

**NASMHPD's Medical Directors Council**  
**Meeting Minutes**  
**May 2, 2004**  
**Crowne Plaza Time Square Hotel**  
**New York City**

**Participants**

Joe Parks, M.D. (Missouri), *Chair*  
Tom Hester, M.D. (Hawaii)  
Ken Jasmir, M.D. (Wisconsin)  
Peggy Jewell, M.D. (Oklahoma)  
Larry Miller, M.D. (Arkansas)  
Ken Marcus, M.D. (Connecticut)  
Bob Nash, M.D. (Wyoming)  
Bill Nelson, M.D. (Maine)  
Dave Pollack, M.D. (Oregon)  
Ranga Ram, M.D. (Delaware)  
Steve Shon, M.D. (Texas)  
Bill Tucker, M.D. (New York)

Andy Hyman, NASMHPD  
Roy Praschil, NASMHPD

**Review/Approval of October 2003 Meeting Minutes**

In the coming weeks, Dr. Parks will send out a revised version of the Medical Directors Council's October 2003 meeting minutes and request approval of the minutes via email.

**Prevention Paper – Position Statement**

NASMHPD's Roy Praschil provided an update on the Council's technical report on prevention and requested input on the development of a NASMHPD position statement on prevention.

The Council prepares two technical reports each year on priority issues in order to assist state mental health commissioners with their decision-making. The technical report provides background information and outlines policy and practice

recommendations. In February 2004, a work group met in Hawaii to begin drafting the

technical report on prevention under the guidance of Alan Radke, MD, (Hawaii), report editor.

The first draft of *Prevention Approaches for State Mental Health Authorities* was recently circulated among work group members for their review. After the work group's review, the Council's editorial review board will consider the report. The plan is to present the full report at the Council's meeting in the fall.

The draft report contains several sections, including an introduction to mental health promotion and prevention; implications for application in the public mental health system continuum of care; special populations (e.g., elderly, youth); and recommendations directed at state mental health authorities (SMHAs), the federal government, and the Medical Directors Council about how to adopt the public health model with prevention initiatives.

During its February meeting, the work group identified the need for a NASMHPD position statement on prevention, which also would serve as a preface for the technical report. The position statement would articulate SMHAs' strong interest in preventing the disabling effects experienced by people with serious mental illnesses and serve as a guide to NASMHPD members and other interested stakeholders.

The NASMHPD Board of Directors reviewed a draft position statement and approved its concept, but requested input from the Medical Directors Council before final consideration at the NASMHPD membership meeting in late June. The position statement also will be discussed during the next regular Commissioner's conference call, during which Dr. Radke will be available to answer any questions.

Medical Directors shared thoughts about both the draft position statement on prevention and the upcoming technical report:

- *Perceived impact on SMHAs' core mission. Medical Directors expressed concern that a position statement on prevention might create the appearance that state mental health authorities were abandoning or undermining their responsibility to people with serious mental illnesses. Mr. Praschil reported that the work group engaged in a similar discussion at its meeting. However, the drafters concluded that such a position statement would not subsume the SMHAs' mandate; it would serve as an adjunct. The intent was to create a case for engaging in more collaboration and other public health strategies that will help SMHAs with their core mission. Medical Directors suggested adding language*

*that provides a context and underscores that people with serious mental illnesses*

