The Changing Landscape for Behavioral Health

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Behavioral Health: A National Priority

SAMHSA’s Mission: Reduce the impact of substance abuse and mental illness on America’s communities

- Behavioral health is essential to health
- Prevention works
- Treatment is effective
- People recover
SAMHSA’s Strategic Initiatives

1. Prevention of Substance Abuse and Mental Illness
2. Health Care and Health Systems Integration
3. Trauma and Justice
4. Recovery Support
5. Workforce Development

SI #2: Health Care & Health Systems Integration

Goals:
- Integration between behavioral health and health care, social support, and prevention systems.
- Support federal, state, territorial, and tribal efforts to develop and implement new provisions under Medicaid and Medicare.
- Support federal, state, territorial, and tribal efforts to influence and support financing models and mechanisms to address behavioral health services.
- Finalize and implement provisions in the Mental Health Parity and Addiction Equity Act (MHPAEA) and the Affordable Care Act,
- Implement quality indicators to advance behavioral health outcomes in the health care.
What do we know?

Table 1. Chronic Health Conditions among Persons Aged 18 or Older with and without Mental Illnesses in the Past Year: 2008 and 2009

<table>
<thead>
<tr>
<th>Mental Illness</th>
<th>High Blood Pressure %</th>
<th>Asthma %</th>
<th>Diabetes %</th>
<th>Heart Disease %</th>
<th>Stroke %</th>
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</thead>
<tbody>
<tr>
<td>Any Mental Illness (AMI)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>21.9</td>
<td>15.7</td>
<td>7.9</td>
<td>5.9</td>
<td>2.3</td>
</tr>
<tr>
<td>No</td>
<td>18.8</td>
<td>10.6</td>
<td>6.6</td>
<td>4.2</td>
<td>0.9</td>
</tr>
<tr>
<td>Serious Mental Illness (SMI)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>21.6</td>
<td>19.1</td>
<td>7.7</td>
<td>5.2</td>
<td>2.6</td>
</tr>
<tr>
<td>No</td>
<td>17.7</td>
<td>12.1</td>
<td>6.6</td>
<td>4.2</td>
<td>1.1</td>
</tr>
<tr>
<td>Major Depressive Episode (MDE)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>24.1</td>
<td>17.0</td>
<td>8.9</td>
<td>6.5</td>
<td>2.5</td>
</tr>
<tr>
<td>No</td>
<td>19.8</td>
<td>11.4</td>
<td>7.1</td>
<td>4.6</td>
<td>1.1</td>
</tr>
</tbody>
</table>

Note: All percentages were adjusted for (a) age group, (b) gender, (c) race/ethnicity, (d) education, (e) marital status, (f) current employment status, and (g) county type/metropolitan status. All associations between mental illnesses and chronic health conditions are statistically significant at the 0.05 level, except for marginally significant associations for SMI and diabetes (significant at the 0.10 level) and SMI and heart disease (significant at the 0.10 level).

Source: 2008 and 2009 SAMHSA National Surveys on Drug Use and Health (NSDUHs).
Overview of Primary Care and Behavioral Health Care Integration (PBHCI)

Primary and Behavioral Health Care Integration

- Improve the physical health of people with SMI by supporting communities to coordinate and integrate primary care services into publicly funded behavioral health settings
- Grantees will form partnerships to develop or expand their offerings with primary health care services for people with SMI, thus improving overall health status
- Eligible applicants comprise community behavioral health agencies in partnership with primary care providers
What are we learning?

• **PARTNERSHIP MODELS**
  – Partnering with a Community Health Center
  – Partnering with a Hospital
  – Implementing Integration on Own

• **ENGAGEMENT**
  – Leadership (organization, local, state) Engagement
  – Client Engagement
  – Community Engagement

• **WELLNESS ACTIVITIES**
  – Tobacco Cessation
  – Dental Services
  – Physical Activity
  – Nutrition
  – Diabetes Prevention and Control

What are we learning?

