

Healing Mind and Body: Behavioral Health and Reform
The Alliance for Health Reform, the Robert Wood Johnson
Foundation and the Open Society Institute
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ED HOWARD: Good day to you. My name is Ed Howard. I'm with the Alliance for Health Reform. And on behalf of Senator Rockefeller, Senator Collins, and our Board of Directors, I want to welcome you to this program on how the issue of behavioral health, which is supposed to take in both mental health and substance use disorders, is handled in the current health reform initiative, and probably a little bit how should it be handled.

I don't need to tell you that we're in the middle of the most critical period for health reform in many, many years. I suspect many of you—and I know many members of Congress and their staffs—are going to be spending at least part of this weekend leafing through this 1,000 page document that the three House committees started working on just a couple of days ago.

One of the factors most likely to affect the potential success of any effort to address the major problems in our healthcare system is how we treat—I guess I mean that legislatively and clinically—mental health and substance abuse syndrome.

Last year, Congress demonstrated that it takes these issues seriously when it passed the Wellstone and Domenici Mental Health Parity and Addiction Equity Act. And now, even

fully into effect, policy makers are faced with the task of fitting all of the substance abuse revisions into a complicated, controversial, broad reform bill.

And what we're going to try to do today is to try to help ourselves and you understand how that is going to work or might work or should work. We're pleased to have two partners in this enterprise as co-sponsors. The Robert Wood Johnson Foundation, which has a strong and long-standing interest in these matters, and the open society institute, which shares that interest, particularly in the aspects related to addiction and funds its own initiative called Closing the Treatment Gap.

I want to thank particularly Andy Hyman at Robert Wood Johnson Foundation. He's the Senior Program Officer there. He can't be here today, but I hope you picked up a copy of his recent *Health Affairs* article as you came in with the yellow one that we didn't have time to put in the packets.

Victor Capoccia from the Open Society Institute is with us today. Victor directs the Closing the Treatment Gap program that I mentioned, and he's a senior scientist at the University of Wisconsin. He also happens to be a veteran of the Robert Wood Johnson program staff, something I just discovered a couple of days ago.

Thank you Victor and thank you Andy for pushing this topic to the front of the agenda at a time when it deserves the attention that we're trying to give it today.

We have a wonderful panel to kick off the discussion. Let me just do a little bit of logistics before we get to them. We're very pleased, again, to be able to tell you there will be a webcast available of this briefing courtesy of the Kaiser Family Foundation sometime Monday morning. By the way, you can get to it, not only at the KFF.org website, but through the Alliance website at allhealth.org where you'll also find copies of all the materials that you have in front of you and of the slides that the speakers are going to be using today.

In addition to the slides and the background, you'll find biographical material on our speakers more extensive than I'm going to have time to give them. You'll also find a green question card that you can use at the beginning of that part of the program to fill out and pass forward. There are also microphones that you can use to ask the questions in your own voice, and a blue evaluation form that I hope you'll fill out to help us make these programs better for you.

So, let's get to the program. These folks understand this bundle of issues as well as anyone that does in town and we're very pleased to have all of you with us. We're going to

Policy for the National Council of Community Behavioral
Healthcare.

He's held key posts related to mental health and
substance use syndrome in state government, in advocacy groups
and what is now Middle Health America. He's advised the federal
agency with responsibility in this area, the Substance Abuse
and Mental Health Services Administration, SAMHSA. Within HHS,
we usually eschew acronyms, but SAMHSA is one we can't avoid,
so if you don't know what it means, find it in one of the
references and internalize it for the purposes of the next hour
and 40 minutes.

Chuck, would you try to lead us through what is
actually going on? You don't have to account for whatever the
mark-ups accomplish this morning, but beyond that, what is the
situation with respect to these important issues as the
initiatives are actually being developed?

CHARLES INGOGLIA: Well, Ed, thanks for that intro and
also for that caveat as I was a little worried as I've been
looking at my Blackberry all morning and amendments are being
offered and things are changing. But I think the good news is,
for those of us who care about mental health and addiction
disorders, is I think going into healthcare reform we were
greatly concerned about the level of inclusion of our issues

And we know it's critically important because of the prevalence of these disorders in American society that in our lifetime, one-in-five Americans will experience some mental health disorder needing treatment. And we also know the huge disparity of the number of people who have these disorders and receive treatment for them.

So I think we were greatly concerned. And obviously I think healthcare reform is fundamentally looking at choice of primary care. But, and I think the good news is, as we kind of go through the slides today, that we're in very standing it seems to me on the most basic level, the bills and their desire to provide coverage to currently uninsured individuals are taking two major approaches, both of which I think will have tremendous impact on people who are currently uninsured and have either a mental health or substance use disorder.

All of the bills so far that have been released are predicated on some expansion of Medicaid. And an expansion of Medicaid that is not contingent on current eligibility categories, but rather on federal poverty level. And I think this will be a really critical issue for our field, exactly what poverty level they agree to for that expansion and in a minute I'll talk about why that is such an important feature.

And then the second major expansion effort is going to

whatever language you'd like to use, some organization that will connect uninsured individuals to private health insurance. And as Ed mentioned in his introduction, certainly at the end of the 110th Congress, we had a tremendous victory in the passage of the Wellstone-Domenici Mental Health Parity and Addiction Equity Act, which finally established policy ending the two-tiered system of insurance coverage in this country where mental health and addiction disorders were treated at a lesser level than private health insurance.

These are their two major ways that Congress is approaching coverage and I think both of them will have impact on our communities. I just wanted to talk a little bit about the importance of the Medicaid expansion. Before we even talk about any of the specifics relative to mental health or addiction coverage, the Medicaid expansion by itself to currently, based on poverty level, to individuals who don't currently qualify for Medicaid will in itself have huge implications for people with mental health disorders.

Kaiser Family Foundation issued a paper in May of 2009 where they looked at the role of Medicaid in healthcare reform, and in that paper they estimated that up to 20-percent of individuals who are uninsured have a very serious mental health disorder or substance use disorder. But that was one of the

So we took a look at that number. We had some funding from the SAMHSA, the Substance Abuse and Mental Health Services Administration, and we did a state-by-state look at the number of people who are currently indigent, being served by the public mental health system, looked at prevalence estimates, and we estimate that the Medicaid expansion in and of itself could result in 2.8 million people who have mental health disorders who are currently uninsured coming into getting coverage for Medicaid and then being treated by the public mental health system.

Currently, the public mental health system serves about 6 million people. So this would account for almost a 50-percent increase in the number of people served in the public mental health system. So Medicaid expansion in and of itself will be a huge accomplishment in healthcare reform.

I'm going to try to talk a little bit about the Tri-Committee bill. And as all of you know, the mark-ups are going fast and furious, so much of what I say could be changed by the time we leave here.

But again, before we even talk about some of the specific provisions that are related to behavioral healthcare, just some of the insurance reforms that Congress is contemplating, will in and of themselves have huge implications

preexisting condition, guaranteed issue, community rating, kind of establishing insurance, the medical loss ratios, each of these things should have tremendous impact for people with mental health disorders and really force private sector insurance to do a better job.

And we're also terrible pleased that in some of the discussions around adequacy of provider networks that Congress also has indicated that both in Medicaid and in private health insurance that they're going to be looking at the adequacy of networks to serve people with mental health disorders and substance use disorders.

