American College of Mental Health Administration
Santa Fe 2009 Summit Report
Written by the Texas Health Institute with "Implications for Texas" included.

The meeting, chaired by Camille D. Miller, President and CEO of the Texas Health Institute, with the theme ***"Behavioral Health: Embracing Health and Wellness"*** was held March 12-14, culminating with ACMHA's 30th Anniversary celebration. ACMHA summit presenters discussed health care reform, the elimination of health care disparities, mental health parity, and emerging peer delivery services and best practices.

What Do We Mean By Health and Wellness?

In order to discuss the role of behavioral health in a health and wellness movement, we must first understand the framework that defines this agenda. Presenters included such topics as Healthy People 2020, the affects of behavioral health on achieving wellness, moving from an illness system to determinants of health, addressing health equity and disparity issues, and the movement to "all health is local and individuals need to take charge of their own health."

"Being One Dimensional in a Two Dimensional World"
Ronald W. Manderscheid, PhD, Moderator
Director, Mental Health and Substance Use Programs, SRA International
Adjunct Professor, Department of Mental Health,
The Bloomberg School of Public Health, Johns Hopkins University

Ron Manderscheid, Ph.D., director of the mental health and substance use program at SRA International, Inc., moderated the opening session. "We're having an economic meltdown," he told summit attendees, noting that it represents a "complete change in the environment in which we operate." "Health reform is an imperative, not an option," said Manderscheid. "We should perceive it as an opportunity for behavioral health care."
The recommendation of a bridge between disease and health is not a new model, but one that has been around for 30 years, he said.

Manderscheid also cited the U.S. Department of Health and Human Services' (HHS's) national initiative, Healthy People 2020, an effort requiring the participation of all federal agencies. The goal of the initiative is to promote health and prevent disease.

"Working Upstream in Mental Health"
Patrick Remington, MD, MPH
Director, UW Population Health Institute, University of Wisconsin Department of Population Health Sciences

Patrick Remington, M.D., M.P.H., director of the Population Health Institute at the University of Wisconsin, Department of Population Health Sciences, said mental health disorders are the outcome of many different causes, including genetics, family history, poverty, unemployment, divorce and social isolation. "We need to think about system change, not conceptual changes," Remington said. "Public health focuses "upstream" on providing environments where people could remain healthy," he said.

He discussed the underlying causes of disease, such as tobacco and alcohol use and poor diet. These causes are well-documented. On the other hand, determining causes of depression, he said, depends on how far you are willing to go "upstream" in areas of public health such as peer pressure, poverty and education.

"Using Food and Nutrients to Achieve Healthy People 2020 Objectives"
Ingrid Kohlstadt MD, MPH, FACN
Food and Drug Administration, Office of Scientific and Medical Programs

Mental illness shortens the lifespan by 20 to 25 years primarily because of chronic disease, Ingrid Kohlstadt, M.D., M.P.H., a Commissioner's Fellow at the Food and
Drug Administration's (FDA's) Office of Scientific and Medical Programs, told attendees. "Food and nutrients can level both physical and mental health," she said.
Dr. Kohlstadt indicated that food and nutrients can help achieve the objective of Healthy People 2020, science-based, 10-year national objectives for promoting health and preventing disease. "People need to be connected and encouraged to do the right thing for their health." According to Kohlstadt, depression and poor nutrition typically do not appear on a death certificate. She noted the "detriments" of trans fats developed during the 1950s from plant oil, originally developed with the intention of making the oils a more solid and healthy substitute for saturated animal fat. "We now know trans fat is unsafe." She noted that one of the components of weight gain in consumers with mental health disorders is the second-generation atypical antipsychotic medications. While some may gain weight and it's still important to continue their medication, some individuals may also become sleepy, she said. "Those 20 extra pounds may cause a person to have sleep apnea," said Kohlstadt. "Astute clinicians can detect that."

Kohlstadt noted that four key areas will help achieve the Healthy People 2020 Goals: 1) therapeutic breakthrough, 2) personalized medicine, 3) early disease detection and 4) clinical preventive services.

