

Insights and Innovations in Community Mental Health

The Erich Lindemann Memorial Lectures

**organized and edited by
The Erich Lindemann Memorial Lecture Committee**

hosted by William James College



**WILLIAM JAMES
COLLEGE**

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Foreward

The Erich Lindemann Memorial Lecture is a forum in which to address issues of community mental health, public health, and social policy. It is also a place to give a hearing to those working in these fields, and to encourage students and workers to pursue this perspective, even in times that do not emphasize the social and humane perspective. It's important that social and community psychiatry continue to be presented and encouraged to an audience increasingly unfamiliar with its origins and with Dr. Lindemann as a person. The lecturers and discussants have presented a wide range of clinical, policy, and historical topics that continue to have much to teach.

Here we make available lectures that were presented since 1988. They are still live issues that have not been solved or become less important. This teaches us the historical lesson that societal needs and problems are an existential part of the ongoing life of people, communities, and society. We adapt ways of coping with them that are more effective and more appropriate to changed circumstances—values, technology, and populations. The insights and suggested approaches are still appropriate and inspiring.

Another value of the Lectures is the process of addressing problems that they exemplify: A group agrees on the importance of an issue, seeks out those with experience, enthusiasm, and creativity, and brings them together to share their approaches and open themselves to cross-fertilization. This results in new ideas, approaches, and collaborations. It might be argued that this approach, characteristic of social psychiatry and community mental health, is more important for societal benefit than are specific new techniques.

We hope that readers will become interested, excited, and broadly educated. For a listing of all the Erich Lindemann Memorial Lectures, please visit www.williamjames.edu/lindemann.

The Erich Lindemann Memorial Lecture Committee presents

THE THIRTY-NINTH ANNUAL
ERICH LINDEMANN MEMORIAL LECTURE

The Contentious Health Care System: Is There a Place for Community Mental Health?

The U.S. health care system has become ever more complex, confusing, incomplete, and expensive. This gives rise to much complaint, contention, differences in goals and values, and proposals for change. Is there a place for Community Mental Health now or in the various proposed futures? Is there a place for supporting mental health, preventing mental illness, care for populations in addition to individuals, and collaboration among agencies and professions? Are these aspects of Community Mental Health valued and beneficial enough to meet criteria such as “cost effectiveness”? Or do we not care enough about them to include them in our health care system now and in the future? A panel representing public health, government, and human service agencies will let us know how this figures in their priorities and plans.

Speakers

Alan Sager, PhD, Professor of Health Policy and Management, and Director of the Health Reform Program, Boston University School of Public Health

Mark Alexakos, MD, MPP, Chief Behavioral Health Officer, Lynn Community Health Center

Moderator

David G. Satin, MD, DLFAPA, Assistant Clinical Professor of Psychiatry, Harvard Medical School, Chairman, Erich Lindemann Memorial Lecture Committee

Friday, May 20, 2016, 2:30 – 5:00 pm

*William James College
1 Wells Avenue, Newton, MA 02459*

Introduction by David G. Satin, MD

Let me give credit to the Erich Lindemann Memorial Lecture Committee, which did heavy thinking and effort and planning and organizing the Lindemann Lectures; Dean Abby, you met outside, Elena Cherepanov, Frances Mervyn, Jackie Moore, who cannot be here, and me. I want to thank William James College, Dean Abby, Director of Continuing Education Program and long a source of intellectual and material support. And thank Nicolas Covino, President of the William James College who has been generous in his recognition and support for the Lindemann Lectures. It's also sponsored by the North Suffolk Mental Health Association, which was an early partner with Erich Lindemann in developing a community mental health program in collaboration with the Massachusetts General Hospital, an academic and community collaboration. It's Chief Executive Officer, Jackie Moore, continues to support the Lindemann Lecture and is a representative of community involvement in mental health planning and services. Let me remind you that those interested in continuing education units will find these available if they register with Dean Abby, complete an evaluation form, and the fee after the lecture. The topic for today is the contentious health care system. Is there a place for community mental health in planning for the future?

The organization of the lecture will be brief presentations by two of us. I want to give a brief presentation of a time when community mental health was a part of public policy, then Dr. Alan Sager will talk about the public health and public policy aspects of the future of mental health care system and Dr. Mark Alexakos will talk about the effects of public policy on practical application in the community, and following that we will open the discussion to the speakers and have the audience participate in the discussion. I would like it very much if the audience helped present issues and experiences rather than simply ask questions of some authority. The authority is not all up here, the authority is collective.

To start, there's general agreement that the health care system in the present day United States is a non-system. Lacking generally agreed upon goals of certain priorities among many other societal values and uncoordinated and inconsistent patchwork of services and governance, and subject to criticism and recommendations from a myriad of interest groups. There's widespread demand for and efforts at change, but again in many directions. Remember the Lord Ronald syndrome, he flung himself upon his horse and rode off madly in all directions. In the eagerness for care of health needs, availability to segments of the population, and decrease in costs and comprehensive control, what place is made for mental health and more specifically, what place is there for community mental health? Politics, economics, and even ideology are ultimately an expression of

values, so how do proposals and plans demonstrate this society cares about mental health and for the mental health as distinct from mental illness?

Let me give you a brief quote from Erich Lindemann fifty years ago, ‘If you take social content seriously and are really willing to abide by your convictions that each patient arriving at your power is only a fragment of a disordered social system, then your relationship to the participant in this social system is very much enhanced. You will become concerned with the family. You will become concerned with the power structure to which the patient belongs, to those people which control his life. You will become concerned with institutional organization in which he is embedded. You will become concerned with city planning, the housing that he has, the prospects for advancement in his life situation, and so on. And you will not only look this common cause in the face and say, ‘Isn’t that too bad, there you are.’ But you will decide to work out these psychological, sociological issues in the community, which you can use as admonition vis-à-vis the power structure, decision makers in the community. To tell them perhaps your next decision might be such order that there will not be so many casualties of a psychiatric kind anyway, and it will be at that point there our intervention of psychological disorders by social means comes about.

We are fortunate to hear the thoughts on the place of community mental health in the future U.S. healthcare system from policy and clinical perspectives.

Alan Sager, PhD

Professor of Health Policy and Management, and Director fo the Health Reform Program, Boston University School of Pulic Health

Introduction by David G. Satin, MD

Our present topic, we are talking about what the plans are for the future of public health system. That was an era when that was the present, the future of community health and mental health. We would like to hear what happens this time around. First, let me introduce Alan Sager, who is Professor of Health Policy and Management and Director of the Health Reform Program—and Director of the certificate program in Health Policy and Law—at the Boston University School of Public Health. He teaches courses on health finance, planning, and management. He has his Bachelor’s degree in Economics and a Ph.D. in City and Regional Planning and served as Vice President of the Health Planning Council of Greater Boston.

Alan Sager, PhD

Thank you David. Thanks for inviting me. Glad to be here. Thanks for coming!

I don't feel at all at home for two reasons: we have trees and also people are sitting in the front row, which we do not do.

Also, where I teach, at Boston University School of Public Health, our classes ordinarily run for 3 hours at a time, so of course that has become my unit of thought. But I understand that we don't really have that much, so in the interest of time I'm going to follow the slides maybe more closely than I ordinarily would, and the jokes have to go so [tears a sheet of paper] Yep. That was the joke! As you doubtless know.

So my talk has the modest title, 'Our Healthcare Should Not Drive Us Crazy,' and we will talk a little about health care and a little bit about mental health. Five points: 1) We already spend enough on health care, but badly, 2) Why are health care costs a big problem? Because they are a big barrier to access generally and particularly to mental, dental, pharmaceutical, and residential services. They crowd out everything else we care about in healthcare and throughout this society. 3) We'll talk about lower supply of care and focus on the mental health and long-term care double standard. And we will consider how to pronounce and spell the word "parity." 4) Barriers to care, out of pocket payments, debt, paperwork, narrow caregiver networks as threats to medical security and to human sanity. 5) Finally, why don't we act, actually act, to contain healthcare costs? And as a special bonus offer, we can contain costs, enable access, promote quality and appropriateness of care, the right configuration of caregivers and liberate money for other things. And then we can rest.

FIRST, We already spend enough on health care. Let's start with a quiz. We have 3 bars: red, blue, and green. They are in a ratio of 1 to 2 to 5. And the challenge is: which one is defense, which one is education, and which one is healthcare? So of course, the red is...education. The blue is...healthcare, right. And the green is...defense. Oh...0 for 3, terrible but you're with everybody else. So the blue is education, right? The red is defense. Oh yeah. And the green is healthcare. So healthcare was 5 and a half times defense spending last year. Maybe you feel you are not doing your share on the healthcare side or the defense side. I'm not saying any of these spending levels is right or wrong, but it's good start to start with an appreciation for some of the relationships. We spend enough on healthcare. Enough for what? To provide the care that works to the people who need it. That's not every service that might conceivably benefit anyone, and not enough to win immortality. It's important to be a little modest, healthcare has never saved a single life. That's an unfortunate phrase, although a human one. I think saving lives is more a philosophical or theological question, but not a healthcare question.

We spend enough on healthcare. How do we know that? Well we can compare healthcare spending per person in the rich democracies of the world, although I don't know that Turkey should stay on that list. Mexico, eh. Poland- less. Estonia, Chile, Hungry- less. Slovak, Czech, Korea, Greece, Israel, Slovenia, Portugal, Spain, Italy...the

average rich democracy. And here we are in red, 2 and a half times the spending per person of the average rich democracy, and of course the green is Massachusetts. Number 1 in the world. We should take pride in something, Red Sox, Patriots, healthcare spending. We're number 1. The Globe of course, National Public Radio, they are a little conservative or they don't bother to look up the numbers. They say "among the highest," we are not among the highest except in the sense of being first. We're highest. This year, I estimate we are going to spend a little over \$100 billion a year on healthcare in the Commonwealth. Now not too long ago that was national healthcare spending, but this year \$102 billion. So what's that? About \$2 billion a week, about \$15,000 per citizen per year, and that is not on healthcare spending that Mass General likes to talk about when they care for patients from other states, other countries, other solar systems. This is spending on Massachusetts residents. \$15,000 per person per year, more than a third above the U.S. per person average. If we spent the national average, which is 2 and a half times the rich democracy average, if we spent on the national average we would save \$27 billion this year which we might spend on other stuff. Please, questions only for clarification not to make a point or for vicious personal attacks, clarification.

Audience Member:

No vicious personal attacks?

Alan Sager:

No, we will defer that to later. Thank you very much.

Audience Member:

So this number doesn't cover, for example, people that fly into Massachusetts or come into the country...

