Moving Forward:
Designing and Financing Effective Mental Health Services in an Era of Transformation

Proceedings Summary
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Symposium

Introduction

The Center for Health Program Development and Management (Center), located at the University of Maryland, Baltimore County (UMBC), works with public agencies and nonprofit community-based entities in Maryland and elsewhere to improve the health and social outcomes of vulnerable populations in a manner that maximizes the impact of available resources. The Center strives to be a source of objective information for state policymakers and seeks to contribute to the national understanding of how to better serve vulnerable populations. As a means of enhancing its mission, the Center hosted its second annual symposium, entitled *Moving Forward: Designing and Financing Effective Mental Health Services in an Era of Transformation* on June 12, 2007. Participants included nearly 130 mental and general health policymakers and health services researchers from 15 different states.

The overarching theme of the day was mental health systems, especially as they pertain to publicly financed efforts such as Medicaid programs and state block grant initiatives. The day was divided into four sessions and two keynote presentations, with the morning sessions focusing on evidence-based practices and the afternoon on systems integration and care coordination.

Symposium materials, including the day's agenda and biographies and PowerPoint presentations from each of our distinguished presenters, can be found at: www.chpdm.org/Symposium/2007Symposium.htm. Below is a narrative summary of the proceedings.

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The day began with welcoming and introductory remarks from **Chuck Milligan**, the Center's Executive Director, and **Freeman Hrabowski**, UMBC's President. Dr. Hrabowski's remarks included mention of the university's mix of programs that relate to human services and mental health, ranging from psychology to public policy and including the efforts of the Center. He noted that the Center fulfills an important role as a bridge between research and state-based practice. Dr. Hrabowski further touched upon the issues of minority education and undergraduate mental health as two issues he thinks about frequently as a university president, and he

applauded the eclectic audience for coming together to discuss and attempt to answer the many questions that surround such issues.

Keynote Session: Challenges to Designing an Effective Mental Health System

Michael Hogan, Ph.D., the recently appointed Commissioner of the New York State Office of Mental Health and former Chair of the President's New Freedom Commission on Mental Health, framed the day by providing an overview of mental health services over the past 50 years. His presentation, Mental Health Policy/Practice Update: How are People with a Mental Illness Faring Today vs. 50 Years Ago?, was based largely on a recently published book by health economists Richard Frank and Sherry Glied, entitled *Better But Not Well: Mental Health Policy in the United States Since 1950*. Early in his presentation, Hogan contrasted the concepts of "exceptionalism" and "mainstreaming," the former being a strategy that emphasizes differences and special needs of individuals with mental illness, and the latter taking advantage of the similarities between mental illness and other forms of disease to promote issues such as parity. Hogan reviewed data that simultaneously portrayed favorable and disappointing changes in the mental health care delivery system over the past 50 years. In general, he observed that care has improved. For example, between 1975 and 1997, effective care delivery for those with Attention Deficit Disorder increased from under 20 to just below 60 percent of patients according to data compiled by Frank and Glied. During that same period, care delivery for schizophrenia also increased.

Such gains were partly attributed to innovation, but Hogan emphasized the importance of "exnovation" (*i.e.*, removing therapies) in enhancing care. With regard to innovation, Hogan expressed disappointment in therapies such as SSRIs for depression and atypicals for schizophrenia (see: www.nimh.nih.gov/healthinformation/catie.cfm).

Hogan also lamented that "real federal parity" legislation is still hypothetical and that stigma and public understanding regarding mental illness have only "somewhat" decreased and increased, respectively. He noted that treatment innovation and exceptionalism both have been eclipsed by efforts that simply expand access to existing care. He further noted that this apparent dominance of a "mainstreaming" strategy over an "exceptionalism" one (*i.e.*, of general health care advancing strategies versus ones that are idiosyncratic to mental health care alone) was something he initially resisted in discussions with Frank and Glied, though he eventually came to sympathize with their economic arguments.

In addition, Hogan cited the work of Ted Lutterman to demonstrate that there is considerable variability between states with regard to mental health aggregate and specific spending, but Medicaid funding has grown to be the dominant player since 1990. Hogan then pointed out potentially undesirable effects of Medicaid treatment by showing data from Ohio, demonstrating an inverse correlation between Medicaid and general state resource funding of mental health services. The potential disadvantage of this cost-shift is that Medicaid has limits on eligibility and services, whereas state general funds do not.

