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**The Road Ahead:
Challenges and Opportunities for Behavioral Health Care During the
Implementation of the Affordable Care Act**

Report of the 29th Annual Rosalynn Carter Symposium on Mental Health Policy

Nov. 7 & 8, 2013

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Introduction

Nov. 7, 2013 – Waypost in the Journey to Parity

Even before its passage by a highly divided Congress in 2010, the U.S. Patient Protection and Affordable Care Act had become the biggest domestic political lightning rod in recent history. From its inception in early 2009, the health-reform debate generated always spirited and sometimes hostile exchanges between those favoring an expansion of health coverage and those opposed to it. These two opposing points of view came to a head in October 2013 with the Oct. 1 launch of open enrollment through Healthcare.gov, the federal health exchange website. This launch represented a political focal point, a critical and much-anticipated status check for the law's implementation.

And frankly, the launch did not begin well. Technical issues plagued the website's launch, and for a few weeks in October 2013, Healthcare.gov *was* Obamacare. ACA opponents equated the website failures with the law's overall prospects for success, while the law's supporters insisted the problems were unfortunate but temporary, and that the ACA was only a few coding fixes away from much smoother implementation.

This polarization was the environment that surrounded the 29th Annual Rosalynn Carter Symposium on Mental Health Policy, whose subject was surely one of the most timely in the Symposium's history: "The Road Ahead: Challenges and Opportunities for Behavioral Health Care During the Implementation of the Affordable Care Act." Held Nov. 7-8, 2013, in Atlanta, the Symposium even featured a keynote address by U.S. Secretary of Health and Human Services Kathleen Sebelius, who over the previous month had become the Obama administration's most talked-about member, other than the president himself.

Yet despite the sounds of talking heads and partisan fury swirling around the nation outside, the participants gathered those two days in the Carter Center's Cecil B. Day Chapel largely avoided politics. In their remarks, the ACA was what it was: Somewhere short of perfect, but nonetheless U.S. federal law, now engaged in a 50-pronged, state-by-state process of implementation. Whatever its shortcomings, the clear consensus among Symposium speakers was that the ACA represented the latest and perhaps most significant step forward in U.S. history to bringing health care — and, specifically, *mental* health care — to the greatest number of Americans possible.

“My view is pretty simple,” said speaker Joel Miller, executive director and CEO of the American Mental Health Counselors Association. “The ACA is mental health reform. If anybody’s got a better way of addressing the needs of people with mental illness, I’m all ears.”

Accompanying this optimistic consensus was the frank assessment that much more work remains, both within and without the ACA rubric. After all, the law was expressly designed to deliver health care through the existing U.S. multi-payer insurance model — meaning it by definition only helps those who obtain coverage. Even the most optimistic supporters acknowledge that a significant number of Americans, particularly those battling mental illness, will fall outside this coverage net.

“We’ve been in a battle to get access for people to health care in general and behavioral health services in particular, and we have had two huge breakthroughs in that battle: one is the ACA and the other is parity,” said panelist Joe Parks, MD, chief clinical officer for the Missouri Department of Mental Health. “But a battle is not done when you have a breakthrough. You don’t win the battle unless you develop and exploit the breakthrough. As we roll out the ACA, there’s an ocean of reality [in front of us].”

The health care parity Parks referenced was made possible by the 2008 Wellstone-Domenici Mental Health Parity and Addiction Equity Act. Signed into law by President George W. Bush, the act held out the long-awaited promise of equity in behavioral health care, but without the required rules for implementation and enforcement, in practice it resulted in little more than just that — a promise. That is, until Sebelius took the stage for her Day 2 keynote lecture.

“It’s my pleasure to share some big news with you today: Later this morning, we will post the final parity rule for mental health,” Sebelius announced to an energized crowd. “Now that incredibly important law, combined with the Affordable Care Act, will expand and protect behavioral health benefits for more than 62 million Americans.”

More than 5,000 public comments guided the writing of the final rule, Sebelius said, and her announcement turned the 2013 Symposium into national news. And it completed a three-decade journey she said was largely made possible through the efforts of the Symposium’s namesake, former First Lady Rosalynn Carter.

“There’s no question that Rosalynn Carter has been an incredible leader in the mental health arena for more than a generation,” Sebelius said. “She’s been a leading voice for those with mental illness finding a way forward. Her advocacy on behalf of the [Wellstone-Domenici Act] in particular has made an incredible difference.”

For her part, Mrs. Carter said she was so excited to host Sebelius as a keynote speaker that “I found myself shaking.”

“Every year I think [that Symposium] is the best one, but I don’t think anybody’s going to top this one, not with Kathleen [and her announcement],” the former First Lady said. “This couldn’t have happened at a better time.

“While probably imperfect, the Affordable Care Act is one of the most advanced public policy achievements yet in moving us toward the goal of access to health care for all Americans,” she said. “While there are many unknowns associated with the legislation, it is a significant step forward in the integration of behavioral health care and general medical care.”

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Behavioral Health & the Affordable Care Act – The Strategic Perspective

“When the winds of change blow hard enough, the most trivial objects can become deadly projectiles. The truth is, in behavioral health, we are the wind.”

--Joe Parks, MD, Missouri Department of Mental Health

Just three months before he left office, President Jimmy Carter signed into law the 1980 Mental Health Systems Act, a bipartisan bill intended to improve mental health care through a broad integration of services, greatly expanding the role of the National Institute of Mental Health and the Public Health Service in the provision of care. Proposed by the President’s Commission on Mental Health that Carter had appointed, the act promised to be a great advance for treatment of the mentally ill. But after President Ronald Reagan took office in 1981, the bill was repealed and its funding was redirected to block grants for the states.

So sat federal behavioral health care policy for nearly three decades, save for a 1996 law that set lifetime coverage limits at parity for mental health care for federal employees and their families. Then in 2008, Senators Paul Wellstone of Minnesota and Pete Domenici of New Mexico successfully attached their Mental Health Parity and Addiction Equity Act as a rider to the much larger and more renowned Troubled Assets Relief Program (TARP) bill, and President George W. Bush signed both in October. The Wellstone-Domenici Act required parity between mental health and physical health benefits in those health insurance plans that offered mental health and substance abuse coverage. It did not, however, require health insurance companies to offer mental health/substance use disorder (MH/SUD) benefits in all or even any of their plans. Fifteen months later in the spring of 2010, President Barack Obama signed the Affordable Care Act. Within less than two years, not only had behavioral health coverage been guaranteed at parity with physical health in some U.S. insurance policies, but the federal government had committed to the greatest expansion of coverage since the creation of Medicare and Medicaid in 1966. Indeed, Medicaid would play a key role, as it became the primary vehicle through which the ACA would bring health coverage to lower-income Americans.