Alan Sager:

Right, this is spending on the citizens of Massachusetts, but there is a tiny amount from out of the country or out of state. Some people make a big deal about it. If we spent at the national average per person, we would save \$27 billion this year. By way of context the taxes we raise in Massachusetts, income tax, sales tax, fees, and the rest are only \$25 billion. So our savings if we spend at the national average would be greater than the entire amount we raise in state on state taxes. And this shows health spending per person by state of residence in the United States. Here's the national average, about \$11,000, and here's Massachusetts at around \$15,000 or 36% per person above the national average.

SECOND, why are our high costs a big problem? Is our healthcare affordable? So the Boston Globe of course gave great play to David Torchiana, he runs a well-known

hospital system. He cited a Commonwealth fund study that found that average family health insurance premiums as a percentage of median income for people under 65 were 18% of median income for Massachusetts but 22% nationally and he cited this study that they've been doing for 10 years, every few years. And he said, 'Well of course health care is affordable because it is a smaller share of personal income.' But actually when you look at more grounded data for the whole state, healthcare spending on Massachusetts residents is 36% above the U.S. average, but personal income per capita is only 26% above and that suggests that we are spending a much bigger share of personal income than nationally.

Another reason why our current healthcare spending is not affordable is that today's healthcare services sponge up money we need for everything else anyone in this room cares about.

Another problem: our age adjusted mortality rate in Massachusetts equals that of Utah and they spend 54% per person as much as we do. Across states, across nations, there is no correlation between spending on healthcare and health outcomes.

And also, a study just out yesterday: the Massachusetts ratio of Social Service spending to healthcare spending is lowest in the country and that again suggest that healthcare spending is crowding out other stuff that matters.

So we spend badly in our country, nationally. We don't cover everyone, we provide less care per person despite our enormous higher spending, and we waste half of what we spend.

So we look at the share of people who have health insurance in rich democracies, the U.S. is near the bottom ahead Chile, Mexico, and Turkey. Although, we used to be just even with Turkey before passage of the ACA, which has covered about 25 million people. The red on the chart is the ACA's improvement in coverage. So we're doing better on that, but if you look at hospital discharges per 100,000 people we are 20% below the rich democracy average. We use the hospital much less, and we make far fewer doctor visits. The average is about 6 and a half or 7, and we're at 4. So we are spending more but getting less. Not good!

Also, here is a very complicated chart but the message is clear. Needs- adjusted probability of a doctor visit in the last 12 months- if you needed to go to the doctor, what's the chance you went? Well, in France the chance was about 92% with very little spread by income, that's the horizontal width of the bar. The U.S. is at the bottom, about 67% with the biggest spread by income. So we're spending more, we're giving less care, and less appropriate care, that's the care that is deemed needed. We particularly deny care to lower-income people.

One of the reasons is that we have fewer doctors per 1,000 people despite our high spending, only about 2.6 compared to the rich-democracy average of about 3.3 and we

have only half as many doctors per 1,000 people in primary care. Big problem...especially as more and more primaries who are around go from having 2,000, 3,000, 4,000, or in the case of my former primary 5,100 patients and go concierge because they weren't making much to save. So we have half as many primary care doctors per thousand, fewer people are going into primary care, and that's a problem. We often talk about the healthcare pyramid, with primary care at its base...that's a shaky base.

In life expectancy at birth across the rich democracies for all people, the United States is among the bottom.

We waste half of what we spend: clinical waste is the biggest share of waste: unnecessary care; incompetently provided; or provided in an excessively expensive setting like a teaching hospital when you didn't need to be there; administrative waste is certainly number 2; excess prices are number 3; and outright theft and fraud is number 4.

But let's not feel bad...50% efficiency. Well a gasoline engine is only about 21-22% efficient. Electricity generation whether it is natural gas, oil, or coal, is only about 32-33% efficient. So there's healthcare at 50%. Home boilers and furnaces 80% going on 95%, so turn up the heat, drive less. There's just one problem. Those other things that are less efficient, like gas engines and electricity generation, those are human technologies and there are physical and engineering and other constraints on efficiency. The constraints on healthcare efficiency are largely human-made. They stem from how we design, shape, deliver, pay, and organize healthcare.

Why are healthcare costs a big problem? For 3 big reasons: 1) They make it expensive and politically hard to cover all people, 2) they make it expensive and politically hard to cover *all* types of care fairly, 3) and they sponge up dollars we need to reform education, job training, housing infrastructure, nutrition, environment, criminal justice, and anything else you care about.

Audience Member:

Excuse me, you say 'they' and that's a very broad base. I'm wondering if you could clarify who 'they' is?

Alan Sager:

By 'they,' I was referring to high health care costs. High costs make it expensive and politically hard to cover everyone, to cover all types of care fairly, or to spend enough on education, job training, housing, infrastructure, environment, criminal justice, and the rest.'

Here's a financially and politically toxic mix, so there we are again with the world's highest spending per person on the left and on the right we see that our income distribution is among the most unequal in rich democracies. We are worse than Portugal but better than Turkey and Mexico. When you have the highest cost and nearly the highest income inequality, and healthcare is so expensive that means you have to move huge amounts of money from people who have it to people who don't because those who don't have the money won't be able to afford healthcare cause it's expensive and they don't have any money, right? Right.

That means that you've got to truck a large amount of money long distances. That means that you have to load it up from people who have it, which means they have to either be willing to give it up or we have to take it from them politically, and we have to move it to people who can't afford healthcare, and that is politically and financially hard to do.

It's always hard to do, but it is particularly hard in the U.S because we have such high spending and such great income inequality so we have to move more money long distances.

One of the consequences of our high spending and political challenges is that high health costs block coverage of many services. 10% of us remain totally uninsured even after the ACA being pretty well implemented. For mental healthcare, about a third of us are uninsured. Drugs, a little bit better because we now cover people badly through Medicare part D for prescription drugs, that's about 16%. Dental care over 40%, long-term care uninsured over 75%. So we spend enough and we spend it badly.

THIRD, we provide less care and there is a double standard for mental health services and for long-term care partly for similar reasons. There's lack of coverage or inferior coverage, why? Well there's a widespread fear in mental health services and also in long-term care that good coverage would be expensive because of high cost per person per day, for many people who might need help for a long time. So it's help for a lot of people, for a high cost per day, for a long number of days, weeks, months, or years. Also, dramatic improvements are notionally less frequent in acute care.

In long-term care and mental health, we often don't see or don't think we see dramatic improvements. Incidentally, for expensive acute care, we often don't see dramatic improvements there either a lot of the time but we tend to not appreciate that. We hope for dramatic improvements maybe more often than we can attain them.

And also in long-term care and mental health, we often suspect that it is hard to measure outcomes, we don't measure outcomes very well. (Big problem in acute care as well. Just try to measure inequality.) There's a related problem helping to explain the double standard of adequate coverage and delivery of care, lower prestige and influence of both patients and caregivers- problems of stigma and denial. One of the reasons we

don't buy private long-term care insurance is that we don't want to think about being disabled and needing a lot of help. The other reason is that few of us can afford the premiums. And that's partly because long-term care is not insurable, as the insurance industry is finding out.

All this results in a of lack of coverage and inferior coverage, ongoing coverage discrimination, and demands that advocates of more adequate financing of mental health or long-term care services prove that more adequate financing results in care that is both better and cheaper. That is a really vicious double standard that we do not apply elsewhere in healthcare on the acute care side. How many times do we ask surgeons or drug makers to prove that their innovation is both better clinically and cheaper? Nah...We don't do that.

So since people have been talking about mental health parity for a long time, I've looked at one summary paper in The Milbank Quarterly 6 years ago, from which this little table is stolen, we say 'abstracted,' 'borrowed,' 'stolen.'

Some 55 years ago, President Kennedy asked that health insurance benefits for federal workers move toward mental health parity, not really implement it. States did certain things, there was a Mental Health Parity Act in 1996, employers gamed it to a great degree. A number of states have mental health parity laws but enforcement is variable and they exempt more than half of the employees in the country. The Wellstone-Domenici Mental Health Act 2008 didn't mandate mental health benefits, and most tellingly it was expected to boost insurance premiums by 0.4% or \$25 billion over a decade, \$2.5 billion per year. When you are spending this year \$3.4 trillion on healthcare and added \$2.5 billion, it isn't a lot of money. It's better than not having the \$2.5 billion, but this is why we have to be careful when we spell out and pronounce the word 'parity' and wonder how hard it is for vigorous, dedicated, smart efforts from good people to make progress toward mental health parity. .

Here's a measure of that. Look at mental health and substance abuse spending, as a share of national health spending over 28 years. We were at 8.7% in 1986, gradually going down a little bit below 7%, kind of a steady trend downwards in the share of healthcare spending going to mental health and substance abuse over the last 3 decades.

That's not a shift towards parity, that's a shift towards less parity. If we look at Massachusetts vs. the nation, the red is Massachusetts and the black is the nation, this is state mental health agencies spending. We were above the national average in 2004, it rose together until the Great Recession started and then we cut substantially starting in 2008-2009 while the national average leveled off. So we now spend about \$10 less per person than the national average. Across the country, we are actually below the median, below the typical state in mental health care spending per person.

FOURTH. Now, barriers to care. So we have less mental health care than we like, less mental health care as a share of healthcare spending than we did 28 years ago, but we have a healthcare world that is driving more and more Americans crazy.

Less supply, more demand, more need.

What we'd like is medical security, which is confidence that each of us gets competent, appropriate, kind, and timely care without worrying about the bill, getting bankrupted by care, or losing our insurance coverage.

Medical security...a very simple idea. That is the least that we should expect from healthcare. Since we've taken immortality off the table. But instead we have healthcare that drives us crazy. We are top in the world for paperwork and narrow caregiver networks, and we are very high in out of pocket costs. I think we are highest in medically induced bankruptcy. Complexity and administrative waste plague caregivers, I don't think I need to tell you that. I think you knew that. Complexity associated with multiple payers, they have different payment rates, different rules for referrals, and all the ways they privately regulate care- formularies, step care, other drug regulations, different forms, different data requirements, different quality measures. It's hard to know what to do. This stems partly from endemic, long-standing mistrust between caregivers and payers. They don't like or trust one another generally, and that doesn't prevail in most other rich democracies nearly to the same degree. Payers are not accountable for adequate payment for good care, we see enormous gaming, manipulating, jockeying, fraud, and theft throughout as we try to move the money in healthcare.

For patients the level of craziness...by the way when I say "crazy," I don't use that in any sense like I know what I'm talking about clinically because my clinical knowledge is way low, like 0. But we drive patients crazy when we ask them to establish eligibility.

If I had time I would show you the form that is used in Ontario to determine eligibility for care. You basically have to prove that you live there for more than half of the year. It's a half-page and there's a half-page of instructions. Of course, on the backside, there's another page in French. So despite this little challenge, 2 pages.

