

## NIHCM Foundation Webinar, April 11, 2019 – Turning the Tides on Mental Health Trends

- Kathryn Santoro: [00:00:00](#) I am Kathryn Santoro, director of programming of the National Institute for Healthcare Management Foundation. On behalf of the NIHCM, welcome to our webinar today. Today's webinar is the second segment in a four-part series exploring innovative strategies and evidence-based solutions to defy deaths of despair and lift our society from crisis. We're seeing this crisis manifest in rising rates of depression, suicide and substance abuse and declining life expectancy in the United States.
- Kathryn Santoro: [00:00:33](#) One out of five adults in the US experience mental illness and one out of five youth ages 13 to 18 live with a mental health condition. Estimate suggests that only half of people with mental illness receive treatment. Turning the tide on current trends in mental health is critical to prevent death from drugs, alcohol and suicide. In future webinars, we'll explore trends in suicide and substance abuse in more detail.
- Kathryn Santoro: [00:01:02](#) Today, we'll focus on efforts to increase mental health screening and treatment as well as early prevention strategies to reduce risk factors for despair. Before we hear from our speakers, I'd like to thank NIHCM President and CEO, Nancy Chockley and the NIHCM staff who helped to convene this event today including Kaitlin Smith, Alexis Wing and Kirsten Wade.
- Kathryn Santoro: [00:01:27](#) You can find biographical information for all of our speakers along with today's agenda and copies of slides on our website. We also invite you to live tweet during the webinar today using the hashtag defying despair. I am now pleased to introduce our first speaker, Paul Gionfriddo, President and CEO of Mental Health America.
- Kathryn Santoro: [00:01:51](#) Paul is a passionate health and mental health advocate and brings a wealth of experience and expertise from his work in the public and private sectors including serving on the National Advisory Council to the SAMHSA Center for Mental Health Services. We're so grateful he's with us today to share his perspective on the state of mental health in America including data for Mental Health America's screening program. Paul?
- Paul Gionfriddo: [00:02:19](#) Thank you very much. It's a real pleasure to be here with you. I am going to be covering a lot of ground. I will try to do it pretty quickly. I've been asked to do an overview and we'll be helping to setup, I think, the subsequent presentations that we'll have today. I wanted to begin by just noting that each year, Mental Health America writes a report called the State of Mental Health in America.

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- Paul Gionfriddo: [00:02:49](#) We draw data from federal sources primarily and not only for the nation as a whole but for all of the states. From our most recent report, some very high level data, reflect something that I think everybody on this call currently understands and that is that a significant number of American adults, 18%, have a mental health condition that many of the people, adults with mental health condition, are uninsured and remain so even though that number is dropping.
- Paul Gionfriddo: [00:03:23](#) While coverage is increasing, access isn't necessarily because one in five adults who experience a mental health condition currently reports an unmet need. There are similar kinds of worries around young people. The rate of youth experiencing a major depressive episode for example, has increased dramatically over the course of just the last four years.
- Paul Gionfriddo: [00:03:46](#) Again, the vast majority of youth with a major depressive episode receive no treatment. Part of the problem is that mental health workforce shortages remain. One of the most promising ways of addressing those shortages, the certified peer specialist, is still getting off the ground.
- Paul Gionfriddo: [00:04:06](#) Mental Health America, we are 110 years old. For most of our life was the National Mental Health Association and we promote mental health as a critical part of overall wellness including prevention services for all, early identification and intervention for those at risk, integrated care services and support for those who need them with recovery as the goal.
- Paul Gionfriddo: [00:04:28](#) Understanding that mental illnesses have been, as a matter of public policy, by having a nonclinical standard applied as a trigger to treatment, so-called danger to self or others, mental illnesses have been the only chronic diseases in America that we, as a matter of public policy, have waited until stage four to treat and then often inappropriately only through incarceration.
- Paul Gionfriddo: [00:04:52](#) A little bit later on, Kitty is going to reference the two systems of care that revolves in the state. Suffice it to say, they've done tremendous harm to people with significant mental health issues. We can do better than that with more screening and better integration. When screening is offered in primary care, screening for mental health problem, it's perceived as helpful 93% of the time.
- Paul Gionfriddo: [00:05:15](#) Primary care physicians have three times more likely to recognize symptoms of mental illness and then follow-up. Post-screening treatment changes are made of significant percentage of the time and positive benefits persist overtime. The fact of

the matter is, we are not screening and identifying and serving our kids with behavioral health needs or adults with behavioral health needs, while screening should be as ubiquitous as blood pressure screening for adults and as vision and hearing screening for children.

- Paul Gionfriddo: [00:05:48](#) The fact of the matter is that it's rarely done. One of the best indicators of this is the evidence from the Department of Education data for the country as a whole. Where in 2015, 2016, we identified fewer than 350,000 people between the ages of three and 21 for special education services on the basis of the SED label. That represents only about one child in every 30. According to the National Institute of Mental Health has in fact or will have a serious mental health condition by the age of 18.
- Paul Gionfriddo: [00:06:23](#) We've got to do significantly better than that in the area of early identification and intervention or we lose too many people. Much of the presentation I'm going to do here will be done from the perspective of people, the individual, the patient for people will refer that way, the consumer, but were founded, Mental Health America, by an individual, Clifford Beers, young man with lived experience.
- Paul Gionfriddo: [00:06:48](#) We often look at things not through the lens of the provider or the system but through the lens of the individual who's seeking help. When people first seek help around the mental health condition, they Google terms like, am I stressed or depressed, depression test or just simply, I want to die. They don't relate to clinical language while clinicians will speak of cognitive distortion, stopping stupid thoughts is MHA's most popular webpage outside of screening.
- Paul Gionfriddo: [00:07:25](#) Mental Health America offers four million screens online that people can take anonymously in those nine particular areas. Here are some of the general results overview from the screening that we offer. Three quarters of the people would take a screen. We have about 3,000 people a day taking the screen. The screen is positive or moderate to severe to the condition for which they screen. Of that group, two-thirds had never been diagnosed actually making our database the largest database in the country that is readily available about a health-seeking population that is not yet in treatment, generally, for the services they seek or for the conditions they have.
- Paul Gionfriddo: [00:08:07](#) The depression screen, the PHQ-9, is by far the most popular. About half take that, followed generally almost equally by those who take bipolar, anxiety and psychosis screens. While some of

the others come in a little bit lower. Eight percent of our screens are international. The race, ethnicity of our screening population is close to the United States Census and 35% of our screeners are aged 11 to 17, 32% are 18 to 24.

- Paul Gionfriddo: [00:08:36](#) That often stops and surprises people until you remember that half of mental illnesses emerge by the age of 14, three quarters by the age of 25, making these diseases and conditions of childhood in our country. Our screening population reflects this. Of those who report a chronic condition, which is going to be important for the discussion about integration throughout this hour, 31% report chronic pain, 13% report lung problems, 12% report diabetes.
- Paul Gionfriddo: [00:09:10](#) That's a general overview of screening but digging down a bit deeper, if you look swiftly into pediatric symptom checklist, which includes two of the screens that we have, the parent screen and the youth screen, you'll see some interesting numbers here when you put data for both 2017 and 2018 put together.
- Paul Gionfriddo: [00:09:30](#) First of all, in the parent screen 64% of the young children on whom they have parents are screening, screen at risk for a significant mental health concern or condition. In the youth screen, 72% screen at risk for a serious mental health condition. Clearly, when people are seeking help, they're seeking help because they already perceived they've got symptoms. They already perceived they need some support and services but they are not yet getting that for the most part.
- Paul Gionfriddo: [00:10:00](#) One of the reasons for this, we can see when we dig down into some of the youth screening data even more deeply. It's because for the most part, we wait until there are conduct problems and when we can observe a behavioral problem within a behavioral health condition such as danger to self or others at the deep end of that. That's when we array our services, that's when we step in and that's when we attempt to change the trajectory of somebody's life.
- Paul Gionfriddo: [00:10:32](#) If you actually look at the way people will respond to questions when they are screening. In fact, in the case of young people, the conduct problem come last. You see more of the dark blue there in the never category, it is the attention problem and the anxiety-depression problem. The internal factors, they come first that they are aware of, they are concerned about and for which they will be seeking help if we gave them an opportunity to do so.

