

President's New Freedom Commission on Mental Health: The Business Case: Mental Health in the Workplace 3/29/2006

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MICHAEL HOGAN, Ph.D.: One of the other areas where, as I said before the break, things have really accelerated very nicely since the commission concluded its work, was emerging leadership in the business community on addressing proactively the challenges of behavioral disorders. And so we have a panel of one of our members, Dr. Henry Harbin, with two other individuals, Dr. Ron Finch from the National Business Group on Health, and then Dr. Nada Stotland, practicing psychiatrist and advocate and professor of psychiatry in Chicago. So I will once again give the very briefest of introductions and then turn this over to our panelists.

Dr. Finch is, as I think I said, Vice President at the National Business Group on Health, which is a health education and advocacy organization – I'm not sure if I'm describing this exactly right – for the nation's largest companies, which took on this task of looking at what were the best practices in behavioral health care for employers.

Dr. Harbin, who was one of our members and has been, for a long time, a strong advocate on this issue, assisted in that study and Dr. Harbin, of course, has served previously as the CEO of Magellan Health and was a founder of Greenspring, a managed behavioral healthcare firm and

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previously did honest work in the public sector as Medical Director in the State of Maryland. [Laughter]

And finally Dr. Stotland, as I said, is a practicing psychiatrist and also a professor at Rush Medical School in Chicago. So this is an area of great concern, and as I said, an area where the cause has been advanced a little bit. So Ron, let me turn this over to you.

RON FINCH, Ed.D.: Thank you, and thank you for having us here today. Henry and I are going to tag team this presentation, with me giving some initial overview and Henry walking through the recommendations.

Let me mention something about the National Business Group on Health. We are the national voice of large employers. We're looking for practical solutions and strategies to give to our member companies about the significant healthcare issues that they're dealing with today. Our members are made up of about 245 of the Fortune 500 companies. We have 62 of the Fortune 100 companies as members, and they provide care to over 50 million beneficiaries. About 17 million of those beneficiaries are children and adolescents. The Business Group was founded in 1974.

I want to share a slide with you that I think is fairly significant; some information here that shows that total healthcare costs in terms of productivity are up from

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2002 up to into 2004, from 20 percent to 22 percent of payroll. If we take a look at the real issue here, it's point two where we're talking about sick leave. Sick leave is showing up almost 100 percent over a two-year period. And we see that overtime is up about 12 percent and the number of replacement workers is actually down by a third.

So employers are doing more and more with less and less in terms of employees, resulting in a higher stress level. If you take a look at this next piece of information, and when we have employers actually reporting what is affecting productivity, we see that benefit managers and medical directors are saying that stress is the number one issue. And take a look at number two - the family issues that they're dealing with. So behavior health issues and the need for behavioral health benefits are significant.

We are also moving into an area of accountability with employees and employee benefits where employers are saying that employees and their family members should be more accountable, and employers are looking at ways of incenting [misspelled?] employees to be more accountable and building in incentives into healthcare plans.

Here is a point I wanted to make - I missed a slide, I'm sorry - costs will continue to go up. If we take a look at this information we see that the cost of family benefits for an employer has moved from about \$7,000 in 2001 to this

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year almost \$15,000. That's over 100 percent increase in cost that the employers are primarily bearing and the co-pays and deductibles have remained about the same amount, with the employer bearing the increased burden on the cost.

We have an incredible crisis coming down the road that's going to make healthcare more important in the workplace. We have an aging workforce, and there's not a cohort of younger workers coming behind this current workforce. And employers are going to be increasingly reliant on this current and aging workforce to stay in the workplace. This will give additional challenge to the current structure of retirement benefits as well as healthcare benefits.

In terms of mental healthcare, during the '80s and '90s business experienced rapid change. We went from a fee for service to a managed care environment. Benefit designs changed. Because of the way we give service we actually fragmented the delivery of care. We changed employer structures. Benefits were outsourced, leaving only a skeleton crew inside a business and again putting a greater and greater burden on those employers that actually remain.

Last year Henry approached us in terms of taking a look at behavioral health. He proposed to us about taking a look at what you recommended out of the commission and seeing how those recommendations could be implemented in large

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business. We had actually been discussing those recommendations before you came to us. I had followed the commission's activities with a great deal of interest from the time it was formed.

When we started talking about doing the guide, and we received a grant from the Center for Mental Health Services to do this work, we actually thought through what do we want to produce. And we came and we decided we did not want just another mental health approach, another mental health document. We wanted real information, real actionable strategies that we could put in place for employers.

When we think about mental health and an employer, there are several different systems that we need to think about. It's not just the healthcare plan, not just the healthcare benefits that we're interested in. It's how we manage employee disability. That's another plan. How we manage productivity, what about employee assistance programs? What's their role, and then what's preventive services'? The U.S. preventative services task force has particular recommendations around screening for depression and substance abuse, but do those screens actually take place and where do they need to take place?

We got very specific about what we wanted to have happen in behavioral health. We wanted to improve the coordination between the vendors of behavioral health to

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overcome that fragmentation. We wanted to standardize and integrate the delivery of behavioral health. And we wanted to include evidence-based modalities, including those that are offered in the community mental health centers and by the public sector; something that's not been recommended before in business.

