

# **Behavioral Health Workgroup Meeting Minutes 3/31/2011 State Capitol, Pierre, SD**

## **Attendees:**

Betty Oldenkamp of Lutheran Social Services, Terry Dosch from the Council Mental Health Centers, Tom Stanage from Lewis and Clark Behavioral Health Services, Steve Lindquist of Avera Behavioral Health, Travis Hanson from the Human Services Center, Scott Peters from the Minnehaha-Lincoln County Mental Illness Board, Phyllis Arends from NAMI, Robert Kean from Advocacy Services, Carol Reiger from the Keystone Treatment Center, Representative Nick Moser from Yankton, Lieutenant Governor Matt Michels, Deb Bowman from the Governor's office, Eric Matt from the Governor's office, Secretary Kim Malsam-Rysdon from the Department of Social Services, Deputy Secretary Lynne Valenti from the Department of Social Services, Interim Secretary Amy Iversen-Pollreisz from the Department of Human Services, Shawna Fullerton from the Department of Human Services, Gib Sudbeck from the Department of Human Services, Cory Nelson from the Department of Human Services, Absent Matt Stanley

Lieutenant Governor Matt Michels, chairman of the workgroup welcomed the group and thanked them for their efforts. The Governor is appreciative of all the hard work and interest in providing behavioral health services more effectively.

Deb Bowman stated that Representative Peggy Gibson will be joining the workgroup. The Governor has asked the minority leaders in each house to appoint a representative, as he thought there should be a bi-partisan approach.

Kim Malsam-Rysdon provided a recap of the previous meeting of the workgroup. Reorganization in and of itself is not useful. We now have the political will to make some real changes and address some systemic, long-standing issues in the system.

Kim Malsam-Rysdon handed out a compilation of comments submitted by the workgroup members concerning their thoughts on a "perfect system", what the guiding principles should be, where improvements could be made, and what issues or problems should be addressed. Workgroup members briefly reviewed the document.

## **Issues and Problems**

Lt. Governor Michels asked the group to look at the issues and problems list and share some that were missed.

Phyllis Arends noted that there was nothing on employment, maybe there should be something on helping people gain employment.

Tom Stanage stated that the availability of beds is an issue and the chemical dependency commitment process doesn't work. We have trouble getting people into treatment even after the adjudication is done. It takes quite some time to even get people into court. There are also issues with law enforcement having to transport people before they get into court. The chemical dependency process doesn't work in areas where there is not an existing detoxification facility. Treating children is also an issue. Their behavior changes and we need to be able to readily move them from outpatient, to inpatient, to other services. Often children end up staying in residential care when maybe they could be moved. Finally, he noted that as an outpatient provider, he has standing appointments and makes arrangements to see people twice a week to prevent inpatient hospitalization, but the system is not geared to do this. It is really hard to maintain productivity and do this.

Tom also stated that keeping appointment times available if there is a need is difficult. With fee for service, providers don't get paid to keep times open. Betty Oldenkamp stated that everyone is booked unless there is a no-show, so it is difficult to deal with crises. Since providers get paid based upon productivity, they need to book as much time as possible and this makes it hard to deal with a crisis.

Amy Iversen-Pollreisz stated that the productivity is built into the reimbursement rate for community mental health centers at less than 100%, but no system is perfectly productive.

Robert Kean indicated that children that are acting up are primed to be kicked out of school. School districts address dangerousness or truancy this way. Coordination between school districts and behavioral health centers is not as good as it should be. A resolution could be to require counselors in every school district, which was considered in the legislature, but severely weakened.

Steve Lindquist stated that the fee for service model needs to be changed. Medicaid does not always pay for the things people need. He believes we need to start all over and align payment with needs. Sometimes people get lost and move from provider to provider. A solution could be regionalizing services or deciding that only the state provides them. Hiring a private company to come in and run behavioral health would save money, but not necessarily provide good care.