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- Paul Gionfriddo: [00:10:59](#) The same is true with all screeners including adult. When you look at the question breakdown in the PHQ-9, which is the depression screen that we have and we have about two million results with the depression with the PHQ-9. Once again, we often think of an earlier stage indicator of somebody with a serious mental health condition related to depression being suicidal ideation. If you look carefully at this slide, you see that the suicidal ideation question, thoughts that you would be better off dead or hurting yourself.
- Paul Gionfriddo: [00:11:33](#) It's the eighth most frequently, positively answered question in the PHQ-9. What we should be responding to is integrated circumstances through screening and through earlier identification intervention if in some of those other things on the list where people are feeling down, depressed or hopeless, feeling bad about themselves, feeling tired or having little energy, having trouble falling asleep or staying asleep or sleeping too much. When those constellation of symptoms are arrayed together, that's the time we need to be intervening if we're willing to change trajectories of live and move people away from suicide.
- Paul Gionfriddo: [00:12:15](#) While 32% of the people in that prior slide basically talk about having suicidal ideation, either half or nearly every day, and John is going to talk more about this kind of information suicide later on in his presentation. In fact, it's not equally distributed across age groups. Half of the screeners age 11 to 17 report significant thought of suicide or self-harm. We all too infrequently recognize what's going on with our kids.
- Paul Gionfriddo: [00:12:50](#) Here's something to keep in mind. It's not a question of there are serious mental illnesses and those are the ones we need to be focused in on. Then, from not so serious things that people will get over. As a matter of public policy, there is no distinction between a traditional serious mental illness and other mental illnesses. All mental illnesses need to be treated and taken seriously from the start.
- Paul Gionfriddo: [00:13:20](#) I'm just digging in a little bit more into the psychosis screeners because often that is one of the conditions that people universally see as a condition that is more serious attention for people, 73% of our nearly 300,000 psychosis screeners scored at risk for psychosis. We only identify about 100,000 new individuals each year with schizophrenia for diagnosis.
- Paul Gionfriddo: [00:13:52](#) Most of the people who will be diagnosed with psychosis are actually appearing in our screening population and in earlier stage of this process. In fact, again, are not in denial about the

symptoms they have. They're actually seeking help about the symptoms that they have. They're looking for us to do something on their behalf and they're more likely to have been diagnosed already in the past with something, but I will say parenthetically, traditionally there might be who have been diagnosed inappropriately with another condition.

Paul Gionfriddo: [00:14:29](#) The whole category of integration is incredibly important to us because so many other organizations that advocate as we do on behalf of patients or individuals or people with lived experience with those conditions come to us and say, "The overlap of mental illness and chronic conditions is really bedevilment to people."

Paul Gionfriddo: [00:14:49](#) How do we figure out and know what to do for somebody with a heart condition? We don't know what to do with a mental illness that comes along with that. Our conference this year in June is being built around the overlap of mental illness and chronic conditions, because it's critically important that we look at these things within an integrated setting. Because between 70 and 80% of screeners who have chronic condition actually screen positive for mental illness as well within our screening population ranging across all chronic conditions and previous diseases in America.

Paul Gionfriddo: [00:15:23](#) In fact, people with chronic conditions have more frequently had a mental health diagnosis in the past, about half of them have, versus as you recall only about one-third of the overall general screening population. When people don't have a combination of condition, we need to do something for them. One of the reasons why the healthcare system hasn't organized itself in a way we do so is because as people say they don't know, providers don't know where to refer people for care and services because we don't have an adequate supply of behavioral health professionals and they aren't adequately distributed around the country.

Paul Gionfriddo: [00:16:08](#) One of the things that we learned by talking to individuals who are health-seeking is that referral to care and services is only one of four things they are looking for. They are also looking for information and education. They're looking for engagement with peers. They're looking for self-help tools that they can use to maintain their health and wellbeing. Even when we can't provide a referral to care and services, we can provide all of those additional other categories of support.

Paul Gionfriddo: [00:16:36](#) At Mental Health America we're doing some of that. In 2018, we launched a screening support site. One and a half million

individuals had over six million views of content. The content that we give people after they take a screen whether it's being positively or negatively, which is customized for them, gives them information and resources in all four of those areas, the learning, the do-it-yourself tool, treatment resources and connection with peers.

- Paul Gionfriddo: [00:17:04](#) It makes a difference to them that we're able to do so from a perspective that they understand because as I mentioned earlier, words matter. I'm ashamed of the way I am. I want to die. I can't get out of bed. I'm feeling guilty. That's the way they talk about the conditions that they have. Our top pages are not clinical pages. They're pages like, I see ghost or shadows. I'm afraid I'm going to kill myself. How do I get a service animal and other kinds of things that help-seeking people are looking for.
- Paul Gionfriddo: [00:17:35](#) My concluding thoughts that mental health problems are common and increasing even if coverage and access improve. That screening is beneficial and it can identify issues and intervention opportunities long before stage four in the mental health arena just as in chronic diseases in general. That both children and adult benefit from ongoing screening and support.
- Paul Gionfriddo: [00:17:57](#) The people with other chronic health conditions are at special risk. While support should be person-driven, the answer is clearly not in the further segregation and continuing segregation of our healthcare delivery system into health and behavioral health but in the integration of care, services and support because that's what leads to recovery. Thank you.
- Kathryn Santoro: [00:18:25](#) Thank you, Paul for that presentation and for your leadership and commitment to improving early identification of mental illness. I think one key takeaway for our audience is that striking data on dual diagnoses and how the healthcare system can partner to develop a more holistic approach.
- Kathryn Santoro: [00:18:45](#) To learn more about efforts to treat the whole person by integrating medical and behavioral health services, we're now joined by Suzanne Kunis, Director of Behavioral Health Solutions at Horizon Blue Cross Blue Shield of New Jersey.
- Kathryn Santoro: [00:19:00](#) Horizon Blue Cross Blue Shield of New Jersey is investing in innovative partnership to bridge gap and access to behavioral healthcare in accelerating efforts to integrate medical and behavioral services, which is improving care coordination among providers and ultimately improving patient outcome.

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- Kathryn Santoro: [00:19:20](#) Suzanne is leading Horizon's efforts including developing new behavioral health programs and services. She joins us today to share this important work. Suzanne?
- Suzanne Kunis: [00:19:31](#) Thanks, Kathryn. Following Paul's lead, I do have a lot to cover and I want to be respectful of everyone's time. You're going to get Jersey speak here to try to help to move this along.
- Suzanne Kunis: [00:19:43](#) Let me go to slide two, it's just really a little bit about the organization. We are the largest and oldest health insurer in New Jersey. We cover over three and a half million members, which represents about 50% of the insured market or over 50% in the insured market. The fact is we feel as an organization very strongly positioned and really an accountability to help to make an impact here. It's a huge opportunity for us with the coverage that we have in New Jersey.
- Suzanne Kunis: [00:20:16](#) I'm not going to go into a lot of this, Paul covered most of this. I think that everybody needs to understand one of the messages that we continuously try to get out there is, mental health problems are very common. Despite that stigma stands in the way of people being willing to get treatment. We looked at some of the Mental Health America statistics et cetera. When you look at chronic illness recognizing that about 59% of people have a comorbid physical health and behavioral health issue.
- Suzanne Kunis: [00:20:45](#) When you start to look at the cluster associated with it, we're talking triple the utilization of healthcare resources for individuals who are struggling with both mental health and physical health issues. New Jersey is not unlike the rest of the country from my past experience but what I can tell you is just focusing on our state. Aside from stigma being one of the greatest challenges that we're facing, we have a significantly fragmented care delivery system and in two ways, limited coordination between physical health and behavioral health providers.
- Suzanne Kunis: [00:21:20](#) On the behavioral health side alone, there are significant gaps in services being provided, an example, if someone has a substance use disorder, they're heading off to a rehab, as they're being discharged from rehab, they're being given instructions to attend an IOP program in the next day. The person does not show up the next day and no one goes looking for them. We're trying to address both the integration of physical and behavioral health but also trying to address the issues within behavioral health itself.



