



Primary Care Behavioral Health: The Case for Integration – An Interview with Roger G. Kathol, MD

by Carole A. Lambert, MPA, RN

Primary care settings have been identified as a gateway for many patients with mental health/substance use (behavioral health, or BH) disorders and primary care needs. This point of access is well known to CAP member physicians, their staff, and their organizations, who meet patients and their families at intersections of need and frustration. According to the Centers for Disease Control and Prevention (CDC), the numbers of people seeking BH services each year are in the millions, whether they come to a physician's office, a community health clinic, or a hospital's emergency department.

To gain a perspective on the need for care, the challenges to accessing and receiving care, and possible ways forward, we spoke with Dr. Roger G. Kathol, president of Cartesian Solutions, Inc.™ in Burnsville, Minnesota. He is board certified in internal medicine and psychiatry and has developed integrated programs for patients with concurrent general medical and BH disorders for hospital systems, health plans, and government agencies for more than 30 years. In the coming months, Dr. Kathol will lead the development of national standards for accrediting primary care BH entities by URAC in Washington, D.C.

CAP: Dr. Kathol, thanks so much for taking time to speak with us. To get us started, give us a context for understanding the need for integrating primary care and BH.

RGK: Well, the challenge to patients is simple and profound: they want treatment but may not be able to get it. The vast majority of BH patients never get to the BH clinical area. These folks understandably fear the

stigmatization associated with being in that setting. But BH payers, common in most U.S. states, wish to pay only for BH services in BH areas.



Dr. Roger G. Kathol

CAP: As great as the need is, accessing care and getting reimbursed for providing care are challenges that are inextricably linked. You've been at this a while. How did we get here?

RGK: The separate payment system, for medical health as opposed to BH, originated as managed care and

was created in the 1980s. This separation persists since BH payers resist efforts to integrate into medical care. So, 70 percent of BH patients are seen primarily or only in the medical sector. Of this group, only 10 percent receive evidence-based BH treatment. They – which include probably 50 percent of patients with serious and persistent mental illness – end up costing buckets of money.

CAP: Our members are dedicated to giving appropriate care but have understandable concerns about incurring liability if they appear to be practicing outside their scope. What is your take on navigating that concern in a primary care setting when there is an expectation of providing BH services?

RGK: BH care is not outside primary care physicians' scope of practice. However, it is often outside their scope of comfort. There are simply too few psychiatrists and other BH professionals to meet the needs of patients with BH problems or to provide assistance to primary care doctors. Most psychiatrists practice in BH settings where they get paid and focus on treating BH issues. This is similar to the role that physicians in medicine take. They treat conditions with which they are familiar, i.e., medical, in the medical setting and quite often avoid taking responsibility for assessing and managing BH issues, largely by asking few BH questions.

CAP: Is there a practical, realistic way forward?

RGK: There are many examples of successfully integrated programs. For instance, one Midwestern metropolitan network of over 10 general medical hospitals introduced psychiatric assessment and treatment into their "medical" emergency departments. The result was a 25 percent decrease in the total cost of emergency department care and admissions compared to when they used stand-alone BH emergency departments. But the most promising approach has come from the Centers for Medicare and Medicaid Services' (CMS) recognition of value through collaborative care – the integration of BH into primary care settings. There are over 80 randomized controlled trials that prove depressed patient outcomes improve and costs go down for years when this model of integrated medical and BH care is tried.

CAP: That sounds like a no-brainer.

RGK: To those of us who have been working in the field, it does since the model reflects a specific, researched model of BH integration. In the model, a psychiatrist is introduced into the outpatient medical care setting, reviews cases regularly – every fourteen days or so – and recommends the treatment to be given by the primary care physician. After this, patients are followed and assessed by the BH team and primary care doctor, and either treatments are adjusted or patients are discharged from collaborative care (when improved). In this setting, the psychiatrist and primary care physician are professional colleagues, working together. CMS approved payment about two years ago. In 2018, specific CPT codes will be used to report BH integration services. Interestingly, medical, not BH benefits pay for BH services through the primary care clinic – a major advance for patients who would otherwise receive no treatment.