The specific goals that we've put in place were to increase and maintain employee health. As I mentioned with this aging workforce it's going to be important to employers. It's becoming increasingly important to increase that health status for those employees. We wanted approaches to managing employee productivity. Employee assistance programs historically had addressed that but had moved away from that particular role. We wanted to control the cost of behavioral healthcare and disability, both. And we wanted to provide quality care to employees and beneficiaries. That's an important element right there: to get the quality approach back into the care that's actually delivered.

To accomplish this we put together a committee of 25 people, mostly from our member companies – benefit managers, medical directors, employee assistance, professionals and a couple of outside professionals, a couple of psychiatrists that were very familiar with business. We put together people who sit around the healthcare table, the decision makers. We had actuaries, pharmacy companies, there also.

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We did a complete review of the new freedom commission recommendations and these people who sit around this healthcare table are shown on this particular slide.

We had key findings that drove our recommendations. One, in 2001 we spent in this country \$104 billion on behavioral healthcare costs. That's 7.6 percent of total. If we trend, as we are predicted to trend, this year we will spend in this country around \$2 trillion on healthcare. If we trend on the 7.6 percent, the cost of behavioral health this year will be \$154 billion. That's a 48 percent increase from 2001. And yet NCQA statistics show that we only have about a five and a half percent penetration rate into the employee population.

Disability cost is a major driver of cost. We have about 217 million days of work loss at a cost of about \$17 billion annually. One of the major findings that we had was that disability for depression is not being actively managed. Employees actually go to primary care and those that have the right conditions that are considered disabling are simply put on anti-depressants and no active behavioral health coordination. The medication is the only approach that seems to be given for treatment of that depression.

Behavioral health is a major cause of disability. It's the fifth leading cause of short-term disability. There are two types of disabilities in major companies: short-term

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disability, which is usually up to a year, and long-term disability is where they're placed on permanent disability. And behavioral health issues are the third leading cause of long-term disability.

The one thing that employers know is that treatment works when we can get employees and beneficiaries to treatment. Because of the behavioral health benefit design, what we call unequal benefits, the primary care setting has become the de facto behavioral healthcare setting. Higher co-pays, limits on care, has caused employees to vote with their feet to go to the primary care setting.

Primary care physicians treat about 50 percent of the depression cases, a little over 50 percent of the anxiety cases. And as I mentioned earlier, psychotropic drugs are a major modality for treatment.

Another major finding is that chronic illness is costly and comorbid depression and comorbid mental illness is not being adequately addressed. One-third of the diabetics experience comorbid depression. That's costly, and the cost of untreated depression in a diabetic is twice as high as for those who are not experiencing depression.

Benefit design constrains access to behavioral health. We'll address that more later. And limiting behavioral healthcare services increases overall medical cost.

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One ironic piece is that we have traditionally managed behavioral health very tightly, but we have not managed prescription that tightly or general medical access very tightly. There's a contradiction.

And the last and major finding here is that the lack of coordination among programs is causing a quality gap and accountability problems. There's a lack of coordination between disability cases and employee assistance programs, where employee assistance programs can be used to ensure that person's treatment and a good return to the work environment. With long-term absences on disability, many employers are having to retrain their employees because of the rapidly changing workplace, especially in companies that are heavy in technology. That's costly and it's very difficult for an employee to come back and retrain after a period of mental illness.

At this point Henry is going to pick up.

HENRY HARBIN, M.D.: I'm going to talk about what specific recommendations were made by this group and then adopted by the National Business Group. But I think the hat you have to put on that we were wearing that you think about, about where these recommendations were aimed. They were aimed at actions that could be taken by the benefit managers by these large companies, or any size employer, and their vendors. So some of these recommendations address benefit

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design changes, which we'll talk specifically about. In other cases, they were actions recommended to the employer when they hire these series of vendors that they manage, in Ron's slide about who's at the table. The MCOs of the managed care companies or your general health managers, your MBHOs or your managed behavioral healthcare managers, the EAP, employee assistance programs, the disability carriers and the [inaudible].

And I think this issue about coordination - those vendors are not coordinated. It was very interesting to sit in this workgroup, which went on for - what, almost a year, Ron - and many of the mental health people were shocked and surprised at the level of the challenge of the benefit managers who are trying to manage these multi-billion dollar expenditures on healthcare, and many of them are not healthcare experts. I mean we get mad at them because they don't know about behavioral health, but many of them [inaudible] and they're managing a dozen very large vendors and trying to figure out what to do about how to do this. So they were very welcoming of this report.

RON FINCH, Ed.D.: Let me show the scope of the problem here. Marriott is one of our members. They have a very diverse population that speaks over 100 different languages. That's in the United States. And they have 76 different health plans.

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HENRY HARBIN, M.D.: So you get a little taste for it. So these were recommendations of the behavioral side that addressed all of those vendors because, as we talked about the findings and, frankly the results and recommendation in earlier panels, you can't fix the behavioral health problems unless you address the general medical system, the pharmacy managers, disability carriers.

So walking through these recommendations, we had a number of things that needed to be done within the general medical system. We already talked about how they treat a large number of people with mental health and substance abuse problems. And the first one was that you've got [inaudible] on the chart. This seems like a pretty simple thing that they would ask. And this is aimed at really primary care physicians who are giving the majority of anti-depressants and many other psychotropic drugs. But study after study shows that they don't consistently put the diagnosis and a treatment plan on the chart for which they're prescribing that drug.

So that was a core recommendation. And to give you kind of - because I can't go into detail on all of these things because Mike's going to cut me off. He didn't cut anybody else off, but [laughter] -

MICHAEL HOGAN, Ph.D.: Yeah, but you're the managed care guy.

