

NASMHPD Medical Directors Council

Meeting Minutes

May 6, 2001

New Orleans, Louisiana

Participants:

Tom Hester, M.D. (Georgia) - Chair
Kenneth Casimir, M.D. (Wisconsin)
Robert Fisher, M.D. (Louisiana)
Brian Hepburn, M.D. (Maryland)
Ted Lawlor, M.D. (Guest from Connecticut)
Richard Lippincott, M.D. (Guest from Louisiana)
Rajbir Minhas, M.D. (Montana)
Larry Miller, M.D. (Arkansas)
Joseph Parks, M.D. (Missouri)
Alan Radke, M.D. (Minnesota)
Steve Shon, M.D. (Texas)
Roy Praschil (NASMHPD)

I. Introductions and Updates from Participants

While introducing themselves, each Medical Director gave a brief state update.

Minnesota's state mental health agency has adopted a regional system where administrators and medical directors are now responsible for regions instead of individual facilities. This move allows the state to save about \$13 million dollars. Minnesota also is working toward having more stakeholders provide basic "safety net" services in the community. The Governor had all state agencies put a certain percentage of their budgets into a pool to fund hospital-like supports in the community. The state also uses dollars from Medicaid's social rehab option and other appropriations to build up treatment services, social supports and affordable housing which enable consumers to transition from hospital-settings.

Texas has begun a statewide benefit redesign group which will examine illnesses defined for the priority population from a disease management perspective. This process will focus on an illness (e.g., major depressive disorder) and determine the sufficient criteria for diagnosis, appropriate evidence-based treatment and medication, and protocol for first, second and lifelong episodes. Universities, community mental health centers, hospitals and medical economists are involved with the process of defining appropriate benefit packages regardless of setting. By the end of 2001, the redesign group should have initial findings on the first diagnosis. The goal of this multi-year process is to have recommendations on

restructuring benefits for the legislature's next biannual session.

Montana's state mental health system is in a state of flux, as the state is trying to determine next steps given managed care has been thrown out. Montana's real challenge is the lack of community mental health services. The state started two PACT programs in Helena and Billings to serve 80 people served in the community, 40 of whom were in the state hospital.

Arkansas is experiencing poor revenue projections, which has resulted in budget cuts for the Division of Mental Health (\$1.8 million in 2001 and \$2.5 million in 2002). These cuts have had a significant impact on the state's administrative and training budgets, particularly its Research and Training Institute. The Division also had to delay the opening of a forensic unit. Division staff are working with the Arkansas Medicaid Director to address the financial concerns and quality of care issues associated with psychotropic medications. Arkansas is also focusing on promoting good psychopharmacological practice; the state established a pilot project where an interdisciplinary team works with nursing home staff and their use of psychotropics with residents. Other efforts include developing a mental health court and pursuing funding to conduct crisis intervention training for police.

The Chief of Adult Services at the University of Connecticut Medical Center reported that, as of July 2001, the state will assign a case manager to work with people with serious and persistent mental illness served by the Center.

Missouri is in its fourth year of focusing on better integration between the substance abuse and mental health systems. Collaboration efforts include regional planning, joint training throughout the year, providing funding to substance abuse providers to provide psychiatric medications, and revamping the social detox program to include professional nursing and physician staff to address consumers' physical and mental health needs. Other activities within the Missouri mental health system include collaborating with the department of developmental disabilities, working on practice guidelines initiatives, drafting protocol for physicians prescribing Clozapine and developing patient education materials regarding generics. Missouri recently surveyed doctors about medication availability and whether doctors felt their ability to prescribe was restricted by formularies. Only 11 percent of doctors felt that they couldn't prescribe what they wanted for Department of Mental Health (DMH) clients, which was down from 40 percent about 3 years ago. Missouri has also noticed that their non DMH-operated beds (e.g., Veterans Affairs, private psychiatric or general hospitals) have dropped by 30 percent in last decade and this trend has accelerated in the past two years. This trend raises the question about the impact that these private sector decisions will have on state mental health systems.