Implications for Texas:
Texas is in a unique position of having public health and behavioral health state program administration consolidated within one agency: the Department of State Health Services (DSHS). DSHS has the responsibility of addressing the Healthy People 2020 Objectives. Efforts should be made to have conversations and strategic plans that span across programmatic areas to ensure that mental and behavioral health issues are addressed along with activities addressing nutrition, obesity, diabetes, and other chronic conditions.

Additionally, emphasis should be taken to strengthen integration, particularly in community-based primary care and behavioral health agencies.

Making the Case for Behavioral Health in the Health and Wellness Agenda
This session focused on the connection between mental health/substance use issues and health and wellness. It transitioned from the first session and helped lay the ground work for the focus of the entire Summit.

Ellen Grant, PhD, LCSW, Health Consultant

Health disparities cause inadequate access to care and substandard quality of care, said Ellen Grant, Ph.D., LCSW, a healthcare consultant. "There is a tremendous impact on the bottom line if companies don't eliminate health disparities," she said. Employers should see the new federal parity law as an asset to help them and to help their employees receive more effective care, not to mention the reduction in hospital and pharmaceutical costs and health care costs overall, Grant said. She went on to say that insurance companies should have a mandate to report on outcomes for health status of diverse populations in the workplace and to provide the data needed to address the elimination of health disparities with the assistance of the new administration in Washington.

Meanwhile, Grant said she is "heartened" by Rep. Patrick Kennedy's (D-R.I.) planned White House Conference on Mental Health and NeuroScience because it has the potential to raise awareness of the neurobiological and experiential interactions that cause mental disorders with implications for more targeted research and better interventions.

David Shern, PhD, President/CEO, Mental Health America

The dichotomy of improving services for the mentally ill and the vision of prevention and promoting mental health must be addressed from a population-based viewpoint and needs to be at the center of the healthcare reform debate, Shern indicated. He noted that mental illness and substance abuse are the most prevalent chronic diseases and contribute to many co-occurring physical chronic conditions.

Dr. Shern noted that a new landmark report by the Institute of Medicine (IOM) titled "Preventing Mental, Emotional, and Behavioral Disorders Among Young People: Progress and Possibilities" underscores the importance—and scientific basis—not only of preventing or preempting the occurrence of major mental disorders among individuals who exhibit preclinical symptoms, but also the need for broad population-based strategies aimed at promoting mental health.

Deborah Fickling, Behavioral Health Ombudsperson, New Mexico Human Services Department

Ms. Fickling emphasized the need for a paradigm shift to promote personal responsibility in all of health care and a need to talk "wellness" rather than focus on illness or disease.

Implications for Texas:
A public health approach is needed to address prevention and wellness. Again, Texas is in a unique position to address mental and behavioral health utilizing a population-based approach. Conversations need to take place with insurers to make the business case for providing preventive services to everyone and to promote outcome-based orientation rather than a procedural focus in terms of reimbursement.

Dr. Nancy Speck will be representing Texas at the White House Conference on Mental Health and NeuroScience and will be able to bring back the latest research findings to make these business and scientific cases to stakeholders and lawmakers.

Self-Directed Care/Disease Management Models
Presenters underscored some of the emerging peer-delivered best practices in key domains framed by national experts to help attendees understand the variety of models and programs available that people may use to manage their own care.

The focus of the discussion centered on living a life in the community and not simply treatment and services. Models included Peer-Brokered Self-Directed Budgeting, Peer Health Care Coaching, and Peer-Run Crisis Diversion.

Harvey Rosenthal, Executive Director, New York Association of Psychiatric Rehabilitation Services

Peer support services and programs are helping people with psychiatric disabilities move toward recovery and live a full life in the community, Harvey Rosenthal, Executive Director of the New York Association of Psychiatric Rehabilitation Services (NYAPRS), told attendees. Peer services are especially needed during these challenging economic times, Rosenthal noted. The services, however, are not modest, nor are they about traditional or clinical treatment, he said. "These services are not about hiring someone to work in

your agency and provide case management services," Rosenthal said. "Peer support is an emphasis on empathy, not pity, on validation and not diagnosis."

