



**Is the Mind Part of the Body? – The Challenge of
Integrating Behavioral Health and Primary Care in
a Reform Era
The Centene Corporation
Alliance for Health Reform
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ED HOWARD: Good afternoon. My name is Ed Howard, I am with the Alliance for Health Reform and I will try to avoid the big echoes that I can hear reverberating back. I want to welcome you on behalf of Senator Rockefeller, Senator Blunt, our Board of Directors, to this program, examining the efforts to integrate behavioral health services into primary care and why that integration is needed. I should say that this is an issue in which both Senator Rockefeller and Senator Blunt have a very strong interest and we want to make sure that we deliver for them a program that is worthy of their level of involvement in this issue and I think every indication is that we are in a position to do that.

We know that millions of people in need of mental health services in America don't get them. And we know that bipartisan majorities in Congress and not just the Alliance Senatorial Leadership have been working to expand coverage for these services for almost a generation now. And as a result, more and more people have coverage for behavioral health. There is some evidence that newly insured people, especially those covered through Medicaid, have even greater behavioral health needs than the rest of the population, but they do have coverage. But will they be able to get the services themselves? There are a lot of unanswered questions about provider capacity, about fiscal capacity, even vestiges of stigma that stand as barriers to adequate access. One promising initiative to overcome those barriers is the idea of integrating behavioral health services into primary care. And today, as we begin National Mental Health Awareness Month, if you will, we are going to look at how that strategy is playing out and what the future looks like for success.

We are very pleased to have, as a partner in today's program, the Centene Corporation as a partner in today's program. The Centene Corporation, which contracts to provide Medicaid coverage in now 20 states and operates a number of related services like nurse call centers and behavioral health services. Co moderating our discussion, we have Dr. Bernard Engelberg, who is the Senior Medical Director for Cenpatico, which is Centene's managed behavior health organization. He is a psychiatrist, as you might expect, but I take special note of the fact that he is a geriatric psychiatrist and I wonder if the folks at Centene thought I needed some help, I don't know. But I'm very pleased to have Dr. Engelberg with us. Bernie?

DR. BERNARD ENGELBERG: Thank you very much, Ed. I'm soon going to be there too, so – I figure we are all going to be needing more help. First of all, saying strictly from my ID, I wish we could all be outside on the lawn, because it's such a gorgeous day. I'm so happy that you all came in here. It's really just beautiful out there. I'm excited.

ED HOWARD: We don't want to lose them, Bernie.

DR. BERNARD ENGELBERG: I'm excited and privileged to be here today because this is an unbelievable time in our lives here. The first time where officially mental health is on par with physical health and our task is trying to integrate the two. So on behalf of

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Centene and Cenpatico, I am delighted to join Ed here and the Alliance for Health Reform and our panelists today for today's briefing. Now, these briefings that are done here by the Alliance, allow us to tackle tough issues such as the integration of behavioral health and primary care, which we are doing here today, and their impact on the Medicaid system.

Now, who is Cenpatico? I am proud to be part of Cenpatico. We are a managed behavior health specialty company within the larger Centene comprehensive portfolio of innovative health solutions. What does that mean? We are part of different specialty groups that works with the overall medical group. We have got pharmacy, we've got behavioral health and we all work in a naturally integrative way of providing healthcare for our members. We manage behavioral health benefits mostly in the public sector – Medicaid, Medicare, SSI, some child foster care and some other products. And one thing our data repeatedly demonstrates is that when we get people into the right care at the right time, outcomes are better and costs are lower. In other words, if you give a member what they need to get healthy and stay healthy at the time they need it, that is the best outcome and the most cost effective. And we see that time and again. Increasingly, we have our understanding, also, about how the key stakeholders such as a federal government, the states, the counties, health and social service, caregivers, are all responding to these new challenges that we have. All of these groups have their own particular challenges and their own particular solutions.

Now, there are a number of opportunities to improve the coordination of care between behavioral health and primary care. Some of these are such as the holistic person centered care and we also have to remember that is not just the bio, psycho, social, but also the vast cultural differences that we have and some of which you are going to be hearing today. We need things like integrated medical records, especially pharmacy. At Cenpatico we have a lot of joint programs where we actually do rounds on our members together with our sub-specialties. For example to prevent neonatal intensive care unit babies from being delivered under the influence of drugs by getting their drug addicted mothers early into treatment and identifying them, of course. Such diverse projects as sickle cell anemia and of course much more known projects such a heart disease. We need more community supports. I actually, as some of you have heard, grew up on the grounds of the State Hospital and was there for deinstitutionalization. We got half of it right. We got the people out of the hospitals, but once we were out, we didn't get the second half – where are we going to put them, how are we going to keep them out of the hospitals? That, we are still working on. Thank God we noticed now that we need peer support and peer support has become more important. And also very important and that I don't want to have short shrift here today, is substance abuse. Substance abuse, which we have throughout medicine and behavior health, is also under parody now and we can have the benefits that we need in order to treat it. At the same time, there are challenges to integrating behavioral health and primary care. We need integration of mental health into what I call ACO like delivery systems. That means not everybody has to look alike. There can be variations and there need to be variations, but how are those variations

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going to look. We need payment reform and we need it focused on quality outcomes. We need a well care system, not a sick care system. How do you keep people well? How do you prevent illnesses from occurring? And we need, of course, electronic healthcare records for everybody to be able to see everything we are doing. We are glad that today's topic is of great interest to the Hill staff as well as the policy, advocacy and research communities. I am looking very much forward to today's discussion and the opportunity to exchange different points of views, discuss the innovations that people are doing, the approaches, as well as though best practices that can help bring about the integration of behavioral healthcare and primary care. And I suspect that I will learn a great deal here today too and to start us off, I will turn this little blinker over to Mike Hogan.

ED HOWARD: Mike, if you don't mind, let me do a little housekeeping before we hear you. I want to remind people that there are lots of good materials including biographical information about our speakers in your packets, including the Power Point presentation that Mike Hogan is about to speak over. And maybe you could pull up that one slide that we came by, Dexter, if you would. We want to encourage you to ask questions. There is a green question card in your packets that you can use at the appropriate time and to fill out the blue evaluation form that you will find in there as we go along. This slide is to remind me to tell you that there is something a little unusual about our evaluation this time. Normally about a fourth of the folks in the room fill out the evaluation. We and Centene want to get you into a high performance mode here and so we are going to offer a payment reform incentive if you will, if we can get 35% of you to fill out the evaluation form. We will donate \$50 to Mary's Center. Now Mary's Center is an FQHC, it's a Federally Qualified Health Center here in DC and in Prince Georges and Montgomery County, delivering healthcare, including integrated behavioral health services, to people and families in need of them, at about a half dozen different locations. And if we can get 50% of you to fill out the evaluation form, that contribution will be \$100. If you look on the screen, you will see there a URL and if you want to supplement that contribution with your own contribution, it is a worthy cause and we would commend you for doing that. One final housekeeping note, if you are Tweeting, you can do it using the #behavioralhealth.

I have made you wait for Mike Hogan's remarks, but they are worth waiting for. Mike Hogan, who has run mental health departments in three states, most recently New York through 2012, he now runs Hogan Health Solutions, a consulting practice in health and behavioral health. He chaired President George W. Bush's new freedom commission on mental health in the early 2000's and he has won more awards for his leadership in the field than I knew existed and we are very happy to have you back on our dais, Michael Hogan, please.

