

Continuity of Care Work group  
Clinical subgroup

Minutes 8/27/13

Subgroup Members:

Present	Not present
John Boronow (cochair)	Ken Wireman
Anne Hanson (cochair)	Joel Kanter
Lori Doyle	Charles Gross
David Maina (phone)	Ann Geddes
Jan Caughlin	
Dan Martin	
Susan Stromberg	
Jennifer Lowther	
Bob Pitcher	
Louise Treherne (phone)	
Linda Raines	

Other Participants:

Lois Fisher  
Vanessa Purnell  
Sarah Rhine  
Kait Roe  
Ari Blum  
Jamie Miller  
Sharon Tyler  
Elaine Carroll  
Kate Farinholt  
Juan Rodriguez  
Caroline Warfield  
Brian Anderson  
Randi Hamilton

DHMH Staff: Erik Roskes

The meeting was called to order at 1600. The minutes from the last meeting were approved.

Erik again encouraged all participants to join the Google group, where extensive discussions are now taking place about various issues. The group is open as required by the MD Open Meetings act and can be found at <https://groups.google.com/d/forum/maryland-dhmf-continuity-of-care-workgroup---clinical-subgroup>. In addition, you can post to the group via email, at [maryland-dhmf-continuity-of-care-workgroup---clinical-subgroup@googlegroups.com](mailto:maryland-dhmf-continuity-of-care-workgroup---clinical-subgroup@googlegroups.com).

During this meeting, there were two formal presentations, which spawned much conversation and discussion. This allowed more time for discussion than in the last meeting.

The first presentation was by Jamie Miller, from Value Options, on the barriers presented by individuals with comorbid mental illness and addictions, and especially those who are “high utilizers” of acute/expensive services but who resist engagement in long term, recovery oriented interventions. VO has adopted an intensive care management approach to these cases. Given that such individuals often move from one hospital to another (especially in Baltimore city), VO is the only entity that is able to track their treatment experiences longitudinally. Their ICM approach is able to address acute episodes differently, given that they often present with acute substance abuse crises but really do not need the sort of 24hour nursing management in an acute psychiatric setting. However, because there are insufficient programs to address substance abuse crises, these individuals appear in emergency departments and psychiatric inpatient units where they are quickly recognized as not in need of the care offered there. These individuals cost the system tens of thousands of dollars per year or more. (This is similar to the discussion last week of the 20-80 rule, wherein a small percentage of the population uses a large percentage of the treatment resources.) Suggested recommendations included:

- Develop fee-for-service codes to allow OP providers to physically meet and build connections with consumers on IP units, prior to D/C
- Develop specialized, dual diagnosis, crisis residential “shelters” with:
  - Crisis counseling
  - Case Management for concrete things like beds, food, entitlements, etc.
  - Ambulatory detoxification
    - *Maybe even the ability to be a “wet” shelter?*
- Create a systemic process for securing a ROI when entering the public health system for coordination of care between the Somatic, SA and MH providers
- Development of dual diagnosis services at many (if not all) levels of care
  - Trainings, certifications, EBPs, CPT codes, fee-schedules, etc.

There were several questions for Jamie:

- Why are only 75 individuals managed in this way? That is the caseload that can be handled given the resources available. The ICM is pretty intensive and requires substantial staff time, including attempts to find the individual in the community after release.
- What is the prevalence of CJ involvement? A low percentage has active parole/probation involvement, though more have CJ histories. The probation agent is engaged as a part of the support team for people on supervision.
- Some discussion of the difficulty getting people to sign releases of information to permit cross-system communication and coordination.
- There is no ability yet to quantify the cost saving, but for the ICM group, each individual had at least 4 inpatient admissions in the prior 3 months. Estimating a cost of \$1200/day over 7 days, this means they cost at least \$32,000 in three months (or \$128,000 a year).
- A big issue is the capacity of community programs to manage people with dual diagnosis. Related to this are substantial legal, regulatory and fiscal barriers to coordinated care. Specifically, there are Federal restrictions on using certain Medicaid dollars to pay for substance abuse treatment. In addition, at present anyway, there are different funding streams for MH and for SA treatment. There is some hope that the funding streams will be joined in FY2015 as a part of the consolidation, but that will not eliminate the regulatory barriers posed by Medicaid. This is not as much of a problem in the commercial world, which has developed medical necessity criteria specifically applicable to people with dual diagnoses.

