Pennsylvania Psychiatric Leadership Council (PPLC)
Meeting Narrative

10/01/18

This Meeting commenced at 8:45AM with PPLC Member Dr. Gordon Hodas' welcoming the attendees.

He shared two stories of folks who had overcome significant obstacles in their developmental years and who then were recognized for their success in their chosen careers. Both noted their success despite the negative aspects of their family/life circumstances using them as motivation for creating successful trajectories for their lives leading them to positive and successful current destinations. He lauded the PPLC for its willingness to address the issues of Social Determinants of Health through the Agenda today and, furthermore, through the recent initiation of the Coalition for the CommonHealth.

There were 35+ in attendance for this breakfast session.

Introductions of Centers of Excellence (COE) Fellows was then commenced and led by Larry Real of the University of Pennsylvania and Horizon House-based COE.

He called the first Fellow, Dr. Leon Cushenberry, of the UPMC Fellowship based in Pittsburgh.

Dr. Cushenberry noted that he has worked in community settings since becoming a psychiatrist, as was his initial intention and goal. He shared that, now that he has been "recently minted" as a psychiatrist, he is just as committed to that work. He has focused on working with minority populations. This led to his receiving a SAMHSA grant and focused on gender and racial minority treatment and the systems which serve them. How to mobilize and work with systems to determining how to modify those organizations to better approach issues such as these has become a goal.

He currently works on an Assertive Community Treatment Team, the first time for that experience for him. He finds it to be edifying and enjoyable. There was a question about “Racial Trauma,” race-based incidents and their traumatic effects on persons involved in them.

Dr. Cushenberry noted his research on this topic and found some culturally adapted tools to help address this trauma. He noted that this type of trauma, often quite similar to that associated with PTSD, is seldom addressed.

There was then a question on the topic of sexual minority and its interaction with issues that can occur for a person who has a racial minority status as well. Dr. Cushenberry noted that he has followed these issues as they manifest in his research and practice.

There was a question about “micro-aggression” in the clinical practice setting. Dr. Cushenberry noted that he has sought research on finding culturally appropriate methods of discussion on these issues, rather than the blunt questions that can be asked and which tend to be invalidating, and thus damaging and unsuccessful in the clinical setting. EMDR has shown itself to be an effective tool in this area. Validating the experience has been the means which he found to be best in practice with these folks in his clinical experience. He also referred to the need for individuals to have their own levels of identity-their own idiosyncratic identification and then to priority rank those issues as to their importance to the person. This can help the person to identify those issues which can help lead to effective dialogue with each other and engender conversation and effective understanding between them.

Dr. Cushenberry ended with a brief discussion of the SAMHSA Grant for which he successfully applied. He noted that there are appointments to one of the 13 specific councils for each successful applicant. He noted how this helped getting him involved in his current Fellowship placement as well as other contacts within the psychiatric community.

Dr. Ashley Un was next, noting that she had just finished her Fellowship at University of Pennsylvania.

She shared her experiences there as being quite varied, including the Veterans Administration, multiple therapeutic interventions, and currently

works with the Mental Health Partnerships, expecting to begin service in the ACT Team based there.

There was a question about integrated PH/BH and how that seems to function so effectively in the Veteran's Administration's array of services. Dr. Un described the coordination between the designated primary care provider in the VA and the determination as to whether the Primary Care Physician (PCP) or the Psychiatrist will maintain the responsibility for the person involved in receiving the care.

There was a question about why community psychiatry gained her interest, versus the other types that were available to her. Dr. Un noted that she wanted to determine if this opportunity would provide her with exposure that she might not, otherwise, get and experiences which were of interest to her.

There was a question about how she interacts with Med Students in discussing her career choices. She noted a requirement for Psychiatry Residents to speak to Med Students at Penn, primarily in the form of teaching a course on practice in the public sector.

Dr. Penny Chapman of the Rural COE based in Erie was next. She took the opportunity to address the chronic and acute nature of the psychiatric shortage as it currently exists in all areas of the commonwealth. This has a higher effect in rural areas, as there are, literally, no specialty practitioners for populations other than Adults, causing the community psychiatrist to practice on all age levels.

She then introduced Nils Magnusson, CRNP in his second year of Fellowship at her center.

Nils Magnusson addressed his recent experience with the Common Ground technology in his clinical setting.

He shared the efficacy of these processes with over 200 Persons in Recovery, all who are members of the CCBH BH Coverage under the Medicaid Program. This allows for the measurement of client satisfaction as well. There is hope to expand this to folks in care with other than CCBH support for their services. He shared that he is often the only treating practitioner at his site and is thankful that he is able to provide those

services to his Consumer population who is so very needy. He has been certified as a CRNP to treat folks in the family medicine setting.
He was then asked to share the Common Ground practice and the tools that are involved in his current clinical setting. He noted that this is an Evidence-Based Practice (EBP) involving software and then including Shared Decision-Making, Personal Medicine of key, strength statements and power statements which can expedite the clinical interviews for the Person in Recovery and the Clinician involved. There is also a technical component that allows the Person in Recovery to log in from home to check into his plan and get reminders of that plan.

There was a question about an involvement with an older Psychiatrist on the concept of shared decision-making. He noted that there are times when agreement cannot be reached with the Person in Recovery and there is a decision made that non-agreement cannot be attained.

Nils shared that he is interested in taking further course work that will gain accreditation for him as a Psychiatric CRNP in practice.

Next was a presentation by a Fellow from the Pittsburgh-Based COE, introduced by Dr. Loren Roth, of that University of Pittsburgh. Dr. Roth thanked the attendees. He noted his disappointment that the Fellows from his setting were unable to attend this AM's meeting. He then noted that there is a "former Fellow" in attendance who will make a brief statement of her Fellowship experience, having graduated about three months ago. Dr. Roth also noted that he has a history of having been the Chief Medical Officer for the UPMC System and noted that reality as a highlighting of the commitment of that system to the intricate and essential involvement of psychiatry and BH services in the overall and effective care delivery of medical services.

Dr. Roth referred to the recent presentation by Nils Magnusson, CRNP, noting the he truly represents the future of care and his orientation toward Team Decision-Making in his clinical pursuits. Dr. Roth noted he was "taught" in his early practice by the Social Workers who were present and involved in the care of folks for who he was responsible. He also referred to the issue of "micro-aggression" as they relate to racism in the early 1970's and the ways in which these issues play into the reality.

Dr. Julia Macedo, former Pitt Fellow, noted her engagement in the Fellowship program and the fact that she is now a full-time psychiatrist at a Federally Qualified Health Center(FQHC), finding her experiences from the COE to have been invaluable in that setting. She also noted that, in her discussions with the current fellows there is a great deal of participation and interest in providing services in the integrated setting.

Innovation in Service Delivery was the next Agenda topic with three presenters set to share perspectives.

Dave Dinich introduced the DHS Deputy Secretary for the Office of Medical Assistance Programs (OMAP), Sally Kozak, noting her significant commitment toward addressing the issues of Social Determinants of Health through OMAP

Sally Kozak, Deputy Secretary, Office of Medical Assistance Programs **–** Deputy Secretary Kozak noted that she has a chronic medical problem which involves her having to navigate the medical care system without having to deal with issues of food insecurity and other problems that faces individuals who are recipients in in services funded by her office. Thus, her goal is move the system of services provided and funded by OMAP to focus on outcomes and how they address Social determinants of health through value-based purchasing.

She noted that, several months ago, there was a roundtable convened among the Physical Health MCO's that led to a decision by the DHS Secretary to tour innovative program sites funded by the MCO's to learn of innovations that are in place throughout those MCO's. These included the Fresh Produce Pharmacy, the Manna Program of food delivery to homes in the Southeast, over a six to twelve-week period for diabetics AND their families living in the community. There is food bank support through the Salvation Army in Pittsburgh which offered food to fill a backpack to take home for their entire family over the weekend. In addition, there was a salad bar added to the cafeteria of the homeless shelter to allow for more nutritious eating by those participants. In addition, there are health care clinics that have been developed in certain areas. Another involves recognition of home environs and the effects they have on the individuals who have allergies and how to help address these types of issues. Food and housing in security are the primary foci of these programs.

There is some expansion to coordinate with smaller community groups and how they follow children born to individuals with food or housing insecurity. This is for a significant time beyond that which is provided for the post-natal period.

There is an effort mounted toward helping folks get SNAP benefits, even if they are of lower levels of value, as even $15.00 per month could goa long was in helping in these areas.

There are some efforts to bundle payments together to help with VBP in her contractors.

The Trauma Informed Dental Room initiative was one of the first questions. Ms. Kozak noted that these involve a larger room to allow the dental folks to work from sides and have the impression of a larger space with waterfalls, etc. This is expected to have a much more significant impact on the traumatized individual who needs dental care but could not access it due to the fears harbored deeply in their psyche's.