“Fifty years of little, tiny steps,” said speaker Howard Goldman, MD, PhD, professor of psychiatry at the University of Maryland School of Medicine. “If you keep a vision in mind and take advantage

strategically of little steps that are afforded you politically, you can make really progressive change. It's an amazingly optimistic thing, in a world where incremental change has a bad name."

Gold Standard of Health Reform: The Triple Aim

In discussing components of the ACA and their implementation, multiple speakers referred back to the "Triple Aim" of health care reform in the United States:

1. Improving the experience of care for individuals
2. Improving the health of populations
3. Decreasing the per capita cost of health care

These three ideas wound through the entire Symposium, usually intertwined with each other in the concepts and practices discussed in speakers' remarks. Many agreed that achieving all three would require significant, sometimes radical, departures from traditional care models, as well as a "move upstream" from individual disease management to population-based preventive health.

"The essence of health reform is this: How do you rebuild a delivery system, engaging professionals who know how to work with patients with multiple chronic health care conditions in a more efficient and effective way?" said speaker Ken Thorpe, PhD, Robert W. Woodruff Professor and Chair of health policy and management in Emory University's Rollins School of Public Health.

According to Thorpe, 80 percent of Medicare spending is linked to patients with five or more chronic diseases, and further, some 80 percent of the growth in Medicare spending over the past 30 years has been due to (often preventable) chronic disease. These two facts speak to the need to both integrate care across delivery channels and to address causes through a population-based public health system. Thorpe had plenty of agreement.

"In much of medicine and public health, there is a greater awareness of the centrality of prevention in population health approaches, but it's something that's been hard to come by in the field of mental health," said panelist Sandro Galea, MD, DrPH, professor and chair of epidemiology in Columbia University's Mailman School of Public Health. "There are 40 public health schools in the country. Fewer than a handful have any real engagement with mental health."

The good news? "ACA really brings prevention to the forefront," said Joel Miller. "It builds on a lot of the recommendations of the Institute of Medicine report on preventing mental, emotional, behavioral disorders among young people. It enables, I think, a new transformation in this area. This is done through a more whole-person, whole-enterprise perspective that focuses on integration."

Mechanisms of Change

So how does the ACA work? Over the course of the Symposium, speakers discussed all of the law's primary components designed to expand and improve health care in the United States, including:

- Medicaid expansion

- Creation of federal and state health insurance exchanges
- Individual and group coverage mandates
- New health insurance requirements and guarantees, including the essential benefits package
- Health care innovation grants

The Medicaid expansion in particular came under frequent focus. It has the opportunity to bring health coverage to an additional 6.6 million Americans living with mental illness, according to the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA). However, with the question of expansion left up to each state, many individuals living with severe and persistent mental illnesses and/or severe addictions will not have access to either an expanded Medicaid benefit based on income or the federal subsidies available to those individuals purchasing insurance through the health insurance exchanges. Many states continue to show declining health and mental health outcomes, and these tend to be those that rely on their public health care systems to deal with indigent care, Thorpe said. Meanwhile some research, like an Urban Institute study cited by Joel Miller, shows that accepting Medicaid expansion would mean a net financial positive for states exactly like these, given the resulting drop in uncompensated care.

“Are we going to be seeing totally different systems, almost like two Americas, in states that don’t expand versus states that expand?” asked moderator Andy Miller, CEO and editor of Georgia Health News.

Other speakers took a longer view. “I’d remind us that not every state agreed to [participate in] Medicaid when it was first launched,” Goldman said. “It’s going to take some time to see how this thing plays out. States have played this silly game before, resisting change.”

Vigilance & (More) Hard Work

All of the political furor only underscores a point many speakers made: Whether ACA implementation is rough or smooth, the work is only just beginning in bringing those living with mental illness the kind of care they need. For one thing, nearly every speaker acknowledged that the ACA is far from perfect.

“People sort of think that we passed this law and now we’re going to get everybody covered,” Thorpe said. “No. We’re still going to have about 30 million people who don’t have health insurance coverage, who are going to have to find alternative avenues and channels to get into the provision of health care.”

Which is why Thorpe and several others stressed that, with so much energy focused on the ACA, the traditional public health care system cannot be forgotten.

“Not everybody is going to be on Medicaid,” said panelist Brian Hepburn, MD, of the Maryland State Mental Hygiene Administration. “When you’re talking about individuals with serious mental illness, we have a tradition of providing a safety net for the uninsured. That’s something, as we move ahead with getting people on entitlements, we don’t want to lose. There will still be a group of individuals who are uninsured and severely mentally ill who are going to need that safety net.”

Others talked about getting closer to the Triple Aim through additional legislation or policy changes. The treatment paradigm for substance abuse, for example, received attention from more than one speaker as integrally related to behavioral health policy.

“We’re going to move to an insurance model for substance abuse. That has not been true in the past,” said moderator Ron Manderscheid, PhD, executive director of the National Association of County Behavioral Health & Developmental Disability Directors. “What we have paid for [regarding substance abuse treatment] is acute care. We haven’t paid for the upstream care that would prevent people from becoming acute.”

“The policy of the United States to criminalize especially addiction disorders has done nothing but drive [up] cost for everybody and has made two, almost three generations of people criminals ... because they couldn’t get access to services,” said panelist Patrick Fleming, MPA, director of the Salt Lake County (Utah) Division of Behavioral Services.

Health Care & the Bottom Line

Several speakers agreed there is growing but still inadequate acknowledgement that behavioral health is inextricably tied to physical health, and this relationship must be reflected in the health care system. If the “first generation” of this awareness was the earliest talk of service integration, and the second generation was the creation of experimental delivery systems such as health homes or accountable care organizations, then it’s the next step that will bring real change and measurable positive outcomes.

“I would argue generation three is full-bore services integration and full-bore financial integration, with very good performance measures for behavioral health,” Manderscheid said. “We have the tragedy of 25 years of premature mortality in behavioral health care. There’s also a tragedy the other way—if you don’t treat behavioral health conditions, the chronic health conditions fester and become much worse.”