And then there are a number of provisions in the Tri-Committee bill that very concretely benefit our community. I think again, going into healthcare reform, those of you who were here in '93 and remember the Clinton healthcare reform debate, a huge question was will mental health and substance use benefits be in the package? What will that look like?

And it's intriguing this time that all of the bills that have been introduced, all of the concept papers say that mental health and addiction services will be part of the core benefit package and the Tri-Committee bill has very strong, also non-discrimination requirements for the extension of the Wellstone parity provisions to this individual and micro

market, which I think is also I think is a tremendous accomplishment.

So the way the parity bill is written is that there's a small business exclusion, but the House actually applies the bill to all the new insurance products offered through the exchange in both the individual and micro market.

Also, we're tremendously pleased by provisions that the House included to special outreach and engagement efforts for people who are uninsured and have mental health disorders. The new commission that's established to implement the exchange is charged with making sure that people who have mental illnesses, develop mental disabilities, other cognitive impairments understand what the exchange is, take advantage of the exchange, and also they have auto enrollment provisions, which we think are also critically important.

If we look at the Massachusetts example, several years into their expansion, the population of people who still are uninsured there tend to be people with very serious addiction disorders and/or mental illness who have not been able to navigate the exchange process there.

Two of the other particular provisions in the House bill that apply to mental health and addiction disorders are also the expansion of a pharmaceutical discount program that's

available to rural health centers and federally qualified health centers and a few other entities.

There's an explicit expansion of this program to community mental health organization and addiction treatment organizations and also some changes in Medicare that are also very important, especially to the mental health side. The recognition of licensed professional counselors and of marriage and family therapists as independent practitioners in Medicare more so within FQHCs and rural health centers.

And here's an example of the next one on the slide. It's something that was in the draft bill that didn't end up in the final bill. We were also hopeful that the bill had proposed eliminating the 180 limit on inpatient psychiatric hospitalization that exists in Medicare, but in between the draft bill and the final bill, that provision was stricken. So we still have an area in Medicare that we need to address.

And then there certainly are also in the discussion of accountable care organizations and medical homes, expansion of school-based health clinics, specific mention of the importance of coordinating mental health benefits. It's rather intimidating with this clock ticking down in front of me, so we're going to try to go quicker here [laughter].

ED HOWARD: We looked for bigger numbers, but we

CHARLES INGOGLIA: Yes, so I think in the Senate, the Senate HELP bill has a comparable number of specific provisions that are very helpful, intriguing that the parity application in the HELP bill is not as generous as in the House. So the Senate HELP Committee only applies parity to group plans of 50 or more, so we're intrigued to see what the Senate Finance Committee releases.

My last minute, I'm just going to go to the Senate Finance Committee. We have every reason to believe based on the concept papers that the Finance Committee released in it a few months ago that parity will be a requirement in the gateway. And also, we know from some of the documents that have been released that the Senate Finance Committee is contemplating medical home demos within Medicaid comparable to what's in the House bill on the Medicare side.

And we also are very hopeful to see how these provisions look and hopeful for a bad reason actually. And it really is related to the realities of the current situation confronting people, especially people with serious mental illnesses in this country that research has demonstrated that people living with serious mental illnesses like schizophrenia, bi-polar disorder, serious clinical depression die, on average, 25 years sooner than other Americans.

And this is because this population also tends to have very high rates of chronic health conditions like diabetes, heart disease, other diseases like that. And current rates of those diseases are frequently untreated.

So we're very hopefully that in the Senate Finance Committee mark that will be released that there will be hopefully an expansion of medical homes within Medicaid and that they hopefully will explicitly include people with serious mental illness. We're grateful of some of the efforts that have been underway to try to address this, most notably Senator Stabenow on the Finance Committee introduced the Mental Illness Chronic Care Improvement Act and Representative Schakowsky introduced it in the House.

And this bill very specifically looks at creating medical homes for people with serious mental illness. So we're hopeful, but we all know based on the comments yesterday that ongoing concerns about the scope and cost of this legislation will likely lead to further changes. But I think starting where we are, we think we're going to end in a good place.

ED HOWARD: Thanks very much, Chuck. Next we turn to Eric Goplerud. He's a research professor at George Washington University and a clinical psychologist at GW. Dr. Goplerud directs the GW research program called Insuring Solutions to

remember, I told you, you had to remember what that meant—and at the office of National Drug Policy. He's a national leader in behavioral health and we've asked him to focus specifically on addiction related aspects of this issue. Eric, thanks for being with us.

ERIC GOPLERUD: Thank you. I'd like to start off by telling you a little bit about what I do on Thursday evenings. On Thursday evenings, I sit with families and young adults who have addiction problems. These are kids who are like your brother, your sister, your child, people with addictions are like your parents or maybe your parents or spouses.

These are folks, one is a returning Afghanistan veteran, another wears proudly his lacrosse t-shirt, others wear t-shirts of their favorite bands. You see them on the streets. What strikes you most is that these are everyday boys, girls, and families. These are your and my daughters, husbands, and fathers.

Now, addiction, alcohol and drug dependence and abuse disorders are very prevalent. About nine-percent of the U.S. population of adults has a diagnosable dependence or abuse disorder. That's comparable in prevalence to depression, diabetes, and cardiovascular disorders, and yet addiction disorders are largely hidden diseases.

According to recent estimates, the total financial cost of drug use disorders in the United States is estimated at \$180 billion. Alcohol use disorders bring another approximately \$185 billion in cost to societies. Six states took a look at what the difference was between the Medicaid expenditures for people with untreated substance use disorders and other comparable Medicaid beneficiaries.

They found that on average, their medical costs were over \$3,000 a year higher. This is for people with untreated substance use disorders matched to people who have similar age, race, ethnicity, et cetera, but do not have a substance use disorder. Their mental health and psychiatric costs to Medicaid were \$245 more per person for the untreated person.

Now, let's take a look at this as a family condition. The health impact of the stress, delayed prevention, disruption of everyday family life, costs almost \$360 per year more for the family members who live with a person with an alcohol use, depend, or abuse disorder. Not only are their costs higher, but there are some studies that indicate at the point of which a person starts treatment for a substance use disorder, the family's healthcare costs drop.

Now, how often, how well do we detect and start treating alcohol and drug use problems if we compare them to

American society and the healthcare system? Alcohol use disorders we identify at approximately eight-percent of the time.

For other disorders such as heroine or opiate dependency, it's higher. It's about 18-percent. But for people with a major depressive disorder, about half of them receive active treatment during the year in which they have their condition. It's even higher for Type II diabetes or for hypertension.

Now, if you detect substance use problems, does that mean just send them to a 28-day treatment or send them off to a self-help group? Well, in fact, the National Quality Forum, which is made up of over 360 federal agencies, employers, employer coalitions, and health plans, determined in 2007 that the science is very strong about the effectiveness of screening, treatment, management, and recovery support for people with addictions.

Not only did the National Quality Forum find this, but we have recommendations from every medical society that has examined and has developed practiced guidelines for their professionals. They recommend screening and treatment of the co-occurring addiction disorder. Federal and state agencies require it. Major payers are requiring it. And international

health organizations such as the World Health Organization are requiring it.

So what happens when we offer effective treatments?

Washington State took a look at their Medicaid beneficiaries. I think this is—you don't have this slide, but some of these slides are the result of late minute changes. Washington State Medicaid Agency took a look at their Medicaid expenditure for following treatment for substance use disorders.