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- Suzanne Kunis: [00:21:50](#) When you go to a primary care physician's office, you probably have a seven-minute office visit, which is the average. Seven minutes is not easy to try to ... it's probably impossible to address behavioral health issues on top of physical health issues. Aside from medical school rotations, most PCPs have not had any formal training around behavioral health and the fact of the issues associated with comorbid issues, comorbid conditions.
- Suzanne Kunis: [00:22:19](#) We also are looking at patients from a holistic perspective. We want providers to treat patients as people not conditions. Thirdly, looking at access issues, we know that about 60% of treating psychiatrists are over the age of 65. You can easily see what that's going to look like in the coming years. Child adolescent providers or psychiatrists, we're talking 15 million kids being serviced in about 8300 child mental health psychiatrists are out in the world, some of them tied up with research and academics et cetera, not necessarily treatment.
- Suzanne Kunis: [00:22:59](#) We are, in New Jersey, are focusing attention with our provider partners on increasing psych residencies and actually doing a lot of training within the medical schools around the integration of physical health and behavioral health. We need more alternative when it comes to traditional treatment providers, psychiatrists, social workers, psychologists. As Paul had indicated, there are not enough behavioral health clinicians out there to be able to address the needs. We're really spending a lot of time and energy around looking at different systems of care as well as different types of interventions that can occur at the primary care level.
- Suzanne Kunis: [00:23:33](#) We have an out of network challenge and I'm sure again, many of the other insurers around the country are dealing with this where we have lots of people leaving the state, heading to Florida, California and Texas for treatment. We have a long way to go to change things up. Part of our responsibility is how do we make care available here in the home community to really take any reason for people leaving the state off the table.
- Suzanne Kunis: [00:23:58](#) The opioid epidemic, there's the lack of evidence-based treatment as substance use, we're really excited on the MIT front for opioids but there's still a lot of work that needs to be done in the model of care if you will. In New Jersey, specifically, as it relates to opioids, on average, eight people die every single day from an overdose. Not a good place to be. Again, making lots of effort to turn the tide but still a tremendous amount of work to be done. Moving to the next slide.

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- Suzanne Kunis: [00:24:33](#) As we were trying to develop our strategy, that's how we're trying to approach what we're doing here in New Jersey. We step back to say, what do we need to think about to ensure that the system of care that we have in place meets the needs of our citizens here in New Jersey. The foundational elements are laid out here, a couple I wanted to mention, quickly are treatment in the home community is clearly an important thing because going away and coming back, the issues are still the same. We want to make sure that we have that support here in the State of New Jersey.
- Suzanne Kunis: [00:25:02](#) Patient navigation, we need to stop patients being lost between physical and behavioral health and between the various treatment modalities within behavioral health. As Paul talked about, these are our most vulnerable members that we really need to step up and go way above and beyond what has been done historically. Community based services, we're very interested and have nice relationships with some of the CCBHCs here in New Jersey, it's these Certified Community Behavioral Health Centers that were SAMHSA granted couple of years ago. The scope of services that they're providing is incredibly positive. The more we work for keeping people in the community and expand those types of programs and community-based services, the better our members will be.
- Suzanne Kunis: [00:25:53](#) We're also looking at how do we remove obstacles to treatment? Aside from the fact that we have to deal with the whole treatment and recovery program for all of mental health and substance use, we want to make sure we're removing all the obstacles, homelessness, joblessness, as much as we possibly can in order to help people to get the services that they need and to live a healthy life. We are a commercial insurer, as well as we have government programs business. On our commercial side, we typically have not paid for services around housing support, peer recovery, but we're totally shifting the dynamic here and trying to get into a new world, on the commercial insurance side and trying to take some really positive lessons out of community health world.
- Suzanne Kunis: [00:26:38](#) Going to the next slide, as we developed our strategy, we went to make certain that we have solutions in place for everyone with needs across the continuum. Most of our efforts have been focused on quadrants three and four, which are the high-end behavioral health, low-end physical health and high-end behavioral and physical health, primarily serious mental illness. Again, what you'll see in a moment is we have solutions across the continuum, but really our greatest effort is looking at those individuals who are in quadrants three and four.

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- Suzanne Kunis: [00:27:13](#) With that as the backdrop, and with the focus on members in quadrants basically two to four, let's talk a little bit about our integrated approach. As I mentioned, we have solutions across the continuum, everything from health and wellness to SMI. I wanted to give you a sampling of some of the work that we're doing. This isn't all inclusive, but it's an idea of some of the things that we're actually working on and have implemented or on the way in the path of launching.
- Suzanne Kunis: [00:27:40](#) As you can see, the continuum of services here, basically the intensity of resources and the level of engagement increases dramatically as you move along the continuum. If you, again, we're highlighting here according to the quadrants, the types of programs and services that we have implemented or will be implementing to support members in each stage of their illness or for health and well being.
- Suzanne Kunis: [00:28:10](#) We've implemented a variety of pilots around integrating physical health and behavioral health. We are supporters of collaborative care model and we reimburse for those services. We are working with provider organizations who have embedded clinicians in their primary care practices. We have hybrid models, the Cherokee model, as many of you are knowledgeable of. Then, we've just recently being 2018 launched a program with Quartet Health.
- Suzanne Kunis: [00:28:42](#) We reimburse for collaborative care. We also reimburse for behavioral health screenings in a primary care setting. We have a huge opportunity to do so much more in the way of education training of a network and we will be doing that in the coming months and years. I wanted to spend more time talking specifically around our Quartet relationship and our AbleTo relationship.
- Suzanne Kunis: [00:29:04](#) I will do that in one moment. Before I leave this, I wanted to mention that we're also trying to look at episodes of care and other value based financial arrangements with provider organizations, behavioral health and I don't ... again, we're not unique here, but there's primarily been a fee for service world, in the commercial side of the of the world. We are trying to move that more from fee for service to fee for value.
- Suzanne Kunis: [00:29:27](#) We've implemented two episodes over the course of the last year. One, in substance use disorder and the second for inflammatory bowel disease and really making behavioral health and physical health, a view, a single view, for providers to help patients to be able to address the issues that they're facing as part of their disease.

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- Suzanne Kunis: [00:29:53](#) Okay. Quartet Health is essentially virtual integration at a primary care level. The value prop here, Quartet leverages proprietary algorithms that they use and take claim data from Horizon, run them through their algorithms and essentially identify members with an undiagnosed or relate with behavioral health problem. This is a primary care physician focused initiative.
- Suzanne Kunis: [00:30:18](#) What they'll do is, as a result of having done the claim analytics, they'll identify people who could benefit by having a behavioral health intervention. At the same time, there is also the opportunity for primary care physicians to surface patients to Quartet. The reason we're doing this is and we're making it available for any person that's being treated in a primary care setting regardless of whether or not they're a Horizon member. We know that there are enough challenges in the primary care setting and enough priorities and timing is not on our side, that we're trying to make certain that is easy for primary care physicians to be able to say, "I've got a patient, regardless of insurance, no insurance, what type of insurance," that they can actually surface to Quartet. Quartet will connect them to behavioral health practices.
- Suzanne Kunis: [00:31:08](#) If there is an app that is used, so we engaged, actually, we have over 1200 primary care physicians in our first pilot and over 550 behavioral health practices in the pilot. There is an app that's used between both practices and so patients can be referred into behavioral health treatment from there, and then the behavioral health practices are able to communicate back to primary care of that, yes, I have your patient. Yes, we have a treatment plan. Yes, there are medications that are involved.
- Suzanne Kunis: [00:31:37](#) It really changes that dynamic. I know for many, many years, primary care providers were afraid to do screenings, because they didn't know what to do if the patient screen positive and how they would respond to that. Now we've got this tool in place where we are actually giving them the opportunity to surface patients, get them into treatment and know on an ongoing basis what's actually going on with those patients.
- Suzanne Kunis: [00:32:01](#) There is an expedited referral and coordination process between the behavioral health and primary care physician. We started this off in January of '18. The first year was really a build year. As I mentioned, we've got over 1200 primary care practices that were involved. During that first year, Quartet has surfaced over 2500 members to primary care as people who potentially could use a behavioral health intervention. Then, 1700 of our members were referred by the primary care

provider, look into Quartet to get that patient set up with treatment.

