

NASMHPD Medical Directors Council
Meeting Minutes
Sunday, May 19, 2002
Philadelphia Marriott Hotel

Participants

Tom Hester, M.D. (Hawaii) - *Chair*
Jim Evans, M.D. (Virginia)
Bob Eilers, M.D. (New Jersey)
Brian Hepburn, M.D. (Maryland)
Dan Luchins, M.D. (Illinois)
Ted Lawlor, M.D. (Guest Participant/
Former Medical Director, Connecticut)
Larry Miller, M.D. (Arkansas)
Joe Parks, M.D. (Missouri)
Steve Karp, M.D. (Pennsylvania)
Alan Radke, M.D. (Minnesota)
Steve Shon, M.D. (Texas)
Dale Svendsen, M.D. (Ohio)
Roy Praschil, NASMHPD

Absent

John Kretschmann, Missouri MH Institute

Review/Approval of December 2, 2001 meeting minutes

The Medical Directors Council reviewed and approved the December 2001 minutes with a minor editing change.

State Reports

Medical Directors gave updates on initiatives and challenges facing their state mental health systems.

Missouri is experiencing the effects of budget cuts. All nonessential personnel will be

furloughed for two days in the coming months. Given the likelihood of continued budget

shortfalls, the state may have to consider service capacity cuts next year. To date, budget cuts have been spread across state departments with alcohol and drug funding somewhat protected due to its federal match requirements. Missouri has lost 30 percent of its bed capacity in the private sector and 60 percent of Veterans Affairs (VA) bed capacity in the last eight years.

Dorn Schuffman now serves as the Director of the Department of Mental Health and continues to stress the integration of mental health with substance abuse and mental retardation/developmental disabilities. The Department is pursuing lower level linkage opportunities instead of big joint initiatives.

Missouri has several interagency efforts focused on suicide prevention and the state suicide prevention plan. Missouri provides suicide prevention gatekeeper training to alcohol and drug counselors as well as community mental health center staff. The schools have also been approached to work on suicide prevention efforts, although there has been some resistance due to the school's strong focus on educational testing requirements. Missouri's mental health department has arranged to be informed of completed youth suicides through the child mortality review board, a board run out of the Medicaid agency which is required to review any death of a person under 18. Thus, the mental health department will be able to approach schools after a suicide event to offer services and training at a timely and critical juncture.

After attending a national suicide prevention conference in Nevada with a public health colleague, Dr. Parks found that suicide prevention is a straightforward message that fosters partnerships and builds constituencies. Missouri used \$150,000 in block grant dollars to fund four small prevention contracts. The state also purchased a training package (video, manual, training curriculum) to train 60 - 70 staff in suicide prevention; these staff will now train others. Given that 25 percent of the substance abuse block grant is devoted to prevention, the substance abuse field already has prevention vehicles in place to target the same risk factors and risk groups. Dr. Parks commented on the importance of using substance abuse's established networks instead of setting up parallel structures. In Missouri, the mental health system provides suicide prevention training to substance abuse's Community 2000 Teams.

Ohio faced the closure of four hospitals last fall. But after a series of public forums, the Governor gave \$23 million to the Department of Mental Health and the closures were averted. Ohio has lost 20 percent of its private psychiatric beds in the last five years. In some cases, managed care pays less than Medicaid for inpatient stays.

Ohio also has a severe Medicaid problem as local mental health boards find they have no other funds to provide as a match. Last week, the Medicaid agency issued a request to control the mental health pharmacy budget. The state is looking at prior authorizations and supplemental rebates as mechanisms to address escalating pharmacy costs. Psychotropics constitute 23 percent of the Medicaid pharmacy budget.

Ohio continues to move forward on its quality agenda, including changing the certification process for agencies to now require quality improvement and use of outcome measures. Ohio is also participating as an evaluation site for the NASMHPD Research Institute's evaluation of national tool kits for evidence-based practices. The NASMHPD Research Institute is expected to house the Center for Evidence-based Practices, a nationally funded project to assist with implementation of the six evidence-based best practices highlighted by the Surgeon General's report on mental health.

Several states that are not participating in the research study but are interested having access to the tool kits have formed a consortium (including Hawaii). To join the consortium, Medical Directors should request that their Commissioners contact Noel Mazade, Ph.D., NASMHPD Research Institute's Executive Director.

