REPRESENTATIVE KENNETH DUNKIN: Good afternoon. I'm state representative Ken Dunkin from -- and I hail from the great state of Chicago. Happy to be here and to talk on this timely issue as it relates to our respective community and some of the solutions that we are approaching. We know that -- we found out what it was earlier today, what it looks and now, the real question, since this is the very last panel, of what to do about it. How is it that we're going to break through and add some value in our respective state legislatures and with us as house members and senate members and how it is that we can really help shift the paradigm. Thank you. So, what some of you all have in your package, you should have is House Bill 150. We passed this about five years ago. This basically is a bill that expanded mental health in our respective state. It created a commission to deal with mental health issues in an urban setting of one million people or more. We obviously saw there was a great need to add an additional amount of services given some of the urban issues and dynamics that a large city such as a place like Chicago endures. And we put together all of the talented psychotherapists, very similar to this panel, faith-based organizations to help us really deep -- dig deeper into adding more or expanded mental health services in our respective community. So, maybe -- it should be in your package, the legislation that we passed several years ago. I would encourage a lot of our state lawmakers to enact this legislation alongside the Affordable Care Act or Obamacare. It only makes sense because there are so many undiagnosed scenarios that exist in our respective community that attributes to the violence, to the depression, and some of the other tenets of mental health that we've learned this day. But I can't give you the solutions and by the way, you know, I'm a -- I'm a MSW by training. I actually did psychotherapy when I first came out of grad school. I went to the University of Chicago, the School of Social Services Administration and that was actually my background. Many of you probably are not aware of that. I was a clinical services director for an HIV -- excuse me, an AIDS organization and I was over all of the case workers and some of the other therapists. So and then, of course, politics got in my blood and here we are today. So, on this panel here, I'm going to introduce each guest and we will have you then speak and then I'll introduce the next one. So, since we have Ms. Nancy Jewell right here to my immediate left, of course, she is the President and CEO of the Indiana Minority Health Coalition, right here. She's a statewide -- it's a statewide not-for-profit organization that exists to eliminate health disparities through advocacy, education, and awareness, research and training. She holds a Bachelor of Arts degree, a Bachelor of Science, and Masters in Public Administration degrees from Indiana University. Ms. Jewell has been involved in minority -- health advocacy since 1987 when she served as a public health administrator within the Indiana State Department of Health.

MS. NANCY JEWELL: I was a teenager.

REPRESENTATIVE KENNETH DUNKIN: She was a teen, can't you tell? Ms. Jewell has published several articles related to the underlying health issues that minority communities face and is an active member of the American Public Health Association. Ladies and gentlemen, Ms. Nancy Jewell.

MS. NANCY JEWELL: And I'm telling you.

AUDIENCE MEMBER: Yeah.

MS. NANCY JEWELL: You all want to hear me sing?

KENNETH DUNKIN: She's not going through.

MS. NANCY JEWELL: Yeah, I think that Ms. Holliday brought up several important issues. Number one, the community really do not know how to diagnose depression. People have chronic diseases and that's why we became more involved in mental health issues is because of chronic diseases that can lead to depression and other mental health illnesses and people don't know that their -- while their chronic disease is not under control and in a lot of times it's from depression. And the primary care docs, what we've been fighting with for a long time is to make sure that the primary care doc who's treating the chronic disease realize or do some type of assessment to see if they're dealing with depression and that's why their chronic disease is not being controlled. So, we have several issues. Number one, your primary care docs and your mental health professionals do not communicate, so a patient can have a chronic disease out of control and actually all they have to do is treat the depression, but also there's the whole issue of insurance. A lot of your insurance coverage do not cover a large portion of mental health and I've had people that have called me that have tried to go and get mental health treatment that they were told they had to come back or their insurance didn't cover it. So, that's another big issue and that's an issue that maybe can be dealt with legislatively up under the Essential Health Benefits. We need to make sure that mental health is covered up under those Essential Health Benefits. In Indiana, over 40% of our counties don't even have a mental health provider.

AUDIENCE MEMBER: Seventy?

MS. NANCY JEWELL: Over 40% of our counties.

AUDIENCE MEMBER: Wow.

MS. NANCY JEWELL: So, you're talking about almost half our counties do not have a mental health provider, and so another issue that can be dealt with legislatively is how do you incentivize mental providers or health professionals period? We have a health professional shortage here in Indiana. But how can you incentivize either through scholarships or some type of loan release so that you have providers that stay here in Indiana. Some of those laws were in effect but they're not in effect now. Also, there's big issue with medication and through clinical trials, they've proven that certain medication reacts differently to different racial and ethnic populations, but if you set up policy that eliminates certain medications from the formulary or if the insurance companies only have these medications in there, it might not cover certain populations as effectively or it might have more side effects to certain populations. I just got a phone call from my daughter, my oldest daughter, and she was calling me to see if I talked to my granddaughter because a young guy in her class just committed suicide. And -- but that tells you -- I'm sure that there were some signs and symptoms and some of them Ms. Holliday talked about, but

there were some signs and symptoms that the family members probably saw but they just said, "Oh, he'll get over it." And I think another part of it is educating the population to what are the signs and symptoms because if these signs and symptoms last longer than a couple of weeks, then it could very well be depression and not just a teenager acting out. So, I think that also a part of the process is to educate the public on what are the signs and symptoms and when do you need to become concerned that it might be clinical depression, because they're also going to be important in trying to make sure that that person goes in for treatments. And I think -- yeah, but legislatively, if we could make sure that the policies that we're creating do not restrict mental health access to mental health services, that's very important and as we move forward into the Affordable Care Act, I know that right now, that's part of the Essential Health Benefits. But here in Indiana, you're still going to have 400,000 people not covered because we decided not to do Medicaid expansion even though the federal government is paying for a hundred percent the first year.

AUDIENCE MEMBER: Yes, yes.

