

NASMHPD Medical Directors Council

Business Meeting Minutes

October 5, 2004

Savannah, Georgia

The Medical Directors Council conducted a business meeting on the final day of its annual Symposium. As the Council's Chair, Dr. Parks (Missouri) facilitated the meeting.

Review/Discussion of Council's Technical Reports

Technical Report on Prevention

The final session of the Medical Director's Symposium (see separate *Proceedings*) featured discussion of the Council's draft technical report on prevention. Co-editor Dr. Eilers (New Jersey) provided an overview of the report and solicited input from medical directors for the final draft. The medical directors recommended that the report include a focus on early psychosis intervention, trauma and suicide prevention; specific actions that commissioners could take to promote prevention; and examples of successful prevention initiatives.

Technical Report on Integrating Behavioral Health and Primary Care

During 2004, the Medical Directors Council also worked on a technical report on the linkage and integration of primary care with Dr. Pollack (Oregon) and Parks serving as co-editors. Dr. Pollack shared a draft with participants and summarized the report.

With Barbara Mauer, MSW, CMC serving as technical writer, the work group consisted of several medical directors, a state Medicaid director, the medical director from the National Association of Community Health Centers, Association of State and Territorial Health Officials (ASTHO) representative, and representatives from Tennessee and Missouri, where they have implemented integration models. The report features guidance to primary care colleagues who treat persons with mild to psychiatric illnesses in their clinics and a framework to provide better medical services for persons with persistent mental illnesses served by the public mental health sector.

The report also discusses policy concerns, including the risk of a parallel mental health system being developed within the public health system. The federal Health Resources and Services Administration (HRSA) has promoted increased attention to mental health concerns in public health primary care clinics by (1) stating that new or expanding federally qualified health centers or rural health clinics receiving federal funds must provide mental health and substance abuse treatment; and (2) convening community health clinics from around the country to form health disparities collaboratives, which periodically meet and learn how to better screen, prevent, treat and organize care for people with hypertension, asthma, diabetes, cancer and depression. Particularly after an infusion of funds following September 11th, the public health system has focused on and

expanded its role in delivering mental health services to clients. Without collaborative planning between the mental health and public health systems, the public health system may develop a parallel mental health system which does not include local community mental health providers.

To provide commissioners with a conceptual understanding of how care can be integrated, the report features the “Four Quadrant Clinical Integration Model.” The model combines mental health and chemical dependence levels of severity on one axis, and medical/surgical/physical health symptoms severity on the other axis. The model can be used to determine which care setting (primary or mental health) and collaborative approaches are most appropriate given the patient’s levels of physical and behavioral impairment. The report also details how behavioral health evidence-based practices can be used when serving people from each of the four quadrants.

A major focus of the report is improving primary care for people with serious mental illnesses and implementing strategies contained in the Bazelon Center’s report, *Get it Together: How to Integrate Physical and Mental Health Care for People with Serious Mental Disorders*. The technical report advises commissioners that state mental health systems need to devote similar attention to ensuring clients receive primary care services as the time they spend on clients’ need for housing or psychiatric medication. One recommendation is to co-locate primary care providers in mental health settings or otherwise create strong links between the two care systems. The other major thrust is providing more coordination at the state and local levels to better support primary care providers as they identify and treat people with psychiatric conditions that show up in their clinics.

In order to co-locate or effectively link primary care and mental health services, effective systems coordination must occur. State-level decision makers from Medicaid, public health, behavioral health and other relevant offices must be involved to support the collaborative efforts. The report includes a number of recommendations on how to achieve that level of system coordination, particularly around financing issues.

During the discussion, medical directors lauded the report and the work group’s effort to be detailed and comprehensive. Participants also offered some thoughts to strengthen the report as it moves toward final form. These comments included:

- Improve the Executive Summary to better orient readers to the multiple thrusts of the report and avoid losing them among complex details;
- Consider breaking the report into three sections, addressing: (1) the behavioral system, (2) primary care system and (3) policy decision makers at the State and Federal levels;
- Mention the MR/DD population and how they fit into this framework; and

- Reorder the sections to improve the flow: importance of the topic; conceptual models; system coordination; and focus on the two specific populations (people with serious mental illnesses and those seen by primary care).

Action: The editors will implement the medical directors' recommendations, but not make any substantive changes to the paper. The revised draft then will be given to the Council's Editorial Board for review and comment. The aim is to complete the review process so the Council can give a short presentation and submit the report at the December Commissioners meeting.