Dr. Svendson also reported on the President's Freedom Mental Health Commission appointed by President Bush in late April. Ohio Commissioner Mike Hogan, Ph.D. will serve as chair of the one-year Commission. The Commissioner will examine both the private and public mental health systems and provide recommendations.

Maryland is also dealing with deficit issues and will likely end the year with a \$3 million deficit. The state's Children's Health Insurance Program is now at 300 percent of poverty and the number of children in the mental health system has skyrocketed. The state mental health system has grown 8 - 10 percent per year over the last five years; 40 percent of individuals in the system are children, almost all of whom have Medicaid or other insurance that require a state match. The state is experiencing the tension of trying to manage this growth while recognizing that Medicaid is an entitlement.

Maryland has the same number of facilities (seven adult psychiatric facilities and three children's facilities) but has considerably reduced the number of beds so that each campus has a smaller number of mental health beds. While there is no strong movement to close state hospitals, budget restraints affect facilities and bed space. Other partners in the mental health system (state hospital associations, acute/emergency room physicians) are beginning to recognize that state hospitals have a function that impacts their roles. State hospitals help to clear out emergency rooms and general psychiatric beds; without state

beds, the overall system gets blocked up.

The backup in the emergency rooms is becoming a major problem. Adolescents who have insurance and require hospitalization are remaining in the emergency room for days because there is no bed available. Dr. Hepburn commented that this is both a capacity problem and a clinical presentation problem. Some of the adolescents are dually diagnosed with mental illness and mental retardation. Private hospitals do not want to accept them as patients due to the financial disincentives to treating individuals who may have long lengths of stay. One Medical Director suggested that hospitals cannot refuse such transfers and that a request to HCFA to monitor those hospitals might be in order. The hospitals would likely counter that they do not have the clinical support for patients who need extra behavioral interventions.

Financial disincentives are also a problem for clinics with large numbers of Medicare patients. For clinics in some of Maryland's wealthier counties, 50 percent of the individuals may be on Medicare. With Medicare's limits, the clinics may recover only 60 percent of what they would have recovered with Medicaid patients.

The state is trying to reconfigure beds and make the inpatient system more efficient. Currently, 40 percent of individuals in state hospitals are forensic. In conjunction with the NASMHPD Research Institute, Maryland will serve as the site to evaluate the tool kits for family psychoeducation and supported employment.

New Jersey is experiencing a budget deficit but mental health is faring pretty well. The state is proceeding with its plan to build a new state-of-the art state hospital. Currently, New Jersey has six state hospitals, including one for children and one forensic facility. The state also has a sexual predator unit run by corrections and housed in an older prison for which mental health provides treatment services. Dr. Eilers participates in a forensic review board which examines admissions/discharge and spends time on media issues. The Department also has a clinical practice guidelines workgroup which is examining best practices.

In **Pennsylvania**, clinical pharmacists equipped with Palm Pilots and built-in data bases were able to go directly to the floors and charts to input data. Afer downloading the data into an Excel database, the state has a powerful mechanism for looking at drug utilization data and managing hospital pharmacies. The state also examined a variety of factors (e.g., weight, diabetes incidence) involved with atypical antipsychotics in state hospital systems and published its findings in a report: *Pennsylvania DPW Office of Mental Health & Substance Abuse Services and Atypical Antipsychotic Drug Study in a State Multi-Hospital*

System.

Pennsylvania manages its behavior health carve out and conducted an external quality review process, in accordance with federal mandates. With the cost of children's services skyrocketing, the state reviewed residential treatment facilities. The state concentrated on three indicators: 1) family involvement (i.e., facility made contact within seven days and involved the family with the treatment process); 2) outpatient documentation and discharge follow-up appointment; and 3) discharge medication (i.e., documentation of medication in discharge summary to be passed on to next provider).

The review found that only 42 percent of facilities made contact with families within seven days; 5.5 percent of patients had documented followup appointment (when the methodology was revised per provider feedback, this number rose to 23 percent); and discharge medication was documented 40 percent of the time. Pennsylvania is going to consider alternatives to residential treatment facilities, including multisystemic therapy and other more intensive home-based services. Given that residential treatment facilities are licensed through a different state agency, the mental health department has relatively leverage with these facilities.

