Balancing Public Health and Individual Liberties: Exploring New Options in Outpatient Treatment Working Group Session


Notes June 1, 2011

Part I

Roger Wolf asked the group to consider what their goals for the morning would be, and the participants agreed that there was a desire to find common ground based on the discussions from the April 25th meeting and the focus might be on disproportionate users of the acute care mental health system.

Steve Sharfstein suggested that the group consider how we could manage better as a mental health system to care for those individuals, and that conditional release in some form might be a viable alternative. He posed the question - how can we encourage patients and achieve better care, and is conditional release a proposal to look at? He noted that details regarding conditional release and appropriate resources should be a consideration in this discussion. He noted that mental health care providers must be trained and incentivized to care about what happens to their patients once they leave a facility and appropriate after-care must be arranged and pursued.

Richard Boldt suggested that those individuals who use a disproportionate amount of resources impact several different areas and different budgets in the health, criminal justice and social welfare arenas. He noted that one attractive aspect of identifying heavy users of the mental health system at “step-down” from a facility is that hospital records might have the best compilation of patient information relating to treatment, housing, family etc. This information is critical in discharge planning and coordinated care. For this reason, he suggested that inpatient discharge is a key moment to coordinate services.

Jane Plapinger suggested that the group brainstorm broadly, beyond just the question of conditional release. The goal of the meeting should be an agreement on a short list of options or an agreement to examine promising practices. She also noted that an important component of conditional release should be holding providers accountable. She mentioned that her agency is engaged in a High Utilizer project, in which 40 people have been identified for greater focus. The program has led to a cost savings of $1 million to date.

Tony Lehman mentioned that the potential group of patients for which AOT might apply is diverse and complex. Many patients are in emergency rooms for violent behavior who should be in the criminal
justice system and many people are in the criminal justice system who should be in the mental health system and therefore – when making any proposal, the group should think about how providers and hospitals should make appropriate placement determinations.

Francine Hahn asked that when the target population is considered, the group remember that, for homeless individuals and families, housing is health care. Housing First is a good model and there is data on it.

Linda Raines noted that it is hard to stay focused with so many needs, but that she would like to see a convergence of views on the criminal justice system and mental health.

Lois Fischer noted that from her experience as a public defender, there are now fewer mental health beds available so there is less inpatient care available, and physician services in hospitals have been reduced. From her experience, patients want treatment but it is not available.

Amanda Pustilnik noted that in NY the providers are evaluated on the number of rehospitalizations which provides an incentive for physicians to ensure proper discharge and continued care.

Jane Plapinger described the Mosaic Community Services program in Baltimore that she works with. The program is a comprehensive non-profit community behavioral health organization that is funded based on a set capitation fee. It has been established for many years as a Medicaid demonstration project in Maryland. It is an outcomes-oriented program with a holistic approach to the individual patient with staff incentives. Ellen Callegary, a board member of Mosaic, also spoke highly of it. The group agreed that the Mosaic program might be a good model for coordinated care.

Steve Sharfstein had two concerns with the MOSAIC program: it has never been expanded despite its success, and every patient in the program is there on a voluntary basis - so many of the hardest to reach patients would be missed.

Laura Cain acknowledged that there are many places where the system breaks down and her hope is that the group focuses on alternatives which approach patients in a dignified way. A key component in treating patients is creating trust because many individuals with mental health problems have come to distrust the “system” over time. The best way to overcome lack of trust is through peer support outreach. Most in the group agreed than peer outreach must be a part of any proposed solution.

Gayle Jordan Randolph suggested that financing and insurance had to be a part of the conversation, and that in discharge planning there needs to be a push toward holding the system accountable. One of her primary concerns is that the type of insurance a person has usually determines the care and follow-up they receive. She commented that any proposed solution must take this into account and that insurance should not determine an individual’s level of care. She further noted that, from her experience at DHMH, different parts of the state may require different solutions and this fact should also be part of any final recommendations.

Tony Lehman raised the issue of capacity and how many people the Mosaic program could handle. Everyone agreed that capacity was a critical issue. Jane Plapinger noted that determining need is doable in Maryland given the record keeping capabilities of the Value Options. She suggested that the
group gather the numbers in order to understand the need for mental health services in the community and the necessary capacity for that number of patients.

Part II

Barbara Hull Francis, Assistant Attorney General, reviewed the legislative history of the existing conditional release statute. Conditional release in Maryland excludes forensic patients, and can therefore be considered a type of administrative release. For a state facility to conditionally release a patient, the patient must not be dangerous and the institution must certify the existence of available and appropriate outpatient resources. Historically, conditional release was offered if the hospital would accept the patient back as an inpatient if his/her condition deteriorated. She also noted that regulations may be needed to interpret the statute consistent with current constitutional standards. The law imposes no requirement on private facilities to ensure outpatient resources but many noted that this distinction between private and state institutions harkens back to the day when wealthier patients were in private facilities and therefore had private means to secure resources. Today, private hospitals have patients with few resources.

Hull noted that the statute has never been used explicitly – nor is there is much case law interpreting the statute – but she believes that Spring Grove hospital based their “convalescent leave” program in the 1980s on the conditional release statute. She believes that convalescent leave was dropped as a policy because there was excess acute care capacity and there was a view that patients who were not dangerous should not be readmitted by the state.

Larry Fitch stated that the conditional release statute is unlike anything elsewhere around the country and suggested it couldn’t be enacted today. The statute provides no provision for enforcement but does commit agencies to act “as resources allow.” Larry felt the statute could be a foundation to build responsibility for agencies. Not all in the group agreed, and Laura Cain felt it was naïve to think resources would materialize just because they were required by statute. This would be akin to an unfunded mandate.