Topics for 2005

Dr. Parks facilitated a brainstorming session during which medical directors suggested topics they would like addressed in the upcoming year – either through a technical report or during a future Symposium. The list included:

Medicare prescription drug changes (Medicare D)

DD/MR linkages with corrections/forensic

Sex Offenders (particular issue for the MR/DD population)

Treatment planning and integrating treatment between inpatient and outpatient settings

Integrating primary care and mental health care, particularly in hospitals

Leadership/Change management (Promoting learning organizations instead of reacting to the latest crisis)

Encouraging universities and training institutions to focus on recovery

Risk management, including DOJ suits

Best practices for dealing with children with ADHD, including collaborating with primary care, which treats most of these children

Serving the behavioral health needs of youth involved with multiple systems

Confidentiality as systems move toward recovery, collaboration and integration

Follow-up on evidence-based practices

Workforce development and curriculum reform

Inclusion of consumers and families to inform discussion

Electronic medical records and integrated technology systems.

Decision-making frameworks for prioritizing competing needs given limited resources

Tool kit on mortality data

Medical Directors Council Liaison Reports

Dr. Pollack gave a brief report as the Council's liaison with the American Association of Community Psychiatrists (AACCP). He invited participants to attend the upcoming AACCP board meeting and evening events occurring over the next few days in Savannah. Dr. Pollack encouraged continued collaborative ventures and flow of ideas between the Council and AACCP. Currently, AACCP is working on a recovery evaluation instrument and a few position papers.

Dr. Miller (Arkansas) serves as the liaison with the APA. He relayed that the APA's state hospital caucus discussed workforce issues at its May 2004 meeting. He encouraged individual medical directors to become more involved with APA discussions, particularly around development of DSM-V, and raise awareness about public sector concerns. There was a brief discussion about whether the Council's technical reports should be reformatted and submitted to the APA in order to increase visibility of and interest in the topics. Concluding the process would require too much time and energy, the group decided not to pursue that path.

Finally, Dr. Parker (Indiana) suggested discussing the Council's mutual interest in the forensic population with the American Academy of Psychiatry and the Law (AAPL), the primary professional organization for forensic psychiatry.

Action: The Council approved a motion requesting that Dr. Parker explore interest in a liaison relationship between the Council and AAPL.

Medical Directors Position Survey and Issue Paper

Dr. Parks shared the most recent version of a paper on the role and position characteristics of state mental health authority medical directors. The Council decided to conduct a survey and highlight the nature and scope of the medical director's role so commissioners could understand the position and how to best to utilize their medical directors. The effort built on a similar survey conducted about ten years ago.

The draft report includes a brief literature survey (limited because little literature exists), and the raw survey data appears in the appendix. Some of the report's findings include:

- 71 percent of SMHAs have statewide medical directors, 17 percent of whom are part-time. Of the states with medical directors, half of the states have a mandate

requiring the position, while the other half used agency discretion to create the position.

- 61 percent of medical directors reported an opportunity to lead change within their states. However, most medical directors do not have much line authority or budget. They lead mostly through their expertise and persuasion versus line authority.
- Characteristics that predicted medical directors reporting feelings of greater influence included: having full time status, being a medical director in a larger state, being paid more and having medical school appointments.
- Medical directors are responsible for a diverse range of activities and are often used for special projects (pharmacy, risk management, new program startup) and trouble shooting.

Finally, the draft report offers a series of recommendations, including technical areas of expertise and personal characteristics to look for when recruiting medical directors (e.g., experience in quality improvement, benchmarking and strategic planning to skills like communication skills, team building, systems thinking).

Medical directors discussed how to strengthen the position paper to make it a useful document for commissioners. Recommendations included:

- Make the connection clearer about the role of a medical director and how it fits the needs of the commissioners. Describe the range of potential relationships between commissioner and medical director, depending on the structures and dynamics within each state.
- Invite Commissioner Jim Reinhard (Virginia), who serves as the NASMHPD Board liaison to the Medical Directors Council, to review and comment on the paper.
- Focus not only what medical directors can do individually, but also what the Council can do as a collective body.
- Highlight the aspects of the medical director's role that transcend individual differences among commissioners (e.g., medical directors provide continuity to ongoing public policy positions given their longer tenure).
- Use a different framework for presenting the topic -- "Challenges and Opportunities in Mental Health Systems Leadership" -- and focus on the role medical directors can play in systems transformation.

- Address how the medical director can serve as a “clinical compass” and provide clinical guidance on policy and programmatic decisions (e.g., decisions about pharmacy use of seclusion and restraint).
- Strengthen the section on core (not generic) functions.
- Invite a knowledgeable human and resource development person to review the document and provide input.

The group also briefly discussed the advantages and disadvantages of increased line authority for medical directors.

The goal is to prepare a document that eventually would be included in the new commissioners’ orientation packet. Dr. Parks requested assistance from other medical directors on the next iteration of the paper, preferably from those who had been in the position for some time.

Action: It’s not clear from the tape if there were any volunteers.