They found that Medicaid beneficiaries who went through an inpatient program post treatment were costing \$170 less per month than untreated Medicaid substance abusers. For outpatients, similarly, there's a substantial savings for methadone programs, one of the treatments for opiate addiction, also substantial savings. Overall, Washington State found a per treated member per month savings of \$311 per treated member per month compared to Medicaid recipients who had a Medicaid disorder.

Now, it isn't just a condition. Substance use is not a condition of poor people. Substance use condition is equal opportunity. The prevalence for alcohol use disorders among employed people is about eight-percent. When treated, substance use reduces employer and employee healthcare costs. A study in Kaiser of employed populations found that ER visits dropped

by 35-percent. Total medical costs went down by 29-percent.

This is in an employed population.

A study in Wisconsin called TREAT that took a look at the impact of screening and briefly treating people with alcohol problems in primary care practices found that the cost benefit ratio just in healthcare savings was four-to-one. Now if you take a look at the research on disease management programs for diabetes, you find similar size cost benefit ratios of three-to-one to four-to-one.

The societal impact is substantially higher. Now, when you talk health reform, you talk about what CBO can score. CBO doesn't score this, but the reductions in car crashes, in property damage, in criminal justice costs are way multi-factor higher in savings.

An analysis by the Partnership for Prevention found that the estimated net savings per individual screened for alcohol use problems was \$254 per person screened in primary care. They estimated the quality adjusted life of your cost of \$1700. For inclusion of conditions within health insurance, a common cutoff point is a QALY of \$50,000 or more is not included. A \$1,700 QALY is a bargain. When they took a look and they systematically reviewed the evidence on the effectiveness of screenings and brief interventions for alcohol problems, of

Taskforce, they found that alcohol screening and brief intervention in primary care was number four of the most cost-effective preventive services recommendation. First, discussing daily aspirin use for adults. Second, child immunizations. Third, smoking cessation. And fourth is alcohol screening.

Now, when we take a look at the health reform bills—and this morning I was looking at the 615 pages of the health bill. Last night I looked at the 1,018 pages of the Tri-Committee bill. And on my Blackberry came in an amendment that came through and was accepted at two o'clock this morning, which makes my side points out of date.

There are clearly some pluses from the perspective of treating this incredibly expensive, common, and treatable condition. First of all, as Chuck has mentioned, parity is extraordinarily important and is included in all of the bills. Second, the emphasis towards universal coverage is very important.

People with mental illnesses and substance use disorders are twice as likely to have no insurance coverage. The average uninsured rate for substance use in mental health disorders is 35-percent. So the more that we move towards universal coverage, the more persons with mental illness and substance use will be able to receive treatment.

Third, as Chuck has mentioned, medication assessment is a critical component of treatment. And the explicit inclusion of substance use treatment programs in the 340B Program is a very major and important success. But there are also some negatives. One is there is much interest in the patient-centered or the person-centered medical home and there is very little or there is no discussion at the present time about the inclusion addiction recovery supports.

Also, prevention and workforce are extraordinarily important. And in my PowerPoint I said that there's no explicit inclusion of substance use prevention and mental health promotion, but as of 2:00 this morning, an amendment accepted by the health committee that was introduced by representatives Tonko and Kennedy explicitly includes mental health and substance use screening, brief intervention, and treatment in the tri-committee bill.

But very important as well is that there's no explicit inclusion in substance use prevention, screening, or treatment in the school-based health programs despite the prevalence and despite the impact it has on kids' development.

Finally, workforce infrastructure pays considerable attention to the mental health workforce and the additions professional workforce is not touched or not included in the

comprehensive system. So with that important point is the addictions are being well covered in the parity portion, but there are a few areas where it really is critical attention be paid.

ED HOWARD: Thank you, Eric. Before we go on, just to clarify, some of us may not know what a QALY is and why it's important. You want to try to explain it?

ERIC GOPLERUD: Sure, a QALY is a way that health economists have of comparing what the health benefit ratio is or how many dollars it takes in a particular health condition to treat it to a point where an individual either does not experience disabilities or limitations in their life over a year period. It's a way of taking health effects and turning them into something with dollars on it.

ED HOWARD: So it's the cost of adding one quality adjusted life here?

ERIC GOPLERUD: That's correct.

ED HOWARD: I see. Okay. Well, you've got the two A.M. results. You've got the morning results. Now we're going to get a little bit of background from a couple of years ago looking at today's situation. Our final speaker is Michael Hogan. He's the commissioner of mental health in the state of New York.

For years, he directed the Ohio Department of Mental

states for its mental health system by NAME, the advocacy organization. He has served as president of the State Mental Health Directors Association back in 2002, 2003, he chaired the President's new Freedom Commission on Mental Health. And I'm pleased to say this is a repeat performance as a panelist on an Alliance program. Mike, thanks for coming back and thanks for being willing to serve as a resource on this panel discussion.

MICHAEL HOGAN: Thanks Ed. It's good to be here. Every ten years we have to do this. Although maybe this time and it sort of looks like this time, and maybe we actually will do it and get it right. So as Ed has said, I primarily represent two points of view. One is I'm sort of the mental health guy in a sense and I'm also a state guy.

And I'm really going to make one point through a few slides, which is that parity is necessary in a sense that—in echoing Eric—but is insufficient to get the mental health results that we need from healthcare reform. And in a way, if you think about the situation that our country is now going through with respect to veteran's mental health care, it just makes that point. We have the benefit, but we're not achieving the result.

And I am singularly unburdened by involvement in the current historic debate going on in this town, which may be

good or bad, I don't know. Although, I do have to go home and deal with the New York State Senate, so we won't go there.

Wide mental health and healthcare reform, this is sort of an outline of what I want to run through. Mental health problems, as with addiction problems are a major concern that every healthcare sector, not just in specialty providers sector and what states are doing. These problems are the most serious health problems and the most costly health problems for kids. They affect their later life health status. They occur across the entire adult health care system as well.

We know how to integrate care, but by and large, we don't do it. So then to speculate a little bit about what does integration mean and how can we achieve it, we'll go up the age spectrum, starting with kids. As I've already said, children's mental health problems are the most prevalent and costly health condition.

That's a quote from Ron Kessler who's done the most extensive work on the origins and frequency of these problems, that kids' behavioral health problems are the major chronic diseases of childhood, which you'll find out in talking to any pediatrician, in the 50 weeks of the year outside of flu season.

And childhood is now when we understand these problems

whole life, experience a mental health disorder, for 50-percent of those people, it will be before the age of 14, for 75-percent, before the age of 23 that the problem will first be experienced. And the average lag time between first symptoms and entering care in the United States is nine years, which sort of goes again, to the service-delivery challenges that we have to address.

And increasingly, we've got effective interventions, including for children, non-pharmacological interventions that we can intervene with many of these conditions with assistance to the parents or therapy to the kid without having to put the medications that we're so concerned about in their minds and bodies.

Another point that is a little bit counter-intuitive, but is quite provocative is that addressing child mental health problems helps us address adult health problems. These are a couple of slides from the ACE study done by Vince Felitti, an internal medicine doc at Kaiser Permanente and Bob Anda at the CDC. So these are their slides.

Felitti got into this study when as an internal medicine doc, he was assigned at Kaiser to run a program for people who were morbidly obese, a weight-loss program. HE designed the program. It was running quite effectively and

people who were losing 80 and 100 pounds started dropping out of the intervention.

