

THE Physicians Report

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THE BEHAVIORAL- HEALTH CRISIS INTEGRATION WITH PRIMARY CARE

WHOLE-PERSON CARE, DRAWING ON THE WHOLE TEAM

As we mature in our efforts to improve healthcare in America, one of the lessons we have learned is that we need to focus more on people and less on diseases. Our patients want and need us to be present with them in ways that make for meaningful, therapeutic connections. We have also learned that we cannot do this alone. We must coordinate our efforts and strengthen relationships with our staff and other colleagues.

All of us need to be on board—physicians, RNs, MAs, and behavioralists—for this to work well.

One way we have achieved this at Confluence Health is through the integration of behavioral-health professionals within our practices. We started with a focus on primary care. Some studies show that up to 70 percent of patients seen in primary care bring some issue related to behavioral health to their visit.

Each behavioralist (primarily a psychologist) is assigned to a team of four to eight physicians and advanced practice providers, and is asked to keep their schedule mostly open for same-day appointments. There is regular dialogue with the teams on “how to use each other best.” Patients with a behavioral-health need are then invited to see our behavioral-health colleague in real time.

So far, the results have been very positive. Patients and care teams feel better supported. We are doing depression screening with reflex-suicide prevention screening for nearly every patient seen; we are also able to act quickly on those cases with positive screening tests. Most importantly, instead of ignoring these challenging conversations due to a lack of time or expertise, or referring patients to a specialty department elsewhere, we have been able through this process to enhance relationships with our patients and clearly improve the quality of our care.

We continue to learn from this model and are expanding to other specialties. We think this is a good example of “whole-person care, drawing on the whole team.”



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Behavioral Healthcare And Primary Care

The Evolution and Benefits of Bi-directional Integration

By David M. Johnson, EdD, LMHC

AN EARLY HISTORY OF DIVERGENT PATHS

In 1963, President John F. Kennedy signed into law the Community Mental Health Act. The hope was that in every community there would be a mental-health center that would have something to offer for every mental-health need people might have. These included treatment for major illnesses, like schizophrenia and major depression, and help for people who were exploring a career change or adjusting to divorce. Quickly the “mental-health system” defaulted to

a “mental-illness system.” Without adequate funding, we were not able to deliver on the promise of mental-health care for people with diverse needs.

Bold and hopeful ideas, such as downsizing state psychiatric hospitals and providing better opportunities for people with mental illness to live in the community, were poorly delivered. State hospitals were downsized, but nothing adequate was set up in the community to serve them. Former hospital patients found themselves homeless or living in substandard housing, abandoned

without competent outreach and engagement services, isolated and eventually deteriorating back into being highly psychotic, anxious, or depressed, and liable to harm themselves or others. The result was increased use of emergency departments, local hospitals, and eventually state psychiatric hospitals for long-term care. Infantilizing day-treatment programs were created as alternatives to hospitalization, but they achieved only containment without real progress toward recovery.



Two separate healthcare systems were launched: one for the brain and one for the rest of the body. The funding models for each were remarkably different.

CHALLENGES WITH DEEP ROOTS

In the 65 years since that time, research has made a significant difference in our ability to treat mental illness and substance-use disorders. However, in the time it took for science-based practices to develop, there were many years when behavioral health couldn't reliably deliver effective treatment. We have since developed an increasing number of evidence-based best practices, which, when followed carefully, have resulted in reliable outcomes providing hope to those with serious mental illnesses.

In those early days another split developed, based on ignorant beliefs about the intersection of mental illness and addiction. The addictions-service-provider community (often staffed by people in recovery from addiction, with lived experience rather than graduate degrees) were disdainful of mental-health providers who relied in part on prescription psychoactive drugs rather than demanding abstinence from all psychoactives, including alcohol and street drugs. On the other side were mental-health professionals with a

variety of psychotherapy theories and assumptions. These included psychoanalytic principles, behavioral conditioning techniques, systems theory applied through family therapy, and healing via the arts.

Therapies were often selected based on the discipline in which the mental-health therapist was most trained, rather than on what a diagnosis could predict would be most helpful. The results were varied, with some clients getting better and others getting worse. Mental-health therapists often held disdain for "untrained" addiction-service providers, who seemed to them to be ignoring the mental-illness underpinnings of addiction.

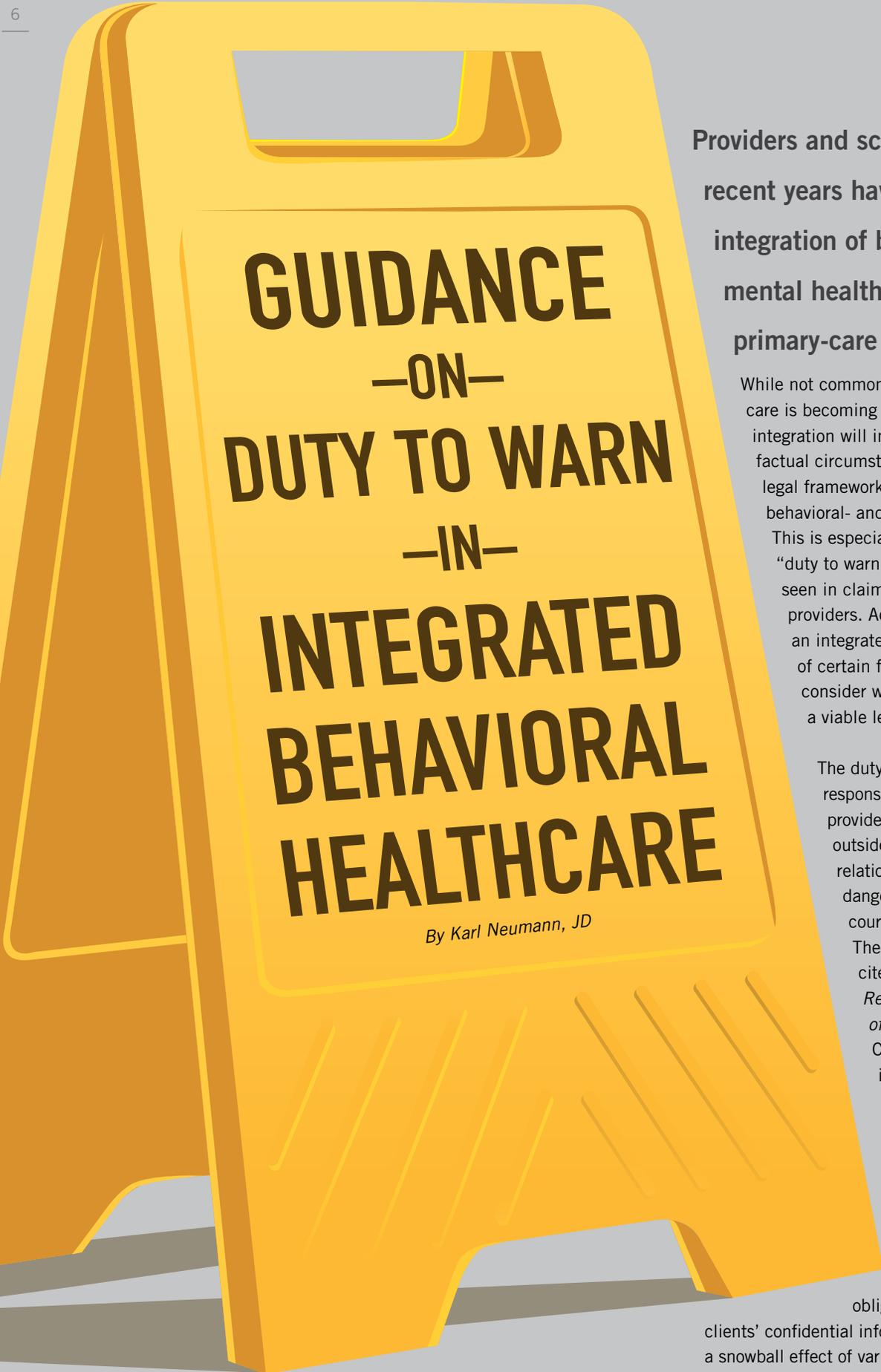
This breach would eventually have to heal before the promises of integration with primary care could become real.

Federally Qualified Health Centers (community health clinics) were funded through a cost-reimbursement system. There was confidence that various local communities would be spending money wisely and delivering state-of-the-art

In 1964, President Johnson signed the Economic Opportunity Act, which included a promise to open Neighborhood Health Centers for underprivileged people. Primary care was increasingly disciplined in treating patients with protocols that research had shown to be effective.

Two separate healthcare systems were launched: one for the brain and one for the rest of the body. The funding models for each were remarkably different.

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GUIDANCE
—ON—
DUTY TO WARN
—IN—
INTEGRATED
BEHAVIORAL
HEALTHCARE

By Karl Neumann, JD

Providers and scholars in recent years have advocated for integration of behavioral and mental healthcare into the primary-care system.

While not commonplace, integrated care is becoming more prevalent. This integration will inevitably present new factual circumstances that our current legal framework has not addressed, for behavioral- and mental-health providers. This is especially true with respect to the “duty to warn,” a legal issue commonly seen in claims against mental-health providers. Accordingly, providers in an integrated setting should be aware of certain factors the courts may consider when deciding whether a viable legal claim exists.

The duty to warn refers to the responsibility of a mental-health provider to notify third parties—outside of the provider-patient relationship—of potential dangers revealed during the course of a patient’s treatment. The duty arose from an often-cited 1976 case, *Tarasoff v. Regents of the University of California*, in which the California Supreme Court imposed a legal duty on psychotherapists to warn third parties of threats made to those parties by psychotherapists’ patients. The case was significant because it cemented an exception to therapists’ ethical obligations to maintain their

clients’ confidential information. That case led to a snowball effect of various states adopting laws regarding a “duty to warn” or “duty to protect.”

THE SCOPE OF THE PROVIDER-PATIENT RELATIONSHIP

One factor courts often grapple with is whether there was a “special relationship” between the provider and patient. Many courts cite the Restatement (Second) of Torts § 315 for the prerequisite that a special relationship must exist before a duty to warn is implicated. In certain jurisdictions, the mental-health provider must have a “definite, established, and continuing relationship” with the patient. In others, the courts emphasize the degree of control the provider had over the patient.

But in an integrated, multi-provider system, does a mental-health provider have a sufficient special relationship to implicate the duty? Considering that integrated care can take many forms, questions will certainly arise as to whether a provider established the requisite relationship. On one end of the spectrum, a specialist in an integrated setting may simply provide recommendations to another provider and not have any direct contact with a patient. On the other end, a specialist may be jointly evaluating the patient and rendering mental-health treatment alongside a primary physician.

With varying approaches to an integrated model, providers will need to be cognizant of their precise role in treating a patient and/or assisting other providers. The scope and nature of their relationship with the patient should be clearly outlined in the records. The particular services being rendered should be documented—e.g., whether the service is a consultation, screening, or actual therapy. While courts are generally reluctant to have bright-line rules, at least one jurisdiction has held under particular facts that an initial assessment for subsequent counseling did not establish a special relationship that triggered a duty. It will also be

important that the provider’s exact role is conveyed to the patient and understood by all persons involved in the patient’s care. Doing so will help remove any doubt as to what the relationship is between the provider and patient and, consequently, whether the relationship is sufficient to trigger a duty to warn.

FORESEEABILITY IN A COLLABORATIVE SETTING

In its most basic form, the duty to warn is called into question when it is asked whether it was reasonably foreseeable that the patient would commit a tort against a third party. The foreseeability factor is often the critical issue in determining whether a mental-health provider had a duty to a third party.

States have adopted various approaches regarding what knowledge is required before a duty will be imposed. Some courts may only impose liability where there is knowledge of a specific threat, as opposed to a vague, generalized one. Some courts require that there be knowledge that a particular person may be harmed, while others only require knowledge that a threat was made against a broader, identifiable class of persons.

The Washington Supreme Court case *Volk v. DeMeerleer*, 187 Wn.2d 241, 386 P.3d 254 (2016) is an instructive example of the foreseeability factor. In this case, a psychiatrist was treating a patient who had previously expressed suicidal and homicidal thoughts during treatment. Approximately three months after last being seen by the psychiatrist, the patient killed two individuals. The Washington Supreme Court held that the psychiatrist owed a duty of care to warn or protect potential victims of the patient. This decision came as a surprise to many in the medical-legal industry, considering that the patient had never specifically named the two individuals killed, or voiced any homicidal thoughts towards them—and

it had been years since the patient’s last documented hostile sentiment. The decision ultimately extended the scope of the duty to all individuals who may be “foreseeably” endangered by a patient, as opposed to just those who are “readily identifiable.” The decision is a reminder of how broadly some jurisdictions interpret foreseeability in relation to persons who may be harmed.

