Mark Masselli: This is Conversations on Health Care. I am Mark Masselli.

Margaret Flinter: I am Margaret Flinter.

Mark Masselli: Margaret, we mentioned California last week in our introduction because the California legislature is getting ready to pass as many as 20 bills having to do with Health Care Reform. One of those bills that passed last week was a key component of Health Care Reform, the federally funded State Health Insurance Exchange that will help individuals by affordable insurance and approving this bill, as California did last week, allows the state to receive federal dollars to create the exchange. I think that makes them the second exchange in the country. It also leverages for the state the ability to negotiate the best rates for its residents.

Margaret Flinter: And hopefully, other states will be following soon and Massachusetts, of course, was the first state to create an exchange when it enacted Health Reform in 2006. Jon Kingsdale heads the Massachusetts Health Connector and he has been a guest on Conversations. He has testified on the experience in Massachusetts saying that it really took four years to establish the program and that it was a good thing to begin that process early. As California has demonstrated by passing Reform Bills, it's committed to health care. And even though the exchanges won't be fully operational till 2014, Governor Schwarzenegger has made it clear he wanted the exchange created before he leaves office in January. Mark, did you see there is also a new poll from the AP showing Californians generally more supportive of health law than the rest of the country, 52%?

Mark Masselli: Very impressive. Arnold always delivers. Well, speaking of trying to win support for the Reform Bill, the administration has announced a huge campaign to sell Health Reform overhaul to American people. The Health Information Center will invest $25 million a year into this effort and it's expected to be co-chaired by two big names, former Senate Majority Leader Tom Daschle and former Senator Kennedy's wife Victoria Kennedy. The Center will explain the intricacies of the new law and a separate health information campaign will work the political side.

Margaret Flinter: Well, they are great choice. They are both excellent communicators, but there is no better communicator than the President himself and President Obama made his own sale speech this week in a televised town hall meeting with senior citizens where he took questions from seniors all over the United States who wanted to address their concerns about Medicare and Health Reform Legislation. This is just the first of many events like this to come.

Mark Masselli: Going back to California and health care, our guest today has been redesigning behavioral health within the UCLA School Mental Health

Project and its federally supported National Center for Mental Health in Schools, Dr. Howard Adelman is co-director for this reform initiative that addresses behavioral health through a comprehensive approach involving both schools and community.

Margaret Flinter: And no matter what the story, you can hear all of our shows on our website Chcradio.com. Subscribe to iTunes to get the show regularly downloaded. Or if you'd like to hang on to our every word and read a transcript of one of our shows, come visit us at Chcradio.com.

Mark Masselli: And as always, if you have feedback, email us at Chcradio.com, we would love to hear from you. Before we speak with Dr. Adelman, let's check in with our producer Loren Bonner with Headline News.

Loren Bonner: I am Loren Bonner with this week's Headline News. President Obama is back on track selling Health Care Reform. This time it's the seniors who have been one of the most skeptical groups of his Reform Legislation. In a televised town hall meeting on Tuesday, the President touted the new law's benefits at a senior center in Wheaton, Maryland. He also took call-ins from seniors around the country. More than 100 events in 26 states were organized to participate in the event. Although new benefits to seniors like the $250 rebate checks to help Medicare beneficiaries pay for prescription drugs was discussed, the bigger question on seniors' minds was if their Medicare benefits would stay the same.

President Barrack Obama: First and foremost, what you need to know is that be guaranteed Medicare benefits that you have earned will not change, regardless of whether you receive them through Medicare or Medicare Advantage. Your guaranteed benefits will not change. Eligibility won't change. Medicare will continue to cover your costs the way it always has. If you like your doctor, you can keep your doctor. In fact, we are keeping taking steps to increase the number of primary care physicians so that seniors get the care that they need.

Loren Bonner: The President was joined by Health Secretary Kathleen Sebelius who has been on the road talking reform to seniors for almost a week now. But she hasn't lapsed on her strong stands to rein premium increases by the industry, particularly for Medicare Advantage providers. The health overhaul's payment cuts to Medicare Advantage providers will help pay for an extension of health insurance to more than 30 million Americans. The insurance industry, which estimates that payment cuts from the health overhaul, will total approximately $200 billion over a decade, says they can absorb those cuts on its own and must pass them on to consumers starting next year. In the town hall meeting, the President reassured seniors of the administration's authority to control this.

President Barack Obama: This law also gives us the power to see to it that insurance companies don't raise your rates just to pay other price. Last week,

Secretary Sebelius reminded insurance companies that we have got the authority to review and reject on reasonable rate increases for Medicare Advantage plans and she put them on notice that we will exercise that authority.

