

# NASADAD /NPN/NTN Annual Meeting

June 7-10, 2011

The Westin Indianapolis  
Indianapolis, Indiana

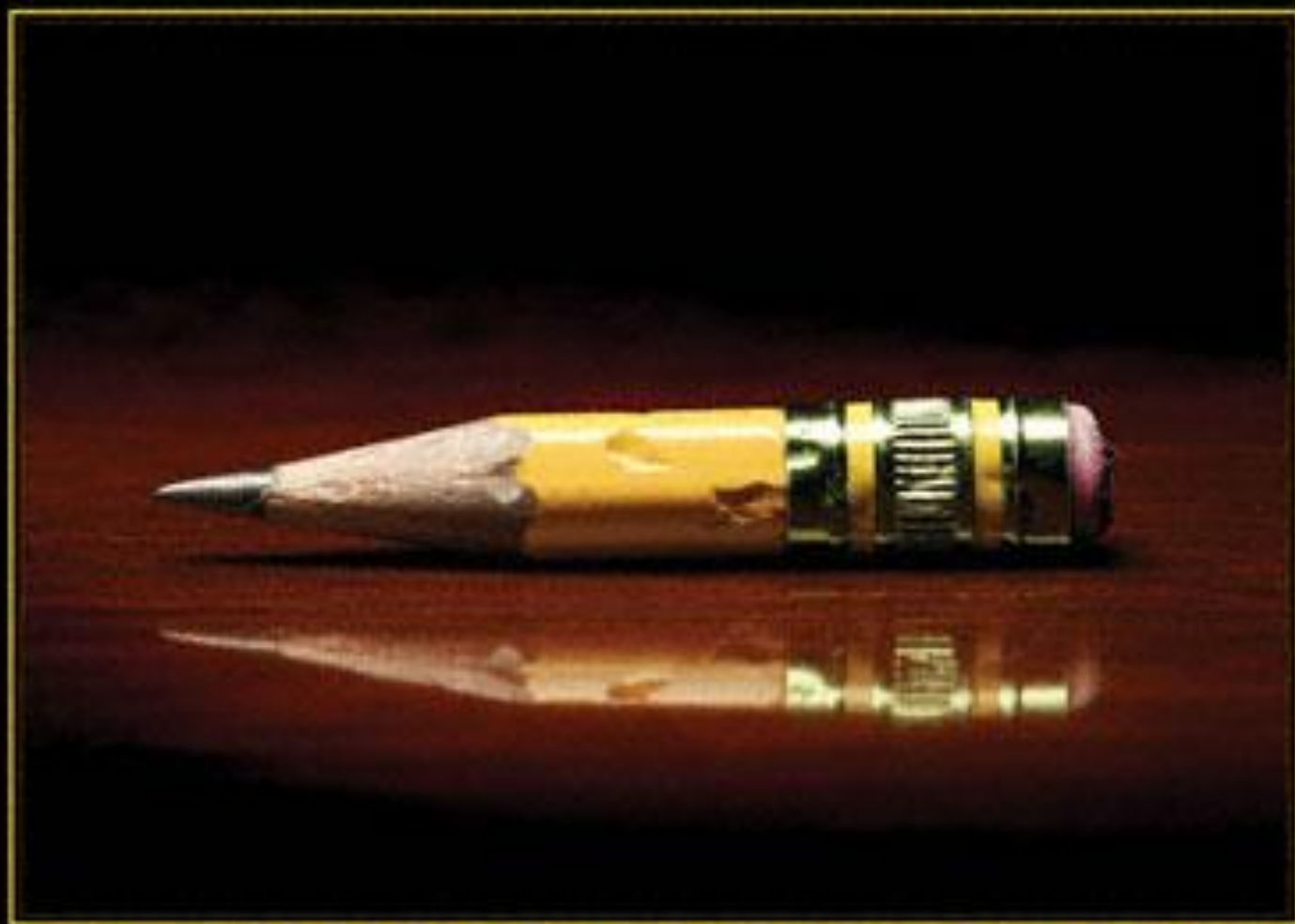
Robert W. Glover, Ph.D.  
Executive Director

The logo consists of a dark blue rounded rectangle with a white border. Inside the rectangle, the text "NASMHPD" is written in white, bold, uppercase letters.