MICHAEL HOGAN: Thank you Ed, it's good to be back. Your modeling paper for performance with an interesting twist, so it's pay for performance with altruism involved. So it might not work in healthcare, but I hope it works with this audience, it's a great idea. I want to also appreciate the opportunity to be here and also to appreciate that Ed

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and his staff at the Alliance continue to sort of shine the light down the path of healthcare in places that sometimes are unexplored, but where we need to go and probably mental health is one of those. I'm going to try to set this up by describing a little bit how we got to this place and what some of the challenges are and this first slide is 150 years of history in mental health in a slide. It starts with 1853 when the Congress actually passed land grant legislation that would cede federal lands to the states to be sold to create mental hospitals, asylums, they were called back then. Which was probably vetoed by President Pierce as an area that the federal government shouldn't get into. For about 100 years, the federal government resisted that, or more than 100 years, followed that approach. And mental health remained a separate system run by states and remained a separate system run by states until and through the creation of Medicare and Medicaid in the mid '60s. But what is really striking is how in the last decade or so, sort of under the heading here of "Life Came at us Fast", how the combination of [unintelligible] Wellstone so called parody legislation with the Affordable Care Act, really moves mental health into the mainstream and the question now is, can we get this figured out? So we are in a place now where mental health – there still is a struggling separate mental health system, although it ain't what it used to be. You know, California doesn't have a Department of Mental Health anymore – to put this in perspective. You are probably better off, as an advocate, to talk to your Medicaid director than your mental health director. So the mental health has kind of moved into the mainstream. We still have, as I said, this safety net, so this sets up the two challenges that I want to reflect on. Mostly the first of those, the need to integrate care everywhere. Disintegration is literally killing us and driving up costs. And second, I will comment a little bit at the end about the need to sustain the mental health safety net.

Just a couple illustrations of why integration is so critical. This Venn diagram sort of shows – in the blue, it's people who have a mental disorder, in the green, it's people that have medical problems and you will see that most people who have got a mental disorder, addiction challenges or mental health problems, also have a medical illness. And how a substantial portion of people with a medical illness also have a mental health problem and the more serious each problem is, the higher the likelihood that the other is involved. So 35% plus of people in med surge beds have got a mental health problem, often depression. The numbers are the same or greater in community based long term care and so on and the inattention to their mental health problems complicates the rest of things. It adds a day on average to the inpatient length of stay, which drives up the cost of readmission. So integration, particularly at the point of service, it really becomes essential to solve this problem.

This is just another illustration – you won't be able to see the fine print here, but it's just a reminder – for me, this is Wayne Katen's slide, but it's actually borrowed from Vince Felitti and Bob Anda, the so called ACE study, which if you don't know anything about it, just go home and take a quick look. Just Google ACE Study, Adverse Childhood Experiences and what their research basically showed is that adverse experiences like abuse or very serious neglect among children, affected the health behavior of these young

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people leading to smoking and obesity and so on. Therefore, leading down the road to medical problems. So they conclude in this study, which involved 19,000 people in the Kaiser Permanente that untreated childhood mental health problems cause more than half of the chronic medical problems in the country. So the brain and the body are connected and bad brain health is not a good idea either for your brain or for your medical circumstances. So we are starting to pay attention to this with respect to the integration of behavioral health services and chronic care. I wish that we could get upstream and focus on treating child trauma when it occurs because that would be the best thing that we could do. But the setting up from two points of view, the need for integration, the degree to which these problems coexist and the second, the way they multiply each other. We need integrated care everywhere. We need it in mental health and addictions care, although that is not my primary focus, to bring medical care into mental health clinics where there is a high prevalence of heart disease, a lot of smoking going on and people are dying on average 25 years earlier if they are participating in mental healthcare because of their untreated medical problems. But even more so, in primary care, which will be the focus of my next couple of slides here, this is just a cartoon from Health Affairs some time ago. The guy is out on the ledge and the cop is saying to him, "We couldn't get a psychiatrist, but maybe you would like to talk to a dermatologist, we were able to find one of those. And in survey after survey of primary care physicians, they report that the hardest specialty care to get for their patients is mental health care, to get somebody in to see a psychiatrist. And since this has persisted for so long, it doesn't seem to me to be too outrageous to say, this problem is not going to be fixed by an expansion of the specialty mental health sector. As a therapist friend of mine used to say, it's okay to want that, but it is completely unrealistic to expect it's going to happen. It makes much more sense to fix it in primary care by appropriately integrating a little bit of mental health care on the floor into the medical practice and we will have some good examples of that in just a moment.

So this is a little bit more about how the absence of integrative care and primary care is a problem. Most PCP's don't have the time or the tools or in some cases, the expertise to do this. So a little bit of training, screening without the ability to treat patients, is not gonna go very well. The statistics tell us now that if you walk into your primary care doc with depression, you have a 50% chance of walking out with a diagnosis and if you get a diagnosis; you have a 50% chance or less of care that is up to snuff – meaning it's consistent with the minimum of what is required. Or a groomer statistic – 50% of the people that die by suicide in the United States saw a primary care physician within the past 30 days. We have a de facto policy of "don't ask, don't tell". But there are solutions that work exceptionally well. They go under the general rubric of collaborative care. The key ingredients are behavioral health professional, social worker, a psych nurse who is on the floor, not across town – because a referral is not gonna cut it. But on the floor, so they can come in and join the physician and the patient right there for a very warm handoff. A psychiatrist available to consult with the physician or with the mental health specialist and finally, following measurement in the practice of care, these are just results from one of the early studies – there are now 80 randomized control trials around the country of

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collaborative care. This focuses on the improvement in the patient's physical condition. Their depression is going to get better as well, but this shows the benefits of integration for the patient's physical condition. And this is a complicated slide that underlines Bernie's point about cost. If you just look at the far right hand column there, you will see it cost a tiny bit more to have the behavioral health program there, but there are net savings that are far greater, mostly in in-patient and pharmacy costs, because care is better titrated.

So there are challenges in doing this. This is – I'm reminded of Atul Gawande's great article about slow change. This is a kind of a slow change because it's much better for the patients, but it takes work for us practitioners. The mental health care may be paid for over here, while the medical care is paid for over here. How do you get both of those payment streams in place in one clinic? So there are lots of obstacles, but since it's better for patients and it ends up in the long run costing less, we have to try it.

I'm going to just tip my hat as I go out, on the need to preserve the mental health safety net, which is not the main focus here, but still remains important for the patients with the most complicated problems. And there is a long story there, but I just want to give a shout out to Senator Stabinow for the Excellence in Mental Health Act, that was included in the doc semi fix this year. And will help sustain behavioral healthcare in our states.

Just some resources that you have in your slides for integrating care, if you are interested and with that, I will pass on the clicker.

BERNARD ENGELBERG: I just have one follow up or clarification, you were saying about primary care not having the time or the tools – do you think, time wise, I'm always thinking that, okay, you can do a very quick questionnaire, but what if your patient says, why yes, I'm suicidal and want to kill myself? I'm wondering if that is the point where primary care says, well, I need a hand off. I need something.

MICHAEL HOGAN: Right, really critical point. So all of that stuff about collaborative care, the evidence is that with those kind of supports in primary care, most routine mental health care can in fact be handled well. But if its suicidality, if it's bi-polar disorder that is active, if its schizophrenia, then you had better call for the Calvary, which is the reason why the direct line of the psychiatrist is critical and the treatment network that they have.

ED HOWARD: Before we hear from Laurel Newman, I just wanted to correct an egregious error that Michael Hogan made in citing the legislation, the Excellence in Mental Health Act, which is actually the Stebenow-Blunt Legislation in the Senate.

MICHAEL HOGAN: Thank you. I have been living in a Democratic state for too long.

ED HOWARD: And actually, it is worth noting that – here is a remarkable development, as small as it is, it was a fully bipartisan piece of legislation that was tacked

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on by unanimous consent on the Senate floor. So it gives us some hope that we might be able to engineer some policy solutions to some of the situations that we are talking about here. And that leads us directly to Laurel Newman.

Miss Newman is from Intermountain Healthcare in Salt Lake City. She is a nurse by profession, she has been the Quality Improvement Implementation Manager for Intermountain's Primary Care Clinical Program for the last three years and for more than a dozen years before that, she was in leadership positions in Intermountain's Mental Health Integration efforts. And those efforts, by the way, are very well known. They have spread not only throughout Intermountain's own clinics, but to community clinics across the country. So we are very pleased to have somebody who has been so deeply involved for so long in this effort, to help us sort out some of these questions. Laurel?

