ALLIANCE FOR
HEALTH REFORM

High-Need, High-Cost Patients: The Role of Behavioral Health
The Commonwealth Fund
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ED HOWARD: Afternoon, my name is Ed Howard; I am with the Alliance for Health Reform on behalf of Senator Blunt, Senator Cardin, and our Board of Directors.

I want to welcome you to this program on behavioral health and its role in caring for high cost, high need patients. Let me just first take a moment to get us on the same page. What we mean by behavioral health, so there is no confusion, at least today. I'm going to borrow the definition from the Larry Green paper that you have in your packets. According to Larry and his co-authors, behavioral health includes patients with mental health and substance use situations, health behavior change, life stressors and crises, as well as stress related physical symptoms. So it's a lot broader than what most people refer to as "mental health" and includes, of note, substance use situations. And it's expensive. You are going to hear a lot of numbers, some stunning ones, from others up here. So it can't be ignored if you are worried about healthcare spending in general.

Along with some of those cost numbers, we are going to look at the health consequences, the physical health consequences of behavioral health problems as well, particularly if they are accompanied by physical problems, which they often are. We are also going to hear about some of the ways at least parts of the healthcare system are trying to meet the behavioral health needs of those high cost, high need patients, in ways that give them relief and reduce excess spending.

We are pleased to have as a partner in today's program, the Commonwealth Fund, a century old philanthropy established to promote the common wheel or the common good. And we are doubly pleased to have as our co-moderator today, Melinda Abrams, who is the Vice President for delivery system reform at the Fund. Melinda watches over their activities in the behavioral health area. We will hear from her in just a moment. Let me just do a little bit of housekeeping before we do that. If you are in a mood to tweet, there is a hashtag "behavioral health" on the screen that you can see and you can use. If you need WiFi to be able to tweet, there are credentials that you can use to tune in, that are on your table and on the screen in front of you. As I said, there is a bunch of good information in the packets that you have, including biographical information for our speakers, which you will not find very voluminous, coming out of either Melinda or my mouth. There is a list of materials beyond what is reproduced, that you can use for further exploration. There is a video recording that will be available on Monday on our website at AllHealth.org and a transcript a couple of days later on that same website, along with all of the Power Point slides that you will see on the screen. We would ask you at the appropriate time to enter into the discussion by asking question of our panel. There are microphones you can use to ask your question orally, there is a great question card in your packets that you can write on and hold up, and you can tweet using that hashtag behavioral health, if you want to give us a question that way, we will be watching to make sure it gets up here.

Now, to get a scope of the issues we are going to explore this afternoon, we are going to turn first to our co-moderator and expert on this subject, Melinda Abrams.

MELINDA ABRAMS: Good afternoon. Great. Thank you all for joining us this afternoon, we are really looking forward to the conversation. I'm just going to provide a little bit of an overview to kind of set the context for the experts on the panel. So, this chart shows a fact that many of you are familiar with, that healthcare costs are highly concentrated. About five percent of the population count for 50 percent of the cost, ten percent of patients account for 65 percent of the cost and this all patients. So it's incredibly concentrated. And so when you think about strategically, how can we try to lower healthcare cost, one logical place to start, potentially, is thinking about those that are really high cost. But not just because they are expensive. Part of the reason they are expensive is they have a lot of needs. They are high need and high cost. They are complex. So it's really about trying to improve the outcomes as well as also increase efficiency and lower cost to the system. These high cost patients, there is some other data that maybe you have seen recently in the Medicaid space, but this is an analysis off of MEPS which shows that really those that are high cost in any given year, may not be high cost the next year. And so also, when you are thinking about targeting those that are high cost, some of them are persistently high cost. Some of them are episodically high cost. And it's actually important for us, as we think about planning and workforce and interventions, to understand who is high cost, what those high cost people look like and the truth is, and Jose Figueroa will get into this when he presents -- it's a heterogeneous population. So among the high cost, there are non-elderly disabled or people with multiple chronic. And how do you organize the system is different and what kind of interventions you would put together for a frail, elderly person living alone, versus someone who is 40 and homebound because of disability, is just very, very different. And that is a really important part of this conversation.

So I keep using this term "high need", "high cost", what are we talking about? What does it mean? So here is what we mean when we say it, just so that again, we are all on the same page. And I'm sure other people can come up with an equally good definition that is different. Clinically, people who have clinically complex needs are likely to have functional limitations, likely to have behavioral health conditions and use a lot of healthcare service. So they are expensive now, or likely to be expensive in the next year or two. So when we talk about high need, high cost, just so people understand, we are not talking about people who are going to be expensive five years from now or ten years from now. Incredibly important conversation, but that is not the conversation that we are really having so much today. Or at least when we talk about high need, high cost, we are talking about those that have a lot of needs as well as also a lot of expense.

So this is analysis that Jerry Anderson and some of his colleagues did for the Commonwealth Fund at Johns Hopkins University off of the medical expenditure panel survey, essentially looking at people with multiple chronic conditions and functional limitations. This is not the be all, end all definition of high need, high cost, but it is really kind of giving you a sense of those with really high needs. This is just illustrative of this very heterogeneous population. By and large, they tend to be older, they tend to be poor and as you will see, the one that is in red, they have a lot of behavioral health problems. So here is where we kind of get at this intersection that behavioral health is one of the drivers of high cost and I think one of the themes you may hear today is, it's not just that

it's additive, but it's multiplicative. It exponentially adds to the cost and the need. It's very complicating and there are lots of ways of addressing it. There are lots of barriers that you are going to hear about and lots of models and options for beginning to address it to the extent of -- that we know what to do.

So in terms of this overlap, here is just a bunch of data, but really, what the point is more than anything else what I said before about the prevalence -- whether you are talking about people who are in Medicare, people who are on Medicaid or the duals and its also about how it really adds to the spend. So we have to actually be more integrative in our approaches, we need to be more coordinated in our approaches and we need to understand that it's not a monolithic group. That it is a heterogeneous group. That is why the work that Dr. Figueroa is going to present about the segments and the key sub groups within the high need, high cost, is so important for planning and for interventions as well as also for policy.

So in summary, it's a heterogeneous population, there is an opportunity to improve. We are going to hear about both the evidence from Dr. Goldman on collaborative care and we are also going to hear about -- from Jeff Richardson, some on the ground models. We are also going to hear from Ben Miller about the opportunity to improve care and some of the policy and payment options that we need to address if we are going to take this on and be serious and try to both improve outcomes and lower costs. And we are going to talk today a lot about behavioral health, but we also recognize that a lot of these patients also have social service needs. And so one of the things that's not really necessarily part of this conversation, but as you see in this last bullet, we recognize and understand that integration of behavioral health and also the social support services, is critical. So with that, I will turn it -- I thank my colleagues and I will turn it back to Ed, who will introduce the rest of the panel. Thank you very much.

ED HOWARD: Thanks very much, Melinda an actually you have biographical information in your packets. What I'm going to do is more identify the people as opposed to introduce them. In fact, Melinda has already given you a sense of, in general, what they are going to be talking about. From our far left, we are going to start with Dr. Jose Figueroa, who is an instructor in medicine at Harvard Medical School and noted health policy researcher. Next to him is Howard Goldman, professor of psychiatry at The University of Maryland School of Medicine and I'm pleased to say, an alum of Alliance briefings past. On Melinda's right, you see Jeff Richardson, the executive director of Mosaic Community Services, the largest community based behavior health service provider in Maryland. And finally, we will hear from Ben Miller -- Dr. Benjamin Miller is a clinical psychologist and a faculty member at the University of Colorado School of Medicine. So without further delay, let us get to the discussion. Dr. Figueroa?

JOSE FIGUEROA: Good afternoon. First I would like to thank the Alliance for Health Reform and the Commonwealth Fund for inviting us today. And so my goal is to give you sort of a macro view of where spending is occurring in these high cost patients and then let the other panelists sort of dig a little bit deeper in the details. So, Melinda just mentioned why it's important.

