Lancaster County

Mental Health Well Being Collaborative – Let's Talk Lancaster

Provider Action Team Meeting

9/23/2015

Suburban Outpatient Pavilion

Wellness Center – Conference Room #1

Attendees: Hannah Stolfultz, Andrew Newcomer, Francesca Zola, Anna Kennedy, Dale Brickley, Gerald Ressler, Kate Downs, Juli Veser, James Marland, Alice Yoder, Heather Hostettler, Julie Weaver, Lisa Riffanacht

Meeting Started at 10:26 by Dale Brickley

Changes made to minutes, minutes approved.

1. **Asset Mapping – Anna Kennedy**
    - ACE Study
        i. 10 standard questions; based on results of 17,000 adults. Concluded: Trauma during childhood has impact on adulthood. Research says this trauma can be overcome.
    - Providers asking 10 ACES questions in order to tailor care to trauma, however, there is no 211 taxonomy code to say that provider is trauma informed care.
    - Anna looked through a report to find standards of care. Looking to better understand how Lancaster County can start to identify providers who have trauma informed care. If high ACE score, are there adequate resources for these clients, regardless of child or adult?
    - Cheryl Sharp, expert on TIC, running 5th learning community with hospitals and providers answering questions. Agree that there are emerging best practices. Providers due best when they assume everyone has trauma.
    - Use 7 domains for every patient; treat everyone as if there was trauma. Some use ACES some use Trauma Checklist. Provider is recovery focused. Support staff is trained appropriately. Create environment to acknowledge trauma.
    - Currently there is no way to search for providers (PCP, BH) how to find care if they are seeking care.
    - There is no universally accepted certification. Some have trainings for 10 hours: very basic. University of Pittsburg has academic credential. Sanctuary model organization.
    - How can the information go back in to the 211 so patients can find a provider that way?

- Cheryl Sharp will write letter to have a taxonomy code changed.
- Anna needs list of what the definition is for trauma informed care before changes can be made.
    i. Changes can't be made to database unless everyone is in agreement of what TIC means.
- Separate between Trauma informed and Trauma Aware.
    i. Two levels might be confusing for public.
    ii. Maybe everyone should work on getting certification.
- 10 hour training is CEU certification for individual not agency.
    i. Agency: need to get national counsel certified
        1. currently have Philhaven, CSG, and Pressley Ridge who have gone through this
- Identify tools so that funds can be identified for everyone who is willing to achieve specific level: but first need common definition.
    i. How do we do that? Put out everything that is currently is available; contact Cheryl.
- Learning communities in ACES connection. They are free and readily available.
    i. For a first step: set up a Lancaster County learning community in ACES connection to get update on news and research.
        1. Model it after Philadelphia learning community (research at Drexel and Penn)
- Sanctuary model is researched based; encompasses the entire experience including staff needs, patient needs, community meetings, consumers.

Actions to be taken:

- Dale: reach back out to Cheryl Sharp about opinion on definition of Trauma Informed Care.
- Wait to hear more from Cheryl Sharp. Have Cheryl come to a meeting to help discuss.

2. **Preferred Provider Status – Anna Kennedy**
    - Physician Action Meeting talked about steps taken if referral is made. Want to make sure it is an easy process.
    - In current system, all providers are in the 211 database. Any provider that agrees to period of time, or individual contact, can be built into system to say "If provider is selected, this is a guarantee"
    - Preferred Provider is one that says "yes we are in , we are willing to take referral"
        i. System can specify what structure and timeline
    - Preferred Provider Recommendation tool being created.
        i. What does it mean to be a provider?
            1. What are the service standards that they can be expected? What should be done when and by whom such as the PHQ-9? We need to determine priorities and how practices use this information. What is the service agreement?

- Group decision: is there already a document or can it be created within 2 weeks.
- Everything is housed within system but need to agree on a "guarantee" for when the referral is made AND can we make a guarantee?
- Can we map out what needs to be done? Is there a way to make the system a smoother hand-off?
    i. 211 database is being used to say "these are patient needs and this is PHQ number, so here are the providers that can be a referral for the individual." Considering: Can physician say "if you refer to these providers you will get a call back…," should there be this extra guarantee.
- How much is going to be influenced by what providers say? Can a PCP call a certain physician based off of their relationship? Are providers building their own alliances or will they be using the system?
- If providers make a guarantee, will the 211 show who can be seen within 2 days?
    i. The 211 can show appointment availability to show when the next appointment is available based off of level of care.
        1. Possible to do this but system needs to be put in place.
- How are PCP's making BH referrals?
    i. Having patients call what is on the back of EAP card.
    ii. They leave it up to the patient, or make suggestion. DVS makes 3 suggestions of places and usually people get in within a week for therapy, psychiatry is different.
    iii. Time is an issue with language barriers and other barriers.
    iv. Provide PCP with screening tool options based on patient demographic and then, based on the results, list referral options. Pulls data from 211 systems.
- What do providers want and will they use?
    i. Providers want to know about insurance piece and will they be covered based on the system.
    ii. Need to know what the possibility is from the providers.
    iii. Providers need communication back that patient went to the behavioral health appointment so PCP has more information on mental health portion.
        1. What is communication back to them?
            a. Providers want diagnoses, meds, next steps
- How many organizations are on board?
- What can happen legally? Some organizations will still need to run release information by legal team.
    i. Any provider who accepts Medicare must comply with seeing within 7 days or referring out AND sending letter to PCP about appointment. Patient can decline PCP letter.
- Do we want a system that will automatically send info from one EHR to another?

