

National Association of County Behavioral Health and Developmental Disability Directors

The voice of local authorities in the Nation's capital

NEWSLETTER

OCTOBER 2011

HEALTH PROMOTION, PREVENTION AND WELLNESS: TRAVIS COUNTY, TX

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As a local mental health authority, we are responsible for focusing on the gaps in the delivery system of services provided for individuals with behavioral disorders and developmental disabilities, along with those who are homeless. However, it's easy to become distracted with obstacles and challenges, especially when resources are limited. Most often in the end, we can only address the most critical issues.

One might assume that mental health is defined as the absence or effective management of mental illness. That is not the position taken here. We prefer to ask, "What is mental health?" The WHO defines mental health as a state of social and emotional well-being, not merely the absence of disorder¹.

The following question then becomes "How does a *mentally healthy community* look?" One perspective is that, "A mentally healthy community is a place where people report low levels of depression, suicidal thoughts, substance abuse, violence, discrimination and stress and high levels of quality of life, work satisfaction, economic security, social support, self-esteem and well-being. But it is more than that. It is a place where people's interdependence and mutuality is recognized, protected and valued."²

However defined, it is assumed that a mentally healthy community must address the needs of individuals, subgroups and the community at large through collaborative planning and fostering a sense of interconnectedness and well-being. The following explores how local planning efforts includes the development of a vision of what our community would look like if it were truly mentally healthy. But the vision is only helpful if community needs and accomplishments are considered, warranting more than effective management or unsubstantiated planning efforts.

Finally, healthcare providers often overlook underlying medical illness in individuals with behavioral disorders for a variety of reasons, among them, stigma and communication barriers.

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Teddi Fine, MA, Editor

¹ WHO, Prevention of Mental Disorders: Effective Interventions and Policy Options (Geneva, Switzerland: WHO, 2001)

² Penelope Hawe, What Makes for a Mentally Healthy Community? Canadian Institute for Health Information, ed., Mentally Healthy Communities: A Collection of Papers (Ottawa, Ont.: Canadian Institute for Health Information, 2008).

Recent studies have found that individuals with behavioral disorders die earlier, suffer more medical morbidity and more frequently receive sub-optimal care than the general population. People with certain behavioral disorders:

- Are more likely to be obese, have diabetes, use tobacco and/or experience dietary issues
- Are more frequently victims of violent crime
- Have an increased vulnerability to coronary artery disease, and
- Use psychotropic medications that make regulating blood glucose and other metabolic conditions difficult

Physical and environmental factors—such as housing, community engagement, cultural experiences, social and emotional learning, employment and access to needed services—all affect individuals with behavioral disorders. These and other issues demand the attention of service system agencies, policy makers and the general public.

Further, under the Affordable Care Act, we see a national focus on prevention to improve the quality of individuals' lives while reducing the cost of health care. Federal grants are offering new opportunities for community-based organizations and community mental health centers to identify effective approaches that treat a whole person's health rather than a disjointed approach too often experience by those with behavioral disorders. Here, we describe our local efforts.

Mentally Healthy Communities and Data. It became evident that community engagement was a core value of our local community's mental health—requiring active involvement from clients, families, government entities, faith-based organizations, for-profit and non-profit corporations to create meaningful social change. In the aftermath of a police shooting of a person with a behavioral disorder, Austin set out to be a national model of a mentally healthy community by examining the daily challenges people with behavioral disorders experience and identifying the features and trends that define a mentally healthy community.

In a ground-breaking, community-based, collaborative process, Austin combed national and international behavioral health indicator research to document progress. Preliminary findings about the interface between behavioral health and other related service systems disclosed that all systems must “own” the answers and share accountability to yield community progress. The ATCIC Mental Health



Task Force was developed; 5 years later, six funders created the Indicator Improvement Initiative to examine (a) the frequency of readmissions to psychiatric hospitals; (b) the number of individuals with serious mental illness in Travis County jails, (c) the frequency at which emergency department were use by individuals with primary substance use disorders, and (d) the discretionary removal of children to alternative education settings at the local school district.

Housing instability emerged as a key issue across all indicators, leading to the development of a permanent supportive housing policy. By tracking data across multiple service systems (community mental health, hospitals use, law enforcement contacts, emergency departments and courts,) more than 445 cases of individual interventions and service changes have been found to improve outcomes for our community to date. We found that data development and community collaboration are essential for system changes that benefit the quality of services for individuals with behavioral disorders.

Suicide Data Development. In 2009 the Texas Legislature enacted a statute to encourage real-time, data development processes around suicide. State-level suicide trend data usually is 3-5 years old, challenging community response and its ability to making community response less relevant and identify timely interventions. Now, Integral Care shares quarterly suicide data in a collaborative approach with the City of Austin Health Department, providing an opportunity to intervene in the community as trends are noted.

Mental Health First Aid. Integral Care's Mental Health First Aid

began in 2009, when two mental health professionals obtained instructor certification. The first course was provided to Integral Care's administrative and direct care employees who work in crisis residential facilities 6 months later. Following a successful pilot, Integral Care promoted the program to various local organizations, including faith-based groups and government employees. The initial success of the training led to new partnerships, including work with the Austin Public Library and diverse human services organizations, among them, hospitals, housing agencies, organizations serving the homeless, law enforcement, schools and the Veteran's Administration.