It was suggested that psychiatric patients whose medications can negatively impact their metabolic processes and that these folks need to be focused upon to help them deal with those physical maladies. Ms. Kozak noted that there is potential for a joint program improvement project to involve the person with psychiatric illnesses in the food and medical support services.

As to Transportation, there is a plan to find better ways to address the issues of MATP over the next near for implementation in 2020. As to Tele-Mental Health, there is a plan in the OMHSAS directed toward those issues.

There was commenter who noted that there are descriptors that are part of recognized Social Determinants of Health that are "Basic needs" as they are addressed in the clinical setting. He referred to the city of Glasgow, Scotland and its efforts toward addressing issues of poverty and services delivered in the community to help the person in need to address some issues that will allow them to participate in educational and care settings that are necessary. There was a question about whether there are open ears on the PA Legislature to address issues beyond the restoration of Cash Assistance to those in the community. Ms. Kozak noted that there

might be ways in which MA funding can be directed toward addressing the issues of community, social needs through the effective application of MA funding.

There was a question about providing incentives to participants that could be interpreted as “kickbacks” and if there is recognition that these are NOT being provided for nefarious purposes, rather to encourage participation. “Is that potential being addressed to prevent further problems”, was asked. Ms. Kozak noted that she is not aware of the raising of this issue from the federal nor state levels at this time.

There was a question about counties being involved in the processes of addressing Social Determinants through the OMHSAS in collaboration with OMAP. Ms. Kozak noted that this is an ongoing plan.

There was a comment on the recent development of the Coalition for the CommonHealth and could the Deputy Secretary view that as a resource of knowledge and movement toward greater collaboration. Ms. Kozak noted that there is recognition for that effort and will involve mu
There was a question on the “Rapid Cycle Community Focused Quality Improvement Plan” is being implemented in the MCO Plans. Deputy Secretary Kozak noted her history in Quality Improvement and the context of the Technology sector in six or twelve week “sprints” question. There is a goal to improve these processes to six to twelve-week intervals which does not include awaiting the eighteen-month delays that come with using and assessing claims data.

Next was Dr. Chris Tjoa to address the group from his perspective as Medical Officer with Community Behavioral Health in the City of Philadelphia. He also noted that he is a graduate of the Penn Fellowship and continues to have an active practice at a local medical process for individuals who have Sx which are not able to be medically explained.
He is also involved in an integrated care project with the City as well. This became secondary in the face of the Opioid Epidemic and the pressing needs for care and inventiveness in attempting to address that issue at this time. He noted that we lose more people every year to opioid overdoses on an annuals basis that we lost in the Vietnam War.

He shared his concerns about the current system that treats individuals in the community with Narcan who are given a card to follow up on a referral

to further care. This is not an effective means to address these problems. He noted that there is more needed to address these problems, but that the PA Department of Human Services is working effectively through its offices to attempt to do so. He also referred to a recent learning experience that he had which addressed the issue of fee for service reimbursement and innovations around waste—services that are actively offered and provided but seems to have no positive effects on the delivery of effective services. One issue was that of documentation and the time it takes, all lost to service delivery.

He then addressed BH service delivery in the FQHC's in Philadelphia. This commenced about ten years ago and involved the addition of BH services to the FQHC in Phila. The Health Center Federation of Philadelphia was very instrumental in the addition of this practice through its leader, Natalie Lefkovich. There is a licensed behavioral health consultant in the FQHC who delivers brief interventions to address Behavioral Determinants of Health in the Clinic setting. These include smoking cessation and others that can be addressed and treated in two or three sessions at the FQHC in that setting. There are now over 42 treatment settings which participate with over 16,000 individuals. The Integrated Practice Assessment Tool (IPAT) is used by CMS to assess the given organization which was administered in these clinic settings. The average score on these is between 4.5 and 6, indicating a high level of co-located services with some verging on integrated care. This was used for the purposes of working with FQHC Administrators to help them move on toward the achievement of scores 6, indicating genuine integration.

The next area of interest for the CBH in Philadelphia is to gain further information and insight into the collaborative care setting and how they might be achieved to further care in those areas.

There was a question about the potential of CMS support for reduction of documentation time to help free up the clinician to work more effectively and provide more care with less waste. One participant noted that there was a recent issuance of direction/guidance as to what is essential in the documenting of services provided to meet the necessary but not overly burdensome levels that seem to be promulgated by the funding agency or Physical Health MCO. There was a comment offered on the need to develop innovative collaboration methods to overflow into the areas of documentation and to do so across the Commonwealth.

