to research data is definitely on the list of things we are trying to change in the reg, but we are having to work with the law and the regs and the lawyers about what it takes to get that and still be in line with the way the law is currently written. So it's actively going through internal clearance. We anticipate it being out for public comment, the revisions, sometime this spring. I don't have a specific date, but we're certainly on it.

And these guys have been very good at working with us, and the folks who are working on that, raise your hands, Laura and Kate, are back there in the --

DR. KAREN B. DESALVO: They raised them really low.

MS. PAMELA S. HYDE: Yeah, they're raising their hands really low.

[Laughter.]

MS. PAMELA S. HYDE: But since you all are advisers, you have the right to get information from them in ways that the public does not yet. So if you want to have more conversation with Kate and Laura in the back there, they can tell you a little bit about what we're proposing or trying to propose, and it just does take a while to get through the clearance process.

But we're very aware of the issue, and we're trying to resolve it.

DR. PATRICK H. CONWAY: Just one, two sentences. I actually had one of the folks in our bundles initiative yesterday come in, a large provider organization. Actually is a safety net provider. And say, you know, because of this, I want you just to exclude everyone with mental health and substance abuse, which we said there's lots of reasons why we're not going to do that. But it does create these unintended consequences, which you know well, that are unfortunate.

MS. PAMELA S. HYDE: Yeah, and I want to just be real clear for everybody. This is not a policy difference within HHS. There are differences of opinions inside HHS that reflect the differences of opinions, I think, in the country about where is the right balance between privacy and access to records.

So, but beyond that, everybody's got the same policy that Patrick just indicated as we're trying to make this data available in the same way that other conditions

data is available and yet respect the law that is there for good reasons and historical reasons. So other -- Karen?

DR. KAREN B. DESALVO: Just a follow-up to Henry. One of the sort of, you know, what can you do parts of the slide, I don't know where it is, is participate in the Learning and Action Network, which is the table that we've sat focusing on the incentives piece. But that was right there up on the slide.

And because this kind of -- the work of that group is not only defining the alternative payment model and quality measures, but also attribution is one of the big topics that's come up. So having that voice there will be really important. I don't remember anybody in my workgroup, the sort of the pre-discussion raising any issues about behavioral health. So let's make sure that you guys get connected.

MS. PAMELA S. HYDE: Yeah, Ken?

DR. KENNETH J. MARTINEZ: Two questions. Can you say a little bit about the impact of all of this effort on individuals with serious mental illness?

DR. PATRICK H. CONWAY: Yeah, I can start. Karen may add on more.

So serious mental illness is we call it out in a few different ways. One, we have a number of Innovation Awards that are directly looking at serious mental illness. We actually have a group within -- across HHS, it's not just CMS, trying to take those learnings and think about, you know, we funded these various Innovation Awards, and the results are starting to come in. You know, what worked? What didn't? Why did certain things work? How would that impact policies or payment models in the future?

Actually, on the mental health, one of the ideas that came in from one of the Innovation Awards was a very targeted change to fee-for-service on sort of a payment of closing the referral loop with mental health. So interesting ideas there.

And I think in our Medicaid space, we've got a number of States that are working on issues related to serious mental illness. We're trying to -- we actually have a network now with the Medicaid medical directors in various States where they are learning from each other in a number of these arenas. And happy also -- my team, in preparation for this, sent me like 50 pages of information of what we're working on. So also happy to have anybody sort of meet with the team and hear more detail on some of these.

MS. PAMELA S. HYDE: I might just add on that one because I think it does come up a lot -- and Karen, you mentioned it, but it was really in passing -- is the way that the more serious mental illnesses and the way that the more serious

and chronic addiction issues get dealt with is really not in clinical practices. They're really over in things that look more like FQHCs, but they're not funded the way FQHCs are.

So I think our system constantly worries about that. The payment models and the changes and stuff that are driving sort of clinical practice innovation don't really get to us or to our public system. So we struggle as a system on how to make sure they're in there.

So the more you look at FQHCs, some of them deal with more serious problems, but frankly, not a lot. So that it's like a separate system over here, and we keep trying to figure out how to get them in that fold, if you will.

DR. KAREN B. DESALVO: It's actually -- I should stop turning it off. I mean, it's worthy of a pretty long conversation, but back to this idea about the data model piece. Some of the really interesting community-based data models of exchange and interoperability are focused on the SMI populations or really high-risk populations.

And I'm thinking about the work in Camden, and Jeff has now layered on top of -- Jeff Brenner has layered on top of his clinical work a data infrastructure to make it more seamless. The Dallas model has been thinking a lot about the fact that people are touching the healthcare system, but they're in and out of many other places, and we lose sight of them and what their care needs are.

DR. KENNETH J. MARTINEZ: Just one more?

MS. PAMELA S. HYDE: Yeah, sure.

DR. KENNETH J. MARTINEZ: What is the role of consumers in this effort? And are they consulted? Are they part of your planning?

DR. KAREN B. DESALVO: You get that information from your patient portal. I'm kidding.

[Laughter.]

DR. KAREN B. DESALVO: They're the hot topic this week. So, sorry that was not funny because there's no context for it. But the --

MS. PAMELA S. HYDE: There's a little inside baseball.

DR. KAREN B. DESALVO: It's a little inside baseball joke about everyone should have access to their electronic health information, which they should. That the consumer is a place where we -- first of all, it's a place that the Secretary starts, and I need to be really clear about that. It's really easy to

quickly get yourself into a very wonky payment model space.

And as we were thinking about what are the ways that we can make a difference for people on a big scale, what are our tools at the Federal level? You move to, you know, ACOs and bundled payments and medical home things and interoperability roadmaps and what not. We are really conscious of the fact that we have to find a way to make this feel different for the average person and meet their needs and expectations.

One of our challenges in that area is that the measures that we have tend to be very topped out. People tend to love their care providers, love their care experience. So it's going to be -- it's one of those places where we're trying to sort out what does success look like, and how do we make sure we're meeting their needs?

Because we have plenty of measures that we collect. It's just that I'm not sure that we've kind of got our head around it quite yet, to be honest. And we're spending a lot of time trying to understand how we can make sure that it touches them and not just the providers.

