Pennsylvania Psychiatric Leadership Council
Planning Group Meeting Narrative
07/18/17

This Meeting commenced at 10:00AM in the Borad Room of the PA Psychiatric Society Offices.

Welcome and Introductions

Deb Shoemaker, Executive Director of the Psychiatric Society, and PPLC Administrator, Dave Dinich, led off the meeting with a welcome and asked the folks on the phone and in person to introduce themselves and share their organizational affiliations. There were approximately 22 persons present with two additional on the phone. This included Dr. Richard Edley, CEO, Rehabilitation Community Provider's Association. He shared the fact that his organization is, and remains, in favor of the unification, as it was originally proposed and in its current form. He also hopes that the Department of Drug and Alcohol Programs and PA Department of Aging will eventually become included in that process. Dave asked several organizations about their endorsement of the proposed unification. The Association of Social Workers and the PA Psychiatric Society have not taken a public position on the issue, but encourage greater collaboration among and between Office of Mental Health and Substance Abuse Services(OMHSAS) and the Department of Drug and Alcohol Programs(DDAP), in addition to the PA Department of Aging(PDA) and the Office of Long Term Living(OLTL).

Our Goals: The Clinical Opportunities for Population Health under a new Department of Health and Human Services
Ken Thompson

Dave then shared the Pennsylvania Psychiatric Leadership Council(PPLC) and its meeting types and frequencies and introduced the PPLC Medical Director, Dr. Ken Thompson to address and frame the topic for the day. Ken referred to the originally proposed Table of Organization of the Department of Health and Human Services(DHHS), as displayed on the power point projection screen, and suggested that the lines of authority need to be considered as "buckets" rather than "silos" in order to improve

access and melding of resources and their use. How to use psychiatric knowledge and the capacity of the BH Workforce to improve services in a unified manner was his expressed intention.
Specifically, he addressed the issues surrounding the psychiatric issues addressed in communities in the process of their serving children. He noted that workers in that field shared that in only 10% of the cases, did the children themselves have a psychiatric problem, while a much larger percentage of their parents and adult guardians/caretakers have them. However, the garnering of those services takes at least three months with the children having to leave their families' homes during that time. He posited: "Why isn't this being treated as an emergency?"
Ken went on to share the need to integrate community medicine and psychiatry as part of the process of addressing public health.
As an example, he then asked about the agency and people who are leading the Suicide Prevention effort across Pennsylvania. It became obvious that there are fragmented approaches, but none that are collaborated and across all populations.
He summarized noting that the efforts of the PPLC and its membership need to be directed to suggesting methods and modalities to better engage the Physical Health community with the Behavioral Health community in order to address the needs of the whole person living in our neighborhoods.
Dr. Hodas added his observations of structure and function and the need to address these in concert.
Richard Edley added that there is an updated table of organization that seems to make more sense today, as the concepts develop and move forward.
Lloyd added the observation from a recent hearing in Pittsburgh on this topic. The presenter from Texas, which is another state in which this type of unification has recently happened, shared that the changes in the bureaucracy were addressed secondarily to the changes in the actual provision of services in the community. Once the practitioners and providers are in the process of providing the integrated services, the bureaucracy will need to and, in fact, will change.
Dr. Edley then addressed the need to match policy changes to the funding that is in place to pay the providers of those services. Thus, the need to include the funding streams with the program offices which actually manage the services becomes increasing more important to make that happen.