Rosenthal cited NYAPRS' Peer Bridger Project, a program that combines two top goals: reducing state hospital census and promoting peer support. The Peer Bridger model infuses recovery and cultural competence in hospital and community service settings, he said. The program is currently implemented in six state hospitals in New
York. "This program helps people make the transition to the community," said Rosenthal. Peer support helps people and systems to get "unstuck." Peer support meetings provide an opportunity to offer a circle of support in each of the hospitals, he said. "We support each other to get out of the hospital, stay out of the hospital and get the hospital out of us," he said. "Peer bridgers live in the community in which folks are returning." They assist consumers leaving the hospital, for example, by helping them locate churches, secure bus passes and other community supports. "They're very focused on transitional support," he said. The Peer Bridger Project has helped about 251 individuals, noted Rosenthal. According to 2007 re-hospitalization data, approximately 136 of these individuals were not re-hospitalized in the state psychiatric centers in 2007.

Steve Miccio, Executive Director, PEOPLe, Inc.

The Rose House Hospital Diversion Program, available in Ulster and Orange counties in New York State, provides a crisis peer support environment for consumers. The program assists consumers who are seeking temporary resident care and respite care from one to five nights in a supportive, home-like environment, said Steve Miccio, Executive Director of PEOPLe, Inc., (Projects to Empower and Organize the Psychiatrically Labeled), a peer-run, not-for-profit organization that provides advocacy and an array of services for people with psychiatric disabilities. The Rose House's services help "at-risk" individuals to break the cycle from home to crisis to hospital. The program offers video games, and an exercise room and "allows people to be distracted from their crisis," Miccio said. "They [consumers] can share experiences with the staff and talk about wellness and recovery." Rose House's services also include "warm lines" —telephone support lines answered by trained consumers who can offer support and listen to concerns. The program uses a "no-nonsense, commonsense approach," said Miccio. The daily rate at the Rose House is $132 a person, compared to hospitalization's daily average cost of $1,200, he said. Figures show that 274 unduplicated guests resulted in savings of $1.3 million "in Medicaid dollars that didn't have to be spent," Miccio said. "It is a return on the investment."

Miccio said he is currently working with peer advocates at Brooklyn, N.Y. psychiatric hospital where a patient died last year in an incident that prompted a national outcry from the field. The role of a peer can be seen as an ally, mentor, partner, cheer-leader or coach, Miccio said. Miccio told attendees that staff at PEOPLe Inc. consider themselves recovery specialists in transformation, "We're a common-sense approach to wellness and healing," he said. "We do expect people to recover."

Implications for Texas:
If Texas had had a "peer bridger" program, the tragedy of the woman released from a Texas state hospital who subsequently died before reaching home, could have been prevented. There is a **dire** need for Texas to develop such a program to assist persons leaving residential facilities to integrate successfully back into the community.

Texas needs several "Rose Houses" to assist people in their recovery and to provide a safe environment for them to live while they are in crisis. Both Harvey Rosenthal and Steve Miccio should be asked to consult with Texas stakeholders regarding how to implement these programs in local communities.

A. Kathryn Power, MEd, Director, Center for Mental Health Services, SAMHSA

"We stand on a precipice of a new day in health care," A. Kathryn Power, M.Ed., director of the Center for Mental Health Services (CMHS) at the Substance Abuse and Mental
Health Services Administration (SAMHSA), told attendees during the March 12 summit luncheon. Power pointed to troubling statistics, noting that the American Psychological Association (APA) reports that one-half of Americans are increasingly stressed. The National Suicide Prevention Hotline reported a 30 percent jump in calls from individuals who have either lost their jobs or their homes or are afraid those situations will occur to them, she said. These "perilous economic times," remain a daunting task for the behavioral health field, she said.

Power told attendees they have a significant role to play in health care reform. "We must bring our intimate knowledge of co-morbid conditions to all discussions of health care reform," said Power. "We must move beyond reforming health care to focusing on reforming health." Power pointed to the recent release of the Institute of Medicine (IOM) report focusing on making the prevention and promotion of mental health for young people a national priority. The report, "Preventing Mental, Emotional, and Behavioral Disorders Among Young People: Progress and Possibilities," was sponsored by SAMHSA. SAMHSA is pleased that the new report updates a previous 1994 IOM report, "Mental Health Disorders: Frontiers for Preventive Intervention Research," said Power. The new report helps provide the basis for understanding the science of prevention, she said. Power noted that one-half of diagnosed mental health cases are diagnosed by the age of 14. "The first symptoms start two to four years before the diagnosis of developmental disabilities," she said. "We have the opportunity to respond." Power added, "This report reaffirms the importance of mental health prevention." The nation, she noted, is now equipped to help young people with healthy habits to live productive lives. The report also revealed school-based initiatives to help improve academic outcomes, she said. "It is good news from the IOM," she said. "We know it intuitively, now we know it definitively."