In closing, Hogan said that many realms of government are now realizing the importance of mental health to their missions. Specifically with regard to the disability

system, he reiterated his concern that such programs have negative consequences yet to be addressed.

Following Michael Hogan's keynote speech, **Steven Sharfstein**, M.D., M.P.A., the president and CEO of Sheppard Pratt Health System, provided comments on changes in the mental health system here in Maryland. Echoing Hogan's story of change in recent years, Sharfstein said that mental health care at Sheppard Pratt (Maryland's largest provider) had experienced similar change. For instance, lengths of stay dropped from an average of 80 days in 1986 to just 9 days currently. Today, Sheppard Pratt has mostly outpatients (approximately 900 in subsidized housing and psychosocial rehabilitation). Despite these significant changes, Sharfstein noted that criminalization (incarceration) and homelessness among individuals with mental illness remain considerable and fundamental problems.

As for mainstreaming versus exceptionalism, Sharfstein said that one cannot mandate either. He explained that there are no solid answers in either direction, but whatever the approach may be, more money is needed.

Sharfstein then discussed the increasing role of the criminal justice system in the treatment of individuals with severe mental illness, and the limited level of funds generally available for community treatment of such disease. He recounted that one of his clinicians recently was so frustrated by the options offered by the public mental health system that he told a family that incarceration may be their best hope of obtaining some mental health care for their loved one. Sharfstein encouraged members of the audience to read *Crazy: A Father's Search Through America's Mental Health Madness* by Pete Earley of the Washington Post for more elaboration and a first-person account of such challenges.

During the Q&A opportunity for the Keynote Session, one question prompted Hogan to respond that funding for homeless individuals with mental illness needs to be increased because outside of California and New York, most states offer no housing supports, and since 1980, such federal supports have actually declined by 80 percent. In response to another question, Sharfstein noted increasing disparity in mental health services use by giving the example of inpatient treatment costs. Those costs, he said, were nearly $1,750 per day; for those with the means to pay out-of-pocket, the average stay was 25 days.

Session 1: Recognizing, Accepting, and Adopting "Proven Practices"

Michael Abrams, senior research analyst at the Center, moderated this session and made introductory comments suggesting (with some sarcasm) that the term "evidence-based medicine" (EB medicine) is a surprising confession by many in medicine that prior and ongoing practice is replete with untested, unscientific procedures. He further noted that Bruce Vladeck, former Administrator of CMS, recently said that increased use of EB medicine would be essential if mental health care was to achieve parity with other aspects of medical care. The aim of this session was to obtain an overview of the potential and challenges of diffusing EB mental health practices at both the state and federal levels.

Anthony Lehman, chair of psychiatry at the University of Maryland School of Medicine, began his presentation, Research and Development: Ready on the Runway, by saying that EB practices

are both cost-beneficial and practical. He continued by listing specific interventions, some of which he considers effective and others ineffective or even harmful.

As an indication of ongoing controversy, Lehman noted that he is criticized by some for dismissing psychoanalysis for those with psychotic disorders. Regarding the magnitude of therapeutic benefits currently sought, Lehman pointed out that if one could develop ways to increase success rates for antipsychotic therapy from 55 percent (current effectiveness) to 77 percent (current efficacy), such gains would represent a huge and very desirable advance. He then presented supported employment treatment effects across several studies to demonstrate both the consistency and variability that underlie this EB practice. Assertive Community Treatment was used as an example of a therapy for which fidelity to the method is "closely linked" to success. EB practices were also said to be available for: conduct disorders, ADHD, anxiety disorders, OCD, panic disorders, and borderline personality disorder.

In characterizing the challenges of dissemination, Lehman noted that psychosocial interventions are disadvantaged compared to pharmacological interventions because they do not have as centralized an industry behind them. To adjust for this, he advocated for transferring pharmaceutical savings (perhaps from formulary strategies) to psychosocial practices that have otherwise been eclipsed by aggressive drug marketing.

Lehman's penultimate slide isolated two "disconnects between science and needs." First is the very limited range of EB treatments—a limitation that means that many treatments persist in the absence of evidence supporting their utility. Second is the narrow range of outcomes considered—a range which usually means that many accepted therapies are not appropriately patient-centered or sufficiently holistic.