Suzanne Kunis: [00:32:37](#) Then, there were several thousand others that had no relationship to Horizon that actually were referred into behavioral health treatment because of the way we set this program up. It's a program that is currently focused on adults. We were again limiting it to a certain ... we have 15 priority health systems that we have engaged primary care practices through. We are not at the point yet where we're able to see a demonstrative ROI because, really, the first year was primarily build year. We expect that we'll be able to analyze up by the end of the first year, by the end of this year.

Suzanne Kunis: [00:33:10](#) Having said that, we have seen such positive feedback from the provider community, like we've never seen before, most providers are not out claiming ... proclaiming the value of a health plan. There has been such great response to this. We have lots of testimonials from providers that are actually utilizing the system that we decided to scale this statewide and we will be doing so in the coming month, even while we wait for the demonstrative ROI.

Suzanne Kunis: [00:33:37](#) The program is currently focused on adults, but our next phase is actually going to be working on the child and adolescent population. We're fortunate in New Jersey to have access to the pediatric psychiatry collaborative, which helps with getting patients, kids that are ... it's funded by the New Jersey Department of Children and Families. There's a way to get people and kids into treatment. We want to take that to a much greater scope if you will over the course of the next years, year or two.

Suzanne Kunis: [00:34:06](#) As much as Quartet was a PCP focused program in a focused integration effort, we also have a relationship with AbleTo, and that is a member focused program. It's virtual therapy and coaching for people with depression, anxiety and stress. You'll see a little bit more of some of the programs that are available. It's the telehealth solution, again, using claim analytics to identify individuals with chronic medical issues that could benefit by a behavioral health intervention.

Suzanne Kunis: [00:34:34](#) It's an eight week program. It includes CBT and coaching by a secure phone or video. They will have one coaching session a week by an individual who is a masters level clinician and they will have a therapy session by a licensed clinical practitioner second day during the week. It's two visits a week, it's an eight week program and there is follow up, support services are

available to the members. The focus of it is to really see how we can intervene and help people to deal with the issues that they're dealing with their medical issue, with their medical problems.

Suzanne Kunis: [00:35:12](#) The outcome focus that we're looking at, we're measuring this by what is the impact on overall total medical expense? Secondly, and actually more importantly, the outcomes focused around what's happening with the scores that the individuals are completing over the course of that eight-week program. The DAS score, depression, anxiety and stress scale is utilized and we monitor that over the course of the program and into the future.

Suzanne Kunis: [00:35:38](#) We are continuing to expand the program. Again, people that go through the program and graduate have greater than 97% satisfaction with the program. We think we're trying to do the right things by having a PCP focused intervention, a member focused intervention, and then lots of other things that fall around both of those.

Suzanne Kunis: [00:35:59](#) The next slide just briefly shows you the extent of the programs that are available, under our AbleTo model but it's really dealing with all kinds of issues that you would deal with in life including traumatic life events, your medical condition, and just basic psychological distress.

Suzanne Kunis: [00:36:21](#) Okay. I mentioned earlier, we have a focus on substance use disorders and the opioid crisis. It's a huge area of focus and we've made a significant investment as an organization in really making certain that we are stepping up and doing all the right things. We're focusing our program around education and prevention, treatment and recovery, community engagements. We're piloting a lot of different solutions and the reason is this is such a huge challenge in the state that we really need to just throw everything at it to see what possibly can be done to help individuals to get into recovery and to stay on recovery.

Suzanne Kunis: [00:37:01](#) Our pharmacy program is quite robust, our lock in has been quite successful. You should see some of the highlights here. We have prescriber focused risk identification programs. We have a prescriber toolkit to help with educating providers around best practices. We're working with the DEA and the partnership for Drug Free New Jersey and so many other community organizations to really hone in on what's happening, what are we doing as key stakeholders in the state and coming from all walks of life, to be able to try to get this crisis under control.

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- Suzanne Kunis: [00:37:38](#) Then, we're really emphasizing that best practices [inaudible 00:37:42] medication assisted treatment and helping to actually establish services in areas of the state where it doesn't exist. As you can see, as I mentioned, increasing access to medication assisted treatment services, we will have a TELL therapy solution set up shortly, that will be specifically focused on substance use disorders.
- Suzanne Kunis: [00:38:04](#) We've actually partnered with an organization called MassHealth Management, we're doing a pilot program and it's a technology enabled peer support where at the point of discharge from a higher level of care, in patient or residential type of program, as well as at the point of entry into outpatient treatment program, individuals will have the opportunity to engage with a peer who is in recovery and they're certified peers. They provide a structured outreach program, a four-time context during the early months.
- Suzanne Kunis: [00:38:37](#) There will be an outreach from the recovery, person in recovery, who is actually the peer to the individual who's struggling with getting in the day and recovery. Then, that patient as well as their families will have 24/7 access to the peer. We thought it was very important that we make sure that the families or support system were able to get into the peer whenever they would see one of their loved ones actually beginning to go down a slippery slope and actually help to bring them back and re-engage in treatment.
- Suzanne Kunis: [00:39:09](#) Lots going on there. Peer support. Again, I know Paul, you have mentioned about it, we are huge supporters of peer services, not just for substance use but also for mental health. Again, typically not a service that has been covered under commercial insurance, but we're trying to change things up to really include a whole new scope of services that will do the right thing to get people care that they need and then into recovery and stay in recovery. In the end, you do the right things and the money will follow.
- Suzanne Kunis: [00:39:43](#) Then lastly, I wanted to spend time on this program that we are going to be launching this summer. We're really excited about it because we think it's very different than what's actually been sitting out there and addressing all the challenges that we've been facing. It's really called our Integrated System of Care, real creative title. Targeting the most vulnerable members that we have, which are the most complex member needs. The core of the program is our behavioral health integrator. It's really a center of care. The first one that we're working with is an organization that is one of the CCBHCs here in New Jersey.

What their role is we're going to continue to provide the full scope of services they do presently for members who actually approach there for treatments. They're also going to be doing a higher level of service in terms of patient navigation. That's really what we're trying to focus on here.

Suzanne Kunis: [00:40:41](#) Our objectives are to reduce the delivery system fragmentation, increase access and improved at navigation of members. We don't want people to keep getting locked in the system and fall through the cracks. Improve the quality and reduce total cost of healthcare. For the last 12 to 18 months, we have focused on developing this model. We've identified the integrator and the roles and responsibilities for the integrator, which again, it's on all aspects of this. Our model of care, the ecosystem includes not just behavioral health issues but it's really bringing in supply the physical health pieces and delivery system as well as addressing the social determinants that we need to address to ensure that people are able to engage in treatment and to stay in treatment.

Suzanne Kunis: [00:41:29](#) We've identified our integrator for our pilot, again, it's in one small area. We've also identified a health system partner, one of the major health systems here in the state. They currently work together on a very small basis but what we're doing is formalizing this approach and really making certain that we have all of the tools in place that we need to including feet on the street, et cetera, et cetera to be able to get people into treatment, regardless of what their treatment issues are, make sure that they attend treatments, services, make sure that we're tracking outcomes, making sure that they're fully engaged, as well as their family, and doing whatever we need to do to try to change the trajectory of illness for people that are in the state and in this pilot program.

Suzanne Kunis: [00:42:18](#) We did seek expert input, we've approached a couple of nationally recognized individuals and organizations for their input and had received great feedback and support for the program that we're launching. We're expecting to be live this summer. It's pretty exciting because if things go as well as we're hoping that they will, then we are hoping of ultimately to scale this statewide. We're going to start in one small corner of the world and go from there. To give you a sense of what we believe can happen, so we have a behavior ... as I mentioned behavioral health practice that we've identified, and we have a health system that we're working with.