There was another observation that this effort, on the part of the PPLC, should highlight the need for input from the practitioner level.
Trevor Hadley added the fact that the scale of changes such as this will determine how, and if, it can be managed and by whom. He noted that a unification such as this, at this scale, can be managed only through bureaucratic processes that are currently in place, and that it will be nearly impossible to guide toward an ultimate success. In fact, he suggested that will be a cumbersome set of processes and requirements which might make such a merger, frankly, impossible in our Commonwealth. The fact is that a change in something such as the Outpatient MH Regulations can, and will, take nearly 8 years to effect. These issues have not been put on the table for discussion, as of yet, by the Wolf Administration, nor the politicians involved in the process. Dave noted that this will require an extensive initiative which shoots very high in trajectory.
Dr. Loren Roth asked if there are specific questions that we wish to answer as part of today's deliberations. Dave responded noting that there might need to be a specific body of folks to offer recommendations to this process as to how to actually effect the integration. Deb added that, at the PPLC Meeting in February, DHS Secretary Ted Dallas asked the PPLC for ideas of how to streamline and make operations of the proposed DHHS more efficient and effective.
Dr. Edley added that there was a letter from the RCPA a few months back that specified certain areas to address: one licensure entity and visit to providers offering MH and SU services for example. Ken, noting his agreement with that observation, shared that the unification must actually appear, show up, in the provision of services in the community with recommendations to make that happen.
Dr. Hodas noted that an overarching approach which will address integrated care provision involved five critical elements:

- The Developmental Perspective—what is normative and what is not for each age level
- A Strengths-Based approach
- A Trauma-Informed approach
- Recovery Model of approach beyond Sx and functional improvement to what the Person in Recovery needs and wants.
- The need for Evidence Based Practices to be further proliferated.
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Dan McGrory shared his perspective of the need to translate this transition to a reality for the persons in service and to those in the process of

providing and receiving care. Ellen DiDomenico shared her impressions of the fact that certain counties have reached/created methods of providing care in a coordinated manner that is compliant with existing regulations and survey bodies in addition to also being effective. She characterized that the State needs to "get out of the way" of the located in providing effecting and coordinated care.

Overview on the Operation of the 4 Departments which were in consideration fro unification. Bob Haigh and Lloyd Wertz.

Bob shared his observations from the perspective of over 39 years of public services. He noted that certain changes in the past have been initiated in order to create better public impressions, rather than to be functional.
He shared certain key factors:

- The overall down-sizing of operations by the State over those years in institutional settings, such as SMH's and Developmental Centers.
- The advent of Managed Care Organizations has further re-charted the course of these changes as part of the Medicaid funding mechanisms.

Lloyd shared the bifurcated nature of the separation of oversight program structure versus the funding agencies in a manner of further confusing the processes and the unlikelihood of their providing efficient and effective services.

There was a robust discussion of the updated Table of Organization specifically for the Deputy Secretary for MH and SU disorder Services.
The issue of Transition Aged Youth and their provision of services was also a topic visit by the attendees at this point in the discussion.
There was also a reference to the finances both in PA and at the Federal Levels. Ken Thompson referred to the huge economic impact that will be suffered by PA in the context of capped Medicaid Federal funding and the fact that this further highlights the NEED to address these issues both to the recipients and providers of the services as well as the overall economy of the Commonwealth.

Loren Roth referred to the questions that need to be created and posed to the DHHS. He referred to the fact that this playing field is much wider than can be addressed with one or several questions, but that there needs to be a well-thought out process to create an advisory body which can assist in those areas of service provision. Dave shared the recent experience of asking some information from the DOH Bureau of Health Planning which

was housed at OMHSAS and the difficulty encountered in securing that through a process internal to the Commonwealth. Loren then went back to ways of offering the needed consultative services and the formulation and framing of questions to be addressed in the process of implementation. Ken went on to note that PA has really good provision of psychiatric services. We then need to share those realities with the Administration in assisting with that.
Gordon returned to the issue of the Legislature in refusing to include the DDAP and PDA and that the change to this process needs to be recognized and confronted in that context. Deb Shoemaker also noted that there were a number of discussions involving her and the legislators who were against the unification process. The lack of sharing at the outset the intended issues to be addressed by the Administration process might have been one of the major issues that negatively impacted the inclusion of PDA and DDAP during the process.
Ken suggested that this group needs to, perhaps by itself, rise above the detailed issue of inclusion of DDAP and PDA in the unification and to move on to the issues which are specific to the practice in the community to better effect the process.
Dr. Hodas suggested that presenting the reality of the negative effects of excluding DDAP from the unification should be further pressed to the legislators. It was noted that there seems to be little insight into the actual problems in the community and that there continues to be a need for advocacy on our part and the part of our service population. There was also a sharing of a person sharing her experience with Co-Occurring disorders in her family's past and that, somehow, her personal experience was deemed to be invalid, as per the SU services advocate. The statement was actually made that Co-Occurring Disorders do not, actually exist, in that presenter's opinion.
It was agreed that the group would break, briefly, for lunch and to work through the next section of the Agenda as a working lunch.

