

Continuity of Care Advisory Panel

August 8, 2013

Meeting Minutes (1pm-3pm)

Spring Grove Hospital Center (Dix Building)

Agenda

- I. Introduction of Advisory Panel Members - Gayle Jordan-Randolph, M.D.
- II. Background -Gayle Jordan-Randolph, M.D.
- III. Workgroup Role -Gayle Jordan-Randolph, M.D.
- IV. DHMH Staff Role -Rianna P. Matthews-Brown
- V. Timeline -Gayle Jordan-Randolph, M.D.
- VI. Final Report -Gayle Jordan-Randolph, M.D.
- VII. Q. and A.
- VIII. Break out into Workgroups
- IX. Reconvene/Adjourn

- I. The meeting commenced at 1:00 pm in the basement of the Dix Building after participants signed in on the designated workgroup sheet and received a copy of the agenda. Dr. Gayle Jordan-Randolph began with opening remarks welcoming all participants to the first Continuity of Care Advisory Panel Meeting followed by a brief introduction by the appointed Advisory Panel members in the following order:

Dr. John Boronow

Clarissa Netter

Dr. Stephen Goldberg

Dr. Randell Nero

Dr. Gayle Jordan-Randolph read the biographies of Margaret R. Garrett and Dr. Anita Smith-Everett who were not physically present.

II. There have been a number of tragedies over the past few years. These significant tragedies have included mass murders with an inference and/or accusations that mental health is related or associated with them. It is unclear if mental health is a component however, the concern in the mental health community has been a “knee jerk reaction” to propose changes on the inappropriate focus on mental health as it relates to access to weapons. The Department of Health and Mental Hygiene has worked closely with the Governor on legislation with respect to access to guns as it relates to: Changes in the reporting criteria and language to supplement Department of Health and Mental Hygiene funding for mental health first aid training throughout the state. This is an opportunity to look at early indicators/risk of mental illness. As you may recall there was a Center for Excellence proposal which examined early stages of creation for mental health first aid. The concern is about what happens to people with symptoms of mental illness; what is the process in Maryland; what are the barriers that

prevent access to treatment and continuing treatment. There are questions that are being asked about continuing treatment; continuum of care from emergency petitions; voluntary admissions; early recognition and crisis services; court ordered evaluations; competency evaluations; aftercare planning; continuity of care and how people fall in and out of treatment. This Advisory Panel will create the opportunity to take a comprehensive assessment of service delivery in Maryland and barriers that may influence access to appropriate treatment.

Questions that were raised by the appointed Advisory Panel members in the August 5, 2013 meeting will be made available to workgroups.

Rarely do we have this opportunity to pull people together from different areas that are vested and interested in treatment of people with mental health in Maryland.

If there are opportunities for proposed recommendations than a compressed, structured, good product for everyone's opinion will be created and the recommendations implemented by DHMH and then next the state moving forward.

- III. Advisory panel members will chair the workgroups and movement between workgroups is acceptable. The goal with this process is to be really open and get input from the community, stakeholders and experts. If you are not on a specific group feel free to attend those meeting and sign in on attendance sheets. Each workgroup will have a DHMH staff member and meeting minutes will be made available. The staff member is the appropriate point of contact for your workgroup.
- IV. Department staff is available to take meeting minutes and assist the Chairs/-Co-Chairs with distributing information and arranging meeting space. DHMH staff is the point of contact and will maintain the contact information for the workgroups.
- V. Each workgroup has been assigned a time to present their reports to the Advisory Panel. The presentation schedule will be emailed to the workgroups. Members of the public are invited to attend these open meetings. The schedule of presentations is as follows:
 - September 4, 2013 (10 am – 12pm) Economic Workgroup
 - September 16, 2013 (1pm -3pm) Clinical Workgroup
 - October 4, 2013 (1pm-3pm) Legal Workgroup
 - October 23, 2013 (1pm-3pm) Social Workgroup
- VI. The Final Report to be presented to the Secretary of DHMH will be due November 15, 2013.

The Economic Workgroup will examine economic barriers that may limit access to care, such as housing, income and health coverage.

The Social Workgroup will examine demographic factors- race, immigration status, language, culture and gender.

The Legal Workgroup will research existing federal and Maryland laws/regulations that impact the state's behavioral health system and provide an analysis of the laws of other states that have been enacted to improve continuity of care.

The Clinical Workgroup will examine factors such as diagnostic evaluations, access to inpatient/outpatient treatment, types of structured treatment (evidence based data), medication, service delivery and quality of care.