Massachusetts, have you ever seen the form we use to apply for the connector the Massachusetts Health Connector, the marketplace and you apply for Medicaid simultaneously? 21 pages. My son, my older son, who is, like, smart could not figure it out successfully. He was on temporarily, they threw him off, and he was working down the hall from Healthcare For All's Helpline, where they have dozens of people working on this. Establishing eligibility drives people crazy.

Choosing a plan. How do you choose a plan in the marketplace? Good luck! Try so compare the premium, out of pocket, caregiver network, actual access.

How do you find out which caregiver provides which services?

Rules, procedures, forms are involved, learning the out of pockets. Also, it's very hard to learn which benefits you are entitled to and often the insurance company doesn't know because they have hundreds of different benefit packages for different employers and different marketplace plans. Plus, things change over time like the staircases in the Harry Potter movie.

We plague people with rising out of pockets. Last decade, premiums rose 58% but out of pockets rose 77%. The share of insured workers with high-deductible plans rose from 4% 10 years ago to 24% last year. Deductibles, co-insurance, out of pocket maximums continue to rise.

Also, nobody can figure out what those things mean. So we're supposed to be smart shoppers, but we don't know what we are going to pay. There's great financial uncertainty. Am I covered? How much am I going to have to pay out of pocket? Magnified by whether you are in-network or out-of-network and good luck trying to figure out whether the anesthesiologist is in-network.

People bear greater financial risk and less risk is shared through insurance. That means older and sicker people pay more when they seek care. Out-of-pockets are a tax on poor people, on sick people and—disproportionately—on older and disabled people. Out-of-pockets prompt delays in care-seeking and prescription filling, especially by poor people. Out-of-pockets are *the most* regressive and unfair method of raising money to pay for healthcare.

Not surprising, they are number 1 on the hit parade of policy proposals by American healthcare economists.

The most regressive method of raising money, and higher out-of-pockets are compounded by growing income inequality in the United States. Further, we are breaking the long-established intergenerational compact. Today's older workers get weaker subsidies from today's younger workers even though people like me and like many of you subsidized older workers for decades when we were younger. That's been broken.

There are 4 ways to make sense of the out-of-pockets that drive us crazy:

- 1) Expediency. Higher out-of-pockets allow employers to slow how much they raise premiums. They are effectively de-insuring workers and shifting costs from the insurance premium that everyone pays to the out-of-pocket costs that people pay only when they are sick.
- 2) Ideology. Worry about high U.S. health costs and failure of past efforts to contain costs. Most health economists urge pushing healthcare to resemble the free market economy they learned about in Economics 1A.

- 3) to induce consumers to shop by price inequality, they need to have more skin in the game. I thought it was adequate to have our pancreases, lives, hearts, circulatory systems, muscles, bones in the game. What game are they talking about?
- 4) Stunted empathy. The pushers of higher out-of-pockets cannot image the circumstances of people not able to afford higher out-of-pocket payments. Most health economists and related folks don't sweat a \$30 co-pay to see the doctor or for a mental health visit, and they don't sweat \$50 co-insurance for a prescription renewed every month for \$600 a year, and they cannot empathize with the circumstances of people who cannot afford that money and who will be deterred from appropriate care seeking by having to pay.

There's a political issue too. In a given year very few people incur high healthcare costs, so boosting out-of-pockets inflicts very little harm on most Americans. They don't care; they aren't sick. Most people in the ACA's often-narrow networks are happy with their networks because they don't go to see the doctor very much; it's not a problem. It's only a problem for sick people. So the sickest 10% of Americans account for 65% of healthcare spending. We see that in country after country, and those are the folks we are concerned about.

Economists try to remodel human patients into consumers. We used to call that social engineering at its dumbest and most cynical. We don't have the data on price or quality, so we boost out-of-pockets well before the price and quality are available. If you ask people to do something that requires something that isn't available, that's like telling people to play in traffic.

This slide shows Japanese kamikaze pilots in the Second World War. We are now, in the U.S., asking sick people to serve as kamikaze pilots in the health care cost-control war.

By the way, very few Japanese admirals and generals volunteering to fly those planes. We're infatuated with higher out-of-pockets for a number of reasons, but what we are mostly asking...you may remember this commercial, let Mikey try it. The youngest kid was asked to try the new cereal. So we're asking sicker people to experience the out-of-pockets to learn how to spend money carefully and contain costs individually—patient-by-patient—because our country is not willing to contain costs politically. The latter is how the world's other rich democracies contain health care costs.

We in the U.S. rely on networks in the same way. Narrow networks give insurers lower prices to start with so they can charge lower premiums, which is great if you have healthy people who don't need a lot of care. Sick people have more problems and gravitate toward bigger networks so they can use the caregivers they are used to seeing. As a result, their insurance gets most expensive because you have older and sicker people

clustering in the more expensive policies, premiums keep going up, and the policies get eliminated. So what we end up with is anarchy. Any anarchists in the room? I don't mean those who read *Homage to Catalonia*. We're not talking George Orwell in Barcelona in 1937.

This is bad anarchy, where you don't have a functioning free market and never can because the free market's 6 key conditions cannot be met in healthcare. Where you don't have political support for competent government action to contain costs. And where you don't have professionalism and fiduciary duty in the face of the economists selling us to enrich ourselves.

Instead, we have accountable care organizations, rewarding doctors for quality, patient-centered medical homes, integrating behavioral health and primary care- two of the least-well-funded activities in health care. Put them together. Expect magic. Medicare Advantage and Medicaid managed care are different ways of reducing public and payer accountability for results. All imagining that the functioning free market will take over, but if you reduce government and there is no functioning free competitive market, you end up with the A-word. So no one is accountable for doing anything that matters, which can drive people crazy especially those people who are ill and who actually need healthcare.

FIFTH, and briefly, there are alternatives. We can use cost-control techniques that actually work in other rich democracies: payers limit spending, contain costs, give budgets to hospitals, salaries for hospital based doctors, regulate drug prices, invite thieves to spend a year in jail for every \$100,000 they steal, promote access by insuring everyone, eliminate out-of-pockets and narrow networks, standardize benefits so seeking healthcare doesn't drive us crazy, boost appropriateness with evidence, and improve the configuration of care with more primary care and retaining more affordable community hospitals so we don't all have to go to major teaching hospitals.

We in the United States of America can do all of those things now because we already spend \$3.4 trillion yearly on our health care. That makes health care the easiest problem to fix in the United States of America because it is the only one, the only problem, on which we already spend enough. Thanks very much.

Mark Alexakos, MD, MPP

Chief Behavioral Health Officer, Lynn Community Health Center

Introduction by David G. Satin, MD

Mark Alexakos is Chief Behavioral Health Officer at the Lynn Community Health Center, he is instructor in Psychiatry at the Harvard Medical School, received his Doctorate in Medicine at the Pritzker School of Medicine, and is MPP from the Harris School of Public Health, both at the University of Chicago. He did his residency in psychiatry at the MassGeneral Hospital and Child Psychiatry at McLean, so he knows this area. And at the Lynn Community Health Center he has developed a culturally diverse, integrating behavioral health, primary care, public schools, and community, and has given presentations on integrated, collaborative care programs. That sounds very promising in terms of community mental health. Dr. Alexakos.

Mark Alexakos, MD, MPP

Thank you. So as many of you know Lynn Community Health Center and William James College have a long history of collaboration. So I took over from Steve Hayes, one of the early graduates from MSPP. He was my mentor for the first year we kind of co-lead the department. And so I hope you guys feel sorry for me after that talk, I have to try to help people in this environment, but I should probably renamed my talk How I Trick People Into Allowing Us to Take Care of People with Mental Illness. I was kind of inspired by Erich Lindemann, so I kind of mix things up a little bit with this talk hopefully that will be okay, but there will be lots of questions afterwards. So I'm going to interweave some personal narrative, but I'm going to argue that health is a right, participation is a right...

Our own interpersonal histories should influence how we approach care. Erich Lindemann was 100% on target. So we have already heard the quote, he says the interpersonal relationships are the foundations that we base our interventions on, but we cant ignore the rest; the family, social...But he took it one step further, we have to influence the decision makers. We cant just sit back. A little bit about my father's life, who was a Greek immigrant. In the context of the ecological model of resilience, we have the science and theory about how we intervene in a community way, in a more holistic way and what we do know is that relationship makes a big deal. So my dad, he grew up in a small village in Greece, and you can see it was a one room house, he had 4 brothers and sisters.

So my relatives are buried there and when new relatives die, they take out the bones, put them in a box, and take them to the church. And so he was very smart, and I don't have a picture of the books but they were still there when I came to visit. A box of books, all kinds of books in different languages, he loved to read. And this old guy in the village, he was one of the only guys left said, 'Oh your dad was one of the smartest guys in the village anybody could ever remember.' But what happened, we know World War II happened, he was a teenager so basically the Greeks were starving. War wasn't bad enough right, he didn't die in the war, but often times after there is a civil war. So there was a civil war and he was up in the mountains where they tried to recruit for the communist revolution. So they tried to recruit my dad, he wasn't sure what he wanted to do, but basically he didn't want to fight in the civil war. The World War was over and he said, 'I don't want to be involved in this.' And they didn't like that, so they wanted him to show up somewhere the next day. And his high school teacher intervened and said, 'Don't go there, they are going to execute you.' His friend got executed and my dad didn't. My dad got into the University of Athens because of that high school teacher. Amazing story. He got a Fulbright scholarship to Harvard School of Education, so talk about resiliency factors. It wasn't just that my dad was smart, it was all these things that were there and available to him.

And so where did he end up? Well he thought he was going to be a professor, my mom was really upset he didn't end up being a professor. He got taught at the University of West Virginia, and all of the students were protesting the war. He was not for war, you know he had this kind of Greek attitude. 'If you want to win, you have to fight. If you don't want to win, don't fight.' That didn't go over well. So his style didn't fit in, and unfortunately he lost that job. So he floated around a little bit, but ended up in Chicago and got a job as a school psychologist, but he couldn't get fired because he got in the Union, talk about a protective factor for him. And its interesting things that just sort of happened. I grew up in the second Greek town, the first Greek town a highway got run through it. My mentor here also, the Italians, you know, that highway didn't get a highway through it. So all the Greeks had to move to the second Greek town. But it was okay it was a great community and of course, Greeks collected all of their families together. So it was my dad, my aunt, and their other relatives, so it was a built in social network. So unfortunately when my brother died at age 7 from leukemia, I was age 6, we had this built in network. And dad probably could have used psychotherapy, he had some paranoia and trauma from the war, but we had enough supports in the neighborhood.