We have known for a very long time that healthcare costs are concentrated among a small group of people. She gave you a statistic that said five percent make up about 50 percent cost, but that is when you include everyone, including kids and healthy patients. When you look at the Medicare population alone and all the work that I will show you will be just highlighting the Medicare population, about 10 percent make up over half the cost in Medicare. And so actually there is an interesting reference from as far back as 1928. The statistic holds. It's been around for a long time. There has been many, many people trying to target this population and people and interventions and policy efforts, but most of them fail. There was work done by Jerry Anderson, who Melinda highlighted earlier, that about only one in six interventions targeting this population, ends up being successful. Then when you actually look a few years later, three to five years later and see that actually half of them are no longer existing. So, sustainability even of successful interventions doesn't last very long. And the problem being, as Melinda alluded to already, is that this group of patients is not a monolithic group. They are a very heterogeneous population. They are four times as likely to have multiple chronic conditions. They have, as we will talk about, two to three times more mental health conditions, they tend to be much more frail. If you look at markers of frailty, they have about a nine fold increase in these markers. And they tend to be poor. So we are using here about -- close to twice as likely to be enrolled in Medicaid as well. And Medicaid being used as a proxy for low economic status. So we have known this for a long time and part of the reason that we have been working with is, can we find a way to break this heterogeneity and come up with more similar, clinically meaningful groups and then after doing that, will the patterns of spending and utilization -- will it be more helpful as a health system or an accountable care organization or providers, would it then be more helpful to figure out how we can more effectively target these patients? So with the help of the Commonwealth Fund, we at the Harvard School of Public Health, we broke down the Medicare population into six groups. The first group and in the interest of time, I'm not going to go into a lot of detail into the specific criteria, but I'm happy to share it at the end of the talk. The first group is the under 65 disabled. So these are people who are in the Medicare population who qualify either through disability or end stage renal disease, into the Medicare population. The next group, as we talked about, frailty has been shown time and time again that it's a powerful predictor of poor outcomes and increased costs. And then we've -- what's left is people with chronic conditions who are not frail and not disabled. This makes up about 60 percent of the Medicare population, which is a big group. So what we did is we broke down that group into three subgroups and based on complexity of the disease, the severity of the disease and the number of chronic conditions. So this is important because there is a lot of other sort of groups trying to break this population into groups and they just use number of chronic conditions. But we believe that certain chronic conditions are not equal to other chronic conditions. So for example, someone with just hypertension alone is not the same as someone with history of stroke. You can imagine that person with stroke needing much more resources and the need for more services. And then finally, the people that are left over are the people who are not disabled, not frail, with no chronic conditions, which we call "the relatively healthy".

So let's say you are a health system or -- and you are responsible for a big group of patients. If you look today and then you were to look one year into the future and ask the question -- so if you are in one of these buckets, what is your likelihood of being in the top 10 percent of the most expensive patients? And what you can see is, from these six segments, the frail elderly are by far more likely to be in the top 10 percent a year later. Almost one in two -- and surprisingly, chronic conditions alone are not a huge predictor of being high cost, which is some work that, you know, when there is a lot of programs that are just purely disease management focused, and they target patients with diabetes or patients with heart failure and don't take other things into account like disability and frailty, that might explain part of the reason why they are not as successful at controlling cost. The next question is, so we know the likelihood, so what is the proportion or the distribution of high cost patients across these six buckets? And what you will see is that two thirds of all high cost patients are just concentrated in two groups. Again, the young disabled and the frail elderly. Then not as much in sort of step-down approach in terms of severity in the other groups. So again, it seems that the -- where the money is, is in the disabled and the frail. When you compare spending of these high cost patients compared to everybody else -- so this is the average spending per person in each group, if you are a high cost patient, compared to a non-high cost patient in the disabled group, the difference is ten fold. Over $70,000 on average per patient versus -- compared to only $7,000. The average Medicare patient, just to give you a benchmark, is around $9,000 to $10,000 a year. And if you look across all segments, it looks actually pretty similar -- high cost versus non-high cost. Not surprising, right? We defined them by being the most expensive patients, but the only difference to point out here is that it seems again that the frail and the disabled are spending a little bit more money and otherwise, they don't look the same.

But why is segmentation important? And this is where breaking them up into different groups is helpful. So if you break down those costs -- I'm just going to show you two groups, just in the interest of time. Medicare breaks up categories of spending into six buckets. Inpatient spending, outpatient, post acute care, which is essentially nursing homes, rehabs, home health services, visiting nurses and then part D, which is drugs and then the carrier includes physician cost, labs, test and then finally the durable medical equipment. If you look at the spending on average of the frail/elderly, you can see that a lot of the spending is in the inpatient setting, some in the outpatient and then the majority of it in the post acute care setting. And then some across the other ones. Then when you look at the under 65 disabled, what you see is that the majority of the cost are Part D drugs. Then some -- and a lot of also inpatient and outpatient. And when you break down and look -- and I will just give you a representative patient of each group, just so it can give you an idea. So frail/elderly, when you look at the data, it's a 75 year old who is frail, uses a walker to get around. She trips, falls, breaks her hip, gets admitted to the hospital, incurs a lot of cost, gets a hip replacement and obviously given her frailty at baseline and even more so after the hip fracture, she is going to need a lot of services after she leaves the hospitalization. She goes to rehab and then spends days to weeks at a rehab and then after rehab, even then she might not be healthy enough to go home and so at a nursing home. After nursing home, she might need home health visiting nurses. And so that is why you see very quickly where the majority of the spending in that group is.

Compared to someone who is disabled under 65 -- this is a person that is most likely someone like a diabetic patient who ends up developing end stage renal disease, requiring dialysis and by that mean alone, they qualify for Medicare. They get dialysis three times a week; they are a very complicated patient. They have to see a nephrologist, an endocrinologist, a primary care doctor and then because of end stage renal disease, they have low red blood cell count. They are anemic. So there is a medication like Erythropoietin that costs a lot of money. They get an injection. So you can see right away sort of the different types of spending and the different types of pattern, just by breaking down the population into groups. So if you're a health system or a policy maker and you are targeting patients and depending on what proportion of patients you have, you can already know what types of services and workforce you are going to need. If you have a lot of frail elderly, you might want to invest a lot of your resources trying to get patients out of rehab, out of the nursing home, safely back into the home. And are you going to need a lot of people to sort of help in physical therapy at home? Where if you have a lot of the disabled, you might want to focus on the potentially part D -- you know, Medicare doesn't negotiate for drug prices, is that potentially a source of spending?

Another example and the last example I will give, is why segmentation is important, is I mentioned earlier how mental health disease is highly prevalent among the high cost, high need patients. They have much higher rates of depression, much higher rates of anxiety disorders, much higher rates of schizophrenia, psychotic disorders and almost anything else you can think of. PTSD, bipolar disorder. And again, I use the example, if you are a health system policy maker and you have a limited amount of resources and you want to develop a program that targets, let's say, depression and you are trying to identify who should be the people in my program and why? And you can see that by segmenting the population, you can look at the relationship between mental health disease and being high cost. And what you see is that the under 65 disabled, 40% of the high cost patients have depression. Whereas if you look at other groups, for example, the minor complex chronic, it's about equal amount. This is just to say that if you are the end stage renal disease person with diabetes and you are depressed, the likelihood of you taking your medication is much lower. Taking insulin is very hard. You might miss a bunch of dialysis sessions. You might not make it to your nephrologist appointment, so you can imagine that you get so sick that you get hospitalized and require a lot of resources. Whereas someone who just has depression alone, a minor complex chronic, even though the -- it's obviously a good thing to control depression, lets say for whatever reason it's poorly controlled, the consequences of not controlling depression in that person compared to some of the end stage renal disease and diabetes is dramatically different. And so that is why we believe that identifying certain populations is important. Understanding their patterns and their needs and utilization is important and then only then can we more effectively and efficiently target these patients. I will stop there.

