Steering the Ship of Health Care Reform

Remarks by

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Attached is the text prepared for delivery; however, some material may have been added or omitted at the time of delivery. Because Ms. Powers was ill and unable to attend, her remarks were presented by Mr. William Hudock.

Thank you for your kind introduction and for the invitation to be with you today. This is a wonderful assemblage of some of the greatest minds in health care reform and I am honored to be among you.

We all know this is a history-making year in American politics, and I believe that when it comes to health care reform, we are poised to be part of historic changes, as well.

Speaking of history-making changes, Charles Dickens opened "A Tale of Two Cities," his story of the French Revolution, with the famous line, "It was the best of times; it was the worst of times."

This truly is the best of times to be planning for health care reform, because everyone who is anyone, it seems, is talking about the need to reform our current system of financing and delivering health care in this country. From politicians on the stump to factory workers on the assembly line, it has become abundantly clear that the status quo is no longer acceptable.

We cannot continue to support a system in which 45 million men, women, and children in this country are uninsured.

We cannot continue to afford a system that by 2016 will cost 4.1 TRILLION DOLLARS and account for one of every five dollars we spend in this country.

And we cannot condone a system that spends this much money on health care and still has people with serious mental illnesses dying 25 years earlier than the general population, largely from treatable medical conditions.

So this is a good time to be talking about health care reform.

However, this is also a difficult time because it has become abundantly clear from State-level health care reform efforts that the current growth in health care spending is unsustainable. And when policymakers look to cut the costs of health care, they frequently consider mental health and substance abuse treatment to be optional rather than necessary services.

Clearly, we have to be at the table in any discussions of health care reform at the State and national level.

But I would like to put forth the bold recommendation, if you'll permit me to mix my metaphors, that instead of just being at the table, we need to help steer the ship.

The analogy of steering a ship is rather apt for the concerns we hear bandied about. As many of you know, I am a Captain in the Naval Reserve. One cannot spend long in the Navy without understanding a bit about how ships operate. I want to share one small fact about ships to illustrate a point. A trim tab acts as a small rudder to turn the larger rudder of giant ships. Noted innovator R. Buckminster Fuller, inventor of the geodesic dome, saw the trim tab as a powerful metaphor for effective individual

leadership because he believed that "small and strategically placed interventions can cause large-scale and profound change." I want to challenge each and every one of us here today to be a "trim tab," a mover of this big ship of healthcare reform.

I can't think of a more appropriate way to describe the work we must do to transform not only the mental health system, but the overall health care system is this country, to one that is consumer-driven, recovery-focused, and evidence-based. And I know we are up to the task.

In fact, I believe we are poised to move the health care reform agenda beyond transformation to innovation.

The term "Innovation Nation" was coined by author and educator John Kao [Kay-oh] to mean "a country that is committed to constantly reinventing the nature of its innovation capabilities to improve the lot of humanity."

Each and every one of us in this room is here because we want to improve the human condition for individuals with mental and addictive disorders. Kao gives us a template. He says we must "move beyond old, established ways of thinking. We [have] to be able to entertain 'impossible' possibilities."

Entertaining "impossible possibilities" sounds like an oxymoron, but it is really just another way of saying that we need to see challenges as opportunities. Can we improve access to health care in this country while controlling costs? Many States, using the lessons of Massachusetts and California, are trying to do just that. I'm pleased to say that my home State of Rhode Island appears to be leading a trend among States to address costs while striving to improve access.

Among the cost-cutting measures Rhode Island is proposing are three that are familiar to all of us:

- Emphasize primary care over emergency care;
- Manage treatment of people with chronic diseases; and
- Establish a database of treatments, outcomes, and costs designed to point the way to better care at lower costs.

To me, this means that the State of Rhode Island is proposing to reform its health care system by making some of the very same changes that several influential reports—such as those by the Surgeon General, Institute of Medicine, and New Freedom Commission—have been advocating; that we at SAMHSA and with our Federal partners have been supporting; and that all of you have been doing.

And it's not just the States that are speaking our language. If you read the health care proposals being set forth by John McCain, Hillary Clinton, and Barack Obama, you will see phrases such as "promote a

broad-based prevention commitment," "make patients the center of care," "use public health initiatives to encourage individuals to prevent chronic disease," and "improve coordination and integration of care for people with chronic conditions."