MS. NANCY JEWELL: And 90%…

AUDIENCE MEMBER: The second year.

MS. NANCY JEWELL: The rest of the years and so you -- right.

AUDIENCE MEMBER: Ninety percent?

AUDIENCE MEMBER: Hundred percent.

MS. NANCY JEWELL: Yeah. So, you're going to have 400,000 people not covered. And I get phone calls all the time of people who do not have insurance and one -- the last call I got was from a lady who not only had some chronic diseases, but she also had a mental health problem that she recognized and she said, "My choice was to pay my premium for HIPP or pay my light bill." She says, "So, what would you have chosen?" And, you know, they cut her off because she couldn't pay that premium for one month. But, you know, you have those issues and you have people that aren't covered and when you're looking at other expenses, you know, you have to make a decision if your health is more important. When I fell because of my dog, when I fell, I had no problems knowing that I was going to go to the emergency room and see if my arm was broken. I might --I might not have made that decision if I didn't have insurance because I would be stuck with the high medical bill from the emergency room. So, I might have just went to CVS, got me an ACE Bandage, wrapped it around, got me a sling and paid under $20 and then just hope and pray it wasn't a broken arm and if it was, then, that would mend on its on. So, those are the type of decisions that consumers have to make especially if they don't have insurance or if their insurance do not cover certain type of costs like mental health --mental health, dental and vision are not really covered that much by most insurance. So, we just need to make sure when you're making policy that you look at that language and make sure that it's not going to eliminate consumers from being

able to access services. Mental health is very important. People camouflage it through substance abuse and stuff, other things when it's really depression of -- or some other type of mental health issue. Do you want me to stop talking, Representative Dunkin?

REPRESENTATIVE KENNETH DUNKIN: We're going to -- we got a wonderful great afternoon. This is the, you know, the solution section, you -- you're on the road, doc. We love it -- we love it. Just keep that fire in the belly. We're coming right back.

MS. NANCY JEWELL: Okay. I'll stop.

REPRESENTATIVE KENNETH DUNKIN: Did that -- Oh, that's all right. You know, we're enjoying it. And by the way, why are you all sitting on that side and I'm over here? Is there something psychological that I'm not missing -- that I'm not getting?

MS. NANCY JEWELL: Oh, you made that decision.

REPRESENTATIVE KENNETH DUNKIN: I made that decision?

MS. NANCY JEWELL: You did, yeah.

REPRESENTATIVE KENNETH DUNKIN: I mean, because you -- but you have a hold of the audience. It's like the preacher only talk. Preacher's on one side of the church. Alright. Our next panelist…

MS. NANCY JEWELL: Go stand right there.

REPRESENTATIVE KENNETH DUNKIN: …is Dr. Caroline Carney Doebbeling and Dr. Doebbeling is the chief medical officer of MDwise Inc. and board of directors Mental Health America here in Indiana. Dr. Doebbeling has spent her career working in the interface at the Medical Care Behavioral Health Care, the delivery of quality health care services to those in need. At MDwise, she has oversight of quality improvement…

AUDIENCE MEMBER: Oh, I'm sorry.

REPRESENTATIVE KENNETH DUNKIN: …medical utilization management, provider relations, complex case and disease management, behavioral health, population health analysis. Dr. Doebbeling earned her MD and MSM. Science degrees at the University of Iowa College of Medicine. She is a board certified psychiatry, psychosomatic medicine and internal medicine. She has a long-standing academic career with numerous post-review publications, clinical teaching and awards, and editorial board activities. She has worked for Walmart Blue Cross Blue Sheild of Iowa and South Dakota where she's developed one of the -- one of the first integrated care management programs in the country. Prior to joining MDwise, she served as a medical director for the Indiana Office of Medicaid until the year 2010. Welcome, Dr. Doebbeling.

DR. CAROLINE CARNEY DOEBBELING: Thank you. And my boss would kill me if I didn't say that I work for MDwise. So, just to get that one on the record and I want to start by thanking you all for inviting me to participate in this timely, very timely and important event. I say timely because of the economic strain put on all of us by the federal government shutdown, and we know that the federal government shutdown disproportionately affects African Americans who work in a disproportionate amount for the federal government. The type of economic strain that we have faced in the country leads to higher incidents of depression and suicide and so I hope we can all push our legislators to do the right thing in the days ahead. I know my background is different from most of you in the room. I was asked to talk a little bit about background before launching into solutions. And I grew up in a town of 600 in rural Iowa and eventually landed here but there's one thing that is common about this. My town today has no commerce. There is one remaining bar, one sort of grocery store and not even a laundromat. It's a dead town. My folks still live there and when I go home to visit, I literally have to sit on the edge of town to get a cell phone signal. So, I know that experiences are different but one thing that we share in common is lack of access to health services and especially mental health services. There was one physician in my town when I was young. The treatment for everything, no matter what your presenting symptoms were, was a shot of penicillin in your rear end, and so, maybe it's better not to have that doctor anymore but we share that in common. We also share something else. I think everyone in this room is aligned around correcting this problem of lack of access to mental health services and to good health care. We share that we're not afraid to talk openly about mental illness and to bring those issues to the forefront and we all understand the importance of the legislative process in making the types of solutions that we can bring to the table important today. My career as a clinician was spent at the combination-- at the interface of medicine and psychiatry. I took care of the depression in patients dying of cancer. I took care of the substance abuse and withdrawal in persons with schizophrenia. And interestingly, I was the person who often would be the physician who diagnosed the MS in someone who was presenting with depressive symptoms, because it's very complex when you combine medical and medical conditions -- mental and medical conditions -- and it's something that it's really important. Chronic disease leads to depression, depression leads to poor care of chronic disease, and we get quickly stuck in the circular type of situation that's very difficult to break without all of the right processes in place in -- and without access to the right services. So, Medicaid expansion was a huge step forward in ensuring that people had insurance to access care. But, in states like Indiana, we don't have Medicaid expansion and are leaving tens to hundreds of thousands of people uncovered with care. And so, in this case, it is absolutely essential that we continue to support and push organizations like SAMHSA and our own state legislators to continue to fund community mental health centers and other types of centers where mental health care is given. Without an insurance card, it's difficult to access services outside of those centers. We cannot afford to see those funding streams especially coming from SAMHSA at the federal level gutted. Otherwise, those services may go away. But unfortunately, having coverage doesn't ensure that mental care is available. There simply are not enough providers out there to provide medication management, evidence-based