CAP: Telehealth has been identified as a care delivery system that can be effective and make mental health services accessible. Can you comment on that?

RGK: There are a number of very good studies now showing that telehealth is as effective as face-to-face encounters. The patient gets the services he or she needs, delivered by a BH professional. As an example, cognitive behavioral therapy delivered via telehealth using standard guidelines is as good as going to the therapist. This approach directly tackles the maldistribution of BH professionals.

CAP: That sounds like another step forward and an advantage for patients. And it's a positive note on which to end our conversation. Many thanks for sharing your experience and vision with us. I hope we can talk again about further progress in primary care behavioral health integration. ↩

Carole Lambert is CAP's Vice President, Practice Optimization, and Residents Program Director. Questions or comments related to this article should be directed to clambert@CAPphysicians.com.

Risk Management — and — Patient Safety News



Healthcare Communication Failure: 13 Ways to Improve Communication

by Ann Whitehead, JD, RN

The Joint Commission estimates that 70 percent of sentinel events include communication breakdowns as one of the root causes of preventable patient injury. When we review our closed claims, we see, but for the communication failure, the patient injury would never have occurred. Also, national data studies reveal that 34 percent of OB cases, 26 percent of surgery cases, and 38 percent of general medicine cases involve one or more communication errors. We find similar results in our CAP claims reviews.

CAP's ongoing, internal and external data review indicates that communications failures often occur at a critical point in the diagnostic process. These situations include:

- Missing incidental findings on a report
- Failure to note something relevant in the patient's history
- Failure to communicate an important finding to the patient or family

There are many other types of communication failures that can result in a claim. These include:

- Incomplete handoff between providers, regarding the patient's condition
- Poor documentation -- either inaccurate, incomplete, or illegible
- Inadequate informed consent
- Failure to respond to the patient's concerns, calls, questions
- Inadequate patient education
- Failure to accommodate low health literacy or provide language assistance, and
- Failure of staff to advocate for your patient and to escalate safety concerns.

Some CAP closed claims examples of communication failures, resulting in patient injury include:

- A hospitalist notes pending labs in the patient's discharge summary and assumes that the primary care physician will follow up. There is no other handoff communication between the physicians. It arrives five days after discharge and after the patient's visit. The patient is unaware of the pending results. The abnormal result goes unaddressed.
- A cardiologist assumes the patient is familiar with the side effects of the newly prescribed anticoagulant medication and prescribes it without fully educating the patient. The patient takes both anticoagulants.
- A nurse documents a change in the patient's condition assuming that the physician will read her note when he rounds. The changes noted go unaddressed in the patient's medical record.

George Bernard Shaw once said, "The single biggest problem in communication is the illusion that it has taken place." The best way to improve communication is to think like a patient safety engineer or a risk manager. Identify the types of critical information that you communicate, anticipate where it might break down, and implement systems to prevent communication failures. The most common ways to prevent communication breakdowns are to:

- Provide copies of labs, a summary of the visit, and the patient's current medication list after each visit
- Request that copies of discharge summaries be sent to PCPs
- Establish missed appointment protocols
- Offer patient education materials
- Implement referral tracking systems

February 2018



Continued from page 3

- Devise a follow-up process for labs and reports
- Standardize handoffs for critical information
- Institute a complaint management process

Communication is challenging because healthcare is challenging! There is an abundance of data and information that must be managed and understood. Only 12 percent of U.S. adults have the health literacy skills needed to manage their own healthcare in our complex healthcare system and, sadly, these individuals' ability to absorb and use health information is also compromised by stress or illness.