But one of the things, you know my dad was funny, he didn't want to talk about anything at home but in the car he would tell me everything. And once I was like as a teenager trying to figure out, 'Dad, what do you do? Don't you get bored giving these kids

tests all day everyday?' and he was like, 'No it's actually okay, and when you think about it I'm trying to help this person.' And I was like, 'How do you help them?' And he was like, 'Well, if they have LD they get help, if they have ED they end up in this place.' This huge building in Chicago at the time that he didn't like, and so that's where my dad got in trouble. But he couldn't get fired because he didn't like getting kids sent to that building...So he did his best, he fought with the teams to keep kids in the mainstream who had emotional disability.

So that's always stuck with me. Life is tough we have to have hope but there's always going to be failure. Edward Kennedy he wanted to universal healthcare, he wasn't able to get it. We have to think about that. You know, we talk about Erich Lindemann, there are a lot of parochial interests, people disappointed him, he disappointed people because he was too optimistic. But you can get a lot more done than you think, you're not always going to be victorious. But if we take it one step further out of healthcare and think about health as a right then you start to think, well how do we help people be healthier? And that gives you a lot more leeway to think about this ecological model and different ways of intervening at different levels.

So we have to educate ourselves, so I did do a Masters program in Public Policy cause I was in medical school during the healthcare reform with Hilary Clinton and I had no idea. Here I was going to become a doctor and I had no idea what the heck they were talking about. So I did this Masters in Public Policy and fortunately I did some of the stuff he talked about, but I could really focus on healthcare. I learned about the environment and fun things like that, but there's this policy model and it's not perfect either. But basically a problem is identified, sometimes there's a focusing event like a school shooting. But we know what happened right? Why did nothing happen with political will? So first you have to have a problem, you have to have some political will and unfortunately with guns and people killing each other there doesn't seem to be much political will, but you have to have a solution.

You can't just have the problem identified and a will to do something, you have to have some idea about what you should do. So there's a whole variety of policy solutions and it should be informed by science, evidence, things like that, experts, and you have to have this open window. Well we had that, right? And this isn't a perfect model because health care reform did get passed. The ACA, and that's what we are dealing with now in Massachusetts, even though Massachusetts we preceded it a little bit. So we are kind of in this phase and the state is trying to deal with all of these issues, we don't want to go bankrupt from healthcare so how do we reorganize healthcare to make it better? And you have to establish procedures, create infrastructure, change things, and eventually you have to evaluate what you are doing and you might end up in this cycle or these two might influence each other a little bit. But its important because if you are providers, you

know your patients, if you study where your patients live, you study their culture and things like that you will know when there is a policy window open for you to influence the politicians, the decision makers.

Anybody from Chicago? Anybody know who this is?

Audience Member:

Jane Adams?

Mark Alexakos:

That's right. So she was an amazing person too, very much like Erich Lindemann. Hull House Settlement. She was depressed, she had Major Depression theoretically, as much as we know. So settlement house is an educated residence in poor neighborhoods and I couldn't even get all the stuff on here that she did; community services, education, medical care, day care, classes, cultural events, she did some of the first juvenile legal clinics, she studied neighborhood conditions. You know this was the basis of a powerful reform movement, Women's Suffrage, the NAACP, the ACLU, she was a pacifist. Richard knows and Elena, where's Elena? Right? Half of the patients that we see have somehow been affected by war. She was a pacifist. So do we keep treating PTSD or do we get our act together and learn how to resolve conflict without war? But you get a peace prize. Unfortunately organized labor...she supported so that protest, and they didn't like that so she stopped getting funding. So their interests against her.

So he was one of my mentors. So he's a child psychiatrist and he trained at MassGeneral as well but it was at the School of Public Health, he's still at the School of Public Health. So he scientifically looked at the social sphere, so he did this project on human development in Chicago neighborhoods. And basically, you know Chicago has so many neighborhoods and they are so diverse that you can demographically and mathematically compare them and have enough power to figure out what's going on to account for race, account for poverty. He basically showed that neighborhoods with residents that were more willing to help each other out were more less likely to have violence whether they were poor or racially segregated. So he pioneered this scientifically validated concept. There's one extension of it, and people said, 'Well of course that makes sense, why did you have to prove it?' Well he said, 'But I did prove it.'

When I was working with him as a resident, I thought, 'I'm going to work with this great guy, intelligent, I'm interested in social psychiatry.' But you know, he was moving in a different direction than me. He said, 'I want you to do something else. I want you to work on this small project, it was this afterschool school in Mission Hill and they were tearing down the project at the time. He said, 'I want you to do a child participation project with these kids so they can survey all the residents who are going to be displaced

by this construction.' They were doing this construction that was supposed to be building better housing for the residents.

So this was this idea of participation and it applies to kids and the United Nations has a charter it has all these articles for kids and many nations have signed onto it, but it also applies to adults and participation is important. And what I learned from these kids, and these kids learned a lot. So they went out and they themselves learned how to survey an entire neighborhood, they made up the questions and talked about what the effects on the neighborhood were, how do people feel about this transition. Those of you that know Mission Hill, they went up on the Hill and they've always heard bad things about the residents that lived up on the hill and they actually said, 'Wow, they weren't who we expected them to be.' And so that really stuck with me and it's important to think about in everything we do, participation is so important. If we don't participate then we will end up with these bad results.

So you know, to do that survey was sort of my first experience trying to trick people into giving us money. We didn't do a very good job, we were trying to get \$15,000 from Harvard Medical School but we only got \$1,000. But I had to fight a little bit because the program director said, 'Who's going to support your salary to go off.' And it's a long story but eventually I got my way. So this was my sort of second experience with tricking people to try to implement programming. So I was finishing my child psychiatry residency and I was working with this prevention program through McLean and they were doing this great prevention program called Rally or Pear [Not sure if spelled correctly], some of you may know it. And they were saying, well we have all of these kids beyond prevention. We can't get them services, they're depressed, they're acting out, they're having all kinds of problems. And so I just started kind of consulting as a resident and I realized a lot of these kids were way beyond prevention. The prevention model was wonderful, they went into the classroom, they do tutoring, they do afterschool stuff, do fun activities, work on social skills. And so I tried to figure out a way to provide clinical services as attached to this prevention model.

But I'm a resident so I don't know anything about much, and so I put this business plan together. And I went to one of the more powerful people at MassGeneral and they kind of laughed at me and said, 'That's ridiculous.' And the school was right next to the Franciscan Hospital Children's Hospital, it was the Taft Middle School [not sure if spelled correctly] at the time and that person said, 'Well, what you really should do is take the child, walk them across the school to the hospital and see them in the hospital.' So he didn't get the concept. So then I went to people at McLean they said, 'Wow, we're really impressed with your business plan. If you see that many people, sure you will cover your salary and stuff but you're going to be totally exhausted and anyway, we want

make any money we will lose money. So forget it, it's a nice idea.' So they wouldn't do it. So Franciscan...I said, 'Maybe I'll walk the kids across.'

The person there was Craig Allen, he was about to move to Connecticut, he was interested, he liked kids, he liked the idea of me being in a prevention program, of me being able to see kids who were beyond prevention, seeing them right there at the school. The school was beyond desperate for services. So they gave me a contract, I tricked them somehow, got some support. And guess what? They cancelled that project a week before it was going to start. So here I am, what am I going to do? They said, 'Well we will pay you fee-for-service.' I said, 'Well, that seems like a bad deal to me, but I'll take it.' And I made more money than what they offered me in the contract because the demand was totally out of control, and that's the sort of lesson of healthcare and the problem with mental health care is that there is a huge demand.

And so randomly there was a grant writer at Franciscans and she had run tons of school grants. She loved the project, we wrote a grant, we got money about \$1.6 million over 6 years. And oddly enough that school closed down and the prevention program decided to move to Jamaica Plain and Franciscan said, 'No way, you're not going to Jamaica Plain. We're staying here in Brighton.' So I eventually expanded into 4 to 5 schools and we did a whole bunch of stuff, prevention, early identification, and quick access to services and we saw 20% of the kids in each one of those schools. So the early identification and quick access to services, no problem. I had like 4 therapists in some of the school, I had meta-evaluations, I did therapy. Now prevention is a little trickier and this is where we need to do a lot more work.

Prevention is hard to do, and what happened is we would go in and do a little prevention and the teachers would leave. You really need the whole school to participate in prevention and that's why participation is key when I talk about participatory rights. And its interesting, they had spent all this money in Boston they put Second Step in every single school at the time and 3 years later when I went into the 5th school started the program and I said, 'Why aren't you guys doing Second Step?' they said, 'What's Second Step?' And whenever I go into a school they always give me a junk office that's loaded with books and garbage to convert into a therapy office, well guess what? There were 8 volumes of Second Step covered in dust. So that tells you how hard prevention is, but that doesn't mean we shouldn't try because we need to do it. There's probably over 50 evidence-based curriculums that could help kids in schools.

So this is the public health crisis, this is this demand that we are talking about. So this is from SAMHSA 2014; 1 in 5 adults have a mental illness, 1 in 12 an addiction issue, 1 in 4 abuse alcohol sometimes, 1 in 10...and then 7.7 million have both. It's a public health crisis- nobody seems to care. So I have a little bit of the economic stuff...this is why the state's freaking out, but they've been freaking out forever. When I was in policy

school they showed these same graphs, we're going to go bankrupt. I don't know, they kept it going for a long time. But basically that's what they say, we're going to go bankrupt and we're spending money, and you heard how we are spending money the wrong way. Marylou Sutters isn't here, but I am among the work groups for the MassHealth reform. So what this state is trying to do, this is for MassHealth not the commercial payers, they're trying to reorganize MassHealth to stop that growth trajectory and also to spend more rationally. So they're going to try to create an accountable care delivery system.

That means they want everybody working together, you get kind of a prepayment or an APM an alternate payment methodology. You get the money and theoretically you spend it in the right way. Although, I don't know. I know we don't trust the hospital because we are an outpatient provider, we're a community health center. So is the hospital going to steal all the money and let us do what we need to do? But we can't be cynical, we still have to look for win-win situations. The nice thing about this is that they want to have integrated community-based partners and linkages to social services. So theoretically, if the federal government approves this there's going to be pools of money that are supposed to go to this. I think it's positive, but we keep our eyes open and we need to be ready. We have to engage decision makers and we have to be ready when the change happens. So these are the 4 ways that we have talked about, this bottom part is those funds. And I don't know if Marylou is going to go into this and we can talk about it a little, but I can tell you as much as I know about it. But if you check the Health Policy Commission's website sometimes the slides change. But you know, here's our idea of different models.