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HENRY HARBIN, M.D.: Yeah, right. [Laughter]

[Applause] That was good. I walked into that one.

[Laughter]

So if the employers were to adopt [inaudible] and say we want you to put in your provider network's contract language that will require this, and you will monitor this. It goes down to that level of specificity. Now the commission members have a copy of the whole guide. It's not in the back for everybody, so if you want to track these specifically it's on page 64 is where they started the text.

The second recommendation in this area was that there should be required screening for depression and other common mental health problems for chronic medical diseases. The national preventative task force has not recommended that it be mandatory screening for all primary care physicians for mental health period. There were qualifiers. But given the high incidence of comorbid mental health and substance abuse problem with chronic medical problems, [inaudible] screen for this.

As Ron talked about, the cost appears to be about double on the health side if you've got comorbid depression/anxiety disorders.

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The third area was recommending that if a primary care office – this is kind of a minimum for the specialists – is going to provide treatment, they need to do some ongoing tracking, and preferably to use standardized screening tools. And it was also a recommendation that was adopted by this group that that be paid for, that the use of the [inaudible] lab tests. So if a busy primary care doc is going to administer the PHQ9 or another instrument that they get paid for it. And the benefit consultants in our group recommended that, and that's what went forward in this document.

Finally in this recommendation was to implement collaborative care. This was a recommendation of the commission, but like many of our recommendations that kind of laid it out there but didn't translate it into actionable steps [inaudible] is really taking the next step and putting it in detail.

So in that section we're laying out what does that mean, better screening, improved communication between the generalists and the specialists, specific payment for case management and disease management activities. As we well know, standard healthcare fee for service systems, Medicare, private insurance, do not pay for the non face-to-face case ... model. This has been shown to be the glue, that it doesn't work if you don't do it.

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And finally also to pay for the psychiatric consultation to the primary care doctors about psychotropic drugs. Again, [inaudible] this program work. That should be paid for as well.

We had a whole series of recommendations about ... performance standards about how should the communication be improved between ... specialists if they're involved. And again, we heard from some of our panelists earlier about the need for [inaudible] the specific areas. We also added to that, given that many employers now have hired medical disease managers to track heart disease, diabetes and other chronic medical problems. But again they're often now fragmented from the behavioral health specialists. So there's another specific recommendation to require your medical disease managers to coordinate with a behavioral health specialist for the tracking of these comorbid problems.

We did address the benefit plan design. Of course, as I mentioned in the collaborative care model, that is a benefit design change as well. That's payment for services that currently aren't paid for. We did review carefully the data on parity for this group. There's a lot of information about it. We had Howard Goman[misspelled?] come and present the latest on the federal employees study, which I understand is being published tomorrow. And so we use this as a

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springboard to educate the employer community about the findings that have been for the last decade on parity and the either minimal costs, or in the case of the FEP study, really no increase in costs compared to plans that didn't have parity.

As a result of all of that, we did come out with a recommendation to support – a term that Ron has used – equalization of benefits to be a little less emotionally laden maybe. But it's parity. It's parity between medical and mental health benefits. It's a recognition that if you're going to use these recommended action steps, increasing the financial barriers to the specialists is going to basically undo most of these recommendations.

So that was another whole area. We also had another specific kind of payment recommendation. One of the concerns – we heard this in the commission, we heard it in this work we did with the National Business Group – is that primary care doctors are afraid to put a mental health diagnosis on the chart because they won't get paid because you've got a carve-out vendor who if you put that ... It turns out that there's little evidence that that actually happens that way. Most carriers do pay a general medical practitioner if they, you know, they put "headache" on there. They put congestive heart failure, and then add depression, anxiety, whatever. But because there's so much confusion we're recommending

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employers to make it crystal clear in their medical policy guidelines that they will pay for this. They will pay if a diagnosis of mental health, substance abuse is made as part of a medical workup. That won't be a reason to reject their claim.

We did not, however, get into making a specific recommendation about what role primary care physicians and their staff should play in doing psychotherapy or other interventions. We sort of left that alone and didn't feel it was our province there to get into saying should they do psychotherapy, should they do other therapies beyond medications or not. In most cases they don't.

Another whole major area is, of course, the problem and benefit of psychotropic drug medications. We've already talked about the fact that the majority of these are given by non-specialists. And there are, in study after study, significant quality problems. The drugs are often not given correctly, wrong dosage, maybe too much, too little. Add the lack of documentation in the general medical charts for so many folks that it's hard to tell is the right thing occurring.

Well there's very little oversight over this, so the recommendation here is that employers require of their vendor, and that could be a pharmacy management company or their MCO - it usually is not the MBHO - to adopt a national

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best practice standard for the review of psychotropic drugs in all classes. And that that be applied by their vendors on an annual basis to survey the practice patterns of providers as to whether they're doing a good job or not a good job, to pick out the outliers, and then to develop on an annual basis a practice improvement plan. We know there are significant problems here, and this is one way to begin to address that, to identify the patterns of usage with that population and that the practice improvement plan have the sign off of not just the pharmacy benefit management company that is the most common manager of the drugs, but of the MCO who has got the primary care doctors and general medical folks in their networks and the MBHO who had the mental health specialist in their network. And unless all three of them are collaborating around a specific plan of education and improvement about the accuracy and quality of prescription drugs, it's not going to change.

