Provider Action Team
MEETING MINUTES

Attendees: Robert Aichele, DO (Physicians Alliance, LTD), Jean Benedict (WSHM), Dale Brickley (Chair, BH Provider Action Team), Karla Campanella, MD (Philhaven), Bill Fife, MD (Lancaster General Health Physicians), Danny Gilmore (Welsh Mountain Medical and Dental Associates), Kirsten Johnsen, MD (SELHS), Roger Kimber, DO (Welsh Mountain Medical and Dental Associates), Jessica Klinkner (Data Collection/ Tracking), David Noll, DO (Wellspan Medical Group Administration - Ephrata), Gerald Ressler (Samaritan Counseling), Alice Yoder (Team administrative support – Let's Talk, Lancaster)

Date: August 27, 2015 **Time**: 7:00-8:00 am **Location**: United Way, Blair Room

ISSUE/TOPIC	DISCUSSION/ANALYSIS	ACTIONS/FOLLOW-UP
Call Meeting to Order/ Approval of Minutes	Dr. Noll called the meeting to order at by reviewing the July minutes and progress of action items.	
Review of PCP & Behavioral Health Practice Models: Dale Brinkley	Dale reviewed the 3 main models used by PCPs seeking behavioral health services for patients: 1. Referral 2. Co-location 3. Integration <u>Referral</u> This is the most commonly used model today by our PCPs in Lancaster County. It is the easiest, but also least effective. In this model, the physician refers a patient to behavioral health services, not a specific provider. It was stressed that often time the BH provider is driven by payer. Because of the vagueness of this type of referral, the PCP doesn't	**Subgroup (Dale, Gerald, Roger):** Create a community standard for what information can be shared and a mechanism for how that happens, answering these two questions: 1. What information can be shared 2. What content each side wants to see

	receive any feedback from the BH provider, and the BH provider doesn't typically receive medical history information about the patient from the PCP. The group addressed a misconceived notion that sharing information would be a HIPAA violation. Two identified opportunities to remove barriers: 1. Educate both PCPs and BH providers on HIPPA 2. Improve 2-way communication (or more, depending on how many providers involved in patient care) It was also noted that closing the loop becomes more important with reporting/documentation requirements. <u>Co-location</u> Currently done with SELHS & CSG (masters level therapist) and Philhaven & PAL (psychiatrist) This model represents a PCP referral to a BH provider in the same building-"ish". The BH provider keeps separate medical records and required a separate intake process (approx. 45 min), so essentially, it is the referral model with a warm hand-off. Because a referral is still required, there are administrative complications because in most situations, there is a lack of dedicated support staff. Although part of the medical home for patients, it doesn't necessarily increase access to BH care. An opportunity to remove barriers is to educate PCP practice staff on the role of the co-located BH provider. Ideally in this model, an onsite psychiatrist would serve as a consultant to patient cases versus seeing each patient—a BH tech/specialist would serve in a triage function. Dale noted a practice would need therapists and a psychiatrists to cover the cost of co-locating a psychiatrist. A question was raised about the type of needs of patients and the appropriate type of professional to co-locate—are they mainly social needs, true BH needs? The consensus was both, but that in this model, you can't bill for addressing social needs. At this point there aren't any shared savings models for BH—data is probably about 5 years out, and	**Alice** and **Dr. Noll** will work on identifying an attorney familiar with Mental Health law to assist in this process.

	according to the Hospital Association of PA, only large hospital systems that provide medical and BH services will see potential savings. <u>Integrated</u> Currently done at SELHS (LCSW) This model is ideal, but is also the most expensive. It is not sustainable in PA (yet!) unless both the medical and BH providers are part of the same health system. The savings will come from a reduction in utilization of physical health services (loss leader program). In this model, the PCP and BH provider would be a part of the same treatment team and share the same medical record system. The psychiatrist jumps in and out of cases, offering brief interventions to get patients to long-term treatment as needed. The medical practice does billing for BH cases, and can bill for addressing social needs.	
Future Action	**Items to include on September Agenda:** • Predictive rate based on national norms • United Way update • Review of algorithm • Discussion of potential education session/panel discussion for providers	
Next Meeting	Meeting adjourned at 8:00 am	**Thursday, September 24, 2015** **7:00-8:00am** **United Way, Blair Room (630 Janet Avenue)**