DR. PATRICK H. CONWAY: Just a few additional quick examples, if it's okay, and I do think we try to lead with the consumer and the person in all this work. You know, in the safety work I mentioned, we've got a number of people driving a lot of that safety work often based, unfortunately, on safety -- harm in their own family that led them to come work with us. They've done a lot of teaching to healthcare organizations.

In all our measurement work, there's consumers or patients or people on the various development panels because that perspective can really change the way you think about measurement. In all of our QI work likewise, all of our quality improvement organizations, and there was some pushback on this initially. Now at the board level, you have to have consumers and patients represented.

I do think that being at the table, I have to thank -- I love that you have like youth advocates here. As a pediatrician, that's awesome that you're here. And I mean, truly just terrific. So I think that voice is what should drive the work, and for the voice to drive the work more effectively, we have to actively engage in a way both in guiding the policy and payments, but also on the ground delivery of care.

DR. KAREN B. DESALVO: And the cost and quality transparency piece is -- this is another part of the folks knowing with the care that they're getting, what's the quality of it, what's the cost of it. So that will be one portion of better information sharing. But in all of our work in the technology space, it relates back to this building not just person-centered access to it through portals or blue button initiatives, but actually, we're moving more towards a person-centered data model of care that gives them a longitudinal record.

And there is some private sector work that's happening in the space, but that's where we're moving our policy and technology work is to make it that much more flexible so that it's not just about the population, but you can get your own information, too.

MS. PAMELA S. HYDE: Henry, I think you were next?

DR. HENRY CHUNG: So now I'm going to go to the sort of the near-term issues, but it touches on one of the things that I'm thinking a lot about, the transformation initiatives that you have.

A lot of the programs that you've been issuing have been very much geared -- the criteria sets for readiness to apply are relatively rigorous for mental health agencies if you think about it, right? So the whole MU thing is bypassed, you know, because there were no incentives for mental health agencies.

So there's an assumption, I think, that when you're thinking about your initiatives that bend the cost curve, you're thinking you must have these readiness elements. I think for the behavioral health community, it's incredibly important to have some dispensation that says, you know, we know that lots of folks don't currently have it. But if you can demonstrate that you're on the way doing this project to getting some level of platform, that would be important.

Other kinds of things like the learning, transmission of that was what you have written on, Patrick, and been so successful in convincing primary care folks and specialty folks that practice networks actually work. That's not kind of consonant with the way that mental health practitioners think and the culture of the way that we work, and so that, even itself, is a huge leap as we think about evidence-based practice and so on.

So I would say that more sensitivity to the writing of these grant requests and allowing particular dispensations or tracks for the behavioral health community to get access to these funds are absolutely key, and they will pay off. That's one.

On the electronic side, EMRs, I feel, have been tremendously successful. EHRs have been tremendously successful. But I think where they fall short technology wise is the whole notion around patient engagement, and it's not just patient portal. It's the way that the care plans are being developed.

So, for example, all the health home work that you guys are supporting, there is a big need to share care planning across agencies. Well, who are we sharing it with? We're sharing it with community mental health agencies and community substance abuse agencies. They're not tied in.

And EHRs are such complex animals. So the question for you would be, you

know, what thought are you giving at the ONC level to that next generation of electronic systems that really focus much better on care planning or at least the dimension of EHRs that claim that they're going to be doing more on the claim care planning dimension?

DR. PATRICK H. CONWAY: On the first one, I agree with your point. So I won't take more time than that.

[Laughter.]

DR. HENRY CHUNG: He's really easy today.

[Laughter.]

DR. KAREN B. DESALVO: Patrick is always so lovely. All right. We agree with you, too, and that in our proposed rule for the new certification, that would go along with the next evolution of meaningful use as an example of the making it easier for patients.

But the patient portal thing is one of the ways people can access their electronic health information. But what you find in folks with multiple chronic illness or even people who use multiple providers, they have what we call "hyper portal-osis." They have lots and lots of portals and codes to remember, and it's frustrating, and the interface isn't necessarily what they want.

So one of the things we've proposed is to push for APIs that would create us an app like you have on your smartphone type environment for your information availability. And that would aggregate your health data from the various sources and give you more control over what's aggregated. There are some ways that that might enhance some of the privacy for you as a person, and we can go back and forth about the pros and cons on it.

We've proposed it. Not all the technology is quite where it needs to be. So we're going to see how things roll out in the next few months. But we're philosophically there and pushing.

And I mentioned it before, and it sounds kind of technical, but it's so important for us to keep thinking about, which is that right now our frame about the data is that it's the locus of control, the power source is the electronic health records held by institutions. And where that's moving is to other trusted third parties that would host your data.

And it could be all kinds of trusted third parties. It could be public entities. It could be a healthcare institution. It could be something new we haven't seen. But you as a consumer could have the opportunity to push data there and have your HIA one or whatever your person-centered data model and not the kind

where you have to type it in, but it goes directly.

So, and there are products like that in the field. There is just a series of policy and technology challenges. The reason it's important to mention is just because I think that it's going to add a layer of complexity to the sources of data, but it's really -- it's relevant because it's going to make us think more about the consumer and the person and not the billing office and the doctor.

MS. PAMELA S. HYDE: It is true that sometimes what we need to share with is the education, school or the jail or the other systems that are not inside the healthcare box. Chris?

MR. CHRISTOPHER R. WILKINS: Thanks very much for your presentation.

Two points, one Medicaid, one Medicare related. Both resting in the substance use disorder domain.

If you are a highly chronic alcohol-dependent person being treated in the publicly funded system in our country, there is a very, very, very high probability that nobody will talk to you about access to addiction medication, incredibly high. Data out of the big States routinely shows that less than 6 percent of the folks treated ever get counseled about, educated about, or get any access to addiction medication if they're alcohol dependent.

If you're opioid dependent, there are a few more options in the methadone and the Suboxone world. It is squarely in the center of the health disparity conversation. And I think it's squarely in the center of how to control Medicaid costs, and anything you can do to help these guys fix it would be appreciated it.