Conveying the correct information, to the correct patient, that is timely and understood is the challenge facing all healthcare practitioners. To improve communication with patients:

- Make health literacy a core value in your practice for all staff
- Verify inpatient understanding using techniques such as Teach-Back
- Adopt universal health literacy precautions – at a minimum, use plain language with all patients
- Provide translation services
- Respond to patient complaints

Effective communication is not only critical to meeting patient needs and improving patient safety, it is also necessary to improve the patient experience and how we manage the delivery of healthcare to all patients. The ability to explain, listen, and empathize can profoundly impact relationships with patients and colleagues. For this reason, invest time to identify communication barriers and develop communication systems that will improve communication with patients and colleagues across the continuum of care. ↩

With patient safety as the objective, CAP risk management specialists are available to assist you to identify patient communication failures and provide advice and guidance to establish systems to catch these failures to prevent patient injury and mitigate risk. Members may request an office practice risk survey by calling **800-252-0555** or by emailing the Risk Management Department at riskmanagement@CAPphysicians.com.

Communication is a key component of the CAP Cares Program, an early intervention program that provides support and advice in the immediate aftermath of an adverse outcome. CAP Cares staff members are available to provide CAP members with information and communication techniques to safeguard their relationship with the patient and manage potential risks. The CAP Cares Hotline is available 24 hours a day, seven days a week, for adverse event/outcome management. We encourage you to call **1-800-252-0555** when a problem arises.

Ann Whitehead is Vice President, Risk Management and Patient Safety for CAP. Questions or comments related to this article should be directed to awhitehead@CAPphysicians.com.

The MACRA rules released last November for Year 2 (2018) of the Quality Payment Program (QPP) include increased flexibility for small and independent practice clinicians participating in the Merit-based Incentive Payment System (MIPS). While the changes aim to reduce reporting burdens for clinicians, other changes happening at the agency's leadership level present some uncertainty on the viability of the path on which MIPS will continue.

But first, looking back to 2017, MIPS-eligible physicians who participated at any level with data collection of measures in the "Pick Your Pace" models have until March 31, 2018 to submit their 2017 data for a payment adjustment in 2019.


As we enter Year 2, rules for 2018 reflect greater support of small and independent practices by implementing additional flexibilities, including:

1. In 2018, many more small practices will be excluded from MIPS compliance because of a modified low-volume threshold. The new low-volume threshold is less than or equal to \$90,000 in Medicare Part B allowed charges or less than or equal to 200 Medicare patients.
2. Year 2 also introduces Virtual Groups. This option gives solo practitioners and groups of 10 or fewer eligible clinicians the option to come together "virtually" to participate in MIPS for a performance period of a year.
3. Year 2 adds five bonus points to the practice's final MIPS score.
4. The Centers for Medicare & Medicaid Services (CMS) will continue funding the community-based

organizations awarded in 2017 that provide free hands-on technical assistance to support and train physicians in practices with 15 or fewer clinicians aiming to achieve greater success with QPP/MIPS compliance. The organization serving California physicians is the Health Services Advisory Group (HSAG). <https://hsag.com/en/medicare-providers/quality-payment-program/>

Potentially impacting the continued rollout of MIPS is the arrival of the newest Secretary of Health and Human Services (HHS), Alex Azar. Mr. Azar was confirmed by the Senate on January 24 following Dr. Tom Price's resignation last fall. While the physician community felt it may have had a sympathetic ear in Dr. Price, with Mr. Azar, there is less certainty on how MACRA will be administered. For example, Secretary Azar has said he is open to mandatory Medicare payment demonstrations (mandatory bundled payments) that Dr. Price rejected.

On MIPS, Secretary Azar has told the Senate Finance Committee: "A key challenge under MIPS going forward will be to measure the quality of care in a meaningful way that does not require an unduly burdensome amount of time and resources."

In January, a group called the Medicare Payment Advisory Commission (MedPAC) recommended eliminating MIPS based on the group's assessment of the burdens imposed by the program. 