In determining whether a threat was reasonably foreseeable, courts look to a number of different factors, such as whether the provider had knowledge of the patient’s (i) homicidal thoughts, (ii) assaultive behavior, (iii) violent acts towards others, or (iv) non-compliance with medications.

In an integrated setting, providers will need to be aware that this information could come from varying sources. The most obvious source is the patient him- or herself. But the challenge for courts will be when knowledge is conveyed to the broader integrated network. Integrated care will involve more communication among multiple providers. It will involve increased and shared access to electronic health records. Friends and family may also report pertinent information to some providers on a patient’s healthcare team but not others. All of this will inescapably present difficulties in determining what a provider actually knew and if liability should exist. It is easy for someone to state in hindsight that a hazard was foreseeable, but the reality is that assessing potential threats can be incredibly difficult during behavioral- and mental-health treatment.

Therefore, providers should keep in mind the foreseeability factors and how certain information might be construed to impute knowledge of a potential hazard. It will be important for providers to document the nature and scope of what they learned during the course of treatment. If a threat is vague and

CRITICAL COURSEWORK

MENTAL-HEALTH TRAINING FOR PROVIDERS AND STAFF



Medical students training for a career in primary or specialty care expect to help their patients manage their physical health. They may not realize they'll be tasked with behavioral-health concerns, too.

Some medical students may undervalue behavioral-health training or wonder how much they will use mental-health training in practice, notes Dale Sanderson, PA, certified Mental Health First Aid trainer with Sound Health, a comprehensive provider of mental-health and addiction-treatment services in Seattle.

"I'm a graduate of the University of Washington's physician assistant training program, which incorporates a great deal of mental-health coursework

in addition to general-medicine training," he says. "Some students wonder how what they're learning about mental health will apply to primary care."

When new graduates begin practicing, however, their view changes. "They quickly understand that mental-health coursework is one of the most important aspects of their training," Sanderson says. In fact, according to the *Journal of General Internal Medicine*, up to 60 percent of treatment for mental health

occurs in primary care, and primary-care providers prescribe 70 percent of all antidepressants.

"They often end up wishing they had more behavioral-health training, not less," he says.

Rising demand for behavioral-health training and support is not expected to slow anytime soon. Despite increasingly integrated behavioral and physical healthcare, two-thirds of primary-care providers report being unable to access



“For many PCPs, building capacity for behavioral health within primary care is a welcome relief. Instead of being on their own in managing patients with complex chronic mental-health conditions, they have the support of another provider trained in behavioral health, often on-site.”

ANNA RATZLIFF, MD, PH.D.
DIRECTOR OF THE ADVANCING INTEGRATED MENTAL
HEALTH SOLUTIONS (AIMS) CENTER
THE UNIVERSITY OF WASHINGTON

outpatient mental-health services for their patients, often citing health-plan barriers or a shortage of local mental-healthcare providers, per the Patient-Centered Primary Care Collaborative.

Training primary-care providers and other healthcare workers to respond to mental-health conditions helps them thrive in a more integrated healthcare environment and improves outcomes for patients, says Anna Ratzliff, MD, Ph.D., director of the Advancing Integrated Mental Health Solutions (AIMS) Center at the University of Washington. Providers trained to support whole-person health will be better equipped to seek out appropriate interventions and work on integrated care teams with behavioral-health providers, she notes.

Even brief exposure to mental-health training appears to benefit providers and patients. A study published in *Issues in Mental Health Nursing*

found that short online mental-health training increased professional confidence and job satisfaction among LPNs and RNs employed at long-term-care facilities. In the study, most respondents strongly agreed that mental-health training helped them take better care of their residents.

“For many PCPs, building capacity for behavioral health within primary care is a welcome relief,” says Ratzliff. “Instead of being on their own in managing patients with complex chronic mental-health conditions, they have the support of another provider trained in behavioral health, often on-site.”

The benefits of mental-health training for healthcare workers are well supported. But which type of training is right for you, or your organization? With a plethora of training options available, the best fit will depend on the roles that exist within each

organization’s staff, the needs of its patient population, and its degree of behavioral-health integration.

MENTAL-HEALTH FIRST AID TRAINING FOR NON-CLINICAL STAFF

Organizations with large populations of non-clinical staff or employees who routinely interact with the general public may be candidates for Mental Health First Aid training, an evidence-based program offered nationwide through the National Council for Behavioral Health.

Research shows that Mental Health First Aid training appears to increase mental-health literacy and decrease stigma for both clinical and non-clinical staff. A study published in the *Australian and New Zealand Journal of Psychiatry* found that Mental Health First Aid training boosted pharmacy students’ awareness of appropriate pharmaceutical treatments for mental illness.

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It's Time to **Get Serious** About the **Safe Care** of Mental-health Patients

By Monica Cooke, BSN, MA, RNC, CPHQ, CPHRM, DFASHRM

One in five persons is currently suffering a significant mental-health or substance-use disorder that could respond to treatment.¹

There is no physical disease that is so prevalent. Additionally, the World Health Organization has reported that depression is now the leading cause of disability in the world.² Where there is depression, there are suicides—which are already at an all-time high. Studies report that the great majority of those over the age of 65 who commit suicide had seen their provider within the last one to four weeks. These time intervals represented opportunities for intervention that were unfortunately missed.

The healthcare industry remains lax in demanding adequate resources, parity, and clinicians for mental health. The lack of clinicians and treatment settings has essentially left no choice

but for emergency departments, acute-care units, and primary-care practitioners to become the de facto caregivers for patients with mental and chemical-dependency disorders.

The link between mental and physical health is well studied and well known among most in the healthcare field, and healthcare providers have a responsibility to understand that a large number of their patients are suffering from mental-health issues. Wonder why your 350-pound, 45-year-old male patient with diabetes, high blood pressure, high cholesterol, and skeletal issues can't seem to follow a treatment plan? Or why the patient who presents very routinely reports that their chest is heavy and it feels as if their heart is beating out of their body—though you can find no

“Hospitals and providers that positively address mental-healthcare needs will contribute to the more effective and efficient use of healthcare resources and will produce positive outcomes for patients and communities.”

AHA, 2010

cause? Don't think about it too hard... there's more to this person than just their body. A person who is so depressed that they cannot get out of bed each morning is certainly not going to be able to be compliant with medical treatment protocols or regimens—and in many similar cases, it is truly the patient's head that is in control of their health.

Such patients are poster children for integrative care. Integrative care is practiced in very few healthcare settings, yet there is evidence from multiple published studies conducted by the American Hospital Association (AHA) that show that providing care that integrates both the physical and mental health of patients significantly reduces emergency-department visits, healthcare-provider visits, healthcare costs, and disability. According to the AHA, “Hospitals and providers that positively address mental-healthcare needs will contribute to the more effective and efficient use of healthcare resources and will produce positive outcomes for patients and communities.” (2010)

Now, there is more to the story than just mental-health and substance-use issues for healthcare providers. Patients with mental and substance-use disorders are not only a risk to themselves; they also present multiple risks to care providers, including professional liability, legal, regulatory, media, and

human-resource risks, and even physical danger. Workplace violence is higher in healthcare settings than in any other industry. This violence can range from simple disrespect or verbal abuse to threats of harm, scratching, punching, and kicking, resulting sometimes in broken bones and even death. Healthcare staff, particularly those in ambulatory-care settings, routinely interact with patients who are abusive or threatening, and much more needs to be done to address this issue: OSHA, the Joint Commission, and many other agencies and professional associations have all made strong statements regarding the industry's need to focus on the wellbeing and safety of its employees. Aggression is not “just part of the job,” and culture shifts are necessary to protect the physical and emotional wellbeing of healthcare workers.

How do healthcare providers help patients with issues such as depression, substance abuse, and aggressive and violent tendencies, which ultimately inhibit them from following their treatment plans or bring about attempts to harm themselves or others? It is certainly a daunting problem. Many non-mental-health providers and caregivers do not believe they have the competency to assess and manage these conditions; some simply “just don't want to work with those patients.” The busy scheduling of patients and extensive documentation in outpatient settings

make it almost impossible for providers to have sufficient time to inquire about their patients' mental status; long gone are the days of Marcus Welby, MD, when providers had the time to sit with their patients and ask the question, “How are you really doing?”

But these patients are not going away. Some speculate that their numbers are going to rise significantly. Providers are in a powerful position to encourage their patients to seek appropriate care, and ultimately help to reduce the stigma attached to mental-health issues. Even patients who don't listen to their loved ones will often listen to their medical provider.

As such, the best answer is for healthcare workers to get better at providing quality care and managing the special risks that these patients can present. There are many interventions and strategies that healthcare providers can use to identify mental-health patients, clinically manage them, and create a culture of safety within the treatment setting. Below are a few first steps toward the safe care of mental-health patients.

STRATEGIES AND INTERVENTIONS FOR THE SAFE MANAGEMENT OF MENTAL-HEALTH AND SUBSTANCE-USE PATIENTS

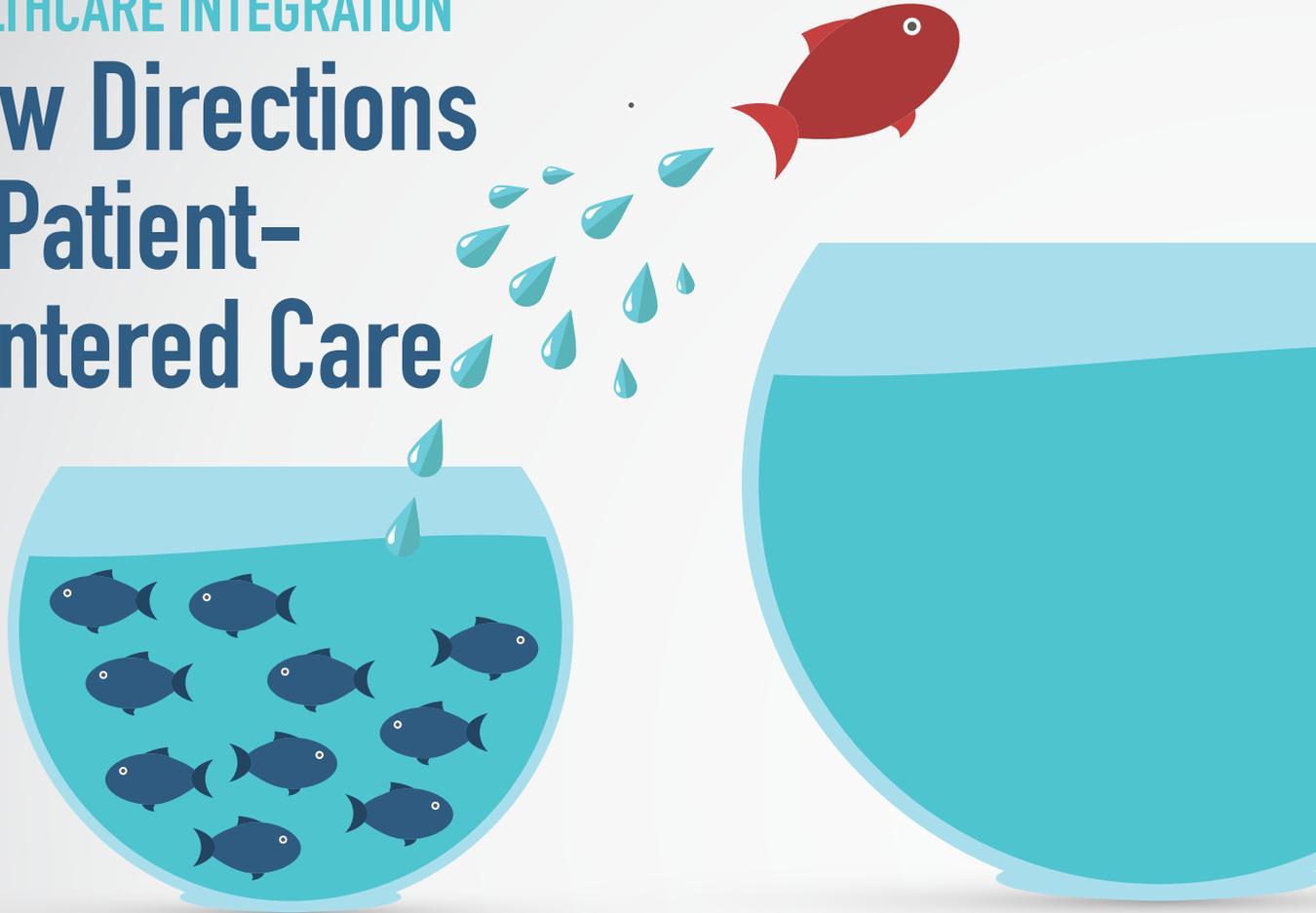
Environmental Strategies

1. Post a welcome sign at the entrance to the building that imparts a culture of safety and gives notice to all who enter of the organization's commitment to a safe environment. The sign could read something like, “Welcome to **X OFFICE/FACILITY**. Our goal is to provide the safest care possible. We expect that all patients, family, visitors, and staff be respectful and non-disruptive while in our treatment setting. Thank you for helping to ensure the safety of everyone.”

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SOUND HEALTH'S BI-DIRECTIONAL HEALTHCARE INTEGRATION

New Directions in Patient- Centered Care



By definition, bi-directional healthcare integration means integrating behavioral-health services into primary-care settings and integrating primary-care services into behavioral-health settings.

In practice, however, behavioral-health integration often flows only one way. Behavioral-health providers frequently integrate into primary-care settings, but fewer primary-care providers join behavioral-health clinics.

Sound Health, a Seattle-based provider of mental-health and addiction-treatment services, is proving that this more elusive form of bi-directional integration—one in which primary-care providers join an existing behavioral-health team with an established patient population—is one

that works. What's more, this model may be uniquely beneficial to patients with complicated health needs.

Members of the Sound Health team agreed to share why they established this care model, how it helps both patients and providers, and what's next. The following Q&A with Dr. Mary Bartels, MD, Sound Health Chief Medical Officer; Katrina Egner, Sound Health Chief Programs Officer; Stephen McLean, Sound Health Chief Marketing and Public Relations Officer; and Ethan

Seracka, Licensed Marriage and Family Therapist (LMFT) and Sound Health Director of Whole Health Integration, helps spotlight the challenges and opportunities involved in bi-directional healthcare integration.

Q: Why does bi-directional healthcare integration tend to flow one way, with behavioral-health providers joining primary-care teams instead of the other way around?



KATRINA EGNER,
SOUND HEALTH
CHIEF PROGRAMS
OFFICER

Katrina Egner: We recently attended a conference on bi-directional integration, and the term assumes that healthcare is integrated both ways. But even at that conference, it was clear that integrating behavioral-health providers into primary care is still very much the favored model. Although there is a lot of support out there for our model, it is much less common. And part of the issue is the difficulty of hiring for primary care because of the shortage of these providers.



ETHAN SERACKA,
LMFT AND SOUND
HEALTH DIRECTOR
OF WHOLE HEALTH
INTEGRATION

Ethan Seracka: I think one of the biggest challenges that we've had is that behavioral health has been underfunded compared to primary care, so behavioral-health services clinics are competing with medical systems with much deeper pockets for primary-care staff.

Katrina Egner: Another challenge is the stigma around the people we serve. There seems to be a bias for medical providers that it would be more appealing to work in a larger health system instead of with the people we serve, who are complicated and dealing with the social determinants of health. It seems like a more challenging role.

Q: Why did Sound Health decide to bring primary-care providers into a behavioral-health setting?

Katrina Egner: The people we serve tend to die 20 years earlier than the

general population. Our clients tend to go without the care they need for several reasons. It's hard to get into primary care, and they're often not welcome, so they don't get served. When the move started happening to integrate behavioral and physical health, there was a lot of interest in putting our clinicians in primary-care settings, but not a lot of interest in bringing primary care to our clients. So Sound Health decided that we would do it ourselves and bring primary care into our clinics.

Ethan Seracka: As whole-health providers, we wanted to make sure to connect with clients' primary-care providers about how their mental health or substance use impacts their health. A year and a half ago, we started looking for a model that would benefit our high-need clients. Our biggest concerns are the people who will be underserved if we integrate behavioral health into primary health and those with serious mental illness and intensive case-management needs who routinely end up back in the emergency department. We hope to target this historically and significantly underserved population.

Q: How does this change impact a patient's experience at Sound Health?

Ethan Seracka: Our optimized goal for integrated care is to provide same-day appointments during which a medical assistant will take vitals, a mental-health professional will talk with the client to assess mental health, substance use, and suicide risk, and a doctor will provide medical care. We would then be able to engage the client in any short-term intervention or supportive services needed, and when we identify a patient who is high-risk or high-need, we can connect them with services the same day.

Q: What were some early challenges in the integration process?



STEPHEN MCLEAN,
SOUND HEALTH
CHIEF MARKETING
AND PUBLIC
RELATIONS OFFICER

Stephen McLean: For behavioral-health providers, there traditionally hasn't been a need for medical equipment used in primary-care settings, so we identified that as a challenge for this type of integration. We have been able to build out space and convert treatment rooms to add tables and other essential medical equipment.

Ethan Seracka: As an organization, we've had to look at scheduling for primary care to maximize doctor availability. We've had to create new workflows to build care pathways for our population, both to provide basic primary-care screenings and to care for patients with more significant primary-care needs along with ongoing behavioral-health needs.



DR. MARY BARTELS,
MD, SOUND HEALTH
CHIEF MEDICAL
OFFICER

Mary Bartels: When care becomes integrated this way, behavioral-health providers wonder if they'll turn into primary-care doctors or lose all their easy-to-treat patients.

Ethan Seracka: We've had to create buy-in from our current clinical staff and providers. In order to make primary care fit, we first must get our staff to activate and get the word out to current clients. The buy-in is part of actively working together as a team of providers.

(Continued on page 17)

STRONGER TOGETHER HOW STRATEGIC PARTNERSHIPS BENEFIT INTEGRATED CARE



INTEGRATION HAS BEEN A BUZZWORD IN HEALTHCARE FOR NEARLY A DECADE, THANKS LARGELY TO THE AFFORDABLE CARE ACT AND ITS FOCUS ON WHOLE-PERSON CARE.

As behavioral and physical healthcare grow increasingly intertwined, research consistently demonstrates that this type of integration benefits patient populations and healthcare organizations alike. Multiple studies show that integrated behavioral and physical care has the potential to improve the patient experience, boost health outcomes, and reduce per-capita costs, particularly for adults with serious mental illness.

But delivering whole-person care that's compassionate and cost-effective requires strategic, creative thinking on the part of healthcare organizations. The many benefits of integration are accompanied by steep challenges as organizations

organizations. That will absolutely need to continue for us to manage our population's health and meet the quadruple aim of healthcare: patient experience, provider experience, improved quality, and decreased cost."

PARTNERS IN HEALTH

Healthcare partnerships often fuse organizations with differing strengths, skill-sets, or geographic footprints, creating an entity greater than the sum of its parts. But partnerships between organizations with similar strengths in the same market can expand access to care, even across multiple markets and specialties.

"As we close in on 2020, we're seeing lots of partnerships developing between community health organizations and behavioral-health organizations. That will absolutely need to continue for us to manage our population's health and meet the quadruple aim of healthcare: patient experience, provider experience, improved quality, and decreased cost."

REBECCA PARRISH, INTEGRATED MENTAL-HEALTH SPECIALIST
AND SOCIAL-WORK MANAGER, KAISER PERMANENTE

build new care pathways, enter new markets, and embrace emerging technologies. Shifting to a new care model while treating patients with complex healthcare needs in a dynamic, competitive marketplace is a balancing act, notes Rebecca Parrish, integrated mental-health specialist and social-work manager with Kaiser Permanente. In this environment, carefully planned partnerships can allow organizations to leverage strengths, serve new communities, and improve access to care.

Integrated mental health is the future of healthcare, says Parrish. "Changes related to Mental Health Parity laws and the Affordable Care Act are supporting healthcare's shift to an integrated model of care," she says. "As we close in on 2020, we're seeing lots of partnerships developing between community health organizations and behavioral-health

One such pairing is the Partnership Access Line (PAL), a partnership between Seattle Children's Hospital and the Seattle-based University of Washington. The PAL provides call-in mental-healthcare support for primary-care providers with questions about mental health-related medication or other issues for patients in their care. The phone consultation is free and covered by HIPAA; no release of patient information is required.

Seattle Children's Hospital psychiatrist Robert Hilt, MD, created the PAL after observing the success of the Massachusetts Child Psychiatry Access Program (MCPAP) during his psychiatry training. "I was participating in a psychiatry training program in Massachusetts at the time MCPAP was formed, and got to observe its creation," he says. "When I moved here and joined the university in 2006, I saw that Washington needed a service

“Providers tell us they are seeing mental-health problems in their patients with increasing frequency, but we see in our consults that the providers are also growing more sophisticated in their approach to mental health over time.”

ROBERT HILT, MD
SEATTLE CHILDREN'S HOSPITAL



like this even more than Massachusetts did. The primary-care providers here were struggling.”

The PAL was established in 2008 as a pilot program and went statewide by the end of that year. Funded in Washington by the state legislature through the Washington State Healthcare Authority, the PAL also serves Wyoming, through a partnership with the Wyoming Medicaid Division (since 2011), and Alaska, through a partnership with the Alaska Department of Health (since 2019).

Providers in those states can call the line Monday through Friday, 8 a.m. to 5 p.m. (Pacific Time) to speak with a Seattle Children's Hospital child psychiatrist, most of whom are also

University of Washington faculty. The program currently supports around 2,000 consults per year, says Hilt.

The robust call volume demonstrates an acute, growing need for pediatric behavioral-health services; despite increased behavioral-health integration nationwide, many pediatricians still lack on-site mental-health support. “Mental-healthcare integration is not nearly as advanced for pediatric practices as it has been for adult practices,” notes Hilt. “Providers tell us they are seeing mental-health problems in their patients with increasing frequency, but we see in our consults that the providers are also growing more sophisticated in their approach to mental health over time.”

Rallying support for the partnership is focused on advocacy and working with legislative leaders, health advocates, and health-system lobbyists. “I’ve been pleasantly surprised at the degree of support we’ve received from the community and from the state,” says Hilt. “Another thing that has been remarkable for us as consultants is just how appreciative providers are for this service. The providers give us very positive feedback.”

JOINING FORCES

When California-based Kaiser Permanente acquired Group Health Cooperative in 2017, more than 650,000 Group Health members in Washington State joined more than 11 million Kaiser Permanente members

in eight states and the District of Columbia. The acquisition created Kaiser Permanente's newest region, extending its unique model of coordinated care and coverage into Washington.

The acquisition allowed Kaiser Permanente to expand the behavioral-health integration work it started several years earlier, says Parrish. "In 2015 we brought together a group of frontline staff members and really started the conversation about how we were going to integrate behavioral health," she says.

Group Health's collaborative approach to behavioral healthcare dovetailed with Kaiser Permanente's integration efforts, enhancing rather than impeding the ongoing work. "We developed a process for population-based mental-health screening for our adult patients, and then spent the following years spreading that throughout the entire organization with the exception of two small clinics," says Parrish.

Expanding integration efforts across such a large geographical footprint required strong local connections in each market. "As we spread this work, we built local implementation teams to champion the integrated work in each of our clinics, and they were the ones who owned it," she says. "We gave them the monthly data and they shared that with their teams. Performance feedback is really important for the sustainment of this work."

Kaiser's model of integrated, team-based care begins when a patient checks in, says Parrish. Patients receive a screening about mental health and substance use at the front desk; if scores are concerning, they'll receive an additional assessment from a medical assistant before they see their provider. Based on a patient's assessment, providers can do brief intervention

work, engage an embedded licensed mental-health consultant, or schedule time with a social worker if needed.

Ensuring a strong match between the goals and values of merging entities can help organizations overcome the inevitable challenges that arise, Parrish says. "Our goal is that every patient who comes in for primary care will be screened for mental health and substance use," she notes. "Our providers were initially hesitant when we started this universal screening—they asked, 'Why open Pandora's Box when we already have so much to do?' But providers have grown to embrace this work, now saying they would not go back to their old way of doing things if given the option. They feel this is really a model that fits in well with our preventative approach to wellness." 

The toll-free Patient Access Line (PAL) connects providers in Alaska, Washington, and Wyoming to child psychiatrists at Seattle Children's Hospital, weekdays, 8 a.m. to 5 p.m. Pacific Time.

Alaska: 855-599-7257

Washington: 866-599-7257

Wyoming: 877-501-7257



Rebecca Parrish,
integrated mental-
health and social
work manager, Kaiser
Permanente



Robert Hilt, MD,
Seattle Children's
Hospital psychiatrist

"When care is collaborative, we avoid duplication of care.

Everyone works together, and if you have a client who is complicated, you can consult with the other provider about what's happening. I really see it as a win-win for our staff and the clients we serve."

DR. MARY BARTELS, MD, SOUND HEALTH CHIEF MEDICAL OFFICER

(New Directions in Patient-centered Care, continued from page 13)

No one person is responsible for a client, but everyone is responsible for all aspects of the care plan.

Q: How does this model benefit patients and providers?

Mary Bartels: I think the benefits of this type of integration really outweigh any type of hesitation that anybody has. I know the staff I work with are really looking forward to having more primary-care providers on site.

Ethan Seracka: We're hoping to make a more rewarding work environment for all the providers and reduce a lot of the frustrations that they have about not being able to get their clients served.

Mary Bartels: When care is collaborative, we avoid duplication of care. Everyone works together, and if you have a client who is complicated, you can consult with the other provider about what's happening. I really see it as a win-win for our staff and the clients we serve. 

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Mandating Coverage and Integration to Remove Barriers to Behavioral Health



For far too long, mental healthcare and treatment for substance abuse weren't viewed as essential health benefits.

Regarding coverage of behavioral health as optional contributed to misconceptions about disorders and further fueled stigmas about mental health, preventing patients from seeking help for both financial and social reasons.

Recent mandates for coverage of behavioral health, and the manner in which these services are reimbursed, are starting to change that, albeit slowly—leading the way to the integration of behavioral health into primary care.

A NEW PATH

The Mental Health Parity and Addiction Equity Act of 2008 required group health plans and insurers that offered mental-health and substance-abuse benefits to provide coverage comparable to that of general medical and surgical care.

By 2013, almost all large group plans included coverage for some mental-health and substance-abuse services, and the U.S. Department of Health and Human Services estimated that about 95 percent of those with small group market coverage had substance-abuse and mental-health benefits, but the federal parity law did not apply to small group plans. In many states, state parity laws offered those covered in this market some parity protection, but usually less than the federal parity requirement.

About one-third of those covered in the individual market had no coverage for substance-abuse services, and nearly 20 percent had no coverage for mental-health services. Even when individual market plans provided these benefits, the federal parity law did not apply to these plans.

In addition, at that time, 47.5 million Americans lacked health-insurance coverage altogether, and up to 25 percent of uninsured adults were estimated to have a mental-health condition or substance-use disorder, or both.

Enter the Affordable Care Act of 2014, one of the largest expansions of mental-health and substance-abuse coverage in a generation. Beginning in 2014, under the law, all new small group and individual market plans were required to cover 10 “Essential Health Benefit” categories, including mental-health and substance-abuse services, and were required to cover them at parity with medical and surgical benefits.

PAVING THE WAY

In 2017, the Centers for Medicare and Medicaid Services adopted a new coverage policy that is now catalyzing the integration of behavioral health into primary care. It began paying primary-care providers for what it’s calling “Collaborative Care” services that they provide to patients who are being treated for behavioral-health conditions. “Collaborative Care” includes medication as needed, the service of a behavioral healthcare manager, and consultations with mental-health specialists.

This new payment policy for behavioral-health integration immediately impacted primary-care providers who were already offering behavioral healthcare to their patients—and it’s having the tremendous effect of increasing the number of primary-care providers who decide to do so, thereby improving access to care for patients across the country.

It will also likely have the effect of encouraging private insurance companies to offer similar payment options for integrating behavioral healthcare with primary care, since those care models are beginning to become more pervasive and are proving to deliver more effective healthcare.

A STATE DIRECTION

A new law in Washington State, signed by the governor in March 2018, is a major step in transforming behavioral

healthcare in that state. It could also serve as a model for others, as it greatly improves access to behavioral health programs by integrating them into other healthcare services by 2020.

Before care was integrated in Washington, Medicaid patients with physical, mental, and substance-use disorders had to navigate multiple systems in order to access the physical and behavioral

physical and behavioral health needs will be addressed in one system through an integrated network of providers, offering better coordinated care for patients and more seamless access to the services they need.” This will bring together the payment and delivery of physical- and behavioral-health services for people enrolled in Medicaid, through managed care.

POTENTIAL PITFALLS

Laura Van Tosh is a leader and activist in mental-health peer (or consumer-run) services in Washington. Van Tosh has worked in advocacy and policy development, and has helped develop mental-health peer services in the past. She founded Peer Legislative Advocates of Washington State to engage the patient population in public policy in Washington and locally was the consumer-affairs director for Western State Hospital in Washington, as well as the adult-services coordinator for the Oregon Health Authority Addictions and Mental Health Division of the Department of Health Services for the state of Oregon. She also provided consultation services on many state and national healthcare policy committees, boards, and task forces. She sees integration as a positive development in many ways, but has reservations about the reimbursement model.

“We have to ask why this is ultimately being done,” she says. “Part of the reason is to save money. That’s the bottom line in Washington and nationally.” She has concerns that if the goal becomes more about efficiencies and saving money, patients may not reap the intended benefits. She cautions organizations to keep the goal of patient care at the forefront, and to avoid getting caught up in the expected savings from this model of care. “People who need behavioral healthcare are worth the money being spent,” she says.



“People who
need behavioral
healthcare are
worth the money
being spent.”

LAURA VAN TOSH, LEADER AND ACTIVIST
IN MENTAL-HEALTH PEER SERVICES

healthcare they needed. These delivery systems often didn’t communicate or coordinate with one another, which led to lower health outcomes for the state’s Medicaid population.

But Washington is now changing how it pays for the delivery of physical- and mental-health services and substance-use-disorder services in the Medicaid program. According to the Washington State Health Care Authority: “Through this whole-person approach to care,



Some mental healthcare policy experts agree with Van Tosh's concern that we could end up spending less on behavioral health than we do now. These experts are concerned that once behavioral-health funding is combined with physical-health funding for an overall capitation rate throughout Washington, it will be much harder, or potentially impossible, to determine what the total Medicaid spend is for behavioral-health services. Nonetheless, some are hopeful that the requirement for a report from the Washington State Health Care Authority to the legislature on how the behavioral-health Medicaid enhancements will be distributed by the managed-care organizations will be a first step toward future oversight by the state on how behavioral-health funding fits into the overall payment received by the managed-care organizations to cover each Medicaid client.

Van Tosh anticipates other challenges to integration. "There needs to be provider education and training, or patients will fall through the cracks and crises will occur," she says. Primary-care providers are already time-strapped, even without being tasked with identifying behavioral-health issues; Van Tosh believes primary-care providers could benefit from guidance and best practices on working closely with mental-health patients. (See the related article, "Critical Coursework," on page 8.)

Additionally, there may be cultural differences to address between behavioral-health and primary-care professionals. "There's been

a comfort level in keeping these silos separate in the past," Van Tosh says, emphasizing that there may be a learning curve as these two disciplines begin to work together.

SIDESTEPPING STIGMAS

Reimbursement is at the heart of what kept behavioral health and primary care separate to begin with. The health system has traditionally reimbursed behavioral-health services separately and at a lower rate, which perpetuated the notion that mind and body should be treated separately in a medical sense, too.

"The whole mind-body understanding is the source of the disconnect," Van Tosh says. "For some reason, people think they're two separate things. Maybe it's because you can't see psychosis, like you can a broken arm, and treatment for behavioral healthcare affects everyone differently, unlike a simple cast for a broken arm."

Aside from growing scientific evidence that physical and mental health are interrelated and should be treated in conjunction with one another, integration has also been shown to help patients seek comprehensive care in a practical sense.

One reason integration is so successful is that primary-care offices are a great place to address behavioral health, since patients are comfortable receiving those services there. This may involve receiving care on-site, in real time; or, for more complex cases, making referrals to providers who are known partners within the extended

team. This practice is in contrast to the usual reliance on referrals to unaffiliated behavioral-health providers, which can lead to poor follow-up and communication and coordination breakdowns; it can also be disruptive and difficult for patients to get to a secondary appointment and location.

Then there's the stigma associated with seeing a behavioral-health specialist at a separate location that specializes in that treatment—a factor that's eliminated when it's integrated into the primary-care clinic. The familiarity of the context normalizes these services by offering them alongside other primary-care services that carry no stigma. In smaller rural areas, where communities are tight-knit, this can be a game-changer, as patients receiving treatment in an integrated-care setting may not have to worry as much about privacy.

Even with all the progress toward integration, only about one in eight Americans who need substance-use treatment gets it, and less than half of Americans who need mental-health treatment get it, according to the Substance Abuse and Mental Health Services Administration. Clearly, much more action is needed. Still, these developments have pushed coverage for behavioral health in from the periphery—making the integration of behavioral health with primary care possible, and thereby starting to eliminate obstacles to efficient treatment, coordination of care, and management of resources. [PR](#)

COMMUNITY
AS CATALYST

PI's New CEO Reinforces the Value of the Member Community



Acclaimed Harvard professor, business strategist, and author Michael Porter noted that businesses need to maintain continuity of strategy, but must also be good at continuously improving. Certainly, both of these elements are required as the spectrum of care teams, practices, hospitals, and payors all work to adjust to the tectonic shifts taking place in healthcare today. One major part of these shifts involves leadership changes.

Succeeding Mary-Lou Misrahy, who served as president and CEO of Physicians Insurance A Mutual Company (PI) for more than 15 years, William (Bill) Cotter was named president and CEO of the company and its affiliates, beginning work in early August 2019. Bill came to PI from Allied World Assurance Company, where he's spent the last 11 years, most recently serving as executive vice president and chief underwriting officer, Professional Liability—North America. While at Allied, Bill also had prior oversight for the development and management of Allied World's insurance operations in Hong Kong, Malaysia,

Singapore, and Australia, in his role as executive vice president of the Asia-Pacific region, which he held for more than seven years.

"One of the most powerful lessons I learned from my father while growing up had to do with the power of the community," Bill notes. "In business, it's called collaboration. In the clinical setting, it's often referred to as team medicine. Regardless of its label, the notion of people coming together to blend their strengths, talents, knowledge, backgrounds, and passions into a common and focused goal has proven itself over and over again."

Soon after his first day, Bill began a focused journey to visit with and listen to members and constituents, and to hear their stories about how the company's strategy is working for them. He heard from them how the company's strategy is making the delivery of care safer, and how it protects and supports them when something doesn't go as planned—and he heard their opinions on the

challenges they face today, and what the future may hold.

The board at PI understood the need for continuity of the company's current strategic plan and the positive momentum it has created. "Bill understands and supports this approach," says Dr. David Carlson, Chair of the Board of Directors. "At the same time, the arrival of a new CEO is a big change for any company. For now, it's business as usual—continuing to execute on the strategies we have in place. We still have goals to meet, initiatives to achieve, and projects to complete." The company is well underway in a multi-year strategic plan that will take it through 2020, is financially strong, and has very capable executive and leadership teams and a Board of Directors that together will ensure continuity and focus.

Community, collaboration, and teamwork are essential to maintaining the strategies that are working here at PI. But they are also the catalysts that will drive change

(Continued on back cover)



Today, there is widespread agreement that there should be no wrong door for a patient with mental-health and addiction issues to choose first in seeking help—whether that be the primary-care clinic, the behavioral-health center, or any other community-service organization.

(Evolution and Benefits of Bi-directional Integration, continued from page 5)

primary care, and it was considered important to reimburse them for their expenses.

Meanwhile, the state of the art for mental-health services was less reliable in guaranteeing consistent and effective care. Commensurately, community mental-health services were funded on a grant basis, with funding levels based not on need but instead on amounts negotiated among members of Congress and elected officials in state legislatures—and always in competition with other social services and education.