I don't want to be blindly optimistic when I know the significant difficulties arrayed before us. We must be vigilant in ensuring that efforts to streamline the care individuals receive don't end up shortchanging the significant services they may need. How can we do so? As leaders in behavioral health, I think it is imperative that we do five things, each of which I will touch on briefly:

1. First, we have to help policymakers and the general public understand that mental health is essential to overall health.

   We must make it clear in all of our conversations about health care reform that a person cannot be physically well unless he or she has achieved a state of mental health, defined by the Surgeon General's Report on Mental Health, as one that results in "positive activities, fulfilling relationships with other people, and the ability to adapt to change and to cope with adversity."

   The ability to adapt to change and to cope with adversity, either in the presence or absence of a mental illness, is a basic tenet of mental health recovery. Recovery shifts our focus from delivering care to helping individuals learn how to manage their lives. To do otherwise keeps us in a paternalistic relationship to individuals and drives up costs by imposing on them services they may not want or need. In any health care reform effort, individuals must be at the center of care.

   We must also put healthcare into context. Effective approaches to healthcare will be coupled with clearly focused approaches to ensure that people with chronic conditions such as serious mental illness have the resources required both to support their recovery and also to help them to move out of poverty and dependency. Judith Cook has pioneered work that shows that coupling effective treatment, employment, housing and asset development strategies can help individuals to move to greater self sufficiency and more sustainable recovery. The field and the candidates should embrace this agenda, both because it creates better outcomes and because it helps to mediate future costs. This model of getting more impact for the same or lower cost will need to be a hallmark of healthcare reform, and especially of mental health reform. Health policy consultant Robert Laszewski has written that our current health care system is a "leaky boat" and that trying to fix it while ignoring the costs of providing care would be like trying to "re-board the Titanic."

2. Second, we must be certain that any health care reform effort is squarely rooted in the concepts and practices of a public health approach. Just as an individual can't be physically well unless he or she is mentally healthy, so, too, must each individual be healthy for all of us to be healthy.

   In a seminal 1988 report, the Institute of Medicine defined public health as "what society does collectively to assure the conditions for people to be healthy." Healthy individuals and healthy

communities go hand in hand. This is the premise behind several national and Federal efforts to promote the health and well-being of individuals living in community.

We are making progress on this front. For example, I applaud the efforts of the National Council for Community Behavioral Healthcare and the SAMHSA funded transformation projects in the states of Maryland and Missouri for supporting introduction into the United States of a successful Australian program called "First Aid." Much like medical first aid, this innovative program trains ordinary citizens to give initial help to an individual experiencing a mental health problem until appropriate professional treatment is received.

One study that compared people who received this training to those who were on a waiting list found that not only did the course improve knowledge of mental health problems and result in participants providing more help to others, it even generated a mental health benefit for the participants themselves. Reducing the discrimination and stigma that often keep people from getting the assistance they need is a critical component of ensuring equal access to behavioral health care under any type of health care reform.

In addition, SAMHSA funds several efforts designed to promote healthy communities, including the work of our Disaster Technical Assistance Center, which provides technical assistance related to disaster behavioral health to States, Territories, and Tribal agencies. We know that mental health consumers are particularly vulnerable in the wake of traumatic events, including natural or manmade disasters, and that such incidents may exacerbate undiagnosed problems, as well.

SAMSHA also supports Native Aspirations, a program that seek to reduce risk factors for suicide, violence, and bullying for American Indian youth, and Project Launch, which will fund development of community-based networks to promote preventive and primary care for children with mental disorders and their families. Any concerted public health approach to health care must recognize the importance of both prevention and early intervention for our country's youth.

Indeed, the underlying premise of the public health model is simple: It is inherently better to promote health and to prevent illness before an illness begins.

This is not only humane; it may be cost-effective, as well. In a 2002 update on the public health of our Nation, the Institute of Medicine notes, "the vast majority of health care spending, as much as 95 percent by some estimates, is directed toward medical care and biomedical research. However, there is strong evidence that behavior and environment are responsible for over 70 percent of avoidable mortality, and health care is just one of several determinants of health."