• **WORKING WITH SPECIFIC POPULATIONS**
  – Racial/Ethnic/LGBT Populations
  – Consumers who Experience Homelessness
  – Rural Populations
  – Deaf Consumers

• **OPERATIONS**
  – Team-based Care (roles and responsibilities), including workflow analysis
  – Continuous Quality Improvement Practice
  – Culture Change (primary care “versus” behavioral health)
  – Use of Health Information Technology
  – Sustainability Planning
PBHCI Program Profile

Physical Health Outcomes

Mental Health Symptoms

Baseline | 6-Month | 12-Month
---|---|---
15.3 | 12.9 | 12.2
Mean Score

No. of Participants

SAMHSA
SAMHSA PBHCI Grantees

Community Behavioral Health Organizations
- Majority are CMHCs, ~40+% are SA providers
- 79% partnering with a Federally Qualified Health Center (FQHC)
- Served over 60,000 adults with SMI and/or COD

Grantee Cohorts:
- 13 awarded 2009
- 43 awarded 2010
- 8 awarded 2011
- 30 awarded 2012
- 6 awarded 2013
- 26 awarded 2014
- 59 awarded 2015

West Regional Cluster (HHS Region 9 and 10)
*Active grantees in bold*

**Region 9 - San Francisco**
- AZ: CODAC Behavioral Health Services (I)
- AZ: Community Partners, Inc. (VIII)
- CA: Alameda County Behavioral Health Care Services (II)
- CA: Asian Community Mental Health Services (III)
- CA: Catholic Charities of Santa Clara County (IV)
- CA: County of Sonoma (VII)
- CA: San Luis Obispo County BH Department (IX)
- CA: Didil Hirsch Community Mental Health Center (V)
- CA: Glenn County Health Services Agency (III)
- CA: Kedren Community Mental Health Center (VII)
- CA: Mental Health Systems, Inc. (I)
- CA: Monterey County Health Department (V)
- CA: Native American Health Center, Inc. (V)
- CA: Ocean Park Community Center (VIII)
- CA: Placer County Health and Human Services (VIII)
- CA: San Francisco Department of Public Health (IV)
- CA: San Mateo County Health System (III)
- CA: Southern California Health and Rehabilitation Program (VIII)
- CA: Tarzana Treatment Centers, Inc. (III), (VII), (VIII)
- HI: State of Hawaii Department of Health (VII)

**Region 10 – Seattle**
- AK: Alaska Islands Community Services (III)
- AK: Juneau Alliance for Mental Health (VIII)
- AK: Southcentral Foundation (V)
- OR: Native American Rehabilitation Association of the Northwest (II)
- OR: Cascadia Behavioral Healthcare, Inc. (V)
- OR: Wallowa Valley Center for Wellness (VIII)
- WA: Asian Counseling and Referral Service (III)
- WA: Downtown Emergency Service Center (III)
- WA: Navos (IV)
Healthcare Integration & System Transformation: Region X

- **Alaska**: Medicaid Reform and Criminal Justice Reform legislation passed 2016; system redesign will utilize 1115 waiver
- **Idaho**: 1915(b) waiver to integrate MH and SUD system in Statewide managed care (2013)
- **Oregon**: Multiple waivers/CMMI funding to create Coordinated Care Organizations (CCO’s)
- **Washington**: BHO implementation, April 2016; full integration by 2020.

Tribal Models of Integration

Kenaitze Tribe
- [https://www.kenaitze.org/denaina-wellness-center/](https://www.kenaitze.org/denaina-wellness-center/)

Muckleshoot Tribe

Southcentral Foundation
- [https://www.southcentralfoundation.com/](https://www.southcentralfoundation.com/)
Since 2010 CIHS has served as a national training and technical assistance center on the bidirectional integration of primary and behavioral health care.

- CIHS is jointly funded by the Substance Abuse and Mental Health Services Administration (SAMHSA) and Health Resources and Services Administration (HRSA).
- CIHS is run by the National Council for Behavioral Health.
- The Center’s primary goals are to:
  - Support relevant funded grants and cooperative agreements working to integrate primary and behavioral health care, providing training and technical assistance (TTA) to communities with cooperative agreements awarded by SAMHSA and HRSA.
  - Develop materials about integrated care for a national audience meeting the needs of SAMHSA and HRSA through researching, developing and disseminating critical information and documents, therein creating greater awareness of the importance of integrating primary and behavioral health care to the overall health of the nation.
Center for Integrated Health Solutions