2005 Technical Report

The Medical Directors Council determined that its next technical report will focus on how a state mental health authority should systematically collect and use mortality data. Dr. Svendsen (Ohio) and Dr. Foti (Massachusetts) volunteered to serve as co-editors. In addition, one participant suggested developing a tool kit on mortality, perhaps as a joint activity between the Council and NTAC.

Participants brainstormed about topics the mortality report could address. Recommendations included: which data to collect, where to find it, and how to integrate it; mortality studies conducted by Massachusetts and Ohio; public health perspective; safety as a core value; IOM principles (e.g., safety and access) as a framework; mortality’s link to integration of primary care; minimum standards for the mortality review process; role of continuity of care in mortality; comprehensive risk assessments that include physical health, as well as risk for suicide and homicide; clearer definitions of expected and unexpected deaths (clarifying which deaths trigger a review); and a focus on deaths in community services, as well as hospitals.

Planning for 2005 Medical Directors Symposium

Participants agreed to continue the format of this year’s Symposium and have two longer sessions and two shorter (one-hour) sessions at the 2005 event.

After discussing several topics from the brainstorming list, medical directors settled on topics for the next Symposium:

- (1) *Medicare D.* NASMHPD's Andy Hyman and Dr. Parks will plan this session on implementation of Medicare Part D (i.e., prescription benefits). While this session was originally slotted for two hours, the group agreed to spend one hour on the topic and reserve the remaining time for evidence-based practices.
- (2) *Evidence-based practices.* The first part of this session will be a panel discussion with a researcher, medical director, and consumer representative talking about the medical director's role in promoting and implementing evidence-based practices. The session also will include a discussion about the tensions around the definition of evidence-based practices and application of evidence-based practices in multi-cultural communities. The second part will feature an update by Vijay Ganju and Howard Goldman on the status of evidence-based practices, SAMHSA-supported tool kits, various state initiatives (e.g., Oregon and Ohio), and reports like *Turning Knowledge Into Practice* published by the Technical Assistance Collaborative and the American College of Mental Health Administration. Dr. Singer (New Mexico) and Mike? agreed to plan and facilitate the session.
- (3) Report out on the Council's technical report on mortality. The co-editors, Drs. Svendsen and Foti, will have the lead on this session.
- (4) Position/issue paper on drug pricing. Dr. Luchins (Illinois) and Dr. Adams (California) assumed responsibility for preparing this paper and the Symposium presentation. Dr. Parks will try to identify a few more medical directors to assist with the paper.

Dr. Parks also will provide an overview of the Council's previous technical reports and the action steps that have occurred as a result of those reports. Several medical directors urged continued follow-up on the technical report on behavioral health integration, given the importance of the topic.

Finally, the group discussed holding a joint meeting with another NASMHPD division (forensic or legal) to discuss overlapping issues. Typically, these meetings include a one-day joint meeting and then divisions have their own separate business meetings. Given logistics and timing issues, the Medical Directors Council will explore a joint meeting with the forensic division in 2006, hopefully timed to coincide with the APA's Institute for Psychiatric Services in October.

Action: Working with NASMHPD's Roy Praschil, Dr. Parks will discuss a joint meeting in 2006 with the forensic division.

Dr. Glover advised the Council that the NASMHPD Board will ask each NASMHPD division, including the Medical Directors Council, to report back on its implementation of at least three objectives contained in the President's New Freedom Commission final report.

Superintendent Summit

NASMHPD will host another Superintendent Summit on May 1-3, 2005 in Washington, DC. Superintendents and staff from the 235 state hospitals are invited to attend the summit. Dr. Glover asked the medical directors to suggest topics to be addressed at the bi-annual meeting.

Many of the suggested topics related to patient physical health care and safety in hospitals, including management of patients' antipsychotic use in inpatient settings; mortality data; communication and collaboration between internists and psychiatrists; protocol to address Hepatitis C; and procedures for conducting a mortality root cause analysis and forwarding results to the medical director. Other topics of interest were bed shortages in the community and the ripple effect on state hospital systems; use of crisis stabilization units; appropriate treatment planning; and workforce safety.

Miscellaneous Discussion

In its final discussion, medical directors addressed the regulatory definition of restraint and the requirement that a professional review the restrained patient after one hour. One state reported hospital staff grappling with the varying interpretations and implications of the expanded definition of restraint -- "any hands on intervention." Several states indicated that they utilize trained licensed independent practitioners (e.g., psychologists, social workers) in addition to psychiatrists to conduct the one-hour review, particularly during off-peak hours. Dr. Glover urged medical directors to discuss these types of issues with NTAC Director Kevin Huckshorn.

Upcoming Meetings

The next Medical Directors Council meeting will occur the morning of May 22, 2005, prior to the annual APA meeting in Savannah.

The 2005 Medical Directors Council Symposium will take place October 3 - 4, 2005 in San Diego. As usual, the Symposium will precede the APA's Institute for Psychiatric Service scheduled for October 5-9, 2005.