The Honorable Edward J. Kasemeyer, Chairman  
Senate Budget and Taxation Committee  
3 West, Miller Senate Building  
Annapolis, MD 21401

The Honorable Norman H. Conway, Chairman  
House Appropriations Committee  
Room 121, House Office Building  
Annapolis, MD 21401

RE: 2013 Joint Chairmen’s Report, page 71, M00L01.03 – Individuals with Serious Mental Illness and Aging in Place

Dear Chairman Kasemeyer and Chairman Conway:

Pursuant to the 2013 Joint Chairmen’s Report (pg 71), the Department of Health and Mental Hygiene (DHMH) respectfully submits this report regarding individuals with serious mental illness and aging in place.

We hope this information is helpful. If you have questions, please feel free to contact Ms. Christi Megna, Assistant Director of Governmental Affairs, at (410) 767-6509.

Sincerely,

Joshua M. Sharfstein, M.D.  
Secretary

Enclosure

cc: Brian Hepburn, M.D.  
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The committees expressed interest in the development of programming that could best meet the needs of individuals with serious mental illness such as community-based psychiatric assisted living and residential rehabilitation programming that includes reimbursement for nursing support, and also the extent to which the Chronic Health Home model can help keep these individuals in community-based care. This report addresses these and other best practices that are currently in place nationwide to address this population.

Development of Programming for Individuals Aging in Place

The Mental Hygiene Administration (MHA) has long recognized that it is serving a growing number of consumers who have increasingly complex medical needs. Beginning in the 1990s and continuing through the 2000s, MHA’s plans and initiatives for older adult consumers, and those aging in place, focused on enhancing opportunities to access and remain in community-based settings. In 1991, the Committee on the Promotion and Improvement of Mental Health Services to the Elderly produced an initial report identifying needed services, availability, barriers to services and to make recommendations to the MHA regarding the overall needs of older adults residing in the community. During this time, groups of stakeholders within the mental health arena and the network on aging met at various times to continue to review systems of care, current service ability, and barriers to services. Many trainings and conferences were held during this time to cross train providers in the mental health and aging systems, and to raise awareness of these growing concerns. It has been continuously noted that this emerging population presents a challenge to Maryland’s Public Mental Health System (PMHS). The PMHS, particularly its residential services component, is primarily designed to address the behavioral health needs of its consumers. When a consumer develops serious medical conditions, the services provided by Residential Rehabilitation Programs (RRPs) are not sufficient to maintain that consumer in his current environment.

In 2000, a small survey of residents of the RRPs was conducted, and findings showed that the number of persons aging in place in these programs was growing. In 2008, the older adult component of the MHA’s Mental Health Transformation Project began studying this issue, and conducted another small survey in the RRPs to identify the prevalence of this issue. The results of the survey showed that “21 of 49 consumers, or 43%, had a chronic medical condition.” The age range for this group was from age 36 to 78 years, with an average age of 58 years. The transformation team and committee explored national programs for further consideration to address this need.

Various recommended plans have been proposed, and the transformation team report states that in responding to this population, MHA will need to address three issues: develop a medical services model for consumers who can remain safely in the RRPs; define at what point it is no longer safe to maintain a consumer in the RRP model; and work with its other partners in other State agencies to provide a way of transitioning consumers to more intensive care settings. Recommendations include regular monitoring of the consumer’s condition, identified as “frequent and regular nursing supervision;” care coordination with primary care physicians and specialists; nutrition evaluations, particularly when the consumer experiences weight loss or
choking episodes; and staff training on care issues (to include understanding co-occurring illnesses, including symptoms), the overlap between disease progression and mental health status changes, when to call 911 or health care providers, pain management, side effects of medication, and fall risks.

In addition, new service programs were addressed.

1. Consumer-driven chronic disease self-management programs, some of which are community-based programs where individuals can learn to take responsibility for the day-to-day management of their disease. Other programs include the Chronic Disease Self-Management Program, an evidence-base program implemented through the Maryland Department of Aging (MDoA), where trained staff can effectively deliver a structured patient education program.

2. Nurse consultant model, which would include periodic monitoring of the consumer’s medical condition, consultation with the primary care provider, consulting with the consumer regarding management of his medical conditions, on-going training of staff on general medical conditions, and assessments by the consulting nurse regarding when the consumer is no longer capable of directing their own health care. If the consumer is no longer capable of directing their own health care, or has a condition which is complex, unstable and unpredictable, the nurse consultant will work with the consumer, RRP provider, and other key personnel in the system to find an appropriate care setting;

3. Care coordination model, where, as a consumer’s medical problems become more acute, it is imperative that the behavioral and physical health and community support services become more integrated. These types of consumers may be prone to admissions to hospitals, nursing homes, assisted living facilities and eventually back to the community, and will require care and coordination and follow-up as they move through these various settings. The consumer’s care needs, at this point, will require care managers or case managers. For these consumers, enhanced behavioral health services should be provided in their various settings. These services would include regular on-site monitoring and therapeutic intervention, access to appropriate day programs including medical day care or psychiatric rehabilitation program (PRP) services, and customized training of assisted living staff to improve care of individual consumers;