Secondly, on the Medicare side, I think the alternative payment model is an incredibly fertile ground for conversations about how to really get a handle on geriatric substance misuse. We've never had a better set of circumstances or conditions to get our arms around that population and really give some relief to those individuals and those families.

DR. PATRICK H. CONWAY: Yeah, I'll be brief on both because I know we're -- on the access to addiction medication issue in Medicaid, I believe this has come up with our Medicaid substance abuse disorder workgroup we just launched with a bunch of States, but I'll take that back and make sure. That's a great point. To Steve Cha, our chief medical officer on Medicaid side. And then, I mean, I oversee -- I'll bring it back to Steve and follow up.

On the Medicare side, I think you're hitting on a key point, and I think it's an under recognized point. Shari Ling, our deputy chief medical officer, is a geriatrician, and this is something we've talked about. We are, in our alternative payment models, encouraging them to think about these issues.

MS. PAMELA S. HYDE: So, Patrick, I know that Sean knows, but you may not know. We're doing an analysis of Medicare about the disparities in behavioral health and health on -- from a parity point of view, and we're going to obviously share that with you once we've done that to see what we need to do about it. And it does hit on this issue of medication-assisted treatment quite a bit.

And Chris, I don't know if you know, but we just recently put out a new guidelines on treating people with alcoholism, alcohol disorders. So that might be helpful, too. Just at least it's out there as a resource.

Okay. Other folks have a comment or a question? So let me just say one more thing. People have raised it, but I want to give you a very specific example. It's kind of my bugaboo at the moment, and you guys know this. You won't be surprised.

But some of this whole issue about measures because we've been struggling with our National Behavioral Health Quality Framework. We keep hitting you up every time with please look at this. It's an evolving document. It is not sort of stuck in one place. But I think somebody said something about we have lots of process measures, not as great outcome measures. I'm trying to think about that, but there are some measures that the metric just works wrong.

A great example is suicide. If you're looking at readmissions and someone leaves your inpatient care and goes and dies by suicide, it doesn't count against you in readmissions. So we have some metrics in our world. Or if you leave your system and go and end up in jail, and you just don't come back, it doesn't show up as a failure, if you will. So there's not a disincentive.

I think we have to do a little bit more work on the measures piece about how we are not either disincentivizing -- Henry mentioned that a little bit -- people doing the right thing, but also how we don't inadvertently say it's actually better if those people leave your system because then it doesn't ding you. So we haven't totally figured that out, although we've got some great work on zero suicide kinds of approaches that might be of use.

Any thoughts about that?

DR. PATRICK H. CONWAY: I think it's a great point, and I know we're working together on this, but we'll need to keep working on it.

MS. PAMELA S. HYDE: See how great they are. They just agree with things. No, they have been terrific. Patrick was one of the first people that started talking about measure alignment. First time I ever heard his voice on the phone. We meet each other on phones a lot.

So the other one I wanted to ask you about was the shared decision-making issue. One of the things this group and yesterday or last 2 days, actually last 3 days, all of our advisory committees have been talking about is SAMHSA's role in treatment issues. Because we don't tend to pay for it. Actually, you do. CMS, Medicare, Medicaid, and then private insurance pays for two-thirds of it. We pay for a little teeny, tiny bit of it. But we really more are trying to influence it, which is why we're always knocking at your door.

But one of the issues we've all talked about, ARC and you guys and us and everybody else, about patient-centered care and shared decision-making. We get a fair amount of criticism for thinking that people with serious mental illness, for example, or people with addiction, serious addiction really have the ability to make good decisions about their own care. So we get kind of pooh-poohed about that, and we get criticized for even sort of thinking that way in some ways.

Any comments or thoughts about that in terms of we've been doing some -- Paolo's been doing some work around shared decision-making in the psychiatric space, and then I think there's also this notion that a person with addiction needs to be a court or somebody else has got to get involved with them and if they're going to be getting care.

DR. KAREN B. DESALVO: I'm glad you raised it, Pam. I would, first of all, clinically, I would agree with you that they're completely in the realm of people that you want to have shared decision-making with. That should be everybody, right?

On the piece about having evidence-based tools available in the clinical environment, just to think about the clinician shared decision-making piece, this is one -- this is the first conversation that we had when I got here was about giving the tools for providers on the front lines if they weren't comfortable with how to handle, you know, addiction and/or medication management of alcohol addiction as an example. So work that we've done together and that is embedded in this because of ARC's role over time is that those tools would be available to remove any barriers because people just didn't know.

But then you're asking the next layer of question is, and we're going to engage patients, and they're going to have their own tools that are consumer facing and/or designed to encourage conversation. I don't know if you had anything else you wanted to add?

DR. PATRICK H. CONWAY: Yeah, just quickly. When I was in the delivery system, I actually co-led our implementation of shared decision-making work. So that gives you a sense that I think it's incredibly important. Two things that we're doing and probably could do more.

You know, one, we're measuring it directly from patients and not excluding some

of the populations you named for ACOs, et cetera, and it affects their payment. So it's a pretty strong signal that we want you to engage your patients in a real way. And we're actually going to ask those patients, those people about your effectiveness in shared decision-making and communication.

Two, we've actually -- one of our models in development in the consumer space is thinking about from the Innovation Center that we need to launch some models -- a model or models around shared decision-making and person engagement to really put some money that would catalyze some activity.

MS. PAMELA S. HYDE: Well, you remember the early conversations. I was really pushing this issue, and Paolo has been doing work with ARC and others around this. So we'd love to work with you.

Charlie has got a last comment here.

MR. CHARLES OLSON: Yeah, that was -- to piggyback off of what Pam said, I noticed that it was specifically mentioned for the -- to allow your patients to have shared decision-making, that really impressed me how much thought went into just having that sentence in there. And it saddens me to hear that something that -- that's something that SAMHSA has been criticized. And working a lot with different nonprofits that focus on just wellness in general, we really do strongly believe that when a person is well, they are the expert in their wellness.

My wellness looks entirely different from somebody else's wellness, and my wellness this year is going to look entirely different from wellness next year or even next month. So how can another person know where I am and what that would look like?

MS. PAMELA S. HYDE: Yeah, that's a great way to end. That's a huge element.

