A surge in apartment construction gave home builders more work in November. And permits, a gauge of future construction, rose largely because of a jump in apartment permits. Some analysts say the gains, though coming off extremely low levels, suggest the depressed housing industry may have reached a turning point. Economists now say 2011 will be the first year since the Great Recession began in 2007 that home construction will have helped the economy grow. Before this year, the industry endured two of the worst years ever. "Homebuilding is through the worst and is now steadily improving," said Paul Diggle, a property economist at Capital Economics. Builders broke ground on a seasonally adjusted annual rate of 685,000 homes in November, a 9.3 percent jump from October, the government said Tuesday. It’s the highest level since April 2010. Still, the rate is far below the 1.2 million homes that economists say would be built each year in a healthy housing market. Construction of single-family homes rose 2.3 percent in November to a seasonally adjusted annual rate of 447,000. Apartment construction jumped 32 percent to a rate of 238,000 units. Single-family homes account for about 70 percent of homebuilding. Builders in South Florida are dusting off their cranes as well, with several new condo and apartment projects in the works. Sensing increased international demand, condo developers are expected to build more than 20 new condo towers in the coming years, according to Bal Harbour-based Condo Vultures. And as more homeowners revert to renting due to the region’s foreclosure crisis, a tightening apartment market has led to new proposals for multifamily projects. Between government-subsidized affordable housing complexes and private rental communities for seniors and middle-income families, there are more than 5,000 apartment units set to hit South Florida’s market in the near future. Nationwide, for the year, work is expected to have begun on 430,000 single-family homes and 185,000 apartments. Those figures remain far below the roughly 840,000 single-family homes and 360,000 apartments that would be started in a healthy economy. Patrick Newport and Michelle Valverde, U.S. economists at IHS Global Insight, said the better-than-expected figures show that the housing industry is “finally getting off the mat.” “It’ll keep getting better through next year,” said Jared Franz, an associate economist at T. Rowe Price. Last year, builders began work on roughly 587,000 homes. That barely surpassed the 554,000 homes started in 2009, the worst year ever. Though new homes represent just 20 percent of the overall home market, they have an outsize impact on the economy. Each home built creates an average of three jobs for a year and generates about $90,000 in taxes, according to the National Association of Home Builders. (Miami Herald, 12/20/11)

About 2.7% of U.S. adults, approximately 5.2 million people between the ages of 18 and 64, reported having a mental health disability in 2009. The prevalence among non-elderly working age adults has increased by 0.7% since 1997 when 3.2 million reported having a mental health disability. The increase in mental health disability was not related to an increase in the number of people reporting significant psychological distress. The findings were reported in “National Trends in Mental Health Disability, 1997-2009” by Ramin Mojtabai, M.D., Ph.D., MPH. Dr. Mojtabai reviewed data for 312,364 adults aged 18 to 64 years from the annual U.S. National Health Interview Survey (NHIS) conducted by the Centers for Disease Control and Prevention’s (CDC) National Center for Health Statistics. Using the annual data for 1997 through 2009, Dr. Mojtabai examined trends in self-reported disability attributed to mental health conditions, disability attributed to other chronic problems, and the relationship of mental health disability to significant psychological distress. The NHIS asks participants about their level of difficulty (0 meaning no difficulty and 4 meaning inability) in performing various instrumental activities of daily living (IADL), such as shopping, walking, or participating in social activities. If the participant’s response is not 0, then the participant is asked to identify which of 19 possible health conditions has caused the disability. For this study, the participants could pick three mental health conditions—depression, anxiety, or emotional problems—as the cause of their inability to perform an IADL. The results are not split out by mental health condition. The NHIS also includes questions from the Kessler 6 (K6) instrument to assess the presence of psychological distress over the past 30 days. The participants rate their distress on a 0 to 4 scale, with 0 meaning none and 4 meaning all the time. Dr. Mojtabai grouped the K6 responses into three categories—0 indicating no psychological distress; 1-12 indicating some psychological distress; and 13 or more indicating significant psychological distress. Dr. Mojtabai defined mental health disability as the self-reported disability attributed to depression, anxiety, or emotional problems. The validity of the NHIS mental health disability question was assessed against the 12 month diagnoses of major depressive episodes and generalized anxiety disorder according to the American Psychiatric Association’s Diagnostic and Statistical Manual of Mental Disorders (DSM) IV and by using the Composite International Diagnostic Interview Short Form administered in the 1999 NHIS. This analysis revealed that 70% of the NHIS participants who self-reported having a mental health disability also met the DSM-IV criteria for the disorders. Only 11% of other NHIS participants met the DSM-IV criteria for depression, anxiety, or emotional problems. Duration of the mental health disability was assessed by asking the participants how long they have had depression, anxiety, or an
emotional problem. Overall, from 1999 through 2009, 312,364 adults between the ages of 18 and 64 completed the NHIS. Of those, 20.7%, about 66,885 adults reported having a disability. The percentage of adults reporting a disability of any sort remained constant across all survey years, 20.7% in the 1997-1999 NHIS and 20.9% in the 2007-2009 NHIS. However among the 66,885, the percentage reporting a mental health disability increased. In the 1997-1999 NHIS, 2.0% reported having a mental health disability. In the 2007-2009 NHIS, 2.7% reported having a mental health disability. Based on population estimates, the 0.7% increase translated to about 2 million more adults reporting a mental health disability. The odds of the NHIS participants having a K6 score of 13 or higher did not increase significantly across the study period. In the 1997-1999 NHIS, 2.9% had a K6 score over 13 indicating significant psychological distress; in the 2007-2009 NHIS, 3.2% had a K6 score over 13. Dr. Motjtabai noted that this change was not statistically significant. The full text of “National Trends in Mental Health Disability, 1997-2009” was published November 1, 2011, by American Journal of Public Health. An abstract may be accessed online at http://ajph.aphapublications.org/doi/abs/10.2105/AJPH.2011.300258 (accessed November 2, 2011). Additional information about the measurement of non-specific psychological distress on the Behavioral Risk Factor Surveillance System survey is available online at: www.cdc.gov/mentalhealth/data_stats/nsphd.htm (accessed December 1, 2011). (Open Minds, 12/19/11)

**Group Health Care Costs Up By 6.1%, Per Employee Cost Tops $10,000**

In 2011, employer-sponsored group health plan costs increased by an average of 6.1%, from an average $9,562 per employee cost in 2010 to $10,146 in 2011. An additional increase of 5.7% is expected for 2012. The 2011 cost increases affected smaller employers (those with 10 to 499 employees) more than large employers (those with 500 or more employees), with group health benefits increasing by 9.9% for small employers, compared to an increase of 3.6% for large employers. These are findings of an analysis of the National Survey of Employer-Sponsored Health Plans, an annual survey conducted by Mercer in late summer. The survey includes public and private organizations with 10 or more employees. The 2011 survey received responses from 2,844 employers. Topics included employers’ plans to offer health benefits, the types of health benefits offered, cost sharing arrangements, and employers’ plans to address provisions of the Patient Protection and Affordable Care Act of 2010. The survey responses represent about 800,000 employers and more than 104 million full- and part-time employees. Additional details included the following:

- Only 13% of employers (9% of small employers and 4% of large employers) said they were likely to terminate their employee health benefits and have employees seek coverage in the individual market in 2014.
- Between 2010 and 2011, the percentage of small employers offering benefits dropped from 57% in 2010 to 53% in 2011.
- 13% of all covered employees are enrolled in a consumer-directed health plan (CDHP) and 32% of large employers and 20% of small employers offer a CDHP option. A CDHP is generally a high-deductible health plan linked to a health savings or reimbursement account that the enrollee uses to pay for health care services until the deductible is met.
- A CDHP plan costs $7,787 per employee, nearly 20% less than a traditional preferred provider organization plan ($9,385 per employee) or health maintenance organization ($9,467 per employee).

The full text of the 2011 National Survey of Employer-Sponsored Health Plans report will be released in late March 2012. The report costs $600; the report plus a separate appendix of supporting tables broken out by employer size, region, and industry costs $1,200. The topline results are available at no cost online at www.mercer.com/press-releases/1434885 (accessed December 5, 2011). (Open Minds, 12/19/11)

**Small Number Of Employers Dropped Coverage For Mental Health Or Addiction Treatment In Health Plans Due To Parity**

About two percent of employers offering mental health or addiction coverage in employer-sponsored health plans in 2008 reported that they had dropped the coverage by 2011, according to a survey conducted by the Government Accountability Office (GAO). About 96% of the employers responding to the GAO survey that offered mental health or addiction coverage in 2008 continued to offer it in their 2010 or 2011 health plans with no change. Because of the study design, it is not possible to tell the percentage of the workforce with employer health insurance that behavioral health coverage or the size of organizations that terminated behavioral health coverage. Fewer employers reported excluding a mental health or addiction diagnosis from coverage in the most recent plan year compared to their 2008 coverage. In 2008, of employers that reported the diagnoses included in their health plan coverage, about 39% reported excluding at least one mental health or addiction diagnosis; in the most recent plan year, only 34% reported excluding a mental health or addiction diagnosis. The GAO noted that their survey results and trends are not generalizable beyond the employers included in the survey; however, the survey data is consistent with other published national employer surveys on health insurance coverage. These were the
findings of a GAO report, titled "Mental Health and Substance Use: Employers' Insurance Coverage Maintained or Enhanced Since Parity Act, but Effect of Coverage on Enrollees Varied." The statistics relate to 168 survey responses from 707 companies that were randomly selected from a group of more than 32,000 U.S.-based companies with from 51 to 100,000 employees. Of the 168 responses received, 130 employers provided information on cost-sharing, copayments and coinsurance amounts for in-network providers. The researchers sought to determine the effects of the Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008, which went into effect for plans issued on or after October 3, 2009. The MHPAEA requires the GAO to examine trends in health insurance coverage of mental health and substance use (MH/SU) treatment services. The GAO reviewed published national employer surveys on health insurance coverage, interviewed officials from the Department of Labor, Health and Human Services and other experts, and surveyed a random sample of employers with more than 51 employees about their MH/SU treatment coverage for the most recent plan year. Additional findings included the following:

- 2% of responding employers that reported offering coverage in 2008 only for mental health conditions, but not substance use disorders, kept this benefit structure in 2011
- 2% of responding employers discontinued coverage of both MH/SU or only substance use disorders for the current plan year.
- The types of MH/SU diagnoses covered in employer plans remained substantially the same between 2008 and the most recent plan year. Fewer employers reported excluding one broad MH/SU diagnosis, but more employers reported excluding a treatment related to MH/SU.
- The most common change to MH/SU benefits reported among those who responded to the survey was enhancing benefits through the removal of treatment limitations, such as the number of allowed office visits.
- Reported use of lifetime dollar limits on MH/SU treatments also declined from 2008 to the current plan year.
- Among employers who reported information on cost-sharing, copayments, and coinsurance amounts for in-network providers generally stayed about the same, fluctuating minimally from 2008 to the current plan year. (Open Minds, 12/19/11)

**Beneficiary Out-Of-Pocket Costs For Medicare Part D Prescription Drugs Dropped 40% In 2011**

In 2011, 2.6 million Medicare Part D beneficiaries with high prescription drug costs spent 40% less out-of-pocket for their medications than in 2010. Those beneficiaries whose annual prescription costs hit the Part D cost-sharing threshold (generally referred to as "the donut hole") of $2,840 spent an average of $901 out-of-pocket (instead of $1,504 in 2010). This change in out-of-pocket payments was due to a provision of the Patient Protection and Affordable Care Act (PPACA) of 2010 that provided a subsidy and prescription discounts. Without the PPACA provisions, these Part D beneficiaries reaching the "donut hole" threshold would have spent an average of $1,504 out-of-pocket to cover their medication costs before qualifying for catastrophic coverage, which starts once claims reach $4,550. The average subsidy was $568. The Centers for Medicare and Medicaid Services (CMS) described the new PPACA provisions for Part D beneficiaries in "Closing the Coverage Gap—Medicare Prescription Drug Coverage Changes Due to the Patient Protection and Affordable Care Act." Starting January 1, 2011, Part D beneficiaries in the coverage gap received help through the following:

- 50% discount on the out-of-pocket cost of brand name prescription drugs, but the full cost of the prescription is counted toward the catastrophic claims level
- The discount on brand-name drugs does not include the pharmacy dispensing fee
- 7% coverage for generic medications, but for generic drugs, the amount paid by the beneficiary is all that counts toward the catastrophic claims level
- From January 1 through October 31, 2011, CMS tracked the total gap discount amount by drug therapeutic use. The outcomes were reported in "Part D Gap Discounts to October 31, 2011." The discounts totaled $1.5 billion, with about 68% of the discounts for ten drug classes, as follows:
  - $207.6 million for drugs to reduce blood sugar
  - $167.7 million for drugs to reduce blood triglycerides and/or cholesterol
  - $152.1 million for drugs to treat asthma and other non-cancer lung diseases
  - $121.3 million for drugs to prevent blood clots
  - $82.1 million for psychiatric drugs
  - $75.4 million for anti-dementia drugs
  - $63.0 million for drugs to reduce blood pressure
  - $62.7 million for cancer drugs
  - $49.3 million for antidepressants
  - $47.3 million for drugs used to treat ulcers
  - $479.4 million for all other drug therapeutic uses (Open Minds, 12/19/11)

**NCCBH VP Appointment**

The National Council for Community Behavioral Healthcare has announced the appointment of Betsy Schwartz as Vice President of Public Education and Special Initiatives, effective January 1, 2012. Ms. Schwartz is resigning as chief executive officer of Mental Health America of Greater Houston to assume the
The impact of the automatic defense cuts by my partner, Mary Evans, and its Centennial in 2009 gave us opportunities to achieve many important strides in organization.

In September 2012, I will finish my sixth year as leader of Mental Health America. Those six years have been filled with many challenges and even more achievements. The renaming of the organization in 2006 and its Centennial in 2009 gave us opportunities to reflect on our legacy and our future. Our work to develop an integrating theme of wellness that is relevant for all people regardless of their current health status positioned the organization powerfully for the health care reform efforts during the last two years. The final passage of mental health parity legislation in 2008-and its expansion in the Affordable Care Act-positions mental health and addiction issues as integral to overall health. "Mental Health America has been a leader in these discussions. We helped to establish the Whole Health Campaign (now the Coalition for Whole Health), which, for the first time, spoke with one voice for the mental health and substance use communities in the 2008 Presidential race, as well as in the health care reform and parity implementation debate. Given our broad perspective on the role of mental health, mental illness and addictions in overall health and our understanding of their relationship with academic and occupational achievement, we are poised to lead the national conversation on strengthening our human capital infrastructure. I plan to continue to work on these issues and, by reducing my span of responsibilities, to be able to concentrate more intensely on them. "It has been a great privilege to lead Mental Health America and I look forward to a terrific future for the organization." (Mental Health America, 12/6/11)

**Congress Contemplates Next Steps In Aftermath Of Supercommittee Failure**

As Congress returned from its Thanksgiving recess, lawmakers last week grappled with their next steps in the wake of the Supercommittee's failure to reach an agreement on a $1.2 trillion deficit reduction plan. Most of these efforts have centered on minimizing the impact of automatic, across-the-board spending cuts that were triggered when the Supercommittee could not produce a plan. These cuts will go into effect in 2013 and will fall equally on defense and non-defense spending. Many important social safety net programs – for example, Medicaid and SSI – are exempted from the cuts. Reports indicate that House Majority Leader Eric Cantor (R-VA) is working to build support for a new proposal that would reduce the impact of the automatic defense cuts by pairing a delay their implementation with a variety of measures that are widely considered to be "must-pass" legislation. Cantor's plan would include $133 billion in spending cuts, a 1-year delay in the defense sequestration, a 1-year extension of unemployment benefits, a payroll tax break, and a "fix" for the scheduled reduction in Medicare physician payment rates. However, President Obama has threatened to veto any legislation that modifies the automatic cuts, and it is far from clear whether a majority of legislators would support such a bill. Meanwhile, discussions continue among other legislators about how to reduce the deficit in the aftermath of the Supercommittee's failure. A bipartisan, bicameral group fashioning itself as the "go big coalition" is holding meetings behind closed doors to discuss a $4-6 trillion deficit reduction plan. In addition,
Representative Paul Ryan (R-WI) has suggested that he may try to replace some of the automatic defense cuts with a deficit reduction plan to be included in his outline for the 2013 budget. (With fiscal year 2012 already two months old, Congress and the White House have begun working on their budget proposals for FY 2013). Such a move could be largely symbolic, as election-year politics make it unlikely the Democratic-controlled Senate and the Republican-controlled House will reach an agreement on the same budget resolution. It is not uncommon for the two chambers to work from separate budget resolutions, smoothing out differences during their later-stage negotiations. For more information on the Supercommittee failing to reach an agreement and a more in-depth analysis of what this means for behavioral healthcare, click here. (NCCBH, 12/11)

What’s To Become Of The ‘Doc Fix’?

News outlets report about what the future could hold for Medicare physician reimbursements now that Congress has, so far, failed to take steps to avert a scheduled payment cut. Also, without congressional intervention, Medicare’s rehab therapy caps will hit in 2012.

The Associated Press: Medicare Cuts Could Hit Jan. 18. Medicare officials say hundreds of thousands of doctors will get a steep cut in payments on Jan. 18 unless a gridlocked Congress issues a reprieve. A provision waiving a scheduled 27.4 percent cut in physician reimbursement was included in the payroll tax legislation now ensnared in partisan political wrangling. On Monday, Medicare sent an alert to some 650,000 doctors telling them it will hold claims for the first 10 business days of 2012 unless Congress acts (Alonso-Zaldivar, 12/20).

Kaiser Health News: Health On The Hill: Senate, House Remain At Odds Over ‘Doc Fix’ Dilemma. Kaiser Health News staff writer Mary Agnes Carey talked with Politico Pro’s Matt Dobias about action on Capitol Hill. Specifically, a Senate-passed bill to stop a Medicare physician pay cut, among other provisions like a payroll tax cut extension, was denied a vote by House Republicans Tuesday afternoon. Until lawmakers pass legislation to avert it, doctors are facing a 27 percent pay cut at the beginning of next year (12/20). Read the transcript or listen to the audio.

Bloomberg: Doctors 27% Pay Cut Won’t Be Unlinked From Tax Bill In U.S. House. House Republicans have no plans to move a stand-alone bill to reverse a 27-percent cut in Medicare fees to doctors that’s set to go into effect Jan. 1, a spokesman for Speaker John Boehner said. Both the House and Senate have opted to address Medicare payments to doctors as part of the impasse over extending a payroll-tax cut set to expire at the end of the year. Congress is deadlocked over the tax, which has become the end-of-session vehicle for unrelated issues, including fees for Medicare, the U.S. insurer for those 65 and older and the disabled (Armstrong and Hunter, 12/20).

CQ HealthBeat: Curtains For The Doc Fix? Maybe So. Physician groups expressed something bordering on contempt for Congress on Tuesday after lawmakers did not resolve a legislative impasse blocking action to prevent a 27 percent Medicare payment cut to physicians set to start Jan. 1. With the Senate apparently finished with its legislative business for the year, and House Republicans adamant in their opposition to a Senate-approved doctor payment patch, action on the issue might be over for 2011. The American Academy of Family Physicians issued a statement saying that the "congressional failure deeply angers family physicians" (Reichard, 12/20).

Modern Healthcare: Lawmakers Raise Prospect Of Stand-Alone SGR Bill. The co-chairmen of the House GOP Doctors Caucus on Tuesday remained hopeful that House and Senate leaders could resolve their differences on a payroll tax cut bill that would also avert a steep Medicare payment cut to the nation’s physicians, but they did not rule out the possibility of a stand-alone bill to address the sustainable growth-rate formula after the new year (Zigmond, 12/20).

The Hill: Criticism Starts As House Nixes Medicare ‘Doc Fix’. Patient advocates immediately started blasting Congress on Tuesday after House Republicans nixed a temporary fix to Medicare payments to physicians. The House voted 229-193 to reject the Senate’s two-month “doc fix” and instead call for a conference meeting with the Senate. Senate Majority Leader Harry Reid (D-Nev.) says the Senate is done for the year. If neither chamber changes its mind, physicians will see a 27.4 percent cut in Medicare payments starting Jan. 1 (Pecquet, 12/20).

Politico Pro: SGR: Another Year, Another Impasse. Republicans and Democrats on Tuesday further retreated into seemingly intractable positions over how to move year-end legislation, with no agreement on how to avert a 27 percent Medicare cut for physician. The posturing on display during a tumultuous session on Capitol Hill makes it difficult to see how leaders from both parties can quickly or cleanly break the impasse. Medicare officials have already said doctors bills won’t be processed in early January to give Congress more time to figure something out (DoBias and Millman, 12/20).

CQ HealthBeat: Rehab Therapy Caps To Hit In 2012 Unless Congress Acts. If Congress doesn't pass a payroll tax package extending expiring Medicare provisions before the end of the year — and there were no signs late Tuesday that it would — Medicare patients suffering from serious medical conditions will face new limits on physical and other therapy in 2012. Patients recovering from stroke or broken hips are the ones most likely to face restrictions that could force them to choose between stopping therapy that could help them regain the ability to care for themselves or paying for it on their
A plan by Republican U.S. Sen. Jim DeMint of South Carolina to slash the federal budget deficit would hit the poorest Americans especially hard, directing 70 percent of its $4.2 trillion in spending cuts at safety-net programs intended to help tens of millions of low-income people. The plan proposes $20 billion in cuts that would affect the affluent. It suggests almost $3 trillion in cuts that would affect low-income Americans, leading one liberal economist to call the plan "cruel." But DeMint, a leading figure in the national tea party movement, says the cuts - including eliminating the earned income-tax credit and child tax credit for Americans who don't earn enough money to owe federal income taxes - are needed.

"During the Clinton years, during the Bush years, even when the economy was booming, we were still adding to the welfare rolls," DeMint said. "We have not helped the people we're supposedly helping. Poverty has gone up in America. "We have trained several generations of Americans to be dependent on government rather than trying to get them off welfare." DeMint's plan won't pass this Congress. Democrats, who control the Senate, easily could kill it if it came up for a vote. However, the budget cuts proposed by DeMint - known as Sen. Tea Party - provide insight into the thinking of one of the Senate's most archconservatives and his tea party allies. DeMint helped raise money for many of the tea party-backed GOP freshmen in Congress. DeMint released the plan last month alongside Republican Sens. Rand Paul of Kentucky and Mike Lee of Utah, though the bulk of its spending cuts would come from the Welfare Reform Act, a bill that DeMint also introduced last month. Paul and Lee are first-year senators who are indebted to DeMint because he helped them win election by contributing a combined $603,520 to their campaigns from his Senate Conservatives Fund.