Suzanne Kunis: [00:42:56](#) Today, there are 77 people who are actually being seen in both systems for physical health and behavioral health. Prior to



actually even implementing some of these changes, we knew that we were partnering with the right people because as you look at the average total PMPM, those individuals who had not visited this practice and potentially not have behavioral health services at all, their total PMPM is 15% lower than those who did not visit that practice.

Suzanne Kunis: [00:43:30](#)

Then, we split it into the physical health PMPM and the behavioral health PMPM. As we mentioned earlier, costs are generally three times higher for individuals that have a comorbid condition. Here, we're looking at again, in the early sample of work that's already being done on a limited basis, we're seeing a 35% lower PMPM on the physical health side of the equation.

Suzanne Kunis: [00:43:53](#)

Again, small numbers, we understand that, but we think it definitely reflects evidence of that strengthened integration between physical health and behavioral health and really will improve overall outcomes and reduce overall cost of care. Our next step here are that we are going to be launching and we'll be monitoring over the course of the next six to 12 months and waiting to see what the results are. It's been a journey getting to this point but we're really excited about the potential. With that, I'm going to end my presentation. Thank you for your time.

Kathryn Santoro: [00:44:31](#)

Thank you, Suzanne. Suzanne highlighted several promising ways that health plan can partner with providers, with their members and their communities to break down barriers to mental health care by reducing stigma, improving access to care, while improving health outcomes and reducing the total cost of care. The rising costs and burden of mental illness is a significant concern for everyone, especially the federal government and the state.

Kathryn Santoro: [00:45:00](#)

Medicaid is the largest payer for mental health services in the US. Our next speaker, Kitty Purington, will share an update on state approaches to improving behavioral health care. Kitty is a Senior Program Director at the National Academy for State Health Policy. She has over 20 years of experience working on state Medicaid policies to support behavioral health needs, including overseeing the development of the Medicaid behavioral health home model for adults and children and [main 00:45:33], Kitty?

Kitty Purington: [00:45:36](#)

Great. Thank you so much and good afternoon everyone. I really appreciate participating in this discussion. I'm going to be talking about the state policy role in improving mental health services and the unique role that states have in this area. I'll talk

a little bit about some of the key challenges facing states and also talk about the specific policy levers that we're seeing states use to address just a scope of challenges in delivering or supporting effective systems and services for people with behavioral health needs.

Kitty Purington: [00:46:23](#) First, I wanted to just review very briefly why states really care about mental health and are very invested in these issues. First, states as Kathryn mentioned, incorporating Medicaid spending a really significant payers in the world of behavioral health services and supports. In fact, Medicaid is the single largest payer for mental health services in the US. State systems developed a traditional role of providing care to people with serious mental illness from the 19th century on. They were really seen as essential elements of the system of care for people with serious mental illness in terms of supporting the asylums and institutions of the 19th and 20th centuries, following the deinstitutionalization of individuals with serious mental illness in the '70s and '80s.

Kitty Purington: [00:47:21](#) This view of the state function of state's being core to supporting individuals with mental illness is still very much alive in the policy world. In some unfortunate ways, as evidenced by what is known as the IMD exclusion or the unappealingly named Institutes for Mental Disease policy. This policy prevents state Medicaid agencies from not being able to use federal funding to pay for treatment within state mental health institutions as opposed to other settings, other inpatient settings.

Kitty Purington: [00:47:59](#) This policy of states really being the primary locus for mental health care is also very much reinforced in the distinctions in benefits and approaches between Medicaid and Medicare, which Medicare until recently paid only 50% of claims for mental health treatment and still, for a number of reasons, still offers a much more limited benefit package for people who have mental health needs.

Kitty Purington: [00:48:29](#) States are increasingly recognizing that mental health is a cost multiplier for their programs. The data is very clear that having a mental health diagnosis increases the cost of care, largely for physical health diagnoses enormously. Medicaid spending for behavioral health diagnoses is roughly four times higher for spending than those without these disorders. People with mental health diagnoses are much more likely to have multiple chronic conditions, use more services such as emergency room, inpatient services and more likely to have readmissions.

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- Kitty Purington: [00:49:07](#) Generally, having a mental health issue coupled with many of the systemic challenges that people with mental health face really makes it a lot harder to do a lot of things. It tends to make people poor. It also often comes with medication regimens that make people prone to metabolic diseases like diabetes. All of these factors have a very significant impact on the mortality rate. People with mental illness, serious mental illness in particular, who die on average 15 to 20 years before their peers without these disorders.
- Kitty Purington: [00:49:48](#) When we talk about state mental health systems or state mental health policies, we are really talking about two quite different systems of care. There's a lot of overlap but they tend to be from the state policy perspective, certainly distinct for a number of reasons with different payment policies and different approaches at the state level.
- Kitty Purington: [00:50:10](#) On one hand, in the first column I have what I'm calling here general mental health services for lack of a better term, which describes the capacity, really, for primary care providers to deliver behavioral health treatments for a range of conditions that tend to be successfully identified and treated in more integrated settings.
- Kitty Purington: [00:50:35](#) This approach to mental health treatment does not necessarily ... It doesn't necessarily align with diagnosis but it can include things like as we've heard depression, attention deficit disorder, anxiety and other disorders that with some support can and really should be addressed early and effectively within settings like federally qualified health centers or school-based health clinics and general primary care.
- Kitty Purington: [00:51:05](#) There are surprisingly a number of barriers to supporting treatment in these settings and states over the past five to 10 years have really been keenly interested in promoting the development of more integrated models for Medicaid populations, who are more likely than other beneficiaries, commercial beneficiaries for instance, to be dealing with behavioral health diagnosis.
- Kitty Purington: [00:51:30](#) State policy makers have really been engaged in identifying policy leverage to help build that integrated capacity in primary care, including support for assessment and screening and the ability to have multidisciplinary teams that can include care coordination and oftentimes a behavioral health specialist sometimes that behavioral health specialist can be located when feasible. Also, looking beyond the walls of the primary care setting and building supports for how primary care

practices can really effectively link with and refer to more specialized care when needed.

Kitty Purington: [00:52:10](#) Also states have been doing quite a bit of investment and pushing out integrated data, Medicaid data, and looking at other ways that technology can support practices to have a better connection to behavioral health services and supports, but also a better perspective more comprehensive perspective of an individual patient's needs that's getting treatment from their practice.

Kitty Purington: [00:52:39](#) Somewhat in contrast, people with serious mental illness very generally speaking typically receive mental health treatment through specialty service providers that rely very heavily on Medicaid and on state fundings. These, these systems are really creatures of the state Medicaid and state funding.

Kitty Purington: [00:53:02](#) As such, states are very involved in defining the service array to funding medical necessity or eligibility criteria for these services, which often includes a diagnosis plus some sort of additional functional criteria that indicates a more intensive need for services. The services provided by Specialty Mental Health System are going to be a broader range of services, more intensive services that typically or generally speaking are not going to be found certainly in Medicare or in commercial insurance packages such as peer support, supported employment, supported housing, and other things that can assist people to recover and live effectively.

Kitty Purington: [00:53:57](#) Because this is really a broad area of concern for states and there are a number of policy issues that states are very involved in. There are things that present persistent challenges as well as some things that are more emerging particularly in relation to the opioid epidemic and FUD challenges generally. For states work in promoting integrated care for their Medicaid populations, promoting and sustaining services across primary settings and especially [inaudible 00:54:30] settings is really an ongoing priority and an ongoing challenge.

Kitty Purington: [00:54:34](#) Understanding what primary care and related settings really need to address mental health diagnosis. How these services can be supported effectively and incentivized has been the focus of a lot of work by state policy makers over the past few years. As mentioned previously, the behavioral health work force is also a huge concern. I think integrated care is often looked at as a way to leverage the workforce more effectively so that state systems can increase access to behavioral health.

