

NASMHPD Medical Directors Council
Meeting Minutes
May 18, 2003
St. Regis Hotel
San Francisco, California

Participants

Joe Parks, M.D. (Missouri) *Chair*
Alan Radke, M.D. (Hawaii), *Vice-Chair*
Steve Karp, D.O. (Pennsylvania), *Vice-Chair*
Neal Adams, M.D. (California)
Steve Bryant, M.D. (South Carolina)
Penny Knapp, M.D. (California)
David Pollack, M.D. (Oregon)
Steve Shon, M.D. (Texas)
Bill Tucker, M.D. (New York)
Kevin Ann Huckshorn, R.N., NTAC Director

Were the following individuals present?

Larry Miller, M.D. (Arkansas)
Bob Fisher, M.D. (Louisiana)
Rupert Goetz, M.D. (Oregon)
Guest ?
Others?

Survey of State Medical Directors

Dr. Parks provided a brief summary of the results from the Council's recent survey of Medical Directors on their roles and responsibilities. He reported that 42 states had returned surveys; the remaining states do not have a Medical Director or only utilize hospital Medical Directors. Dr. Parks highlighted some of the survey results:

- 79 % of respondents are full-time Medical Directors, while 21% are part-time.
- Most are salaried.
- About half of the respondents work for state departments that include the substance abuse agency.
- Approximately one third of respondents work for state departments that include the MR/DD agency.
- The bulk of the Medical Directors report to the CEO.
- The bulk of Medical Directors are part of the executive team.
- One third of respondents have their own office staff and no other line authority.
- Medical Directors have limited budget control; better than half of the respondents had no

budget while the remaining respondents controlled small budget amounts relative to the total agency budget.

- Medical Directors spend much of their total time on administration; Medical Directors report they spend under a day per week on ongoing care.
- Medical Directors feel they able to lead change.

Some participants expressed interest in further analysis of the data. Dr. Parks agreed that certain questions and variables might lend themselves to further analysis (perhaps questions 11, 12, and 13).

After the data analysis is complete, a small work group comprised of Drs. Karp, Pollack, Zachik (Maryland), and Svendsen (Ohio) will use the data to draft an issue paper for Commissioners on the utility and range of uses for a Medical Director.

Action: Dr. Parks will explore the possibility of further analysis with the researcher. He will circulate the final survey results and the eventual issue paper among members of the Council's editorial review board.

Status of the Technical Reports

Technical Report on Terrorism

Dr. Tucker relayed that the work group met May 5 - 6, 2003 to begin drafting the Council's Technical Report outlining the possible role of state mental health authorities in responding to terrorism. With Dr. Steury (District of Columbia) serving as editor, the work group included Dr. Zachik, Dr. Rosin, Commissioner Jim Stone (New York), Commissioner Terry Cline (Oklahoma), Brian Flynn, DC's staff person for disasters, and NASMHPD staff.

The work group identified an overarching theme to guide the Technical Report: As the purpose of terrorism is to instill terror, those with mental health expertise have an important role to play in disaster response. The work group discussed: 1) the issue of credentialing, particularly given the volume of volunteers who simply show up to "assist" during disasters; 2) the lack of clinical preparedness related to trauma, PTSD, and disasters; 3) the varying roles of Red Cross chapters during times of disaster; and 4) the need to train a few, pre-identified mental health responders on how to deal with the press.

Medical Directors contributed some additional thoughts. They urged that the Technical Report acknowledge the varying abilities among SMHAs to assume leadership roles in disasters; clarify the connection to all-hazards planning and training occurring in many states; and review and be consistent with the work of AACP's Disasters Response Committee.

One Medical Director noted that the risk of an all-hazard event is greater than the risk of a terrorist event. For example, a tornado can be just as devastating to a community and requires a well-organized response from the mental health community. Dr. Parks commented that while

this Technical Report will focus on terrorism, the Medical Directors Council may elect to produce subsequent papers on related topics, as has occurred with previous Technical Reports.

Dr. Parks added that the Technical Report will feature many recommendations, particularly on the importance of relationships and planning. There will be recommendations aimed at Commissioners, state mental health authorities, Medical Directors, and NASMHPD. The goal is to have a draft report ready for the Commissioners at their July meeting.

Action: Kevin Huckshorn will provide a packet on Tony Ng's program to Dr. Steury, who will forward the information to the technical writer.

Technical Report on Prevention

Dr. Radke provided a brief update on the prevention Technical Report and requested guidance from Council members. He and Dr. Eilers (New Jersey) are co-editors. The goal is to convene the work group at the end of August or beginning of September on the West Coast. The participants will include the co-editors, another Medical Director, two Commissioners, representatives from NASMHPD's older persons division and children's division, a facilitator, two experts, and a technical writer. Dr. Radke may serve as facilitator to enable another Medical Director to participate.