The second presentation was by Elaine Carroll from OOOMD focused on the role of trauma in people’s lives and on the ways in which they express their responses to trauma. She sent a number of materials to the Google group– these are on the drive as well. The ACE study abstract is available at

<http://www.ncbi.nlm.nih.gov/pubmed/9635069?dopt=Abstract>. The ACE study concluded that there is “a strong graded relationship between the breadth of exposure to abuse or household dysfunction during childhood and multiple risk factors for several of the leading causes of death in adults.” Some of these causes of death relate to mental illness and substance abuse. The philosophy of a trauma-informed approach to care is that it is ineffective to treat the “symptoms” (e.g. depression, substance abuse) without addressing the underlying causes (trauma). The principle is to move from a “what is wrong with you” approach and toward a “what happened to you” approach. At times, treatment resistance is engendered when we approach traumatized people using the first approach. In addition, some of our interventions may be experienced as re-traumatizing. She ended her presentation by discussing a study in Baltimore, recently completed, of trauma informed interventions. The group discussion included a discussion regarding what data is available to support the conclusion that trauma-informed approaches are more successful or effective. The Balto County Detention Center has had a trauma program for women and for men. Compared with the baseline 50% return rate over 2 years after release, the trauma intervention recipients had recidivism rates of 16% (women) and 28% (men). There was some discussion about how to separate the effect of the trauma-specific intervention from the more general case management and interpersonal therapy interventions that took place.

The clinical group was asked to discuss the potential role of jail-based competency restoration for defendants found incompetent to stand trial. There was some discussion of the competency evaluation and incompetency commitment process. Erik estimated that perhaps 800 individuals per year are committed as IST and then committed to state hospitals. (Erik submitted a data request to the MHA Office of Forensic Services for actual FY13 numbers.) At Perkins, people found IST remain for a fairly long LOS, but at regional hospitals the LOS is relatively brief. At SHC the LOS is around 80 days. In part this is due to the nature of the cases sent there (with a fair proportion of cases having a maximum sentence of 90 days, precluding the IST commitment from exceeding that limit).

The economic subgroup has reviewed literature suggesting that jail-based restoration of competency is cheaper than a hospital-based approach. John suggested that this may be due to the far higher accreditation requirements in hospital settings, which necessarily raise the cost of care there. Anne pointed out that NCCHC, which accredits many jails, forbids jail clinicians from engaging in the gathering of “forensic evidence”, which would require that NCCHC accredited facilities to hire staff specifically to provide competency rehabilitation and assessments. This might offset the cost saving to some extent. In addition, there are ethical guidelines for both psychiatrists and psychologists strongly discouraging acting in both a clinical and forensic role for a given case. Thus, there would be no economy of scale in smaller jails, which would be unable to do this. It is not clear to the clinical subgroup what the actual cost saving – factoring in the costs that counties would encumber if competency restoration were moved to county jails – would actually be.

In addition, the clinical subgroup strongly believes that jail is not an appropriate place for people with acknowledged mental illness to be. It is worth noting that jail-based restoration options have arisen in places where there were inadequate state hospital resources to perform this function. Thus, in Texas, Erik worked with a midsize jail that was struggling with a 9 month waiting list for state hospital beds even after a court-order requiring transfer was cut. The jail staff there concluded that, given a choice between providing competency education/rehabilitation or waiting 9 months, it was better to provide the restoration interventions. This is decidedly not the case in Maryland, where we have a highly functional and effective approach to addressing incompetent defendants’ needs.

If there is to be a “cost-cutting” approach, the clinical subgroup concluded that there are some changes that could be made, but these all would require statutory changes. Among these are the very long “Jackson” limits, far longer than are the case in most states. There has already been an active discussion of this topic on the group.

The next meeting is on 9/3/13 at 1600 at Sheppard Pratt Conference Center. Room and call-in information to follow. Please try to be on time.

We will have two presentations.

- Kait – consumer perspectives on barriers to care
- Edgar Wiggins, Ari Blum, Jennifer Lowther – crisis intervention and its role in continuity of care

This will be our penultimate meeting, and we will need to use our last meeting on 9/10 to wrap things up and to try to devise a few key recommendations to the larger workgroup.

The meeting ended at 1730.

Minutes prepared by Erik Roskes