Listen, thank you guys so much for being here with us. We really appreciate it. We've really been revving up for this conversation, and you've stimulated a lot for us, and it occurred to me in talking, this group is by FACA is allowed to have some predeliberative conversations for certain things. So there may be things that we want to use them for in ways that we probably haven't thought about in the past.

So, okay. Great. Thanks, everybody. Really appreciate it. And I think we've been -- we've had a little shy of 100 people on the phone across the country also listening. So thank you.

DR. PATRICK H. CONWAY: Thank you.

MS. PAMELA S. HYDE: So I think Kana is going to walk them out while we turn our attention to the next piece, which is actually public input, and we are going to

have to do a little bit like we did yesterday, which is because we put this out at a certain time, we really have to do it at that time because there are people who may not come on until then.

So we've got just a few minutes here before -- oh, okay. We stole Laura from Karen's shop downtown, and she's been a great addition.

So we're going to spend just a couple minutes before 12:15 p.m. talking about that question I asked you earlier. Okay, now that you've had conversations this morning. You've listened to the conversations yesterday. You've kind of seen -- some of you are new, but some of you have been here two or three times now -- how we do these meetings.

We have the center-based and the tribal and the women's committee usually on Wednesday. On Thursday, we have the joint group and try to deal with sort of cross-cutting issues. And then, on Friday, you guys get into some heavier duty things that cross the whole organization. Given that and given what you've heard and given there's only so much time, what would you propose that we spend time on next time?

And as you think about that, remind you I don't know that we'll do it this way, but the last year or two, we've been having face-to-face meetings in sort of April, spring time, and then we've been doing our meetings by phone during the summer, late summer, August time. I don't know we'll do it that time again. We may decide to -- we started that during the time period where we really tight on travel money. We may not be quite so tight in the future. So we may bring you back in August or whatever.

But do we have dates already, Holly? What are the potential dates?

LCDR HOLLY BERILLA: We have the 26th, 27th, and 28th. I'm sorry. Potential dates for next year for center councils would probably be the 26th. The Joint National Council would be the 27th, and then the SAMHSA National Council would be the 28th of August.

MS. PAMELA S. HYDE: Now these dates are always tough because it doesn't matter what date we pick, somebody says, "I'm going to be on vacation. My kid is going to be out of school." Usually what we find is that right before Labor Day, people are back at home, getting their kids into school or whatever it is they're doing. And September and October starts really busy times of Recovery Month and conferences and stuff. So that's why we sort of have picked that this time works.

It doesn't mean everybody can make it, but at any rate. So potential dates. Put those on your calendar, August 26th to 28th. And now I've given you 2 minutes to think about it. What do you think what leaves you with, gosh, we really should

take X next time?

DR. KENNETH J. MARTINEZ: There are two topics. One, yesterday, when you were doing work with the panel, you said what about families? What about families? And I think, you know, there's a need to talk about the role of families, and in some ways there are two types of families. One is the families of adults with serious mental illness, and then the families of children with very different needs and agendas and roles.

And so, I think they are two different topics, you know, when you ask about the role of families. So that's one issue.

And I think along with that, when we talk about families, we're also talking about the role of youth, and youth and their own care prior to 18, and then the young adult's role between 18 and 26 or so. So that's one big topic.

And then, of course, you wouldn't be surprised by me bringing this up, which is disparities, behavioral health disparities. And by that time, I think you will have more data on the impact of the disparities impact statement, and the role that that's played in looking more closely at health and behavioral health disparities. And it would be great if we could in more depth deal with that issue.

MS. PAMELA S. HYDE: Yeah, that one, they're both great issues. But that one is an especially good issue because we've done it before, but it's been a while. We haven't done it in the last couple of years in these groups. So it may be time to come back to the disparities issue. Good point.

Henry?

DR. HENRY CHUNG: I think, with Gail, as a part of our committee, it would be great to go over and review measures. I got to look at what Paolo shared with me, very helpful as far as I can tell. But I think it would be good to kind of get folks involved around looking at these measures. They will be so critical to payment and what providers emphasize in trying to collect. Are they feasible to collect? So measures I think would be a good one.

DR. ERIC B. BRODERICK: I'd like to expand Henry's suggestion. I assume, Henry, you're talking about patient-centric measures?

DR. HENRY CHUNG: Patient-centric measures or even the clinical and outcome metrics that are being -- yeah.

DR. ERIC B. BRODERICK: Okay. Both of those are really important, but the conversation this morning about that was stimulated by the ecologic model, we were sort of flipping back and forth between individual-centric stuff and community-centric stuff. And in order really to bring the behavioral health

community into the public health world, you have to have the conversation about if -- I said to Mary, if Tom Frieden were sitting here and someone asked him what's the public -- what's the health of Rockville, he would start talking about the very familiar community-based measures about infant mortality and all the things that CDC talks about.

But I think it's really important to have conversation within the behavioral health community that if you asked about the behavioral health of Rockville, what would you say? And there'd be no shortage of data. But there's, I think, some utility to talk about perhaps getting people's opinion, the community's opinion, the thought leaders' opinion about what those measures might be consistently from one community to the next or from that community over time because you have to have a way to know is the community getting better or not.

And so, as Chris talks about, you know, getting those data about where the resources get applied and where the need is and what the status of the health of the community is, I mean, that's a pretty fundamental public health thing. So --

MS. PAMELA S. HYDE: Yeah. Actually, that's a great point because you may -- you probably remember our National Behavioral Health Quality Framework is in three buckets. One is the provider bucket. So that's kind of the individual client bucket. One is the payer bucket. So it's like what do we want -- how do we want the provider to behave to affect treatment? And then one is the population bucket, but we tend to do it as population for behavioral health, not for community.

So it would be a great conversation, I think. Yeah, good.

All right. What else do you think should be on the list?

MR. CHARLES OLSON: I'd like to second what Ken said about families. I've been on the National Advisory Council for a couple of years now, and I think that that's something that I can't immediately come to mind that we have really discussed. And I can foresee some interesting conversation in there.

