Behavioral Health Task Force: Primary Care (including Urgent Care) and Behavioral Health Work Group

Notes: Activities between December 9, 2014 and January 5, 2015

In addition to the minutes of the December 18 meeting, the text of email conversations is included that support the discussions and direction of the work group.

Notes from the Work Group Meeting on December 18, 2014
Congruent Counselling Conference Room
Attendance:
Lisa Lomas
Becky Bell
David Leichtling
Mark Donovan
Beverley Francis-Gibson
Maura Rossman
Joy Stephens
Vickie Miles

After excellent conversation about various aspects of how primary care can influence behavioral health services, there were several emerging themes the work group wants to pursue. The notes of the conversation also follow.

1. Website – what would the contents include so that providers can inform the public about the availability of their services in real time; so that providers know who to refer to effectively; and so that consumers can access services efficiently and in the time they need?
2. Ombudsman Program (more than one person) to both keep the website up to date and to work with providers and consumers to facilitate service delivery. (Beverley suggested the Alzheimer's Association model)
3. Safety Net of Service

   Policy Issue: Better mental health benefits in all insurance plans

Notes:

Payment issues – concerns could use better information on not only what they have but also how they can use it. (Becky)

Rates are difficult to understand even for providers because of the variety of plans

No raise in rates in 10 years – (Mark) rates are also variable by location

Pay to providers is low limiting their ability to offer variable hours, incentives, etc.

Transition aged youth – youth transitions from high school to college. Schools coordinating with others perhaps (Dave) Accessing ACA exchanges – often people who come to therapy are already out of school. Pediatrician-transition. Youth who will not give permission once they reach majority age. Consider a website that could serve this need and ER transition that tells who is willing to see the underserved, what their particular interests are….easy way for provider to have name displayed or removed about dynamic – communicating availability. Marketing…consolidating all the databases.

Consumer friendly – where can people go – how can they find the services…?

Update constantly – have good key word search within the site. Marketing

Website could have patient self-assessment screening tool, (ADHD, autism) EHR (what is this and tools are there…EPSDT (Maura) BhIP consult service

Primary Care…training to handle more issues…what is the best referral. Pay for performance may push improvements in screening and referrals Money drives the changes (and assures survival – actually) Exposure of physicians in training to quality mentor providing types of patients in need of these kinds of services. How can influence…

How can we keep an active and accurate list readily modified by providers…?

What is a good referral system to social services?

Family practice docs – looking to meds and counselling for depressions…

Speakers' bureau of physicians – drug reps bring them around sometimes…

Maura – CME pediatricians talking about anxiety, depression – behavioral health issues in children

Know what you don't know and can we make the referral system easier….

Can we work with HCC and other colleges to help link transitional youth to behavioral health providers? Joy reports that there is a high turnout for depression screening at HCC.

Becky: Data collection on real time service delivery. How could it be collected…County would pay of an occasional survey – Dave

Vickie: Temporary disability program through the state. Becky: disability system is hard to understand and use…Vickie: promote and better understand state resources that are available…helping consumers deal with their life situations. Job Work Force Office could be educated…

Ombudsman program

Parents trying to help youth who need help seeking counselling themselves: Not reimburseable (ICD does not recognize)

Look at some of the "aging" models

Roadmap – tip sheets – satisfaction on website….

NAMI recommended list – coordinate with them

Consider how to use the Library System, HCPSS, and Hospital

Treating people at the earliest point in their "illness" but hours are not available by providers…

Downward spiral Money and access – how can primary care help support.

From: Mark Donovan <finn67@gmail.com>
Date: December 17, 2014 at 11:21:14 AM EST
To: Rebecca Bell <rbell@usmd.edu>
Cc: Leah Blain <lblain@chasebrexton.org>, Beverley Francis-Gibson <bfgibson.namihc@gmail.com>, "Dmrstar22@gmail.com" <Dmrstar22@gmail.com>, "jstephens@howardcc.edu" <jstephens@howardcc.edu>, Lisa Lomas <lisa.lourylomas@yahoo.com>, Steven Snelgrove <ssnelgr1@jhmi.edu>, Vickie miles <vmiles61@yahoo.com>, David Leichtling <dleichtling@cmpractice.com>
Subject: Re: BH Task Force: Primacy Care Working Group