Compounding these initial inequities in funding were public policy changes made from 1981 to 1989, including a move to blend grant funds for community mental health and those for addictions with other grant funding in the form of block grants. States agreed to accept less money in exchange for more discretion on how they would spend that money, which eventuated in there being less money than there had been before for addiction and

mental-health services, and in some states making arguably tragic decisions to divert much of that funding to other purposes, such as building new roads. During the 1980s, significant damage was done to the progress made in treating substance-use disorders, especially in treating heroin addiction; a “Just Say No to Drugs” campaign, for example, undermined the nascent treatment-oriented approach to helping people reduce addiction.

HOW HEALTHCARE INTEGRATION STARTED

The first step in the integration of behavioral healthcare in primary healthcare was the creation of the concept of behavioral healthcare itself. Though an awkward term, behavioral health is a way of considering substance-use disorders and mental/emotional-illness disorders as belonging in the same family of illnesses that significantly impact how people act. Thinking of things this way, mental-health providers began to appreciate the fine work being done in many substance-use disorder organizations.

They witnessed the resourcefulness and credibility shown by people with lived experience in managing their own addiction disorders, working as treatment-team members for others with substance-use disorders. Because of the success of the role of Peer Support Specialists in coaching clients in symptom management and navigating for resources and other healthcare, these specialists were increasingly employed in mental-health centers.

Simultaneously, the substance-use-disorder treatment community realized that it was often helpful for clients who had both mental illnesses and substance-use-disorders to continue their chemical-dependency treatment and participate in mental-health treatment with access to psychoactive

medication. Chemical-dependency counselors were integrated into mental-health centers and eventually developed specialty care for co-occurring disorders. We saw increasing success when collaborating, and began to speak with one voice as we envisioned the advantages of a future together. While there are still sensitive areas in the integration of substance-use-disorder treatment and mental-illness treatment, many are dedicated to making it work, finding ways to learn from each other and campaigning together to be integrated with primary care.

In the 1990s and early 2000s, it became increasingly clear that treating the brain separately from the rest of the body would not bring the best possible results. Early visionary leaders engaged primary healthcare providers and behavioral-health providers in collaboration with one another. Medicaid-insured patients with high behavioral-health needs were often most comfortable in community mental-health centers, and felt unwelcome in community health clinics. Other Medicaid-insured patients showing signs of mild or moderate depression and anxiety very much identified as patients in a community health clinic, and didn't see themselves as belonging in the stigmatized behavioral-health centers.

Initially, simply being aware of each other as valuable healthcare providers in the lives of our mutual patients required encouragement and training. The next step in collaboration entailed mental-health centers embedding some of their staff into the community health clinics to provide individual therapy to patients. Mental-health-center psychiatrists began to give consultation to primary-care staff about prescribing psychoactive medications for their patients.

The next step entailed embedding primary-care health providers inside

community behavioral-health centers. This was particularly important for those clients whose psychiatric symptoms and unusual appearance made them feel uncomfortable in the community health clinics where families went for their healthcare.

With success on both sides of the experiment, the next step was for staff in both the behavioral-health clinic and the primary-care clinic to identify where patients would best be served. Careful diagnostics and symptom-severity tools helped to identify which setting would be most successful as the healthcare home for patients with different levels of psychiatric symptoms.

Together, the Substance Abuse and Mental Health Services Administration (SAMSHA) and the National Council for Behavioral Health funded scores of projects across the nation to develop primary-healthcare clinics inside behavioral-health centers. The impact on the wellness of the patients involved proved so positive that the Affordable Care Act was built in part around the principle that coordinated and collaborative behavioral and physical healthcare was necessary for improving health and containing costs. Bi-directional integration of primary and behavioral-health care became the expected standard.

As researchers looked further into population health, it became apparent that addressing the social determinants of health had a powerful impact on the lives of individuals and the health of the general community. A current focus in healthcare reform is on integrating timely access to food, housing, quality education, and employment in ways that also address racial and ethnic differences to eliminate disparities.

Today, there is widespread agreement that there should be no wrong door

for a patient with mental-health and addiction issues to choose first in seeking help—whether that be the primary-care clinic, the behavioral-health center, or any other community-service organization.

INTEGRATED HEALTHCARE'S NEXT HORIZON

As we progress further into the era of value-based payment, in which funding is based on the improvements we make in the lives of those we serve, rather than on how many widgets of service we provide, accountability for outcomes will be of paramount importance. With increased use of research-proven treatments and improved technology for monitoring outcomes and tracking actual expenses, we are best able to make wise decisions about the most effective and efficient treatment pathways and service-provision protocols. We can also be smart about financial-risk assumptions. No matter which perspective we use to examine how best to achieve the quadruple aim of enhancing patient experience, improving population health, reducing costs, and improving the work life of clinicians and staff, the benefits of the bi-directional integration of primary and behavioral healthcare are obvious. 



David Johnson is chief executive officer of Seattle-based Navos is one of the largest behavioral healthcare provider in the state of Washington. Their mission is to transform the quality of life for people vulnerable to mental illness and substance-use disorders by providing a broad continuum of care. Diversity, inclusion, and equity are vital to their mission, and that translates to dozens of innovative varieties of treatment, healing, and support for a diverse range of King County adults and children, many of whom live in poverty. For more information, please visit navos.org.

VIRTUAL HOUSE CALLS

Increasing Access to Behavioral Healthcare for Patients and Their Families



Today, more patients and their families can access high-quality behavioral care without leaving their homes. Driven by an increasingly tech-savvy society with an increasing need for mental-health services, the growth of behavioral telehealth helps eliminate barriers to behavioral healthcare for individuals and families.

Particularly for patients in rural and underserved communities who might otherwise need to travel for hours to visit a provider in person, telehealth promises behavioral healthcare that's private, cost-effective, and convenient.

But telehealth isn't just about convenience. Research shows that behavioral telehealth supports positive outcomes for patients. A systematic review published by the Agency for Healthcare Research and Quality found that telehealth is an effective treatment for psychotherapy. According to a

The researchers found that psychiatrists and counselors are the behavioral-health professionals most likely to use teletherapies.

report from the Substance Abuse and Mental Health Services Administration (SAMHSA), teletherapy can increase medication compliance, motivate patients to enter treatment, and reduce symptoms of anxiety and depression. Another study found that trauma-focused cognitive behavioral therapy could be delivered via one-on-one videoconferencing without compromising its therapeutic benefits; the study noted significant clinical improvements and high rates of satisfaction from both patients and providers.

Nearly half of behavioral-health providers use some form of telehealth, according to a 2018 study by the Behavioral Health Workforce Research Center at the University of Michigan. The researchers found that psychiatrists and counselors are the behavioral-health professionals most likely to use teletherapies.

But the adoption of telemedicine for behavioral health still lags behind primary care and specialty care, researchers note. That's particularly true in pediatric behavioral healthcare, says Mark Lo, MD, MS, emergency medicine physician with Seattle Children's Hospital. The result: too many pediatric patients and their families struggle to access effective behavioral healthcare, or spend too much time driving to far-flung appointments.

In April 2018, Dr. Lo and Sarah Orth, Seattle Children's Hospital's telehealth senior program manager, established the Telehealth Direct to Consumer pilot program to help bring pediatric telemedicine up to speed. The program initially served patients in the Autism Center's Pediatric Feeding, Biobehavioral and Medication Evaluation and Management programs. It has since expanded to include the organization's Psychiatry and Behavioral Medicine, Neuropsychiatry, and Program to Enhance Attention, Regulation and Learning (PEARL) clinics.

Over the program's first nine months, participating area teams met with 119 different patients during 295 video visits, saving families some 48,465 miles of driving. Reduced driving time was far from the most significant benefit, however. Easing the challenge of coordinating multi-provider appointments relieved a significant administrative burden, allowing providers to see more patients and increasing access to care.

“One thing that did surprise me when we started doing home telemedicine visits is the insight that we’d gain by seeing our patient’s home environment.”

MARK LO, MD, MS,
EMERGENCY MEDICINE
PHYSICIAN, SEATTLE
CHILDREN'S HOSPITAL



“Healthcare is no longer about the solo provider,” says Lo. “A lot of these visits are multidisciplinary. You may have a mental-healthcare provider, a social worker, a dietician or athletic trainer, several different ancillary services, or an interpreter. As we coordinate all of this care for a single visit, telehealth has taken a bit of the burden out of scheduling these massive, multi-provider visits—providers don’t all have to be there in person at one time, but can beam in via telehealth.”

The program yielded some surprising benefits, too. By enabling providers to see parts of a patient's living space, videoconferencing helped care teams devise more effective treatments for persistent problems. “One thing that did surprise me when we started doing home telemedicine visits is the insight that we’d gain by seeing our patient's home environment,” Lo notes. “For example, with our feeding clinics, we’d be able to understand why a proposed intervention wasn’t working, because we could see how a patient’s home was set up, and then we could propose a different management system based on that information.”

Treating pediatric patients via telehealth presents unique challenges around patient privacy, Lo says. Because telehealth gives providers less control over who may be in the room during treatment, ensuring that patients and their families understand safety and privacy protocols is essential. “One of the challenges of tele-psychiatry for people who are minors is figuring out how the family is going to be involved,” Lo notes. “In a clinic environment, we’d be able to go through the safety protocols with parents or caretakers, and ask them to step outside of the room when needed. With telehealth, when we’re speaking to a minor patient at home, it’s a less controlled environment.”

Overcoming these challenges helps improve access to care for pediatric patients in the Puget Sound area and beyond. Just as importantly, pediatric patients can spend less time traveling to healthcare appointments, and more time just being kids. “Pediatric telemedicine is coming along,” Lo says. “I think adult telemedicine has paved the way, and I think we’ll be able to take some of those findings and use them to advance telemedicine for pediatric populations.” 

“Mental Health First Aid is designed to train people in the general community to recognize mental-health concerns and provide support and appropriate referral. It is not diagnosis or treatment.”

DALE SANDERSON, PA
CERTIFIED MENTAL HEALTH FIRST AID
TRAINER, SOUND HEALTH

(Mental-health Training for Providers and Staff, continued from page 9)

Over a one-to-two-day training course, attendees gain the skills to help someone experiencing a mental-health crisis. Front-desk staff in medical offices, emergency first responders, and others who work with the public in healthcare settings can benefit from the training, says Sanderson.

“Mental Health First Aid is designed to train people in the general community to recognize mental-health concerns and provide support and appropriate referral. It is not diagnosis or treatment,” he notes. “Within the healthcare system, both primary and ancillary staff can benefit from the training as well. There are several different modules, including those for youth and first responders.”

LADY GAGA BRINGS STAR POWER

The fast-growing program has earned high-profile praise from media outlets like *The Wall Street Journal*. Earlier this year,

Lady Gaga’s Born This Way Foundation partnered with the National Council for Behavioral Health to bring Mental Health First Aid to high schools. To date, more than 1.5 million people across the United States have received Mental Health First Aid training from a dedicated base of more than 15,000 instructors.

“Mental Health First Aid is a very interactive training, with a lot of attendee participation,” says Sanderson. “The attendees learn about and practice how to respond in different scenarios involving depression, anxiety, psychosis and substance abuse. The class utilizes an adult-learning paradigm that’s designed to keep attendees engaged.”

In addition to teaching participants tools for helping those experiencing a mental-health problem, the training helps address stigmas that may present a barrier to empathy, says Sanderson.

“Mental Health First Aid focuses on ending the stigma of mental illness. Participants are asked to look at their own opinions of people experiencing mental illness, which may create stigmas that isolate the person in crisis. For people around the person in crisis, these unconscious stigmas can really inhibit their ability to help and ultimately impede the journey to recovery of the person who is struggling.”

Hope and recovery feature prominently in the training, he adds. “For individuals who are suffering, the one thing you can do more than anything is to provide hope for recovery,” he says. “That by itself is a powerful message that will go a long way in setting the stage for people to get help and do better.”

TRAINING FOR CLINICAL STAFF AND NEW PROVIDERS

A growing slate of training programs are available to healthcare providers

interested in building their skills and knowledge in behavioral health. The Substance Abuse and Mental Health Services Administration provides information about classroom-based and online training programs for new providers, practicing behavioral-health providers, and clinicians in primary care.

Some, like the one-week targeted continuing education program offered through The Behavioral Health and Integration Training Institute, are geared toward those in the mental-health field. Other programs, like the Certificate Program in Primary Care Behavioral Health from the Department of Family Medicine and Community Health at the University of Massachusetts Medical School, are designed for clinicians working in or transitioning to an integrated behavioral-health setting.

