Appendix D
Organizations represented in Interviews and Discussion Groups

Interviews

1. Poudre Health Services District
2. Colorado Department of Human Services
3. Alcohol and Drug Abuse Division, State Office
4. Colorado Behavioral Healthcare Council
5. Community Corrections
6. Consumers
7. County Court Judge
8. Disability Connection/RAFT
9. District Court Judge
10. Families
11. Federation of Families
12. Foothills Gateway, Inc.
13. Health Care Policy and Finance, State Office (HCPF)
14. Hope Counseling Center
15. The Hub, Juvenile Assessment Center
16. Island Grove Regional Treatment Center
17. Larimer Center for Mental Health
18. Larimer County Child Welfare
19. Larimer County Department of Human Services
20. Larimer County Division of Health and Human Services
21. Larimer County Sheriff's Office
22. Larimer County Workforce Center
23. Managed Adolescent Care
24. Mental Health Association
25. Mental Health Services, State Office
26. Mountain Crest Behavioral Healthcare Center
27. Multi-Disciplinary Assessment Team (MDAT)
28. Namaqua Center
29. North Range Behavioral Health
30. Office of the District Attorney
31. Poudre School District
32. Poudre Valley Health System, Inc.
33. Poudre Valley Hospital Emergency Room Physicians
34. Poudre Valley Hospital Foundation
35. Private psychiatrists
36. Private psychologists
37. Signal

Discussion Groups

1. Community leaders
2. Community psychiatrists
3. Community psychologists
4. Consumers
5. Criminal Justice
6. Families and consumers
7. Health and human service agency staff
8. Human resource directors
9. Inpatient psychiatrists
10. Larimer Center for Mental Health staff
11. Mental health providers
12. Non profit agency staff
13. Physicians
14. Public forum
15. Religious leaders
16. School personnel
17. Volunteers

Appendix E
Specific tasks to be accomplished

The following table includes specific tasks identified at the beginning of the community wide mental health and substance abuse planning process and the current status of each.

Task		Status
1.	Develop a local steering committee with consumer representation	√
2.	Identification of the key mental health and substance abuse players	√ (See Appendix D for a list of organizations represented in interviews and discussion groups.)
3.	Develop a series of profiles to describe providers	√ (See Appendix L for service profiles on key agencies)
4.	Compilation of data which describes those in need of mental health, state and national issues	√
5.	Uncovering of relevant national models	√ Begun; on hold until top priorities determined
6.	Review components of "Ideal Mental Health System" and determine which exist adequately and which need improvements	√
7.	Summarize and prioritize issues needing to be addressed	√ Proposed – pending Steering Committee discussion on 2/2/01
8.	Develop strategies to impact top priorities	√ Begun; will be addressed by Steering Committee on 2/2/01
9.	Develop plan with action steps, timelines and responsibilities	Phase II
10.	Provide regular updates to the community with opportunities for feedback	On-going, opportunities have included public forums, discussion groups, individual meetings. "Report back" meetings will be planned once report is finalized.

Appendix F
Retaining Inpatient Psychiatric Care in Larimer County, CO

June 11, 2000

The Mental Health Crisis Nationally

There is no national mandate or funding source for the provision of mental health care for the indigent. In the absence of a universal system of health care, America has long relied on a patchworked safety net system, comprised of hospitals, clinics, financing, and programs that vary dramatically across the country.

Safety net providers are "those providers that organize and deliver a significant level of health care and other related services to uninsured, Medicaid, and other vulnerable patients."

The funding and organization of the safety net have always been tenuous and subject to the changing tides of politics, available resources, and public policies. Today, there are new and unprecedented challenges to the safety net system due to several trends:

1) The full impact of Medicaid managed care in a more competitive health care marketplace
2) The separation of care for Medicaid patients from care for uninsured individuals
3) The erosion of direct and indirect subsidies that providers have relied upon to help finance uncompensated care (e.g., the Balanced Budget Act, Medicaid dollars previously used to support infrastructure, growth of managed care which prohibits cost-shifting, etc.)
4) The shifting tides of the managed care market (the %age of HMOs reporting a profit was in the 80th+ percentiles 1990-94, but has been in the 40th percentiles in 1996-97) which mean that many communities have plans coming and going
5) Increasing numbers of the uninsured and growing demand for care
6) The increasing concentration of care for the uninsured population among fewer providers

Nationally, those trends are endangering the fragile patchwork of safety net providers in almost every community.