This is again another recommendation of the commission in our evidence-based practices [inaudible] in psycho-forum [misspelled?] recommendations. This is trying to take a step well how would you actually implement this in a pair market. We also talked about the need to use this information to update the formularies on an ongoing basis. And we particularly made a point that you want to use the data on what are the effective drugs, and what are the ones

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that are working best – not just on the price of that one medication, but what has been most efficacious on helping people recover.

Now am I going too long? Am I on track for time?
Okay.

A major area I think would be of interest to the commission and many people in the public mental health system, State and federal, would be this next set of recommendations about the seriously mentally ill kids and adults. And I think Ron and I – at least I did, and we've talked about this before – we had more modest expectations for this group when we started.

And we found, frankly, a very willing audience from the 10 companies that lent their benefit managers to this group – companies like Time Warner, IBM, 3M, General Mills. They were very receptive and very encouraging. So we took another step and said in addition to all these other things, you have a number of people that you're insuring – kids, adolescents and adults – that have much more serious illnesses than a major depression with mild to moderate level of functional impairment. And your benefit structure, frankly, are mostly fairly traditional. You cover inpatient, you cover outpatient professional office visits, and you cover day treatment or partial. But you don't cover many of the specialized, non-hospital community-based services,

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whether they're ACPAC [misspelled?] teams, therapeutic foster care, targeted case management – things that have been in the public sector for decades, paid for by both State governments and Medicaid, in many cases if it's done right.

And many of the benefit managers said to us, yes, we're very well aware that we calls from the parents we get who are not doing well. They're out of the hospital and there's no – other than a once a month visit to an office-based practitioner. We said, well part of the problem are your benefits. You don't recognize these types of programs. And therefore they're not paid for. And sometimes even if they had the flexibility, they're not clear about it, so their managers don't tap them.

And you've got – another problem is even if you pay for this, you don't have these providers in your commercial networks that are going to deliver this. They are in the public system. They're funded by Medicaid. They're community health centers, whether they're private non-profit or private for profit. And you'll need to add those providers to your commercial networks in order to fully address this problem. So that's in there.

We also did not in listing – we listed some of the evidence-based treatment. We were not, in the time that we spent, able to go into all of them. And I will say, make a plug here that some of the evidence-based practice in the

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public sector have not been translated into easily billable units. And we didn't have time to do that. So we threw in some of them that were very important. We then asked that this be an annual review by employers with their management vendors about what are the latest evidence-based practices in behavioral health. And they should be adopted if there's evidence to support it.

Two more. Disability – and I'm going to ask Ron to present the last slide on employee assistance because that is one of his many areas of expertise in his long career in the behavioral health arena. I don't know whose been at the longest run, you or me, but we've been at this a long time. [Laughter]

I was surprised at some of the information we found about how mental health disability cases were handled in the private sector. The most common practice in many cases was to have the person with depression, for instance – often that certification was done by a general medical practitioner. A behavioral specialist never saw the person. And they were routinely given two months on disability to wait for the meds to work. So we made a series of recommendations here: one is that anybody ill enough, whether to substance abuse or mental health problem, to be eligible for disability have a mental health specialist part of their evaluation and part of the ongoing monitoring of the treatment; and that the

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employee assistance programs be more actively engaging in trying to facilitate a return to work.

All right, Ron, I'm going to ask you to do the last slide.

RON FINCH, Ed.D.: Over the last 15 years we have seen a significant change in employee assistance programs. They have become something other than what I have historically defined as employee assistance programs and have become programs that actually extend benefits. And I think many employers, with good intention, put extended benefit programs in because of the limits on the behavioral health programs. Also employee assistance programs can provide services to those people with the V codes that don't meet the medical necessity guideline for going into treatment in the behavioral health system.

So we have readdressed employee assistance programs to move in employee assistance back into managing productivity, to be part of the management of that employee who is experiencing problems. And so that employee can be restored to full productivity. And that's going to be increasingly important with this limited workforce that's going to be available.

We've asked, as Henry mentioned, that there be a coordination between employee assistance and disability to ensure that that employee has a full range of services that

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are necessary while they're on disability, but also after they return to work, so they can have some continuity of assistance. We recommend that employee assistance programs continue to provide the counseling that cannot be provided by the behavioral healthcare system, but we're also recommending to employers that they eliminate the redundancy between their health plan and employee assistance program, so as to eliminate the confusion about where one goes for care.

One important area that I did not expect to come up from this committee was that of taking a look at the organization of work, the work environment itself, and taking a look at the physical and emotional impact on employees. We don't currently have good tools for assessing the impact of the organization of work. And employee assistance programs need to be working with a larger human resource team to come up with approaches to evaluation of the organization of work and developing appropriate interventions.

That's the end of our recommendations. Again, this was a rewarding work for us to do. It's been well-received by our employers. We get calls almost daily about getting additional copies of the guide. It's become a subject of conversation at meetings between employers and their health plans. And we released this December 12th and it's been downloaded over 7,000 times from our website. So we think that this has been welcomed by our employers. Behavioral

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health is really not understood by employers well, and I think this has given them additional tools. So thank you for giving this project to us.

[Applause]

MICHAEL HOGAN, Ph.D.: I think we all agree that this is extraordinary work, and I know there'll be questions and comments on it by our members. But let's proceed to Dr. Stotland's commentary and then we'll open this up for some conversation.