3. This speaks directly to my third point, which is the need for us to continue to promote the importance of integrated behavioral and physical health care. We know that on average, 35 percent of individuals with serious mental illnesses or substance use disorders have at least one undiagnosed medical disorder. We also know that half of all care for mental disorders is delivered in general medical settings, but primary care practitioners vary in their ability to recognize, diagnose, and treat these disorders. Clearly, we must embrace a more holistic approach to health care which recognizes that the mind and the body are one.

This focus on integrated care requires not only a shift by providers to work collaboratively, it also requires a shift in the underlying approach to delivery of care. Kirk Strosahl, who has trained Federally Qualified Health Centers in a model of integrated care, believes that 90 percent of general medical care is behavior change. One way to help individuals make the changes necessary to improve their health and their quality of life is to have them participate in decisions concerning their own care. This seems so reasonable and sensible it is sometimes difficult to believe that the concept of "shared decision making" is fairly new in mental health.

Shared decision-making allows individuals and providers to partner to make health care decisions. It combines the provider's medical expertise with the individual's knowledge of what gives his or her life meaning and value. Shared decision-making is particularly useful when a proposed course of action has both potential advantages and disadvantages.

This is not a new concept in health care. Some 500 decision aids are now available, most in general health care. These tools provide information, help clarify values, and guide individuals in making a decision consistent with their preferences.

However, shared decision-making is not widely practiced or accepted in mental health care, in part because many providers mistakenly believe that people with psychiatric disabilities are not competent to participate in treatment decisions. This stereotype persists despite research which indicates that a clear majority of individuals with mental illnesses are both able to make health care decisions and desire to do so.

Shared decision-making is entirely consistent with health care reform efforts that seek to put individuals at the center of care.

To promote the use of shared decision-making in mental health care, SAMHSA has awarded a contract to develop and pilot test some innovative shared decision-making tools specific to mental health.

4. Fourth, we need to work smarter. We know what works to help individuals with mental illnesses and substance use disorders recover, but we need to be more diligent in promoting the use of these evidence-based practices. Equally important, we must take the steps needed to pay for what works and stop paying for what doesn't work. We must be good stewards of the funds that we have in order to demonstrate that we need and will use wisely the additional funding that we seek. Some examples will illustrate this point.

   Assertive Community Treatment reduces hospitalizations for people with serious mental illnesses and, according to some studies, is no more expensive than traditional care.

   Supported employment promotes rehabilitation and return to mainstream employment for people with psychiatric disabilities.

Integrated treatment for co-occurring disorders reduces alcohol and drug use, homelessness, and the severity of mental health symptoms.

These are but a few of the evidence-based practices SAMHSA has defined and described in a series of evidence-based practice toolkits aimed at consumers and family members, providers, and policymakers. We are also developing an extensive catalogue of evidence-based and promising prevention and treatment interventions through our National Registry of Evidence-based Programs and Practices or NREPP. I would encourage you to visit the NREPP Web site at www.nrepp.samhsa.gov.

But it's not enough to say we should be promoting evidence-based practices when we know that many States and communities are struggling with budget problems that might make them think twice about implementing new programs and services. We need to put our money where our mouth is by aligning funding at the Federal level to support the type of care we want to foster. Recent decisions can be interpreted to indicate that the federal government is not of one mind concerning the use of some evidence based practices. However, such an interpretation is overly simplistic and does not reflect reality. SAMHSA is working to resolve how to appropriately fund evidence based practices in a manner that is consistent with federal law and regulation. It is likely that the solutions will look different than what some state plans allowed. Our goal is to develop solutions that are efficacious, cost effective, sustainable and less subject to retrospective penalties through audit.

Our work also includes interagency cooperation by a group of Federal Partners that includes nine Federal departments, the Social Security Administration, and the Equal Employment Opportunity Commission. These agencies have joined together in an unprecedented effort to promote mental health transformation.

One of the major efforts of the Federal Partners Financing Workgroup is to address barriers to reimbursement in primary care, which we are doing with our partners in the Health Resources and Services Administration, the Indian Health Service, and the Centers for Medicare and Medicaid Services. No one individual, agency, or level of government can advance health care transformation on its own. Transformation and innovation require a broad-based commitment to collaboration and cooperation. Industrialist and innovator Henry Ford once said, "*Coming together is a beginning; keeping together is progress; working together is success.*"

5. Finally, it is not enough to promote the use of evidence-based practices if we have no data that prove they work. We must show that what we do is cost-effective and that it works.