psychotherapy, and the types of social work needs that exist. There aren't enough individuals working today at grassroots level to help people navigate a very complex system whether it's the medical system or the mental health system. We need, as a group, to do whatever we can to support training and behavioral health and substance-abuse care. We need to promote evidence-based care, care that we know that works, and that care can be delivered by a variety of people whether those are peer support, specialists at the very grassroots level to highfalutin psychiatrists, you know, who are only doing the small, time-limited medication management for people. We need to support training across the spectrum for everyone. I wanted to point out that in Indiana, the Essential Benefit package does include mental health coverage so the plans participating in the healthcare exchanges will be providing mental health coverage which is a good thing for the state. We need to support cultural and linguistically-appropriate care. There are even designations in the country for health plans to have designations that their providers have met these types of goals and experiences. I can't say how important that is because shared experience is very important in getting the kind of care you want. It's kind of the thing like, "Why do we have so many women delivering babies today?" Because a lot of us don't want to have a man delivering our baby because they don't know what it's all about or they can't feel, you know, the kind of pain that we felt and that sort of thing. You have to be able to identify with your provider. You have to know that that person on some level gets you and isn't looking at you like you're just another textbook presentation of depression, that your provider can understand the social context and the -- everything around, I guess, I'll say, everything around what your depression or your mental health issues are presenting as. And a lot of times depression, as we know, is a biologic illness but the antecedents of depression, those things that can tip someone over into having a full-fledged mental illness are those that you have to be able to understand and put some kind of context around. I also want to add, from a legislative point of view, that licensure is important. So, while we need to have systems of care that support people in the community, for evidence-based care, licensure puts a floor, it puts a common standard of competence under providers so that I know when I'm going to a provider that I can expect to get evidence-based and competent care and not something that is outside the realm of what we know works to help people get better. I found early on in my career that I was able to do more for the health of our population from the podium than I was from the examination room. And I started moving more in that direction to be able to reach more people and to do more things at that level. I began working in the political process a long time ago and in Indiana, thanks to Mental Health America, Steve McCaffrey, the Governor's Commission on Mental Health, I've been able to work with teams on several pieces of legislation that have moved things forward for our state. With support of groups like NAMI or Mental Health America, I think people can move forward the agenda that needs to be moved forward and I strongly urge you all to get involved in those groups, to get your constituents involved in groups like that, to try to learn from groups like that, to understand who needs to do what in order to make something happen and what the language needs to look like to support our -- the kind of care that we need to have. I think it's important for you all as legislators to understand more than just the constituent who comes and

complains about not getting what they need but to understand from those people who are getting what they need about what's working in those systems and then try to replicate those systems. If there are people in your community who are doing well and getting the services, what's unique about those healthcare systems, that insurance plan, those clinics, those providers? How can you replicate the good stuff to make sure that the bad care and the lack of insurance or the poor coverage doesn't continue? Use the good models, propagate the good models. They're out there and they work. Most importantly, I'm thankful that we're all here together to work on this and I think it's a huge step forward that we have groups like yours working on mental illness in the country. I'm grateful to know that you are willing to join folks like Mental Health America and NAMI and other organizations in moving forward the agenda for getting appropriate care for mental illness and substance-abuse in our country. Thank you very much for allowing me to participate in your group.

REPRESENTATIVE KENNETH DUNKIN: And thank you, Dr. Doebbeling. Thank you. Our next speaker is Renee Vaughn. She's -- a Masters of Social Work and licensed social worker here in the great state of Indiana. She is In-Vitro -- an In-Vitro Biologist here at Eli Lilly. She's an ordained elder to the Greater Indianapolis City -- Circle City District of the Free Will Baptist Church Denomination and a licensed social worker. She received her B.S. Degree in Chemistry from the University of Indianapolis and her Masters of Social Work from Indiana University. Ms. Vaughn works as a laboratory scientist at Lilly and as a ministerial staff at the Free -- First Free Will Baptist Church. Ms. Vaughn decided to combine her degree of social work with ministry after noticing the need in the faith-based community for mental health counselors. Ms. Vaughn currently offers practical applications of scripture combined with psychoeducational tools with the goal of changing stereotypical attitudes towards mental health treatment and care. We should also note that Ms. Vaughn happens to work for Eli Lilly but today, she is not, I repeat, is not speaking on behalf of Eli Lilly.

MS. RENEE VAUGHN: No, I'm not.

REPRESENTATIVE KENNETH DUNKIN: Her views here today are her own. In fact, NBCSL learned of her because of her work as an ordained church elder working in the African-American faith community to raise awareness about mental health issues. So, she is speaking in that particular category today. Ladies and gentlemen, Ms. Renee Vaughn from the Free Will Baptist Church here in Indianapolis.

AUDIENCE MEMBER: Great.