Following these caveats, Lehman concluded by saying that EB mental health practices do offer an array of effective treatments that can be tailored to individuals, but despite this resource for providers, "there's a huge gap between science and service."

Neal Adams, M.D., M.P.H., director of special projects for the California Institute of Mental Health (a not-for-profit), presented perspectives from the states on the implementation (and lack thereof) of EB practices. Adams began his presentation, State Perspectives in Evidence-Based Practice Implementation, by commenting on the low usage of EB practices, noting that patients receive recommended treatment only about half of the time and further adding that "deficits in adherence...pose serious threats to the health of the American public."

Adams spent considerable time diffusing myths about EB practice. For example, he said that EB practices are more than just randomized controlled trials. Instead, they are practices that can draw from many sources and permit considerable flexibility while also allowing accountability.

He cautioned against EB practice mandates as they can lead to passive-aggressive responses rather than more efficient diffusion. Alternatives to mandates include: manuals or toolkits, training (pre- or in-service), quality improvement modeling or team leadership, and dissemination research. Adams then emphasized implementation for the duration of his presentation.

One model of implementation that he presented came from the University of South Florida: core implementation (training, coaching, performance measures) surrounded by organizational components (administration, evaluation, program selection), surrounded by a third level (social, economic, and political factors). Another model from Ohio delineated five stages of change, from pre-contemplation to maintenance. Yet a final model/framework was used to demonstrate implementation as part of an ongoing cycle involving repeated training, evaluation, and intervention/strategy selections. These complexities and interrelationships were noted as important points of consideration for systems working to diffuse EB practice.

Adams contrasted flexibility with fidelity, the latter noted as a key construct of EB practice. He discussed financial consensus and strategies, including cost neutrality and bundling services for billing purposes and for performance. One slide noted the following important ingredients to any implementation strategy: skilled and knowledgeable experts; formal and informal organizational structure supporting implementation/change; and good relationships with consumers and other stake-holders.

Adams' final slide, entitled "Policy Pinball," reminded the audience that all EB practice diffusion typically needs to confront sometimes unpredictable political, economic, and clinical practice challenges.

Session 1 concluded with **Ronald Manderscheid**, Ph.D., director of mental health and substance use programs of the Constella Group. His opened his presentation, Diffusing New Practices to Improve Care Quality: A Federal Perspective, with some ideas on systematizing the process of diffusion. With regard to "senders" of mental health service innovations, Manderscheid said that there is a lack of consensus about what therapies are ready, especially amongst consumers and providers. The current SAMHSA website and hypothetical online training were noted as communication channels of critical import to federal EB diffusion efforts.

Next, Manderscheid differentiated between EB practice and "practice-based evidence," the latter being what one does when evidence is lacking or when it does not work. Ongoing questions include: the limits of the evidence; perspectives of the evidence; benchmarks (measurements) for evaluation; and is the practice really novel?

Manderscheid believes that motivation for the "receiver" of EB practices is critical. He advocates for the following motivators: money (e.g., pay-for-performance), ease of use, and harnessing consumer demand. He stated that Maryland is way ahead with regard to EB practice use, and the federal government has the role of "consensus builder" among payers, researchers, providers, and consumers.

Manderscheid argued for a major effort to train providers in EB practice and practice-based evidence. He referred to SAMHSA's Strategic Plan for Workforce Development (www.samhsa.gov/Workforce/Annapolis/WorkforceActionPlan.pdf) as a guide. He also called for pay-for-performance strategies and online training protocols targeting consumers.

In closing, Manderscheid referred the audience to Stephen Leff's "A Brief History of Evidence-Based Practices" (see: download.ncadi.samhsa.gov/ken/pdf/SMA01-3938/MHUS02_Chapter_17.pdf).

