

Crisis Services Work Group
Meeting Notes
February 19, 2008
Dorothea Dix Campus, Adams Building, Room 264

Members Present: Amy Blackwell, Wendy Webster, Sarah Wiltgen, Jack Naftel, Dr. Tony Lindsay, Ellen Holliman, Mike Watson, Foster Norman, Barbara Beatty, John Tote, Robin Huffman, Dr. Marvin Swartz, Dr. Darlene Menscer , Peter Mumma.

Members Absent: Dr. David Rubinow, Dr. Brent Myers, Patrice Roesler, Carl Britton-Watkins.

Executive Support Team Present: Mike Hennike, Linda Povlich, Leza Wainwright, Stuart Berde, Mike Lancaster, Michael Vicario, Yvonne Copeland, Jack St. Clair, Tara Larson, Walker Wilson.

Others Present: Barbara Whitaker, Katherine Davis, Martha Are, Elizabeth Sasser, Martha Brock, Louise Fisher.

I. Work Group Survey Results

The survey responses fell into four broad categories. The first category is the relationship between the community system and the regional hospital system, which crosses over the work of both Work Groups. This group includes comments about changing incentives for the use of state hospitals, comments about downsizing hospital beds, etc. The second category focused on systems barriers. Comments from this group included issues with funding, organizational and procedural process, accountability issues, case management locus, etc. The third is staffing concerns. This has been reflected in previous meetings, particularly as it relates to insufficient psychiatrists and other qualified providers.

Lastly, comments that focus right in on crisis services themselves. This included variance and unavailability of crisis services across the state, insufficient community inpatient capacity and stabilization, facility based beds, inadequacy of number of mobile crisis teams, free standing detox facilities, transportation of patients in crisis, substance abuse support, etc.

In addition, there were many issues related to crisis that don't necessarily correspond directly to gaps in crisis services. One of the things we need to do at a later point in time is circle back to some of those broader systemic issues. Not doing it today doesn't mean it's not important. Right now we have to really focus our work on what needs to be put in play to meet the Secretary's mandate re: gaps in crisis services and the core, basic floor.

We also have available new data about costs for people presenting in EDs across the state. The legislature requested information from DMA, and DMA has provided information about Medicaid paid claims, split by diagnosis. The variance by LME doesn't seem to be explained by

total population. Among populations, there are relatively few DD folks presenting at the ED, and the MH and SA numbers are very similar. We will soon have information about most frequent procedures related to each high level diagnosis.

II. Core elements: access, assessment, disposition

In the spirit of the Secretary's request we have begun to develop a definition of what crisis services should be available to all citizens. The core elements are access, assessment and disposition. We need to identify key pieces, what we need to have and what gaps currently exist. We recognize that crisis services are part of a system and all the pieces need to work together, and those pieces, including outpatient services, will be part of a second level of conversation. For now we will stay focused on the core crisis services.

Core components of Access:

- Phone number someone can call
- Access to a knowledgeable clinician, and ideally a care manager/case manager
- Preferably someone who knows them and their situation
- Anyone with an emergency should be seen within 2 hours, and with urgent situation should be seen within 48 hours.

The current cost model pays for LMEs to provide 24/7 access, the ability to speak to a clinician. This is in place with most, but not LMEs. When the 24/7 access isn't available, or isn't effective, consumers are further encouraged to go to ED's, which is already a cultural preference for many people who receive all of their health care from hospitals.

Goals:

- Every LME has a 24/7 screening, triage and referral unit that a consumer can call and talk to a clinician. The LME can provide this service directly or contract it out. Many currently contract for the after hours/weekend portion.
- If the caller is an existing consumer, the LME has a copy of the consumer's crisis plan, with current medications.
- A procedure is in place so EDs treating existing consumers also have access to the crisis plan and the LME is engaged.

Gaps/?'s/Issues:

- Not all LMEs have a functioning 24/7 crisis line.
- EDs don't always have access to crisis plans
- About 40% of the folks presenting with crisis are not already consumers
- Mobile Crisis Teams (or other acceptable method) for LMEs to work with the hospitals
- What percentage of calls can be dealt with at that stage – without additional need for assessment and disposition?

Core components of Assessment:

- Face to Face assessment by qualified, licensed clinician
- 95% of the population is within 30 minutes/30 miles of that clinician

Goals:

- Face to face assessments available 24/7
- New consumers should also receive an assessment from the LME
- LMEs are paying for availability, not cost for services
- CIT trained police forces
- DD expertise on MCTs
- START programs

Gaps/ ?'s/ Issues:

- Some LMEs don't hold providers accountable
- EDs determine that crisis plans are unacceptable.
- Locality of the face to face assessment – hospitals, crisis centers, provider offices
- What level of clinical acuity should the clinician providing the assessment be equipped to handle.
- Does medical evaluation also occur during assessment? Does it have to be a medical assessment, or someone with medical skills involved in that assessment.
- Transportation to a facility based assessment center – MCT, police, EMS, family, etc..
- First responder follow ups, holding providers responsible for existing consumers
- New consumer has access from several options including MCT, walk in capacity – ED or facility based crisis – and CIT
- Variability across LME's and regions make it hard to define the problem
- Does single stream funding make it easier to put these strategies together
- We could price ourselves out if we encourage LMEs to build new assessment facilities
- 30 Min/30 Mile rule may mean that providers cross LME boundaries
- Appropriate and timely consequences when the LME doesn't provide the core service
- Use of Secretary of State website to store crisis plans
- Geriatric cases and TBI cases need good assessments

Core components of Disposition

- State hospitals will take the behaviorally challenged consumers
- Local, community based psychiatric beds are available for other crisis consumers

Goals:

- Increase local, community based psychiatric bed capacity
- Crisis respite beds for DD
- START model
- Convert long term beds to crisis/respite beds
- There's not enough money to say the state will pay for every indigent bed. We talked about to keep people who have inpatient beds from closing them - if they will maintain a certain level of occupancy, maybe 75-80%, we' pay for 10% of the indigent days to incentivize you to keep those open. For new beds that have high occupancy, we'd pay for 100% of the indigent days in the new beds. We'd pay for the 187 new beds regardless of which indigent patient went into it. And 10% of the indigent beds that are eligible to take involuntary commitment if you maintain 80% occupancy.

Gaps/ ?'s/ Issues

- How to expand high end disposition – inpatient psychiatric care or facility based crisis or detox or residential SA treatment.
- Follow up and track those who identify themselves as being in crisis
- Drill deeper on the needs of patients who have been in 7 day or less state hospital stays to determine what types of beds are needed (for treatment, diagnosis, gender, age)
- In a timely manner MCTs work with hospitals to work out disposition
- More robust hospital liaison, community care liaisons at the LME level? Especially for new consumers.
- Options for geriatric or TBI consumers for whom rehabilitation is not likely.
- Statutory change – forces hospitals to give up CON if they don't use it.
- Incentivizing hospitals including money for up-fit

Next Meeting:

Submit your ideas to staff by noon on Tuesday, Feb 26. Staff will take the submitted ideas and begin to put recommendations in a format for feedback.