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BEHAVIORAL HEALTH UPDATE: July 2016
A Monthly Report for Members
of the American Hospital Association www.aha.org and the
National Association of Psychiatric Health Systems, www.naphs.org

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1. CMS delays data-collection of three IPF Quality Reporting measures to January 1, 2017.
2. Updated IPFQR resources are online.
3. AHA and NAPHS urge CMS to reconsider three measures included in proposed rule on future IPF quality reporting measures.
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1. **CMS DELAYS DATA-COLLECTION OF THREE IPF QUALITY REPORTING MEASURES TO JANUARY 1, 2017.** The Centers for Medicare and Medicaid Services (CMS) has postponed until January 1, 2017, the collection of data for three measures in the Inpatient Psychiatric Facility Quality Reporting (IPFQR) Program. These measures are "Transition Record with Specified Elements Received by Discharged Patients" (#0647); "Timely Transmission of Transition Record Measures" (#0648), and "Screening for Metabolic Disorders" (not NQF-endorsed). IPFs were

originally to begin collecting these measures starting July 1, 2016. Data-collection that begins on the revised date of January 1, 2017, will apply to the Fiscal Year (FY) 2019 payment determination. IPFs will be required to report all four quarters of data or face a payment reduction. Reporting periods for all other measures remain unchanged. In an email to IPFQR facilities, CMS said that "since the adoption of the measures, we have received a number of requests for further information, as well as questions concerning their interpretation. These issues were only addressed in full in the most recent updates to the IPFQR Program Manual and the Outreach and Education webinar, which reviewed those changes. Accordingly, we have further delayed the initial collection of these measures to allow providers sufficient time to incorporate this updated information into their collection operations." In May, the American Hospital Association, National Association of Psychiatric Health Systems, Federation of American Hospitals, and the National Association of State Mental Health Program Directors' Research Institute (NRI) sent a joint letter urging CMS to postpone the data collection after hearing from members that the measure specifications were still in flux, which greatly inhibited their ability to accurately collect data. For more information on IPFQR issues, contact the CMS program's support team at https://cms-ip.custhelp.com or 844-472-4477 or 866-800-8765.

2. **UPDATED IPFQR RESOURCES ARE ONLINE.** Newly-updated tools (including a program manual and paper abstraction tools) are now available online to assist facilities participating in the Inpatient Psychiatric Facility Quality Reporting (IPFQR) Program. Key updates to the *IPFQR Program Manual* include a refined definition of terms for the "Transition Record with Specified Elements Received by Discharged Patients" and the "Timely Transmission of Transition Record" measures; an algorithm to identify the initial patient population for the "Transition Record Measures"; and additional information for the "Screening for Metabolic Disorders" measure (Measure Information Form, algorithm, and data element dictionary). In addition, two new and one updated paper abstraction tools for the IPFQR Program are online. These tools provide an optional, informal abstraction mechanism to assist IPFs in the collection of data for the IPFQR Program. New are "Data Collection Tool for the Transition Record with Specified Elements Received by Discharged Patients and Timely Transmission of Transition Record Measures" and "Data Collection Tool for the Screening for Metabolic Disorders Measure." Updated is a "Non-Measure Data Collection Tool." Access all documents on the Quality Reporting Center website (under "IPFQR Program Resources and Tools"). All will also be available on the IPFQR Program "Resources "page of the QualityNet website at a later date. For further background, also see a recording, presentation transcript, and slides from an IPFQR Program webinar (originally held June 8) titled "IPFQR Program 101 and New Measures Review." The archived webinar reviews resources pertaining to specifications for three new measures.

