

HEALTH CARE REFORM:
CHALLENGES AND OPPORTUNITIES FOR
BEHAVIORAL HEALTH CARE



The 25th Annual Rosalynn Carter
Symposium on Mental Health Policy

NOVEMBER 5 AND 6, 2009

Welcome to the 25th Annual Rosalynn Carter Symposium for Mental Health Policy. In 1985 I envisioned bringing the nation's mental health leaders together to work cooperatively. The first year, nine organizations were represented. We now have more than 50, and our gathering remains the only opportunity for such diverse groups to convene and discuss the issues at hand. I am honored by the esteem in which the symposium is held and proud of all that we together have accomplished.

The field of mental health has changed dramatically in the last quarter century. We have learned so much about mental illnesses and how to treat them. Most importantly, we now know that most people can recover from mental and substance use disorders and lead fulfilling lives — going to school, working, and having meaningful relationships. Yet stigma continues to be an obstacle, and we have a tremendous amount of work to do to ensure that everyone receives the mental health services and medical care they need.

In this 25th year, let us celebrate our partnership and renew our commitment to improve the lives of all those who suffer from mental and emotional disorders. I and my colleagues in the Carter Center Mental Health Program are grateful to you who have made these symposia so successful, and with your help we look forward to overcoming the remaining challenges and creating a brighter future for all people.

With warm wishes,

Rosalynn Carter

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OPENING REMARKS

Rosalynn Carter

Chair, Carter Center Mental Health Task Force

It's hard to believe that it has been 25 years since our first symposium. When I think about it, though, I've been working on mental health issues for a very long time: four years in the governor's mansion, four years in the White House, and 25 years at The Carter Center.

Mental health advocacy has been a major part of my life and one that I have enjoyed, meeting so many wonderful people — those who need help and those with whom I have worked to try to bring that help. At the same time, it has been frustrating when I think about how little progress has been made. I hope, though, we are on a good path now. I believe people are beginning to understand more about mental illnesses, and hopefully stigma is lifting a little bit.

We have a timely topic for our symposium today: health care reform. A lot of changes have been made since that early symposium, but some things remain the same. For instance, our first symposium addressed stigma, and we still are wrestling with it. Ever since the 2003 President's New Freedom Commission on Mental Health report stated that the mental health system in this country is "in shambles," the mental health community has been talking about transformation. Now the entire health care system is in transformation, and we have the opportunity to ensure that mental health is a key element to any new plan. Mental health must be a part.

In transforming the system, we have to take into account that it will be important to prevent the health system and the financial system from being overwhelmed by people with chronic diseases, which is what is happening today. We still want to care for everyone in need, but we must focus more on health promotion and disease prevention initiatives. And we have to do something about the fragmentation of care.

We also are going to have to move quickly to implement evidence-based medicine. It takes years from the time an evidence-based program is developed until it reaches the people it is meant to help. There are ways to move the process along, so that proven programs are more immediately available. And we also need to more diligently monitor care and assess outcomes. When we look at controlling chronic illnesses and find a care program that generates successful outcomes, we need to be ready to implement such a program as soon as possible for people who are struggling.

For behavioral health care reform, the integration of mental health, substance use, and primary care has been identified repeatedly as an absolutely critical goal. Without appropriate integration, modifications in the field like insurance expansion, promotion and prevention tools, and potential savings through financing simply will not be effective. Thus, it is through replacing a fragmented system with a more effective integrated one that national health care reform actually will impact the behavioral health care field in America.

Our challenge today is to recommend the steps to take to make this happen and ensure that behavioral health care in America genuinely improves.



REFLECTIONS ON THE 25TH ANNIVERSARY

David Shern, Ph.D.

President and CEO, Mental Health America

This year is the 100th anniversary of Mental Health America, which was founded by Clifford Beers in 1909. It has been a great time for us to reflect on the history of our organization, the vision that we have had over that period, and to take a look at the progress that we have made and the areas in which we still have a lot to accomplish. Over the past 25 years, The Carter Center has been a tour de force regarding the most important issues that we have addressed, and its presence as an intellectual and action leader has truly been extraordinary.

When we had a dinner for the 25th anniversary of the Florida Mental Health Institute, Mrs. Carter was kind enough to join us. That was my first opportunity to really work with

Behavioral health is central — not peripheral — to making the difference that we need to improve the overall health and well-being of this country.

her directly, and I was struck by her humanity, her humility, her openness and generosity, and the extraordinary affection that she draws out of others. I think part of the character and

fiber of The Carter Center reflects her spirit, as I understand it. It is really about getting the job done, not about the person at all.

If you look through the list of symposium topics, you will see the issues that have characterized the mental health system over the last 25 years. I group those into five major areas with a few important reports punctuating that 25-year history.

Group 1: Stigma

The very first symposium was held around stigma, and one theme that emerges throughout the 25 years is the importance of public education. To address stigma the Mental Health Program developed the Rosalynn Carter Fellowships for Mental Health Journalism. After their experience here, journalists are changed forever with regard to these issues. More than

100 journalists have now gone through the fellowship program and learned better how to report accurately on mental health issues.

Group 2: Prevention and Promotion

The Carter Center has been unique and quite distinctive in embracing prevention and promotion, critical and important areas since the very beginning of its work. Prevention is fostered throughout many of the symposia, even before we had the extraordinary science base around the prevention of mental health and substance use conditions that we have now.

Group 3: Importance of Trauma

Related to the prevention theme is the importance of trauma. One of the most profound experiences I have had was hearing about the ACE (Adverse Childhood Experiences) Study during the 2007 symposium, and the long-term consequences traumatic experiences have on health and well-being. What happened post-9/11 and post-Hurricane Katrina were some of the traumatic events that gave us an opportunity to think about the effects of the environment, particularly environmental trauma, on health and illness.

Group 4: Disparities

Disparities with regard to particular groups, again, reflect a trauma theme to the degree to which trauma is most clearly embodied by poverty in this country. It includes all the related traumatic events that ultimately result in extraordinary health disparities.

Group 5: Health Care Reform

Around the early 1990s, and before the Clinton era of health care reform, there were activities at The Carter Center addressing this issue. At this symposium, we are going to start talking about

some of the fundamental issues associated with increasing the efficiency and effectiveness of a very expensive and under-performing health care system. Behavioral health is central — not peripheral — to making the difference that we need to improve the overall health and well-being of this country. That discussion has changed fundamentally over the last 25 years in part because of the work of The Carter Center.

Conclusion

And that brings me then to the shoulders of giants. We are so fortunate at this point in time to be standing on this tripod of reports that really summarize the field. One is the “Surgeon General’s Report on Mental Health” in 1999. David Satcher, M.D. [former surgeon general] was skeptical initially about whether or not the science base was really adequate to have a surgeon general’s report. But he concluded that there was a phenomenally strong science base and that there was no health without mental health.

That was followed by the “President’s New Freedom Commission on Mental Health,” which called for a transformation of the entire mental health system. The commissioners asked Mrs. Carter to name the most important thing that has changed over the last 25 years. Commission Chairman Mike Hogan said they expected she might say something about new medications or public attitudes. But what she said is so important: recovery should be an expectation for every person who has a mental illness.

Finally, we have the Institute of Medicine report “Crossing the Quality Chasm” featuring the work around behavioral health care and how fundamental that is to health care reform overall. It describes the challenges that we face in identifying and moving forward the critical issues that we need to achieve.

That brings us to today to the importance of chronic illnesses as cost drivers and as absolute destroyers of overall health status. We have a

chance to fully understand that mental health, and substance-use conditions really are the most chronic illnesses. The average age of onset is 14, and the average age of latency to treat is 10 years, which causes more disability in the United States than any other single set of health conditions.

These issues comprise the American mosaic with regard to behavioral health, mental health, and substance-use conditions. These things do not happen without an enormous amount of work and commitment. There is a lot to be proud of, and so I commend you on that and on the 25th anniversary of the Rosalynn Carter Symposium on Mental Health Policy.



KEYNOTE ADDRESS

What We're Not Hearing About in Health Reform: Innovations in Chronic Disease Prevention and Care Management

Kenneth E. Thorpe, Ph.D.

Woodruff Professor/Chair, Health Policy and Management, Rollins School of Public Health, Emory University

I am going to talk about everything you are not hearing about in health care reform. If you listen to the news or read the newspaper, you would think that the entirety of health care reform has one or two things in it: a public option and taxes, and that's it.

The debate on health care reform is much broader. It encompasses not only the issues around the financing and coverage of Americans in a health insurance system, but it also deals fundamentally with issues around cost, quality, and modernizing the delivery system

The separation of prevention and treatment must end.

how they are treated, how we can improve on those treatments, and, most importantly, how we can prevent disease in the first place. These issues touch all Americans, whether they have health insurance or not. These are foundational issues.

Much of the health care reform discussion, appropriately so, is on how we expand coverage to the 15 percent of the population who do not have it. On the flip side, it is important to remember that 85 percent of the public has health insurance, and as they watch this debate unfold, they are thinking, what is health reform going to do to make health care less expensive, more affordable, more sustainable, and improve the quality of their health care? In 2006, the last time we had good data on this, 96 percent of

We are getting exactly the health care system our financial incentives provide.

health care reform, but these other issues are fundamentally important as well.

infrastructure. This is what I really think of as health reform and the fundamentals of how people get their care,

people who voted had health insurance. They are focusing on delivery system design, cost, and quality. Coverage is an important part of Americans' thinking about

Most of our payment models have not changed since the 1960s. Medicare is a terrific example. It was modeled after the Blue Cross/Blue Shield programs dating from the 1950s. Other than adding coverage for the disabled and end-stage renal disease, as well as a drug benefit, how Medicare operates is basically unchanged since its passage in 1965. But the types of patients and their clinical needs and requirements in the system today are very different than they were in the 1950s.

A typical patient then was probably an acutely ill, episodically treated patient. Now, it is people who have persistent, ongoing, chronic health care conditions whose medical and insurance needs are quite different. Our payment systems also need to recognize that the clinical makeup of patients in our health care system today has fundamentally changed from the 1950s. How do we modernize and build a delivery system and prevention infrastructure in this country to recognize and treat more effectively the patients in today's system? We have to build prevention into these models in a way that is fully integrated in the notion of treatment. The separation of prevention and treatment must end.

To get there we need to change the way we pay. We are getting exactly the health care system our financial incentives provide. If we want a different system, we need to provide different financial incentives, a different way to set the system up, and a different way to pay.

If you think about fee-for-service Medicare, the benefit design is not matched very well with the types of patients treated in the system today. Medicaid, private-sector payers, and so on, all do some type of care coordination. Some of it is okay, some not so good. But they all do it. Ironically, the only program in the country that does nothing in terms of helping patients manage their conditions is Medicare, which makes

absolutely no sense. Medicare owns the chronically ill population; 95 percent of spending in fee-for-service Medicare is linked to chronically ill patients. And this is a program that does virtually nothing in terms of primary prevention and care coordination.

The conditions driving the growth of spending in the Medicare program have changed. Twenty years ago, the leading driver of spending increases in Medicare was heart disease because the technology of treating heart attack and stroke patients was evolving very quickly.

Medicare

Six conditions are driving the current growth in spending in the Medicare program: diabetes, hypertension, hyperlipidemia, asthma, back problems, pulmonary disease, and depression. Often, all of these conditions are lifestyle related. They are largely ambulatory-based conditions that require some type of medication interventions to manage appropriately. In-patient hospital care is not generally part of care unless patients are not successfully managed. Many of the cost drivers are potentially preventable conditions. They require a delivery system model that, for the most part, does not exist and a payment system that recognizes the need to work with patients outside of the physician's office and the hospital.

We have high rates of preventable hospital admissions and readmissions. Economists like to point to technology as a leading driver of increasing health care spending. That is probably true of the last 50 or 60 years, but not of the last 20 or 30 years. We know our rate of obesity has doubled, accounting for about a third of the growth in health care spending, and that it is linked to a whole range of chronic conditions. Mental health and substance abuse fall into this category as well.

What Are the Opportunities?

If we could intervene earlier in terms of lifestyle with adults who are 30, 40, 50, and 55 years old and change the health profile of people coming into the Medicare program, we would make an enormous difference in what that program spends on health care. Look at lifetime spending for

people 65 and above, who are of normal weight with no chronic disease versus people who are overweight or obese and have one or more health care conditions. Normal weight adults spend 15–40 percent less over the course of their lifetime. That is a lot of money. If we are looking at opportunities to change clinical trajectories in the program and save money, we need to look outside the Medicare program to try to affect behavior, health, and prevention in a more coherent national strategy, because not only will it improve health outcomes, it also will save money.

What Are the Challenges?

We work in a fragmented, silo-based health care system largely because of the way the payment systems work. We are incentivized to work in separate, distinct, silo-based arrangements. But that makes it very difficult to work successfully with patients who have multiple conditions.



About 95 percent of Medicare spending is linked to chronically ill patients. The typical patient driving most of the spending is an 80-year-old woman who is living alone. Maybe she's a little bit overweight. She has diabetes, high blood pressure, bad cholesterol, back problems,

Why would you want a co-pay for a service that is almost, by definition, not discretionary?

asthma, pulmonary disease, arthritis, bouts of depression, and on down the chronic disease list. These folks probably see two or three different

primary care physicians and six or seven specialists in four different jurisdictions. None of their care is coordinated or integrated with a coherent thought process or clinical game plan. That is a significant challenge.

Diabetes is a good example of our very reactive system. Too often we will not pay for diabetes counseling, education, working with diabetic patients at home, and making sure they get annual eye and extremity exams. But if the need for an amputation arises, we will pay for that. That does not make a lot of sense. We need a different paradigm that focuses aggressively and proactively on fully integrating prevention and treatment. A population-based public health model is a good way to go.

Reform Proposals

The discussion coming out of Washington about prevention is narrowly focused. There are people who continue to write stories or make statements about prevention saying it does not save money, and they focus on one form of prevention: detecting disease, such as cancer screens. Certainly, that is an important form of prevention but, obviously, that form is not designed to save money. It is designed to find problems, intervene early, and give people a better prospect of having healthier, longer lives. Other forms of prevention do not get as much focus, especially in averting disease — diet, exercise, nutrition, smoking, alcohol use, and so on.

The good news: Potentially, as much as 80 percent of diseases like diabetes, hypertension and hyperlipidemia, co-morbid depression, and even cancers are preventable. Eighty percent —

if we put into place a prevention system in the schools, community, workplace, and integrate it into the design of our health benefits.

Reform is moving in this direction. There is a recognition that we need to do more in terms of primary prevention, in detecting disease, and in getting better adoption of clinically recommended cancer and other screens, largely by eliminating cost sharing linked to those types of services. I find it ironic that the American Cancer Society and other organizations say that we want to make sure women have periodic mammograms — but then have to pay \$100 for it. Why would you want a co-pay for a service that is, almost by definition, not discretionary?

Congress also has put in a new Medicare benefit that would provide a health risk appraisal during a physical, with no cost sharing, unlike the “Welcome to Medicare” physical now. As we are welcoming you on one hand, we are charging you on the other. Not surprisingly, not a lot of people took the program up on having that baseline assessment of their health, which would enable their provider to put together a care plan to manage the patient. That cost sharing will be eliminated.

Managing Care and Building Integrated Systems

We know from public polling data that we have to eliminate the term “medical home.” But it is an important concept, one that provides a patient-centered, integrated way of working with patients to make sure their care is coordinated appropriately among providers. It is a team-based approach to providing health care, not so much by physicians but by nurses, social and mental health workers, nurse practitioners — people who deliver primary health care and work with patients at home on making sure that their care is managed appropriately.

There are proposals in the reform package that will do that, as well as some more payment reforms, moving slowly away from fee-for-service payments toward bundling to provide incentives for the system to better integrate and to have hospitals make sure that, when patients leave, they have addressed needed transitional care. These things do not happen today because we do not pay for them.

We have a lot of evidence on medical homes about what works. We have great evidence from the Geisinger system and the Marshfield and Cleveland clinics. They are integrated, large, multidisciplinary clinics that provide great care. But, most Americans do not get their health care at Geisinger or Marshfield. Most American medicine is tremendously fragmented. In fact, 40 percent of primary care physicians work in groups of one, two, or three doctors. That is true of about 70 percent of primary care practices. So, the challenge is in integrating some of the functions and replicating what some of these successful clinics do, but in community-based settings.

How do we replicate that model? With the Partnership to Fight Chronic Disease, we are identifying key elements that are successful in making sure that we prevent chronic disease complications by working with patients to manage their conditions. A comprehensive approach includes transitional care, a close integration between a care coordinating team — nurses, nurse practitioners, nutritionists, diabetes educators, social workers, and mental health workers — coaching the patients. That team must be integrated very closely with the primary care practice so they are closely aligned.

Proposal

This is the proposal: Provide funding to states to establish and build community health teams in different hospital service areas throughout the state and have them available to work with Medicare and Medicaid patients, as well as privately insured patients, as a way of quickly scaling and replicating successful integrated system models. It would require a federal investment of about \$30 billion over 10 years to do it, which in Washington sounds like a lot of money. But, in the context of doing a health reform bill of a trillion dollars that varies by 10 percent every other day, this is certainly an investment that is not only worth making but is fundamentally something that we should be doing as part of the reform package.

The idea is to build these community health teams with primary care providers in order to integrate mental health, acute care, and chronic care management. Teams would work very closely

with the primary care physician practices and community health centers. Together, they comprise a virtual medical home. The combination of the teams and the primary care practices looks similar to a lot of what goes on in these very successful, integrated, large-group practices. Building this infrastructure is an important part of what we do in health reform. We need to have the information technology available so we can track patients and make sure that patients are progressing in ways that are consistent with their individual care plans.

Additional Evidence-Based Components

We have 15 years of randomized trials that examine what works to prevent and manage diseases. The problem is that, in the reform debate, prevention, medical homes, community health teams, and

payment reforms are in there — but as throwaways. They are included as pilots. To me, a pilot is just a vernacular way of saying, “We’ll put it

in there. We’ll check off the box. And we can move on to something else.” In Washington terms, “pilot” means that, by the time you design it, bid it, let it run out, and evaluate it, we are 10 years down the road. We do not have 10 years for this. We can build this into our health care delivery and prevention systems right now. We could set the target for doing this as the next three to five years. That is a reasonable time frame for patients, payers, and providers to adjust. If we do not set goals like that, we will never get to the point where we need to be.

In Washington, “pilot” means that, by the time you design it, bid it, let it run out, and evaluate it, we are 10 years down the road. We do not have 10 years for this.

Making a Difference

There are other functions that we know would make a difference:

Targeting patients: Make sure that we are intervening where we can to prevent disease and keep people out of the hospital or institutions.

Medication adherence: Half of all prescriptions go unfilled. Some of that is because of health literacy; some of it is cost sharing. For many



chronic illnesses, if prescriptions are not filled or if they are cut in half or dosed out inappropriately, patients have adverse health outcomes.

Transitional care programs: Twenty percent of Medicare patients are readmitted to the hospital within 30 days. Not all, but most, of those readmissions are preventable. A transitional care program could cut readmissions in half.

Just that one change in Medicare would not only improve the quality of care but, over the next 10 years, it would save \$100 billion in terms of preventing unnecessary readmissions to the hospital.

Integrating the Care Coordinator and Provider and Eliminating Silos

Three or four years ago, Vermont went statewide in building community health teams that integrate mental health, cardiac conditions, and acute care. These community health teams work with physician practices in each part of the state. In the medical management of depression

or hypertension or diabetes for several 45-year-old patients who differ only in the source of their insurance, their care plan and how they work with their nurse or nurse practitioner and physician should not depend

on who is paying the bill. It should depend on what we know works best in terms of clinical

management. But, generally, that is not the way that medicine is practiced today.

Every payer in Vermont contributes to the salaries of these community health team workers. From the physicians' standpoint, they know that every patient who comes out of their office who has co-morbid depression, diabetes, hypertension, and so on is going to have the same type of care management protocol regardless of who is paying the bill. Physician practices have one set of reports to do, not 27, and look at one set of metrics. From the patients' standpoint, finally they have somebody working with them at

home to help them engage and manage their diseases. It is a very different model.

Community-Based Prevention

Just under a billion dollars is available for community-based primary prevention. Does it work? Yes, if it is designed right. The Diabetes Prevention Protocol, a national, randomized trial done several years ago, was a very specific diet, exercise, and lifestyle intervention targeting overweight, pre-diabetic adults to reduce the incidence of diabetes. Within two years it did so, by 58 percent. Just for reference, when Metformin, a well-established generic drug, was used, it reduced the incidence of diabetes by 24 percent. That intervention is replicated in community-based settings. The YMCAs are doing it, and getting similar results, at 15 percent of the original cost. Within two years, they are saving money.

These are inexpensive, about \$150 per person, per year. And Medicare should be paying a share of the cost for people who are 40 and 45 and 50 years old because simulations have shown that, even if they pay a third of the cost for a 50-year-old adult to do community-based primary prevention, it will be cost-saving for the program. Yes, they are incurring dollars now, but they have a substantial reduction in the incidence of diabetes among patients coming into the program. We know what works. We have

We have randomized trials. We just need to understand their design, scale them, replicate them, and have leadership push it forward.

randomized trials. We just need to understand their design, scale them, replicate them, and have leadership push it forward.

Most policy-makers in Washington think prevention is simply detecting disease. Prevention is a much broader set of interventions that deal with everything from averting disease to working with chronically ill patients who have complex, multiple, chronic conditions to make sure their conditions do not get worse — another form of prevention. We need interventions and approaches that are effective on both sides of the scale and, yes, we need to increase traction with people getting appropriate clinical screens.

The community health team proposal moves us down that path to eliminate some of the fragmentation in the system to integrate mental health care and acute care and chronic care and prevention — all in one place. We can put these teams out there and provide the incentives for physicians to use them. But, until we change the way that we pay for health care, and pay providers and pay hospitals, it is going to be tough to get the type of virtually integrated systems that we are trying to design. Many states are not waiting for the federal government to do

this. Why? The payoffs are near term; they do not cost that much money to do; and they are not politically contentious.

The Good News

There are primary prevention and secondary prevention. There are models that will innovate on the delivery system side that build better integration in the medical home and community health teams. All of these reforms are tepid — directionally correct, but modest. Continuing to push on expanded coverage is critically important. We need to have that as a fundamental part of doing broader reforms in terms of competition, eliminating adverse selection, and eliminating underwriting.

If we are going to make a difference in terms of improving the health of the population and preventing disease, then the types of things that we have just been talking about need to be in the [health care] package. We are trying to improve health and improve the quality of care that people get in this system. The types of reforms mentioned get short shrift in the debate, but they are the foundational health reforms that will make the difference in achieving that goal.

Questions & Answers

Q Most health care professionals do not receive in-depth training on behavioral health care issues, nor are they exposed to the mental health and addiction recovery model. What strategies do you recommend be put in place to remedy this?

A *K. Thorpe:* You have to do this as a team. Patients have a constellation of diseases that require a broad range of medical professionals. You need input from everybody to put together the best care plan about how best to approach behavioral change with a particular patient.

Q How are we using lessons learned from other countries' experiences to inform the design of these community health systems?

A *K. Thorpe:* Some European countries are a little further ahead of us on this. But, ironically, in the U.K., where they have the Primary Care Trust, they are not doing enough, even with that approach on care coordination. We have learned the most from the integrated practices here in the U.S.: Kaiser in Oakland, Calif., and Puget Sound, Wash.; Marshfield Clinic; the Cleveland Clinic; Geisinger — all these are great examples of how to build integrated, team-based approaches. What we have done with these community health teams is to identify the key moving parts, build them into teams, and then find ways to quickly scale and replicate them.

Q With a global [bundled] payment system, how can we make sure that funding for mental health services is sustained?

A *K. Thorpe:* One way is to make sure that you get more payer collaboration. I would start with just Medicare and Medicaid as an example of pulling dollars together into these payment systems so that you have a set of covered services that makes more sense.

Q Is our prevention science so good that we can say not to do this is unethical?

A *K. Thorpe:* The science of prevention has changed in the last 10–15 years. The data over the last five years clearly showed that one of the key ways of saving money and improving health outcomes is by changing behavior and averting disease. The case was made that the key drivers are rising rates of obesity and the explosion of chronic disease, and all the money is linked to chronically ill patients. If we are going to do something on the cost side, we have to take prevention and treatment integration more seriously as a national public policy than we have in the past.



PANEL I: CLINICAL PROCESSES: BUILDING THE HEALTH HOME

Moderator, John Bartlett, M.D., M.P.H.

Senior Adviser, Primary Care Initiative, The Carter Center Mental Health Program

The Carter Center's Mental Health Program convened the Medical Home Summit in July 2009. It brought together 35 leaders from the fields of primary care, behavioral care, and health promotion and prevention for a two-day dialogue about using the rubric and concept of the medical home as a platform to scale up evidence-based approaches to integrating behavioral health care and primary care.

It is estimated that more than 60 percent of behavioral health care is actually delivered in the primary care setting. More than 50 percent of people who suffer from depression and receive treatment are treated in primary care. On the other side of the equation, people who suffer from severe and persistent mental illnesses die 25 years earlier than other members of their birth cohort because of untreated medical conditions, unhealthy lifestyles, and social determinants of health like poverty, stress, and poor social supports.

So, we were very interested in using a technology that had received a tremendous amount of attention in the current discussions about health care reform to see if it could be a potential platform for scaling up closer, more effective integration of primary and behavioral care.

MAIN PRESENTER

Larry A. Green, M.D.

Epperson-Zorn Chair for Innovation in Family Medicine, Department of Family Medicine, University of Colorado

It is a propitious moment for primary care, public health, and all the mental health tribes to work together — not someday but right now. My primary identity is as a family physician. The way I look at things has been dramatically influenced by a quarter of a century of having my own patients and practice.