Three economists in Washington who examined the trio's proposal - including two who formerly worked for prominent Republicans on Capitol Hill and at the White House - agreed that poor folks would bear the brunt of the plan DeMint put forward to aid a special deficit-reduction panel set up by Congress. "This plan places a disproportionate burden on low-income groups," said Alan Viard, a budget analyst at the American Enterprise Institute policy group who sat on the White House Council of Economic Advisers under Republican President George W. Bush. Patrick Louis Knudsen, who was a GOP analyst on the House Budget Committee before he joined the conservative Heritage Foundation earlier this year, praised DeMint's plan but agreed that poor people would feel most of its spending cuts. "This would be a stronger set of proposals if it did something on Medicare, particularly for upper-income people," Knudsen said. "One of the big flaws of Medicare is you can be a millionaire and get your X-rays paid for by the government. That doesn't make sense." DeMint's plan doesn't provide such an income test for Medicare, which will cost the government $549 billion this year. But it would end Social Security benefits for people with $1 million or more a year in income. That would save the government $17 billion over a decade. DeMint would save an additional $3 billion by stopping commodity-support payments to wealthy farmers. Those cuts are the only ones he proposed that are directed at affluent Americans. He proposed almost $3 trillion in cuts aimed at low-income people. DeMint said in an interview that poor people would be far worse off if the U.S. economy sank under a mountain of federal debt - currently $15 trillion - and the country went the way of Greece and other European nations that were facing forced austerity measures. "The picture I'm trying to paint is, we're in a big raft headed for Niagara Falls," he said. "There is no sense of urgency in Washington to deal with the problem. We can't help the poor - we can't help anyone - if the country goes down the tubes or we start massive inflation." DeMint said his plan represented only the first round of necessary spending cuts. Other rounds need to be far greater and would have more of an impact on better-off Americans, he said. He defended reducing benefits for the poor and adding work requirements for food stamp recipients, some of whom, he said, have abused the program. "A lot of middle-class people are now using food stamps," he said. "Many Americans are sick of seeing the guy in front of them in the grocery line using food stamps to buy steaks." Beyond the $4.2 trillion in spending cuts, the plan would narrow the deficit by saving $660 billion in interest payments on the reduced debt that would result from a lower budget deficit. DeMint's plan would net an additional $203 billion through sales of government property. "It's comprised completely of spending cuts and no tax increases, but then targets the lower-income programs while sparing the big middle-class programs," Viard said. "They could have designed a spending-cut program that was more balanced, but they obviously were not willing to incur the political cost of taking on Social Security and Medicare." Andrew Fieldhouse, a budget expert with the liberal Economic Policy Institute, was more critical. "It's cruel," Fieldhouse said. "It's inexusable to cut supports that help those adversely affected by the economic downturn." The plan's single biggest cut, which would come from DeMint's welfare bill, would save the government $1.7 trillion over a decade. That would happen by dropping Medicaid benefits to 2007 levels if the national unemployment rate falls to 7.5 percent. The current rate is 8.6 percent. DeMint's plan angered House Assistant Democratic Leader Jim Clyburn, D-S.C., who sat on the bipartisan 12-member debt panel that failed to meet its congressional mandate to reduce the federal deficit by at least $1.5 trillion. "These cuts would decimate low-income income people," Knudsen said. "One of the big flaws of Medicare is you can be a millionaire and get your X-rays paid for by the government. That doesn't make sense."
income and middle-income families," Clyburn said. "They are inhumane and un-American." But Robert Rector, a Heritage Foundation economist who advised DeMint in crafting his Welfare Reform Act, said the plan was reasonable. "It's not like he's trying to do away with the welfare state," Rector said. "He's just saying that the welfare state, like any other set of programs, has to face overall budgetary restraints." (Miami Herald, 12/20/11)

Obama Health Care Law: Supreme Court Sets Date To Hear Oral Arguments

March madness is coming to the Supreme Court next year. The justices have designated three days, March 26 to March 28, as the oral argument dates for the health care cases. The Court agreed to hear the challenges to the Affordable Care Act in November, setting aside an extraordinary five and a half hours for oral argument. The main event will be on Tuesday, March 27, when the Court will take up the constitutionality of the health care law's minimum coverage requirement. That provision, commonly called the individual mandate, requires virtually all Americans to purchase health insurance or pay a penalty. The Court has set aside two hours for argument over whether Congress' passage of the individual mandate exceeded the legislature's powers to regulate interstate commerce or lay and collect taxes under Article I of the Constitution. On Monday, March 26, the Court will hear an hour of argument over whether a Reconstruction-era federal statute, the Anti-Injunction Act, bars the justices from making a decision on the individual mandate's constitutionality until after the provision goes into effect in 2014. The Court will consider two additional issues on Wednesday, March 28. Ninety minutes will be dedicated to whether the individual mandate is so central to the health care overhaul that the entire law must fall should the justices find the mandate itself unconstitutional. An additional hour of argument will address 26 states' claim that the law improperly expands Medicaid by coercively conditioning states' receipt of federal funds on their participation in the new health care exchange system. These three days of oral argument will occur almost exactly two years after President Barack Obama signed the Affordable Care Act, sparking a slew of lawsuits across the country. The four courts of appeals to consider the issues now before the Supreme Court have split on the constitutionality of the individual mandate and the application of the Anti-Injunction Act, but have all rejected the challengers' arguments about state coercion and the centrality of the individual mandate. The justices' decision in the health care cases will likely come down at the end of June. (Huffington Post, 12/19/11)

High Court Sets March Dates For Health Law Arguments

March 27 will be the day for two hours of arguments over the provision, which starting in 2014 will require most Americans to carry health insurance or pay a penalty. The high court is expected to announce its decision by the end of June.

The New York Times' The Caucus: Supreme Court To Hear Health Care Case In Late March. The Supreme Court announced on Monday that it would devote three days in late March to hearing arguments in challenges to the 2010 health care overhaul law. A decision in the case is expected by the end of June (Liptak, 12/19).

The Wall Street Journal: High Court To Hear Health-Care Case In March. A typical case is allotted an hour for argument, but the court scheduled five and a half hours for the health-care case, reflecting how novel some of the questions are and the importance of a dispute that could define the limits of federal power for decades to come. The main part will take place on Tuesday, March 27, with a two-hour argument over the minimum-coverage provision, which starting in 2014 will require most Americans to carry health insurance or pay a penalty (Bravin, 12/20).

Los Angeles Times: Supreme Court To Hear Arguments In March On Healthcare Law. The Supreme Court announced Monday that it would hear arguments over three days in late March to decide the constitutionality of President Obama's healthcare law, another sign the justices see the case as a once-in-a-generation test of the federal government's regulatory power. The 51/2 hours of argument are believed to be the most time devoted to a single case since the 1960s (Savage, 12/19).

Politico: Supreme Court Sets Health Care Arguments For March. The health care showdown of 2012 has been scheduled. The Supreme Court announced Monday that it will hear three days of oral arguments on various pieces of the health reform law on March 26, 27 and 28 — just days after the law's two-year anniversary (Haberkorn, 12/19).

Reuters: Supreme Court Sets Obama Healthcare Arguments. Oral arguments on President Barack Obama's sweeping U.S. healthcare overhaul will last 5-1/2 hours spread over three days from March 26-28, the Supreme Court said on Monday. The Supreme Court last month agreed to hear the 5-1/2 hours of oral arguments, one of the lengthiest arguments in recent years. There have been similar marathon sessions in a handful of big cases dating back over the past 70 years (Vicini, 12/19).

Bloomberg: Health-Care Hearing Before U.S. Supreme Court Scheduled For March 26-28. The U.S. Supreme Court said it will hear arguments on President Barack Obama's health-care law over three days, from March 26
to March 28. Releasing a schedule today that has few, if any, precedents in modern court history, the justices left room to expand the 5 1/2 hours they already allotted for argument. The high court generally hears arguments for a single hour in each case (Stohr, 12/19).

The Associated Press: Court Schedules Week Of Health Care Arguments. The Supreme Court announced Monday that it will use an unprecedented week’s worth of argument time in late March to decide the constitutionality of President Barack Obama’s historic health care overhaul before the 2012 presidential elections. The high court scheduled arguments for March 26th, 27th and 28th over the Patient Protection and Affordable Care Act, which aims to provide health insurance to more than 30 million previously uninsured Americans. The arguments fill the entire court calendar that week with nothing but debate over Obama’s signature domestic health care achievement (Holland, 12/19).

Fox News: Supreme Court Schedules Health Care Cases. The Supreme Court announced Monday that it will hear a series of cases regarding President Obama’s signature health care law between March 26-28. Four hearings are scheduled on different aspects of the law. March 26th – Anti-Injunction Act issue (1 hr) 10am March 27th – Individual Mandate (2 hrs) 10am March 28th – Severability (90 mins) 10am; Medicaid issue (1 hr) 1pm. Speaking to Fox News Radio, Virginia Attorney General Ken Cuccinelli, who spurred the 26-state lawsuit, said the amount of time dedicated to arguments indicates how seriously the high court takes the constitutional questions pertaining to the law (12/19). (Kaiser Health News, 12/20/11)

Analysis: Deficit May Be Biggest Threat To Healthcare Reforms

A mounting U.S. deficit could pose a much greater threat to the survival of President Barack Obama’s healthcare reforms than either the Supreme Court or 2012 elections. Many health experts say innovations in delivering medical care and the creation of state health insurance exchanges for extending coverage to the uninsured are likely to continue in some form even if Obama’s 2010 Patient Protection and Affordable Care Act is struck down or repealed. But former top healthcare policymakers from Democratic and Republican administrations warn that some of the most promising measures for controlling costs, while improving quality and access to care, could run aground as early as 2013 if a new Congress and administration respond to the fiscal pressures with arbitrary spending cuts. "If the plan is what’s on the table now, which is cut, cut, cut - shift the burden to poor people and taxpayers, take away benefits, take away Medicaid coverage - things will get worse," said Dr. Don Berwick, who left his temporary post as Obama’s head of Medicare and Medicaid this month after Republicans blocked his Senate confirmation. The Affordable Care Act is designed mainly to extend healthcare coverage to more than 30 million uninsured Americans by expanding Medicaid for the poor and establishing state exchanges where people with low incomes who do not qualify for Medicaid can buy subsidized private insurance. It also calls for innovations that could guide America's $2.6 trillion healthcare system, the world’s most expensive, toward incentives to contain costs. The law faces fierce Republican opposition and is heading into a period of unprecedented turmoil. Next spring the Supreme Court is expected to rule on the constitutionality of the individual mandate, the law’s lynchpin provision that requires all Americans to buy insurance. Months later, voters will deliver another verdict by deciding whether Republicans or Democrats control the White House and Congress. Current and former healthcare officials have great hopes for changes that reward doctors and other providers for how well patients progress rather than compensating them according to the number of tests and procedures they perform. “These reforms really have the potential for a longer term impact on healthcare costs,” said Dr. Mark McClellan, who oversaw Medicare, Medicaid and the Food and Drug Administration under President George W. Bush.

Gaining Momentum

Some innovations, like "bundled payments," set cost targets for specific conditions that teams of doctors must meet. Others reward healthcare providers for keeping patients healthy or for delivering successful outcomes while saving money. The innovations were already taking hold in the private market before Obama signed the healthcare bill into law in March 2010. Their momentum has gained pace sharply across the United States as a result of the law’s efforts to apply them to Medicare and Medicaid, which combined spend about $900 billion annually to provide care to 100 million beneficiaries. The year-old Center for Medicare and Medicaid Innovation has about two dozen innovation models that it intends to develop with private partners over the next few years. Experts say innovations in delivering care are durable because they offer providers a way to cope with growing cost pressure from employers who sponsor health insurance and from government agencies forced to cut spending. "This is a response to market realities, not just reformist interests," said Don Moran, a Washington-based healthcare consultant who served in President Ronald Reagan’s Office of Management and Budget. The climate for innovation could change dramatically after Election Day in November if Washington responds to deficits with across-the-board cuts to Medicare and Medicaid that reinforce the traditional fee-for-service approach to healthcare. Innovations are vulnerable because they have yet to established a cost-cutting track record to which the bipartisan Congressional Budget Office can assign tangible dollar values for deficit reduction. Gail Wilensky, who headed Medicare and Medicaid under
President George H.W. Bush, worries that Congress will opt for the standard practice of cutting payments to doctors and other healthcare providers, who may react by dropping Medicare patients. "That's the only thing Congress will get credit for and so that's what they'll do. We know this is not our future if we want to do well by our seniors," she said at the Harvard School of Public Health forum on Friday. Some analysts say deficit pressures could encourage the Obama administration to delay segments of the healthcare law, including state health insurance exchanges and the requirement for each individual citizen to have health insurance. Such a move could save tens of billions of dollars in government spending, while giving state and federal officials more time to set up exchanges that have taken shape slowly amid uncertainties posed by the Supreme Court case and the election. An administration official said there are no plans to delay the law's implementation. "That idea has never been discussed and is not under consideration," the official said. The election also is unlikely to decide the law's fate unless Obama loses re-election, according to analysts who say Congress is unlikely to overcome partisan gridlock even if Republicans eke out a slim majority in the Senate. McClellan acknowledged that state exchanges could go forward even if the individual mandate were overturned in court, repealed after the election or weakened by political and budgetary pressures. Instead of a legal requirement for purchasing insurance, McClellan said the government could design effective voluntary rules that encourage people to participate in exchanges. He said an obvious model would be Medicare Part D, the prescription drug benefit that offers rewards for people who enroll early and penalties for those who show up late. McClellan acknowledged that state exchanges would not be as robust without the individual mandate but said that fact could result in deficit savings. The administration official said there are currently no plans or conversations taking place about using Part D enrollment restrictions in place of the individual mandate. (Orlando Sentinel, 12/18/11)

**A Piecemeal Approach To Health Law In States**

The Obama administration’s surprise announcement Friday that it planned to give states broad leeway to pick the benefits offered under the federal health care law offers yet another example of a gradualist approach to carrying out its signal domestic policy achievement. Facing vociferous Republican opposition, a looming Supreme Court decision on the constitutionality of the law and the practical challenges of overhauling the vast health insurance market for small businesses and individuals, federal officials are choosing to avoid some crucial choices until well after the 2012 elections. While critics accuse the administration of political expediency, the officials insist the decisions have been based on sound policy judgments. In passing a good deal of the decision-making to states, the administration has guaranteed that Americans will continue to face a patchwork of state regulations that make coverage uneven and inefficient. People in Utah and Wyoming, for example, are likely to have more limited access to expensive services now mandated in states like Massachusetts and Maryland — at least until 2016, when a senior administration official said the federal government plans to establish a national standard of essential benefits. And consumer advocates worry that some states will limit benefits too strictly. While the law requires health plans to offer services in 10 broad categories, including hospitalization, emergency care, and maternity and newborn care, policies could restrict, for example, the number of covered visits a pregnant woman could make to her obstetrician or which prescription drugs to pay for, said Timothy S. Jost, a law professor at Washington and Lee University who is an expert on the health law. "I think what Congress had in mind was creating a uniform national level of benefits that would be available to everybody," he said. But by giving states more authority, President Obama will most likely make his plan for health care reform more politically palatable, potentially encouraging reluctant state officials to cooperate with his efforts to expand coverage to tens of millions of Americans who are now uninsured. And the decision gives him a way to address the politically treacherous balancing of the law’s potentially conflicting goals: assuring health care that is both comprehensive and affordable. States will be allowed to set benefits at levels similar to what they are now, making coverage not much more expensive than it is today. The administration has also ducked for now the thankless task of determining whether costly services like behavioral therapy for autistic children or in vitro fertilization for infertile women should be covered. Under federal guidance, which will be finalized in regulations next year, those decisions will be made by the states. States now collectively mandate more than 1,600 health services but vary widely in which ones they require. With some exceptions, like bariatric surgery or acupuncture, experts expect benefits for most basic services to be fairly consistent across the nation. “There will be some variation on the margins, but insurance is still going to look very similar from one state to another,” said Larry Levitt, a senior official at the Kaiser Family Foundation, a nonprofit group that closely studies the health insurance market. And for individuals who buy policies directly rather than through their employer, the level of benefits under the health care law will often be a significant improvement, Mr. Levitt and administration officials said. Some Republican state officials were pleased with the administration’s decision. Sandy Praeger, the Kansas insurance commissioner and a Republican, said it “removes a fairly significant barrier” to state compliance with the new federal health care law. “It demonstrates their continued desire to be flexible with the states,” she said. But other conservatives contend that the administration is avoiding difficult
decisions. Ed Haislmaier, a senior research fellow at the Heritage Foundation, said it was politically smart to let states make these choices, but warned that they were likely to choose rich benefits whose costs could sink the entire effort. “All they’re trying to do is avoid making tough calls before the election,” Mr. Haislmaier said. The attention of legions of lobbyists for employers and insurance companies is likely to shift now from Washington to state capitals. “The decisions about what is covered will be fought out state by state between highly organized, narrow, special-interest groups” and state officials, said Helen Darling, chief executive of the National Business Group on Health. So far, criticism of the announcement has been surprisingly muted. Just two weeks ago, a coalition of dozens of the nation’s largest disease advocacy groups — including the American Cancer Society, the American Diabetes Association and the National Alliance on Mental Illness — wrote to Kathleen Sebelius, the secretary of Health and Human Services, demanding that states be explicitly barred from determining what services to cover. Ms. Sebelius did just the opposite, but many of the groups said they were pleased. In implementing the new law, the administration has softened or delayed some provisions that critics argued were disruptive. When companies like McDonald’s, for example, faced having to either abandon or enrich policies that provided more limited coverage than the new law required, they were granted one-year waivers. And when several states said they could not enforce new rules that required insurance companies to spend $8 out of every $10 they collected in premiums on their customers’ well-being, the administration agreed to let them phase in the requests. Some experts say the administration is now taking a similarly cautious approach as it chooses not to force states to adopt costly benefits, buying time for states to experiment and the federal government to study which approaches work best. (New York Times, 12/20/11)

**IOM Authors Disagree With HHS Decision On Essential Benefits**

Political Pro talks to researchers who helped develop the IOM recommendations for the federal government on what should be offered in health plans. At the same time, a number of media outlets look at news about the implementation of the 2010 health care law.

**Politico Pro:** IOM Authors Fault HHS On Benefit Safeguards. Authors of the Institute of Medicine report on essential health benefits called the recent HHS guidance a “missed opportunity” for ensuring health insurance affordability. Most of the attention went to HHS’s decision to give states great latitude in determining the benefits package. But also missing from HHS guidance issued Friday was any mention of premium targets or using medical effectiveness to select benefits. Both had been key recommendations from October’s cost-conscious IOM report (Millman, 12/21).

**Modern Healthcare:** Providers Speculate On The Promise And Peril Of Pioneer ACOs. Providers are telling Modern Healthcare this week about the biggest potential upsides and downsides stemming from their organizations’ participation in the Pioneer ACO program. Here are some highlights (Zigmond and Daily, 12/21).

**Fox Business:** Affordable Health Insurance Options For Young Adults. A study by eHealthInsurance.com found that 73% of employers are expecting an increase in dependent coverage in 2012 due to the law passed in 2010. Some states allow dependents to remain on these plans until age 30. Young adults do not have to be financially dependent on their parents or live with their parents to remain on their parent’s plans. They can even be married (Hynek, 12/21).

**Modern Healthcare:** Public Support For Reform Rebounds: Poll. Public support for the healthcare reform law ended the year as it began after faltering during October and November, a monthly Kaiser Family Foundation poll found. The December poll found 41 percent of respondents considered the Patient Protection and Affordable Care Act favorably. Favorable responses started the year at 41 percent and hovered between 41 percent and 43 percent throughout 2011, with the exception of 39 percent in August; 34 percent in October and 37 percent in November (Evans, 12/21).

**CO HealthBeat:** Public Opinion Back To An Even Split On Health Care Overhaul. Americans once again are nearly evenly divided in their opinions about the health care law, following a rocky autumn in which public approval lagged, according to a Kaiser Family Foundation tracking poll issued Wednesday. ... Kaiser Family Foundation President Drew Altman said in November that he suspected voters were listening to criticism of the law aired during a series of Republican presidential debates (Norman, 12/21).

**Kaiser Health News:** Public Can Be Swayed On Health Law’s Mandate, Survey Finds. The individual mandate is the Affordable Care Act’s least popular provision and lies at the heart of the legal challenge to the law before the U.S. Supreme Court. But a new poll finds that public opinion can be swayed by how the mandate’s implications are described (Rau, 12/21).

Two outlets take a look at what’s ahead in 2012.

**Kaiser Health News:** New Year, New Health Care Battles (Video). Kaiser Health News reporters detail some of the major issues they expect will be in the news in 2012, including the GOP’s fight to repeal the federal health law and what Republicans may offer instead; states’ efforts to control growing Medicaid costs; the rising cost of health care for consumers (12/21). Watch the videos.

**CNN Money** (Video): Save Money On Health Care In 2012. Speaking directly with your doctor about costs and
restrictions can help you save money on health care in 2012 (12/21). (Kaiser Health News, 12/22/11)

HHS Avoids Backlash By Allowing Flexibility On Essential Benefits

By allowing states the flexibility to make key decisions, the administration avoided a "political hot potato" regarding essential benefits — the medical benefits insurers must cover under the U.S. health care.

Bloomberg: Obama Health-Insurance Decision Passes Political 'Hot Potato' To States. The Obama administration avoided a potentially brutal lobbying battle over the medical benefits insurers must cover under the U.S. health care overhaul when it decided last week to hand the decision off to states. ... Business groups will argue for a narrow set of benefits to save costs while consumer advocates push for expanded coverage. The decision shifts the debate to statehouses and away from the White House, and lets President Barack Obama say he's giving governors and legislatures more flexibility within their own communities to confront rising medical costs and control changes the 2010 health care law is bringing to insurance markets (Wayne, 12/19).

Polictico: First Crack At Essential Benefits Dodges Backlash. The Obama administration's first crack at defining minimum health benefits did exactly what consumer groups hoped it wouldn't do: It gave states a choice of "benchmark" plans rather than spelling out the details. But the administration seems to have pulled it off — because there was no backlash to be found from groups that championed the law (Millman, 12/18).

Denver Post: States Get Flexibility To Design Benefits Under Health Care Reform. A large Colorado consumer group said states will now have to resist insurer and anti-reform influence, and work hard to set high standards for patients. "In this guidance, HHS has effectively ducked their responsibility to make critical decisions," said Dede de Percin of the Colorado Consumer Health Initiative. "This approach potentially encourages and exacerbates a coverage race to the bottom among states" (Booth, 12/17).

Kaiser Health News: HHS Gives States Flexibility On Health Law's 'Essential Benefits'. States will be given wide latitude to decide what 'essential benefits' insurers must offer in their health policies come 2014, the Obama administration said Friday in a move that pushes off final federal rules on the topic until an unspecified date (Appleby, 12/16).

The Hill: HHS Defers To States, Will Let Them Decide Which Benefits Health Plans Must Cover. The Obama administration said Friday that it will defer to the states on one of the most important mandates in the health care reform law. The Health and Human Services Department said states will take the lead in determining the benefits that every health plan will soon have to cover. Defining "essential health benefits" is among the most important steps in implementing the Affordable Care Act. The law lists 10 broad categories of benefits that every plan sold to individuals and small businesses will have to cover, beginning in 2014. It leaves the specifics of that mandate to HHS. And HHS said it intends to pass the job down to states (Baker, 12/16).

Reuters: States To Weigh In On Basic Health Coverage. U.S. health officials will allow states to select the basic set of medical benefits that must be offered by insurance plans participating in new exchanges mandated by the federal healthcare overhaul, the U.S. government said on Friday. The Department of Health and Human Services announcement relates to the so-called essential health benefits for millions of Americans expected to qualify for coverage sold through state-based insurance exchanges beginning in 2014 (Krauskopf, 12/16).

The Associated Press: States Get Say On Health Benefits In Obama's Law. The Obama administration Friday rolled out a benefits framework for millions of people who will get private insurance through the health care overhaul, but states will decide the specifics. Under the new law, the federal government must set a basic benefits package for private insurance. That's tricky territory for the administration, which is trying to avoid the "big brother" label on health care. Obama will be defending his signature domestic law on two fronts near year — before the Supreme Court and the voters (Alonso-Zaldivar, 12/16).

NPR: States Would Get More Flexibility On 'Essential Benefits' Under Proposal. It may or may not be a punt, but the Obama administration wants to let states play a bigger role in deciding what constitutes an "essential health benefits" package when it comes to health insurance. The Department of Health and Human Services issued what it called a "bulletin" outlining a policy it hopes to impose. In other words, it's not even yet a formal regulation. The idea is to give states "more flexibility and freedom" to implement the part of the health law that includes the essential health benefits requirement. Under the proposal, rather than having the federal government set a package of benefits for plans sold to individuals and small businesses, states could match the benefits of specified plans currently available to their residents (Rovner, 12/16).

Minnesota Public Radio: Health Coverage Required Minimum To Be Set By States. The Department of Health and Human Services will set a basic framework for what insurers must cover, but states will fill in the details. There is wide variation in the treatments and procedures that states require insurers to cover. A statement from State Commerce Commissioner Mike Rothman said the move "will provide Minnesota flexibility to ensure health plans sold in Minnesota meet the unique demands of Minnesota's consumers, economy, and health care

December 26, 2011
Essential Benefits -- Who Decides?

Since the passage of health reform Affordable Care Act, many have wondered what would be covered in the benefits offered through the State Exchanges. We have been reassured that the benefits that are “essential” would be comprehensive yet affordable. But essential to whom? What is an essential benefit and who gets to decide? Tough questions. No easy answers. Today HHS released a bulletin putting part of the issue to the States. States will have more “flexibility” to determine what is in the essential benefit package. Of course, not complete flexibility. These benefit plans MUST include, at least, the ten categories of benefits that are defined in the law. Those categories include:

Section 1302(b)(1) provides that EHB include items and services within the following 10 benefit categories: (1) ambulatory patient services, (2) emergency services (3) hospitalization, (4) maternity and newborn care, (5) mental health and substance use disorder services, including behavioral health treatment, (6) prescription drugs, (7) rehabilitative and habilitative services and devices, (8) laboratory services, (9) preventive and wellness services and chronic disease management, and (10) pediatric services, including oral and vision care.

Do you see anything that is missing? Do you see anything in this list that a plan offered to an individual or small group in your state might NOT include? Look again. Item #7 – “habilitative” services and devices; and item #10 – “pediatric services, including oral and vision care.” These categories are not commonly found in the more restrictive plans offered to individuals and small groups. In fact, the concept of a “habilitative benefit” is not widely understood nor is there a common definition, particularly among private insurance pans. HHS acknowledges that some plans in a state might not include those services, so they are working on a way to better define these services and allow states the “flexibility” to get creative about how they offer these services. For people who may need help maintaining function not just regaining it, this is a process they should watch very carefully. Here are some questions that you might want to know about what is unfolding:

1) Why give states more flexibility to define what services are essential? Is a person in Florida really all that different from a person in Nebraska? Are there diseases in Florida that do not occur in Nebraska? Not really. The idea of “state flexibility” is often proposed to mitigate political opposition and deflect charges that this is a government takeover of health care. But it probably won’t work here, because the law actually does define what is essential -- the ten categories. And there is no real flexibility for states to drop an entire category.

2) The law says that benefits must be equivalent to a “typical employer plan.” Who defines what is typical? Is there any such thing? Actually, HHS went to some trouble to try to figure that one out. They analyzed a variety of benefit packages in the states and determined that the real variation was not so much across the ten categories (except for habilitation and oral and vision care for kids), as in the cost sharing for these services. So states can vary cost sharing and they can also choose what a typical or “benchmark” plan will be – it could be the largest commercial HMO plan in the state, the largest small group plan, or a state or federal employees plan. If a state declines to choose, HHS will do it for them with a default plan.

3) What if a service I need is not considered “essential?” Where does chiropractic care fall in the ten categories? What about acupuncture? In vitro fertilization? Contraception coverage? Contraception coverage WILL be considered essential (if it is FDA-approved). That question has already been asked and answered by HHS. As for other services, this will be a state by state decision.

4) If your state already mandates that certain services be included in the benefit packages sold in my state, what happens to those benefits? There are literally hundreds of state mandated benefits across the 50 states, and there is considerable variability. Only a few states mandate autism services; many more mandate chiropractic. But here is where HHS most definitely punted and even poked states a bit in the eye. Since there was no way that all state benefit mandates could be included in a benefit package that was still affordable, HHS left it to the states to pay for the mandates they had already passed -- and states have to include those mandates in the essential package, at least for the first few years of the Exchange. State mandates are a mixed bag. Some are lobbied by the providers themselves; others by consumers and families. If you are giving states flexibility about adding services, it makes sense that they should have to live by the decisions they have already made.

5) How did HHS define a “medical necessary” benefit? They apparently did not. Even though the Institute of Medicine report recommended that this term of art be based on evidence not just the judgment of an individual doctor, HHS has not yet issued their recommendations. You may never have encountered a denial from your health plan because the service you and your doctor requested was not considered "medically necessary." But it is important to understand how this term is used in your plan. Appeals are a worthless exercise if you, as a consumer, do not understand the process by which a plan determines what they will pay for.

What is good about what the essential benefits as we understand them now? For one thing, mental health and substance abuse services are considered essential -- and that means no annual or lifetime limits, just as with...
medical services (after 2014); maternity care is included and essential, and not all small group or individual plans include maternity care; children can get some vision and dental care; if you have had an accident and you need ongoing physical therapy, there is a chance you can continue to get coverage to maintain your level of physical ability. Also, if your state mandates coverage of services you value, like acupuncture or chiropractic care, those benefits will be included as well. What’s next for essential benefits? There is a comment period during which time any person or group can submit their opinions and questions to HHS. (Public input on this proposal is encouraged. Comments are due by Jan 31, 2012 and can be sent to: EssentialHealthBenefits@cms.hhs.gov.) Sometime in 2012, HHS will issue final regulations. And then? Well, check out what is going on in your state. 2014 is not that far away. (Huffington Post, 12/16/11)

Minimum Essential Health Benefits Will Be Largely Set By States

The Obama administration will give states broad latitude to define the minimum benefits that many health insurance policies will be required to offer under the 2010 health-care law, officials announced Friday. The plan sparked criticism from interest groups on all sides of the issue. Consumer advocates worried that millions of Americans could end up with insurance substantially less comprehensive than the law’s drafters intended. Representatives of employers and insurers warned of an opposite scenario: A state could make the benefits package so comprehensive that the resulting plans would be prohibitively expensive. Obama officials have yet to spell out key details, but Friday’s announcement offered a road map for how the administration intends to implement the health-care law’s “essential benefits” mandate. An important provision of the law, it requires affected plans to provide a minimum package of benefits in 10 coverage areas, including maternity care, prescription drugs, mental-health care, rehabilitative and habilitative services, and pediatric services with oral and vision care. The mandate will apply to new policies purchased by individuals or small businesses beginning in 2014. The law leaves it to the discretion of Secretary of Health and Human Services Kathleen Sebelius to determine whether to specify precisely which procedures and services should be covered and to what extent insurers can limit the frequency of their use. Friday’s announcement suggests Sebelius will largely pass the decision on to states. Her proposal calls for each state to select an existing health plan to use as the “benchmark” for the items and services all covered plans in the state must include as part of the minimum package. The benchmark plan can be either the largest HMO plan in the state’s private market or one of the three largest plans covering small businesses, state employees or federal employees in the state. If a benchmark plan does not cover services in the 10 mandated categories, states will have to come up with supplementary requirements through an as-yet-unspecified process. If a state does not designate a benchmark plan, the standard will be the small-business plan with the largest enrollment in the state. At a news conference, Sebelius said the arrangement would ensure state leaders can “tailor” health insurance requirements to local conditions and priorities. “Coverage that works in Florida may not work in Nebraska,” she said. But she also stressed that all 30 million Americans in plans affected by the rule would be guaranteed a minimum level of coverage that many currently lack. According to government estimates, more than 1 million Americans will gain prescription drug coverage, for instance, and more than 8 million will gain coverage for maternity care. Consumer advocates expressed concern that unless the services covered under the general rubric of each category are specified, many plans will be able to comply with the mandate while still offering substandard care. “Let’s say a plan only covers generic drugs. Well, a lot of cancer drugs are only brand-name,” said Stephen Finan, senior director of policy at the American Cancer Society Cancer Action Network. Just as important, he said, is how much plans limit use of the services they cover. Also potentially subject to abuse, consumer advocates said, is a provision that would let insurers modify benefits they offer under the minimum package as long as the total cost is not changed. “This is a grave disappointment,” concluded Debra Ness, president of the National Partnership for Women & Families. Employers and insurers also were unsatisfied. Many states require coverage of services beyond those in the minimum package, noted Neil Trautwein, an official at the National Retail Federation who chairs a group of employers and health plans called the Essential Health Benefits Coalition. Friday’s proposal includes a provision that, for the first two years, would effectively allow states to include those additional requirements as part of the minimum benefits package — potentially increasing the cost. Sebelius declined to set a limit on the cost of the minimum essential package, as recommended by an advisory panel of experts she commissioned. “The ultimate test of these plans is going to be, ‘Will people be able to buy them?’” said Trautwein. “And that question really was not addressed today.” (Washington Post, 12/16/11)

Implementing Health Reform: A Bulletin On Essential Health Benefits

On December 16, 2011, HHS released a “bulletin” describing the approach that it intends to take to establishing the “essential health benefits” under the Affordable Care Act. A bulletin is a form of guidance that lacks the legal stature of a rule. HHS believed, however, that the states, insurers, consumer advocates, and the public needed some indication as to the direction HHS was intending to take in defining the EHB, and the Bulletin was intended to serve this purpose until an
actual rule is issued. The “essential health benefits” (EHB) concept is one of the most important innovations of the ACA. The EHB is a menu of services that specific types of health plans must cover. Essential health benefits can be covered, however, with various levels of cost sharing, and cost sharing is addressed separately by the ACA. Different plans could each cover the same EHB and differ dramatically in their actuarial value and their cost. Beginning on January 1, 2014, all small group and individual insurance plans (in or out of the exchanges) must cover the “essential health benefits package.” The essential health benefits package includes the EHB, but also imposes limits on out-of-pocket spending and deductibles in group plans, as well as the metal tier cost-sharing level requirements. The EHB (but not necessarily the EHB package) must also be covered under the ACA by catastrophic plans, plans in the Office of Personnel Management (OPM)-administered multi-state plan program, the basic health plan in states where it exists, and at least some Medicaid plans. Insurers may provide benefits in addition to the EHB and states may require plans subject to their regulation to provide additional benefits. If states require “qualified health plans” or multi-state plans to cover benefits in addition to the EHB, the state may pay the cost of additional benefits. “Qualified health plans” are plans certified to participate in the exchange, but may also be offered outside of the exchange. The federal cost-sharing subsidies that are available for lower-income Americans beginning in 2014 only apply to the EHB and not to additional benefits offered by plans. The EHB requirements do not apply to large group plans and self-insured plans, although employer plans must meet a “minimum value” standard that has yet to be defined.

The Process Of Identifying Essential Health Benefits Under The Affordable Care Act

The ACA specifies in some detail how the EHB are supposed to be identified. First, the ACA lists ten categories of services that must be covered in the EHB. Some of these have long been standard, like hospitalization and ambulatory patient services. The EHB list also includes a few services, however, that are not uniformly covered today, including habilitation services and pediatric oral and vision care. HHS is supposed to ensure that the EHB scope of benefits is “equal to the scope of benefits provided under a typical employer plan,” based on a survey conducted by the Department of Labor. The CMS Chief Actuary is directed to certify that the EHB meet this standard. HHS is also required to receive public comment as it defines the benefits. HHS must ensure that:

- The benefits are balanced among the 10 categories;
- The EHB definition does not “make coverage decisions, determine reimbursement rates, establish incentive programs, or design benefits in ways that discriminate against individuals because of their age, disability, or expected length of life”; and
- The EHB take into account health needs of diverse population groups.

HHS must also periodically review and update the EHB. The EHB must cover emergency care without prior authorization, network participation, or out-of-network cost sharing requirements; must permit stand-alone dental coverage; must ensure mental health parity; and cannot include abortion coverage. In addition to receiving the DOL report and receiving public comments, as required by the ACA, HHS also commissioned the Institute of Medicine to prepare a report on how the EHB should be determined. This study took much of 2011 and contributed to the delay in HHS getting an EHB definition out. State legislatures will be meeting shortly to consider the legislation they must adopt to be ready for the state exchanges to be operational for 2014, and an item that will certainly be on their agenda is what to do with state mandated benefits that exceed EHB requirements. Insurers, moreover, will need to price their exchange and small group products early in 2013 to be able to offer them when exchange open enrollment begins in late 2013. Although HHS is apparently not ready yet to issue proposed regulations on this issue, some guidance on HHS plans was needed. The Bulletin attempts to fill this need.

States Will Get Flexibility In Defining Essential Health Benefits

It is likely that the intent of those who drafted the ACA was to establish a uniform national EHB standard. This is not what the Bulletin proposes, however, at least for 2014 and 2015. Rather the Bulletin proposes that each state define its own EHB within federal guidelines. States will do this by choosing among federally-defined “benchmark” plans. This is the approach that the Children’s Health Insurance Program (CHIP) has used since 1997 and that states may use for some Medicaid populations. The Bulletin signals that HHS intends to extend this approach to those groups guaranteed the EHB under the ACA. For 2014 and 2015, states may pick a benchmark plan from one of the following four categories:

(1) the largest plan by enrollment in any of the three largest small group insurance products in the State’s small group market (a product being a package of services and riders offered by an insurer and a plan being a specific selection of benefits and cost-sharing);
(2) any of the largest three State employee health benefit plans by enrollment;
(3) any of the largest three national Federal Employee Health Benefit Plan options by enrollment; or
(4) the largest insured commercial non-Medicaid Health Maintenance Organization (HMO) operating in the State. If a state fails to pick a benchmark plan, the largest plan in any of the three largest small group products will be the default. Under the Bulletin, exchange plans and plans offered in the individual and small group market must cover the services included in the benchmark plan.
Although the ACA amends the Medicaid statute to require Medicaid benchmark plans (including plans covering adults under 138 percent of the poverty level) to cover the EHB, the Bulletin focuses on private plans and provides that further guidance will be issued for the Medicaid program. Multi-state plans are not addressed, although this approach may be problematic for them. The benchmark approach allows the states to defer having to pay for mandated services that exceed the EHB. If a state chooses a small group market plan, that plan will presumably cover all mandated benefits and thus the state will not need to pay for extra benefits. HHS will apply this approach for 2014 and 2015, but gives notice that it may cease to cover some state-mandated benefits beginning in 2016. Of course, a state that chooses to include mandated benefits within the EHB will also probably need to cover them for at least the Medicaid expansion population. Most benchmark plans will cover most of the ten categories of services listed in the statute. Many small group plans do not currently, however, cover behavioral health and habilitation care and pediatric oral and vision services. (Individual health plans also often do not cover maternity care, but individual plans will not be a benchmark option.) If the benchmark plan does not cover a particular category of services, the state must supplement the benchmark plan using the benefits from the largest plan in the category covering the missing services, or, if none is available, benefits from the FEHBP plan. The Bulletin discloses alternatives that HHS is considering for ensuring coverage of habilitation and pediatric oral and vision coverage—including a required equivalence between habilitation and rehabilitation services and basing oral and vision coverage on services covered under federal employee plans. All plans must cover mental health and substance abuse care, including behavioral health care at parity with physical health services. Insurer flexibility. The menu of benchmark plans gives the states considerable flexibility in defining the EHB. Beyond that, however, the Bulletin signals the intent of HHS to give insurers additional flexibility. Health plans need only offer benefits that are “substantially equal” to the benefits of the benchmark benefits (as is currently the case in CHIP). Insurers will have “some flexibility to adjust” the specific services they cover and quantitative limits on benefits. The Bulletin states that flexibility “would be subject to a baseline set of relevant benefits,” but it is far from clear how this baseline will be set. HHS is considering allowing actuarially equivalent substitutions of benefits within categories, but possibly also between categories, subject to “a higher level of scrutiny” ... “to mitigate the potential for eliminating important services or benefits.” HHS will also permit flexibility with respect to drug coverage as long as all categories and classes of drugs are covered. Health insurers will also be allowed to update their benefits on an annual basis. The Bulletin, however, promises guidelines to ensure balance and discourage discrimination. HHS will review and update the EHB and re-evaluate the benchmark approach. Future blog analysis by others will explore in more depth the policy issues raised and settled by the Bulletin. The Bulletin gives states some assurances that they will have a good deal of control over the EHB. On the other hand, it will also give them more political responsibility than some might like. It assures insurers that they will continue to have a lot of discretion in establishing their benefit packages, although beginning in 2014 many will need to cover some benefits they have not heretofore covered. Consumers may be reassured that state benefit mandates are probably not going away soon. Many are likely to be concerned, however, that the Bulletin is not going to establish a uniform, comprehensive floor of benefits that many had hoped for. (Health Affairs Blog, 12/16/11)

**Obama Insurance Decision Passes ‘Hot Potato’ to States**

The Obama administration avoided a potentially brutal lobbying battle over the medical benefits insurers must cover under the U.S. health-care overhaul when it decided last week to hand the decision off to states. The Dec. 16 ruling, coming less than a year before the presidential elections, gives states the power to set coverage levels for the policies uninsured people will buy through regulated marketplaces, called exchanges, starting in 2014. Business groups will argue for a narrow set of benefits to save costs while consumer advocates push for expanded coverage. The decision shifts the debate to statehouses and away from the White House, and lets President Barack Obama say he’s giving governors and legislatures more flexibility within their own communities to confront rising medical costs and control changes the 2010 health-care law is bringing to insurance markets. "Obama has taken all the grief he can stand over health care," said Erik Gordon, a business professor at the University of Michigan in Ann Arbor, in an e-mail “He doesn’t want it to give the Republicans any more political ammunition. He is passing the hot potato to the states.” About 24 million people are projected to buy coverage through exchanges by 2019, according to the Congressional Budget Office. Premiums will average $5,800 for individuals and $15,200 for families in 2016.

**Similar Services**

Under the new guidelines, state lawmakers must either set coverage levels in line with widely subscribed small-business plans in their communities, or peg them to benefits included in their state employees’ health plan, federal employee plans or the largest commercial managed-care plan in the state. Generally, health plans for small businesses, state employees and federal workers “cover similar services,” including doctors’ visits, hospitalization and outpatient mental health, according to a study conducted by the U.S. Health and Human Services Department ahead of the Dec. 16 announcement. Differences arise in areas such as...
prescription drugs. While they’re covered as a basic benefit by all government employee plans, only 84 percent of small business plans include them. The others require additional premiums, the study found. Small business plans also don’t tend to cover dental care, acupuncture, bariatric surgery and hearing aids, unless states require it, the study showed. Federal plans cover those services.

Business’ Preference

“Businesses would rather deal with states, many of whom are far more sympathetic than Washington is to claims that high benefits will bankrupt employers,” the University of Michigan’s Gordon said. “Given the competition for jobs, I expect to see regulatory arbitrage bid down required coverages,” he said. The lack of national standards may allow some states to skim in areas such as maternity coverage, said Debra Ness, president of the National Partnership for Women & Families in Washington, in a statement. The administration’s ruling is “a grave disappointment” that ignores the health-care law’s direction “to develop a detailed package that would apply uniformly to plans across the nation,” Ness said. States that have delayed implementing the health-care law have one less excuse for not moving forward, said Ethan Rome, executive director of Health Care for America Now, a coalition of labor and civil rights groups that supports the statute.

Balancing Priorities

“’This shifts the battle over essential benefits to state capitals, where the insurance lobby is strongest and where it will advocate for inadequate benefits that won’t meet the needs of people,’” Rome said. “State regulators need to have a transparent process in making these important decisions and should stand up for consumers.” Neil Trautwein, a vice president at the National Retail Federation, heads a coalition of business groups and insurers lobbying for a narrow coverage package. He says both the federal and state governments need “to develop a rule that balances state-selected and reasonably comprehensive benefits with affordability for employers and Individuals,” no matter which state is involved. Rules that do otherwise “will make health coverage more expensive for employers and individuals to purchase and make jobs more difficult for employers to create,” he said.

Guaranteed Coverage

Many states already set minimum benefit levels in regulating insurers. Idaho, for instance, mandates insurers to cover just 13 types of health services while Rhode Island requires coverage of 69, according to the Council on Affordable Health Insurance, an industry group. The health law, though, left open many questions involving how they would be set up and run, opening the way for the Obama administration to control that through regulatory guidelines. The decision not to impose national standards is in line with other moves by the administration this year as it develops rules to expand coverage to a projected 32 million people.

More State Options

Regulations released by the U.S. Department of Health and Human Services in July gave states wide latitude to design and run the markets. The administration also offered conditional certification for states that make good-faith efforts to establish exchanges but aren’t able to meet a 2013 deadline. HHS also issued several directives it said were aimed at giving states more options to design their own Medicaid programs. States and the federal government run Medicaid, with the U.S. approving changes in eligibility standards by granting waivers from national law. The program is among the biggest expenses for states and also a prominent vehicle to expand coverage to the uninsured under the law. A February letter from the U.S. to states raised the prospect of dropping some adults with incomes exceeding 133 percent of the federal poverty level from the program to close budget shortages. Still, foes of the 2010 health-care law say the moves don’t go far enough. The law itself is the issue, not how it is regulated, said Senator Orrin Hatch of Utah, the senior Republican on the Finance Committee, suggesting that it will remain a key campaign issue in the presidential elections no matter what the Obama administration does to dim protests on specific issues. “The framework proposed by the administration takes away the right of individuals to chose the health care plan that best fits their needs,” Hatch said after the administration announced states would set benefit rules. (Washington Post, 12/19/11)

As Attacks Continue, So Do Health Law Implementation Efforts, Challenges

The Hill and Reuters report on the health law’s numerous 2012 battle fronts — starting with the Supreme Court’s review of the law and moving toward the November elections. Meanwhile, however, other news outlets report on continuing implementation of the measure, including the creation of a federal health exchange and defense of its prevention fund.

The Hill: Year Ahead: Health Law Under Attack On All Fronts. President Obama’s health care reform law will be under attack on every conceivable front next year. Its first life-or-death experience lies in the hands of the Supreme Court, which could potentially strike down the Affordable Care Act as early as June. Even if the high court upholds the law, it could remove its individual mandate — prompting a bitter debate in Congress and
within the administration on how to go forward without it. Next obstacle: the November elections. Every Republican presidential candidate has vowed to repeal the law, through executive orders and by signing repeal legislation. Republicans are expected to keep control of the House, and with Democrats defending 23 seats in the Senate, the GOP has a shot at gaining the 60-member majority needed to get anything through (Pecquet, 12/18).

Reuters: Analysis: Deficit May Be Biggest Threat To Health Care Reforms. A mounting U.S. deficit could pose a much greater threat to the survival of President Barack Obama's health care reforms than either the Supreme Court or 2012 elections. ... Former top health care policymakers from Democratic and Republican administrations warn that some of the most promising measures for controlling costs, while improving quality and access to care, could run aground as early as 2013 if a new Congress and administration respond to the fiscal pressures with arbitrary spending cuts (Morgan, 12/18).

Kaiser Health News: Feds Face Challenges In Launching U.S. Health Exchange. With many states unwilling or unable to get insurance exchanges operational by the health care law's deadline of Jan. 1, 2014, pressure is growing on the federal government to do the job for them. But health care experts are starting to ask whether the fallback federal exchange called for in the 2010 health law will be operational by the deadline in states that will not have their exchanges ready (Appleby, 12/19).

CQ HealthBeat: Preventive Services May Improve Health, But Not Health Care Costs. The health care law provides $15 billion in mandatory spending over 10 years, starting in fiscal 2010, for a "sustained national investment" to improve health and help restrain costs in the private and public sectors. The prevention fund supports research, health screenings and immunization programs, and it will pay for local efforts to increase exercise, improve people's diets and reduce tobacco use. Congress has appropriated $1.25 billion for the fund. ... "The prevention and public health fund represents one of the most meaningful investments in wellness in our history," said Sen. Tom Harkin, D-Iowa, a champion of disease prevention programs (Bristol, 12/16).

California Healthline: PCIP Enrollment Numbers Rise A Bit. In the first year after the program launched in October 2010, it added about 375 enrollees a month. At the one-year mark, enrollment stood at about 5,000 Californians. That was a far cry from early guesses about how many people would sign up. The capacity of the program was originally estimated at 23,000, so it has been an ongoing concern for MRMIB officials that the enrollment growth rate has been relatively mild. Recently, those numbers have climbed. In the past couple of months, new enrollees topped 700 a month, and rose above 800 in the past month (Gorn, 12/16).
differing computer systems in 50 states plus the District of Columbia. Matt Salo, executive director of the National Association of State Medicaid Directors, notes that computer systems in some states are quite old and may need substantial upgrading. While the federal government is putting up 90 percent of the money for the upgrades, Salo says there is some question about whether there is enough “physical capacity in the IT systems world” to get it all done in time. “Our members have been having conversations with the vendors since the law was passed, and they are coming to the gradual conclusions that no, they don’t have the capacity to do this everywhere in the time frame,” says Salo. Political threats also abound. No one knows whether the Supreme Court will invalidate part or all of the law next year. It is also not clear how much funding will be available to launch and operate the federal exchange, and the 2012 presidential and congressional elections could delay or derail the entire process if Republicans are victorious. Still, at this point Schuyler says he is confident that the Obama administration “will be able to provide a federally facilitated exchange” in time to meet the law’s requirements. Although federal officials are saying very little about their progress, they have signed contracts worth more than $150 million with several private contractors who are working on creating the federal exchange. Late last month, Oregon’s top insurance regulator, Teresa Miller, was hired by the Department of Health and Human Services to oversee development of health insurance exchanges. The administration is taking a three-pronged approach, says Schuyler, who formerly was director of technology at the Utah Health Exchange. First, a Federal Data Services Hub is being built to pull together needed information across agencies, such as the IRS and Social Security. States will be able to “plug in” to that data hub if they run their own exchanges. The Department of Health and Human Services has signed a five-year contract worth roughly $69 million with Columbia, Md.-based Quality Software Services to set up the hub. The second prong is to beef up the healthcare.gov site to include more information on health insurers and the health law. While the site already has some information on private insurers by zip code, more is coming. And finally, the federal government has signed a $94 million contract with Fairfax, Va.-based CGI Federal Inc. to build the federal exchange. The firm is also helping with the healthcare.gov site. A company spokeswoman referred questions to the government. Despite the contracts, some state officials, Medicaid directors and health-care experts are nervous. Many significant questions remain unsettled about the operation of exchanges, they say, whether the marketplaces are managed by the states or by the federal government. They still don’t know, for example, the final rules on “essential benefits” the federal government will require insurers to offer in all policies sold on the exchanges. Details on what the federal exchange will look like are still lacking. Also not clear are the standards — and the work required — for the states to upgrade their computer systems so they will link with the federal data hub. States will be assessed in January 2013 as to whether they will be ready by the fall of that year. “There’s an enormous amount to be decided and put together and built before these key milestones can happen,” says Laura Minzer, executive director of the Illinois Chamber of Commerce’s Healthcare Council. “The fact that so little has happened [at the state and federal level] is good cause for alarm.” What’s happening in Illinois shows that even when a state has authorized an exchange, political disagreements can stymie efforts to move forward. “A study group met over the summer, but didn’t come up with any clear recommendations,” says Minzer. A big part is politics, she adds. Some lawmakers — both Democrats and Republicans — fear that any movement to implement the law threatens their re-election chances. Others want to wait to see how the Supreme Court rules. “Even though we are a blue state — the Democrats have a majority in the House and Senate — there’s a nervousness going into the [2012] elections,” she says. “There’s speculation that nothing will happen on the exchange until after the elections.” It is possible to set up exchanges fairly fast, says John McDonough, one of the principal authors of the Massachusetts law that created a similar site, called the Connector. In that state, the exchange was up and running within about six months of the law’s enactment, he says. “Massachusetts had a head start because it had already done a modernization of its data system, so it’s not completely analogous,” says McDonough, now director of the Center for Public Health Leadership at Harvard School of Public Health, “but it doesn’t take as much time to get an exchange up as a lot imagine.” McDonough says in his conversations with Obama administration officials, he has found them “hell-bent on meeting the Jan. 1, 2104, deadline by hook or crook.” (Kaiser Health News, 12/19/11)

Exchanges Will Help Firms Amid Uncertainty

The Patient Protection and Affordable Care Act was signed into law by President Obama on March 23, 2010, with provisions of the bill scheduled to be phased in through January 2018. The next round of significant and material changes is scheduled to take effect January 1, 2014. It’s important for business owners to consider these changes — including tax relief, premium subsidies and the availability of “state insurance exchanges” — as we prepare our operating plans for the coming years. Like many small businesses in the D.C. area that provide goods and services to the federal government, we are small enough to purchase insurance through state insurance exchanges but our average salaries are too high for us to qualify for tax relief. Under the law, tax credits are currently available to qualified small businesses through 2014. Businesses with up to 25 full-time employees who earn average wages of $50,000 or
less excluding the owner and who contribute at least 50 percent of the total premium can qualify for a subsidy. The subsidy works on a sliding scale — employers with fewer workers earning less money may qualify for a larger subsidy. As a health care professional, I have always made employer sponsored health insurance a business priority. However, over the past several years it has become an increasingly difficult benefit to maintain, manage and afford. In an effort to protect this benefit for my employees, our company implemented a high deductible plan with a health spending account (HSA) two years ago, which has helped to slow the effects of premium increases. That being said, as a small business we will remain exposed to significant rate increases from year to year until we either grow to a size that would provide a more even distribution of risk or have access to another risk pooling arrangement. It is this uncertainty and my desire to continue my commitment to employer sponsored health insurance that makes me and millions of other small businesses supportive of the exchange concept. These state-based exchanges, or pools, were included in the law partly because of a concerted effort by organizations such as Women Impacting Public Policy (WIPP), a national nonpartisan public policy organization, of which I am a member, advocating on behalf of nearly one million women owned businesses and representing 59 business organizations. Small businesses have been waiting for years for a pooling mechanism to facilitate the purchase of affordable health insurance for their employees. To that end, it is critical that the proposed exchanges are structured in a way that most effectively combines small businesses together to maximize their buying power, avoid adverse selection and reduce actuarial risk, making the small business segment more attractive to insurers. Given our current benefit design, there is some concern that under health reform, the limit on the amount that can be deposited in an HSA tax-free will be significantly reduced, which could potentially be disadvantageous to my employees and their families. However, this risk could be mitigated if we are able to purchase insurance with similar benefits through an exchange for a lower premium. As our nation continues to focus on job creation and employment, it is critical to recognize the direct correlation between health and productivity, and the role that access to affordable health insurance plays in promoting a healthy and sustainable workforce. (Washington Post, 12/16/11)

Viewpoints: Is Wyden-Ryan Medicare Plan A Game Changer?; The GOP And The Individual Mandate

The Washington Post: Healing Medicare. In the maelstrom of dysfunction and partisanship better known as the 112th Congress, it is always surprising and gratifying when lawmakers from opposing parties manage to work together. That is particularly true when their collaboration involves an issue as politically charged and substantively complex as Medicare. So we begin by congratulating Sen. Ron Wyden (D-Ore.) and Rep. Paul Ryan (R-Wis.) for having the tenacity to try again, with a revamped version of Medicare reform unveiled last week (12/17).

Forbes: Why Wyden-Ryan Is A Game Changer On Medicare Reform. (The new bipartisan Medicare and health care reform plan from Democratic Sen. Ron Wyden and Republican Rep. Paul Ryan) isn't perfect — no plan that can get through Congress will ever be — but it's likely to be our best chance at getting both parties to come together. If Democrats and Republicans can't agree on something along the lines of Wyden-Ryan, Medicare reform is dead. On the other hand, if it succeeds, Wyden-Ryan may turn out to be one of the most significant legislative initiatives of the decade (Avik Roy, 12/17).

The Lund Report: Tell Ron Wyden To Say No To The Privatization Of Medicare. Last time we checked, Senator Ron Wyden was elected to represent the state of Oregon. Now that he's forged a dangerous Medicare compromise with the leader of the Tea Party caucus, we're not sure he remembers what state he represents. Here in Oregon, we like our Medicare just the way it is (Steve Hughes, 12/16).

The Wall Street Journal: Why Mandated Health Insurance Is Unfair. Should all Americans be required to have health insurance? ObamaCare said yes, and the issue is now central to the Republican presidential primary. Mitt Romney championed an individual mandate as governor of Massachusetts. Newt Gingrich once backed the idea too, egged on by several conservative think tanks, though he's now opposed. Its constitutionality aside (that'll be decided soon by the Supreme Court), is a mandate a good idea? (John C. Goodman, 12/19).

Bloomberg: How 'Mandate' Became Republican Candidates' Scarlet Letter. Absurdly, a central issue in the Republican presidential primary campaign is not so much the "individual mandate" for health care as which candidates once supported it. Individual mandates are a requirement that every person carry health insurance — self-paid, paid by an employer or paid by the government — and there is nothing heinous about them. What this dispute illustrates is the unflagging opposition that Republican politicians have for President Barack Obama, whose health-care plan features an individual mandate (12/18).

Des Moines Register: The Des Moines Register's GOP Caucus Endorsement: Mitt Romney Is Best To Lead. But more subtle distinctions apply to Romney on some major issues where he has been accused of flipping or flopping. He helped create health care reform in Massachusetts that is strikingly similar to the much-derided "Obamacare," for example. Yet Romney argues reasonably, though not entirely persuasively, that while all states should be free to experiment with their own
reforms, it is wrong for the federal government to force a one-size-fits-all plan on the entire nation (12/17).

USA Today: Reduce Abortions, Realign U.S. Politics. It’s political gospel that evangelicals are a solid Republican bloc because they vote only for candidates who oppose abortion. And on the whole, this is true — as they’ll likely again show in the upcoming Iowa caucuses. But something’s up: wiggle room. While evangelical opposition to abortion is firm, the evangelical vote is not fixed (Marcia Pally, 12/18).

Arizona Republic: Arizona's Spendthrift Days Are In The Past. In that spirit, the federal government should not shed its financial responsibilities onto states as it begins the much-needed process to trim spending. Likewise, Medicaid expansion under “Obamacare” remains the biggest long-term threat to Arizona's state budget and threatens to undermine our successes in reining-in state health care spending. I'll continue to lead the charge until this law is repealed by Congress or rejected by the U.S. Supreme Court (Gov. Janice K. Brewer, 12/17).

Des Moines Register: Are We Taking Medical Research For Granted? The enormous focus on budget cutting that is permeating so much of today's political dialogue could seriously compromise America's historic leadership in medical research. Not only would such an outcome slow medical innovation and result in drastic, multibillion-dollar cuts targeting cancer, Alzheimer’s, diabetes, heart disease and other major health threats, but it could also undermine the enormous benefits of medical research as a driver of economic growth (Raynard S. Kington, 12/17).

The Seattle Times: Health Care Improvement At Washington State And Federal Levels Calls For Courage. Elected officials seem to view cuts to social services as the only path to deal with our economic woes. Yet we all know deep cuts will only worsen everyone's health and cost us all more. The better and healthier approach would be to increase revenue — but that will take a great deal more courage (Charles Mayer and Teresa Mosqueda, 12/18).

Milwaukee Journal Sentinel: Progress On Infant Mortality, But Not Enough. Milwaukee made progress in the past year in its fight to improve the city's infant mortality rate, but lasting change will not be achieved unless there is more buy-in from the community. ... The health of a city is tied to the health of its children. When a baby dies, it becomes our problem regardless of the mother's socioeconomic class, marital status or race. You can keep complaining about the poor, or you can use that energy and help find solutions (James E. Causey, 12/17).(Kaiser Health News, 12/19/11)

HCA-HealthONE® Responds To Community Need for Behavioral Healthcare

Due to state budget cuts in recent years, mental health services have lost millions of dollars, making it difficult for patients to obtain much-needed care. Public and private psychiatric hospitals or specialized units have closed leaving Colorado at a loss, ranking the state 50th in the nation in terms of psychiatric beds per capita. One out of every four Americans experiences a diagnosable mental illness or substance abuse every year. Mental illnesses are more common than cancer, diabetes or heart disease and can affect persons of any age, race, religion or income. "Just like in other areas of medicine, we have made great strides in the treatment of psychiatric disorders, both in terms of better medicines with fewer side effects, as well as more focused and evidence-based psychological treatments," said Dr. George Bussey, HCA-HealthONE Chief Medical Officer. "But also, just like diabetes and heart disease, psychiatric disorders have their episodic flare-ups and need for more intensive interventions and then close follow-up. This is why we are so pleased to be able to provide a continuum of care at our new facility – so that we can address not only the acute phases of illness, but also the follow-up necessary to prevent or minimize the future need for intensive treatment." HealthONE's expansion of behavioral health care will include a 40-bed adult psychiatric inpatient unit when it opens. Future plans include adding an intensive outpatient and partial outpatient programs. "At one point in time, Denver and Colorado were known for their excellent mental health services across the continuum of care. "With our new unit and planned partnerships with community Behavioral Health providers, we hope to once again bring positive attention to Denver and Colorado for its level and sophistication of mental health services," said Dr. Bussey. The new HealthONE adult psychiatric inpatient unit will complement the existing HealthONE Senior Care Center, which provides mental health services to the aging population. HealthONE's parent company, Hospital Corporation of America (HCA) operates behavioral health care centers at 54 locations in 17 states and works with all 164 HCA hospitals and emergency locations to support behavioral health needs of those we serve. In 2011, HCA and HealthONE partnered with the National Alliance on Mental Illness (NAMI) to help dispel the stigma of mental illness and support individuals and families affected by mental illness. HealthONE has regional alliances with NAMI and fellow mental health advocacy organization, Mental Health America of Colorado (MHAC). "Mental Health America of Colorado envisions a healthy Colorado and that includes greater access to high quality behavioral healthcare," said Don Mares, CEO of MHAC and former State legislator and Denver Auditor. "HealthONE's behavioral health services—the expansion to include adult psychiatric inpatient care—will have a tremendously positive impact on mental health care for the Denver metro community.
E-Newsletter – National and Industry News
Florida Council
December 26, 2011

and throughout the State," said Mares. For more information on HealthONE behavioral health services and to track construction progress, visit www.HealthONEcares.com.

About HealthONE: HealthONE is the largest health care system in the metro Denver area with more than 9,000 employees and 3,000 affiliated physicians. HealthONE hospitals have a long and trusted legacy going back more than 130 years with St. Luke's, more than 85 years with Presbyterian Denver, more than 105 years with Swedish and more than 60 years with Rose. The current health system was created in 1995 as a Colorado company and a joint venture between The Colorado Health Foundation and various affiliates of HCA. The Foundation grew to the second largest charitable foundation in the state and in October 2011 sold its share in HealthONE to HCA (NYSE: HCA). (PR Newswire, 12/16/11)

Baylor Launches Chronic Disease Initiative

Baylor Health Care System has formed the Institute of Chronic Disease and Care Redesign, a systemwide initiative led by Dr. Clifford Fullerton. Fullerton, the system's vice president of chronic disease, and his team will focus on the growing prevalence of chronic diseases among patient populations and developing innovative solutions for managing chronic disease. The ICDCR was founded on the premise of providing care for chronic disease patients that is more accessible, understandable, and easy to navigate while working with patients to improve compliance to treatment plans and personal accountability. The institute's mission is to improve coordination and transitional care models across the entire continuum. The focus will be on clinical integration and process innovation across all sites of care with the purpose of bringing better care, better health and better value to people. In the current health care environment, patients diagnosed with chronic diseases drive almost 80 percent of health care costs. Most of these costs can be tied back to the gaps in care that occur once a patient is discharged from the hospital or leaves the physician's office. The institute will work to reduce gaps in care and drive down the costs. The ICDCR will initially focus on the following chronic disease management improvement efforts: diabetes, heart failure, coronary artery disease, respiratory illnesses, mental health and obesity. "I have a strong passion for quality care and I used to think you could do it one patient at a time, but now I find that the best way to see the most improvement is to look at a population of patients and try to improve their care," Fullerton said. "We can do that by looking at our data, identifying where the deficiencies in care are, and involving both the patient and physician in developing initiatives that will close care gaps and improve the coordination of care." (Dallas Business Journal, 12/16/11)

The Truth About Animal-Assisted Therapy

You know the impact your pet has on your life. But can the same sense of healing, security and unconditional love that your furry friend gives you be transferred in therapy? This is a question people like Amy McCullough, M.A., and Cynthia Chandler, Ed.D., are answering with a definitive “Yes.” The American Humane Association defines animal-assisted therapy (AAT) on their website as: “a goal-directed intervention in which an animal is incorporated as an integral part of the clinical health-care treatment process. AAT is delivered or directed by a professional health or human service provider who demonstrates skill and expertise regarding the clinical applications of human-animal interactions.” Here are four more facts you might not know about animal-assisted therapy:

1. They are not dependent on a specific theory. Animal-assisted therapy encompasses all types of psychology theories from psychoanalytic to behavioral. Amy McCullough, who is the American Humane Association's National Animal-Assisted Therapy Director, explains that animal-assisted therapy is "utilizing an animal as an adjunct to a therapeutic process" regardless of theory. In general, AAT "becomes another tool in their tool kit for the type of therapy they practice."

2. They are not service animals. Although often confused with service animals, there are significant differences between them. Service animals, for example, are protected by the American Disabilities Act, live with owners who have physical and emotional disabilities and assist them solely with daily living. In contrast, therapy animals work with professionals and clients.

3. They don't just include dogs and horses. While you will most likely hear about dogs and horses, therapy animals run the gamut from llamas to dolphins.

4. They help individuals with a wide variety of causes and settings. Therapy animals assist therapists in helping clients with a multitude of goals such as improving self-esteem and developing social skills, as well as providing help for anxiety and post-traumatic stress disorder (PTSD). They also work in a wide variety of clinical settings from psychiatric hospitals to nursing homes.

Benefits of Animal-Assisted Therapy

Cynthia Chandler, Ed.D is a counseling professor at the University of North Texas, the Center for Animal-Assisted Therapy's founder and director and the author of Animal Assisted Therapy in Counseling. She brought up a common question skeptics have when considering the benefits of animal-assisted therapy: "Well that sounds cute, but why I would really want to bring my dog to work?" Pet lovers will happily vouch for the positive impact their pets have on their lives. But is there anything significantly beneficial about involving animals in therapy? McCullough seems to think so. In her nine
years as a volunteer, she's worked with her dog Bailey and a recreational therapist at an inpatient psychiatric hospital. While there, she's witnessed an increase in patient participation in group therapy and changes in patient behavior. She also found that practical skills such as hygiene and self-care, specifically for patients with severe mental health issues, could be addressed more easily and with less discomfort in Bailey’s presence. “He (the therapist) would ask me sort of what did Bailey have to do to be able to come in here today and so I would talk about [grooming, nutrition and exercise] and he would use that as a jumping-off point to talk about how that’s important for all of the people in the room to think about.” Animal-assisted therapy can also help individuals develop social skills. AAT helps clients realize behavioral cues practiced with a therapy animal can be “use(d) beyond the 45 minutes that they are with the animal and apply this skill to other settings whether it’s getting along with their peers or talking to their counselor.” The relationship between therapy animals and the therapist can also be a model for a healthy relationship. For example, Chandler says that clients gain information about how to form and maintain relationships and trust by watching how a therapist responds to the animal and the animal responds to the therapist. “The therapist and the therapy animal, their interactions, their relationships serves as a good model for client that helps the client feel safer in a session.” The presence of animals themselves is soothing and can more quickly build rapport between therapist and client. In addition, therapy animals, especially horses and dogs, have built-in survival skills. That makes them able to pick up social cues imperative to human relationships. Therapists then can process that information and use it to help clients see how their behavior affects others. And they can do this in an immediate way. Chandler says, "If they say or do something the animal doesn’t like, the animal will just go and react negatively immediately and if they do something the animal likes, the animals going to react positively immediately. It gives them a chance to practice caring skills and social skills with a being which is simpler to do that with than a human.”

**Does Animal-Assisted Therapy Really Work?**

AAT began in the early 1990s and thus is a relatively new field. Since then, it has grown in popularity, has gained wide acceptance and is evolving into mainstream psychology. This is evident in the increasing number of universities such as the University of North Texas that offer a graduate course in animal-assisted therapy. Therapists and potential clients may wonder, however, what makes AAT more beneficial than traditional talk therapy. Skeptics may question the lack of research to back up the benefits of AAT. McCullough says, "There’s a lot of anecdotal information and case studies, but there’s really a need in this field for a broader long-term study." Her organization is currently working on a multi-site study with AAT and pediatric oncology patients and their families. But though the research may be sparse, Chandler says the research is out there and has been increasing since 2002. She cites one study, for example, that showed a significant drop in stress hormones such as cortisol, adrenaline and aldosterone and an increase in "health inducing and social inducing" hormones such as oxytocin, dopamine and endorphins after 20 minutes with a therapy dog. Working with a therapy animal has also resulted in behavioral improvement in children and a reduction in depression for elderly with dementia. To her, the research speaks for itself. “There is actually a psycho-physiological, emotional and physical (component) to interacting with a therapy animal.” And the key that links all of these positive benefits comes down to oxytocin. In addition to lowering blood pressure and heart rate, it is a powerful healing mechanism. “Oxytocin is one of the best, most powerful, wonderful, healthy social hormones we have and it’s the one that’s the most grossly affected in a positive way through human-animal interaction.” She says animal-assisted therapy is here to stay simply because the oxytocin effect is undeniable. Therapy animals have also returned the positive benefits of touch to counseling. Touch has been understandably removed from therapy, especially with counseling youth, but at a cost. Therapy animals also provide a purely nonjudgmental space for individuals to work out their problems. Chandler says, "Animals do not prejudge you. They don’t know that you’ve had a divorce. They don’t know that you’re dealing with sexual abuse." Sometimes it’s petting an animal itself or their ability to teach us in the present moment what we find too difficult to learn on our own. But it’s also the sheer presence of an animal, their acceptance and admirable ability to express themselves without holding anything back that makes animal-assisted therapy so powerful. McCullough says it best. "They accept you for the way you are flaws and all. They are so forgiving and they are always happy to see you. Their behavior is just so consistent and so consistently happy that I think it’s just comforting to people knowing that there is a being there that you can always count to be happy to see you and not judge you for anything you’ve done.” If you are interested in seeking animal-assisted therapy, you can contact the American Humane Association, the American Counseling Association or ask your veterinarian to refer you to an animal-assisted therapist in your neighborhood. (PsychCentral, 12/16/11)

**Recession Hurt Parent-Child Ties, Survey Finds**

The recent recession took a toll on parent-child ties, with parents who were under financial strain reporting that they felt less connected to their kids and kids saying they were less likely to act with generosity, a new study finds. Researchers from University of Nebraska-Lincoln and Brigham Young University analyzed data from a survey done in 2009 and then again a year later of about 500 families in the Seattle area about their feelings of depression, economic stress and family relationships.
The families were mostly white, middle- to upper-middle-class and college educated. The children were young adolescents, aged 10 to 14. From one year to the next, parents who reported increasing financial pressure were also more likely to report symptoms of depression, according to the study. In turn, depressed parents were more likely to report feeling less connected and less close with their child. Likewise, parental financial strain and depression also affected the children. Children whose parents were struggling were less likely to say they volunteered, helped their friends or their families, found enjoyment in doing small favors for others, or tried to cheer up people who were feeling blue -- a group of positive behaviors researchers call "pro-social behaviors."

"The effects of the economic strain are present and having an impact on families that we consider middle-class and upper-middle-class," said lead study author Gustavo Carlo, currently a professor of human development and family studies at the University of Missouri.

"These are families you'd think maybe aren't feeling the effects of the economic crisis in the way that other communities are, or that might have access to resources that other families might not have easy access to." And the families interviewed were from the Seattle area, which wasn't even as hard hit during the downturn as other regions of the country, Carlo added. "One can only imagine how these effects are being felt by families in areas where the communities have really suffered tremendously from the economic situation," he said. The study appears online and in the December print issue of the Journal of Research on Adolescence. To be sure, not every parent experiencing economic strain will become anxious and depressed, said Velma McBride Murry, a professor of human and organizational development at Vanderbilt University in Nashville, Tenn. "If you enter this situation having an increased vulnerability to depression and anxiety, economic strain elevates it, or sets it off to where you are more likely to experience greater devastation than people who are much more mentally stable," Murry said. But the current study adds to a large body of evidence that cuts across income levels and racial and ethnic groups and shows that economic stress can have a "cascading effect" on the whole family, Murry said. When under financial stress, parents who are used to being able to give their children a cellphone or new clothes suffer mentally when they can no longer do so. As money worries mount -- they're not sure they can pay the mortgage, or the utility bill, or a medical expense that comes in -- parents can become overwhelmed, irritable, short-tempered, depressed and withdrawn. "Then it erodes communication in the family, and reduces the connectedness that parents have with their children," Murry said. The kids feel it, too, and their attitudes and behavior can also suffer. Prior research has shown that the kids aren't bothered by the loss of the material goods -- the new cellphone or the clothes -- but by the impact it's having on their family, she added. "Prior studies have found that kids will say, 'it's not the stuff that I miss. I miss my relationship with my parents. That has shifted and the environment in my family has shifted,'” Murry said. Parents who are feeling economically strained and depressed should seek out emotional support, whether it's from family and friends, their church or from a mental health professional, Carlo urged. "They may have to pay some extra attention to work on the quality of the relationship with their child," he said. (HealthDay, 12/16/11)

More Quality Measures To Be Added to ACO Rule

CMS adopts an APA recommendation to the ACO final rule that people with mental illness, including substance abuse, be included in the definition of "at-risk" beneficiaries. The federal government has adopted a number of changes recommended by APA to its final rule on accountable care organizations (ACOs)—changes that are aimed at reducing the risks inherent in starting an ACO as well as easing burdensome reporting measures and allowing ACOs to keep a greater share in the money saved. As part of the new health reform law—the Patient Protection and Affordable Care Act—ACOs are designed to encourage more integrated care for Medicare beneficiaries and to improve care while reducing costs. In response to a proposed rule issued by the Centers for Medicare and Medicaid Services (CMS) in March outlining rules for ACOs, APA provided the agency with detailed analyses and recommendations. In its final rule issued in October, CMS adopted APA’s recommendation that people with mental illness, including substance use disorders, be included in what are defined as "at risk" beneficiaries who must be protected against discrimination and assured access to high-quality health care. In addition, CMS acknowledged the need for more mental health and substance abuse quality measures and will work on developing them with input from interested parties. The agency also adopted recommendations aimed at making it easier for physicians—especially those in small group practices—to participate. "When CMS released its proposed ACO rule in March, ACO participation seemed nearly unachievable to many physicians, including those who work for large multispecialty practices and health systems," Julie Clements, deputy director for regulatory affairs in APA’s Department of Government Relations, told Psychiatric News. "Our assessment is that the revised rule, published in the Federal Register on October 20, provides a better opportunity for physicians, including those working in smaller practices, to participate in the ACO Medicare Shared Savings Program.” Here are highlights of the final rule:

- The standard financial model for ACOs will still be shared savings, and the program will function essentially as a pay-for-performance program.
- There are specific provisions supporting participation by physician-owned organizations and rural providers.
There will no longer be requirements to withhold shared savings payments to cover potential future cost increases.

- ACOs will be allowed to share in savings beginning with the first dollar of savings earned.

- There will be 33 quality measures instead of the 65 originally proposed. In the first year, ACOs will be required to report only that they have recorded the quality measures ("pay for reporting"); in the second year they will be required to report savings ("pay for performance").

- ACOs will have more advanced knowledge of what kind of beneficiaries make up their pool than under the old rule.

- The requirement that at least 50 percent of an ACO’s primary care physicians be “meaningful users” of electronic health records was eliminated.

- There will be a rolling application process. The 2012 start-up date for ACOs has been pushed back from January 1 to either April 1 or December 1.

Report: Laura’s Law Works For Mentally Ill Los Angelenos

A little noted Laura’s Law Progress Report quietly filed by the Los Angeles County Department of Mental Health earlier this year shows Laura’s Law has reduced the incarceration and hospitalization of people with severe mental illness and saved taxpayers money which can be used for other purposes. Laura’s Law allows courts to order certain historically violent, dangerous, or incarcerated individuals to accept treatment as a condition of living in the community. To be eligible individuals must have a serious mental illness that causes them to be unlikely to survive safely in the community without supervision, and been in a hospital, prison or jail at least twice within the last thirty-six months; or involved in acts, attempts or threats of serious violent behavior toward self or others within the last forty-eight months. In addition to these stringent criteria meant to apply the program only to those who need it the most, L.A. also required them to meet extra criteria that theoretically would make these individuals even more difficult to treat. The results were outstanding:

- Laura’s Law reduced incarceration 78% During the six months prior to enrollment in AOT, program participants were incarcerated for approximately 388 days. But during the six months after enrollment in AOT they were incarcerated for only 85 days, a reduction of 78%.

- Laura’s Law reduced hospitalization 86% During the six months prior to Laura’s Law participants were hospitalized for 345 days. While enrolled in Laura’s Law only one person was hospitalized (for 49 days) for a reduction of 86%.