Dr. Karp relayed Pennsylvania data on seclusion and restraint. The state went from 19,000 seclusion and restraint hours in March 1992 to 60.25 hours of seclusion and restraint in March 2002. The state has been able to achieve such dramatic reductions *not* by employing different terms or definitions nor "hiding" people in forensic units. Some have argued that Pennsylvania's reductions were possible because the state has primarily intermediate care hospitals. However, Dr. Karp pointed out that the state has three forensic units which admit people who are acutely psychotic. The seclusion and restraint data from these units has not been different from the data from civil hospitals. Dr. Karp will be a presenter at the July 202 APA Committee Meeting on safety. The meeting will focus on use of seclusion and restraint, suicide and medication errors.

Pennsylvania is in the process of implementing TMAP with patients who have schizophrenia. Allentown State Hospital has piloted the algorithm for eight months while Mayview State Hospital has piloted it for three months. Administrators need to watch out for changes in diagnoses (e.g., to schizoaffective disorder) to avoid using the algorithm in addition to deviations from the algorithm (e.g., less use of Clozapine monotherapy). Pennsylvania also conducted a polypharmacy study in two hospitals and determined that while the rates for polypharmacy were high, the documentation of proscribing rationale was poor.

Virginia's budget shortfall is prompting mental health to work more closely with a variety of

agencies and resources. Dr. Evans will host a follow-up meeting in June 2002 with an array of partners, including medical schools, payers, Department of Health, Department of Corrections and managed care programs, to figure out how to address their common issue of bed shortages.

Virginia is also looking at innovative strategies to restructure its service system and operate more efficiently. Dr. Evans visited Arkansas to observe its step-down forensic program for substance abusers who need more intensive supports before they hit the street. Virginia streamlined its forensic process, trying to move people through the process without releasing people prematurely. The State legislature decreed that anyone with a misdemeanor NGRI will be released in a year. A safety valve is that the hospital can seek to civilly commit those individuals, if needed, at the end of that year.

Virginia had a performance and outcome measurement system in place but had to dismantle it because the local communities found it too complex. The state is trying to salvage some indicators, as well as assist practitioners in community settings in their medication proscribing practices.

Illinois experienced a budget shortfall and ended up closing 150 beds. The state will close one facility and have nine remaining facilities by July 2002. Looking to next year, the legislature is proposing a 5 percent across-the-board cut for the community system as well as some more targeted cuts. Dr. Luchins highlighted the issue of shifting money into communities from state hospitals and then having those resources eroded. When 5 percent cross-system cuts are proposed in the community, there is no dramatic outcry because no one understands the impact. In contrast, when hospitals are threatened with cuts, unions and localities are quick to protest and advocate. If funding continues to shift from hospital to communities, how can that funding be maintained and protected in the community?

Illinois also brought in a group of experts from the United States, Australia, England and Canada to address early detection of psychosis. Dr. Luchins explained there is compelling literature that indicates systems can detect people that are pre-psychotic, 40 percent of whom will become psychotic. When these individuals are treated, their rates of psychosis are lower and, if they become psychotic, their hospitalization rates are reduced, minimizing the "collateral damage" associated with psychotic breaks and forced hospitalizations.

Historically, discussions about prevention have been linked with a shift toward serving persons without serious mental illness. Early identification and intervention of psychotic

individuals may be a preventive approach for state mental health authorities to explore

further. Illinois is putting together a project in Page County to run public service announcements and work with schools, public health, and local doctors to identify potential pre-psychotic individuals and have a team evaluate them.

Dr. Lawlor, Director of Public Psychiatry at University of Connecticut and a guest at the Medical Directors Council Meeting, gave an update on **Connecticut**. Dr. Lawlor discussed the use of beta blockades with persons who have mental retardation to address impulsivity and explosiveness. The University of Connecticut Health Center admits 25 - 50 percent of all acute Department of Mental Retardation admissions while state hospitals admit 25 percent. Dr. Lawlor reported that their success rate is in the 50 - 75 percent range using beta blockades. Connecticut has a retrospective (not prospective) Medicaid payment system and their discharge rate is \$7,500 for every discharge. When the physicians immediately introduce beta blockers upon admission, they observe a marked diminution in behavioral problems. As a result, patients become more attentive and responsive to behavioral programming.

Dr. Lawlor also described how the University of Connecticut Health Center signed its first contract to provide services to a Federally Qualified Health Centers (FQHC) and the possible ramifications for the future of community health care. With the FQHC contract, the Center will provide psychiatry services and receive Medicaid reimbursement on a cost basis with 100 percent Federal moneys. Under this arrangement, the Center must also provide services to the uninsured. Dr. Lawlor estimates that the Center will end up receiving 20-30 percent more in reimbursement after considering the offsets. Another advantage to this arrangement is providing primary and behavioral health care under one roof. To find out more about FQHC's, Medical Directors should contact their Departments of Health.