**NASMHPD**

# Summary of Topics

- About (Me) NASMHPD
- NASMHPD Priorities
- Substance Abuse and Mental Health Collaboration and Integration
  - Brief Historical Overview
  - Environmental Drivers
  - Association Collaboration and Opportunities
  - Behavioral and Primary Health Integration



# RETIREMENT

BECAUSE YOU'VE GIVEN SO MUCH OF YOURSELF TO THE COMPANY THAT  
YOU DON'T HAVE ANYTHING LEFT WE CAN USE.

A light blue map of the United States is visible in the background, showing state boundaries. In the top left corner, there is a dark blue rounded rectangle with a white border containing the text 'NASMHPD'.

# **NASMHPD**

**Represents the \$36.7 Billion Public Mental Health System serving 6.4 million people annually in all 50 states, 4 territories, and the District of Columbia.**

**An affiliation with the approximately 220 State Psychiatric Hospitals: Serve 200,000 people per year and 50,000 people served at any point in time.**

# NASMHPD Structure

- NASMHPD's **Primary Members** – Commissioners/Directors of State and Territorial Mental Health Departments
- NASMHPD's **Structure** Includes 5 Divisions and one council -- Comprised of Agency Directors of Special Populations and Services
  - Children, Youth and Families
  - Financing and Medicaid
  - Forensic
  - Legal
  - Older Persons
  - Medical Directors Council

# NASMHPD Structure (cont.)

- Three **Affiliates**
  - National Association of Consumer/Survivor State Mental Health Administrators
  - Multi-State Disaster Behavioral Health Consortium
  - National Coalition on Mental Health and Deaf Individuals
- Purpose of Divisions, Council, and Affiliates is to Provide **Technical Assistance** and Expert Consultation to Commissioners on Issues Specific to those Populations
- **NASMHPD Research Institute, Inc. (NRI)**
  - a separate 501 c 3

# What is Driving NASMHPD's Current Priorities?



*USA Today*

*Front Page*

*Thursday,*

*May 3, 2007*



# People with Serious Mental Illness Experience 25 Years Lost Life: A Public Health Crisis

- Smoking
- Obesity
- Suicide
- Substance Abuse
- Inadequate  
Medical Care



Lutterman, T; Ganju, V; Schacht, L; Monihan, K; et.al. Sixteen State Study on Mental Health Performance Measures. DHHS Publication No. (SMA) 03-3835. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 2003.



# NASMHPD

## Vision:

Mental health is universally perceived as essential to overall health and well-being with services that are available, accessible, and of high quality.

## Mission:

NASMHPD serves as the national representative and advocate for state mental health agencies and their directors and supports effective stewardship of state mental health systems. NASMHPD informs its members on current and emerging public policy issues, educates on research findings and best practices, provides consultation and technical assistance, collaborates with key stakeholders, and facilitates state to state sharing.



## Guiding Values:

Recovery and resiliency are the overall goals and certain fundamental values guide NASMHPD in its mission:

Person- and family-centered

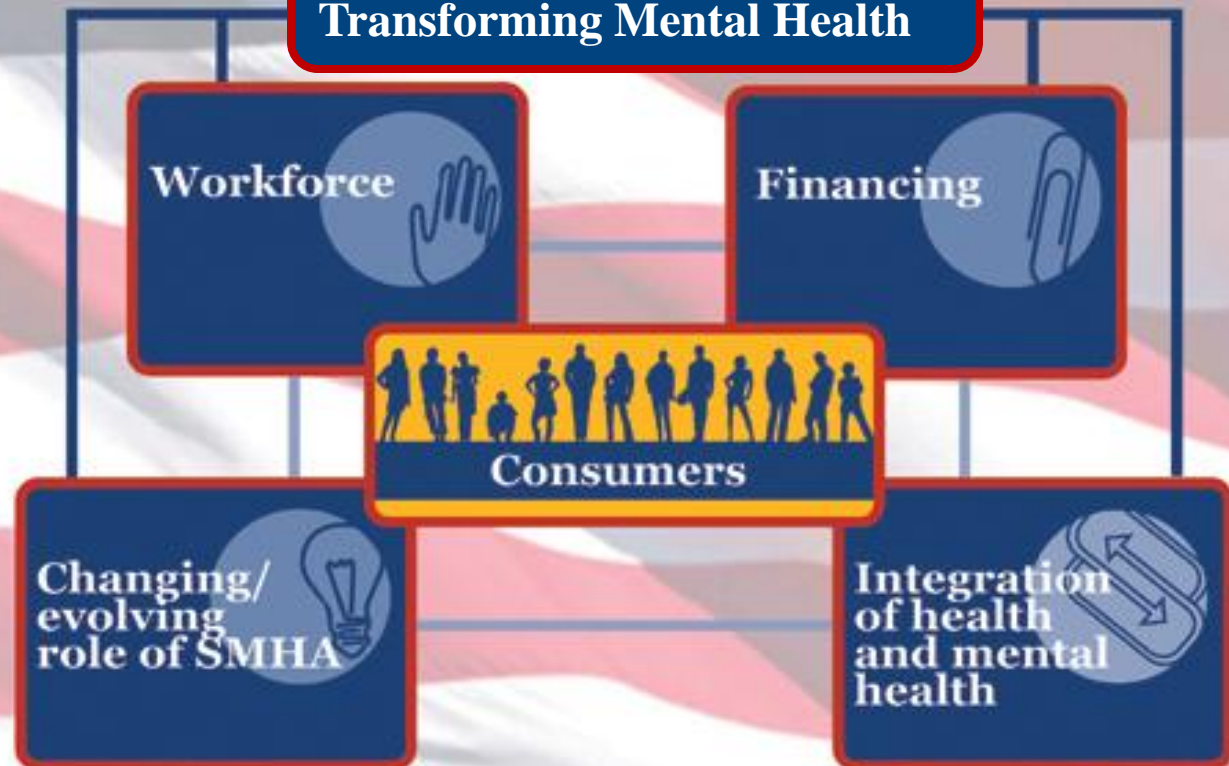
Integration of health and mental health services

Attention to prevention and early intervention

Community integration

Emphasis on diversity

## Priorities for NASMHPD Transforming Mental Health



*Recovery & Resiliency*

# Sharing with CMS

## NASMHPD's Vision and Priorities for a “Good and Modern” Behavioral Healthcare System

- Financing (Medicaid) (10 pages)
- Health Information Technology (HIT) (7 pages)
- Workforce (8 pages)

## NASMHPD Policy Brief

### Financing and the Public Mental Health System

#### I. Background

As the State Mental Health Authorities (SMHAs), NASMHPD members have an important role to play in the implementation of the Affordable Care Act (ACA) and the Mental Health Parity and Addictions Equity Act (MHPAEA). That responsibility demands effective partnership with the U.S. Department of Health and Human Services' Centers for Medicaid and Medicare Services (CMS) and Substance Abuse and Mental Health Services Administration (SAMHSA), as well as with State Medicaid Directors and Single State Authorities (SSAs) for State Substance Abuse Systems. Despite the growth in Medicaid's role, the financing of safety net behavioral health services remains largely a state responsibility with contributions from the Federal mental health and substance abuse block grants.

Demand for care and the complexity of the conditions affecting individuals seeking treatment is growing. The National Institute of Mental Health (NIMH) estimates that 26.2 percent of Americans – or roughly 57.7 million people – are affected by mental illness in any given year (NIMH, 2010). Approximately one-fourth of Americans will have a mental disorder in a given year, and almost half (46.4 percent) will be afflicted during a lifetime (NAMI, 2009). According to the 2008 National Survey of Drug Use and Health, approximately 22.2 million – or 8.9 percent – of the American population over the age of 12 were classified as having substance abuse or dependence in the prior year (SAMHSA, 2009). Many of these persons have historically had difficulty accessing care because their insurance plans lacked sufficient coverage for mental disorders or required higher out of pocket contributions for behavioral health care. Others lacked insurance coverage all together. Health reform cannot succeed in improving access, reducing costs and improving quality without the full inclusion of behavioral health in reforms of financing mechanisms, the delivery system, and quality.