- Laura’s Law reduced hospitalization 77% even after discharge from Laura’s Law Since discharge from Laura’s Law participants had 81 days of hospitalization, or a reduction of 77% in days of hospitalization.

These results are from a small pilot study, but are consistent with results in Nevada County, CA results in New York and other states that use laws like this to improve patient care, keep public and patients safer and save money. California counties are among the last in the nation to make use of this treatment modality. The services are funded with Mental Health Services Act funding. Los Angeles Supervisor Michael Antonovich estimated Laura’s Law cut taxpayer costs 40% and called for hearings which will be held on Tuesday, December 20. (Huffington Post, 12/16/11)

AP Data: States Shed Thousands Of Public Employees

State governments across the country have cut more than 80,000 jobs since the beginning of the recession, reflecting steep drops in tax revenue and providing a drag on the economies in many parts of the country, the Associated Press has found. Data collected by AP reporters in all 50 states show the number of government employees has declined along with per-capita general fund spending. The national average of state employees per 1,000 people has dropped from 8.1 to 7.6, thanks to layoffs and hiring freezes since the 2007-08 budget year. State workers have been at the center of some of the most heated debates this year over the appropriate size and scope of government. Those debates will resume in 2012, especially as many states continue to struggle with budget deficits and seek to reform public pension benefits. General fund spending has rebounded beyond pre-recession levels in 24 states, but the remaining 26 are still a collective $42 billion lower compared with the budgets approved in 2007. Economic pressures combined with Republicans gaining control of more statehouses around the country have created ripe conditions for shrinking state governments, said Robert O’Connell, executive director of the Tennessee State Employees Association. “You end up with this chopping up of state services and getting rid of state employees,” he said. Even as the total number of state employees has plummeted, the ratio of public employees per 1,000 residents varies widely by state, the AP reporting found. Alaska had the most with 34.9, while Illinois had the fewest with 4.1 after cutting more than 4,000 workers from the state payroll since 2007. The AP figures exclude K-12 teachers and employees in higher education systems. Indiana, Ohio and Michigan were the only other states with five or fewer state employees per 1,000 residents. Each has seen steep reductions in the number of state workers since 2007 because of budget pressures. States with smaller populations had the highest number of state workers per 1,000 residents, led by Alaska, Delaware (18.7), Connecticut (17.6) and Wyoming (16.7). The fifth-
highest rate was in Virginia, where there were 14.4 state employees per 1,000 people despite the state shedding nearly 1,700 state workers between the 2007 and 2011 budget years. Virginia’s high level of state employees may be linked to its ranking third in the country in state-maintained highways, although successive governors have sought to chip away at the number of road workers employed by the state. Only 12 states bucked the trend of dropping state workers from the rolls. In Texas, the number of state government employees rose by more than 7,300 between 2007 and 2011. But Mark Miner, a spokesman for Republican Gov. Rick Perry, stressed that the state’s rising population meant the number of state workers dropped from 6.07 to 6.02 as measured per capita. Perry is seeking the GOP presidential nomination. Florida showed a net increase of 7,500 state workers since 2007, but most of those are due to an accounting change in 2009 that reclassified 14,000 county health officials as state employees. The state had previously paid their salaries, but the positions weren’t reflected in the state budget. Republican Gov. Rick Scott signed a budget this year that led to widespread layoffs of state government workers, and a report released in December shows the state government had 3.5 percent fewer employees as of June 30 compared to the previous fiscal year. One of the country’s biggest flashpoints over state employees this year occurred in Wisconsin, where Republican Gov. Scott Walker won passage of a new law ending most collective bargaining rights. He said it would give state officials more flexibility to deal with a $3.6 billion state budget shortfall. While Wisconsin ranks 41st in the country with 6.2 state employees per 1,000 people, the law also covered thousands more by including teachers and local government workers. Opponents alleged the move was designed to crush the public employee unions, which typically align with Democrats. “I don’t think this is an issue that is particularly driven by if we have a particularly large or small number of public employees,” said University of Wisconsin political science professor Charles Franklin. General fund data between the 2007-08 fiscal year, when the recession began, and this year show similar disparities in state spending. Eight states are spending more than $4,000 of their general funds on each state resident this budget year, while another eight are spending less than $1,500 per capita. General fund spending on a nationwide basis averaged $2,430 per capita. Even with the recession, 20 states have posted increases in per-capita general fund spending since 2007. But for 12 of them, the improvement was less than $150 per person. The biggest drop in per-capita spending occurred in Wyoming, where natural gas prices began to drop about the same time the recession began. The state, which had spent $3,442 per state resident in the 2007-08 budget year, is spending about $675 less this year. Lawmakers prepared for leaner years by placing surpluses into savings and creating an endowment to cover college tuition. The next biggest drop was in New Jersey, where the state is spending $615 less on each resident than in 2007-08, down from $4,009. The Garden State also has shed nearly 9,100 state workers, the third-largest reduction in total state employees after New York and Georgia. A deadlock among Minnesota lawmakers over how to close a $5 billion budget gap caused a 20-day government shutdown last summer. Connecticut has cut 6,000 state workers from the rolls since 2007. In Washington, Democratic Gov. Chris Gregoire wants voters to approve a temporary sales tax increase to offset some of the cuts that lawmakers are making to deal with a $1.4 billion shortfall, including the possibility of a shortened school year. Michigan’s general fund spending was the lowest among the states per capita, but a special dedicated fund for education makes the state’s $833-per-capita spending appear artificially low. The next lowest were Nevada, Florida, Arizona and South Carolina. (AP, 12/18/11)

Many Not-For-Profit Hospitals Spend Less Than 2% On Charity Care

Media outlets ponder the financial status of not-for-profit hospitals, as well as the challenges facing those in rural communities. Also in the news, the hospice industry continues to fare well.

Modern Healthcare: Out In The Open. Hospitals that receive hefty tax breaks to provide community aid spend a small fraction of their budgets on free and discounted medical care for those who cannot afford to pay. A Modern Healthcare analysis of new federal data on the sector’s spending found subsidized medical care accounted for 1.52 percent or less of total expenses for about half of hospitals operated by more than 1,800 not-for-profits. Two out of three hospitals spent less than 2 percent. The median profit margin was 3.13 percent (Evans and Carlson, 12/19).

The Spokesman Review/The Seattle Times: Talk At Federal, State Levels Alarms Rural Hospitals. Many of Eastern Washington’s small hospitals are bracing for cutbacks as federal and state governments look to save money....Twice this year, the federal government has pointed to its “critical access hospitals” program as ripe for change. The White House believes it can save $6 billion over the next decade by trimming the Medicare dollars it sends to these 1,300 hospitals stretched across the country. A worse prospect for regional hospitals, however, is the continuing budget woes of state government (Stucke, 12/18).

The Washington Post: Aided By Referral Bonuses, Hospice Industry Booms. Hospice care, once chiefly a charitable cause, has become a growth industry, with $14 billion in revenue, 1,800 for-profit providers and a base of Medicare-covered patients that doubled to 1.1 million from 2000 to 2009 (Waldman, 12/17). (Kaiser Health News, 12/19/11)
Cocaine Losing Its Allure In United States

Once the glitterati’s drug of choice, cocaine appears to have achieved the dubious status of a has-been drug, forcing drug cartels enriched from trafficking the white powder to find new markets and diversify their illicit products. Between 2006 and 2010, domestic use declined 37 percent, according to the latest National Survey on Drug Use and Health. That's no blip on the screen. Workplace drug tests proving positive for cocaine went down 65 percent in the same time frame, according to data provided to the government by a major testing firm, Quest Diagnostics Inc. And while the government-funded 2011 "Monitoring the Future" survey found teens consuming greater amounts of marijuana, cocaine rates plummeted to their lowest levels since the 1980s. The numbers "should be heralded as basically very good news about cocaine," said U.S. drug czar R. Gil Kerlikowske, director of the Office of National Drug Control Policy. Use of crack, the smokeable rock-crystal form of cocaine, is a fraction of what it was in the 1980s and '90s. Despite some variations, "the crack epidemic, as it was, appears to be over," said Dr. Westley Clark, director of the Center for Substance Abuse Treatment, a part of the U.S. Department of Health and Human Services. "Have we made progress? Yes, but there's still demand (for cocaine)," he said. "It's not zero." Cocaine's lowly status in the drug world's pecking order is a far cry from its high point in the 1980s when Colombian "coca cows" wrecked havoc in the streets of Miami and spawned a cutting-edge TV show, Miami Vice.

Price Up, Quality Down

Experts point to several factors explaining the decline. Colombia supplies more than 90 percent of the cocaine to the U.S. The Colombian government’s crackdown has reduced cocaine production by 60 percent since 2001, according to the drug czar’s office. Accordingly, the price of cocaine has gone up since 2007 while purity levels have gone down, according to Drug Enforcement Administration data. Also, decades of drug education and prevention programs are having an effect. The sum total seems to be having an effect on the Mexican cartels that move the vast majority of cocaine across the U.S.-Mexico border. Cocaine seizures along the border fell 28 percent between 2006 and 2010. There is a vigorous debate in federal law enforcement circles on what seizures say about the cartels' drug strategy, whether the higher numbers reflect tougher law enforcement and whether falling numbers signify a shift from a particular drug like cocaine. Officials believe flagging down fewer and progressively smaller loads of cocaine shows the marketplace downturn is affecting the cartels. Whatever the case, cartels appear to be adding new revenue streams. Methamphetamine, for instance, is now part of the traffickers' inventory. While seizures of cocaine along the border were in decline, those for methamphetamine (as well as the cartels' traditional cash cows, marijuana and heroin) went up.

Other Revenue Streams

In addition, the cartels are diversifying into counterfeit computer software and pirated DVDs, as well as stolen car parts and human trafficking. Further south, Colombian and Venezuelan traffickers have expanded cocaine exports to previously untapped markets overseas. In the past two years, huge cocaine shipments totaling 1,870 pounds destined for Europe, Asia and Africa have been intercepted in Nigeria and Ghana. In October 2010, Australian police seized 1,012 pounds of cocaine from two vessels. Some cases involving DEA agents overseas read like they were ripped from the pages of a thriller. Three al-Qaida associates were arrested in Ghana in December 2009 and sent to the U.S. to face charges of transporting cocaine through West and North Africa, with the proceeds destined for al-Qaida affiliates and FARC, a longtime narco-terrorist guerilla army. The DEA also has investigated links between the Lebanese terrorist organization Hezbollah and shipments of cocaine through Africa to Europe and the Middle East. Last week, Justice Department prosecutors in Washington's Virginia suburbs charged Ayman Joumaa of Lebanon with cocaine smuggling and money laundering in a scheme involving Mexico's Las Zetas trafficking gang. Earlier this year, the Treasury Department concluded that Hezbollah profited from Joumaa's drug activities. Joumaa remains at large. U.S. officials remain cautious about chances that the cocaine-use downturn is here to stay. "When it comes to drugs, the U.S. has a bit of a memory problem," Kerlikowske said. "We don't always recognize the dangers of something, and lo and behold it comes back." (Houston Chronicle, 12/18/11)

Competition Hasn’t Worked In Health Care

Republicans and Democrats have the same problem with the Congressional Budget Office: it refuses to score competition between health-care plans as a surefire way to lower the cost of health care. This annoyed Democrats during the health-care reform debate, as it meant the Affordable Care Act didn’t get any credit for the competition it would foster on its exchanges. It’s annoying Republicans now, as it means their Medicare-reform plans need to impose blunt spending caps if the CBO to certify them as deficit reducing. But the CBO is in the right here: No matter how much sense competition makes in theory, no matter how obvious it is that it will drive down the price of health care, the fact is that it keeps failing when we put it into practice. When I asked Sen. Ron Wyden to give me examples of programs that made him confident that competition could work, he mentioned the Federal Employee Health Benefits Program (FEHBP) and the California Public Employees Retirement System (CalPERS). Rep. Paul Ryan has also pointed towards the FEHBP as a model for his plans.
The only problem? Neither system controls costs — a fact that poses difficulties for both conservative efforts to reform Medicare and Democratic efforts to reform health care:

The Medicare program includes Medicare Advantage -- a menu of competitive managed-care options meant to provide better service at a lower cost. That, too, has been a failure. In order to keep the private options in Medicare, Congress has had to continuously raise their payment rates above those of the traditional Medicare fee-for-service (FFS) program. In June 2007, the Congressional Budget Office wrote (pdf), “Medicare's payments for beneficiaries enrolled in Medicare Advantage plans are higher, on average, than what the program would spend if those beneficiaries were in the FFS sector—so shifts in enrollment out of the FFS program and into private plans increase net Medicare spending.” More recently, conservatives have turned to the Medicare Prescription Drug Benefit (also known as Medicare Part D) as an example of a competitive market program that has cut costs. And there’s something to this argument: Part D has cost less than originally expected and has worked much better than its liberal critics feared. The question is what accounts for Part D’s performance, and whether it could be exported elsewhere in the health-care system. Medicare’s actuaries say (pdf) that the reason the program is costing less than Congress expected is that pharmaceutical innovation has unexpectedly slowed in recent years. That’s meant the program is paying for fewer new, expensive drugs than anticipated, and more old, generic drugs. This has cut costs substantially, but not through inter-plan competition. For much the same reason, national drug spending -- which includes non-Part D plans -- has been 35 percent lower than we expected in 2006. Enrollment in Part D has also come in beneath expectations. CBO predicted that 93 percent of seniors would enroll, but only 77 percent ultimately entered the program. This has also contributed to lower overall spending. Going forward, however, the actuaries expect the good times to end. They predict annual spending growth of 9.7 percent in Part D over the next decade. This is due to “projected further increases in Part D enrollment, changes in the distribution of enrollees by coverage category, and the expected resumption of per capita drug cost growth rates that exceed the rate of increase in other categories of medical spending.” It goes without saying that 9.7 percent spending growth is not sustainable. It’s also hard to know the counterfactual for Part D: What if Medicare was running the drug program itself? The Center on Budget and Policy Priorities notes (pdf) that Medicare Part D is paying more for drugs than Medicaid pays. “According to CBO, requiring drug manufacturers to pay Medicaid-level rebates (or discounts) for drugs dispensed to the Medicare beneficiaries who receive Medicare’s ‘low-income subsidy’ to help them afford the premiums for Medicare drug coverage (most of whom are dual eligibles) would reduce Medicare Part D costs by $112 billion over the next ten years. This is strong evidence that reliance on private insurance, has raised, rather than lowered, the government’s costs.” That leaves us without a clear example of a competition-based program substantially cutting costs. As I wrote yesterday, I hope that’s simply because we haven’t yet cracked the code on competition. Cutting costs through competition comes with far fewer downsides than cutting costs through government price controls. But cutting costs through competition has not yet worked. Cutting costs through price controls, conversely, has worked, as even the most cursory analysis of international health-care systems proves:
people of Mexican origin with the following levels of exposure to American culture: non-immigrant households in Mexico with no exposure to the United States, Mexicans from migrant households who lived in Mexico until age 15, children of Mexican migrants raised in the United States and Mexican-American children of U.S.-born parents. The researchers gathered data by performing face-to-face interviews with nearly 1,800 adults aged 18 to 44 years in the household populations of Mexico and those of Mexican descent in the United States. The results show that, compared to the general population of Mexico with no history of migration to the United States and Mexicans from migrant households who lived in Mexico until age 15, 11.5 percent of Mexican-American children with at least one U.S.-born parent met the DSM-IV criteria for conduct disorder. This level is similar to the non-Mexican-American, U.S.-born frequency of 10.6 percent. “We found a striking epidemiological pattern with differences across generations that are both larger in magnitude and more narrow in scope that anyone expected,” said Joshua Breslau, a researcher with the RAND Corp. in Pittsburgh. “Future studies will be needed to identify the specific environmental factors that contribute to these differences.” The study appears in the December issue of the Archives of General Psychiatry, one of the JAMA/Archives journals. Source: University of California (PsychCentral, 12/18/11)

Schizophrenia Risk Increases When Small Genetic Differences Combine

When combined, single DNA letter difference in two separate genes may increase one’s risk for developing schizophrenia, according to Johns Hopkins researchers. Scientists have had a difficult time pinpointing the causes for psychiatric diseases such as schizophrenia and autism, because these disorders may be triggered by several small genetic changes that alone may not trigger the disorder, but in the right combination may cause disease. Severe DNA differences in the genetic letters of the DISC 1 gene are known to cause schizophrenia and other major mental disorders. However, these large changes are uncommon and do not account for the majority of people with schizophrenia. Nevertheless, researchers believe DISC1 to be an entry point for studying the cause of the disease, and defects in DISC1 combined with defects in other genes may contribute to the disorder. “We studied the function of two proteins known to interact, FEZ1 and DISC1, in cells and animal models, which suggested that these proteins work together in adult brain development,” says Guo-li Ming, M.D., Ph.D. professor of neurology and neuroscience and member of the Johns Hopkins Institute for Cell Engineering. “When we looked at the human genetic sequences of DISC1 and FEZ1, we found that a combination of small DNA changes raises risk for schizophrenia.” To see if FEZ1 and DISC1 work in unison in adult brain development, the scientists reduced the

Conduct Disorder May Be Linked To Environmental Factors

The frequency of non-aggressive symptoms in conduct disorder rises significantly across generations of Mexican-origin populations after they migrate to the United States, according to an international team of researchers. Conduct disorder, as defined by the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) of the American Psychiatric Association, involves persistent symptoms including aggression or other violations of age-appropriate norms that cause significant clinical impairment. Behaviors that characterize conduct disorder include bullying others, getting into fights, fighting with a weapon, cruelty to people or animals, stealing with confrontation, forced sex, property destruction, theft and rule breaking. “Our study shows that there is a large difference in risk for conduct disorder between Mexicans living in Mexico and people of Mexican descent living in the United States,” said Sergio Aguilar-Gaxiola, a professor of clinical internal medicine at UC Davis. “This increase in risk occurring across generations within a migrating population strongly points to the influence of early childhood environmental factors in the United States and the potential to intervene to reduce the prevalence of conduct disorder.” For the study, UC Davis and RAND Corp. researchers evaluated the prevalence of conduct disorder associated with migration from Mexico to the United States. Conduct disorder symptoms were assessed across four groups of

(Kaiser Family Foundation)

The reality of our health-care debate right now is that both parties keep trying different versions of a cost control strategy that hasn’t worked because they’re uncomfortable with the cost control strategy that has. (Washington Post, 12/16/11)
level of FEZ1 in newborn neurons in the hippocampi of adult mice and then evaluated the cells with a microscope. The neurons with less FEZ1 looked similar to those with less DISC1; they were bigger and had longer feelers that stretch out and communicate with other nearby neurons. The scientists hypothesized that these proteins may be working together in neurons to regulate cell size and feeler length, and if something interferes with this process, a psychiatric disease may develop. The researchers also analyzed current cases of schizophrenia to determine if combinations of single-letter DNA changes in DISC1 and FEZ1 made individuals more prone to the disorder. The scientists examined a large patient database, the Genetic Association Information Network, created by the National Institutes of Health to identify genome associated diseases. Using statistical methods, the researchers examined four different single-letter DNA changes in the FEZ1 sequence in 1,351 schizophrenia cases and 1,378 healthy individuals. They found that single-letter DNA changes in FEZ1 alone did not boost schizophrenia risk. However, when the scientists examined the four different FEZ1 DNA letter changes in combination with the DISC1 single DNA letter change already known to slightly increase schizophrenia risk, they discovered that one particular FEZ1 DNA difference along with the DISC1 change drastically increased the risk for schizophrenia by two and a half times. "By continuing to examine interactions of key genes involved with disease in cells and correlating the results with patient databases, we can begin to unravel the genetic contributions of psychiatric disorders that previously were a mystery to us," says Hongjun Song, Ph.D., professor of neurology and director of the Stem Cell Program at the Institute for Cell Engineering. "Finding sets of proteins, like FEZ1 and DISC1, that synergistically work together to cause disease will also give us new drug targets to develop new therapies." The research is published in the November 16 issue of Neuron. Source: John Hopkins (PsychCentral, 12/18/11)

Blood Test May Predict Antidepressant Effectiveness

Researchers at Loyola University Medical Center say they may have found a way to predict whether an antidepressant will work on a depressed patient. A recent Loyola study found that the blood test for a protein called vascular endothelial growth factor (VEGF) could help predict successful treatment. The researchers found that among depressed patients who had higher than normal levels of VEGF, more than 85 percent experienced partial or complete relief after taking escitalopram (Lexapro). Fewer than 10 percent of depressed patients who had low levels of VEGF responded to the drug. "This would be the first time we would have a predictor for how well a patient would respond to an antidepressant," said Angelos Halaris, M.D., Ph.D., first author of the study. About 60 percent of depressed patients do not respond fully to the first prescribed medication, researchers note. This means doctors must prescribe several different medications before finding one that works. "It would greatly benefit our patients if we could predict ahead of time whether a given medication would be effective for a certain patient," Halaris said. The Loyola study involved 35 patients who took escitalopram for depression. Escitalopram belongs to a class of antidepressants called selective serotonin reuptake inhibitors (SSRIs). Other common SSRIs are Prozac, Paxil and Zoloft. Scientists aren't certain why SSRIs work in some patients but not in others, the researcher notes. One possible mechanism is that SSRIs help restore a chemical balance in the brain. Some scientists have proposed a second possible mechanism, called neurogenesis, which means that SSRIs help to regenerate brain cells in specific parts of the brain that have atrophied in depressed patients. The Loyola study supports the neurogenesis theory. It appears that escitalopram jump-starts brain cells that have become inactive. This regeneration is fueled by VEGF, which stimulates the growth of blood vessels and works in other ways to keep brain cells healthy and active. It appears that in patients with higher levels of VEGF, there was more regeneration, helping to reduce depression, the researchers found. In patients with lower VEGF levels, there was less regeneration of brain cells and, therefore, less relief from depression. If the finding is confirmed by further studies, it could lead to a blood test that would help physicians tailor treatment, the researchers note. If a patient has low levels of VEGF, the physician might skip SSRIs and try alternative classes of antidepressants, such as bupropion, or alternative therapies, such as psychotherapy or Transcranial Magnetic Stimulation (TMS), researchers explain. Today, a VEGF blood test would be very expensive, but the cost likely would come down significantly if a VEGF test were to become widely used, Halaris said. Source: Loyola University Medical Center (PsychCentral, 12/16/11)

Texting For Alcohol Intervention In High-Risk Young Adults

A new study explores text messaging as a method to interact with young adults to reduce alcohol consumption and decrease binge episodes. The novel intervention uses the mobile platform to intervene among young adults who present at a hospital Emergency Department for alcohol-related problems. Researchers examined the use of text messaging, both to collect drinking data from young adults after Emergency Department discharge, as well as provide immediate feedback and ongoing support to them. The researchers found that text messaging is effective on both levels. "Each day in the U.S., more than 50,000 adults 18 to 24 years of age visit hospital Emergency Departments, and more than one-third report current alcohol abuse or dependence," said Dr. Brian Suffoletto of the department of emergency medicine at...
the University of Pittsburgh and corresponding author for the study. "Thus, Emergency Departments provide a unique opportunity to both identify young adults with harmful or hazardous drinking behavior and intervene to reduce future injury and illness." Unfortunately, emergency-care providers rarely have the time or expertise to screen for or discuss problematic alcohol use. Further, the current health care delivery model in the U.S. does not encourage hospitals to have counselors on duty for Emergency Department intervention, nor are patients with acute drinking issues necessarily interested in having those discussions immediately. "Given that mobile phones are essentially ubiquitous among young adults, and texting in particular is a heavily used communication tool, we sought to build and test an automated text messaging system that could conduct a health dialogue with young adults after discharge," said Suffoletto. "We believe that our study is the first to test a text-messaging-based behavioral intervention to reduce alcohol consumption." Researchers believe admittance to the Emergency Department can be used as a teachable moment or behavior-change point for those at risk for an illness — alcohol-induced injury or organ destruction. "This is a first step. I can envision other tools — such as phone apps and social media sites — being deployed eventually," said Dr. Donald M. Yealy, professor of emergency medicine, medicine, and clinical and translational sciences at the University of Pittsburgh School of Medicine. Suffoletto and his colleagues identified 45 18-to-24-year olds (24 women, 21 men) from three urban hospitals as hazardous drinkers based on their Alcohol Use Disorders Identification Test-Consumption scores. The young adults were randomly assigned for a 12-week period to either weekly text messaging feedback with goal setting (Intervention), weekly text messaging drinking assessments without feedback (Assessment), or the Control group. "First, we were able to show that young adults will interact with an automated text messaging system to both provide weekly drinking reports and respond to goal-setting challenges," said Suffoletto. "Second, our preliminary findings suggest that young adults who are exposed to our intervention reduce the number of drinks they consume as well as the number of binge episodes." More specifically, at the end of the three-month period, participants in the text messaging group had 3.4 fewer heavy drinking days in the preceding month, and 2.1 fewer drinks per drinking day when compared to baseline. Suffoletto suggested that the use of alternative interventions, such as text messaging, is an effective method for physicians to reach young adults after they are discharged from the Emergency Department. "Our study findings are preliminary, yet encouraging, evidence that ecological assessments tied to real-time feedback using mobile communication technology can effect change in young adults with harmful or hazardous drinking behavior," he said. "Future work should focus on ways to optimize patient participation in programs and the integration of mobile communication with traditional interventions." Both Suffoletto and Yealy see additional uses for these findings. "Clinicians who care for young adults and adolescents in other care settings may [also] decide to use mobile technologies to support and extend already existing resources to reduce the burden of alcohol use and alcohol-related risks," said Suffoletto. "Researchers interested in behavior change [for other] substance-use disorders may decide to build and test similar behavioral interventions using mobile communication devices, such as apps, to effect change." "I could envision beginning such a program in other populations — like those with heart failure, or high blood pressure, or an infection — to aid compliance with agreed-on plans," added Yealy. "The average person who either is struggling with an alcohol-use disorder or knows someone who is might be encouraged to know that researchers are exploring non-traditional approaches to supporting self-change," said Suffoletto, "and finding ways that make it easier for an individual to get help." Results will be published in a forthcoming issue of the journal Alcoholism: Clinical & Experimental Research. Source: Alcoholism: Clinical & Experimental Research (PsychCentral, 12/16/11)

**Rhode Island Medicaid To Launch Mandatory Health Homes For SMI Population**

On November 23, 2011, the Centers for Medicare and Medicaid Services approved Rhode Island’s Medicaid plan amendment to implement health homes for 5,400 adults over the age of 18 with serious and persistent mental illness (SPMI), including dual eligibles. Rhode Island is the second state to receive approval for health homes; Missouri was the first. The Rhode Island Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (BHDDH) will receive $12.7 million in enhanced federal funding—a 90% Medicaid match rate—for the coordination of physical care and behavioral health care for individuals who have serious and persistent mental health conditions. The amendment also provides funding for children with special health care needs and their families who receive services through the Department of Human Services’ comprehensive, evaluation, diagnosis, assessment, referral, and re-evaluation initiative. BHDDH has automatically enrolled all adult Medicaid beneficiaries with SPMI into the Health Home program; about 35% of these individuals are currently enrolled in a Medicaid managed care organization (MCO), and will remain enrolled with the MCO. The Health Home teams will coordinate needed health care services with the individuals’ MCO. The Health Homes teams will be located at nine BHDDH-licensed community mental health organizations (CMHOs). Health home teams consist of a Master’s level team coordinator, a psychiatrist, a registered nurse MA-level clinician, a community psychiatric support (CPST) specialist/hospital liaison, a CPST specialist, and a peer specialist. Other team members can include primary care physicians,
The CMHOs will rely on health information technology to support health home services, and BHDDH will query provider organizations about the use of health information technology in the delivery of care coordination services. BHDDH may also establish pilot tests of a subset of provider organizations, such as those with electronic health records and patient registries to measure changes in health outcomes, experience of care, and quality of care among Health Home clients. A primary goal is reducing readmissions per 1,000 member months for CMHO clients enrolled in a Medicaid health home. BHDDH will also calculate cost savings attributable to the care coordination provided through the health homes by comparing baseline costs of Medicare and Medicaid beneficiaries who would have been eligible for CMHO services to their actual costs one year and two years after enrollment in the CMHO health home. In addition to reducing readmissions and costs, BHDDH has six goals for the health home initiative:

1. Improve care coordination—Measured as changes in completeness of patient record documentation, the percentage of patients who have a primary care professional and who have an annual physical exam, and the percentage of patients who receive timely follow-up care following a hospital discharge.