Hello Everyone,

I thought I would offer something to think about before tomorrow's meeting (8:00 am in Columbia: 10630 Little Patuxent Pkwy. Suite 209). While this issue, and many of the issues we need fixed or implemented, are too large for our county to enact, someone needs to consider change. A major problem for getting psychiatrists to accept insurance is CareFirst (BC). Care First has a requirement that if

any group practice accepts BC, then everyone joining the group must accept BC. The problem is, BC is the lowest payor. I had two psychiatrists who joined my group after leaving a group that refused to accept BC. Again, by virtue of my company having a contract with BC, these new doctors had to accept BC. Because of this, I was paying these doctors 10% less then they had made at their previous practice. There was nothing I could do and attempts to negotiate with BC was not successful. Both doctors quite 6 months after starting with us. One went to cash only and the other went to another practice that did not accept BC. Unfortunately, BC has my hands tied. If I was able to not require these doctors to accept BC, then I would likely have two psychiatrists who accepted other insurances: Cigna, Aetna, Johns Hopkins, Etc.

Unfortunately, in the new application for medicaid, there is a similar clause that says that every member of a group who is contracted with medicaid must accept medicaid. I am assured this is not true, However, if it does become true, I will need to cancel all my pending medicaid contracts with every provider on my staff. We can't be available to help anyone if we close down.

Contracts that require every member of a group to accept a bad product is bad for therapist access. This is a major reason why many practices will not accept BC. In my practice, I have 5 out of 30 therapist who are willing to take medicaid so we have applied to accept medicaid. If everyone in my office is required to take medicaid, I will need to cancel that agreement and no one will accept medicaid.

More Drama: Tricare will not accept licensed counselors (LCPC's) despite being licensed in the State of MD and despite counselors being 55% of the field in the US (including PHD, Social Workers, and Licensed Counselors). This means my practice, which includes two military veterans who are LCPC's can not see veterans who have TriCare.

Something to think about,

Mark

On Tue, Dec 16, 2014 at 2:24 PM, Rebecca Bell <rbell@usmd.edu> wrote:

I was wondering if thee is a summary or any info about the Hopkins data project either in a document or online?

Also, I was recently told to look into Lisa Ferentz who's in Baltimore and does training in trauma for mental health professions – she also does training for medical doctors on somatization, physical effects of trauma, ways to help patients through exams which may be triggering to them, and how to assist patients through flashbacks, etc. --- I was wondering if (non-psychiatrist) MD's, both in primary care and ERs, feel adequately trained in this area or if there's also a need for that as well? -- Maybe we can add that to the list to discuss.

She has blogged about Trauma & Primary Care (http://www.lisaferentz.com/2013/06/trauma-and-primary-care/) and also Working with War Veterans (http://www.lisaferentz.com/2014/05/working-with-war-veterans-a-new-paradigm/) among other things on her site www.lisaferentz.com

From: Leah Blain [mailto:lblain@chasebrexton.org]
Sent: Tuesday, December 16, 2014 10:56 AM
To: 'Beverley Francis-Gibson'; 'Dmrstar22@gmail.com'; 'jstephens@howardcc.edu'; 'Lisa Lomas'; 'finn67@gmail.com'; Rebecca Bell; 'Steven Snelgrove'; 'vickie miles'; 'David Leichtling'
Subject: BH Task Force: Primay Care Working Group

Hello Primary Care Working Group members,

As we discussed, this is a small group list to keep in contact between meetings. There is no specific agenda for the group email, but it could be a good place to share resources, links, articles, etc., that are pertinent to our discussion and/or to kick around ideas that you want folks to have some time to marinate on between meetings. It doesn't look like the minutes from the last meeting are posted yet, but some themes were:

- Mapping assets (providers) and needs (population characteristics) in the County
- Resources for Primary Care Providers across levels of need (psychoeducation, self help, referrals, etc.)
- Connecting transition age groups with a full range of social supports

- Concerns about the effects of privatizing, especially in addictions (e.g., repeat of 1998)
- Early screening and biomarkers
- Peer based curriculums (e.g., NAMI)
- Connecting people with services (e.g., DBT, CBT) not just providers
- Primary care screening tool utilization and primary care mental health integration
- Urgent care access – does this really address the gap and how do we create it?

Again, this is just a summary of what I was able to jot down. Use this as you will. Unfortunately, I won't be able to join you all for the meeting this Thursday, so if someone would be kind enough to update those of use that can't attend, it would be much appreciated. I look forward to hopefully seeing many you here at Chase on January 6th.Leah