Gabriela Villanueva is CAP's Public Affairs Coordinator. Questions or comments related to this article should be directed to gvillanueva@CAPphysicians.com.

Refer a Physician Colleague to CAP

Since our founding, CAP members have played a significant role in helping to grow our membership by referring other high-quality physician colleagues. **When a member tells us that a colleague would be a good fit for CAP, we take notice!**



If you know of any nonmember physicians practicing in California who might love CAP, we'd appreciate the referral. Either:

visit CAPphysicians.com/refer
email Refer@CAPphysicians.com
call 800-356-5672

As a thank you gift, we will send you a

\$25 Starbucks or \$25 Amazon Gift Card

for each physician you refer and allow us to use your name.*

your choice!

*Maximum of five (5) gift cards per member per 12-month period.

Free Webinar

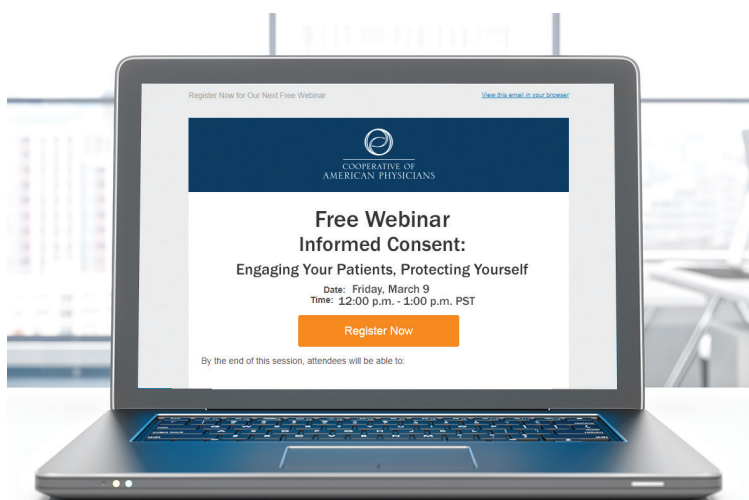
Informed Consent: Engaging Your Patients, Protecting Yourself

*Did you know that 34 percent of all medical liability lawsuits among spine surgeons can be attributed to improper informed consent?**

Join CAP for a free lunch-hour webinar that will cover the essentials of informed consent to help you reduce the chances of a medical liability lawsuit, while effectively and respectfully communicating must-know information to your patients.

Presented by Randall W. Porter, MD, a neurosurgeon with Barrow Neurosurgical Associates and founder of Medical Memory, "Informed Consent: Engaging Your Patients, Protecting Yourself," will take place on Friday, March 9 from noon to 1:00 p.m. PST and touch on the following topics:

- What are the basic elements of informed consent?
- What are the implications of improper informed consent?
- What leads to the decline of patient understanding? How can this lead to poor communication?
- What are the seven steps of the informed consent process and how can you protect yourself?
- What should a provider disclose about conflict of interest?



This information-packed hour will provide you with the tools needed to help strengthen your informed consent and conflict of interest processes to better protect yourself and your patients.

CAP physician members and their staff can register online for this free webinar at <http://info.themedicalmemory.com/CAP>.

We look forward to your participation. ➦

*Becker's Spine Review, July 5, 2017

February 2018



Healthcare Law and Medicine Educational Symposium

The Cooperative of American Physicians, Inc. (CAP) is pleased to partner with the Los Angeles County Bar Association for a symposium covering the hottest topics intersecting law and medicine. This event is free for CAP members, and CAP members are welcome to bring a physician guest who is not a CAP member.

Tuesday, March 20

Los Angeles County Bar Association
(Downtown Los Angeles)

Dinner: 5:30 - 6:00 p.m.

Program: 6:00 - 9:15 p.m.