ED HOWARD: Thanks very much. We will turn now to Dr. Goldman. Must be something in the Maryland water, neither Dr. Goldman nor Jeff Richardson has any slides. So you are not missing them in your packets.

JEFF RICHARDSON: We want you to come visit us.

HOWARD GOLDMAN: You may feel differently after I speak. I also want to thank the Alliance and the Commonwealth Fund for holding this session and for inviting me. I look around the room and I see a number of familiar faces and even some people who have greater expertise in integrative care than I have. But I think I'm even happier to see people who I have never seen before in a session like this, because it's a sign that perhaps the importance of this particular area is growing and more and more people will become interested and involved in thinking about behavioral health in the context of broader healthcare delivery.

My job is to address the question: Is there anything we can do about the problems in patient care that Jose Figueroa has suggested from his data looking at Medicare patients and the answer is, most definitely there are effective interventions. There are a range of integrated care interventions that have demonstrated effectiveness and I'm going to talk about one in particular. The one called "collaborative care" that has probably the largest evidence base to support it. I wasn't going to present you with a cavalcade of slides with data about each of the more than 60 randomized clinical trials that demonstrate the effectiveness of this intervention, particularly for individuals with depression, but also with a range of other behavioral health conditions that are seen in primary care settings. I really just want to characterize this intervention and tell you a little bit about how the studies in this area have evolve and it's partly selfish in that I think it's a good opportunity to encourage new organizations being exposed to behavioral healthcare and healthcare research, to see how other organizations became involved. And in fact, while I wrote the first paper on integrated care, for me, more than 30 years ago, I really have observed this area of research and care as a non-expert. My own area of expertise is in the treatment of individuals who have psychotic illnesses and are very disabled in the specialty mental health settings. But I have been curious and concerned as a broad health policy person, about the problems that were reflected in Jose Figueroa's data about the needs to do a better job with people with less than disabling mental illnesses that are often co-morbid with general medical conditions and are very needy and as we have seen, they also present a problem to the healthcare system and society because not only do they have high needs, but they generate very high costs.

But the good news is that this intervention, collaborative care, is very good, very effective at treating the behavioral health condition and with a comparatively small investment of additional mental health resources, reduces the overall cost of care and it does it while improving the quality of life and reducing symptomatology and dysfunction. So it's really the best of all worlds in terms of interventions. It's one of the most effective interventions that we have in the field.

So what is it? Basically we are talking about the delivery of specialized behavioral health services in the context of a primary care setting. Historically, the way this has been handled is through referral. Primary care sees lots of individuals who have behavioral health conditions, by and large, while those doctors think that it's their responsibility to help their patients, they often don't feel that they have adequate training or expertise to

do that. So the historic way of handling this is to make a referral to this specialty mental health setting.

The whole idea of the collaborative care model is to stop that referral process, which often ended in people not receiving care. Not really having any continuity of care. And the results were really inadequate. So the idea was, if patients preferred to stay in a primary care setting, why don't we enhance the capacity of primary care to deliver behavioral health services that are effective? Behavioral health was not the only area to think about this problem. There were specialized general healthcare problems that would present in primary care settings. Things like chronic obstructive pulmonary disease, rheumatoid arthritis. Congestive failure. Diabetes. Present in primary care settings, patients prefer to be treated there, general medical doctors don't always feel comfortable. The pattern was to refer. It is interesting, but at the University of Washington, in Seattle, a whole school of thought about how to intervene, grew out of the work first of Ed Wagner and Michael Von Korf, looking at all of these chronic conditions and they developed this strategy, the Collaborative Care Chronic Care model. But it turns out that several psychiatrists became interested in this work -- also, at the University of Washington, Seattle. And so Wayne Caitlin, who just died over this past year, tragically, developed the idea of using this collaborative care model for the treatment of depression in primary care settings. And he extended his work to other investigators, collaborated with Ed Wagner and Michael Von Korf, also with Greg Simon and then later with Jurgen Unutzer, to develop this collaborative care model for the treatment first of depression and now other behavioral health conditions.

Now, the reason why I say, selfishly, I wanted to talk about the collaborative care and the impact study in particular -- this was Jurgen Unutzer's study -- of collaborative care and late life depression, is it was also an initial study by a foundation that had not previously worked in the behavioral health area. So this is by way of saying that it's encouraging to know that over time, additional foundations and organizations have taken on the issue of behavioral healthcare. The John A. Hartford Foundation approached me in the mid 1990's to help them strategically plan a wish to have an initiative in behavioral healthcare. They originally came to me because I work in Medicare policy and they are interested in late life. But the group that I convened decided that what we really needed to do was treat late life depression in primary care. So they said, "So, Howard, do you want to run this initiative?" Fortunately we had invited a few people who really were experts and including a very young at that time, psychiatrist who was very energetic, Jurgen Unutzer. He had been at UCLA and now he's at the University of Washington, he's now the Chairman of the Department. We turned the study over to him and he created impact, which was then the largest treatment study for depression every conducted. It was conducted in 18 primary care sites and eight states and I was very pleased to just stand on the sidelines. Jurgen considers me to be the obstetrician for the impact study. And it was very interesting to see. They ran this study in veteran's administration health settings, in primary care settings, in Kaiser, in HMO's. They ran them in multiple specialty group practices and they ran them all over the country and the results were the same everywhere. They doubled the effectiveness of the treatment of depression for an investment of about $500. Over the course of this intervention, they got a return -- let's

see, Jurgen sent me -- a cost savings of over $3,000 for the investment. A return on investment of over six to one. That's a pretty remarkable set of findings. But it wasn't a singular finding. As I said, it was replicated in each of the settings in the eight states and eighteen sites. Whether they were VA or multi-specialty group, there had already been several randomized trials with mid-life depression. Since the publication of the impact study in 2002, while a series of papers from 2002 to 2004, there are over 60 randomized trials showing that this intervention is superior to any comparator they have ever thrown up against it. This is unprecedented. This is an intervention that needs to be implemented. In my final minute, I just want to make sure that you appreciate that we have a long way to go to get this implemented across the country. We have shown that it can be implemented in all of these diverse settings, but there are terrible problems of implementation related primarily to financing difficulties -- impediments, particularly in a fee-for-service approach, because if you look at the structure of collaborative care, it requires that there be a nurse manager who meets with the individual patient. There is a specialty psychiatrist who's consulting to the team of the nurse care manager and the primary care doctor. They have to have time to consult with each other. They need the time to talk to the patient. Another characteristic of collaborative care is that there typically is a measurement base. Patients are admitted, they are given for depression the PHQ9. It gives them a score for depression and that is used to follow the progress of improvement. But many of these services are not financed in the traditional fee-for-service way and so our field's movement towards more creative financing. The ability to serve people with several services in one day to pay better for non face to face care, are all challenges that we face. Medicare has made some recent changes; other private insurers are looking at it. But while we have established the evidence base for this intervention, we still have a ways to go to improve the policy environment so that it can be available to all people who might need it. Thank you.

ED HOWARD: Thanks very much, Howard. Let's turn to Jeff Richardson.

JEFF RICHARDSON: Howard, what a lovely segue to talk about financing and hand it off to the provider in the group. First, again, my name is Jeff Richardson; I run a program called Mosaic Community Services in Maryland. Most of you guys know where Maryland is, right? Good. Friday afternoon, I just wanted to check. I don't have slides, but I really want to make an open invitation that if any of you guys want to do a road trip, come out and see some of our programs. See this live, see what is working, see what is not. I would love to host a group there any time at your convenience. I think a lot of the things that are happening, and I think because they said it earlier, there are a lot of things that have started that have failed because of financing and other reasons. There is a lot of interesting things going on in the provider community that have shown success and have been extraordinarily positive. But I think we have to find ways to sustain these models to keep it going. My organization serves about 2500 folks a year and just to give you a sense about what we do, we are community behavioral health. And in that space, we are not in one big, shiny building somewhere. We are spread out in the community. We have 120 locations. We provide housing; we provide outpatient community mental health services, addiction programs, and in-home services. We have 700 staff and half of them are really never in an office, they are in people's homes, they are in the community, doing a variety

of things. So we are not in one place. But our focus has been -- again, on the other side of the collaborative care model, we are the behavioral healthcare provider and we are the ones providing the behavioral health services. And so what I wanted to talk about and I'm really hoping you guys have some questions and I'm delighted to tell you -- I have a list of programs in integrated care that have failed. It's almost longer than the list that has been successful. But really that is kind of the space that we are in. We have to try and innovate and I think there is a lot of exciting opportunities ahead of us, but there is a lot of things around the way these programs are financed that will really help us maintain that traction.