Tom Stanage provided that in South Dakota we have capitated rates and fee for service. South Dakota might be the only state that does it this way, but it is also the reason the mental health budget hasn't been impacted more by cuts in the past.

Deb Bowman stated that co-occurring disorders are common in mental health, i.e. addiction and behavioral issues together. She wondered how the system could address these conditions better. She noted that in the developmental disability system community solutions are first, and was not sure why this wasn't so in behavioral health. She also stated that she was concerned over the duplication of dollars and wondered how to prevent duplication, i.e. ongoing emergency room visits due to mental illness, not physical problems. She wondered if we need to start over with a system of care for mental health and addiction issues. Providers in South Dakota do a great job trying to meet needs given the current system and dollars available. She indicated that it was

imperative to develop a system around people and their needs and the workgroups recommendation should be to revamp the system and start anew.

Cory Nelson stated that we don't always do a great job determining what the initial problem is. If someone shows up, we just figure out how to serve them with what we can do. Getting the person to the right service at the right location, time, and cost is important. Following up is also very important. As an example, he provided that 59 of 60 acute care beds were filled this Monday, and then the number dropped to 37 on Wednesday. He stated that this is not a good utilization of resources and that HSC would be happy to reduce beds if community services were available.

Amy Iversen-Pollreisz stated that those utilizing the highest level of care do not get a lot from the system, because the system does not fit them. There is no crisis response and the system is generally not sure what to do with people, so they go to HSC. Tom Stanage stated that the system needed to be reorganized from the top down.

Amy Iversen-Pollreisz further stated that the state needed to have a structure to help a community to respond to an emergency situation. There are plans being developed in Rapid City and Sioux Falls. She also believes it is important to identify, assess, and then work with people that oftentimes do not want services.

Deb Bowman stated that we need to get data on where patients go and what services they receive. We should figure out how many resources were used on one person that could have been spent on ten others at a lower level of care.

Amy Iversen-Pollreisz stated that often people want services that they cannot get because they are at the wrong door.

Rep. Nick Moser provided an example of a student he was working with. A high schooler broke up with his girlfriend then engaged in some troubling behavior. The child's sister came home and believed the child was trying to take his life. As a result, the child spent a night in the emergency room, one day at the hospital, then six weeks at HSC. After the child went back to school, everyone knew they spent time at HSC and that is difficult for the child.

Cory Nelson stated that we have too much subjectivity in our system. Often those that want to put more of an investment in their community have lower usage rates.

Steve Lindquist stated that Minnesota did have 16 bed mini-hospitals across the state. Now the legislature is trying to close all of them. During this process, that state began to look at who needed high-end service. They then put in place mobile crisis teams and longer term transitional living facilities. As a result, Minnesota has seen a reduction of in-patient services. Some states have done mobile crisis training, as is being done in Rapid City and Sioux Falls. South Dakota has many low-end or intermediate patients that should be kept closer to home. The fee for service model does not provide incentives for providers to keep people home in the communities.

Gib Sudbeck stated that the population his division's facilities are dealing with have changed dramatically. They use to serve a handful of people with mental health issues, now 75% have of the folks have both diagnosis and many are people in need of high level services. These patients also have other serious issues to include liver failure, heart disease, and other chronic conditions.

The population being served is much more damaged than 10 years ago. He stated that this indicated there was a need to work closer with health care providers.

Deb Bowman wondered if maybe this was just an indicator that we didn't have the services available to address issues earlier.

Carol Regier explained that today people are using drugs, more and different ones than have been seen in the past which results in faster disease progression. Carol also provided that these patients cannot receive care anywhere other than Keystone. Everyone is afraid to serve these people because of the high dosage they are taking. Linking to the medical community will enable us to intervene sooner. Right now these individuals just bounce from system to system.

Carol Regier stated that the ASAM criteria are good for those that are chemically dependent. She thought the question was where to place them when you need to step down their treatment. In smaller areas, there is nowhere to place these patients.