3. **AHA AND NAPHS URGE CMS TO RECONSIDER THREE MEASURES INCLUDED IN PROPOSED RULE ON FUTURE IPF QUALITY REPORTING MEASURES.** In separate comment letters, both the American Hospital Association (AHA) and National Association of Psychiatric Health Systems (NAPHS) submitted comments to the Centers for Medicare and Medicaid Services (CMS) on a proposed rule updating requirements for the Inpatient Psychiatric Facility Quality Reporting (IPFQR) Program. Both AHA and NAPHS advocated against inclusion of two substance use measures (SUB-3: "Alcohol & Other Drug Use Disorder Treatment Provided or Offered at Discharge," and subset SUB-3a: "Alcohol & Other Drug Use Disorder Treatment at Discharge") proposed for FY2019 payment determination. The AHA comment letter (see page 34) said that "we believe CMS has not adequately explored whether this measure is needed for improvement…..To add a quality measure that will increase burden on IPFs, without fully knowing whether it has the potential to improve quality, is premature and misguided." In the NAPHS comment letter, NAPHS added that the "SUB suite of measures does not appropriately address the needs of patients in psychiatric inpatient services" as they "were developed to be population screening measures." Both associations also did not support the measure of "Thirty-Day All-Cause Unplanned Readmission Following Psychiatric Hospitalization in an Inpatient Psychiatric Facility (IPF)." According to the AHA letter, "The AHA

does not support the inclusion of this measure for numerous reasons, including the fact that it has not been reviewed and endorsed by NQF." AHA suggested that that the proposed measure not be included in the program until it has been adjusted for sociodemographic factors. "Measures that fail to adjust for sociodemographic factors, when there is a relationship between those factors and the measure outcome, lack credibility, unfairly portray the performance of providers caring for more complex populations, and may serve to exacerbate health care disparities," AHA wrote. NAPHS recommended review of the 24-month timeframe for collection of this measure data to determine a facility-level sample size. "We also recommend very careful monitoring of the results of the Medicare claims data review as it relates to readmissions based on our concerns with the strength of empirical evidence of the link between the quality of inpatient care and the rate of readmission," NAPHS wrote.

4. **IPF QUALITY REPORTING PROGRAM DATA-SUBMISSION PERIOD HAS BEEN SHORTENED; WILL RUN FROM JULY 19 TO AUGUST 15 IN 2016**. The Centers for Medicare and Medicaid Services (CMS) has announced that the Inpatient Psychiatric Facility Quality Reporting (IPFQR) Program's data-submission period has been re-scheduled to begin on Tuesday, July 19, and end on Monday, August 15. An email to the field noted that CMS "acknowledges that this delayed start date will result in a shortened, four-week data submission period. CMS would like to call attention to the following steps that have been taken to facilitate your processes in light of the shortened submission period." CMS has 1) removed age strata and quarters from the *QualityNet Secure Portal* web-based data collection tool, significantly reducing data entry burden; 2) provided screen shots and general data submission guidance via the IPFQR Program Manual dated June 7, 2016; and 3) arranged for a step-by-step review of instructions on the data submission process during a July 7 IPFQR Program webinar titled "IPFQR Program: Keys to Successful FY 2017 Reporting" (go to www.qualityreportingcenter.com for details on registering for the 2pm Eastern webinar). All of the following requirements must be completed by August 15 in order to qualify for receipt of the full Annual Payment Update (APU). First, each provider must ensure that the facility has at least one active Security Administrator (SA) as of August 15. If you are not sure of your SA status, you can check with the *QualityNet* Help Desk at 866-288-8912. Second, you must complete a Notice of Participation (NOP), unless one is already on file. If an NOP is on file, then no action is required, as it will carry over year after year. IPFs that decide not to participate in the IPFQR Program should call the IPFQR Program Support Contractor at 866-800-8765 regarding next steps. Third, IPFs must submit aggregate data for each of the following measures: Hospital Based Inpatient Psychiatric Services (HBIPS-2, -3, -5); Substance Use (SUB-1); Tobacco Use (TOB-1, -2/-2a); Influenza Immunization (IMM-2); Use of Electronic Health Record; and Assessment of Patient Experience of Care. (*IMPORTANT REMINDER:* CMS has delayed reporting of three measures – 2 transition of care measures and metabolic screening – until January 1, 2017.) Fourth, IPFs must complete the Data Accuracy and Completeness Acknowledgement (DACA). The opportunity to correct or otherwise modify your data ends on the August 15 data submission deadline. CMS encourages all participating hospitals to submit data at least two days prior to the deadline to allow time to address any submission issues. For assistance, contact the Hospital Inpatient Value, Incentives, and Quality Reporting Outreach and Education Support Team at https://cms-ip.custhelp.com or 866-800-8765.