He couldn't figure this out. He started doing health interviews to sort of get a sense of what their history had been and what had brought them to this point. And the breakthrough came when he asked a woman "how old were you when you had your first sexual experience" and she said "11" and it was her father.

And in 26 years of internal medicine work, he had encountered one prior case of incest before this. It led him to start looking more seriously to these adverse childhood experiences that are listed at the bottom here—psychological and physical abuse, sexual abuse, having an addict or someone with serious mental illness in the household. This is sort of the theory of how this works, that these adverse childhood experiences lead to maladaptive health behaviors via cognitive and emotional impairment, like smoking for example that then leads to later life problems.

So this is an example of how this works, a very simple slide that looks at the number of different adverse childhood experiences that people had in relation to the onset of smoking by the age of 14. It's an exponential relationship. If you've experienced multiple health challenges, you're much more likely

everybody. But then, this is the impact on COPD. So what we have here is adverse—

ED HOWARD: COPD stands for...

MICHAEL HOGAN: Chronic Obstructive Pulmonary Disorder, sort of a classic medical problem. So what we have is childhood behavioral problems, that are treatable by the way, leading to adult physical health problems.

So that's the case, in a sense, for kids, some of the same for adults, and very similar to what Eric has talked about. We see a very high co-morbidity of these conditions. So about 35-percent of people who go in the hospital for anything have also got depression. And on average, depression will add a day to your two or three hospital stay and it'll compromise your follow-up care unless the depression is treated, which it's usually not.

So that's acute hospital care, same thing with care in outpatient clinic settings, same thing with chronic illness care where the prevalence of depression alone is greater than 30-percent. And I knew this from my mother who was depressed and had diabetes, that if she wasn't treating her depression, she was not going to do the blood sticks, period.

So we understand this from the research, unless we're taking care of and mediating the mental health problem, we're

problems as well. So the mental illness care is a prerequisite to achieving health outcomes that we want for those individuals that have both.

But then this point that I want to close with is a couple different ways of how integrating care is the exception rather than the rule. So we now are in this environment of post-parity for a couple of years. This slide looks at trends in the detection and treatment of mental healthcare. We have a time series here for comparison in the early 90s and the early 2000s.

If you just focus on the two bars over on the right which represent the portion of people who have a serious mental illness who are getting any care for it. And what we see, so this is the 45-percent that Eric mentioned before. So 45-percent of people with a serious mental illness diagnosis are getting any care whatsoever. We see a dramatic increase from the early '90s. And those of you who might be familiar with the Baver Health environment is saying, well I didn't see an expansion of care like that during the '90s, why did this happen? How come so many people were getting care? And the answer is one word, which is Prozac.

And this increase in care consists of people who were not willing to go see, as my mother would have said, a shrink,

after they'd seen direct to consumer marketing which is sort of a funny angle on this and saying you know doc, I think I'm having these symptoms and maybe I could use some help.

And generally what they get is one prescription of an SSRI. They never get to an adequate level of dosage. They never get the psychotherapy they need to learn how to manage this condition in the long-run, but they experience a tiny bit of symptom relief and they stop. So our illustration here of how challenges in the service delivery system are critical.

This is data since 2002 on the percentage—this is an article just out in *Psychiatric Services*—of people with depression whose care is adequate. Adequate is defined here as enough of a medication and enough of a psychotherapy so that the research says it's got a pretty good chance of addressing your condition.

So what we see is a degradation actually over this period of time, the same period of time that we have parity. In the percentage of people with depression who are getting minimally adequate care. And why is this? Maybe there's less direct to consumer advertising. Maybe it's the black box warnings.

We don't exactly know what the trends are, but the underlying dynamic, again, is that access to the benefit is not

point that Chuck has already illuminated about how integration of care is a two-way street. So I've been emphasizing integration of mental healthcare into mainstream health settings.

The other point that Chuck has illustrated is why we have to integrate medical care into specialized mental health settings because patients are dying from untreated medical illness. They think they're going to a clinic when it's a mental health clinic. And we in mental health have been as guilty as our colleagues in general healthcare that we yell about how they don't treat from the neck up, but we don't treat from the neck down at some level, but if these folks try to go to a medical clinic, they don't fair very well there.

So this is just data from one of the first studies that showed how terrible this was about population with mental illness in Massachusetts showing a five times as high odds ratio of dying from cardiovascular disease in your late 30s for people with a mental illness. So we've got to have integration going both ways.

And this is my simple-minded prescription of what it's going to require if we're going to actually achieve this degree of integration, whether it's mental health care in the healthcare setting—I think this is consistent with what Eric

it's care for physical medical problems in the mental health settings. And one, you've got to look for it. If you don't screen for it, you're not going to find it, as the Preventive Services Taskforce recommendations on depression now say.

We also understand that from the research, that lots of general medical settings can handle simple mental illness, but really they're only going to do it if there's a mental health person who is on the floor, not at the other end of the phone, not coming in once a week, present in the setting. So I think, to achieve integration, we've got to have the capacity of having somebody there who can detect these disorders, which is what the research studies that have done this kind of care have proven for us.

So in medical settings, we're going to have to have a psychiatric nurse, a social worker, or a psychologist who's present. In mental health settings, we're going to have a nurse practitioner or an internal medicine person who is present in the setting if we want anything other than a theoretical victory in this regard. So screen for it, provide the care, measure the care, relatively simple.

So I'm going to end, in a sense, with this, our together being on this historic opportunity to achieve this degree of reform. But just reflecting, applying Robert Frost to

is the place where if you go, they have to take you in. And that's what we have to achieve. Thanks [applause].

ED HOWARD: Alright, thanks very much, Mike. Now you get a chance to enter the dialogue. Microphones, as I said, are available for you to ask questions. And the green question cards, if you would like to write one down and hold it up, someone will snatch it from your hands and bring it forward.

Let me start as we go in that process with a question that actually flows from the paper that you saw next to—I can't even remember what color it was, but outside the packets it was something that Victor Capoccia called attention to—yes it is yellow, both of them were yellow.

Eric pointed out that CBO doesn't score savings from avoiding car crashes. The question is, there are a lot of people around town who think that CBO doesn't score savings from healthcare, and I wonder how much of the dramatic kinds of savings that were illustrated in the studies that were cited are being tracked in the CBOs scoring of whatever provisions there are in these bills or is this fairing just as well as some of the other preventive care measures? Speculation? Actual results?

ERIC GOPLERUD: There are some preliminary results, not from CBO, but were done CBO-like that were done by Rick Harwood

where he estimated parity coverage will result in a cost-savings of about \$180 billion annually in reduced healthcare costs. A very preliminary CBO score was that that was low.

ED HOWARD: That it was low?

CHARLES INGOGLIA: Well, I think Ed, the simple and unfortunate answer to your question is I think they treat our prevention offsets the same way that they do general prevention in that they're not really able to calculate it to include it in there. They really have a strict guidelines around direct federal outlays and things that they can't quantify, they can't. And I think that's part of the tension. Certainly though, I think all of us who have interaction with the hill bring these issues up, and I think they have a great deal of resonance. It's just harder on the official CBO process.

ED HOWARD: Yes, would you like to—no the lady behind you was first I believe. If you would both keep your questions as short and as direct as you can and identify yourselves.

ANISHA DHARSHI: Sure, good afternoon. My name's Anisha Dharshi. I'm with the National Quality Forum. And this is incredibly informative to some of our work because we're just starting to undertake building upon the practices that we endorsed a few years back that Eric and others talked about. I'm curious in terms of reform, quality of care and improving

aside from addressing just provision of care, do you have any thoughts or strategies on how to actually link evidence with practice and also improving quality of care that's delivered for substance and mental health disorders? Thank you.