Kim Malsam-Rysdon stated that, again, this shows that there is too much focus on high-end issues.

Gib Sudbeck believes another issue was trauma in the community when people are kept in the community based system. Family members, judges, and others will call saying people need to be committed, which creates trauma.

Tom Stanage stated that his system has been asked to deal more and more with people that are not traditional SPMI. His system and HSC are getting hit by populations that haven't traditionally been served by the mental health system, but there is nowhere for them to go.

Deb Bowman reiterated that providers are doing a good job given limited resources and the limitations of the system. She stated that she has been a big advocate for more finances for mental health and alcohol and drug treatment, but increasing funding for people with mental illness and alcohol and drug is more politically difficult than increasing funding for people with developmental disabilities.

Phyllis Arends explained treating people that have symptoms, but are not seeking treatment or endangering others is a concern. She gets many calls from people that say my husband, brother, sister is 45 and always worked, but now they won't take medication or see a therapist, what can I do. If they are not a danger, they have to wait to receive necessary services. She stated that we need to reach out to these people and get them help. For people who don't understand they are mentally ill, outpatient commitment orders are good. Maybe person to person contact with mental health centers would be good, even though that doesn't fit into SPMI.

Amy Iversen-Pollreis stated that when people are in crisis and we try to throw mental health services at them, they often don't want them. There are ways to engage these people, but often these services are not billable.

Phyllis Arends noted that we have better options if the individual is homeless.

Betty Oldenkamp stated her belief that everything she heard shows a commitment to change the system. The piece to face up to is discovering what each group needs to do to change differently.

For example, some may need to reduce infrastructure and redirect resources to a lower level of care.

Gib Sudbeck stated that in behavioral health we operate in crisis every day rather than proactively planning. There has to be a better way than to wait for the phone to ring to help someone that is drunk or suicidal.

### **Guiding Principles**

Lt. Governor Matt Michels redirected the group from the fiscal aspect and towards guiding principles. He asked if there were other guiding principles that were not captured on the handout.

Tom Stanage stated that with mental illnesses, symptoms change, especially with children. Any mental health system needs a continuum of care to provide the least restrictive environment for the individual. He also noted that this continuum needed to be central to any system.

Betty Oldenkamp stated that flexibility in the system was also important.

Gib Sudbeck believes that we need to look at harm reduction versus total reduction of chemical dependency. We must work on getting people in an apartment, getting them a job, and taking other steps to stabilize their life. Often these people are still drinking, but living a much better life and not utilizing as many expensive services.

Kim Malsam-Rysdon wondered where harm reduction fell in the concept of recovery.

Tom Stanage stated that tertiary prevention in disease management is minimizing the harmful effects of chronic illness. He noted that alcoholism is really a chronic illness that is a lifelong issue.

Amy Iversen-Pollreisz provided that we need a system that is person and family driven, individualized, and based on what patients need and want. Some people don't want abstinence, but they may agree to reduce the level of drinking and possibly move toward abstinence at some point. There is no one-size-fits all solution.

Gib Sudbeck believes the reason was that it got conceptualized that patients won't be better unless they completely abstain. Relapse is viewed as a crisis, not a process of recovery, but many view it as a failure and place individuals in inpatient services. He believed the better approach was to determine the trigger for the behavior and address it.

Carol Regier stated that the one day at a time approach to recovery through AA is the most effective so far. A big part of alcohol treatment is dealing with relapse. Forty percent of people will relapse and they need to realize that doesn't mean they are total failures. She believes we needed to teach people what to do when they relapse.

Deb Bowman stated that there is negative view of relapse for the person and his/her family, and the discussion always turns to what is wrong with the person. It is so negative and hurtful.

Kim Malsam-Rysdon stated that the family needs to be treated as well, in order to be an effective support system.