Under the ACA provisions, increased numbers of uninsured individuals who are at-risk for or who have behavioral health conditions, will now be covered for care. The Kaiser Family Foundation (KFF) estimates that 15.9 to 22.8 million more children and adults will enroll in Medicaid by 2019, depending on the success of states' outreach efforts (KFF, 2010a). In a different study, researchers estimate that approximately 5.4 million uninsured persons with mental health and substance use disorders (MH/SUD) will obtain coverage through the expansion of Medicaid, while many more will gain coverage through the health insurance exchanges (Donahue et al., 2010). In addition to the expansion of coverage found in the ACA, expectations are rising about access to care as a result of the Mental Health Parity and Addictions Equity Act (MHPAEA). MHPAEA requires most health plans to increase coverage and eliminate discriminatory rules and payments, making benefits for mental health and addictions treatment comparable to the coverage provided for all other health conditions (MHPAEA, 2008). While the implementation of parity presents challenges, the parity law improves access to services for many individuals living with behavioral health conditions.

Both the ACA and MHPAEA create an unprecedented opportunity to implement comprehensive health insurance coverage, including coverage for mental health and substance use (MH/SU) conditions, for nearly all Americans. The ACA also contains provisions that address gaps in financing to support home- and community-based services, integration of behavioral health and primary care services, and delivery system models to reduce costs and improve quality. SMHAs play a vital role in the development, delivery, financing, and evaluation of mental health services within this rapidly evolving public healthcare environment and are poised to contribute their specific knowledge and experience in meeting the needs of citizens at risk for or with behavioral health conditions, with the effort to implement the reforms promoted by federal policy, program, and legislative initiatives. SMHAs remain committed to meeting needs of the most vulnerable persons, including those who may not be eligible for federally

## **NASMHPD Policy Brief Health Information Technology (HIT) and the Public Mental Health System**

### **I. Background**

Health Information Technology (HIT) is a critical component in the move to modernize healthcare to increase quality, reduce medical errors, and bend the cost curve of medicine by making healthcare more efficient. Two recent federal laws that have a major impact on overall healthcare HIT raise concerns due to their lack of full inclusion of mental health and substance abuse.

As part of the American Recovery and Reinvestment Act of 2009, the Health Information Technology for Economic and Clinical Health Act (HITECH Act) contains over \$22 billion to promote the adoption of Electronic Health Records (EHRs) by physicians, hospitals, and other health providers plus funding for the implementation of Health Information Exchanges (HIEs) that will allow health providers to share their EHR data to better coordinate and improve care. Unfortunately, mental health and substance abuse providers are excluded from virtually all EHR incentives and, in some states, are not active participants in the HIE planning and implementation.

The Affordable Care Act (ACA) of 2010 relies heavily on the use of EHRs and HIEs to “bend the cost curve” by making the expanded health coverage affordable to all. The ACA will focus on outcomes through the enhancement of Accountable Care Organizations (ACOs) and Health Homes as well as investing in prevention and wellness by giving service recipients more control over their own care. The ACA will greatly expand the number of individuals with mental health and substance abuse disorders who will now have insurance coverage for some of their treatment. The ability to obtain and share data related to outcomes will be adversely impeded by excluding mental health and substance abuse providers in HIT initiatives.

Persons with serious mental illness (SMI) experience high levels of co-morbid health conditions and die up to 25 years sooner than the general population. NASMHPD believes the benefits of integrating behavioral health data with health data are great and that appropriate policies and practices can be implemented that permit the sharing of behavioral health data while protecting the confidentiality and privacy of personal health information. However, some state HIE efforts are not fully including behavioral health in their planning and implementation. To the extent that state HIT systems have already begun to strategize and plan without fully including behavioral health, strong leadership is needed to ensure that health and behavioral health systems work in tandem.