MS. RENEE VAUGHN: Thank you. Thank you. I appreciate being invited and being trained I got the instructions so I won't talk about the science at all. Maybe a little bit because they kind of fits but -- and I don't really speak from notes so I'm just gonna tell you the story. So, I noticed being in ministry that we kept getting this repeat people coming up for prayer, coming up for prayer, you know, they're fasting and in the churches that I affiliate with, although I am Free Will Baptist now, some really not denominational, people go to deliver us classes or they come up, we slap allover them, they fall out in the floor, they're

slobbering, rolling around and then they get up and they still have the same problem. So, I said, "This is -- we need to do something else." And my pastor was really open. I'm kind of an out-of-the-box thinker. So, what I started doing was offering a bereavement sessions once a year around the holidays because I noticed that that's a real difficult time for individuals. And I have a way where I do lecture and then we do an interactive exercise and then, I have people do what they need to do as far as to release some of the -- allow them to cry and be themselves. And I started training people on how to not run up to people and fan them if they're crying or you anything. Give them a Kleenex, a hug if they need it and just let them -- let them do whatever they need to do. And so, through this journey of trying to put together workshops, I realized that I needed what the doctor said, licensure. And so, I thought about doing clinical psychology but I said that that's gonna take too long and I'm too old and I don't want to do it, not right -- not at this point of my life. So, social work really got me there because the types of clients that I see and part of the difficulty and I'll just stick with our community, is that there is a huge stigma with having a mental health problem. People feel like, "Well, I'll just go to the pastor and pastor will pray for me and everything is going to be all right," which it is not, it doesn't work like that, not for everybody especially if, and I'll have to do the science because I know better, if there's a chemical imbalance in the brain and they need medication. So, when people come to me for prayer and they said, "Well, I've been crying a lot. I haven't been sleeping a lot. My appetite is gone and I just want prayer to do better." So, I say, "Okay. I'm gonna pray for you but are you seeing a doctor or have you talked to somebody?" "Well, the doctor did give me this medicine." And then we stop and then I usually go aside and have this conversation about the medication and, "You should check in with your doctor and maybe you should talk to somebody other than just talking to God and to the minister." And I, I do case management for my church and one of the barriers that I have been finding out is there's not a lot of providers, especially providers that accept Medicaid or have grants where they can see people for a nominal fee because since I am not a clinical social worker, I cannot -- I don't practice, I don't do therapy but I am a licensed minister so I can do a little bit of something. I try to be very careful. So, what I usually do to help people start on their journey is I'll have a workshop that deals with how you think or I'll have one workshop in your personal appearance, what does God say, you know. And so, we did some cognitive behavioral type things and then at the end of the workshop, I have a list of therapists that I've sort of -- I know and I know can provide some care and I refer people but a lot of times the barrier is they don't -- either they have Medicaid, their provider does not accept Medicaid or if they had grant money at the beginning of the year, the money is gone. And so, since this state didn't take that Medicaid or whatever grant or whatever it's called, then other grants and other funds would be nice to be available especially for not-for-profits and the other thing is not-for-profits, a lot of times, can't get the funding because it's either connected to a religious organization that doesn't meet criteria even though we are rendering services. So, that's just my -- where my heart is and the way I educate the congregation is I do workshops. We partner, we partnered with NAMI. I went around personally and signed people up to go to the faith-based training through NAMI, and that's the National Alliance on Mental Illness, and they went through the training. I also tried to not normalize but make it

more like -- depression is like diabetes. You treat your diabetes, don't you? So you need to go get some treatment for the depression or whatever else that is bothering you that is not maybe a physical health thing. So, those are the types of things that I tried to help motivate people in my church and other church-type organizations and I'm very vocal about it. I am an advocate for taking your medication, I never tell people when they come to get prayer, "Stop taking your medicine," I say, "Take your medicine," and if they've been through a lot of what we call deliverance classes, my first question is, "Well, it's not working, what else are you -- are you willing to do?" And it's been somewhat effective. Thank you.

REPRESENTATIVE KENNETH DUNKIN: Let's give our panelists a round of applause. Appreciate that. We're here for solutions now and we sincerely appreciate some of those solutions but here are some other questions. And I'm just amazed and startled how places like here in the State of Indiana that you're missing a gift horse, a golden opportunity to help people all across the state at zero cost to you, 100% and then, 90% for 4 years after that that your House and Senate and your governor simply don't take advantage of that opportunity that the majority of the -- of Americans supported. I mean, because mental health is a solution -- mental health therapist is a part of the solution but the State of Indiana just rejected it and other states as well, it's amazing. You know, the politics of this is just tremendously, you know, disbelievable quite frankly. That means a lot of people, for example, in Indiana, are going to suffer. So, with that, are there any common insurance coverage gaps for mental health services that which make -- sense for us as legislators to mandate as at least minimum requirements in coverage or would it be better for a legislator to encourage rather than to mandate this coverage?

MS. NANCY JEWELL: Well, here in Indiana, if you encourage and don't mandate, some things don't happen.

REPRESENTATIVE KENNETH DUNKIN: Speak with mic.

AUDIENCE MEMBER: What was that?

MS. NANCY JEWELL: So, you know, I think that, you know, just like with mental health medication, we're always having to go down there and try to force that issue, make sure the formularies aren't changed. So, I'm not sure how effective encouraging is in other states but I know that there's been some laws encouraged here that haven't happened yet when it comes to health care. So, I guess, in my opinion, mandating, but mandating with some enforcement agency. You can mandate but if nobody's watching it, it doesn't happen. And we have some laws like that, too, so that's my opinion.

REPRESENTATIVE KENNETH DUNKIN: Yeah, and you know, part of our challenge in this country is that as state legislators in most of our states is the power of the insurance lobby.

AUDIENCE MEMBER: Yeah.

MS. NANCY JEWELL: Right.

REPRESENTATIVE KENNETH DUNKIN: They are alive and well.

AUDIENCE MEMBER: Yes.

REPRESENTATIVE KENNETH DUNKIN: They play a significant role in the House and Senate with what gets done and that's -- due in large part because of their financial and political muscle that they have in discouraging certain scenarios. I mean that's…

AUDIENCE MEMBER: Money.

REPRESENTATIVE KENNETH DUNKIN: It's money, it's cash money. Let's call it what it is. So, with that, Representative -- Senator Catherine Pugh.