Power noted that SAMHSA plans to expand its "What a Difference a Friend Makes," an initiative for young people ages 18 to 25 that is designed to help motivate a societal change toward acceptance and decreasing the negative attitudes that surround mental illness. The initiative will be directed to the African American, Native American, and
Asian youth community with the goal to reduce stigma and bias and help young people support one another, she said.

To have an impact on health care reform, Power told attendees to "never forget the core mission to ensure quality care for individuals with mental health and substance abuse" issues. "We have a critical role to play to provide leadership to the field," she said.

Implications for Texas:
We should connect Tarrant County Project Transform with SAMHSA's social marketing campaign geared toward youth to help in the expansion of the "What a Difference a Friend Makes" initiative. Notably, there is an absence of emphasis on Hispanic youth in this initiative and Texas may be able to help with that focus.

Baseline data needs to be collected on the prevalence of mental health disorders in Texas so that as the economic downturn worsens, there is data to support and target specific interventions to meet the growing population.

Again, Texas needs to capitalize on the public health infrastructure to promote prevention of mental health problems, particularly among Texas youth.

Jack Stein, PhD, Director, Division of System Improvement, Center for Substance Abuse Treatment, SAMHSA

Many of the mental health-related presentations during the Summit parallel what's happening in the substance abuse field, Stein told attendees. He said lost productivity in the workplace and health care costs attributable to substance abuse amount to $276 billion. He pointed to SAMHSA's National Survey on Drug Use and Health (NSDUH) report, which found that more than 20 million people who need substance abuse treatment do not receive it. Additionally, 95 percent of people in need of some type of treatment do not believe they even have a need for treatment, Stein said.

Stein noted that a number of strong studies demonstrating the cost-effectiveness of services need to be leveraged more effectively. He noted that the field should learn a better way of packaging these reports in a way that actually resonates with policymakers." Progressive health care reform efforts are occurring in Massachusetts and Vermont, he said. "How can we share these lessons nationwide and on a federal level?" asked Stein.

Pamela Greenberg, MPP, President/CEO, Association for Behavioral Health and Wellness, ACMHA President Elect

Greenberg said that for the last 10 years she has been advocating for mental health and addiction parity. She said she was pleased to see that the federal mental health parity was included in the economic stimulus package. According to a provision in the new federal parity law, the Government Accountability Office (GAO) will provide a report to Congress that will address any exclusion of specific mental health or substance use diagnoses by health plans, said Greenberg. Also, "If we see a lot of changes in the [implementing regulations for parity] that will give us a chance to go back to Congress," she said.

Ronald W. Manderscheid, PhD, Director, Mental Health and Substance Use Programs, SRA International, ACMHA Board Member

Manderscheid spoke about the Whole Health Campaign that was initially organized at the 2007 Santa Fe Summit to create a common platform on healthcare reform. The campaign, which originally comprised 40 organizations, now has 107 organizations enlisted, he said. Manderscheid reiterated the campaign's three key principles: 1) to ensure good insurance coverage for mental health and substance abuse coverage, 2) good integrated care and 3) good preventive and early intervention efforts. "We impacted the Democratic and Republican platform with those principles," he said. A plan to put together seven policy papers for health reform is expected to be completed by the end of March 2009, he said.

Manderscheid also noted that the issue of universal coverage is a major one for the field. Universal coverage is "going to take a multifaceted approach, which will include Medicaid, Medicare and the State Children's Health Insurance Program (SCHIP)," he said. "One third of people with mental health and substance abuse have no insurance," Manderschied noted.

Implications for Texas:
Texas needs to have conversations with businesses and insurers, making the business case that mental health and substance abuse prevention and treatment will help their bottom line, particularly as we move forward on health care reform and the implementation of mental health parity.