And then I just want to keep pushing the youth stuff. I know that SAMHSA has made strides in it. We got a youth panel about a year or maybe a year and a half ago, and you know, you're working on other things right now. But even if it's through the National Advisory Council or communication in between, I would really like to see SAMHSA be a leader in that nationally because I think States would follow suit.

MS. PAMELA S. HYDE: Great. Thank you. Gail?

DR. GAIL W. STUART: So I'll go to the other end of the spectrum and say the elderly. NQF, you know, the only measures they're adopting are falls. I mean,

you know, we really don't pay enough attention to that population.

MS. PAMELA S. HYDE: Yeah, good point. We actually have somebody, Brian Altman, who's out for a couple weeks with some health issues. But he's been serving as our liaison to the White House Conference on Aging, which is coming up. They haven't done one for about 10 years, and we've been really trying to incorporate behavioral health into that conversation.

So good point. Anybody else? Chris, Junius, Cassandra, anything else to add? These are actually all great topics, and you're right, we haven't done families, I don't think. Or specifically. We have done a youth specific, but we haven't done families. I think that how to engage families, I think, is definitely on our minds these days. So having your advice about that would be helpful.

And then the measures and disparities we've done before, but it's been quite a while and not with this focus that we've had today. So, so great ideas. Anything else?

[No response.]

Agenda Item: Public Comments

MS. PAMELA S. HYDE: All right. Let's move to public comment. We're just right on time. The issue here is we take comments from the public. Mostly we are listening. We are not trying to engage and respond so much. We're just listening to public comment.

We have people signed up, and do we have a list of folks who are interested in speaking? And if so, we're going to call on them and ask them to keep their comments to about 2 minutes. We can always come back around for further comment if there's time, but we want to make sure there's time for people.

What have we got?

LCDR HOLLY BERILLA: We've had a couple comments on the webinar. Oh, Operator? If you have public comments or people interested, can you open the line for them?

OPERATOR: Absolutely. We do have one question in queue.

MS. PAMELA S. HYDE: I'm sorry, Operator. We cannot hear you. We've got to have a way for you to be louder. This is just not going to work.

OPERATOR: I'm sorry. Can you hear me now? I can hear you. I am speaking into the conference.

MS. PAMELA S. HYDE: We really can't. What's our --

MALE SPEAKER: You can ask what she had it before. She had it up pretty high before.

MS. PAMELA S. HYDE: Our sound person is saying you had it up higher before. Is there --

OPERATOR: Okay. Can you hear me now?

MS. PAMELA S. HYDE: That's better. That's getting better.

OPERATOR: Okay. I put it -- I'm sorry. We actually switched operators. So the other one is on break. But can you hear me better?

MS. PAMELA S. HYDE: That's a little better. Yeah, thank you.

OPERATOR: Thank you. I'm sorry about that. I just wanted to remind everyone if you would like to ask a question, please hit *1 from your phone and record your first name and your last name quickly when prompted. But we do have two people in queue.

Our first question comes from James Gallant. Your line is open.

MR. JAMES GALLANT: [on telephone] Hello? Yes, my name is James Gallant. Can you hear me?

MS. PAMELA S. HYDE: We're having a hard time hearing. You have to be really close to the microphone, whatever your microphone is.

MR. JAMES GALLANT: Okay. Here I go. I'd like to have you reconsider the rights of the families. You know, you're talking about the family-centered practice and what not. But where the court-ordered legal rights fall in, is that to be required on a psychosocial assessment and to protect them and their legal rights that they have in place, to protect their interpersonal relationships with their family and their family support structure that you're trying to create. Well, they have legal rights for that, and that should be under the plan at all times and to have them address that.

And I would also like you to consider the parliamentary procedure. In some of these, you're going down, you said the States are doing all they want to do, but everybody is doing something different and you can't tell them what to do. But the one thing that's missing from all of this seems to be the American way of parliamentary procedure to where meetings have been shoved out into the private sector. And you know, they do business a little differently out there.

So we should be thinking about the public sector and the proper procedure. Everybody gets to vote. I'm finding a lot of people don't get to vote on these boards and committees and task forces. They don't ever vote. So that seems to undermine the democratic process.

Are you hearing anything that I said?

MS. PAMELA S. HYDE: Yes, we are. Thank you. Appreciate your comments. Thanks.

Do we have another person on line? Operator, do you have another person on line?

OPERATOR: We do not -- we do have another person on line. Were you not able to hear the other participant?

MS. PAMELA S. HYDE: Yeah, we heard that. It was a little fuzzy, but we got it. I think we got the --

OPERATOR: Okay. I just wanted to make sure. We do have someone else on the line. Would you like to take the next question?

MS. PAMELA S. HYDE: Yes.

OPERATOR: Okay. Give me one moment here. I'm going to raise her volume. One moment. Okay. The next question comes from Renae Starks. Your line is open.

MS. RENAE STARKS: [on telephone] Good morning, and thank you for holding this open forum and conversation.

I'm with the International Association of Medicine Backers. And can you hear me?

MS. PAMELA S. HYDE: Yes. Again, it's a little -- even more volume would help.

MS. RENAE STARKS: I understand. Her voice sounds muffled.

MS. PAMELA S. HYDE: Yes. Go ahead.

MS. RENAE STARKS: Okay. I'm asking this morning -- well, the participants in our group, what we're looking to do is collaborate with anyone who's open, innovative, and willing to have this conversation even under grants. Right now, the Federal Government has quite a few brain development grants that are going on, and that also pushes jobs for the nurses.

So I haven't heard anything about that kind of a collaboration and association to go after the new dollars. So I'm offering and thinking that our group has everyone categorized into four groups -- those who will, those who won't, those who do, those who don't. And we try to expand those through clinical trials.

And then with our portion or the technical portion, how we get all the information to everyone is through a software that we give to the clients and they participate in what's going on with their health, that they can also give permission to have SAMHSA or NIH or any other person who's interested a private log-in to their information, and that way, they can have better health coordination.

MS. PAMELA S. HYDE: Okay. We got part of that. I'm not sure -- did you all around the table hear that one? It was about collaboration of grantees and certain stakeholder groups and others that we're not getting as much reach to that I think she's making the point.

Am I getting your point, ma'am?