SENATOR CATHERINE PUGH: Yes, Senator Catherine Pugh from the State of Maryland. I heard a lot of talk about church and the church's role especially in mental health issues as it relates to the people attending church, so I was wondering, because we are here talking about solutions, should there be some advocacy on our part as it relates to making sure there's some type of mental heath services available at the church level? I know there's always, you know, that separation of church and state…

AUDIENCE MEMBER: Right.

SENATOR CATHERINE PUGH: …but when you think about all the people because they always say on Sunday morning, there are more African Americans in one particular place than any other time, you know. So I was just wondering how would you -- how do you look at that and how would you propose that?

MS. RENEE VAUGHN: Actually, the church that I attend, we made a separate entity away from the church even though it's related to the church. And then, I know some other church organizations, they have counseling facilities connected to the church but it's not the church. So -- and people tend to use those types of services especially like some of the workshops I run, the fee to get in the workshop because people appreciate what they pay for…

SENATOR CATHERINE PUGH: Uh-hmm.

MS. RENEE VAUGHN: …is maybe a can of food. And then we donate that to some place and then the place gives us a letter, thanking everybody for the donation because there's several things going on with the population that I work with. So, I'm trying to meet a lot of the different challenges but also meet those needs when it's around mental health. So, that would be helpful to get, like I said, more grants that religious organizations that are nonprofit can access.

DR. CAROLINE CARNEY DOEBBELING: If I could take a crack at that. Although, I'm not with a faith-based organization, I have sometimes strong opinions about how things might work. Those in the room who know me will be well aware of that, but I think we need to vote with our feet. We need to use and purchase our insurance from plans that cover mental health and not buy insurance from those plans that don't or those plans that try to strictly limit the formularies that cover the medications that we have. I think we need to work with health plans that work with the community and deliver their care at grassroots levels

instead of making decisions only in the corporate office. And I think that we need to attach funding streams to having, like I said with licensure, baseline levels of care. So, if funding streams or grants are going to faith-based organizations or community-based organizations, link those to organizations that have that kind of service structure in place. Let that flourish, really help set up the design for what we know is best in promoting care, so that we're not giving our hard-earned dollars away to groups that aren't using those dollars for care that we know that works for their constituents.

MS. NANCY JEWELL: Yes, let me make one comment. What you can do is make sure that if you want faith-based organizations and other community-based organizations funded through federal dollars or state dollars, a lot of times in the RFP, it restricts who can apply for those dollars. And a lot of time, it's with the State Board of Health or FSSA here in our state. So, it restricts faith-based from getting dollars from like SAMHSA and other organizations that would fund mental health and substance abuse services. So, that's something you guys can work on is looking at some of those restrictions in the language so that organizations that are really out there serving people can apply for those dollars.

REPRESENTATIVE KENNETH DUNKIN: Alright. Solutions, solutions. Senator?

SENATOR CONSTANCE JOHNSON: Thank you. Senator Connie Johnson, Oklahoma. And Dr. Doebbeling, as you're speaking is there any way -- and this is not my question but is there anyway for groups like NAMI and other mental health agencies to evaluate these plans that are out there and then put out some advice about whether they are offering the full package from mental health services, just a thought?

DR. CAROLINE CARNEY DOEBBELING: Sure. With the Affordable Care Act and the Expanded Coverage through the exchange, everyone is required to have the baseline of the Essential Benefit package. So look closely at what those companies are doing above and beyond that. How many visits can you have without prior authorization for instance? What kind of medications are on the formulary? Is that company willing to work with you in the community to help expand the coverage or put providers in places that are convenient for you? Are those companies willing to do things outside the box in order to get care? I think the next thing is to look at the companies and see who's doing what in the community to help people get signed up for care in the first place, whether that's Medicaid or care through the exchange. In Indiana, we have that big hole in between the two, but on those ends, how to do that. Many plans are ranked nationally if they're part of NCQA, so you can look at national rankings for that, those only tell a small part of the story. There is a consumer assessment of health plan. Some plans are class certified culturally and linguistically appropriate services certified, so there are many different ways to do that. And then, finally, work with people in the health plan that you may know and use them to help your group navigate the system. I know I can speak for my company, we do that regularly. We partner with the community. We don't have a philosophy that we come do an event in your neighborhood. We want to come be part of your neighborhood, so I think really looking at the philosophy of the plan will help you answer those questions.

SENATOR CONSTANCE JOHNSON: Thank you. And so, my question is I heard you all talking about incorporating -- well, what do you think about incorporating mental health screenings in the chronic disease care setting? For example, we know a lot of people with diabetes suffer PTSD, anxiety, and depression. Have you given any thought to actually requiring those screenings to take place on a regular basis like their regular care does?

DR. CAROLINE CARNEY DOEBBELING: A lot of providers do do that today especially in the chronic diseases. This will circle back around to your health plan question but at MDwise, I made it mandatory that everyone who is being screened for case or care management has to be screened for depression because we take care of all of those chronic diseases. You have to take care of depression alongside that. Similarly, we ask about substance abuse with treatment or enrolling folks in case management or care management. I think it is absolutely essential no matter what the chronic disease is because of side effects from medication, because of inflammation caused by chronic disease, or just the burden of the disability that comes along with chronic disease that folks are screened regularly for that.

REPRESENTATIVE KENNETH DUNKIN: Okay. Alright. We – who was first?

SENATOR LONNIE M. RANDOLPH: Thank you.

REPRESENTATIVE KENNETH DUNKIN: Please introduce yourself.

SENATOR LONNIE M. RANDOLPH: Yeah, Lonnie Randolph, Senator, State, State of Indiana. Dr. Doebbeling, question, okay? I noticed on your -- on your bio, you served as the Medical Director for the Indiana Office of Medicaid until 2010. Can you tell us in terms of exactly what your duties and obligations were with the Medicaid at that time? And tell us how does that change or different from how it's going to do now in terms with Affordable Care Act? What changes would have to be made? And what additional responsibilities --if anything you -- individual of that category in that position would have with Affordable Care Act?