• Target Populations
  – SAMHSA Primary & Behavioral Health Care Integration (PBHCI) Grantees
  – SAMHSA Minority AIDS Initiative Continuum of Care (MAI-CoC) Grantees
  – HRSA Behavioral Health Expansion Grantees
  – Broad Stakeholder Community

Services Available from CIHS

• Tools:
  – Web-based Resources (http://www.integration.samhsa.gov)
  – Curated Content / Snackable Content
  – Issue Briefs and Factsheets
  – Monthly eSolutions Newsletter

• Group Learning Experiences:
  – Regional and Online Learning Communities
  – Trainings and Presentations
  – National Webinars

• Individual Technical Assistance:
  – Phone and video consultations, e-mail, site visits
For More Information & Resources

- Visit www.integration.samhsa.gov or e-mail integration@thenationalcouncil.org

Some Thoughts about Integration

- Health care specialties speak different languages
- SUD services and MH services are not fully integrated
- Integration requires re-education/re-orientation
- One model is not universally applicable
- Integration should be bi-directional
- The journey to full integration will be a long and winding road, with bumps and potholes along the way
What are we trying to achieve?

A person-centered system of care that realizes improved outcomes and better services and value.

MODERNIZING 42 CFR PART 2
Congress recognized that the stigma associated with substance use disorders and fear of prosecution deterred people from entering treatment, and enacted the statute authorizing 42 CFR part 2 to ensure an individual’s right to privacy and confidentiality.

For decades 42 CFR part 2 has been in the vanguard of personal privacy protections and the cornerstone of treatment programs across the country.

BASICS: 42 CFR Part 2

- Implements federal drug and alcohol confidentiality law (42 U.S.C. §290dd-2).
  - Protects confidentiality of the identity, diagnosis, prognosis, or treatment of any patient records maintained in connection with the performance of any federally assisted program or activity relating to substance abuse education, prevention, training, treatment, rehabilitation or research.
CONTEXT: 42 CFR Part 2

The law and regulations were written during a time of great concern about the potential use of substance use disorder information against an individual.

The purpose of 42 CFR part 2 is to ensure that a patient receiving treatment for a substance use disorder in a part 2 program is not made more vulnerable than an individual with a substance use disorder who does not seek treatment.

WHY REVISE 42 CFR PART 2?

Regulations first promulgated in 1975 and last substantively updated in 1987.

Significant changes have impacted health care delivery since then:

- New models of integrated care that rely on information sharing to support coordination of patient care.
- Electronic infrastructure for information exchange.
- New focus on performance measurement.
CONSIDERATIONS IN REVISION 42 CFR PART 2

Breach of privacy of information protected by part 2 can still lead to civil and criminal consequences for patients, including:

- Loss of employment, housing, child custody.
- Discrimination by medical professionals and insurers.
- Arrest, prosecution and incarceration.

PREVENTING UNINTENDED CONSEQUENCES

Importantly, the consequences of fewer and laxer privacy controls and regulations can disproportionally penalize minority, underserved, and otherwise marginalized populations.

- In this context, loosening privacy controls could increase rather than reduce health disparities, and impede rather than promote access.
LISTENING TO THE PUBLIC

- SAMHSA held a Public Listening Session in 2014 to solicit feedback on 42 CFR part 2.
  - Approximately 1,800 individuals participated in the session (in person or by phone).
  - SAMHSA received 112 oral comments and 635 written comments.

THE PROCESS: 42 CFR PART 2 NPRM

- In addition to considering the wealth of public input received from the Listening Session, SAMHSA collaborated with its federal partner experts in developing the NPRM.
- NPRM published in the Federal Register on February 9, 2016 (81 FR 6988).
- Comment Period was 60 days and closed on April 11, 2016.
- 376 comments were received.
Final rule published in the Federal Register on January 18, 2017 (82 FR 6052).

Federal Register effective date initially scheduled for February 17, 2017.

Review by the administration resulted in a revised effective date of 3/21/2017.


Snapshot of Final Rule Major Provisions
PROTECTION AND FACILITATION

Final rule is intended to modernize the part 2 rules by facilitating the electronic exchange of substance use disorder information for treatment and other legitimate health care purposes while ensuring appropriate confidentiality protections for records that might identify an individual, directly or indirectly, as having a substance use disorder.