Actions to be Taken:

- Meeting to be held possibly during beginning of November
    - Invite chief officers, medical provider groups, behavioral health groups, and information technology people.
- Anna will type a brief description about what they are being invited to: Written up by Anna.
- Ask at physicians meeting what exactly they want from 211?
- Alice Yoder will check with an expert in regards to releases of information and standard of care
- Group Decisions:
    - What can be released from behavioral health provider to PCP referral source?
        - Whether patient did or did not attend appointment

3. **PALCO Update – Lisa Riffanacht**

- Plans to start pilot program with Catholic charities and Pressley ridge.
- Will be application for people who need assistance with copays
- Do expect people to pay part of their copays up to $10. Then from $60,000 fund will pay provider the cost.
- If uninsured, the patient must also see what insurance they would be eligible for and have them sign up for it.
- Require people to attend health literacy class that discusses what copay and deductibles are.
- Sign responsibility form about showing up for appointments as well as a HIPPA release to speak with PCP.
- Planning on starting pilot October 1st.
- Be central spot to give information to PCP from BH doc.
- Asking providers to sign provider sign-up, may specify how many people they are willing to see.
- Referral can come from anybody to get someone signed up.
- In regards to the release:
    i. Does there have to be a universal release? Does there have to be a release from each organization to the other?
    ii. How much is the patient encouraged to share information with primary care doctor?
- Most information sent is very brief. Client can specify what is sent to docs.
- What about Health literacy? Currently finding documents that are more health literate than what is already provided. Do we wait to make moves towards this?
    i. Save this discussion for later.
- It would be nice if we could release information without a release: standard group of information.
    i. Most lawyers may not be comfortable with it.

- Outcome measurement: Whatever assessment tool is being used, must record whether or not improvement has been made. Whether it's PHQ or something else that is quick and simple.
- Looking for a tool that can be given at every appointment. PHQ-9 can't be given every day. Example: ORS is given each appointment. PHQ-9 used every 120 days as an outcome measurement. Behavioral health will have a different standard than PCP.
- Can each organization have a different tool? PCP uses as a screening tool.
    i. Have consistent tool but outcome tracking can vary between organizations.
- If a patient isn't showing up for the appointments, why?
- When somebody wants to come back even though they didn't follow guidelines, can they come back?
- PALCO originally said if patient misses 3 appointments they are out forever.

Actions to be Taken:

- Lisa: Draw up workflow of where process starts to where it ends.
- Decision: How to determine continuation of care and when to end it?
    - Providers make decision of when they are done.
    - Therapist should be able to make the judgement based off of their own ethical judgement. Will be part of treatment planning.
    - Completed treatment plan and use of outcome measures to assess.
    - Regular progress from start to discharge
    - Use assessments after month to reassess for continuation.
- Outcome Measurement:
    - Successful and unsuccessful discharge
    - Status at last visit seen.
    - If incomplete treatment plan:
        - Patient finished yes or no?
        - Patient showed improvement yes or no?
            - If yes, based on what?
            - If no, why?
- Decision: Can funds by released to PALCO?
    - Group voted yes.

4. **Materials for PCP's/Consumers – Ross / Lisa Riffanacht**
    - Ross searched SAMSA and looked for materials on depression and anxiety
    - Consider literacy level of information
    - What is already being used?

5. **Psychiatrist Recruitment – Dale Brickley**
    - Need part-time psychiatrist
    - Julie spoke with Steve about finding a provider

6. **Provider Survey – Julie**
    - Made Changes
        i. Introduction added 'Lancaster County'
        ii. Question 2: Refined mental health presence and included internal and external trainings
        iii. Question 6 was added
    - Is 300 high enough for range?
        i. Include additional breakdown
            1. 300-400
            2. Over 500
            3. Blank to insert an estimate
    - Survey will be ready to send when the changes are complete
    - Survey will be sent to the steering committee
        i. Asking that only one person from each organization fill out the survey
    - Add to survey
        i. Who completed survey?
        ii. Agency
        iii. Contact information for follow-up
        iv. Question 3: add 'internal and external'

7. **Update on Physician Committee – Dale Brickley**
    - Tentative Screening Models
        i. PCP-BH Communication
            1. Providers would like to know diagnosis, medications, and treatment plans.
            2. Would like one sentence that states primary goal for treatment and discharge goal summary.

Dale Brickley ended meeting at 12:20pm.

Next Meeting: October 28th at 11am at Suburban Outpatient Pavilion – Wellness Center – Conference Room 2