MICHAEL HOGAN: I'm not sure how on point this is, but there is some concern in our field, the mental health field, for some quarters that comparative effectiveness is a threat. And I can understand if you've been through what our field has been through over the last generation, why you would think it would be a threat.

But the data are much more consistent with what Eric has illustrated that is that these conditions that are costly untreated are effectively treated and are a bang for the buck. So it's an indirect answer or a non answer to the question but I think there is, these investments, at a modicum of quality, are likely to pay off very well.

It also goes to the question that I was raising about coverage alone is insufficient or as people said before, it's the service delivery system, stupid and that's going to be the second generation reform. If we can just get a bill, that's going to be a great first step and then we can figure out, through regulations and so on, how to implement it well.

ERIC GOPLERUD: If I could add a little bit. Elizabeth

quality of care delivered in routine primary care practice and sort of the headline has been that 55-percent of the time, you receive evidence-based practice that was substantial variation. So if you took a look of the 25 conditions that they examined, depression care came out sort of mid-length. Alcohol care came out 25th out of 25.

Now that could be a reason to say okay, well we need to do more work on that but if you dig in a little bit more, you see that when physicians in a primary care system is prescribing medications. They do it pretty well. About 85-percent of the time, you got evidence-based quality of care. Ordering and monitoring lab results again, pretty high, up in the 70s. When primary care has to talk to patients, whether that's diabetes education, weight management, alcohol counseling, depression counseling, they do it very poorly, about 15-percent of the time.

Now it isn't that physicians and primary care doesn't want to do it, you have to take a look at what the reimbursement system reinforces and extending coverage isn't going to do anything to address the issue that if you counsel a patient, you're going to lose money. Until we address that issue of, and that's a major part of the patient-centered medical home is to try to bring up, in some way, that

evidence-based practice just by doing guidelines or counseling or education. You've got to figure out a way to pay for it.

ED HOWARD: Yes, go right ahead.

TOM BRYANT: I just want to make a comment.

ED HOWARD: And you are?

TOM BRYANT: I'm Tom Bryant. I've been around forever but I'm now wearing a new hat as the Legislative Director for the National Coalition on Mental Health Consumers and Survivor Organizations, it's a relatively new organization. I just want to make a comment, what Mike said about screening. Now that I'm wearing a consumer hat, I hear very loudly consumers' concerns and one of their real concerns is screening. It's a two-edged sword. I mean there's no denying that what Mike said is true.

You can't treat that woman until you and pick it up and the earlier you pick it up, the better it is but the two-edged sword is that you label people. You've got to build in some kind of safeguards in screening like consulting with parents or being sure they're on board particularly if you're doing screening in schools and I've learned in my short association with this consumer movement that in order to get attention, you've got to be the squeaky wheel and that, I'm going to start squeaking that. Screening is good but screening has got caveats.

The second point that I want to make is that I am, as many of you know, I'm associated with the Carter Center and we had about, three weeks ago, what we called a summit meeting, which was a rather a grand title for the medical home concept and we had primary care people, behavioral health care people, and prevention and health promotion people.

It was a very small conference, 35 people, and out of that came some recommendations, which we have instantly tried to get to that people, the committees and the Congress about improving their definition of medical home to include all three of those in this integration forum.

I am encouraged, in these 1,000-page bills, how many times mental health and substance abuse are mentioned, particularly mental health and I agree, we've got a long way to go with substance abuse but also in the hospital, there's a 22-page section on the medical home.

One of the things that came out of the Carter Center summit was a desire to turn it, I noticed that some of this legislation referred to as the health home rather than the medical home, and some, you would say a health care home. Anyway, those are just points that I'm trying to make.

ED HOWARD: Yes. Go on.

MICHAEL HOGAN: If I could make one thought about this

combined health care expenditures for mental health and substance abuse disorders, they're greater than cancer. They're greater than heart disease. They're the greatest health care cost in this country. Yet, these are the two conditions for which the care system for the people with the most serious disorders absent a reform system is run by states.

So I think, to some extent, what people are concerned about in screening is being relegated to a second class publicly operated system. It has a very different meaning if you're going to get acceptable care in your physician's office or your pediatrician's office, which is going to take some, as we've said, some accommodations to do that. So stigma is the reflection of the segregated system that we've had. If we can achieve an integrated system recognizing the need for protections with respect to screening, that burden will come down dramatically.

ED HOWARD: Can I just ask if the panelists have any further thoughts about the adequacy of what's in those 22 pages in the counterpart sections and the other bills? Medical home's been talked about a lot. Are we far enough along to be able to actually do it?

CHARLES INGOGLIA: I think conceptually we are. I think there's enough evidence around what works from co-locating

and reverse it. I think we're on a pretty firm foundation and we had a paper that we included on the contraries that lay out that evidence. I mean I'm intrigued in the 22 pages that are in the tri-committee bill, the title is "Promoting Primary Care and Mental Health Services in Coordinated Care." I think that's the only mention of mental health in the 22 pages is in the title.

So I think we have a little way to go in making that a little more explicit. I think we also have great hope that the Senate Finance Committee might have a more explicit description of that in their package.

ERIC GOPLERUD: And I would point out that addictions or substance use doesn't show up anywhere even in the title and that we know from some very good research on depression that there are some components, which need to be in place and those include care management, which doesn't have to be physician-run.

It probably won't be physician-run and access to specialists. Those things are absolutely critical and they appear to show up as well for good diabetes care, good cardiovascular care, good substance use care, are those components of a care manager and access, ready access to specialists.

MIRIAM ROWLAND: Yes. Hi, my name is Miriam Rowland and I'm with Fight Crime, Invest in Kids. I was very heartened to hear Dr. Hogan talking about the importance of screening, identifying and treating children's mental, emotional, behavioral difficulties early on because that is cost-effective.

I'm interested in all of your views about the fact that children are actually one area where there's some good coverage now through early periodic screening, diagnosis, and treatment, which not only is for Medicaid kids but also some CHIP kids as well and that, in fact, until yesterday both the House and Senate, thankfully the House Education and Labor fixed it yesterday but until yesterday, both bills would actually take 10 million kids off CHIP, many of whom have EPSDT through their state programs and actually put them into an exchange where the benefit package may be less comprehensive and less likely to get them mental health treatment.

MICHAEL HOGAN: I think your point is very well taken and it raises a conundrum and I say this is again, if somebody's naïve about the dimensions of reform but some of the very best evidence with respect to children is in early intervention and preventive programs like Nurse Family Partnership or Incredible Years or some of the other examples

where they might be described in a sense as iron-clad parent coaching because it's more than a few sections of parent education.

It's helping parents who may have grown up in foster care themselves and never really learned how to parent and don't have a grandmother to do the tasks that they want to do. The payback for those programs, we know, is extraordinary. Where and when and how we address that need, because those are the programs that can help kids grow up healthy without having to put meds in their bodies, not for all these disorders but for many of them.

So I don't know who and where we get to that question. It's really heartening for me that the administration has proposed a substantial expansion of the nurse family partnership that it may not be a health care issue per say. I don't know that we may not quite be at a time to solve that one.