Some providers may be seeking more specialized, targeted training, like the online training for psychiatrists working in primary care from the AIMS Center. Through a series of modules, this training prepares psychiatrists to develop, implement, and work within an integrated care team.

“Translating the research into the real world has been the focus of the AIMS Center for the last 14 years,” says Ratzliff. “We’re looking at how organizations can effectively practice collaborative care, and the most effective ways to do trainings for the organizations and maintain fidelity to the collaborative-care model.”

Participating in training on behavioral-health integration is a vital step for providers in today’s integrated healthcare environment, Ratzliff notes. But organizations should view provider training as one step in a much larger process. As clinicians begin to put their newly acquired behavioral-health

skills into practice, organizations must continually monitor the quality of care, anticipate turnover, and have plans in place to train new providers who join the organization.

“For organizations in the later phases of [behavioral-health] integration, we see challenges in continuous quality improvement,” Ratzliff says. “You have to continually monitor your organization, and plan for continuous quality improvement and training early in the integration process. That means anticipating team turnover and being prepared with training plans for new people coming into the team.”

Training in behavioral healthcare strengthens the skill-sets of providers across disciplines, ultimately resulting in healthier populations. “You need to deliver whole-person care, because there is no health without mental health,” Ratzliff says. “We’ve learned that the key to building capacity for behavioral health in primary care is helping providers conceptualize mental health as primary care. This allows organizations to build capacity in a thoughtful way.” 



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MENTAL HEALTH FIRST AID: CLASS NOTES

Mental Health First Aid training focuses on recovery, resiliency, and the belief that individuals experiencing these challenges can and do get better.

Topics covered include:

- Depression and mood disorders
- Anxiety disorders
- Trauma
- Psychosis
- Substance-use disorders

THE MENTAL HEALTH FIRST AID ACTION PLAN

(ALGEE, the Mental Health First Aid motto, is a mnemonic for this five-step action plan.)

- A**ssess for risk of suicide or harm
- L**isten non-judgmentally
- G**ive reassurance and information
- E**ncourage appropriate professional help
- E**ncourage self-help and other support strategies

INTERVENTIONS LEARNED

Participants learn how to apply the Mental Health First Aid Action Plan in a variety of scenarios, including when someone is experiencing:

- Panic attacks
- Suicidal thoughts or behaviors
- Non-suicidal self-injury
- Acute psychosis (e.g., hallucinations or delusions)
- Overdose or withdrawal from alcohol or drug use
- Reaction to a traumatic event

Source: National Council for Behavioral Health, 2019

Know the Liability Implications of Offering Behavioral Health Through Telehealth



Telehealth is an increasingly common and valuable tool to improve access to and quality of mental-health treatment.

But as providers add this digital access to their practices, they should be aware of the liability implications.

Establishing a practitioner-patient relationship. The first step when initiating telehealth treatment is to establish a practitioner-patient relationship. Although in-person contact is not essential, having no contact or simply having patients complete questionnaires cannot establish the necessary relationship. Telehealth practitioners must genuinely form

patient relationships prior to providing treatment and prescriptions.

Obtaining patients' informed consent for telehealth encounters is also essential. Telehealth technologies are unique and novel; patients must agree to the use of telehealth in their care and know their rights to stop or refuse treatment. As with any medical care, practitioners should verify the understanding of all parties regarding (1) the provider's credentials; (2) the nature, capabilities, and limitations

of technologies employed; and (3) a mutual agreement that telehealth is appropriate given each patient's care needs. Some states (e.g., California) require practitioners to obtain patient consent and inform patients of the benefits, risks, and limitations unique to telehealth treatment.

Like consent, appropriate observation and evaluation of patients must occur before the provision of any care or prescription. While evaluations need not necessarily be in person, practitioners

should employ sound judgment and discretion to determine the level of contact needed on a patient-by-patient basis. By definition, telehealth does not permit in-person evaluations; telehealth practitioners should determine if circumstances require something more. Where in-person contact is considered necessary, telehealth practitioners can either engage surrogate examiners to be present with patients or recommend in-person appointments to those patients.

Knowing the limitations of care.

Practitioners' responsibilities also include knowing the limitations of the care to be provided. Telehealth allows practitioners to provide any appropriate treatment for patients, including prescriptions. But just as in traditional settings, these practitioners must recognize situations that exceed their expertise or ability, or in which technological limitations frustrate treatment—and should refer these cases elsewhere for appropriate care. Notably, telehealth software prevents in-person examination of a patient's gestures and body language, and awareness of this potential source of miscommunication is critical to avoiding misdiagnoses and consequent malpractice liability.

Out-of-state licensing. Despite telehealth theoretically making it possible to treat patients anywhere in the country, practitioners should be aware that many states prohibit sustained practice with out-of-state licenses. Furthermore, mental-health professionals incur a practice-specific duty to take reasonable precautions to mitigate or prevent foreseeable injury to others caused by their patients (R3d (Torts) § 315), and telehealth practitioners should be especially aware of these signs, particularly in light of the technological limitations and physical separation from their patients that telehealth involves. It is a best

practice, for example, to obtain each patient's emergency contact information so as to assist endangered patients.

Telehealth simplifies patient

interactions, but it does not obviate practitioners' record-keeping practices. Practitioners must accurately and adequately document patient encounters so that records clearly, concisely, and correctly reflect treatment. Records must be permanent, confidential, and readily available to patients and their treatment providers in accordance with laws and regulations related to maintaining and transmitting such records. HIPAA and HITECH—medical privacy and security laws—require that telehealth software encrypt patient data; Skype, FaceTime and other commercially available communication services fail to meet this requirement. Practitioners must have telehealth-specific video-conferencing providers execute a business associate agreement to maintain patient confidences pursuant to HIPAA.

Telehealth prescriptions entail the same professional accountability as prescriptions penned during an in-person visit. Practitioners must evaluate the indications, appropriateness, and safety considerations for each telehealth prescription in accordance with current standards of practice; for example, practitioners should exercise special caution when prescribing DEA-controlled substances through telehealth. Integration with e-prescription services can help telehealth practitioners ensure accurate and error-free prescribing practices. 

Sources

Eric A. Norman and Ashley L. Blackburn, attorneys, FAVROS (Seattle, WA)



(Duty to Warn, continued from page 7) ambiguous, and does not reasonably identify any class of persons, it should be noted as such. It will also be important that the provider document how he or she learned the information and through what source(s). Claims often live or die on the foreseeability factor, and having a documented history of what critical information was actually conveyed, if any, will assist in determining whether there is a viable claim.

CONCLUSION

The courts have not yet had meaningful opportunities to interpret the duty to warn in an integrated healthcare setting. Because the law is not uniform and integrated healthcare varies drastically, it is difficult to formulate definitive rules or guidelines that will broadly apply to all practices. However, foundational factors, such as whether there is a requisite special relationship and foreseeability of harm, should be kept in mind when rendering services in these integrated settings. And as integrated care becomes more prevalent, we can expect the courts to provide additional guidance on whether or not the duty is implicated under specific factual circumstances. In the meantime, providers should familiarize themselves with the current framework and how their particular jurisdictions apply the duty. 



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QUESTIONS?

Physicians Insurance: Risk Management, 800-962-1399, risk@phyins.com

RESOURCES

phyins.com/magazine/guidance-new-duty-warn-or-protect-standards

(Safe Care of Mental-health Patients, continued from page 11)

2. Conduct a safety-risk assessment of the treatment setting to help ensure that staff and patients within that environment are safe from potential harm. This assessment should ensure that:
 - a. Potential ligature risks are minimized
 - b. Safety glass is installed in reception areas and treatment rooms
 - c. Furniture cannot be easily lifted
 - d. Needles/syringes and medications are secured
 - e. Prescription pads are secured, with minimal access
 - f. Pictures are secured to the walls
3. Conduct routine surveillance and searches of the patient-treatment area or rooms for potentially dangerous items (plastic bags, sharp objects, ropes or strings, etc.).
4. Establish “safe” rooms close to the central nursing station and away from doors that provide for easy egress (ambulance bay, exit doors, etc.). These rooms can be a permanent fixture, or be able to be converted from other rooms for use in an emergency.
 - a. Bathrooms used by high-risk patients should be safely designed or allow for constant supervision of high-risk patients while in use.
 - b. Different-colored gowns, scrubs, or socks should be used for easy identification of mental-health patients or patients at risk of elopement (legally defined as

patients who are incapable of adequately protecting themselves and who depart the healthcare facility unsupervised and undetected, or who wander aimlessly without regard for their own safety).

Competencies and Training

1. Train all staff in the organization in customer service and verbal de-escalation techniques. Many aggression events occur as the result of a staff member ignoring or being rude to a patient. Training staff in how to present themselves to patients, and how to manage aggression if it presents, can greatly increase safety.
2. Train all staff who manage aggressive/violent patients in non-violent crisis management, so that safe procedures are consistently followed. At a minimum, trained staff should include security personnel, ED nursing staff, mental-health staff, and nurse supervisors.
3. Educate staff in common mental-health and substance-use conditions, including depression, bipolar disorder, anxiety/panic disorders, opioid addiction, and alcohol and benzodiazepine abuse.
4. Train all staff members in restraint and seclusion procedures, and ensure they have a solid working knowledge of the federal guidelines surrounding the use of restrictive interventions.
5. Train all staff who function in a “sitter” role (defined as the one who provides the patient constant observation) in that role’s responsibilities, as well as in de-escalation techniques.

Assessment and Clinical Care

1. Assess all patients for suicidality and aggression risk, and implement frequent assessments (every one to two hours). Note: anxiety/agitation are usually the first signs of increasing risk.
2. Perform reassessment at critical junctures and transitions in care, such as changes in level of functioning, changes in observation level, and discharge.



a serious chronic health condition or terminal illness, which are linked to a higher incidence of suicidal thinking or attempts. These patients should be assessed on each visit and provided either with appropriate medication or therapy to manage their symptoms, or with a referral.

5. Educate patients with regard to mental-health and substance-use disorders. This can be done individually as it applies to the patient, by providing a brief discussion and written information from a reputable medical website. Providing brochures in the waiting room that offer educational material on various conditions can also work to decrease stigma and inform patients/visitors on these disorders.

6. Establish patient-provider agreements for patients who are believed to be seeking drugs or are abusive of care staff. The provider should review this agreement with the patient to ensure their understanding of it. Such an agreement could include provisions for termination of care and referral to another provider in the case of violation.

Resources

1. Provide adequate mental-health-professional support to allow for timely and comprehensive assessment. Crisis counselors, social workers, or advance-practice nurses are invaluable in assisting with assessment and discharge planning.
2. Consider hiring a mental-health clinician to provide integrated care for patients in primary-care settings who are assessed to be in need. This clinician could be a psychiatric social worker, advanced-practice nurse practitioner, nurse therapist, or other licensed clinician. Tele-

psychiatry could also be an option if there are limited mental-health resources.

3. Maintain a list of local-area providers of mental-health and substance-use services, and provide referrals for evaluation and/or treatment when patients are identified. It is also suggested that these resources be made available in the waiting room. If the patient does not have an issue, it's likely that they know several people who do, and may be able to offer valuable information to someone in their family or community.

All healthcare providers have a responsibility to provide safe, quality care to their patients. By implementing these strategies, they can work to improve the safety of patients and fellow caregivers alike. 



Monica Cooke, BSN, MA, RNC, CPHQ, CPHRM, DFASHRM, is the founder of Quality Plus Solutions LLC and provides behavioral-health risk assessments

and Legal Nurse Expert services nationwide to assist behavioral, emergency, acute-care, and long-term-care settings in the safe management of behavioral and substance-use patients. She is nationally known as an expert in the field of behavioral-health risk and patient safety, and speaks around the country on risk and workplace-violence topics to healthcare professionals.

Sources

- ¹ National Institute for Mental Health - <https://www.nimh.nih.gov/health/statistics/mental-illness.shtml>
- ² World Health Organization - <https://www.who.int/news-room/fact-sheets/detail/depression>

3. Assess all patients for depression, anxiety, and substance use at least annually in primary-care settings. There are multiple evidence-based tools to this end that patients can self-administer when they arrive for their appointment, including Patient Health Questionnaire-9 (PHQ-9), Generalized Anxiety Disorder-7 (GAD-7), and the CAGE or CAGE AID.