"What the Pittsburgh Regional Health Initiative is doing to improve health entities" presented by Carol Frazer, Jenn Condel of the Pittsburgh Regional Health Initiative.

The group had an exercise for the group to demonstrate the need to understand their relationship of knowing and having the parts and where they are located in order to build the toy involved. This was made relevant to our earlier discussion of how to take the available resources, secure them for the involved agency, and use them to provide the services which

are needed and for which we are funded. It was also clarified that the supplier needs to understand what the final product will look like in order to understand the supplies that are needed. This highlighted the need to have policy and procedures written and re-crafted to direct the employees in the provision of the actual service/supply that is needed in order to produce the results that are desired. This needs to be re-framed on an ongoing basis, thus reflecting the need for continuous quality improvement. There was further discussion of what data might be needed in helping to understand the processes in place and how they might be best altered to meet the needs of the consumer.

The Governor's Goals in Unification, and the Secretary's Vision
Teresa Miller, DHHS Secretary Designee and current Insurance Department Commissioner, was introduced by Dave Dinich, who again called for attendee introductions for her benefit.

Dave then shared some of the AM discussions and the desire of the group to address the unification from the perspective of Population Health. For example, looking at the issues for children, which cross the traditional boundaries of the current structures, needs to involve the overall assessment of those needs and the services needed to address them coming from other areas across those lines.
Commissioner Miller noted that she is willing to share her background, but would rather learn of the recommendations from the group. She was then asked about the issue of Mental Health Insurance Parity. Commissioner Miller noted that she had advocated for Social Workers and for MH Parity in the state of Oregon and later in the Obama Administration in implementing the MH Parity Law from that level. She noted that this issue is being approached from several levels:

- One is checking the policies that are offered and their compliance with the las
- The second is the investigations of complaints.
- The third is a market conduct examination that can be accomplished by her staff.

This third avenue seems, from her perspective, to be the most likely to achieve the desired results of assessing parity across plans and companies. These examinations take an extended period of time, as they require close examination and sets of questions as they progress. Richard Edley stated the reality that the actual parity of benefits is one level of parity, but that there can be additional requirements for pre-authorization

that can be more onerous for a BH service. The role of Medicaid, versus that of private insurances is another area for discussion and concern. Issues of differences in appeal processes between private insurers and Medical Assistance is also relevant.

Ken Thompson then took on the role of sharing the history of the PPLC as well as the purpose of today's meeting. He then went on to note that the purpose of today's meeting is to develop a list of specifics that can be shared in assisting to provide an integrated DHHS array of services.

He also shared the concept of primary healthcare as needing to include all aspects of care to achieve mental and medical health care in our communities, not further separation of specialties across the continuums. He also stressed that there need to be goals of integration in services in our communities, or the whole process of unification might be futile. This especially applies to "diseases of despair" of Mental Illness and Substance Use. He then focused on framing a relationship to allow for an ongoing process to discuss, in detail, the issues in the community which will include the PPLC in that discussion with the new DHHS.

Loren asked about the format that might be best to share the discussions/recommendations of this nature.

Commissioner Miller shared her excitement about the possibilities of the unification and the Governor's disappointment that the DDAP and PDA will not be part of the process, at least at the outset. She then referenced the fact that older Pennsylvanians will be part of all the issues across the proposed DHHS areas of service. However, the PDA will not be represented in all of those areas of influence within the DHHS. This is a loss to that population. She then referred to the current Secretary of Administration, who has some experience in these processes. She noted that there needs, initially, to be a plan to maintain the Agency to assure basic operations continue to be handled during the developmental period. After that is assured, there is a need to think about the services that are provided and having that community or group of stakeholders to inform the unification process. That could involve, literally, following an individual to and through the application and receipt of processes in order to gather an understanding of how they operate and how they can be improved to assist the Consumer/Person in Recovery.