In order to address those risks, federal and state policies must be addressed. The fragility of the local safety net system has the potential to become a national crisis.

- *Much of the above material was adapted from "America's Health Care Safety Net: Intact but Endangered," from the Institute of Medicine's Committee on the Changing Market, Managed Care, and the Future Viability of Safety Net Providers, 2000.*

The State Crisis

In a memo written jointly on May 26, 2000 by the Colorado Behavioral Health Care Council and the Colorado Health and Hospital Association to the leaders of the state legislative Health Care Task Force, the authors noted that "Colorado is facing a crisis with regard to access, funding and provision of services to non-enrolled indigent persons needing mental health services. This crisis can be attributed to an increasingly high volume of mental health patients and limited resources within both hospitals and mental health agencies to care for those patients."

The memo notes the shortage of state beds for the indigent population and the shortage of practitioners working in this area, and goes on to note that over a three-year period there has been a 42% increase in the number of self-paying mental health patients being seen in emergency rooms.

While local community Mental Health Centers have a broad mandate to provide services, there are insufficient state general fund dollars to cover the mental health needs of the indigent population, and centers are not expected to serve all needs of all indigent people in a community.

The Inpatient Psychiatric Care Crisis Locally

Summary
The local inpatient psychiatric hospital (Mountain Crest) does not have enough psychiatrists willing to admit inpatient psychiatric patients, and to take the corresponding call required of all admitting physicians.

The burden of call has fallen to the four remaining psychiatrists willing to admit patients; two at Mountain Crest, and two who are employees of the Larimer Center for Mental Health. The result of this burden has been that the four psychiatrists, despite heroic efforts, have been barely able to keep up with the workload, and are rapidly approaching burnout.

Larimer County is in danger of losing its inpatient psychiatric hospital if solutions cannot be found. The impacts of losing local inpatient psychiatric care include potential losses in quality, access, and the loss of community resources to other communities. Quality could potentially suffer due to increasingly fragmented care and the loss of care close to family and friends; limited geographic access will create transportation challenges. The economic impact and ripple effects have not yet been fully determined. The ability to refer to other inpatient hospitals is shaky, since other hospitals are also in danger of closing.

The potential for finding a solution to this community problem is enhanced because the community has already launched a comprehensive mental health/substance abuse planning process. Top officials from major mental health/substance abuse agencies are already engaged with consumer advocates in learning about the variety of current mental health/substance challenges and in devising long-term improvements.

Background
Mountain Crest is the only inpatient psychiatric unit in Larimer County; it is run by the Poudre Valley Health System. PVHS purchased the for-profit Mountain Crest hospital in 1998. PVHS merged its nonprofit hospital-based services into the Mountain Crest site, incorporating the culture of a service that served all people, no matter what their insurance status, with the culture of an organization that had primarily served the insured. Under the PVHS umbrella, the services are nonprofit and are provided to all.

Over the course of the past two years, the number of community psychiatrists willing to admit patients and take corresponding call has dropped from 13 to 2. While most of those psychiatrists remain in the community, they have reduced their practices to outpatient work.

Risks for the Major Players and the Community

- Consumers could lose an important, accessible, community-based service
- The community could end up without an inpatient facility for ALL payer classes
- Families could end up having to travel long distances to see and participate in treatment with their loved ones
- Poudre Valley Health System could end up without the minimum number of psychiatrists and call required to keep inpatient services viable, and they would have to close Mountain Crest
- Closure of Mountain Crest would only exacerbate the already fragmented crisis services, and PVHS would still have patients presenting at the ER
- LCMH could end up having to transport all their inpatient patients to Greeley, Longmont, or Denver, which face similar challenges in maintaining services and staffing. They would have to develop a system for the Medicaid patients who present at PVHS ER.
- Local mental health agencies and law enforcement could face even more difficult challenges in getting people the mental health care they need

Potential Solutions

In order to create potential solutions to the crisis in providing psychiatric inpatient care in this community, four key organizations came together: PVHS/Mountain Crest, Larimer Center for Mental Health, Poudre Health Services District, and the Health and Human Services Department of Larimer County. Representatives from each organization discussed the extent of the problem, the risks to the community of losing inpatient psychiatric care, and the need for both short term and long term solutions.