Because prevention and health promotion are so prominently featured in the discussions around health care reform, and because so much of our concept of recovery, as a field, is closely linked conceptually with some aspects of prevention, we decided to invite representatives from health promotion and prevention to the Medical Home Summit as well. Representatives from primary care, behavioral care, and health promotion and prevention discussed the challenges and opportunities of using the concept and rubric of the patient-centered medical home as a vehicle for promoting closer integration in practice.

There was very strong agreement about both the importance of closer collaboration among the three fields and the importance of continuing discussions. We have developed legislative language that has been given to both the Senate and House through various congressional staffers. We also delivered a congressional briefing about the Medical Home Summit. Right now, we are in early discussions with the American College of Physicians about holding a health education summit to look at whether we are training the health clinicians of today, the students, to operate in a reform-reinvented delivery system.

My worldview has been sculpted by watching babies be born with and without grandmothers in the room, and with and without spouses, and babies born to too young or too old mothers. My worldview has been impacted by taking care of adolescents who drop out of the health care delivery system just as they start smoking and

experimenting with drugs; by taking care of young growing families that try to forge their life together, holding two or three jobs while they are trying to raise kids; and by watching people develop chronic diseases that they did not have to. My worldview also has been sculpted at people's bedsides when they die, listening to regrets, and by trying to practice medicine in a screwed up mess.

Not too long ago, on a Friday afternoon, my cell phone went off. A young woman, whose voice I did not know, said, "Are you the Dr. Green who is Kate Green's dad?" She started to cry, then managed to compose herself to where she could say:

"You have to help me. You do not know me but I know your daughter. We went to high school together. I am coming apart, and no one will help me. The psychiatrist I had when I was a teenager is out of town. Her answering folks say there are no appointments for five weeks. I have already been in one emergency room this week, and because I have a private psychiatrist, they say that they cannot take care of me."

Everyone turned her down and, in a moment of desperation, she called the father of a high school friend from six or seven years ago.

What happened over the next few hours is pretty interesting. In 31 years, I have never practiced in a place where I was not in walking distance of a psychiatrist or a psychologist. On another phone, I called a psychologist I have worked with while I kept the young lady on the cell phone. The psychologist told me if I could get her to the office, we would work this out.

So, I guided her by cell phone into the parking lot and through the door into our practice. Two-and-a-half hours later, she had had the services of a consulting psychiatrist, a consulting pharmacologist, two family physicians, a psychologist, and the Walgreens drugstore across the street.

At 9:30 that night, that same voice, very calm, said, "Just called back to thank you. I think you saved my life." Now that story calls us to task to recognize the horrible deficiencies of the system we are working in and, simultaneously, to recognize the great potential to make a difference.

What We Know

I want to do a very quick recap of what we know that describes the situation that we are in:

- The science has matured: We live in a constant dialogue between our genetic endowment and our environment, and nothing is going to change that. It is unclear why we parse brain problems so differently from kidney problems.
- Prevention of mental health, behavioral, and substance use problems is feasible and will be enriched.
- Chronic diseases are too complex for simplistic, linear solutions.
- Community-based problems require community-based decision making, and our resources and political will are systematically weakened by being ensconced. It impedes our collective action on what we know we need to do.
- Our country is in the midst of struggling with too much "me and mine" and not quite enough of "us and ours." We know we can do much better. So, the "we" in this, in my opinion, is all of us — primary care, substance use, mental health, prevention, behavioral, and public health. Our language betrays us. We just need to take care of whole people and become very person-centered.

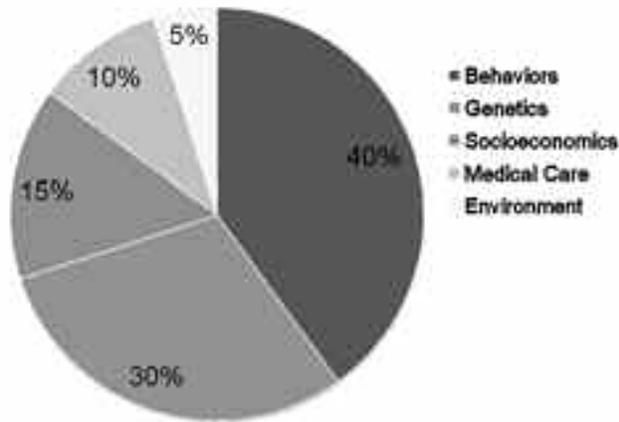
It is unclear why we parse brain problems so differently from kidney problems.

Primary Care

This graph (see next page) is not precise but it is accurate. That 40 percent of behavior and that 10 percent of health care are pretty close to why you die before your time and why you suffer when you did not have to. This has been documented and reported several times since 1991. And it is getting dangerously close to 20 years later and we still are not doing much about recognizing this.

Thanks to the Prescription for Health Program, I saw a lot of what goes on. In 27 practice-based research networks, we learned very quickly that primary care is full of good ideas about how to get this done. They want to do it and are punished when they do. It is not that they are not justly rewarded. They are actively punished for doing it. When we left off the work, we had

Reasons Americans Die Prematurely



40% is due to health-related behaviors. Since we know that health behaviors can be changed, it follows that programs of health behavior change should be systematically incorporated into any plan for comprehensive health care.

McGinnis JM, Foegle WH. Actual Causes of Death in the United States. JAMA 1993;270:2207-12.
Mokdad AH, Marks JS, Stroup DF, Gerberding JL. Actual Causes of Death in the United States, 2000. JAMA 2004;291:1230-1245.

delivery system, primary care accomplishes three things: it improves results, reduces cost, and reduces inequities.

Costs and Imparity

The United States health care system increases cost, has mediocre to poor results, and increased inequity. This is consistent with the evidence about primary care because we have a weak primary care system. If U.S. health care could secede and

26 out of 27 projects that had succeeded in installing systematic approaches to health behavior change addressing the big four behaviors. But, they could not sustain them because of payment problems.

People who think primary care is the easy part of medicine are those who have never done it. We have substantial, compelling evidence from this country and all across the developed world that, positioned properly and balanced in a

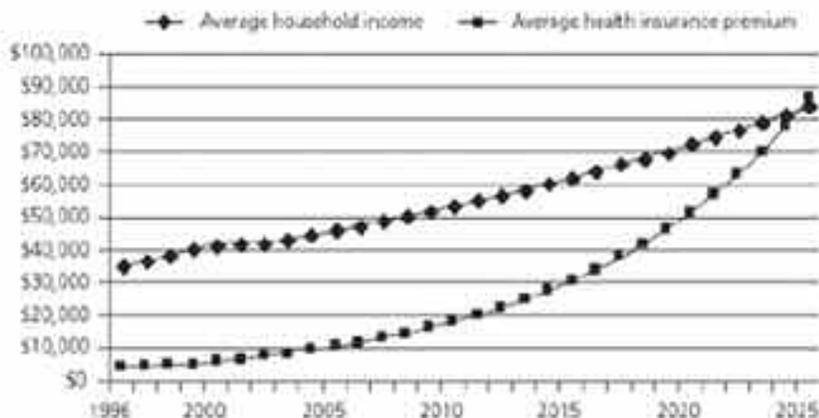
become its own nation state, it would be the sixth largest country on the planet.

We have plenty of money, but it is remarkable how little of this money makes its way to behavioral medicine, prevention, mental health, and primary care. Systems folks say you can identify the purpose of a system by what it produces. The United States has the best wealth-care system ever created. It spins off cash like nothing else. Even this year, in a recession, what sector kept adding jobs straightaway? Health care.

Here is another way of looking at escalating cost and imparity (see graph at left). The top line is an econometric projection of the average U.S. family's income, the bottom line is the projection of the average cost of a health insurance policy for a family in the United States. You will notice that, by the time you get out to 2016, the average cost of a health insurance policy will be 50 percent of the average family income. That is the year that medical students who just matriculated this year will be entering practice.

Annual Health Insurance Premiums and Household Income, 1996 to 2005

(Robert Graham Center: Devoe et al)



This is a genie that is never going back in the bottle. We are going to have a restyled, redesigned primary care system. And we are going to have it in the next decade. The unanswered question is how adequate will it be for integrating care?

What Will It Take for This to Happen?

We have a group in Colorado called ACT, Advancing Care Together. We are trying to figure out how to launch comparative case studies. We think that what has the highest leverage for getting into action mode is to start doing it in the settings in which it has to happen and see what goes wrong and what goes right.

We are working with an evaluation team and hope to align the logic model from our steering committee with an embedded multi-mixed method evaluation. We want to get this set up where we can start testing practical trials in diverse settings under various circumstances. This has worked before, and we believe that we can advance the field and change care by doing something like this. It is our belief that, if we can

get this going organically in a few states, we can sweep them into some sort of learning collaborative and call it a national program.

Conclusion

As we work together, I am going to think that I have a great way of taking care of people, and you are going to say, stop it, you cannot do that. We have to be willing to say, stop it, you cannot do that. Do it some other way. This is how we are going to feel for the next five to 10 years. This is not for the fainthearted and it is not going to be easy. This is a propitious moment. We are at a point where if we can work together and move from contemplation to action, we can make a very, very big difference by taking a leap forward for millions and millions of people.

This is a genie that is never going back in the bottle. We are going to have a restyled, redesigned primary care system.

If U.S. health care could secede and become its own nation state, it would be the sixth largest country on the planet.

RESPONDENTS

Linda Rosenberg, M.S.W.

President and CEO, National Council for Community Behavioral Healthcare

We have three pieces of work ahead of us as part of the health care reform. We have universal coverage to achieve payment reform, and then delivery system reform. We have a number of things facing us, and one that is just beginning to dawn on people is: We are going to get what we asked for. Now the question is: How are we going to manage that?

Mental health and substance use benefits are in every one of the bills that were considered. They will be in the final bill. If we are successful, they will be robust benefits or, at least, have the potential to be robust benefits. We may have to litigate some of it eventually, but there will be a benefit package. What that will mean is there will be an acceleration of something we already are experiencing.

Many people who grew up in the mental health system, the system based on exceptionalism, either in substance use or mental health, grew up in a system where you got a quarterly payment. You got a federal or state grant, did a program and, then, did your business. Over the last 20 years, mental health has moved toward an insurance model, but not completely. Substance use is not really an insurance model in this country; it still is a grant model or a private pay model. Once everyone has a benefit, 94 to 95 percent of Americans will have a mental health and substance use treatment benefit; then, the specialty system will be an insurance system.

We know that 30 million of the uninsured are both uninsured and poor. Of that group, 7 to 8 million will need mental health treatment. So, we are going to see tremendous demand.

Working together is not only going to be desirable, it is going to be necessary because we are going to be in this together.

We believe that the most effective way to cope with change is to help create it.

Whenever the National Council faces an issue, we look at it from both a practice perspective and from a policy perspective. We believe that the most effective way to cope with change is to help create it. We have a number of initiatives, but I want to focus on our health promotion work.

We have several learning communities that have grown and continue to grow. How do you bring a behavioral health organization and a federally qualified health center together and how do you work in an integrated way to deliver holistic, seamless care? It is taking the concepts and saying let us try it out in communities that have practiced the same way for generations now and need to begin and think differently. That is part of our leadership role.

Policy is necessarily fundamental for practice change. But changing practice is very difficult.

Every year, we have a group of behavioral health care organizations come to the table with their federally qualified health center. They have used registries and have collected data in ways they never have before. But it was hard work, and they are worried about being able to sustain it, because one of the things I learned is that as difficult as policy is, it is not as hard as practice change. Policy is necessarily fundamental for practice change. But changing practice is very difficult. Changing culture and institutionalizing new ways of doing business require constancy of leadership and purpose often for three to five years.

Donna Thompson, R.N., M.S.

CEO, Access Community Health Network

The Access Community Health Network is a federally qualified health care system located in Chicago. We have about 55 community health center sites, many with co-located partners, covering about 1,700 square miles. We are in Cook and DuPage counties. Many people who are familiar with Illinois say,

When we look at the policy side and the kind of work that we are trying to do, we need to be watching and trying to move the parity regulations. Just because you pass a law does not mean it is going to mean real access. That is something I learned in the few years now that I have been in Washington, D.C. We have to make sure that it is not just a benefit that gets managed to the point where no one has access.

We have gotten an amendment in health care reform on the Senate side that says that health care homes need to be open to people with serious mental illnesses and that behavioral health providers can serve as a health care home if they meet accepted standards and practice. We also have gotten an amendment introduced on the House side regarding qualified behavioral health centers. You know, if you do not measure it, you cannot improve it. And if you do not pay for it, it is not going to be very good quality. We need to make the safety net seamless. This would begin to do that.

We also are very hard at work trying to get more money in the federal block grant, which is almost counterintuitive in an insurance age. But this is going to be years of work, this implementation. In the interim, states are in terrible trouble with money shrinking, and so we are in jeopardy: most creative programs, diversion programs, and school-based programs are being cut and staff being laid off. We need help and the only group that can print money is the federal government.

We have had some real successes. We are in a time of great opportunity and have tried to take the challenges. I think the real secret is to take challenges and turn them into opportunities.

DuPage County? I say yes, one of the wealthiest counties in the United States. But, it also is an area where about 90,000 people are on Medicaid and about 60,000 people plus are uninsured. The numbers of the underserved are growing, and we want to make sure communities are not invisible.

Behavioral Health in a Primary Care Setting

I have been a nurse for about 32 years, and I still make rounds in the health centers. Once as I was making rounds, probably in the early 1990s when I first started at Access and we only had about nine health centers, I was talking to one of the providers, asking about a patient whom I was made aware of who had depression. I said, “What are we going to do about it?” And he said, “We?” “Yes,” I said, “we.” He looked at me. “Well, I will tell you what, Donna. It is hard for me to provide care when I know what to do but I do not have the resources to do anything about it.” That is symptomatic of so many of the issues in our health system.

Over the years as we have grown and looked at our patients’ needs, even though behavioral health conditions are not as overt as maybe high blood pressure or diabetes, they are the underpinnings of so much. Many times, regardless of the community, when people are in that exam room with their provider, it all comes out: issues around home; stress, especially now in the last year or two; and the different cultural biases around the stigma of behavioral health.

So we tailored our programs to meet the needs of about 215,000 people who walk through our doors every day. The majority of patients are female. And 70,000 are uninsured, meaning that they are not eligible for any benefit. Even though the majority of our patients are African-American and Hispanic, I think our providers speak 34–35 different languages. These are not languages that they keep in their back pocket; they use them every day.

Our models are not one-size-fits-all. How you will embrace and create a behavioral health model really is about embracing the community, and working with the community, to see what

works. Teaching, research infrastructure, and co-location have been key investments that we have made over the years. They leverage our resources as a community health center with those partners.

When talking about the health center, it also is important to understand that we see patients from all walks of life and all insurance categories. It has been very important for us to make sure that our patients understand that we are about quality. So, whether it is Joint Commission accreditation or making sure that we get high marks in the Blue Cross/Blue Shield Star, that is one way we keep the bar raised high so that everyone benefits.

We also have invested in addictions programs. For many women who suffer from opiate addiction, the thought of leaving their children and going into treatment is just something they will not consider. And, so again, we talk about co-location and try to broaden our bandwidth. Many times, when someone has a behavioral health or an addiction issue, they have neglected their primary health care needs. While we are addressing those needs, we also can say, “You have diabetes that you were

Part of our role is to make sure that advocacy for a seamless system is addressed in the larger system and that, regardless of payer type, any patient can move seamlessly through a system of care.



not aware of,” or “Here is an undiagnosed asthma. Let’s get you on the right medication and monitor you.”

We are looking at issues around literacy and culture to make sure that whatever we design really fits the communities’ needs.

Looking at whether we could have these services in all 50-plus locations, we have created “hubs” where we have behavioral health services within those hubs and do many referrals within our own region of health care. That is a way of leveraging limited resources but, also, within communities to help people navigate for needed services.

Part of being able to be a federally qualified health center is that we do get an enhanced Medicaid billing. But at the same time, we have encountered barriers. At the state level, we cannot bill for two Medicaid encounters for specialty and primary care on the same day. We all know that, in a regular model, if your primary care provider said you needed to see a cardiologist, and that person happened to be in that day, you would say, “Let’s walk across the

hall.” If you are on Medicaid in Illinois, you cannot do that. Only one person or one provider can be billed. Part of our role is to make sure that advocacy for a seamless system is addressed in the larger system and that, regardless of payer type, any patient can move seamlessly through a system of care.

Medical Home

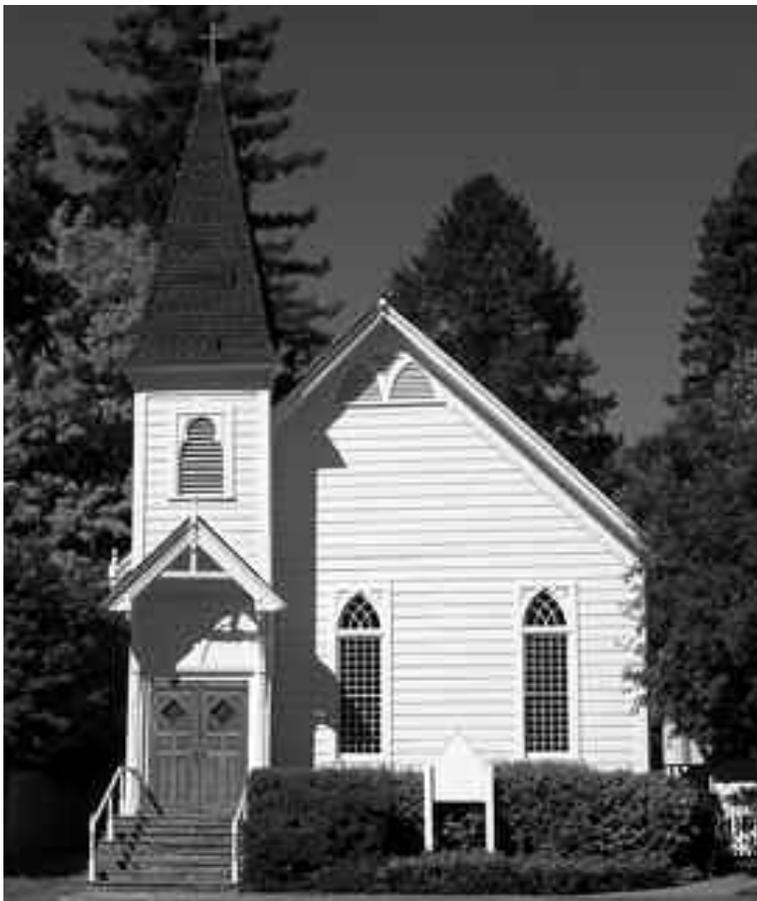
When we go into communities, we look for partners who can influence the community’s perceptions. When we talk about the medical home, it is about relationships, not only with the patients but also with the community. We found that, through the faith-based community, we have been able to leverage a lot of bandwidth and look at cultural issues that often people do not want to discuss. We also make sure, through the faith-based community, that they understand where our resources are so that they can help navigate their parishioners to those resources.

Information Technology

The electronic health care record is going to be key to fully integrating the system. It not only looks from a horizontal but also from a vertical perspective at how to make sure that you can guide a patient effectively and efficiently through a system of care. We are not just thinking about the medical record internally; we also are thinking about our external partners and how we can communicate with them comfortably.

Our investment in information technology is going to be key to our getting from where we are now into the future. It will be critical to make sure that our patients have at their own fingertips information about their health record. We are looking at issues around literacy and culture to make sure that whatever we design really fits the communities’ needs.

It is exciting when we think about how as a health center we can leverage our bandwidth with future partners, and how we have applied our learning over the last 15 or 20 years in a health center model. We still have much more work to do. We rejoice in serving a community that so many people run from and that we run toward. We want to make sure that we get them to wellness.



Larry Fricks

Director, Appalachian Consulting Group; Vice President of Peer Services, Depression and Bipolar Support Alliance

About the time Mrs. Carter first started convening these symposia I was in a psychiatric hospital, so I did not make the first one. I resisted treatment. I did not like the prognosis — bipolar illness — because it transmitted a sense of hopelessness about my future. Ultimately, I went on medication, gained 70 pounds, and my first marriage unraveled. A psychiatric illness, a chronic illness, or any kind of disability puts so much strain on your relationships.

There I was. My wife was divorcing me, and I was told that I probably could not handle work because it was too stressful. That really cracks me up. Have you ever tried social isolation and poverty for stress? Now, there is some stress for you.

So, I gained 70 pounds, and none of my clothes fit. When I walked upstairs, my heart felt like it was going to explode. I started isolating myself. I did not want to leave the house. And it really surprised me that my psychiatrist, who was a good psychiatrist, did not address the 70 pounds. I actually think I lost some confidence in him because he did not address that weight gain and how I was feeling and the negative self-image that it created, which speeds you into thoughts of suicide.

In a health home that might not happen. Somebody may say, wait a minute, did you notice all this weight Larry is gaining? In the 1990s, we were dying 15 years prematurely. One of the big reasons we are dying faster is the new psychotropic medications. If I had been in a health home in the 1990s and was told I had to have these new psychotropic medications, and there was no feedback about what it did to insulin, weight gain, and cardiovascular issues, then I might have accelerated my death.

We are fortunate that Georgia was the originator of the Medicaid-billable peer-support movement. The Carter Center is partnering for the first summit in the country with the 23 states that are now billing Medicaid for peer-support services.

On the first day, we are going to look at what is going well, where the problems are, and make recommendations for the other 27 states and Washington, D.C.,

to create this workforce. But the second day is where the real buzz is because then we are discussing the results for three transformation grants that are just wrapping up in Georgia, Michigan,

and New Jersey. These grants will be used to adapt the peer workforce to what we call peer-support whole health. Peer-support whole health is having a peer help you figure out one small thing you can own to change your health behavior, write it into an individual service plan with the right objectives and goals so that it is Medicaid billable, and then the peer helps you reach that goal.

Now we are building a lot of this off the work of [Emory University professor] Ben Druss. He brought to our attention the Kate Lorig Chronic Disease Model at Stanford University, the most famous chronic disease model where peers change peers' health behavior. They had never tried it out with our population, and so we are very excited.

The outcomes from this transformation grant are phenomenal. We had an eight-week study with it at two care centers. We showed that, with a peer supporting a peer, almost everyone was able to write up his or her goal and put it in an individual service plan. It was Medicaid billable, but we had a few challenges. You have to link the health issue back to the behavioral health, so we had to work on how you put that language in there. At the end of eight weeks, everybody had improved on their health goals and 20 percent fully met their health goals. Another exciting part of the study was that we evaluated how important it was for a peer to help you choose that goal. Everybody ranked it high. That was just huge in the motivation factor.

Peer-support whole health is having a peer help you figure out one small thing you can own to change your health behavior, write it into an individual service plan with the right objectives and goals so that it is Medicaid billable, and then the peer helps you reach that goal.

We have started the Peer Support Wellness Center in Decatur, Ga., and that has cut hospitalizations for participating consumers by 66 percent. There is no coercion. The minute clients walk through the door, a peer specialist greets them and starts talking about wellness. They do not talk about their illness. They do not talk about their disability. It is totally strength-based.

Prevention is almost impossible when you are living on a Social Security check. We are the most unemployed of any disability group in the

country: 90 percent unemployment. As we move into this health home concept, do not forget the social services like supported employment, supported housing, what poverty does to absolutely crush your soul, and the role of peer support to help people believe they can recover.

In these health homes, we want certified peer specialists who are trained in peer support and whole health to change health behavior, and we think that probably the future will be better for those of us who experience others treating us like the head is connected to the body.

Raymond J. Fabius, M.D., FAAP, FACPE

President, CMO and Co-Founder, HealthNEXT; Strategic Adviser for the President of Walgreens Health and Wellness

I had an opportunity to provide corporate medical leadership for Cigna, U.S. HealthCare, and Aetna. General Electric hired me to be their global medical leader for a few years before I went off to turn around a company on the American Stock Exchange that was the largest provider of workplace health solutions. But, through all that, I remain grounded in my days in pediatrics. Like my mentor Larry Green, I come here today with just one message and it is about relationships.

One of my teachers of psychiatry in medical school told me that behavioral health and psychiatry are really the study of the space between two people. No one is thrown into the need to study and understand the space between two people like those who work inside a health home.

One Sunday night, I got a call from one of my patients, a father who was a “Mr. Mom.” He was frantic because his wife was coming home from a business trip and I already knew that this marriage was on edge: they had two children with attention deficit disorder. The boys came home with green feet, and he did not know how to explain it to her. I had trained at one of the best children’s hospitals in the country, Children’s Hospital Los Angeles, and took care of kids with renal transplants and immune deficiency disorders. Never once did I take care of brothers with green feet.

The conversation went something like this:

Dad: It looks like they are wearing socks.

Me: Did you put new socks on the two boys today?

Dad: Yes, but they were brown socks.

Me: Did the socks get wet?

Dad: Yes, they were playing in the puddles after a rain.

I had family members in the textile industry and knew that, sometimes, socks have a blend of colors and not all of them bleed onto the skin.

Me: Explain to your wife that the kids were wearing new brown socks that got wet and now they have green feet.

That father thanked me and, to this day when I see him in my community, he believes that I kept his marriage alive through that phone call.

Fast forward: One of my colleagues has two kids who have developmental issues. I have been mentoring them throughout their lives, and yet I got a phone call last week that the teenage son was found with opiates at the high school. The school wants to expel him. There is no place for him to go to finish school, and he is almost a senior. He has a chance to go to college. It appears as if he really is addicted. His parents cannot understand how this could have happened under their watch.