We Can Quit! A Tobacco Free Initiative.

Integral Care recently launched a tobacco cessation initiative, prohibiting use of tobacco products at its facilities in February. This initiative is part of a federally funded program, working in tandem with local government agencies and other community partners, to provide a safe environment for consumers, employees and visitors while promoting healthy behaviors.

Survey data were collected on the organizational culture, as well as the prevalence and cost of tobacco among consumers and employees. Strategic internal and external communications were developed and consistently used throughout the process, using non-punitive language. Integral Care employees received training on nicotine replacement therapy, responses to frequently asked questions and tobacco-cessation resources including a Quit line, free counseling and peer support, and prescription reimbursement.

Disaster Response. After Hurricane Katrina and the influx of individuals fleeing the storm, Integral Care collaborated with Austin Travis County Health and Human Services to develop an integrated, all-disaster community response. Regular, frequent communications coordinate the mental health response to suicide clusters, natural disasters such as wildfires, hurricanes and tornadoes to respond sensitively to the unique behavioral health needs which arise in such disasters.

Behavioral Health and Primary Care

Integration. More and more, primary care and behavioral health providers are working collaboratively. The models, known variously as Integrated Primary Care or Integrated Behavioral Health, usually involve a primary care physician assuming management of some of the less complicated psychiatric disorders with support from mental health workers such as licensed therapists. In some situations, a consulting psychiatrist may be available to support the therapists and primary care physicians.

The programs' hallmark is to maintain the patient in the primary care setting and not refer them out to a separate mental health care system. Integral Care established *E-Merge*, an integrated behavioral health program, through the City of Austin's FQHCs. *E-Merge* integrates behavioral health care services within primary health care clinics to comprehensively address a patient needs. The goal is to help patients



achieve improved physical and behavioral health care by concurrently addressing their expressed needs. The reverse integration treatment model recently implemented at Integral Care includes the benefits of the *E-Merge* program in behavioral health treatment settings. In an exact parallel, the psychiatrist is the primary point of responsibility for prescribing and monitoring the treatment for all aspects of the patient's care.

Community Awareness. Integral Care engages in a host of community awareness activities, such as school and university health fairs and other initiatives such as NAMI Walks, a national effort sponsored by family advocates of people living with mental illness.

Other activities include participating in the Mexican Consulate's Bi-national Health Week and Children's Mental Health Awareness Day.

Integral Care's largest event is the Central Texas African American Family Support Conference, a collaborative event sponsored by community partners from the public and private sectors. The conference provides expert information to families and the community about local mental health, developmental disabilities, substance use disorders, and physical health issues. Integral Care also hosts quarterly community forums on policy and program issues affecting consumers, providing opportunities for advocacy. Social media and other emerging technologies for the distribution of information and resources are also being explored. These and other diversity and inclusion efforts are now underway and a central focal point to reduce our community's health disparities.

Future Directions. Building on solid foundations, Integral Care is committed to expanding health promotion and wellness efforts by further emphasizing exercise, diet and lifestyle choices for individuals with behavioral health disorders. This includes enhancing relationships with local universities to develop internship opportunities, research capabilities and collaborations to inform behavioral health practices. By supporting data development and collaborative efforts, Integral Care hopes to continue adding resources to a woefully under-funded system. More information will come as data development is used to measure the positive impact these cumulative wellness and prevention activities will yield on the lives of those we serve.

BITS FROM DC



Dear NACBHDD Colleagues:

In just a few days, we will convene for our Fall Board Meeting in Albany, New York. This event will be very special for several reasons: This is the first time that we will meet with the Conference of Local Mental Hygiene Directors, and their Executive Director, Kelly Hansen. We will have the wonderful opportunity to meet colleagues from New York, to learn what they are doing, and to plan joint activities for the future. Similarly, this Board Meeting will be our first opportunity ever to meet with Lynnae Rutledge, the Administrator of the US Rehabilitation Services Administration (RSA). RSA provides important services for persons with disabilities, including those with behavioral and developmental conditions. I hope to see many of you in Albany!

In October, we have put considerable effort into preparing an updated document on specific recommendations for the mental health and substance use benefits to be included in the Essential Health Benefit (EHB) to be announced in a few months by HHS. The Essential Health Benefit will be the “floor” benefit to be used for state health insurance exchanges and the Medicaid expansion under the Affordable Care Act. In addition to preparing this document, we have also been invited to participate in an HHS Listening Session later in October. For us, the Essential Health Benefit is a “must do” if we are to participate effectively in the Affordable Care Act.

Judging from your reaction, our first *Under the Microscope* on October 1 was a great success. Each month, we plan to present another analytical and synoptic piece that is of practical use to you for your program operations. We are very fortunate to have Teddi Fine as our Editor/Writer for *Under the Microscope*, *Headline DC* and our monthly e-Newsletter.

Very best wishes for the harvest season and for Halloween!