*remain their priority population.*

- *Absence of specific preventive interventions.* While the draft provided background material on prevention of mental health problems, some participants were concerned that the report might be too generic and not specifically helpful. Medical Directors indicated the importance of discussing evidence-based prevention activities, and not just referencing them in the report's appendix as is currently planned. Even a few paragraphs on specific interventions in the report would capitalize on the opportunity to educate Commissioners about important prevention developments, help them evaluate alternatives, and make systematic decisions. Some participants recommended that the report identify what is currently possible in the prevention field, the target population, effectiveness of recommended interventions, and cost information. Others suggested highlighting preventive efforts that really address issues that bring people into the state mental health system (e.g., early intervention with youth in order to prevent institutional placements such as hospitals, foster care, and prisons).
- *Range of preventive approaches.* *The current position statement seems to promote the whole population approach or the public health model. However, SMHAs may be interested in preventing problems that are common to people with serious mental illnesses (e.g., substance abuse, medical illnesses, homelessness) and adopting a high risk population approach.*
- *Partnership with public health.* The technical report also could educate Commissioners on how to align themselves with public health colleagues and discuss the value of such collaborations from partnership. Similarly, Medical Directors discussed the role of SMHAs in promoting primary, secondary, and tertiary prevention.
- *Suicide prevention.* *Medical Directors noted that discussion about suicide prevention did not appear in the position statement. Suicide prevention is a concrete, understandable concept and research has shown that adequate treatment of depression prevents suicide.*

Participants also discussed the need for the position statement to create a compelling argument for Commissioners to consider initiating or expanding their systems' focus on prevention. A position statement should mention promising practices and discuss the advantages of being part of the public health setting. The document also should indicate the opportunities for Commissioners to incorporate a prevention focus within

their existing activities.

*Action:* The Medical Directors Council suggested that NASMHPD consider adding language to the position statement that:

- provides a context underscoring the SMHAs' fundamental responsibility to people with serious mental illnesses and importance of not displacing services and treatments.
- addresses the need for more research to better understand the fundamental mechanisms of mental illnesses and, thus, design better preventive interventions.
- briefly mentions specific interventions, including early psychosis, suicide prevention, and trauma-focused care.

If Medical Directors have any additional comments or suggested language, they should direct their comments to Roy Praschil before the end of June.

### **Integrating Mental Health and Primary Care**

Dr. Pollack, editor of the technical report on integrating mental health and primary care, provided a status update on work to date. He has conducted several conference calls and worked with consultant Barbara Mauer to develop an outline for a relevant document that would not duplicate other efforts on this subject. Dr. Pollack provided a 2-page outline of the proposed report for participants to review.

The work group will meet July 19-20, 2004 in Portland. Drs. Bartels (New Hampshire), Duckworth (Massachusetts), and Parks also will work on this technical report. NASMHPD will identify at least 2 Commissioners to participate in the work group. The work group also will include representatives from the state Medicaid association, Association of State and Territorial Health Organizations, the consumer mental health administrator group, National Association of Community Health Clinics and a Medical Director of a community health clinic, as well as representatives from several effective primary health/mental health programs (e.g., from Tennessee and Missouri).

While reviewing the outline with participants, Dr. Pollack pointed out that the third and fourth sections of the report should provide the most useful information to Commissioners. The third section will address methods for paying for integrated services while the fourth section will discuss the different structural models for

integrating services.

Participants discussed one of the financing issues raised by the outline. Dr. Pollack talked about the October 2003 directive issued by the Centers for Medicare and Medicaid Services stating that Medicaid authorities were responsible for paying for behavioral health services that are provided in federally qualified health centers (FQHCs). Even in states that do not exercise the behavioral health option and do not cover counseling or case management, the Medicaid agency has to pay for those services when they are delivered in an FQHC. Medical Directors highlighted several issues and questions generated by this policy change, including the risk of creating a mental health system within public health settings that operates parallel to the public mental health system.

Medical Directors also discussed several strategies for partnering with primary care colleagues, including (1) working with universities to develop refresher courses for psychiatrists on new developments in primary care and provide assistance to primary care physicians on prescribing psychiatric medications; (2) co-locating mental health teams in primary care settings or providing on-site or telephonic consultations; and (3) sharing treatment algorithms (e.g., ADHD and depression algorithms) and, in return, learning tools that can help psychiatrists conduct better health screenings.

*Action:*

Based upon input from the Medical Director's Council, Dr. Pollack will expand the discussion in the technical report to include use of consultation models and screening instruments by both mental health and primary care practitioners.