In this regard, I think it's important for us to point out that doing nothing clearly doesn't work. For example, a State of Oklahoma Task Force found that the State spends more than $8 billion annually on direct and indirect costs associated with untreated and undertreated mental illnesses, substance abuse, and domestic violence. In Connecticut, a 30 percent cost reduction in mental health services at a large corporation triggered a 37 percent increase in medical care and sick leave by employees using mental health services, thus costing the corporation more money rather than less.

We must collect and disseminate data that reveal the types of services we are providing, what they cost, and the outcomes they produce. SAMHSA's National Outcome Measures or NOMs are beginning to help us quantify meaningful, real-life outcomes for adults and children with mental and addictive disorders.

The mental health NOMs, for example, include measures that depict how well consumers are managing their illnesses and living and working in the community, with a focus on recovery and resiliency-oriented measures. These include:

- Improved functioning for individuals receiving mental health services;
- Obtaining and keeping a job or enrolling and staying in school;
- Decreased involvement with the criminal justice system;
- Securing a safe, decent, and stable place to live; and
- Having social connectedness to and support from others in the community such as family, friends, co-workers, and classmates.

Data in these and other critical areas—including the treatment process and the quality of services—tell us how we are doing at transforming the mental health treatment system and where we need to improve.

In addition, we are now developing prevalence data on depression in 40 States through supplements to our Data Infrastructure Grants and an intra-agency agreement with the Centers for Disease Control and Prevention. Already, the data reveal significant associations between depression and such chronic diseases as heart disease, diabetes, and asthma. These data are critically important to our understanding of what it means to create a public health, integrated approach to the treatment of both behavioral health and medical conditions.

I'm also pleased to report that, for the first time, as part of our Mental Health Transformation State Incentive Grant or T-SIG program, we are beginning to measure <u>the process of infrastructure change</u> in those areas that we believe are needed to transform the delivery of mental health services to adults and to children and their families.

We have our first set of data available. They reveal that, within the next 2 years, the first group of 7 States will have:

- Made more than 150 significant policy changes, including more than 35 regarding the financing of mental health-related services;
- Trained some 20,000 providers in best mental health practices;
- Made 65 significant organizational changes to support transformation;
- Expanded data accountability systems across 450 organizations; and
- Implemented state-of-the-art mental health practices in more than 1,000 programs.

We are collecting these data to help us determine whether infrastructure changes lead to service changes and whether service changes lead eventually to client outcome changes, though we may not see these changes in client outcomes during the life of the grants.

Finally, I think it is up to all of us here today, in government and in the private sector, to support additional applied research to prove that the care we provide produces the outcomes that both funders and consumers want and need to see.

Wrap-up and Conclusion

In closing, I'd like borrow some wisdom from Harvard Business School Professor Clayton Christensen, who wrote in his book *The Innovator's Dilemma* about the need to make "a vital distinction between innovation that simply improves what is and innovation that defines what could be."

We have an opportunity, through discussions about health care reform at the State and national level, to define what 21st century health care in the United States can and should be. At SAMHSA, we are engaging in these very discussions and will be asking many of you to join us as we develop a 5-year strategic plan for the Center for Mental Health Services that will help us keep the momentum going.

As we look out 5 years, we may be talking more about innovation and less about transformation. We most certainly will be examining and using new technologies in both the clinical and business sides of our organizations that will help shape the future of the health care system. And we will continue to stress the need to recruit, train, and retain a workforce capable of practicing integrated, culturally competent, evidence-based care.

What won't change going forward is the reason for doing the challenging and rewarding work we do.

All of our hard work to transform the design and delivery of health care in this county will be worth it when the individual who has schizophrenia and diabetes receives integrated care for both disorders.

It will be worth it when the person who was told she would never work because of her psychiatric disability reports for her first day on the job.

And it will be worth it when instead of relinquishing custody of their child to qualify for mental health services, a family sits at the kitchen table to help him with his homework.

Let's work together for the success that Henry Ford spoke about because the people we serve deserve nothing less.

Thank you. If we have time, I'd be happy to take your questions.