

Continuity of Care Work group
Clinical subgroup

Minutes 8/13/13

Subgroup Members:

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

Other Participants:

Helen Lann
Vanessa Purnell
Sarah Rhine (phone)
Kait Roe
Howard Sigler

DHMH Staff: Erik Roskes

The meeting was called to order at 1600.

Ground rules were discussed, including the fact that meetings are open to the public and that the meeting would be recorded. Minutes will be published on the DHMH website.

There was some discussion about email exchanges, and the subgroup is exploring the proper role of email exchanges between meetings, or using some other format such as a Google Group to share information. There is a need to balance our responsibility to ensure open and transparent process as well as the tight timeframe which favors frequent exchanges of opinion between meetings.

John Boronow has arranged for our use of the Conference Center at Sheppard Pratt for the next four Tuesdays at 4-5:30 pm. As scheduled, our last meeting is to be held on September 10, and our formal report will be presented on September 16.

John presented a detailed handout listing the various points at which continuity of care is threatened or blocked. He highlighted certain areas that he viewed as prime discussion points for the subgroup, including

- Noncompliance/nonadherence to treatment.
- The clinical review panel process and issues that arise preventing treatment
- Issues related to concurrent alcohol and drug use.
- Lack of day to day continuity among and between providers, cross-coverage issues, and a need to define an acceptable community standard of clinical care.

- Lack of adequate medical services for MI popn, including appropriate, sensitive emergency medical services.
- Services for transition age youth
- The short length of stay in general hospitals, and the need for accountability for hospitals that treat people so briefly that they are not well when released.
- Communication regarding prior treatment outcomes, and other information sharing.
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Noncompliance, choice, and treatment over objection

There was extensive discussion of the difference between

- Individual people who choose to discontinue their treatment, for good reason or not, and
- Systemic barriers that prevent people from continuing in treatment

The idea here is that this subgroup may be able to impact the latter, while not being able to do anything about the former. Thus, if people cannot continue treatment because they cannot obtain timely appointments, or cannot afford their medication copay, systemic changes could improve continuity of care. However, systemic changes can never affect individual choices to discontinue care.

The pushback on this was the potential role of outpatient commitment for at least some people who discontinue care on their own. In 45 states (see <http://www.treatmentadvocacycenter.org/solution/assisted-outpatient-treatment-laws>) there are such laws, though the details differ in terms of the criteria for eligibility, the due process required, and the resources provided for executing the law.

Opposition to the use of outpatient commitment is the principle that competent individuals have the right to make their own decisions – even poor decisions – if those decisions do not harm others.

One suggestion for assisting in coordination of care around the issue of noncompliance: is there a way to trigger an electronic alert to a prescribing physician when a patient does not fill or refill a prescription? This could then allow the doctor to do some outreach or case management. But of course, this requires resources both for the technology (probably relatively easy if legal issues can be resolved) as well as for doctors offices in terms of staff time for the outreach (likely requiring funding not currently available).

Resources and availability of treatment services

The discussion then turned to the need for adequate resources, even in states where there is outpatient commitment. There is substantial literature that supports the conclusion that when funded correctly it can be effective.

One potential barrier is the need for access to medications and to timely appointments. Another is the need to streamline access to Medicaid. Kait described the difficult getting access to Medicaid if one moves from another state, even if the individual was on Medicaid in the prior state. This is not the case everywhere – in some states, recognition of prior eligibility in another state leads to a rapid eligibility finding in the new state.

There was some discussion regarding access to timely appointments, and the concern that this not result in an unfunded mandate that providers see all comers within 24 or 72 hours. Providers are

already obligated by regulation to see people in a certain timeframe and they cannot afford to do it. If this is to be a recommendation, it will need to come with specific resource suggestions.

On the solutions side, the importance of using and building peer run services was emphasized. Examples abound – in Maryland, there are wellness and recovery centers in many parts of the state. Another example, not available here, is a peer run crisis intervention program in NY (see <http://www.nyc.gov/html/doh/html/mental/parachute.shtml>). Services like these can be very useful for engagement and connecting. In addition, the use of peer navigators or peer supports as an extension of programs, with an eye toward engagement, was discussed. This intervention was felt to be especially needed in inpatient units, where clinicians can sense which patients are less likely to follow up with aftercare plans: peer connections could be used to tip people over into a motivational state more likely to lead to connection with aftercare programs.

Along these lines, the idea of pre-release connections by the outpatient provider – or by peers – can help to reduce no-show rates. The State recently got a Second Chance grant to do pre-release “inreach” into city correctional facilities to try to improve engagement in services. Anne noted that released prisoners have elevated mortality rates during the initial weeks after their release, so engagement in treatment in the community is very important. How this is paid for after a grant is over is an open question. (Erik recalls a similar model program at Patuxent from around 2000 that had to be discontinued when the funding from BMHS was no longer available.)