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- Kitty Purington: [00:55:06](#) It's particularly challenging to support a diverse workforce and a behavioral health workforce that can address the particular needs of older adults, children and also the needs of people who live in rural areas. On women state sort of more specialized mental health systems, states are really realizing that mental systems which are fundamental to overall health need to be able to participate in state health reforms and payment reforms. In many states, mental health systems have been the purview of smaller providers who operate on very narrow physical margins. As such are very challenged to participate in payment models involving risk for instance or they may not have the data capacity that large medical systems are able to purchase to support their practices.
- Kitty Purington: [00:56:14](#) There's a lot of investment to be made within these systems to support evidence based or best practices to support the use of data and health information technology and the overall capacity to participate in value based purchasing and state health reforms. There are certainly organizations that are large and sophisticated and are doing this work are participating in these kinds of state health reforms and have a lot of this capacity but there are probably more that are not there yet.
- Kitty Purington: [00:56:50](#) In addition to this emerging issues, states have a long standing interest in supporting a continuum of care for individuals with serious mental illness that can help overt crisis that can maintain housing, that can avoid corrections involvement and other outcomes, other adverse outcomes that can resolved when people with these often very significant challenges are not able to access care in a way that is timely and appropriate.
- Kitty Purington: [00:57:19](#) It's an ongoing challenge for state policy makers exacerbated by things like IMD exclusion mentioned earlier and the challenge of managing state budgets and limited resources. Also, across those general and specialty mental health systems, states are really grappling with the so-called diseases of despair and how to balance these scarce resources and at the same time invest a lot of increasing amounts of federal funding in ways that can sustain capacity.
- Kitty Purington: [00:57:56](#) We do see states looking at the foundations that they have built through integrated care as a way to support things like medication assisted treatment to do that more effectively. Also looking at ways that both general and specialty systems can do a better job of recognizing and understanding how social determinants come into play here.

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- Kitty Purington: [00:58:20](#) My last two slides provide brief overview of the varied policy leverage. These are kind of the key policy leverage that states have to address some of these challenges. Starting with support for integrated care that is happening in primary care practices and FQHCs and places like that. Obviously, as we discussed previously for a long time, the prevailing thought was that states should keep mental health and physical health benefits of the Medicaid. The state level separate with the thinking that in capitated MCO environments, mental health treatment would receive short shrift, that one is definitely swinging back with more states contracting for both physical and mental health services in a unified contract with the thinking that this will remove some of those unintended violent consequences and promote better clinical integration of care.
- Kitty Purington: [00:59:18](#) These are by no means all of the states that are engaged in this but certainly Arizona, Florida and Washington are a few outstanding examples. There are many other states that are moving in the direction of contracting for an integrated package of the services as a way to get a more comprehensive integrated service or aid for people regardless of where they seek care.
- Kitty Purington: [00:59:41](#) They have also taken advantage of Medicaid 1115 waivers and sort of the more specialized waiver known as Delivery System Reform Incentive Payment to reorient their systems of care to have a more integrated approach and capacity. In states like New Hampshire and New York, we have seen significant investments in primary care and things like care coordination and other supports that can help primary care be more able to address the mental health needs of their Medicaid populations and be able to link them more effectively to the services that they may need.
- Kitty Purington: [01:00:19](#) These, New York and New Hampshire, as well as other states are piloting things like incentive payments and quality improvement initiatives and other strategies that could help move the needle on mental health outcomes and mental health access.
- Kitty Purington: [01:00:36](#) The State Innovation Model program of significant federal initiative has seen similar investments by states. In SIM, there were two rounds of states. Two rounds of states were awarded a pretty significant amount of funding for three-year pilots. Looking across these states, I would say a majority of them, of the states, the state initiatives funded under this program have integrating behavioral health as at least a component if not a focus.

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- Kitty Purington: [01:01:08](#) SIM states are using those funds for things like provider training, a lot of development of capacity at the provider level in screening and treatment and care coordination. States are using tools like peer-to-peer teleconsulting, the eco model creating integrated data analytics for providers that may not have access to them and other supports but a goal of improving that integration at the primary care level.
- Kitty Purington: [01:01:39](#) Health homes are another somewhat newish Medicaid option that many states have embraced that also allows states to provide a more comprehensive package of care. This model that help a model support team based care and conserve almost as a wraparound set of services for a primary care practice to again include that care coordination piece, which can be so vital in helping an individual manage not only their mental health condition but any comorbid conditions.
- Kitty Purington: [01:02:12](#) It allows primary care practices or can allow primary care practices to access case management, pure navigators and other supports to assist people with complex needs in a primary care setting. Some of the key policy levers on this slide, they're the same as the previous slide. The policy levers may be the same in some cases, but states are maybe using the policy levers in different ways to get that improvement in the specialty mental health care that they deliver through Medicaid.
- Kitty Purington: [01:02:53](#) For instance while Medicaid manage care as a common tool, we do see states develop more specialty managed care programs to address the physical and behavioral health needs on individuals with more serious mental health conditions. In states like New York and Arizona, they are developing plans that are integrated plans. They provide physical health benefits that also a much more robust set of services to address the needs of people with more serious conditions so that they can access both the range of services in a specialty mental health system but also have their physical health care integrated.
- Kitty Purington: [01:03:34](#) A major trend for states right now in terms of behavioral health is the use of 1115 waivers of Medicaid vehicle to be able to do significant reforms in substance use treatments. A number of data taken advantage of 1115 waivers to be able to waive the requirements or waive the prohibition on using federal payment for IMDs. This is allowing states to bring in or to be able to incorporate things like residential treatment for SUD into their Medicaid service array.
- Kitty Purington: [01:04:06](#) A similar opportunity exist to use these 1115 waivers to expand the continuum of care for people with serious mental illness as

well, although, that is more recent and just does not have as much update but it does show some promise in being able to have additional flexibility to develop a more comprehensive continuum of care.

Kitty Purington: [01:04:30](#) Similarly, states are using SIM as a way to invest in behavioral health and states have also have success using SIM to support the adoption of health information technologies in places like community health centers, which as I mentioned have not typically have the opportunity to have the resources to develop to implement a health information or an HER and may not have been able to access federal funding that supported that. Some states have used SIM as a way to build that capacity and also create stronger linkages between community and mental health and primary care.

Kitty Purington: [01:05:07](#) Health homes have been very popular as a state policy tool to design new models of care more comprehensive care for people with serious mental illness, similar to the health homes that support primary care, states are using health homes as another team based model to provide better integrated care for people with serious mental illness and also be able to build in things like peer supports or peer navigators.

Kitty Purington: [01:05:36](#) These health home models refining are increasingly, I would say, replacing traditional targeted case management services as a more flexible approach to provide that kind of service. Finally, 1915i State Plan Amendments are another tool that states have to explore ways to provide more comprehensive community supports to individuals with serious mental illness. The appeal of the 1915i option is again states are always looking for flexibility to be able to address the needs that are particular to their states. The 1915i option can help states get some of the social determinants of health that really disproportionately affects people with mental illness.

Kitty Purington: [01:06:25](#) Through these amendments, they can they can fund things like housing and employment supports that can assist people in ways that will be on to medical care and medical treatment and can ultimately support recovery and support the ability of people to maintain a life in their community.

Kitty Purington: [01:06:52](#) Thank you very much. I believe that's my last slide. These are some additional resources that can be found at our website. I really appreciate the opportunity to speak with you.

Kathryn Santoro: [01:07:03](#) Thank you, Kitty. It's very clear from your presentation that these are implementing innovative approaches to approve



behavioral health and how important this is in order to address the diseases of despair that Kitty mentioned.

Kathryn Santoro: [01:07:17](#) We'll hear much more about these diseases and deaths of despair from our next speaker John Auerbach, President and CEO of Trust for America's Health or TFAH of prevention oriented Washington based policy, advocacy and research organization. John has held senior public health positions at the CDC and as both Boston and Massachusetts State Health Commissioner.

Kathryn Santoro: [01:07:43](#) At each level, his work involved efforts to promote health and prevent suicide and other leading causes of death. Under his leadership, TFAH's Pain in the Nation work has drawn critical attention to deaths of despair in America and facilitated dialogue on how to advance evidence-based strategies to promote wellness. We're pleased that John is with us today to share his work, John.