The first question posed during the Q&A session was a request for comment from the speakers regarding how aggressive Medicaid agencies and mental health authorities should be when exhorting their providers to adopt EB practices. In response, Manderscheid said that the key is for providers and patients to work together to harness such practices. Adams added that it is important that providers and patients have access to resources that help them identify such practices. A second question asked for some clarification on what research is available regarding EB practices. Manderscheid referred to a recent Institute of Medicine report that focused on interventions for developing countries and identified numerous EB strategies that cost $1 per person per year or less. A third question pertained to the relevance of diagnostic methods in implementing EB practices. To that, Lehman acknowledged the limits of the Diagnostic Statistical Manual (DSM), but also optimism about the future of neuroscience and genetics to add specificity to disease identification. Adams pointed out that many EB therapies (e.g., supportive employment) can be used in the recovery phase for more than one specific type of mental illness. A fourth question asked for source material regarding outcome measures for school-based mental health service delivery of EB practices. Lehman referred the individual to Mark Weist at the University of Maryland. Manderscheid referred to a consumer survey for children, developed in Australia for adults but recently tested in Virginia for youths: the MHSIP Youth and Family Survey (see: www.mhsip.org).

Session 2: From Research to the Private Sector: How Private Sector Entities Make Coverage and Service Decisions

As private sector entities are interested in diffusing therapeutic interventions that have been demonstrated to be both clinically and cost-effective, the goal of this session was to describe how private employers and large group purchasers make behavioral health coverage decisions. **Michael Nolin**, the Center's deputy director, moderated the session. He noted that the Center has held several symposia over the past few years, most of which have included a focus on public-private interactions.

Rhonda Robinson Beale, M.D., the chief medical officer of United Behavioral Health, provided a clinical perspective as to why specific practices are added to behavioral health plans and how they are monitored through outcomes.

Robinson Beale's presentation, Designing Effective Behavioral Health Services, emphasized that solid behavioral health programming is linked to overall decreases in all medical costs. At the same time, she predicted with considerable confidence that behavioral health funding in the private sector would remain flat into the foreseeable future, requiring innovative solutions to evolve the effort. Still, she made the "return on investment" argument by citing several studies that indicate a positive cost offset for effective medical-behavioral interventions

Robinson Beale discussed three strategies that promote EB practice. First are behavioral-medical approaches, which include identifying eligibles, tailoring assessments, coaching, wide referral networks, monitoring of timeliness and outcomes, and outreach to consumers. Second are condition management

approaches, which involve early identification, severity stratification, and a wide scope of services including case management and web and telephone-based tools. Third are managed delivery systems approaches, which include identification using diagnoses, utilization patterns, referrals, severity stratification, acute case management, stabilization or recovery services (e.g., employment, housing supports), reminder systems, and specialized providers and contracting.

The last slide of Robinson Beale's presentation summarized valued-based behavioral health benefits. She concluded by noting that problems in the delivery system include great variability across providers and an absence of outcomes monitoring. Regarding most providers, Robinson Beale said "they don't really know what their outcomes are." From there she described a program instituted (presumably by United Behavioral Health) for their outpatients that involves the collection of outcomes information, including substance abuse and work absenteeism data. These data are then made into "profiles" that are periodically delivered to the provider so that they can self-monitor and adjust the treatment plan they have been implementing.

Rick Lee, M.P.H. and senior vice president for employer solutions at Magellan Health Services, provided a complementary presentation on the benefits design process in the private sector from a business perspective. Lee made the case that employers are beginning to spend energy on increasing access to behavioral health care rather than denying it. He displayed several slides related to the "hidden" workplace costs associated with behavioral health problems, including lost productivity and "in-office absenteeism." As a result of these costs, employers are moving toward behavioral change programs, such as behavior modification techniques, incentives and reinforcements, and personal action plans. These programs are targeted toward a more inclusive range of people rather than limited to those with a behavioral health diagnosis.

Lee's presentation, Employers' Coverage Decisions in Private Insurance: Deciding What to Cover and Include in Benefit Designs, spent considerable time arguing for the benefits of behavioral health coverage. He noted that while behavioral health care accounts for only 1-2 percent of total benefits, 60 percent of all health care can be linked to behavioral health issues. Depression-related illnesses impact 9 percent of the workforce, resulting in 25.6 days of lost work per person. Lee further noted that only 20 percent of behavioral health claimants consume 70-80 percent of the behavioral health dollars and 75 percent of behavioral health expenditures "stem from preventable chronic conditions." He cited the Institute for the Future to demonstrate that behavior accounts for 50 percent of the determinants of health status while genetics and environment account for only 20 percent each.