“Let’s remember something: [The ACA] is not a ‘gift’ to the mental health and substance use field. We’re not being ‘given’ something just because it’s fair, just because it’s ‘our time,’ or just because there’s a Democratic administration,” said panelist Tom McLellan, CEO of the Treatment Research Institute. “You can’t run the rest of health care if you don’t manage substance use and mental health.”

In the end, many speakers acknowledged that it will likely be successes and appeals related to the Triple Aim’s third target — reducing per capita cost for health care — that will carry the day and result in the most deliberate change.

“Health care in this country is a business — it’s not social policy,” said Pat McManus, PhD, RN, president and CEO of the Black Health Coalition of Wisconsin. “We talk a lot about the policy around it, but that’s why the policy around it is so crazy, because it’s *not* social policy. It’s business.”

“The unfortunate truth about not only Washington but the health care industry is that we have the health care system that we pay for,” Thorpe said. “The way we pay for services has a huge impact on how services are delivered. We [need to] change the way we pay so that we promote integration [and]

whole-person care, [and] we have a system that does not just pay for the amputation for the diabetic, but ... wants to prevent somebody from getting diabetes in the first place.”

Along these lines, there were several success stories related to the capitation model. One has been unfolding for nearly a quarter century in the Salt Lake County Health Department.

“We have been capitated for a very long time, about 25 years. I think we were one of the first systems in the country to go capitated,” Fleming said. “It was a major success. We were able to really eliminate unnecessary hospitalizations. We took those dollars and developed a robust community-based treatment system. The consumers were treated much, much better, families appreciated it a lot more, and it wound up saving a lot of money.”

The ACA has launched a three-year pilot program involving hundreds of providers nationwide who have agreed to move to a bundled-payment model for Medicare services. If it succeeds, as other similar experiments have in the private sector, that would be a huge boost to integrated care.

Still, some speakers reminded the Symposium audience that improvements need not wait on this kind of dramatic shift in the U.S. health care payment model. Even Fleming, who extolled the benefits of capitation in Salt Lake County, wasn’t quite ready to write off the status quo.

“Traditional people think cost-reimbursement models are dead. They’re not,” he said. “Fee for service gets a bad rap.”

“I realize the brave new world is thinking about different ways of financing and getting away from fee-for-service — which I support,” Goldman said. “But we could do a lot better even in a clunky, old, fee-for-service model if we got rid of some of the antiquated roadblocks about how we *bill* for services. A small degree of creativity would go a long way.”

Back to the Future

As Steven Sharfstein, MD, MPA, said in his Symposium-opening keynote, there are many parallels between the Affordable Care Act and the 1980 Mental Health Systems Act signed by President Carter. Sharfstein, president and CEO of the Sheppard Pratt Health System, said both bills emphasized integration of primary care and behavioral health. Both paid special attention to provision of care for underserved and high-priority groups such as the homeless and the severely and persistently mentally ill — “who would have been in state hospitals in a prior era but now live in the community,” Sharfstein said. Both awarded innovation grants for experimental approaches.

“Both acts,” Sharfstein said, “had, at heart, a public health perspective, a population focus.”

And, of course, the last true measure of both acts will be not in their writing or the political wrangling over their passage, but in the effectiveness of their implementation—a lesson learned by mental health supporters all too well after President and Mrs. Carter left office. The 2013 Symposium took place on the cusp of the most politically charged period of ACA implementation—the opening of the public insurance exchanges and the enforcement of the individual mandate—and attendees were well aware

that many of their fellow Americans wanted nothing more than to turn back the clock on the ACA and render it just as toothless as its 33-year-old predecessor.

But retreat was not on the Symposium agenda. Instead, the speakers focused on practical matters over the event's nearly two days. How could ACA supporters ensure that enough people enrolled in health insurance to make the law work financially? How would the ACA bring a greater level of access to mental health care? And how will the law help change the delivery of mental health services to ensure that the best, most individually appropriate care possible reaches the greatest number of people possible?

Sharfstein got things started with a framing discussion of the history of mental health care and federal policy. The remainder of the two-day agenda addressed the kind of questions elaborated above, beginning with a focus on outreach and enrollment and going on to examine access and the actual delivery of services.

Outreach & Enrollment

“We have to change hearts in order to treat minds.”

--Kathleen Sebelius, MPA, U.S. Secretary of Health & Human Services

Because the ACA is built on the U.S. health insurance model, its success absolutely depends on having sufficient numbers of people enrolled to make the system financially viable. Specifically, there must be a population of low-demand health consumers — the “young healthies,” as they have come to be called — sufficient to cover the costs of the higher-demand consumers. Therefore federal health officials, as well as state-level ACA supporters both public and private, devoted tremendous attention to marketing and outreach campaigns to raise awareness of the law. Officials working in mental health knew they had a particularly difficult set of challenges and obstacles to ensure that the people they served were adequately represented among the enrollees.

“When there aren’t targeted efforts to reach people with mental illness or substance use disorders, they don’t enroll at the same rates as persons without those conditions,” said moderator Kevin Malone, analyst in SAMHSA’s Office of Policy, Planning and Innovation. “As mental health policy professionals, this is the space we need to own and we need to understand, something we can work on.”

Stigma regarding mental illness may be on the decline, but it’s still real enough to help discourage mental health consumers from getting the help they need. However some speakers saw enrollment in health coverage under the ACA as another step forward in defeating that very stigma.

“What better way to dramatically reduce the stigma, the discrimination, the outright rejection that keep people from seeking timely needed help than opening up this massive door of coverage?” said Joel Miller.

“Just think for a moment,” Sebelius said, “how different things would be if everyone felt like they could access treatment without the fear of being judged. Imagine what it would mean if people felt as comfortable saying they were going for counseling as they do saying they’re going for their flu shot or physical therapy.”

Trusted Messengers

By far the most-discussed outreach strategy at the Symposium was the need to build coalitions and partnerships, both to attack the problem from multiple angles and also to help the message resonate in local communities.

“We truly believe this is going to need to be an all-hands-on-deck effort, and what that looks like is us partnering with as many types of stakeholders as possible,” said Jessica Kendall, MPH, outreach director for Enroll America, a nonprofit organization founded specifically to sign Americans up for health coverage. “When you put our partners in a room together, they do not necessarily always get along, but they all agree that getting people enrolled into coverage is essential.”