She noted the beginning of the process will be once the enabling legislation is passed. However, the creation of improved services which are coordinated and collaborated will be ongoing, needing to be adapted going forward in the future, a process which will, likely, never end.

Joni Schwager posed a pointed question about how the decision could be made to NOT include DDAP in the unification process. Commissioner Miller shared her perspective that this was a legislative decision and that the legislators need to answer and for which they need to take responsibility. Regardless, there is a desire that those served by DDAP and PDA will be brought along through further efforts and the highlighting of their loss of coordinated services due to their exclusion in the unification process. Lobbying was raised as part of the issue as to how and why we have gotten to this, less than desirable, point.

Dr. Hodas expressed his appreciation to Commissioner Miller for her attendance and active participation today. He shared his desire that the array of services offered by an effective DHHS must be arrayed based on developmental stages of the persons being served, at the Bureau Level in the DHHS organization. He also noted that these need to include all four facets of: Prevention, assessment, treatment, and recovery.

It was suggested that this would not involve the combining of silos, rather the utter elimination of those structural limitations which limit the joint planning and service provision involved. Sally Walker noted that, absent those types of efforts, folks do not get what they need. Rather they get what is available to them in our current structure. Ms. Miller noted that there is more of a need to assure there is sharing across the lines that have been projected on the Table of Organization, rather than a predetermined type of structure.

She also shared that her plan to lead DHHS, even in its current size and without DDAP and PDA, will involve the involvement of staff who will welcome the opportunity to work with colleagues and other stakeholders. Those who cannot, will not be able to be part of her leadership team. She further stressed that input from the persons in recovery through quarterly meetings with those stakeholders and other avenues to be created and used. Dr. Eberts offered his observations on the difficulty in treating those with addictions issues in the clinical setting in the community. Ms. Miller noted that this might require the changing of regulations or other means that have not, yet been created, which are currently in place or can be put in place to achieve that potential.

One positive that was shared by Ms. Miller was the implementation of the 21st Century Cures Act and its intention to offer “warm handoff” services to individuals with SU problems in Emergency Rooms who need to treat their SU addictions immediately.

Ms. Miller approached the end of her time with the group asking the group to inform her of the issues that they see in the community as they arise or

continue in the practice of community psychiatry. Ken Thompson iterated the fact that PA is the only state in the nation which has an active group, such as the PPLC and that the group can provide the counsel to her office as no other can.
Other comments were offered on the need for sustainable models to encourage integrated practices, which must be created to address the issues that prevent these from happening.
The System of care to support children and youth in the system was shared by Crystal Karenchak and the need to have that continue and grow to better inform these processes. There were additional suggestions to include the Transition-Aged Youth as part of the involved stakeholders as well as the encouragement of ongoing quality improvement for the DHHS as a whole.
There was an invitation to Ms. Miller and all other attendees to plan to attend the PPLC Meeting scheduled for October 9, from 10:00AM and through the afternoon at the Hershey Lodge and Convention Center, immediately preceding the RCPA Annual Training Conference.

After Commissioner Miller left the room, there was further discussion about how to directly impact the legislators who are involved in preventing the inclusion of PDA and DDAP in this unification. Loren Roth suggested that a subtle broadening the mandate of the PPLC might be needed to assist the Commissioner in understanding the capacity of the PPLC as serving in this type of capacity.

The next steps were agreed upon to re-write the letter to Commissioner Miller and the group's meeting in the future, if the opportunity arises. It was also suggested that we could offer further research from other states which have included SU and Aging service departments in a unification process. It should be clear that the PPLC wishes to partner with the Commissioner's efforts in effecting and implementing the unification. That can be the "ask" from the PPLC for this purpose.

Respectfully submitted,

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