For more information about topics and speakers, as well as to register for this event, please:

Visit— www.CAPphysicians.com/LACBA

Email— RSVP@CAPphysicians.com

Call— **800-361-5569**

February 2018

2018 Litigation Education Retreat Schedule

Recognizing the damaging effects a lawsuit can have on a physician's personal and professional well-being, CAP invites its members to attend its daylong Litigation Education Retreat. CAP offers the free program several times each year.

At the program, a nationally recognized expert in the field of behavioral health will provide valuable suggestions on alleviating the stress associated with being named in a lawsuit, while legal and communications experts will help physicians develop the skills that will improve their chances for a favorable outcome.

The first Litigation Education Retreat of this year takes place in Los Angeles on Saturday, April 14. CAP, a CME-accredited provider, designates this educational activity for a maximum of six AMA PRA Category 1 Credit(s)[™].

CAP will also offer Litigation Education Retreats in San Diego County on June 23, and in Orange County on October 20. If you are interested in attending one of the retreats, please contact

Andrea Crum at **800-252-7706** or at

LERinfo@CAPphysicians.com.

Case of the Month

by Gordon Ownby



Court SLAPPs Down Hospital's Legal Defense Strategy

In a colorful and blunt opinion, the California Court of Appeal spared few words in saying what it thought about a hospital's legal strategy to defeat a suit brought by a physicians group alleging unfair competition. Physician-hospital policy wonks, read on.

At issue is a legal defense called an "anti-SLAPP" motion. "SLAPP" stands for "strategic lawsuit against public participation" and the motion allows defendants to seek an early dismissal of harassing lawsuits concerning protected rights of a defendant. If the motion shows that the activity complained of is a protected activity, such as free speech in connection with a public issue, and that there is little likelihood the plaintiff will ultimately prevail, a judge can strike the complaint completely. Anti-SLAPP motions can be successful when hospitals use them to defend against suits that arise out of peer review activity.

In *Central Valley Hospitalists v. Dignity Health*, a group of hospitalists sued Dignity Health alleging unfair business practices, intentional interference with contractual and prospective economic relations, and breach of contract. In its pleadings, the medical group, CVH, claimed that St. Joseph's Medical Center in Stockton, operated by Dignity Health, induced certain physicians to leave CVH, harassed CVH physicians while at the hospital, discouraged physicians from working with CVH, and referred CVH patients to Dignity Health-related home healthcare providers without appropriate CVH physician orders. (At this point in the litigation, no allegations have been proven.)

In its final general allegation, the suit states: "This Complaint does not allege wrongs or facts arising from any privileged peer review activities. Any reading of this

Complaint which would implicate such activities is disavowed as excluded from this specific litigation."

Despite that statement (and despite an offer from CVH's lawyer to Dignity Health's lawyer to amend the complaint if there was any confusion on the peer review issue), Dignity Health filed an anti-SLAPP motion to strike the complaint that argued: "Specifically, this lawsuit challenges protected activity because it arises out of the physician peer review process – which the California Supreme Court has confirmed is an 'official proceeding authorized by law' – and thus it falls within the scope of [the anti-SLAPP statute]."

CVH opposed the motion, arguing the complaint was not based on peer review and filing declarations from three physicians and CVH's attorney himself. In denying the anti-SLAPP motion, the trial court judge commented on the absence of any actual acts or facts alleged by CVH to support its contentions but said such an absence of facts does not allow a defendant to insert its own.

"Dignity Health cites no authority, nor could I locate any, that permits a defendant making an anti-SLAPP motion to satisfy its . . . burden by its own evidence of what it believes the plaintiff's claims are based on," the judge wrote. "If there are no acts alleged, there can be no showing that alleged acts arise from protected activity."