Loren Bonner: The Obama Administration is making every effort to defend Health Reform against critics in the first phase of implementation and as provisions begin to kick in this year, this is the first of many high-profile Health Reform events that President will be doing heading into the November election. He will keep on doing them as long as he is President since some of the biggest provisions don't kick in until 2014.

This week on Conversations on Health Care, we are exploring behavioral health in children and adolescents. Mental health problems for kids have been labeled a major chronic illness in childhood. About 20% of children are believed to have some form of behavioral mental illness but fewer than one in five receive treatment, partially due to the lack of available therapists, counselors, and child psychiatrists. In most cases, parents take their children to a pediatrician when faced with their behavioral health issue, but it's a major challenge for mainstream providers like pediatricians to diagnose and treat the problem. Mike Hogan is the Commissioner of Mental Health in New York.

Michael Hogan: The challenge of having mainstream people that children see all the time come back again to teachers and to pediatricians to be able to figure out if there is a problem or not. Pediatricians, for example, are reimbursed for really just a couple of minutes to see each child. And so, the amount of time it's going to take for a pediatrician or somebody in their office to go through a questionnaire with parents, for example, to figure out if this problem with paying attention really is attention deficit disorder or whether it's just a normal or a passing thing, it takes a long time, it may take half an hour to really get a careful history to enable a reliable diagnosis, and pediatricians are likely to not get reimbursed for that time.

Loren Bonner: Hogan says you run into additional barriers after diagnosis, this can include problems finding a professional and then having to deal with whether the care will be covered by insurance. The New York State Department of Mental Health is trying to provide more support to these frontline health care providers who see mental health cases most frequently. The department is planning on collaborating with pediatricians and family practice doctors across the state to provide them with training on how to identify and treat these conditions. At the same time, it will make sure these consultations are readily available with child psychiatrist over the phone or through video right there in the doctor's office. Telepsychiatry, a form or telemedicine, has been used over many years to help patients who have difficulty accessing a mental health provider. Although it's been effective and the department has been involved in a telepsychiatry initiative to address consultation needs, Hogan says it's hard to bring the technology into every pediatrician's office.

Michael Hogan: It hasn't been as flexible as just picking up the phone has been. So, we keep trying different things to get at the problem and we think that the combination of the training and the telephone consultation with the ability to do the video consultation as a backup, maybe if we put all these things together, we will make **it then**.

Loren Bonner: Let's turn out to our interview with Dr. Howard Adelman who can tell us more about addressing behavioral health more effectively through an approach that involves both the community and the school.

Mark Masselli: This is Conversation on Health Care. Today, we are speaking with Dr. Howard Adelman, a national leader, who has been bringing behavioral health to schools and the Co-Director of the School Mental Health Project at UCLA and its federally supported National Center for Mental Health in Schools. Welcome, Dr. Adelman. Your work is focused in on helping children and adolescents succeed and you do this by helping communities and schools develop mental health and behavioral health services for kids right in the schools, thus eliminating all the barriers and delays that young people often face when they need help. What was the inspiration for you? What convinced you that this was a critical step and that it would work?

Dr. Howard Adelman: Well, I started as a teacher and I really became concerned very early with the number of kids who just weren't doing well at school and often not only manifesting learning problems but related behavior and then emotional related problems. And it became quite clear that you didn't just place the _____ 10:54 of all this on the youngsters that they were coming from different backgrounds and different economic structures and different families and were having different types of interactions at school. So we really started to look at and say there is a wide range of barriers here that need to be looked at and that got us down to the business of saying well, who is in the business of trying to deal with some of this, and of course, that means schools and the surrounding communities.

Margaret Flinter: So Dr. Adelman, as you built and refined the model, I would like to talk a little more about those barriers. I think one is likely to encounter policy barriers and also what we could call the "bias barriers", perhaps the unwillingness of schools, or teachers, parents, school boards, even insurers to be willing to accept or to support behavioral health services being delivered in the school setting, not necessarily by the school personnel. Can you tell us the kinds of barriers that you have faced and particularly barriers that you see to more widespread implementation of the model, because the model hasn't caught on so extensively throughout the country?

Dr. Howard Adelman: Well, we all talk about two sets of barriers here. The first step that we are talking about are really the things that given the way kids interfere with kids being successful and so on. You have now raised the second

set of barriers and those are really system barriers, what do you need to do if you really have some different ways of working and need to have major institutions shift a little bit to deal with it. And we have, over the years, really looked at this in terms of a very broad prototype – we don't really talk about models because we find when people work with schools, they don't respond well to the idea that you come in with some model. What we have really focused on are sort of blueprints of prototype framework that can be adapted by schools and schools in working with communities. We are identifying an underlying barrier and it is all related to the policy, that what we see as we try to work with schools a lot of fragmented pieces going on, somebody gets an idea or somebody passes a piece of legislation for a specific type of approach. It all ends up playing out in the school and school working with the community in a terribly fragmented way and people have gotten on to that for some time and they started to talking about well we have got to coordinate things better. And as we studied this and started to really understand the underlying problem, we saw that it really was a matter that almost everything we were talking about and concerned about in terms of helping kids was marginalized in terms of school improvement policy.

