
**CURB
Meeting Minutes
May 21, 2014**

PRESENT:

Board: Michel Benoit, MD, Patricia Berry, MPH, Delores Burroughs-Biron, MD, David Butsch, MD, Ann Goering, MD, John Mathew, MD, Paul Penar, MD, Norman Ward, MD,

DVHA Staff: Daljit Clark, Aaron French, Jennifer Herwood, Susan Mason, Thomas Simpatico, MD (moderator), Scott Strenio, MD, Kara Suter

Guests: Cyrus Jordan, MD, Madeleine Mongan, Robert Pierattini, MD, Jay Persico

Absent: William Minsinger, MD, Richard Wasserman, MD

HANDOUTS

- Agenda
- Draft minutes from 3/19/14

CONVENE: Dr. Thomas Simpatico convened the meeting at 6:35 pm.

1.0 Introductions

2.0 Review and Approval of Minutes

The minutes were reviewed and approved as written.

3.0 Updates:

None

4.0 Old Business:

○ **Provider Code Review Form – Daljit Clark**

At the last meeting, CURB members commented that insurers have no mechanism in place to request codes/services covered that are not covered. DVHA has had a process in place to request services but have agreed to create a more efficient and clear process. DVHA staff spoke with Hewlett Packard (HP) DVHA's fiscal agent and DVHA IT staff and asked them to create a portal through which providers can request codes/service to be reviewed for coverage. The portal will be a secure confidential site for providers to submit their request for review. HP and DVHA IT staff are working on finalizing this option. Once it is finalized DVHA will notify all providers with access to the link.

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5.0 New Business:

Psychiatry Embed in Primary Care Model – Dr. Robert Pierattini

This is a huge public health problem that is paralyzed by the complexity of funding. There is a new opportunity with the change in payment reform.

The problems for Psychiatry are:

Access – The third next available appointment at Fletcher Allen Health Care (FAHC) is 128 days. This is the longest of any medical care at FAHC.

Finances – Psychiatrist are paid around 2/3 the value of comparable work in other specialties. The service is about \$1.3 million negative in recent years. The current funding model only works for simpler patients. There is no provision for risk, acuity or case management. The issue is global.

Results - Any mental health (MH) or substance abuse (SA) disorder triples medical costs whether severe or not. This may be due to access of care. If care were integrated there would be a reduction in costs on the entire medical expenditure. The increase extends across many disorders. There is potential savings through integrated mental health and medical services. The amount saved is equivalent to the total spent on psychiatric services provided by physicians.

FAHC Psychiatry is already doing this, but it is not sustainable.

- Primary care health masters level clinicians embedded in the primary care family Medicine sites. Provides Psychiatric therapy, problem solving and life guidance.
- FAHC inpatient with focus on children and adolescents.
- Psychiatric consultation to hospitals – inpatient.

Medical Home Primary Psychiatry – this pilot will:

- Increase access
- Support the medical home
- Support primary care physicians
- Provide psychiatric expertise in a setting familiar and convenient to the patient
- Interface with external mental health programs

The Medical neighborhoods are programs that provide a level of services that are not feasible in the medical home.

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Essential elements:

- Psychiatry to primary care site or Medical Home
- Psychiatrist provides formal and informal consultation
- Offers presentation or participation in case conferences
- The office staff does routine things like prescription refills, calls and emergencies
- The Psychiatric care is by the entire medical home teams, not the tradition of “my psychiatrist”
- Care may alternate between Primary Care Physician (PCP) and Psychiatrist

Proposal:

- Asking for joint sponsorship of the program and joint assessment of the results

One time consultations are often not useful; this model diverts consultation.

Potential Impact:

- Can this model be expanded to other primary care practices outside of FAHC?
- Will it improve patient care and clinical outcomes?
- Will a modest investment yield significant savings?
- Will this model reduce PCP burnout and turnover?
- Will this improve patient and PCP satisfaction?

Discussion:

- How do we match the resources to the effort?
- How to get paid for services?
- There is payment for tele-psychiatry but the MD has to pay for the room.
- Department of Corrections (DOC) has a medical home system with use of many levels of MH professionals and a high level of members with MH issues.
- Many demo projects in the USA and internationally.
- Can this be expanded beyond FAHC?
- Patients scheduled in advance for chart review, some evaluation and staff education.
- In the ACOs there are 17% with a major MH diagnosis.
- PCPS are afraid of opiate seeking patients with guns; turnover is serious.
- There is no way to do the cost shift because MH reimbursement with commercial insurances is not better.
- “Take it or leave it” fee schedule. Refuse to negotiate

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- Mandate to not hinder the patient so the patient pays more copayment, but it is a free market regarding payment.
- DOC pays and it is constitutionally mandated to provide care. Why isn't anyone trying to partner with DOC? Prisoners will return to the community.
- The system is compartmentalized.
- This needs to expand beyond FAHC.
- Community Health Ctr of Burlington has a similar model that is being proposed. Is there anything to be learned from this program?

Action Item:

Next Steps:

Need to ask for consensus of a staffing/patient ratio. We have mechanism to fund shared resources like the community health systems.

Tom proposes using CURB as a resource to figure this out. By next meeting we will have digested this and will discuss it again.

Bring the Blueprint model as a teaming, non-fee for service, payment-reform context. Capacity based payment not driven by procedure codes and fee for service.

6.0 Technology Requests – Dr. Scott Strenio

- **Genetic Testing** – The CPT coding was implemented in 2013. We review all requests for genetic testing for analytic validity, clinical utility, budget impact and ethical implications. We determine clinical utility based on many resources including:
 - Peer-review literature
 - Technology assessments
 - Professional association opinions and guidelines
 - Direct discussion with providers
 - Other medical and commercial policies

We are currently pursuing a Hayes license for genetic testing. Hayes Health Assessment Technology is evidence based and clinically focused. It is a valuable tool for creating sound evidence based policy which will enable appropriate coverage decisions.

Discussion

- Tests must have a direct impact now and obviate the need for other testing

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- Hayes helps us to know which tests have direct relevance
 - DVHA has a policy that we must follow. Hayes can help lead us to creating solid evidence based criteria
 - Hayes has geneticists available to us as well as criteria and a library
 - Using local expertise to help with bundling and disseminating information to clinical
 - How would knowing the result of this test impact the Physician's care of the individual
 - There are roughly 100 cases per month.
- **Sovaldi and Hepatitis C**– The cost is roughly \$84,000 per prescription and when combined can be \$125,000/ 12 weeks. The cure rate is 90%. There are 600-700 new cases per year. There are 10,000-15,000 patients in the “woodwork”, not identified yet. To treat all could cost roughly \$40 million.

The VA has a comprehensive plan.

Discussion

- We try to prioritize by who needs the prescription now
- The new drugs are coming that do not require the addition of interferon
- The focus is on aggressive cases
- If the recipient is unable to be compliant or continue to use IV drugs they would not be prioritized
- We do consider extenuating circumstances via a form
- Unless there is impending liver failure, we can postpone prescription until all oral meds come out with the next year.
- We are working with commercial insurances and DOC to collaborate
- Cure vs control, many medical problems can be prevented, but they can get re-infected
- One paradigm, what must be done to have a liver transplant

Adjournment – CURB meeting adjourned at 8:35 PM

Next Meeting

July 16, 2014

Time: 6:30 PM – 8:30 PM

Location: Department of Vermont Health Access, Williston, VT