Dr. Radke outlined the different directions the editors were considering for the Technical Report: 1) a discussion of primary, secondary and tertiary prevention using evidence-based practice recommendations featured in the Surgeon General's report; or 2) an examination of current prevention activities with public mental health systems (e.g., suicide prevention, substance abuse, trauma, victimization, and early identification of psychosis) and the relationship with other prevention stakeholders.

A Medical Director suggested that the report should adopt the IOM's terms for prevention (i.e., universal, selective, and indicated). Dr. Radke responded that perhaps the Technical Report would use both sets of terms. Another participant added that using the term "universal" may help advance the prevention dialogue as it implies accountability to the population at large.

Another Medical Director commented that the work group could examine lessons learned from the mental retardation/developmental disability field, particularly the emphasis on person-based planning, focus on the family, and the power of family advocacy. Perhaps such a focus would also cultivate the interest of NAMI and other advocacy groups in early intervention.

Dr. Parks recommended that the Technical Report's initial section outline how Commissioners might think about prevention and include a list of specific targets of opportunity (e.g., suicide prevention). It would also be helpful to leave a place holder for any prevention recommendations that flow out of the final report to be issued by the President's New Freedom Commission on Mental Health.

Additional feedback from Medical Directors included: the need for Commissioners to understand the whole prevention continuum and consider strategies to involve SMHAs with different parts of the continuum; acknowledgment of those who might use a discussion of prevention to move the system's focus away from people with serious mental illness; the importance of providing guidance to states which do not have current prevention activities; awareness of lessons that can be learned from the drug and alcohol systems; and the need for emphasis on early detection of psychosis, medical mortality and morbidity, and prevention of substance abuse within the population of persons with serious mental illnesses.

Action: Drs. Radke and Eilers will finalize the work group meeting details. Drs. Knapp and Pollack expressed interest in participating in the work group. Dr. Radke requested that Medical Directors with good prevention information and literature send those resources to Kevin Huckshorn at NTAC for wider dissemination.

2003 Best Practices Symposium

Dr. Radke shared the latest planning for the Council's 2003 Best Practices Symposium. The Symposium will focus on four topics:

- reducing medical morbidity with Drs. Pollack and Duckworth (Massachusetts) serving as chairs
- effective use of LOCUS (or service planning) with Drs. Adams and Radke as chairs
- guiding physician practice particularly around pharmacy issues chaired by Drs. Parks and Luchins (Illinois)
- utilizing ORYX and CARF presented by Dr. Littrell (NASMHPD Research Institute).

Participants discussed the format for the 2-day meeting to be held in Boston preceding APA's Institute on Psychiatric Services. Due to concerns about travel expenses and time out of the office, Medical Directors agreed upon the following agenda:

Tuesday evening, 10/28:
session 7-9 p.m.
business meeting 9-10 p.m.

Wednesday, 10/29:
session 8-10 a.m.
session 10-12 p.m.
lunch/business meeting 12-1 p.m.
session 1-3 p.m.
business meeting/2004 Symposium planning 3-4 p.m.

Action: Medical Directors asked that Roy Praschil explore arranging a shuttle at the end of the Symposium to transport participants to the hotel hosting the APA Institute.

Public Mental Health Training and Workforce

Medical Directors discussed a recent journal article written by Commissioner Mike Hogan (Ohio) that addressed the inadequacy of education and workforce training for all the behavioral health disciplines. The article provided examples of key core competencies and outlined strategies for graduate education training, as well as training for front-line professionals, paraprofessionals, and consumers.

Participants echoed the need to enhance training to produce a skilled workforce prepared to work in multi-disciplinary programs. They stressed the importance of clinicians who are able to be multi-disciplinary team leaders and use such core skills as leadership, negotiation, and delegation.

Dr. Radke relayed how Hawaii is talking with schools of nursing, social work, and other disciplines about integrating public mental health into their training programs. Current training programs provide very little exposure to the public mental health population; upon graduation, junior clinicians are not interested in public sector jobs because they are not familiar with the work or population. Dr. Parks shared that Missouri has successfully attracted new psychiatrists from universities where the department of psychiatry is a wholly owned subsidiary of the state Department of Mental Health and the faculty are state employees. (e.g., University of Missouri, Kansas City)

The group also discussed how Medical Directors could provide assistance to training directors, such as providing public mental health training modules of varying lengths that could fit easily into the curriculum. While short training modules will not be comprehensive, they may elicit curiosity and interest in the public mental health field.

Dr. Fisher discussed Louisiana's efforts to train clinicians in the full system of care. Most residency programs simply send residents to a state hospitals and/or outpatient mental health clinics. In Louisiana, the training program includes placements on PACT teams, respite services, outpatient clinics, and outreach. The program encourages collaboration not only across the mental health system, but also with non-mental health systems (e.g., prison, police).

