

Appendix J

All Issues Emerging from Community Conversations

From 18 Discussion Groups & 59 Interviews
October 5, 1999 — May 26, 2000

Clear, Immediate Access to System/Services

- * Assessment & Appropriate Placement
- * Crisis Response for mental health and substance abuse issues
 - Now: multiple and fragmented approaches for crisis; no common community protocol
 - Non-medical detox—currently have none in our community
 - Swing beds—do we need a few beds at PVH for observation or detox?
- * Reliable, Timely Information Source Regarding Resources
 - Complete, accurate, easily accessible (phone & web) information regarding all services available; one source with most answers
 - Multiple entry points
 - Triage to determine extent of need and appropriate service
 - Psychological evaluations
 - Immediate response to crisis (24 hours)
 - Walk-in, hot line, trained on call crisis team

Assistance in Navigating Complicated Systems; Consumer & Family Support

- Neutral ombudsman
- Help consumers maximize insurance support
- * One agency (some advocated for independent agency) for assessment/triage, intake, referral, care coordination and follow-up
 - Models: Colorado Springs - multiple agencies pitch in to pay for coordination services;
 - Cheyenne – school district pays part of mental health center staff person time to do crisis/coordination
- Outreach: getting people with needs to come to the services
- Respite care for families
- Consumer to consumer opportunities: education, advocacy
 - Use all community resources (neighbors, friends, employers, service clubs, churches)
 - Volunteers (CSU students, etc.) can provide a daily support system (are you up? did you take your meds?)

Continuum of Care Available

- Provide appropriate level of care for need (now often providing higher level of care than needed due to lack of options; management by crisis, with people being punted)
 - Crisis (see previous section)
 - Outpatient
 - * Need no/short waiting list

Hard to get kids in
Limited number of psychiatrists accepting CHP+ kids; must go outside community
People with milder needs face long waiting lists (opposite of prevention)

Intermediate Level of Care (Acute Treatment Unit (ATU), "Step down", "Halfway", "

Partial" or "Transitional" Services
Need for this level of service mentioned numerous times

Residential

Not just for LCMH referrals; need RTC for D/A
* Several adolescent RTC's opening—may decrease the amount of money child welfare is spending outside Larimer County

Temporary inpatient

Have psych observation beds at PVH, along w/short term detox, to sort out issues

Inpatient

Currently a crisis (see detail section later in document) Lockdown
Nothing local for 10-11 year olds
* Need immediate follow-up care from inpatient to outpatient
Allow PCPs to admit & use psychiatry consults
Concern that beds have been turned back to state hospital
Should PVHS be billing Medicaid, not county, when treating inmates?
Do we need more than 15 beds? Could it be within the main hospital?
Is there adequate safety at Mountain Crest?

* Medications:

Can LCMH have "on call" for medications only?
Not appropriate to refer to ER for medications
Refer from ER to Northside for medications
Role of PCP's in medication delivery: training for PCP's
More access to psychiatric medications clinic at Health District
High cost of medications

Family Services

Education, support groups and treatment for family members
* Services more consumer/family driven

Sometimes care is provided at higher level than needed because there is no other option

Create a system that provides treatment at an array of different levels:

Increase number of community psychiatrists that will participate in indigent care
Improve primary care physicians' role in treatment
Use physician extenders whenever possible

Biggest gap for kids is for middle income, moderate needs kids with no insurance

* In some cases, people can get assistance only if they break the law, are declared "negligent," or use the word "suicide"

Options for substance abuse treatment not conducive to keeping a job

Some agencies won't take voluntary placements; wait until court order (payment source)
Do police appropriately use PVH & Mountain Crest instead of LCMH?
Blend mh w/other services, not separate facilities
Can Mountain Crest be modified to allow step-down services? Juvenile criminal justice? Public/private acute treatment unit?
Substance abuse: payers won't pay for 30 day treatment tracks; people turned down for variety of reasons (suicidal, age, prior history)

Follow-through: Continuity of Information and Care

- * Care Coordination
Family care coordinators are overworked – schools, mental health center
- * Continuity of Care from One Part of System to Next
Inpatient to outpatient
Detention to release
Medications Monitoring

Co-occurring Diagnosis (MH/SA/DD)

- * Need for services, providers with dual diagnosis training & capacity
Collaborative treatment plans
- * Now: Treatment postponed while providers try to figure out who will pay
Need clear understanding of interplay of MH, DD and ADAD at state level

Inpatient Care Crisis

- Adequate psychiatric services
- * Crisis: too few psychiatrists (4) admitting; approaching burnout
 - * Can't admit without taking call rotation; high burden because so few psychiatrists admit, especially problem re: weekend call
- Reimbursement for indigent care
Psychiatrists take on high liability for indigent care (concerns: no follow-up on dismissal)
Psychiatrists need incentives
Managed care reimbursement rates declining; stays declining; = lower income
Supply of psychiatrists in community low
Would staff model at PVHS/Mountain Crest solve problem?
No psychiatric training facilities feeding into our area on a regular basis

School and criminal justice system issues

- Criminal Justice
- Need criminal justice and school systems that understand kids with mental illness
 - Need more humane restraint system
 - Police transport is time consuming, needed most at peak hours
 - Detention not an appropriate detox site but is used that way

Services in schools

- Teachers need training
- Parents need to know sooner about problems; need policies that ensure early involvement; need to share information in laymen's terms
- Parents' voice not respected
- Meetings need to be at hours that don't jeopardize parents' employment
- Schools need more on site mental health services
- Parents wish schools would do more; schools being asked to do more than funding allows
- HUB good idea but time consuming for school personnel

Knowledge of Mental Health Issues and Resources

- * Public education and outreach
 - * Massive campaign (speaking at neighborhood groups, messages in utility bills, grocery bags, public restrooms)
- Training for faith community, law enforcement, teachers, parents, judges, case managers, service providers, medical professionals, entire school system (bus drivers & lunch room to board members)
- * Education in schools (as part of curriculum)

*** Prevention/Early Intervention**

- Mental health identification and services in schools
- * Early intervention to avoid exacerbation and jail
- How to prove that it's worth the investment?
- Outreach/training
- Early diversion programs within criminal justice system; restorative justice

Services Needed for Special Populations

- * