Behavioral Health in the Primary Care/Patient Centered Medical Home

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We are watching healthcare reform rapidly evolving and changing in front of our very eyes. The future of healthcare delivery continues to lean more towards the Patient Centered Medical Home Model. Primary care settings are becoming a gateway to identify and treat many individuals with behavioral health and primary care needs. To better address these needs, many primary care providers are now integrating behavioral health care services into their office. Models have emerged that include the use of care managers, behavioral health specialists, or emergent consultation models.

Integrating care is vital to addressing all the healthcare needs of individuals with mental health and substance use problems. Integrating care facilitates better communication and collaboration between PCP and Behavioral Health providers and supports a better provision of care for the overall patient.

I have seen the first hand benefit of integrated behavioral health care, over the past several months, as I have been providing direct rapid assessment and treatment services within a large PCP practice. The management of the patient is central to the recent shift away from focusing on “episodic acute care” to a greater emphasis on overall consumer health management of defined populations, especially those living with more chronic health conditions. This shift in focus results from closer collaboration of both primary and behavioral healthcare integration efforts, as patient centered health homes recognize the importance of caring for the whole person.

The PCP Patient Centered Medical Home offers more linkages to community supports and resources as well as enhances coordination and integration of primary and behavioral healthcare to better meet the needs of consumers who struggle with multiple chronic illnesses. This approach centralizes care management and supports individuals as they work toward improved self-regulation goals. An additional goal of this model is to improve healthcare quality while also reducing costs.

As a clinician working within an integrated primary care practice the consumer feedback has been very positive. Patients are less stigmatized to follow up with behavioral health treatment recommendations if the services are easily accessed within the PCP office.

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Mcare Settlement Is Good News

The Pennsylvania Medical Society (PA-MED) and the Hospital and Health System Association of Pennsylvania (HAP) have settled our litigation with the commonwealth regarding the Mcare Fund – our appeals of prior assessments and the challenge to the transfer of $100 million to the general fund from Mcare in 2009.

The agreement requires that $200 million be returned to physicians, hospitals, and other health care providers who pay assessments into the fund – $139 million in refunds for prior assessment overpayments and $61 million via a reduction to the 2015 Mcare assessment.

As the statewide physician organization covering all specialties, PAMED was able to coordinate with HAP and the Pennsylvania Podiatric Medical Association (PPMA) to get this landmark agreement completed.

Here are some answers to early questions physicians are asking:

Who is eligible for the refunds?
Physicians will be eligible for a refund if they paid an Mcare assessment (or an assessment was paid for them) for any time during 2009, 2010, 2011, 2012, or 2014 (excluding 2013).

When will I get my refund?
The refunds likely will not be made until 2016 due to the extensive calculations required to determine the amount payable to each eligible health care provider. However, the 2015 assessment will be reduced by about one-third.

What address will my refund be sent to?
When the refunds are ready to be sent to providers, physicians will receive a letter from Mcare, followed up by a lump sum payment from the Treasury.

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There is less stigma and greater comfort to follow up with outpatient mental health treatment in co-located behavioral health services offered within a PCP office. Rapid assessment and triage is more readily available and better coordination of care is evident between the mental health provider and PCP. Linkages to additional services are also easily provided and monitored to assist with better compliance and patient follow up.

There has been a higher success rate with getting patients seen for somatic complaints, depression, anxiety, ADHD, eating disorders, nutrition and wellness concerns, substance abuse concerns, behavioral concerns, developmental concerns, and self-harm concerns through the provision of co-located services.

The benefits have been overwhelmingly positive and the support and collaboration with the Primary Care Physicians have been amazing. The future of health care delivery is resting heavily on this model and from what I can tell the future seems bright! There will be ongoing tracking and monitoring of outcomes to further support the benefit of the patient centered medical home model to demonstrate that the outcomes truly provide the best care overall to each consumer. This ultimately means that time will tell if this is the best approach to use in the long term. From a first-hand report I feel this is a very good starting point!

Editor’s Note: Mr. Brindle is the Director of PCP Integration Services Springfield Psychological and the President Elect of the PA Chapter of the National Association of Social Workers. References available upon request

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Social Media Provides an Opportunity to Educate Patients

An Interview with DCMS Member Laura Offutt, MD

Social media is a powerful tool for health promotion and education, and for physicians to ignore this medium is to miss a huge opportunity for health improvement. That is a strong statement, but it is one in which I truly believe.

Over the past two years, I have been experimenting with the use of social media to reach teens about health related issues. This was inspired by my experiences as a physician in academia, clinical practice and in industry, and as a mother of two children ages 12 and 16.

I think most would agree that one mark of a good physician is one who keeps learning, and I believe that learning about social media and its potential to reach patients about health is important.

I have ventured down this path by starting a teen health blog called Real Talk with Dr. Offutt, and have supplemented it with slowly using social media platforms, including Twitter, Tumblr, and a few others. This project definitely falls into the “See one, do one, teach one” philosophy with which we all are familiar.