5. **HOUSE ENERGY AND COMMERCE COMMITTEE UNANIMOUSLY PASSES MENTAL HEALTH REFORM BILL.** On June 15, the House Energy and Commerce Committee voted 53-0 to approve the *Helping Families in Mental Health Crisis Act* (H.R.2646) after several modifications were made to the bill as a result of bipartisan negotiations. In separate comment letters both the AHA and NAPHS expressed support for the bill and specific provisions, including the bill's call to codify a Medicaid managed care regulation allowing optional state coverage of Institutions for Mental Disease services for adults and to reauthorize suicide prevention programs, among others. See the AHA letter and the NAPHS letter. Both organizations committed to working with Congress to advance comprehensive mental health reform legislation.

6. **SENATE AND HOUSE CONFEREES TO BEGIN NEGOTIATIONS ON OPIOID LEGISLATION IN JULY.** House and Senate conferees will begin meeting the first week of July to reconcile both chambers' bills aimed at addressing the opioid crisis. The Senate passed the *Comprehensive Addiction and Recovery Act*, S.524, in March, and the House passed several bills related to opioids in May. The Senate has designated seven conferees to work with House Republican conferees and House Democratic conferees. The Senate's conferees will be the chairs and ranking Democrats from three committees (**Sens. Chuck Grassley** (R-IA) and **Patrick Leahy** (D-VT) of the Judiciary Committee; **Sens. Lamar Alexander** (R-TN) and **Patty Murray** (D-WA) of the Health, Education, Labor and Pensions Committee; and **Sens. Orrin Hatch** (R-UT) and **Ron Wyden** (D-OR) of the Finance Committee); as well as **Sen. Jeff Sessions** (R-AL).

7. **AHA AND NAPHS COMMENT ON MEDICATION-ASSISTED TREATMENT PROPOSED RULE.** In separate comment letters, both the American Hospital Association (AHA) and National Association of Psychiatric Health Systems (NAPHS) provided feedback to the Substance Abuse and Mental Health Services Administration (SAMHSA) on its proposed rule on "Medication Assisted Treatment for Opioid Use Disorders." The proposed rule would revise the highest patient limit for the prescribing of buprenorphine from 100 patients per practitioner with an existing waiver to 200 patients for practitioners that meet certain conditions. In the AHA comment letter, AHA's Senior Vice President of Public Policy Analysis and Development Ashley Thompson noted that the AHA supports SAMHSA's proposal to increase the number of patients a physician may treat with buprenorphine for opioid use disorder. **"**Every day hospitals see the devastation caused by the opioid epidemic, and they appreciate the many steps the administration is taking to support providers and first responders as they work to save lives," the letter said. "Increasing the patient treatment limits for MAT is aligned with other important federal government actions, such as the allocation of additional federal funding for MAT, as well as Naloxone, and the development of opioid prescribing guidelines for chronic pain by the Centers for Disease Control and Prevention (CDC)." NAPHS also supported the proposed rule. In the NAPHS comment letter, NAPHS President and CEO Mark Covall also noted that raising the limit from 100 to 200 patients "is just one step in addressing this opiate epidemic. At the same time that the limit is raised," he said, "we as a nation need to build a much stronger infrastructure for treating these debilitating, but very treatable disorders. We need to ensure the federal parity rule (the *Mental Health Parity and Addiction Equity Act*) and regulations are working for patients with substance use disorders. We need to make sure that there is comprehensive health insurance coverage to facilitate access to these services. And we need to ensure that there is a full continuum of care available in our communities – from outpatient through inpatient care – including hospitalization, residential treatment, and medication-assisted treatment programs, such as Opioid Treatment Programs (OTPs)."