VII. Questions/Answers : Dr. Gayle Jordan-Randolph served as the facilitator:

1. How are we defining continuity of care (what will be the workgroups definition)?
 - Kait Roe (There are many definitions. Can I go from provider A to Z and outside the state and still have a system that works for me for safety, access, availability of medications? That is continuity of care for me as a patient)
 - Dr. Raul (Communication between providers of care. There is no communication which really leads to treatment of patients in isolated pockets within the community. Somatic care problems develop because there is no communication).
 - Dr. Goldberg (From a corrections standpoint it does not mean continuing the same care because often when people come to the hospital it changes. The access to drugs is different, the setting is different; confined environment; own perspective distorted. It's continuum of patient care).
 - Jane Kaufman (Any activity that ensures continuity of care through transitions of care that goes beyond making referrals. You need to make sure referrals go through and actively coordinate care/ peer navigators).
 - Kait Roe (Continuation of clinically appropriate patient centered care).
 - Evelyn Burton (It's getting into care. There are a group of folks not currently in the system and the only treatment they are receiving is in emergency rooms and hospitalizations or they are homeless).

2. Are there questions and/or concerns related to Morbidity and Mortality?
 - Erik Roskes (There is data available after release from prison which results in discontinuation of care. The state of Texas has data).
 - Zereanna Jess-Huff (Data for integrated care crossing disciplinary and organizational boundaries is available).

3. What population are we focusing on for this panel?
 - Dr. Jordan-Randolph (We should look at the severe and persistent mentally ill. We don't want to dilute the impact of the group however, we need to focus on this population).
 - Dr. Raul (Instead of diagnosis, can we focus on frequent hospitalizations because so many issues are involved and every diagnosis will fall into that category/severe and persistent mentally ill).
 - Dr. Jordan-Randolph (The state's definition is very narrow and focused).
 - Dr. Seifert (Is dangerousness part of the definition, does it depend on the difficulty and complexity of the case)?
 - Dr. Jordan-Randolph (For this workgroup severe persistent mentally ill will be used). The definition is available on the Value Options website and can be circulated.

-What about the youth? (We will focus on adults 18 and over).

-Steve Davis (I am concerned about focusing on the current definition because it does not focus on milder versions. There are variations from provider to provider and the diagnosis can drive what happens. The concern is for people who don't meet the definition but churn up a lot of resources (high utilization definition).

-Dr. Jordan-Randolph (The purpose of this exercise is to find data sets that we are requesting (specific indicators from experts); another limitation is the public mental health system; the talk is about disparities and the inability to have access to robust data so we can make recommendations).

-Edward Wiggins (There is significant involvement with substance use and the disorders associated with people with chronic mental health illness. We need to treat co-occurring disorders effectively and detoxification. The system is bifurcated in terms of funding).

-Susan Stomberg (Maryland has or had a grant specifically to deal with working on how to transition youth to adulthood and not necessarily into adult services).

-Kait Roe (I am concerned about limiting the definition around SPMI. Only if you are really sick do you get services. This kills the patient centered concept and early intervention is vital in mental health).

Discussion: Led by Dr. Jordan-Randolph The following topics were offered as suggestions for the workgroups to examine:

1. The percentage of time and resources expended by "High End Users" or "Frequent Fliers"
2. The Civil Commit and Emergency Petition Process

Comment: Dr. Jordan-Randolph – (I thought the numbers had declined considerably and coincided with court orders. The use of Emergency Petitions has declined considerably.

3. The Voluntary Admission Process and the role of Clinical Review Panels
4. The purpose and role of Forensic Evaluations and Aftercare
5. Discharge Planning Across the Board
6. The outcomes associated with release planning for parolees
7. Information for adherence and access to medication
8. The role and use of Telehealth
9. Crisis Services
10. Primary Prevention and Mental Health First Aid
11. Education and Training
12. The appropriateness of evaluations and treatment
13. The role and effectiveness of peer support
14. Ambulatory Outpatient Civil Commitment

Comments:

-Bob Pitcher (I am struggling with youth being left out the conversation. In Maryland 50% of the funding is with children and families.

-Dr. Jordan-Randolph (We have to start somewhere. My experience is with kids and the service delivery system is complex. The group's recommendations may or may not be applicable to children's services. We have to start someplace and may not end there.

-Dr. Raul (As a somatic care advocate, there needs to be a universal information exchange form that the hospitalist faxes. I do not see any coordination for mental health and exchange of information as it relates to mental health).

-Dr. Goldberg (I'm part of the Economic Workgroup. Continuity of care and communication should be tied to compensation. There's a pool of money for the public mental health system (look at low hanging fruit). It's the high end user group that uses money disproportionately that significantly impacts costs. If it's addressed through SPMI' limited definition, we can streamline the process and provide better care that is patient centered. If there's a flat number and reduce costs to free up money for continuity of care for housing....economics....opportunities to address streamline).