She and her husband met me at a local restaurant. I suggested we talk about why they have such an advantage here. I know you love



each other. I know you love your boys and that they love you. You have an intact family. That puts you above 60 percent of these cases. Both of you work hard, you have an income, and you have some means and wherewithal. That puts you above 80 percent. Not only do you love each other, you have friends and family and the ability to network with experts in the different fields like me. I am certain you will lick this problem.

With that the tears started to evaporate, and the glass did not look half-empty, it looked half-full.

This is really what is missing from health care today. I did not get paid for this; it was not part of any payment code. This is just something that you do in a good health home.

I have always liked to talk about this concept of relationships by starting with what people complain about. Every year, Consumer Reports conducts a study asking patients and doctors what they do not like about the system. Patients say they could not schedule an appointment

within a week. The doctors say patients wait too long to make an appointment. We have a system that is tarnishing relationships.

Patients who have a trusted clinician are lucky. They also have more effective access to health care. The literature is replete with examples of the power of that relationship, the power of that simple caring. One study actually led to a Hutus metric. This study showed that if a primary care doctor asked, “Do you smoke?” and spends less than five minutes talking to a patient about stopping smoking, there is as high as a 10 percent quit-smoking rate. The best programs in the country brag about a 20 percent reduction. A trusted primary care clinician can get half the way there in fewer than five minutes. Another study looked at what caused women to get a mammogram once or annually. The most obvious response: the doctor told them they should get a mammogram.

The depth of the relationship increased the likelihood of participation in our disease management program.

On the side of tertiary care, periodic primary care sessions have led to much better outcomes. It is not a matter of shifting some patient with a chronic disease to a specialist but of coordinating care, building a relationship, and showing how much you care.

As I mentioned, in my last corporate role I was the president and chief medical officer of a company that provided workplace health solutions. What we studied, and subsequently published, was the difference between doing telephonic disease management with patients, which our company did from a distance as many others do, and a disease management program, which was delivered through trusted clinicians at the workplace.

We were able to show a much greater contact rate, because we knew where these people were, and a three times greater participation rate. While this says behavioral improvement, what this really shows is actually a six times greater retention rate in the disease management program for an entire year.

Perhaps what was even more striking was if the employee who had chronic diseases used our facility for both primary care and pharmacy, we had the highest participation rate. If they used us only for pharmacy and then engaged the general medical community, I might say randomly, we

still had a much higher rate than just the telephonic approach. If they used us only for episodic illness care but did not use us for pharmacy or primary care, we still had a much better participation rate than telephonic. The depth of the relationship increased the likelihood of participation in our disease management program.

This is just as true in behavioral health. In my pediatric practice, we had an embedded child psychologist full time. This integrated effort allowed for early identification and treatment, greater medication adherence, greater treatment compliance, greater symptom reduction, greater satisfaction with therapy, and greater provider comfort and satisfaction. If we could provide greater satisfaction with therapy for patients and greater provider comfort and satisfaction in the process, we will be able to build more trusted relationships.

As an adviser to Walgreens, I have been vehement in making sure that the nurse practitioners who take care of episodic illnesses in Walgreens retail clinics report what they do to the patient's primary care doctor. To my surprise, 40 percent of the people who access the retail clinics do not have a health home; they do not have a trusted clinician to send the report to. They are medically homeless. This has to stop in this country.

Questions & Answers

Q Would each of you comment briefly on the obstacles to effectively working together, and propose a solution in the context of the medical home and reinvented primary care system.

A *L. Green:* Obstacles: Language and money. Solutions: Use plain English and share the money. The super-specialized, overly-expensive, sub-specialty medical system is going to have to have some of this money diverted to behavioral health, primary care, and prevention.

A *L. Rosenberg:* Fee-for-service is a fundamental barrier to an effective health care home. As part of the cost containment after the expansion of coverage, we will see various ways of creating a capitated system.

A *D. Thompson:* Two solutions are getting more evidence-based intervention out to communities and educating the primary care provider.

A *L. Fricks:* Another obstacle is the population that lives in poverty and on Social Security, as opposed to someone who has health insurance.

A *R. Fabius:* Fragmentation of the system. Fragmentation is the opposite of relationships. My own practice solved the problem when we embedded a behavioral health therapist into the practice. Before that time, a psychologist or psychiatrist could decide whether they wanted to accept my patient or not based on their own convenience. But once that patient is a shared patient, then there are collaboration and mutual accountability and that is a relationship.

Q Many mental disorders and substance use disorders begin in childhood and adolescence. Can you address the challenges and opportunities for children's behavioral health and health reform?

(continues next page)



Questions & Answers

A *D. Thompson:* At Access, we focused on the parent centering program and early assessment of depression. The behavioral health component has to be a key aspect of whatever is designed.

A *R. Fabius:* My wife and I have a son who had across-the-board developmental delays. One of the best experts in the field of developmental delays told us to have very low expectations. That child graduated from Emory Law School and is a very successful attorney in a large law firm.

A Labeling children at a very young age is an inexact science. Regardless of the diagnosis, it is extremely important that the parents have an opportunity to be hopeful. Intervention programs are important, if not for the child then for the parent, so that they think they are doing everything that can be done.

A *L. Rosenberg:* The nurse-family partnership program, where a registered nurse works with a young family for two years from the time that child is born, has made a tremendous difference. We have to look less at specific mental health or substance use programs and more at programs that just deal with families, their situations, and communities and give them a leg up. Often, with poor young families, it is a matter of understanding child development, and part of this program is to teach those milestones.

A *L. Green:* We pretend that it is possible for a child to be healthy in a totally unhealthy family or community. Basically, everything is connected to everything else. We do ourselves harm if we draw too tight a line around age groups. Most countries have one primary care system for people over the age of 65, and another one for those 45 to 64, and another one for people in their 30s, and another one for the teenagers, and another one for the primary school folks, and another one for the newborns.

A *J. Bartlett:* Pediatricians came up with the concept of medical home at the Medical Home Summit 20 or 30 years ago. Over time, the concept morphed from bringing medicine into the home to finding a stable place where people could get access to all of the needed integrated health care, team-based treatment and services. The American Academy of Pediatrics is fully committed to the concept of the medical home, stating that every child should have a medical home within the next five or 10 years.

A *R. Fabius:* Behavioral health, prevention, and primary care have been arguing for parity for a long time. The primary care world says, Could you just make it so an annual physical could be covered at 100 percent? The prevention world says, Can you cover those things that are evidence-based, like mammography, at 100 percent? There are many reasons why it makes sense for these three to come together.

Q What has the discussion been regarding these same issues on mental health reform and integrated care as it relates to America's rural and frontier areas?

A *L. Rosenberg:* There is a North Carolina model in the Medicaid program that we may see replicated in other places where you have a team of behavioral health care specialists who cover multiple practices. We cannot expect every primary care practitioner, or practitioner with two or three people, to have a behavioral health team embedded, rural or urban. We have to think of other ways of delivering this service that will be efficient and effective. I think you can do that and replicate it in commercial insurance, too.

A *D. Thompson:* In Illinois, I have been advocating for the reimbursement by Medicaid for telemedicine. When you are in a rural community, you might be 50, 60, 70 miles away. But often, if you are in an urban area, it becomes distance and resources and how

Questions & Answers

you navigate the uninsured and underinsured to places that will accept them. We have to look at technology as an avenue.

A *L. Green:* There are about 55 to 60 million people who qualify for a health services research definition for living in a rural setting. We cannot walk off from this population and say we will make it work in an urban setting where we have paid resources. One size does not fit all. In the information age, these practices can be swept into virtual units and groups that can do amazing things. In many instances, rural communities are better positioned to hit the high performance marks before the urban areas do because they actually know each other. Those relationships are already in place. They know what a community is.

A *L. Rosenberg:* In Indiana, they were able to treat about 70 percent of bipolar disorder patients in the federally qualified health center through text messaging. The medical director would text back and forth with the primary care doctor and nurse practitioner, talking about dosage or symptoms.

A *R. Fabius:* Bartenders, the clergy, cab drivers, and barbers and beauticians are key providers of behavioral health. Only if my patients could not get their problem resolved through them or through family and friends would they access a clinician.

On the prevention side, you have physical education teachers, nutritionists, health educators. On the medical side, one of the most underutilized clinicians in this country is the pharmacist. Think about the opportunities that we have to engage a much broader group of well-trained, committed, dedicated, caring people into this fight.

A *L. Fricks:* Rural America also has things that are better for stress and for a social network, and those are major resiliency factors.

A *L. Green:* Where is it written that the health care providers in training now are the ones we want, and why do they have to have the job descriptions they have now? Medical assistants are underutilized, and they have such great connections in those communities.

A *J. Bartlett:* Last fall, the Mental Health Program [at The Carter Center], working with the National Center for Primary Care at Morehouse, held a meeting on integrated care called Making It Real. We brought together a small number of early adopters — representatives from organizations that had made the commitment to do some kind of evidence-based approach to integrated care — with many people from organizations that were interested but had not yet made that commitment. The idea was to energize them and transfer learning.

Kathy Reynolds was there. She said, “Do not worry about the money. It is the right thing to do from a moral and a business point of view. You are going to save money down the road. We do not need to work with organizations that want to do this on a grant basis because what we find is when the grant goes away, the program goes away. And leadership is important. People in the breakout groups would say, I cannot do this unless I get paid for it. And the early adopters would say, politely, that is not the right answer.”

A *L. Rosenberg:* We have pockets of early adoption and excellence across this country. What we need is to be able to bring it together, harness it, share it, and encourage others to take the risk and take a step.

DINNER KEYNOTE

Alan Deutschman

Journalist, Author of “Change or Die”

My introduction to this subject of changing behavior, changing the deep-rooted patterns of how we think, feel, and act, came accidentally about five years ago. I had spent 15 years writing articles for business magazines, and I would write profiles of people who were college dropouts. People like Bill Gates from Microsoft or Steve Jobs from Apple.

Five years ago, I was writing an article about the International Business Machines Corporation (IBM) and how it was changing its culture and becoming more innovative. They invited me to their conference on the future of health care, which attracted an extraordinary panel of experts — people distinguished in their field who had long careers of 40, almost 50, years in health care and who were leading major institutions.

I assumed IBM would be talking about technology and how it would provide solutions to our issues with health care. I was ready to hear

about digitizing the records of health care patients and the advances that would come from that. I was expecting to hear about decoding the human genome. I was expecting technological marvels that required tremendous amounts of computational power and supercomputers.

But that is not what I heard.

The first speaker, Ray Levy, was the head of the Global Medical Forum. He said he had been in medical school in the 1950s, and things had not really changed. The same problems were there in the health care system. As a medical student, he remembered reading studies saying that around 80 percent of the money we spend on health care was because of behavior, the way people act every day. It was for illnesses and diseases that were largely preventable because of the choices that we make: we smoke, we drink, we eat too much, we do not exercise enough, and we have difficulty managing stress and anxiety.



Today, nothing has changed. Overwhelmingly, our behavior is the unsolved piece of the health care system. We have had extraordinary breakthroughs in surgery, in pharmaceuticals, and yet it still comes down to smoking, drinking, overeating, not exercising, and not dealing with stress. He said we really do not know how to get people to change their behavior. For all of our sophistication and our technology, this remains the riddle.

I was astonished. I thought, surely we must know how to influence people's behavior. How can this panel of experts just throw up their hands? The coup de grace came from the next speaker, Ed Miller, the dean of the Medical School of the Johns Hopkins University and the hospital CEO. He said, let me tell you about heart patients, people with severe heart disease. These patients suffer awful chest pain throughout the day. They get to the point where it is too painful to do the things that make life worthwhile. They cannot cross the street before the traffic light turns red. They cannot climb the stairs in their houses. So, they go for coronary bypass surgery, an amazing surgery. Transplanting a vein from an arm or a leg takes away their chest pain, and they feel remarkably better.

But then they have that conversation with their cardiologist who says, "This is your 'change or die' moment. We have temporarily removed your pain, but this intervention does not last long." Often, several years after surgery, the artery gets clogged again; with angioplasty, it is often only six months.

The cardiologists say to their patients: "You have a life-threatening illness. This is your wake-up call. From now on, you have to start living in a healthy way. You have to stop smoking, drinking, and overeating, and you have to manage stress and start exercising, or you are going to die. This surgery was a temporary fix. Go and live healthy."

You would not think heart surgery would be a repeat business, but it is. Heart surgeons get the same patients back onto their tables again and again. Ed Miller said at Johns Hopkins they have studied what happens to these patients after the "change or die" speech. Two years later, 90 percent have not switched to a healthier lifestyle.

They have gone back to the same behaviors that resulted in their being on the operating table. Ninety percent.

That blew me away. Here I was, writing for a business magazine about innovation and change in the business world, and I had evidence-based research saying only 10 percent of people can change, even in a life or death situation. That went against everything I had learned. In the business world, people believe that crisis inspires change. What could be a greater crisis than the fear of your own death?

In the business world, they think facts rule the day. The most successful, best-selling business book of our time is "Good to Great" by Jim Collins. The key idea is in the title of Chapter 4: "Confront the Brutal Facts." We think if we give people the facts about the situation, they will change. But they do not. In my research, I found that the three main ways we try to inspire change — The Three F's: facts, fear, and force — generally fail.

The Three F's

First, we start with facts. We assume that, like ourselves, other people are educated and rational, and they can understand the facts if we enlighten them with accurate information. We assume that they can make the right choices, and we are going to treat them as rational people. So we give them the facts of the situation, but they do not change.

Then we say, well, we are rational but maybe they are not. That must mean they are emotional. Why not appeal to their emotions? And what is the strongest emotion? Fear. So, we will say, "You have to change or you are going to die." That does not work either. When people return home from the hospital, for the first couple of weeks they will ask in the supermarket, "Where is the wheat bran?" Then they quickly go back to their old behaviors.

Finally, after facts and fear, we try force: falling back on the moral authority of our position, not trying to reason with or persuade people, just trying to bludgeon them with our degrees, our position, our stature. "I am your doctor and I say you have to change." Or: "Do it because I am the boss." Or: "Do it because I am the parent." And you know how effective that is. Facts, fear, and

force — that has been the approach we take with heart patients, the extent of the psychology we use for people with serious heart disease who desperately need help and desperately need to change their lifestyles to prolong their lives.

I came back from this conference deeply depressed for the state of humanity. Then I fell back on my instincts as a journalist and said, I am going to see if there are case studies that falsify this theory. Maybe someone knows how to inspire people to make dramatic changes in their deep-rooted patterns of behavior.

Dean Ornish

I was living in San Francisco at the time, three blocks down the street from the University of California at San Francisco's School of Medicine. Many of my neighbors were doctors or medical students. Through them, I heard about Dr. Dean Ornish's research. I had only thought of him as a popular, supermarket, paperback diet doctor. It turns out he is a professor at the medical school. He had done several serious, controlled, peer-reviewed studies, published in leading scientific and medical journals.

Ornish took on these same heart patients who had awful chest pain, and whose insurance companies were willing to spend what can easily be over \$100,000 for coronary bypass surgery. Instead of surgery, he told them, "We are going to try to change the way people live without using surgery and pharmaceuticals, and get these patients to live a healthy life." Generally, these were people in their late 50s. They had already had a heart attack. They had family histories of heart disease, and they had hypertension. They were not gung-ho. Often, family members or spouses pushed them into this rather than the patients doing it eagerly on their own.

Instead of taking a gradual, incremental approach, from the start Ornish tried a radical change in the way they lived. He put them on a radical, low-fat diet — not just vegetarian, but a nearly vegan diet where you get fewer than 10 percent of your calories from fat and where you eat no meat and no dairy, except for 8 ounces of nonfat yogurt a day. Patients were also told they were not going to smoke or drink at all. And, they were going to exercise and have connection, spirituality.

He left the cardiologists aside with their "change or die" speech and brought in a team of coaches, mentors, teachers, and a vegetarian chef. They put the heart patients into small peer cohorts, and then brought in the chef to say, together, we are going to cook a very healthy meal. He also brought in a personal fitness trainer to exercise together, even though it is just walking in the beginning. Many of these patients had no idea how to live in a healthy way, no idea how to cook tofu. They did not even know what tofu was. Some of these people had never exercised and did not know how.

He put the patients into yoga and meditation classes. He did not call it "yoga and meditation," that might sound too weird, too San Francisco. Instead, he called it "breathing and relaxation exercises." Patients were also placed in peer support groups, with psychologists, to have a chance to talk to other people about what they were going through.

After this one-year program was over, the patients were left on their own. Five years later, 77 percent had stopped or reversed the progress of their severe heart disease without pharmaceuticals or surgery. The peer groups formed in the program stayed together, long after the program ended. And they made a dramatic, radical change in lifestyle.

I read Ornish's research and thought, If Johns Hopkins finds that 90 percent of patients do not change to healthier lifestyles, why is there a program where almost eight out of 10 do? It was an incredible difference in results from a totally different approach. I went looking for anomalous examples of programs with different problems and different populations as their target, programs that could take seemingly impossible, unsolvable, intractable problems and achieve extraordinary results.

Delancey Street Program

I knew about another San Francisco program that I found even more extraordinary, the Delancey Street Foundation. There is a stretch of the waterfront near downtown, near the base of the Bay Bridge and the Giants' baseball stadium, called South Beach. You see what looks like very expensive condos.



Actually, this complex is a residence for about 400 ex-convicts who are living together in the Delancey Street Program. About 80 percent of the residents have been heroin addicts, and many were alcoholics. A majority of them had multiple substance addictions. Generally, they had long histories of felony convictions, often going back to when they were 12 or 13 years old. Many of them have been homeless; most came directly from the state prison system. There have been studies in the prison system using the Robert Hare test for diagnosing psychopathic personality. Basically, they have determined that the typical inmate in North American prisons is moderately psychopathic.

People who are new to Delancey Street come up with their own explanation for what is happening based on thinking with their criminal mind. Often they say, this must be an elaborate cover for a drug sale operation. In their experience, the only people who live in beautiful condos on the waterfront are drug dealers. So they think, this is brilliant, like posing as one of the San Francisco liberal programs but it is really a drug operation. I want to get in on it. Then they get there and it does not make any sense to them for some time.

They come to Delancey Street and live together in this beautiful complex, with only one person who is not a former drug-addicted convict: Mimi Silbert, the co-founder of the program. She is in her late 60s and a grandmother. Barely 5 feet tall, she weighs about 100 pounds. And she is there with all these former heroin-addicted convicts in a program where they live together without drugs, without alcohol, without threats, and without violence. Typically, after four years or so in the program, they graduate and go out and live in the greater society as law-abiding, productive, self-supporting members.

The program has never taken any money from the government. From the beginning, it has been entirely self-supporting. They get donations of clothing from the Gap and other San Francisco businesses, but they have never written a grant proposal. They have supported themselves with businesses, run entirely by the people at Delancey Street. I take friends to the Delancey Street Restaurant, which has thrived for many years in one of the most brutally competitive restaurant markets in America.

Delancey Street also runs a moving company. Twice I hired their vans and movers. They were by far the most reliable moving service in a

notoriously unethical, unreliable business. Delancey Street also runs a bookstore café and sells Christmas trees in vacant lots all around the city. They have all these businesses that pay for themselves as they are educating themselves, getting marketable skills, and going on to positions in the outside world.

I compared Delancey Street to the general situation for ex-convicts in America. A few years ago, the Justice Department did the largest study ever of criminal recidivism in America, looking at over 200,000 people and what happens to them when they get out of the state prison system. Not surprisingly, about 30 percent were rearrested within six months. Within three years, 67.5 percent were rearrested.

Some people drop out at Delancey Street. Some people find prison is actually easier and more comfortable than learning an entirely new way to live. But overwhelmingly, Delancey Street

There are three keys to unlocking profound change.

I call them “relate, repeat, and refrain.”

produces people who get off drugs, alcohol, and violence and who live as productive members of society. I wanted to see what made these examples work, to look at the underlying principles to

better understand this. I think that in Ornish and Delancey Street, and in other programs, the common factors are these: there are three keys to unlocking profound change. I call them “relate, repeat, and refrain.” “Relate” is about relationships. I think it is crucial to begin with a close, emotional relationship with a person or a community of peers that inspires hope.

Relate

Why don’t facts, fear, and force inspire change? You are dealing with people who have given up hope, who are demoralized. You can give people the facts of their situation, but if they do not know how to overcome those problems, if they have tried time and time again and nothing has worked, if they have no idea what to do, of course they go into psychological self-defense. They go into denial. They avoid thinking about the problem. They blame it on someone else. We all do this.

What breaks through that psychological self-defense is a relationship that inspires hope, relationships with people who believe that we are capable of change. The problem with heart patients may be that cardiologists do not believe their patients can change to healthier lifestyles. They have hundreds or thousands of patients over the years, and they have seen how few of them have actually made real lifestyle changes. They say, “You have to change or you are going to die,” but they do not really believe that you can change.

You get to spend a very short time with the cardiologist. Their time is very expensive. In the Ornish program, though, you spend a lot of time with the coaches and trainers, people who believe you can change. Having people who believe in you and then seeing people like yourself who are successfully making the change — that inspiration is what Delancey Street is really all about.

Newcomers to Delancey Street are known as immigrants. They see the people who have been there longer who, like them, are the second or third generation who have grown up in poverty, in crime, in addiction, but who are now living without drugs, without alcohol, without violence. They see, and they realize that it is possible for them.

It takes about a year for this to happen. Silbert puts all of these new immigrants into groups of 10, which she calls “minions.” It is from the Jewish tradition that, if there is no rabbi, no individual to be a leader, the group itself can be the leader, if you have 10 members. So all the immigrants to Delancey Street are there in groups of 10 and responsible for each other.

When our ancestors came here, not knowing the language, coming in poverty, needing to learn the ways of a new country — that is the metaphor for these people coming from the criminal, addicted underclass to learn to become part of the middle class. It is as if they are going to a new country, and they help each other learn its customs, rules, and traditions so they can be successful in it. They are in the same kind of small groups that are in the Ornish program. What I call “relate” is about the close emotional relationships that inspire hope, whether it comes from the coach or the mentor or, very importantly, from the community of peers.

Silbert and Ornish have successfully bridged two worlds. As a professor at a leading medical school, Ornish bridges the world of Western scientific medicine and some of the concepts from the holistic and Eastern health worlds. That is why he does not say “yoga and meditation” to people. He says “breathing and relaxation” exercises. Silbert has doctorate degrees in criminology and psychology from the University of California at Berkeley, and she trained police officers before she began working with criminals. She can bridge those worlds. That is a talent to be able to speak both languages, to be able to understand both mindsets, to be able to find the short-term benefits that make sense to people, even when they are thinking with their old mindset.



Repeat

The second commonality is what I call “repeat”: practicing, learning, and mastering the new set of skills for the new healthier behaviors that we need. In the Ornish program, it is learning how to cook healthy, how to exercise, how to do things like yoga or meditation that can help defuse stress.

People coming into Delancey Street have no idea what it means to be law-abiding, prosperous members of the middle class. It is a foreign world to them. Delancey Street teaches them what they need to know about how to walk and dress like a member of the middle class, things we have taken for granted. They will need to know a completely different culture if they are going to survive.

The ex-convicts and ex-addicts teach each other. If someone reads at a fourth-grade level, they teach someone who reads at a first-grade level. If someone has a particular skill, they teach it to someone else. You cannot assume that criminals coming out of jail are going to know how to live differently in a world that they have never been part of and never known its ways.

Reframe

The third and final step of the change process I call “reframe.” This is when you finally have a shift in the way you see the world. You take on a new conceptual framework, a new ideology. In the end, after relationships with other people have broken the resistance, after you have taken the time to repeat — to learn and practice and master this multitude of new skills — only then do things start to make sense to you.

There is a certain point at Delancey Street where they stop thinking with their criminal minds and start thinking with their middle class, law-abiding minds. In the Ornish program, there is a fundamental shift in the idea of health and the idea from the old system that doctors are heroic and patients are helpless, that patients get sick and doctors cure them. They come to believe the new idea that patients can take responsibility for their health. They know that, every day, their actions can help improve their health through their own agency, their own responsibility. This is a fundamental shift to a mindset that would not have made any sense in the old way of thinking. I think that the shift only comes at the end. First, we need others to drag us into this new world that we do not understand. But we are going there because we believe in them and they believe in us.

We need to do the hard work of complex new learning because that is what change is about. It is like learning a foreign language. It is like

learning a new sport. You would not try to play golf by saying, “Okay, I am going to play golf. I think that I will go out and buy some clubs and

If you come from the third generation of drug addiction, poverty, and crime, then it is actually a rational solution to be a criminal, to be hardened emotionally when the lives of the people around are in constant jeopardy.

community. Any kind of real change is like that; it is about complex new learning.

Everyone has their own way of doing things that is their solution. It might be a bad solution, like smoking, drinking, overeating, venting rage at people, and using illegal drugs. Those are bad solutions to the underlying problems of loneliness, isolation, despair, depression, and

Complex new learning is hard. It is something that we often stop doing after our formal education is complete because complex new learning means being a beginner at something. It means struggling, it means failing.

criminal, to be hardened emotionally when the lives of the people around are in constant jeopardy. That is a solution but there are better solutions you need to learn.

go to the course and just start swinging.” You would never get beyond the first hole! You would need teachers and people to play with who are learning together. You would want

anxiety, but they are the solutions that people know. They need to learn better solutions. If you come from the third generation of drug addiction, poverty, and crime, then it is actually a rational solution to be a

Complex new learning is hard. It is something that we often stop doing after our formal education is complete because complex new learning means being a beginner at something. It means struggling, it means failing. It means the potential embarrassment of being seen struggling and failing. Think of what it is like to learn a new language and how frustrating and humiliating that can be. That is what change is about. The only way to get people through it is to be supportive, to show your belief in them, to coach them, to have them together in communities that are supportive, until they can get to a new way of looking at things that will be totally foreign to how they were before.