Steve Sharfstein agreed philosophically with the idea of agency responsibility and asked about criteria to target a small group of patients for services. How could authority be given to intervene if the patient declines treatment and follow up? There was a discussion relating to the degree to which the discharging facility would retain authority over a patient. Under the conditional release statute, the hospital retains authority but the constitutionality of this (if the patient is not a danger to himself or others) and the stripping of individual liberty that this implies was troublesome with many in the group. Steve suggested that an appropriate solution might be allowing a coordinated care team to “pester” patients to continue care. The parameters of what this “pestering” might look like and enforcement if someone continues to refuse care might look like needs further discussion.

In terms of identifying people for targeted, coordinated care, Francine Hahn said that the Dept. of Housing and Community Development and the Housing First program have criteria to identify vulnerable people. These could serve as a model. There is also a program, Homeless Management Information System (HMIS) (called “ROSIE” in Baltimore), which tracks a homeless person’s contacts with the social welfare system in Baltimore.
Laura Cain suggested that a change in the law is unnecessary to develop a program providing additional services.

Ellen Callegary emphasized and the group agreed that the existing conditional release statute has no enforcement mechanism and it’s difficult to think of an enforcement mechanism that would not eventually fall back on the “dangerous to self or others” standard to force a person into inpatient care.

**Part III**

Roger Wolf asked how the group would like to spend the final hour.

Ellen Callegary asked whether the focus should be on whether the law can be tweaked to help the targeted group. Laura Cain suggested that if the group wants consensus, she needed to understand whether the group was talking about committing the system or committing the individual, or both?

Steve Sharfstein responded that it was about committing the system to provide ongoing appropriate assistance to patients in need, but acknowledged that there are civil liberties issues that might arise with patients that need but refuse treatment and asked Laura Cain if she was comfortable with engaging patients who don’t want to be bothered and what would be acceptable in terms of engaging those patients.

Linda Raines interjected that a law was not necessary to undertake outreach as a resource for patients. She was also concerned that encouraging outreach does not commit a system to providing better services.

Tony Lehman asked - if an assertive outreach team were established - how would the treatment team connect with the patient at discharge. Jane Plapinger suggested there would need to be a locus of responsibility and that we could brainstorm on how that could happen, but conditional release could be a part of it. Larry Fitch said a lot of information would be in the hospital record already. Richard Boldt stated that you could create automatic triggers that would indicate that a specific patient needed a specified degree of outpatient care coordination.

Larry Fitch noted you would need to involve financing mechanisms, incentives, housing, and still some group of patients would always refuse treatment. Jane Plapinger emphasized that resources are a critical issue because outreach is expensive and time consuming. Right now her agency has a pilot ACT team with two peers focused on engaging high utilizers. They are testing whether more peer staffing helps.

Jane Plapinger and Linda Raines suggested that, as a group, we take a first step and recommend a coordinated care model for high utilizers, evaluate it and then determine if there is still a group of patients who fall through the cracks and refuse treatment. Then we can come back to the drawing board and talk about alternatives for this small group. Many in the group agreed that this might be a good first step because at the current time, we are not sure how big the group of patients is that we are really talking about and how many of them could be helped by aggressive coordinated care.

Laura Cain agreed that it was a good idea to provide outreach and accountability and she could support those activities, but not conditional release.
Barbara Hull Francis suggested that, in the future, the group discuss a facility’s options upon discharge of a patient. Amanda described Florida’s statute which includes enforced involuntary transport for evaluation. Larry said that can happen now with the emergency evaluation law in Maryland.

Linda Raines encouraged the group to focus where there is consensus because there is no consensus in the room on AOT. Ellen Callegary felt there was consensus on a person-centered approach and system accountability.

There was a general discussion on where a pilot program would be started. Baltimore City and Frederick County were suggested as possible areas. Jane Plapinger noted the number of high utilizers in Baltimore City.

Larry Fitch offered that the statute could be used just as a model for language to require system accountability.

Diane Hoffmann asked whether evaluation data was available and Jane offered that Value Options could provide baseline data. Richard Boldt offered that Jay Unick has used Medicaid data in his research and could be a resource for the group in this area.

Steve Sharfstein suggested three subcommittees:

1. **Program Committee**: develop a model program which is patient-centered and offers system accountability. This committee will consider criteria, resources and funding.

2. **Outcomes and Data Committee**: propose how the model should be evaluated in its process and outcomes.

3. **Evaluation Committee**: offer the best ways to provide for, and evaluate system accountability, including whether that should include changes to policy, regulation, or statute.

There was general agreement to this framework, but the group agreed that descriptions of the committees should be drafted and distributed to the group and then individuals could choose where to participate. A general discussion of whom else could participate or support the working group followed. Suggestions included people from the Mosaic program, the housing community, IGSR, Helping Other People Through Empowerment, local foundations, and Value Options were mentioned.

**Addendum:**

Janet Edelman recommended the following additions/corrections to these notes:

During the meeting she spoke in support of AOT and asked if we could learn from the N.Y. experience and studies done on the 10 years of N.Y.’s experience with the assisted outpatient treatment law. She asked that we narrow the discussion and not try to fix everything that is wrong with the system. She noted the references in the minutes about a lack of understanding about how big the group of patients that we are talking about. She mentioned during the meeting that New York State had used AOT on approximately 8,000 people over 10 years and that we could extrapolate that number for Maryland’s population. Ms. Edelman referred to the places in the notes where it is stated “the group agreed...” or "most in the group agreed", and suggested that in her view this could not be determined since some people at the meeting were silent and no votes were taken.