The ACO, that provides a whole range of services, integrates with the MCO, the Managed Care Organization. There's a model B where you can kind of go it alone and here's for smaller providers that do some things. So the real question in healthcare reform is can we use the current infrastructure? I think we have to, right? We can't build it all from scratch, we're already spending tons of money. So I was right on the \$3.2 trillion, I think my \$550 billion for school must leave out some pocket that you had. But it's interesting, it's about \$10,000 per person. But as you know, we spend a lot. So that's the Lynn Community Health Center and up here is the brand new Marshall Middle School, one of the middle schools we are in.

So what can mom and pop stores teach us? Personalized service, so we have massive institutions but this is what patients want. This is what we want, personalized service. So this is a little of what I try to do. When I got to Lynn Community Health Center, fortunately there were more people who were engaged and willing to help people in the community, but I had to trick people again. So I was here, me and Steve ran the department in 2008. Unfortunately, he passed away. But this is the work that I've been

doing with a large group of people including William James interns and William James graduates. We are seeing 20% of our patient population, so we have about 4,000 patients. We went from seeing 10% to 20%, that's a lot of growth. And this is like the average number of visits, about 11 visits a year so that's not a big expense.

We are not seeing the same patient a thousand times, cause people were worried about that. These are total visits. Elena, do you know what this is from? Elena is over with me. Why did we dip here? That's when we implemented EPIC, so if you want to talk about paperwork look at what that did to us. We've gone from 25,000 visits to 90,000 visits, but visits by themselves aren't important. I've been hiring a lot of people, a lot of graduates, so these are the number of people, we are up to 82 FTE's but that doesn't include the interns. We have about 20 or so interns. So we've gotten \$9 million in grants to do this over the 8 years, now that's a little messed up right? If this was a true market, there's huge demand so the prices should go up so I should be able to expand the services. But there's market failure, so my reimbursements are so low that it barely covers margin. So actually I have to overwork people and people complain, 'Mark you overwork me.' And I say, 'Oh, come on, we're helping the community. People are sick, what's wrong with you? Dig a little deeper.' But sometimes there's only so deep we can dig.

In a normal market, we would have enough money to invest and expand those services. The prices would rise, but there's artificial barriers keeping it down. And you guys know who are in private practice, that's how the market is correcting itself. You go and you can set a price. So my child psychiatry friends probably make 4 to 5 times per hour what I get reimbursed for managed care in a cash market. Same kind of stuff, so I'm going to talk a little bit about teamwork in integrated care. So if you have a behavioral health problem, you are more expensive. Those of you who are familiar with the Adverse Child Events Study, the more adverse events that you have in childhood the worse you do in a whole range of things in adulthood. If you have both a chronic medical condition and a behavioral health condition you are even more expensive.

So 7 times in a Medicare population, 4.2 this is a commercial population, and again this stuff is off the Health Policy Commission website. So at Lynn Community Health Center, we are undertaking creating patient-centered homes and integrating primary care and behavioral health care so that we have teams of people working together to take care of people and create that mom and pop grocery store feel. We are not 100% there but these are some ideas around integrated care, so it's a really long systems transformation. At the bottom level we are doing collaborative care across the boards, every service is integrated. I didn't think it would happen so quick, but the reason it happened so quick is because primary care providers like it, behavioral health care providers like it, I was able to staff up to meet the demand, and that's our contribution.

I have 3 therapists on each primary care team integrated. But we do other kinds of things here, we're not quite to...you know, they talk about disease management, population management, a full-team based care model that means that your whole team is working with you and you are at the center of...kind of the patient directs it. So just an overview, we have 5 primary care homes, 3 family teams, 1 pediatric, 1 off-site location, behavioral health is on-site. We have 1 maternal care home, OB basically integrated OB not talked about enough. A lot of data shows that depressed moms or moms that don't do well, we are already missing the boat by age 5, that's too late. And I see that in kindergarten, I see severe behavior problems and you can intervene earlier. So this is powerful, I have a psychologist who is able to meet the moms right away; they are screened for depression. The OB doctors don't even have to screen, half the time they know. At the school and the Child's Wellness Initiative, we didn't screen at all. We met with teachers, teachers went through every kid in the classroom, and they know. And some kids were self-referred, and these are kids in the 1st grade, they would self-refer.

They just didn't want to have fun, they knew they had a problem. Screening is important too. We have a behavioral health care home, recently funded. So we have a home at a central site, primarily to focus on a group of seriously mentally ill patients. We have 300 patients now, we think that will rise to 600 or 700 patients. The rest of our central behavioral health site, about 5 to 6 therapists and prescribers are attached to one of those primary care homes, so there's communication. We have an addiction care home with about 350 patients, we have 8 integrated school based centers, and 5 that are BH only. I'd like them all to be integrated but I need capital, so to turn a school space into a licensed clinic takes money. Money that's not available all the time. So this is kind of the model.

Utah. I went out to visit Intermountain, they have an integrated model of care. They are one of the better, lower-cost providers and there's an article on how their integrated efforts have paid off. We do a little bit better because they still have to refer their patients to somewhere else and we get to keep our patients. But the idea is that it takes a long time to get a lot of people to work together. So we're a team-based care model, we have a co-location, warm hand-offs, universal care planning, disease management, population management, but we have to learn to work together. That takes time, because we are so used to working by ourselves. Oh you're the doctor. I tell the patient what to do and that's that. We have to work as a team, and team leaders have to know how to run their team, they have to know how to work out conflict, they have to know new skill sets. When you have nurses, doctors, therapists working together they have to understand each others' language. When you have a nurse that needs to be able to talk to the patient about Depression, people have to learn from each other. In the medical home model,

where we have the seriously mentally ill patient we have therapists talk to patients about their high blood pressure, about things like that.

Again, I'm not going to go much into the high value, they all want us to do more with less and the outcomes to be better and cost to be less. I'm pretty low cost so I'm not worried about that. Patient-centered, we could do a lot more. We are hiring peers and just starting with that. But that's a real shift when you're in an organization, you're thinking about yourself, it's hard to put your patient first and have them upfront. But we do a lot of culturally competent orientated things and we have a lot of care management programs, but not enough. So what about outcomes? Is this doing anything? I think it is. If you talk to the psychology interns and postdocs they will tell you, 'I've made a difference in my patient's life.' If you think about my dad's life, all of these things make a difference.

So we are engaging 75% of patients who are screened for Depression. Now I don't know the outcomes yet, but this takes a lot of...there's a lot of money going into these systems just to get this. So this is the prescription opioid crisis and opioid abuse. Right, we have to be in the community and recognize that this is a disaster. Lynn is one of the hotspots, people are dying. So we have an addiction home, it's a team model and we provide medication assisted treatment, group, individual, psychopharmacology, primary care treatment, nursing education, care management. So the patient when they show up they get their primary care, their addiction treatment, their mental health treatment all in one spot. They don't have to go to 5 different locations. Again, mom and pop grocery store- easy access.

Does it make a difference? So this is what the insurance company gives me to say how good am I doing? So we identify 46% of the patients that we initiate with addiction. That's our bar there, this is from MBHP. So the 90% bar is green, so we're doing pretty good 90%, but that's not so great. We are only initially treating half, so I can't say that I should give myself a pat on the back. Now this is engagement, these are patients who have only had 3 visits, so we're at 21%. Well there's the 90%, so we are way above 90%, so we are doing something a little bit better. But boy we are bad as a nation...we are only engaging 20% of patients with addiction, we got a long way to go.

So I'll switch gears a little bit. This is how I get some of my programming started. So Steve Hayes brought a group of us together, so you guys did start at William James College the Global Mental Health Masters program, which is a wonderful concentration now. And Richard has his wonderful history of culturally competent care and the HPRT model which is very similar, right? Where you provide integrated care, trauma informed care, have it all together. Richard here is focusing on the job services, the New American Center, Natasha, they are focusing on training and job services. So we have had interns go over to the New American Center. We screen all new refugees in our primary care

clinic, and we follow them up. The problem is no body is interested in giving you a grant for this. I could do so much more with this.

So I'm not going to give up, I've invested money in it. And you know where that money comes from, where we have our own profit? Because we have a pharmacy. So we take the money from the pharmacy, but I only have a little bit to play around with. So it's market failure. If I get a grant...I don't know...With the way people are feeling about immigrants, I'm not sure there are going to be refugee grants. We'll see. I got lucky with the other ones, I was ready, I was waiting. I'm going to be waiting for this too. So hopefully this could be much expanded. We could have onsite services, connected to the community, start to add in prevention. The students...some of the Bhutanese patients who have some of the highest suicide rates couldn't even walk a couple of blocks from there to our behavioral health department. So one of the things we did, people walked with them. We had a community health worker right there doing a group to engage this population. And I don't have a slide, but we did have a Bhutanese New Year celebration. So this is how I use an institution and an infrastructure to impact a community. So there was Cambodian New Year, Zumba, but we're not doing enough though. There's no where near that we are doing enough. So Zumba in the square, Black History Month, we have a walking group.

We have about 200 patients in a walking group, 1 peer runs the walking group on the other 2 days at the YMCA and when it's nice they walk outside. So we have group therapy, they do meditation right before, and then they walk. 1 day a peer walks, so we could have walking groups 2 or 3 times run by peers. Walking makes a big impact on people with diabetes, pre-diabetes, so instead of paying all that money on the pills and all this stuff. We have this baby café, so moms come and they support each other and breast-feed their babies. Wicked summer camp, cooking matters...There's no money to do some of this stuff. But not to get too depressed look what we did with cigarette smoking. We did a good job, they want to do better. But look at how we worked together collaboratively to reduce cigarette smoking.

So again, sort of in conclusion, you know, healthcare reform when we are looking at healthcare reform we want to think about how we can impact at all of these levels. So if there was no Fulbright Scholarship, my dad would have never came here and I never would have been here to help all these people. So there's a lot we can do, we want to keep our eyes open, you guys want to keep your eyes open and participate. Use your own interpersonal experience to influence the changes that you make, the care of your patients, and the narrative in the community.

Discussion

David Satin:

Thank you. Talking about bringing mental health services to physical health services and to the community, and a lot of creative ways to finding places in the community for this. I would like to ask both of you and the audience as a whole the original question for this Lindemann lecture; 1) What is...people are dissatisfied with the health care system as it is now, although you are finding ways of doing it, good things, anyway. If everybody has ideas about what should change and how to go about it, what do you all think the American healthcare system would be like, lets say modestly in 5 years, and is there a place for community mental health in that healthcare system? That is community mental health in terms of involving the community in deciding what mental health is and what should be done about it. And helping them- community people, key caregivers, and community residents- to make people healthy and keep people mentally healthy, and them do the mental health work, and mental health professionals be the consultants, and the trainers, and the researchers about how do to this rather than the only people who can do it.