Ron Manderscheid
Executive Director, NACBHDD

STATE-BY-STATE MENTAL ILLNESS RATES REPORT RELEASED

SAMHSA’s new state-by-state analyses of the prevalence of mental illnesses—including serious mental illnesses—among adults reveals significant variation across the country. *The NSDUH Report: State Estimates of Mental Illness* reports:

- Nationally, 44.5 million adults aged 18 or older (19.7% of the adult population) experienced a mental illness in the past year.
- The highest mental illness rate was in Rhode Island (24.2%); the lowest rate was in Maryland (16.7%).
- Nationally, 10.4 million adults (4.6%), experienced a serious mental illness (SMI) in the past year. SMI rates ranged from 3.5-percent in Hawaii to 7.2-percent in Rhode Island.
- Arkansas, Idaho, Rhode Island, Utah, and West Virginia had the highest rates for both SMI and other mental illnesses.
- Alaska, Maryland, North Dakota, Pennsylvania, South Dakota, and Virginia had the lowest rates across both measures.

Mental illness is defined by diagnostic criteria in the *Diagnostic and Statistical Manual of Mental Disorders-IV* (DSM-IV). “Any mental illness” refers to the presence of any mental, behavioral or emotional disorder in the past year that met DSM-IV criteria. Among adults with any disorder, those whose disorder caused substantial functional impairment (i.e., substantially interfered with or limited one or more major life activities) are defined as having serious mental illness (SMI) and the most urgent need for treatment. The findings can provide insight for county and state behavioral health authorities and service providers about the value of effective treatment and prevention programs to restore lives and to reduce economic and societal costs. For more, go to: http://oas.samhsa.gov/2K11/078/WEB_SR_078.cfm.



DEFINING AN ESSENTIAL HEALTH BENEFIT PACKAGE FOR THE ACA

While requiring health plans to offer a package of essential health benefits (EHB), the Affordable Care Act left the task of defining those benefits to the Department of Health and Human Services. The first step toward that definition was released on October 7 in an HHS-commissioned report by the Institute of Medicine (IOM), *Essential Health Benefits: Balancing Coverage and Costs*. In a word, its focus emphasized “affordability.” Thus, rather than spell out a list of services to cover, an activity almost guaranteed to pit provider against provider and interest group against interest group, the IOM advisory committee recommended the EHB package be built on mid-tier health plans currently offered by small employers, expanded to include certain services such as mental health, and squeezed into a real-world budget. The report specifically recommends that while the needs of the most vulnerable should be considered along with medical effectiveness, safety and relative value, the cost of each benefit should be weighed carefully before including it in the EHB.



The US Department of Health and Human Services will seek public comment through nationwide listening sessions in advance of any decisions, and will likely set final rules in place next spring.

THE AMAZING, SHRINKING LOCAL HEALTH DEPARTMENT

Job losses are rampant across local health departments according to a 2010-2011 National Association of County and City Health Officials (NACCHO) survey. Over half of all local health departments either reduced or eliminated one or more program—most often in mental health, maternal and child health, illness prevention, chronic disease screening and emergency readiness. Since 2008, of 155,000 jobs in county health departments, almost 35,000 have been lost to layoff and attrition. In the first half of 2011 alone, 44% of local health departments lost at least one employee, collectively dropping 5,400 jobs; and 52% of local health departments expect more cuts in coming fiscal year as federal and state coffers shrink to reduce mounting deficits. The report does highlight a few bright spots, however. It highlights stories of counties that have sought innovative solutions, through adopting efficiencies of scale and changing their tax status, to meet the health care needs of residents, despite challenging times. To read the report, go to: <http://www.naccho.org/jobloss> .

HILL HAPPENINGS: THE GOOD, THE BAD, AND THE UGLY

- **FY 2012 APPROPRIATIONS.** The federal government is still in business – at least until November 18 with yet another continuing resolution while House and Senate continue to debate. Meanwhile, details of the 2012 House Appropriations Committee bill have been released. It provides \$153.4 billion in funding, a \$4 billion cut from FY 2011, but \$13.6 billion more than the House proposed earlier this. The measure would prohibit expenditure of funds under the ACA, including the Prevention and Public Health Fund (PPHF), until 90 days after the end of legal challenges to the Act. (See legal section of this newsletter for more on that issue.) It is likely that several omnibus bills will be considered, rather than either one *uberbill* or 12 separate appropriations measures. With luck, that will come before November 18.
- **BUDGET SUPERCOMMITTEE CONTINUES TO DELIBERATE.** The Supercommittee has hearing from many people as it looks for ways to shed trillions over 10 years, among them, members of House and Senate. For example, Senators Lieberman and Coburn are pressing a proposal with \$500 billion in Medicare cuts over 10 years. House Budget Committee chair Ryan is urging that tax credits to enable consumers to purchase health care be substituted for Medicare and federally subsidized employer-sponsored health coverage. Most every health advocacy group – including the Coalition for Health Funding—has weighed in as well. What is clear, however, is that if the Supercommittee does not act, funding for the vast majority of public health initiatives, from the ACA to disease prevention and from existing programs for at-risk populations to health will feel the budget ax.