NADA STOTLAND, M.D., M.P.H.: Thank you. I'd like to thank the commissioners for inviting me to testify and all the attendees here for their attention to the pressing problems with mental healthcare in the United States.

We've all had the opportunity to learn from each other this afternoon, and I've not been able to resist putting some of that information into my comments. So if anybody's following along they'll find that there are a few additions as I speak that are not in the printed comments. Also my slides are rather incidental. And so I'll try to remember to change them at the right time. There are just a few of them. But really my oral comments are the gist of what I want to communicate.

I serve on the board of the National Mental Health Association (or NMHA), and I'm the vice president of the American Psychiatric Association, which is the oldest and one

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of the largest medical specialty organizations in the country. And the National Mental Health Association is in a similar position in the advocacy community. I feel that collaboration between the mental health professional and advocacy organizations is essential, as is our collaboration with the business community. American mental healthcare, which does not deserve the title of a "system," is still woefully lacking. Public education and public opinion have improved. Our ability to recognize and treat mental illnesses has improved, but there are enormous barriers to access to that diagnosis and treatment. Mental illnesses lose many sufferers their employer-based insurance and dump them into the public sector and in the public sector, deinstitutionalization without commensurate movement of resources into outpatient services has landed persons with mental illnesses in jails and prisons, on our streets and warehoused in nursing homes.

In the private sector the healthcare of non-elderly, non-disabled individuals falls mostly to the business community and we strongly commend the Business Group in Health for its historic contribution and commitment to mental healthcare. That report is a very powerful too, as you've already heard. America listens to our business leaders. Their investment in mental health issues, as compared with that of mental health professional and advocacy groups, is

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perceived as objective, practical, realistic – not self-serving. Their observations about the utility of mental health diagnosis and treatment to society at large carry enormous weight.

Another powerful organization is the Partnership for Workplace Mental Health, a program of the American Psychiatric Foundation. The partnership works with business to address three barriers to their investment in the mental health of their employees: fear of mental illnesses, lack of information about the business costs of untreated mental illnesses, and incorrect assumptions about the costs of mental healthcare.

Now let me go back. I speak from the perspective of a physician. I've worked as a psychiatric consultant to other medical specialties. I've served as a director of psychiatric education at the University of Chicago medical school. I've served as chief medical officer in the Illinois Department of Mental Health and as the chair of a large community hospital working with Dr. Godbole, department of psychiatry as an advocate and throughout and to this day as a clinician. I also will add, after hearing the powerful remarks of Marley that the youngest of my four daughters is a person with a GED because of mental illnesses and symptoms, who's now a graduate of Harvard Law School, thanks to treatment.

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I know very well what we can do, given the right resources and structure, and what is really happening on the ground in people's lives. So having given credit where credit is due, let me tell you some of my experiences, concerns and remedies.

Here are some experiences. Hospitalizing a patient who's been housebound with depressive symptoms for three months and her family finally gets her to the emergency room. I put her in the hospital. I order thyroid function tests and I find out that she's very, very hypothyroid, and that's very likely what's causing her symptoms. But I can't get an endocrinologist to see her because that's a different plan. And that endocrinologist she would have to go to a different hospital to see an endocrinologist that's covered by her insurance and so I begged my endocrinologist in my hospital to please see her for free and will never get paid for it. Meanwhile I'm talking to a clerk on the telephone who wants to know why can't we just send this patient home for outpatient treatment, and I'm saying it took three months to get her out the front door. So outpatient treatment at this point is not a very practical suggestion.

Another experience hospitalizing an acutely suicidal patient, talking to a psychiatric colleague at an insurance company, and he's saying, "If you say this patient isn't

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suicidal in the hospital, but will become suicidal again if she's discharged, I'm not even covering this stay."

Being paid out of pocket by patients who can or can't really afford it because they don't want to use their mental healthcare that is covered because they're worried about the effect on their employment.

And lastly, for now anyway, getting a call from a former United States senator, whom I happen to know, who says where can an indigent individual (that she knows) with substance abuse, and another serious psychiatric diagnosis as well, where can this person get care? And telling her there is nowhere I know of. Here's some people you could call to beg for care, but if this person isn't on Medicaid or eligible, there isn't anywhere for this person to get care.

These are not rare experiences. These are everyday experiences in the lives of my colleagues and our patients. The commission, the Workplace Partnership and the Business Group on Health have recognized that early recognition and comprehensive treatment of mental illnesses benefits not only the worker, but the workplace. And you've heard many of these things. I'll tell you about them from my perspective. It's not only the catastrophic cases that take their toll. There's that presentism. I travel a lot. I have to call airlines, and you know how you always get that message that this call may be taped for quality purposes. I know that

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some of those people who don't produce quality when they get taped, some of those employees who sound sullen, who are slow, it's because they have untreated mental illnesses, and I prefer to call other companies when that happens.

Although the grand psychiatric schemes of 80 years ago didn't bring us a mental illness free society, prevention, thank goodness, is back in the scientific and policy spotlight. We can identify risk factors, including trauma and abuse, for mental illnesses. We can let parents know when their children are having emotional and behavioral difficulties at school, despite all the fuss about screening and hysterical assumptions about what would happen if we do that, which we have to do. We can identify and address early signs and symptoms before they reach the status of diagnosable disease.