8. **JULY 20 IS DEADLINE TO COMMENT ON JOINT COMMISSION FIELD REVIEW OF BEHAVIORAL HEALTH CARE ACCREDITATION MANUAL.** The Joint Commission is reviewing the Behavioral Health Care accreditation manual and identifying any standards that require maintenance, such as clarifications to existing language, new elements of performance (EPs), and revisions to notes. They are seeking input from the field on the proposed requirements, with comments due July 20. Go online to comment.

9. **AUGUST 1 IS DEADLINE TO COMMENT ON JOINT COMMISSION'S PROPOSED OUTCOME MEASURES FOR BEHAVIORAL HEALTH CARE MANUAL.** The Joint Commission is developing new proposed outcome measures requirements for Behavioral Health Care organizations. The new proposed requirements require that Behavioral Health Care organizations assess individual outcomes through the use of a standardized tool or instrument. Results of these assessments would then be used to revise goals and objectives identified in individual plans of care, treatment, or services, and to evaluate outcomes of care, treatment, or services provided to the

population(s) served. Go online by August 1 to comment on the proposed outcome measures requirements.

10. **VA EXTENDS FREE PTSD CONSULTATION PROGRAM TO PROVIDERS OUTSIDE THE VA.** The PTSD Consultation Program, launched in 2011 to support Department of Veterans Affairs (VA) providers, is now available to providers outside of the VA who are treating veterans with PTSD. Consultation is consistent with evidence-based practices for PTSD. The Center's consultants are psychologists, psychiatrists and other mental health professions who have an average of 17 years of experience treating patients. Providers can ask questions about treatment, medications, differential diagnosis, improving care for veterans, resources, and more. The program also offers providers treating veterans with PTSD access to continuing education, online courses, videos, and a monthly lecture series. To talk to an expert clinician, email PTSDconsult@va.gov or call (866) 948-7880. A set of outreach messages are also available to share information on the program.

11. **STUDY: ALL MENTAL DISORDERS COMBINED (INCLUDING DEMENTIA) TOPPED THE LIST OF MOST-COSTLY CONDITIONS IN 2013, WITH SPENDING OF $201 BILLION.** In 2013, mental disorders (defined broadly) topped the list of the most-costly conditions in the United States, according to a study using a new methodology. While past studies have generally focused on databases looking at the civilian noninstitutionalized population (and have included some double counting of spending that involves multiple conditions), the new analysis published online May 18 in *Health Affairs* adds estimates of costs associated with institutionalized individuals (including patients in nursing homes as well as long-term psychiatric hospitals) and active-duty military. "The inclusion of institutionalized populations has a significant impact on total spending and brings mental disorders to the top of the list of medical conditions with the highest estimated spending: $201 billion in 2013," the authors note. More than 40% of this total spending is for institutionalized populations. In the study, the definition of *mental disorders* includes dementia (including Alzheimer's disease). Dementia accounts for $38 billion of the total $201 billion overall spending for all mental disorders. For comparison, the conditions with the next-highest spending totals are heart conditions (at $147 billion) and trauma (at $143 billion). Spending on all types of mental disorders (including dementia) had a 5.6% growth rate between 1996 and 2013, yet mental disorders were not among the top 10 conditions with the fastest spending growth.

