NCIOM North Carolina Institute of Medicine
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TASK FORCE ON MENTAL HEALTH AND SUBSTANCE ABUSE

NORTH CAROLINA INSTITUTE OF MEDICINE
630 DAVIS DRIVE, SUITE 100
MORRISVILLE, NC 27560

SEPTEMBER 18, 2015
10:00 am - 3:00 pm

Task Force members in attendance: Lee Atherton, Grant Baldwin, Andrew Clendenin, Glenn Field, Tana Hartman Thorn, Brenden Hargett, Rebecca Hunter, , Jessica Herrmann, Sheila Hutchinson, Jean Steinberg for Billy Lassiter, Beth Melcher, Adrienne Mims, Theodore Pikoulas, Mary Lynn Piven, Sy Saeed, Luke Smith, Chad Stevens, Dianne Walker, Kim Young

Co-Chairs in attendance: John Santopietro

Steering Committee members in attendance: Cathy Hudgins, Eric Christian, Sonja Frison, Jehan Benton-Clark, Starleen Scott Robbins, Flo Stein

Guests/Speakers in attendance: Nancy Henley, Beth Daniel, Keith McCoy, Alex Obert, Nnenna Lekwauwa, Cassandra Gardner, Kim Taylor

NCIOM staff in attendance: Adam Zolotor, Berkeley Yorkery, Diana Dayal

NOTE: PDF copies of all presentations available online at
http://www.nciom.org/events/?task-force-on-mental-health-and-substance-abuse

INTRODUCTION AND WELCOME TO THE TASK FORCE

Our Task Force co-chairs will bring the meeting to order and facilitate member introductions. We ask that each Task Force member introduce him/herself with name, title, and organization.

John Santopietro, MD, FAPA
Chief Clinical Officer of Behavioral Health
Carolinas Health System

CONSUMER PERSPECTIVE: TELEPSYCHIATRY

Luke Smith, MD, Psychiatrist and Executive Director, El Futuro NC

Dr. Smith introduced El Futuro's school telepsychiatry pilot program. He gave an overview of the history of project implementation and challenges in the community. El Futuro has worked with the Kate B. Reynolds Charitable Trust and Community Care of North Carolina (CCNC)

to partner with rural pediatric clinics to offer behavioral health services to the Spanish-speaking population. Telepsychiatry offers Latino patients the opportunity to build stronger relationships at the primary care level and discuss behavioral health issues with a physican they trust.

Kimberly Taylor and Cassandra Gardner from Bonlee School joined the meeting remotely to give further insight into the efficacy of the project. A principal, Kimberly Taylor, and school nurse, Cassandra Gardner, from Bonlee School at Chatham County Schools joined the meeting remotely to share their experiences helping children and their families using this technology. Through the school pilot program, students receiving telepsychiatry treatment from El Futuro are seen by the school nurse on site; the school nurse gathers vitals, height and weight status, and asks the student how their prescribed medicine is working. Then the student is connected to an El Futuro provider over the computer using a connection equipped with audio and video.

Discussion issues included access to care limitations for Spanish-speaking patients, such as transportation and language. Children are especially limited to receiving consistent behavioral health treatment due to parent's issues with work hours and limited transportation. Task Force members were especially interested in the success of building trust in the community between the education system and the family to treat the whole patient, particularly at a young age.

TELEBEHAVIORAL HEALTH AS ALTERNATIVE ACCESS POINT

John Santopietro, MD, FAPA, Chief Clinical Officer of Behavioral Health, Carolinas Health System

Dr. Santopietro discussed the Behavioral Health Telepsychiatry program of Carolinas Health Care System. Based on the IMPACT Training model at the University of Washington AIMS Center, Carolinas Health System has implemented a yearlong pilot program to connect patients to a psychiatrist, mental health specialized pharmacist, behavior health coach, therapist, behavioral health provider, and primary care physician in one visit. Using HIPAA-secure video technology, the telepsychiatry team conducts virtual rounds through 18 emergency room facilities in Charlotte, North Carolina.

Key points of discussion included sustainability and funding for the program. Dr. Santopietro explained how the project is currently internally funded by Carolinas Health System with no billing for services. Leaders are seeking external funding for upfront costs in the next year, with the expectation that the money saved will pay for the program itself in the long-run.