HEALTH POLICY FELLOWS SOUGHT

Robert Wood Johnson Foundation. Up to 6 grants of up to \$165,000 each will be made in 2012 for year-long health policy fellowships in Washington, D.C., for exceptional midcareer health professionals and behavioral and social scientists with an interest in health and healthcare policy. **Deadline:** November 9, 2011. Go to RFP: <http://www.rwjf.org/applications/solicited/cfp.jsp?ID=21374>

Commonwealth Fund/Harvard University. Up to 5, 1-year fellowships leading to MPH or MPA degrees are available for 2012-13 to help prepare current US physicians for leadership roles in physicians for leadership roles in formulating and promoting health policies and practices that improve the access to high-quality care at the national, state, and/or local levels for minority, disadvantaged, and most vulnerable populations. **Deadline:** For more information, go to: <http://www.commonwealthfund.org/Fellowships/Minority-Health-Policy-Fellowship.aspx>

HHS NEWS AND NOTES

- **CLASS ACT PUT ON HOLD.** HHS reports that it has stopped working on the long-term care component of the ACA known as the Community Living Assistance Service and Supports (CLASS) Act because it cannot yet determine how best to ensure the program's economic solvency. Intended to help protect people against the need to impoverish themselves to pay for long-term care for chronic illnesses, the CLASS Act was intended to serve as a self-sustaining insurance plan for working adults. By paying a voluntary premium while working, they could collect a modest daily cash benefit to help pay for home or nursing home services if they became disabled in later life. The fate of the program remains unknown as this newsletter goes to press, but the Administration vows to fight any effort to repeal it.
- **NHSC AND BEHAVIORAL HEALTH.** An October 25 (3:00-4:30 p.m., ET) webinar by the SAMHSA/HRSA Center for Integrated Solutions will explore how the National Health Services Corps program, with benefits that include loan repayment and scholarships for healthcare professionals, can benefit county and other behavioral health and primary care provider organizations and agencies. This webinar will provide a history of the program, highlight the resources provided in a new manual, and explain how organizations can apply to participate. Register online at: <http://www.centerforintegratedhealthsolutions.org/about-us/webinars>
- **COMPREHENSIVE, COORDINATED PRIMARY CARE INITIATIVE.** To help primary care practices deliver higher quality, more coordinated, patient-centered care, CMS/Medicare will work with commercial and state health insurance plans to offer added support to primary care doctors who better coordinate care for their patients. Based on innovative practices developed by large employers and leading private health insurers in the private sector, the voluntary initiative—with increased Medicare payments to primary care providers adopting the model—begins as a 4-year demo in 5-7 health markets. The aim is to enable primary care physicians not only better engage patients in their own care, but also assist patients with serious or chronic diseases; help them follow personalized care plans; give patients 24-hour access to care and health information; deliver preventive care; and work with other doctors, including specialists, to provide better coordinated care. This has clear implications for collaborations toward integrated primary and behavioral care. Public and private health care payers interested in applying to participate must submit a Letter of Intent by November 15, 2011. For more information, go to: <http://innovations.cms.gov/areas-of-focus/seamless-and-coordinated-care-models/cpci/>
- **BUNDLED PAYMENT EXTENSION.** CMS has extended the deadline for submitting Bundled Payments for Care Improvement letters of intent and applications until Nov. 18. The initiative is looking for "proposals from health care providers who wish to align incentives between hospitals, physicians and nonphysician practitioners in order to better coordinate care throughout an episode of care."
- **HHS INSPECTOR GENERAL REPORTS GAPS IN MENTAL HEALTH CARE.** In a report released by Montana



Senator Max Baucus, the HHS Inspector General reports that despite the fact that American Indian and Alaska Native populations experience excessively high rates of substance abuse and teen suicide, as many as one-fifth of Indian country hospitals and clinics have no mental health services; only half provide drug abuse treatment.

- **FY 2011 SAMHSA AWARDS.** SAMHSA has made end-of-year FY 2011 grant awards, among them 5 grants totaling \$1.8 million to help prevent suicide and prescription drug misuse by older adults; \$2.2 million for 8 awards to support peer-to-peer substance abuse recovery services; 11 awards totaling up to \$13 million for adult mental health and substance abuse treatment court collaboratives; and 15 grants totaling \$7 million to improve services to children and adolescents who have experienced traumatic events. Finally, SAMHSA awarded \$15 million in ACA funds as grants to improve coordination of healthcare services delivered in publicly funded community-based behavioral health settings, including community mental health centers and public health departments.
- **REAL CHOICE SYSTEM CHANGE GRANTS.** CMS has made \$1.98 million in awards to 6 states to develop sustainable partnerships with state housing authorities. The goal is to create long-term means of providing permanent, affordable rental housing for people with disabilities who are also Medicaid beneficiaries.