The other piece that is really important -- Howard mentioned the collaborative care piece around the intervention provided in primary care. Behavioral health and what I do, is that we simply don't provide an intervention in an office. Much of what we do is focused on the things Melinda mentioned earlier about those social determinants of health. We operate and we provide over 500 beds of permanent housing to people in the community. We provide employment services. We provide family services. We provide drop in supports for consumers. We provide services that help people keep their benefits, help them engage their community in a way that you can provide an intervention, but if you are not providing that range of community based supports, it's going to fail. So when we are talking about policy and we are talking about programming, keep in mind, it's simply not enough just to talk about that intervention that happens in that office. It's all the things that surround that person once they leave. We provide services in some of the poorest communities in Baltimore and ones in some of the -- and a variety of suburban ones as well. So there is a variety of ways that we provide these services. So let me go through a few of them in the seven minutes that I have left. Gosh, I could talk for hours about this, but you guys wouldn't want that.

First, let me just talk about a model that we have developed that I think is not unique, it's not rocket science, but one of the things that we felt really strongly about, particularly in one of our Baltimore city locations, is coordinating and creating an access point for well coordinated services beyond mental health. So what we have is a site -- actually, a couple blocks from where all the riots happened in Baltimore city, where we have created a center for integrated care services. And what we have done is establish a site that we are providing addiction, mental health, primary care -- we actually operate our own primary care practice in that location. Because we were finding that people weren't able to access primary care services that they felt comfortable in. And the locus of supports and controls for them were coming into one of our programs to get those supports. Additionally, we provide pain management services, which is another area of real significance, that we were seeing a lot of people who were doing drug seeking, dealing with depression, doing lots of things that weren't terribly helpful towards their overall health and were partnering with a pain management group that actually reached out to us to provide mental health services for their pain management centers. So a lot of what we do -- and we provide this all in one coordinated fashion and I think if you read any of the articles that were attached to the handouts, one of the things that is really important in collaborative care and any notion of integrative care, is that people who are working with a person are coordinating their efforts, they are communicating, they are working in a

way that is simply providing a service next to another one, is not sufficient. It is helping people both talk to each other, collaborate as a team and coordinate those services efficiently. And I think that is where we have seen some of our greatest results. The folks that we serve, one of the things that is very important is that it's important that we felt that these services are provided in one of our settings, was that we have seen way too many people die needlessly because they weren't getting access to care. We have had people show up in primary care offices, particularly folks with severe and persistent mental illness, where the doctor wasn't sure if it was a psychotic disorder or they really were having chest pains. And that lack of coordination has created some really horrible events over the years. I think we have seen that as a big issue for us.

The other thing that I'm going to touch on in the next couple of minutes that I have left is behavioral health homes, which has been a big, big piece of our -- over the past couple of years, a service that has helped us coordinate, particularly for folks who have a chronic and persistent mental illness. And what that program does is provide us with nurse care managers, a supervising physician and a team of staff that are really looking at the overall health needs of folks with chronic and persistent mental illness. And what they are doing is helping people both get medical screenings, follow-up on their medical appointments and share all that social logistics that we all go through. Just think about the day, if you get a prescription, trying to get to the pharmacy to get it. To make sure that you talk to the other doctor who is supposed to talk to the other doctor -- it can be a -- I guess there is a polite term for it, but it can be cluster, right? When you are trying to get all of this done. Imagine in a community where there are not a lot of resources for you and you are dealing with your own issues about really finding a place to live and all of this surrounding that individual's capacity to be successful and effective. So these programs not only provide medical intervention, they are helping coordinate all of those social determinants that help someone maintain their overall health. What we are doing is we are looking at Medicaid claims data for this group and we are able to evaluate overall costs and patterns of use of a number of things. We talked earlier about polypharmacy. We are able to evaluate medication and medication prescriptions and also the full medical utilization of those folks in our programs. And what we found is actually -- since we have implemented this program, we were just looking at some data actually last week. We measured the past three months prior and we have seen a drop of 82% in terms of overall non-behavior health medical costs for this group of consumers. And that is a staggering number. And again, what we have done is nothing that is magical, but it's doing the things that Howard said earlier, that fee-for-service doesn't pay for. It's all that connective tissue that makes all of these things happen. And so for me, that is an important principle, no matter what we do.

A few other things I just wanted to touch on and I think this is important, is we are partnering with a number of primary care practices. We are actually trying to work towards a collaborative care model with an FQ8C in Baltimore. We also attached our mental health services to a pediatric practice, providing a collaborative care model in the city. But all of these are not well funded, so we have really scotch taped these together with chewing gum and glue and whatever to make this work. But this notion of how we can do this in a more collaborative fashion and get a support for this, is really significant.

A few other things that have been really important that we have tried to do is that along with a lot of partnerships with hospitals, crisis programs. We provide a lot of crisis services to people. And at that point, people are getting stepped down from hospitals with behavioral health needs, but really don't have physician services in place, well coordinated housing and other services. So the role of crisis programming and helping people effectively link into medical services has been absolutely vital. The relationship that we have with hospitals is continuing to be very important to us. We also are finding ourselves in the position of -- I don't know, private label provider in many systems, where we are actually being linked in and we are providing services under someone else's sort of brand about providing behavioral health. Because in all of our communities across the country, the access to mental health providers is a huge challenge. There are not enough of us to do this work. So it's really important to be able to link these limited resources in a much more effective fashion.

The last piece of thing I wanted to touch on is, again, one of the things that we are all working on, is also working directly with the payers. Beyond Medicaid and Medicare, we have been approached by some private insurers to essentially look at their high cost users and there are a lot of creative activities that are happening around engaging people in care and supporting them from that transition of being in a hospital setting in a high cost setting, to one in the community. And much of what we are doing is not super sexy, exotic stuff. It is making sure someone has a bed, has a place to live, is near their friends and that they have a team of clinicians that can support them in their success. So I have got 11 seconds left. I went through a lot of stuff.

The last thing I wanted to make a plug for and if you haven't heard about it, is the Excellence in Mental Health Act, which has been a really critical piece of legislation and for us, it's a game changer. And what that is allowing us to do, is look at a perspective payment system for behavioral health providers. It will create a national standard for these services and it will make -- it will create some of that connective tissue that I talked about, about being able to provide the case management and the coordination and be able to deliver services in a much more efficient fashion, with primary health and behavioral health linked effectively together. So hopefully you guys have lots of questions. And if you are not -- I will leave my card, come by and visit us. I really -- what we do and what community providers are doing is so important and they are so woefully under funded across this country. We need your support. Thank you.

ED HOWARD: We will turn to Benjamin Miller now to --

BENJAMIN MILLER: Good afternoon. So, my name is Ben Miller, I am the Director of the Eugene S. Farley Junior Health Policy Center at the University of Colorado. Show of hands real quick, just so I know who is in the room -- how many of you would you classify yourself as a behavioral health something? I would say provider, but you represent behavioral health. Okay, how many of you represent more of the medical side of that equation? Okay, hands back down. How many of you actively right now are in the process of working on something where you are bringing behavioral health and medical

together? Okay, pause. Don't put them down. Just take a look around for a minute. This is approximately -- 61% of the room right now. Thank you. I'm not an economist. What you see here and what you have heard so far is that we now have a movement on our hands, my friends. This is not a good idea. This is not more evidence do we need. We have a movement where we are able to demonstrate conclusively that when you address the mind and the body, people get better and you save money. But most importantly, and this is kind of my whole point and this is why I gave you the take-aways at the beginning -- if we really want to do what is right for people, we give them access to comprehensive services wherever they need them. This is not about making people go to 22 different places just to find the right kinds of providers that can take care of that piece of them. This is about defragmenting healthcare and integrating at levels that will make a difference for people. I don't want that to get lost here; because I am going to a lot about money. You know, I'm in Colorado and so the bumper sticker on my mountain bike says, "Death to fee-for-service" and we are all about that. And we will really actually be able to achieve a lot of payment reform that supports better behavioral health in primary care and I'm going to hopefully give you some ideas on that today.