CHARLES INGOGLIA: The only other thing that I would say though, the Medicaid expansions that Congress is contemplating would likely capture a lot of those kids if CHIP were, it phased out even though I don't think that's what's going to happen. So I think that could also, and for many states who especially use managed care for their CHIP

expansion, I think that would actually, Medicaid would be a better choice for them.

ED HOWARD: One other quick thing to say before we go on to some other folks. Go ahead.

MARTY STEIN: I just want to add a little conundrum and to make things a little complicated. I'm Marty Stein. I'm a psychiatrist. There's a small elephant in this room that is, and I'm surprised we didn't talk about it, it has to do with the issue of confidentiality and sharing information, which can hurt people.

At 11:00 this morning, just before I left, I got a phone call. It was for a woman who said I'm with CareFirst, I'd like to talk to your wife. I said well do you work directly, no, no I'm with Healthways. We do teachings for CareFirst. I said do you report back to CareFirst. Yes we do report back to CareFirst. CareFirst decides to deny and except my claims, right? Yes. Well I'm not talking to you.

This is one of the elements that has to do with, there's still so much stigma out there and so much employment and other discriminations based on mental health issues that the information that is collected can be very dangerous to us. I'm not sure how we're going to fix that.

MICHAEL HOGAN: My two cents about that is I think

are still too many people who will fail to do what's needed to provide minimally adequate care in some paranoid ideation that they're breaching something on the one hand.

On the other hand, we know that there are problems that exist and the other arena where information gets out and it impacts somebody's employment. A system in which care for these disorders was on a par with care for other health problems is one where confidentiality, in my view, would have a different meaning.

ERIC GOPLERUD: I think an absolutely critical issue, which was partially not addressed or was wholly unaddressed in the stimulus package is the inclusion of mental health and especially substance use disorders and electronic medical records both in terms of the support and supplements that will be going to help them become electronically capable, but also really the attention to the privacy of records, which I think is a fundamental issue, which in the mental health and substance use fields, we've probably been acutely sensitive to but I think becomes really an issue that is more general of how do individuals protect the privacy of information that they feel is important and how do they also have informed consent about what the consequences of denying access to that information on, perhaps, coordination of care or quality of

disclose it advertently or inadvertently against the individual's wishes, there are some real teeth and enforceability including individual right of action.

ED HOWARD: And do we know whether any of that is under active consideration in either the tri-committee bill or the bills that are in the Senate?

CHARLES INGOGLIA: No, neither the Health Committee bill nor the tri-committee have any provisions really related to electronic health records or privacy. So that was rather extensive privacy protections built into ARA and I think that's the only place in ARA in the High Tech Act where mental health is mentioned, is related to those mental health and substance use as related to these privacy protections.

ED HOWARD: Yes, go right ahead Mary.

MARY POLTZ: Hello. I'm Mary Poltz. I'm an APA, triple AS fellow in Senator Wyden's office. This is a workforce question related to the anticipated Medicaid expansion. So to get more behavioral health clinicians on the floor and integrated into primary care, I'm wondering your thoughts on increasing or allowing LPCs and licensed family therapists to become providers for Medicaid similar to the tri-care bill that's incorporating those clinicians into Medicare. So your thoughts on broadening providership to LPCs and licensed

marriage, family therapists as well as other ways to increase the workforce.

MICHAEL HOGAN: Is there anybody here from the APAs? If there's nobody here from the other professions, I'll say-

FEMALE SPEAKER: I'm a psychiatrist.

MICHAEL HOGAN: Okay well then, why don't you step outside and talk [laughter].

CHARLES INGOGLIA: Well I think the other reality is that most of the kind of independent practitioner rules for Medicaid are really state decisions. That states determine what are the scope of practitioners they're going to recognize for independent practice and reimburse in Medicaid.

I think this becomes one of the tricky things in our grand federal/state partnership that is known as Medicaid is how many things are determined here in Washington versus how many things are determined in states. My experience has been the issues around the types of practitioners is wholly a state activity.

ED HOWARD: And how does that affect it, if at all, by the move to medical homes and team-based care and patient-centered care?

MICHAEL HOGAN: This is an inter-professional war with the iron triangle of the professions that sort of control

programs in the universities and my hope is that if the market place changes as it will change, we hope under reform that then it will move the ideologs along to a reasonable posture but until that, it's a ground war in 50 states.

ERIC GOPLERUD: Let me talk from a little different side. There was a very good book that Richard Frank and Sherry Glied wrote recently. I think it was called something like "Better but Not Well."

One of the points that they make in that is that over the last 20 years, we've seen a shift in mental health from being an exception and everything had to be separate, separate professionals, separate service systems, separate health records. Everything was separate to it being really recognized that it's not exceptional. In fact good medical care involves integration and awareness of mental health and then I think addictions as well.

One of the things that these professional warfares seem to ignore is the fact that, as Chuck pointed out and also Mike did that we have so much co-occurring conditions, medical, psychiatric substance use conditions that having these professions that only deal with one part but not another really doesn't go with where people are, which is they often got multiple conditions and particularly the sickest people have

So the 25 years of premature mortality of people with serious mental illness is primarily a result of their smoking, sedentary lifestyles, medications that they're taking, and other risk factors. People who have a heroin or other addictions have 18-plus years of life lost. So we really need to be addressing the whole person and hopefully the professions will catch up to that.

ED HOWARD: Yes, I believe you were next.

REGINA HOLLIDAY: Hello. My name's Regina Holliday and I'm representing ePatient. My husband was diagnosed with kidney cancer on March 27th and we were hospitalized for three months before passing away. During that entire time period that he was on three different kinds of anxiety medication, he received a total of two hours time in therapy or with a psychiatrist while hospitalized even though he repeatedly said he was suffering from depression due to his diagnosis.

I wonder how the new legislation and our current standards were going to address hospitalized care for depression, anxiety, in a therapeutic way and my second point question being the parent of a child with autism, is how are we going to make the admission process within hospitals more accessible to people who have autism or potentially anxiety tendencies? The current process on the five different hospitals

that we were in had forms that don't even have a window for diagnosis of autism.

On top of that, the environment that you are within is completely antiproductive to a high anxiety patient or somebody with autism.

MICHAEL HOGAN: Right. Right.

ED HOWARD: Tough questions.

MICHAEL HOGAN: Right. A comment about the first and that, to go back to echo what Eric has said, this stuff has got to be paid for to exist. I mean there used to be a whole profession almost of consultational liaison psychiatry. If psychiatrists in hospitals working primarily on medical floors to exactly help patients but also their caregivers with challenges like this but that hasn't been explicitly paid for and so it's tended to go away.

So it's an illustration of how the benefit alone is not enough. If we can achieve legislation with a benefit, that will be a historic leap forward but then the question of how we make a health care system that really is accepting of, as Eric said, whole people, is a challenge that's before us.

I don't really see this momentous opportunity that's before us, speaking to these issues at all, which is unfortunate in a way but at the same time, if we can just get

we have the opportunity then to go on and address some of these questions and in a way that is more honorable.

CHARLES INGOGLIA: And I guess, Mike, the only thing that I'm kind of building on your comments earlier, I think that parity is necessary but not sufficient and I think we're in a critical phase that Congress has passed comprehensive parity. It's now being cross-referenced in these bills as kind of being the starting point.

I think what lots of this will hinge on then is the regulatory process that's currently underway between the Departments of Labor, Treasury, and Health and Human Services and how do they decide to implement that parity mandate the Congress has given them. What kinds of conditions will they place on employer-sponsored health insurance related to scope of benefit? What will parity mean in an ongoing way? I think that will likely be the other piece of this that's related but not directly addressed in the health care debate.