Businesses need to provide screening and employee assistance in times of stress and employee – including management – education to reduce stigma and enhance integration and accommodation. Mental illnesses in employees' family members can be as demoralizing, terrifying and demanding for them, or more so, than mental illnesses in the employees themselves. There is no way an individual can function after a night searching for an adult child who has disappeared onto the streets, or comforting an anxious and depressed child, or protecting the family from a family

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member whose untreated mental illness has resulted in violence or threats of violence. Insurance has to cover the whole family.

The brain is a part of the body. Covering one part of the body with one insurance plan and another with a different uncoordinated plan is a set up for duplicated efforts, or worse, serious problems falling between the cracks. Most people, not just some, most people with serious mental illnesses have other serious medical illnesses – most, 70, 80 percent.

There is no rationale for limiting mental healthcare as compared with the rest of healthcare. Everyone has said that this afternoon. And there are two lessons here: Mental healthcare should be covered, just like the rest of care; and it should be an integral part of that care.

Recovery is the driving force behind mental health research and care today. It is not enough for our treatments to make patients feel somewhat better. We aim to help patients feel and function as well as they did before they became ill. For individuals with the most severe illnesses, coverage must include so-called wrap around services – help with housing and occupational rehabilitation. And treatment has to last as long as it takes to keep someone well.

The NMHA and the APA applaud the voluntary efforts of enlightened businesses and we understand the disinclination

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to make those changes mandatory. However, given the historical and continuing discrimination against mental illnesses and mental healthcare, given people's geographic mobility in our society and the variable and patchwork nature of State laws and regulations, we observe that the only way to make sure workers and their families get the care they need is to require non-discriminatory insurance coverage. Mental illnesses are as real and as treatable as the diseases such as hypertension and diabetes that affect the other parts of the body and consume most of our healthcare resources. We are fighting stigma with considerable success, but we are also fighting a millenia of fear and exclusion. A survey reported several years ago that many or most employers admitted to using employees' medical records, as revealed by the reimbursements from their health insurance, to make promotion and retention decisions. Smart employees know that. In the end it hurts everybody.

As the Business Group on Health reports, the odds are extremely high that an employee given good treatment will be a good employee. Employers need to guarantee the privacy of employees who seek mental healthcare. The National Mental Health Association and American Psychiatric Association have strong working relationships with the business community. The foundation and the APA publish mental health works – which you have several copies in your handouts – with

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information on mental illnesses and treatments that is directly relevant to the world of business. And it's also available at www.workplacementalhealth.org.

Together the advocacy, professional and business communities can alleviate the pain, improve the functioning of the millions of individuals and their families needlessly suffering from mental illnesses. Thank you for this opportunity for the important work you have done, and for your insistence on taking the results of your work into our communities where millions of people are needlessly suffering and losing their lives. Thank you.

[Applause]

MICHAEL HOGAN, Ph.D.: Thank you Dr. Stotland and all members of the panel. I think this last presentation builds a bridge between the promise of many of the recommendations that have been made and the realities that are still faced by consumers and families and caregivers.

I think I want to sort of open this up to questions or comments that commissioners have. Everybody here who is – I know from our experience of working together – is extremely active has been sitting here extremely patiently. Recognizing that we'll try to be succinct in our comments and questions.

Dr. Godbole?

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DR. ANIL GODBOLE: I'm delighted to see my colleague and fellow combatant. From time to time we have fought battles together on behalf of our patients, so happy to see you here.

My comment is about the presentation done by Dr. Henry Harbin and Dr. Finch. I really have to commend the work that you have done. A number of things that you have brought up and identified and have made recommendation about were variously discussed in the commission as a whole, but more particularly – in more details in some ways – in some of the sub-committees, the evidence-based practices, the psychotropic medication sub-committee, the committee on behavioral health and general health interface. So many of the committees, but because of the constraint on the time and the scope of the number of recommendations that we could make, we could kick the ball only so far in some areas. So it was really gratifying to see that we sort of maybe set just the groundwork for what needed to happen and to see that it did happen, actually, that you have kicked the ball much further. And this can be potentially a groundbreaking effort on your part. And I hope that all the important stakeholders carefully read this. But not just read it and put it on the shelf back again, somehow practically translate it.

This document and what is contained in this can have far-reaching consequences on benefiting and moving towards a

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transformation that we are talking about and also breaking the stigma.

HENRY HARBIN, M.D.: Well thank you. I want to point out Ron Finch's role and Helen Darland [misspelled?], his boss the CEO, and she's receiving an award this evening. When I first called after Catherine Power said she would support this, and I called Helen Darland to ask the business group. 'Cause trying to get the business as a group to act as one - they're all independent. It's not like going to Medicare or Medicaid where you may not get through to them, but it's one entity, one central thing.

But this is the largest such health policy group out there. And Helen was very interested in doing this and said, "Well I have the person for you." And I had met Ron before, and he is a very experienced behavioral health person. He's worked in the public sector and the private sector. He's worked four businesses.

And I think the two of us partnered up with a lot of other people to drive this, but this is an opportunity. Our goal is to get this implemented in all the major businesses. And that's phase two, which might take longer than my lifetime, but maybe not. And I think the business group is a key element in continuing to drive this. And I think part of the use I see of this guide is there's been a lot of work for the APA with various business coalition by mental health

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associations, local practitioners, but they often have not had a platform about what should you do you. What do you want a business to do? Well it's laid out here in a lot of detail.

And our hope is to work – we've been talking with Richard in NIMH, with Catherine at CMHS again, and some private foundations and other entities about taking the next step and making it easy for these businesses to adopt this. We've made the case here. We've made the policy case that this is in their self-interest to do these things. Now we need to make it easy to operationalize many of recommendations and adopt it and put it out there.