John Auerbach: [01:08:09](#) Thank you, Kathryn. I'm going to focus on one particular aspect of mental health trends and that's the increase in suicides. Suicide prevention is one of several health topics that are priorities for us at Trust for America's Health. We work with congress and the administration as well as with state and local government and the general public on this issue. Our work is generously supported by the Well Being Trust and many of the materials and lessons I'm about to share reflect their commitment and their expertise.

John Auerbach: [01:08:48](#) As we've already noted, there's been a striking increase in terms of the number of suicides in the last decade. This chart just shows it with the dark blue line. We've gone from about 29,000 to 47,000 suicides annually in the last 20 years. Over the same period of time that's shown by this chart, we've seen a rapid increase in the number of deaths from alcohol and from drugs. These three causes of death are not coincidental. When we consider the root causes of each, we see notable similarities and this suggests that we consider them in relationship to each other especially when we emphasize prevention.

John Auerbach: [01:09:31](#) Therefore, while I'm going to focus on suicide, I'll return to the topic of the common upstream factors associated with the three causes of death. In addressing suicides, we also believe that a comprehensive approach is needed. One that starts with a detailed look at the data at studies that looks at the evidence about risk factors and the ways of reducing those risk factors that looks at the role of multiple sectors including healthcare and public health but also education business housing and

public safety just to name a few, things about the entire spectrum of need from infancy and childhood through adulthood and from primary prevention to emergency intervention.

- John Auerbach: [01:10:20](#) Our series of efforts under the title Pain in the Nation does reflect that approach. You'll hear me talking a good deal about policy. With regard to suicide specifically, this chart indicates that all demographic populations have been affected and are seeing increases. The increases you see in this slide are those that took place over a 10 year period from 2008 to 2017. While all are affected, some have had the largest increases such as those under 34 years of age, black and Latino populations, those in rural areas and women.
- John Auerbach: [01:11:01](#) Of course it's worth noting that some of the populations have higher overall rates that these increases were built upon such as white men, white populations in general and men. These rates still are higher even though for those populations even though this chart may show them having a lower increase. Looking at the data by subpopulations actually is important for a number of reasons. One is the importance of promoting equity. While all may be affected by the risk associated with suicide and other forms of mental health, there are important differences that exist with regard to access to high quality care. Low income people and people of color in general face elevated challenges.
- John Auerbach: [01:11:48](#) It's important to focus on reducing some of the underlying causes of trauma that may contribute to suicide or risk. These may be more likely to be seen at certain subpopulations. These underlying causes including such things as adverse childhood experiences, which are more likely to affect populations with more limited economic resources or populations facing systemic discrimination are noteworthy if we are to pay attention to the promotion of equity in our work and make sure that all people have a fair and just opportunity for wellness.
- John Auerbach: [01:12:30](#) The next slide also just shows that those differences really extend to states. This chart actually, the chart that you're seeing there combines the risk associated with alcohol, drug and suicide deaths. You can see that there are significant differences. The states with the highest suicide rates are Montana, Wyoming and Alaska. That would suggest that there are particular challenges in what are sometimes referred to as frontier states that may have major geographic barriers to care and specific types of risk factors including access to guns that require specific approaches to address the conditions they face.

- John Auerbach: [01:13:16](#) When a suicide attempt is made it's usually a tip of the iceberg with regard to risk. Our comprehensive approach attempts to think about all the ways that intervention could have been possible. This pyramid reflects that with the top section reflecting those who actually dies as a result of suicide. The bottom reflecting a much broader section of those who are at elevated risk because they've endured some form of trauma or adverse childhood experiences. In between are escalating conditions and diagnosis that reflect greater and greater risk of suicide. This conceptual image is a reminder that we can intervene long before someone is suicidal by working at this lower stages of the pyramid.
- John Auerbach: [01:14:08](#) A complimentary pyramid reflects the various stages of risk and suggests when and how we should best intervene with for example attention to change in the conditions in people's lives. At the bottom of the pyramid and higher levels of the pyramid assume that the adverse experiences may have already occurred and they focus more on screening and building resiliency. A focus on all levels of the pyramid is part of that comprehensive approach I was mentioning.
- John Auerbach: [01:14:41](#) We in public health really think about upstream and here's some of the categories that we think about when we try to work not just within the healthcare system but also at the community level and at the family level. I'm not going to mention much about what are the optimal approaches within clinical settings because you've already heard of those. I will just mention in this regard that a policy that really matters a lot is access to comprehensive health insurance. The Affordable Care Act provided that for an additional 20 million people who as a result may have easier access to mental health services including those that can help to prevent suicide. That was built as well on the work that was done in the Mental Health Parity and Addiction Equity Act of 2008.
- John Auerbach: [01:15:40](#) This notion of parity, I think, as a policy issue is important for us to keep our eye on because even though that act was passed in 2008, there still are challenges with regard to parity and coverage and great work is being done by Patrick Kennedy and The Kennedy Forum to pay attention to the efforts that we still need to focus on policy level to ensure that a parity becomes a reality in the provision of high quality mental health services.
- John Auerbach: [01:16:12](#) Again, we covered the issue of integration so I'm just going to skip over this slide. I will mention that an excellent set of services or a model for how to address issues related to suicide have been developed in the Zero Suicide framework at the Zero

Suicide Institute at EDC. I won't go into it here other than to say that it provides an excellent model and the people interested should google that at Zero Suicide and EDC to receive the materials related to it.

- John Auerbach: [01:16:57](#) I do want to instead focus on more of the upstream, more of the social determinants for consideration. I'd start by saying that when looking at suicides it's important to think about the methods of suicides because that's just some of what needs to occur both in the clinical setting but also at the policy level in addressing some of those social conditions.
- John Auerbach: [01:17:27](#) This chart for example shows the leading methods of suicide deaths. You can see that the light blue line related to suicide deaths from firearms is by far the highest and has been increasing steadily over the last decade and longer. The red line refers to suffocation and hanging and that too has been increasing rapidly over the last 10 years.
- John Auerbach: [01:18:02](#) Paying attention to those causes of ... the methods that are used in suicides are important for both clinical and policy reasons. Clinically, this is an example of why it can be important to pay attention to those. A study was done which indicated that when clinicians screen and counsel people who may have a mental health diagnosis or a suicide ideation they can reduce the risk by focusing on ways of making both guns less accessible or potentially dangerous medications less accessible.
- John Auerbach: [01:18:54](#) As you can see from the chart, counseling had a significant impact in terms of reported behavior. This slide provides, I think, some surprising information about suicide. In that, it indicates that according to a recent analysis by the Centers for Disease Control that more than half of people who die by suicide didn't have a known mental health condition prior to their diagnosis. CDC found that this was particularly true for men and that those men were most likely to die from firearms.
- John Auerbach: [01:19:53](#) This slide focuses a little more deeply on what were the precipitating circumstances in those deaths where there wasn't a prior mental health diagnosis? They found that there was a range of circumstances that precipitated the suicide. Those included things like relationship problems, about 42% of the suicides in this category had those risk factors, or financial or housing-related problems adding to about 20%.
- John Auerbach: [01:20:32](#) As a reminder that suicide and drugs and alcohol misuse are related about 28% had a substance abuse problem. When I was

the Massachusetts Public Health Commissioner, we actually found that among those with the highest rates of suicide, with those returning from armed services abroad. We also found that those recently released from correctional facilities had significant high risk behaviors that place them at risk as well. That suggests that in major transitions from stressful situations, special attention should be paid to those populations.

John Auerbach: [01:21:06](#) To address the range of conditions that CDC found among those who died of suicide, a number of responses are needed. Certainly, there should be screening for those who may be going through those situations and reference and linkage to appropriate services as we've heard. Other approaches could address the underlying causes themselves such as developing policies that promote housing stability, economic opportunities and strong family support as well as criminal justice reform.

John Auerbach: [01:21:37](#) There are number of materials that have been developed for people who want to work at that upstream level. This slide illustrates one of those. It is a new report called "Promoting Health and Cost Control in State or facts", and it provides 13 evidence-based state policies. Many of which will lessen the social determinants associated with suicide or with substance abuse disorders including the ones that I was mentioning that CDC identified as part of the circumstances prior to a suicide.