### **Program for Fall Symposium**

The Medical Directors Council's Symposium will occur in October 4-5, 2004 in Atlanta in conjunction with the Institute for Psychiatric Services. The 2004 Symposium will be a day and a half meeting featuring the following sessions:

- 2 hours on trauma with Dr. Karp (Pennsylvania) and Kevin Huckshorn, RN, MSN (NTAC) as session chairs.
- 2 hours on pharmaceutical issues with Dr. Parks as lead.
- 1 hour on prevention. While Dr. Wagner (Rhode Island) had volunteered to chair the session, he was not involved in the prevention technical work group. Dr. Radke likely will chair this session.
  
- 1 hour on mortality with Drs. Tucker and Svendsen (Ohio) as chairs. Additional

Medical Directors who expressed interest in working on this topic included Drs. Duckworth, Miller, Fisher (Louisiana), and Cline (New Mexico).

Roy Praschil will be in touch with Medical Directors who are chairing sessions to finalize planning during early summer.

Dr. Parks reported that he had spoken with Commissioners briefly about the Council's interest in possibly launching a death registry to track mortality within state mental health systems, perhaps in conjunction with NASMHPD Research Institute. Commissioners voiced no objections and did not provide any feedback on the initial concept. Dr. Parks will schedule a call among interested Medical Directors to explore the idea further and decide if/how the Council wants to pursue the mortality issue.

### **NASMHPD Updated Web site with Listserv**

Roy Praschil report that NASMHPD is in the process of updating its Web site so that users will have easier access to information and resources on the Web. Each NASMHPD division – including the Medical Directors Council – will have its own listserv capability. NASMHPD will issue instructions on how to access the expanded capacities in the coming month. Mr. Praschil also will explore what additional Web capacities could be available to the Council (e.g., web-based library) and at what cost.

### **Pharmacy Utilization Management**

Medical Directors discussed the growing number of state contracts with Comprehensive Neurological Sciences (CNS), a company that provides pharmacy utilization management. To date, 11 states have contracts with 6 more anticipated.

Some participants observed that a contract with CNS or similar company is one of several strategies that can be used to enhance pharmacy utilization and decrease the amount of polypharmacy and off-label prescribing. Participants also discussed a range issues of associated with such contracts, including potential influence of pharmaceutical companies on state policies; loopholes created by grandfather clauses; and other entities that could operate the pharmacy utilization function (e.g., states themselves, NASMHPD).

Dr. Parks reported that Missouri is saving approximately 3 percent on its pharmaceutical costs as a result of its enhanced pharmacy utilization management. Although this effort is not solving the problem of spiraling pharmaceutical expenses, the reduction in pharmaceutical costs is greater than the cost of running the utilization program.

The group agreed it would be helpful to have an ongoing discussion about pharmacy utilization management. Dr. Parks will include this discussion item on the agenda for the Council's next meeting.

### **Medicare Part D**

Dr. Parks reported on upcoming changes to Medicare Part D as a result of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003. Between May 2004 and January 2006, the federal government faces an ambitious timetable of writing, publishing and finalizing regulations, writing contracts, finding vendors, and enrolling clients. The public mental health consumers who will be affected by the changes are those who are dually eligible for SSDI and SSI. While it is unclear how many SMHA consumers will be impacted, Dr. Parks estimated that about one third of the people served by Missouri's public mental health system would move from the state-operated pharmacy program to a federally-contracted, private pharmacy behavioral management program.

NASMHPD and advocacy groups are concerned about the regulation's implementation, specifically the exemption of psychiatric medications; grandfathering of psychiatric medications; appeals and grievance process; and consumer education to advise them of upcoming changes. Many questions will not be addressed until the formularies are constructed and regulations are written.

Participants discussed conducting a survey of Medical Directors to determine (1) the number of SMHA consumers on SSDI who would make the switch; (2) a pre/post measure of the changes in Medicaid and SMHA costs; (3) a baseline of populations that did not switch (like individuals on SSI) to provide a cost comparison.