Louisiana's state mental health system is moving toward disease management and instituting clinical protocols. In particular, the state is aiming to admit consumers to the level of care they need on the continuum and then ratchet them down to the least restrictive environment as quickly as possible. The state

continues to collaborate with academic partners; Louisiana State University runs all of the state general or charity hospitals while Tulane runs the state's forensic program. Louisiana also belongs to the multi-state purchasing consortium which allows the state to purchase its pharmaceuticals at a great savings and receive free drug samples to assist indigent patients. Threatened budget cuts are the biggest challenge in Louisiana. In addition, the state is overwhelmed with forensic patients; forensic patients take up 55 percent of the state's beds. If this trend is extrapolated out to 2020, the state won't have any civil beds left. Since forensic patients are criminally committed, the state mental health system does not control their length of stay.

Maryland instituted a statewide administrative services organization (ASO) four years ago. When the state releases its RFP for the ASO, it expects four bidders with the ASO administrative costs running at about 3%. This last year Maryland experienced a \$30 million budget shortfall, primarily due to the cyclical delay in processing claims, increased number of uninsured consumers and increased number of people with dual diagnosis (mental illness and substance abuse and mental illness and developmental disability). Maryland is in the process of modifying some reimbursement structures to address gaps and disincentives in the system. As several hospitals are refusing to take Medicaid and Medicare patients, the state is moving toward a prospective payment system to address this issue. In addition, hospitals are reluctant to admit people with psychiatric problems whose longer length of stay may conflict with the rate methodology. Dr. Hepburn is working with the rate and health care commissions to try to improve incentives to take people into the general hospitals and possibly exclude people with developmental disabilities from the methodology.

Wisconsin is working on minimizing its use of seclusion and restraint and has introduced new training and policies. Some of the challenges facing the state include a hiring freeze for patient care staff and budget concerns.

Georgia is engaged in a push to maximize federal revenue streams, including the Medicaid rehab option. This effort will involve a major change for community providers who will have to begin billing for services as of July 2001. In addition, after a three year trend of dramatic reductions in admissions and lengths of stay in state hospital beds, the trend has flattened and recently shown a slight increase. Thus, the state is anticipating pressure on state hospital beds. The Medical Director position in Georgia has recently changed to now have the executive directors of regional planning and purchasing boards report to Dr. Hester.

Multistate Issues

Appropriate levels of care

Several Medical Directors spoke of the importance of funding all levels of care (e.g., psychiatric hospital beds, general hospital beds, residential beds, supported residential and community placements) to appropriately treat persons with mental illness. When some of these levels of care are not adequately funded, consumers end up in levels of care that they don't need and/or that don't serve them well.

Georgia examined this issue and hired an outside utilization group to apply LOCUS criteria to all state hospital patients and determine who met criteria for Level 6, who did not, and what level of care was recommended. As a result, the regional purchasing board has the aggregate data to determine which levels of care services need priority funding.

The private sector's decreasing interest in serving persons with mental illness also has an impact on the available treatment options and supports. In particular, as economics change, private hospitals are less interested in contracting with the state to provide inpatient services. As the private sector and Veterans Affairs get out of the business of providing services to people with serious mental illness, the public mental health system will continue to feel the impact.

Some states have developed flexible treatment settings to meet this range of need. Georgia has crisis residential programs operated by the community mental health centers. Since the program is under 15 beds, the services can be Medicaid reimbursable. These community-based crisis programs have taken tremendous pressure off of hospitals.

People who have developmental disabilities and mental illness

The difficulty of finding inpatient beds for persons with the dual diagnosis of mental illness and developmental disabilities was also discussed. General hospitals may be reluctant to accept these individuals, fearing lengthy stays, community placements that cannot remain open and/or families that do not want the patient to return home.

Minnesota has responded to this issue by using crisis beds for persons with developmental disabilities, particularly as most of the crises are more behavior-related than psychiatric. If the person does require a psychiatric bed, they also bring the treatment team and support staff to them for the 3-5 day inpatient stay and then return the person to the less-restrictive crisis bed.

Texas' state facilities has special units which are funded with both mental illness and mental retardation dollars. These programs allow interdisciplinary teams to cross-train and work together to address the unique needs of this dually diagnosed population.