The following proposed strategies were created (final decisions are pending action by the respective organizations):

<u>Immediate/Temporary Action (July – December)</u>

1) A shared, six-month project will be created for the purpose of reducing the current work burdens of the four psychiatrists taking call.

   The project will be sponsored by all four entities. The Health District will serve as the fiscal agent of the project; management will be determined by a council of the funding partners, which will meet periodically during the term of the project.

   Temporary psychiatric services will be purchased in order to set the weekend call rotation at no more often than a 1 in 6 rotation, with the physicians from Larimer Center for Mental Health temporarily taking 1 of the 6. In addition, temporary services to allow each Mountain Crest psychiatrist a weeks' vacation will be purchased. Total cost of the project is estimated at $43,000.

2) PVHS contracts with psychiatrists for indigent care

3) Memorandums of understanding will be created between all parties in order to clarify roles, responsibilities, and resources

<u>Longer Term Action (begin in August; complete by end of year)</u>

1) Create a sustainable community-wide shared response to the crisis. Engage in negotiated discussions with the goal of enlisting at least 10 local psychiatrists in the call rotation (at that point, LCMH psychiatrists would take on an individual call schedule). Issues to be addressed

include such things as a department of psychiatry (and seat on the PVHS Medical Executive Committee); pay for indigent care; improved protocols for providing crisis, inpatient, and followup care; and a reasonable burden of call.

The community mental health/substance abuse planning project members may assist with this goal; the negotiations will be sponsored by PVHS and the Health District.

2) Develop written roles, responsibilities, and scheduling

Systems Change Commitment (begin in June; complete first stage by end of year)

1) Adopt a planning model that explores a variety of ways to better utilize community resources. Engage in comprehensive community mental health/substance abuse planning with the goal of organizing service delivery and financing so as to make the most efficient use of available dollars in a coordinated continuum of care.

2) Participate in a coordinated, informed effort to share information and recommendations with legislators and other policy makers

Appendix G

All Colorado Hospital Discharges

1999 Payer Mix

PAYER	DISCHARGES		Percent of Discharges	
	Psych Patients	All Other Patients	Psych Patients	All Other Patients
HMO/PPO/Managed Care	6,770	157,711	35.7%	40.2%
Medicare	3,462	91,272	18.3%	23.3%
Self Pay	***2,798***	***20,646***	***14.8%***	***5.3%***
Commercial/Indemnity	2,409	50,393	12.7%	12.9%
Medicaid	1,528	43,397	8.1%	11.1%
Colorado Medically Indigent	***1,073***	***7,793***	***5.7%***	***2.0%***
Blue Cross/Blue Shield	431	10,440	2.3%	2.7%
Workers Comp	208	3,611	1.1%	0.9%
Champus	139	1,958	0.7%	0.5%
Other Government	89	1,524	0.5%	0.4%
Other Liability	39	2,694	0.2%	0.7%
Charity	1	691	0.0%	0.2%
Unknown	1	26	0.0%	0.0%
Total	**18,948**	**392,156**	**100.0%**	**100.0%**

NOTE: Not all Self-Pay patients are necessarily low income/indigent patients. Some are insured but have inadequate mental health benefits.

Source: Colorado Health and Hospital Discharge Database, 1999.

Appendix H
Need for Mental Health Services in Larimer County

Prevalence of Mental Health/Addictive Disorders

More than 60,000 people in Larimer County are likely affected by a mental health or substance abuse disorder:

	% of Population Affected	Number	Estimated Number who are Uninsured
Children (<17)	20%	12,400	1,800
Adults	28%	51,000	7,600
Total		63,400	9,400

Note: uninsured based on 15% estimate

Type of Disorder

	Mental Health Only	Addiction Only	Mental Health and Addiction
Adults	68%	22%	10%

Prevalence of Significant Impairment Due to Mental Health

19,000 - 22,000 people have **significant** functional impairment due to mental health:

	% of Population with impairment	Number with impairment	Uninsured
Children (9-17)	5-9%	3,000 – 6,000	450 – 900
Adults	9%	16,000	2,400
TOTAL		19,000 – 22,000	2,850 – 3,300