Shawna Fullerton stated that prevention has always been viewed separately. She believed that we needed to analyze how we can do more with prevention. She noted that the federal government is seeing that and putting money into block grants for prevention.

Rep. Nick Moser provided that within the sponsor program of AA, the sponsors don't look at a relapse as a crisis.

Kim Malsam-Rysdon asked the group to talk about evidence based prevention only if we are discussing prevention.

Gib Sudbeck stated that underage use and binge drinking is the big problem in South Dakota. Local policies, practices, and putting together a program in the community are key.

Deb Bowman wondered how prevention groups were measuring success. She wondered if there was a measurement showing there is a difference.

Gib Sudbeck provided that he had data showing a higher first use age, decreased truancy, and higher grade point averages. These programs work, but moving them across the state is difficult.

Shawna Fullerton stated that substance abuse and suicide prevention has been emphasized. She thought the emphasis should be broader; there is no reason to have one group based on prevention. The trouble with implementing broader based programs is building local level capacity to put measurable pieces in community programming and taking the public health model. She stated that a prevention program should be broad, not focused on one or two areas. She believes the state needed to do something different at the front end. Right now, if a child comes to the teacher indicating they are suicidal the police are called, then the child goes to the ER, and then to HSC. This is a duplication of services and unwise.

Terry Dosch stated that prevention and early intervention are the front line. Trauma avoidance is also very important, as it dictates what is done. Evidence based to him means best practices measured by documented success. Accountability is very important. He stated that we must measure success based on results.

Amy Iversen-Pollreis believes services must be culturally sensitive. If the state individualizes care, we need to take into account the culture of the family and community. For some, if a person's car is at the mental health center, that is viewed as a bad thing.

Kim Malsam-Rysdon explained that trauma informed care curriculum is used for staff at some facilities serving children. A good example is in minimizing use of restraints. Abused children are further traumatized by restraint use.

Steve Lindquist stated that a guiding principal should be to financially incentivize outcomes and not services. We don't do a good job of that right now.

Deb Bowman wondered what the best practice was and if the concept of trauma informed care was this just something another state is doing that doesn't work here in rural states.

Steve Lindquist stated that the outcome is more important than the practice; there are many practices that can lead to good results.

Lieutenant Governor Matt Michels stated that measurable outcomes are the key. These can be different in different locales. In Pine Ridge, it may be getting children to school.

Rep. Moser wondered if providers be less likely to take patients under an outcome based system.

Tom Stanage noted that with the current Medicaid and Medicare system the performance based care idea was tried and abandoned.

Deb Bowman stated that, in the Medicaid industry, performance measures have disincentivized people from taking tough cases. We want to incentivize people to take tough cases.

Robert Kean wondered how the federal government would be in allowing us to experiment using a new type of system.

Amy Iversen-Pollreisz stated that other states are using a case based system, so believe South Dakota should be able to do so as well.

Lynne Valenti thought a guiding principle should be that people are served in the least restrictive environment appropriate to meet their needs.

Matt Michels stated that primary care in the behavioral health system should be for people that are from South Dakota, not other states. Whether we get a compact or not, we should design our system unique to South Dakota, understanding that we get Nebraskans and Iowans as well. It is a displacement issue that is immoral.

Cory Nelson stated that 10% of people at HSC are either forensic (from the criminal justice system) or out of state and these individuals displace large amounts of funds that could be used for treating South Dakotans in mental health crisis.

Gib Sudbeck stated that our definition of residency is so very broad.

### **Utilization of Care**

Matt Michels moved the group toward a discussion concerning appropriate utilization of care.

Carol Regier stated that she believed appropriate utilization was the right terminology. She believed that we can't just say that a person must fail at outpatient care before being moved to inpatient care. Some people do need inpatient care right away.

Scott Peters stated that we need to be a partner with organizations for community based care. This is becoming a popular model in the medical community.