John Auerbach: [01:22:14](#) They do such things as lessening housing and economic crises and combat some racial and other form of discrimination. Other evidence based approaches that are worth noting include the Centers for Disease Control's Health Impact in 5 Years or HI-5 initiative and the Beaumont Foundation's City Health Initiative, each of these can be good for their research tools and technical support. Of course, we would be helpful to contact anyone and let them know of how to reach those materials.

John Auerbach: [01:22:56](#) Finally, I would summarize by saying that when thinking about suicide and truly thinking about mental health in general, a multi-sector approach is best. Those sectors certainly include clinical care and public health but they also do extend to other sectors like education, the criminal justice system, housing economic opportunities. The blue chart you see on this slide is from the Centers for Disease Control and there are excellent package on preventing suicide. They illustrate that there is a role indeed for every sector and for each individual in terms of considering how to lessen the likelihood of suicide or negative outcome, how to help in terms of getting people services and screened and connected to services. Also, how to think about the ways that we can have an impact on the conditions in

people's lives so that we promote health and well-being and reduce the likelihood that people will end up needing many of the mental health services that we've been discussing as essential for those with symptoms.

John Auerbach: [01:24:21](#) In conclusion, I just want to say, please check these various sources for additional information. Our website is one site that has a comprehensive set of resources available. Kathryn, thank you very much and back to you.

Kathryn Santoro: [01:24:40](#) Thank you. We're going to jump right into Q&A. Suzanne, going back to your presentation. We have a couple questions come in about wanting some more detail on your use of predictive analytics to identify numbers with thinking zero health conditions and could you talk a little bit about how if you're using claims or how you're identifying a potential need for behavioral health services?

Suzanne Kunis: [01:25:09](#) Sure, thanks. A couple of things, I mentioned our relationship with Quartet Health and we actually provide claim data to them. That's where the algorithms are run in terms of identifying individuals with under met or unmet behavioral health needs. Theirs is really more of based on what's happened in the past. AbleTo, as I mentioned, similarly runs algorithms with its member focused programs and identifying individual's comorbid conditions that can benefit by an intervention.

Suzanne Kunis: [01:25:41](#) Within Horizon, we actually have our own predictive models that we use around people who, for example, we're looking at things like readmission on individuals who are at risk there. We're looking at opioids and patterns for individuals who are actually suffering from various opioid challenges whether it's ever been diagnosed or not, mostly not and providing interventions associated with that.

Suzanne Kunis: [01:26:09](#) Yes, it's a combination of claims. Other data that we use internally from external resources and everything compiled into our engine, if you will, for predictive models.

Kathryn Santoro: [01:26:22](#) Great. Thank you. This question is for the full panel. We talk a lot about integrating mental health into physical health but are there policy level discussions or things happening in your communities about integrating the physical into behavioral health setting?

Kitty Purington: [01:26:45](#) Hi. This is Kitty. I do think that that is the work that many states are undertaking as part of their behavioral health model.

Oftentimes linking to primary care and looking for ways to provide direct links from community mental health centers to primary care. Some are also bringing primary care into community mental health centers although, I think that that in many ways, that's a tougher model because first, people may want to continue to access their own primary care provider as well as their own community mental health providers.

Kitty Purington: [01:27:28](#) Also it's a more challenging business model to really be able to support full primary care within the community mental health setting. States are looking at ways to fund nurse practitioners and also develop a more integrated capacity for case managers and the behavioral health connections who work in those settings.

John Auerbach: [01:27:49](#) This is John. I would also add, there's a long list of regulations and financial barriers, sometimes capital barriers, to that integration. I think that the states that have made the most progress have figured out ways of reducing those regulatory barriers increasing financial incentives because these busy organizations both on the behavioral side and on the primary care side really need guidance and assistance in terms of the integration.

John Auerbach: [01:28:26](#) It's a complicated field. It's not easily done without policies in place that make it easier at the state level.

Suzanne Kunis: [01:28:36](#) This is Suzanne. In New Jersey, again, I can speak to what the work has been done by these Certified Community Behavioral Health Centers that have been under the SAMHSA Grants. The ones that we're working within our pilot, they have done an incredible job of bringing a behavioral health home alive within their behavioral health practice.

Suzanne Kunis: [01:28:59](#) One of the things we found and they found is that so many of the individuals that actually would benefit by services of a behavioral health home don't have primary care physician already engaged. It's really, in many cases, if there are primary cares, you don't want to disrupt this relationships. You want to establish role coordination and collaboration but many, many of these folks on special serious mental illness side really have not had primary care relationships in the past. It's really been a good opportunity to make those connections.

Kathryn Santoro: [01:29:34](#) Great. Thank you. John had touched on some of the issues and role parts of the country. Suzanne had also mentioned the online tools that you're doing. We had a few questions that came in just about the unique challenges for rural mental health

and what some of the solutions are. Also, just if any of the other speakers want to comment on the use of technology going forward in the mental health field.

- Paul Gionfriddo: [01:30:05](#) Are you asking me that? This is Paul.
- Kathryn Santoro: [01:30:07](#) Sure. Do you want to start Paul?
- Paul Gionfriddo: [01:30:11](#) No. That's one of the things that we're doing with our online screening program and there are a number of others who have used technology to, for example, do historical phone sessions for therapy. There's a tremendous amount of activity as we discover.
- Paul Gionfriddo: [01:30:33](#) We do online screening. It's very easy to take it to scale. It's very inexpensive and do online follow up to services many of which are delivered in virtual environments. Understanding that people need to have is that we are not bound by physical neighborhood from the way we were even five or 10 years ago and especially our young people are living in virtual neighborhoods that are nationwide and worldwide.
- Paul Gionfriddo: [01:30:57](#) There is going to be tremendous amount of activity in these virtual environments. With increased use of technology, it's something the state should be interested in from a regulatory perspective as well as a promotional perspective. It's something that the nation as a whole should be interested in, in terms of the building and the development over the next five to 10 years of our healthcare and behavioral health care delivery system particularly the integrated one.
- Paul Gionfriddo: [01:31:24](#) It will not happen and technology use will not move further if we don't address the inconsistency in federal rules between things like 42 CFR Part 2 which establishes a different privacy standard for substance use or treatment from that which HIPAA provide for nearly everything else. If we don't get alignment around the rule making and conform, for example 42 CFR Part 2, these archaic structures to HIPAA something that was developed 20 years ago. We will put significant roadblocks and obstacles to the use of technology particularly technology that allows people to cross physical state lines and other physical barriers.
- John Auerbach: [01:32:11](#) This is John. I think we've talked to a number of people in frontier states and rural states who have highlighted some innovative approaches and certainly those include telemedicine where that is being used. People are often identifying the



importance of such services being reimbursable. In some instances that is a challenge for them to be reimbursable. They are also highlighting that there needs to be a training and support in terms of how to handle that kind of intervention in terms of the clinical practice, the confidentiality rules.

John Auerbach: [01:32:55](#) Training is identified as very much needed. A second approach that has been tried in rural or frontier areas is using nonconventional satellite sites to offer services. Those include nonclinical sites where there may be a couple of times a month for example using some office spaces that are available in a community where people have an easier time getting to and that instead the clinicians can come at designated times to that facility.

John Auerbach: [01:33:33](#) There too the importance of reimbursement and licensure requirements for satellites is something that needs to be a part of a state planning and reimbursement issues.

Kathryn Santoro: [01:33:48](#) Thank you for those comments. We are out of time. I do want to thank our panelist speakers who took time from their busy schedules to be with us today. I also thank our audience for joining us. We hope that you leave with some ideas to take back to your work and to your communities and that you've been inspired by this panel today and the fantastic work that they're doing across the country.

Kathryn Santoro: [01:34:11](#) We'd appreciate it if you'd take a moment to share feedback on this event by completing every survey which can be found on the bottom of your screen. We hope that you'll also look for announcements about the third and fourth webinars in our series where experts will share more about suicide prevention initiative and also efforts to increase access to evidence-based treatment for addiction. Thank you all again for joining us today.