Minnesota has experienced challenging political and economic times, facing a state shut down last summer due to no budget agreement, a state strike in October 2001 and a November forecast of a \$1.9 billion shortfall. Thus, for the last six months, the department of mental health has been rewriting plans to restructure state operated services in order to meet ominous and moving budget targets. After the mental health department proposed reductions that would mean cutting ten 25-bed units and not serving 800-900 people, the legislature found more funding.

On a positive note, a state work team has engaged in a year-long strategic planning process examining utilization and care management. The team is about to report out its findings and recommendations. As a result, Minnesota will move toward patient-centered

planning as the foundation for its mental health service delivery system. The system will

place the patient in the center and incorporate the Levels of Care Utilization System (LOCUS) to achieve patient-centered outcomes. The aim is to restructure the entire public mental health care system into one system where behavioral health services, policy and funding are integrated. All funding streams would be consolidated into one pot and providers would draw money out of that pot to serve patients who come to them.

To address the shortage of state hospital beds, Minnesota uses contract beds. If patients are Medicaid eligible and in need for acute hospitalization for less than 45 days, they can be committed to the contract beds and discharged back to community. The use of contract beds undergoes vigorous utilization review as the state does not want these individuals simply transferred to state hospitals. Minnesota hospitals receive an enhanced Medicaid rate for these beds. The state began by contracting with two hospitals and will spread the use of contract beds statewide through an RFP.

Minnesota applied the level of care utilization system to the patient population in its state hospital beds. The state found that one third of patients required community level of care even though they were in a state hospital bed. The state is looking at alternative strategies to promote community care. One strategy to maximize bed capacity is to dually licensing beds as both hospital beds and halfway house beds (Rule 36 in Minnesota) and staff them accordingly.

When Minnesota shifted its hospital funding into the community, the state chose to send state-funded staff into the community. For every bed that was closed down, a FTE staff (e.g., nurse, social worker, psychologist) went into the community to fill a resource gap identified by the county. Thus, the staff were clinically managed in the community but their positions were still protected by the union. Initially, concerns were raised because the state staff were higher paid than community practitioners. However, the issue forced community providers to examine and adjust their wage structures to retain staff.

Finally, Dr. Radke addressed the problem of when patients have dual eligibility. Because Medicare is the first payer, none of the community hospitals will accept these patients because they cannot afford to provide treatment under Medicare's reimbursement rates.

Texas' Dr. Shon gave an update on medication algorithm development. The state hosted a consensus conference in January 2002 where there was agreement that Clozapine was being underutilized. Texas has reconstructed the algorithm and elevated Clozapine accordingly. The revised algorithm, which should be up on the web site by June 2002, indicates that Clozapine should be considered after two failures of monotherapy and not

after four monotherapy trials. One Medical Director underscored the importance of

providing leadership around proscribing Clozapine, saying it was a better and less expensive medication, albeit more demanding of physicians' time for monitoring.

Texas is nearing completion of a three-year benefit redesign process and will submit the redesign proposal to the legislature in January 2003. To serve the public mental health system's priority population as defined by the legislature, the redesign will offer four defined case rates reflecting evidence-based practices:

- Level 1: medication and case coordination
- Level 2: medication, psychotherapy and case coordination
- Level 3: medication, intensive case management (including psychosocial rehab)
- Level 4: medication and Assertive Community Treatment

Texas conducted a national consensus conference on psychotherapy for people with depression and bipolar disorders during which participants culled through the evidence base and examined various models, medication efficacy, psychotherapy efficacy in order to recommend the proposed levels. The state will conduct a similar consensus conference for psychosocial rehabilitation models by the end of 2002.

With these benefit levels in place, the public mental health system can quantify the costs of serving people in the priority population appropriately with evidence-based practices. Conversely, if budget cuts are proposed, the system will be able to quantify the number of people who will not receive services. The benefit levels will encompass people with schizophrenia, bipolar disorder, major depressive disorders and crisis intervention for any diagnoses below a certain GAF level.

Dr. Shon suggested that a key to being able to develop the redesigned benefits is the state's previous commitment to implementing evidence-based processes throughout the system. All 42 Texas community mental health centers have ACT as a required service. The department has conducted statewide training on supported housing and supported employment. All contracts require the use of medication algorithms. The groundwork was laid to promote these evidence-based practices, which are now being rolled into the benefit package. To establish the case rate, the state is working with a medical economist to examine previous rates, pull data out of the Medicaid system, and incorporate data from other systems (e.g., VA, Department of Defense).