-Steve Daviss (Do we have data from CRISP available regarding medical utilization)?

-Zereana Jess-Huff (Value Options can do a data dump into managed care).

-Mike Abramson (Hilltop Institute produced data that is ongoing that Steve Daviss needs; chronic health homes is a solution; the waiver is currently being reviewed).

-Dr. Jordan-Randolph- (A DATA WORKGROUP needs to be established. Please email Stacy Reid Swain if you are interested in participating in this workgroup. The ability to communicate the limitations surrounding access to records is needed in an "Informational Memo" that clarifies the limitations and encourages with clear recommendations that a release of information at the beginning of the process is critical.

-Erik Roskes (The use of language is important. Avoid saying "Release of information at the beginning of care).

-Dr. Goldberg (If someone is incarcerated, there is no free choice. How much information can they give without violating HIPPA)?

-Tim Santoni (Historically, if you look back there is a 1997 Attorney General opinion that states that for Medicaid recipients information can be exchanged for mental health and somatic providers).

-Kait Roe (Discuss with the patient in front of them. Providers more invested in this can save your life when you go to the emergency room why it's in the best interest to share the information. Training in this area of how to approach the patients is necessary.

-Dr. Raul (How can a patient with mental illness make this decision)? Consider the following:

1. Competency to make mental health decision
2. Guardianship
3. Personal health record
4. Advanced Directives

-Dr. Jordan-Randolph (What's the role of CRISP in the emergency room)?

-Dr. Goldberg (There should be a HIPPA 'exception' for corrections in the clarification memo regarding release of information).

-Erik Roskes (If the records are sealed than how can we encourage info sharing? Can it be shared later on and released by a hearing officer? (real- time information) How does this comport with the requirement that reports not be shared)?

-Dr. Goldberg (I suggest modifying the rule and acknowledge that it's going to happen (information sharing) because of adjudication).

-Kathleen Ellis (CRISP is developing a system (serious confidentiality issue; take advantage of its capabilities).

-Steve Davis (The notification is live; challenge with privacy and confidentiality on the backburner).

-Dr. Raul (What about HEDIS? You do not need patient's permission).

-Lori Doyle (What is the process? Who does the final product go to?)

Comment: Dr. Jordan-Randolph (The Final Report goes to the Secretary who will use the recommendations moving forward)

-Steve Davis (What is the output of the recommendations? Are they designed to influence changes in legislation or regulations?)

Comment: Dr. Jordan-Randolph (The recommendations identify gaps and propose suggestions and solutions that are implemented; whether immediate, intermediate, or longterm). A standardized data set is needed. There are limitations in the regulations that make it difficult. Data is needed on the commercial side.

-Kathy Seifert (On the commercial and Medicaid side communication easier because we take all insurance in one building. There are states that solve confidentiality issue with policy.

-Dr. Jordan-Randolph (Are there disparities in terms of geography, rural vs. urban)?

Comment: Kait Roe (I'm originally from very rural Maine. Tele-health is a huge piece in Maine. There is concern with parity law that should be enacted. With the Maryland Exchange what happens to those folks and the uninsured population and folks that go in and out of MD exchange? How do we best utilize those 'gifts'; systemic design to silo everything is a huge barrier (MCO system access); 'not what did we do wrong' but 'blame the patient'.....do I have enough medication? People are delicate in their transition. Is it systemic, disinterest, unwillingness or inaction)?

-Joel Kanter (We need to promote the idea of continuity of care as an important professional skill. How to connect and do it in legal ways and how to collaborate with people. There should be active training that the Department can promote and share information with new professionals who come into practice and don't communicate with previous provider. It's 10% law and 90% will and skill (communication).

-Zereana Jess-Huff (The use of laptops and time is a big issue with continuity of care).

-Evelyn Burton (There is no one (1) case manager assigned to make sure coordination happens. This existed before fee for service. Do we carve out folks with severe persistent mental illness back into a grant system with a designated person to ensure coordination? With fee for service it won't happen.

-Lori Doyle- (We are looking into health homes).

-Scott Rosen (There are strengths within the current fee for service system. We should distinguish between what is needed for folks who are willing and accepting service vs. those that are ambivalent and refusing service. There are misperceptions about what confidentiality is precluding us from doing).

IX. The meeting concluded with Dr. Jordan-Randolph thanking everyone for their participation. Everyone was reminded to sign-in on the attendance sheets and provide their contact information to DHMH staff members.

Prepared by Stacy Reid Swain, Esq.

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