Unique challenges of encouraging behavioral change were reviewed, including the problem that behavior has irrational components. Referring to psychological concepts such as the placebo effect and the importance of the patient-doctor dyad, Lee advocated for coaching as an important strategy for promoting behavioral change.

The presentation closed by stressing the importance of tailored interventions to motivate idiosyncratic behavioral change while simultaneously noting that such approaches can be resisted by employers who make the mistake of relying on "denying benefits to the 1 to 2 to 5 percent that have DSM conditions."

The Q&A session began with a question about the relevance of exnovation from the insurer perspective. Lee said that substance abuse counselors were previously in the workplace, whereas now they are offsite so as to provide more confidentiality for clients. Robinson Beale said the biggest challenge regarding exnovation was monitoring outpatient care, which can be so variable and diffuse in comparison to inpatient care. A question about how coaching approaches coincide with group therapy approaches (e.g., Alcoholics Anonymous) prompted reference to the Internet as a resource for patients to communicate with one another, but also as a resource that is yet not readily available to many Medicaid clients. One audience member noted that public mental health benefits are typically much more generous than private ones and asked the speakers to comment about that apparent inequity. Lee responded that employers typically are focused on worker productivity, not mental health costs. Robinson Beale commented that many employers actually had very limited knowledge/understanding of what mental health benefits they support. Finally, two audience members asked about mental health parity. In response, Lee said employers want pay-for-performance and cost sharing strategies (co-pays). Robinson Beale agreed, and further noted that innovation, including strategies that favor outcomes rather than specialty-based reimbursement, would be key to actually achieving parity. Lee gave a specific example of incentive-based strategies regarding co-pays: citing the work of Jack Mahoney, he noted the favorable potential of eliminating co-pays for chronic condition treatment because it is not wise to discourage such utilization. As he put it, "why would you want to create an economic barrier for an asthmatic to get a nebulizer?"

Luncheon Presentation: Mental Health Systems Transformation: Imperatives and Pitfalls

Spurred by the President's New Freedom Commission on Mental Health, ambitious mental health systems transformation efforts are underway in a variety of states. **A. Kathryn Power**, M.Ed., the director of the Center for Mental Health Services of the Substance Abuse and Mental Health Services Administration (SAMHSA), gave an energetic presentation on transformation activities at both the federal and state levels.

She began by saying "we are moving forward at all levels," and emphasized the importance of financing mental health services along with other aspects of that delivery system.

At the federal level, Power described four dimensions of work in transformation. First, SAMHSA is awarding five-year State Incentive Grants to governors in an effort to give states wide latitude to implement mental health infrastructural change. (Power noted 55 different kinds of ongoing transformation across states). So far, Maryland and eight other states have been awarded these grants. Second, an unprecedented federal Executive Steering Committee on mental health has been created, bringing together top level officials across agencies involved in or affected by the mental health service delivery system. Among their challenges is to promote consumer-centered care, clarify federal funding opportunities, and eliminate the "many urban myths" that sometimes surround them. Third, the Center for Mental Health Services is providing consultants to states for transformation efforts. And Finally, SAMHSA is disseminating EB practice toolkits. Each kit includes implementation guidelines and fidelity measures; in the future they will also include information about available funding streams.

Following this description of federal activities, Power commented that states are the "centers of gravity for transformation." She noted that Georgia was the first state to offer Medicaid-funded peer services; Ohio is using computer technology to involve consumers; and Oklahoma is conducting a financial analysis to build a business case for investment in mental health. New Mexico's Collaborative was also noted as an innovation that will likely advance the recovery movement because it has encouraged several different agencies to increase coordination.

Power cited the importance of public-private collaboration in the overall delivery of mental health services. She strongly recommended the following document to the audience: "An Employer's Guide to Behavioral Health Care Services," a collaborative effort complied under the auspices of the Nation Business Group on Health (see: www.businessgrouphealth.org/pdfs/fullreport_behavioralhealthservices.pdf). Practices outlined in that report, she said, are backed by years of evidence and are ready for widespread use.

Power concluded her presentation by stating that transformation is meant to be a "complete upheaval" of the current system and a multiphase process with many components.