LANGUAGE MATTERS

In the final rule, SAMHSA made terminology changes throughout for clarity, consistency, and to modernize the regulations (e.g., from “alcohol and drug abuse” to “substance use disorder”).

- SAMHSA changed the name of the regulations to: Confidentiality of Substance Use Disorder Patient Records.
CONSENT REQUIREMENTS (§2.31)

The final rule:

• Allows, in certain circumstances, a patient to include a general designation in the “To Whom” section of the consent form.
  — Distinction between those with and without a treating provider relationship with the patient.

• Requires an explicit description of the “Amount and Kind” of substance use disorder treatment information.

CONSENT REQUIREMENTS (§2.31) (cont.)

The final rule retains the “From Whom” provision of the 1987 regulations (as amended) with minor updates to terminology.

• The final “From Whom” provision of the consent requirements specifies that a written consent to a disclosure of patient identifying information must include the specific name(s) or general designation(s) of the part 2 program(s), entity(ies), or individual(s) permitted to make the disclosure.
CONSENT REQUIREMENTS (§2.31) (cont.)

⇒ The final rule requires the consent form to include a statement that the patient understands:
  • When using a general designation in the “To Whom” section, their right to obtain, upon request, a list of entities to whom their information has been disclosed, pursuant to the general designation (see §2.13).

⇒ The final rule permits electronic signatures (to the extent that they are not prohibited by any applicable law).

CONFIDENTIALITY RESTRICTIONS & SAFEGUARDS (§2.13)

⇒ The final rule requires that, upon request, patients who have included a general designation in the “To Whom” section of the consent form must be provided a list of entities to whom their information has been disclosed pursuant to a general designation (List of Disclosures).
  • However, in the final rule, SAMHSA clarified that the entity that serves as an intermediary, NOT the part 2 program, is responsible for complying with the List of Disclosures requirement.
The final rule clarifies that the general designation on the consent form may not be used until entities required to comply with the List of Disclosures provision have the ability to do so.

SAMHSA may issue subregulatory guidance on this provision.

The final rule clarifies that the prohibition on re-disclosure only applies to information that would identify, directly or indirectly, an individual as having been diagnosed, treated, or referred for treatment for a substance use disorder, such as indicated through standard medical codes, descriptive language, or both, and allows other health-related information shared by the part 2 program to be re-disclosed, if permissible under other applicable laws.
PROHIBITION ON RE-DISCLOSURE (§2.32) (cont.)

SAMHSA made some additional minor clarifying revisions to §2.32 relative to:

- The use of general authorizations.
- The restrictions on using information to criminally investigate or prosecute a patient with a substance use disorder.

APPLICABILITY (§2.12)

- Applicability is based on the definition of Program, which did not change except for updating terminology.
- Consistent with SAMHSA’s previous FAQ guidance, a practice comprised of primary care providers could be considered a “general medical facility” and be subject to 42 CFR part 2 if the practice is both "federally assisted” and meets the definition of a program under § 2.11.
SECURITY FOR RECORDS (§2.16)

The final rule:

- Addresses **both paper and electronic records**.
- Clarifies that both part 2 programs and other lawful holders of patient identifying information must have in place formal policies and procedures for the security of records, including sanitizing media associated with both paper and electronic records.

SECURITY FOR RECORDS (§2.16) (cont.)

- Must reasonably protect against unauthorized uses and disclosures of patient identifying information and protect against reasonably anticipated threats or hazards to the security of patient identifying information.
- Replaces relevant language in other sections with reference to the policies and procedures requirement in §2.16.

⇒ SAMHSA may provide subregulatory guidance on this provision.
MEDICAL EMERGENCIES (§2.51)

- The final rule revises the medical emergency exception to make it consistent with the statutory language and to give providers more discretion to determine when a “bona fide medical emergency” exists.
- SAMHSA is considering issuing subregulatory guidance addressing this provision.

RESEARCH (§2.52)

- The final rule allows a part 2 program or other lawful holder of patient identifying information to disclose part 2 data to qualified personnel for purposes of conducting scientific research if the researcher provides documentation of meeting certain requirements for existing protections for human research (HIPAA and/or HHS Common Rule).
Thank You!

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