ED HOWARD: Yes sir?

PAUL GOLD: Thank you I'm Paul Gold with University of Maryland, clinical psychologist by background. I did want to follow along with the issue of parity not being sufficient to deal with incentives of organizing care particularly with people with severe mental illness and severe addictions, both

of which in a broad sense, are lifelong, chronic illnesses that require lifelong interventions.

The parity legislation passed last fall and the health care reform bills out right now, I'm having trouble seeing what incentives are in those bills and legislation that incentivize providers coordinate around the care of a given patient. That would include not only physicians and psychiatrists or addiction psychiatrists but also employment specialists and benefits providers and so on.

In the past, some of these extra health services have not been reimbursed except under Medicaid waivers, for example, certainly not in private insurance but these things are going to be necessary because people will need the health care, the mental health care, the addictions care but they will also need help getting back in the labor force, integrating in the community, getting more education, and so on.

How will, and this is what I'd like the panel's impressions, how will the current provisions in the various parity bills incentivize organization of providers who are paying for things but were not looking at the structure of systems of care and how providers from very different fields will help people and their support systems return to an ordinary life? Thank you.

MICHAEL HOGAN: I'm having a flashback sitting here to a conversation about 15 years ago when I was still or then a state mental health director, which tells you how old I am and a number of us have been invited to a meeting with the Tipper Gore-led Mental Health Taskforce as part of health care reform to dialogue about the question of whether the state mental health systems would be willing to, in effect, over time and with protections give up their budgets and resources and facilities in return for full inclusion within a comprehensive health care system.

Two things happened back then is we said yes we would and reform did not happen not just for that reason. There are lots of other reasons but a lot of it involved sort of that reform putting on the table questions that people weren't ready to answer. I sort of think that the question you're raising is a very important question that if we were to slow the process down and ask it, it would likely keep reform from happening.

So I sort of come back to this is a time when the quest for the perfect could be the enemy of the good. If we could get the good, it would be really good and then we could have some wonderful conversations.

ERIC GOPLERUD: One point from the evaluations of parity in Vermont and in the federal employees' health benefits

complete than in the federal recently passed parity legislation.

What they found was in both instances but especially in the very well studied federal employees health benefits study that access to care increased substantially especially to outpatient services but what did not change was the quality of care that was delivered. If you started out with mediocre quality, you got more mediocre quality for more people.

So what we are not going to have completely addressed in this reform is what do you do about quality? So I think this is an important issue, again as Mike said, let's not stop the train. We probably can't anyway but this accountability, monitoring performance and monitoring outcomes, I think is absolutely essential or otherwise we just give more of mediocre care for the spending.

CHARLES INGOGLIA: But wouldn't you say, I think we have some good indications though. I think the medical home pilots, the accountable care organization pilots are all movements in that direction of how do we have long-term relationships and responsibilities with patients, with consumers that lead to positive outcomes and cost savings.

The question's going to be how well are those implemented, studied, and expanded over time but I think

the chronic natures both of mental illness and addiction disorders. So I think the successful implementation and adaptation of that over time is hopeful.

ED HOWARD: Yes ma'am?

ELIZABETH PRUITT: I'm Elizabeth Pruitt with the State Mental Health Program Directors and my question is about the premium incentives for participating in wellness programs and President Obama has talked a lot about that and if you just hear about it and the success that some of the programs have had, it sounds very encouraging but what is a premium incentive is also a penalty and for people with serious mental illness, it's often very difficult to quit smoking for example.

Some of these incentives relate to just participation, which I think we would encourage people, whether they have a mental illness or not, to participate but in some instances, it's for indicators. I just want to raise that concern and see if anyone has any comments on that on how to find a balance between incentivizing participation and wellness and yet not have it be a back door health status discrimination.

ED HOWARD: And if I'm not mistaken, the HELP Committee bill does include some liberalization of the current rules in that area.

ELIZABETH PRUITT: Yes. Right now, you can vary the

heard 50 and I believe in the HELP Committee bill. It also specifically mentions that premiums can be adjusted according to whether you smoke or not. While that, on one hand, is something that we would like to see reduced in all populations, people with a serious mental illness smoke a large percentage of the cigarettes.

I think it's up to 44-percent of all cigarettes are smoked by people with serious mental illness. So you're really hitting a very specific group of people more than you do the general population.

MICHAEL HOGAN: I don't know, Elizabeth. I guess what just comes to the top of mind for me about this is that there are dangers in these approaches. I think the flavor of this is a little different now than it was back, I don't know how many years ago, when we were talking about like the bare bones Medicaid options where it felt, to me, like more of a threat back then.

In a post-parity environment, it feels to me like maybe it's less of a threat. More of it's an opportunity. Beyond that, who knows? I come down again. I think I've said this for the eighth time now.

Let's get legislation passed and then let's work through the regulation process and then let's start focusing on

being tied up in knots around mid-range concerns keep us from getting this reform done but this is just intuition.

ELIZABETH PRUITT: Thanks. It's helpful.

ED HOWARD: Yes? Go right ahead.

EILEEN CARLSON: Hi. My name's Eileen Carlson and I'm with the American Nurses Association. My question is with respect to substance abuse. It seems like the biggest crisis, health care crisis, in our country as far as lack of access and lack of treatment is for people who suffer from serious substance abuse problems.

Unless you're very wealthy or very lucky, you can't even get into one. So my question is this. Do you see any of these bills helping that situation and if not, what would you like to see? Does there need to be creation of a new kind of treatment center? Is the existing infrastructure adequate and we just need to fund it greater? I'd just like your input on that.

ERIC GOPLERUD: Well that's lobbing a softball very slowly right over the center of the plate [laughter]. One of the wonders that you can do with word or with PDF is do a global search and see whether your favorite word comes up in a 1,000 page document. One of the very interesting things in relation to your question is that there are a number of places

comparable definition or description or support for addictions recovery.

So in talking about the medical home or talking about health professional training or health professional incentive grants or children's mental health programs, they all talk about mental health but they tend not to or they very rarely talk about substance use.

Now I think that one of the, this is basically a coverage reform set of bills. Unless you have some explicit coverage that talks about addictions, you're going to not have it. In the current system and we've done some research into the coverage of addictions pre-parity, and we could find no other condition that had more discriminatory health insurance coverage than addictions.

Mental health was right up there but addictions was far worst. So it's not surprising that we have an under funded, overworked, inaccessible substance use treatment system because it has not been part of health reform.

The inclusion and parity of mental health and substance use treatment and workforce expansion, I think will go a long ways towards it but as we talked about with quality, sort of a lot of this is in the regulatory details but if it isn't in the bill, I'm concerned that it's just not going to happen.

MICHAEL HOGAN: It's also hard just reflecting what you said Eric. It's hard to sort of think about how dramatically the ground is shifting around us in this regard and how rapidly these things are evolving. I always think about when I was back in Connecticut a zillion years ago, a study that was done in the Yale-New Haven ER that involved a quick look at 100 consecutive trauma cases asking two questions.

One was, was substance abuse or overuse implicated in the trauma, question number one. Question number two was following a resolution of the trauma, was there a referral for substance abuse treatment? The answer to the first question was 50-percent. The answer to the second question was zero.