That is the basic model I developed by looking at Ornish and Delancey Street, looking at corporate culture turnarounds, factories that went from being dysfunctional to being high quality. I hope it will be useful to you when you look at the potential for radical, profound, dramatic change and how that can be more powerful than small, incremental changes. If the change is big enough that you can see the benefits early on, then that is extremely motivating. For the Ornish heart patients, it is extremely hard for them to go from eating cheeseburgers and french fries to eating tofu. But after one month, they have experienced typically a 90 percent reduction in the frequency of their chest pains. And they say, “You know, this is a really hard change in our lives, but we feel the benefits.” We need that kind of big leap in many fields, that kind of big change to show the benefits and to keep the change going, keep it motivated.

PANEL I I: COMPARATIVE EFFECTIVENESS: MOVING FROM RESEARCH TO PRACTICE

Moderator, Benjamin G. Druss, M.D., M.P.H.

Rosalynn Carter Endowed Chair in Mental Health, Associate Professor of Health Policy and Management, Rollins School of Public Health, Emory University

I want to put this issue into context with a brief story: A woman driving in Washington, D.C., realizes she is lost. She pulls over to the side. She sees a man sitting at a bus stop.

Woman: Can you help me? I was supposed to meet a friend an hour ago but I am completely lost.

Man: I would be happy to help. You are at 38 degrees longitude and 77 degrees latitude. And, you are driving a black BMW.

Woman: Are you a researcher?

Man: I am. How did you know?

Woman: What you told me is technically accurate, but it is of absolutely no use to me. I am still lost and, if anything, I am later than I was before.

Man: Are you a policy maker?

Woman: How did you know?

Man: Well, you have no idea of where you are or where you are going, and you made a promise you cannot keep. You are exactly where you were before, but now you are blaming me for it.

So, there has been a long and complicated history of how research can be used to inform clinical care and policy.

I think there is an increasing consensus that, if health reform is to have any hope of improving care, it is going to have to be guided by data on which treatments work and which treatments work best. That is at the heart of comparative effectiveness research. Comparative means that it is looking at, at least, two treatments at a time and looking at which ones work better. Effectiveness means it is not looking under test tube or laboratory conditions, but it is trying to understand how these treatments are used in the real world. Increasingly, research means not just

traditional randomized trials but, also, other kinds of work, like secondary data analysis and simulation studies.

This kind of research is important for all of medicine, but it is particularly important for mental health where there is a higher degree of variability across the kind of services that are delivered and across the kind of providers who are delivering the services. Mental health researchers are already actively engaged in this work. A 2007 Congressional Research Service report found that, across all groups of conditions, more comparative effectiveness research

was already going on for mental disorders than for any other class of conditions, with about a fifth of all such studies identifying what was happening within mental health.

The American Recovery and Reinvestment Act of 2009 provided \$1.1 billion in funding for comparative effectiveness research, and substantially more commitment is likely to be provided as part of health care reform. The Agency for Healthcare Research and Quality is the government agency most directly charged with both fostering comparative effectiveness research and funding it by expanding its internal capacity and by funding external investigators in their work.

Today, we are lucky to have Carolyn Clancy, who directs that agency, discuss the current state of the field of comparative effectiveness research and where mental health fits into that picture. Responding to her talk will be four other distinguished panelists.

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MAIN PRESENTER

Carolyn Clancy, M.D.

Director, Agency for Healthcare Research and Quality, U.S. Department of Health and Human Services

Every year, we report to Congress on the state of health care quality and the state of disparities in health care. Health and Human Services Secretary Kathleen Sebelius released in May the most recent National Healthcare Quality Report and National Healthcare Disparities Report. One finding was that nearly 30 percent of adults with mood, anxiety, or impulse control disorders received minimally adequate treatments. This is in contrast to some other metrics, which show no differences by age. However, if you look by race and education, you do begin to see differences.

According to the Disparities Report, the proportion of adults with a mood, anxiety, or impulse control disorder who received minimally adequate treatments for depression — hardly the “Everest” of our ambitions — was lower among African-Americans and Hispanics than for whites and lower for Hispanics among all groups. People with less than a high school education also tended to receive the worst care.

The proportion of adults with a major depressive episode who received treatment is significantly lower for African-Americans than for whites and lower for Hispanics than non-Hispanic whites. Interestingly, there are no statistically significant differences by income or education level.

These types of findings are probably fairly common with many aspects of quality. We spent \$2.3 trillion on health care in the United States in 2007, but we continue to have pretty

Comparative effectiveness research is all about identifying which treatments work best for which patients and how we make the right thing to do the easy thing to do.

pervasive problems with the quality of care. One reason is the challenges we have experienced historically in translating scientific advances into practice. Just to give you an example, we are seeing more and more report cards these days. We are all about transparency. We want to know how we are doing, but the consumer websites are not very consumer friendly yet.

In 2007, the group that accredits health plans took a measure off the scorecard. This is really a big deal for two reasons. First, there are not that many areas where we can say care is so routinely excellent that we do not have to look at it anymore, it just happens. This is so for people who have had a heart attack and are getting a beta-blocker to reduce subsequent mortality.

Second, those whose performance is reported on in general are not real pleased about giving up an area where they are doing well. That they are choosing to do it is a big achievement. That is the good news.

The less than good news is we have to figure out a way to do better. Across many different populations, we are beginning to see that the quality of care is the most difficult for people with chronic illnesses or people for whom one of those diagnoses is a mental health or mood disorder. Researchers are discovering this. People who run disease management programs encounter this all the time.

Comparative Effectiveness Research

We are looking at our newly increased capabilities for conducting comparative effectiveness research as one component for addressing this and other issues. Comparative effectiveness research is all about identifying which treatments work best for which patients and how we make the right thing to do the easy thing to do. These two elements have to be linked. This is not about us building a better library; it's about shortening the lag in translation and focusing on effectiveness.

For those of you who do not live in this world where the words efficacy and effectiveness have deep, profound meaning, I will give you one example. When I first started practicing medicine, we had just started making Americans everywhere feel terribly guilty about cholesterol. This was based on a very well done clinical trial. Typical of many clinical trials, it enrolled middle-aged white men whose only condition of interest was a risk factor for coronary disease. And this is

very important. They were compliant with unpleasant medicines, and National Institutes of Health was able to demonstrate that lowering cholesterol levels was associated with a subsequent decrease in mortality. I have never had a patient who meets all those criteria. That is the difference between efficacy and effectiveness.

The Agency for Healthcare Research and Quality has been around for nearly 20 years. Our mission is to improve the quality, safety, efficiency, and effectiveness of health care for all Americans. We are a research agency. Achieving this mission means that we have to be producing information that is useful and easy to use.

Some of our big, overarching priorities include our work in patient safety and quality and our comparative effectiveness research. Over the past five years, we have also had the opportunity to support about \$260 million worth of research evaluating selective applications of health information technology for their impact on quality and safety.

We also have supported a fair amount of work on mental health. In the past couple of years, we have expanded our focus on the complex patient, or people with multiple chronic illnesses. About 20 percent of people incur roughly 72 to 80 percent of our health care expenses. The vast majority of these folks have multiple chronic illnesses. This is the group of people for whom we spend the most money and provide the worst care, a deadly combination.

Our budget for fiscal year 2009 is \$372 million. If you put that number next to our mission, you can either think that we are psychotic or incredibly ambitious. I like to think that we are right at that fine line between the two. But again, this emphasizes the important focus areas for us. We have had an explicit program focused on effectiveness and comparative effectiveness of services since 2005.

Medicare Drug Bill

We have very explicit authority in the Medicare drug bill. Not many people outside of our bubble care about authorizing language. But it is important because it makes it very clear that this is not research as usual.



The first part of the bill directs Health and Human Services to set priorities for this work based on very broad input from the public and private sectors. The second part is research and synthesis. Ultimately, researchers do not set the priorities, the secretary of Health and Human Services does. And that is precisely the approach we have taken with the program. The third part of this bill talks about making the information available to multiple audiences in a useful way. I do not know a researcher breathing who is not passionate about doing that. That passion — and the skill set to do it well — are not necessarily the same thing. So, we have had a very explicit center developed to focus on communication and clinical decision sciences.

Comparative Information

There are more and more diagnostic and therapeutic situations where we have multiple options. What we have not had is comparative



Comparative Effectiveness and the Recovery Act

- The American Recovery and Reinvestment Act of 2009 includes \$1.1 billion for comparative effectiveness research:
 - AHRQ: \$300 million
 - NIH: \$400 million (appropriated to AHRQ and transferred to NIH)
 - Office of the Secretary: \$400 million (allocated at the Secretary's discretion)



Federal Coordinating Council appointed to coordinate comparative effectiveness research across the federal government

information that lets clinicians and patients figure out what is the best option for the individual, based on different benefits or harms associated with each treatment. Moving health care into the information age tends to work extremely well in institutions where there are a lot of residents and where the more senior people tell the residents to “just do it.” That is how we are doing it now, and we have to. But we will get to a place where, instead of going on paper charts and effectively being lost, the information generated as part of providing care to patients will contribute to what many are referring to as a learning health care system.

In other words, we can get smarter as a byproduct of delivering care. Does that mean we have to be very careful about confidentiality and security of that information? You bet. But again, this is about research that informs the decisions that clinicians and patients are making under conditions of enormous uncertainty.

Research Products

We are developing a solid collection of comparative effectiveness research products, both online and in print. There are also summary guides for clinicians and patients. For medical journals, there is often a patient page. Usually, it is not that helpful for patients, but it is a little more appropriate for doctors who want a Cliff Notes guide to what is happening outside of their

own particular specialty or discipline.

Our patient guides are very different. They use a variety of techniques to try to explain information to patients and make it accessible so they can think about multiple options with different profiles of benefits and potential adverse effects. If you are talking about medicine that you have to take every day, or if you are trying to decide whether you should have surgery, radiation, or hormones; or, if you want to wait and see if you have prostate cancer. These are very different cognitive tasks.

Allocation

The American Recovery and Reinvestment Act, or ARRA, included \$1.1 billion for comparative effectiveness research. Almost immediately after the election, Capitol Hill staff members got to work on the Recovery Act, and all of them needed to be brought up to speed.

The \$1.1 billion was allocated as shown on the graphic on this page. NIH received \$400 million, and \$400 million is allocated at the secretary's discretion. She is not setting up her own research agency, but we have been thinking of that as a terrific opportunity to invest in infrastructure, data investments, dissemination, and so forth, and also to focus on expanding the current research enterprise.

Defining Comparative Effectiveness Research

In terms of what the definition of comparative effectiveness research should be, there were two major inputs for the \$400 million. Generally, all the definitions are very long, but one focus they share is on real-world settings. The Federal Coordinating Council's version includes references to topics identified in response to the express needs of patients and clinicians. That is a very different deal for research. Also new, and reinforced by a separate group at the Institute of Medicine, is the focus not just on clinical interventions, but also on care delivery interventions.

Stakeholders

At the agency, all aspects of the work are guided by ongoing involvement of multiple stakeholders. We even have an explicit stakeholder panel. The panel includes consumers, clinicians, industry representatives, and others, and they struggle with issues such as: What is the best way to present this information? What are the most important questions?

With this \$300 million allocation, we are going to try first to anticipate what new breakthrough treatments will be coming online in the next three to five years to get the best possible evidence about now. This work should not be a gatekeeper to the diffusion of breakthrough treatments, and that will make a huge difference in people's lives. But at the same time, we all need to know who is most likely to benefit and what the trade-offs are if you agree to have a breakthrough treatment. No country has figured out how to do this well.

Assessment

We will continue to include a focus on reviewing prior studies. One of the big "ah-ha" moments for me occurred about 10 years ago, when we first started supporting what we call evidence reports. These are very rigorous reviews of all studies in a particular area.

One topic that was nominated to us was, how do the new treatments for depression compare with the old ones? This is a very practical clinical question: "Should I be sticking with what I know works, or should I try some of these new ones?"

Immediately, we found there was a huge pile of studies on antidepressants, which was no surprise. We have a huge number of products. Almost all of them are short-term and examine the impact of particular treatments compared to a placebo for someone with a new diagnosis.

Most clinicians have that opportunity periodically. In primary care, that is a very small piece of the action. A lot of the action is people who have other issues; or they meet some but not all of the criteria for an official diagnosis; or they vaguely describe their condition: "I have not been feeling great. I am not myself. When this happened a couple of years ago, I got Prozac," or

some other treatment that seemed to work. Feedback and assessment of where the gaps are in the current research base are very important.

We are going to try to focus on identifying those gaps more rigorously. If you read a research paper, the gaps — or what we should do next — are a blend of gaps identified by the research, all filtered through researchers' very strong opinions and judgment. That differs from society saying, "What are the most important gaps to focus on?"

We are not going to answer all possible questions. We will be focusing on dissemination and translation, and generating new evidence. Career development is also important. We are going to need a workforce that can do the research, is bilingual (I would argue), and understands the needs of the clinical care system and how the research is done.

Integration

Our work is not focused on types of services. We do not necessarily just compare drugs or devices or surgery. We also look at other issues, such as conditions. Depression and other mental health disorders are some of our priority areas. In addition to making broad recommendations to Health and Human Services, the Institute of Medicine articulated 100 specific research questions for comparative effectiveness research. Integrating mental health and primary care is in the top quartile of their 100 questions.

Frankly, I think we have been in denial. We have been thinking that we can just skate through this. We have to become better at training primary care physicians in primary care mental health and at the co-location systems of primary care and mental health, on outcomes, including depression and anxiety. One challenge I have seen in visiting a variety of organizations is that they have to be very careful when they try to operationalize that co-location. State laws require that they maintain a firewall between their efforts.

For the past 50 or 60 years, we have had well-developed conceptual blueprints for doing clinical trials. We cannot rely entirely on them. Even though they are important and wide-reaching, they cannot possibly address all questions. First, forget spending all our money on

health care. All we would do is spend it on clinical trials. Many people do not want to be in such trials. Some issues are just not practical.

As we work toward an entirely wired health care system, one that is easy and makes our job

We have an opportunity, and a responsibility, to make sure the studies include people who look like all of us.

easier, we are going to have a lot more data that is clinically detailed. We can learn some from billing data, but it has important limitations. When we can combine information from

multiple systems electronically and easily, then we can use different approaches. However, we have to make sure that these approaches are rigorous and get the same kind of focus and attention given to clinical trials.

The CHOICE Initiative

Throughout all discussions on comparative effectiveness, there has been a lot of concern that this would restrict choices. The CHOICE initiative will be a series of pragmatic, clinical, comparative effectiveness studies. The usual design for a clinical trial is on top of usual practice, which is increasingly chaotic. You bring in a small army of researchers, and they collect all kinds of data that would never be collected in real-life clinical care. And they pay doctors and their staffs, and perhaps patients, for follow-up and so forth.

When the project is done, when everybody goes away and we go back to our usual life, our aspiration is to conduct practical studies routinely in a scalable way in clinical care settings. That means compromises and trade-offs. This is not about saying to researchers, “Hey, while we are here, what other information would you like because, someday, it might be useful.” This has to fit into the workflow of clinical practice.

This initiative also includes a very strong focus on populations that are traditionally underrepresented in research. We are interested in working with organizations to develop or enhance registries, which has been a very important research tool.

Other Initiatives

One other investment to keep your eye on is for a citizen reform panel. Our stakeholder panel has been unbelievably helpful. We think we need to take that approach with multiple stakeholders participating and working together as citizens — and effectively put it on steroids. We will be launching another initiative on improving care for complex patients with multiple clinical illnesses.

There are important synergies between health information technology and comparative effectiveness because of the different kinds of research, and a lot of it is not getting used. The real question is how health information technology and comparative effectiveness can be aligned so that the research is easier to do and becomes an important part of translating.

Feasibility

Technically, we know how to deliver information to the point of decision making. What we need to do is to organize the decision behind that. There is a kind of myth and rumor circulating that comparative effectiveness amounts to anti-innova-



tion. It goes something like this:

Scientists are developing things that can save and transform your lives. But those gatekeepers over there take forever. They are going to do these studies, and you cannot have the information until they are done. We should get rid of them. It absolutely does not have to be that way.

That myth does not acknowledge two facts. One is that we do not have a very good system today for easily identifying all of the people who are likely to benefit from a particular new breakthrough. It is a little haphazard and random. That is part of the translation lag.

Also, we do not routinely get a signal when a patient meets all the criteria for new treatments and their disease fails to respond. For that signal to get back to the folks who are developing the interventions now is an act of altruism. We need to receive that signal in a much more consistent way if we are going to continue to lead the world in innovation.

Our focus now is on making sure that this research is descriptive, not prescriptive. The ongoing tension about how this information will be used is not going to go away. We can be as transparent about the use of this information for practice and policy as we are trying to be at the

agency about developing this information. But I do not think that is going to obliterate people's fears anytime soon.

This is the fear, I think, that resonates with most of us: "I might be denied access to something that would save my life or make a huge difference, based on studies that do not include people who look like me." We have an opportunity, and a responsibility, to make sure the studies include people who look like all of us.

This comes back to the fact that, right now, clinicians and patients are making decisions under conditions of enormous uncertainty. That is not the only reason undergirding our challenges in health care, but it is a big part of it. What is very exciting is that we have the tools and skills and, now, the will to make a big difference. In theory, this is a fabulous new opportunity. But, as Yogi Berra once reminded us, "In theory there is no difference between theory and practice. In practice there is."

I have come to the conclusion that I am probably an implementer. I am trying to warn policy makers and researchers about the roadblocks and potholes in their way as they try to get to where they want to go.

***"In theory there is no difference between theory and practice. In practice there is."* — Yogi Berra**

RESPONDENTS

Hyoung Un, M.D.

National Medical Director, Behavioral Health, Aetna Health Plans

The world that I live in is pretty messy. We have about 800,000 providers throughout Aetna, and about 4,000 hospitals. We also have about 80,000 mental health providers and about 100,000 customers with probably multiple benefit designs. That confounds the heck out of me.

I am going to discuss some of the challenges associated with going from comparative effectiveness research into practice, not the least of which will be creating a business case for doing so. We can do comparative effectiveness research, but, unless our customers, our employers acquire it, it is not going to get included in the

benefits. And unless I disseminate that in a simple way, our providers are not going to practice it. Dr. Clancy was able to show a fairly significant prevalence of behavioral health disorders for which we still have profound access issues. Not only is the quality questionable, but just getting people to treatment is difficult.

A recent study shows how much prescribing is done in the primary care setting. It used to be anti-anxiety agents and antidepressants. Now we are on to mood stabilizers. Clearly, we have an issue that it is getting worse, not better. As we look at large data and population data sets, about 10 percent of the folks are driving about two-

thirds of the cost. Most of those are chronic conditions where there is an overrepresentation of behavioral health disorders. That impacts our customers because, at the end of the day, what they want are productive employees.

The days of impairment are significant for depression, a fairly prevalent disorder. You are looking at the direct cost — hospital, lab tests — and the indirect cost associated with that. In fact, that is the majority of the cost. Really, we are at a point where we need to do something because we cannot sustain the current pattern.

There is good evidence that treating depression in primary care is a great thing to do. Yet, we find it very difficult to implement. Different health plans have different models related to delivering depression management in primary care. We do not have a consistent model, though, to rally around and say, this is the model. We don't want to confuse the providers trying to implement different models.

Most of our practices consist of small numbers of physicians and are not organized to sustain an integrated behavioral health practitioner. Clearly, we will need to have different solutions to manage behavioral health issues. Comparative effectiveness research around effective dissemination should be very helpful. A one-size-fits-all approach is just not going to fit everyone.

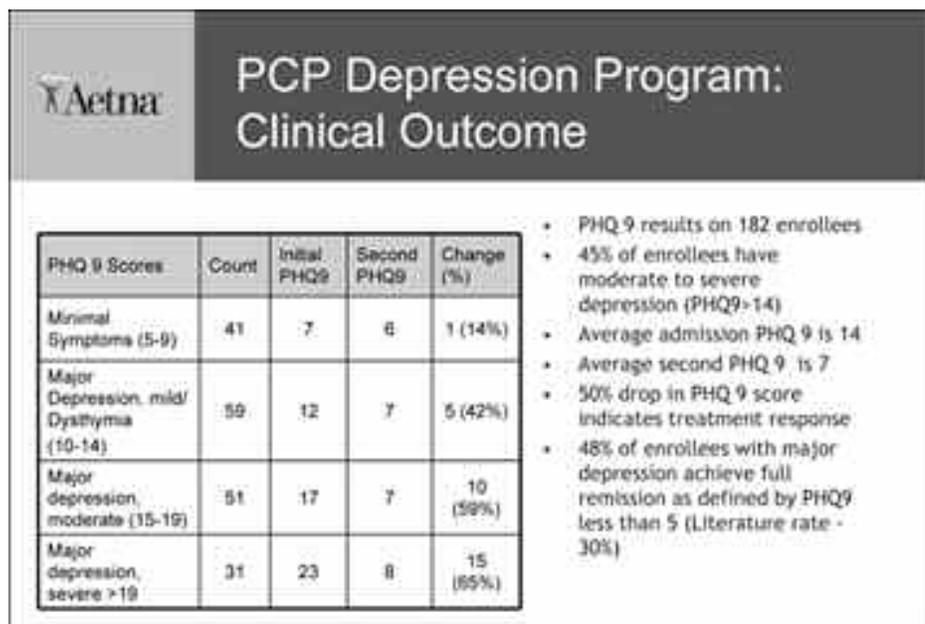
We also have issues related to our behavioral health providers who, by and large, have a more conceptual framework than primary care

physicians. There are also issues of language, of concept, and of a healthy respect for both models. Then, of course, we have a financing issue where funding for behavioral health and primary care may be different.

Health plans have similar kinds of struggles. Ben [Druss] talked about integrating behavioral health back into Aetna from a carve-out to a “carve-in.” Probably the biggest benefit out of that integration was to change the culture of the organization so that we started to talk not about medical or behavioral health issues, but about an issue of health that entails both perspectives holistically. From that conceptual framework, we developed systems and clinical models that were integrated. That was probably the best output from carving in behavioral health.

Consistent with that, we have focused a lot on integrating behavioral health in primary care. We have multiple initiatives that are going on now, but we are operating somewhat blindly because the guidance from dissemination research is limited. We are hoping that these initiatives will have outcomes as suggested by our analysis as well as the research literature. This in turn will provide the business case for wider dissemination. We started these initiatives because we thought it was the right thing to do and believed that there was a good business case for doing them.

If you look at these 182 enrollees who are being treated in the primary care setting (see graphic on this page), they are severely to moderately depressed. When we do get them into the program, which is a big challenge, they actually do better. They respond. There are hints of the beginnings of a business case. Again, this is critical. You need to have the business case for these programs to be adopted and disseminated. Going from just pharmacological management of behavioral health disorders into a more rational, balanced model of psychotherapy plus medication seems to create some savings. This is preliminary data but at least it is a hint that we are moving in the right direction.



There are about 4,000 board certified child psychiatrists in this country. We have decided to try to replicate the Massachusetts model in the private sector to reimburse for screening for pediatric issues and the ability to provide telephonic consultation with a child psychiatrist. Getting an agreement to provide telephonic consultation reimbursement was a challenge. Generally, there is payment for telephonic

consultations and office visits. Initiatives around disseminating, screening, and brief intervention are tremendously important, as is integrating behavioral health providers in primary care settings. As we start to get the dissemination and translational research, we should be able to create clinical models and reimbursement systems that support behavioral health management in a primary care setting.

Nico Pronk, Ph.D., FASCM

Vice President, Health Management, HealthPartners; Health Science Officer, JourneyWell

I will focus on a couple of points and support them with examples from comparative effectiveness research in health promotion and disease prevention. Based on the literature, we know adherence to a few simple lifestyle behaviors makes a profound difference in people's health. Physical activity, no-to-moderate alcohol use, no tobacco use, and eating five fruits and vegetables a day make a huge impact on longevity, extending life by 10 to 14 years. Adherence to those four simple behaviors has an amazing impact on the incidence of new disease, stroke, heart disease, and diabetes. But, they also are associated with mental health.

Feeling depressed, feelings of being at high risk in stressful situations, and other emotional health concerns are strongly associated with those four simple behaviors. Realizing that, how do we go about behavioral change? Do we focus only on individual interventions?

There are multiple levels of interventions and levels of influence: using an individual program focus, supported by interpersonal or group-based and organizational approaches, and finding ways through these organizational policies to make a difference and exert influence, whether that is in the physical or the social cultural environments.

Effectiveness research provides guidance on what works. Comparative effectiveness research provides guidance on what works better. From a population health perspective, there are a couple of important points:

- Where do we find the greatest yield as we try to make decisions, particularly about resource allocations?
- Where do we want to put those resources? Is it medication A or medication B?