In pursuing their fight, Dignity Health's lawyers met a skeptical panel at the First District Court of Appeal in San Francisco. In its written opinion, the appellate court noted that though the complaint was "factually inadequate in supporting detail" the essence of the

February 2018

medical group's complaint could be gleaned from it and from the declarations filed with the court. "That case includes among other things Dignity Health interfered with the hiring and/or retention of CVH staff by inducing key physicians to quit CVH and work for Dignity Health's partner, Sound Physicians; harassed CVH physicians to the point they quit; refused to provide privileges application paperwork to physicians who wanted to join CVH; meddled in patient care in ways that endangered patient safety and increased malpractice risks; and inappropriately targeted CVH's primary care patients." That was what CVH's case was about, the court said.

"Not only that, CVH said it was not suing about peer review; expressly excluded peer review from the complaint; offered to stipulate that there would be no

discovery as to peer review; and offered to amend the complaint to clarify the bases of the business torts at issue," the court continues, its sarcasm evident.

"No matter to Dignity Health. Ignore all that. Ignore what was pleaded. The case was peer review."

In supporting the trial court judge's original decision to deny Dignity Health's anti-SLAPP motion, the Court of Appeal lamented the resources spent over the argument. "So here we are 22 months – and untold attorney fees – later, addressing defendant's appeal. We affirm." ↩

Gordon Ownby is CAP's General Counsel. Questions or comments related to "Case of the Month" should be directed to gownby@CAPphysicians.com.

Should You Offer Employees Healthcare Benefits?

Key employees and leaders are essential to the long-term success of your practice. Hiring and keeping the right team in place can make a difference in your patients' welfare and determine how patients feel about you as a physician. So how can you attract and retain the best employees? One consideration: healthcare benefits.

While healthcare benefits are optional for smaller employers, they are of critical importance to most employees. In fact, nearly three in five (57 percent) employees report benefits and perks as being their top consideration before accepting a job. Offering benefits may cost you more initially, but the long-term benefits can far outweigh additional costs.

When you offer a benefits package, it shows a vested interest in your employees. Offering benefits can help promote good morale and keep employees happier and healthier. If employees have access to wellness and preventative-care doctor visits, they tend to take fewer sick days; this, in turn, translates into better service for your patients and overall increased productivity. Offering benefits also creates a loyalty to you as an employer and reduces the likelihood of valued employees leaving due to of lack of benefits.

When you contribute to your employees' benefit plan, it also lowers the cost of providing coverage for you and your family and provides better coverage options because you are purchasing your coverage as a group.

Let CAP Agency show you how you can provide the best benefits to your employees at the lowest cost.

Contact us today at **800-819-0061** or click on the link www.CAPphysicians.com/enroll to get a quote for dental and vision insurance today. ↩





COOPERATIVE OF
AMERICAN PHYSICIANS

Cooperative of American Physicians, Inc.
333 S. Hope St., 8th Floor
Los Angeles, CA 90071

PRESORTED
STANDARD
US POSTAGE PAID
LOS ANGELES, CA
PERMIT #1831

February 2018

IN THIS ISSUE

- 1 Primary Care Behavioral Health : The Case for Integration –
An Interview with Roger G. Kathol, MD
- 3 Risk Management and Patient Safety News:
Healthcare Communication Failure: 13 Ways to Improve Communication
- 5 Public Policy:
MACRA: The Journey Continues
- 6 Refer a Physician Colleague to CAP; Receive a Gift Card
- 6 Free Webinar:
Informed Consent: Engaging Your Patients, Protecting Yourself
- 7 Healthcare Law and Medicine Educational Symposium
- 7 2018 Litigation Education Retreat Schedule
- 8 Case of the Month:
Court SLAPPs Down Hospital's Legal Defense Strategy
- 9 Should You Offer Employees Healthcare Benefits?

CAPsules® is a publication of the Corporate Communications Department of the Cooperative of American Physicians, Inc.
333 S. Hope St., 8th Floor, Los Angeles, CA 90071 | 800-252-7706 | www.CAPphysicians.com.

We welcome your comments! Please submit to communications@CAPphysicians.com.

The information in this publication should not be considered legal or medical advice applicable to a specific situation.

Legal guidance for individual matters should be obtained from a retained attorney.