There was a question about any previous efforts mounted by the PPLC to address this issue on a state-wide basis. While there have been none of recent recall, it was agreed that there needs to be, even if it only addressed the salient issues that need to be included in the record across all of the EHR products.

Ken Thompson, Medical Director, PPLC—**How Psychiatric Services are brought to one FQHC setting in Pittsburgh.** He began by comparing these efforts toward integrated care as being very different and innovative in addressing issues in this area. He also compared this to the proliferation of flu vaccines to be administered to a greater portion of society, not just the elderly, very young, or healthcare workers. However, over the recent years, it has been noted that the flu has resulted in the deaths of over 85K people in our nation. Obviously, proliferation has been a reasonable approach to take. He then asked about what type of services actually have the capacities to contact a significant majority of folks in our communities. He noted that this framework is health and primary health services. He noted that this is the 50th anniversary of the "Alma Aa" as a declaration that the state of complete physical, mental, and social well-being is not the absence of disease or infirmity. Thus, Primary health care is the capacity to address the whole person health needs of a given community leading to whole person care.

Dr. Thompson then related this directly to the FQHC in which he works, the Squirrel Hill Health Center. He shared that there are two health systems which serve the area and that there are still great strides to make to help the regions in which it is located to be more collaborative in establishing and providing whole person health care. Currently that Health Center serves about 10,000 active patients in its surrounding area. Well over half are not fluent in English, having re-located to the US in the Pittsburgh area over the past decades. He also shared that many folks enter the practice, due to the fact that there three to four month waiting periods for seeing a psychiatrist in other community settings. There are also pediatricians and OB/GYN practitioners in this clinic setting as well.

He also shared that there are folks entering the clinic who are in a high need state for psychiatric services, not the "worried well" as seen in some private settings. The immediate access to Therapies and Peer Supports are also part or the operational model. There is a requirement to see a primary care medical professional first and then referred to the psychiatric

providers or therapist to help address their issues. There are weekly case meetings, but there are many instances of discussion on an ongoing basis as well as assisting staff at the front desk and phone reception areas to help them is working through the issues that can be brought to the clinic by the Psychiatric and SU patients. He shared that hit is inevitable that there will be something learned about a patient by a clinician that was not known before.

There is also a recent addition of Medication Assisted Treatment (MAT) with the recent hiring of a full-time psychiatrist. Dr. Thompson refers to the practices as being beyond integrated toward the offering of fused services across those lines.

There was a question about the offering of services to individuals whose cultural histories are disparate from ours. The first answer was that there must be a number of questions offered and the answers need to be fully understood. The next is the recognition and response of those cultures' practices and beliefs that can affect treatment.

There was a question about funding of these services. Dr. Thompson shared the basics of a PPS rate funding of services provided for each visit and the writing into the rate setting of those costs.

There was a question about the need for the FQHC's to gather and perform advocacy for this model of care and why this has not happened. It was noted that Hamilton Health in Harrisburg has had a very positive impression and effect on the local, Commonwealth legislators' impressions on the operations of the FQHC's.

Dave shared some critical announcements before the beginning of lunch and the end of this meeting.
He noted that Dr. Thompson is a true expert on international practices involving getting psychiatry involved in the provision of whole person healthcare.

Kathleen Cantwell also noted that the PPLC's Family Inclusion Competencies for Psychiatrists has been posted to the PARecovery.ORG website, the fruition of a ten year effort. This effort was an extensive one over time and involved the high level of input from several parties including: Phyllis Solomon, Ellen Berman, Edie Manion, Dave Dinich, and Ms.

Cantwell. In addition, support form OMHSAS was greatly appreciated including that from Crystal Karenchak and Sherry Peters as well as Deputy Secretary Lynn Kovich.

Chris Minnich of CCBH noted that there is a small group working toward how to engage the spiritual and religious aspect of a persons' overall health and invited others interested to add their input.

Deb Shoemaker shared the background on the development of the Coalition for the CommonHealth in the context of the initial effort to integrate the four Departments of Health, Aging, Human Services and Drug and Alcohol Programs. There was a question about the capacity to address the issues related to documentation in the Regulatory Task Force of the Coalition. It was suggested that this goes beyond the capacities and breadth of that group.

The next PPLC Meeting will be held in in the late winter 2018 or early spring of 2019. There will be notices sent to membership as those plans evolve.

Respectfully submitted,

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