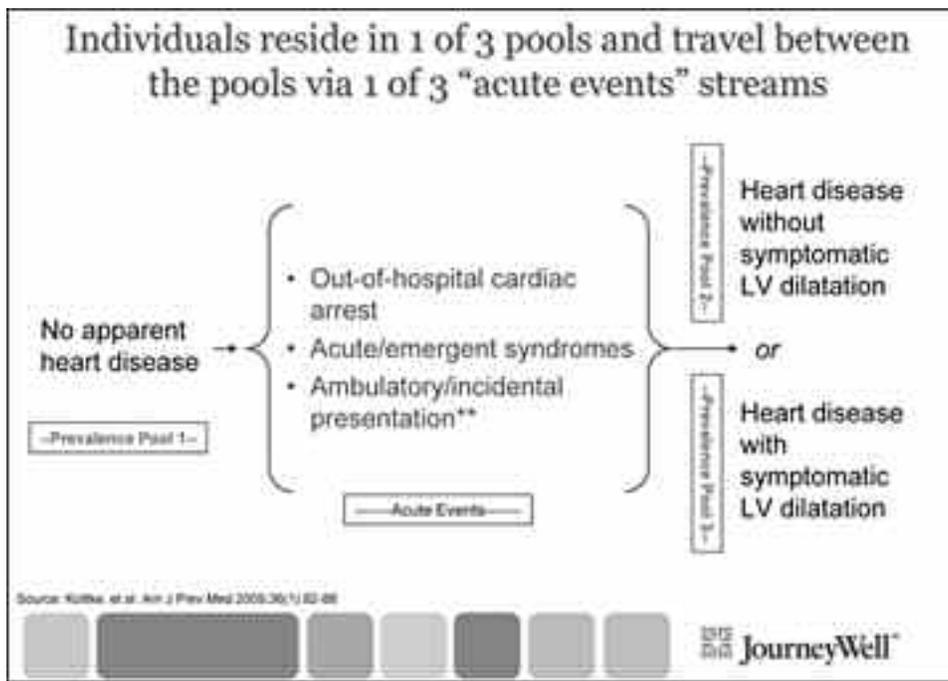
But we should not stop there. We should go beyond that and ask:

- How about behavioral interventions compared to medications?
- How about different behavioral interventions?
- How about behavioral interventions versus policy?
- What kinds of policy interventions, what kinds of environmental interventions?

The list goes on. Limiting the focus merely on clinical-based, medication-based interventions would not help us deliver on that promise of comparative effectiveness research.

The first example is very focused on identifying the opportunity for the yield. This is a project that is focused on the comparative effectiveness of heart disease prevention and treatment strategies, an analysis that really reports on the expected number of deaths prevented or postponed if perfect care, or current levels of care, were delivered before, between, and at the time of an acute event for heart disease. We modeled the U.S. mortality rates for 100,000 people age 30 to 84 and divided them up into

Effectiveness research provides guidance on what works. Comparative effectiveness research provides guidance on what works better.



three prevalence pools via three classes of acute events and then modeled the death rates that would be prevented or postponed.

The three pools have marked differences in their mortality rate (see graphic on this page). First, there are the folks that are in the “no apparent heart disease” condition, and then there are people who have heart disease with or without left ventricular dilatation. In the middle, you can see the acute events. These account for the vast majority of cases where heart disease is identified, either out-of-hospital cardiac events; acute or emergent syndrome, such as chest pain; and ambulatory and incidental presentations.

The kinds of interventions that we looked at in this model are interventions of known efficacy. Twenty-one interventions are modeled. They range from physical activity, particularly among apparently healthy people, all the way to automated external defibrillators in the community and pacemakers.

Looking at the results, perfect care interventions would actually prevent or postpone these prevalence pools in 60 percent of deaths due to heart disease. Treatment during acute events, the middle section of the model, only prevents 8 percent. The vast majority, 33 percent, comes out of the apparently healthy individuals, the people in the community at

large. Twenty-three percent is related to those folks who already have heart disease with or without left ventricular dilatation.

Finally, if we just take a look at physical activity interventions alone, 45 percent of deaths prevented or postponed would come from that variable by itself. So, when you think about yield, it is not just in the context of clinical treatment. There is definitely a role for addressing behavioral health risks.

Nearly all of the achievable benefit not yet achieved would accrue from preventing the first event or preventing recurring events. A consideration of these data may be important in shaping

strategies to increase the value of the services the health care sector provides to employers, communities, and society at large.

In data on smoking cessation from Kevin Volpp at the University of Philadelphia, financial incentives compared to medications or behavioral treatments clearly appear highly effective for smoking cessation as a therapy. Cessation rates between nine and 12 months are tripled at 15 to 18 months, two and a half times as high as the control group. This is after withholding the financial incentive six months after the first year. Clearly, the impact of financial incentives appears to be as strong as pharmaceutical interventions. Comparative effectiveness is a great tool here to compare the impact of the more clinical interventions to new, nontraditional, and integrative ways of changing behavior.

Another example is weight, particular in the context of an obesity epidemic. In a project conducted as a collaboration between HealthPartners and Kaiser Permanente Care Management Institute, we asked, “Which of these different lifestyle strategies would you choose to get the greatest yield?”

We conducted a systematic review of randomized, controlled trials from the literature and also included observational cohort studies

that were at least five years in duration. The results were analyzed and organized by lifestyle strategy. So the weight loss results are presented by (clinician) advice to lose weight, diet only, diet plus physical activity, exercise only, meal replacement, very low-calorie diets, and anti-obesity medications.

On the graph on this page, the first thing you note is that advice only does not seem to do very well for weight loss. Interestingly, while this is a very low-cost intervention, people did not gain any weight over time. Meanwhile, the rest of the country continued to gain weight during the same four years. Furthermore, you can see that the diet and exercise combination is as successful in weight loss and weight maintenance as meal replacements and pharmaceutical approaches to weight loss.

Comparative effectiveness research, in the context of health promotion and disease prevention, provides really good information, if these studies are done well. The challenge still remains that once you find out what works, you need to do something with it. By itself, comparative effectiveness research does not get us where we need to be. We need to use it as a first step into figuring out how to bring these solutions into a competitive marketplace, and, for that, you need business models.

You need to find ways to connect research to practice, not just translate research into practice. Two paths may be considered here. One path is research-informed practice doing as much as they can, based on what we know works. The other path is practicing informed research so the generated hypotheses are truly based on insights that come from a practical perspective and are important questions to answer. Then, translate the research outcomes — particularly those research learnings that are based on systematic reviews and comparative effectiveness research — into scalable, sustainable, and standardized

solutions that have undergone the scrutiny of having been couched in a business model that makes sense.

As part of this approach, two-way communication is absolutely critical. The

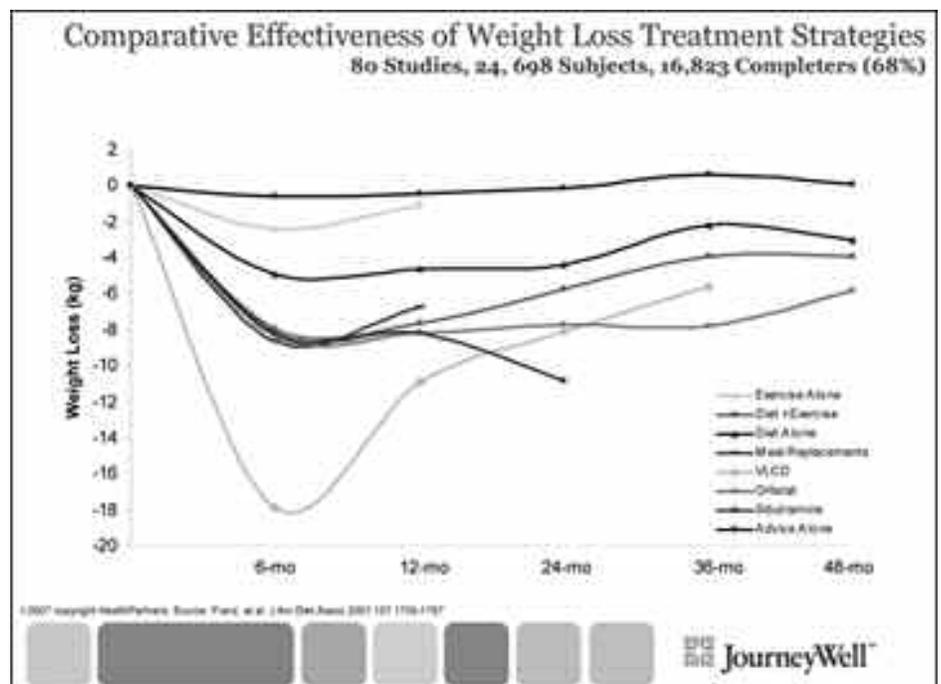
product design component in the context of a business model and a business case, tied to customer insight, is absolutely paramount. Once companies lose track of their customers, they may well be on their way out of the market.

The challenge still remains that once you find out what works, you need to do something with it.

Sustainability

A good way to think about a bridging effort between research and practice, even how practice can connect to community as well, is this notion of sustainability. Sustainability is something that makes sense from any angle. Think about applying research into practice but also how practice can succeed and make the market work. Within the context of market dynamics, sustainability may be a good guiding principle.

From a business perspective, sustainability is a core capability to get to net profit. Sustainability in its broader context relies heavily on a supply chain that respects the natural resources involved in products. As such, the triple bottom line in business refers to people, planet, and profit — when respecting the natural resources of the



planet and caring for the people of the company, profitability may actually be more likely than not. As an example, it is probably not by mistake that the Green Index on the Dow Jones consistently outperforms the average Dow Jones. Compare and contrast this “triple bottom line” of business to a “triple aim” in health care — the simultaneous achievement of exceptional patient experience, population health improvement, and affordability through reduced total cost of care. In order to achieve this triple aim, the health care sector will have to consider the effective and efficient integration of primary care, specialty care, mental health, and health promotion/disease prevention. Achievement of this triple aim in health care will provide a reasonable basis for sustainable solutions in health and health care.

Conclusion

Comparative effectiveness studies will also guide us in identifying where we can find the greatest yield for our investment energies. It is pretty clear that there is a robust impact of health behaviors in overall population health, and, particularly, when you look at different health behaviors, we have a lot to learn from comparative effectiveness research. What we learn should not be limited to medication A versus medication B. There is a need to include behavioral, policy-based, and environmental studies as well. Finally, translation and dissemination should be carefully considered from a customer perspective. Meet the needs of those customers and use sustainability as an overarching organizing principle to get to optimal process and outcomes.

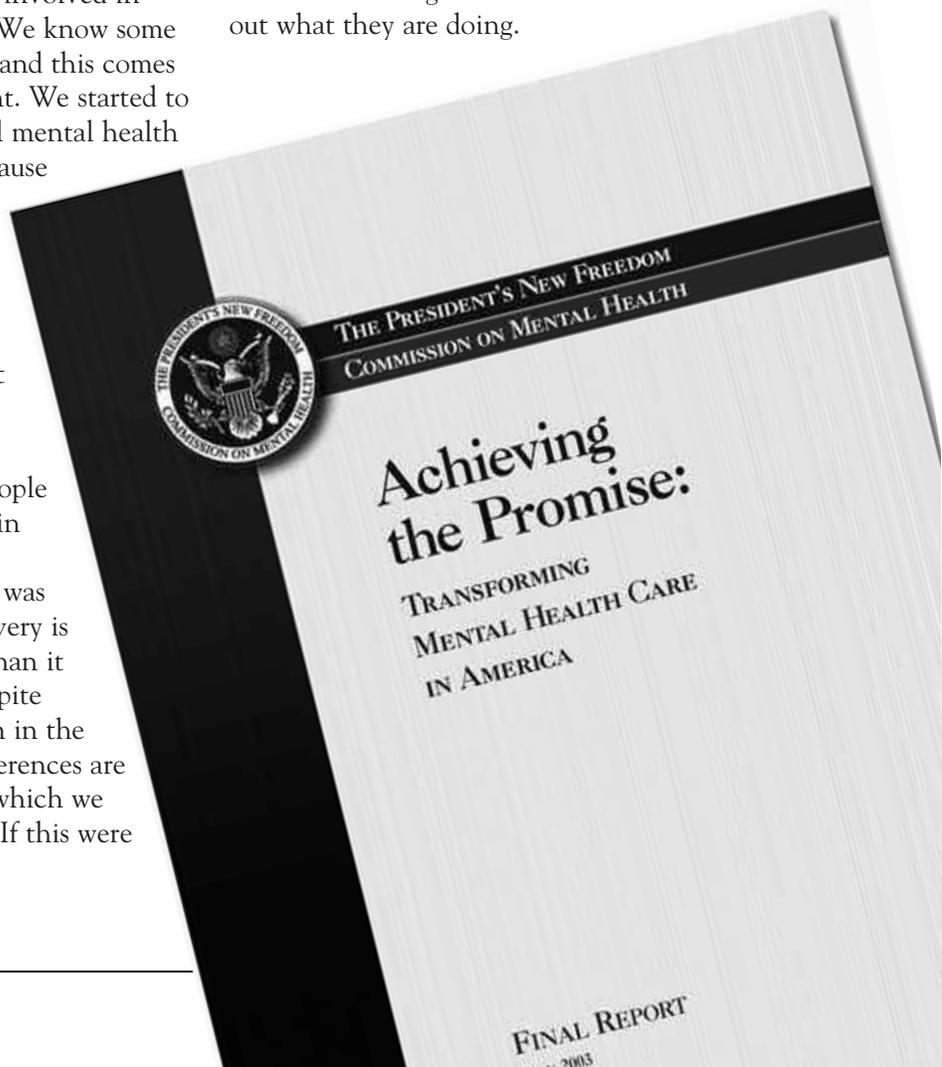
Daniel Fisher, M.D., Ph.D.

Executive Director, National Empowerment Center

We need to understand much more about what factors are involved in relationship building. We know some of them. Empathy is a huge one, and this comes out in the peer support movement. We started to develop, spontaneously, a parallel mental health system by necessity, I believe because our present formal mental health system remains broken. That was the conclusion of the President’s New Freedom Commission on Mental Health Report. And the problem has not improved tremendously.

Two different studies have compared the recovery rate of people with major psychiatric problems in the developing world and in the industrialized world. The finding was the same in both reports — recovery is higher in the developing world than it is in the industrialized world, despite the use of much more medication in the industrialized world. Two big differences are community and relationship, to which we have not paid enough attention. If this were

happening in cardiovascular research, we would be running to these countries to find out what they are doing.



People's own lived experience is another source of information that we really should be tapping more. I was a biochemist at the National Institute of Mental Health, and I did a lot of research in the 1960s and 70s on biosynthesis of serotonin. I was very much a believer in the model that, if we knew all the chemistry, we would understand what made people happy and what made them unhappy. It was seen as very effective research in terms of the factors governing the synthesis of dopamine and serotonin.

However, it was my conclusion from that research — that we were machines — that led, in some ways, to my own schizophrenia. The logical conclusion of a chemical model of behavior is that we are machines and that relationships do not matter. In fact, I felt that there was no reason to relate. All I had to do was go to the lab and do my chemistry. I became very unhappy and went into my own world. In Finland now, they would say psychosis is monologue. It is having only one version of the world, and that version was that I was a chemical reaction. My boss was impressed because, he said, you really got into the problem. But I could not get out. I could see the chemistry, but I could not see the people.

I was hospitalized on three occasions, and the time at Bethesda Naval Hospital was very difficult. However, I did get a lot of help there from a corpsman. Who is the most helpful, the person with more training or the person with less training? Almost always it is the person with less training. It is the authenticity of the person that is crucial. When someone feels their life is not worth living, they want to know a human being is there, first and foremost, that there is a person who cares, who believes in them, who gives them hope. And there, it was a corpsman.

Our training takes away our human responses. That is a terrible thing. We need to have people share their personal experiences. That, I understand, is happening at the Medical College of Georgia where peers play a role in the education of young residents, and residents can learn from people's firsthand experience, learn what it means to go through psychosis and know there is still a person there. A person is always there.

There were good parts during my training, but there were bad parts, too. The good part occurred before there had been such a heavy emphasis on medication. There was still an emphasis on relationship building, on therapy. Anybody who enters this field should undergo their own therapy as well. What is the recovery program? It is the person.

Recovery is higher in the developing world than it is in the industrialized world, despite the use of much more medication in the industrialized world.

Possible Approaches

Now, I want to give a couple of examples of approaches that I think are very important. First, I think we need to reframe our concepts of what the problems are when people have long-term psychiatric problems. A biological model has certain limitations because it means we only look at their chemistry and we only look at medication. But we know that there are other factors that play a big role, not only from looking at practices in developing countries but also from looking at psychosocial approaches.

But it is not just the bio-psychosocial model. People have real needs, real dreams. We should not pay lip service to person-centered planning. People want a life. One of the most innovative programs I have seen is in Florida. It is person-centered, which is really life coaching.

People have set aside a budget — which they control — with a life planner, and they set up a life plan, not just a treatment plan. In order to get back into the community, people need to know that they have a life in the community. Their dreams have to be the source.

Personally, I could only recover when I decided that I had to be with people, serve people. That was meaningful to me, and it remains so. I could not get enough meaning out of working with rats. I kept asking my boss, "When can I see somebody who actually has been diagnosed with schizophrenia?" I had to be diagnosed in order to see somebody who was diagnosed with it. I was told, "You are a Ph.D. scientist, you cannot do clinical

Our training takes away our human responses. That is a terrible thing.



engaged. They are voluntary, and we have hardly any voluntary psychiatric hospitals any more. There is continuity of care because people are able to retain an involvement with their psychiatrist. There is also less trauma because the person has control and can continue to work.

The finances certainly are terrific, but beyond the finances, it helps people on their road to recovery, and this is an area where I think we need more research. I proposed to the deputy commissioner that we have one pilot, maybe

work.” We need to bridge that gap between the people who are working in the laboratory and the people who are working outside.

Right now, I am working on an innovation, a peer-run crisis respite. Hospitalization is a traumatizing experience. It would change practice if, as part of their training, psychiatrists were hospitalized and would not know when they were going to get out.

The major basis of trauma is isolation and powerlessness. That is exactly what we cause when we hospitalize a person. We remove them from their community, and we take away their efficacy and their empowerment. We should be doing everything possible to create alternatives to hospitalization. There are models, but it is difficult to get the money. Researching alternatives to hospitalization would be a terrific thing to do.

There are small respite programs, 20 beds total, run by consumers in six different states. The Massachusetts deputy commissioner has gotten excited because the two beds in a peer-run respite will save the state \$1 million a year. That caught their attention. She went to New Hampshire to look at Stepping Stones, one of the first peer-run respites, and interviewed people who had been residents. They would come in and stay about seven days. It is a relationship that keeps them

three beds. She said, “How about six.” Well, we want to do it right, so maybe we will do three.

We have supported employment, life coaching, self-determination budgeting, certified peer support, peers doing the teaching, and now peer-run respites. I think what we are starting to do is create another mental health system in the ashes of the one that is here. It is a lot of work with no money, but we do it from our hearts. We believe that we can help each other.

We have an annual alternative conference, 600–700 people in Omaha, Neb., in 75 workshops. This is an evidence-based practice. People, all diagnosed with serious psychiatric problems, are able, every year, to pull off this conference and teach each other about our new innovations.

We must be doing something right in this peer movement and peer support because people come from all over the world to observe what we are doing. I will be going to Portugal to speak on recovery because, they said, it is an American concept. We have this wonderful jewel, and I hope that we are able to support it in a respectful and a meaningful way through research so that we can validate it. We who have been through these experiences are the evidence, and we need to be engaged in the research.

Michael S. Barr, M.D., M.P.H., FACP

Vice President, Practice Advocacy and Improvement, Division of Governmental Affairs and Public Policy,
American College of Physicians

I spent most of the 1980s in training, first in medical school and then in internal medicine residency. On reflection, there were two keys to my success as a young physician. First, to recognize very early on that to survive as a student and a resident, although I had to prepare for the chief resident and attending physicians, I really needed to befriend the nurses — trust them, respect them, and learn from them. That lesson continues to influence me now. Now, of course, it is much broader because I learn from the whole health team, including my patients.

More important, perhaps, to today's discussion is the second key to my success: the white coat. The white coat was essential, but not for the reasons you are probably thinking. It was not its major power, or the dashing way it made me look, or how it hid my wrinkled shirt and stained tie. It was the pockets and all the stuff I could carry with them. The more pockets the better: three on the inside, three on the outside. It did not matter that I had to walk sideways through doorways with all this stuff.

With the white coat on, I was transformed from a sleep-deprived, almost brainless resident to a complete walking encyclopedia of knowledge. I had in my pockets infectious disease guides, antibiotic dosages, EKG rollers, and interpretation cheat sheets and pneumonics of all sorts of differential diagnoses, pocket guides for ICU care, insulin algorithms, when to check drug levels. The list goes on and on.

As my white coat got heavier and heavier, I started to look for alternatives. As soon as they were available, I bought new gizmos instead of paper-based products to stuff into my pockets. First, there were advanced calculators, then the Franklin Book Readers with the Physician's Desk Reference, then the early personal digital system, such as the Sharp Wizard and several generations of the Palm Pilot. Now I carry an iPhone essentially with unlimited Internet access, my favorite medical calculators and information sources, and the ability to phone a friend when I cannot find the answer.

Although the availability of information is now, literally, at my fingertips, the time available to access and absorb the information has not changed. In fact, it may have decreased. There is more to do and more complex decision making to undertake. It is still a challenge to find reliable, critical information efficiently comparing choices of therapies, interventions, and diagnostic tests.

Comparative effectiveness research, coupled with appropriate implementation of health information technology, should provide me many opportunities to improve clinical care and patient outcomes. But a critical prerequisite is the need to organize the delivery system. Major investments in health information technology will not be able to overcome a dysfunctional health care delivery system. Without fundamental changes, the expected dividends of improved quality, applications of comparative effectiveness research in real time for real people, and any hope for the bending of the curve on health care costs will be difficult to realize.

We need to foster the development of a team-based, patient-centered approach to providing care. This will require not only major changes to existing practices but a reevaluation of the training programs that produce health care professionals.

We need a delivery model and a reimbursement system that support health care teams to improve access, coordinate care, apply the best knowledge in collaborative discussions with patients and families, and embrace the concept of continual improvement. This will be quite a challenge, especially since offices of five or fewer physicians provide about 76 percent of ambulatory visits. These offices typically do not have the resources to undertake these kinds of changes alone.

Although the availability of information is now, literally, at my fingertips, the time available to access and absorb the information has not changed.

To this end, there has been an enormous amount of energy and effort put forth in the past three years or so to promote the concept of the patient-centered medical home, or health care home, or health home — whatever you want to call it — and novel reimbursement strategies to support it.

While this concept is more than 40 years old, it has received a new life as a call to action for health care communities: employers, payers, consumer organizations, federal and state agencies, health services research, and other key stakeholders. This is a model for continuous, coordinated care throughout a patient's lifetime to maximize health outcomes. The practice is responsible for providing all of the patient's health care needs or appropriately arranging that care with other health care professionals. This includes preventive services, treatment of acute

and chronic illness, mental health services, assistance with end-of-life issues, and referral when appropriate.

For health care teams and medical homes to be effective, they will need information at a mouse click on the most patient-specific guidance that health information systems can deliver, providing a clear, concise, and actionable format and providing the context of the normal patient-care workflow. It is a clinical decision support function, but it must be built on evidence-based guidelines and comparative effectiveness research that takes into account the care setting, patient-stated preferences, and relative clinical conditions.

The actions and response to this guidance could also be used to inform quality measurement and cost-of-care measurement, as well as continuous improvement in those guidelines as data is aggregated about the outcomes generated by that same clinical guidance. The following scenario is an example.

Mrs. Smith, a 75-year-old woman, contacted her medical home complaining of chest pains. She reached the nurse almost immediately, who did a quick assessment of her concerns using an evidence-based algorithm embedded in the office. That helped document the history and her decision, which was to have Mrs. Smith go immediately to the emergency department of the nearest hospital.

Electronically, the nurse forwarded appropriate medical records to the emergency department. Upon arrival, the physicians confirmed that Mrs. Smith was indeed in the midst of an acute coronary event. Her pain was difficult to control.

Question: Should the physicians take her immediately to the catheterization lab or delay intervention and try to manage her medically?

The clinical decision support provided by the electronic health record cited recent data from the *New England Journal of Medicine* comparing outcomes from early versus late intervention. On the basis of that, they suggested that Mrs. Smith would benefit from early interventions.

So, the physicians did a cardiac catheterization and determined that Mrs. Smith would benefit from a stent placement.



Question: Should they use a perimental stent or a drug-coated stent?

Again, the electronic health record provided guidance from recent studies that there was little difference in outcomes between the two options, so she got the less expensive perimental stent.

Typical medication regimens after stent placement include Plavix. The electronic health record highlighted new information indicating that some patients have a genetic variance that makes Plavix less effective and results in high risk of clotting, despite the medication. Unfortunately, this type of genetic testing and personalized genomic medicine was not yet available.

The hospital routinely screens for depression in elderly patients, especially those with certain conditions associated with a higher prevalence of depression, such as cardiovascular disease. Mrs. Smith was depressed and therapy was initiated prior to discharge.

The discharge process, guided by the electronic health record, was developed upon recent research about best practices. The nurse organized the discharge plan and developed an after-hospital care plan with all of the appropriate information: appointment, pending

tests, and a follow-up plan. A pharmacist was identified who would contact the patient shortly after discharge to make sure she was following the medications and asking any questions if the medication presents any challenges.

Dr. Jones' nurse contacted the patient after discharge to answer any questions and to confirm the follow-up appointment set up by the discharge nurse. Then as planned, Mrs. Smith kept her appointment with Dr. Jones five days after discharge. All of the relevant medical records, laboratory tests, consultation reports, and medication changes were exchanged with the office's electronic health record and available when Dr. Jones sat down to speak with Mrs. Smith.

A key point in this scenario is that all of the information provided was available at the point of care. It generated a consequence of normal workflow and supported documentation, and was presented in a clear and actionable format. It was up-to-date, provided options based upon the best available evidence, included both quality and cost comparisons, took into account specific characteristics of the patient, and most importantly did not require that the members of the clinical team wear a 30-pound white coat.