Other needed resources for especially for individuals with addictions include:

- An ability for hospitals/providers to access information about prior treatments, in order to make informed and wise treatment decisions
- Wet shelters
- Non-demanding alternatives
- Reimbursing inpatient units even for people without axis I psych d/os.
- Standard inpatient groups need to focus on SA issues as well as more classic mental illness issues

There was a fair amount of discussion of the need for increased and more comprehensive crisis services in all parts of the state, with models varying depending on the nature of the jurisdiction and its population. There was reference to a CSA review of crisis services, but nobody could point to a specific document. During this conversation, providers using “walk in” or “crisis” appointments as a way to avoid more serious crises was also discussed, which also is a strategy used for intakes, where high no show rates create financial strain. This also would shorten the time to follow up, which can reduce relapse/readmission rates.

However, there was the caveat that there are some individuals who preferentially only use these “walk in” appointments and never engage more fully in treatment with a specific provider. This carries liability that many providers cannot accept. However, Helen noted that there is one county that has used a walk in strategy to improve engagement with great success and agreed to bring data to the next meeting.

As is always the case in these discussions, the subject of adequate, available, affordable housing was brought up toward the end of the discussion, with open acknowledgement of the frustrating range of laws, statutes and regulations that can interfere with properly housing people with mental illness, especially if they also have addictions issues and correctional/criminal histories.

Coordination and communication

The discussion then moved to the importance of better coordination of care between SA and MI providers. There are access issues for specialized integrated dual diagnosis services as well as coordination for people in parallel care. It was noted that integrated care needs to accommodate all four quadrants (see <http://old.thenationalcouncil.org/galleries/business-practice%20files/4%20Quadrant.pdf>, page 3-4). And as we move toward a fully integrated behavioral health system, the entire population needs to have services available to meet their needs.

In addition, there are other coordination gaps:

- Parole and probation: some patients are in need of behavioral health services but are also under the jurisdiction of a conditional release plan pursuant to parole or probation. Coordination with our criminal justice partners is very important, and can be challenging if caseload size is not addressed.
- Coordination between hospitals and correctional facilities across the transitions from one to another. Formulary issues can complicate these transitions.
- Unexpected released from court, at which time an individual can be sent
 - To a hospital,
 - To jail/prison, or
 - To the community.

These unexpected releases may preclude the preparation of an aftercare or transition plan, demanding that the transition be managed after the fact. Crisis or drop-in centers can be very useful for people suddenly finding themselves in the community without adequate preparation.

David raised the issue of the “frequent flyer” who utilizes ER and inpatient resources because of urgent internal crisis driven by substance abuse and lack of resources such as housing. This led to a complex discussion as to whether such individuals are in the purview, and the conclusion is that they are, in large part because BH integration makes them a part of our population. But there was fair agreement that inpatient psychiatric units may not be the needed resource for such individuals. Part of the issue for David was that these patients get admitted and then ask for controlled substances, and his staff cannot confirm that they have been in a treatment plan with such medications provided. Information sharing – especially with pharmacies, can be highly valuable in managing such patients effectively, cost-effectively, and safely.

Coordination of care often requires time and interpersonal contacts that are not reimbursed. Solutions to the need to coordinate will need to take this time into consideration, or providers will not be able or willing to do it. Alternatively, the use of electronic records could automate some of the information exchange, but this faces significant technical barriers at this point in time. Health homes may be a partial solution to this problem, if they are able to continue managing care throughout changes in the patient’s location (inpatient, outpatient, etc). Lori noted that ACA permits certain types of behavioral health programs, such as PRPs and methadone maintenance programs, may create health homes within their existing structure. In this model, the state pays a case rate that accommodates the time needed for the coordination functions. Some concern was expressed that this is only a 1-year model, and cited research that health homes require at least 2 years to begin to show savings. In the health home model, care coordination is the key in keeping costs down.

Work for the subgroup in coming meetings

What data do we need? A suggest query to VO: can we get data on people who come in from other states and who need to wait for Maryland MA to kick in? Processing at state level may lead to delays. Have to cancel old plan to get the new one. Scary for people.

While this involves a relatively small group of people, it could shed light on systemic barriers around getting found eligible and then getting MA coverage, a problem that applies to anyone applying for the first time, whether coming from another state or not.

There was substantial discussion as to what this group's charge is:

- Is it to recommend potential solutions? Should these include recommended legislative changes?
- Is it something more encapsulated: identify a few problems that are fixable?

An open question was whether this group should be making recommendations regardless of cost considerations, and it was agreed that our focus should remain clinical, and our recommendations should be made without concern as to cost. Those concerns about costs – and savings – will be folded into the final product based on the Economics subgroup's considerations.

John closed the meeting by suggesting that we develop 6 or 8 domains to focus the discussion over the next four weeks, and that subgroup members provide information and research on these various domains. An initial draft will be shared for consideration.

The meeting ended at 1737. Next meeting will be on 8/20/12.

Minutes prepared by Erik Roskes