4. Pay close attention to patients who have been recently diagnosed with



CASE STUDIES

LEARNING FROM THE LEADERS

HOW CHCs INTEGRATE BEHAVIORAL HEALTH FOR BETTER ACCESS

Community health centers have long been a leader in integrating behavioral and primary healthcare.

It's part and parcel of their mission to address the holistic needs of their often underserved, underinsured, and uninsured patients; and as a result, many of these centers have expanded beyond core primary practices into a variety of other services in order to provide more comprehensive access to high-quality, affordable offerings. This has generally made community health centers more experienced than many providers in making integration work seamlessly and effectively for patients.

We asked two community health centers—one in Oregon, the other in Alaska—about their success in integrating behavioral and primary healthcare. They shared what's working, the lessons learned, and the challenges of navigating this often frustratingly complex environment to meet patients' needs. Through it all, they stress the enormous value of this integration, because of the profound difference it makes for their patients and providers alike.

UMPQUA COMMUNITY HEALTH CENTER, ROSEBURG, OREGON

Umpqua Community Health Center provides primary medical, dental, and behavioral-health services at six locations throughout Douglas County. Its primary medical services include general and preventive healthcare, chronic-disease management, pediatrics, a comprehensive women's-health program, rheumatology, infectious-disease medicine, immunizations, referrals to specialists, and same-day access for acute care. Its nine dentists provide a full range of dental services. For behavioral healthcare, it now offers psychiatric medication and evaluation, addiction medicine that includes medication-assisted therapy, and treatment for



anxiety, depression, bipolar disorder, and stress-related problems. The center also offers counseling with licensed clinical social workers and behavioral-health coaching.

When the center decided to delve into behavioral-health services—first on an outpatient basis in May 2015—its goals were simple: to provide services to the greatest number of patients immediately when a need is identified; and to allow medical providers to focus on medical treatments rather than counseling, thereby reducing session times and preventing primary-care-provider burnout. In January 2017, the center took the next step and began developing integrated behavioral health—that is, a team of licensed behavioral-health providers was embedded in the primary-care clinic to assist at the point of care for patients’ medical appointments, as requested by the primary-care provider or the patient. The pilot program—inaugurated for two of the center’s medical teams—began in June 2017 and ran for six months. The program opened to the entire clinic in January 2018.

“The integration is going very well, based on past and present feedback we have been receiving from patients and providers,” says Lorie DeCarvalho, PhD, Director of Behavioral Health Sciences at Umpqua Community Health Center. “That feedback has been overwhelmingly positive.”

PROMISING RESULTS

In surveys following the pilot program, patients expressed they had better relationships with their medical teams, felt more supported, and experienced symptom reduction at a faster rate due to their needs being immediately addressed.

Prior to the integration, most of the center’s medical providers had expressed feeling overwhelmed when dealing with



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emotional and mental-health issues—and expressed relief after the integration began, for access to consultations with behavioral-health providers in assessing their needs and determining appropriate treatment plans.

The integration came with internal challenges, too, of course. The main difficulties, DeCarvalho says, were in overcoming perceptions that integrated behavioral health would create workflow issues—such as slowing the primary-care providers down and bogging up exam rooms—and logistical problems in referral processes, billing, and coding.

“It helps to provide education upfront to medical providers about the services available to them and the benefits to their workflow,” DeCarvalho says. “It’s important to spend time conceptualizing the workflows between the behavioral-health consultant and the primary-care provider. Referral and billing procedures need to be factored in before launching as well.”

The effort was entirely worth it for Umpqua Community Health Center. “Having effective communication between the medical and behavioral-health provider in that milieu helped us to better coordinate the services and treatments patients receive from us, which only serves to provide them better care,” DeCarvalho explains. “Rotating licensed behavioral-health providers into primary care works better than devoting one or two set individuals. This exposes the patient to all of our behavioral-health providers and ensures continuity of care for the patient.”

According to DeCarvalho, they’ve seen that integrated behavioral health tends to reduce reports of symptoms of anxiety and depression in patients, as well as hospitalizations for patients with significant behavioral-health needs. It has simply been shown to improve overall health-behavior outcomes.

The center has some exciting next steps in the works. “We are planning on physically restructuring the primary-care area into treatment pods and having medical and behavioral-health providers in closer proximity, which will essentially increase our ability to communicate and interact with one another,” DeCarvalho says. “This will further increase our cohesiveness as medical teams, and help us provide more seamless and efficient integrated care to our patients.”

(Continued on page 38)



CALL TO ACTION

IT'S TIME TO CONTACT YOUR WASHINGTON
AND OREGON CONGRESSIONAL DELEGATION

Congress reconvened in September and lawmakers will spend the last remaining months before the 2020 election year addressing several topics, including measures to address surprise medical billing, prescription-drug costs, prior-authorization reform, appropriations spending, and other legislative initiatives that impact healthcare in the United States.

Physicians Insurance works in partnership with its national trade association, the MPL Association, to promote medical liability reform and build bipartisan support in Congress on federal legislative matters. Anne Bryant, Senior Director of Government Relations, currently chairs the MPL Association's Government Relations Committee. (www.mplassociation.org)

At present, there are two legislative initiatives before Congress that are important to MPL insurers and medical professionals:

GOOD SAMARITAN BILL INTRODUCED IN U.S. SENATE

On May 7, 2019, the Good Samaritan Health Professionals Act of 2019 (S. 1350) was introduced by Senator Bill Cassidy, MD (R-LA), and referred to the Senate Health, Education, Labor and Pensions Committee. This legislation would provide federal and state medical-liability protections for medical volunteers, limited to those responding to federally declared disasters. The bill is virtually identical to legislation that was approved by the House Energy and Commerce Committee last year following extensive negotiations with committee Democrats and the American Association of Justice, a

national plaintiff trial lawyer association advocating on behalf of those injured by negligence or misconduct.

The Bill:

www.congress.gov/bill/116th-congress/senate-bill/1350

Legislative Contact:

Senate Health, Education, Labor and Pension Committee:

Senator Patty Murray (D-WA), Ranking Member

www.murray.senate.gov/public/index.cfm/contactme

LIABILITY-REFORM BILL INTRODUCED IN U.S. HOUSE OF REPRESENTATIVES

On July 9, 2019, the Accessible Care by Curbing Excessive Lawsuits ("ACCESS") Act of 2019 (H.R. 3656) was introduced by Representative Richard Hudson (R-NC) and referred to the Committee on the Judiciary and Committee on Energy and Commerce. This legislation is a comprehensive medical-liability reform bill that is modeled after proven reforms currently in place in several states around the country, such as California and Texas. The bill ensures full and unlimited recovery of economic damages, such as lost wages, past and future medical expenses, rehabilitation costs, and other expenses. The bill also permits the additional recovery of up to \$250,000 for non-economic damages, such as damages awarded for pain and suffering. All provisions included in the legislation provide for state flexibility, meaning no provisions are construed to preempt any state

EDUCATION

laws, whether adopted before, on, or after the date of federal enactment.

It also includes reasonable statutes of limitations for filing lawsuits from one to three years, with an exception for minors under the age of six, and sliding scales on attorney fees of 40% on the first \$50,000, 33 and 1/3% on the next \$50,000, 25% on the next \$500,000, and 15% on any amount in excess of \$600,000. In addition, provisions encouraging more open communication between patients and providers, such as the protection of statements of apology and actions of compassion, are also included in the legislation.

The Bill:

www.congress.gov/bill/116th-congress/house-bill/3656

Legislative Contact:

Committee on the Judiciary:

Representative Pramila Jayapal (D-WA)
jayapal.house.gov/contact

Committee on Energy and Commerce:

Representative Kurt Schrader (D-OR)
schrader.house.gov

**Representative Greg Walden (R-OR),
Ranking Member**

walden.house.gov/contact-greg

Representative Cathy McMorris Rodgers (R-WA)

[/mcmorris.house.gov/contact](http://mcmorris.house.gov/contact)

WE NEED YOUR HELP

Please consider reaching out to members of Congress in Washington and Oregon and encouraging them to co-sponsor and support the bill before their committee. Our hope is to increase diverse bipartisan support to activate and move these federal legislative initiatives forward.

If you would like more information, please contact Anne Bryant at Anne@phyins.com or 206.200.6055.

phyins.com/govt

ONLINE COURSES

Integrating Primary Care with Behavioral Health

As a healthcare professional, you may or may not be sure what the term “integrated care” means, what the implications are for future healthcare practice, or how you might participate in an integrated-care environment. This course explains the costs, benefits, and goals of various integrated-care models and configurations. You will learn ways that behavioral-healthcare professionals can function effectively in such an environment, along with key challenges to and characteristics of well-functioning integrated-care systems.

Best Practices for Delivering Telehealth

Learn how to select and apply the most appropriate treatment modalities for telehealth when working with individuals across behavioral-health settings; describe considerations when building rapport and engaging clients remotely via telehealth; and learn how to summarize specific research describing the strengths and weaknesses of telehealth practice, including the standardized use of electronic assessments.

HIPAA and Behavioral Health

This course addresses some of the most common HIPAA-related legal and ethical challenges faced by behavioral-health professionals, including those who work in hospitals, clinics, community mental-health centers, addiction-treatment centers, and private practices. This course will improve your understanding of HIPAA Privacy and Security Rules and how they apply to your day-to-day professional responsibilities as a behavioral-healthcare provider.

Reducing Medical and Treatment Errors in Behavioral Health

In this course, you will learn the scope of medical and treatment errors within the overall healthcare system, and specifically in behavioral-health settings. You will explore the types of medical errors, including error-prone situations, and the use of root-cause analysis to determine why and how an error occurred. You will explore best practices to improve client safety and outcomes, and learn your responsibilities for reporting medical errors.

phyins.com/behavioralhealth



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Trial Results



The following summaries are Physicians Insurance cases that have gone to trial and are public record. In reporting these legal results, it is our goal to inform members about issues that impact healthcare professionals. While we share information we think may be informative, we choose not to disclose the names of plaintiffs or defendants when reporting these results.



DELAYED DIAGNOSIS OF MENINGEAL INFECTION, RESULTING IN DEATH

SPECIALTY: Physician Assistant and Emergency Medicine

ALLEGATION: The patient initially presented to the Emergency Department on February 1, 2009, complaining of sinus pain, an abscessed tooth, swelling in the right side of her forehead, and headache. The patient was evaluated by a physician assistant (PA), who conducted a physical exam and reviewed a sinus CT report from January 2009 revealing extensive sinus disease. A new head CT without contrast was ordered and was negative for bony erosion into the cranium, but did show extensive paranasal disease with some edema of the scalp on the right side. The PA diagnosed the patient with extensive sinusitis, and prescribed oral clindamycin and hydrocodone and referred the patient to an otolaryngology (ENT) provider with instructions to call the following day to schedule an appointment. The PA was also aware of the patient's plans to have an infected tooth extracted in the following days.

The patient was seen the following day by an ENT provider. An endoscopic nasal exam was conducted and a culture was obtained. The patient was diagnosed with chronic maxillary sinusitis, bony erosion around tooth no. 2 into the maxillary sinus, acute ethmoidal sinusitis, and

acute frontal sinusitis. In addition to the oral clindamycin, the patient was also prescribed a prednisone taper to help with inflammation.

On February 3, 2009, the patient had the infected tooth extracted. Later that evening, just before midnight, the patient returned to the Emergency Department and was seen by the emergency physician for complaints of worsening pain. A physical exam confirmed the patient did not have a stiff neck, forehead swelling, scalp swelling, or confusion. There was no indication of a cerebral abscess and no acute intracranial findings. The neurological exam was negative and was without focal deficits in any form. The patient reported 10/10 pain, which was attributed to the recent dental extraction, biopsy, and the fact that the patient had missed doses of the pain medication and antibiotics. The ED physician administered 900 mg of intravenous clindamycin, Dilaudid, Reglan, two liters of saline, and Tylenol, and monitored the patient's condition, which continued to improve. The patient was discharged with careful instructions to return to the Emergency Department the following day if symptoms did not continue to improve or if any new symptoms presented.