Terry Dosch noted that educating the consumers of mental health care and the families is important. The family needs to understand what the standard of care is. Some parents want their kids in HSC longer than they should be. People also need to be informed about what their options are. Appropriateness and levels of service are keys. This is an opportunity to develop levels of care and determine how they are accessed.

Kim Malsam-Rysdon stated that family engagement in the process is important and asked Terry to speak more to that issue.

Terry Dosch replied that finding the happy medium between over-engaged and apathy is important. It takes lots of time and manpower to make sure families are appropriately engaged. Ultimately, having a relationship with the client and family keeps everyone engaged in the process. It is a must to build a relationship and advise them. Then, the patient may follow recommendations more often.

### **Provider Recruitment and Retention**

Lt. Governor Matt Michels stated that we need to get various health care professionals into our state and there is a dearth of providers in all areas. He wondered if there was a guiding principle for a system to nurture licensed mental health professionals.

Terry Dosch noted that HSC does a variety of internships, which are valuable in exposing students.

Cory Nelson stated that we still do not require a medical residency rotation at HSC, where students could get more comprehensive exposure to mental illness.

Terry Dosch stated that HSC is taking care of the acute cases. In Sioux Falls, medical students get no exposure to the acute treatment phase, and they could certainly benefit from that.

Phyllis Arends noted that there was merit to peer specialists. Sometimes people relate better to family members or others that have been in similar situation. Also, we need to educate people about symptoms of mental illness and who to call if there are issues. Reaching out to high school children and encouraging them to go into these fields is also important.

Deb Bowman noted that we have efforts in many communities such as SCRUBS camps. One of the First Lady's priorities will be to promote Science, Technology, Engineering, and Medicine. She will be attending many of these camps.

Kim Malsam-Rysdon stated that there should be geographic access to care and equal access across the state. This means our staff needs to look differently. Maybe we need more peer providers in rural areas.

Robert Kean stated that we need to encourage a supportive environment for providers as well. We ask a lot from clinical psychologists. Working on weekends, traveling, and other concerns create problems with retention. Providers work hard, often for less pay than elsewhere.

The dearth of professionals the state has to rely on is scary. If elements of health care reform go through, we will have trouble implementing the outpatient services.

Deb Bowman wondered if this was a workforce development issue and how the state could create a nurturing system and be a regulator. She believed this area may fall more on the providers.

Shawna Fullerton thought this may be an issue for the universities. They can nurture workforce development.



Deb Bowman thinks what Cory Nelson and his staff is doing at Canistota Nursing Home by supporting staff and teaching them how to work with the patients is an excellent example of nurturing providers.

Tom Stange thought this was an issue for providers.

Betty Oldenkamp thought that if the compensation cannot be given, groups needed to provide something else to keep employees happy.

Representative Moser wondered what the reason was for the dearth of doctors in the state.

Deb Bowman noted that doctors are choosing to go into specialties, rather than becoming a family physician or psychiatrist. This is an issue nationwide.

Tom Stange stated that there is a shortage nationwide, especially for child psychiatrist and that all of South Dakota is a mental health shortage area except Minnehaha and Pennington counties.

Lt. Governor Matt Michels noted generational differences. Younger generations work to live, rather than live to work. Sometimes they don't want the lifestyle that comes with these jobs. He stated that an example of this is the cadre of hospital people that have been added so practitioners don't have to take call.

Carol Reiger stated that at the school level people need to get more exposure to mental health and drug and alcohol treatment. We need to get to students and show them there is a problem and we need their help.

Deb Bowman wondered if the state needed to have a conversation with systems and medical school on focusing GME dollars on psychiatry.

Cory Nelson stated that our state hospital is not eligible for federal loan reimbursement, and neither are Pennington or Minnehaha counties. With recent changes, an employee can be half time at HSC and somewhere else and qualify for loan reimbursement. All state hospitals are carved out from being a shortage area because they specialize only in psychiatry.