MS. RENAE STARKS: Yes.

MS. PAMELA S. HYDE: Thank you. That's a good point. Both of these are good comments. Thank you.

Are there other comments?

MALE SPEAKER: All of these came in from the webinar. Do you want --

MS. PAMELA S. HYDE: Okay. So do we have Kyle Lloyd on the phone?

MS. RENAE STARKS: I'm sorry?

MS. PAMELA S. HYDE: Do we have a person named Kyle Lloyd on the phone?

MS. RENAE STARKS: Your voice is really muffled. The person that was supposed to introduce me I could hear clearly. Your voice is really muffled.

OPERATOR: Can you hear me? That's as loud as actually I can go.

MS. PAMELA S. HYDE: It's pretty -- it's pretty hard to hear. I apologize. Our system is --

MS. RENAE STARKS: I can hear you clearly. What did she ask? I'm sorry.

OPERATOR: Oh, no. I think someone was asking for someone that was actually on the phone line. Was it Kyle?

MS. PAMELA S. HYDE: Yes, Kyle Lloyd has written in some questions. I'm asking if he is on the line to make a comment?

OPERATOR: Give me one moment. As of right now, no one is signaling. Give me one moment to see if I can find that individual.

MS. PAMELA S. HYDE: Okay. In the meantime, we will read a couple of his comments. "How do we get from reactionary treatment methodology to proactive preventive treatment methodologies? This is the movement we really need." I think some of our comments and conversation have been about that today.

Kyle also says, "Is assertive community treatment being replaced, or is it still the best possible community SMI community support model?" And we haven't talked specifically about assertive community treatment, but clearly, ACT teams are clearly part of service delivery models for SMI.

"What's the current national barometer reading on peer support impact in the mental health field?" Paolo, I don't know if you want to say a word about what we're doing on peer supports while we're looking for other comments?

MR. PAOLO DEL VECCHIO: Sure. Imminently, like in the next day or so, we hope to post for public comment the draft core competencies that we've been working on for peer support workers, and that will be available for several weeks for people to provide comment on that. We're also in process of taking those core competencies to peer workers directly around the country to get their direct feedback on that, with our goal by the end of this fiscal year to have that available for public release.

MS. PAMELA S. HYDE: Great. So this is an area we're doing quite a bit of work in. We also have a comment from one of our other advisers who has been writing in. Jeremy Lazarus, do you remember him? Yesterday, he had to leave a little bit early yesterday, I think.

He says, "Do you think with the current trajectory with integration that there might be an opportunity for patients with serious mental illness being served in some fashion in integrated settings, as opposed to or in separate places? Or do you foresee better integration between integrated systems, ACOs, with SMI populations?"

I think we touched on some of that. So I don't know if you're still on the line, Jeremy, but thank you for the question and comment. And in fact, I think we'll go in a minute here, if any of our other advisers are still here and want to actually come on up to the table, if you want to ask a question or make a comment, we'll definitely do that as well.

Let me see if there's anything else we missed here. James says -- James

Gallant again says, "I'm waiting for answers on the questions posed concerning rules, guidelines for State, county suicide prevention planning."

Yes, absolutely, we have plans that every State provides us through their block grant funding. So each State should have that, and we've provided some guidance about how to do that to each State. It should be found in the block grant application. Anne was in here a little bit earlier. So if you want to look, James, in the block grant application when it comes out in the next few weeks, you should see it there.

He also asks about, "What about court-ordered legal rights?" And obviously, we are not the lawyers. We work with people who are in need of treatment, whether they come to us through courts or through other methods. We do a lot of work in co-funding the drugs courts, for example, and other criminal justice-related services in order to make sure that people who are involved in court systems or jail systems get access to treatment.

I think those are the main comments we have. Operator, are there other comments, other people who want to comment today?

OPERATOR: There are no further questions on the phone.

Agenda Item: Closing Remarks and Adjournment

MS. PAMELA S. HYDE: All right. Thank you so much.

Anything else from the rest of you here in the room today? Any final thoughts, anything else that's got your mind going at the moment, or have we filled you up enough? You've certainly filled us up. We always appreciate this. I can't tell you how much.

Lisa, come on up. Lori, come on up. Some other of our -- these are folks from -- Leighton, Sade, come on up. These are folks -- and I'm sorry. I just blanked on your name from the TAC. What, the guy -- no, the guy. Come on up. I'm sorry. Forgive me. I am blanking on your name. But he is another of our -- Adrian. He is another of our advisers. So you guys come on up. If you want to make a comment, please do.

Leighton?

DR. LEIGHTON Y. HUEY: As a member of another advisory council, the discussion today has been incredibly useful, and I don't want to pose any more logistical issues for you, Pam. But I think it would inform the work of the other advisory committees to have this caliber of discussion available and shared to them, to the groups.

MS. PAMELA S. HYDE: So you think we should do this first? We're always struggling with what are --

DR. LEIGHTON Y. HUEY: Well, I understand. I understand. That's why I'm saying I'm not trying to pose another logistical issue for you.

MS. PAMELA S. HYDE: Yeah, yeah.

DR. LEIGHTON Y. HUEY: But it is -- it would be very helpful. It would guide and inform the discussion.

MS. PAMELA S. HYDE: Right. Thanks for that feedback.

We actually really encouraged people to stay this time if you could because we thought you might appreciate the conversation. So thanks. We'll figure out -- we'll have to think about how to do that.

DR. LORI SIMON: Yeah, I absolutely second what Leighton said. It was just totally enjoyable for me to listen to this caliber of discussion, and I absolutely agree with that.

The one comment I just -- I mean, I have lots of comments, but I'll send you an email. But the one -- the one comment that I did want to just mention because we just saw the discussion about from ONC. The reality is, is that there are still a lot of problems with meaningful use and more so with behavioral health. And I'll just throw out a couple of statistics.

There are approximately 40,000 psychiatrists in this country, approximately. About half of those are in Medicare and/or Medicaid. So that's about 20,000. Of those, in 2013, 385 attested to meaningful use Stage 1.