Mark Masselli: You know Dr. Adelman, your approach to this blueprint to mental health in the schools calls for a continuum of interventions and resources both from the school and the community, as well as the development of strong partnerships with community-based mental health providers. But many of those organizations are already facing long waiting list. They are struggling financially. What's the advantage for these organizations to refocus and deploy clinical staff in the school settings and are there efficiencies or advantages to placing their staff in the schools versus the community offices?

Dr. Howard Adelman: Well, obviously it's a very big and important question. We need to break it apart a bit. The first issue is that when we are talking about a full continuum of interventions, you are no longer just talking about deep and clinical services. And one of the things we work with community providers and other community resources with is understanding that they have a role to play in the whole continuum which starts with the promotion of healthy development which moves on into real primary preventive type strategies, then moves on down to the issue of what you do and how you set things up, so that at the first time, if somebody is having trouble, you have interventions that can move in, and then finally, move down to sort of the systems of care level where you have kids who have chronic _____ 15:02 severe problems. Now, if you think of the whole continuum, then what we are saying to agencies, for example, is that you will never have enough resources, and particularly now we know they just keep contracting, but you will never have enough resources in order to really deal with everything as a clinical problem nor should you because in the schools, we work with which of course are big urban centers and pro-rural school, we are finding that there are up to over 50% of the kids who are not doing well. Well, you can't treat all 50% on a one-by-one clinical model, there are just not enough resources to do it. So we really have to work with both ideas, one how do we come in and

do things on the more universal level and the more targeted level, and then finally, having reduced the number, reduced the flow of referrals than having more resources to work with those one by one. The other thing we work with is trying to get schools to really understand that they need to redeploy their resources in a way and then work more systematically with the community to bring in resources in ways that help fill critical gaps and not just expect every agency to be able to help every school with clinical services.

Margaret Flinter: Dr. Adelman, we share with you a passion for eliminating any barriers or delays for kids and their families getting mental health services when they need it. And in our community health center, we have implemented behavioral health programs in school settings and several communities in Connecticut. One of the most striking outcomes we have seen, and we have only been able to measure this in one community where we provide a full-time behaviorist in every school, is a sustained reduction in the number of kids who present to the ER with psychiatric emergencies since the program began. So we would hope that that indicates some success with more upstream early interventions, but we would be very interested in hearing about the results of any outcome studies or evaluations that might provide insight into the effectiveness of the services that you have developed and tell us what we can learn from that.

Dr. Howard Adelman: Well, if we think about this as a full range of program, sort of the continuum of interventions, we have not been just zeroing in on what we can do one on one. And so that we don't want to just use the service language, we really want to talk about what are we doing today in relation to schools in terms of reducing the number of kids who don't show up, that the absentee rate is a very important figuring and what we see very early in the game when schools start to work with this is an improvement in their overall attendance rates. And that's a very good thing for schools because of course their funding is based so much upon who shows up and who doesn't show up. Second thing we focus on is in terms of the number of inappropriate referrals that go on the schools that have now finally faced up to the fact that they have been contributing to a great deal of misdiagnoses around learning disabilities and ADHD and that as they function in a different way, they start seeing fewer and fewer of these kids inappropriately diagnosed and sent for specialized services which of course then frees up people to really work with kids who have those two problems.

Mark Masselli: Today, we are speaking with Howard Adelman, Co-Director of the School Mental Health Project. Dr. Adelman, we have talked about health care workforce issues with many of our guests, but we are usually talking about primary care providers, physicians and nurses. But we are equally concerned about training the next generation of behavioral health providers and training them to the model like School Health Services, can you tell us about your efforts or those at the Center for Mental Health in Schools to train the next generation across the country and to prepare them for the school settings?