Okay, data. You heard a lot, I'm going to give you a little bit more. This is our pretty little slide. I just want to point out a couple of things that logically don't make any sense. I hope you can see these. We know that two thirds of primary care physicians can get access to specialty behavioral health. But yet, we also know in the same vein that when patients present to primary care, they actually have quite a few mental health conditions. What is wrong with that picture? Where is the disconnect? Look at the other side of that slide here. 46% of folks in their lifetime are going to have some type of mental health or substance use need or issue. But yet, 67% of those folks don't get the care that they want or need. And look at our kids. There is a study that just came out last week -- that 35% of kids' mental health issues are only managed in the pediatric setting. All these data are not new. All these data -- you heard Dr. Goldman say this -- have been worked on for 25-30 years now. My own chair of my department wrote for the Institute of Medicine. That mental health and primary care are inseparable and any attempts to separate the two leads to inferior care. He actually wrote that report the year I graduated high school, which is a lot longer ago then you might think. We know that this is the time to do something. I use the slide from my good friend at Cherokee Hill Systems, a leader and exemplar in the world of integrating care. This slide simply shows you that we need to change the dominant paradigm for how we perceive mental health. We need to change the culture of addressing mental health, behavioral health and substance abuse issues, if we actually want to begin to meet people where they are at. And you can look here at the center column here; you can see the far left. If you look at the components of care associated with any type of delivery, look at the center column. -- the traditional approach for mental health and then look at the far column -- how that changes when you shift into a primary care setting. Behavioral health providers that are churning out left and right -- I'm one of them, that come from graduate schools, have to be taught that to remain relevant in the larger healthcare milieu, we need to have generalist skills that can be applied in multiple settings. This is not just about making sure that you can deliver specialty interventions in one setting. This is about being applicable for many people in

multiple settings. We have an opportunity to change the way that we train our providers to make them more aware of the impact they can have in primary care.

In the real world, what this looks like, we observed close to 19 practices all over the country. This was work that was sponsored by our friends at the Agency for Healthcare Research and Quality, as well as at the Colorado Health Foundation. And we found that when you go into practices that are doing a good job of addressing behavioral health in primary care, they don't often follow a road map. They often don't follow the latest, greatest evidence that might be very compelling. They do what they think is best for the people that they are seeing every day. And we found that practices engage in three different behaviors simultaneously. Almost concurrently. They consult. Behavioral health is consulting on issues related to behavioral health. They coordinate care, so that if they need to have a patient that goes and seeks specialty services, they are there to help facilitate that coordination. They can collaborate instantaneously with the providers that are there onsite. And they do this almost without even knowing. They have work flows to facilitate their involvement with the primary care practice, but the function that they play out day in and day out, is really about what that patient needs in the moment.

Okay, so I told you about my "death to fee-for-service", that was punchline for that one. But if we really get to where we are now in healthcare, we know that there is substantial evidence that helps us really see that people get better when you address their whole. We have not yet come to a place that we have changed the financing and the policy to accommodate clinical integration. Which means that every day, there are frontline practices like those that Jeff described that are doing this work, that are doing it because it's what's right for people, but they are not supported financially. I'm going to try to give you a couple of ideas on what this looks like here.

Let me tell you briefly about a project that we did in Colorado that was called Sustaining Healthcare Across Integrated Primary Care Efforts. This was a three year project where we looked at paying behavioral health and primary care differently. We said fee-for-service is a bad idea; it relegates providers to their respective arms of the silo. We want to pay the team to take care of that practice of those people. So you can see here, what we did, we basically gave the practice a global budget. We estimated a baseline expenditure that really took into account the people that were showing up at practice, the type of providers you had in practice and then we gave them a budget very similar to what you probably did and had as a kid. You had an allowance. This is how much money you have to do what you want to do. We did that with primary care. We included behavioral health though. This allowed the behavioral health providers to do whatever they felt they needed to do to take care of the patients. This did not say to them -- we did not say to them, you have to only do X, Y and Z, because that is what we are going to pay for. We allowed them to do what was best and here is what we found. And actually, the last point on here is really important. We allowed the primary care practices to own their own behavioral health services. They became a member of the team and not an auxiliary or specialty function that exists in a different room or a different part of the practice. They were a member of that primary care team. Therefore, being a natural extension of that primary care function. And here is what we found -- this is after three years. We just got these

data last Friday from an actuary, so they are not really that cutsie yet. But I just want to tell you briefly that when we provided a global budget to primary care that included behavioral health, within 18 months, these are three practices that we looked at, we were able to see a 5.5% in Medicaid reduction -- these are total cost of care numbers here folks. Three percent in Medicare and then in the duals, which get a lot of attention in policy, we saw a 5.4% reduction. Now we are still in the process of analyzing our commercial data and we are also in the process of writing all this up. Just to put some numbers on this for you, this is close to two million dollars in 18 months and three practices by integrating one behavioral health provider in each of those practices. By investing in primary care and giving them unfettered access to behavioral health. This is real, this is compelling. This is the type of data that we need to be taking and saying to whoever we are trying to convince to pay for care differently, "Listen folks, it's not about changing the way that we pay for mental health. This is about investing in primary care, which includes behavioral health."

Payment recommendations. Obviously we need to do everything we can to get away from paying for those units. The hamster wheel medicine that is so common out there, we have to eradicate. We have to think about ways that we can support the practice and hold them accountable with some type of payment to that practice for their population. And we need to consider, in the opportunities where we are integrating primary care into behavioral health, how can behavioral health providers begin to share in some of the gains when appropriate? How can they begin to take risk for some of these conditions that historically haven't been included within their portfolio? So consider your policy.

These are the biggies, folks. Now, I live in a world of policy where I talk about this day in and day out. But you need to consider in all of your respective universes, what impact carving out the behavioral health benefit has on people. You just ask yourself -- what does that mean and how does that limit what we are able to do? Secondly, we do need to consider a lot of these home grown assessments that are out there, that have basically been promulgated over time on ways to measure pieces of health. Are they relevant? How can we consider standardizing a lot of our assessment methodologies to take care of people? Third, we need to see the mental health system for what it is and we need to reinforce that system and allow it to be a stronghold for specialty mental health. We need to recognize that we have really missed a boat here in allowing more specialty mental health services to be strong by not necessarily putting the dollars where they could go to support those services. And then finally we need to dispel the myth that its one size fits all for behavioral health. In payment and in policy, when we talk about behavioral health, we need to be very clear in the context in which we are talking about behavioral health. It is not one size fits all, folks. When patients present to primary care, they might need something right then in that moment. They may not need to go to another setting for that. However, a lot of our policies dictate that there might be one place for you to go for your care. We have to change that.

In closing -- I'm going to give you the takeaways again. I already gave them to you, but just so you can walk away. The legacy systems and the highly antiquated payment methodologies really limit our ability to provide behavioral health in primary care.

Number two: There must be no wrong door for patients in our community. Wherever they show up, when they use the term "behavioral health", we need to be able to allow them access to someone. Number three: All health policies really should be measured against the question, will this limit my patient's choice in receiving behavioral health where they want? If the answer to that question is, yes folks, we need to reconsider it. If the answer to that question is yes, ask yourself- why are we doing it? Thank you.