RON FINCH, Ed.D.: We do have some anecdotal information that employers are actually using the guide to revamp their programs, even those that were more progressive. We are hopeful that we will do an implementation project, a couple of real demonstration projects taking this guide and putting them in place. We've already had businesses to volunteer to be the demonstration site. So that could be very exciting to actually have a national demonstration project where we learn about implementation, how to do this and obstacles we'll face and then to build tools that other employers can then use to put these recommendations in place.

MICHAEL HOGAN, Ph.D.: Just a couple of comments that I wanted to make. One is – and Henry alluded to this before

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– but Dr. Howard Goldman who's here and who advised the commission throughout its entire process has been participating in a study on the constant impact of the parity or equitable coverage – whatever you want to call it – with the Federal Health Employee Benefit Program.

Now it'll be in the newspapers tomorrow and it's embargoed until 5:00. So unless we want to stay late we're not going to learn too much about it. But I will say that you ought to read the newspapers tomorrow and what you'll see will be quite consistent with the extraordinary work that's been done here.

It also occurs to me there are at least two other reasons why the work by the business group is so critical. One, it really is, as you've emphasized, both comprehensive and practical. These are well-thought through consensus steps from lots of perspectives about how to do this. The fact that it comes from large employers who are sort of the icons of leadership in this country, I think is important for lots of reasons because they employ lots of people. But really these recommendations ought to apply to any large insurance program. These recommendations can be equally applied to Medicare or Medicaid. And some of the problems you talked about, for example I was thinking about the point of documentation and connecting that back to Stephanie's testimony where in tri-care or in having to go outside for

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the therapist and the documentation not being in the right place has caused all kinds of problems for her. So these recommendations ought to be ones that find their way through the whole health and behavioral healthcare systems.

Any other comments, questions? Bob?

DR. BOB FISHER: Yeah I had one quick question. The recommendations sound very reasonable. The business case with just a little bit more information would be quite solid, and you either deny the evidence or you change your behaviors.

But my question has to do with the workforce, mainly the behavioral healthcare workforce and also the primary care workforce. To what degree do you think that they'll be ready to face a change that could occur because of what you've spoken about?

HENRY HARBIN, M.D.: I don't know if anybody has an answer, but I – you have to parse out, I mean we had a whole series of recommendations, obviously. But Bob, the general medical system is a major player in the delivery of behavioral healthcare, and they're already doing it. And in some cases they're doing it well, but in a lot of cases they are not. And a lot of these recommendations that have been out there a while – and some of them came out of the commission, they're just laid out in more detail here. They've been two decades worth of experience that if you

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implement these collaborative care models for common mental health problems – I'm not talking about the most serious problems. You'd need a different paradigm in the specialty system for that. But with some of these fairly specific wrap around services – case management, disease management, some consultation, little bit better screening and education – they work. And that doesn't require a significant revamping of this.

But there's also an accountability issue here. If an internist is going to take on the responsibility, prescribe a very powerful medication, they're going to have to step up to the plate – as they would in any other illness they handle – and diagnose the patient, communicate to the specialist, make a referral if necessary, and monitor the patient. This is basic medicine, and it's what most practitioners would see as their responsibility if they were treating any other problem. So I don't think we're asking them to do something out of ordinary. They're doing it for most other common medical problems. And unfortunately as we've seen in surveys, they're not doing it consistently with kids or adults.

There's a lot of people who talk about the challenge in the behavioral health workforce, but I guess I'm a firm believer if you pay adequately and you pay for these services, there'll be a workforce. Probably more than Dan says, I want to make sure there's consumer input. I was

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saying in this commission, if the financing is important – we love saying those things, you probably got sick of hearing us – but I think if you finance these things properly, there will be a workforce. It doesn't mean I'm simplifying it, but that's kind of my bottom line belief in this.

MICHAEL HOGAN, Ph.D.: I just want to make a comment about this, Henry, and link it to some of Dr. Fisher's concerns. It's a question that was brought to us from the audience, and it is how do you envision State implementation of peer support services. And I think the answer is if you pay for it, they will come. And whether it gets paid for, given what Medicaid is thinking about doing with respect to limiting rehabilitation services is very much at issue right now. So there are lots of other things that are required: leadership and training and so on. But this is, I think, a good example of your point.

Yes Dr. Stanlon [misspelled?]

DR. STANLON: I'll address the psychiatric workforce for a moment. We seem to have an attitude in our country that if you go to medical school you're going to be a rich person and nobody needs to help you. And the reality is you finish your residency, you're 30 years old or a bit older, and you owe \$200,000, and that accrues interest 'cause there aren't even good loans anymore. And then we'd like you to take a couple more years to become a child psychiatrist

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'cause there's really a shortage of that – while your loans continue to accrue interest. And maybe you'd like to have a family before you're 40 years old. So you probably are starting your family and so on. And I agree with you completely. We have to help people, we have to incentivise people to go to underserved areas and to go into underserved fields. And it's simple enough. It isn't just venality, you have to be able to pay the rent and the mortgage and for your own health insurance. And we have a problem with that in primary care as well as in psychiatry, and we just can't expect people to pauperize themselves.

MICHAEL HOGAN, Ph.D.: Other questions or comments from commissioners? Yeah, Anil again?