DR. CAROLINE CARNEY DOEBBELING: At the time that I was at the Indiana Office of Medicaid, I was responsible largely for overseeing the quality improvement component. There hadn't been one prior to that and I think the biggest accomplishment that we had at that time was putting in place a pay-for-performance program for the managed care organizations serving the state. There hadn't been one prior to that. We put in a very aggressive pay-for-performance plan under the time that I was there. And I'm very proud of that accomplishment because we saw improvement in HEDIS scores which are different types of scores used to measure outcomes or processes in health care markedly improve across the State of Indiana. One of those specifically related to follow-up for mental health hospitalization. I was involved in many of the different programs at that time, some of which made it and some of it which didn't make it or got, you know, some nominal responses because of political events or political ideas in the state at that time. I quickly learned that the best ideas might not always make it because of the political

process. Today, the Indiana Office has a part-time medical director. There is no full-time physician sitting in…

REPRESENTATIVE KENNETH DUNKIN: That's crazy.

DR. CAROLINE CARNEY DOEBBELING: …that office, which is concerning to me. I think that…

REPRESENTATIVE KENNETH DUNKIN: I'll say.

DR. CAROLINE CARNEY DOEBBELING: I think that in order to have the office need -- to be where it should be, there is a lot of hiring that needs to be done to fill in some of the holes that -- transitions that have occurred over time. They've lost a lot of folks there so there are small number of people to do a very big job and that would be very beneficial for that office to correct. The office doesn't directly have anything to do with the exchange. That's outside of the Medicaid Office. And the exchange is run primarily through the Indiana Department of Insurance, and the health plans who are participating in that, and those decisions are made somewhat outside of the Medicaid Office.

REPRESENTATIVE KENNETH DUNKIN: Okay. Alright. Our final two questions here, just a question. So, have you -- if you were there, Dr. Doebbeling, right today, would you promote and push for the adoption of the ACA especially as it relates to mental health, at least?

DR. CAROLINE CARNEY DOEBBELING: I always have been a proponent of pushing for that. A little bit in my personal history, my oldest brother was a congressman who voted for the ACA. He was a congressman from Pennsylvania. He then subsequently lost his office to a Tea Party candidate after he voted for the ACA. And so I am a strong proponent of that. Not for political reasons but because if you'll look at the evidence, people who have insurance coverage have better outcomes.

REPRESENTATIVE KENNETH DUNKIN: Hello.

DR. CAROLINE CARNEY DOEBBELING: They have access to…

REPRESENTATIVE KENNETH DUNKIN: That's what I'm talking about. See?

DR. CAROLINE CARNEY DOEBBELING: …preventive care screening.

REPRESENTATIVE KENNETH DUNKIN: Come on, doctor.

DR. CAROLINE CARNEY DOEBBELING: They have access to…

REPRESENTATIVE KENNETH DUNKIN: Common sense.

DR. CAROLINE CARNEY DOEBBELING: They have access to mental health care. May not be to every provider in the state but they do have better access because of an insurance card. They have access to preventive care and they have access to medications without which, they can't get, they can't afford. And so politics aside, covering people is the right thing to do.

REPRESENTATIVE KENNETH DUNKIN: That's what I'm talking about. Come on, doctor. Alright. Excellent.

REPRESENTATIVE GREG PORTER: Thank you. Thank you, Mr. Moderator. And Greg Porter from Indiana, via Internet, question. Is there a role for the community at large to play in addressing depression? This is from the people from the Internet. Thank you.

REPRESENTATIVE KENNETH DUNKIN: Alright. Solutions. Solutions.

MS. NANCY JEWELL: Why did you put it over by me?

REPRESENTATIVE KENNETH DUNKIN: How do we solve it now, Dr. Renee?

MS. NANCY JEWELL: Well, I think the community at large should become more educated about how to detect if somebody's having symptoms of depression. I think a lot of it people don't understand. If you see somebody that just cries and have mood swings, you know, they put it off as something else and they'll be okay. Like the little boy I talked about earlier, you know, 17 years old, somebody had -- he had to have had some type of symptoms but I'm sure that his parents and other people didn't know that he was having symptoms of depression so he ended up committing suicide. So, I think educating, that's part of what we do because we're a consumer advocate group statewide, is try to educate people about mental health symptoms as well as other health disparity issues. Our whole mission is to eliminate health disparities in racial and ethnic minority populations. So, we educate through our local affiliates but we're not the only one. NAMI is out there educating people, trying to make sure people have information. I think that information is the strongest weapon you can have in trying to fight any type of disparity, and I also wanted to note that you have more young Black man killing themselves…

REPRESENTATIVE KENNETH DUNKIN: Yes.

MS. NANCY JEWELL: …than we've ever seen.

REPRESENTATIVE KENNETH DUNKIN: Absolutely.

MS. NANCY JEWELL: And it increases every year.

REPRESENTATIVE KENNETH DUNKIN: Yes.

MS. NANCY JEWELL: And, you know, something has to be done to try to get to those young Black men to prevent that from happening and decrease that disparity.

REPRESENTATIVE KENNETH DUNKIN: Right. There's a direct correlation with the Affordable Care Act and the overall health of all communities. Representative? Name, rank and serial number.

REPRESENTATIVE G.A. HARDAWAY: Yes. State Rep. G.A. Hardaway from the great state of Tennessee.

REPRESENTATIVE KENNETH DUNKIN: Alright.

REPRESENTATIVE G.A. HARDAWAY: The issue that you brought up earlier about the role of the faith-based community in addressing mental health. We actually had such a program in Tennessee that was done by two pastors, and they were called the Emotional Fitness Centers. And the program was actually set up after one of our own representatives who passed, Gary Rowe. So, there's a model out there. The problem is trying to get the majority of the legislators to fund it. But you touched on -- this previous question touched on where I wanted to go. And that's how do we train, educate, access a necessary -- the necessary resources in order for our first responders, fire, police, EMTs, our teachers, our pastors, et cetera, those who engage the community on a regular basis, so that now that we have resources as far as funding for services available, how do we get these people educated and trained so they recognize…

AUDIENCE MEMBER: Right.

REPRESENTATIVE G.A. HARDAWAY: …those people who need to access the mental health providers? And are there any particular funds in the Affordable Care Act?

REPRESENTATIVE KENNETH DUNKIN: Excellent question. All three of you all need to answer that. Come on.

MS. RENEE VAUGHN: Well, I don't know about the funds in the Affordable Health Care Act. One of the things that I try to do is I always try to collaborate and partner. So, we have an organization here called the Greater Indianapolis Church Federation, where a lot of churches belong to that. So, I try to network through organizations that touch different types of church organizations to get the information out there to the pastors and sometimes you have to go through the pastor's wife to get the information that you need to into the church or just different -- I also belong to the National Association -- well, the Association of Black Social Workers, so we do community things where we try to get information out, but one of the biggest things that we found in our church that helps, is that we talk about it on Sunday morning when we have most people sitting in there. And we try to say it in several different ways. We write it down. We say it or we do, like, you know, audiovisual type things to try to touch all of the individuals. But one of the other things that I have noticed is you give the people the information but they're not sure, especially if they don't have health care, they don't want to know what's going on with them. And so it's getting past those types of barriers of what we're trying to do with the Affordable Health Care is for everybody to have access so that's one of the other barriers.

REPRESENTATIVE KENNETH DUNKIN: Before Dr. Doebbeling speaks, is there sort of a latent competition within the Black church when it comes to mental health and -- yeah, sort of, you know, might lose a good portion of our congregates because the Black church has always been very therapeutic for all of us for decades. Is that why there is a major chasm of communication between -- and sort of addressing that publicly at the pulpit on a regular basis like we've done for AIDS and for crime and other issues? Because this is a major epidemic.

MS. RENEE VAUGHN: No, that's not really it because there's, you know, people are not working, and tithes and offering is really important, so the focus has been diverted to so many other things in our community because a lot of times in our community, the African-American community, people are unemployed. Just like I was saying with -- yeah, that's an urgent need but people need to eat. And people need to have a house so I do a lot of that kind of stuff too, case management. And so that's why the message -- the messaging, it doesn't seem to be out there because there are other critical needs.

DR. CAROLINE CARNEY DOEBBELING: I would add not to your statement about the churches per se but people with mental illness, especially depression lack motivation and lack ambition. And so if they're given a complex health system to navigate through, they don't have the wherewithal necessarily to be able to do it as a direct result of the disease that they have. So, services like those you're offering with case management become very, very important to help people figure out where to go and how to get there.

MS. NANCY JEWELL: Yup, and you have to realize just like when HIV/AIDS…

REPRESENTATIVE KENNETH DUNKIN: Right.

MS. NANCY JEWELL: …was first around,that was taboo. Nobody would talk about it. They wouldn't go in for testing or anything else. And mental health issues is the same way. Nobody wants to say. They don't recognize a mental health condition as a chemical imbalance, you know, because they're friends will say they're crazy and that kind of stuff. So it's -- that's still taboo -- I'm sorry. That's still to taboo just like HIV and AIDS and some other diseases in the past. And I think that's good that you guys talk about it from the pulpit and get the stigma off of it so people feel comfortable going in for services.

REPRESENTATIVE KENNETH DUNKIN: Excellent question. I have a question. Representative, you trying to -- you know I cut people off about two hours ago.

AUDIENCE MEMBER: Oh, I didn't know that.

REPRESENTATIVE KENNETH DUNKIN: Yeah, yeah, but come on. See, we're in your state, you know. I know who he is. Now, look here. But I got the mic. Come on, Representative.

FORMER REPRESENTATIVE BILL CRAWFORD: Thank you, Ken. Representative Dunkin: I just simply want to say that -- in relative to the last couple of questions. We operate in Indiana under the 4C principle. Collaboration, Cooperation, Coordination, and Communication and that is -- I'm proud of the fact that the Indiana Minority Health Coalition was driven statutorily. We created in the early '90s a -- and began to fund it in 1994 and over the -- since 1994, we've given as a state over a 33, 35 million dollars into the Minority Health Coalition. They've got chapters around the state where Latino coalitions that we meet, we don't know the issues of Latino Coalition, Rural Coalitions, Suburban Coalitions but you bring people in and get them vested in it and you can move tremendously in terms of solving the problem. The church community, the business community and the--I would encourage those members. Then you have

the Indiana Black Legislative Caucus, you contact them. They can give you a copy of the bill. It requires collaboration between the State Board of Health, the coalitions. They train the workers. They go out and they get people. And you got to meet people at their level of interest. I don't know--I live in the--I live in the most urban community in the State of Indiana. I don't know the rural except just this past weekend, I was down in Southwestern Indiana, just across the border from Kentucky. I will be--in November, I'll be up in Northwest Indiana. We started the coalition in all candor, I'm -- was just elected Vice President of the Indiana Minority Health Coalition. I don't get paid. I'm a volunteer, never got a dime but I'm committed to serving a statewide organization. We can take it upon ourselves to address our problems. HIV/AIDS, there's a HIV/AIDS Coalition. There's coalitions that address different needs but it's a coalition of the willing because if we all join together, we draw two fists together and if I support your issue and you support my issue…

AUDIENCE MEMBER: Uh-hmm.

FORMER REPRESENTATIVE BILL CRAWFORD: …and we support the rural issue and the suburban issue, we've got a number of people vested in terms of solving the problem. The objective is that as Hajj Malik El-Shabazz says--many of you refer to him as Malcolm X…

AUDIENCE MEMBER: Right.

FORMER REPRESENTATIVE BILL CRAWFORD: …All too often, we make the mistake of confusing method with objective.

AUDIENCE MEMBER: Uh-hmm.

AUDIENCE MEMBER: Uh-hmm.

FORMER REPRESENTATIVE BILL CRAWFORD: And if we--he said it…

AUDIENCE MEMBER: Uh-hmm.

FORMER REPRESENTATIVE BILL CRAWFORD: …if we all agree upon objective, reducing disparities, health disparities, whoever it impacts on, if we agree upon objectives, we won't fallout over methods, tactics or strategies to achieve the objective. The objective is to provide greater health care. And I would…

AUDIENCE MEMBER: Uh-hmm.

FORMER REPRESENTATIVE BILL CRAWFORD: …encourage you also to look at January 11th, 1944…

AUDIENCE MEMBER: Uh-hmm.

FORMER REPRESENTATIVE BILL CRAWFORD: …when president--then President Roosevelt gave his State of the Union address. He talked about a Second Bill of Rights and essential to that Second Bill of Rights was the ability to enjoy good health care.

AUDIENCE MEMBER: Yes.

FORMER REPRESENTATIVE BILL CRAWFORD: Read that. You know, that's the part of history, he didn't get it done but we need to go back and create that Second Bill of Rights that ensures people access to housing, to health care, to education and to other things but it's…

AUDIENCE MEMBER: Uh-hmm.

FORMER REPRESENTATIVE BILL CRAWFORD: …on us to do it. Don't wait on somebody to give it to you.

REPRESENTATIVE KENNETH DUNKIN: Absolutely. And I think it's important you're a senior legislator to really go back and press your House and Senate, your governor to get some of that affordable care. It's not for politicians. It's for our communities throughout the state. It's -- that's -- there are billions of dollars, too much money left on the table, legislators, who rejected this ACA.

AUDIENCE MEMBER: Right.

REPRESENTATIVE KENNETH DUNKIN: At least segment it to some -- to some portion. It just -- it doesn't make rational sense. You can collaborate, cooperate all you want but as Representative Smyre said, it takes coal to run a train.

AUDIENCE MEMBER: Yeah.

REPRESENTATIVE KENNETH DUNKIN: It takes gold to run a health--mental health campaign, in this context.

MS. NANCY JEWELL: Uh-hmm. May I make…

REPRESENTATIVE KENNETH DUNKIN: Get…

MS. NANCY JEWELL: …a statement?

REPRESENTATIVE KENNETH DUNKIN: So, you know, we're going to wrap up but…

MS. NANCY JEWELL: Okay.

REPRESENTATIVE KENNETH DUNKIN: …you absolutely can. Let's have--let's have a 60-second closing statement because I'm getting excited on how we can get some of this money here in our great State of Indiana and other places where we…

MS. NANCY JEWELL: Right.

REPRESENTATIVE KENNETH DUNKIN: …need some help because everybody here ain't healthy.

MS. NANCY JEWELL: No, they're unhealthy. Last year, there were 47 states that had Offices of Minority Health that was working with the community. We just got notice, and Antoinette has left but we have six

State Offices of Minority Health that are closing. One thing that you can do as legislators is make sure there is some language in the law that requires the State Departments of Health to have an Office of Minority Health.

REPRESENTATIVE KENNETH DUNKIN: With some money.

MS. NANCY JEWELL: With some money. You're right. And we were blessed to have the Black Caucus here that pushed that for us but in some states, the Offices of Minority Health are closing and that's tragic because the other departments within the State Board of Health aren't addressing minority health issues.

AUDIENCE MEMBER: Right. Right.

MS. NANCY JEWELL: So, if -- what I'll do is I'll send out a list -- I guess, who do I send to?

REPRESENTATIVE KENNETH DUNKIN: It's in our list [inaudible]

AUDIENCE MEMBER: I already got it. That's not a [inaudible]

MS. NANCY JEWELL: Oh, did you get it? Okay. Antoinette gave--got it to you. Okay. And try to push even the ones that aren't closing now. Some other ones will be closing eventually. We're trying to push some language through with some funding to support these Offices of Minority Health. And that's my 60 seconds.

REPRESENTATIVE KENNETH DUNKIN: That was about six hours, but it's okay.

MS. NANCY JEWELL: Okay.

REPRESENTATIVE KENNETH DUNKIN: We love you doc. Solutions. Solutions.

DR. CAROLINE CARNEY DOEBBELING: Solutions, link everything to the economic argument for doing what's right that tends to fly in statehouses pretty well these days and secondly use data to back up what your beliefs are. I think it's imperative to back up what you're supporting with numbers and data. And make sure that your state's Medicaid Office or your state's Public Health Office has the data in hand because many of them aren't collecting it to a degree that you can do the drilldown that you need to be able to the drilldown to support your cause.

MS. RENEE VAUGHN: And since I'm representing the faith-based communities, still prayer does change things so we still need your prayers…

AUDIENCE MEMBER: Yeah.

MS. RENEE VAUGHN: …with-- along with your hard work and I also want to throw out there, collaboration is good. There is a bill or something out there, healthcare navigators. Use the navigators. That's very--it is helpful. Thanks.

REPRESENTATIVE KENNETH DUNKIN: Ladies and gentleman, let's put our hands together for Ms. Renee Jewell--Nancy Jewell, Renee Vaughn and Dr. Caroline Doebbeling. These are rock stars. They came up with solutions. Thanks for adding value, ladies. We appreciate you very much. So, next year or next time, we'll sit on this side, okay? Alight.

MS. NANCY JEWELL: And then you sit on this side?

MS. RENEE VAUGHN: A threefold cord…

REPRESENTATIVE KENNETH DUNKIN: Thank you so much.

MS. RENEE VAUGHN: …is not easily broken.

REPRESENTATIVE KENNETH DUNKIN: This concludes our, "What to Do About It" session as relates to us as legislators. I think we were duly informed and I sincerely appreciate it. My name is Ken Dunkin from the great State of Chicago.