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Mental Health Integration Council Introductory Comments

Let me start out with who am I, meaning where have I come from to end up as the Commissioner of Health you are all familiar with and what will I bring to the table as we discuss and debate critical issues.

I trained as a medical student at the University of Rochester, and the philosophy of the school could be summed up as John Romano and George Engel's biopsychosocial framework. This model, or approach as it was called, systematically considers biological, psychological, and social factors and their complex interactions in understanding health, illness, and health care delivery. Do some of the words I just recited sound familiar from the legislation this council is based upon? The approach values humanistic qualities and stands in contradistinction to the purely and reductionistic biomedical approach.

I did my internal medicine residency training at UVM, where the Dept. of Medicine and especially the primary care track and the general internal medicine practice, Given Health, were completely wedded to Dr. Larry Weed's Problem Oriented System of care, which capitalized on a comprehensive approach integrating physical, mental, and social health and a new way of not only organizing medical data but using clinical reasoning skills.

During my last decade of practice I became a member of the PC-PH Integration Workgroup, which took two fields sorely in need of integration and created a structure within which each could benefit the other, and paved the way to a more population health focus in clinical care. As I transitioned to this job, the bio that was written still rings true: my practice in general internal medicine had a focus on health promotion and disease prevention, preventative health screening and clinical nutrition, chronic disease management, and solving complex diagnostic dilemmas. With this experience, I understand the challenges our health care system holds for both patients and physicians. This informs my interest in improving public health through policies that foster a culture of health.

I tell you all this at the outset because we are going to spend a fair amount of time with this word integration, defining it and demonstrating its benefits, and talking about where it is lacking. The law requires us to establish integration where it may be lacking, and to identify the obstacles to integration, and to hopefully do so in a way that provides the better outcomes we all expect and that medical literature tells us will follow. This should be time well spent. And the legislation also instructs us to ensure the mental health system is seamlessly woven into an integrated holistic system of care – so we may need to also define that and list the attributes of such a system so we will know if and when we have gotten there. And finally, we cannot forget to mention two other themes from the legislation: redesign must lead to equitable access to needed care, and those all too familiar words health care reform, meaning our efforts are

fundamental to reforming the financing and sustainability of health care, just like any other medical or technological issues. And inescapably, whatever we develop must continue the needed transition of our health care payment system from fee for service to a value-based one.

I need to weave in a few realities now. The front page headlines and the daily hard issues remain the waiting in EDs for mental health care, the inadequate facilities and beds leading to unsatisfied customers and often exacerbations of illness and adverse behaviors, the tragic impact this has on children and adolescents, the perpetual workforce needs. And in addition, the aging population and the fact Vermont leads, in the wrong direction, with increased suicide rates. And the focus on periods of crisis as opposed to the more routine and long term aspects of care that would hopefully avert such crises and that should be the work of this council. My hope is that we all recognize these issues, all of them longstanding, but not be overly focused on them and paralyzed by them. Because indeed, my hope is that the vision of mental health integration we arrive at will be part of the path to preventing and perhaps solving these problems.

Let me tell you about some innovations that have worked or are currently working that may frame our efforts together. With the conclusion being mental health, substance use disorder, and modifying adverse health behaviors all belong in the vision for an integrated system, and in some instances are already there.

First, primary care has always been delivering mental health care, and continues to do so. Indeed, around 35% of primary care is diagnosis and treatment of mental health disorders or aspects of disease. It does this very well. And for a couple years in my practice there was true integration of mental health into a holistic system of care – first, Given Health had behavioral counseling integrated into the practice as early as the 1980s. Second, the Blueprint for Health has CHTs that include access to health behavior counseling. And third, earlier in this decade several of the UVMMC primary care practices, mine included, had a psychiatrist embedded in our practices, present on site a day a week to see our patients, be available for corner consults, communicate through the EHR with us. An effective means of using a scarce resource in a wise way. It improved care and communication and tried to deal with the firewall issue of getting information from the mental health side to the medical practitioner – something we need to also attend to here.

Second, everyone has heard of Hub and Spoke – at its foundation, this is a system that supports the primary care community by providing addiction medicine expertise to the physicians and patients in the mostly primary care spokes who are receiving buprenorphine. It also has a bidirectional system so referral back to hubs for consultation and management can occur if a patient develops more complex needs. This system has been called a model for the country for SUD, and other states frequently request technical assistance from us. The system had so much going for it that we are moving on a rapid timeline to replicate this type of care approach for patients with dementia across the state. One thing the system can be appropriately criticized for is that the co-occurrence rate of SUD and MH issues can be as high as 70%, and the

concurrent care of the MH issues must be improved upon. And though the patients fortunate enough to be cared for in the spokes have a genuine decrease in stigma issues, the same cannot always be said for the more complex people in the hub setting lining up for their daily methadone dose.

Third, I mentioned health care reform previously. No matter what you think of the All Payer Model or the ACO One Care, you should be aware of the important principles already in play: a care management system for expensive or prevalent conditions or higher risk patients, a preventive component for so-called Quadrant One (meaning those without chronic conditions and generally healthy), and a quality management and evaluative component that includes common conditions that are commonly managed in primary care such as depression.

Finally if you haven't read our SHIP, please recognize that the 6 priority health and social conditions include child development, chronic disease prevention, oral health, substance use prevention, the social determinants of health, and mental health. All on a foundation of a vision of health equity and a principle that MH and SUD prevention must be integrated into primary care. I'm looking forward to trying to achieve this vision with you all.