2. Reduce preventable emergency department visits—Measured as changes in the percentage of patients with one or more emergency department visits for physical or mental health conditions, and patient satisfaction surveys.

3. Increase use of preventive services—Measured as changes in the percentage of patients who smoke, use illicit substances or abuse alcohol, reduce body

4. Health promotion—The services encourage and support healthy ideas and concepts to motivate individuals to adopt healthy behaviors and self-manage their health. The services may be provided by any member of the CMHO health home team; however, psychiatrists and nurses will be the primary professionals providing referrals to a wide array of community and social support to address medical, behavioral, educational, social, and community issues that may impact overall health. The CPST specialists will be the primary professionals providing referrals; however, any health home team member can provide referrals.

BHDDH has six goals for the health home initiative:

1. Improve care coordination—Measured as changes in completeness of patient record documentation, the percentage of patients who have a primary care professional and who have an annual physical exam, and the percentage of patients who receive timely follow-up care following a hospital discharge.

2. Reduce preventable emergency department visits—Measured as changes in the percentage of patients with one or more emergency department visits for physical or mental health conditions, and patient satisfaction surveys.

3. Increase use of preventive services—Measured as changes in the percentage of patients who smoke, use illicit substances or abuse alcohol, reduce body
Columbia-Suicide Severity Rating Scale Validated for Suicide Prediction In Adults & Adolescents

The Columbia–Suicide Severity Rating Scale (C-SSRS) accurately predicted the risk of suicide attempts by adults and adolescents involved in three multi-site studies with diverse participants and objectives. The C-SSRS was found to be more accurate than other suicide assessment instruments at identifying the intensity of suicidal ideation and risk posed by behaviors, such as self-injury or making preparations for an attempt. Previously, the strongest predictive risk factor for suicide has been a previous attempt. The C-SSRS was designed by researchers from Columbia University, the University of Pennsylvania, and the University of Pittsburgh to be used as part of the NIMH-funded Treatment of Adolescent Suicide Attempters study to quantify the severity of suicidal ideation and behavior to identify those at risk of attempting suicide and to track treatment response. The C-SSRS is a short (Negative assessments take 3.5 minutes to complete; positive assessments take an average of 7.7 minutes) test that is available in two formats—both a paper version and a computer-based version. The assessment has two yes/no questions on suicidal ideation. If the answer to both is no, the test ends. Yes answers are followed up by additional questions about four behaviors to assess the severity of ideation. Severity is assessed on a 1 to 5 scale, with 4 and 5 indicating the highest risk and need for follow-up intervention. The C-SSRS is designed for use in multiple settings, including by emergency first responders, the military, prisons, hospitals, schools, and judicial systems. Formal mental health training is not required to administer the C-SSRS; after a 30-minute training, anyone can administer the assessment. The researchers also noted that the C-SSRS can also be used in primary care settings as a prevention tool; 45% of people who complete suicide saw a primary care professional in the month prior to death and 80% visited a health care professional in the prior year. About 75% of those seeking help for depression see a primary care professional and not a mental health professional. During the three months before death, 64% of suicide completers reported psychological symptoms to their primary care professional. The 30-minute C-SSRS training is provided by researchers from Columbia University free of charge and is available in an minute interactive DVD-based format. Those completing the training are certified to administer the C-SSRS, and will receive a training certificate valid for two years. More information about the C-SSRS and training is available online at www.cssrs.columbia.edu (accessed November 30, 2011). The findings on the validity of the C-SSR were released in a report, titled "The Columbia-Suicide Severity Rating Scale: Initial Validity and Internal Consistency Findings from Three Multisite Studies with Adolescents and Adults," by Kelly Posner Ph.D. and colleagues. The researchers sought to evaluate the validity of the C-SSRS relative to other measures of suicidal ideation and behavior. Research on suicide prevention and interventions requires a standard method for assessing both suicidal ideation and behavior to identify those at risk and to track treatment response. The authors examined the psychometric properties of the C-SSRS and the Scale for Suicide Ideation to compare the sensitivity and specificity of the measures in predicting the risk of suicide attempts. They analyzed outcomes of three multi-site studies that used various suicide assessment instruments, including C-SSRS. The studies included the following objectives and population groups:

- A treatment study of 124 adolescents who had attempted suicide in the previous 90 days.
- A medication efficacy trial with 312 adolescents diagnosed with depression who were taking escitalopram (Lexapro); the study excluded patients considered at-risk of suicide.
- A study of 237 adults presenting to an emergency department for psychiatric reasons who came to the...
emergency department following a suicide attempt or non-suicidal self-injury

The researchers also analyzed 35,007 C-SSRS baseline and one or more follow-up assessments electronically administered between September 2009 and May 2011 to 3,776 participants in 14 clinical studies focused on depression, epilepsy, insomnia, and fibromyalgia. Their records were scored positive or negative with respect to the presence or absence of suicidal ideation and behavior. Positive reports were those where the individual had a suicidal ideation score of 4 or 5, or had a suicide attempt history, or had preparatory behaviors. Of the 18,513 follow-up assessments completed, 1.6% (296 assessments completed by 201 individuals) were prospective reports of a suicide behavior since the previous assessment. The full text of “The Columbia-Suicide Severity Rating Scale: Initial Validity and Internal Consistency Findings from Three Multisite Studies with Adolescents and Adults” was published in November 2011 by The American Journal of Psychiatry. An abstract may be accessed online at http://psychiatryonline.org/article.aspx?articleID=180115 (accessed December 1, 2011). (Open Minds, 12/19/11)

Use of Retail Clinic By Commercially Insured Increases 10X In Two Years

In 2009, people with commercial health insurance made 6.5 visits per 1,000 to retail clinics. That utilization represents a ten-fold increase since 2007, when the rate was 0.6 visits per 1,000 per month. These were the findings of a report, titled "Trends in Retail Clinic Use Among the Commercially Insured," by J. Scott Ashwood, MA; Rachel O. Reid, BA; Claude M. Setodji, Ph.D.; Ellerie Weber, Ph.D.; Martin Gaynor, Ph.D.; and Ateev Mehrotra, M.D., MPH. For the purposes of this analysis, a retail clinic was defined as providing a limited set of common, non-urgent health care services in a clinic space located in a retail store or pharmacy. Additional findings included the following:

- Retail clinic use was unrelated to the availability of a primary care physician.
- 6.9% of all health care visits for 11 non-urgent health conditions (such as bronchitis, upper respiratory infections, ear infections, flu, and conjunctivitis) were made to a retail clinic.
- Proximity to a retail clinic was the strongest predictor for using a retail clinic; people living within a mile of a retail clinic were 7.5% more likely to use a retail clinic than people living 10 to 20 miles away.
- Females were more 0.9% more likely to visit retail clinics than males.
- Adults ages 18 to 44 were 1.6% more likely to make a retail clinic visit than adults ages 45 to 64.
- People without chronic health conditions were 0.9% more likely to visit retail clinics than people with a chronic health problem.
- Patients with higher incomes (defined as living in a zip code where the median annual income exceeded $59,000) were more 2.6% likely to use a retail clinic than lower income groups.

The researchers used data from a commercially insured population of 13.3 million people under age 65. Between 2007 and 2009, 3.8 million people in the study population visited a retail clinic. The researchers were unable to determine if the growth in retail clinic use represented substitution for other sources of care or if it represented new utilization. The full text of “Trends in Retail Clinic Use Among the Commercially Insured” was published in November 201 by American Journal of Managed Care. An abstract may be accessed online at www.ajmc.com/login (accessed December 13, 2011). (Open Minds, 12/19/11)

Some Hospitals Turn To Post-Discharge Clinics To Help Hold Down Readmissions

For patients, the transition from hospital to home is a critical time. Discharged with follow-up instructions and often a fistful of medications, many need medical guidance. But too often a smooth handoff to a primary-care physician doesn't happen, and small recovery glitches become larger ones. The result: In short order the patient is often back in the hospital. According to a study released this month by the Center for Studying Health System Change, a Washington-based research group, a third of adult patients discharged from a hospital don't see a physician within 30 days -- and experts say this is a key reason so many of them are readmitted. Some hospitals are trying a new strategy to interrupt this predictable and pricey pattern: post-discharge clinics. These hospitals are identifying patients who are more likely to have trouble after discharge, either because of their medical conditions or because they lack health insurance or a primary-care provider, and funneling them to the clinic where they receive one-on-one assistance. Deloris Eason, 64, was discharged from Boston’s Beth Israel Deaconess Medical Center earlier in December, after having been treated for severe stomach cramps, diarrhea and vomiting. Clinicians weren't sure whether she had had a bad case of food poisoning or colitis, an inflammation of the colon. Because her primary-care physician couldn't see her until mid-January, hospital staff referred her to the post-discharge clinic. By the time she came in four days after leaving the hospital, Eason was feeling better but was concerned because she hadn't had a bowel movement since returning home. The practitioner at the clinic told her to give it another day and then take a laxative. If that didn't work, she was instructed to come back. "I had a chance to ask questions I didn't get to ask at the hospital," Eason says, "key questions that came up after I got home." The doctor also checked that she was following the diet she had been given and was taking her antibiotics, and made follow-up appointments for her with a gastroenterologist and her primary-care provider.

E-Newsletter – National and Industry News
Florida Council
December 26, 2011
The clinic helps streamline the process of getting patients in to see their primary-care physicians, says its medical director, Lauren Doctoroff. A typical patient visits Beth Israel's post-discharge clinic, located near the hospital, just once or twice. But treatment may last longer at post-discharge clinics affiliated with safety-net hospitals that serve large numbers of low-income, uninsured and other vulnerable patients. One such hospital is Tallahassee Memorial Healthcare's Transition Center. Clinicians say they see most patients for up to two months and will extend that time frame if necessary. "We're a bridge until we are guaranteed they are in...primary care," says Dean Watson, Tallahassee Memorial's chief medical officer. The center targets patients at high risk for readmission, including the uninsured, those who don't have a primary-care physician or who can't get an appointment with their doctor within a week of discharge, and patients who have been admitted at least three times in the past year. Patients who are referred to the center work with clinicians to develop a plan for their ongoing care and receive referrals to rehab or other medical services. The center's staff finds a primary-care provider for them if they need one and connect them with social services for such needs as transportation, food and home care. Since the center opened in February, more than 600 patients have visited it, says Watson, and emergency room visits and hospital readmissions have decreased by 61 percent for these high-risk patients. Hospital officials and policy experts agree that the impetus for the post-discharge clinics comes in part from new penalties for certain hospital readmissions that will take effect starting in 2012. Under the 2010 federal health-care overhaul, hospitals that have higher than expected higher than expected 30-day readmission rates for three conditions - pneumonia, heart failure and heart attack -- may face Medicare payment penalties. But some analysts question whether the clinics are an efficient solution. "Creating a whole separate post-discharge follow-up clinic when you've got an outpatient network in existence could be duplicative," says Ann O'Malley, a senior researcher at the Center for Studying Health System Change, the Washington-based research group that did the study that was released this month. "What we need is better support of the primary-care infrastructure in the community." Even with that, some patients are likely to fall through the cracks. Barnes-Jewish Hospital, a safety-net hospital in St. Louis, opened a post-discharge clinic about three months ago. Medicare-eligible patients with chronic obstructive pulmonary disease, pneumonia, heart attack and heart failure are referred to the Stay Healthy Clinic for follow-up care. But there's a hitch. Even though the hospital schedules the initial post-discharge appointments and offers to arrange a ride for patients to the clinic, about half of them don't show up. "We're trying to understand it," says John Lynch, the hospital's chief medical officer. It's unclear, he says, whether patients don't understand the importance of the appointments, for example, or feel better and don't think they need to come in. With roughly a third of high-risk Medicare patients being readmitted within a week of discharge, it is critical to look for answers. "We'll continue to try to tweak it," he says. (Kaiser Health News, 12/20/11)

**After Drugs And Dark Times, Helping Others To Stand Back Up**

The taste of cocaine and the slow-motion sensation of breaking the law were all too familiar, but the thrill was long gone. Antonio Lambert was not a young hoodlum anymore but a family man with a career, and here he was last fall, high as any street user, sneaking into his workplace at 9 o'clock at night, looking for — what, exactly? He didn't really know. He left the building with a few cellphones (which he threw away) and a feeling that he was slipping, falling back down into a hole. He walked in the darkness, walked with no place to go, and then he began to do what he has taught others in similar circumstances to do: turn, face the problem, and stand back up. "I started talking to myself, out loud; that's one of my coping strategies, and one reason I relapsed is I had forgotten to use those," said Mr. Lambert, 41, a mental health educator who has a combined diagnosis — mood disorder with drug addiction — that is among the scariest in psychiatry. He texted a friend, someone who knew his history and could help talk him back down. And he checked himself into a hospital. "I know when it's time to reach out for help." The mental health care system has long made use of former patients as counselors and the practice has been controversial, in part because doctors and caseworkers have questioned their effectiveness. But recent research suggests that peer support can reduce costs, and in 2007, federal health officials ruled that states could bill for the services under Medicaid — if the state had a system in place to train and certify peer providers. In the years since, "peer support has just exploded; I have been in this field for 25 years, and I have never seen anything happen so quickly," said Larry Davidson, a mental health researcher at Yale. "Peers are living, breathing proof that recovery is possible, that it is real." Exhibit A is Mr. Lambert, a self-taught ex-convict who is becoming a prominent peer trainer, giving classes in Delaware and across the country. He is one of a small number of people who have chosen to describe publicly how difficult it is to manage such a severe dual diagnosis, including the sudden setbacks that often come with it. "He is an extreme example of how much difference passion and commitment can make, given where he's come from," said Steve Harrington, the chief executive of the National Association of Peer Specialists, a group devoted to promoting peer support in mental health care. Mr. Lambert, who has climbed out of a deep hole with the help of religious faith, medication and his own forms of self-expression, puts it this way: "There are a lot of people dealing with mental illness, drugs, abandonment,
abuse, and they don't think there's a way out. I didn't. I didn't."

Bean Bean In Spider City

His grandmother was the first person to call him Bean Bean, and the boy was so skinny that he couldn't shake it. He couldn't avoid the older toughs in the Brighton section of Portsmouth, Va., either, and he spent some of his school-age years taking beatings. That was Brighton back in the day, and at least those fights taught survival skills. Not everything did: He remembers being sexually abused at age 6, by an older boy in the neighborhood — brutally. He had no one to tell, even if he had known what to say. His mother and father were split, living blocks apart, each a fixture in the neighborhood's social swirl of house parties, moonshine "shot shops," card games and other attractions. His mother, called Chucky, was often out, sometimes leaving the boy at a friend's house for "a few hours" that turned into an entire weekend. For much of that time, he waited on the porch. He idolized his father, a truck driver and warehouse worker who lived nearby but spent his free time out, too, drinking and playing cards. "During that time I was an alcoholic, but I would go out and try to find him when I heard he was out," said his father, Edward Lambert, in a recent interview at his house in Brighton. He gave up drinking years ago for God, and father and son would eventually become close. But not before the son began to stand his ground on the street, earning a name as an up-and-coming gangster by age 12, a regular presence at Palmer's Corner, home base for the heavies, the alpha males of Brighton — Spider City, as they called it. He was soon into drugs, first as a courier and then as local muscle, armed and very dangerous. He began using more and more cocaine, crack usually, and soon acquired another trait. "We regarded craziness as an esteemed quality, something to be admired, like white people admire courage," Nathan McCall wrote in "Makes Me Wanna Holler," his 1994 memoir of growing up in Portsmouth. "In fact, to our way of thinking, craziness and courage were one and the same." The skinny boy grew big, strong and crazy enough that he would ride around on his bike with a sawed-off shotgun on the handlebars, pull up to a group of dealers and throw an empty bag on the ground in front of them, with these instructions: Fill it up. Now, "I would shoot the gun off in the air to show I was serious, then just take the drugs and move on to the next pack of dealers, and lay them all down," he said. He was a junior in high school. No one who was there has forgotten it. "It got to be where people, dealers especially, they would watch the street for Bean Bean in the same way they would watch for the police," said Henry Maurice Hunt, a stepbrother and fellow gunslinger from back then who still lives in the neighborhood. "If they saw Bean come onto the street, they were gone." It couldn't last, and it didn't. He survived several gunfights, taking a bullet behind the ear in one (it is still lodged there), and in another being ambushed from behind and hit in the legs, arms and pelvis; those bullets were all removed without lasting damage, except for prominent scars. But the police were onto him now, and by 1991, at the age of 21, he was in prison, sentenced to 22 years for malicious wounding with a firearm and other charges, according to Portsmouth court records. He was not a model prisoner at first. He incited a protest at one institution, after which guards confined him to a "segregation" cell, away from other prisoners, for nearly two years. He began to read in there, the Encyclopedia Britannica, then Robert Ludlum, James Clavell, Sun Tzu, anything he could find. That curiosity nourished a deepening ambition that one day in 2002 turned to conviction. "This young thug I knew from the neighborhood comes in, first day of a life sentence, and he puts his hands up and says, 'Hey, man, I'm here!' — like he's coming into a house party," Mr. Lambert said. "That did it. I knew I had to get out and find a life, something. I didn't know what, or how."

Living By Your Story

He got a lifeline, is how, and it came just in time and from an unexpected source. It was June 2003, and Mr. Lambert was out of prison (having earned time for good behavior) and living in Virginia Beach, close to home but not too close. Married with daughters now, he was becoming particularly skilled at installing and finishing floors. His life looked to be taking some shape, if not yet direction. But the work hours were long, money was very tight, and a spat with his wife opened up a well of resentment and despair that seemed to have no bottom. In prison, he remembered, a doctor gave him a diagnosis of depression and prescribed medication. But the pills did nothing for him, and he decided it was bunk; he could handle himself fine. Down he went, back to the streets of Brighton, crashing at friends' apartments and feeling lost, moody and desperate for his medication of choice. The gunmetal taste of cocaine was irresistible, and at least it broke the fall. But his mood would return darker, and he would have to get high again. That is how it almost always goes with a dual diagnosis of addiction and a mood disorder, doctors say: Each problem inflames the other, in a cycle that is extremely difficult to break. Yet break it he soon did, leaving two ounces of cocaine and his pistol in his stepbrother's house one morning and walking out. It was about 6 o'clock, and he was drifting toward the George Washington Highway, feeling in some ways more hopeless than he had behind bars — when his cellphone buzzed. It was his mother now living in California, and she had just seen something on late-night television: an advertisement for Teen Challenge USA, a Christian-based recovery program. She gave him a phone number. He wrote it down, sat on the stoop of a boarded-up house and thought about it for a long time, and then dialed. The man on the other end listened and offered to waive the fee if the young man pledged himself to God. He made the commitment that morning and has been a regular churchgoer since. "I honestly believe the prison
got him off the streets before he died,” his father said, “and God did the rest.” He completed the program, in Greensboro, N.C., and soon found a job at a warehouse there, beginning as a temporary worker and advancing to assistant distribution manager. He was living clean, the family was intact and according to his medical records, a local therapist put him on lithium, a standard treatment for severe mood swings. It was a friend from church who told him about peer-support work, showing him an ad for peer specialists at a local mental health clinic, Envisions of Life, and he jumped at the chance, taking a pay cut in exchange for a caseload. “He had the worst cases; he had to go into these high gang areas, places no one else would go,” said Sue Bethune, his boss at the time, who is now a mental health consultant in Greensboro. “He really opened the door for the program to be able to send people in there.” The work was exhausting, it put him dangerously close to cocaine dealers (hence the later relapse, which resulted in misdemeanor charges), and relations at home were again badly strained. He began to set his sights higher: on training peers. In 2007, he attended a training talk by Mr. Harrington, the chief executive and founder of the national peer association. “He was asking all these questions that reflected a lot of thought,” Dr. Harrington, now a postdoctoral fellow at Boston University, said in an interview. “When I heard more of his story, I told him, ‘Look, you can do what I do.’” They stayed in touch, and soon Mr. Harrington called to say he had scheduled Mr. Lambert to give a keynote speech at an event in Michigan. He boarded a plane in Greensboro, unsure of what he was getting into. “I didn’t even know what ‘keynote’ meant,” he said. “I thought I might have to sing.” The story told itself, and people in the audience who feared for a loved one with similar problems wanted to hear more. Parents from all walks of life, doctors, clergy members and co-workers have pulled him aside to see if he could talk to a wayward son, or a daughter into drugs. He joined Dr. Harrington to form a company, Recover Resources, which sells peer support manuals, DVDs and other educational materials. A training session in June, hosted by the Delaware Psychiatric Center and run by Mr. Lambert, was life-changing for at least two of the attendees. One was a Navy veteran from nearby Newark, Del., who had also struggled with substance abuse and a psychiatric diagnosis. “I knew from the first smoke break that this was someone important for me,” said the veteran, Justin Thompson, 28, who has since completed his peer certification under Mr. Lambert and now works as a peer specialist. The two have become close friends. “I just related to him right away, his passion, his story, the positive energy he brings — all of it.” Another was June Benson, a single mother of three who had had her own run-ins with the law and drug use. The two felt an instant connection and began to talk regularly by phone. (Mr. Lambert was going through a separation at the time and is in regular touch with his own children.) “He told me everything; those were some expensive phone bills,” said Ms. Benson. “But to come out of all that and be the man he is now, it’s just a miracle.” He soon contracted with Delaware Psychiatric to provide peer services at the hospital and began speaking with Horizon House/Delaware, a clinic in Wilmington, to set up a peer specialist college. Mr. Lambert and Ms. Benson moved in together in July and are engaged to be married. “You got to understand, for me, right now, what I been through, it’s sometimes hard to believe it’s all real,” Mr. Lambert said. “But I know my own mental illness and my addiction are real; I feel like they’re out there right now, doing push-ups, getting ready to take me down again. That’s why I got to have my own system for staying strong.”