The Transformative Role of Health Information Technology
Discussion in this session focused on Health Information Technology in the healthcare delivery system. The policy/issue context sets the stage for its role in provider-consumer communications, continuous quality improvement, and self-management for recovery. How can data/reports impact clinical care? Why is data important? What data is available? What technologies are helpful? How is data shared among partners in the system of care while assuring protections of confidentiality?

"The Role of Health Information Technology in Improving Care Coordination & Quality"
Garrett Moran, PhD, Associate Director, Westat

Dr. Moran outlined the policy and political context for health information technology. This included:
- Facing a major economic crisis & budget cuts
- Health care spending growth unsustainable
- US health care quality is not commensurate with our level of spending
- Too many serious medical errors
- Growing problem of uninsured
- Significant disparities in care across groups
- Health information technology is seen as a key part of the solution
- American Recovery and Reinvestment Act includes $20 Billion for Health information technology

Dr. Moran stated that treatment of chronic conditions drive health care costs (85% of all health care spending is for chronic conditions) and **mental disorders** are the fourth most costly type of chronic disorder.

Health IT can support:
- Better quality – through compliance with established clinical guidelines and continuous quality improvement
- Self–management – through collaborative care planning and shared decision making and personal health records
- Reduced costs – by using service and outcomes data to determine which interventions and system structures are cost effective
- Reduced prescription errors – through computerized provider order entry
- Health information exchange – between provider organizations and public health

"The Role of IT in Mental Health Integration"
John Wadsworth, Data Architect, Intermountain Healthcare

John Wadsworth presented four principles for IT success in mental health integration:
- Communication – Problem with language between IT staff and clinicians; IT Staff do not speak "clinical" (e.g., PHQ9, Vanderbilt, SSRI) and clinicians do not understand IT "speak" (e.g., EMR, Enterprise Data Warehouse); IT solutions must support clinical work flow (not too many "clicks."
- Data Capture – Data entered must be able to be retrieved. Text may add value, but is difficult to search effectively; Need to use standard coding and all multiple sources for data capture (claims, billing, Rx, EMR)
- System Interoperability – must be able to integrate between care management and EMR – systems must not be siloed.
- Meaningful reporting – Must involve users (including frontline staff) in determining who needs the data, what data is needed, when should it be reported, and what is the purpose of the report.

Lessons learned by Intermountain Healthcare in the development of their system included:
- Clinicians must partner with IT throughout entire project life-cycle
- Support clinicians and IT in open communication
- Capture information in coded format
- Make data accessible (reports or direct access)
- Let business drive requirements for reporting:
  - Meaningful measures

- Credible data
- Fit to clinical work flow
- From simple (spreadsheet) to complex (business intelligence)
- Welcome feedback from consumers – iterative process

Wayne H. Cannon, MD, Primary Care Clinical Program Leader, Intermountain Healthcare

Dr. Cannon presented several key messages regarding design of clinical integration systems:
- IT needs to be part of the team
- Receiving data at the point of care is preferred by clinicians and improves care
- Coded data will get into the database more readily if entering it is part of the regular day to day process
- Population-based data is also important to the system and clinicians

Dr. Cannon presented the Mental Health Integration Treatment Cascade Model that is integral to the transformation of delivery and cost at Intermountain Healthcare. This model involves standardized mental health integration tools to gather patient information and assist in risk stratification, diagnosis, and care planning.

Implications for Texas:
As Texas moves forward with the Health Risk Assessment Pilot along with Clinical Management for Behavioral Health Services (CMBHS), care needs to be taken to evaluate the interoperability of the data that is being captured and to ensure that these tools do not generate additional staff time and costs to the providers.

Additionally, there are some inexpensive Personal Health Records systems that should be investigated for use with Mental Health Transformation (MHT) consumers. These records could assist the consumers with self management and give providers needed information at each visit.

Finally, Texas public health infrastructure lends itself to providing population-based data that is needed by clinicians. There should be movement to work in sharing this information in a more real-time environment to make clinical decisions.

Addressing Diversity and Health Disparities in Promoting Health and Wellness

This session addressed the intersections of health, mental health, and wellness requiring attention to both cultural perspectives on each of these concepts and the structural barriers to equitable services within culturally diverse populations. A holistic conceptualization of "health" and the integration of health and mental health service delivery may contribute to the reduction of health and mental health disparities. A dialogue around these issues and the potential promise of using a public health approach to mental health service delivery was presented.

