HEALTH REFORM AND BEHAVIORAL HEALTH SERVICES IN MASSACHUSETTS: PROSPECTS FOR ENHANCING INTEGRATION OF CARE

KEY ISSUES FROM JUNE 2011 STAKEHOLDER SUMMIT MEETING

Consumer Quality Initiatives

Heller School for Social Policy and Management, Brandeis University

Reservoir Consulting Group

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BACKGROUND ON FEDERAL HEALTH REFORM IN THE COMMONWEALTH OF MASSACHUSETTS: FOCUS ON INTEGRATION

The Patient Protection and Affordable Care Act of 2010 (ACA), the landmark legislation establishing federal health care reform, and the federal Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), have important implications for people with mental health and substance use conditions. These recent reforms have the potential to dramatically enhance access, service delivery and financing of behavioral health care through insurance expansions, regulations, and delivery system changes.

The ACA expands access to public insurance through extension of Medicaid eligibility and to private insurance through health insurance exchanges and an individual mandate.[1] The MHPAEA requires that behavioral health benefits be no more restrictive than those for general medical care if covered in private health plans with more than 50 employees, but does not mandate that plans offer behavioral health benefits. The ACA extends the reach of parity by mandating that health plans include behavioral health benefits equal to the scope of general health benefits in order to qualify for participation in health insurance exchanges.[2] In Massachusetts, these federal reforms took place in the context of major accomplishments in state health reform. The 2006 passage of the Massachusetts Health Care Reform Law aimed at universal health insurance through several mechanisms including an individual mandate. Health reform in Massachusetts has so far resulted in coverage for 98.1% of Massachusetts residents.[3]

Provisions of the ACA also promise to improve integration of medical care by encouraging the development and diffusion of new delivery and payment systems. These include Patient-Centered Medical Homes (PCMHs) and Accountable Care Organizations (ACOs).[1, 4, 5] PCMHs are designed to provide patient-centered, coordinated, and accessible care addressing the full range of health care needs. ACOs are entities that assume accountability and financial responsibility for a broad continuum of care that includes different levels and types of care, such as primary and specialty care and hospitals.

The effort to increase service integration, including for people with behavioral health conditions, is critical to maximizing the potential gains from health reform. Behavioral health services have historically suffered from lack of coordination, suboptimal delivery of evidence-based treatment, stigma, and other challenges in addition to discriminatory insurance coverage. Access to treatment for behavioral health conditions has increased over the past decade, but there are concerns regarding the reduced intensity of treatment and greater reliance on medication, among other issues.[6] Behavioral health advocates fully recognize that insurance coverage does not necessarily translate into high quality and accessible services.[7] Health insurance, even with parity, typically does not cover the educational, vocational, or housing supports people with behavioral health conditions often need. Peer support also provides an important component of recovery-oriented services and must be included in efforts at improving integration. Thus, despite progress, many challenges in behavioral health services persist and are related to the need for better integration across behavioral health, general medical care, and recovery support services.

Patient-centered, integrated care has been highlighted as necessary for high-quality care by the Institute of Medicine in its report on *Improving the Quality of Health Care for Mental and Substance-Use Conditions.*[8] In order to ensure that integration becomes a reality for people with behavioral health issues, their needs must be fully considered as federal health reform is implemented in the Commonwealth. Bringing together varied perspectives is critical to developing comprehensive solutions. Consumer Quality Initiatives and Brandeis University co-sponsored a stakeholder summit meeting on behavioral health service integration in the context of health reform to help meet those goals.

SUMMIT MEETING ON HEALTH REFORM AND BEHAVIORAL HEALTH INTEGRATION IN MASSACHUSETTS

OVERVIEW

This report is based on a summit meeting of key behavioral health stakeholders in Massachusetts held on June 24, 2011. The purpose of the meeting was to discuss the implications of health reform for integration of behavioral health care, and to identify key issues that must be attended to as implementation of health reform proceeds.

Over 35 individuals attended the meeting. They represented multiple stakeholder groups including consumers, providers, policymakers, government agencies and researchers. The morning included two presentations with panel responses (summarized below) followed by discussions open to all participants. The afternoon consisted of workgroups and concluded with group discussion. Primary support for the meeting was provided by a grant from the Robert Wood Johnson Foundation Community Health Leaders program, with additional support from the Institute for Behavioral Health at Brandeis University's Heller School.

This report summarizes the presentations and key themes identified by participants. The meeting and this report will help to inform a larger forum on behavioral health care under federal health reform sponsored by the Blue Cross Blue Shield of Massachusetts Foundation, the Massachusetts Department of Mental Health, and the Massachusetts Health Policy Forum to be held in the fall of 2011. It will also inform other policy and implementation efforts that are underway.

KEYNOTE PRESENTATIONS AND RESPONSES

1. HEALTH REFORM AND BEHAVIORAL HEALTH

Presentation by Richard Frank, Ph.D., Department of Health Care Policy, Harvard Medical School

Dr. Frank highlighted provisions of the ACA that are likely to have an impact on behavioral health services, including coverage expansion and delivery system reforms. Coverage expansion is important because individuals with behavioral health conditions are more likely to be uninsured. The majority of expansion will occur through Medicaid and the employer mandate. Expansions occur in the context of parity, but behavioral health services will be covered in an "essential benefits package" yet to be defined. Delivery system reforms impact the organization and financing of care. Models for integrating care will include: (1) providing evidence-based behavioral health practices in primary care settings, (2) developing specialty medical homes for consumers with complex health care needs, and (3) increasing care coordination for individuals with serious mental illnesses dually eligible for Medicare and Medicaid. Financing links between health care and social services, such as through Medicaid's 1915(i) state plan option, is necessary because the role of state behavioral health authorities and federal block grant programs may change significantly.

PANELIST RESPONSES

BARBARA LEADHOLM, MSN, MBA, COMMISSIONER, MASSACHUSETTS DEPARTMENT OF MENTAL HEALTH (DMH)

The goal is to build consensus for a population-based approach that will improve access and define and focus on health outcomes. There are already building blocks of integration in place in Massachusetts, including person-centered and community-based services, such as the CMS demonstration project Money Follows the Person (MFP) and medical homes that include behavioral health. We have workgroups focusing on bringing primary care into specialty treatment settings, and on Medicare/Medicaid dual eligibility. The need for a state behavioral health authority is stronger than ever given the potential changes associated with health reform. In Massachusetts, DMH plays a key role linking and aligning stakeholders to provide community mental health services. Health information technology, including electronic health records and interoperable data systems, is critical to improving coordination.

MICHAEL BOTTICELLI, M.Ed, DIRECTOR, BUREAU OF SUBSTANCE ABUSE SERVICES, DEPARTMENT OF PUBLIC HEALTH

People with substance abuse disorders appear to be overrepresented among those who remain uninsured. There is still a need for safety net/block grant funding to support this population. Enrollment and eligibility issues need to be reexamined because many individuals with addictions, while eligible, have not enrolled. Additionally, some individuals may not be able to meet certain enrollment requirements, such as a home address or a valid Massachusetts ID, or to afford premiums and deductibles. More information is needed regarding models of care to attract this population, which is primarily young, male, and treatment-resistant. Integration of addiction and general health care requires (1) culture change and technical assistance; (2) establishment of a formal relationship between the Bureau of Substance Abuse Services (BSAS)and Medicaid; and (3) measurement of health outcomes using standardized performance measures. Various options may exist to get and keep this population insured, such as state agency using funds to support enrollment and minimize churn.

2. INTEGRATION OF UNHEALTHY ALCOHOL AND OTHER DRUG USE CARE IN PRIMARY CARE

Presentation by Richard Saitz, MD, MPH, FACP, FASAM, Boston University Schools of Medicine and Public Health, Boston Medical Center

Dr. Saitz described primary care as the foundation of the health care system. Potential benefits of integrating behavioral health care into primary care for patients with alcohol and other drug problems are: (1) better-quality, safer care for medical and behavioral conditions; (2) detection and management of medical and behavioral health issues, including for the spectrum of unhealthy substance use; (3) promotion of healthy behaviors; and (4) more effective use of health services. The Patient-Centered Medical Home is a model for integrating behavioral health and primary care. The PCMH consists of a team of health care providers, including a personal physician who provides first contact and continuous comprehensive care. The comprehensive, coordinated, population-based nature of PCMHs aligns well with core components of primary care. Dr. Saitz presented evidence of the feasibility and efficacy of addressing unhealthy substance use in primary care. Integrating care faces challenges at patient, provider and system levels, but could greatly improve care.

PANELIST RESPONSES:

BRUCE BIRD, PH.D., CEO, VINFEN CORPORATION

Care coordination can be improved through patients learning to coordinate their own care in addition to delivery model reforms like patient-centered medical homes and ACOs. The challenges moving forward are threefold: (1) how to integrate medical and behavioral funding methods while protecting fragile behavioral and community rehabilitation and recovery services, (2) finding evidence-based practices that can be adopted although technologies have yet to be deployed, and (3) securing funding when substance abuse care is merged with mental health care.

CASSIE CRAMER, LICSW, SOMERVILLE CAMBRIDGE ELDER SERVICES, M-POWER

Ms. Cramer discussed the challenges of navigating the health care system by referring to her own experience as a teen with depression, and to her experience working in the field as a social worker. She advocated for increased development and financing of health promotion and wellness initiatives in the community. She pointed out that exercise, and in her case running, plays a significant role in overall wellness, and that availability and affordability of exercise programs is important. She recommended a holistic approach that addresses one's social, environmental, physical, emotional, spiritual, occupational and intellectual domains.

MARYANNE FRANGULES, EXECUTIVE DIRECTOR, MASS ORGANIZATION FOR ADDICTION RECOVERY

Ms. Frangules reflected on her experiences in overcoming eating disorders and battling addiction. She advocated for an empowered patient and the importance of a consistent support system from a team of providers and peer recovery support services. She urged that referral and delivery systems work together to create an integrated recovery plan for people with mental health and addiction service needs.

NANCY PAULL, CEO, STANLEY STREET TREATMENT AND RESOURCES (SSTAR)

To decrease health care costs it is critical to screen for behavioral health conditions, teach patients about self-care, offer needed services, and coordinate patient care more efficiently. Lack of communication among providers and lack of trained staff are barriers. The problems could be addressed through: (1) specialized care managers for specific diseases; (2) consolidation of multiple systems of electronic medical records into one primary system; and (3) universal mental health and substance abuse screening.

MAJOR THEMES IDENTIFIED AT THE SUMMIT MEETING

Throughout the meeting, participants offered commentary on a variety of topics related to health reform and integration of behavioral health services. In addition, there were three afternoon facilitated work groups, all of which reported back to the larger group. The following is a list of major themes drawn from these discussions.

1. COVERAGE EXPANSION DOES NOT AUTOMATICALLY TRANSLATE INTO OPTIMAL ACCESS OR QUALITY OF CARE

There was broad consensus that coverage expansions under health reform are necessary but not sufficient to ensure full access to high-quality care. Participants voiced the concern that financing for evidence-based housing and employment supports, which are not definitively covered by Medicaid, will be cut. Improved care coordination, delivery of evidence-based services, well-trained providers, and a full continuum of services across both medical and social service domains are all additional critical elements of good behavioral health care.

2. INTEGRATING BEHAVIORAL HEALTH AND GENERAL HEALTH CARE AT THE STATE LEVEL IS ESSENTIAL

Many behavioral health supports and services are not reimbursed by health insurance, but rather are funded through mental health and substance abuse block grants to states. The ACA is expected to result in significant changes to block grants as more treatment services shift to being covered under Medicaid or commercial health plans. While behavioral health providers will have the opportunity to take advantage of the expanded funding opportunities offered by the ACA, participants voiced concern about this transition. Concerns included the loss of block grant-funded services, such as housing supports, and the fact that many substance use service providers have never billed for Medicaid and may not meet the requirements to qualify for Medicaid reimbursement. Changing from grants-based financing to financing through third-party billing will be extremely challenging not only for providers but also for DMH and BSAS. Implementation challenges could create a supply problem and an angry constituency. Participants observed that health reform implementation means behavioral health authorities will have new roles to play and that it is advantageous to continue to increase coordination across DMH and BSAS.

3. NEW MODELS FOR INTEGRATING CARE HOLD PROMISE FOR IMPROVING BEHAVIORAL HEALTH CARE

Health reform provisions encourage formation of PCMHs and ACOs, both of which promise to improve care for people with mental health and substance use conditions. This is especially important given the frequent comorbidity of general medical and behavioral health conditions. Participants expressed consensus that primary care practices must have the appropriate training and personnel to fully assist patients with behavioral health conditions. Furthermore, some subpopulations, such as persons with serious mental illness, may be best served by specialty medical homes, such as community mental health centers. This requires improvement in how primary care identifies and addresses mental illness and addiction problems, and requires that specialty behavioral health settings improve the quality of their linkages with primary care. The specialty provider will need to establish working relationships with other providers to form ACOs. How these new models are implemented will determine the extent to which people with behavioral health conditions will benefit.

4. HEALTH REFORM IMPLEMENTATION MUST BE ACCOMPANIED BY INCREASING THE USE OF EVIDENCE-BASED PRACTICES

Participants agreed that there is a major need to increase the provision of evidence-based practices to optimize health. The focus in federal health reform on prevention, care management and integration means that there may be an even greater impetus to ensure that providers delivery effective services. Evidence-based practices include a wide range of services, such as Screening, Brief Intervention and Referral to Treatment (SBIRT) in primary care settings, collaborative care for depression and other approaches related to the Chronic Care Model, [9] motivational interviewing, pharmacotherapy for substance dependence, and mental health consumer-operated programs.

5. HEALTH CARE INTEGRATION BENEFITS GREATLY FROM THE USE OF HEALTH INFORMATION TECHNOLOGY

Health information technology (HIT) offers a promising tool to facilitate the integration of care by improving the frequency and quality of communication between patients, providers, and organizations. One essential component of HIT is electronic health records (EHR). EHR facilitate the collection, management, and exchange of information about patients' health and health care use across providers and organizations in a timely manner and can be used to measure the quality of care for quality monitoring and research. Behavioral health providers need to adopt and implement clinical and administrative data systems that communicate with general health providers' data systems ("interoperability"). However, behavioral health care measures and providers are not currently part of Medicare's incentive payment program to use EHR. Very few specialty behavioral health service providers are equipped with EHR and/or interoperable data systems. Stakeholders cited concerns about upfront costs to adopt and implement EHR. Further, it is crucial to consider patient privacy issues when developing and implementing HIT.

6. INTEGRATED CARE BRINGS CHANGES TO FINANCING AND PAYMENT MECHANISMS

Participants commented on the financing and payment implications of integrated care. With Medicaid expansions, more specialty behavioral health providers will likely want to become eligible to bill Medicaid; this will require some learning and effort. Medicaid policies preventing primary care and behavioral health providers from billing on the same day will need to be changed. Provider payment approaches may also be changing. Massachusetts may be moving away from a health care financing system that retrospectively pays for each service provided towards a payment system that prospectively pays a group of providers or an organization like an ACO a predetermined amount per member per month. These payment changes aim to improve the value of health care by improving coordination, case management, communication, and prevention to improve quality while reducing costs.

7. EFFECTIVE CARE COORDINATION IS A CRITICAL ASPECT OF BEHAVIORAL HEALTH CARE INTEGRATION

People with mental health and substance use conditions often have complex needs, requiring care coordination to achieve the best outcomes. In addition to—or in the context of— the new integrated care models such as PCMHs and ACOs that are encouraged in health reform, there should be increased adoption of specific evidence-based practices that address coordination. These include primary care-based collaborative care for depression and Program for Assertive Community Treatment (PACT). PACT is an intensive multidisciplinary program for people with the most serious mental health needs that integrates psychiatric care, medical care and psychiatric rehabilitative services. An innovative approach to coordination is the Medicaid demonstration program "Money Follows the Person" which permits an individual to receive a budget they use to select services and supports to help them live and thrive in the community.

8. WORKFORCE DEVELOPMENT IS VITAL TO THE DELIVERY OF QUALITY BEHAVIORAL SERVICES IN INTEGRATED, TEAM-BASED MODELS OF CARE

Integrated care delivery models, such as PCMHs, will require workforce development in understanding mental health and addictions, as well as leadership and teamwork. Workforce development encompasses education in medical school and other clinical schools, and training for practicing professionals. Cross-training will also be important, e.g., for addictions treatment or primary care providers to become adept at identifying and appropriately responding to mental illness. More general training is also indicated, such as mentoring to support medical providers to better understand people with behavioral health care needs and training for specialty providers to become ready for third party billing. Training in evidenced-based behavioral health practices must take place at all levels.

9. OUTREACH TO HARD-TO-REACH POPULATIONS IS CRITICAL

People with serious mental illness and addictions often do not utilize health services due to their high rates of poverty, homelessness, imprisonment, immigrant status, and transportation barriers. Individuals in correctional facilities often receive

minimal treatment and may have difficulty obtaining care when they re-enter the community. In general, these populations may have difficulty accessing primary care services, have major unmet medical and behavioral health needs, and are often very costly to treat. Veterans are another special population. Although veterans have access to the Veterans Health Administration (already an integrated health care system), many veterans seek care in other settings that do not address their specific issues, such as post-traumatic stress disorder. New health delivery systems will need to take these needs into account.

State funding has been available throughout the years to pay for outreach programs that provide appropriate health care for difficult-to-reach populations. Participants voiced concern that an insurance model may not effectively reach out to these groups, and special initiatives will continue to be needed.

10. PEER SPECIALISTS ARE VITAL CONTRIBUTORS TO INTEGRATED CARE TEAMS

Peer specialists work with consumers to help them understand and support their recovery process. Peer specialists use their lived experience to inspire consumers, many of whom have not been encouraged and lost hope. They are vital members of treatment teams, educating staff on recovery principles. In Massachusetts, they serve as members of various types of mental health treatment teams, including Program for Assertive Community Treatment, day treatment, emergency services, and inpatient care. Emerging evidence supports the cost-effectiveness of peer support services as an adjunct to clinical mental health services and supports.

11. PERSON-CENTERED PLANNING IS ESSENTIAL TO RECOVERY

Person-centered planning allows a client and his/her treatment team to work together to identify the client's desired treatment preferences and long-term hopes and then to develop strategies to achieve those outcomes. The process assumes an active and informed role for the client to choose treatments, services, and supports. Shared decision-making—an interactive process in which providers and patients simultaneously participate in all phases of the decision-making process and negotiate a treatment plan—is one approach to patient-centered planning. Decision support mechanisms to help clients become more knowledgeable about treatment and clarify their values help them become more active participants.

Key components of person-centered planning emphasized at the summit include the provision of culturally appropriate care, access to behavioral health treatment across a continuum of care, peer services and housing supports. Attendees recommended that there be insurance coverage for a wide range of services, including rehabilitative services (e.g. employment supports). Medicaid's 1915i state plan option allows for services that bring together medical care with other social services, providing a good vehicle to fund a variety of linked services.

12. HEALTH REFORM IMPLEMENTATION MUST TAKE ACCOUNT OF HOUSING NEEDS OF PEOPLE WITH BEHAVIORAL HEALTH CONDITIONS

Massachusetts has a large system of residential treatment centers; many of the clients in these systems have nowhere else to go. Summit participants felt there has been little discussion about how the residential system fits with health care reform. An overarching concern is that if Medicaid starts to focus more narrowly on a medical care and stops funding housing, people who rely on residential programs and other housing supports will face an uncertain future. People with substance use disorders would benefit from a case management system to reach out to support homeless clients. DMH has a system in place to support their clients who become homeless, and that system should not be dismantled. It is important to adequately fund housing supports.