DR. ANIL GODBOLE: I just wanted to make a quick comment since Howard Goldman is still here in the audience that he has considerable experience with the [inaudible] project where they were able to develop very sophisticated toolkits for each of the evidence-based practice that was disseminated through the State. So when it comes to dissemination of something like this document across 500 Fortune companies with multiple vendors and all that, it may be useful to translate something like this into a toolkit for implementation purposes, something modeled after the Nesbit [misspelled?] model.

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RON FINCH, Ed.D.: That's exactly our proposed next step is to do those demonstration projects and pull together those toolkits. One area where we really need to pay particular attention where there's very little done is in the whole area of preventive care that could be done through worksite programs other than employee assistance programs.

I would like to go back to your question about implementation of the recommendations. Some of the healthcare companies are doing that now on their own. Dr. Ahn [misspelled?] from Aetna was on our committee and you see that Aetna is starting to take a look at their behavioral health. Much of what we were recommending here is actually being implemented at Aetna. And I think that was profiled in the Wall Street Journal/New York Times, how that was actually being done.

Other areas I think will be more difficult to implement. Getting in and looking at organization of work and doing an evaluation of the worksite - I think there's a lot of work that needs to be done there. And there are not good instruments out there right now to actually do the evaluation of workplaces. So to a greater or lesser degree, some of these will be difficult, others will be more difficult.

HENRY HARBIN, M.D.: One thing we need to add is that we thought complete copies of the guide were going to be

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handed out, but they can be downloaded from the National Business Group website, the whole thing. As Ron mentioned, 7,000 copies to date have been downloaded. So it's free, it's available. Your tax dollars were at work here.

MICHAEL HOGAN, Ph.D.: Gail and then Ginger?

GAIL: Just very briefly, Mike, but I, too, want to laud the work of the National Business Group. I'm particularly interested and want to encourage you about your focus on evidence-based practices and paying for what works. My understanding is there's additional toolkits underway, particularly in supportive housing and peer support, consumer support as well. The extent that we can continue – I like your theme, Mike, about connecting the dots, and ensuring that as we formalize more emerging evidence-based practices and we document them and we're making the stronger case, making sure that we get these into the groundwater of payment/reimbursement mechanisms will be so important to trying to expand the scope of our work. So thank you very much.

HENRY HARBIN, M.D.: Couldn't agree more Gail. And you and I have talked about this before. Unfortunately even some of our fairly standard community-based treatment programs, alternatives to hospitals, that have been out there a while with toolkits, they don't address the reimbursement side. They're not translated to billable codes for third

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party payers of any kind, public or private. And it's just another barrier to get them paid. But we ran into this. We were going to drop a lot – particularly some of the children's services, frankly, are the fuzziest. And payers are not going to pay for it if you can't describe exactly what they're paying for and how to pay for it and so on. So whether it's Medicaid or private insurance, I think there is some work that needs to be done to add that chapter to each of these toolkits. How do you pay for it, and what way should you pay, and what's the easiest way to do it?

RON FINCH, Ed.D.: The PAC services were easy to implement. That's one of the services that we recommended. Therapeutic foster homes were very easy. While not an evidence-based treatment, modality therapeutic nurseries – that's something that's very much in need by our employers to have that service in place.

MICHAEL HOGAN, Ph.D.: Ginger?

GINGER: I just think this is one of the most exciting presentations that I've heard, just really wonderful. I had two questions. One is did you raise in the conversations what Dr. Stotland brought up either in the issue of retribution and/or incentivising the implementation of your plan, either on the payers' side and how to protect against retribution on the workers' side, number one. And number two, just a comment in terms of the issue of the

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workplace studies and the organization of work. I didn't know perhaps if you looked into the field vocationalism, vocationalists [misspelled?] and psychiatric rehabilitation for the re-entry in terms of assistance in that integrated review.

RON FINCH, Ed.D.: Yes we actually have. In terms of organization of working, looking at that, we've actually been in discussions with people at NIOSH and some of our members. Two of our members are now currently doing a study of their own organization's work and actually assessing the healthcare impact on the employees. So we're going to try to follow the lead by one of our employers to continue to do that work.

In terms of one comment that was made, I want to make sure that we address one issue on confidentiality. Confidentiality of healthcare records in major employers is a major issue. It's against the law to violate confidentiality, so I don't know of any of the employers in our membership that are using information in an inappropriate way. In fact they don't have access to that information. If we look at it very carefully, probably most of the major executives in a corporation have had their own coach around mental health. And we should be sponsoring - if we have a physical every year, we should be having a behavioral health check up every year that should be part of that ongoing annual review. And if you know corporations, there are

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executive physicals that are separate and different than others because of the costs of losing a major executive.

MICHAEL HOGAN, Ph.D.: I want to thank the members of the panel and indeed for all of the panelists who are here today for just an extraordinary job. I think the stories that you have told really stand by themselves and make it clear that these remain issues of great significance in this country and that where hope is provided and good care is available, the recovery really is and can be a reality. And it's really wonderful to hear that there are areas where these concerns and the recommendations that we've made are being advanced. And so for all the members of the commission I want to express our appreciation to the Campaign for Mental Health Reform for, first of all, bringing friends together again, which we enjoy as well as appreciate; and second to be able to cast a little light on the challenges that are faced by so many people in our country. This commission completed its work on time and now we'll complete this meeting almost on time. And I thank everybody who has been here for a long and thoroughly engaging day. Thank you very much.

[Applause]

[END RECORDING]