ED HOWARD: Great. Thanks very much, Ben. Q & A time! You have three options. One of them is not to just raise your hand. If you want to ask a question orally, go to one of the microphones where you see them on either side of the room, fill out a green card and hold it up and one of our staff will bring it forward. Or you can tweet using hashtag behavioral health. If you are asking a question, I would ask you to identify yourself and your affiliation, but before we do that, I want to let Melinda exercise the prerogative of the chair. She and I have been talking back and forth based on what we have been hearing and we want to get something in that we thought would be useful for you to frame the conversation.

MELINDA ABRAMS: So I want to thank everyone for the presentations and then I just was gonna quickly ask a question that touched on one topic that really hadn't come up and that was really about -- well, I guess actually Jeff did mention, there aren't enough providers. So I guess the question is, is this really a problem of person power or is this a work force problem? Or is this a coordination problem? In that by which I mean, is it really about we need to train more people or is it about how we use the existing workforce and think about it in more creative ways?

JEFF RICHARDSON : I can just answer that first by just saying, yes to all of those things you just said. I think there are a couple pieces there that we're seeing in terms of, how do we utilize a specialized mental health staff, for example, psychiatrists? One of the things, that I think you heard in bits of the data, that the majority of people that actually don't get mental health services in mental health facilities. They're getting them in primary care settings. And one of the things that we have done, and we think could be an important model to do is to train and provide consultation services, as a more effective means to utilize some of that specialized staff. The second is, is looking at other methodologies, and really supporting them. One being the use of telemedicine consultations.

One of the things that we are piloting, and have been using, is some app-based, phone-based applications that are showing some other ways to extend very limited capacity. You know, I don't live in a mountain state. But I live in, almost as bad, a beltway state, where if someone needs to get to one site to another, to see someone, we're not taking advantage of technology. So I think a lot of it has to do with utilizing those resources in a much more effective fashion. And providing consultation, not just on the mental health side, but on the primary health side, where a lot of those primary health resources, which are very limited, can be actually provided and built in to some of the mental health programs. Because I don't, and I think frankly, we don't do a good job identifying where people should be treated in each of these systems.

MELINDA ABRAMS: Great. Why don't we start over here?

AUDIENCE MEMBER: You actually addressed some of my question in what you were bringing up.

MELINDA ABRAMS: Oh, I'm sorry.

AUDIENCE MEMBER: My name is Teresa Walsh. I'm here from the Advisory Board Company. I've been leading the Integrated Behavioral Health Research there for about the past three years or so. And my question was on the provider shortage front, I'd be very curious to hear all of your perspectives on the role of telehealth, as a potential compliment to integrated behavioral health services. What some of the challenges are there, both in financing, also in just the implementation, and what you see as kind of the future compliments to this model, as we're getting better virtual technologies?

BENJAMIN MILLER: So I'll start really quickly. Thanks for the question. First of all, I think this is a two-fold issue when it comes to workforce. While quantity is easy to talk about, that we need more, I actually think there's a huge quality problem. And I don't want to point fingers, but actually, if we consider training for the workforce of the future, then they need to have different skill sets than they currently have. So we need to consider, what type of training and education are we giving to our providers to work in these nontraditional settings? That'd be number one. The second piece from a policy perspective is we have major mal distribution of the workforce. And if you just look at where the workforce currently presides and where they exist, it's like a lizard to a warm rock. They typically go to urban areas and they stay there. And we need to figure out ways to distribute more according -- I mean, I have frontier areas in Colorado that we really do need to have incentives to put the providers in those spaces.

To your final point around telehealth. Personally, in a lot of our experience, we've seen beautiful telehealth rooms in practices that are very empty, and have a little bit of dust on them, because no one's using them. Is that a byproduct of payment or policy? I'm not sure, but I do know one thing. When we talk to a lot of those providers in practices, they say that people want connection with a person. And you can initiate some of those interventions through telehealth, after you get to know the individual. But oftentimes, people really want to press the flesh and get to know you first.

MELINDA ABRAMS: Thank you.

JEFF RICHARDSON: I just want to echo what Ben just said about training. And I mean, in these models, and we were even talking earlier about the collaborative care, there really is a different model of the way behavioral health staff should be working. There's a much more short term, brief focused interventions that people generally aren't well-trained in when they come out of graduate programs and the like. And yeah, I've seen the issue with those dusty tele -- I have seen that, too. And I think what's happened is sometimes, the easy stuff is to buy the stuff, the good shiny equipment. The sort of the hard grinding part is finding the resources to train people on how to adequately use it, and

really support staff in developing those models, which I don't think we've done a good job with.

MELINDA ABRAMS: Over here.

AUDIENCE MEMBER: Stuart Gordon, National Association of State Mental Health Program Directors. Ben and Howard, can you talk about the degree to which the absence of meaningful use incentives for behavioral health providers is served as a barrier to integrating health records? And Ben and Jeff, can you talk about the role of peer support in your two organizations?

ED HOWARD: Now when you're talking about meaningful use, we're talking about the HITECH payments, is that right?

BENJAMIN MILLER: So, those of you not in Wonk world, when we looked at the HITECH Act, behavioral health was not included as a provider that could be incented to participate in that. So yes, this is problematic, and it's problematic on multiple fronts. And behavioral health, when they weren't incented to really go out and have the resources to buy EHR's, they bought what they could. And in many cases now, a lot of those products that they purchased are not up to par or up to snuff, to be able to get meaningful data out of. A lot of the data that you can extract from some of these electronic health records are not in discreet fields. They're still in narrative format, and it's very challenging. And I think we have put ourselves backwards quite a bit with that, especially in the specialty mental health sector. So that's kind of a point number one.

Point number two, to that, is that there are opportunities now, when we consider more integrated delivery systems in ACO's, to think about how a lot of our medical centers could be partnering more with some of our mental health centers, and looking at ways that they can have similar EHR mechanisms. Now, this is happening. It used to be well; we need to have a different EHR, because we're providing different services. And what we're finding is that some of those functions are actually necessary, or are available in these EHR's. They're just not utilized. So it's a tremendous problem, and we're all trying to undo it.

MELINDA ABRAMS: Great.

JEFF RICHARDSON: Just to the use of, first on the -- I'll mention peer supports. But first, on the EHR piece around meaningful use. I said earlier, I have 700 staff. And under the meaningful use criteria, we had 35 staff eligible for the meaningful use funds. So you know, I don't want to pick on our electronic health record provider, but if you'd like, I'll tell you quietly. But we've had a lot of work we've had to do with it, and it's a system that's been constant flux. And I think there is a lot more that's going on, in that space around behavioral health providers, doing much more linkages directly with primary health, hospital systems, particularly with some of the largest vendors are really starting to work together. Epic, which almost every hospital system in the world has, is starting to

do much more active work with behavioral health providers, because of the hospitals pushing the issue.

But it's got a long way to go, and the behavioral health providers are woefully undercapitalized. And so, beyond the Meaningful Use Act, there wasn't any money to invest in that. And you heard me mention earlier about the Excellence in Mental Health Act, which we really hope will help support that. In terms of peer supports, both in integrated care and overall, they are a critical piece of what we do. And we've been talking a lot about mental health, but also on the addiction side. And I think, we employ a lot of people in recovery, both in mental health and in addictions. And we've talked about people getting access to primary health services. We have people that literally were dying, because they weren't getting treatment for cancer, that have talked to other people about what that means to do that. And a huge issue in our field has been smoking, particularly folks with chronic and persistent mental illness. And so, we're doing a lot to help people quit smoking, and you know, that has been a very powerful role of peer supports they've had, beyond the traditional ones that they've had in mental health.

MELINDA ABRAMS: Peggy?

AUDIENCE MEMBER: Hi. Peggy O'Kane, from NCQA. Howard, this is a question for you. I think the beauty of the collaborative care model is the process design and the managing against outcomes that really -- both of those things created discipline that's very unusual in care anywhere. I wonder, has anyone tried this with the seriously mentally ill, that kind of process design and outcomes based approach? And if you could just speak to that.