LAUREL NEWMAN: Thanks Ed, I want to thank you for the opportunity to share with you 15 years of progress in just a few moments. Integrating mind, body, healing in primary care through a team approach, improves patient outcomes and population health at a lower cost. Intermountain is a highly integrated healthcare system headquartered in Salt Lake City, Utah. Our operation includes hospitals, a medical group and a wholly owned insurance plan. Another significant differentiator is our system wide clinical programs, which have been long established and are part of what we call a "secret sauce" and I will talk about one of them here today. So our core business, our efforts are ultimately centered around what matters most to our patients, employees, members and communities. So perfecting the clinical work station. Best clinical care in the world doesn't matter if no one can afford it.

Mental health integration at Intermountain has changed the culture of primary care by standardizing and measuring a team based care approach that includes mental health as a normal part of a routine medical encounter. Results of improved quality and lower cost have been benchmarked over the last 15 years by measuring how clinic teams progressed through five key integrated steps. The first one, here on this slide, is leadership and culture. Champions – so champions would be our primary care physicians, our clinic managers, establish a core value of accountabilities and cooperative leaderships. The second key is work flow. Engaging patients on the team and matching their complexity need to the right level of team resource and support. The third key is information systems. Our registries, data bases, our EMR, to support team communication and tracking of patient outcomes. The fourth is the financing and operations. So this is where the clinic manager, maybe our assistant ops directors, they project budget and sustain FTE's to measure ROI. And then the fifth one is our community resources. So each clinic actively looking at their community resources, community partners, to help engage the population in sustaining wellness. The evidence that multiple team touches, that are standardized and supported by institutional leadership, impact the cost and quality of patient outcomes, is compelling to consider in our reform efforts. Our research demonstrates that delivering mental healthcare via a coordinated team, using the MHI approach, improves staff and patient routine experiences and promotes positive patient

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outcomes. Patients and staff in MHI clinics described an organized process of care in roles using standard tools to help engage the patients in treatment decisions. Normalizing mental health as an organized team process, within the social context of primary care, offers promising results for improving outcomes for patients with chronic disease.

So these five integrated steps, these key steps, are measured by a team score card that build an improvement road map, guiding our teams through what we call three expected implementation phases. So each clinic goes through a score card and they measure themselves with these key components. So the first phase we call the “potential” phase. These clinics are thinking about mental health integration. They have access to our care process model tools, but have not yet operationalized MHI. The second phase is the adoption phase. These clinics have hired the MHI providers; maybe they are doing some retraining of the staff, of the team roles. Patients have access to integrated care. The third phase, we call “routinization”. Clinics have full implemented the five key components that I have talked about and achieved progress towards the triple aim outcomes. So 80% of mental health care is provided by the primary care physician, who is supported by a fully MHI team. This slide here – this streamline process, has resulted in expedient growth in scaling MHI throughout the Intermountain Health System. Over time, as more clinics have become routinized, the length of time to achieve this has decreased. So you can see in this slide in 2010, there was a major jump in routinization. Two critical medical group initiatives contributed to this. The first one was that our – it was more operationalized. Our assistant operations directors, our clinic managers, had more accountability to this process. They were monitoring and rewarding the teams and then the second one is when we implemented our medical home, called Personalized Primary Care – PPC, when we implemented this three years ago. So when we implemented that, there was a support for care management resources and primary care incentives were established.

So patients with depression, treated in a routinized MHI clinics, were 54% less likely to visit the ER than those patients not receiving MHI team care. Across all service lines, growth of per patient charges increase by 19% for those patients in MHI, compared to 30% in a non-MHI clinic, achieving a \$667 savings to our health plan.

Managing population health requires treating the whole person in the context of social conditions in which they live. Therefore, engaging patients and expanding teamwork beyond the medical clinic to their family and community is critical to sustaining positive health outcomes over time. Patients and their families are the experts; they are the expert advisors in helping us design and evaluate our system of care. So we are currently coordinating our MHI – Mental Health Integration. Our medical home. ER outreach and technology efforts in real communities to design team based care that includes community team members. So strong community relationships, linked to a positive ambulatory delivery system will promote the opportunity to measure quality of life.

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BERNARD ENGELBERG: Laurel, it sounds like you have done a lot of really good integrative work there already and really have tried to do one system. But there is an elephant in the room. Substance abuse. And correct me if I'm wrong, but you can integrate all records and everything, you can't integrate substance abuse. That blinds doctors like myself, it's very frustrating. We end up as pushers, giving the wrong meds to people who abuse them. Have you handled that at all? Have you been able to address that in any way?

LAUREL NEWMAN: I wish I could say yes, but no, unfortunately – we do have a strong partnership with NAOMI – National Alliance of Mental Illness. I know that they have, I think a bridging, where they help patients through substance abuse, but as far as actual care with substance abuse in the clinic, no.

BERNARD ENGELBERG: That is going to be a big challenge.

ED HOWARD: We are going to turn next to Nick Macchione who directs the Health and Human Services Agency for the County of San Diego. I hadn't really internalized this – San Diego County is a huge geographical area. Nick, was it larger than six states or something like that?

NICK MACCHIONE: 20 states.

ED HOWARD: I knew it was something like that. It's big. And Nick's agency is one of the nation's – therefore, one of the nation's largest local integrated delivery system for Health and Human Services. Among other services, it integrates primary care and behavioral health services. And Dick Macchione himself is an award-winning national leader in service delivery innovation and organizational leadership. His biographical details, I commend to you, in your materials. Nick, thank you for coming across the country to share your experience with us.

NICK MACCHIONE: Thanks. Thanks for having the sunshine here for me. First, really a shout-out to the Alliance and Centene putting forward this very important conversation. Because I hope what comes from this is really some more evidence based policy making. We have to get this right if we are going to achieve wellness and you are going to hear me talk about this wellness across the lifespan.

Just a little bit about San Diego first. We are a big community. Over three million residents. We have the structure of county government and the lens I'm going to give this is from county. In California particularly, with exception of three cities, public health, behavioral health, social services, is rendered through the counties, as is many other states as well. So county has played a very important role in convening and furthering this conversation about the funding, policy making, service delivery and then convening, very importantly. Diversity in San Diego – and I think we have to hit on this, is that as a diverse nation, this challenges us further. How do we provide culturally appropriate

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services? This is something we have worked on quite a bit in the last decade in San Diego. We have 18 Indian sovereign nations. Busiest border crossing. At one of our welfare offices, we call it Family Resource Center, we speak 55 different languages. So we are a very diverse area, which again, influences the delivery system.

In terms of my agency – Health and Human Service Agency, back in 1998 with the influence of welfare reform and it's very interesting – we are the bookends now of welfare reform in the '90s and healthcare reform. But welfare reform was a catalyst for us to look at. How to provide services in a more integrative way. We were siloed and we brought in all these different programs that we have today. And we looked at this from kind of “womb to tomb” in our delivery system and in that, very importantly, the purpose of partnering with our community – and that is a fair amount that we do is we contract with our organizations in part because even though we have 6,000 employees, we are a large, integrative delivery system, a lot of advisory boards, we do not run a general acute care hospital in San Diego. We do have a psychiatric hospital and a sub-acute care facility. But we contract with the general acute care private non-profit hospitals. So that is a little bit of uniqueness to San Diego, which talks about the importance of public-private partnerships in what we do.