TECHNOLOGY REQUIREMENTS FOR TELEBEHAVIORAL HEALTH

Alex Obert, Information Services, Carolinas Health System

Mr. Obert presented the implications of the HITECH Act, designed to "promote the widespread adoption and interoperability of health informative technology." Important facets include audit controls and Business Associate access controls. There are two types of

telemedicine providers: (1) Business Associate – a vendor that has access to PHI, responsible for providing technology, lower risk and higher security for CE, and (2) Conduits – a vendor that provides transportation of information but does not access it other than on random basis to ensure performance, lowest security, highest risk for CE. Carolinas Healthcare System uses Vidyo infrastructure, operated within CHS firewalls.

HIPAA-approved options for telebehavioral treatment include: Vidyo, Cisco, Polycom, Philips, Cerner, VeeSee. Apple FaceTime requires patching/security and is therefore not recommended by HIPAA. Skype, Google Plus, and WebEx are also not approved. Important discussion points surrounded selecting technology based on risk, compliance, and organizational process of healthcare provider. HIPAA in this instance is not a barrier to providing telebehavioral healthcare. Issues include a lack of conduit between Epic and Cerner electronic medical records.

TELEBEHAVIORAL HEALTH BILLING OPTIONS

Beth Daniel, MSN, RN, Associate Director for Practitioners & Facilities, Division of Medical Assistance, NC Department of Health and Human Services
Nancy S. Henley, MPH, MD, FACP, Chief Medical Officer
Division of Medical Assistance, NC Department of Health and Human Services

The Division of Medical Assistance is currently undergoing the process of revising telehealth policies. The current policy concept is centered on a "practitioner identifying a patient's need for higher level of knowledge/kill and calling on another practitioner with the needed knowledge/skills." This is known as request or referral for consultation, according to National CPT rule.

The proposed policy revision will be based on National Medicaid Evidence Based Decisions collaborative run by Oregon Health Sciences University. The DMA policy process will involve obtaining stakeholder input, research, policy development with Division of Medical Assistance, NC Physician Advisory Group review, fiscal analysis, and external postings.

Discussion centered on the current use of telepsychiatry in Managed Care Organizations across the state. Suggestions for policy revision include expanding eligible sites to schools, homes, prisons, jails, and other state institutions. Contracting from areas of greater availability of physicians to lesser resourced areas was also discussed a point of concern regarding competition and reimbursement.

PROVIDER PERSPECTIVE: BARRIERS TO EXPANDING THE USE OF TELEBEHAVIORAL HEALTH SERVICES

Keith McCoy, MD, Cardinal Innovations Healthcare Solutions, Acting Chief Medical Officer/Medical Director

Dr. McCoy discussed issues facing Managed Care Organizations in providing behavioral health services across North Carolina. There is a serious need for an increase in number and distribution of mental health physicians; currently, 28 counties have with no psychiatrists but others have an excess of resources centered on a hospital. Furthermore, child and adolescent psychiatrist are especially needed, as general psychiatrists are not equipped to effectively treat youth.

Cardinal currently operates under the B3 system, using Open Access Model of Care and Just-In-Time prescribing in order to serve the Medicaid and uninsured indigent population. Recognizing the high no-show rate, the program instead offers prescribing for medications needed two weeks ahead of time. Likewise, telesystems allow flexible management of an unpredictable member population in terms of availability and resources to afford treatment. This system allows for immediate access and keeps behavioral health patients out of crisis centers.

The B3 System is designed to be easy to use but often highly inefficient due to a limited relationship between the psychiatrist and primary care physician. Given that primary care practices have a limited subset of patients who are Medicaid and an even smaller subset with behavioral health needs, it is challenging to encourage primary care physicians to connect with psychiatrists affiliated with a specific MCO. Furthermore, health systems often avoid billing to MCOs. Dr. McCoy brought up the need for regional referral systems. This was supported by Task Force members in discussion.

Other issues discussed included the need for a Payer-Source Blind System that allows Medicaid to participate with other providers. The need to integrate virtual behavioral health into primary care was emphasized in conversations with universal screening and registries to connect patients to intervention resources. EMR dissonance is also an issue for MCOs and providers.