NEXT STEPS

Health reform offers both opportunities and challenges in terms of behavioral health service integration. The summit meeting and this report were designed as part of an ongoing process to help ensure that the needs of people with mental health and substance use conditions are fully considered in the process of health reform implementation in Massachusetts. The broad range of

stakeholders at the meeting identified many important themes and issues, which should help to inform ongoing health reform implementation.

Importantly, the results of this summit meeting will contribute to shaping the agenda for the upcoming forum on behavioral health care under federal health reform sponsored by the Blue Cross Blue Shield of Massachusetts Foundation, the Massachusetts Department of Mental Health, and the Massachusetts Health Policy Forum at Brandeis University. The themes identified at the summit meeting should also be of interest to other groups or initiatives underway in the Commonwealth related to health reform and behavioral health. Ultimately, health reform implementation efforts must recognize that behavioral health is central to the overall goal of maximizing health and containing costs, and that behavioral health stakeholders have much to contribute to the restructuring of our health care system.

REFERENCES AND RESOURCES

REFERENCES

1. Alakeson V, Frank RG. Health care reform and mental health care delivery. *Psychiatric Services* 2010;61(11):1063.
2. McGuire TG, Sinaiko AD. Regulating a health insurance exchange: implications for individuals with mental illness. *Psychiatric Services* 2010;61(11):1074-80.
3. Massachusetts Division of Health Care Finance and Policy. *Health Care in Massachusetts: Key Indicators.* February 2011 Edition.
4. Druss BG, Mauer BJ. Health care reform and care at the behavioral health-primary care interface. *Psychiatric Services* 2010;61(11):1087-92.
5. Barry CL, Huskamp HA. Moving beyond parity : mental health and addiction care under the ACA. *New England Journal of Medicine* 2011 Aug 17 E-pub ahead of print.
6. Mechanic D. Behavioral health and health care reform. *Journal of Health Politics, Policy and Law* 2011;36(3):527-31.
7. Delman J. Impact of Health Care Reform Law. *Voices for Change*. 2011.
8. Institute of Medicine [IOM]. *Improving the Quality of Health Care for Mental and Substance-Use Conditions*. Washington, DC: National Academies Press; 2006.
9. Wagner EH. Chronic disease management: what will it take to improve care for chronic illness? *Effective Clinical Practices* 1998;1(1):2-4.

RESOURCES

STATE RESOURCES

Bureau of Substance Abuse Services, Department of Public Health
http://www.mass.gov/dph/bsas

Department of Mental Health
http://www.mass.gov/dmh

Department of Public Health
Htpp://www.mass.gov/dph

Division of Insurance
http://www.mass.gov/doi
Health Care Reform
http://www.mass.gov/?pageID=mg2subtopic&L=4&L0=Home&L1=Resident&L2=Health&L3=Health+Care+Reform&sid=massgov2

Massachusetts Health Policy Forum
http://masshealthpolicyforum.brandeis.edu/

Massachusetts Health and Human Services: For Consumers
http://www.mass.gov/?pageID=eohhs2constituent&L=2&L0=Home&L1=Consumer&sid=Eeohhs2

MassHealth
http://www.mass.gov/MassHealth

FEDERAL RESOURCES

Centers for Medicare and Medicaid Services: Money Follows the Person
https://www.cms.gov/CommunityServices/20_MFP.asp

Centers for Medicare and Medicaid Services: Health Insurance Reform for Consumers

Overview
https://www.cms.gov/HealthInsReformforConsume/

The Mental Health Parity and Addiction Equity Act
https://www.cms.gov/HealthInsReformforConsume/04_TheMentalHealthParityAct.asp#TopOfPage

HealthCare.gov
http://www.healthcare.gov/

Substance Abuse and Mental Health Services Administration: Health Reform
http://www.samhsa.gov/healthreform/

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