I really appreciate the comments made by Dr. Engelberg about – it's about wellness. And we firmly believe that. So much so, that in 2010, the county board of Supervisors approved the very audacious ten year plan to integrate broadly not just what we do in Health and Human Services, but the nexus of where health meets safety and also economic resiliency. How do all of these three things really come together? And that is pretty audacious doing that for three million people. But over ten years, the importance of going beyond just integrating mental health and substance abuse and primary care, but the role that social services has. The role that the economy in terms of jobs and housing has, which I will hit on in a moment. In our behavioral health system, we have integrated mental health and alcohol and drug services. I jokingly sometimes refer to it as – it was like giving birth to a porcupine and men don't give birth. So – painful process. And it shouldn't have been. But it was. And I think the fidelity to the professions, the fidelity to the practices, were different. Yet, as it was pointed out by Mike, there is a lot of commonality in overlap between people who are confronted with mental health challenges and illnesses and ongoing drug issues as well as primary care issues. And we did integrate that across our entire delivery system. And in that, from prevention to intervention to outpatient case management of residential and then our acute care hospitals. We asked the question of, how are we making sure that the medical home is in place in all of these levels? When we are talking about prevention and our anti-stigma campaigns. Talking about the role of stigma in primary care settings, so that we can deal with in the primary care world, the importance that we are dealing with and their assumptions and mischaracterizations of people living with mental health challenges so that as Mike pointed out, we can deal with those low to moderate presenting challenges at the primary care clinic. But you have to deal with the stigma of that workforce. So in all of these areas for us, it was very important bringing in that medical home. In fact now,

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particularly for those that are chronically medical ill that are homeless, it is more about a housing first medical model or a housing first health home that we talk about. Getting them in a home – safe housing situation, to provide the wrap around services. Now, we had – I must say – some assistance. Financing is a big issue. This is probably one of the – fortunately with the Affordable Care Act now, we present more opportunities in getting people linked to mental health services. Ironically, we have a shortage of mental health providers. However, for us in California, we did have a woefully under funded mental health system up until a help of our millionaires – there was a voter proposition that was passed in 2004, we called it the Mental Health Service Act. It's a sales tax on millionaires. And what that did is really bolstered the funding for our outpatient. It did support components around prevention, early intervention, infrastructure like evaluation, but also technology, another big piece. Tele psychiatry, because of the shortages. I mentioned San Diego is pretty diverse; we have rural areas in San Diego as well. So providing our hubs in the urban areas to provide tele psychiatry in the rural areas was a big piece in the help as the Mental Health Service Act.

And then, very importantly for us was this concept that in this Mental Health Service Act, there was a focus on the culturally competent delivery system. There is stigma among stigma in mental health. There is stigma about mental health, but then there is stigmas around cultural differences. And so we saw this as a great opportunity, a rallying, if you will, to begin to look at how we were not only bringing in our very diverse service providers and retraining our work force, but having conversations where we were actually embracing diversity. And how those services were being provided in school settings and clinic settings and community based settings. And this really then gets into how we in San Diego look at the integration of one, we call it behavioral health, but across the lifespan. You see, there are people, there are children born – the ACE Study, I appreciate that, it was referenced, that was based in San Diego in part. And I will add something, Mike brought out, that for six adverse occurrences, it was also shown it was ten years of life that was lost. So in addition to a poor quality of life presented with chronic challenges, one's lifespan was actually reduced. So the importance of looking at what happens prenatal, we know that literature now in terms of childhood obesity, is linked to a great deal of cortisol and stress and the environment of the prenatal setting. But how do we look at and provide services to families, young children, across – knowing that some of them stay in our system for life. And what the focus is, how do we get them off the system? And it can't be done just alone; by the way, we see them by behavioral health and primary care. You have to provide those community based social services. And that is the education.

For the older adults, same issue. So as we looked at the continuum, we see this continuum that the delivery system changes. There is forces and drivers. First division of the integration and then with direct intent, developing a service delivery system that has more accountable – we call it the Accountable Care Community, where everyone has the interplay and the interrelationship from primary care setting to the pediatrician, to the social worker, to the teacher, to the parent, to the individual. And the other drivers you

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will see, in wrapping up here, is financing. How do we move to value based? It's amazing and hospitals will talk about volume to value. We need to do the same here and we have evidence to show that, including the work force. The P3, by the way, that is policies, partnerships and practices in action. So how do you put all of these things and then see them through and showing results? So I will look forward to your questions, thank you.

ED HOWARD: Thanks very much, Nick. Finally, we turn to Dr. Lonnie Fuller, who is a physician at Baltimore Medical System, which is the largest federally qualified health system in Maryland. In that capacity and in several others in his previous professional life, Dr. Fuller has been both delivering care directly and guiding the delivery of care by others. In all of those positions, he's been right on the frontlines of clinical integration. So we are very pleased that you have dropped down from Baltimore to share with us some of that experience. Dr. Fuller?

LONNIE FULLER: Thank you very much. Can everybody hear me in the back? Okay, good. So I'm from Baltimore Medical System, I'm a General Internist and we take care of patients of a very diverse nature. We don't have 55 languages, but we do have interpreters who speak 11 different languages in our center. We have a contract with the Baltimore Refugee Center and Resettlement Center, so refugees coming into the Baltimore area, come through and become our patients. The largest three groups are Napoli, Burmese and Arabic. But we also have people who speak Tigrinya and a host of other languages.

So BMS – we provide over 150,000 visits a year. It's primary care for adults and kids, OBGyn, behavioral health services, both sides of the city. We have partnerships that relate to today's conversation with Mosaic Health and Care First. Mosaic Health, we contract with them to provide us with a nurse practitioner in mental health and also with an addictions counselor who comes to our site once a week. The addictions counselor has been very helpful not just because he has appointments with patients that we can refer to him, but he also participates on one of our task forces. We have a – started out as a pain management task force and has evolved into a controlled substance task force because the issue of the overuse and addiction to opiates and Benzodiazepines is one that we face in large part in Baltimore and we have actually developed certain protocols for weaning people from more dangerous drugs to less dangerous drugs.

So the scope of the problem – I don't know how many of you have read it, probably most of you have not, but there is an article called Primary Care, Will it Survive? It was written by Dr. Bodenheimer, a family practitioner at the University of California in San Francisco. It's in the New England Journal of Medicine in 2006. And one of the things that he points out in there is that if you take the average primary care doctor in America with the average size panel of patients and say, how much time would it take to deliver all of the preventative health services that are recommended and all the chronic illness services that are recommended? Now remember, this is not when you are sick, this is not

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when you have a heart attack, pneumonia, break a leg, have a rash, get a cold – none of that. Just preventive and chronic illnesses would take 18 hours a day. That is why the percentage of US graduates going into primary care drop by 50% in ten years. Because you are taking people who have succeeded all their life and now every day, fail. We work 11 hour days, squeeze in 13 hours worth of care and the [unintelligible] sticks and you all tell us that we are doing a bad job. Really. So we have this 18 hour dilemma. The other point is that we treat most of the country's depression and anxiety. It's not done by mental health professionals, it's not done by psychiatrists, it's done by us. There aren't enough psychiatrists in the world to treat all the people in America with depression and anxiety. In fact, if you look around the room, count every two tables, somebody there suffers from depression. And if you look around your table, somebody there suffers from anxiety. Now the secret in medicine is that all the people who want to become psychiatrists, did it because they needed it. I'm an internist so – I figured out what I needed, so I married a child psychiatrist. But I would venture to guess that the advocates for mental health services also have a high prevalence of mental health needs. So the ratios that I just told you are probably a little higher in this room. We have a cultural obstacle. As a physician, I was trained that the best trained person will deliver the highest quality. So if I have a cardiology question, I ask a cardiologist, I don't ask the nurse. And if there is a problem, I push everybody who doesn't have as much training as me out of the way and I do it myself. That is how we were trained. It's really an obstacle because there is an 18 hour day and there are things that can be done by other people competently who have less training than me. But if I take them all on myself, they don't get done at all. And then if you ask, well what is better quality – a medical assistant doing it 90% right or me doing it zero, it's probably the medical assistant doing better quality.

Depression and anxiety screening traditionally has not been done due to time constraints. Patients are scheduled every 15 minutes, I'm 30 minutes behind, the waiting room is full, and I'm looking at this patient with high blood pressure, diabetes, arthritis, and they really do look depressed. If I open that can of worms, it's another 20 minutes. And if they are suicidal and then I have to go and say, let me find a nurse to call and get a helpline and now somebody sits with them while they call the crisis center on the phone, the waiting room explodes. So we have traditionally not investigated it because we – we just get crushed. Many Medicaid patients with uncontrolled physical diseases have co morbid uncontrolled behavioral health illnesses. And in Medicaid it's a higher population with uncontrolled behavioral health illnesses. Those illnesses have made it so that they don't navigate life very well. So they don't have a job with benefits. Therefore they are on Medicaid and come to an FQHC. The most common behavioral health co morbidities for us are depression, anxiety and bipolar disorder. And at the bottom, there is a 12 month prevalence of the – this is from the National Institute of Health, US adults, depression 6.7% - so that is one of out of 16. Anxiety is one out of five and bipolar is one out of 40. These are really common and in fact, when you look at anxiety, my personal belief is that is why prohibition failed. Because people go, at the end of the week, you know what, man? I need a drink. That is why they call it "Happy Hour" because you go with your problems and you kinda let 'em go.