LEGAL HAPPENINGS

- **ACA TO SUPREME COURT.** After separate appellate decisions both affirmed and denied the legality of the ACA's individual insurance mandate, both sides in the battle have asked the Supreme Court to rule on the matter by hearing arguments and weighing judgment on the highest-profile legal challenge to the law, brought by 26 state attorneys general and the National Federation of Independent Businesses. The Justice Department specifically wants to overturn an 11th U.S. Circuit Court of Appeals ruling that Congress did not have the authority to require people to buy insurance. The administration says the coverage mandate is protected by Congress's power to regulate interstate commerce. ACA opponents say that the mandate oversteps by requiring people to "perform an economic activity." Should the Court agree to hear the case, a decision on the constitutionality of the ACA's individual mandate could come as early as June, just months before votes are cast in the 2012 election.
- **SUPREME COURT HEARS MEDICAID RATE CASE.** The decision in first case before the Supreme Court this year will answer whether patients and healthcare providers can sue to block states from cutting their Medicaid rates. The suit challenges the 9th Circuit Court of Appeals holding in *Toby Douglas v. The Independent Living Center of Southern California* filed a number of years ago after California proposed a series of Medicaid cuts, some as high as 10% and decided in the State's favor in 2008. While Medicaid doesn't specifically include a right to sue over payment levels, it does require states to keep payment rates high enough to encourage provider participation. The outcome of the challenge will be known in a few months.
- **SETTLEMENT ON FOSTER CHILD MENTAL HEALTH.** Following a 9-year court battle, a settlement in a precedent-setting class action case was given preliminary approval. The beneficiary, as many as 10,000 children in foster care in California. Under the settlement, California will be required to provide more effective and timely mental health services for children either about to enter or living in foster care.



FROM FIRST USE TO TREATMENT ADMISSION: 15.6 YEARS

The average time from first use of a substance to treatment admission is 15.6 years, according to a new SAMHSA report based on the Treatment Episode Data Set (TEDS) of 669,000 adults admitted for substance abuse treatment for the first time in 2009. The findings showed the average time for first use varies by substance: 20.2 years for alcohol, 14.5 years for cocaine, 12.3 years for heroin, 11.9 years for stimulants, 11.9 years for marijuana, and 7.8 years for prescription drugs. For men, the average time between first use and first treatment admission is 16.5 years, compared with 13.8 for women. To read the report, go to www.oas.samhsa.gov/2k11/026:WEB_TEDS_026.cfm

ADDRESSING THE CRISIS OF SUICIDE IN OUR COUNTIES

NACo Annual Meeting Workshop

Deborah Donaldson, Division of Human Services Director
Sedgwick County, Kansas

NACBHDD Executive Director Ron Manderscheid submitted a proposal to convene a workshop for the National Association of Counties' (NACo) Annual Conference focused on addressing suicide in counties. The process through which proposals are accepted is highly competitive; due to his good work, the NACBHDD proposal was approved.

Beginning with an overview of the suicide crisis in America and existing public mental health solutions already available to respond, the workshop focused on helping counties appreciate the importance of developing and implementing a suicide prevention and on providing tools and strategies to help do so.

I had the opportunity to moderate the session and make a short presentation about the Sedgwick County, KS, suicide prevention program that has been in existence for around 10 years. Sonoma County, CA, Supervisor Shirlee Zane, who lost her husband to suicide in January, gave a compelling presentation that emphasized that suicide is an equal-opportunity tragedy that can happen to anyone. The audience was very supportive of her and what she had to share. The second speaker, Elena Tindall, Suicide Prevention Coordinator for Santa Clara County, CA, described their suicide prevention plan that is now being implemented. She emphasized the need for community involvement to help ensure that the plan is structured specifically meet county resident needs. The last two speakers, Robert Bossarte, PhD, and Steven Dobscha, MD, are associated with or from the U.S. Department of Veterans' Affairs. They discussed best practice and trends in suicide prevention, particularly among wounded warriors. Many in the audience appeared to have been unaware of current statistics regarding the prevalence of suicide across the country, such as the fact that more people die by their own hand than by homicide.



The workshop was highly successful. Attendance was good; the majority of those who attended stayed for the entire session. One county commissioner told those in attendance that after hearing this presentation, she planned to return to her home county and ensure they developed a plan. The session continued beyond its allotted time due to the number of questions asked; number of people approached speakers with questions long after I ended the program officially.

As a result of this presentation, I recommend that NACBHDD continue to propose and provide other workshops at the NACo conferences. With the success of this workshop other proposals from NACBHDD would likely both be very competitive and of interest to the many participants in the conferences. I would also like to thank Jim McDermott, Ph.D. for his help with this workshop.

AROUND THE STATES: AN UPDATE

- **ARKANSAS.** The State insurance commissioner has asked the state legislature to support the State's application for funds to create an insurance exchange. The governor had said he would not seek such grant funding unless the legislature appears to support development of the exchange required under the ACA.
- **FLORIDA.** With the highest rate of uninsured people in the country, Florida has a nearly \$880,000 healthcare reform grant last week despite Governor Rick Scott's strong resistance to implementing the law and his vow to reject all Federal government funding to that end.
- **ILLINOIS.** Governor Pat Quinn has decided to delay implementing its decision that could strip nonprofit hospitals of their property tax exemption.
- **IOWA.** As of September 1, new Medicaid prescriptions for psychoactive meds are limited to a 15-day supply. The stated reasoning behind reducing the previous 30-day supply for new Medicaid prescriptions relates both to cost savings and to avert the waste of these expensive medications.