The expansion of insurance coverage under the ACA will change the financing of mental health and substance abuse services. As states braid current and future funding streams and methodologies, NASMHPD strongly encourages that all of HHS work together to incorporate behavioral health into the design, implementation and use of EHR and HIEs in order to share data, improve outcomes and accountability while eliminating redundancy and burden in reporting.

These three HIT areas (EHRs, HIEs, and Federal Reporting) are all interrelated. If mental health providers are unable to implement EHRs, and if state and local mental health authorities are not included in planning for HIE, critical information from the mental health system will either not be fully included or have the ability to be integrated as primary care moves to electronic data-sharing. Without the development of HIEs that can accept electronic data from mental health providers while meeting all of the requirements of HIPAA, 42CFR, and other applicable statutes, even those providers that are able to implement EHRs will be unable to meet the HITECH Act’s “meaningful use” criteria regarding sharing of electronic data. In addition, mental health entities will be unable to utilize their electronic data to



## NASMHPD Policy Brief

### Workforce and the Public Mental Health System

#### I. BACKGROUND

There has been a widely recognized workforce shortage in the field of behavioral health for many years. It involves both specialty-level providers in mental health and addictions as well as primary care providers who frequently are needed to respond to persons with behavioral health needs. According to the Health Resources and Services Administration (HRSA), 77 million Americans live in areas that are not adequately served by substance abuse or mental health professionals, the majority of which are rural and remote.

That shortage will enter a crisis phase as the practical implications of parity and healthcare reform roll out over the coming months and years. The role of the specialty behavioral health sector will continue to change and modify, as it has in recent decades, but perhaps with more rapidity. The need for behavioral health services within primary care settings will be in much higher demand. The fact that so many individuals may have access to a new insurance benefit does nothing to change the reality of access to and availability of comprehensive and competent health services. Coverage does not equal availability.

In their review of behavioral health policy over the last fifty years, Frank and Glied summarized that the services and supports for people with serious and persistent mental illnesses were being performed “better but not well.” (Frank & Glied, 2006)<sup>1</sup>. Taken together, this suggests that both capacity needs and competency must be considered.

Effective workforce development strategies must address the following challenges: (a) recruitment and retention; (b) accessibility, relevance, and effectiveness of training; (c) staff competency in integrated care, evidence-based practices, and recovery-oriented approaches; (d) attitudes and skills in prevention and treatment of persons with mental and substance use conditions; (e) leadership development; and (f) workforce roles for persons in recovery and family members (Hoge et al., 2007).<sup>2</sup>

At this critical juncture, the Substance Abuse and Mental Health Services Administration (SAMHSA) and HRSA have engaged in a new partnership focused on developing national technical assistance capacity to support workforce development and the integration of behavioral health and primary care. It can be anticipated that there will be considerable growth in the provision of behavioral healthcare within primary care settings, including but not limited to Federally Qualified Health Centers, but there will also be the need for highly specialized services for adults with serious and persistent mental illnesses (especially those with co-morbid substance use conditions) and for seriously emotionally disturbed children, youth and their families. It is essential in the coming cascade of change that we address both of these environments and that we sustain the gains the field has made in its understanding of the importance of recovery and resilience for those historically served by the public behavioral health systems.

In this very fluid environment, it is anticipated that there will be a swirling confluence of vectors that will interact simultaneously, but the two most powerful may well be structural issues (how services are designed, administered, delivered and regulated) and how those services and supports are financed. Will reform push for unidirectional integration of behavioral health specialty competencies into primary care

<sup>1</sup> Frank, RG & Glied, SA. (2006). *Better But Not Well: Mental Health Policy in the United States Since 1950*. The Johns Hopkins University Press, Baltimore, MD.

<sup>2</sup> Hoge, M. A., Morris, J. A., Daniels, A. S., Stuart, G. W., Huey, L. Y., & Adams, N. (2007). *An action plan on behavioral health workforce development*. Cincinnati, OH: The Annapolis Coalition on the Behavioral Health. (Available on-line at [www.annapoliscoalition.org](http://www.annapoliscoalition.org) or at [http://www.samhsa.gov/matrix2/matrix\\_workforce.aspx](http://www.samhsa.gov/matrix2/matrix_workforce.aspx))

# Additional NASMHPD Priorities

- Housing
  - Policy Brief Being Developed
- Employment
- Trauma Informed Care
  - Health and Substance Abuse Implications

# Mental Health and Substance Abuse: Brief Historical Environmental Scan





# TRADITION

JUST BECAUSE YOU'VE ALWAYS DONE IT THAT WAY  
DOESN'T MEAN IT'S NOT INCREDIBLY STUPID.