Dr. Shon also addressed the issue of cultural competency, relaying that NASMHPD is

hosting a meeting on cultural competence in June 2002. Texas and California have

established a workgroup to focus on interpreters in mental health, given their respective Spanish and Asian populations. In conjunction with the national and two state community mental health center associations, the workgroup hosted a meeting in Texas to discuss the parallel issues of training interpreters in both states. The workgroup accomplished its goals of creating a curriculum; developing a training system for individuals to deliver the curriculum; and training mental health staff to use interpreters appropriately. The work group is moving toward developing a certification process so that interpreters can carry their certifications with them as they move among sites.

Arkansas has experienced two rounds of budget cuts and the state hospital has a \$1.4 million projected deficit. The ACLU suit alleging that the forensic population was not receiving timely admissions, evaluations or treatment went to trial in December 2001. Three private psychiatric units in general hospitals have closed leaving only two such units in the state. The impact has been longer waiting lists and backed-up emergency rooms. A Governor's mental health task force has convened to look at this issue.

The Department of Justice continues to be involved with **Hawaii** as a result of legal action in 1989. The original action focused on treatment of adolescents in hospitals, including concerns about overcrowding and staff/client ratios. The scope has now widened as the court-appointed Special Master ordered an expert consensus plan to examine Hawaii's system of community services. The expert group convened and put forth a comprehensive set of recommendations, ranging from housing and employment to suggestions as to how the division office should be organized. Hawaii will find out over the summer whether these community-related recommendations will become an order of the court, as well. Medical Directors may want to track these developments in Hawaii, particularly if they have DOJ activity.

Public Psychiatry and the APA

The Medical Directors Council had a brief discussion on the interaction between the American Psychiatric Association and APA member working in the public sector. Participants suggested that, if APA really wants to make the organization relevant to psychiatrists in the public sector, the APA needs to change its focus. Psychiatrists have fled to specialty organizations because those organizations are more oriented to their issues. Dr. Miller is part of an APA task force that just presented a report to the Assembly on persons with serious and persistent mental illness and psychiatry. This task force is intent on keeping the needs of the public mental health system and the population it serves on APA's agenda.

NASMHPD/Medical Directors' Environmental Scan

At the previous meeting, Dr. Hester suggested that the Medical Directors provide their perspectives on emerging issues and trends to the Commissioners, who were in the midst of their own environmental scan. Roy Praschil reported that Bob Glover and Noel Mazade completed their environmental scan with the Commissioners, although there is no written report as of yet. Roy provided a list of the top ten issues identified by the Commissioners:

- funding and financing (44 states are in budget shortfalls)
- criminal and juvenile justice
- evidence-based practices
- co-occurring
- violence
- elderly
- children, youth and families
- cultural competence
- prevention
- recovery

Roy noted that the first four topics, in order, were most frequently mentioned while the remaining topics were cited at about the same frequency.

The Medical Directors discussed methods for elaborating on this list given their specific roles and perspectives. The goal is to not change the Commissioners' list but to highlight priorities from the Medical Directors' perspective. There was some discussion as to whether the Medical Directors Council should offer to be part of the environmental scan on a regular basis. Another alternative is to send out a brief survey to the full membership of the Medical Directors Council and prepare a 1-2 page report of the findings.

Action: At the July meeting, the Medical Directors Council will discuss how to identify and highlight the top issues facing Medical Directors across the country.

NASMHPD Website Support

Roy Praschil reported that NASMHPD has a webmaster on staff who can devote some time to the Medical Directors Council page. However, the Council may need to manage its web page differently in the near future. The Council cannot operate a listserv because there is no funding available. However, Medical Directors can send out emails (or provide an email to Roy, who will forward it) and Medical Directors can circulate their responses by hitting

“reply to all.”

Publishing Medical Directors Council's Technical Reports in *Psychiatric Services*

During a conference call, the NASMHPD Board approved the concept of the Medical Directors Council publishing their Technical Reports in journals with one caveat: the introduction of any article to be published will reflect the Board's position on the Technical Report.

Action: Dr. Hester and Dr. Parks will follow-up with John Talbot at an APA luncheon in two days to discuss next steps for having an article placed in *Psychiatric Services*. Dr. Parks will add the NASMHPD Board's position to the article's introduction.