Liz Baxter, MPH, executive director of the Oregon Public Health Institute, said organizations in her state like We Can Do Better and Cover Oregon have adopted much the same approach, and the key is working with trusted local organizations and voices.

“If there’s a phrase I would love to do away with, it’s the notion that there are populations that are hard to reach,” Baxter said. “Folks have natural [places] they go for help. If we can do as much as we can to partner with those natural avenues of access, we will find out that people aren’t as hard to reach as we might think.”

Maryland is well positioned to succeed, according to Brian Hepburn, because of all the work that’s already been done to match people with mental illness to the services for which they are qualified. He said the last five years have seen a 50 percent increase in individuals who receive public mental health services. These existing pathways will make it that much easier to reach people about enrollment in insurance.

“In many ways, the outreach is already there for the serious and persistently mentally ill who are without insurance, because they have been in the public mental health system,” Hepburn said. “Especially over the last 10 to 15 years, there’s been an effort to move those individuals into entitlements.”

And in Wisconsin, Pat McManus, PhD, RN, president and CEO of the Black Health Coalition of Wisconsin, follows a simple rule: *We go where they are*. McManus relayed a story about visiting Milwaukee’s Rescue Mission, a shelter for homeless single men, and enrolling 77 men in about three hours.

“Many of [these men] have nothing that’s consistent for them except inconsistency, so they truly appreciated our spending time talking to them,” McManus said. “People need to know the message and the messenger. Both are extremely important, especially among populations who are more marginalized, who don’t get the information they should get in the first place, who have been frankly victims of the [same] system that now wants to help them. They don’t trust it, they don’t believe it, and they want to hear from somebody who can help them.”

The Message

Given all the furor over “Obamacare,” the fact that audiences are mistrustful of what they hear is not too surprising. So what messages would be most effective in reaching them, and what do they absolutely need to know?

Kendall said her organization keeps it simple. They often field calls from people who simply need help, regardless of whether that help comes from health insurance provided via the ACA, from existing public health services, from traditional Medicare or Medicaid, or from any number of other available services. Therefore they focus on getting people into the health care system through any door available.

“People overwhelmingly want health coverage,” Kendall said. “They want it. They just feel they cannot afford it, or if they can afford it, it’s not a very good coverage option for them. It’s difficult to navigate, it’s overwhelming, it’s expensive, and there’s a lot of fine print.”

Enroll America relies on four key messages to draw people into taking that first step and applying for coverage. They are:

1. All insurance plans have to cover doctor visits, hospitalizations, mental health and substance use disorder services and prescriptions.
2. You might be able to get financial help to pay for a health insurance plan.
3. If you have a pre-existing condition, insurance plans cannot deny you coverage.
4. All insurance plans will have to show costs and what is covered in simple language with no fine print.

“All of the case workers and social workers and folks who are working in health centers and have access to consumers, they need to know these messages,” Kendall said. “If you have people calling your organization and have beautiful music for them to listen to, you can put these messages on your on-hold message: ‘Go to healthcare.gov and apply.’ The key thing is making sure you move that message to your community, to your network, to the folks you work [with] to make sure it reaches consumers.”

Meanwhile, said Michael Barr, MD, MBA, of the 137,000-member American College of Physicians, in the midst of all this positive messaging finding its way to consumers — messages of “better quality at lower costs, healthier people, healthier populations, and happier people, happier clinical teams” — it might be prudent to deliberately share some of that optimism with providers.

“When I talk to physicians, they get a different picture,” said Barr, the organization’s senior vice president in its Division of Medical Practice. “They think of this as lots of very small carrots and big sticks. They don’t want to hear it, they don’t want to see it, and they don’t want to talk about it.”

One Door for Care

Finally, when all the outreach and marketing achieves its objective, comes the time of action: enrollment. And ACA backers have spent considerable effort trying to make the process as smooth and easy as possible, website problems notwithstanding. Many states and private organizations like Enroll

America have worked with Medicare and Medicaid to build enrollment portals not just to health insurance under ACA, but to all public services to which consumers are entitled.

“This is supposed to be a seamless process,” Kendall said. “The vision is that a consumer should be able to go online, pick up the phone or fill out a paper application and have a single, streamlined process where they don’t need to know any of the weedy, wonky, behind-the-scenes details of what happens to their application.”

Likewise, in Maryland there is the Maryland Health Connection: “a single, streamlined application ... used to determine eligibility for Medicaid or for the exchange,” said Hepburn, adding that as of the time of the Symposium, some 82,000 Marylanders were in the system to begin receiving health coverage secondary to the ACA.

“We wanted one door [in Oregon],” Baxter said. “That meant it was one door for people getting commercial coverage or getting Medicaid. It was going to be one door if you were getting that premium subsidy or you weren’t. It would be one door if you were in the individual market or in the smaller employer market. We wanted to have one portal, one door, [and] make it as simple as possible for people to get coverage.”

As David Shern, PhD, CEO of Mental Health America, summarized in his Symposium-closing remarks, the common themes regarding outreach and enrollment were all customer-focused: “Keep it simple, keep it as straightforward as possible, go where the people are, and play on trusted relationships,” said Shern, adding that ACA supporters, health advocates and professionals aren’t the only ones invested in big enrollments.

“We should have strong shared interests with the insurance industry,” Shern said. “[They] are motivated to try to make sure ... they get a good mix in terms of young, healthy people, to make the insurance part of the model work.”

In the end, despite the significant and well-publicized website troubles plaguing both the federal and several state exchanges, several speakers reported that people were indeed signing up for health insurance by the time of the Symposium — and would continue to do so in the months following, as website problems eased and the outreach campaigns continued.

“Even with the problems with the technology, Americans continue to sign up every day, sign up online, on the phone, on paper, and in person,” Sebelius said. “The demand is huge. The interest is huge.”

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Access

“Health insurance coverage ... is the passkey to the delivery system. It’s stable, solid, consistent, affordable, sleep-better-at-night security and protection for you and your loved ones.”

--Joel Miller, American Mental Health Counselors Association

While the Affordable Care Act’s success may depend initially on the number and demographics of the enrollees, its success also clearly depends on providing those enrollees with access to actual health care services. Providing such access involves both the adequacy and comprehensiveness of the services covered and the existence of an appropriate and distributed work force. Still, and more than ever in the wake of the ACA, access to U.S. health care typically starts with insurance coverage, and the new health law “ushers in a golden age for coverage of behavioral health services,” according to Joel Miller.