Questions & Answers

Q How are you most hoping information about comparative effectiveness research will be used as you move from having the data to actually using the data to change care?

A *C. Clancy:* A theme that cuts across this was a notion of making a business case extremely practical. A system that is really designed for clinicians and patients to have information — and the best information — at their fingertips remains a fuzzy concept.

A *N. Pronk:* Both systematic review and comparative effectiveness research are our first points of observation. They give us an understanding of what works and what works better for the complex programs that we are interested in.

Basically, we took a step back and asked what other information is absolutely key to using this process, to creating a programmatic solution in practice? Besides the information that is specific to the topic emerging from the medical health related research, we add as much as we can from a business research perspective, from all sorts of fields. This is a very chaotic, very gray process.

So, you prototype it, try it out, tweak it and change it, and you come up with a final solution that you can sell. It is literally based on a business case. It has a business model behind it and a price point that allows it to be successful in the marketplace. Then you implement it.

Phone-based coaching is a good example and has changed over the last decade. You could not sell phone coaching 10 years ago. It was too expensive. Today, it is a periodic, phone-based interaction with a lot of e-mails in between that allows an integrated approach.

A *D. Fisher:* Unless we find out how people can be integrated back into the community, how people form social networks, and how people are able to find meaningful work that connects with their life purposes, we will be penny-wise and pound-foolish. We need to look at reform of Social Security, at long-term service and supports, and, gain greater trust between the government and

the people. Within the disability community there is a split about whether or not effectiveness research should be run by the government or by a private entity. I lean toward the government doing it, but only if it actually has citizens panels and genuine transparency.

A *H. Un:* How the business case is conceptualized is changing. There has been a significant move to look at things like disability cost. That is an interesting area, particularly for behavioral health where we can make significant inroads.

Comparative effectiveness is a starting point. When it gets into markets, something happens. What was produced by the research, and what the marketplace actually has, may or may not have any relationship to each other.

A *M. Barr:* Even though we are talking about business cases, I think we need to be careful that we always include the word quality because, to a lot folks, business case means rationing when they think about comparative effectiveness research. They hear, you are going to reduce cost. I think the external world thinks rationing is implied in the business case, and that certainly is not what we are trying to do. We always need to be cognizant of asserting that this is improving quality and reducing cost.

Q Expand on the need for systems and population-based comparative effectiveness research. How does that fit within the broader portfolio of the more individual treatment-based, typical comparative effectiveness research?

A *C. Clancy:* When we talk about comparing specific treatments, there are issues that relate to some types of treatments, for example cognitive treatments and relationship building where there are lively debates about how much should be standardized, how much customized, and what is the role of qualitative research. I do not see that as such a huge issue.

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We have no idea how to describe components of a delivery process because, after all, the system we have was built without any thought for that whatsoever. Even in a five-person practice, you often have five individual doctors who have their own preferences. Their staff would tell you how important those preferences are for even minute aspects of how files are labeled. The notion of care processes is never mentioned in medical school.

We are actually going to have to build some vocabulary. Recently, the question was asked, given the current state of science in this area, do you have to have a comparator? My National Institutes of Health colleagues had reached the conclusion that they could not label something comparative effectiveness if one arm was a placebo.

A *N. Pronk:* If there was an opportunity to create or introduce a methodology to actually bring comparative case studies forward, this would be an opportunity for that, where we can look at populations and see how they do and then monitor and measure the context. There is a need for comparative case studies, or case studies in general, so that there is more practice-based experience available for broad dissemination.

A *M. Barr:* At the practice level, most physicians are still focused on a patient. The idea of generalizing for the population health within that practice is foreign to many physicians. First of all, they do not have the data to know where to direct their interventions, and they have not been trained how to do it. That is a big challenge, both in training and in the system-based competencies.

A *D. Fisher:* It is difficult to work as a team when you have been trained to be the person who writes the orders, but the organization of information sharing among disciplines is crucial. I think there needs to be cross-training to foster appreciation of what each discipline does and to become familiar with its language.

Q How do you figure out the right balance between what works across an entire population versus the needs of heterogeneous subpopulations when you are doing effectiveness research? When using data that describes a general population, how do you think about whether it does or does not apply to a particular population?

A *C. Clancy:* The [Agency for Healthcare Research and Quality] is extremely interested in heterogeneity and comorbidity. I would define heterogeneity very broadly to include multiple components of social diversity.

The agency has a very strong focus on priority populations: working with different entities to create data resources for this kind of work now and in the future, to community health centers and other types of sites, and to focusing very specific targeted investments to supplement, for example ongoing centers of excellence focused on racial and ethnic minority issues and people with disabilities. Many of these communities have very different conceptualizations of their own models about the effectiveness of medical treatments.

A *H. Un:* One of the issues in managing population is to subsegment it. In order to sub-segment, you need to have the data, and very often, we have significant challenges in getting that data. About six years ago, we [Aetna] were starting to collect data related to ethnicity, and there was a huge uproar. But based on that data, we were able to identify that certain ethnic groups did not get into disease management. I think we can become more sophisticated about our interventions based on the research. We are going to need to get to a conversation about collecting that information as well.

A *C. Clancy:* Particularly for chronic illnesses, I think one additional distinguishing factor — and this, I think, is often associated with age — is ease and familiarity with various applications of communication and health IT. Teenagers will find the recommendations and preventative

Questions & Answers

services task force as an iPhone application without much coaching. People in their 20s are extremely comfortable with the notion of doing some kind of cognitive sessions by phone. How do we develop and evaluate practical approaches that are customized to people's capacities?

A *D. Fisher:* To be culturally competent is difficult to instill and elicit from people. Everybody comes in with a different culture. We can focus on certain ethnic groups and say they are culturally different. But everybody is of a different age or has different background, especially in this country. I learned that it is as much an attitude of humility and of being a learner as it is knowing the right foods or the right music that go with a particular population.

Q When you see a study that says that a certain treatment works or does not work, how do you think about whether that actually applies to the population that you are working in and whether it might be different across some of the groups? At what point do you feel comfortable with that, and at what point might you feel you need more information, either from the research or from your own internal data?

A *D. Fisher:* I had a lot of people on atypical antipsychotics and started to notice pretty early that they seem to be getting diabetes or gaining a lot of weight. Then it came out in the literature that this was a significant side effect. One thing I have learned is to talk to as many people as possible if you are going to make any changes to medications because everybody — especially in mental health — gets very attached to that medicine.

The research was very helpful and it was objective research that was carried out without any support from a particular industry. We need more of that kind of information. We need it especially in the mental health field. We need a Physician's Desk Reference that is written by people who are not attached to any company. I am confident that, if the information is administered and brought together by pretty objective sources in an understandable form that is very important to the consumer and to the family, we will have better decision making.

A *N. Pronk:* The product resulting from the research tends to be from the best evidence available. Starting with randomized control trials, using criteria that is still acceptable, you get a series of systematic reviews and comparative effectiveness research recommendations that are based on the group average.

In practice, I have yet to meet that average person. You have to build into the design of these programs enough flexibility to work around the average. Added to that, there is a notion of heterogeneity of responsiveness. The same intervention does not necessarily bring about the same result in each individual.

That is where the design of the program is so important. Do not become so rigid in the design that either you succeed or you fail. It is much more about experience and making sure that the experience is exceptional for people going through programs that are intended to bring about a positive effect. If that does not happen, the experience is still good. The process is probably as distinct and important a variable as the selection of the intervention itself.

A *H. Un:* Embedded in your question is an assumption that this is a rational process. Health care purchasing is, by and large, rational; but, especially in mental health, there is some component that is very irrational and driven by the demands of that workplace. What is helpful is to have a clearinghouse of information to make sure that it is consumable by the business groups so that they can then translate that into whatever policy looks like.

A *C. Clancy:* We have not had a report yet that effectively says Option A, thumbs up; Option B, forget it. It is just clinical decision making, very much shades of gray. What we have not done is been very strategic about being systematic in assessing whether a breakthrough result from a clinical trial can be generalized to other populations. A lot of how we make decisions is about beliefs and not a whole lot about evidence.

PANEL III: INFORMATION TECHNOLOGY: PUTTING THE PATIENT AT THE CENTER

Moderator, Jürgen Unützer, M.D., M.P.H., M.A.

Professor and Vice Chair, Department of Psychiatry and Behavioral Sciences, University of Washington Medical Center

I am a great IT health user but I am not an IT health producer. We all know health care is very slow to adopt information technology. We have to be one of the industries at the tail end on adoption, and mental health is even slower, probably 10 or 15 years behind the rest of health care.

“Putting the Patient at the Center of the Information Flow” is the subtitle of this panel. And I will begin with a story about one of my patients. This was a man in his early 50s. He was a heating and air conditioning mechanic. He ran his own business and fell on hard times.

Over a three-year period, he laid off several of his employees and then lost the business. Then his wife died from cancer. This poor man developed a severe, a profound depression and went to his primary care doctor who he had not seen for a long time. The doctor says, “Your diabetes is out of control. You are developing early stage congestive heart failure. I am worried about you.” The man looks terribly depressed and, realizing this, the doctor starts the man on an antidepressant.

Not so sure he should take yet another pill, he does not start that medicine. Four weeks later, he comes back and looks even worse. He is making almost no eye contact and the doctor says, “What are you doing?” He answers,

“I am not doing very much. I am drinking a six-pack of beer every night and trying to forget.”

The doctor says to himself, okay, yet another problem. He is drinking too much and the diabetes is still out of control. The doctor makes another effort to try to start treatment for depression.

One month later the man comes back to the office. He looks terrible and sounds almost psychotic.

“Gee,” he says, “I think everybody will be better if I was not around. I think I am starting to rot from the inside.”

Now he is starting to sound not just depressed but almost psychotic depressed. The doctor is really worried about this man, and says, “I am going to make you an appointment across the street at our mental health center.”

Two weeks later, the man sits in the waiting room of the community mental health center and looks around him. He sees many people who do not look very much like him, they are younger, and there is a guy in the corner who is talking to himself. This man says to himself, “Geez, what does this doctor think is wrong with me? I must be going off the deep end.”

He has an intake appointment with a wonderful, master’s level mental health provider who is an intern and who had just finished her training. He says, “Look, I do not really know why I am here, and I am not feeling good today. I did not sleep last night, and today my right foot is more swollen than it is normally, and it is really bothering me.” This poor intern was really spooked. She looks at him. The man does not look well physically, he looks like he could get sick, maybe even die on her. She tells him he needs to see one of their doctors.

A week later he comes back, same place, and he has an appointment with the psychiatrist. The psychiatrist looks at him and says, “Wow, this guy looks really sick. The last time I saw somebody like that was in my internship, and that was some 10 years ago. I am really worried about him.” He says, “We need to get this diabetes under control, your congestive heart failure is not doing well, and you are drinking way too much. We have to set up treatment for your alcohol problems as well, but that is not something we deal with here in the mental health center. So, we need to get you back to your doctor to get this under control.”

The man does not come back. A couple of weeks later, he drinks half a bottle of Jack Daniels and tries to shoot himself. But he is

drunk, so he misses and ends up in the intensive care unit at our tertiary care hospital. That is where I meet him. He says to me,

“I started feeling like a tennis ball. I went to one place and they shot me across the net because maybe there is something on the other side. Then they said there is another place you need to go to for something else. I do not think they really could help me with any of this.”

The truth is we do not talk to each other. We all do our thing in our little silos.

We reconstruct the story and it turns out that man had had a lot of services. He had been seen in a primary care clinic, a community mental health center, and in an alcohol substance abuse facility where he had had one intake appointment. He had also gone to the Department of Vocational Rehabilitation. They said he had depression, he was sounding psychotic, and he needed to see a psychologist for a psych evaluation before they could do very much with him.

When I said I wanted to ask him some questions about this depression, he got this funny grin on his face. He said, “Well, you know, I have

The practice change is the really hard part because that is what is going to require us to look at our different cultures. We are going to have to look at each other’s languages. We are going to have to learn how to talk to each other.

already been asked questions about depression at six other places in the last couple of weeks. Do you guys not talk to each other?”

That is a fabulous challenge. The truth is we do not talk to each other. We all do our thing in our little silos. I do it in the mental health side. Somebody else did it in the primary care side. Somebody else did it on the alcohol side. We do not talk to each other. And then, he had a much harder question for me. He said, “I have had six assessments asking me these same questions. When does the treatment start?”

I have spent most of my career thinking about getting primary care providers and mental health providers to work better together. I have been

working at this interface for a long time. I grew up in postwar Germany, a time when there was nothing much to feel good about being a German. My generation really embraced this notion of being European, not being German or French or something else. We worked very hard at making this a reality. My parents said, “Are you crazy? Germans and French people talk different languages. They have different cultures. They eat different foods. They have been killing each other for hundreds of years. You have to be out of your mind.”

Well, it turns out that is not the case anymore. We now have the same currency. We do not have any more borders. We can have kids go to universities across all these different countries. If we can get Germans and French, who have been killing each other for hundreds of years, to talk to each other, we can probably do that in some other silos as well.

We have 25 years of research that shows us you can integrate mental health in primary care. In the last five years, we have begun to see some movement from research to practice. In Minnesota, we have the Diamond Project where there are now 80 or more clinics doing integrated care. We have Hart Foundation–funded efforts in Texas where we work with five communities to integrate care. We also have the National Council Collaborative partnering with mental health and community health centers.

Are there challenges in doing this? Many challenges. We need policy changes to make this work, and we need payment reform. We can make the policy changes. The practice change is the really hard part because that is what is going to require us to look at our different cultures. We are going to have to look at each other’s languages. We are going to have to learn how to talk to each other. And that patient of mine, he actually gave us the challenge. He said, “Do you guys not talk to each other?” Health information technology can help us talk to each other. It can help us share information, and it includes the patient in that information flow.

RESPONDENTS

Robert Kolodner, M.D.

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Iwant to share an observation, an underlying concept, and a prediction for the future.

An Observation: The successful electronic health records adoption by organizations, providers, and individuals is very much akin to successful mental health and substance use treatment and recovery. In both cases, you need to engage the patient or client in the process, and peer interaction may actually help to boost the success of that effort.

Underlying Concept: I led a group that developed the mental health software for nationwide use throughout the Veterans Administration (VA) in the early 1980s, when I was at the Atlanta VA. When we released the software in 1985, it was the very first clinical software package that the VA had deployed and made available nationwide. The mental health area was the first clinical area in the VA to benefit from these new information technologies.

As a result of that effort, I developed the belief that the fundamental health IT a provider needs — whether it be for treating mental health, substance abuse, or any of the medical or surgical problems — is very similar across the specialties. We in mental health have unique challenges in terms of funding and the biases our patients face, but our information technology needs are pretty much the same as for the rest of medicine.

A Prediction: We have been hearing a lot about peer-to-peer support, the impact of positive attitudes and hope, and the importance of relationships for helping people successfully change their lives. Those characteristics are also what we are seeing emerge on the Web among the youth. The personal use of health IT by individuals, their families, and their significant others may be the most powerful driver for transformation and change in the health care delivery and support system and may turn out to be the source of the drive for our true national health care reform.

All of us have a role, a contribution we make in mental health and substance abuse treatment, or in other disciplines. That is the hat we wear. Take that hat off for a moment, and be aware that we have another hat underneath. It is the hat we have in common: we are all recipients of care from our health care system. We may have different conditions, but we are going to receive care and have the same questions and challenges.

“What is the quality and the value of the health care services that you demand for yourself, and for your loved ones, and for your friends and neighbors?”

“What is the quality of health — not health care but health — that you want and deserve for yourself and your loved ones?”

Problems with Information in the Health Care System

Health IT is a central strategy for health care transformation. Some of the challenges relate to information or, more specifically, to the lack of information made available, that leads to unnecessary hospitalizations. The absence of information also leads to unexecuted orders, which means the care was not delivered as planned. An incredible waste is that about 20 percent of tests are duplicated because the previous results cannot be found or retrieved and brought up in a timely manner. There are also avoidable errors, such as drug errors, that occur far too frequently. Even when they have the information, providers cannot keep track of all the interactions among these drugs.

Safety and Quality

The Institute of Medicine report talks about the 98,000 patients who die from avoidable errors each year, and the quality issue is even greater than the safety issue. Many deaths that occur from problems related to quality are not counted in the estimate of avoidable deaths. For example,



if someone with chronic lung disease gets an immunization for influenza and for pneumonia (Pneumovax), their death rate decreases by 80 percent.

In 1995, we had an influenza vaccination rate for vulnerable patients of only 33 percent in this country. That meant many people died unnecessarily, yet their deaths were not counted in the total avoidable deaths because they were not caused by an “error.” Instead, they were the result of an omission, and that is in the quality arena. Omissions, too, feed into the poor quality of care and can lead to unnecessary hospitalizations.

Most of us will get on an airplane without thinking because we know it is safe. You can see from the error rate that it is incredibly low, as it is with luggage. Airlines handle a lot of luggage yet we complain bitterly about lost luggage.

The best we do on any of our quality measures is giving immunizations — somewhere between 70 and 98 percent. According to the Rand Study, you have a 55 percent chance of getting evidence-based care wherever you get care across the country. That is where the quality and reliability of health care are compared to a variety of other activities, and the health care system touches almost everyone’s life.

The need for health IT has been recognized in mental health. The President’s New Freedom Commission on Mental Health goal six states:

“(1) Use health technology and telehealth to improve access and coordination of mental health care, especially for Americans in remote

areas or in underserved populations. (2) Develop and implement integrated electronic health record and personal health information systems.”

Because of the fragmentation of the mental health system, we need the technology to tie together the information. The commission report specifically targets the electronic health record and the personal health information systems.

Privacy

In mental health and substance use, we say we have special privacy requirements because we have sensitive information.

However, when you talk to providers in other specialties — more importantly, when you talk to the individuals who have a variety of different conditions — there are several other conditions that people do not want disclosed, such as infertility treatments and HIV. Each of us has sensitivities. Privacy and security concerns are not just limited to behavioral health. There are a variety of consequences that could occur if there are breaches in security or if our genomic data is stolen.

The real concern we have is consequences: stigma, loss of job, or bias preventing us from getting a job or being approved for insurance, or other kinds of adverse outcomes. On the other hand, if we let this fear stop us from having our health information available, we could have some other, very real consequences.

Emergency Access

When Hurricane Katrina hit New Orleans, everything was disrupted. People lost their homes. Those who had chronic illnesses often lost all of their medications and access to their medical records. There was a quick, self-organizing effort among pharmacies and health delivery organizations to put together an emergency information resource called Katrina Health. It enabled medical staff across the country to retrieve the outpatient prescriptions for individuals affected by Katrina so they could have their conditions treated — except if you had a diagnosis of mental health or substance

abuse or chemical dependencies! Those drugs were not put on Katrina Health and were not available to health care workers.

But there was one exception: veterans with behavioral disorders. The VA did have electronic health records. Twenty-four hours after Katrina hit, veterans treated at VA facilities along the Gulf Coast who were dispersed across the country — even those receiving mental health or substance abuse treatment — had their records and medications available to emergency medical providers.

Intervention

Chronic illness for most individuals occurs at the end of life. For some people, mental health problems and developmental disorders can occur at any time of life. One problem with our health care system today is that, until very recently, it has been built almost completely around intervening and reacting very late in the stage of illnesses. That raises the cost and is also inconvenient.

If you think about the amount of information we are unable to handle today just providing chronic care interventions, imagine what it is going to be like trying to do prediction and avoidance based on huge amounts of genomic data and trying to correlate a person's unique profile with the literature. We already are overwhelmed. Without IT, we will not be able to handle that at all.

What we really want from health care is to stay healthy. We want prevention. We want to take care of ourselves as much as possible and not have to go somewhere for treatment. When we have to get care, we want it to be convenient and of high quality, with coordinated care. To receive that level of care, we need to be able to move our health information across providers throughout our lifetime.

A patient I treated as a psychiatric resident had a history of having a manic or depressive episode every 17 years. However, the hospital archives the records after three or four years. Each time he had an episode, you could not review and learn from what happened before. And yet, that information needed to be available throughout his lifetime. From a patient's viewpoint, sharing my health information among providers needs to

be something I trust. I need to be confident that access occurs for whomever I want, whenever I want. I get to choose. It is about better health, not about the health care.

One of the reasons why I talk about the future of “health and care” and not “health care” is the idea of it being person-centered, not patient-centered. We should not limit our attention to helping people because they are already in care or in need of care. We should be supporting health throughout life, whether a person is healthy or not, or receiving health care or not.

What we really want from health care is to stay healthy.

Health IT

As far as health IT, it is the health information that is most important. The technology is needed not only to retrieve it but so that when I, as a user, have the information, I can integrate and use it. Whether I am a healthy individual, or one with an acute or chronic condition, a caretaker, a health care provider, a public health worker, or a researcher, I can see the most important information and not be overwhelmed. As a health care provider, I want something much better than I have now, not simply the equivalent of a thick chart in front of me. I also want to have the tools to be able to access the relevant research literature information.

In order to achieve individual and population health and well-being or wellness, there is a whole health care transformation that needs to occur. That involves changes for both the care provider as well as the individual. Population health improvements require changes to advance public health, quality monitoring and reporting, comparative effectiveness research, as well as our emergency preparedness and response.

We should not limit our attention to helping people because they are already in care or in need of care. We should be supporting health throughout life, whether a person is healthy or not, or receiving health care or not.

Access

The information systems supporting this transformation must have the capacity to access and use the information and integrate it across sites

where it is stored. As much as we have talked about coordinated care between primary care and mental health, we need to be able to move the information across all health care providers.

There are three types of health IT applications that are most prominent:

- Electronic health records or electronic medical records, the tool individual health care providers or health care organizations use when they are delivering care.
- Personal health records that individuals and their caretakers use to manage their health.
- A whole set of population health information tools that are needed by researchers, public health workers, and others.

For these applications to work, we need the rest of the big pieces of health IT — the standards and the network. Without these, you have a Tower of Babel, even if you could move information across. Security and privacy have to be at the heart of their design and implementation.

IT Users

There are three clusters of health IT users:

- Health care providers with their EMRs [electronic medical records] or EHRs [electronic health records].
- Individuals and the whole “personal health” arena.
- Population health.

For each user, there are real health IT transformations and advances being made, but we still do not have the needed IT tools and information. The big change we need for health IT to be used pervasively throughout the care system will take a lot of work. It is not going to be easy, and we need to do it in a way where we are not paying all of our money into the IT systems. They are there to enable, not as an end in and of themselves.

Funding

What has changed since last year is that suddenly there is some funding. A portion of the stimulus bill, called the HITECH Act, is comprised of two parts. One part designated \$2 billion to the

Office of the National Coordinator. The previous budget had been \$64 million annually for the past few years, and it had been going down slowly in terms of absolute dollars. The HITECH funding increase was quite a jump. These dollars are allocated to get the infrastructure in place and includes grants to communities, workforce development, and other investments.

The second part, through Medicare and Medicaid, provided money into the system of care delivery for changes. The amount of funding can only be estimated, because the bill provided for a payment to providers as an incentive for them to do certain things. Therefore, you had many people trying to calculate how many providers would meet it. The official estimate was about \$17.2 billion “net,” meaning that close to \$35 to \$40 billion dollars would be paid out. Over 10 years, the accrued cost savings would offset the expenditures to bring the cost down to \$17 billion net. The amount is still less than half the projected cost to fully populate all health delivery sites with health IT.

The result: Right now, at least in the area of health records, some care providers are paying attention. There are several new terms, initials, and acronyms; new policies and standards committees; and discussions about “breach notification.” But the term that is standing out among all the rest is “meaningful use.”

This term holds the key for an individual practitioner, a hospital, or a health care enterprise to get HITECH incentive money. Total payments can be up to \$44,000 for an individual practitioner under Medicare, up to more than \$60,000 for Medicaid providers, and millions of dollars for hospitals. To qualify for that incentive money, they need to be a meaningful user: a provider who makes “meaningful use” of a certified record while also reporting quality and exchanging information.

Business Model

There is potential opportunity for dramatically dropping the cost of health IT systems for providers. Clay Christensen writes that a quantum improvement in health care requires a disruptive technology, a new business model, and a whole new ecosystem — a network of new companies supporting that business model.

Recently, he said head-on competition drives up price because, to win in head-on competition, a company adds features to its products. You compete in the current marketplace by adding new capabilities.

We have been experiencing and seeing IT price reductions today. My cell phone is more powerful than my desktop computer was just a few years ago. In some mobile phones, there is a complete computer, and mobile phones are going to get even more powerful. This has changed the way we do our activities. There will be continued improvements in IT generally that we will be able to apply to health.

There is a whole social network community we have been hearing about. There is “Web 2.0” and a “Health 2.0” where individuals with similar conditions post their records on the Web for all to see! Privacy and security? It is their record, right? This is not a HIPAA issue; they can post it. The largest collection of data for a patient with Lou Gehrig’s disease is actually a database that patients put together. We hear themes of peer-to-peer activity, of discovery, of support. People are forming relationships through computer interactions with other people in their online community. It is a new world.

Open-source software is another new business model. Instead of making a profit by locking users into a proprietary solution, a company can offer low-cost software. Companies and users can then work to create the very best electronic health records or personal health records together, as a collaborative group of thousands or millions worldwide. Participants who need a business opportunity can sell support and services configuring health IT products and help the community move forward. But open source does not mean free. It means lower cost and an opportunity to collaborate, to innovate, and maybe, to unleash the creativity we have within us by interacting with one another.