12. **LABOR DEPARTMENT OUTLINES NON-QUANTITATIVE TREATMENT LIMITATIONS THAT MAY TRIGGER THE NEED FOR FURTHER PARITY ANALYSIS.** The Department of Labor's Employee Benefits Security Administration (EBSA) has posted a new fact sheet to help identify whether health plans are in compliance with the federal parity law (the *Mental Health Parity and Addiction Equity Act* or MHPAEA) and regulations. See "Warning Signs – Plan or Policy Non-Quantitative Treatment Limitations (NQTLs) that Require Additional Analysis to Determine Mental Health Parity Compliance." The document includes examples of plan provisions for mental health/substance use disorders which the agency says should trigger careful analysis of medical/surgical coverage to ensure MHPAEA NQTL compliance. Absent similar restrictions on medical/surgical benefits, the range of examples the Labor Department details (such as fail-first policies, plans/policies that exclude residential level of treatment for chemical dependency, or preauthorization and pre-service notification requirements) "can serve as a red flag that a plan or issuer may be imposing an impermissible NQTL," the document states. "Further review of the processes, strategies, evidentiary standards, or other factors used in applying the NQTL to both MH/SUD and med/surg benefits will be required to determine parity compliance. Note that these plan/policy terms do not automatically violate the law, but the plan or issuer will need to provide evidence to substantiate compliance."

13. **FLYER ENCOURAGES CONSUMERS TO "KNOW YOUR RIGHTS" ON PARITY.** The Department of Labor (DOL) and the Substance Abuse and Mental Health Services Administration (SAMHSA) have produced a consumer education flyer to inform individuals about their rights under the *Mental Health Parity and Addiction Equity Act* (MHPAEA). "Know Your Rights: Parity for Mental

Health and Substance Use Disorder Benefits" is an online and printable brochure that provides examples of common limits placed on mental health and substance use disorder benefits and services that are now subject to parity. The brochure also provides consumers with tips on finding information about their health plan benefits and coverage. It informs consumers about their right to appeal a claim, if denied.

14. **SUICIDE, DRUG OVERDOSES AMONG FACTORS CONTRIBUTING TO FIRST INCREASE IN OVERALL U.S. DEATH RATE IN A DECADE, CDC REPORTS.** The U.S. death rate increased last year for the first time in 10 years, according to preliminary data from the Centers for Disease Control and Prevention's (CDC's) National Center for Health Statistics (NCHS). Based on 2015 provisional data, the age-adjusted death rate for all causes rose to 729.5 deaths per 100,000 people in 2015 (vs. 723.2 in 2014). Causes of death increased between 2014 and 2015 for, among other things, homicide, firearm-related injury, suicide, and unintentional injury (12-month period ending with the third quarter of 2015); and drug overdose (12-month period ending with the 2nd quarter of 2015). The last increase in death rates was reported for the 2004-2005 timeframe. It's important to note that "although provisional estimates have been shown to be reliable, they are based on incomplete data and may under or overestimate rates based on 2015 final data," the CDC said.

15. **STUDY LOOKS AT ACA'S DEPENDENT COVERAGE EXPANSION AND OUT-OF-POCKET SPENDING BY YOUNG ADULTS WITH BEHAVIORAL HEALTH CONDITIONS.** In 2010, the *Affordable Care Act* (ACA) extended eligibility for dependent coverage under private health insurance, allowing young adults to continue on family plans until age 26. A study published online May 16 in *Psychiatric Services* reports that young adults ages 19–25 with behavioral health disorders were significantly less likely than an older group (ages 27-29, who were not eligible for dependent coverage) to have high levels of out-of-pocket spending after the ACA provision took effect. "The reduction was pronounced among young adults from racial-ethnic minority groups," the researchers said. Also see a Substance Abuse and Mental Health Services Administration (SAMHSA) blog on the study.

16. **AHA REPORT OFFERS GUIDANCE TO HELP HOSPITALS STRENGTHEN BEHAVIORAL HEALTH WORKFORCE.** A report by the American Hospital Association (AHA) offers information and guidance to help hospitals and health systems develop their behavioral healthcare workforce to meet future needs. Based on a literature review, the report looks at how hospitals and health systems are bridging the gap between the need for behavioral health care in their communities and a shortage of trained specialists. It also offers examples of how to integrate behavioral and physical health in new and innovative ways, and seven steps to guide and spur dialog among internal and external stakeholders on the issue. See an AHASTAT blog post by Pamela Thompson, AHA senior vice president and chief nursing officer, for additional background.