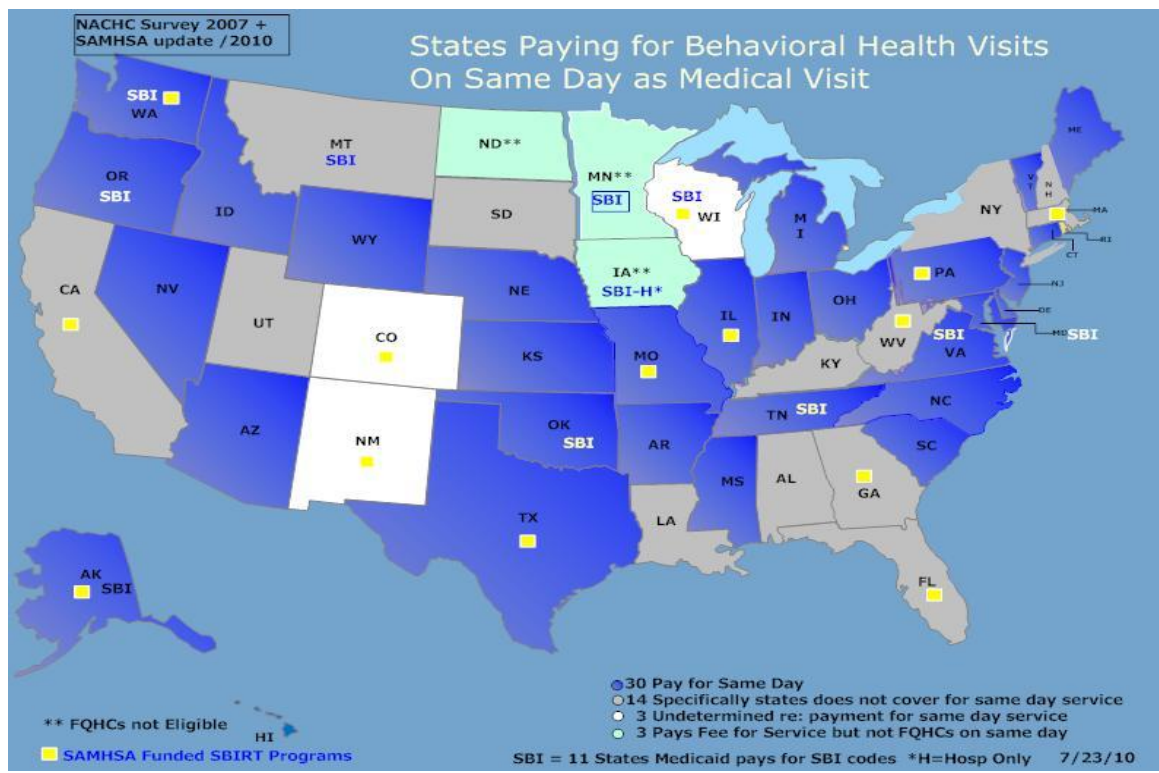
- **NEBRASKA.** The state has decided to delay establishing an insurance exchange required under the ACA until the U.S. Supreme Court rules on the individual mandate lawsuit.
- **NEW YORK.** With the threatened breakdown of negotiations with state employees unions, Governor Cuomo has issued tentative layoff notices for over 3,000 employees. Among the hardest hit agencies: the Office of Mental Health, with 643 layoffs; the Department of Correctional Services, with 446; and the Office for People with Developmental Disabilities, with 386. Discussions are ongoing; stay tuned.
- **PENNSYLVANIA.** In a strategy apparently untried in other states, Pennsylvania's Medicaid director hopes to help save costs by encouraging Medicaid recipients—beginning with those still in the Medicaid fee-for-service system—to visit higher quality, lower-cost hospitals and providers. The incentive? A payment of as much as \$200 to the beneficiary, based on the saving to Medicaid for a hospital-based procedure or physician visit. Apparently, the State's Medicaid advisory board was unaware of the proposal. It remains unclear if it will fly or if it saves. This proposal comes 6 months after the State terminated its State-funded health plan for low-income adults, many of whom appear to remain uninsured.
- **TEXAS.** As part of its initiative to reduce the risks trauma among at-risk persons with mental disorders or developmental disabilities, the Texas Department of State Health Services has made a toolkit available online for use in any setting in which seclusion or restraint is used. The document—built with the assistance of the Hogg Foundation for Mental Health—can be adapted for use by other states and service systems. For more information, go to: <http://www.dshs.state.tx.us/cultureofcare>
- **UTAH.** The State Department of Health is promoting the use of electronic health records to better coordinate care and reduce costs under the Medicaid program by encouraging physicians and hospitals to apply for the EHR incentive program which pays providers to go paperless.
- **VERMONT.** A single-payer health system is now the law in the State, replacing traditional State plans and fee-for-service reimbursement. The program, Green Mountain Care, would establish a state-funded-and-managed insurance pool with nearly universal coverage for residents. The state could contract some functions to private insurers; residents in self-insured employer plans could retain existing coverage. Because many system details need to be worked out in law and regulation, a 5-member board has already begun revamping the health care payment and delivery system, including reimbursement rates.
- **WASHINGTON.** In an effort to meet an overall 10% reduction in social and health services, the State health and social services department has proposed cutting substance abuse treatment funding by half in the 2012-2013 biennium, effectively eliminating all detox services for adults as well as adult inpatient, outpatient and alcohol and drug abuse treatment with the exception of pregnant and parenting women and individuals in drug courts. Pharmacy services providing buprenorphine and methadone also would be eliminated.