The transformation of health is really a change in the locus of control — moving it to where the users of health IT products and the individuals who are receiving care can become an

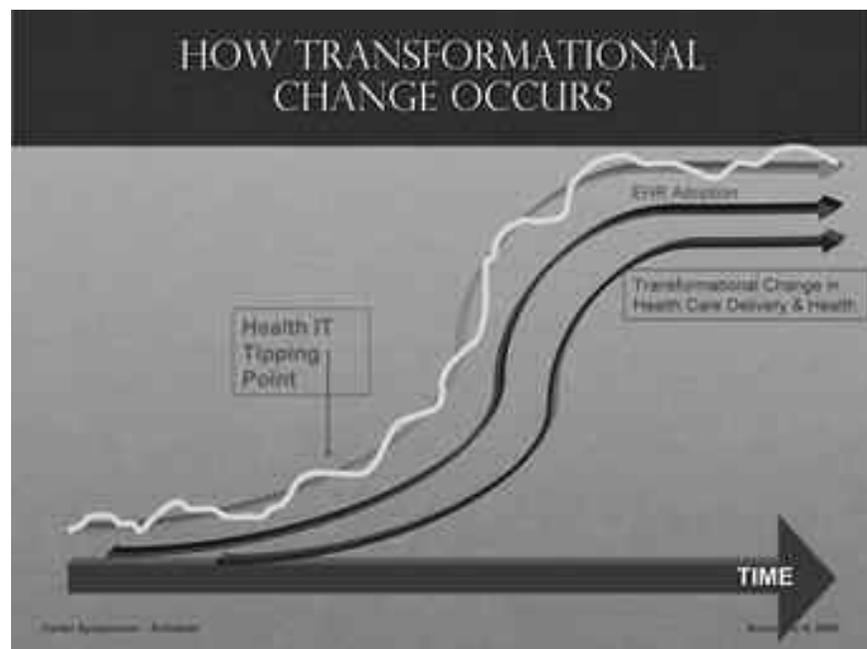
active part of the improvement process and can even help to drive the change.

I want to share with you three

quick concepts that capture what we all experience. One concept is summarized in the usual sigmoid curve. Sometimes we feel as if we are going forever, and it is flat and nothing seems to be happening before things suddenly start to take off. Someone pointed out that this is not only a curve for how change occurs. It is also the growth curve for a pumpkin and most other growth that occurs. If we look at farming as an example, after a farmer plants a field, nothing seems to be happening, but there is really a lot going on that is unseen before plants become visible and growth suddenly takes off rapidly.

The smooth green sigmoid curve (see graphic on this page) depicts where we are at now, the changes that we have been pursuing to increase the use of health IT. However, even when that tipping point occurs in provider attitudes and motivation, it takes a while before most health care providers are using electronic health records or individuals are using personal health records. And once that happens, there is a period of time for them to get comfortable with this new resource before they start innovating and

People are forming relationships through computer interactions with other people in their online community. It is a new world.



transforming. Therefore, this is a process that takes time, and as change agents, we need to be aware that it will take a little time to make progress. Nothing is quite as smooth and straight as these curves depict. When you are one of those plateaus shown on the wavy green line, you need to keep pushing on, believing that the change is going to occur.

The second concept provides insight regarding the accuracy with which we can predict the impact of personal health records and about changes health IT might catalyze within health care delivery. Our challenge is similar to what you might have been thinking about the Internet and the World Wide Web when you first heard about it in 1994 or 1995. What did you imagine it could become? Maybe an easier way to get some information? Who could have imagined the kind of changes that have happened. First, ways to get the information, then starting to buy, and then starting to create. This is the kind of transformation that having health IT tools in place, once we get comfortable, can really help us to transform — not just reform but transform — health and care in a person-centered manner; for example, to help people “get to recovery” and to improve their health.

The third concept highlights a repeating pattern. The concept happened to be applied to new medical treatments and depicted the process that new ideas go through: first, rejection and then boundless enthusiasm, such as thinking that a new treatment is going to cure the world, before finally achieving an accurate understanding of benefits, risks, and limitations of the treatment. For example, early in our residency, my fellow colleagues and I were ready to recommend that societies put lithium in their water supplies, so that the world would be better because of its beneficial effects. And then we learned about more and more side effects and all the bad consequences, so many doctors and patients became disillusioned with lithium as a treatment for bipolar affective disorder, and finally, we reached a better understanding of where and how it should actually be used.

More recently, an organization named Gartner has been making money by selling insights gained from their “Hype Cycle.” It looks awfully familiar. It is the process that we go through as a

society for almost every idea. It happens to apply for technology. There is a trigger, the peaks of inflated expectations, the troughs of disillusion, the slope of enlightenment, and then figuring out how to actually use it. It also applies to reactions to proposed changes such as medical home and for other concepts that we are looking at such as peer support. I found it also tended to be pretty accurate for predicting the cycle of the polls for a presidential candidate, inevitably going up and down. And if you think about the predictions on the likelihood of success in the current health reform activities — where we are at any given time — we will know when we get the outcome of the legislative activities which prediction was made from the trough perspective and which one was actually accurate.

When we achieve the health success we all need, which will especially help the fragmented health care delivery system we have for mental health and substance abuse conditions, all of us — you, me, our loved ones, friends, and others — will have safe, high-quality, efficient, convenient care wherever we are. At that point, health IT will be woven into the fabric of both the delivery system and the whole support system. We will be able to choose where and to whom that information is available, and we’ll have the tools necessary to use the information we have to help us make informed choices for our health and well-being. We will need to trust that our privacy is protected when we have a successful health information system.

As I conclude, I want you to go back to when you had taken your hat off. Remember that this health IT is an enabler, not “the answer.” It is necessary, but not sufficient, for us to make the improvements we want in the quality and value of health care services — and most importantly in the quality of health — that we want for ourselves and our families. Now if you’ll put your professional hat or your advocacy hat back on, let’s figure out how we can work together to make sure that we have health IT in place, because without health IT, we will not be able to achieve the rest.

Ronald Manderscheid, Ph.D.

Director, Mental Health and Substance Abuse Program, SRA International, Inc.

Language and words have a huge impact on what we do and how we live. In the health information technology world, we have not gotten there yet. Rob Kolodner has presented a wonderful vision of what is possible with health IT at the personal level and at the population level. A critical part of that is that IT is democratizing, it puts everybody on an equal footing. However, we currently are adrift in an old, rickety, paper boat on an electronic ocean, during a tempestuous electrical storm.

Currently in behavioral health care we waste about \$13 billion a year processing at least 1,000 different forms for claims payments, and all of them have different coding systems. We have not begun to make the translation to the e-world. This shows in how we organize our work and in how we do these claims. We are controlled by fear and misunderstanding. We are controlled by regulation. And the net consequence is we have done nothing in this field to move this agenda forward.

Why is this so? We lack the needed leadership at the national level. We have no plan regarding our destination. The behavioral health field is not connected to the broader health IT world, nor are we connected to the health agencies that are beginning to do this. This is about relationships.

The standards rescue boats are too little and too slow. There are standards from Certification Committee for Health Information Technology and other things. They are on the way, but it is taking years to get us there. We are not there yet.

We do not have the necessary resources to do this in behavioral health care. To completely move the health system to electronic health records and personal health records will cost about \$400 billion. We have just begun to make the initial down payment.

How can we begin to change this? We need a national plan for behavioral health care for how we are going to move this agenda. An essential element in developing that plan is that it be based in a leveling, democratizing approach. This is to ensure we understand that what we are

about is working with, and empowering, consumers, helping them to help themselves moving forward. IT is ideally suited to do that.

The health home concept can be the paradigm for what we ought to be doing in IT. We have exactly the same problems in IT that we have in the health home. We have problems of relationship and problems in models. We also have problems regarding how consumers and families will have a major role.

We need to include linkage with the health IT world. The

whole new movement of shareware, or open-source software, is very important to us. Out there in the grass roots we are beginning to say we ought to use shareware because it is much cheaper, it is developed. We ought to be using Vista software in our mental health and substance abuse operations. We ought to be building health information exchanges at the secondary level out of shareware. There is an opportunity to include these things in our plan. We need to have a plan.

I do not think that we can get there with the current federal legislation. We need new legislation. We need new funding in this area, and we need people at the federal level who are qualified to work in this area who also understand behavioral health care.

In drafting this legislation and revamping at the federal level, we have a wonderful opportunity to use personal health records. Personal health records are tools that belong to consumers, tools they can use to manage their own care and their own relationships. This is a very important tool that is very friendly to behavioral health care.

Beyond electronic health records and personal health records, we also need to understand virtual clinics — electronic places that people can go to for information. They can do self-

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The standards rescue boats are too little and too slow.

assessments and self-care, either through smart systems or avatars or even telephonic care. The Department of Defense has pioneered these. There are hundreds of millions of dollars a year being put into development of these virtual clinics. We also need decision support systems and decision support tools that translate comparative effectiveness research into meaningful use at the clinical level.

Michael Best, Ph.D.

Assistant Professor, Sam Nunn School of International Affairs, Georgia Institute of Technology

I am going to address the issue of the role of information technology in behavioral health in the absence of a mental health sector. I also want us to think more broadly about information and communication technologies in the service of mental health issues, also in the absence of a mental health system. It goes to the issue of striving for health and wellness, not health care.

In a video segment created by Sam Togbeh from the West African country of Liberia, he talks about his experience during the Liberian civil conflict. Many of you know Liberia recently emerged from 14 years of brutal civil war.

A brief profile: Togbeh lives in Congo Town in the suburbs of Monrovia, the capital of Liberia. He is an ex-combatant. He went through primary education, perhaps to the fifth grade. He is not print literate or computer literate. He engaged in the United Nations' Demobilization Disarmament Reconciliation and Reintegration Program, which tried to bring him back into his broader community. And, he is a goalkeeper for an amputee soccer team.

To make the video, Sam used a system that we developed at Georgia Tech called the Mobile Story Exchange System. An interactive digital media system for browsing and creating stories, it is designed to allow all Liberians to share their personal recollections around the civil conflict, but really around anything of interest to them.

This is a broader initiative exploring the role of rich digital media and information technologies in post-conflict reconciliation and reconstruction, essentially asking whether IT can

So, we have a major agenda here going forward. We need to have a national plan and we need people to step forward who are willing to volunteer time to develop that national plan. Action is urgently needed. Our paper boat is becoming saturated with water and is sinking.

help a nation heal after civil conflict. We have worked very closely with the Truth and Reconciliation Commission of Liberia. It is work that we also have done very closely with The Carter Center.

As Liberia continues this massive job of rebuilding its infrastructure after 14 years of civil conflict, psychosocial services have been almost nonexistent, even in the presence of demonstrably severe and endemic mental health challenges.

Post-traumatic stress disorder is important and major among those challenges. It was widely reported that during the civil conflict and during much of the demobilization process, there was one sole mental health professional in the entire country. During the Demobilization Disarmament Reconciliation and Reintegration process, efforts focused primarily on taking guns away from the ex-combatants but not on addressing the former fighters' psychosocial challenges.

In contemplating the role of information technologies as tools for this kind of psychosocial development, and in the absence of a mental health sector as we think of it, we are using theories of truth and how truth telling can form a core restorative and healing process. For instance, the Mobile Story Exchange System allows individuals to offer narrative truths. They are able to share their own personal stories as a powerful and, we believe, critical aspect to post-conflict reconciliation and national healing.

We have been able to measure the effect the use of interactive digital media systems has had. The General Self-Efficacy Scale is a

psychological self-inventory. We were able to show that the use of rich information technology systems provided a 25 percent increase in the Self-Efficacy Scale in people's sense of their own capabilities in the presence of difficult circumstances. And these impacts on self-efficacy were not related to whether the individuals liked or appreciated using the information technology but were related to the impact of the civil conflict on the individuals. In other words, the more harm they had experienced during the war, the bolder their impact on using the information technologies.

James McNulty

Vice President, Peer Support, Depression and Bipolar Support Alliance

I am an optimist, but I am going to say some things that are not going to be all that optimistic.

The consumer community has used narrative for many years. We call it recovery storage, recovery narratives. We use it with one another to heal and to help lead our peers. Those of us who may have started in recovery 15 or 20 years ago help those who are still finding their way. I think that may be a universal quality in subcultures or cultures that have had major traumatic events. A mental illness would be a major traumatic event in just about anyone's life.

Lately, I have been part of discussions in a variety of venues where I have seen lip service given to the idea of putting patients or consumers or persons "in the center." But then, after the obligatory, "Okay, let us bring them in and put them at the center," the talk gets down to the real technical details of how we do this. That disappoints me. One of the things I have observed over many years is that when you do not bring the people in to help you design a system that they will be using, you end up doing it badly. It often does not work well for them. I would caution everyone to make sure that consumers and patients are truly at the center. And that is going to require a complete change in how professionals view the world.

At one meeting, where we were talking about the future of mental health, my friend said we were "blue-skying." He said, "My vision 20 years

We need to think beyond the United States and in contexts where the absence of behavioral health services still can be served somewhat by information and communication technologies.

We were able to show that the use of rich information technology systems provided a 25 percent increase in the Self-Efficacy Scale in people's sense of their own capabilities in the presence of difficult circumstances.

from now is to have no psychiatrists." I thought about that and I understood where he was coming from; I do not agree with him. I do not want to be my own psychiatrist. I have enough trouble taking care of the rest of my life, never mind prescribing for myself.

But I understood what he was saying, and I do not think it is necessarily the fault of psychiatry. If you look at medicine in general, there is a rich literature by doctors who have had the miserable experience of having to undergo treatment in a medical facility.

Universally, they were appalled at how bad things were. They could not believe the treatment they received and the indifference with which they were treated.

This is not psychiatry, this is general medicine. If you do not have a system that really does put the needs and the desires of the people who you are allegedly serving at the center, then you are going to continue perpetuating a system that, in spite of all the bells and whistles and fancy technology, is not going to change much.

If you do not have a system that really does put the needs and the desires of the people who you are allegedly serving at the center, then you are going to continue perpetuating a system that, in spite of all the bells and whistles and fancy technology, is not going to change much.

I am a great believer in technology. The fact of the matter is the Internet is neither good nor bad. It is, and can be used for, good. It can also be used for bad. Technology really can be an enabler, but it is not the only answer.

Technology really can be an enabler, but it is not the only answer.

Many of the people with whom I work, my friends and the people I care about, live on the other side of the digital divide. They do not have access to the things that many of us take for granted, like the BlackBerry.

How do we truly engage people and put them in the center? I can tell you from personal experience that when you are a patient in a psychiatric facility, they have a way of putting

you in the center, or they did. They would put you in the center of a circle of clinicians, all of whom would ask you questions, trying to diagnose you, trying to figure out what your problems were. There might be 10, 15, there might be 20, depending on how treatment resistant you were. Very often we were seen as part of the problem because we were resisting the treatments.

Dr. Green used the phrase, “We are not going to put the genie back in the bottle.” There are two genies we are not going to put back in the bottle. One is the idea of bringing primary health care and mental health care closer together, which I think is a worthwhile goal. The other is recovery, and the concept of recovery. Mental health consumers and substance use consumers believe we can have a life.

In February, Ron Manderscheid presented at a meeting and said something I thought was very profound. He said the mental health movement has a lot to teach the rest of medicine, which is the idea of recovery. The professionals are not the ones who are going to teach recovery. The consumers will have to teach it. Now, there may be professionals who are in recovery and they can certainly help. But that is not something that we can surrender to other people because, frankly, it will not be done right.

Johns Hopkins gets 10 percent of its coronary patients to adhere to any form of treatment that will reduce their angina. Ornish, with a simple little program — a vegetarian chef, radical diet change and exercise — gets 80 percent adherence over a five-year period. That is remarkable. Why are we not using it? I have been seeing a cardiologist for the last four years. She has never mentioned Ornish to me.

Think about what Alan Deutschman said [about influencing cardiac patients]: we use facts, fear, and force. Now think about the other part, the three Rs: relate, repeat, and reframe. I beg you, do not forget the terms and do not forget that you really have to put the person at the center, in spite of all the bells and whistles.



Tom Trabin, Ph.D., M.S.M.

Associate Director, Adult System of Care, Alameda County Behavioral Health Care Services

A huge team of people throughout the country is working on health information technology and electronic health record systems. This team is there to improve the lives of the clients who we serve in a very dedicated way. That is the core value.

I have been involved with three projects that, together, illustrate how a very large public mental health system can, with widespread adoption of health information technologies, accomplish great things. The backdrop for these projects is California's Mental Health Services Act, which passed about five years ago. It is a "millionaire tax" that brings approximately \$1 billion of new revenues into the state public mental health system every year. Its core values include system transformation and helping with consumer wellness and recovery. The funds have to be used for that, not for bolstering existing elements of the system.

A percentage of that amount every year is targeted specifically for building a health information technology infrastructure. The state has defined transformation with regards to IT, not exclusively but most notably, as electronic health record systems. This is the overall message that I want to convey: with sufficient, targeted funding, technical assistance, standards, and leadership to hold the vision, we can accomplish great things through widespread information technology adoption to improve the care and lives of the clients who we serve.

Project #1

The first project is an annual conference on behavioral health information technology. It is now the largest in the country and has been going for 10 years. What I want to share with you is not so much the conference but the planning process, which involves about 25 constituency groups, each of whom appoints the person they want to represent them on the planning committee. These groups include consumer, family, and provider organizations, as well as county, state, and federal agencies.

Separately and together, they generate several ideas first. This year, we had 80 ideas for topics. Part of my job is to blend these together into cogent presentation sessions. We came up with about 25; sometimes it is more. I give it back to them to rank order the topics. Every year, I have great confidence in the collective rank orderings as being truly representative of the issues we face with regard to health IT .

Some changes have occurred over 10 years. The first five years preceded the Mental Health Service Act, which preceded former President George W. Bush's executive order calling for the health care field to adopt the electronic health record within 10 years. In the last five years, both initiatives began to take place.

Here are some of the changes that I think mirror what we are going through as a nation.

Perennially, there have been topics about how to select and implement health information technology. However, the code words used initially were Management Information Systems, and Health Information Technology. It was only in later years that we started using the words electronic health records. Earlier, people were concerned with billing systems and scheduling systems. It did not seem feasible that we could get to actual clinical functionality.

We moved from electronic health records to personal health records and then to how we use these new modes for improving care. Years ago, there were no presentations by consumers and family members. We moved to having both groups on the planning committee and as presenters. We also developed scholarships to bring in consumers and family members to speak out from the audience as well as to make sure everybody else hears that important perspective.

We began the conference without much attention to standards, an unpopular topic. We moved into privacy and security, which have remained issues. But then, we moved into the HL7 electronic health record functional model standards and into the Commission for

Certification of Health Information Technology Standards interoperability. How are we going to talk to each other across counties?

We moved into electronic signature recognition, so it keeps evolving.

Initially, we did not talk about data; but as people are developing electronic health records, all kinds of possibilities presented themselves. More recently, the topics have grown into how do we use data from electronic health records systems for performance measurement and quality management?

For many years, we have had federal and state officials coming to talk about the latest in policies. This year, the committee did not vote for speakers from state and federal agencies. Instead, the highest ranked topic was “New Models for More Closely Coordinating Physical Health, Mental Health and Substance Abuse Services: Implications for Health Information Management Systems.” The message here is that, as an electronic health information infrastructure is built systemwide, issues evolve toward more use for improving the quality of care.

Project #2

The next project is an emerging coalition of the majority of the 58 counties in California. They have to buy into this coalition, and the first work of the coalition is to design the content categories within treatment plans.

Within that format, a pick list or libraries of examples of what to choose from, enables case managers and consumers to select what is most fitting for a treatment plan. It can include a client’s own words. It need not be constraining but, if there are things from the pick list, then those act as data points that can serve as a base for decision support, prompts to help guide what a clinician and a consumer might choose next. It can also act as data points for progress and measurement of outcomes.

Encouraging consistency and quality of documentation that will pass muster with Medicaid auditors is a dilemma in California and nationwide. It is even more daunting in California to be able to document to those requirements and also to the Mental Health Services Act.

As a coalition, producing these pick lists will help enormously to streamline training and documentation and help consumers and case managers work more closely together. It will also provide an interoperable standard throughout the state as clients bounce back and forth, some between counties that might have different kinds of software.

Our field has been notoriously backward in being able to generate and agree upon standards for content. We need, among other things, to have content that we can put in as a pick list in the treatment plan module. Most of the existing software does not have that at this time.

Project #3

The third kind of project is the personal health record. The HL7 personal health record committee recently developed a national, functional standard for personal health records that is now registered with the National Institute for Standards and Technologies. It is there for testing and use.

The first personal health record to develop a profile and register it is a behavioral health personal health record (PHR), called the “health authority based PHR” because it is a record for the public health and mental health system. It is nestled within the network-of-care websites that are now spread across 486 counties in 24 states, with 322 of those sites and counties focused predominantly on mental health. This site has been touted in the President’s New Freedom Commission Report on Mental Health as a model of how to use information technology so consumers provide more ready information to them — not only the issues and cutting-edge practices in behavioral health care but also on how to navigate through the confusing bureaucracy of the public mental health system.

There are thousands and thousands of consumers who have gone to the personal health record within that set of Web offerings and have made initial entries. But the rate of return to that is fairly low. That is typical of personal health record systems throughout the county in the general health care arena. There have been efforts by insurance companies, by Microsoft, Google, and by major employer groups to give

personal health records to consumers and have them use them. The uptake has been notoriously challenging.

Conclusion

I want to underscore that to get to a point of using elegant health information exchanges, regional health information organizations, and electronic health records with clinical decision support, we start with a rather unromantic, slow

building of an infrastructure of health information technology and then an electronic health record system shell. That foundation is essential before we can build upon it. We need leaders who keep the vision alive and in front of people. Those of us in the behavioral health care field must be at the table as recipients of the kind of funding and technical assistance support that is now becoming more available to our whole health care system to enable these wonderful things to happen.

Questions & Answers

Q All these different IT efforts may need an IT or IT health care home. Where are the leadership opportunities there?

A *R. Kolodner:* State mental health and substance abuse agencies have decided that they want to adopt the Vista software for application in their state hospital system and, sometimes, to extend that to the community system as well. There are for-profit firms purveying this software, which cannot be sold. A lot of technical assistance is needed with this, as well as adaptation of the software into the context. There is movement going on but it is a grassroots-initiated movement.

A *T. Trabin:* Some vendors who serve the behavioral health part of the VA software are thinking about purveying it out into the community, outside the VA. They have to pay attention to some complex billing and reporting requirements for folks with whom the VA does not have to work or worry about. Some things can be standard across our field, but many other things need to be implemented and configured locally for local and workflow needs.

The major cost of implementing software tends to be not in the product itself but in the local configuration and in the support and the upgrades. That gets to be very involved for an individual organization. I would not encourage an off-the-shelf “plug and play.” Many who have considered it have been rudely awakened and found to be sorely unprepared.

About leadership: We need leaders to write and publish, speak and lobby, and hold discussions with trade associations. This will help educate all of us on what is involved with selecting and using well this wonderful electronic health record.

We also need lobbying efforts with standards organizations that will be shaping our products and, most important of all, lobbying in Washington because we are left out of significant benefits within American Recovery and Reinvestment Act. And, we are not part of the Centers for Medicare and Medicaid Services reimbursement incentives for those who use electronic health records.

Q Treatment and recovery data for children and adolescents with mental health substance abuse may be in schools, child welfare agencies, juvenile justice, and in other kinds of child-focused social service systems. How do we interface with these systems and health IT?

A *R. Manderscheid:* Person-centered health IT needs to adhere to a person and not to a provider. That is absolutely critical. If it adheres to a person, then it can transcend specialty mental health and health care and can move through social services and so on. If it adheres to a provider, you have problems with translation across different systems.

A lot of development is going on with respect to children. Part of the development of virtual clinics is from people who work with children and who are going online to learn what is going on with respect to that work and to do assessments. A tremendous volume of activity is generated in that area, but not necessarily out of the behavioral health field. More likely it is out of the Department of Education, Head Start, and other programs.

A *R. Kolodner:* Activities are being developed nationally that we need to be aware of, to see how they evolve. The network for connecting across different communities was designed to be secure and to implement personal choices about whether they want their information to flow. But it was not restricted to just health care entities.

The first live use of that network between two entities, a section of Virginia and Social Security, was a non-HIPAA [Health Insurance Portability and Accountability Act] release of information so that the individual could get his disability determination faster and begin getting insurance coverage. And the community began getting its money faster.

There is no reason why that same release could not go to other entities because it is the individual who is releasing it. We had begun some discussions early on with the Department

Questions & Answers

of Education about whether this could be something that would allow them, with the person's permission, to get the records they need.

Generally, people seem to feel they should own their own health record. Now, I can see several practical difficulties to ensuring that that happens. But conceptually, it is the way I would like to see things go.

A *T. Trabin:* There are some excellent treatment planning software modules that are focused on assessment and treatment planning for children and adolescents. And, in a treatment planning coalition taking place in California, there will be a children's service workgroup, as well as a transitional age youth workgroup, an adult workgroup, and an older adult workgroup, recognizing that different content is needed for each of those age groups.

A broader question here is, what happens in the electronic health record system to those folks who are providing services out in the field? We have tablets, we have ways to enter and upload data into a more central system in a wireless and secure fashion. Now we also have electronic signature pads a person can take along to get signatures and upload that as well.

Q If there is a personal health record for an adolescent, who owns that record? The adolescent? The family?

A *R. Kolodner:* This issue of what happens when the parent is taking care of the record and when that changes over gets caught up in the politics of the day, specifically in the abortion discussion.

Entities that are releasing the records are staying away from that space because politically, it is dynamite.