I actually was one of them. And I actually was eligible or had to actually attest to Stage 2 last year, and when I started looking at it, because you have a little into the next year to do it, I realized I couldn't do it because I just had not done enough things that I needed to in order to satisfy the criteria.

Now if I'm having -- for those of you who don't know, I have a big background in computers. I worked in the computer field for 18 years before -- before becoming a physician. And I'm also involved with the American Psychiatric Association's health information technology in HL7s and indirectly SAMHSA, because SAMHSA is involved in HL7 as well in all their HIT efforts. So, so with my background, if I'm having a problem, you know, it's an issue.

I've also seen numbers floating around the last few weeks in emails I've been receiving because Stage 3, the rules have just come out for comment. And what I'm seeing is that only 2 percent, are the numbers I've seen, of eligible providers

have attested to Stage -- have been able to attest to Stage 2. So that's not just behavioral health.

The other thing that's extremely concerning to me, and this is not just behavioral health. I'm from the New York/New Jersey area, and what I'm starting to see is that more and more Medicare providers are not taking on any new Medicare patients.

That's not numbers that you're going to see. I was talking to Jeremy Lazarus yesterday, and he goes, well, you know, we track that through the AMA, and people aren't opting out so much. It's not that they're opting out because they're still treating their current patients. They're not taking on any new patients. And so, for me to even help a patient find a primary care provider who's on SSD in Connecticut, it was extremely difficult.

Now in terms of behavioral health, behavioral health providers have not been in Medicare as much as they probably should be. But in terms of incenting them, we're going the other way. And what I truly -- I'll just make one last statement. What I truly have come to believe is that the reason why more and more doctors are not taking on any new Medicare patients, it's not the money, the reimbursement money. Because the reimbursement money has always been known. It's less. You understand that. You just deal with it.

I think what's happening is because things like PQRS and meaningful use are putting more and more demands on providers, Medicare providers that they have to comply, and up until this year, this would have been an incentive-type thing. Now it's becoming punitive.

So as of 2015, if you haven't satisfied these criteria or submitted this data, you're being dinged percentage here, half a percentage there. So it's a huge issue.

MS. PAMELA S. HYDE: Yeah, I really appreciate that, Lori. And actually, when you send that email, will you make sure you cc Anne, with an "e", Herron, and Chris Carroll, who was just sitting here. Because they are kind of working together on this issue of payment barriers that we really want to understand and make sure we know what's going on.

On the meaningful use stuff, I think Karen knows that. I mean, I think she's really struggling, too, to try to help figure out how to do this. And it's getting harder even for regular docs, if you will, as opposed to the specialty docs as well.

All right. Sade?

MS. SADE ALI: Yes. Sade Ali from the CSAT NAC. I would just like to say you really worked us these last --

MS. PAMELA S. HYDE: I'm glad to hear that. We're going to get our --

MS. SADE ALI: Yeah, you really have.

MS. PAMELA S. HYDE: -- work. I mean, our money's worth.

MS. SADE ALI: Yes, you have. And, but sitting here today and listening to this dialogue, I have maybe a request that may not be able to be fulfilled, but I'd really like to see more presence of HHS here.

Because I think that the work that we are doing is so -- and the people who you gather to do this work and the minds around this table and in the national advisory councils that are represented around the country is so impressive, I'd like for HHS to not only for us to be able to see them, but for them to see us as well.

MS. PAMELA S. HYDE: Thank you.

We have had parts of HHS. Obviously, Karen and Patrick are from CMS and ONC. We've had HRSA people here before a couple different times. We've had Education, which is not HRSA, but another part of Federal Government.

Are there other people, and I think you might have been in the room when we said we have a standing person, who's just not here today, from the VA on this committee. Are there particular other parts of the HHS family you'd like to see here?

MS. SADE ALI: Well, you know, we talked about partnerships and working together, and I think that even on this level, it would be nice for us to be able to have dialogues with other -- other parts of the healthcare system that impact the work that we do. So that we know who they are and they know who we are as well.

MS. PAMELA S. HYDE: Okay. Thank you. Yeah, Ric?

DR. ERIC B. BRODERICK: Pam, if we're going to talk about families next time, I'd suggest ACF.

MS. PAMELA S. HYDE: Good idea. Okay, great. Lisa or Adrian, you have a question? Or thoughts, comments?

MS. LISA WADE: Hi, thank you. I wanted just to thank you for being able to sit here face-to-face.

This is my first meeting here, and I heard the word "partnership" thrown around a lot. And I also heard "funding challenges" thrown around a lot. And I think you

really can't look to a better source for dealing with issues of funding than tribes because, obviously, we're all stretched very thin.

And the word "partnership," you know, I never really thought of SAMHSA as a partner before because I always thought of you as a top-down organization that's bringing things to implement upon us. And I really think that it's important to consider the word "reciprocity" in this partnership. And so, you know, I'm coming from a place when you talk about this band of challenges from one place to another across America, you know, we have that in one State, 229 tribes with very different needs and very different value systems and all -- you know, all different kinds of challenges.

And I think the take-away for me here has been that there is kind of maybe a lack of understanding of some of the real challenges out there. I know you have a lot of great datasets, a lot of great data. I'd really like to see some more qualitative dialogue happening. And I would like to see that, you know, encouraged.

And I think this idea of funding challenge, you know, one of the things that I think seems most beneficial would be to really create some of those dialogues and get some of those partnerships brewing, some more collaborations. And you know, we work with some really effective coalitions in Alaska because we're stretched all over the place, and our resources are stretched really thin. And we've adopted a model of reciprocity even in our integrations where, you know, it's a responsibility for us in our healthcare in Alaska, as Alaska Native people.

We're customers. We're called customers. We have a responsibility in seeking our treatment and working with our providers collaboratively. And so, you know, I think there's a lot of good things to learn from going out and getting outside of this area and really working on a partnership, and I'd like to see that developed a little bit more. Coming from a small tribe, I don't know that I would feel that from an agency like this.

And I think there is a possibility for that, but I don't think it's there right now, and I think if you'd ask the majority of those 229 tribes in Alaska, I think they would probably echo similar statements. And I understood that there was a trip made up there, and I really -- you know, it's hard to envision how big Alaska is and how great the challenges. I mean, we all know what the statistics are about our State.