HOWARD GOLDMAN: That's a nice observation, Peggy. With respect to people with more persistent illness and psychotic illnesses, there is some effort to do measurement based care. One of the problems with pay for performance, as you would really clearly understand, is there's a concern about cherry picking people at the front end. So the world of working with people who are disabled is, we want to encourage people to take the most disabled, the most difficult individuals. And so, the focus there has been on fidelity to the evidence-based practices. And when you rate the whole program on the basis of their likelihood of getting a good outcome, you don't work against recruiting those who are most disabled. But there are some measures that are used in performance. You look at employment, for example, in first episode psychosis services. We do look at that as well as symptomology. But I think it's a very nice observation that we have not done it as much in the treatment of people with psychotic illnesses. We have with measurement based care and depression treatment.

ED HOWARD: And if I can, let me just bring Ben into the conversation. Ben, the savings that you were describing in your slide were very impressive. What's the tradeoff? What kind of measurements did you use to make sure that you didn't save, because you didn't deliver the services?

MELINDA ABRAMS: On the quality.

BENJAMIN MILLER: Yeah, on the quality side. So we did something. We actually built off a federal program that's been going on for a couple of years now, called the Comprehensive Primary Care Initiative, and it's out of CMMI, through CMS. And one of the things, for those of you not familiar, is that this is a multi-payer initiative that allowed for payers to come together, and they agreed to support common measures, and they agreed to support the primary care. They had milestones throughout that program. Milestone two for the Comprehensive Primary Care Initiative focused on behavioral health integration. Which meant the practices then received multi-payer support, to start to tackle some of these issues. So the quality and the outcomes that we described -- and I can't actually tell you the entire story here.

We have data that show, and I didn't bring it today, that there was an increase in the number of patients that were identified for behavioral health. That's not a shocker, right? Because now you're incented to actually pay attention to it. But we held the practices accountable for addressing those behavioral health issues. It wasn't that you just could cast a wide net and find a whole new bunch of cases. We actually made sure that the practices were then accountable for those patients. Now, that methodology for payment and that risk stratification that they're using now, we are in the process of trying to scale. I don't want to go into too much detail on that. I wish I had my payer friends up here, to tell you a little bit about it. But we actually did not see a decrease in quality, when it came to the behavioral health facets. And we actually saw an increase in some of the outcomes, if you can believe it, in three years' time.

MELINDA ABRAMS: Excellent.

AUDIENCE MEMBER: Doug Tynan from the American Psychological Association. I want to thank everyone for great presentations. I want to go back to Dr. Figueroa's first presentation regarding healthcare costs in the frail elderly versus other populations. And I think that points out that we sometimes use a very middle-aged centric view of all adult healthcare, and we don't fully appreciate the needs of the elderly. I think when you look at that group, home health aides, home visiting; those are your greatest needs. We may well in the future be in a world where these folks get around in a Google car. And if they need a prescription, it's going to arrive by drone from Walgreen's. And, we're not that far from it. That's coming soon. However, I think the conceptualization of mental illness in that population has to change.

When someone is 80 or 85 or 90, and they say they're depressed, I had a disagreement with you characterizing that as a depressive disease. When you can't walk very well, and as my father said, when he's 90, the hardest part of 90 is you've outlived all your friends, and you've lost all this social reinforcement, we have to think about depression in a different way. Is it a normal reaction to adverse events? And if so, then you treat it very differently, and not treat it as a psychiatric illness. It is perhaps one of the stages. And I really think, from the New York Times' article on Tuesday, showing the highest costs are on dementia in the last five years of life, I guess I'm summing up by saying, I really think we ought to think about it in terms of, how do you create services that provide, address

those needs? And maybe it is better training of home health aides, and have them have backup support from mental health professionals.

ED HOWARD: Howard, do you want to --

HOWARD GOLDMAN: Well, I did want to remind us that the impact study that I referred to was on late life depression.

AUDIENCE MEMBER: It was defined as over 60 in those papers.

HOWARD GOLDMAN: Yeah, but a fair number of --

AUDIENCE MEMBER: So, I don't think I'm late in life, I hope.

HOWARD GOLDMAN: Well, I'm feeling that right now. There is a distinction between demoralization and clinical depression. And the PHQ-9, which was the criteria and measure used is pretty good at distinguishing them. And what we found in the impact study was that the individuals, who participated, responded to conventional clinical treatment. On the other hand, there certainly are other interventions that are useful for people who don't have clinical depression, but are demoralized or lonely. I can say that in aging relatives of my own, it was pretty easy for me to distinguish between the times when they were demoralized and sad, and when they were clinically depressed. There wasn't much question in my mind.

MELINDA ABRAMS: And I think your general comment speaks, I mean is exactly the point we were trying to make. That how we handle kind of certain kind of mental health disorders should vary based on the subgroup or the segment of the population. And should we think differently about how we address it in the frail elderly? And I mean, so I think it's exactly the conversation we want to have going forward.

JEFF RICHARDSON: And if I could add, Howard mentioned the PHQ-9. I mean, that's a very basic tool that I think is something that across healthcare, if we had people were more and more obligated to fill that out, that would be a very useful tool to provide that discrimination in terms of needs. And I think it's not used often enough.

AUDIENCE MEMBER: Hi. Thank you all so much for speaking today. My name is Monda Napondian [sp], and I'm from the National Council for Behavioral Health with the Center for Integrated Health Solutions. And my question for you all today is, you all talked across the board about how high cost, high need patients have existed for a long time, and that you've known that collaborative care models have worked for a long time as well. And in the room, we saw that there are a lot more people working towards these efforts, which is wonderful. But my question to you is, with these centers created, how much of it doesn't actually get to the patients that actually need the help? What does outreach look like, and how is that incentivized either economically or in other ways that you might have thought about? Because at these centers, they're sitting, collecting dust, kind of like you were talking about, with the telecommunications. Then, what is the

point? How do we reach the most marginalized populations and the diverse populations that really need our help? Thank you.

MELINDA ABRAMS: Jeff, do you want to --

JEFF RICHARDSON: I mean, I think it's a great question. And we started off by saying and Melinda said it, that there's a number of different segments here, and how we approach people is very different. I think the way that we talk overall about mental health and behavioral health has to change. I mean, we kind of talk about it very often, but it is an organ, right? And we need to start not pretending it isn't, and the way we evaluate people is make this part of the discussion. I think for disenfranchised populations, access to care, and cultural competency, trauma informed care, all of those pieces have been critical about creating those access points. And you know, I do think we really need to be able to go to -- and Ben said this earlier, about we need to go where people want to get care, not make them go find it. And so, I discussed earlier what we were doing in Baltimore, there's hundreds of providers across the country trying to do this. So we need to make behavioral health available, where everyone gets those services from. And in marginalized communities, we need to make a bigger effort to support the safety net providers that are delivering that care.

BENJAMIN MILLER: So I think it's important to recognize that we all would be quite naïve if we didn't understand that we're up against a ridiculous amount of history and culture that we're trying to change. Our society has been taught that we think of mental as separate. And so of course, we have stigma. Why would you want to have that highlighted and identified as a problem that you face? When you integrate at whatever level, you actually normalize the whole mental health piece. You make this just a part your health. So when we talk about health, health is health is health. That is ultimately the goal here. It is to change that culture, and to change that paradigm. Now, one final thing here. The power of primary care, which many of you probably already know, is through what we call comprehensiveness and continuity.

Comprehensiveness is that you're responsible for the whole of health. Continuity is that you have an established relationship over a period of time. Think about your primary care providers, the people that you go to, and talk to about your common cold or whatnot. You're likely more to talk about those mental health issues to them, than maybe anybody else, just because they are the person in the healthcare arena that you talk to the most. How can we normalize mental health? We can have a primary care practice or culture that says, well of course, you know, we address that here, too. Of course, we have somebody on our team that can help you take care of that.