Dr. Howard Adelman: Well, we do a tremendous amount through our center to try to really create initiatives and work with the organizations that are responsible for the ongoing professional development and now we have been trying to reach back to universities and colleges who prepare professionals for various roles. And in each case, the emphasis is first and foremost on making sure that they understand a different approach to this whole thing so they don't just come with a straight service-oriented model and start understanding their role has to be for the whole continuum. And then secondly, we are working with them to provide the type of tools that will help them do the work and we keep developing a wide range of tools, a major toolkit on our side and so on so that people will do that. In addition, we now have several initiatives working with other collaborative. So scholastic _____ 19:46 reached out to us and we are collaborating with them on some major work in Louisiana and then four major districts around the country and some of that's in conjunction with the American Association of School Administrators. So on each case, we are talking about leadership development, leadership initiative, developing some online courses related to all of that, and we are starting to see people really tuning in a lot better. It's going to take a long time before we change the nature of how people are trained, but it's starting to happen.

Margaret Flinter: Very exciting. Dr. Adelman, the Federal Health Reform Bill, that we passed a few months ago, provided for development and expansion of school-based clinics but it didn't address behavioral health services in schools specifically, I don't think. And in fact, my assessment is behavioral health services didn't get nearly as much attention as medical care. Were there specific elements that you and your colleagues were advocating for to be included in that legislation?

Dr. Howard Adelman: Well, some other complication there was that Congress was focused on the parity issues in general and I think they got distracted and they will need to, in future, nipping and tucking and tinkering with the health law start to face up to some of these issues. They have not paid enough attention from our standpoint to schools as a major concern in this whole process. CDC has. They have a whole coordinated school health process which includes the concern for behavioral health issues. But the other aspects that the Federal Government have yet to really deal with and start to understand how the pull those together and it was truly even before this Health Care Bill because even with the Surgeon General's focus on mental health, there was a very limited look at how this all connects with bringing school and community together. So we have been advocating for some time for people to start thinking about it as a school-community issue and how they would then include and embed mental health fully in that.

Margaret Flinter: Dr. Adelman, we would like to ask all of our guests on Conversations this question, when you look around the country and the world,

what do you see that excites you in terms of health care innovations and who should our listeners of Conversations be keeping an eye on?

Dr. Howard Adelman: _____ 22:04 right now where there is just a lot of ferment and a lot of dissatisfaction so we are seeing a lot of people step up. I think a couple things that people might want to pay attention to, because they are at such an important policy level, is that two states, Iowa and Louisiana, in their State Departments of Ed have really started to take all the step out of the margins and put together what we would refer to as a three-component framework or blueprint for their school improvement reform. So, moving from a two to a three-component framework and the third component really does talk through the step we are talking about. And that's just really going to be very important as other states start to look at and see what they are doing and see that as a model. It's already affected some of the discussion around the reauthorization of the Elementary and Secondary Education Act. Another thing that's been happening is the sense they have really pushed hard to try to get its various resource centers to start working together and be a better source of resources for people around these concerns and they have established a national initiative to improve adolescent health. And that would be an important thing for people to tune into and start supporting so that they can get the type of federal coordination so that they will get a better access to resources.

Margaret Flinter: Today, we have been speaking with Dr. Howard Adelman, Co-Director of the School of Mental Health Project. Dr. Adelman, thank you so much for joining us on Conversation.

Mark Masselli: Each week, Conversations highlights a bright idea about how to make wellness a part of our communities into everyday lives.

Margaret Flinter: In past weeks, we have brought you a variety of stories about the ever expanding world of mobile health technology and this week's bright idea brings you yet another example. Although it's in the early stages of development, the new mobile therapy system is a promising approach to helping people with behavioral health disorders and mental illness. Designed by Dr. Margaret Morris of Intel Corp, mobile therapy allows patients to use their cell phone to track their moods throughout the day as well as sleep and eating patterns. The program which can be downloaded on most phones prompts patients to record the information at random intervals each day. And by relaying the input to their therapists, it helps them stay in touch throughout the week. By compiling results over time, it provides insight into the patients' behavioral tendencies which in turn can help their therapists treat the illness more effectively. Mobile therapy has been coined "a therapist in your pocket" because it goes beyond simply recording data to actually suggest specific therapeutic exercises for patients according to those inputs. These can include advice on reducing stress through breathing techniques or muscle relaxation _____ 24:46 more specific **interaction**. By enabling patients to better monitor everyday's stress, the program not only

increases the quality of life but improves health in the long term. Mobile therapy is not the only new mental health act that's making a difference in patients' lives, recently, a program is developed that allows teenagers who are being treated with cognitive behavioral therapy to do their homework that therapeutic exercises such as daily mood dairies on their cell phones. Teenagers notoriously don't like doing homework, but using cell phones, that works. Like these other applications, mobile therapy is helping all kinds of people better connect with their therapists and take greater ownership of their health. Now, that's a bright idea.

Margaret Flinter: This is Conversations on Health Care. I am Margaret Flinter.

Mark Masselli: And I am Mark Masselli, peace and health.

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