Vivian Jackson, PhD, LICSW, Senior Policy Associate, National Center for Cultural Competence and the National Technical Assistance Center for Children's Mental Health, Georgetown University Center for Child and Human Development

Arthur C. Evans, Jr., PhD, Director, Philadelphia Office of Behavioral Health and Mental Retardation Services

Dr. Jackson stated there is no real difference in prevalence of major mental illness among different population groups. However, there is less access to and availability of mental health services, lack of

receipt of needed mental health services, poorer quality of care, and under-representation in research among minorities.

Disaggregation of data is very important. Dr. Jackson gave an example of using Geographic Information Systems (GIS) to see where providers and services are located in contrast to where people live.

Several models and tools were presented to the participants (see attached PowerPoint presentation), including: 1) matrix on mental health disparities, 2) Africentric Practice, 3) Cultural & Linguistic Competence Benefits, 4) a conceptual framework for a public health approach to children's mental health, and 5) intervention model for children's mental health.

The definition of cultural competence requires that organizations have a clearly defined, congruent set of values and principles, and demonstrate behaviors, attitudes, policies, structures and practices that enable them to work effectively cross-culturally. Five elements of cultural competence at the organizational level include the ability of the organization to: 1) value diversity, 2) conduct cultural self-assessment, 3) manage the dynamics of difference, 4) institutionalize cultural knowledge, and 5) adapt to diversity through policies, structures, values, and services. There are cultural and linguistic implications for: 1) core functions – what we do, 2) human resources and staff development – who we are, 3) fiscal resources and allocation – where the money goes, 4) collaboration and community engagement – who our partners are, and 5) contracts – whom do we entrust to deliver services and supports.

To address cultural diversity, organizations should:
- Use standardized and validated protocols when available and appropriate,
- Require that data is disaggregated according to race and ethnicity,
- Require cross-training of behavioral health and primary health providers,
- Expand the diversity within the workforce by aggressively recruiting and supporting the training of the minority individuals,
- Encourage a community-based and public health approach to treatment,
- Ensure equal distribution of services across communities, and
- Remove barriers to the provision of integrated behavioral and physical health care in social services settings.

Implications for Texas:
Since Dr. Vivian Jackson is with the National Center for Cultural Competence and the National Technical Assistance Center for Children's Mental Health, Georgetown University Center for Child and Human Development, it would be to Texas' advantage to engage her in a workshop or forum with the children's mental health forum organizations on cultural diversity and/or the community collaboratives. This is a wonderful resource of which we should avail ourselves.

In the Beginning: Teaching True Integration and Client Centered Care
Educating medical students to appreciate the importance of treatment integration of physical health, public health, mental health and addictive disorders, and the critical roles they can play is a win-win situation for everyone. Establishing relationships with medical and behavioral health disciplines during professional training is far easier than expecting separate professions to be able to adapt to each other after they are established. This session provided insights from medical school faculty, students, and consumers who believe in this important curriculum content.

"Behavioral and Social Science Teaching at UCLA David Geffen School of Medicine"
Margaret L. Stuber, MD, Jane and Marc Nathanson Professor, Psychiatry and
Biobehavioral Medicine, Semel Institute at UCLA

Dr. Stuber presented on the curriculum at UCLA David Geffen School of Medicine for integration of physical and behavioral health. This curriculum provides for inter-professional education between

advanced practice nurses and third-year medical students. These students are committed to working with underserved populations.

Frank C. Day, MD, MPH, Assistant Clinical Professor of Emergency Medicine, UCLA

The team teaching environment at UCLA is co-led by a physician and a Behavioral Health Specialist. Video vignettes with virtual patients, interactive web-based tutorials, e-portfolios that track progress and assist in the development of action plans, email and blog functions are all elements of the curriculum.

Implications for Texas:
The medical associations of Texas (TMA, TPS, TAFP, TSPP) should be enlisted to assist in the development of a graduate medical education (GME) curriculum around integrated healthcare. A web-based curriculum could be designed around the recent TMA Physician's Resource Guide on Integrating Child and Adolescent Health into Primary Care. Psycho-pharmacology modules developed by Dr. Steven Pliszka should be used as a starting point in the curriculum development. Consultation from UCLA might be useful in working with the medical schools to implement these practices in Texas.