The discussion of cross-cutting state issues concluded with suggestions that NASMHPD might want to convene work groups around (1) levels of care and associated costs (e.g., costs of state-operated, private beds and crisis community-operated beds); (2) forensic issues, perhaps as a joint effort with the Forensic and Legal Divisions; and (3) providing services for people with mental illness and developmental disabilities, perhaps as a joint effort with the National Association of State Developmental Disability Directors.

Review and Approval of December 3, 2000 Meeting Minutes

The Medical Directors Council reviewed the draft minutes from its December 3, 2000 meeting. The minutes were approved and accepted.

Action: The Medical Directors Council approved the past meeting minutes.

Report on Superintendents National Summit

According to NASMHPD Executive Director Bob Glover (who was unable to attend the Medical Directors Council Meeting due to illness but passed along his thoughts via some of the participants), the Superintendents National Summit in March was well-received. Some of the topics that Superintendents were particularly interested in included the Olmstead decision and the hospital's role, using electronic charts for state psychiatric hospitals, violence and mandated treatment and responding to needs of trauma survivors. The Superintendents are establishing regional groups to continue discussion and information-sharing. The plan is developing that the Superintendents will have a national meeting every other year with a regional meeting to occur during the off years.

NASMHPD Position Statement on Restoration of State Hospital Cemeteries

The Medical Directors received a copy of the draft NASMHPD Position Statement on Restoration of State Hospital Cemeteries, which Dr. Hester helped to draft. The position statement was approved by the NASMHPD Board and will be voted upon by the membership at the summer Commissioners' Meeting. As Dr. Hester explained, addressing this issue is a real opportunity for healing among state mental health systems and consumers.

A few Medical Directors had some minor language suggestions to clarify the statement. While it was unclear if such changes could still be incorporated, Roy Praschil agreed to pass along these comments to Bob Glover.

Report on 2000 NASMHPD Medical Directors Councils' Technical Reports

Dr. Hester gave a brief overview of the process and history of the Medical Directors Council developing Technical Reports. The Council develops and issues two reports per year on hot button issues with recommendations geared toward state systems and national organizations. The two reports for 2000 were:

- *Seclusion and Restraint II* which has been completed, approved and distributed. Rupert Goetz, M.D. (Oregon) served as Chief Editor.
- *Pharmacology*. This report was done in conjunction with several Medicaid Medical Directors, a successful first attempt to draft a technical group with another group. The report is available for distribution. Dan Luchins, M.D. (Illinois) served as chief editor.

One participant suggested that the next step for the Council to undertake is to submit the Technical Reports in a shortened form to various journals. With little additional work, the Council could achieve wider dissemination of the Council's work and raise awareness of NASMHPD. For example, material from the psychiatric medication Technical Report might be placed in the *Mental Health Administrator* while *Psychiatric Services* might be interested in the seclusion and restraint topic. Participants agreed that the Council's Editorial Advisory Board could assume responsibility for placing such articles in peer journals and other publications.

Roy Praschil mentioned that the Medical Directors Council needs to explore other funding for the Technical Reports in future years. Currently, pharmaceutical companies fund the effort, but such support is not appropriate for some topics (e.g., the 2001 report on polypharmacy). Participants suggested investigating SAMHSA or NIMH funding.

Action: Roy Praschil will ensure that the current Technical Reports are posted on NASMHPD's web site. Roy or Tom will talk with Bob Glover about the idea of publishing shortened versions of the technical reports in journals.

Report on 2001 Medical Directors Technical Reports

The Medical Directors serving as editors for the 2001 Technical Reports gave updates.

- Joe Parks, M.D. (Missouri) reported that the work group on polypharmacy had its technical writing meeting in early May. The work group convened seven psychiatrists, two consumers, three pharmacists, two Commissioners and a technical writer. The process resulted in consensus on a number of general and specific recommendations, such as the importance of communicating and working with consumers on medication issues and the value of instituting some process (e.g., prior authorization) where more than 2 antipsychotics can't be prescribed without formal approval.
- Brian Hepburn, M.D. (Maryland) expects the first draft on outpatient commitment to be available in June. This work group met earlier in the year and involved a representative from the Forensic Division, two Commissioners, several Medical Directors, a consumer and an expert consultant, Paul Applebaum. The report will address the issues of community safety, violence and mental illness, options, coercive treatment, advanced directives. Dr. Hepburn relayed that the group reached consensus that (1) coercion should not be a replacement for lack of services; if services are in place, systems may not need the choice of outpatient commitment and (2) single case incidents should not drive policy on this issue.