I have learned much by delving into this virtual world, as well as interacting with teens in person to understand their curiosity about health issues and their behaviors online with regards to searching for answers to health questions. A few facts have really struck me as relevant to my work:

- Essentially all teens are online.
- Among the teens with whom I have spoken, nearly 100 percent have looked online for health information.
- Teens compared to adults, in general, explore different health topics online. They most often explore topics relating to sexual health, substance abuse, mental health, and relationships.
- Teens do not want simply to “receive” information; they want to discuss it, and often use social media to do so amongst their friends.

We live at a time when about half of the 50 states do not require sexual health education in public schools, and that education is not always required by law to be medically accurate. Although much health education can occur in the recommended annual checkup, my colleagues in patient care can attest to the many limitations therein, not the least of which is time.

In addition, many teens and parents do not recognize the value of the annual checkup as they get older, despite common medical problems in this age group such as obesity, depression and stress levels, lack of up-to-date vaccinations, and substance abuse. Many teens simply do not have access to regular health care, and in many school districts, school nursing and health education resources have decreased.

Thus, there are huge gaps in adolescent health care. And I believe I am not alone among my medical colleagues in recognizing that health choices and behaviors made by young people during their teen years will ultimately affect their lifelong health.

My hope is that Real Talk with Dr. Offutt grows to become a relevant, accessible, accurate and unbiased teen health resource that supplements what doctors, nurses, parents and teachers provide every day for teens they care about. I also hope that it can help fill some of the gaps that currently exist with teen health education.

Real Talk with Dr. Offutt certainly is a work in progress, and I am fully cognizant that those in full-time clinical practice cannot take the time out of their already packed days to create a similar resource; however, I hope that this can help them in our common mission of insuring that teens transition into adulthood with healthy bodies and minds.

Real Talk with Dr. Offutt can be found on Twitter, Tumblr, BlogSpot and Pheed.
MOC Controversy

Maintenance of Certification (MOC) is a hot topic of discussion among physicians nationwide as well as in Pennsylvania. At the recent annual meeting of the Pennsylvania Medical Society’s House of Delegates (October 17-19, 2014) MOC was the subject of three resolutions which had been submitted for discussion, as well as an educational session for physician members.

Previously, in July the PAMED Board had a lively discussion about MOC and the process by which physicians are re-certified. Recognizing that there is growing discontent among many Pennsylvania physicians about the onerous re-certification process, the board formed a task force to bring recommendations for potential action back to the board by the October House of Delegates meeting. This work resulted in the development and approval of a statement of principles and a statement of concern regarding maintenance of certification (available upon request to DCMS/PAMED members).

During the House of Delegates meetings in October, it was noted that the purpose of the MOC process was to demonstrate that physicians have kept up with changes in their specialties, although many of the comments and much of the testimony centered on flaws in the exams and the very significant cost to practicing physicians to maintain certification from one of 24 specialty boards. It was also noted that many of the boards had “grandfathered” physicians and did not force them to endure the process of recertification, while others were facing a need to become recertified or risk being discharged from hospital staffs or third party panels.

One physician commented that his primary care board’s exam “was like playing medical trivial pursuit – it was not relevant at all to my practice”. A few others commented that their “preparation and involvement in their own recertification process had indeed helped their practice to function better”. There was also much criticism of the high cost to prepare for and take the exams, as well as some egregious financial practices on the part of one of the largest specialty boards.

The resolution which was ultimately adopted will have the PAMED Delegation to the AMA to ask the American Board of Medical Specialties to eliminate practice performance assessment modules from the requirements of MOC. The PAMED Delegation will also be proposing that the AMA develop and disseminate a public statement to the American Board of Internal Medicine that their current ABIM MOC program has the appearance of being focused too heavily on enhancing ABIM revenues and fails to provide a meaningful, evidence-based and accurate assessment of clinical skills.

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The refunds for physicians will go to the physician’s license address, so physicians should make sure that this address is up to date.

Will I be required to remit my refund to an employer who wrote the check for my assessments?
This will vary depending upon your circumstances. For example, even though an employer wrote the check, you may have ultimately borne the cost due to an overhead reduction from your compensation pool. The settlement does not impact any contractual or other obligation that a health care provider may have to remit a refund provided under the settlement to another provider or entity.

The Mcare Fund provides medical professional liability coverage to physicians, hospitals, and certain other health care providers above their basic coverage. The covered health care providers must pay an annual assessment to cover the cost of the fund’s claim payments and other expenses.

As part of the agreement, PAMED and HAP will withdraw our challenge to the 2009 diversion. However, the settlement includes key protections against any future diversion.

The commonwealth has agreed to operate the fund on a pay-as-you-go basis going forward. This means that health care providers will not be required to put money into the fund until it is needed and the fund will not be able to build up substantial reserves such as those diverted in 2009.

The Mcare Fund is administered by the Pennsylvania Department of Insurance. Moving forward, the commonwealth has agreed that it will be operated as a trust fund and its funds will not be considered the general revenue of the commonwealth.
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