“The passage of health care reform really was a milestone in the long-standing effort to ensure access for all Americans to appropriate, high-quality behavioral health care,” Miller said. “[Coverage] is the key that opens all the other doors.”

Medicaid expansion alone, Miller said, represents a coverage opportunity for about 6.6 million Americans living with mental illness, and the exchanges could enroll as many as 6.8 million more. Combined with the parity rule, that means the ACA could provide access to behavioral health care for about 13.5 million people who didn’t have it before.

“For the first time, we can not only say that we’re on a path to having the millions of Americans with no health insurance coverage have an opportunity to access that coverage, but that all coverage ... will finally cover mental health and substance abuse services,” said Kathleen Sebelius. “For the 85 percent of Americans who have health coverage, the [ACA] expands access to mental health and substance abuse preventive services ... without any co-pays or out-of-pocket fees.”

Making Parity a Reality

The first step in making sure that an expansion of coverage also means an expansion of access to mental health services is to make good on the promise of parity. Sebelius moved this fight forward with her Symposium announcement of the final rule for implementation of the Wellstone-Domenici Act, and the

ACA will move it further through its mandate for the essential benefits package. The law mandates that every health insurance policy in America must provide the following 10 benefits:

- Mental health and substance use disorder services, including behavioral health treatments
- Preventive and wellness services and chronic disease management
- Ambulatory patient services
- Emergency services
- Hospitalization
- Prescription services
- Maternity and newborn care
- Rehabilitative and habilitative services and devices
- Laboratory services
- Pediatric services, including oral and vision care

However, the regulations for the implementation of the ACA released in 2010 by the Department of Health and Human Services left the details of these benefits up to the states, and few speakers thought this delegation was a good idea. Just as with Medicaid — “If you’ve seen one, you’ve seen one,” Thorpe said — Thorpe said that it all depends on which insurance plan a state picks as its benchmark plan, and many states were picking “vintage plans from the 1950s, 1960s, and 1970s,” rather than more “forward-thinking” policies.

“If there’s a piece [of ACA] I would wish away, it’s that every state would create an essential health benefit,” said Liz Baxter. “I wish we just had one across the country.”

In addition to the potential impact of varying essential benefits state to state, Joe Parks also cited the enforcement problem. “Who is going to look through all these individual state benefit plans and see if they are individually compliant with parity?” he asked.

Treating the Flood of Demand

So what happens when 13.5 million people suddenly get access to behavioral health care (to say nothing of the millions more receiving physical health coverage for the first time)? Panelist Nancy Ridenour, PhD, professor and dean of the University of New Mexico College of Nursing, said she used to have a recurring dream when she worked on Capitol Hill.

“[In my dream] I had opened my clinic, and when they opened the door I was trampled by all the folks running in to get care. I stood up, dusted myself off, and I walked outside, and I looked and looked and looked, but I could never find the end of the line [of patients],” Ridenour recalled. “This is a metaphor for what we’re facing in this country in terms of the [health care] workforce.”

“Stigma continues to drop, which releases pent-up demand. A lot of the recent press coverage in response to mass shootings is more about increasing mental health services than gun control, and that will increase demand,” said Joe Parks. “More and more, mental health services are seen as a solution. Do we have the people to provide that solution?”

Parks provided some sobering numbers, including one study that found that 96 percent of U.S. counties have “some unmet need” in the realm of behavioral health. The same study found that, to serve its current population of about 300 million, the United States is short roughly 30,000 psychiatrists. (“That’s about a whole town of us,” Parks added. “And that would be a weird town.”)

“The psychiatric workforce has been shrinking and will continue to shrink,” he said. “Our service delivery model, and the way we use psychiatrists and the way other services in the system depend on some level of psychiatric involvement, is unsustainable. We’re going to have to change what we do, or radically reduce the amount of services we deliver in our current standard method.”

One idea that received broad support is that of cross-training the behavioral health workforce, particularly as the delivery model moves more toward one of integrated care. There has long been discussion of beefing up the behavioral health training for primary care providers, but what about other people in the system?

“We have a workforce that we are not using to their fullest capacity, and we need to do something about that,” Ridenour said. “Probably even more important than the numbers is [the fact that] we’re not using the workforce we have to its fullest potential. That is a loss of resource that we need to take care of.”

Ridenour provided the example of community health workers in New Mexico, people who have a high level of familiarity and expertise with specific local cultures and can engage the population. She said state health authorities are looking at ways of standardizing training for such roles and providing a certification.

Another example came from Utah, as Patrick Fleming described a new statewide program of school-based mental health and family resource facilitators. Combined with some additional training for classroom teachers, the idea is to help identify kids earlier who could benefit from behavioral health services and get them the help they need.

Peer Support & the Astronaut

One of the better answers to the workforce shortage might be found in the very population to be served. Several speakers preached the virtues of peer counseling as a proven support model.

“There is something about having the lived experience that gives us an understanding when working with people who are new to recovery and [helps us show them] how they can embrace their own personal journey to recovery,” said panelist Peter Ashenden, director of Optum Health Behavioral Solutions and a peer counselor himself.

Ashenden shared the story of John, who for years had moved in and out of one mental health program after another. At each stop, he would tell the support professionals that he wanted to be an astronaut. And every time, the counselor listened patiently before telling John that a career in space simply wasn’t realistic. Before long, John was out of the program and on his own. Then one day he started a peer-counseling program, and on cue he shared his dream of being an astronaut.

“This time the reaction was, ‘That’s something we can certainly take a look at,’” Ashenden recalled. “‘Why don’t we compose a letter together and write to NASA and see what the requirements are.’”

A few weeks later, John received a thick packet from NASA that detailed all the training and education necessary to become an astronaut. Once he saw this information, straight from the agency that sends people into space, John rethought his ambition, and his peer counselor was able to find that what interested John was being around things that could fly. Today, with the help of that program, John is a tax-paying citizen working at his regional airport.

“He is as happy as can be,” Ashenden said. “That’s the difference in how those of us with the lived experience can approach individuals.”

“The reality is our providers are getting much better outcomes [when they incorporate peer support],” said moderator Arthur Evans, PhD, commissioner of the Philadelphia Department of Behavioral Health and Intellectual Disability Services. “Whether we have randomized control studies or not, we have a lot of evidence that when we incorporate peers into our service system, it makes a huge difference in quality outcomes.”