During the luncheon Q&A session, Power cited efforts by SAMHSA to deal with each of the following three issues:

1. War-triggered post traumatic stress (Power herself is in the military and sat on a recent commission looking at this and other issues associated with care for veterans).
2. The delivery of culturally competent care (an effort she said lagged behind most others at SAMHSA).
3. The diffusion of integration models for behavioral and other aspects of medical care (Power said that at least five such models existed and she predicted that SAMHSA would soon host a meeting on this issue).

Session 3: Bridging the Agency Gap: Coordinating State-Financed Mental Health Services

Because mental health services are dispersed across a wide variety of human services agencies, this session explored strategies to improve the coordination of mental health services across agencies and programs. The executive director of the Maryland Mental Hygiene Administration, **Brian Hepburn**, M.D., served as the moderator.

Larry Fricks, the director of the Appalachian Consulting Group, opened Session 3 by providing a consumer-oriented perspective on navigating the fragmented service system. As a consumer in the mental health delivery system, Fricks reported that consumers with mental illness have to deal with three issues: the symptoms, the stigma, and the negative self-image.

Fricks continued by describing some innovative programs, including his peer-to-peer counseling program first implemented as a Medicaid-reimbursable program in the state of Georgia. He also referred to the emerging self-management model that is currently being studied by Benjamin Druss at Emory University. To emphasize the need for effective programs such as these, Fricks provided several slides demonstrating the extraordinary increase in relative morbidity

and mortality experienced by those with mental illness (a disease burden correlate that Kathryn Power also referred to in her remarks). Specifically, he cited a study which found that "people with serious mental illness served by the public mental health system die, on average, 25 years earlier than the general population" (National Association of State Mental Health Program Directors, 2006, p. 11).

Fricks concluded by saying that increased morbidity and mortality is linked to many preventable medical conditions (e.g., metabolic and cardiovascular diseases) and health behaviors (e.g., smoking and substance abuse), thereby exposing the need for a comprehensive disease management approach to facilitate recovery for individuals with severe mental illness.

The second presentation for this session was given by the president of DMA Health Strategies, **Richard Dougherty**, Ph.D. He reviewed several Medicaid behavioral health financing options, including the authority/collaborative arrangements between Mental Health Agencies (MHAs) and other state or more local level entities. His presentation, Organizing and Financing Mental Health Services, began by addressing trends and their origins.

State-based trends included: multiple strategies, increasing use of federal funds, and increasing managed care use. Variation was attributed to historical idiosyncrasies related to how agencies share responsibilities among themselves (statewide and locally), differences in the adult versus child care approaches, managed care design (e.g., fee-for-service vs. waiver with a partial carve-out), and the use of novel strategies.

Dougherty briefly reviewed five models for managed behavioral health care: regional carve-outs; integrated plans; risk-based behavioral health carve-out; carve-out with an administrative services organization; and severe mental illness population carve-out.

He then touched on financing approaches from at least eight states. The most elaborate was that of Massachusetts. It has a centralized MHA under a state Health and Human Services Department. The MHA had a statewide and several area offices and also purview over a managed behavioral health authority. The MHA fed resources to various other state agencies as well as to managed care organizations or providers via fee-for-service payments.

Diagrams for Michigan, California, Pennsylvania, and Tennessee health systems were also presented. Dougherty used a slide depicting the New Mexico Behavioral Health Collaborative to point out that despite increased cross-agency and cross-state coordination, many "boxes" (silos) still exist in that system. A separate slide depicted the myriad of subcomponents that typically compose state efforts concerning the mental health of children and adolescents (e.g., schools, MHAs, juvenile justice programs, and SCHIP). One slide showed a coverage decision flow chart for Rhode Island regarding the use of services that fall under the state Department of Human Services and/or the Department of Children, Youth and Families. Dougherty also discussed Maine's mental health spending to identify gaps between funding and actual services streams. This type of data review (revenues versus actual spending) is a strategy of accounting advocated for all states and inspired by work initiated in 2004 by Ted Lutterman et al. called the "Other State Agency Study" (www.nri-inc.org/projects/OSA/).

Dougherty's conclusions regarding organization and financing of mental health

services indicate that some reforms could be FFS-based, that money should "follow the person" so as to incentivize continuity of care, and that provider financial situations should be considered.