Other Medical Directors addressed the importance of continuing education and retraining for the existing work force so public mental health can provide a truly person-centered, recovery-oriented system. Paraprofessionals, who are the backbone of public mental health care, also have tremendous training needs.

Dr. Karp urged that Medical Directors establish collaborative relationships with universities to improve training. While state public mental health systems may lean toward funding fellowships or faculty positions, there may be a limited return on that investment. An alternative is to encourage and invest in university programs that offer multi-disciplinary cross-professional training. States may achieve better results by funding an integrated model which trains a range of clinicians.

Action: The Medical Directors Council will continue to discuss this topic and possible future activities (e.g., white paper, workshop) during the business meeting at the 2003 Symposium.

Liaison with AACP

Dr. Pollack serves as the Council's liaison to the American Association of Community Psychiatrists (AACP) and encouraged Medical Directors to join and/or participate in AACP. As chair of AACP's program committee, he explained that AACP will sponsor two sessions at the upcoming APA Institute: 1) a session on the impact of budget cuts on mental health services with a focus on the impact on such specialty areas as rural mental health, children's services, and consumer services; and 2) a session on medication cost containment and improving clinical practice through improved prescribing practices. Dr. Pollack suggested that the Medical Directors Council may want to jointly sponsor the first session with AACP and be involved with the planning.

He also shared that the AACP winter meeting will occur in Hawaii in February or March 2004. Dr. Pollack requested that Medical Directors try to attend the meeting and that the Council consider co-sponsoring the meeting. Co-sponsorship would not require a financial commitment. If Medical Directors are presenters at the winter meeting, their travel may be covered by AACP.

Finally, AACP provided a set of recommendations to the President's New Freedom Commission on Mental Health, which are available on the organization's web site. Dr. Radke suggested that the Medical Directors Council may want to endorse the position statement, which reflects many of the issues of concern to public mental health psychiatrists.

Action: Dr. Parks will discuss the following items with NASMHPD Executive Director Bob Glover: joint sponsorship with AACP of the budget session at the upcoming APA Institute; possible co-sponsorship of the AACP's 2004 winter meeting; and endorsement of AACP Position Statement to the President's Commission.

Discussion about HIPAA and use of ICD-9/DSM

Dr. Parks reported that he informally surveyed fellow Medical Directors about HIPAA's impact on the use of ICD-9 and DSM for billing purposes. He explained that under the Health Insurance Portability and Accountability Act (HIPAA), all electronic batch transactions must meet HIPAA standard formats. While clinicians can still diagnose in DSM, diagnoses and other data elements must conform with ICD-9 to be sent in for payment.

Dr. Parks raised that concern that states may not have an adequate cross-walk between the two diagnostic systems when the state is in the role of the payer. As a payer of services, the state cannot require community mental health centers to report data in batches that are not in HIPAA

standard format (i.e., ICD-9). Thus, DSM Axis IV and V information cannot be included in information batches.

Dr. Parks indicated that fellow Medical Directors responded they did not anticipate problems around this issue. Meeting participants agreed that the incident rate would likely be so low that no significant problems would occur. The group reached consensus that this was not an issue that required Council follow-up.

Managing Budget Impacts

One Medical Director discussed how his state handled a major cut in its medication budget mid-way through the year. Crafting an add-on to its TMAT process, the state designated Class I- IV categories for its medications. State clinical staff were asked to consider prescribing Class I medications for their patients, absent best practices or other available clinical outcome data to guide their prescribing. Managing the voluntary program through retrospective peer review and not using preauthorization, the state has remained within its reduced medication budget. A future challenge may be the state Medicaid agency's desire to adopt a similar system and move it into the community services and use utilization review.

Dr. Adams shared that California is using a tiered structure for its contracting. The state has increased its negotiating and purchasing power by purchasing medications for several state systems, including mental health, prisons, segments of the state university system, and the youth authority. California did not want to move toward prior authorization or market share arrangements to control medication costs. Dr. Adams maintained that public managers' greatest concern around medication costs should be their inability to control utilization, not just per tablet expenses. Public mental health systems need to be in the business of buying episodes of care. California's tier system is an attempt to move in that direction as the state will assign tiers based upon treatment cost not just tablet prices.

Other Medical Directors agreed that the system needs to consider episodes of care and cost accountability. Dr. Pollack suggested that state mental health systems share medication management strategies with one another to learn what works. Another Medical Director cautioned that the science may not exist yet to calculate the cost of an episode of care, which may lead to inappropriate conclusions and restrictions.

Next Meeting

The next Medical Directors Council meeting will occur July 2003 in conjunction with the Commissioner's summer meeting in San Diego.