A *R. Manderscheid:* Privacy and confidentiality are very different issues in mental health and substance abuse. In substance abuse, federal legislation, 42CFR2, prevents the release of care information by a provider to others on a person who has a substance abuse diagnosis. That legislation is cited frequently as a reason why we cannot do electronic health records for people with substance abuse problems. The more modern thinking on that is we must be able to preserve privacy and confidentiality. But we also need to be able to do electronic records and take advantage of modern encryption to make it feasible to meet both of these requirements simultaneously.

Q Much of health care IT has, thus far, seemed to focus on reconstructing thousands of forms into an electronic format. How do we shift to an effort around health care IT to not reconstruct what we already have?

A *R. Manderscheid:* Health literacy is appallingly low in this country. If the Institute of Medicine is to be believed, something like 90 million Americans cannot interpret their own health care needs. For health care reform and personal health care records to be effective, people have to be educated to use them properly.

It is going to be the emergence of the personal health records in those tools that meet the real needs of the individuals. Then, it can begin to help them engage with the existing system, or the new system that will be the real disruptor.

GENERAL DISCUSSION

Thomas E. Bornemann, Ed.D.

Director, Carter Center Mental Health Program

Every year, symposium participants are divided into working groups. These groups provide a vital mechanism for developing the symposium topic into programmatic initiatives and activities. This year, participants were divided into six working groups and were given the following charge related to mental health policy: *Explore the challenges and opportunities facing behavioral health care and health promotion/prevention as they attempt to integrate into a reformed and empowered primary-care-driven delivery system.*

The following discussion represents the comments and recommendations that were put forth by each working group.

Children and Adolescents: Discussion centered on components that would need a lot of attention in creating new policy. Screening and assessment in a system of resiliency were deemed important, but more flexible funding of evidence-based practices would be necessary. Engaging children and families would also be an important opportunity; youth-led groups were suggested for the engagement effort.

Parents can also play a role in behavioral health: educating parents so they know how to talk with their children, including mental health information for new mothers, would let parents know what to look for and what to expect. Behavioral health questions should be part of diagnostic screenings, and doctors should have an early childhood systems framework (0 to 6 years old).

Cultural competence — a willingness to take cultural perspectives into account — would be absolutely necessary. Financial silos currently act as a primary barrier to health care integration; we need the ability to fund and make payments in other ways. Fiscal incentives might allow doctors to address behavioral needs in the primary care sector. Expanding services through integrated care would also prove useful. Sharing information

and increasing communication between providers would help all parties access a more accurate view of the problems at hand.

Overall recommendations included developing a National Children's Agenda at the presidential level that builds on universal health care. This agenda should drive a public health approach that addresses developmentally appropriate needs across the population (including prevention and health promotion). This agenda should also work across all child-serving systems and collect outcomes that reflect progress across all life domains (health, safety, education, well-being, vocational readiness, social, spiritual, etc.). In order to promote resiliency and protective factors, we also must promote the availability of holistic assessments — preconception through transition age — that link youths and families to services and supports that match developmental needs.

Workforce Development: We must expand the concept of who the workforce is and how we train that workforce to work together as equal partners in care that fit the outcomes people desire while being served in their communities. Consumers and family members are central to training the workforce, and we cannot ignore the value of care providers who extend beyond traditional, multidisciplinary teams (judges, pastors, etc.). We envision a workforce that believes in recovery, even when the individual has lost hope, and we need to encourage and support the application and education process for different groups, especially those with relevant experience.

The future health care workforce needs to be integrated, networked, collaborative, and community-needs-driven. It should be organized around the tenets of population health and the principles of recovery, including primary, secondary, and tertiary prevention, while sharing collective accountability. We must embrace the principles of social justice throughout the system, including recruitment, training, supervision, and

evaluation to ensure reduction and elimination of inequities, disparities, stigma, and discrimination, thereby attracting and welcoming workers and consumers.

The workforce is accountable for ensuring that the health and well-being of all providers are as equally valued as those we serve. We must build evidence- and practice-based products and services that prevent and avoid behavioral health problems, and we should prioritize cross-training existing primary care, behavioral health, and other community providers to provide effective, empathetic, and empowering care. We have to reduce fragmentation in services and financing by stimulating integrated care through community participation and networking with organizations.

Cultural and Ethnic Minorities: There are a number of challenges and opportunities in the arena of cultural and ethnic minorities. Financial challenges include funding for recovery support, abolishing discriminatory payment systems and fragmented funding, and retooling our current funding balance, which is out of order. Workforce challenges include distribution, provider confidence, poor collaboration, provider distrust, lack of diversity and listening skills, and unconventional resources.

We need to address social contexts, such as social determinants, language barriers, stigma, classism, discrimination, and racism. We have opportunities to invest in the community and allow it to determine its own strategies. We can identify and establish funding streams and fund a peer workforce. Primary provider training should be given with fiscal support in behavioral health care. We need to establish accountability mechanisms to diversify the workforce and identify benchmarks for positive outcomes.

We must address stigma, historical trauma (e.g. Tuskegee), fatalism, racism, and classism. Promoting the improvement of life experience should be on par with quantitative data and attend to class structure. We should integrate primary care and behavioral health care to increase access to care and decrease stigma. We need to develop an integrated, community-owned health care delivery system that: aligns incentives for financing; supports community-defined evidence; fosters health information technology, promotion, and prevention, fosters

comparative effectiveness research, addresses stigma, has culturally relevant, team-based care, and is accountable and outcomes-driven. We must also expand and improve the capacity of the primary care and behavioral care workforce to meet the needs of racially, culturally, and ethnically diverse communities in an integrated setting; this includes the need to improve funding for diverse populations, improve funding for a peer workforce, and find new systems of debt forgiveness and service incentives.

Research: The role of research should be to act as the interface between science and policy. Physicians, politicians, and researchers must know and understand the appropriate methods for policy research. We need information on the effectiveness of deploying staff in different ways on a primary and behavioral health care spectrum. Research must tackle science and practice, and we must have models for comparative effectiveness. We need to organize practices in different settings and use time efficiently.

Research needs to document and record what we are doing now, and it should demonstrate the value of our work and the value it has for different stakeholders. It should identify that integrating mental health care into primary care practices is of value, but how do we address the public and mental health systems? We cannot address them solely at the primary care practices level.

Research needs to respond to the needs of the community and implement the best practices. We need visionary direction (e.g., a disease trajectory) instead of just practical questions. Research isn't only about finding the best treatment strategies, but is also about promoting healthy activities; it must keep the public healthy and include emotional and psychological health measures.

We can institute an agenda to track what is going on now, like the advancements in parity regulations and health care reform. Policy needs a feedback loop, and a long- and short-term agenda. Researchers must be involved in program design and implementations and use existing data sets (CMS, BRFS) to track the impact of health care reform. Essentially, we need to build a registry for gathering promising practices to guide policy and reforms, and conduct research on the

effectiveness of promising practices in the registry. We can use existing data sets to track the impact of health reform and develop implementation strategies to ensure widespread dissemination of effective practices.

Reimbursement and Financing: Several objectives were discussed, including improving coverage while containing the costs of health care. We also must shift from a fragmented, specialty-driven care system to an integrated, coordinated health home with a strong wellness and recovery focus. One way to achieve this would be through a financing structure such as capitation. Threats to capitation include inadequate primary care provider reimbursement from sources such as Medicaid and inadequate rates for evidence-based practices to assure fidelity and sustainability.

We must tackle provider readiness gaps and report undercapitated systems. We must fund substance-use prevention, treatment, and recovery services and implement a “scope of services” policy under parity. We must shift from grants to universal insurance and benefits coverage, with different payment mechanisms for people with “mild and moderate” conditions and

people with “serious and disabling” mental illnesses. We need reporting systems that promote accountability but also support practice management and improvement outcomes.

Opportunities in the area of financing could arise in the form of blended Medicare and Medicaid payments or presumptive Medicare eligibility for chronic psychiatric conditions. We can replicate effective integration models, such as the Diamond project in Minnesota or Intermountain Health Care in Utah. Stronger federal benefits could be made available to mitigate variations in health care across states.

When challenges were discussed, several questions arose. How do we deal with the shortage of resources? Are siloed behavioral health care services obsolete? How will we allocate limited resources, and how do current insurance practices demonstrate value? We need clearly articulated clinical integration models with defined outcomes tied to core payment with performance incentives, and financing that supports designs and outcomes (e.g. bundled payments).



Population Health and Prevention: There are a number of challenges and opportunities in the area of population health and prevention. One of the largest obstacles is the lack of training among providers; there is no orientation toward the primary care health model. There also is a lack of resources, and prevention services are not reimbursed. We have failed to honor the mind, and currently focus less on our mental health as opposed to our bodily health (even though they are one and the same). Health literacy is lacking in regard to mental and behavioral health, and stigma abounds.

There is a lack of policy in the arena of mental health, and mental health and public health are often considered separate entities. Physicians frame people as patients and not as people; we should switch to a model of empowerment and personalization instead. There is only tentative understanding as to how approaches can be applied to the general population, and there is a lack of understanding of the importance of mental health. A final challenge is that we currently have a health care system resistant to change, and it is not cohesive or comprehensive.

Opportunities do exist to improve the health of the population. We can use a subgroup of the population to enhance our understanding of what works and what doesn't (e.g., using the homeless population as a dependent measure). We can redefine how we view integration and focus on reframing health care reform. We can look at best practices to identify points of success and how to bring them to scale, and identify successes occurring at the community level. We must embrace and disseminate case studies, and welcome the concept of mental capital as a resource. We must enhance decision making at the institutional level, and acculturate our decisions. We must share our health data to

empower others and spread knowledge. We can use pharmaceutical companies as partners, and involve faith-based communities. We also can introduce mental health into health education curricula for children.

Perhaps a population-based approach does not exist because we don't have the authority to implement a mental health approach — we as a collectivity have not identified an authority. We need to consider the different sectors that need to be approached and how we impact them. To achieve change, we can advocate as a field that the U.S. Preventive Services Task Force (Agency for Healthcare Research and Quality) and the Task Force on Community Preventive Services (Centers for Disease Control and Prevention) work on mental health issues as well as integration into primary care. We can advocate that health reform prevention financing should focus on mental health promotion and include partners like the CDC, the Substance Abuse and Mental Health Services Administration, National Institute of Mental Health, and Health Resources and Services Administration.

We must recognize the role of public health advocates in promoting mental health in their communities and invite national partners to the biennial mental health surveillance meeting at the CDC on Sept. 8, 2011. We can create an online community of "healthy people" that includes advice for improving personal and community health. We must make sure that mental health and substance abuse are included in this work and that the work in the community also addresses those issues. We need to obtain and fund community-level research on population-based interventions that have evidence, including comparative effectiveness work globally.

CLOSING REMARKS

Rosalynn Carter

Chair, Carter Center Mental Health Task Force

Our intent for this symposium was to learn about health care reform and how we in the mental health and substance-use communities can join with our primary care and prevention colleagues to help inform the debate. The recommendations that have stemmed from our discussions are good. But they are not just to be read. They must be acted upon.

It is crucially important that we make policy makers understand that integrated care is better care. They need to know that we have models that work for delivering high-quality, cost-effective integrated care.

The singular most important contribution that the mental health field can make to national health care reform is developing an effective plan to promote and achieve effective integration of mental health and substance use with primary care and prevention.

I charge you all to contact your policy makers and your senators and representatives and tell them what you've learned. Only through our active advocacy and persuasion will the recommendations we have produced in the course of this symposium have a real impact.



Biographies



Michael S. Barr, M.D., M.B.A., F.A.C.P.

Michael S. Barr is vice president, practice advocacy and improvement, for the American College of Physicians. Dr. Barr's focus is on public policy relating to the patient-centered medical home, quality improvement, practice redesign, and health information technology. He has overall responsibility for the college's Center for Practice Improvement and Innovation, Regulatory and Insurer Affairs Department, and Medical Laboratory Evaluation Program. Before joining the American College of Physicians staff in February 2005, Dr. Barr served as the chief medical officer for Baltimore Medical System Inc., a Joint Commission–accredited, multisite, federally qualified community health center, from 1999–2005. He was on faculty in the division of General Internal Medicine at Vanderbilt University from 1993–1998 and held various administrative positions including physician director, medical management programs, for the Vanderbilt Medical Group. Dr. Barr holds part-time faculty appointments at Johns Hopkins University and George Washington University.



John Bartlett, M.D., M.P.H.

John Bartlett is the senior project adviser for the Primary Care Initiative of the Carter Center's Mental Health Program. He coordinates the activities of the initiative, which is intended to help with better recognition and treatment of mental health and substance abuse problems in primary care. Dr. Bartlett is a psychiatrist and a former treatment system manager who specializes in quality and accountability issues for mental health, substance abuse, and chronic health care. Before joining The Carter Center, he was a partner at the Avisa Group, a policy, research, and consulting firm that specializes in behavioral health care. Dr. Bartlett also has served as the senior medical director and vice president for CIGNA Behavioral Health and as an executive vice president for clinical strategy for Charter/Magellan Health Services. He received his medical training at Yale University and completed his psychiatric residency at the UCLA School of Medicine, where, following his residency, he was a Robert Wood Johnson Clinical Scholar.



Michael L. Best, Ph.D.

Michael L. Best is assistant professor at the Sam Nunn School of International Affairs and the School of Interactive Computing at Georgia Institute of Technology where he is also research faculty with the GVI Center and directs the Program in Information and Communication Technologies for Development at the Center for International Strategy, Technology, and Policy. He is also a faculty associate of the Berkman Center for Internet and Society at Harvard University. Best is co-founder and editor-in-chief of the journal *Information Technologies and International Development*. Best's research focuses on information and communication technologies for social, economic, and political development. In particular he studies mobile and Internet-enabled services and their design, impact, and importance within low-income countries of Africa and Asia. He researches engineering, public policy, and business issues as well as methods to assess and evaluate development outcomes. Best is also interested in the impact of technologies on the development-security nexus and on postconflict reconstruction and reconciliation.



Thomas E. Bryant, M.D., J.D.

Thomas E. Bryant received his M.D. and J.D. degrees from Emory University in the late 1960s. He came to Washington as the director of health affairs for the U.S. Office of Economic Opportunity (the War on Poverty). He then joined the Ford Foundation where he founded the National Drug Abuse Council, a think tank and advocacy organization in the private sector funded by foundations and went on to serve as chair of President Jimmy Carter's Mental Health Commission. He is president of the National Foundation for Mental Health and the Aspirin Foundation of America and vice president for outreach of the Hospice Foundation of America.

He was a founder of the Rosalynn Carter Mental Health Task Force and the Rosalynn Carter Institute for Caregiving in Americus, Ga.



Carolyn M. Clancy, M.D.

Carolyn M. Clancy, M.D., was appointed director of the Agency for Healthcare Research and Quality on Feb. 5, 2003. Prior to her appointment, she served as the agency's acting director and previously was director of the agency's Center for Outcomes and Effectiveness Research. Dr. Clancy, who is a general internist and health services researcher, is a graduate of Boston College and the University of Massachusetts Medical School. She serves as senior associate editor for Health Services Research. She has served on multiple editorial boards and is currently on the board of the *Annals of Family Medicine*, *American Journal of Medical Quality*, and

Medical Care Research and Review. Her major research interests include improving health care quality and patient safety and reducing disparities in care associated with patients' race, ethnicity, gender, income, and education.



Alan Deutschman

Alan Deutschman is one of America's most provocative thinkers about leadership and change. He is the author of four books including "Change or Die: The Three Keys to Change at Work and in Life" and "Walk the Walk: The #1 Rule for Real Leaders." In a 21-year career as a journalist, Deutschman has been *Fortune* magazine's Silicon Valley correspondent and a contributing editor at *Vanity Fair*, *New York Magazine*, and *GQ*. Most recently, he was a senior writer for *Fast Company*. His articles have also appeared in the *New York Times Magazine*, *Wired*, and on *Salon.com*. He has taught at General Electric's Crotonville executive training

center and delivered keynote addresses to leadership conferences for organizations such as National Public Radio.



Benjamin E. Druss, M.D., M.P.H.

As the first Rosalynn Carter Chair in Mental Health at Emory University, Dr. Benjamin E. Druss is working to build links between mental health and broader public health and health policy communities. Dr. Druss joined the Rollins School of Public Health faculty in 2003; previously, he served on faculty in the Yale School of Medicine Department of Psychiatry. He works closely with the Carter Center Mental Health Program, where he is a member of both the Mental Health Task Force and Journalism Task Force. Dr. Druss has published more than 100 peer-reviewed articles, largely focusing on the policy and systems issues on the interface between

primary care and mental health. He has received several grants from the National Institute of Mental Health and the Agency for Healthcare Quality and Research to develop and test models to improve physical health and health care for mental health consumers.



Raymond J. Fabius, M.D., C.P.E., F.A.C.P.E.

Dr. Raymond J. Fabius is the co-founder of HealthNEXT and recently served as strategic adviser for the president of Walgreens Health and Wellness. These two roles have him focused on population health management and building organizational cultures of health. Previously, Dr. Fabius was president and chief medical officer of CHD Meridian Healthcare, a provider of workplace health and productivity solutions, serving nearly 100 corporate clients in over 250 locations. Dr. Fabius has been a global medical leader at General Electric, responsible for the health and safety of more than 330,000 employees. He is a recognized early framer of the population health field and has written two books on the topic, including “Total Care Management.”



Daniel Fisher, M.D., Ph.D.

Daniel Fisher is executive director of the federally funded National Empowerment Center in Lawrence, Mass. He conducts workshops, gives keynote addresses, teaches classes, and organizes conferences for consumers and survivors, families, and mental health providers to promote recovery of people labeled with mental illness by incorporating the principles of empowerment. Dr. Fisher has recovered from schizophrenia. He was hospitalized several times prior to becoming a psychiatrist and is one of the few psychiatrists in the country who publicly discusses his recovery from a mental illness. He is a role model for others who are struggling to recover, and his life dispels the myth that people do not recover from mental illness. His recovery and work in the field were recognized by his selection as a member of the White House Commission on Mental Health. Fisher received his bachelor’s degree from Princeton University, his doctorate in biochemistry from the University of Wisconsin, and his doctorate in medicine from George Washington University. He is a board-certified psychiatrist who completed his residency at Harvard Medical School.



Larry Fricks

Larry Fricks currently serves as director of the Appalachian Consulting Group and vice president of Peer Services for the Depression and Bipolar Support Alliance. For 13 years Fricks was Georgia’s director of the Office of Consumer Relations and Recovery in the Division of Mental Health, Developmental Disabilities, and Addictive Diseases. He is a founder of the Georgia Mental Health Consumer Network that now has some 3,000 members and a founder of Georgia’s peer specialist training and certification. He served on the planning board for the Surgeon General’s Report on Mental Health and currently serves on the advisory board for the Rosalynn Carter Fellowships for Mental Health Journalism. Fricks is the 1995 recipient of the Clifford W. Beers Award given annually by Mental Health America and the 2001 recipient of the American Association for World Health Award for significant contributions to improving community mental health.



Larry A. Green, M.D.

Dr. Larry Green is professor of family medicine and the Epperson-Zorn Chair for Innovation in Family Medicine at the University of Colorado Denver. He was born and raised in Ardmore, Okla., graduating from the University of Oklahoma with a major in psychology. After graduating from Baylor College of Medicine in Houston, Texas, he did his residency in family medicine in Rochester, N.Y., at Highland Hospital and the University of Rochester. He is a founding board member for Partnership 2040, a community-based participatory research enterprise in the Denver area, and chair of the council overseeing the community engagement component of the Colorado Clinical Translational Sciences Institute funded by the National Institutes of Health. He currently is a member of the National Committee on Vital and Health Statistics, and co-chair of the steering committee for Preparing the Personal Physician for Practice, a national comparative case study of family medicine residency innovations.



Robert M. Kolodner, M.D.

In September 2009, Dr. Robert Kolodner transitioned from the federal to the private sector to continue his work to improve the health and well-being of individuals and communities worldwide by advancing the proliferation and rapid, collaborative evolution of health information technology tools and solutions. From 2006 to April 2009, he served as national coordinator for the eHealth initiative in the Office of the Secretary of the Department of Health and Human Services. His responsibilities included developing, maintaining, and directing the implementation of a health IT strategic plan as well as directing activities related to advancing the nationwide adoption of person-centered, interoperable health IT solutions. Dr. Kolodner received his undergraduate degree from Harvard College, his medical degree from Yale University School of Medicine, and completed his psychiatric residency at the Washington University School of Medicine. He has medical specialty board certification in psychiatry.

Ronald W. Manderscheid, Ph.D.

Ronald W. Manderscheid, Ph.D., is the executive director of the National Association of County Behavioral Health and Developmental Disability Directors. Concurrently, he is adjunct professor in the Department of Mental Health, Bloomberg School of Public Health, Johns Hopkins University; consultant to SRA International Inc.; a member of the Secretary of Health and Human Services Advisory Committee on Healthy People 2020; and president-elect of ACMHA — The College for Behavioral Health Leadership. Manderscheid serves on the boards of the Employee Assistance Research Foundation, the Danya Institute, and the Public Manager. During the Clinton National Health Care Reform debate, Manderscheid served as senior policy adviser on National Health Care Reform in the Office of the Assistant Secretary for Health at the U.S. Department of Health and Human Services. At that time, he was also a member of the Mental Health and Substance Abuse Work Group of the President's Task Force on Health Care Reform.



Jim McNulty

Jim McNulty is vice president of Peer Support for the Depression and Bipolar Support Alliance. In previous roles, he served as the director of the Office of Consumer Affairs for the Division of Behavioral Health, State of Rhode Island, and Magellan Health Services' director of consumer and recovery services. He is past president of the National Alliance on Mental Illness. He currently serves on the SAMHSA/CMHS National Advisory Council and is chair of the council's subcommittee on consumer and survivor issues. A Rhode Island resident for many years, he serves as the president of the MDDA of Rhode Island, a recovery-oriented support and advocacy group for people who share the lived experience of mental disorders. He has received numerous awards for his service to the mental health community and continues to work for significant reform in the mental health and substance use systems of care.



Nicolaas P. Pronk, Ph.D., F.A.C.S.M.

Nicolaas P. Pronk is the vice president for health management at HealthPartners, a large nonprofit, member-governed integrated health system in Minneapolis, Minn. He is also health science officer for JourneyWell, a division of HealthPartners focused on health and wellness solutions for employers and health plans across the United States, and a senior research investigator at the HealthPartners Research Foundation in the area of health behavior change and population health. Pronk is widely published in the scientific literature and is currently an editorial board member for several scientific journals. He is the founding president of the International Association for Worksite Health Promotion. He received his doctorate degree in exercise physiology at Texas A&M University and completed his postdoctoral studies at the University of Pittsburgh Medical Center and Western Psychiatric Institute and Clinic in Pittsburgh, Pa.



Linda Rosenberg, M.S.W.

With more than 30 years of distinguished service in mental health policy, services, and system reform, Linda Rosenberg is a leading mental health expert. In 2004, she was named president and CEO of the National Council for Community Behavioral Healthcare, a not-for-profit advocacy and educational association of mental health and addiction treatment service organizations. Under her leadership, the National Council has grown to 1,600 member organizations, employing 250,000 staff serving 6 million adults and children in communities across the country. Prior to joining the National Council, Rosenberg was the senior deputy commissioner for the New York State Office of Mental Health. A certified social worker, trained family therapist, and psychiatric rehabilitation practitioner, Rosenberg has held numerous faculty appointments, serves on numerous agency and editorial boards, and writes and presents extensively on mental health and addiction issues.

Donna Thompson, R.N., M.S.

When Donna Thompson joined Access Community Health Network (ACCESS) as chief operating officer in 1995, she was well-familiar with the difficulties patients faced because they lacked access to primary and preventive care. For more than 20 years, Thompson has been on the frontline of patient care delivery. Now CEO of ACCESS, a post held since 2004, she demonstrates daily how a focused commitment to high-quality community health care can save lives, revitalize communities, and preserve the possibility of a healthy life for hundreds of thousands of patients. In her nearly five years as CEO, Thompson has led ACCESS to become the largest federally qualified health care organization in the country. ACCESS serves more than 215,000 patients annually, including 70,000 who are uninsured, in 50 health center locations across the greater Chicago area.



Kenneth E. Thorpe, Ph.D.

Kenneth E. Thorpe is Robert W. Woodruff Professor and chairman of the Department of Health Policy and Management, Rollins School of Public Health of Emory University in Atlanta. He is executive director of the Institute for Advanced Policy Solutions/Center for Entitlement Reform and co-directs the Emory Center on Health Outcomes and Quality. He is also executive director of the Partnership to Fight Chronic Disease, a national coalition of patients, providers, community organizations, business and labor groups, and health policy experts committed to raising awareness of policies and practices that save lives and reduce health costs through more effective prevention and management of chronic disease. He has authored or co-authored more than 85 articles, book chapters, and books and is a frequent national presenter on issues of health care financing, insurance, and health care reform at health care conferences, on television, and in the media.



Tom Trabin, Ph.D., M.S.M.

Tom Trabin currently serves as associate director of adult services for the several hundred mental health, alcohol, and drug programs within the Alameda County Behavioral Health Care service system in California. He also continues to organize and chair the Behavioral Health Information Management Conference and Exposition for the 10th consecutive year. He helped lead behavioral health efforts to establish and promote national electronic health records and personal health records standards through committees for HL7, SAMHSA, and the HIMSS Davies Award Committee; national quality standards through committees for SAMHSA, JCAHO, NCQA, and CARF; and performance measures for the Mental Health Services Act through the California Department of Mental Health. Trabin served on the Institute of Medicine Committee that recently produced *Improving the Quality of Healthcare for Mental and Substance Use Conditions*. He has written more than 60 publications, including several books, and has given presentations at over 150 international, national, and regional conferences.

**Hyong Un, M.D.**

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