DISCUSSION OF POTENTIAL RECOMMENDATIONS

Conversations centered on the issue of Medicaid reimbursement, as physicians are reimbursed at a rate far lower than the cost of a visit. An enhanced rate for telepsychiatry services was suggested, as well as a saving-based system to incentivize more efficient practices by DMA.

Dr. Smith and others discussed the question of rigid policy concerns on the side of public systems that have not been a source of limitation for private systems. The MCO credentialing system for telepsychiatry is a major barrier to contract which could be addressed with delegation, as done by Cardinal.

Other barriers for MCOs are the health center designation limitations, particularly schools. One member explained that schools cannot be a medical home to a patient while Task Force members argued that school nurses can be a great point of access to care in each school health clinic. A school can be labeled a site if one provider there is Medicaid credentialed and

instances have occurred where expansion was granted to a full district. Overall, limitations on credentials and Medicaid billing for MCOs are a point of confusion for many providers.

While telepsychiatry offers direct and easy access to patients on the provider side, it is unclear if issues may arise with behavioral health risks in the home. So far, there have not been any reported serious problems with telesystems, and have, in fact, been more effective for group treatment than other alternatives. Concerns include privacy over an audio/video connection and addressing a serious episode or emergency. Call-center models could address this problem by utilizing existing hotline models.

USING TELEPSYCHIATRY TO IMPROVE ACCESS TO EVIDENCE-BASED CARE

Sy Atezaz Saeed, M.D., M.S., FACPsych, Professor and Chairman, Department of Psychiatry and Behavioral Medicine, Brody School of Medicine at East Carolina University, Director, North Carolina Statewide Telepsychiatry Program (NC-STeP)

The North Carolina statewide telepsychiatry program (NC-STeP was developed in 2013 to connect individuals experiencing acute behavioral health crisis in an emergency department with specialized psychiatric treatment through the telepsychiatry network. Seventy-one hopsitals across North Carolina are part of the NC-STeP network and there are five clinical provider hubs. In the past two years, more than 12,000 telepsychiatry assessments have been conducted under the program. A health information exchange system allows the different hospital electronic medical record systems to "talk" to one another.

Quality management and outcomes monitoring are required of participating sites and is reported quarterly. NC-STep has allowed most patients who enter the emergency department experiencing acute behavioral health crisis to be seen in a timely manner. Providers are satisfied with the program and it has produced benefits, however, it faces challenges due to staffing, financing, and other challenges.

Outpatient Telebehavioral Health Services

Billy R. West, Jr., MSW, LCSW, Executive Director, DAYMARK Recovery Services, Inc.
Philip Nofal, MD, JD, Medical Director, Daymark Recovery Services, Inc

Mr. West talked about the role of telebehavioral health in meeting the needs of the 53,000 North Carolinians that DAYMARK serves every year. Telebehavioral health has allowed DAYMARK to increase their capacity to meet the needs of clients by eliminating their waiting list, providing on demand assessments for appointments, and reducing their no-show rate. Additional benefits of telebehavioral health cited by Mr. West include the reduction of patient travel time, the ability to quickly see patients in distress, the ability to include off-site and part-time behavioral health specialist as part of their workforce using telehealth technology. Mr. West also discussed that this technology is increasingly available as the costs have plummeted in recent years.

Dr. Nofal discussed the ongoing challenges of providing behavioral health services in many rural areas of North Carolina due to the unequal distribution of behavioral health specialists, particularly psychiatrists, in the state. Telebehavioral health is an excellent tool to ensuring that individuals in rural counties have access to behavioral health professional services, even if they do not have a local provider. He also discussed the hardware and software technology behind DAYMARK's telehealth services. About half of DAYMARK's psychiatrist staff of 60 perform telebehavioral health services. In 2014, their psychiatrists provided over 9,000 telebehavioral health services. Additionally, they have licensed clinical social worker on staff who is dedicated to telehealth who performed 305 telebehavioral health assessments in 2014.

DISCUSSION OF POTENTIAL RECOMMENDATIONS

Conversations focused on barriers to telebehavioral health including: Medicaid rates, credentialing requirements, lack of knowledge about the technical aspects of telebehavioral health, the need for more statewide collaboration on telebehavioral health issues, and training and workforce issues. The Task Force will be working on recommendations to tackle some of these barriers.