MELINDA ABRAMS: I guess the last thing I would really quickly say is while we've known that healthcare costs are concentrated for some time, we've known that the population is heterogeneous for some time, and the evidence has been growing for some time, what is different is the payments models and the shifts that we're seeing in the delivery, where there is a greater interest and more incentives to push towards collaborative care, comprehensive care, population health. And that's part of where I

think we have a greater appetite among health system leadership, to consider new ways of delivering care. Because now, it can align with their quality and their financial goals. But we still have a number of barriers. Sorry, that was just --

ED HOWARD: Before you get a chance to ask your question, do you want to add something, Howard? Go ahead.

HOWARD GOLDMAN: I just wanted to agree with Melinda.

ED HOWARD: Always good, always good.

MELINDA ABRAMS: Okay, he can do that.

ED HOWARD: Before you ask a question, we are running close to the end of the time. I think the folks who are lined up behind the microphone may be the last ones we're going to be able to accommodate at the microphones. And I'd like to implore you to pull out this cute little half page evaluation from your packets, and give us some feedback on how we can continue the conversation on this topic, suggest other topics, give us some speakers you'd like to hear. Give us some feedback. Thank you. And thank you for your patience.

AUDIENCE MEMBER: I'm David Connolly of the Connolly Group. We represent the two largest marriage and family therapist groups in the country, and we also work very closely with the licensed mental health counselor groups. That's 40 percent of the mental health workforce in this country, forty percent who are excluded from Medicare. They cannot bill Medicare. This has a number of effects. One of which is that if you cannot bill Medicare, then you cannot treat a dual eligible. Because in states like California, you can't be reimbursed by Medi-Cal, until you bill Medicare first. So these practitioners are unavailable for the elderly and for the dual eligibles. So when you look at Dr. Figueroa's charts about Medicare and the elderly, I kept putting up an asterisk in there, because you're only pitching it to 60 percent of the workforce.

And the big problem that we experience throughout the country is that everybody else covers these services. So when the patient reached his 65, they age out of coverage, and where do they go? And a number of our members work in the referral end of delivery, and they have nobody to refer to. And the other point to Dr. Miller's observation about where the providers are, these two groups are the majority of mental health providers in rural areas in this country. And here again, this exacerbates the problem of them not being able to be a Medicare provider. So that's an observation I'd like to make to Melinda's point about workforce, and to the policymakers in the group, please pass the legislation that will enable 40 percent of the workforce to become Medicare providers.

MELINDA ABRAMS: Great, thank you.

AUDIENCE MEMBER: Hi. I'm Sarah Scholle from the National Committee for Quality Assurance. I actually have an observation and a question. So in our patient center medical

home, standards that cover about I think 60,000 clinicians, we have increased our expectations for integrating behavioral health. And we are hearing from the world of primary care that this is just too hard. We've upped the ante way too high for primary care. So, would love to get your reactions to that. And the second is a question for you. I was on a panel for the Institute of Medicine about the use of evidence-based psychosocial interventions. And I wonder what the panel thinks about the opportunity for encouraging implementation. That's something we're not actually sure how we should be measuring it or encouraging it.

BENJAMIN MILLER: So I'll take the first part, Sarah. That's a great question. Yes, this is hard. Yes, we knew it was going to be hard. And if you look at, and Jeff already said this. He's got examples of where there's failure. What we found that sets up practices to be the most successful is that we give them access to practice transformation supports. And I know that may seem like a no-brainer to many of you folks. But if simply asking a new provider that's been taught to operate in their own silo, to come into a new setting, and then just work as a team is really challenging. You've got to have this assimilation of cultures where people can come and work together to benefit the team. That requires transformation. That requires somebody that knows how to help practices change workflows, to work on how they're going to measure things differently. To work on, whose responsibility is it when the patient says I'm depressed? That's hard stuff, and that flies in the face of how a lot of our primary culture has been when it's about the 15 minutes, or the seven minutes, or however long. So I would say that's my really quick and short answer, Sarah, but we have to give them some help.

JEFF RICHARDSON: I would just add to that, that I think the failure is not in the practitioners. It's the failure in management. Because I think a lot of what's happened is there's been, in many cases, someone says, oh yeah, we can get a grant if we just sort of, if we do this. And it's foisted onto the primary care clinicians to solve this, and at the same level, expected to practice in the same way they always have. I think the collaborative care model, I can tell you we've worked with a couple centers, where it was doomed to failure because there wasn't a commitment at the management level, to change the mode of practice, to look at outcomes very differently. But it was simply added as another task that had to be handled, at the point of encounter, and it was not supported.

AUDIENCE MEMBER: Hi. I'm Garrett Moran. I'm with the Westat and the AHRQ Academy for Integrating Behavioral Health and Primary Care. And I wanted to comment briefly on the issue of, Melinda, your issue of the workforce and what the issue there was, and also in the relative effectiveness of telehealth approaches. I think that, I agree that maldistribution of providers is a huge issue. But while Ben might be able to attract people to the beautiful scenery in Colorado in rural areas, I'm from West Virginia originally, and it's much harder there. So we really do have to do a better job of integrating telehealth, and there's some great examples of doing that. Howard talked about Jurgen Unutzer's work. In the State of Washington, Jurgen has, the university there has supported over 150 clinics throughout the state, including the most rural areas in the State of Washington.

They are treating, using the collaborative care model, about 8,000 people a year, with a care manager in the local practice site, a lot of FQHC's, some community mental health centers. So they've got a care manager on site, and they're using telehealth consulting psychiatrists. They're treating 8,000 people a year with four FTE's of psychiatrist time. That's just mind blowing. And it points to the incredible inefficiency of our allocation and utilization of professional resources. Yes, we have a shortage of professionals. But if we were smarter about the way we used them, if we made greater use of telehealth, we could stretch those resources much further than we are. And Jurgen has a young John Fortney [sp] who has done a series of studies, in which he's demonstrated that not only can you get equivalent results, but you can actually get better, superior results using a telehealth model, that's well constructed, well managed, well implemented, than you can get with face to face services. So, I've got the studies on my computer here. I can show them to you. He can really get great results with telehealth, and it's a great solution to provider shortage.

MELINDA ABRAMS: That's great, really helpful.

HOWARD GOLDMAN: Close with just what I think is an amusing story. I always find it amusing to think about telehealth as a new technology. I interviewed my first patient by closed circuit television in 1972, in the emergency room at Mass General Hospital. We had a closed circuit television arrangement with Logan Airport for patients who became emotionally upset at the airport. So it's not a new technology. And what Garrett Moran just said, I think is well documented in the literature. We really have to do a better job at expanding the rarest service, which are the consulting psychiatrists. And we have to learn to use the existing workforce in better ways, to do the face to face activity in collaborative care, the care management piece. Which makes it possible, Sarah, for a primary care doctor not to be; feel completely overwhelmed with what is a very difficult expectation if you're doing it alone? But is a very simple thing to do, if your role is that of the prescription writer and monitor with a nurse manager and a consulting psychiatrist.

ED HOWARD: Melinda, do you have a closing word?

MELINDA ABRAMS: I guess my impression from this panel is while a number of challenges were raised and emerged, I also leave with a certain amount of optimism. Because I feel like a lot of what we know, a little bit about what to do, there's certainly an implementation gap. There are some barriers certainly in terms of payment, in terms of policy. But I am encouraged by a lot of the enthusiasm and interest, and I think renewed energy towards behavioral health integration. And I think that there's a lot on which to draw, on how to get it done. So thank you all for coming.

ED HOWARD: And, go ahead. [applause] I accept on behalf of both of us. Please fill out those blue evaluation forms, as you're going. And let me just say that in echoing what Melinda said, this is the most spirited discussion of this topic that I have heard in years, in one of our sessions. And you're to thank for that, as well as our panel. My apologies to those of you who wrote some really good questions on green cards that we weren't able to get to in time. If it's any consolation, I have a whole page of questions that I didn't get

to. And so, maybe we'll repeat this in just a little bit. Thanks to Commonwealth for helping us put this together. And thanks to our panel, and if you would help me thank them with an appropriate round of applause, I'd appreciate it. [applause] Terrific job.