Integrated/Coordinated Care and the Impact on Health and Wellness
What is it about integrated care models that better assists individuals to focus on health and wellness, rather than becoming a series of co-located treatment providers? What do health professionals – physical and mental health – need to do better to help individuals achieve health and wellness?

"From Fragmentation Through Integration to Health Promotion"
John Bartlett, MD, MPH, Senior Project Advisor for Mental Health Program
Activities, The Carter Center

Fifty percent of treated depressive episodes are treated **only** in primary care. Of these, only 30% show significant improvement. "Integrated care can double these results," said Dr. John Bartlett.

Dr. Bartlett talked about the Carter Center Primary Care Initiative, which has the goal to identify and act upon policy levers to scale up evidence-based approaches to integrated care. Dr. Bartlett discussed two of the current projects: 1) Direct to Consumer (DTC) educational/empowerment campaign, and 2) Medical Home Summit – June 2009.

Dr. Bartlett indicated that national healthcare reform will focus on population-based prevention and wellness. The opportunities for behavioral health care include:
- Long-standing focus on recovery and "a life in the community for all,"
- Training in behavioral and social sciences, and
- Extensive experience in the public sector with issues of support systems.

Challenges include:
- A disease focus, and
- Growing influence of prevention and occupational medicine in the field of health promotion.

"Integrating Care: Examples and Possibilities"
Michael Boyle, MA, President/CEO, Fayette Companies

Michael Boyle talked about the Fayette Companies' experience with co-location and integration. Fayette Companies is behavioral health organization located in Peoria, Illinois. Initially, Fayette Companies had screens on public health issues regarding smoke detectors, car seats, abusive relationships, etc.; however, these screens were just filed, not used, so they dropped the screens. Their experience with co-location was that it didn't add value. When they put primary care into MH centers, with part-time

physician from the medical school, they saw a great increase in chronic disease screening and a significant decrease in emergency room (ER) use.

There is a business case for Federally Qualified Health Centers (FQHCs) to integrate with Community MHMR Centers. Persons with severe mental illness often have desirable insurance coverage. There is a better penetration rate than for disparate populations.

Fayette Companies' next venture is to create an integrated crisis center with linkages to primary care and behavioral health care. This center would have a "living room" atmosphere and persons would be greeted by peers. Peers would also provide follow-up when persons leave the crisis facility.

Mr. Boyle indicated things that could be taught to primary care providers to improve services include:
- Motivational Interviewing,
- Cognitive Behavioral Techniques,
- Contingency Management/ Use of Motivational Incentives, and
- Community-based Services Approaches.

An exciting concept presented was the use of mobile Center for Health Enhancement Systems Studies (CHESS) systems that work with personal digital assistants (PDAs) and "smart" phones that are being used by children with asthma (also with women with breast cancer). Patients receive the phones and respond to surveys and "push questions." Patient teams earn points the more they use them. These phones are considered "cool." Cancer patients that used CHESS and provided feedback to physicians and nurses had significant improvements in longevity and better pain management and outcomes. There was no difference, however, in depression scores. Initial analysis indicated that physicians did not know what to do with the mental health issues.

Implications for Texas:
Care should be taken with the Health Risk Appraisal Pilot to ensure that follow-up is completed with persons who are found at risk; otherwise, there will be no utility in proceeding.

Texas should consider a pilot with the mobile CHESS systems. The potential for this application, particularly with children and young people is unlimited.

Take-Home Messages
- The need to focus on "whole health"
- Need to integrate MH/SA, Public Health and Primary Care at the community level – Look at Community Improvement Model
- Data Integration
- Technology – utilize PDAs, social networking, and web-based online supports
- Emphasize "health homes" as opposed to strictly "medical homes" that also coordinate behavioral health care
- Workforce Development: Health Coaches/Peer Specialists
- Utilize the faith-based community, schools, and other community-based organizations for health promotion including mental health
- Training/Certification Programs/Academies for providers and peer specialists
- Customer-directed services – provide a wide range of services utilizing "braided funding" – customers select from a "menu" of services
- Start with veterans and active duty families