Status of 2002 Technical Reports

Seclusion/Restraint (MI/Deaf)

The draft report on use of seclusion and restraint with people who are deaf and/or hard of hearing is being reviewed by participants from the January work group meeting. Roy Praschil reported that participants wanted to approve not only drafts of the Technical Report but the final report. Representatives of the community who have mental illness and are deaf and/or hard of hearing requested to be given the status of a division or council within NASMHPD. While the Board declined the request, Commissioners asked for a session on these issues at a future Commissioners meeting.

MH Disaster Response to Terrorism

Roy Praschil advised that the Technical Report on terrorism will not be produced until the next fiscal year, likely fall 2003. He suggested that the Council produce the terrorism report and one additional Technical Report in 2003.

Suggested Topics for Future Reports and Symposiums

Medical Directors quickly provided topic ideas for future Technical Reports and Symposium sessions. Suggestions included linkages between primary health and mental health; shortage of resources (e.g., psychiatric beds and psychiatrists); early intervention for psychotic disorders; cultural competency; suicide prevention rates and risk approaches; technology transfers for evidence-based practices, including an update from the NASMHPD Research Institute on the Center for Evidence Based Practices; and an update on medication algorithms.

Action: Email Roy Praschil at NASMHPD with topic suggestions for the Symposium

or Technical Reports. The Council will discuss and decide an additional topic for next

year's Technical Report at the July meeting.

Roy will advise Noel Mazade that the Medical Directors Council would like to meet with him (perhaps at the Summer Commissioners Meeting) to discuss the organizational relationship between the Medical Directors Council and NASMHPD Research Institute, particularly around The Center for Evidence Based Practices and outcome indicators.

A Medical Director requested that NASMHPD's government affairs person look into changes to the J-1 visa in response to security issues. Given that 1 out of 4 current psychiatrists are immigrants and half of the psychiatry trainees are immigrants, the J-1 visa issue has tremendous potential to affect the human resources within the state mental health system, particularly in rural communities.

2002 Best Practices Symposium

Roy Praschil sent out letters to session chairs and gave them until July 12th to respond. He suggested the Council may want to revisit the planned session by Phil Veenhuis and Steve Shon, "Lessons for State Clinical Directors from Business Management," because Dr. Shon will not be able to attend the Symposium. Roy will check with Dr. Veenhuis to determine whether he wants to proceed with the session. If he does, Dr. Radke can assist him. If not, the Council can plug in a session on the recommendations for interface between the mental health and criminal justice systems offered by the national project sponsored by the National Governor's Association.

Next Meeting

The next Medical Directors Council meeting will occur the morning of July 14, 2002 in conjunction with the NASMHPD Commissioners Summer Meeting in New York City.

Review of Videotape

To close the meeting, the Medical Directors Council reviewed the videotape *Detection of Suspected Neuroleptic Malignant Syndrome* in order to provide feedback to the National Technical Assistance Center (NTAC).

Topics discussed by Medical Directors in May 2002

State budget deficits Maryland, Virginia, Minnesota	Missouri, Ohio,
Suicide prevention	Missouri
Pharmacy budgets	Ohio, Pennsylvania
Evidence-based practices	Ohio, Maryland, New Jersey
Reduction in/Unavailability of state beds Virginia, Illinois, Arkansas	Missouri, Ohio, Maryland,
Treating persons with mental illness and mental retardation	Maryland, Connecticut
Seclusion and restraint	Pennsylvania
Treatment algorithms	Pennsylvania, Texas
Residential Treatment Facilities	Pennsylvania
Performance and outcome measures	Ohio, Virginia
Shift of resources from hospital into community	Illinois, Minnesota
Preventive interventions with schizophrenia	Illinois
Federally Qualified Health Centers	Connecticut
Medicare's low reimbursement rates	Maryland, Minnesota
Cultural Competence	Texas

Dr. Hester posed two questions to Medical Directors to elicit a quick scan of issues:

Which states have some degree of medication algorithm activity?

Texas, Missouri, Ohio, Maryland, New Jersey, Pennsylvania, Virginia, Illinois.

Hawaii is setting the stage.

Which states are feeling pressure on their psychiatric bed capacity?

Texas, Missouri, Ohio, Maryland, New Jersey, Pennsylvania, Virginia, Illinois, Connecticut, Minnesota and Hawaii