And is there a place for prevention, for not only taking care of people who are sick but taking care of people who are well to prevent them from getting sick and to help strengthen wellness? That's one of the definitions of mental health in the World Health Organization, not just sickness but maintaining health and a productive and satisfying life. Is there money for that? Is there planning for that? And most of all, is there a will do to that? Are people interested in doing that? Because, in my historical example, there were people who did not like that who wanted to stop the people from fiddling with the political system, with the planning system, with the organization, with the community, with public policy. And they squashed it, by saying it was destructive and none of our business and we are not competent in that field. Is there going to be any interest in making the community, the society, healthier and more supportive of mental health or is this not going to be on the agenda for the healthcare system in the United States in 5 years? What's it going to be like? Is there a place, an interest, in community mental health in that?

Mark Alexakos:

Well I can attempt. I wish I had a crystal ball. So certainly there is a will to want to reform things, and the people I've talked to who have asked my opinion. So part of the conception of the ACO is that the money we have heard about that is either wasted or spent inappropriately, that chunk of money would be re-distributed to things like primary care, things like prevention. So the question that I've always asked them, I said

well with the demand and what we know about the demand, and I've proven there's not that large of a stigma so when I build it everybody comes. I'm not dragging people off the streets to come and they are not staying forever either, so...There's certainly a huge demand in a public health crisis, I think people realize that. I don't know 100% if there's going to be enough money. So I would envision, we could just reform payment and that's all it is.

You just changed how you pay us. So you pre-pay us and we just keep doing the same thing. It's always easy once we learn something to just keep doing the same thing. So that would be a bad outcome. You could, like in the 80's, change how you pay for things and adding review and cut mental health services across the board, both inpatient and outpatient. That would be a bad outcome. But if you look at some of the data, it would be really foolish for people to do foolish things. Right? You saw how if you don't treat people with mental health problems, the costs just keep going up. I think in 5 years, I hope things will be doing moderately well. There will be about 3 to 4% of that budget redistributed to outpatient care, primary care homes, integrated homes. The hard thing is always parochial interests. So the hospital has to downsize, what does that mean? How long does that take? How am I going to fight it? Fighting is a strong word, I try to always look for win-win situations, but that has some pain. Just like it's painful for me to build all these services, it's painful to dismantle services or let them shrink.

You know, we have a fragmented system so community mental health centers, private practitioners, primary care all scattered all over the place, that's a big challenge to get everyone working together. I think if you fund integrated care, but if a lot of the money goes to community mental health centers and those community mental health centers still try to work in isolation, it's a better outcome. At least there's more access. The hope is that the community mental health centers will work with the community health centers or the hospitals or the outpatient clinics to manage care better, coordinate care better if that makes any sense. I think there's probably going to have to be a second wave of transformation to really get at prevention, but we absolutely 100% have to focus more money on prevention, it's absolutely going to pay off. It's a blind spot."

Audience Member:

Just a quick question...the community health center, is that in the public sector or could it be a private group practice?

Mark Alexakos:

Yeah, so we're a federally funded community health center. Yeah, so we're a community health center. We are very unusual, we're basically...so what Steve Hayes and Bill Manzoos (spelling?) started in the 70's, that a community mental health center. So

we are probably the only community health center that has as much mental health as we do, so we're unusual. But community health centers are usually more focused on primary care, they are federally funded, we are a part of the Safety Net clinic, there are hundreds across the country. There are also community mental health centers that were started by the Kennedy legislation and they focus on the seriously mentally ill, but they can have a broader mission too. There are some that are quite large and some that are medium sized, just like there are some health centers that are quite large and some that are medium sized. So they're also a part of Safety Net Clinic, so the idea is how do you integrate that. There's also private practices, group practices, there's a huge network...I focused a little bit more because I work in a community health center so I work with the Safety Net, a vulnerable population. But the ACES study was a San Diego, middle class....but you know the issues are the same. Doesn't matter if you are poorer or if you are richer. It just comes in different packages.

Alan Sager:

So every year we spend \$200 billion more on healthcare, and it mostly goes to the people who already have it because their bottom line is more money for business as usual because people are dying. And they need more money to do their job, and they have been able to make that stick politically. Financing is open ended, it flows to them, and nobody thinks about trade-offs. Nobody thinks about, well, if we could spend less here, we could move it there to mental health or to prevention or to other things.

The ACA does some of that, the ACA trims the growth in Medicare spending to hospitals and doctors. That's about how half of it is financed, half of the improvement in coverage is financed by slower increases in payments to doctors and hospitals. But when doctor and hospitals in return ask for the right to keep raising prices to private insurance because their costs are going up, nurses and others, kitchen works, custodians are asking for increases...and drug costs keep going up, supplies. So nobody has enough money and people die everyday.

We don't have a way of doing what other countries do, which is identifying the trade offs where if you spend more money on acute care, there's less money for prevention. If you spend more money on somatic health, there's less money for mental health. And if you spend 2.5 times the average rich democracy on healthcare, there's less money for education, housing, nutrition, job training, and all the other things that make up primary prevention at a social level. The public health world that I live in is full of talk about the importance of housing, the importance of job training, education, nutrition...all the things that city planners were talking about in the 60's and 70's. Trouble is, where do you find the money? Nobody's got the tools to make the trade offs. Now social workers say

you have to organize against an enemy. Whose the enemy? Well drug makers will serve for a while, but how do you organize against the teaching hospitals?

So right now, some of the unions have a ballot initiative that would shrink the differential in payment between partners and everybody else, and yet we have the Chair of the Health Policy Commission- not the Staff Chair, but the Board Chair- saying to the newspapers today, 'Well not so fast, it's a blunt instrument. You can't take money away from these people!' He's been saying that for 30 years, okay? Teaching hospitals never lack for political friends, especially in Massachusetts. Doing God's work on earth...how do you argue with that? It's not a matter of good vs. evil, its good vs. good. Who's the enemy? How do you pry the money loose?

By the way, we haven't yet talked about the multi hundred trillion dollar investment we have to make in protecting our cities from a 6-foot rise in sea levels. Have you seen the picture of Fenway Park with the infield 6 feet deep in water. Not just in storms. So we have these challenges we face, not to feel bad on a beautiful Friday afternoon, but because we are still a rich country, we can do better, but I think people need to be willing to talk to one another about this and identify the horror stories that will motivate- people bankrupted by their healthcare even though they have insurance, the ACA with the \$16,000 out of pocket maximum for family care, we can do better.

The path forward...here's the challenge I would like to offer very briefly. Imagine you go to sleep tonight and you wake up in 20 years. Okay? 2036. And you learn that we fixed all of this, we have a balance between mental health and somatic health, between prevention and acute care, between community services and specially provided services. The only challenge we have is how did it happen- politically, professionally, and financially? If we haven't got a dream as well as an enemy, we haven't got a dream of how to make it come true. It will be harder. So dream big, dream happy.

Audience Member:

"What's your dream?"

Alan Sager:

Well, I think I've said enough for now. I think it's your turn.

Audience Member:

What about single payers?

Alan Sager:

Single payers is what countries do after they have already decided to contain costs. It's not a magic bullet, it ratifies a prior political agreement. Once we have the agreement, single payer, coordinated, all payer...It's all rock and roll, it all works. But the

challenge is summoning the political will to contain costs and cover everyone. Changing business as usual...scary. So healthcare needs strength-based therapy to make that transition to let go of what's bad and move towards something durably affordable and humanly and medically valuable. Single payer, fine. I'm all for it.

Mark Alexakos:

There are strengths and weaknesses in each system. There's not a perfect system. So what single payer does, it would take out and streamline administrative waste so you might get another 5-10% of money somewhere put else based off the administrative waste. The weaknesses- if you don't manage it well, you could run into problems and you might not fund everything. So you have to have a good social contract to run it well. People who are service providers, like you and me, have to still provide the services.

Audience Member:

I'd like to put in a word for some optimism. I think that Lynn Community Health's story gives me a lot of optimism of some important infrastructure at the micro-level, which is where I work to, that I think moves us toward a more integrated care. But macro-level, I mean I've been an adult for over 40 years and I've hoping for healthcare to advance. I feel that it has. We've passed the Affordable Care Act, Supreme Court has reinforced it, it may be vulnerable but I think we are moving forward as a country towards new solutions. And my kids are completely for the presidential candidate who is for Medicare for all, single payer. I think there's a change underway, I think it's more how to keep it moving. I think the other problem...we're in Massachusetts, we're not in the middle of the country and there are different cultures within the country, and I think that's a lot we have to come to terms with as a country. But I'm cautiously optimistic.

Mark Alexakos:

We should be very optimistic. I've done a lot even before reform in a fee-for-service system, so we can do a lot more than we think. So absolutely we need to be optimistic and keep pushing the ball forward. Edward Kennedy failed, I failed at a many projects along the way as well, but that doesn't mean we're not going to keep the ball rolling. So we should absolutely be optimistic and be driven by our own interpersonal experience and goals and doing the right thing, because there is a lot more that can be done. But it's getting there slowly.

Audience Member:

Dr. Alexakos, when you went out to Utah to find out about their healthcare system, what did you see as the driving forces that lead to the difference in our expenditures here in Massachusetts vs. Utah? Could it be related to all the teaching hospitals we have and

all of the higher expenses, advanced testing, and all of the specialized services we order here?

Mark Alexakos:

Yeah, it's clear that hospital care is driving up costs. So Utah is a little unusual, so Intermountain Care is...I don't remember off the top of my head...but they basically provide care to the majority of the state, I don't remember if it's 40% or 50% or 60%. They control the network, so it's a little bit more of a homogeneous population but yeah, because they have that control and they have heavy investment in data and management. So what I didn't get into is all that data and management and it's starting to manage disease management in populations and take money out of the waste and put it in the place where it is needed, and then analyze that same money how it can improve outcomes, it takes a big investment.

We are starting to invest in that in a very small scale, and Intermountain is impressive cause they have taken that money and invested it in the technology or what we call lean business management principles to drive down costs and improve outcomes. But on an integrated level, also, they have a management system where they spread out to all their clinics even their smaller clinics, their group practices. They integrate things. One thing I noticed though, I was having dinner with one of their psychiatrists and he was like, 'Well what do you do with your patients,' because they didn't staff it enough to meet the demand, 'What do you do with your patients when you don't have any more room?' I said, 'Well I don't do anything with them, I keep all of my patients. We keep all of our patients.' So that was one of the things when I went out there, that was my one contribution, and what I learned from the school base is that we actually can staff things to meet the demand and it actually takes a huge pressure off the system so we can start to work to take care of people better. So they kind of shift some of their patients out, but they do an outstanding job. But they have more control.