But I think that really it wouldn't be too much work to create some webinars and -- although the technology may be so, I don't know. But some webinars or some teleconferences where we can actually develop that partnership a little bit better and work on that reciprocity.

MS. PAMELA S. HYDE: Yeah, thank you for the comment. We are always struggling with how big and vast the country is and how big and vast the number of tribes are and how to get out to all of them. Our regional administrators are

doing a lot more being out there than -- I mean, we -- obviously, there's only a couple of us or six of us maybe here around the table at the leadership level. So we have made trips out to Alaska more than once.

We've made trips recently to the Plains. We've been to the Southwest, where I live, actually. I go there quite often. I was just with a tribe and on tribal lands last Monday. So we do different things, but we're trying to get, obviously, our grantees and our project officers, they have a lot more interactive discussions.

I think the question you're raising is sort of how do we do that more regularly using technology or some other ways? Because it's just literally impossible to do all the personal getting out there. But it is a struggle we constantly are aware of.

And actually, if I could just say one more thing because I was just dealing with it this morning? We just yesterday or the day before had the discussion with the TTAC, the STTAC about -- TTAC, whatever we're calling it at the moment -- about making sure that traditional practices get more attention and get in NREPP and stuff.

And we're getting pressure, I won't say where because it's not necessary, but pressure to move NREPP to a much more evidence-based, experimental, NIH-type experimental, quasi-experimental design, and nothing else. So, you know, we're just getting constantly pulled, and I'm actually pushing back a little bit and saying how are we going to make sure that we have practice -- thank you, practice-based evidence, and how are we going to respond to our Native colleagues who are asking us to pay more attention to those things right when we're being pulled to do it actually the exact opposite way?

And I think this whole 3 days has been about that tension that we are pulled in between doing more of this, don't do that. This is what people in the field tell us they need, but this is what Congress and our critics are telling us to do. So we are sort of constantly struggling with that, and that's not to say anything other than I recognize the struggle and I recognize the balance we're trying to create here.

So thanks for your comments, Lisa. It's really helpful. Kind of keeps us grounded in don't forget as we're getting pulled over here to keep this on the table. So thank you.

Adrian, you got any comment you want to make?

MR. ADRIAN SPOTTEDHORSECHIEF: Yeah, I'm Adrian SpottedHorsechief from the Pawnee Nation of Oklahoma, and you know, myself, this is my first time here. And not fully understanding what it is that was going to be discussed, you know, the person that usually comes up here wasn't able to be up here. So he sent me in his place.

But you know, listening and listened to all the discussion and dialogue that's going on, this is a very serious issue with substance abuse, mental health, you know? You know, as you look around the room, everybody here is different backgrounds, different understandings, beliefs, different homes, you know, different environments that they were growing up in, and that's the same way with indigenous tribes across this country.

You know, she talked about 200-some tribes up in Alaska. You know, in Oklahoma, we have 39 different tribes, you know? And I can't stress enough that we all have our own beliefs, our own traditions, our own culture, our own language, our own customs. We have different things, different views of the world, you know, than everybody else has.

And so, you know, yes, we could always sit there and say that we all bleed the same, and we do. And we all have issues, you know, the same. You know, but we all deal with them differently. And one of the things is that, you know, with that in mind of the differences that are per individual, you know, not one system is always going to work for that person, you know?

Myself, I worked at St. Anthony's Hospital in Oklahoma City in behavioral medicine, you know, and talking to the doctors and the therapists in there and stuff, you know, the things that they were talking about is that we -- we have this idea, philosophy, or practice that we use these treatment ways to help these children and adults, you know? And it's not going to work for everyone, you know?

It might work for a few, but it's not going to be that way for everybody. So, and I think that's the essence of the things that I think about is that, you know, if we could get to the point to where people could understand on a tribal aspect, I guess, each tribe and how they deal with things, even the areas or the locations, you know, that's a big factor, their environments. And so, I think that's the key to trying to take more steps forward of helping people.

The comments that was made earlier today, you know, we've talked about youth, having the youth involved. That's a great thing, but I think one of the things I heard today was about families. I think that's a huge thing because you're concentrating on youth, but what about the home? You know, what about the parents, grandparents, aunts and uncles, or whoever they're living with? Single parent, you know?

How everything works together, because you could give the tools to all these youth, but then when they go home, you know, and it's maybe a stressful environment. And it's kind of like this thing I said the other day is that, you know, we try our best to try to help these individuals, but then, you know, we kind of set them up for failure because we're putting them right back into the same situations

that they're coming from, you know?

And so, we have to look as far as trying to see to help continue to make things I guess you'd say like a better environment for them, you know? The tools that they need to try to help understand, you know, where they came from, how they overcame these obstacles, and now where they're getting ready to go back to, you know, which is usually ultimately the same environment.

You know, because at home where I'm at, you know, we have different issues that might be bad issues at other places. You know, meth? Meth is big in Oklahoma. I was telling some of the people it hasn't really hit our tribe that much.

It's not -- it's an issue that doesn't matter if it's one person or 50 or however, but it's not as bad as maybe prescription pills. That's huge in our tribe, you know? I know people that, you know, they sell things, you know, do whatever they have to do to try to get those pills. So somewhere in there, they got hooked on that, you know?

And so, it's trying to figure out what's -- I guess what the problem is and trying to get it taken care of. But other than that, you know, I could probably talk all day, but I'm just thankful to be here and to listen to what everybody is talking about here, and you know, I know we all got one common goal in sight. That's to help people.

So I thank everybody here for their input and everything that they're doing and just pray that things will get better, you know, as time goes on.

MS. PAMELA S. HYDE: Thanks a ton for your comments. Thanks to both of you for your new participation with our TTAC and our advisory committees.

Anything else anybody wants to say for the good of the order?

[No response.]

MS. PAMELA S. HYDE: Well, once again, just thank you for your time, your advice, your product, your smarts, your stimulation, and we will kind of have our heads swimming this weekend as we think about what to do next.

So appreciate it. Safe travels, everyone, back home.

[Whereupon, at 12:45 p.m., the meeting was adjourned.]