During the Q&A portion of Session 3, Dougherty remarked that cohort (special population) pilots are the norm for interventions because state officials are generally too fearful to risk wide-spread and permanent implementations.

Session 4: Moving from Silos to Systems: Coordination of Somatic, Mental Health, and Substance Abuse Services

While Session 3 addressed interagency issues, this session addressed fragmentation issues associated with the traditional boundaries that tend to separate mental health, substance abuse, and somatic care systems. **David Salkever**, Ph.D., professor of public policy at UMBC, moderated this session.

David Shern, Ph.D., president and CEO of Mental Health America, gave the opening presentation, From Silos to Systems. He began by noting that mental health practitioners were previously optimistic that full coverage integration (i.e., full inclusion) of mental health services in managed health care plans would promote greater overall health care coordination. He reviewed several points of evidence supporting the goal of increased integration of mental health, substance abuse, and somatic care. He then described a Florida demonstration project comparing FFS, carve-in, and carve-out programs for a Medicaid population. This demonstration did not indicate any carve-out/in design effects on access, quality (in fact FFS was noted as being most correlated with guideline compliance), or cost.

Shern then reviewed Aetna's PCP depression initiative as a specific example of primary care and mental health care integration. Favorable longitudinal changes were reported in an uncontrolled observational study with regards to symptoms assessed using the SF-12 mental and physical health indicators. Reviews of medical utilization and costs indicated decreases with time. Shern's penultimate slide demonstrated the multitude of state entities in Florida that deal in some manner with mental health and substance abuse problems. It also showed that coordination problems extend far beyond primary care and mental health care efforts.

Shern concluded his presentation by stating that strategic leadership and information management are critical.

Allen Daniels, Ed.D., professor of clinical psychiatry at the University of Cincinnati, continued the session with a discussion of individual care coordination as a remedy for cross-silo fragmentation. He opened his presentation, Managing the Coordination of Care Across the Health Care Spectrum, with a review of the effects of mental illness on other chronic conditions and the associated costs. Specifically, he showed how co-morbid depression increases treatment costs several-fold for many common and sometimes chronic somatic conditions. Daniels' data came from a 2002 study by Sheehan et al., which was also noted by at least two other presenters. In making the case for coordination of care, Daniels also cited the 2005 IOM report on Mental and Substance Use Disorders and noted that poor linkages across systems of care was one of the report's six targets.

Following his introduction, Daniels described five successful models of care coordination. The first model was from the UC Health Partners and was conceptualized with a simple 2x2 matrix of care ranging from routine primary care to intensive coordinated care. The Stages of Change Model of Prochaska and DiClemente was used to delineate the sometimes cyclical path of desired behavioral change. The strengths model of care (Rapp, 1985) was cited to underscore the importance of client-centeredness. A chronic care model (Wagner, 1998; Daniels and Adams, 2007) emphasized patient outcomes and their involvement in their own care. The final model, a peer support model that, as the name implies, involves recovered individuals working to assist those with current mental health needs. Here Daniels noted that insurers currently were not paying for peer support despite success in places such a Georgia (as noted in Larry Fricks' presentation).

Daniels then discussed how fostering productive team activity is a critical component of case management. He cited "Motivational Interviewing," developed by Miller (1992) as a useful construct to building team cooperation. Techniques central to this method include: empathy, avoiding argumentation, and supporting self-efficacy.

In conclusion, Daniels stated that providers are constantly presented with gaps in medical care that are opportunities for case management. His example of this is medication non-compliance, which can escalate gradually to a point where, with time, only a small percentage of clients actually maintain their recommended medication regimen. The implication of this example is that case management strategies can and should address undesirable interruptions in therapy.

Sally Kroner, M.D., a psychiatric consultant for Medicaid to the New Mexico Human Services Department, provided the final presentation of the session, States as Change Agents. Kroner gave an overview of the newly formed New Mexico Behavioral Health Purchasing Collaborative and discussed its successes and "lessons learned" in coordinating care across the behavioral and somatic health domains. The collaborative, developed in 2005, includes 17 state agencies and manages all behavioral health funding in the state, including Medicaid, block grants, state general funds, and community corrections.