Going back to the bottom line, Parks pointed out that peer specialists working in collaboration with other bachelor’s-level personnel and backed up by a licensed clinician result in much lower cost interactions than a nursing model. As far as any perceived lack of scientific evidence for peer support, Parks cut to the chase in characteristic fashion. “This isn’t peer-reviewed research,” he said. “This is health care operations.”

“I leave you with a significant challenge: to truly integrate peer support into all service delivery,” Ashenden said. “I am a person who lives with challenges of both diabetes and mental health condition, and my body reacts when either one flares up. In my life, peer support services are an integral part of my recovery.”

Service Delivery

“To our providers, we said: ‘You need to focus on outcome-based services, and you don’t need to worry about cranking out enough patient encounters just to get payment. That’s not what it’s all about.’”

--Patrick Fleming, MPA, Salt Lake County Division of Behavioral Services

The problem with overhauling a health care system is that people, unfortunately, don’t stop getting sick or hurt while you’re doing it. Every day across the country, doctors, nurses, lab techs, pharmacists, physician assistants, certified practitioners, counselors, therapists, and everyone else in the health care system works long hours to care for the patients they have right in front of them.

However, as many speakers discussed, there remain major changes to be made in how the United States delivers health care to its citizens if the Triple Aim is ever to be approached, much less met. And these changes touch every aspect of the system, from the most basic and structural to point-of-service details like the nature of patient-caregiver interactions. The prominent metaphor of the Symposium to describe these changes was one of “moving upstream”: focusing much more attention and resources on wellness and preventive care, and providing a wider scope of health evaluation at this earlier point in the continuum of health and illness.

“We must not let the urgent crowd out the important,” said Sandro Galea. “Urgent is my illness. Urgent is my depression. Urgent is my fracture, my heart attack. It is important, beyond the urgent, to think about populations and potentially think about prevention.”

Populations and Integrated Care

Galea spent much of his panel presentation making the quantitative case for population-based approaches to mental health care, walking his audience through a primer in basic statistics to prove that, no matter how hard it looks, the current, individualized model will always miss significant numbers of people with disease. However, by moving upstream and focusing on proven root causes and the earliest indicators of mental health issues, we can reduce the number of people who need acute care—and, subsequently, redirect resources to identify a higher percentage of those who eventually do.

“The positive about recognizing that social, physical drivers [of mental illness] have a place is that many of them are malleable,” Galea said. “If you accept that social isolation is one of the biggest drivers of

depression in this country today — which it is — [be encouraged that] social isolation is malleable. When was the last time we've heard anybody within the health industry talk about social isolation interventions? We don't do that. We should."

Another broad approach is simply to expand the points of care for mental health, including everything from training primary care providers in evaluative techniques and expanding their prescriptive scope, to expanding the mental health workforce into nontraditional settings, to going further with proven models for integrated care.

"We're going to have to find some interesting and unique ways to deploy the mental health workforce to get the job done," said Joel Miller. "[We'll need to deploy] the mental health workforce in rural areas and inner cities and across the United States and a lot of pockets where [that workforce] simply does not exist. The good news is there are a whole slew of delivery-reform provisions in the ACA."

Some of those provisions will reward states for moving to integrated care models such as health homes and accountable care organizations, as well as to alternate payment systems such as capitation. Indeed, the ACA uses payment policy to nudge states toward integrated care.

"Medical homes, medical neighbors, health homes, whatever you choose to call them, they're the foundation," said Michael Barr. "Without well-designed primary care, you can't have all these accountable care models. It just doesn't work."

"The real answer is in integration and co-location. Patients prefer location; they don't say, 'Oh goodie, I want to go to as many locations as possible and answer the same questions as many times as possible,'" said Joe Parks. "[Co-location of services] builds relationships between the health care providers, and that's the way we all get stuff done. I'm [more likely] to take a referral ... if I know I'm going to run into you at the coffee pot later that day."

As mentioned earlier, the ACA also promises financial support to test new approaches through its Investing in Innovation Fund. However a few speakers expressed impatience at the prospect of long, even perpetual experimentation if it comes at the expense of proven solutions that can be implemented now.

"The [ACA] put a lot of money into doing pilots. We have thousands of pilots, and it will take five, 10 years to figure out what the results are from the pilots and whether they worked or didn't work, and whether they're even sustainable," said Ken Thorpe. "We know how to engage and work with patients who have multiple chronic health care conditions, doing transitional care, health coaching, medication therapy management, health literacy. We know these things work. We need to implement them. We are not one pilot away from a miracle."

Of Metrics and Measurement

One task that will be critical, whether the care model is an experiment or a decades-old practice, is the collection and evaluation of effective data. Discussion of what data to gather, how to gather it, and what to do with it once it's been gathered made its way into nearly every Symposium session.

“Data management is going to be very, very important for us to be successful with ACA,” said Nancy Ridenour. “We need to figure out how we can have systems that can give us the data we need, and we need folks who can help us interpret the data we already have.”

When it comes to mental health, what are the proper metrics? Which data should be reported by health providers, which by insurance companies through claims data, and which by the patients themselves? If the move toward integrated care is ever to take a firm, irreversible hold, the health care industry will have to define the right metrics to recognize and reward the proper outcomes.

“What is an episode of care?” asked Patrick Fleming. “What are some of the desired outcomes? In behavioral health, we’re a little behind the curve on that.”

“There is a thirst for measures that really reflect higher levels of performance, optimal performance. We want to move away from measures that are so silo-based,” said Helen Burstin, MD, MPH, senior vice president for performance measurement of the National Quality Forum. “If you really thought in a more patient-centered way ... you would move toward more outcome measures, including patient-reported outcomes.”

Just as, in an ideal world, health care providers would integrate and collaborate in clinical endeavors, so would they work together in defining the appropriate measures of care and gathering the data, Burstin said, stressing the need for composite metrics. And more than one speaker shared her support of letting patients help define the right outcomes, at least to some degree — particularly since patients have a way of cutting through scientific or bureaucratic confusion and zeroing in on what’s really important.

“The outcomes I’m hearing from people are they want things like an education,” said Peter Ashenden. “They want a job. They want to have some money in their pocket. Finally, they want a date on Saturday night. Is that really very different than anybody else who’s sitting in this room?”