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So we have a couple of approaches. The first one is physician or clinician and medical assistant. So there is a tool called a PHQ4, it's got four questions, two screen for depression, two screen for anxiety. If either one is positive, you do a PHQ9 for depression or a GAD7 for anxiety. If you are going to do that, it takes about five to seven minutes if it is positive. Now, most of the time they don't want to tell the medical assistant their whole life story, but it still takes five to seven minutes to do it. If I were to do that, it would add five to seven minutes to every third visit. Again, that's before we get into dealing with the problem. So my medical assistant does this for me. She screened 81% of our patients and in fact, we don't screen them once a year, we screen them at every routine office visit. Because I don't know which visit they are going to come in depressed and which visit they are not, so I want to catch it. Before I go in the exam room, I know the diagnosis or if it's somebody that I'm treating for depression, I know what their undated score is and whether they are getting better or not. So let's say we are diagnosing them with depression for the first time, instead of going in and asking the questions and hearing the 20 minute story, I say, we screen all of our patients for depression, it's nothing about you, but I looked at your scores and they came up kind of high and it looks like you might be depressed. Are you feeling depressed? And they go, yeah. I say well, here is what we can do. And in 20 seconds, I'm through the diagnostic phase and I'm into, here is what we can do. We can do therapy, we can do medications, we can do both – what is your preference? And we move forward from there. So by doing this, in a year, she saves me 120 hours or a half hour a day. And remember, 18 hours a day is not possible. So here is a way where the medical assistant can improve the care that I'm delivering and make my life more possible.

We have another approach. Primary care medical assistant and a licensed clinical social worker. We learned this system from the Cherokee Health System down in Tennessee. We took a site visit down there and it's really cool. If the patient scores high on a PHQ9, the MA calls a social worker to go see the patient before I even go in the room. So the therapist gets the story of – well, my mom died and then this happened and the house burned down and I have this and I was beaten and there is a whole bunch of trauma in there, right? They go in, they identify the stressors, they initiate a relationship and then they set a follow-up appointment. That is much better than me saying, hey, wow, you got these things, I'm going to refer you to Billy. No, Billy is in a room, makes some contact, they build a rapport and then there is a much better chance that they will follow-up. I then go and focus on the behavioral health medications if they want them and their physical health needs. Their stressors are addressed and then after that, they can focus on their diabetes. Because if a person is really depressed or really anxious, they can not focus on their diabetes. Diabetes is managed outside the office. They have to do the work. If their mental health is crazy, they cannot do the work. And the other thing and what they do at Cherokee is they set up these brief visits where I will put in my note, I would like the patient to work on exercise – getting some exercise on a regular basis. They will meet with the therapist and do some behavioral management and work with him to set goals and okay, great. Then meet with him once a week or every two weeks – wow, you

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walked two times last week, let's see if we can get it to three. Better care saves me another 30 minutes per week. I'm putting these things about saving me 30 minutes per week because primary care is in a crisis.

Another approach and this was mentioned earlier, the impact model, which was developed out at the University of Washington and I learned it during a stint I spent in Seattle. What happens is, I'm treating a patient with medications, the therapist is treating him in therapy and they are not getting better. That happens, some people have more complex disease and tougher to treat. There is not enough psychiatrists. There just aren't. And the time to get them into the psychiatrists is long. So when our system – not only do we have social workers that we can do the warm hand offs, but I can send a patient off with a social worker and ask the social worker, do me a favor, I would like a consult from the psychiatrist. The social worker meets with the patient, gathers their list of medications and they have a neat thing, they have rounds every Friday morning for two hours. And they present the patients the same way a resident would present to their attending. The psychiatrist in a very short period of time, instead of doing a full hour and a half evaluation, gets a sense of what is going on and says hey, tell Dr. Fuller I recommend he do this and if that doesn't work, try that. That comes back to me electronically and then the next time I see the patient, I do it. Or if I'm not going to see him for a while, I call him on the phone, we get him the medication at their pharmacy and I see him back in a month and see how they are doing. So I can get psychiatry input within two weeks. Psychiatrist doesn't see the patient, but I can get their expertise to help the patient's health in less than two weeks. And if it still doesn't work and they really need to be managed by the psychiatrist, we can then make that transfer.

Policy recommendations. So when they asked me to come here, they said, hey, you are going to have a bunch of people who do policy, give them some recommendations. So the first one – continue experimenting and moving away from payment for volume and towards payment for effectiveness of care. If you just say, well here is an extra \$50 for this visit, you are not going to get anything different. But if you lay out some things and say hey, here is some extra dollars if you make a difference and by the way, here is what the literature says you can do to make a difference, then we might get headway. Pay for the brief social worker encounters. The handoffs and the behavioral modifications. Right now, those are not paid for unless it's a regular visit, they can't bill for it. And the only reason why we have it is because Care First gave us a grant.

The next one is, pay primary care doctors to treat depression and anxiety. The insurance company tells me that if I put as a primary diagnosis any behavioral health diagnosis, the payment is – the bill is declined. I have to say, well they have insomnia. Or I have to hope they have high blood pressure. I have to put a physical thing down there when really – if you are a payer out there, you are getting skewed information. Because the problem wasn't insomnia. The problem was that they have anxiety. But that is not coming through to you as a primary diagnosis because you won't pay us for it. You do the carve out and

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you only pay the behavioral health companies for it. So those are my three recommendations, thank you.

ED HOWARD: Good recommendations. I actually would commend that kind of a listing to any of our other panelists and to Dr. Engelberg as well, in case you want to chime in as we go forward. There are microphones fairly close to the front of the room where you can go to ask your questions verbally if you would like. Remember the green cards you can write on and hold up and we will bring them forward and get the panelists to address them. If you go to the microphone, please identify yourself and your organization if you have one and be as brief as you can so we can get to as many questions as possible. Yes, go right ahead.

AUDIENCE MEMBER: My name is Doctor Caroline Poplin, I'm a general internist, I retired from Bethesda Naval Hospital and now practice at the Arlington Free Clinic. I'm very concerned – I have treated plenty of anxiety and depression. I'm very concerned about the Intermountain System, it sounds like a great system for manufacturing with lots of very tight specifications and if you meet them and turn out a quote, unquote quality product, then you get more than if you turn out a product that has some defects in it. I can tell you, psychiatric treatment doesn't work that way. I don't need to use a depression screen to identify a patient who is depressed. The patient never comes in for depression, they patient comes in for a sore throat. And by talking to the patient, which is what the patients want, you can see if they are depressed or not. You don't use the word "depression", you use the word "stress" and everybody relaxes and we can talk about it. I think the number – you can generate a lot of numbers, but our tools and our medications aren't very good. I think relationships are what matter and time. And we just have to make time for this. You can make a lot of measurements and you can show that you have reduced costs with these measurements and if I have to make a measurement, I will meet it, but I don't think that will necessarily help the patient.

ED HOWARD: Laurel, do you want to take first crack at a response?

LAUREL NEWMAN: Sure. Can I ask if you can explain a little bit more of how you feel that Intermountain is more about measuring and - ?

AUDIENCE MEMBER: Well, it sounds like Toyota, you have to meet a whole bunch of metrics, you have particular tools, the teams are all assessed and you look at the measurements and you look at the amount you have had to pay and you decide whether it's cost effective or not.