Kroner's presentation focused on both physical/behavioral health integration and substance abuse/mental health integration. Before July 1, 2005, when Value Options (VO, www.valueoptions.com) became the managing behavioral health entity, New Mexico employed a fully integrated behavioral health approach with all services offered in Medicaid, although providers had to contract with multiple entities. Pharmacy reimbursement was tied to provider type. Kroner believes that VO has created a simpler "common process" for referrals. Communication across entities is facilitated by monthly meetings to discuss complex cases, but "turf wars" persisted (e.g., for autism, both physical and behavioral health providers claimed jurisdiction). According to Kroner, New Mexico suffers from a significant shortage of mental health workers, though gradual improvement is being realized with state-sanctioned rate increases. Another current challenge is integration in non-Medicaid programs (e.g., uninsured). For substance abuse, the Medicaid benefit is very limited, which also inhibits better integration (e.g., only 12 hours of outpatient therapy for those over the age of 21).

Before the collaborative was formed, New Mexico was quite fragmented regarding the delivery of mental health and substance abuse services, except for screening programs in both systems. Kroner said that this fragmentation persists and must be addressed. New Mexico's long-term goal is to integrate mental health and substance abuse treatments at the provider level into one agency that will provide both services and not just screening. If this were to happen, Kroner continued, it would need state mandates (e.g., licensing, certification) to foster the change. She believes an important part of the process is consensus development that includes providers and consumers.

During the Q&A for Session 4, a question about tailoring programs for minority groups yielded a response that included careful consideration of HIPAA guidelines. An inquiry regarding information technology's importance in integrating disparate health systems prompted Shern to affirm its central importance. Kroner further lamented that too many of New Mexico's providers do not have an IT infrastructure. During the discussion, Kroner also said that New Mexico's providers were generally not skilled in the treatment of those with dual diagnoses (i.e., substance abuse and mental illness).

Reflections

Howard Goldman, M.D., professor of psychiatry at the University of Maryland School of Medicine, framed the day's proceedings by commenting on "three key policy tensions" currently in the mental health services policy arena.

The first tension is between the strategies of exceptionalism and mainstreaming. Goldman said that Frank and Glied's recent book (reviewed by Hogan at the beginning of the day) nicely describes how the mental health field has moved away from separate and special health policy provisions to ones that place mental health more in the mainstream of medical care. He noted that this emergence into the mainstream is not complete (in part because parity has not been achieved), and he also noted that being in the mainstream carries with it challenges. Goldman further stated that concern about these challenges was not new and dated back to his experiences from the 1970s.

The second policy tension surrounds the locus of control for mental health service delivery, ranging from localities all the way to the federal level. Goldman asked these rhetorical questions: where should responsibility fall, and what is the right balance of resources at each level? He also stated that public-private tensions are part of this locus of control issue, and that "finding the right balance of resources and responsibilities is probably one of the most important general questions that needs to be resolved."

The third and final tension Goldman described and focused on was that between the concept of "transformation" and less iconoclastic and dramatic policy change. He elaborated further:

> Transformation has embedded within it a vision of tremendous change…And yet, the reality is that we live in a world not of broad, fundamental, ideologic change, but in fact we live in a world driven by incremental change….How then do we pull off transformational change in a world where incrementalism is often the best chance that we have?

As part of his argument in favor of gradual strategic change toward transformation, Goldman introduced the term "sequentialism," a series of incremental steps that leads one to success. As a metaphor, he noted that a hitchhiker, in lieu of the perfect pick-up, can make considerable progress by finding rides in the direction of his or her intended destination.

During the final few minutes of his presentation, Goldman reflected on what he believed to be the single most important new idea cast in the New Freedom Commission Report. In doing so, he noted that many would distinguish: recovery, consumer-centered care, or evidence-based practice as the most important novel concepts put forth in that distinguished report. Goldman, however, identified "stewardship" as the most important new idea from the Commission and linked that concept to the battle against fragmentation.

Goldman went on to comment that in New Mexico, the stewardship provided by Governor Richardson, Pamela Hyde, and others was exemplary, whereas in other states, including Maryland, the underlying infrastructure is the strongest component of their systems. According to Goldman, Maryland, among other states, has excellent resources such as well-established EB practice programs—which in part have been developed by strong state leadership—and yet no broad stewardship has emerged to move the overall mental health service system toward complete transformation.