Alan Sager:

My Mormon friends also tell me that it also helps if you have a religion that's down on alcohol, caffeine, and is up on incredibly hard work and social integration and community, job, and houses of worship. So it is a multifaceted arrangement with some pluses and minuses. I think they would say as well, so I think that's part of the picture.

So I will give into temptation...so President Trump [This was late-spring 2016!] or President Ryan may sign a bill repealing ACA, it's good to have optimistic thoughts but it's also good to have "what if?" But then I think there would be a terrible backlash especially when Ryan would privatize Medicare, which is just another way of the government bailing out taking care of older sick people, and there might be a backlash.

Because we tend to react against evil better than we pursue good things, so it may be that we build ourselves up to an enemy that we can really sink our teeth into.

Audience Member:

I'm curious what you think about...nobody used the word today but you were all talking about it...social determinants. I think you were abbreviating it when you were talked about population health. I'm curious what you think the economic opportunities are around models like Camden, for example, where they have had some terrific success focusing on some super-utilizers and really wrapping around those people with all of the services and supports and home-based interventions. I'm curious what your thoughts are- how important is that and is there an economic opportunity for that as well?

Alan Sager:

Economic opportunity for individuals in trouble, sure. But also we've also seen the de-industrialization, loss of dozens of millions of jobs that paid well replaced by jobs that don't, formerly prosperous towns that are now riddled with meth and unemployed people. So we know that by ripping out the heart of an economy is kind of bad for the rest of the circulatory system. So how do we re-build jobs like candidate Dukakis said, 'good jobs at good pay.' What does that mean? How do we re-invent the economy?

It's a little bit of a challenge, and also whatever the economy looks like how do we move from having nearly the worst income distribution to something that is more balanced so that everybody can afford a decent standard of living? If they work and have a chance to work and have a chance for the education that helps them work...social determinants....serious matter. We're whistling past the graveyard on that one.

Mark Alexakos:

Fortunately in the MassHealth reform they are talking about taking...the idea with MassHealth reform is that if we can get the Medicaid costs down, the federal government will give us a pile of money to transform the system in the next 5 years. So they are talking about funding agencies to help manage social determinants of health. Well what does that mean exactly? I was talking and I said, 'Who are the agencies you're talking about?' and they said, 'Well you, maybe.' And I said, 'Oh, ok. That's interesting to know. Who else?' And they didn't really...so its kind of a good notion, but we have to actualize it and there's a lot of concepts in there.

There are some patients who aren't super high utilizers that have a lot of social determinants of health and get help. So we have what I call office-based case management and they do a lot- they fill out forms, DTA, a whole bunch of stuff, Food Stamps, a whole range of things. But my case managers call it "burn and churn case management" Guess what? Nobody pays for it, but that person who got the Food Stamps

appreciates it. So hopefully the system will pay for it, but there are other kinds of case management models. So peer supports can engage in both that support network, if we're talking about that sociological/ecological resiliency, strengths-based model, you can have peers. They like to get paid, there's a whole movement to support patients. There can be peers for health, peers for mental health, peers for addiction and recovery coaches. Then there's also community health workers or community brokers. Nobody pays for translation, so when I have to pay somebody \$50 or \$100 to translate for the Bhutanese group well, guess what? I'm losing money because I'm probably getting paid about \$150 total for that group and I still have to pay the therapist.

So there's some things that we do that are non-sensical. So I hope by social determinants they will pay for community health workers and cultural brokers. There's a next step, when you're talking about how do you intervene with high-utilizing patients there is a science behind that. It doesn't always get funded, so for those of you who are familiar with Wisconsin (not sure if this is the right word) and there are programs for community treatment, a full intensive wrap around model to keep seriously mentally ill in the home; studied, evidence based. Well the only people who can get that are if they can get into DMH, so like I have a patient who at 8 years old is Bipolar and is in a full therapeutic school, DMH has rejected her 3 times. And she doesn't come to see me, once every 3 months.

She doesn't see a therapist. She was restrained 3 years ago 20 times a month in the therapeutic school, and she won't go get DMH services she can't get a PAP team, that's what she needs. So we have an intensive care management integrated model, that's about \$3 million of funding over 5 years. We started to impact hospitalizations, but guess what? The ROI was not any good because our total medical expense went up. But it's not enough time to study, I don't want to waste a lot of time with that so it got re-funded. But this is the game I have to play, so that's one of my failures. So there are a lot of intensive wraparound programs for high-utilizers but people aren't 100% convinced if there's going to be a return-on-investment. Basically there is, there's a lot of miles we definitely need to invest.

So there's the social determinants of health upfront to manage prevention so people don't get worse. But for those very expensive patients who aren't doing well, we got healthcare for the homeless models, but there's a lot more that could be ramped up. I hope that we will be able to do some of that, I'm a little suspicious. But I hope that with at least the Medicaid reform there will be a lot more money put into this. What people don't realize is that people with first break psychosis are treated horribly in this country. If you are on a commercial plan out until age 26 and you have a psychotic break, is your commercial plan going to pay for any kind of wraparound DMH-type service? So you have to get very sick, very very psychotic, possibly ruin your chance at rehabilitation. You

know, my dad had a stroke and went straight to rehab, no problems. And when he had to go to the nursing home because he had a second massive stroke, my mom was able to put the house into a Medicaid trust so we wouldn't have to mortgage the house in order to pay for the nursing home. That doesn't happen for your young child who is diagnosed with schizophrenia, it's just horrible what we do. That needs to be fixed, and this kind of social determinants of case management and health management needs to be a spectrum of intervention. I'm sorry, I went all over the place with that.

Audience Member:

Maybe you can help me know if I'm speaking loud enough, because I would rather not use a microphone but if the group doesn't think I'm speaking clearly...I want to give you my vision and in the time we have try to be clear. If I had received the copies of your presentation ahead of time, I could have gone up to the mountains and come back with the answer just like Moses. But in the absence of that, let me make my best effort. I went to medical school and residency training, but my best education was at the School of Public Health. And people like Lindemann, but he had already died when I came along, were my mentors. So this is my idea...At the School of Public Health, they taught me the most important thing I can give to a patient- and we will talk about what a patient is- is trying to make the patient in front of us as agents for change. That was my major goal, not curing pneumonia, not giving immunizations, but making every patient who sat in front of me like people in this room say, 'What can we do to help?' And I enlisted them to help me create agents of change all willy-nilly. The other thing is how to take a problem and make an opportunity.

So I took a major epidemic that we have now, opiate addiction, and I said, 'How can we figure out who those people are so that before they get sick we can help learn from them.' So these are some of the ideas that I created from that opportunity. One is...first of all, I don't know who in this room is sufficiently self-aware to become agents for change, you really have to know yourself, your liabilities, and your strengths. Who is the patient? For me, it's not the mother, the dad, or whatever, it is the 3-generational family system. So if you came into my room as with a child who has an addiction or has been traumatized, I would want to know not only about you and your issues, and your parents issues, and your grandparents issues. Tom Lee, who used to be the head of Partners talked about the 3-generational family system. If I'm only working with you and maybe your kid, I'm not going to get very far. But if I learn that your dad was an alcoholic or was abusive to his wife or whatever, that is meat on the table for us to work with. So figuring out who is the patient, it is a 3-generational family system.

There are different kinds of doctors. The kind of doctor I am, I don't give a shit about how much money I make, I want to figure out how much time are you and I going

to work together to solve the problem. If I'm rushing you out in 15 minutes then I'm not going to learn anything, I have to be prepared to sort of sacrifice income to figure out how I can enjoy what I'm doing. There was a paper written in the New England Journal saying, 'The New Dilemma for Doctors,' because the new dilemma is that psychiatrists get a hundred or two hundred dollars for a patient. A primary care doctor gets what ever you get for 15 minutes. I wouldn't have anything to do with the healthcare system that limits me to 15 minutes. I want to go back 3 generations and have an impact, that's the second thing. You know why Kennedy made no progress with parity, because only recently we heard that his sister who was born developmentally delayed and caused stigma in the family, so they gave her some sort of lobotomy.

There are family secrets rife in this room, and unless we take the time to deal with our own stigma and the stigma of people around us, we are going to learn nothing. So we have to be prepared to spend time, we have to get adequate reimbursement. Who wants to be a primary care doctor if they are giving you essentially \$30 for 30 minutes? That gets nowhere, if we are not going to be serious the game is over. That's from my opinion. So those are a few of the issues that I would deal with, which is to say that not all doctors are alike. Some just want to get through the day, have a nice car, go on a good vacation. I'd rather stay home and enjoy my work. Does that give you a beginning sense of my vision? How can you help me put that into words? This is a two-way street.

David Satin:

Howard King.

Mark Alexakos:

Well you should come work for me. So we routinely see 3 generations at the Lynn Community Health Center. You're right on target. I mean, you work individually off that interpersonal relationship. How do you intervene with the family? Where can you effect with the social determinants of health? You know, as a child psychiatrist you don't get taught that as an adult psychiatrist we intervene at all of these levels all the time. Get a kid in after school, get a kid in a program, get supports. You know, this whole issue of value vs. volume in a fee-for-service system, to keep the whole system afloat you have to crank through volume. And certainly I know that my therapists see too many patients a day, it's not as bad as primary care or psychiatry where we have to book many in an hour. They're in a little bit better shape, but they are overwhelmed. It's overwhelming. So absolutely, investing up front time to assess a patient and form a proper relationship, its not something that people are talking about at that level of detail. But it has to happen because it makes a lot of sense. Invest a little up front instead of cranking thorough 15 minute spots.

Audience Member:

We know that primary health care is collapsing. I've been with Mark in primary health care and I've been in primary health care since 1981, and he's done an amazing job at the Lynn Community Health Center preventing these trends. But the Mayo Clinic studies show that 56% of American physicians have burnout and more than 40% say that the quality of their life is terrible. And now we have this epic phenomena that was in the Globe where we know that it is basically destroying American medicine. You know, I think that we like to demonize American physicians as greedy, horrible people. But you know, in my practice, and the practice in Lynn and in other places, there are many idealistic young people, many idealistic psychologists, social workers, people who want to make a difference but they are the health disparities of the field. You want to save money, take it away from primary health care.