### **Commitments, Alternative Treatment, and Civil Liberties**

Lt. Governor Matt Michels stated that the Governor and Chief Justice are committed to finding alternatives to incarceration. He wondered what the guiding principal should be in relation to commitments and loss of liberty because of illness.

Travis Hanson agreed that there is a point where forced medication or institutionalization was necessary, but there should be many points prior to that point. He stated that mental health courts are worth looking at. These exist in Florida, and divert people out of the system. South Dakota should review the process and see if it should be non-judicial or if the courts should be involved earlier in the process.

Phyllis Arends noted that often, law enforcement has first contact. If they are trained and know referral sources, then they will be able to take people to community places, rather than more intensive treatment facilities.

Scott Peters thought the goal should be to place persons in the optimal place for recovery, in the least restrictive manner, and at reasonable cost. The crisis intervention program is not just for law enforcement, but firefighters and other first responders. We must train in rural communities, not just in Pennington and Minnehaha. Most counties cannot support mobile crisis teams.

Also, we need a more formalized, sequential jail diversion program. Four steps are involved in doing this: identifying a person with mental illness or chemical dependency and placing them somewhere other than jail, if charged and in jail and mental illness recognized then diverting them from jail (getting more referrals with staff education in jails), having mental treatment options to incarceration where appropriate (train court system so a specialized judge with training may deal exclusively with mentally ill people), and following up for evaluation after the sentence ends so they do not re-offend and become part of the mental health system or prison system again. We must also deal with the population that cannot access treatment or only receives incomplete treatment. The VA system will not take veterans on a hold or someone that has a criminal charge, even a misdemeanor. Indian health is also a concern. Often, facilities cannot get payment for services.

Lieutenant Governor Matt Michels wondered if there was a way to create a principle from the survey dealing with involuntary commitment or incarceration as a last resort.

Scott Peters stated that the system is flooded with so many commitments; facilities release people within a few days. He provided that law enforcement does not have training to divert people from jail. People are released and then re-admitted on a regular basis.

Lieutenant Governor Matt Michels thought we needed feedback from Lynne Valenti based on her expertise. Lieutenant Governor Michels then excused himself to attend another meeting.

Lynne Valenti thought the laws should reflect the concept that people should be cared for in the least restrictive environment. If the focus is on that we will not have the problems we have today. Often, people receive inpatient treatment or are committed because there are no less restrictive alternatives to inpatient hospitalization available. The chemical dependency process does not work for families; we need a better process. A process where we have the ability to petition for involuntary commitment and forced medication at the same time would be useful. Often, it takes too long to get people on their medications. Having a judge that handles mental health commitments would be effective in more rural areas.

Cory Nelson commented that the commitment process needs a consistent point of contact.

Tom Stange wondered if since the chemical dependency process is a court based process and that doesn't work, if there is a concern with implementing more court based systems.

Lynne Valenti responded that the chemical dependency process is not set up as well as it should be. In order for success, there would have to be buy in from the court system. In states where there is buy in, even where there is more volume than in South Dakota, they do not have the same problems.

Kim Malsam-Rysdon summarized Lynne's comments as treating people in the least restrictive environment as the overall guiding principle and then specifying ways to implement that concept.

Tom Stanage believes establishing a continuum of care is also an important guiding principle.

Deb Bowman believed the next concern was to consider the next steps and compile information into a working document for moving forward. After DSS and DHS compile the information it will be sent out to the group and then another meeting will be scheduled in approximately one month.

Kim Malsam-Rysdon asked the group to continue sending guiding principles out and stated that these suggestions would be added to the information DSS was compiling. She also stated that, at the next meeting, the group would be in a position to begin talking logistics to move forward.

Deb Bowman urged the group to provide DSS states that are a model in this area and maybe recommend parts of their systems that could be used in South Dakota. The meeting was adjourned.

Members will be notified of next meeting date and time.