17. **ADULTS IN POOR PHYSICAL HEALTH REPORTING BEHAVIORAL HEALTH CONDITIONS HAVE HIGHER HEALTH COSTS, STUDY FINDS.** Adults aged 18 to 64 in poor physical health who also reported behavioral health conditions (i.e., mental or substance use disorders) had higher total health care expenditures than adults in poor health without behavioral health conditions, according to an April 26 Center for Behavioral Health Statistics and Quality (CBHSQ) Short Report. The higher health costs for people with poor health and behavioral health problems were due to their higher physical healthcare expenditures, the report found. These higher costs hold true for all types of insurance coverage. The report's estimates are based on 2012 data from the Medical Expenditure Panel Survey (MEPS) of the U.S. civilian noninstitutionalized population.

18. **SHORT REPORT LOOKS AT CHARACTERISTICS OF CRIMINAL JUSTICE SYSTEM REFERRALS DISCHARGED FROM SUBSTANCE ABUSE TREATMENT.** In 2011, there were

1.7 million discharges from substance abuse treatment programs; of these, 34.4% (or about 588,000 discharges) came to treatment through a referral from the criminal justice system. That is a key finding from a Center for Behavioral Health Statistics and Quality (CBHSQ) Short Report titled "Characteristics of Criminal Justice System Referrals Discharged from Substance Abuse Treatment and Facilities with Specially Designed Criminal Justice Programs." This percentage was the second highest referral source, following individual/self-referrals. The largest share of criminal justice referrals was via probation/parole (35.9%), followed by state/federal and other court referrals (15.7 and 14.3%, respectively). The report is based on 2011 Treatment Episode Data Set-Discharges (TEDS-D).

19. **AHRQ REPORT LOOKS AT DISPARITIES WITHIN SERIOUS MENTAL ILLNESS.** "Adults with serious mental illness (SMI) often experience gaps in access to needed health care compared with other populations," notes an Agency for Healthcare Research and Quality (AHRQ) Technical Brief on *Disparities within Serious Mental Illness*, and disparities may be "even more pronounced between certain groups of patients with SMI." The final AHRQ report describes and reviews the effectiveness of interventions that address disparities based on race, ethnicity, gender, economic disadvantage—including housing stability and socioeconomic status, and geographic location. Also examined are disparities that arise for individuals identifying as lesbian, gay, bisexual, and transgender (LGBT) and those who have difficulty communicating in English (because it is a second language). "We found a number of promising interventions mainly focused on economically disadvantaged individuals, including homeless individuals and racial or ethnic minority disparity groups," the researchers said. "Depressive and psychotic disorders are the most targeted diagnoses in the interventions seeking to address disparities in SMI. The most salient intervention enhancements included the use of collaborative care; intensive case management approaches, such as CTI and ACT; and specific culturally adapted therapies, including those involving families of individuals with SMI. Telepsychiatry also appears to be a promising intervention, and there is ongoing research in this area as well as other behavioral health technologies, which will hopefully enhance access and adherence to treatment."

20. **AHRQ: BEHAVIORAL HEALTH ED VISITS UP FOR CHILDREN 17 AND YOUNGER.** Emergency department (ED) visits for children ages 17 and younger with mental health, alcohol, or substance abuse problems increased from 622 per 100,000 children in 2007 to 750 per 100,000 in 2013. This is one of the findings in the Agency for Healthcare Research and Quality's (AHRQ's) Chartbook on Healthy Living. *The chartbook* is part of a family of documents and tools that support the AHRQ's *2015 National Healthcare Quality and Disparities Report* (QDR).

