

PRIMARY CARE PHYSICIAN ADVISORY COMMITTEE

Meeting Minutes, April 20, 2005

Members in Attendance: Stanley Block, MD; Sarah Fessler, MD; David Gifford, MD, MPH; Arnold Goldberg, MD; Ellen Gurney, MD; William Hollinshead, MD, MPH; Sharon Marable, MD, MPH; Richard Wagner, MD. *Guests:* Paul Block, PhD; Sandra Boehlert, MD; Jim Bonnar, MD; Amy Chandler; Jonathan Dupré; Mark Fields; David Kahn, MD; David Lauterbach, ACSW; Katherine Lyon, PhD; Lauren Nocera, MSW, MPH; Kathleen Spangler, Esq; David Spencer; Craig Stenning; Rob Tractenberg; Linda Valianti. *HEALTH Staff:* Blythe Berger. *PCPAC Staff:* Carla Lundquist, Mary Anne Miller, RN, MPH.

Unable to Attend: Munawar Azam, MD; Jeffrey Borkan, MD, PhD; Mark Braun, MD; Herbert Brennan, DO; L. Anthony Cirillo, MD; Herbert Constantine, MD; Charles Eaton, MD; Michael Fine, MD; Victor Lerish, MD; Ray Maxim, MD; Omar Meer, MD; John Murphy, MD; Donya Powers, MD; Mark Schwager, MD; John Young.

- ***Behavior change is the core method of disease prevention, which is the key for reducing the cost burden of health care.***
- ***A variety of collaborative and integrated approaches for primary care and behavioral health are working in RI, but efforts are needed to expand access to behavioral health care for the uninsured and for children and adolescents.***

Dr. Wagner opened the meeting at 7:40 AM. Minutes of the March 16, 2005 meeting were approved as written. Dr. Wagner noted that the PCPAC Mental Health Workgroup had addressed the issue of Primary Care (PC) and Behavioral Health (BH) in 2001-2002 with emphasis on communications, collaboration and child/adolescent access to BH services. Practice models established in the last few years have shown that collaboration is not always sufficient; integration and co-location of PC and BH services is necessary to address the co-occurring illnesses/co-morbid states suffered by a great number of patients with BH conditions.

Models for Advocacy and Collaboration: Paul Block, PhD, Co-Director, Psychological Centers, provided an overview of the Allied Advocacy Group (AAG), which was established in late 2000. A wide variety of stakeholders met to review issues and explore options to increase access to BH care and released its first report in June 2002 *"Putting It All Together; Rhode Island's Hope for Building a Health Care System (Some Assembly Required)"*, urging integration of PC and BH to improve quality, contain costs, and facilitate access. As noted by Surgeon General Richard Carmona, behavior change is the core method of disease prevention, which is the key for reducing the cost burden of health care. The AAG sponsored a policy roundtable in June 2003 to develop a specific plan for a coordinated statewide effort, detailed in the roundtable report *"Taking the next step toward solving Rhode Island's healthcare crisis: An action plan for integrating behavioral and primary care"*. The consensus goals of the Policy Roundtable are to support: 1) co-locations of BH and medical services (as a first step) and 2) specific collaborative projects consistent with practices needs/interests. National evidence shows cost offsets are greatest for BH services that target medical conditions. The AAG is currently continuing its efforts on advocacy, education, information dissemination and support of integrated models of care, and under a SAMHSA contract, is working a model project with focus on collaborative services for seniors.

Psychological Centers operates co-located services with five partner organizations, and other collaborations between PC and BH partners together reach ten communities statewide. The unique operational characteristics of a collaborative care project depend on the physicians and office staff participating, the patient population, the targets for behavioral intervention, the history/longevity of the collaboration, the relationship between PC and BH providers, and the BH services offered. Key issues to consider for co-located or integrated PC & BH projects: 1) Access to BH services – are there sufficient adequately trained, skilled providers using appropriate interventions for the numbers of referrals that will be made; 2) Financial viability and funding streams – affordability differs for PC and BH providers, and BH providers are accustomed to administrative/ insurance demands that PC practices are unprepared to handle; and 3) Quality of care – are the services available going to meet the referral goals, and are the services subject to sufficient quality control. Current collaborative efforts are not yet able to address two major statewide concerns, the lack of access to children's BH services and access for the uninsured.

Models of Integration: Four models of PC & BH integration in RI were highlighted and discussed.

Co-Location of PC within BH Services: Tri-Hab, Inc./Thundermist Health Centers. Tri-Hab, an agency of Gateway Health Care, provides residential services/transitional housing for homeless adults. Tri-Hab partners with Thundermist to establish medical homes for its clients by having Thundermist NPs co-located at Tri-Hab to conduct initial physical examinations on-site; follow-up is with the same provider at Thundermist. There are no out-of-pocket costs to the patient, and the appointment no-show rate has dropped from 50% to 25%. The model is grant-funded and supported by social services staff at both agencies, and provides the opportunity for effective care of this population.

BH within a PC Model: The Providence Center/Providence Community Health Centers. The Providence Center (TPC) established BH services at two Providence Community Health Centers (PCHC) sites with grant funding support in 2002. During the grant period uninsured patients were seen, but post-grant services have been limited to insured patients. Major challenges faced: 1) TPC operates at only two of five PCHC sites, leading to high no-show rates (>50%); 2) it is hard to find bilingual providers; and 3) patient records located at TPC are difficult to get to PC site. TPC is currently pursuing grant funding to expand access for the uninsured and provide PC services at onsite at TPC.

Integrated Collaboration and Cooperation: Kent County Mental Health/Various PCPs. Kent County Mental Health (KCMH) requires patients to have a PCP/medical home in order to move into the center and will connect patients to one of its PC partners (116 practices in the area) as needed. PCPs get the opportunity to have direct conversations with BH providers, which is key to treatment of trauma-based physiological conditions and to patient BH stability post-program. KCMH also provides short-term psychological consultations to partner PCPs.

Integration with Integrated Medical Record: Family Care Center (FCC), Memorial Hospital of RI (MHRI). Community Counseling Center (CCC) Behavioral Science team therapists work side by side with medical residents and CCC psychiatrists are on faculty at the MHRI Department of Family Medicine, training physicians to work with BH providers on a daily basis. BH appointment information and notes are sent to the PCP the same day via the shared electronic medical record.

NEXT PCPAC MEETING WEDNESDAY, JUNE 15, 2005