### **CMS Transition to Prospective Payment for Psychiatric Inpatients**

Dr. Parks previously sent an email to Medical Directors addressing the proposed rule to modify prospective payments for psychiatric inpatient beds. Under a revised prospective payment system, public sector and private, free-standing psychiatric hospitals would generate higher payments for their bed base, while general hospital inpatient psychiatric units would receive lower payments for their beds. The estimated payment shift in both directions would be approximately 20 percent. Originally, the rule was scheduled to be effective on April 1, 2004. However, at this point, it is unclear when it will go into effect.

One concern about the proposed rule is that general hospitals would experience additional

pressures on their profit margins and may end up closing their psychiatric units. Losing

these beds could shift the whole system, further diminishing psychiatric bed capacity in communities. NASMHPD's response to the proposed rule, as outlined in a letter in the Medical Directors' packets, was to request further study on the rule's implications, particularly the consequences for private hospitals. While the increase in payments for public hospitals is appreciated, the anticipated impact on the bed shortage is of great concern.

## **NASMHPD Legislative Update**

NASMHPD's Andy Hyman described the efforts of NASMHPD and other mental health advocacy groups to build upon the momentum generated by the President's Commission on Mental Health's final report. Key mental health groups have combined to form the Campaign for Mental Health Reform and coordinate a common legislative agenda. Key issues are (1) suicide prevention; (2) custody relinquishment to obtain Medicaid coverage and expansion of community-based waivers for children requiring care in a residential treatment center (Keep Families Together Act); (3) criminal justice and mental health system coordination (Mentally Ill Offender Treatment and Crime Reduction Act); (4) appropriations; and (5) SAMHSA reauthorization.

The President's 2005 budget gave SAMHSA \$44 million for states to plan and develop comprehensive state plans, as suggested by the Commission's report. CMHS Director Kathryn Power has the lead in addressing and implementing the Commission's recommendations. NASMHPD's Steering Committee on Quality and Accountability (chaired by Steve Mayberg, PhD and Tom Barrett, PhD) has been tasked with developing and articulating NASMHPD's vision for a future system consistent with the paradigm shift outlined in the Commission's report. This vision will address the development of state comprehensive plan, role of block grants, and the role of the federal government and SAMHSA. Mr. Hyman recommended that a couple of Medical Directors participate in this process. Dr. Parks volunteered to be involved with the steering committee's work.

Medical Directors briefly discussed what their vision for comprehensive state plans. Perhaps the plan could outline the necessary mix and levels services for a true continuum of care, including number of beds, psychiatrists, and case management levels. If the right mix of services was identified, states could know how to build their systems toward that model. The goal would be to establish an evidence-based model (or parameters) that could provide direction to states seeking to enhance their systems. Participants noted that the political challenge would be the tension resulting from designing a system that serves people appropriately with evidence-based practices, but

was only able to serve a portion of those eligible for services due to resource constraints.

Mr. Hyman commented that the Commission's report addressed the need to realign programs and develop capacity, but no one knows how to achieve that goal. As a result, the Campaign for Mental Health Reform will examine the system change efforts in several states and try to discern what needs to happen at state and federal levels to help realign those systems. For example, New Mexico's behavioral health collaborative pooled its resources and plans to provide a continuum of care and wraparound services as of January 2006. Learning from these state experiences will help formulate a policy agenda that articulates specific action steps for change within federal programs.

Medical Directors urged NASMHPD to push for specific examples and concrete action steps when discussing realignment and collaboration with state and local change agents. Planners need to avoid the fantasy that systems can collaborate their way out of problems. Another participant urged consulting with additional states to broaden the applicability of the findings.

#### **Medical Director Position Survey/Issue Paper**

Dr. Parks announced that the issue paper reporting the results of the Medical Directors survey has been revised further; another version will be shared with Medical Directors in the coming months.