The Day To Day

That system is based on a close monitoring of his moods, which respond only partly to the medication. It includes self-talk, often in the car or between appointments (“If this car ends up in the wrong part of town, you’ll be flat on your face”); and performance of mime, which he has done with a troupe and individually, often in churches, complete with makeup, flowing robes and gospel accompaniment. But when Mr. Lambert feels his mind capsizing fast, he has to have company, usually Ms. Benson’s or Mr. Thompson’s. He feels he needs a peer himself, someone with a history who knows what it looks like — from the inside — to be struggling mentally, deep in trouble, and feeling dead out of options. Someone who can be an advocate, a companion, who can share his or her own story: who can simply be there, if that’s what it takes. Mental health researchers have tested the effect of peers in a variety of settings over the past decade. When they are “specialized” — that is, their history is similar to that of their clients, the way Mr. Lambert and others teach it — peers tend to reduce the rate of psychiatric hospitalizations and, where appropriate, increase the use of programs like Alcoholics Anonymous. Not, in the end, that it’s about the money. In his travels as a trainer and a peer, Mr. Lambert has read clients’ poems, accompanied them shopping, and sometimes sat and watched an episode of their favorite soap opera. And he has taken on Mr. Thompson as a protégé, a peer trainer in training. For both, it means being on call, for their students and for each other. On a recent Saturday morning, Mr. Lambert was home alone, watching college football, when he felt a pulse of that same darkness and exhaustion that led to his last relapse. “I call it the monster,” he said. “I was lying there on the couch, and after a while, the college football was watching me.” He called Mr. Thompson, who hurried over with a pair of fishing poles. The two of them fished that afternoon. They fished and had a smoke and talked about nothing much, and neither could say exactly when it happened but it did. The monster was gone. (Ocala Star-Banner, 12/19/11)
AstraZeneca and Targacept Announce Top-line Results From Second Phase 3 Study Of TC-5214 As An Adjunct Treatment In Patients With Major Depressive Disorder

AstraZeneca and Targacept, Inc. today announced top-line results from the second of four RENAISSANCE Phase 3 studies investigating the efficacy and tolerability of TC-5214 as an adjunct therapy to an antidepressant in patients with major depressive disorder (MDD) who do not respond adequately to initial antidepressant treatment. The study, RENAISSANCE 2, did not meet its primary endpoint, change in the Montgomery-Asberg Depression Rating Scale (MADRS) total score after eight weeks of adjunct treatment with TC-5214 as compared to placebo. These results follow the recent announcement of top-line results from RENAISSANCE study 3, which also did not meet its primary endpoint. Both RENAISSANCE 2 and RENAISSANCE 3 were flexible dose trials. The two remaining efficacy studies in the RENAISSANCE Program for TC-5214 are fixed dose trials. Top-line results for both fixed dose trials, as well as for a long-term study designed primarily to evaluate safety, are expected to be available in the first half of 2012. TC-5214 was overall well tolerated in RENAISSANCE study 2 and showed an adverse event profile generally consistent with prior clinical trials of TC-5214. Analyses of the full data set from the RENAISSANCE study 2 remain ongoing. Regulatory filing targets will be reviewed following results of the remaining RENAISSANCE Program studies. A potential New Drug Application filing in the United States is planned for the second half of 2012, with a potential EU Marketing Authorization Application filing targeted for 2015.

About the Targacept and AstraZeneca Collaboration

In December 2009, AstraZeneca and Targacept signed a collaboration and license agreement for the global development and commercialization of TC-5214. The initial goal for the collaboration is to develop TC-5214 as an adjunct treatment for MDD in patients with an inadequate response to a selective serotonin reuptake inhibitor (SSRI) or serotonin/norepinephrine reuptake inhibitor (SNRI). TC-5214 is also being studied in a Phase 2b ‘switch’ monotherapy trial, known as the EXPLORER study, in patients with MDD who do not respond adequately to initial treatment with an SSRI or SNRI.

About the RENAISSANCE Program (TC-5214)

The RENAISSANCE Program consists of five randomized, double-blind, placebo controlled Phase 3 studies. In RENAISSANCE study 2, 1,320 patients with MDD were screened at 45 sites in the United States (75% of evaluated patients) and 25 sites in India. Of the patients screened, 710 initially received one of seven SSRIs or SNRIs on an open label basis for eight weeks to determine the extent of therapeutic response. At the end of the eight weeks, 319 patients who did not respond adequately, based on predefined criteria, were randomized into the double blind phase of the study and received either a flexible dose of TC-5214 or placebo, twice daily, while continuing the SSRI or SNRI therapy for an additional eight weeks. The dosage of TC-5214 was initially 2 mg/day and could be increased at the discretion of the investigator to 4 mg/day and 8 mg/day based on tolerability and therapeutic response. In addition to RENAISSANCE 2 and RENAISSANCE 3 (previously reported), the RENAISSANCE Program includes two fixed dose studies (RENAISSANCE 4 and RENAISSANCE 5) designed to evaluate the efficacy and tolerability of TC-5214 as an adjunct treatment to SSRI/SNRI therapy and RENAISSANCE 7, a long-term study designed primarily to evaluate safety in which patients receive a fixed dose of TC-5214 or placebo, plus a baseline SSRI or SNRI, for one year.

About the Montgomery-Asberg Depression Rating Scale

The Montgomery-Asberg Depression Rating Scale (MADRS) is a commonly used 10-item questionnaire that psychiatrists employ to measure the severity of depressive episodes in patients with mood disorders.

About Targacept

Targacept is developing a diverse pipeline of innovative NNR Therapeutics™ for difficult-to-treat diseases and disorders of the nervous system. NNR Therapeutics selectively modulate the activity of specific neuronal nicotinic receptors, a unique class of proteins that regulate vital biological functions that are impaired in various disease states. Targacept's lead program, TC-5214, is being co-developed with AstraZeneca and is in Phase 3 clinical trials as an adjunct treatment for major depressive disorder. Targacept leverages its scientific leadership and proprietary drug discovery platform Pentad™ to generate novel small molecule product candidates to fuel its pipeline and attract significant collaborations with global pharmaceutical companies. For more information, please visit www.targacept.com.

(Reuters, 12/20/11)

HHS Selects 32 ‘Pioneers’ To Test New Health Care Model For Seniors

The Department of Health and Human Services announced Monday a group of 32 medical providers that will work with the federal government to test an experiment in improving the quality and lowering the cost of health care.

Los Angeles Times: New Partnerships Aim To Lower Medicare Costs, Improve Care. The Obama administration Monday announced new partnerships with 32 of the nation's leading medical providers that have agreed to work with the federal government to improve the quality and lower the cost of care for Americans who rely on Medicare (Levey, 12/19).
The Associated Press: Medicare Launches Experiment To Improve Care. Medicare says it's launching a national experiment to improve care for seniors, and hopefully save taxpayers money as well. Officials announced Monday that 32 networks of doctors and hospitals around the country are becoming Pioneer Accountable Care Organizations, or ACOs. Behind the acronym is a coordinated approach to medicine so that risks like high blood pressure and elevated blood sugars are managed better and patients get help leading a healthier lifestyle (12/19).

Kaiser Health News: Capsules: 32 'Pioneers' Selected To Test New Health Care Model For Seniors. Thirty-two groups were named Monday to test a new health care model, called for in the health care law, which is designed to improve care for seniors while reducing costs" (Torres, 12/19).

Politico Pro: ACOs: The Role Of The Patient. Success or failure for the newly named Medicare ACO Pioneers may depend on one thing they can't control. Their patients. ACOs will bring health care providers together and hold them accountable for costs and outcomes of the patients for whom they provide the most care. Patients will be assigned to the ACO — but they aren't obligated to stay within it. They can go to outside doctors — who don't necessarily follow the same treatment protocols as ACO physicians, and don't necessarily share the kind of health information that makes care coordination possible. Patients can even opt out of the data-sharing that facilitates care coordination even if they continue to see ACO doctors (Feder, 12/20).

Boston Globe: Massachusetts To Debut Medicare Pay Plan. Massachusetts is set once again to become a testing ground for a major federal effort to overhaul the health care industry. Five of the 32 hospital systems and physician groups that will become "pioneers" in a program to change how doctors are paid for the care they provide Medicare patients are from Eastern Massachusetts. Starting Jan. 1, the program will give them a budget to care for their estimated 150,000 patients, rather than a payment for each test or treatment (Conaboy, 12/20).

Arizona Republic: Banner To Test New Medicare Program. Banner Health Network is among 32 health systems tapped by Medicare to test a program under the nation's new health care law that aims to compel hospitals and physicians to improve health quality for seniors and lower costs for the U.S. government. ... Banner Health Network is the only health care provider in Arizona tapped for the initiative. The program expects to enroll an estimated 50,000 Medicare recipients in Arizona who typically would have about $500 million in annual medical costs (Alltucker, 12/19).

Bloomberg: Health Alliances To Share Medical Savings. A university health system in Michigan and a Boston center affiliated with Harvard Medical School are among the first hospitals to join the health care law's most ambitious attempt at reducing medical spending, the government said today. The Department of Health and Human Services designated 32 health systems part of a partnership with Medicare to encourage the formation of networks known as "accountable care organizations" (Wayne, 12/19).

WBUR's Common Health blog: What Boston's Pioneer ACOs Will Mean For Patients. As we reported last week, five Boston area hospitals and physician groups will have a dominant role in a federal experiment that could transform Medicare. All Medicare patients who see doctors through Atrius Health, Partners HealthCare, Beth Israel Deaconess Medical Center, Mount Auburn Hospital or any of the Steward Health hospitals will be affected. The question is how? The Centers for Medicare and Medicaid Services (CMS) today announced 32 organizations that will "Pioneer" the move to accountable care organizations (ACOs). Greater Boston, with five of the 32, will have a large concentration of doctors and patients testing ways to coordinate care and reduce costs (Bebinger, 12/19).

Minnesota Public Radio: Feds Choose 3 Minn. Health Systems For National Program. The U.S. Department of Health and Human Services has chosen three Minnesota health systems to take part in a national program designed to improve patient care while lowering costs to Medicare. The Pioneer Accountable Care Organization program will test different ways of paying hospitals and doctors based on the quality and cost of the care they provide rather than the number of procedures or tests they perform. Allina Health System, Fairview Health Services and Park Nicollet Health Services — all based in the Twin Cities — were chosen for the Pioneer ACO program (Stawicki, 12/19).

(Minneapolis-St. Paul Minn.) Pioneer Press: Allina, Fairview And Park Nicollet Chosen For Medicare 'Affordable Care' Program. Three health care groups in Minnesota will be among a select group of hospitals across the country to participate in a new Medicare program that hopes to improve care while cutting costs. The U.S. Department of Health and Human Services said Monday that 32 health care organizations across the country will participate in the Pioneer Accountable Care Organizations program (12/19).

The Detroit Free Press: U.S. Lauds 3 Michigan Health Systems For Model Medicare Programs. Three health systems in Detroit, Ann Arbor and the suburban Flint area were among 32 cited by the federal government Monday for having model programs to improve care for Medicare patients. The Detroit Medical Center, the University of Michigan and Genesys Health System in Grand Blanc were chosen to test a new federal payment strategy. If successful, payments will be based on how a system performs on quality measurements, not volume of business, as it is now (Anstett, 12/20). (Kaiser Health News, 12/20/11)
Prescription Drug Abuse Aided By Internet Pharmacies, MD Ignorance

Abuse of prescription drugs has reached epidemic levels, yet many physicians are often unaware of the availability of controlled substances over the Internet. In a commentary in the journal Annals of Internal Medicine, investigators describe the probable contribution of Internet pharmacies to the problem and outline potential strategies for addressing it. Experts say awareness and new policies to combat the trade are critical to halt the growing abuse of prescription drugs. Measures are necessary to address the availability of these drugs on the Internet and increase physician awareness of the dangers posed by Internet pharmacies. “Controlled prescription drugs like Oxycontin, Xanax, and Ritalin are easily purchased over the Internet without a prescription, yet physician awareness of this problem is low,” says Anupam B. Jena, M.D., Ph.D., lead author of the article. “Abuse of medications purchased from websites can pose unique challenges to physicians because patients who abuse these medications may not fit clinical stereotypes of drug abusers.” The authors note that abuse of controlled prescription drugs now exceeds abuse of all illegal drugs combined, except marijuana. In November, the U.S. Centers for Disease Control and Prevention reported that the death toll from overdoses of prescription painkillers such as Oxycontin has more than tripled in the past decade. Some illegitimate online pharmacies sell drugs with no prescription or medical information at all while others ask for completion of a questionnaire before a prescription is issued by a physician who has never seen the patient. Studies from have found that 85 percent of websites offering controlled prescription drugs do not require a prescription, and many that do allow the prescription to be faxed, increasing the risk of forgery or fraud. “The Internet serves as an open channel for distribution of controlled prescription drugs with no mechanisms to even block sales to children. This is particularly dangerous given that addiction is a disease that, in most cases, originates with substance use in adolescence,” said Susan Foster, M.S.W., of the National Center on Addiction and Substance Abuse at Columbia University, which contributed to the commentary. Additional investigations by U.S. agencies have verified the ease with which controlled drugs can be purchased online, but little information is available on how drugs acquired that way are used. While some surveys suggest that as many as 10 percent of prescription drug abusers obtain their drugs online, the authors stress that such surveys probably underestimate the situation and would not reach individuals most likely to abuse prescription drugs purchased over the Internet. They also note that surveys in drug treatment centers would totally miss local drug dealers, who are increasingly likely to access their supplies online. Earlier this year Jena and Dana Goldman, Ph.D., director of the Schaeffer Center at USC and a co-author of the commentary, published a study finding that states with the greatest expansion in high-speed Internet access from 2000 to 2007 also had the largest increase in admissions for treatment of prescription drug abuse. They estimated that for every 10 percent increase in high-speed Internet use during those years, admissions for prescription drug abuse increased 1 percent. “Prescription use starts with the physician,” said Goldman, “and we need to more actively engage them to control illicit use. Access to universal, electronic prescription records would be of great assistance in this regard.” Both federal and private agencies have taken measures to reduce the impact of illicit Internet pharmacies, including the 2008 passage of the Ryan Height Online Pharmacy Consumer Protection Act, which specifically prohibits delivery of controlled substances prescribed by a physician who had never examined the patient. But it is not know whether that law and related efforts, such as FDA warning letters to Internet pharmacies and their service providers, are at all successful. The authors note that regulatory efforts also are “stymied by these pharmacies’ ability to appear, disappear, and reappear constantly,” and the reluctance of search engines to stop running ads for rogue online pharmacies. The increasing online availability of prescription drugs may entice individuals believed to be at low risk for drug abuse to overuse controlled medications. The authors note that, while physicians and other health care providers should play a major part in addressing the challenges posed by Internet pharmacies, their awareness of the problem and ability to recognize and treat substance abuse of any kind is usually limited. “Physicians need to educate patients about the risks of purchasing any medications over the Internet and should consider brief but routine questioning about Internet-based medication use,” said Jena. “Given the ability of illegal online pharmacies to evade law enforcement efforts, physician awareness and involvement will be crucial to reducing this problem.” Source: Massachusetts General Hospital (PsychCentral, 12/20/11)

New Medical Payment Model Draws On Mental, Social Factors

A key component of health care reform involves changing the way providers are paid, moving from a fee-for-service medical model to one based on holistic outcomes. Health care in America is expected to become more complex as the aging American population is burdened with a composite array of medical, mental, social and financial issues. Metrics to define and measure patient complexity are necessary to guide how care is organized, how physicians and health care systems are paid, and how resources are allocated. Researchers report that some primary care physicians (PCPs) are a step ahead in satisfying the new model as the PCPs define patient complexity using a broader range of factors — including mental health, social factors and financial issues. The PCP approach appears to provide a
more accurate indication of case complexity replacing traditional methods that merely look at comorbidities (the presence of one or more disorders) and cost. “Simply counting the number of comorbid conditions does not really capture whether a patient is complex,” said Richard W. Grant, M.D., M.P.H., the paper’s lead author. “All primary care physicians can point to patients of theirs with very complicated medical histories who are relatively straightforward to manage, whereas other patients can be a real challenge despite relatively few medical diagnoses. Our results emphasize the importance of social and behavioral contexts that can create important barriers to delivering high-quality primary care.” The study enrolled 40 primary care physicians from 12 private practices and community health centers. Participating physicians used a web-based tool to review a list of 120 of their own patients and indicated those who, in their view, were complex. For those complex patients, they were asked to indicate which of five domains — medical decision-making, coordinating care, mental health or substance abuse problems, health-related behaviors, and social or economic circumstances — were involved in that determination. The authors found that primary care physicians designated about one-quarter of their patients as complex – with older, more experienced physicians and those working in community health centers reporting higher proportions of complex patients. Compared to non-complex patients, complex patients were older, more often women, and had more clinic visits to many different providers. Complex patients were also prescribed more medicines — including prescriptions for antipsychotic medicines — were more likely to miss appointments, and were more likely to live in neighborhoods with lower income and educational levels. The authors then found that the results of physician assessment differed substantially from those of other common methods for assessing complexity. “Managing complex patients requires greater clinician effort, increased health care resources, and substantial family and community support,” said Grant. “In order to redesign our health care systems to more effectively care for complex patients, we need a better handle on exactly who they are. By asking primary care physicians about their experiences with their own patients in a systematic and quantitative way, we were able to bring out the importance of social and behavioral factors, in addition to specific medical problems. “This work may help guide efforts to redesign health care systems so that we can deliver high quality, cost-effective care tailored to individual patient needs.” The article is found in the journal Annals of Internal Medicine. Source: Massachusetts General Hospital (PsychCentral, 12/20/11)

NCSL Report Shows State Revenues Rising For Second Consecutive Year

For the second consecutive year, state budget officials are forecasting a growth in tax revenues over the prior year, according to a new report from the National Conference of State Legislatures. Although two-thirds of states that are anticipating tax growth in 2012 estimate that it will be under 5%, even small revenue improvements are good news for states. Nonetheless, states will likely continue to make cuts to their budgets over the coming year as they grapple with the ongoing effects of the economic recession and the expiration of federal stimulus dollars. (NCCBH, 12/15/11)

Are Accountable Care Organizations A Fad, Or The Future? New National Council Resource Helps You Find Out

On October 20, 2011, the federal government announced final rules providing guidance on how Accountable Care Organizations should be structured. These final rules could create a tipping point to help behavioral health provider organizations become part of the new healthcare ecosystem under health reform. A new resource from the National Council outlines the key elements of the final rules and their implications for behavioral health providers. It answers the key questions:

- What really makes an ACO?
- Who can create and join an ACO?
- Where do behavioral health providers fit in?

The report also explains how behavioral health organizations can "ride the wave" and make the case for their participation in ACO. This report is the latest in our series helping provider organizations prepare for the changes ahead under health reform. To view additional resources, visit our website or check out our blog, MentalHealthcareReform.org. (NCCBH, 12/11)

ASAM and CTI Announce Online SBIRT Training Course

The American Society of Addiction Medicine (ASAM) and Clinical Tools, Inc. (CTI) recently announced that an online SBIRT training course is available. This online training course will provide users with the training needed to appropriately screen for and identify substance abuse, plan and implement a tailored brief intervention, improve care management and referral skills for brief treatment or severe problem/addiction treatment, and will apply the SBIRT approach to substance abuse problems by individualizing these clinical skills to different patients. (NCCBH, 12/11)

SAMHSA Develops a Guide for Substance Use Disorder Counseling

SAMHSA’s “Scopes of Practice and Career Ladder for Substance Use Disorder Counselors” guide give learners the tools needed in order to appropriately screen for and identify substance abuse, plan and implement a tailored brief intervention, improve care management and
IN THE NEWS

Study Finds Connection Between Unemployment Rates And Alcohol Consumption

While some previous studies found that positive health outcomes, including a reduction in excessive drinking rates, improve during economic downturns, new research finds that binge drinking and alcohol abuse and/or dependence actually increase with a rise in the unemployment rate. The study, by University of Miami health economist Michael T. French and collaborators, uses panel data from the National Epidemiological Survey on Alcohol and Related Conditions (NESARC) from 2001 to 2005, which is the most recent relative to existing studies. It includes a rich set of measures on alcohol consumption that were not looked at in earlier studies, such as alcohol abuse and dependence. The findings are reported online by the scientific journal Health Economics in a study titled "Macroeconomic Conditions and Excessive Alcohol Consumption." French and his team found that binge drinking increased with a rise in the state-level unemployment rate. Driving while intoxicated and alcohol abuse and dependence also increased for both genders and across all ethnic groups. Further, the consequences of the unemployment rate on excessive alcohol consumption was demonstrated for all population subgroups in the study, with African-Americans and those aged between 18 and 24 years displaying the largest binge-drinking effect. The researchers also found that unemployed unmarried adults and adults with fewer children were more likely to demonstrate alcohol abuse and dependence. (NCCBH, 12/11)

CDC Study Indicates Overall Drunk Driving Rates Have Fallen Since 2006

According to a recent analysis by the Centers for Disease Control and Prevention, in which researchers looked at data from a 2010 national telephone survey of nearly 210,000 people, drunk driving incidents have fallen 30% since 2006 and 2010 incidents were at their lowest level in almost 20 years. Noting that other studies have shown people are drinking more during the economic downturn, Dr. Thomas Frieden, CDC Director, posits that the decrease in drunk driving incidents signals that people may be turning away from bars, nightclubs and restaurants to do their heaviest drinking. In an interview with the Associated Press, Dr. Frieden suggested "one possibility is that people seem to be drinking at home more and driving less after drinking." While drunk driving numbers have fallen, they remain daunting. Compared to an estimated peak of 161 million incidents of drunk driving in 1993, the CDC found that nearly 1 in 50 respondents admitted to having driven drunk at least once in the month prior to being interviewed, which scales up to more than 112 million episodes of drunk driving in 2010. Dr. Frieden notes that "in fact, nearly 11,000 people are killed every year in crashes that involve an alcohol-impaired driver.” Other findings in the CDC study:

- Men ages 21-34, who make up only 11% of the population, were responsible for 32% of all incidents of drinking and driving.
- In general, men were responsible for more than four out of five drunk driving incidents in 2010. (NCCBH, 12/11)

Two Studies Highlight Alcohol’s Role in Exacerbating Other Serious Illnesses

Alcohol dependence is widely recognized as a chronic and fatal disease in its own right, but two recent researchers have highlighted the contributing role that heavy alcohol use plays in other potentially fatal diseases. Research supported by the Finnish Foundation for Cardiovascular Research analyzed the uniformly required autopsies of victims of sudden cardiac arrest and cardiac deaths in Finland and found that only 78% of heart deaths were due to coronary artery disease, a buildup of plaque in the coronary arteries that is commonly assumed to be the cause of most heart attacks. The primary causes of “nonischemic sudden death” (NSD, or coronary deaths not attributable to coronary artery disease) were found to be alcohol consumption and obesity. Nonischemic heart disease is usually linked to a disease in one or more of the heart muscles, which causes the heart to pump ineffectively, reducing the transport of blood and oxygen throughout the body. Some 23% of those deaths were independently traceable to obesity, while 19% of them were attributable to excessive alcohol consumption. Meanwhile, another study links heavy alcohol consumption with a greater risk of developing lung cancer. Stanton Siu, MD, FCCP, of Kaiser Permanente in California presented a new study at CHEST 2011, the annual meeting of the American College of Chest Physicians. Dr. Siu and his research team studied 126,293 people who provided baseline data from 1978 to 1985 and followed them until 2008 to determine their risk for developing lung cancer in relation to a variety of suspected causal factors: cigarette smoking, alcohol consumption, gender, ethnicity, body mass index (BMI) and level of education. Of the 1,852 people who developed lung cancer during that period, cigarette smoking remained a strong predictor of all types of lung cancer; however, heavy alcohol consumption (> 3 alcoholic drinks per day) also increased the lung cancer risk, with a slightly higher risk related to heavy beer consumption as opposed to wine and liquor. “Heavy
drinking has multiple harmful effects, including cardiovascular complications and increased risk for lung cancer,” said lead researcher Siu, MD in a news release. “We did not see a relationship between moderate drinking and lung cancer development. So it appears probable that most middle-aged and older moderate drinkers have coronary artery protection and no increased risk of lung cancer risk.”

**New Study Assesses Public Health Costs Of Excessive Alcohol Consumption**

Excessive alcohol drinking is the third leading cause of death in the United States, leading to 79,000 premature deaths. Among other things, binge drinking causes increased disease and injury, property damage from fire and motor vehicle crashes and lost productivity. Although the public health impacts of excessive alcohol consumption are known, its economic cost has not been assessed for the United States since 1998. Using data from 2006, a new study in the American Journal of Preventive Medicine by Mathematica assessed costs for health care, productivity losses, and other effects, including property damage associated with excessive drinking. On a per-capita basis, the economic impact of excessive alcohol consumption is approximately $746 per person and is attributed mostly to binge drinking. (NCCBH, 12/11)

**Data Spotlight**

- The percentage of adults with no health insurance is the highest on record, with 17.3% of adult’s uninsured in the third quarter of 2011, according to a new poll by Gallup. Three years ago, in the third quarter of 2008, only 14.4% of adults lacked health insurance. Gallup cautions, however, that the record high also coincides with a methodological change that samples cell-phone only respondents, who tend to be younger and thus more likely to be uninsured. Thus, a portion of the increase could be linked to that change.