Editorial Advisory Board Appointments

Dr. Hester reviewed the process for other Medical Directors (outside the immediate working group) to review draft Technical Reports. The Council had established an Editorial Advisory Board to approve technical report subjects, review and approve technical reports prior to distribution and consider suggestions for items to be posted on the web page. Participants agreed that this structure still made sense and suggested some Medical Directors to fill the “vacant” spots on the Board.

Participants then brainstormed possible topics for 2002 Reports to suggest to the Editorial Advisory Board. The topics (some of which may be used for future Best Practices Symposium) included: consumers with dual diagnosis (mental retardation/mental illness); utilization management of planning for services (private/public beds, levels of care); juvenile forensic issues (suggested by Bob Glover); joint project with NASMHPD's Forensic Division; mental health courts; trauma and recovery; suicide (as follow-up to recently released Surgeon General's report); implementation strategies for states for evidenced-based practices and telepsychiatry.

Action: On the handout describing the Editorial Advisory Board's structure and function, modify the Board's function by deleting "consider suggestions for items to be posted on the web page" and adding "promulgate technical reports, including presentations and peer review publications"

Add the following people to the Editorial Advisory Board:

Steve Bartels (N.H.) for Northeast
Brian Hepburn, M.D. for Northeast
Robert Fisher, Louisiana for South
Kenneth Casimir, Wisconsin for Midwest
Penny Knapp, California for West

Dr. Parks will contact Drs. Bartels and Knapp to see if they will serve.

Roy will give the list of possible topics for future Technical Reports to Bob Glover and then members of the Editorial Advisory Board.

Memorandum of Understanding with the American Academy of Community Psychiatrists

The Council reviewed the draft Memorandum of Understanding with the American Academy of Community Psychiatrists, which was written by Dr. Parks and reviewed by Dr. Glover. The MOU needs to be signed by NASMHPD representatives and forwarded to AACCP for their signatures. The Medical Directors Council Chairperson will serve as the AACCP liaison.

XII. 2001 Best Practices Symposium

The Medical Directors' Council 2001 Best Practice Symposium will occur in October 8-9, 2001 in Orlando, Florida. Roy Praschil sent out the draft agenda for "Transforming Knowledge and Research Into Practice in Public Mental Health Systems." CME credits will again be available.

The 2001 Symposium will feature the following sessions:

NRI's Performance Measurement System Update. Dan Luchins, M.D. is the Section Chair for this closed session.

Children Psychopharmacy Issues. Brian Hepburn, M.D. and Penny Knapp, M.D. are Section Chairs.

Continuity of Care from the Hospital to the Community (Successes and Failures). Alan Radke, M.D. is the Section Chair.

Update on practice guidelines including changes by APA and modifications by the tri-universities. Steve Shon, M.D. chairs this Section.

A participant suggested that NIMH might be willing to fund this last session on practice guidelines.

Miscellaneous

Seclusion and Restraint National Meeting

NASMHPD is planning a 2.5 day national meeting on seclusion and restraint involving a range of stakeholders. The meeting will occur in late fall or early winter. Bob Glover requested that one or two Medical Directors assist with shaping the agenda, finding faculty and identifying important topics. Depending on scheduling, the following Medical Directors are available to participate in planning: Rupert Goetz, M.D., Joe Parks, M.D., Alan Radke, M.D., and Tom Hester, M.D..

ORYX feedback.

Dr. Radke urged participants to attend the eastern or western ORYX user group meetings in fall 2001. He suggested that the Medical Directors might want to provide input on the issues of case mix, risk adjustment, and the data's practicality.

Next Meeting

In conjunction with NASMHPD Summer Commissioners Meeting, the next Medical Directors Council Meeting will occur July 29, 2001, 8 AM-12:00 PM in Minneapolis, Minnesota. The Commissioners Meeting will run through Tuesday, July 31st with Monday, July 30th being the joint meeting day with the Children's Division. For the next Council Meeting, participants agreed to continue using up to 1.5 hours for informal introductions/updates and to supplement their updates with relevant materials (e.g., articles) of interest to other Medical Directors.