CARE INNOVATIONS SUMMIT

Transforming healthcare delivery by invigorating the marketplace of ideas

The HHS Center for Medicare & Medicaid Innovation and Office of the National Coordinator are joining with the West Wireless Health Institute and Health Affairs to co-host the first ever *Care Innovations Summit* on *January 26, 2012, in Washington, DC*. It will bring together leading innovators from inside and outside the healthcare industry to allow for knowledge sharing, matchmaking, and engagement to drive transformation of our healthcare system. The goal is to facilitate dialogue and drive action towards *better care and better health at lower cost through continuous improvement*. The Care Innovations Summit will showcase 40 or more projects across the country that are enabling achievement of better health and care at lower cost through continuous improvement. Want to be one of them? Go to: <http://hcidc.org/index.php/apply-to-present/apply-to-present> Registration for this free Summit is open; space is limited. To sign up, go to: <http://hcidc.org/index.php/apply-to-present/apply-to-attend>



NOTE:

- SBI indicates that the state has “approved” SBIRT codes, not that the SBIRT codes have “activated in the Medicaid System”. Three states with activated SBIRT codes in their Medicaid claims payment systems are AK, TN and VA.
- Gold boxes indicate a state has a SAMHSA grant supporting SBIRT services.

MORTALITY AMONG OUR PEERS: BETTER, BUT NOT WELL
HAS THE DISPARITY ACTUALLY BEEN REDUCED IN THE LAST FIVE YEARS?
 [Reprinted from Behavioral Healthcare Online]
 Ron Manderscheid, PhD,
 Executive Director, NACBHDD



As we paused to honor September’s Recovery Month and October’s Mental Illness Awareness Week, we must also forge ahead to assess our progress in combating premature mortality among public mental health peers.

What changes have actually occurred since the release of our April 2006 study in *Preventing Chronic Disease* which shows that public mental health peers die, on average, more than 25 years younger than other Americans? On one hand, these dramatic and unsettling findings have had a very profound effect in mobilizing our field. On the other, they also appear to have had much less effect in several critical contexts. Here, we want to explore this paradox.

First, as a reflection of an extremely urgent public

health problem, these findings have had a dramatic effect on our advocacy, on our efforts to transform services, and on our efforts to promote wellness in the mental health field. By 2007, the Center for Mental Health Services (CMHS) at SAMHSA had initiated a highly visible 10 by 10 Campaign to reduce the 25 year disparity by 10 years within a 10 year period. This campaign has been supported strongly and persistently across the field by peers, providers, researchers, and program managers. Now, slightly more than half a decade later, we must ask: Has the disparity in mortality actually been reduced?

Because a major factor in the premature mortality of peers is the absence of needed primary care, service transformation efforts have accelerated rapidly toward

full integration of behavioral health and primary care; these efforts have been memorialized in the Affordable Care Act of 2010, and in major program initiatives of SAMHSA and HRSA. Health homes that bring together mental health, substance use, and primary care services are being planned and implemented. As we race toward the initiation of the state health insurance exchanges and the expansion of the Medicaid program in 2014, we can fully expect the movement toward health homes to accelerate even more dramatically. Now, we must ask: How many peers actually access and use these primary care services today? What health effects do they achieve?

Efforts to promote wellness also have exploded across the field. Numerous, local, peer-led projects are underway to define wellness regimens for self and others. Also, many websites operated by peers, researchers, and by the 10 by 10 Campaign itself offer advice on weight control, smoking cessation, and lifestyle improvement. In a broad sense, these undertakings lend veracity to consumers' self-efforts to recover and to retake control of their own lives. Now, we must ask: How many peers actually engage in these wellness regimens? What health effects do they achieve?

Each of these developments should be great cause for rejoicing: As a field, we are making dramatic progress. Yet, clearly, much, much more also remains to be done.

As early as 2007, participants in a major meeting on recovery hosted by CMHS/SAMHSA called for the collection of annual data on mortality of public mental health peers, as well as much better data collection to understand the relationship across the life cycle between mental illness conditions and other chronic illnesses, such as heart disease and diabetes.

The very recent announcement by Secretary Sebelius of the Million Hearts Initiative holds great promise in this regard. As a result of this Initiative, we expect extensive collaboration between SAMHSA and CDC around data collection on mortality of peers and targeted program development of community and person-level interventions to reduce mortality rates significantly. The Initiative will target major lifestyle factors, such as smoking, food consumption, exercise, and other key behaviors that affect one's health. The Initiative has the potential to provide a great boost to

wellness efforts already underway.

It is also very clear that second-generation antipsychotic medications play a major role in leading to the metabolic syndrome, which, in turn, is a major risk factor for the chronic illnesses, such as heart disease and diabetes. Yet, to this day, we do not have an evidence-based practice that requires wellness counseling and monitoring when a psychiatrist or other physician prescribes one of these second-generation medications. We must develop this important practice and implement it broadly.