The following evening, the patient was noted by family to be speaking gibberish and acting oddly, and ultimately collapsed. An ambulance was called, and the patient was taken to the hospital. Upon arrival, the patient was obtunded and non-responsive. An MRI/MRA showed a diffuse cerebritis with significant brain swelling, a right-to-left midline shift, and very little cerebral flow. The patient continued to deteriorate and passed away. The cause of death was brain herniation resulting from cerebral meningitis. A small amount of erosion was found in the back wall of the patient's frontal sinus bone and in the dura, which communicated with the right cranium and caused the corresponding subdural empyema.

PLAINTIFF ATTORNEY: Mary Schultz

PLAINTIFF EXPERTS: Richard Beck, MD, Otolaryngology, Richard Sokolov, MD, Infectious Diseases, James Winters, MD, Emergency Medicine, Elliot Felman, MD, Family Practice

DEFENSE ATTORNEYS: Bruce Megard and Eric Byrd, Bennett, Bigelow & Leedom

DEFENSE EXPERTS: Frank Riedo, MD, Infectious Diseases, Gregory Moran, MD,



Emergency Medicine, Jeffrey Larson, MD, Neurosurgery

RESULT: Defense Verdict, Spokane County

IMPROPER PRESCRIPTION OF OXYCODONE RESULTING IN DEATH

SPECIALTY: Family Practice

ALLEGATION: Beginning in 2007, the patient had been seen for various medical issues, including back and leg pain for which pain medication was prescribed. In July 2011 it was found that the patient had violated the pain contract based on a urine toxicology report that showed positive for THC. The prescription for narcotics was discontinued. The patient returned in October 2012 with continued pain complaints and was refused narcotic pain medication.

The patient returned to the clinic in 2015 and received prescriptions for various medications, including valium and narcotic pain medication. On June 12, 2015, the patient was prescribed 90 oxycodone pills for pain. On June 15, 2015, the patient's wife called the clinic and stated that only seven of the 90 pills remained, and that the patient was slumped over and could barely walk. She was instructed to take the

patient to the Emergency Department, but apparently did not do so. The patient was found dead at 4 a.m. on June 16, 2015.

PLAINTIFF ATTORNEY: Robert Lloyd and Tim Greene with the Law Office of Greene & Lloyd

PLAINTIFF EXPERTS: Thomas Clark, MD, Pathology (Tacoma, WA), Michael Schiesser, MD, Internal Medicine/Addiction (Fall City, WA), Howard Miller, MD, Family Medicine (Renton, WA), Tracy Skaer, PharmD, Pharmacy (Spokane, WA)

DEFENSE ATTORNEYS: Michele Atkins and Chad Beck with FAVROS (Seattle, WA)

DEFENSE EXPERTS: Brigit Grimlund, MD, Family Medicine (Seattle, WA), Bill McCarberg, MD, Family Medicine/Addiction (San Diego, CA), Larry Lewman, MD, Pathology (Clackamas, OR)

RESULT: Defense Verdict, King County

IMPROPERLY PERFORMED HIP SURGERY IN LEG-LENGTH DISCREPANCY

SPECIALTY: Orthopedic Surgery

ALLEGATION: The patient had a long history of medical treatments, including back surgeries performed in 2005, 2006, and 2007, and a knee surgery performed in 2008. The patient developed hip pain in 2012 and was diagnosed with avascular necrosis of the right femoral head.

The patient was first evaluated by the orthopedic surgeon in May 2012 for hip pain, as well as for groin pain and complaints of sciatica in the right leg. A right intraarticular hip injection took the edge off the pain, but the pain continued to worsen. On June 26, 2012, the orthopedic surgeon performed a total right-hip arthroplasty after performing the usual pre-surgery templating. The goal with surgery was to prioritize stability over leg length. Two weeks post-op, the patient was

found to have the left leg 1 cm longer than the right. Thereafter the patient continued to complain of low-back, groin, and right-buttock pain. Hip motion was good and did not cause discomfort.

On December 12, 2012, the patient underwent a fourth back surgery by another provider as a result of stenosis and radicular pain. In March 2013 the patient again began complaining of right-hip pain that went down her thigh. In January 2014 the patient sought care from another orthopedic surgeon for back pain and attributed it to a leg-length discrepancy caused by her hip surgery.

In 2017, in spite of several additional providers recommending against additional hip and spine surgery, the patient underwent another spine procedure in December.

Defense experts testified that the patient's post-op groin pain and other complaints were the result of chronic degenerative disc disease at L4–5 and not related to the hip surgery.

PLAINTIFF ATTORNEY: William J. Macke (Portland, OR)

PLAINTIFF EXPERT: James Ryan, MD, Orthopedic Surgery (Albany, OR)

DEFENSE ATTORNEYS: Karen O'Kasey and Colleen Scott, Hart Wagner (Portland, OR)

DEFENSE EXPERTS: Joel Hoekema, MD, Orthopedic Surgery (Bellingham, WA), Timothy Keenen, MD, Orthopedic Surgery (Tualatin, OR), Paul Duwelius, MD, Orthopedic Surgery (Portland, OR)

RESULT: Defense Verdict, Clark County

MORE INFORMATION

Do you have questions about integrating behavioral health and primary care?

Check out the **Substance Abuse and Mental Health Services and Health Resources and Services Administration** (SAMHSA-HRSA)'s Center for Integrated Health Solutions: bit.ly/2hoD6Sr

Another helpful tool is the **Quick Start Guide to Behavioral Health** (bit.ly/2mfM9dX), an interactive flowchart to walk you through some questions to consider and resources to answer your questions.

Also visit **The Center for Integrated Health Solutions** at bit.ly/2mf0Ttr or call 202-684-7457. The Center promotes the development of integrated primary and behavioral-health services to better address the needs of individuals with mental-health and substance-use conditions.

(Learning from the Leaders, continued from page 33)

The center also plans to increase the number of providers so there is one integrated behavioral-health provider for every four medical providers; and to provide more education about additional services that integrated behavioral-health providers can give to patients, such as assisting in the management of chronic medical conditions like diabetes, chronic pain, smoking cessation, and lifestyle management.

LESSONS LEARNED

DeCarvalho's advice for other community health centers:

- Don't be afraid to ask other clinics for guidance.
- Educate medical providers prior to beginning a pilot program, and continue presentations on a consistent basis.

- Educate providers, medical support staff, and front-office staff who serve in integrated behavioral health about the processes, so everyone is on the same page and working as a cohesive team.
- Get billing codes and procedures into place prior to beginning the program.
- Focus on workflows ahead of time.
- Use licensed clinicians.

“Integrated behavioral health seems to be trending in the Northwest region, as the medical field is recognizing the correlation among stress, lifestyle barriers, and medical diseases,” DeCarvalho says. “We believe that integrated behavioral health will continue to become more widely studied and utilized, both in this region and across the nation. Caring for the whole person—body, mind, and spirit—and integrating medical science with behavioral-health sciences leads to greater health and healing. “

ANCHORAGE NEIGHBORHOOD HEALTH CENTER, ANCHORAGE, ALASKA

The long-term vision of the Anchorage Neighborhood Health Center (ANHC)—to address the unmet primary-healthcare needs of its community—has been instrumental in guiding its evolution over time. The organization's transformation is significant, from its humble beginnings as Alaska's first community health center in 1974, when it was merely a handful of clinicians in a trailer, to its existence today as one of Alaska's largest and most comprehensive primary-care medical and dental practices. In 2018, ANHC served nearly 11,500 patients through more than 48,000 visits.

Their facility has all services located in a single building, organized into three medical pods and a full-service dental clinic, each of which supports collaborative team-based care. In

addition, there are in-house X-ray and laboratory services, a pharmacy, patient education to support diabetes and other health conditions, and enrollment and eligibility counselors.

The latest step in the center's development—integrating behavioral healthcare—honors the significance of behavioral health as an integral part of primary-healthcare services, and represents a whole-person approach to health and well-being.

Every medical patient at ANHC has a primary-care team, including a primary-care provider and nursing and care coordination. The patient's primary-care provider works with care-team members to coordinate all routine medical care, including exams, lab tests, medical imaging, diagnosis, and treatment. Additionally, the provider is charged with identifying emotional and lifestyle factors that affect the patient's health, and, when appropriate, will refer patients to other resources such as behavioral-health professionals, complementary therapies, or addiction-treatment professionals. The center's team of behavioral-health providers partners with the primary-care team to provide consultations, brief therapy, specialty care, and medication management. They work closely with the medical providers to help patients with behavior modification to support their medical care plans.

Anchorage Neighborhood Health Center first introduced behavioral-health services in 2015, with one psychologist on staff. As of today, the program has gone through several transitions and now has two Licensed Clinical Social Workers on staff, in addition to psychologist Dr. Hannah Ekstrom, who manages the behavioral-health program and plans to continue growing the center's team of providers. One of these three behavioral-health providers is always available for

same-day consultations for patient visits, and there are plans to have specific behavioral-health providers dedicated to each medical pod for better continuity of care.

Ekstrom explained that there's a difference between offering traditional psychotherapy and integrating behavioral-health services. "Integration is not simply offering specialty care in a primary-care clinic—and we have to define that clearly," she says. "Behavioral health isn't its own silo. When we offer integrated services, we're looking at a shared-treatment plan, not just a primary-care provider identifying depression, for example, and sending the patient for external treatment."

The center has found that this model results in reduced stigmas in seeking behavioral-health treatment, as well as better follow-up. "If you can address a problem, right then and there at the time it arises, there's no waiting," Ekstrom says. "There's support, and it's in a familiar place with providers with whom patients already have a comfort level."

Behavioral-health services in ANHC's integrated program include traditional psychotherapy, psychiatry, and behavioral-health consultation. Services are offered for behavioral-health conditions, substance-use disorders, chronic-disease management, stress management, and grief and loss, as well as for many other life needs. Additionally, Ekstrom points out the importance of identifying how patients can engage with healthy behaviors, such as medication adherence or lifestyle changes, with the support of tools and resources through the integrated behavioral-health team.

A WORK IN PROGRESS

The expansion of integrated behavioral-health services at ANHC is a work in progress—and Ekstrom believes the

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HANNAH EKSTROM, PHD,
DIRECTOR, BEHAVIORAL
HEALTH PROGRAM, ANCHORAGE
NEIGHBORHOOD HEALTH CENTER

program should always be viewed in a spirit of continued growth and adaptation. "All integrated programs are different, and we've tried different things," she says. "It all depends on the needs of the patients and the organization as a whole. No matter what you try, you're always learning lessons and improving along the way."

"We are very data-driven, and we elicit a lot of feedback," she adds. "We know people are going to primary care to address behavioral health—our patients are asking for more behavioral healthcare from their primary-care providers at our center, and our primary providers are asking for it too." She notes the continued support for the program from ANHC providers, who recognize the significant improvement in overall care that results from partnerships with behavioral health.

"When we screen for behavioral-health problems on a primary-care visit, we are better at identifying those problems and addressing the barriers that make it difficult to engage in care," she says. Those barriers sometimes include social problems that affect health, such as homelessness; and ANHC has an outreach team, which primarily helps patients access insurance options but also connects them with any social-

service providers and community-support referrals they might need.

There are other clinics in Anchorage and throughout Alaska that are providing integrated care, but there aren't enough behavioral-health services in the area to match the need, Ekstrom says. Recognizing that, her center's larger goal is "to integrate behavioral health on a community level—with our relationships with external providers, too—not just integrate on a center level."

For community health centers embarking on the integration process, Ekstrom advises that they "engage with everyone who works at the clinic, at every level, from the board of directors to the front office," and "find a shared language for the different types of professionals you're bringing together."

She also advises against siloing patients. "Don't type the patient," she says. "Don't say, this is a primary-care patient, or that one is a behavioral-health patient. They all belong to all of us."

But most of all, she suggests, "Be thoughtful in how you move forward. Don't try to do everything at once. Remember that you're integrating, not forcing something. And always be willing to adjust course, while keeping the end goal in mind." 



Hannah Ekstrom, PhD, psychologist and manager of the behavioral-health program at Anchorage Neighborhood Health Center



Lorie DeCarvalho, PhD, director of behavioral-health sciences at Umpqua Community Health Center



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In this issue of *The Physicians Report*, you will find stories of how the strengths of community, team medicine, and collaboration are being put toward solving the integration challenges between primary care and behavioral health. Notes Bill, "This is not the only new frontier healthcare is facing, but it is a critical one that impacts everything from value-based care contracts to the opioid epidemic, homelessness, and everything in between. Together, we as a community will find the solutions that can make a meaningful difference in the lives of patients and those who care for them."

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