Role of Technology

In the year 2013, when the discussion turns to metrics, it must also address technology, and there was no shortage of speakers who mentioned the vital role that advances such as high-performance computing and “Big Data” analytic capabilities will play in the health care system of the future. Electronic health records (EHRs), of course, were mentioned most often. Miller said EHRs are key to any functioning, productive, integrated measurement system, and he was not alone.

“If you don’t have a good electronic health record ... you better get one now,” Fleming said. “Or you’re never going to be able to move toward [payment based on] case rates or capitation. You must [get an EHR system]. It’s just the most important thing in the world.”

“I know there are concerns about privacy and confidentiality [concerning EHRs],” Miller said, “but that train has already left the station. We should get on it and [figure out] how we can manage that part of the process.”

At the time of the Symposium, privacy and technology were indeed in the news as debate raged nationwide about the appropriate limits of electronic government surveillance. However, just as analytics on a massive scale can have frightening implications, so can it promise hope — especially in a more population-focused health care system.

“I’m excited about the opportunity that Big Data now offers for the health system, and I’m talking at a system level,” Ridenour said. “We now have the computational power to really make a difference with data to change how we operate.”

Ridenour also spoke of promising technologies such as telehealth systems, which allow clinicians to consult with patients remotely and hold particular benefits for rural areas where caregivers can be separated from their patient populations by dozens, even hundreds of miles in all directions. Finally, she said, patients themselves will help drive the health care system toward new technologies, as they become more and more comfortable themselves with platforms that allow them to take more active roles in their own care.

“They are very interested in technology,” Ridenour said. “Many of them are loading their physiology and health records on the web [themselves] now. So we need to take advantage of where our population’s going with technology and use that to help in the health care system.”

Conclusion

At the time of this writing, health insurance enrollment under the ACA had recovered from its slow start. Problems plaguing the federal Healthcare.gov website had mostly been resolved, although some state exchanges still struggled with technical issues. By the end of March 2014, more than 6 million Americans had enrolled for health insurance through a federal or state exchange, and millions more received coverage through state Medicaid expansions.

Debate over the law still raged, particularly as the November 2014 midterm elections loomed ahead, but as they climbed into the several millions, enrollments under the health law seemed to shift the discussion points. Millions of Americans were receiving health coverage — often for the first time. Gradually the talk of returning to a pre-Obamacare status quo faded into the background, and the political back-and-forth — while still acrimonious and even bitterly so — absorbed the health coverage status of these millions as a given.

All the implementation challenges and opportunities discussed just a few months earlier at The Carter Center remained. The ACA represented at once the most exciting opportunity to expand mental health coverage in memory — the result of a hard-fought, decades-long advocacy effort across the public and private sectors — and a national steam whistle, letting the nation's mental health work force know that the hard work had just begun. No doubt some of that work will figure in the agendas of future Symposiums.

“There are so many challenges ahead,” Rosalynn Carter said in her concluding remarks. “Our Symposiums are always good because we’re with people, everybody working for the same thing. It’s so exciting to do.”

“Ray Charles famously sang about ‘Georgia on My Mind,’” Kathleen Sebelius said. “For nearly three decades, this Symposium here at The Carter Center has been Georgia *for* the mind.”

Keynote 1

Steve Sharfstein

“One of the big battles today, as reflected [not only] in Washington but all across the country, is: What is the appropriate role of government, and what is the appropriate role of federal government?”

In 1832, Dorothea Dix was teaching Sunday school to inmates of the Cambridge city jail, some of whom were incarcerated for the “crime” of mental illness. Massachusetts was in the midst of a typical New England winter, and the jail was somewhat short in creature comforts like heat. When Dix complained to the jailer, she received a curt reply. “Madam,” said he, “the insane require no heat.”

Steve Sharfstein, MD, MPA, president and CEO of the Sheppard Pratt Health System, opened his Day 1 keynote address with this anecdote, a fitting introduction to the history Sharfstein related of the U.S. federal government’s history of involvement (or lack thereof) in the care and treatment of those struggling with mental health disorders.

“They were called insane [in Dix’s time],” Sharfstein said. “They were in jails, in alms houses, poorhouses, attics, basements. They were homeless. This offended Dorothea Dix right down to her Christian core, and she decided to devote her entire life to becoming a champion on behalf of the insane. [Dix became] the most successful single citizen reformer in the history of this country, [contributing to] the establishment of some 32 asylums in 18 states (asylums were not a bad word in those days; [they were] humane, small institutions for the mentally ill).”

Dix also helped give rise to the act that Sharfstein said “set the policy for the next 100 years” when it came to Washington and mental health. Her advocacy led to the passage of the 1852 Bill for the Benefit of the Indigent Insane, which Sharfstein said was also called the “12.5 Million Acres Act.”

The bill called for the provision of federal land grants to states for the purpose of building asylums for the mentally ill, but it was vetoed by President Franklin Pierce on the grounds that he could find no constitutional authority to make “the federal government the great almoner of public charity throughout the United States,” according to Sharfstein.

It wasn’t until President Dwight Eisenhower signed into law the Social Security Disability Insurance program in 1956 that the tide began to shift. Eisenhower also established the Commission on Mental

Health and Illness, which Sharfstein said was the first major federal commission appointed on the subject.

“[Eisenhower also] was very involved in expanding the mission of the National Institute of Mental Health (NIMH) that had been established a few years before,” Sharfstein said. “He was very concerned about the issue of mental illness because of his experience in World War II and how that changed views about the importance to the nation of acute mental illness.”

Some years later, President John F. Kennedy signed the 1963 Mental Retardation and Community Mental Health Centers Construction Act, which Sharfstein said marked the beginning of a “radical, different idea” of a national network of mental health centers created with federal support but with the goal of becoming self-sustaining. This dream was partially realized under President Lyndon Johnson, who of course also signed Medicare and Medicaid into law.

President Richard Nixon, however, made “a number of efforts” to defund the centers, including a proposed reorganization of NIMH, Sharfstein said. Nearly ten years later, history would repeat itself when President Ronald Reagan moved to effectively repeal the 1980 Mental Health Systems Act signed by President Jimmy Carter.

“Elections matter,” Sharfstein said. “I have wondered over the years how much time we’ve lost, how much opportunity we’ve lost to provide quality care and treatment for those with mental illness because of the repeal of the Mental Health Systems Act. Franklin Pierce is absolutely the intellectual progenitor of Ronald Reagan and his views about the role of the federal government. This battle continues today.”