4. Enhanced RRP model, which provides personal care services and nursing oversight, combined with the behavioral health services offered in a traditional RRP. Providers would be required to meet standards above the level of an RRP and would need to have some characteristics of an assisted living facility. This model may require a new set of regulations to operate; and

5. Nurse delegation model, which would follow the nurse delegation authority found in COMAR 10.27.11.03. An RRP could conceivably employ a registered nurse contractually, thus keeping staffing costs to a minimum.
Reimbursement for Nursing Support

There have been several barriers to reimbursement for nursing support. To address the barriers, MHA awarded two RRPs with grants to hire nurses. Despite having grant funds, the programs report that nurses are not allowed to provide “hands on” care in the RRPs because of their understanding of the scope of practice as specified in the Nurse Practice Act. In lieu of “hands on” care, the nurses assist in the coordination and integration of consumer services, and provide training and teaching both to staff and residents regarding disease management, and assist with the residents’ primary care physician visits.

Way Station RRP has established the position of “residential nurses.” These positions were established to meet some of the existing care gaps. The positions are conversions of direct service FTEs. They have met the most urgent needs such as wound care but are insufficiently available to meet the needs which would prevent increasing RRP discharges to assisted living and nursing facilities.

Chronic Health Home Model

Among the aging in place population, the chronic health home model (health home) will serve those with serious persistent mental illness receiving Psychiatric Rehabilitation Program (PRP) or mobile treatment services, and will specifically focus on improving care coordination, services, and outcomes related to chronic conditions, primarily those that are somatic.

Health homes for individuals with chronic conditions will augment the State’s broader efforts to integrate somatic and behavioral health services. The program will target individuals with behavioral health needs who are at high risk for additional chronic conditions, offering them enhanced care coordination services from providers with whom they regularly receive care. Health homes are designed to enhance patient-centered care, empowering participants to manage and prevent chronic conditions in order to improve health outcomes, while reducing avoidable hospital encounters. Health homes will provide six core services, as follows:

1. Comprehensive care management;
2. Care coordination;
3. Health promotion;
4. Comprehensive transitional care;
5. Individual and family support; and
6. Referral to community and social support.

These services can be accomplished through connecting participants and caregivers to the myriad of supports and services available to them, offering health promotion activities, monitoring both somatic and behavioral health needs, and assisting with transitional care. The health home becomes the locus of care, building participants’ self-management capacity while reducing avoidable hospital usage and improving outcomes. For a patient to be discharged from the health home, relocation, incarceration, or loss of eligibility would need to occur. The following is the system set in place to keep such individuals in care:

- Development of care plan: Using the initial assessment, the health home will work with the participant to incorporate health home-specific goals into the individual’s treatment
plan, including goals and timeframes, community networks and supports, and optimal clinical outcomes.

- **Delineation of roles:** The health home will assign each team member clear roles and responsibilities. Participant individual treatment plans (ITPs) will identify the various providers and specialists within and outside the health home involved in the consumer’s care.

- **Monitoring and reassessment:** The health home will monitor individual health status and progress towards ITP goals. This will include documenting changes, adjusting care plans as needed and updating indicators in eMedicaid, a web-based system that Maryland Medicaid has developed for providers to enroll in the program, check participant eligibility and obtain payment information, every six months at minimum.

- **Outcomes and reporting:** The health home will use the eMedicaid portal and other available health information technology (HIT) tools possibly including electronic health records (EHRs) to review and report quality metrics, assessment and survey results, and service utilization in order to evaluate client satisfaction, health status, service delivery, and costs.

- **Population-based care management:** Providers will monitor population health status and service use to determine adherence to or variance from treatment guidelines. The health home will identify and prioritize population-wide needs and trends, then implement appropriate population-wide treatment guidelines and interventions.

    At the present time, Way Station PRP, located in Frederick County, has begun to implement a pilot “Health Home” program. Currently in home services criteria require a somatic diagnosis.

**Looking into the Future**

Older adults are the fastest growing segment of the population. As this population increases, so does the prevalence of mental health needs. Efforts are needed to create more opportunities for residential services and other housing models; increase the expertise of staff in the PMHS regarding older adults; and to create opportunities for older adults to participate in all MHA health and wellness initiatives.

External barriers exist such as Medicare being the primary insurer for many older adults, and therefore, some services are not available for these consumers in the PMHS. MHA continues to explore opportunities for needed services to enable older adults and those aging in place to continue to reside in the community.

In summary, MHA has long invested efforts to support persons aging in place to access and remain in community settings, and to overcome barriers to providing additional services to those residents in RRP who experience chronic somatic conditions. MHA supports coordination and integration of somatic and psychiatric treatment; training for staff regarding best practices and models of care for an aging population; partnering with other State agencies, such as the MDoA and DHMH’s Office of Health Services (OHS), which administers the State
Medicaid program, and exploring opportunities for collaboration; and continually seeking the input and recommendations of advocates and key stakeholders in the aging and mental health arenas. Due to these efforts, many mental health consumers are continuing to reside in the community and admissions to more restrictive environments are delayed or prevented.