21. **MOOD DISORDERS AMONG MOST EXPENSIVE INPATIENT CONDITIONS IN COMMUNITY HOSPITALS IN 2013, AHRQ FINDS.** A Statistical Brief (#204) from the Agency for Healthcare Research and Quality (AHRQ) presents data from the Healthcare Cost and Utilization Project (HCUP) on costs of community hospital inpatient stays in the United States in 2013. According to National Inpatient Hospital Costs: The Most Expensive Conditions by Payer, 2013, mood disorders were the 15th most expensive conditions in 2013 treated in U.S. community hospitals when all payers were considered. Mood disorder was a top-ranked condition for stays covered by Medicaid (ranking 3rd most expensive for this payer), by private insurance (14th), and for uninsured stays (7th). Alcohol-related disorders (one of three of the 20 most expensive conditions for uninsured stays) did not appear in the top 20 for any other payer. "The hospital costs represent the hospital's costs to produce the services—not the amount paid for services by payers—and they do not include the physician fees associated with the hospitalization," AHRQ notes.

22. **SAMHSA RESOURCES DESIGNED TO HELP PROMOTE "NATIONAL WELLNESS WEEK" IN SEPTEMBER.** The Substance Abuse and Mental Health Services Administration (SAMHSA) has an ongoing Wellness Initiative to raise awareness of health disparities among people

with serious mental and/or substance use disorders and the general population. According to SAMHSA, "research indicates alarming health disparities between people with serious mental and/or substance use disorders and the general population. These individuals are likely to die decades earlier, mostly due to preventable, chronic medical conditions." In 2016, SAMHSA is offering a variety of materials to help organizations promote the annual "National Wellness Week," which will be held September 11 through 17. Resources include guides, posters, and publications.

23. **AHRQ OFFERS TOOLS TO HELP PATIENTS AND CLINICIANS MANAGE BINGE-EATING DISORDER.** New evidence-based tools from the Agency for Healthcare Research and Quality (AHRQ) are available to help adult patients work with their healthcare providers to make informed treatment decisions for binge-eating disorder. A research summary for clinicians and a companion plain-language brochure for patients outline the benefits and harms of various treatment options, including psychotherapy and medications. To enhance shared decision-making, the clinician publication includes talking points, and the consumer brochure offers sample questions to ask clinicians. A free continuing medical education module provides healthcare providers with information and skills to support shared decision-making. The new tools are based on a systematic review that evaluated the evidence on the effectiveness, comparative effectiveness, and adverse effects of treatment options for patients with binge-eating disorder.

24. **ANNUAL CDC COMPENDIUM ON NATION'S HEALTH INCLUDES SELECTED BEHAVIORAL HEALTH DATA.** A limited set of selected data on mental health and suicide is included in a 400+-page annual report on the state of the nation's health from the Centers for Disease Control and Prevention's (CDC) National Center for Health Statistics. Among the information included in *Health, United States, 2015: With Special Feature on Racial and Ethnic Health Disparities*, for example, is data showing that suicide rates in 2014 were higher than homicide rates for males and females of all age groups (see Figure 3; Tables 29 and 30). In 2014, suicide was the 10th and homicide the 17th leading cause of death in the U.S., the report notes. Also, between 2004 and 2014, the drug poisoning death rate involving heroin increased more than five times, going from 0.6 to 3.3 deaths per 100,000 resident population (see Table 27).

25. **KAISER SLIDESHOW LOOKS AT COST AND OUTCOMES RELATED TO MENTAL HEALTH AND SUBSTANCE USE DISORDERS.** The Kaiser Family Foundation has pulled together a 36-chart collection of the latest statistics on mental health and substance abuse disorders in the United States. Slides look at prevalence, outcomes, access to care, and overall spending on mental health and substance abuse disorders. International comparisons are provided, as well as demographics and details on the most common disorders among adults and children. The chart collection, *What Are the Current Costs and Outcomes Related to Mental Health and Substance Abuse Disorders?*, is part of the Peterson-Kaiser Health System Tracker, an online information hub dedicated to monitoring and assessing the performance of the U.S. health system. More information about the analysis related to the slideshow is available through the tracker.

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