LAUREL NEWMAN: Well, how mental health integration is set up at each clinic, we have about 85 clinics where there is team based care. And we like to measure it as far as, you know, those three different phases and we are finding out that if clinics are in the routine phase, yes, there is increased patient satisfaction, increased physician satisfaction, they are getting their needs taken care of. So we have a team base where it's not where

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the psychiatrist or the psychologist is at a co-location. They are actually there at the clinic with the physician. So if the physician is talking to the patient about their diabetes and something comes up about stress, then the physician says, you know what, would you fill out this – we have this MHI packet, tools, will you fill this out, it will help me better understand what is going on with you. Your complexity. And then from that, the patient says, okay. Fill it out –

AUDIENCE MEMBER: Or the patient hands the questionnaire back to you.

LAUREL NEWMAN: Back to whom?

AUDIENCE MEMBER: Back to whoever gave it to them?

LAUREL NEWMAN: The packet gets back to the primary care physician and then the primary care physician looks at it, says, you know what, this patient has a complex – there is a lot more going on here with this patient. So the physician might say, I think I can take of this patient, or I think I'm going to need my care manager to help. Or, I think this patient might need some therapy. So it's more of a team approach so the physician doesn't feel like they are on their own.

AUDIENCE MEMBER: Okay, I understand -

BERNARD ENGELBERG: I'm sorry to interrupt here, you have a big line in back of you. I want to acknowledge what you are saying and you are making a point. There are going to be different strokes for different folks. If you remember what I said, I think there should be a diversity of systems. And they all will be addressing different populations and different needs. So what you are saying is dead on and we have to be careful not to put everybody in one bucket and as you say, be a manufacturing thing. But these are systems made for many different things – for rural people, for people with severe mental illnesses, for severe physical illnesses, so they are gonna be room also for what you are talking about. I just think there are going to be many different systems now. So -

AUDIENCE MEMBER: Bob Greiss with the Institute of Social Medicine and Community Health. I'm very interested in this panel because you represent different stages, different entities on a continuum of care and for – we have a representative of a real population based approach – namely the San Diego public system, Department of Health, where population health is really their main focus. So it isn't just what does a clinic choose to do or what does a primary care doctor do with all the constraints that they are under, but what can be done in a generic system where the government is actually accountable for everyone getting appropriate care? And I – this is rare to even have a model like this. I was not aware that San Diego represents that. Because I actually think that those kinds of solutions are more likely to be replicable in other jurisdictions if it becomes a requirement of the Federal government, then if we just allow competition in the marketplace to enable certain types of providers to prevail. So my question is really,

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how does the structure of population health in San Diego allow you to look upstream with a more efficient way of addressing the kinds of problems that have been identified by the other representatives on the panel? Could you be specific? Not just in terms of the structure of the organization, but why that gives you more options in figuring out how to respond from an efficiency point of view to the range of issues that mental health and primary care represent.

NICK MACCHIONE: Great question. I think it is population based. Clearly our model is full fledged with metrics and LiveWellSD.org, you can see the evaluation we put up of how we are measuring the impact. I think the point made is, when someone is depressed as Dr. Fuller was talking about, that they need to go and exercise. How many of our communities, where it's not safe, you can't go and exercise. So the nexus between safety and health, where they meet, is crucial. Because if we make the statements, which is yeah, you need to go exercise and we don't assess – is the community safe and enabling, which is population based, they won't be able to exercise. And therefore, bringing in and working with law enforcement entities and the community itself – very important, we do a lot of resident leadership. How do we make their neighborhoods – and we look more at neighborhoods – San Diego is very large, but healthcare is local, population based is even more local. So how do you look at those communities – and I say this – I think this is true, in many markets, not all. We are resource rich, innovation poor. And I mean that even in San Diego. There are resources in our community we are not leveraging. And so much of what we are doing is a lot of the IHI principles. The Institute for Healthcare Improvement – with one exception. I think we call it triple AIM 2.0. The 1.0 talks about healthcare, the population health, but it is also about population health and social well being and how do you do that? And we have tons of examples that I welcome you to look at a website that now, four years into this, we have measured and are showing and it's actually a collective impact. A lot of people are now coming on board.

AUDIENCE MEMBER: Hi, my name is Al Guido and I'm with Guy Consulting Services, I represent among other organizations, the National Council for Behavioral Health and they represent 2000 community mental health centers and community based service providers across the country. Just a quick comment and a quick question. I thank the Alliance and Cenpatco and Centene for sponsoring this very important event today.

I wanted to briefly mention, Dr. Hogan, thank you for bringing up the Stabenow-Blunt Matsue-Lance Excellence in Mental Health Act. That is a nearly billion dollar eight state Medicaid demonstration program. It requires certified community behavioral health clinics that are certified under that demonstration to team with federally qualified health centers, primarily in serving the co morbid chronic diseases of people with serious and persistent mental illnesses. [unintelligible] also finances a 60 million dollar to substance abuse and Mental Health Services Administration finances the so-called Primary Care Behavior Health Integration Grant Program – that is a 60 million dollar program that again, attempts to create a team approach between community behavioral health providers on the one hand and federally qualified health centers on the other to address

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that same issues, which is the very high prevalence rate of chronic diseases among persons with serious and persistent mental illness, lower [unintelligible] from the Hersa Samsa Center for Integrated Health Solutions is actually here in the audience today. My question relates to health information technology and the role that it plays in facilitating integrative behavioral health and primary care. We were left out of the high tech act, so psychiatric hospitals, community health centers, licensed psychologists and outpatient and inpatient addiction providers are ineligible for the Medicare and Medicaid reimbursement under the high tech act to purchase electronic health records. Senator White House, Senator Portman in the Senate, Representative Murphy and Representative Barbara on the House side have both introduced legislation House and Senate, to correct that situation. I just want to understand a bit more about the role that EHR's play in the integrated models he described a few moments ago and I will take your response sitting down. Thank you.

NICK MACCHIONE: Well, San Diego is a Beacon community, one of 17 Beacon communities. I was on the original board. It was painstaking that we did not include our psych hospital and a lot of our mental health outpatient [unintelligible] as part of the Beacon community. We have demonstrated – interesting now, the acute care hospitals are the ones really up in arms wanting to tie the connectivity to the psych hospital and to mental health outpatient. And so we are on that quest now in San Diego and our fiscal year is July, we are going to be linking our psychiatric hospital at par with our acute care general hospitals. But I wholeheartedly agree that was a gross interpretation of not thinking of the mental health interface; because it has a huge interplay with not only, by the way, acute care hospitals, but the jails. Least we forget, jails are the largest mental health provider in many jurisdictions. So the connectivity at the jails is also what we are working on in San Diego and I believe that is true in other communities as well.

BERNARD ENGELBERG: Nick, I just want to echo what you said. I absolutely agree with you that integrated medical records, medical mental health records are going to be of primary importance in integrating healthcare all together.

ED HOWARD: Actually, if I can interject, there is a question raised by one of the folks who wrote it on a card, that is relevant here. It really concerns the interaction of electronic health records and HIPAA, but more broadly privacy concerns in an era where we haven't banished stigma for behavioral health services. How big of a concern is that in each of your situations and what are you doing about it?

MICHAEL HOGAN: I would just say about that Ed, that in my view – first to go back to the previous point that the head and the rest of the body are connected. It's got to be connected in medical records, period. And the fact that it was left out of high tech was driving with the rear view mirror – it was a reflection back to that old time when we had a separate system and as these folks have indicated, we don't have that anymore. It's got to be integrated. My view about this and the laws that were alluded to with respect to special privacy requirements for alcohol and drug treatment, remain an issue for

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integrating care, but when it comes to mental health care, my personal view is that HIPAA provides all the protections that are needed and it takes professionalism, it takes a careful working relationship with patients, but HIPAA is not an obstacle to integrating mental healthcare in primary care. Measurement is an obstacle, IT is an obstacle, we have to play some catch up on those arenas. HIPAA is not a problem

BERNARD ENGELBERG: I also wanted to say something about destigmatization. Years ago, I worked in a staff model HMO and actually Bill Reedy, the clinical director of mental health and that staff model HMO here today, and we had integrated medical records and we had close to a million members I think and that was very, very seldom an issue, when it becomes a normal process of healthcare. And becomes integrated. So that is actually a positive path towards integration.