- More than 188 tons of unwanted or expired prescription meds were turned in during Prescription Drug Take-Back Day on October 29 at 5,327 sites around the country. Click here to read more.

- Mental health and substance abuse treatment spending declined as a share of overall health care spending, according to a recent SAMHSA study, falling from 9.3% in 1986 to 7.3% in 2005.

- The National Alliance on Mental Illness (NAMI) found that 28 states and Washington, D.C. have cut nearly $1.7 billion from their mental health budgets since the 2009 fiscal year, despite the increased demand for services during these difficult economic times.

- A new study by the Consumer Electronics Association says 36% of consumers would be interested in sending health data to their doctor via a wireless device, 33% are interested in managing their health records online and 32% would be willing to consult with their doctor via online video.

- The death toll from overdoses of prescription painkillers has more than tripled in the past decade. The CDC found more than 40 people die every day from overdoses involving narcotic pain relievers, and four times as many prescription painkillers were sold in the U.S. last year than in 1999.

- Between 1999 and 2008, the number of young adults ages 18 to 24 hospitalized for combined drug and alcohol overdoses increased by 76%, reaching 29,202 cases in 2008. Researchers calculated that the costs of hospitalizations among this age group for alcohol and drug overdoses exceeds $1.2 billion annually. (NCCVBH, 12/11)

**GOVERNMENT AFFAIRS UPDATE**

**NIH Announces Results From A Study On The Treatment Of Prescription Opioid Addiction**

According to a recent study, people addicted to prescription painkillers reduce their opioid abuse when given sustained treatment with the medication Suboxone. Suboxone is a combination of buprenorphine, which is used to reduce opioid craving and naloxone, which is a drug used to counter the effects of opiate overdose. Results of the study show that approximately 49% of participants reduced prescription painkiller abuse during Suboxone treatment. This success rate dropped to nearly 9% once Suboxone was discontinued. This study, published in the Archives of General Psychiatry and was conducted by the National Institute on Drug Abuse, was the first randomized large scale clinical trial using a medication for the treatment of prescription opioid abuse. "The study suggests that patients addicted to prescription opioid painkillers can be effectively treated in primary care settings using Suboxone,” said NIDA Director Nora D. Volkow, M.D. “However, once the medication was discontinued, patients had a high rate of relapse – so, more research is needed to determine how to sustain recovery among patients addicted to opioid medications.”

**CDC Report Says That Smokers Want To Quit But Ignore Treatment**

While nearly 70% of people who smoke say they want to stop, a new report by the CDC says that in the past year only about 32% of smokers used counseling and/or medications that could help them quit. The report shows that 52.4% of adult smokers tried to quit within the past year and that 48.3% of smokers who saw a health
professional in the past year got advice on how to quit smoking. In this report, which was conducted by the National Health Interview Survey, more than 27,000 Americans were questioned about their smoking habits. The findings also correlate with whether or not someone has health insurance. Those without health insurance are less likely to see a physician which in turn causes them to be less likely to be counseled about quitting, making the uninsured the lowest group to use medication when attempting to quit. For people enrolled in Medicaid, whether they get counseling and/or can enroll in smoking-cessation programs and get medication depends on the state in which they live. CMS leaves it up to the states to decide whether or not to cover such programs. For those enrolled in Medicare, smoking-cessation coverage has expanded over the past two years and now all Medicare beneficiaries are covered. Among private insurers, coverage varies. However, under the health care overhaul, insurers will have to provide such coverage by 2015. Smoking and exposure to secondhand smoke kills an estimated 443,000 Americans each year and causes about 130,000 cardiovascular disease deaths per year in the United States, accounting for approximately one of every six health care dollars. (NCCBH, 12/11)

Depression Treatment: Better But Still Not Great

Depression affects 1 in 6 Americans in the course of his or her lifetime. And while antidepressant medications have seemingly revolutionized treatment, making the depressed well again is a largely hit-or-miss proposition. A review of advances in depression treatment published in the Lancet this week acknowledges the limitations of current treatment, but looks ahead hopefully to several new therapies -- among them, deep-brain stimulation. "In actual practice, most patients need several sequential treatment steps to achieve remission," said the authors of the Lancet "seminar," all from the University of Pittsburgh's Western Psychiatric Institute and Clinic. More than 3 in 10 depressed patients who seek treatment are unlikely to see their depression lift completely after trying several courses of antidepressants. "No fully satisfactory treatments for major depression are available," the authors concluded. The authors noted that as researchers uncover some of the things that go wrong in a depressed person's brain, better diagnosis and potentially better treatments will emerge. Among the possibilities: genetic tests that can help predict how well a patient will respond to the plethora of antidepressant medications available; brain imaging techniques that might help diagnose depression and shed light on how it works; new evidence that some psychotherapy can be effective even when delivered via telephone and the Internet; and two potential new "rescue drugs" -- ketamine and (also known as SAMe) -- that appear to bring about short-term remission at least of depression that has failed to yield to standard drugs and psychotherapy. Transcranial magnetic brain stimulation -- already approved by the FDA as a treatment for depression -- and deep-brain stimulation -- not yet approved, but for which research evidence is accumulating -- also appear promising, the authors wrote. But as regulators and psychiatrists deepen their understanding of deep-brain stimulation, the authors warned, they should be attentive to the possibility it could increase patients' risk for suicide. (Los Angeles Times, 12/19/11)

Pediatricians Can Help Keep Kids Out Of Trouble

By the time they're old enough to vote, roughly one in four Americans has had at least one criminal arrest. By age 23, an estimated 33 percent -- and perhaps as many as 41 percent of young adults -- have been arrested at least once, excluding traffic violations. The authors of a new study say their analysis is the first contemporary look at national arrest prevalence in this age group since landmark research in the 1960s. "The percentages are not really all that different up to age 18," said lead researcher Robert Brame. "The biggest differences are from 18 to the early 20s, and most occur in the 19-to-22 age range." Pediatricians have a role in preventing violent or unsafe behaviors in young at-risk patients, said Brame, a professor in the Criminal Justice and Criminology Department at the University of North Carolina at Charlotte. "We don't think that kids get arrested in isolation, we're assuming that other issues are going on in their lives and we want pediatricians to be aware and try to understand and start a broader discussion about what's going on in the lives of young people," Brame said. Dr. Paula Braverman, who chairs the Committee on Adolescence of the American Academy of Pediatrics, agreed. "Pediatricians have an opportunity to identify risk factors that are associated with increased chances of involvement in behaviors that can lead to delinquency," she said. Even during routine checkups or visits for medical issues, "we're asking about school, what's going on in the family. We're asking about drug use and we're screening for mood and mental health issues." Referrals might be for substance abuse services or mental health counseling, Braverman said. With child abuse or neglect, "we report to the appropriate authorities," she said, but the doctor's responsibility doesn't end there. "We would facilitate referrals for appropriate treatment and support children through that." The new study appears online Dec. 12 and in the January 2012 print issue of Pediatrics. The researchers used National Longitudinal Survey of Youth data from 1997 to 2008 for 7,335 young people aged 8 to 23. For 18-year olds, between 16 percent and 27 percent of youth will have at least one criminal arrest, results indicate, and by the time they reach 23, between 25 percent and 41 percent of young adults will have an arrest record. Surveyors asked about arrests but not specific crimes. However, in 2009 arrest figures from the
U.S. Office of Juvenile Justice and Delinquency Prevention, arson topped the list, followed by vandalism, disorderly conduct, robbery, burglary and car theft. The researchers said they would look at racial and gender issues in future research. The study didn’t explain why arrest risk grew so much for young adults, but the authors suggested a couple of possibilities. "The criminal justice system is more punitive today. In adult systems, in 1972 to 1973, there were 100 inmates per 100,000 people in the population. It’s an increase of about five times more today," Brame said. "So we’re mindful of that." Another possible reason is that the transition from childhood to adulthood takes longer than it used to. "We speculate that society as a whole is going through a phase of extended adolescence," Brame said. "The phenomenon has a name, ‘emerging adulthood.’" Braverman described protective factors for children, which include "having a resilient temperament and close relationships with family, teachers, and other supportive adults and peers; having a strong future orientation; and having beliefs and expectations that are associated with success in school and avoidance of substance abuse and involvement in crime." "Getting these kids to a pediatrician on a regular basis is probably the easiest concrete thing that parents can do," Brame said. "And kids may tell pediatricians about issues and experiences that they don’t feel comfortable discussing with parents." The main message, he said, is "this is not rare, it’s happening a lot. Pediatricians can help." (USA Today, 12/20/11)

Federal Officials Extend Medicaid Waiver For Mass.

The waiver will change how hospitals are paid and will test new delivery system models.

The Hill: CMS Extends Medicaid Waiver In Massachusetts. The federal government on Tuesday extended a Medicaid waiver in Massachusetts, which was first implemented as part of then-Gov. Mitt Romney’s healthcare overhaul. The waiver will now run through 2014. It is focused primarily on efforts to improve the cost and quality of the Medicaid program and better coordinate care. The waiver provides incentives for hospitals to improve their efforts to integrate their services (Baker, 12/20).

Boston Globe: US Extends Medicaid Waiver For Massachusetts. The federal government approved a plan yesterday that extends Medicaid funding for the state’s innovative health insurance law through mid-2014 and shifts the way hospitals that treat a large portion of poor patients are paid. ... The waiver is key to funding the 2006 health care law that provides subsidized insurance plans for low-income people and requires most state residents to have health insurance (Conaboy, 12/20).

AP/MSNBC: Mass., Feds Agree To $26.7B Health Care Extension. (Gov. Deval) Patrick praised the three-year, $26.7 billion Medicaid waiver — a $5.7 billion increase over the previous waiver. Patrick said the money will help the state preserve existing eligibility and benefit levels in Medicaid and Commonwealth Care programs. Commonwealth Care is the subsidized insurance program established by the state’s landmark 2006 health care law (LeBlanc, 12/20).

CQ HealthBeat: Massachusetts Gets Waiver Continuing Its Health Coverage Law. The law in Massachusetts that has elevated coverage levels in the state to the point where more than 98 percent of its residents have health
E-Newsletter – National and Industry News
Florida Council
December 26, 2011

insurance has hinged on a key "waiver" — and the Centers for Medicaid and Medicare Services has now extended it (Adams, 12/20). Politico Pro: Massachusetts Medicaid Waiver Approved, Key To State's Reform. Some of the funds will also go to test new delivery system models aimed at containing the state's high health costs. The nearly $27 billion waiver provides an additional $5.7 billion to restructure the state's Safety Net Care Pool to "promote health system and payment transformation, and to undertake several innovative new programs to advance children's health care coverage and parents' access to health care coverage," CMS Administrator Marilyn Tavenner wrote in a letter to the state on Tuesday (Nocera, 12/20). (Kaiser Health News, 12/21/11)

How Do You Hold Mentally Ill Offenders Accountable?

Mental health and law enforcement officials in California are trying to find ways to hold violent psychiatric patients accountable without punishing people for being sick. It's a response to escalating violence in the state's mental hospitals, where thousands of assaults occur annually. Only a tiny fraction of them, however, result in criminal charges. One case that did was the attack on Jill Francis, a psychiatric technician. She was punched by one of her patients at Atascadero State Hospital on California's Central Coast. Months after the incident, there's still a bruise under her left eye from reconstructive surgery. "I received a laceration above my eye, which took seven stitches to close," she says, cataloging her injuries. "My eye was actually pushed back and down, I had fractures in the bone below my eye, and I got a concussion, [all] from one punch."

More In This Series

In Calif. Mental Hospitals, Assaults Rarely A Crime Violence Surges At Hospital For Mentally Ill Criminals At California Mental Hospitals, Fear Is Part Of The Job

The patient who allegedly hit her is Desmond Watkins. According to law enforcement officials, Watkins has previously been in prison for assault with a deadly weapon. And when Francis met him, he was in Atascadero for the second time. Francis says Watkins "just got fixated all of a sudden that he wanted to go back to prison, and that by hitting someone that would enable him to go back." Watkins may get his wish. He's been charged with three felonies, including aggravated battery.

The 'Mentally Disordered Offender' Law

He's one of thousands of Californians caught in the revolving door between the state's prisons and mental hospitals. Many of those people make that back-and-forth trip because of a law unique to California known as the Mentally Disordered Offender law. It says prison inmates who have committed serious crimes and have been diagnosed with a major mental illness can be forced to serve their parole in a state hospital. And each year that they're in the hospital, they get a trial to determine whether they're still mentally disordered. At Atascadero State Hospital, there are more than 600 mentally disordered offenders, as many as there are at all of the other state hospitals combined. In fact, they make up a majority of Atascadero's patients. "As a group, the mentally disordered offenders are the most aggressive," says Atascadero hospital director Jon De Morales. That's why the toughest ones are housed on a special unit, he says, with tiny private bedrooms and windows that allow staffers to see inside. "Kind of stark," says De Morales, peering into a room with a bed bolted to the floor and no other furniture or decoration. There are criminals who happen to exhibit symptoms of a mental disorder, [and] there are mentally ill people who happen to have committed crimes. They all end up in the same place. - Jon De Morales, director of California's Atascadero State Hospital

De Morales, who has worked at Atascadero for decades, has developed a theory about his patients. First, he says, "there are criminals who happen to exhibit symptoms of a mental disorder." Then, "there are mentally ill people who happen to have committed crimes. They all end up in the same place." And they all get treated the same. But they shouldn't, says San Luis Obispo County District Attorney Gerald Shea. He thinks mentally disordered offenders should be subject to the same laws in the hospital that they were subject to in prison, where any violent act against a staff member, no matter how slight, is treated as a felony and results in a longer sentence. Shea says extending this law to cover parolees in the hospitals is only fair. "We just feel that the employees at Atascadero State Hospital shouldn't be subjected to lesser protection than their counterparts at the state prisons," he says. So Shea sent a memo with his legal arguments for the change to his state senator, Sam Blakeslee. Blakeslee now plans to introduce a bill that would turn Shea's idea into law. But the senator says the increased penalties would not apply to every patient. "You've got people who have been determined to be so mentally compromised that they're not guilty by reason of insanity or incompetent to stand trial. This legislation would not apply to those individuals," he says.

'Enhanced' Treatment, More Staff

But some of those individuals are chronically aggressive. So even if Blakeslee's bill passed — and similar legislation has failed in the past — it would not solve the violence problem. That's why the Department of Mental Health is now experimenting with what it calls an "enhanced treatment unit." The first one, a pilot project, just opened at Atascadero. "Some of our own staff and the public ... think of the enhanced treatment unit as a 'bad boy' unit or a secure unit," says De Morales. "It is not." The unit will have more intensive treatment, says De Morales, and more staff, all of whom have volunteered.
Health Screens Limit Substance Abuse In Pregnancy

Pregnant women who smoke cigarettes, use alcohol or take drugs increase the risk of medical complications for the baby and mother. That's well-established science. Now, a program developed by the Kaiser Permanente Health System for women at risk of substance abuse during pregnancy could save nearly $2 billion annually in health care costs if implemented nationwide. The study is published online in the American College of Obstetricians and Gynecologists' Journal, Obstetrics & Gynecology. The program takes an early intervention approach to improve maternal health and reduce health care expenditure. The cost-benefit analysis of the Kaiser Permanente Early Start program follows a 2008 Kaiser Permanente study that showed the program helps pregnant women at risk of substance abuse achieve similar health outcomes — for both mothers and their infants — as women who do not use cigarettes, alcohol or drugs. The program decreases maternal and neonatal morbidity and stillbirths, said the study's lead author Nancy C. Goler, M.D. "Now, we're able to show everyone that not only is it the right thing to do, we will save money," Goler said. "This program is a very low-technology intervention that has an enormous net cost savings." The program involves screening pregnant women by urine toxicology tests and substance-abuse screening questionnaires. In the study, researchers examined 49,261 women and, comparing the health care costs for pregnant women in four groups, found the Early Start program yields an average net cost benefit of $5.9 million annually. One group of women at risk for substance abuse in pregnancy participated in full Early Start services, including a one-hour psychosocial assessment and follow-up appointments. The second group of women at risk for substance abuse had limited Early Start services, including a one-hour psychosocial assessment without follow-up. The third group of women at risk for substance abuse did not access Early Start, and the women in the control group tested negative for substance use in pregnancy and were not at risk. Researchers believe nearly $2 billion could be saved for every 4 million births each year if the program was implemented nationwide, the study estimated. Experts believe a critical factor toward Early Start's success is the program's accessibility to patients. The program is located at the same clinic in which pregnant women receive their routine prenatal care, Goler said, adding that appointments with the woman's prenatal care provider and her Early Start specialist are coordinated. More clinicians should move their substance-abuse prevention programs for pregnant women into prenatal care sites, Goler noted. Source: Kaiser Permanente (PsychCentral, 12/21/11)

GPS Helping Substance Abuser Find His Way To Sobriety

James Ness is carrying around a GPS device he hopes will tell him where not to go. A recovering drug and alcohol abuser in court-ordered counseling, Ness is equipped with a smartphone that warns him when he's getting near old haunts that fueled his addictions: A north Denver bar. An apartment building packed with hard-partying friends. Enough risky points in Aurora to make him write off the whole city. And since Ness is deaf, the Global Positioning System application vibrates rather than beeps. Other applications on the phone give him a "panic" button with direct access to his counselor. If his local adviser isn't available, Ness can link through a video sign-language translator to other trusted friends. Another button offers motivational videos; still another links to a Facebook-style chat with other hearing-impaired clients supporting one another in recovery. The phone is good cop/bad cop in one. His talks with supportive friends might be interrupted by an automated text from Arapahoe House, his counseling center, reminding Ness that it's his day to give a urine sample. Ness, 40, is eager to add all the lifelines he can get. Some of the same technology got the auto mechanic into trouble in the first place, with the wrong kind of Facebook friends and time wasted in YouTube distractions. Ness and Arapahoe House think it's only fair that new grants help the recovery center connect people for the right reasons. "I'm here for a drinking problem, not to socialize with the wrong friends," said Ness, speaking through an American Sign Language translator at Arapahoe's Thornton clinic. Arapahoe House, one of the largest detox and treatment centers in the West, is working to expand options for deaf and hard-of-hearing clients. Many of the new technologies could apply to all clients in need of reminders and lifelines. The center, though, will first focus the smartphones on deaf clients, using the targeted federal grant and technology developed at the University of Wisconsin. Eighteen percent of the general population is hard of hearing, said Arapahoe deputy director Art Schut. Addiction problems in the deaf and hard-of-hearing community probably reflect the wider population, but deaf clients have higher readmission rates for treatment, he said. Arapahoe treated 65 deaf and hard-of-hearing clients last year. Ness said he has sat in group meetings with hearing clients, frustrated at trying to communicate his true experience or feelings. New technology can draw in more clients like him to those meetings, and also let him sign with counselors, friends and translators when he's away. Schut said Arapahoe continually looks at where it is "unfriendly" to clients in need, and deaf communications was one of them. He also notes a
National Academy of Sciences study on substance abuse saying 2 4/7 access for patients is a key to successful treatment. "This technology brings that possibility to bear," Schut said. The treatment center hopes to extend the technology to nearby 140 people over three years. Melissa Hickerson, a counseling supervisor at Arapahoe’s Thornton location, showed Ness some of the features she wants him to try. One of the applications developed by the Wisconsin researchers prompts the phone user to weekly surveys on their mood and behavior. If a client like Ness punches in a “5,” saying he has been getting no sleep, the app immediately notifies a counselor who can reach out to Ness for quick help. The clients are largely in charge of their “bad” or high-risk locations for the GPS warning feature. But counselors can encourage them to add in locations, if they aren’t being honest with themselves about where trouble is coming from. Arapahoe doesn’t use the GPS feature to track clients as if it were a punitive ankle bracelet. It does reserve screening power, though, over photos clients might upload, and on the circles of friends within support groups. Ness works through the phone lessons and then gives a thumbs-up, saying he’s not only going to learn the apps but urge them on other deaf friends who aren’t admitting their problems. “I’m going to go for it,” he signs. (Denver Post, 12/22/11)

HUD Awards $71.9M To 331 Florida Homeless Programs

U.S. Housing & Urban Development Secretary Shaun Donovan on Dec. 20 awarded $71.9 million to renew funding to 331 homeless programs operating in Florida. “The grants we’re awarding will literally keep the doors of our shelters open and will help those on the front lines of ending homelessness do what they do best,” said HUD Southeast Regional Administrator Ed Jennings Jr. “It’s incredible that as we work to recover from the greatest economic decline since the Great Depression, the total number of homeless Americans is declining, in large part because of these funds.” Last week, HUD announced its 2011 “point in time” estimate of the number of homeless people in America. Approximately 3,000 cities and counties reported 636,000 homeless persons on a single night in January 2011, a 2.1 percent decline from the year before. HUD’s Continuum of Care grants provide permanent and transitional housing to homeless persons as well as services including job training, health care, mental health counseling, substance abuse treatment and child care. (Orlando Business Journal, 12/21/11)

AMHSA Announces A Working Definition Of “Recovery” From Mental Disorders And Substance Use Disorders

A new working definition of recovery from mental disorders and substance use disorders is being announced by the Substance Abuse and Mental Health Services Administration (SAMHSA). The definition is the product of a year-long effort by SAMHSA and a wide range of partners in the behavioral health care community and other fields to develop a working definition of recovery that captures the essential, common experiences of those recovering from mental disorders and substance use disorders, along with major guiding principles that support the recovery definition. SAMHSA led this effort as part of its Recovery Support Strategic Initiative. The new working definition of Recovery from Mental Disorders and Substance Use Disorders is as follows:

A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.

"Over the years it has become increasingly apparent that a practical, comprehensive working definition of recovery would enable policy makers, providers, and others to better design, deliver, and measure integrated and holistic services to those in need,” said SAMHSA Administrator Pamela S. Hyde. "By working with all elements of the behavioral health community and others to develop this definition, I believe SAMHSA has achieved a significant milestone in promoting greater public awareness and appreciation for the importance of recovery, and widespread support for the services that can make it a reality for millions of Americans.” A major step in addressing this need occurred in August 2010 when SAMHSA convened a meeting of behavioral health leaders, consisting of mental health consumers and individuals in addiction recovery. Together these members of the behavioral health care community developed a draft definition and principles of recovery to reflect common elements of the recovery experience for those with mental disorders and/or substance use disorders. In the months that have followed, SAMHSA worked with the behavioral health care community and other interested parties in reviewing drafts of the working recovery definition and principles with stakeholders at meetings, conferences and other venues. In August 2011, SAMHSA posted the working definition and principles that resulted from this process on the SAMHSA blog and invited comments from the public via SAMHSA Feedback Forums. The blog post received 259 comments, and the forums had over 1000 participants, nearly 500 ideas, and over 1,200 comments on the ideas. Many of the comments received have been incorporated into the current working definition and principles. Through the Recovery Support Strategic Initiative, SAMHSA has also delineated four major dimensions that support a life in recovery:

- Health: overcoming or managing one’s disease(s) as well as living in a physically and emotionally healthy way;
- Home: a stable and safe place to live;
- Purpose: meaningful daily activities, such as a job, school, volunteerism, family caretaking, or creative
endeavors, and the independence, income and resources to participate in society; and

Community: relationships and social networks that provide support, friendship, love, and hope.

Guiding Principles of Recovery

Recovery emerges from hope: The belief that recovery is real provides the essential and motivating message of a better future – that people can and do overcome the internal and external challenges, barriers, and obstacles that confront them.

Recovery is person-driven: Self-determination and self-direction are the foundations for recovery as individuals define their own life goals and design their unique path(s). Recovery occurs via many pathways: Individuals are unique with distinct needs, strengths, preferences, goals, culture, and backgrounds, including trauma experiences, that affect and determine their pathway(s) to recovery. Abstinence is the safest approach for those with substance use disorders.

Recovery is holistic: Recovery encompasses an individual’s whole life, including mind, body, spirit, and community. The array of services and supports available should be integrated and coordinated.

Recovery is supported by peers and allies: Mutual support and mutual aid groups, including the sharing of experiential knowledge and skills, as well as social learning, play an invaluable role in recovery.

Recovery is supported through relationship and social networks: An important factor in the recovery process is the presence and involvement of people who believe in the person’s ability to recover; who offer hope, support, and encouragement; and who also suggest strategies and resources for change.

Recovery is culturally-based and influenced: Culture and cultural background in all of its diverse representations, including values, traditions, and beliefs, are keys in determining a person’s journey and unique pathway to recovery.

Recovery is supported by addressing trauma: Services and supports should be trauma-informed to foster safety (physical and emotional) and trust, as well as promote choice, empowerment, and collaboration.

Recovery involves individual, family, and community strengths and responsibility: Individuals, families, and communities have strengths and resources that serve as a foundation for recovery.

Recovery is based on respect: Community, systems, and societal acceptance and appreciation for people affected by mental health and substance use problems – including protecting their rights and eliminating discrimination – are crucial in achieving recovery.

For further detailed information about the new working recovery definition or the guiding principles of recovery please visit: http://www.samhsa.gov/recovery/ (SAMHSA, 12/22/11)