You want to save money, take it away from social workers. There's no case management, we don't have any case management. Mark knows this, you can't pay for case management. So basically, people are going to the specialists and saying, 'We got too many specialists!' Research pointed this out years ago that the more specialists you have in the heart, the sicker people are in the heart. The more urologists you have, the more prostate disease, that the problem is that we have a massive disparity between the primary health care system, community health, community mental health, primary health care pediatrics, etc. and the people at the top that are sucking in all the money. And you know, I've said this for years at MassGeneral. I've said, 'Let's stop doing back surgery that no one needs. Let's stop doing stints that no one needs. Let's stop doing hysterectomies that no one needs, and start giving it back to the community and prevention.' You know what the answer is? I don't want to tell you. It's a four letter word. So I don't know how you guys relate to this. There is something wrong with the system that is destroying primary health care. And I think there is no community mental health without primary health care, and that is what Mark has shown at Lynn. I think this is the wave of the future, the wave of the past, and the wave of the present. I'm interested in your responses.

Alan Sager:

So why is primary care like the weather? Because everybody talks about it and nobody does anything about it.

It would take 3 or 4 months' increase in 1 year's health care spending to level primary care doctors up to the level of the average 'ologist'. The amount of money involved is substantial in one sense but it's tiny in another sense because, as you said, the folks who are cutting and otherwise making a lot of money want to keep making a lot of money, and the people at the teaching hospitals and community hospitals rest on that

revenue flow. As opposed to the arrangements that we have in every other rich democracy where the hospital has a budget and tries to spend it carefully.

So there are ways to get at this and when fewer and fewer people have family doctors, or when their doctors register how angry they are, maybe we will see some movement. But primary care for everyone is absolutely affordable.

But then we have the challenge though after we've raised the number for primary care doctors, you mentioned social workers and nurses will follow, other health care workers. The problem is the health care workers generally make more than their counterparts in other countries and more than comparably skilled people in the U.S. economy. So there's a real challenge, so there are constraints and things we have to fight through, but if primary care is the base of the healthcare pyramid then we have to make it solid again. And we can absolutely do it, but it's hard because in other countries family doctors are half of all doctors. Here we are a third, and primary care doctors get out voted in medical societies and elsewhere. And also, the medical school faculty say to medical students, 'You want to go into primary care? What's wrong with you? I thought you were too smart for that.' So we have a really toxic environment in many medical schools contributing to this, and it's partly the money and it's partly the prestige.

Mark Alexakos:

Yeah, there's a combination of factors and certainly when I was a medical student, if you think that going into primary care is bad, if you tell them you're going into psychiatry...I'm not even a real doctor so...Other things that happen is when you're in the hospital system, the hospital is focused on the hospital. It's amazing, I still don't know how I got that program off the ground at Franciscan, it was a grant writer and a COO that liked to do new programming. But all of the hospital meetings were about, 'If we get 3 more people on this bed and 3 more beds filled, we will add \$1 million profit to the bottom line.' So that was their focus. They kind of...I had grant money and they ignored me, so I tricked them.

But when I came to a community health center you can see how much I could do, we're all outpatient, we're focused on the same mission but we need that money that's wasted on other things to take it to expand services. But we are also not the nexus of prevention, so some of that money needs to flow out into the community where we have people participating in intelligent prevention program type things that needs to filter out to the community. You know, an outpatient health center delivery isn't going to be the best way to deliver...so I think we are going to need a third wave of reform to tell you the truth. Now from a financial perspective, how do you get out of this hole where they prepay you? That's the theory, they prepay you so instead of seeing patients for short visits all the time, you're going to add value to see the person longer. It should start to

correct itself. So if you get prepaid per member per month, why would you spend that money on a useless hysterectomy that somebody doesn't need?

Instead you'll either pocket that money for profit or you will invest that money into care, that graph I showed where mental health patients are 7 times more costly in that person. So there's a lot to do, whether there's enough infrastructure that that will translate...There's something called market failure, so if the hospital is the head of the ACO are they going to gently land their inpatient reduction so they don't harm their workers? I've worked with hospitals, they are very mission-driven, they think they are doing the right thing. Cancer care, you go down the line. I have a friend who worked in the pharmaceutical industry, he felt the drug he was making was going to save somebody's life. They are not evil people, but somehow when we come together we're doing some things wrong.

Audience Member:

Just would like your opinion about the fact that our professional organizations seem to work across purposes with each other. So the Mass. Psych. Association does not talk to the Department of Education, so when we are trying to...I'm thinking about community mental health, I used to run the Newton Public Schools Mental Health Services. So my question is how do we get schools, for example, to work with community mental health, primary care? How do we get organizations like the Mass. Psych. Board of Licensure to talk with the Department of Education or the Medical profession? I'm just wondering if you had any thoughts on that?

Mark Alexakos:

I'd love to brainstorm with you. It's certainly my vision...so if you think about the infrastructure we've already invested in, how do we use it? Schools are unbelievable in being able to deliver services and prevention to kids. And so if the school gives me space, it's not problem I can see kids enough and get paid enough that I can sustain that kind of service. Or the school can give me some money to do it. The key is how do we all work together? And look at which prevention programs do you need. You know that model of policy intervention? You have to define what the problem is, define what the solutions are, create political will, so people in government, people in state education departments, in local education departments.

One of the things that I run into in this work that I've done is that you have to be very flexible. Each principal runs their little domain in their own way and sometimes in my 12 schools I got about 9 that are humming and 3 that are hurting. I've got inroads, but it's not a fully centralized vision from the public schools. And Boston was even worse, but at the local level people love the schools. But to get a whole school prevention

program, can you imagine instead of spending all that money on the testing....And that's what the focus was so it was hard to get them to think about whole school prevention. So we need some vision in there. Yeah, we got to get the message out there. I've been trying to get money for that to do the whole school prevention linked to direct services, so if anybody has money for that...

Audience Member:

I think the key word is political will. And I think as I listen to this discussion I am optimistic and excited about the endeavors that you are doing at Lynn, but also very pessimistic about the political environment that we face in this country today. The idea of income disparity is not going away, there are people who have wealth and continue to hold onto that wealth. And mental health in particular as Erich Lindemann said is dependent on many other factors; education, housing, nutrition, safety in the community. Unless there is some huge shift in our political environment here...what we are doing is wonderful but it's almost like rearranging the deck chairs on the Titanic. We are doing wonderful things individually, many of us are idealistic still, inspired to do the work we are doing, but we are throwing them in by the barrels upstream and fishing them out one at a time downstream. I worked for many years at Cambridge Health Alliance at a primary care clinic, in fact I worked with Pat Lee who you may know...Wonderful man, he did wonderful things there.

We all did, we worked as a team. But we were strapped financially, we were overwhelmed with the population we were working with, we were cut as far as finances from the state by MassHealth and Medicare is always tightening its belt. As Dr. Sager pointed out, change occurs in this country when there is a crisis. All the New Deal changes occurred because of the Depression. Unless there is some ground shifting change in this country politically, I think all the things we do will be helpful, necessary, but not sufficient to really shift things in the way that we all expect and hope for.

Alan Sager:

I think you're right. Crisis makes the difference. The other thing that makes the difference is testing in advance some ideas and knowing what to do when we get the votes as a result of the crisis. I don't know that we are making a whole lot of good experiments right now, I think a lot of magical or rhetorical solutions are floating around out there. Patient-centered medical home is a great idea, we don't really know how to do it. . Testing these things out, finding what works and what doesn't.

Right now the reform phrase is 'paying for value not volume,' accountable care and all that. The trouble is that volume isn't our problem because we give 20% less hospital care and 40% less doctor care than the average rich democracy, so we are shooting at a

target that doesn't even exist. It's a fantasy remedy for a fantasy problem. Like if you don't diagnose it, it's hard to treat it. So getting ready will be valuable, and we can do that and I think we will but we have a lot of dreaming and not a lot of concrete experimenting. Intermountain is a great example of a natural experiment that people have pioneered and made work. Kaiser is another one that has been around for 70 years. We can do more of that so when the opportunity comes, we will know what to do, we will be ready.

Audience Member:

One of the things that I am hearing in terms of crisis, you know addiction and substance abuse addiction, that its going to be looked at more seriously now because it's not just affecting minority communities, its affecting white people in the suburbs and that's going to give more attention to the issue which to me is the morale of the country is in peril. And a lot of people just feel hopeless, and yes some people get addicted because they have an addictive personality but why do they even go there in the first place? It's because they feel so hopeless, and there's nothing better to do than get high. So that's my comment.

Mark Alexakos:

Well it's a complicated issue and obviously some more prevention activities. You don't want to be downstream, like you said, you want to be upstream with prevention activities. The reality is that it's complicated. That graph I showed earlier about opiate prescriptions paralleling the heroine prescriptions, the CDC didn't want to put on there that the 3rd leading cause of death is the hospital killing you. So sometimes we are doing the right thing and sometimes we are contributing to a problem. We want to look at opiate prescription guidelines at the health center, but part of the \$9 million is doing to what I'm calling addiction-informed care. We have every single primary care team and behavioral health worker know how to assess for addiction, treat addiction, and we also have the addiction home. And it took me 4 years but I was ready, 4 years ago being an addiction psychiatrist when nobody cared about it.

So the money came, we can expanded the services. So we are a hotspot for heroine overdose, about 400 people in our suboxone program, and another 50 on vivitrol, I'm working with Middleton Prison just early stages, but that's the kind of community collaboration that we have. So again its downstream treatment, but we certainly have to treat people...it's complicated causes for why people end up where they end up. But it's the same thing, everybody goes to college, binge drinks, and 5% become alcoholics, unfortunately. So that's why we need direct with Universities to write public health campaigns. It's not just about getting your liver replaced when you have cirrhosis, but we as therapists cant solve all the worlds problems. Work together.

David Satin:

I'll say again, all of these economic, political, and technological problems end up being problems of values. What do you value? What do you want to put your resources into? Gimmicks I don't think are going to work. Accountable care organizations, medical homes are no different that I can tell from health maintenance organizations or the family practitioner, that was a medical home for you at one time. And calling it something different and funding it the same way but under different guise is not going to solve the problem because its going to reflect the values that you want to implement.

So somebody said, it's a matter of political will and politics to a greater or lesser degree reflects the societies wishes. So if the society wants something, it will filter through and be implemented through the political process. The problem is I don't think we are clear about what our values are, we are not unified about what our values are, and we speak in many voices or don't speak at all. And I think it will end up being some matter of society coming together and articulating and agreeing upon what they want to get accomplished and then finding the mechanisms to accomplish what they have determined and not something that is old fashioned. We could go on for a long time. Do you have a last comment?

Audience Member:

My colleague here questioned why we have such silos in our community where the mental health people, school teachers, and the community don't collaborate. Margaret Hannah, before she cam here to William James, got a national grant to do just that and she is a hidden jewel in this building, but I don't think she has been discovered yet by the community. What I would like you to do is because you are here and you can say, "Margaret..."

Audience Member:

We worked together on that.

Audience Member:

So if you have the information and the data available, if only we are going to open the extra doors and let the air come in. So that's my response that William James can give if only we discover them and they let themselves be discovered.