NICK MACCHIONE: The other tragedy on this, in terms of HIPAA, it take a lawsuit in California, the KDA Lawsuit, is the cross over youth. These are children in our Child Dependency System that present with mental health challenges and I would say as a nation, we have a lot to do to stand up to serving these children. These are children that are not getting screened and so both for mental health challenges as they come into the dependency system. In San Diego, we had 5200 children in the Child Dependency System, it's much larger in LA. So the KDA lawsuit requires us now to link the systems between mental health and child welfare, but also probation because some of these kids entered the probation system. It can be done, the mechanisms are there, it's really the political will, allowing us to share that data.

BERNARD ENGELBERG: Next question, please.

AUDIENCE MEMBER: Hi, I'm Bob Roy, BMJ. All of this systemness is great, but a shrinking but still significant portion of primary care physicians are in either sole practice or very small practice. How do you move this into that population and sort of the related question then is, how do you get particularly these types of physicians, but really all primary care physicians to move from ignoring everything to referring everything and finally, in sort of a middle ground where they are really doing something.

LAUREL NEWMAN: It has been difficult, especially with the physicians and they are the ones that are slowly doing the care. So it's been a lot of training, also a lot of trust with those team members. So we have what they call a brown bag or a meeting where the psychologist or the psychiatrist, the care manager and the primary care physician meet in a lunch, maybe in a lunch room and talk about cases. And this also helps the physician gain trust with that MHI provider. So it has been difficult. Not all physicians grasp this concept of team based care. They want to take care of – or they are kind of also in the point where they don't want to take – they don't want to know. And I think a lot of it has to do with training and explanation of really how team based care can help their practice.

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LONNIE FULLER: I want to add to that, I think that there are – some of my colleagues who – if someone has a behavioral health issue, they just save it for the psychiatry and there aren't enough psychiatrists to do that. And so it is incumbent upon us to help patients who have behavioral health illnesses that we can either manage or that we can get assistance in managing. And the nice thing about it is when the patient's depression or anxiety or bipolar disorder is under better control, they become a much more engaged partner in their diabetes. In their high blood pressure, in their heart failure, in their COPD. People would tell me, look, I can't talk about smoking right now, I'm too stressed. Cigarettes help calm me down. So helping people deal with those issues, for me, makes it much more rewarding because then the dialogue is about helping empower them to take ownership of their health.

MICHAEL HOGAN: I would say also, we have the answer from the nurse and we have the answer from the physician, which is really the good answers, but I will give you the systems answer. Those solo practitioners – wait a couple years. The giant sucking sound is medicine being organized, hospitals purchasing practices and economics are driving it – it's a problem. It's still going to be a clinical problem, but system wise it's disappearing.

NICK MACCHIONE: I want to add too, on this one. With this particular audience. One of the alarms for us is that, when you look at medical education and you talk to – and in my case I have talked to a very esteemed medical school in the Northeast and here in San Diego and the students coming in to practice psychiatry, what they are choosing to go into is not community psychiatry, they are going into institutional care. That is alarming because if you are looking – as you see where the modeling is, we are going more from hospital to community care. But we don't have the work force. And that is something, in talking with them; we funded a fellowship out of necessity, because of the severe shortage of psychiatrists. But the importance of FQHC's that they have in the safety net is just – I can't begin to score the importance of them, but the future workforce is something of alarm for us in this arena.

LONNIE FULLER: I want to add a piece to that. 20 years ago, maybe, when managed care was growing in the US, there was a move to have therapy done by non-physicians and have the psychiatrists do mostly medication management. A lot of psychiatrists went into psychiatry because they liked the engagement with the patients and now they found that that time was not allotted for and they were not to do those activities anymore. You might say, why didn't that happen in the OBGyn? Well, because women would say, I want to see my OBGyn. Well, what happened in psychiatry is nobody was saying, hey, I want to see my psychiatrist. That stigma stopped that from happening. So many psychiatrists don't go into the community sector because all they are doing is, every 20 minutes, evaluating meds and going to the next patient. They don't find that as rewarding. So there is a shortage.

BERNARD ENGELBERG: You speak my language.

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LONNIE FULLER: I married a psychiatrist. I see it every day.

BERNARD ENGELBERG: Next question please.

AUDIENCE MEMBER: My name is Brian Sims, I'm with [unintelligible] Medical Center, so I have two questions. The first one is a really quick one. One of the things that I find interesting is how interchangeable we use mental health and behavioral health and is there a real distinction? And if so, how important is that in policy decisions and the way that the conversation goes forward and has that kind of shifted from mental health to behavioral health kind of pushed the agenda forward for gaining access to mental health? My second question is, as an acute care facility, hospital facility; there are a lot of challenges in integrating mental health and behavioral healthcare, you know, target populations, financial feasibility, the scope of the program. So initially I thought this question would be best for Laurel, but actually I have heard some good insight from a number of members on the panel. Just kind of some insight on facing those challenges and how well can an acute care facility deal with that on its own? Or what are some of the important strategic partnerships to kind of deal with the scope of the program that is important for a community based hospital to take on?

LAUREL NEWMAN: So do you want me to answer the second question?

AUDIENCE MEMBER: Anybody who has any insight is fine.

LAUREL NEWMAN: It's true, behavioral health, mental health – we actually have a behavior health clinical program, that piece is our hospital based, our psychiatrist, our LCSW's, psychologist, they are co-located in a certain area. Just in a building where patients would go and see them. In mental health integration, which is part of another clinical program, it's our medical group where mental health actually is an integrated into the primary care setting. As I said before, we have MHI providers physically there for the primary care physician. So that is – again, we are interchanging those all the time, it seems like, as well at Intermountain Healthcare.

LONNIE FULLER: Two parts – you had two questions. The first one is, mental health/behavioral health. To me, it was moved to behavioral health because it was less of a stigma and it was easier to talk about and get stuff done. The second question is more interesting to me actually. The hospitals are beginning to communicate with us when a patient is in the emergency department or gets admitted to the hospital. They have always done that to a certain extent, but they are becoming much better at it. There is a weird almost perverse funding issue here, so if a patient gets admitted to the hospital, the hospital makes money. If the patient then goes home and comes back within 30 days, the hospital gets dinged. So the hospitals have set up programs – really strong, community support programs that last 30 days. For people who go to the ER a lot, there is no ding, so – and I remember when I was in Pennsylvania and working with Medicaid, we talked to

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some hospitals briefly and the incentives were all wrong. And so it was very hard to build a dialogue that says, let's work to reduce hospitalizations that you don't need. I think the integrated systems have a much better shot at that because everybody is on the same team. But in the traditional payer/provider dynamic, that is a lot harder to work out.

BERNARD ENGELBERG: We have two more people standing there – please.

AUDIENCE MEMBER: Hi, I'm Vi Schaefer and I'm from Gartner and my job is I prognosticate how information technology will influence healthcare over the next ten years. Because of that, I come to a lot of these forums, which are certainly some of the most important convening of experts. My question today is slightly different than the others. Last week, the Institute of Medicine convened its first committee meeting on diagnostic error in medicine. There is recent research such as the British Medical Journal at Johns Hopkins research on the incidence of medical diagnostic error. In that committee meeting, some of the testimony pointed out that the first thing you have to do if you are going to tackle something is measure it and pointed out that I think the joint commission has 1200 endorsed measures. National Quality Forum has 700 endorsed measures and zero of them have anything to do with diagnostic error. I can see how this is gonna go. Institute of Medicine work, the electronic health record, the accountable care measures in Medicare plan are all around the process of care and presume that you are on track on diagnosis. I feel like the prospects are that our journey in mental and behavioral health will take this same, very long trajectory, unless you in the room and you in the panel find a way to intervene in the IOM diagnostic error work and elevate the dialogue such as the data you had here about the failure to diagnose depression. Because so much of the diagnostic error is gonna point to the ambulatory setting and the primary care physician, that the already burdensome challenge of changing what they do, changing to team, changing to – as the shared savings guys say, practicing at the top of their license. Well, focus so much on the physical side, that this artificial separation of mental, behavioral and physical will just perpetuate for a long time and I'm wondering, for the Alliance and for you all, how engaged are you with the IOM diagnostic error research and process? How much of an advocacy do you think is important for you all to assert in that?