Keynote 2

Kathleen Sebelius

“As Martin Luther King Jr. used to say, ‘It’s important to preach to the choir. Otherwise they might stop singing.’”

“I’m not alone in this room who would say that [mental health advocacy] is personal,” Kathleen Sebelius told the Symposium audience, “In the last six months, I’ve had two of my family members experience crises, and both of them were eventually able to receive help and support because they had resources and families and friends to turn to. But in either case, it wasn’t easy, and the handoff from crisis and stabilization to community support was lucky at best. So I know, having walked through that experience myself, how difficult this is for way too many families.”

As the U.S. Secretary for Health and Human Services, of course, Sebelius was much more than personally invested in the ACA’s success when she delivered her Day 2 keynote. She was the public face of the Healthcare.gov launch and the ACA’s first open enrollment period, and neither had begun well. Sebelius acknowledged the difficulties but kept a distinctly positive tone in her remarks, especially praising all The Carter Center’s and Mrs. Carter’s work over the last three decades while looking ahead to all the changes made possible by the ACA.

“We’re at a unique moment in history,” said Sebelius, whose father John Gilligan served as director of the U.S. Agency for International Development under President Jimmy Carter. “As Rosalynn Carter has spoken about so eloquently, the things we’re on the verge of achieving today are things we didn’t even dare to dream about a generation ago.”

Sebelius’ audience no doubt expected her to run through a litany of advances in health care under ACA, and she obliged them. They probably did not expect the secretary to honor the Symposium by using it as her venue to making national news by announcing the final rule for implementation of the 2008 Wellstone-Domenici Parity Act. The rule, she said, would require insurance companies to provide:

- Comparable clinical standards and cost considerations for physical and mental health benefits;
- Information on claims evaluation, especially when claims are denied;
- Information on the decision processes that determine medical necessity, and provide an appeal avenue; and
- Parity at intermediate levels of care (“Somewhere between hospital care and a visit to the doctor’s office,” she said).

However, even in advance of the final parity rule, Sebelius said significant progress had been made since the 2008 act was made law. In addition to the rule, that day her department released a study that showed most large health plans had already eliminated high cost sharing for both inpatient and outpatient behavioral health care, as well as different deductibles for mental health and substance abuse treatment. The study, she said, also showed “a significant decline in restrictive day limits on inpatient care, and outpatient limits have largely been eliminated.”

“Nine in 10 Americans with substance abuse disorders don’t receive the care they need,” Sebelius said. “Sixty percent of Americans with a mental health condition don’t receive the care they need. There’s no question we need to expand access to treatment, services, and support.”

Sebelius also talked about mental health priorities beyond ACA, specifically mentioning President Barack Obama’s \$100 million BRAIN (Brain Research through Advancing Innovative Neurotechnologies) Initiative to study and map the human brain. Such work, she said, was fueling “previously unimagined advances in the way we treat mental illness.”

“We as a country and perhaps as a world need to understand that our understanding of one another has to get a lot better,” Sebelius said. “We need to move past the idea that when we talk about mental health, we’re talking about somebody else. It’s not somebody else. It’s all of us.”

Resources

A selection of organizations, websites, and other materials cited during the 2013 Rosalynn Carter Symposium on Mental Health Policy

Federal Resources

- “National Strategy for Suicide Prevention: Goals and Objectives for Action,” U.S. Surgeon General report, 2014 (<http://www.surgeongeneral.gov/library/reports/national-strategy-suicide-prevention/index.html>)
- Centers for Medicare & Medicaid Services (CMS) (www.cms.gov)
- Healthcare.gov (<https://www.healthcare.gov/>)
- National Institute on Alcohol Abuse & Alcoholism (<http://www.niaaa.nih.gov/>)
- Substance Abuse & Mental Health Services Administration (SAMHSA) (www.samhsa.gov)
 - SAMHSA SSI/SSDI Outreach, Access, and Recovery Technical Assistance (SOAR TA) Center (<http://www.prainc.com/soar/>)

State/Local Resources

- BadgerCare, Wisconsin Department of Health Services (<https://www.dhs.wisconsin.gov/badgercareplus>)
- Central City Concern (Portland, Ore.) (<http://www.centralcityconcern.org/>)
- Cover Oregon (www.coveroregon.com)
- Health Care for the Homeless (Baltimore, Md.) (<http://hchmd.org/>)
- Maryland Health Connection (www.marylandhealthconnection.gov)
- Maryland Parity Project (mhamd.org)
- Milwaukee Rescue Mission (www.milmission.org)
- Oregon Healthy Kids (<http://www.oregonhealthykids.gov/>)
- Oregon Public Health Institute (www.ophi.org)

Professional Associations

- American Psychiatric Association (<http://www.psych.org/>)
- American Psychiatric Nurses Association (APNA) (<http://www.apna.org>)
- American Psychological Association (<http://www.apa.org/>)
- American Public Health Association (<http://www.apha.org/>)
- Association for Addiction Professionals (NAADAC) (<http://www.naadac.org>)
- International Association of Peer Supporters (<https://na4ps.wordpress.com/welcome/>)
- National Association of Medicaid Directors (NAMD) (<http://medicaiddirectors.org>)
- National Association of Peer Specialists (NAPS) (<https://www.peersupportworks.org/>)
- National Association of State Mental Health Program Directors (NASMHPD) (<http://nasmhpd.org>)

Advocacy Organizations

- Council on Social Work Education (CSWE) (<http://www.cswe.org>)
- Enroll America (www.enrollamerica.org)
- Faces and Voices of Recovery (<http://facesandvoicesofrecovery.org/>)
- Get Covered America (www.getcoveredamerica.org)
 - Action toolkits: <http://www.getcoveredamerica.org/action-center/toolkits/>
- Mental Health America (www.mentalhealthamerica.net)
- National Action Alliance for Suicide Prevention (<http://actionallianceforsuicideprevention.org/>)
- National Alliance on Mental Illness (NAMI) (www.nami.org)
- National eHealth Collaborative (<https://www.himss.org/>)
- National Federation of Families for Children’s Mental Health (<http://ffcmh.org/>)
- Partnership to Fight Chronic Disease (<http://www.fightchronicdisease.org/>)
- Pillars of Peer Support (<http://pillarsofpeersupport.org/>)
- Project ECHO (Extension for Community Healthcare Outcomes), University of New Mexico (<http://echo.unm.edu/>)
- We Can Do Better (www.wecandobetter.org)