Related research also is needed urgently to define more clearly the different metabolic effects of the different second-generation antipsychotic medications. These drugs are not equal in their side effects, and we must understand the differences. Recently, a National Institute of Child Health and Human Development (NICHD) panel successfully advocated for FDA to require a box-label warning on the drug olanzapine because of its serious metabolic effects in teenagers.

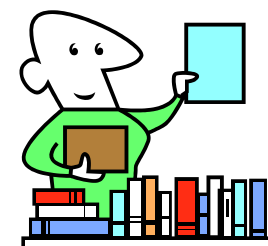
Unfortunately, however, this is only an isolated incident rather than a systematic process. We must undertake the necessary advocacy so that the research we need is conducted and applied appropriately.

Finally, just a brief comment about disease prevention and health promotion. Although it is obvious that preventing disease is much preferable in both a personal and a fiscal sense to chronic disease, we have not actually behaved as if this is true. Hence, we have expended little effort to understand how to delay the onset of chronic illnesses, such as heart disease, among peers, and we have expended almost no effort to understand the salutary effects of promoting positive mental health and wellbeing. Included here are hope and the promise of recovery. These are areas of great future promise. We must advocate strongly so that this work will begin very soon.

Nearly six years has elapsed since the release of our original research on mortality. Yet, to use Richard Frank and Sherry Glied's conclusion about mental health policy, overall, the efforts of our field to address this urgent public health problem are "better, but not well". We must continue to make essential improvements rather than rest on our laurels. The actual lives of peers we know and love depend upon our efforts



ON THE BOOKSHELF: RECENT POLICY PUBLICATIONS OF NOTE



- **Urban Institute/Kaiser Commission on Medicaid and the Uninsured.** *Innovative Medicaid Initiatives to Improve Service Delivery and Quality of Care: A Look at 5 State Initiatives* outlines efforts in AL, OK, OR, PA and WA to delivery medical home models, describing strategies, lessons, and opportunities under the ACA. For more, go to: <http://www.urban.org/UploadedPDF/412411-Innovative-Medicaid-Initiatives-to-Improve-Service-Delivery-and-Quality-of-Care.pdf>
- **Institute for Health Policy Solutions.** *Fiscal Risks from Differences in Basic Health Plan versus Federal Tax Credit Income-Test Timing* describes how states will be affected by the gap between basic health plan subsidy levels (based on income at application), and federal funding (based on annual income). For more, go to: http://www.ihps.org/pubs/BHP_Fiscal_Risks_from_Income-Test_Timing_Differences_2Sep2011.pdf
- **UCLA Center for Health Policy Research.** *Stressed and Strapped: Caregivers in California* explores the demographics and both physical and mental health status of family or friends serving as informal health caregivers, including such problems as psychological distress, unhealthy behaviors, diabetes and cardiovascular problems. Go to: <http://www.healthpolicy.ucla.edu/pubs/files/caregiverspbsep2011.pdf>
- **Georgetown University Health Policy Institute/Robert Wood Johnson Foundation.** *The Role of Exchanges in Quality Improvement: An Analysis of the Options* examines state options for driving health care quality improvement and delivery system reform at the plan and provider levels through insurance exchanges – including the importance of engaging stakeholders in developing and implementing policy. Go to: <http://www.rwjf.org/files/research/72851qi Georgetownexchange20110928.pdf>
- **Henry J. Kaiser Family Foundation.** *Employer Health Benefits 2011 Annual Survey* analyzes employer-sponsored health plan trends in premiums, coverage, eligibility, employee-cost sharing. Enrollment, plan types and other factors, all within the context of health reform. Go to: <http://ehbs.kff.org/pdf/2011/8225.pdf>
- **Kaiser Commission on Medicaid and the Uninsured.** *A profile of Medicaid Managed Care Programs in 2010: Findings from a 50-State Survey* provides a state-by-state examination of Medicaid managed care organizations and contracts (including primary care case management and MCO programs), how they measure, monitor and improve quality, and implications for ACA implementation. For more, go to: <http://www.kff.org/medicaid/upload/8220.pdf>
- **Robert Wood Jonson Foundation.** *Refocusing Responsibility for Dual Eligibles: Why Medicare Should Take the Lead* shows how 40% or more of Medicare and Medicaid costs benefits 9 million enrolled in both programs (dual eligible) and how the majority of dollars spent are federal. Thus, efforts to slow costs should rely less on states and more on better Federal management of Medicare-financed acute care services. For more, go to: : <http://www.rwjf.org/files/research/72868qs68dualeligiblesfull20110930.pdf>
- **Kaiser Commission on Medicaid and the Uninsured.** *Five Facts about the Uninsured* explores the factors underlying the lack of health coverage, including employer-sponsored insurance, among over 49 million low and moderate income people, and the repercussions of being uninsured, including both medical debt and unmet health needs. Go to: <http://www.kff.org/uninsured/upload/7806-04.pdf>

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MARK YOUR CALENDAR for March 21-23, 2012 and the ACMHA's annual summit in Charleston, SC. The focus is on the role communities play in promoting resiliency and recovery through the development of social supports and networks. This focus is fully congruent with the Affordable Care Act, the recent National Prevention Strategy, the recent CDC strategic plan on positive mental health, and the recently announced HHS Million Hearts Initiative. Please plan to join us.