# Historical Overview

- Has been focused on the differences between discrete mental health and substance use conditions
- Separation of administrative, financial, regulatory and program structures
- Mirrored in divided eligibility rules, professional standards, service models, delivery systems

# Common Ground Creation

- **1970s:** Collaboration and integration has long been a survival and delivery strategy in underserved rural areas and with disparities populations
- **1980s:** Behavioral Managed Care builds integrated care networks for Medicaid and other insurers
- **1990s:** Failures in parallel and sequential treatment approaches to serving individuals with dual disorders inspired integrated treatment models (ACT, IDDT, MTC), COSIG, Policy Academies
- **2000s:** Mental health transformation drives adoption of a core tenet of the substance abuse field – Recovery – creating critical common ground

# Mental Health and Substance Abuse Collaboration and Integration



# Environmental Drivers for Collaboration and Integration

- **Political/Administrative Structures:** 30 States integrate SSAs and SMHAs creating State Behavioral Health Authorities or Umbrella HHS Agencies
- **Consumer Needs:** inexcusable morbidity and mortality tied to complex co-occurring conditions
- **Economic Climate:** pressure for effective use of limited public resources
- **Eligibility and Payment:** 2014 expansion will secure Medicaid's dominance and standards



## Examples of Collaboration

- Joint NASMHPD-NASADAD Board Meeting (December 1, 2010)
- Quarterly Meetings of Public Sector Association Executive Directors
  - NASADAD, NASMHPD, National Association State Directors of Developmental Disability Services (NASDDDS), National Association of States United on Aging and Disabilities (NASUAD), National Association of Medicaid Directors (NAMD)

## Examples of Collaboration (Cont.)

- NASMHPD, NASADAD, and SAMHSA Jointly met with National Association of Insurance Commissioners (NAIC) (Winter 2010)
- CSG Justice Center Criminal Justice/Mental Health Consensus Project: A Framework for Responding to Adults with Behavioral Health Needs (Mental Illness, Addictions and Co-occurring Disorders) Under Correctional Supervision Expert Panel Meeting (May 24, 2011)
- CMS TAG Calls (Monthly)



# Joint NASADAD and NASMHPD Hill Advocacy

- The Capitol Hill representatives of NASADAD and NASMHPD have initiated joint advocacy around:
  - The FY 2011 Continuing Resolution
  - The FY 2012 Labor/HHS Appropriations Bill....particularly joint meetings with congressional staff in key U.S. Senate offices.
- **Objective:** Sustain bipartisan support for the *top line SAMHSA budget* across both addiction and mental health programs [with a particular emphasis on the MH and SAPT Block Grants].

# Additional National Association Collaboration Opportunities

- Meet demands of members for guidance and assistance on integration
- Reinforce recovery framework as shared vision for consumers
- Disseminate emerging knowledge on collaborative and integrated care results
- Institute joint policy, practice and training academies
- Provide technical assistance on integrated solutions and execution strategies
- **NASMHPD Research Institute, Inc. (NRI) - Joint Data Collection with NASADAD**

# Behavioral and Primary Health Care Integration

- Drivers: Consumer needs, primary and specialty care professional supply shortages, quality improvement and performance payment initiatives
- Issue: Will mental health and substance abuse be integrated as separate subspecialties or as a behavioral health specialty?
- Issue: Will collaborative or integrated delivery models dominate?
- Issue: Will Medicaid response to high risk/high cost members drive the design?

# We're All In This Together!

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## ACQUISITION

THE DISCOVERY THAT YOU'RE NO LONGER A BIG FISH IN A SMALL POND,  
OR EVEN A SMALL FISH IN A BIG POND, BUT A SMALL FISH IN A BIG FISH.