So if you then go to what you said about the efficacy of brief interventions in physician offices that have so clearly demonstrated their effectiveness but only about less than a quarter of physicians, without a little boost, feel comfortable doing that. With just a little boost, their comfort level is increased. So these things are, thank God, changing as we go forward.

ED HOWARD: Could I just follow up because we've got a couple of questions on cards that follow naturally from this exchange. It has to do with references that all of you have made to the importance of primary care and care for mental

the office of a primary care provider, sometimes in the mental health facility. How is it that you adjust, whether it's adjusting payment, whether it's doing training or some combination of that, to bring it about more quickly and how much of that progress is likely to come from what we see in the legislation so far?

A simpler question is that this legislation primarily separates services into two categories according to the questioner, primary and preventive care on the one hand, specialty care on the other, where do mental health and substance use disorders fall on that spectrum?

MICHAEL HOGAN: Yes [laughter]. So I think that pediatrics is a useful place to look, I think, for how these issues are being addressed because pediatricians, as I said before, are overwhelmed with behavioral health problems sort of all the time. It's every pediatrician's, in a sense, biggest challenge depending on how comfortable they are with it.

The American Academy of Pediatrics, over the next year, is going to come out with a package of materials that are essentially designed to equip every pediatric practice over the long-term with the ability to deal with these challenges. They recognize that it's going to take reimbursement changes and it's going to take training changes and it's going to take all

these things but essentially, their attitude about it is we've been waiting for the cavalry and we don't think they're coming.

I think it's a useful way to think about it. So we know that the vast majority of these conditions, if you just look at them numerically, depression, anxiety, simple depression, anxiety, a lot of ADHD, problem drinking that hasn't really escalated can be dealt with very well in primary care settings of all types but if and only if people are paying attention.

So we've got to, as I've said, Mike Hogan's one liner is, if there's not a behavioral health specialist on the floor, don't expect it to happen. So let's get to a place where we have that and then we can build on that with these other connections is my simple minded logic.

CHARLES INGOGLIA: I think the medical home or kind of integration way of describing that is you need a care manager onsite. I think the innovation proposed in medical home is having that care manager there. I think our recommendation has been that there needs to be a behavioral health care manager financed by that wraparound payment.

So I think the basic infrastructure is there. I think the curious thing, not curious thing, really good news is that even the folks involved with the patient-centered primary care collaborative, they had a meeting yesterday and I think three-

about the role of behavioral health care because of the prevalence in primary care, the complications that it presents to other chronic illnesses.

So I think there's a growing recognition that we need to have, not just that it needs to be addressed but needs to be addressed in a planned way and I think, as these things continue to evolve, that seems to be at the heart of this.

ERIC GOPLERUD: I think the other piece in some ways, Mike talked about it really well, which is that a lot of the organizations are feeling that this is an integration that has to be done whether we get it in health reform or not. There was a fairly small SAMSA grant program that Chuck and other groups have advocated for but National Council was really out on the lead on, it was going to award what, 11? They received over 300 applications. There was a medical education training program on substance abuse screening, brief intervention, and treatment.

They were going to award, I think, five of these. They had over 100 medical schools apply. Chuck's organization is running a collaborative between community health centers and community mental health centers. They have far more applications than they can manager.

There is clearly a hunger out there for getting this system together. I don't think it all has to be national health

will help but folks are working on those things right now and really hungry to try to get it together for patients.

ED HOWARD: Let me ask a completely unfair question to our panel. Any changes in the recommendations from the Massachusetts Cost Control Panel yesterday that dealt, in large part, with ways to bundle payment to encourage people to focus on outcomes rather than on specific delivery of specific services that might either be helpful or a hindrance and being unfair to the panel, let me be unfair to the audience as well.

If there's anybody in the audience who's been involved in that and can explain it, help us take everybody off the hook including me but it does seem to me that that kind of discussion is exactly what the folks in Massachusetts have been grappling with and what the folks in those markets have been grappling with.

One of the problems is there aren't any pediatricians in the demonstrations that Medicare is going to be putting in place, which seemed to be most of the payment manipulations that Congress is comfortable doing right now.

ERIC GOPLERUD: Well how about not answering your question by another answer. I understand it's done in Washington all the time. The Commonwealth Fund has taken a look at what are corporate payment reforms and they really made two

recommendations. One is around the patient-centered medical home and increasing the rates for providing glue.

The second one is bundling and particularly bundling hospital so that it also extends out to 30 days for some period of time afterwards both of which seem like very reasonable ways of moving with one fly in the ointment.

That fly in the ointment is something that was asked earlier, which is about patient privacy that some of the federal privacy regulations on substance abuse and state privacy regulations on mental health records make it extraordinarily difficult to coordinate care between levels of service, between the hospital and ambulatory or between hospital and primary care.

So many of these reforms will probably work for diabetes but until we also deal with this privacy issue, we're really going to have difficulties making it work for serious mental illness and addiction.

ED HOWARD: Okay. Thank you. Yes? Go right ahead.

PAMELA DUDZIK: Hi. My name is Pamela Dudzik. I'm a Project Coordinator for the Geriatric Psychiatric Nursing Collaborative. I just wanted to go back to the workforce issue, which you've talked about at length. I was just wondering, it's a relatively simple question.

You've said that the different health services are working right now to address the issue of the need for individuals or service providers who have knowledge of the mental health and substance abuse issues but I was wondering if either of the bills provides any funding for any of this training because it is needed. It can't always come from the organizations themselves.

CHARLES INGOGLIA: So I think there's some minimal attempts at this. There's, in the House bill, there's notions of interdisciplinary care training and in the HELP bill, multidisciplinary community HELP teams but I think, there's a little bit of attention but not nearly as much as we would like.

I think one of the things we need to look at is how do we expand, perhaps, other federal initiatives related to workforce like the National Health Service Corps to more explicitly include behavioral health care, mental health, and addiction providers as well as settings.

So I think the tension between primary care and specialty care also extends to other provisions in the bill not just to service delivery but also to workforce development. I think there certainly is room to improve.

ERIC GOPLERUD: And also these bills are authorization

training here and there, those are all authorization monies. They're not appropriation monies. So whether something happens, happens on an annual basis in the Appropriation Committees.

MICHAEL HOGAN: So again, it seems to me that we have not, we can't pretend for a minute that we've adequately thought through the workforce issues now. So forget that on the one hand. On the other hand, if we look back, for example, if we look at Richard Frank and Sherry Glied's book, we do see that over the last generation, the supply of mental health professionals has increased dramatically. So something, we think we're in crisis but it's better than it used to be.

So that's why it's simplistic in a way but I come back to thinking that if we can create the expectation that this care is provided, I think the market place is going to, over time, work its way. It's a pretty high level glib response but I think that's what our history has been at some level and that approach is to, we've been fretting about the supply of primary care physicians and we've been fretting about the supply about nurses for quite some but absent incentives, not much has happened.

So I think if the incentives change a little bit, I think the workforce supply's going to have to change as well to respond.

ED HOWARD: Okay. Well we are almost out of time and we are, perhaps, not out of issues to explore but I think we are at a pretty good stopping place. There are more unanswered questions that will unfold by the hour and we won't ask you to come back at 2:00 in the morning to try to respond to them but I do want to thank both the Open Society Institute and the Robert Wood Johnson Foundation for helping us to explore these really tough issues.

Thank you for filling out those blue evaluation forms that I know you're pulling out of your packets as we speak. I'd ask you to join me in thanking our panelists for exploring some really tough issues in their very, very coherent way [applause].

[END RECORDING]