MICHAEL HOGAN: I will jump into this – I will take it a level up and that is to say that the measurement enterprise in this country in healthcare is a train wreck. There are too many measures, they are too micro, there are all these problems and generally mental health isn't measured at all. If mental health measurement goes in that kind of direction, it's a loser. Because if you get that concrete, you are missing the point. But if you ask a different question, which is, does good mental or behavioral health have anything to do with your overall health? Well, the answer to that is like, duh. It's a really big deal. You feel better and it makes your medical health better because you can take better care of yourself and you can work more collaboratively with your physician. So I don't know who we see about that or where we go but it's really imperative that a measurement approaches begin to think sensibly about mental health and not go down the rabbit hole of this false specificity that bedevils the rest of healthcare.

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ED HOWARD: Let me remind you of Mary's Center and what is riding on you filling out the blue evaluation form. Yes, go right ahead.

AUDIENCE MEMBER: My name is Wendy Slavid and I'm an independent consultant and Dr. Fuller, I enjoyed your presentation and your descriptions of working with social workers and medical assistants and you mentioned that the work that you were able to do in that area was through a grant or some funding and then you also brought up how it's important that there is more of that done. I'm just curious about how people on the panel feel about that and whether you have any ideas. Just because, I have heard from primary care physicians that a lot of them don't do the mental health screening or acute treatment because they are not paid for it.

MICHAEL HOGAN: It's a really big problem. I mean, this collaborative care thing, integrated care, is a best buy if you look at meta analysis and if you look at all the research. But despite the tremendous impression that is given from some real leaders on the panel, not including me, mostly it's not happening out there and it's not happening for a whole variety of different reasons. But the ability to get paid for it, as you say, is a real big problem and paying for it via grants is like, not gonna solve the problem. So it's helpful in an FQHC environment to be able to have the wrap around payment and to be able to build cost. That helps. So proactive FQHCs can do a really good job of this. But Dr. Fuller's point about the coverage of the social work or the ability to bill for medical treatment of something that happens to be a brain disorder and not a liver disorder is really critical. And this is a cutting edge issue that is going to make or break integration. Can it get paid for? Can the necessary procedures get – and work get paid for in primary care settings? If you have got organizations like Intermountain that look at his holistically, then you can see how it can happen. But if you have a carved out behavioral health thing over here and a medical plan over here and these contract with these guys and these contract with medical people and they don't talk to each other, that is going to be a problem. So figuring how to integrate payment is going to be critical to enable integrated care.

ED HOWARD: Actually that opens the line of questioning to something that has been mentioned on a couple of question cards and that is, how will – assuming that integration is an idea whose time is coming, if not come already, how will the current arrangements that so many Medicaid programs have to carve out these services – how are they likely to fair? Is that a dying breed, or is it going to get breathed new life into it as we try to develop the better payment systems?

MICHAEL HOGAN: It's a really good question and the separate carve out thing, sort of can't work in the long run to get this done. On the other hand, I have seen other examples where the way it works is that the behavioral health PM gets dumped into the mainstream plan and it becomes profit margin. I'm being a little – I'm jumping at it a little hard, but there has to be an investment in this. So the money has to move into an integrated

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payment structure. And then you have to invest in the right things, which are the kind of approaches that folks here have talked about and it's sort of – one of my thoughts about this is that integration is a great thing, but we better not implement it the way we implemented the institutionalization. To go back to what Bernie said before. We better actually pay for it, if we expect to get it right.

LONNIE FULLER: The physical health plans are already paying for a chunk of it already, because when I see the patient, I have to bill for some physical ailment and if they have one, great and if it's a symptom, I put that. But there is a barrier there to aggressively bringing people back and managing what is going on with their health and I think that the physical plans – I think they know that they are already paying for a chunk of it, I think there is a better way to go.

BERNARD ENGELBERG: I think payment reform is going to be essential for any of this to work. If it doesn't happen, we are not going to get it – especially recognizing that it is not just – like you said, Mike, dollar profit margins because also what you do on the behavioral side has such an enormous effect on the physical side and that has to be recognized in payment reform itself too, for that to go away and to work.

NICK MACCHIONE: In California, the seriously mental ill, we pay for it completely in our full service partnerships and so forth and that we can assure that integration happens and with great results. I think the concern lies with now the presentation of the ACA and where a huge expansion – nearly two million Medicaid just in California, and that is how do the plans – who we are at the table with, working with taking more of the low to moderate? And I will tell you that some plans are more receptive than others on that. But that is going to be really important in the next few years to getting this right.

AUDIENCE MEMBER: Caitlyn Connelly with the Elder Care Workforce Alliance. I wanted to talk a little bit about training and preparation of this workforce. We know that mental health issues such as depression present themselves differently in older adults as they do in different populations. How do you account for that in the training that you are providing and the preparation that you are giving practitioners when they are getting ready to take on this new treatment?

MICHAEL HOGAN: One of the things that I think is helpful about this, is that the – all of the research about integration, going back to impact and whatever, started out with older people and so it's far better researched and the effectiveness of it is far better established than it is interestingly, with any other age group. So one of the guys that has done a lot of the research, Jürgen Unützer, just ended up as the chairman of the Department of Psychiatry at the University of Washington, which I think he's ambivalent about on the one hand, but it's a good sign to have somebody in charge of a University Department of Psychiatry that is basically training people to do the work of integration, not to be a psychiatric hospital at some level. The training stuff moves slowly because the [unintelligible] own part of it and the State Licensing Board owns part of it and it gets

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started sort of like a locomotive, but I think changes in the delivery system are going to force it to – not to happen.

ED HOWARD: I have a question that ought to be a slam dunk for this crowd. It's a very factual question and that is, are the routine mental health checkups part of the preventive and wellness services covered by the Affordable Care Act? That is to say, with no copay or deductible? No? They are not? [people speaking from audience, hard to hear them]

LAUREL NEWMAN: I thought there were some behavioral and assessment codes that are covered under the Affordable Care Act that we are using at Intermountain. So I think that there are some codes that you can use.

ED HOWARD: We are going to find out the definitive answer to that question and post it on our website - how is that? Allhealth.org where you can also find all the materials that are in your packets. What may very well be the last question.

AUDIENCE MEMBER: My name is [name], I'm a research scientist at National Committee for Quality Assurance. I have a question about, in your opinion, which is more scaleable, bringing mental health into primary care or the ROA bringing primary care into mental health service settings? Or if you think it's the trend in long term, is integration of medical and behavioral health benefit, which this really does not matter. But for now, I want to hear what is your opinion? Which is more acceptable based on what is paid and what is not?

BERNARD ENGELBERG: I would like to just take the first stab at this because it's near and dear to my heart. I think it goes both ways and the reason is because you have to be where the patient is. They might be just seeing their mental health provider and no one else and that might be where you have to access the physical health is through the mental health provider and vice versa. People do not go thinking, oh, I'm going to see a mental health provider. They go to their PCP. So I think that basically, both roads are valid and that this is part of integration that you can access all systems from different points.

LONNIE FULLER: I think that for the severely mentally ill, that it is – there has been attempts to do it at the mental health sites. And I have actually participated in some of that when I was back in Philly. When I look at primary care now and all of the systems of care that we are working on and we are not anywhere near great at it yet. I think it's going to be hard for a mental health facility to have the system infrastructure in place to manage all of those different diseases. I think it's more scaleable to have people with some of the more common and relatively milder mental health illnesses managed in a physical health arena. If you just give us depression, anxiety and bipolar disorder, it covers a lot of people and then we can use our regular systems for primary care, but if you try to build all of those systems in the behavioral health side, I think it's gonna struggle.

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ED HOWARD: Alright well we have come to the end of our allotted time. Incredible amount of good information, lots of good questions and interchange. I want to thank you for being so attentive and full of good questions and for filling out your blue evaluation form. I want to thank our colleagues at Centene and Cenpatico for helping us put this program together and ask you to help me thank our panel for a really wonderful discussion of a tough, tough subject.

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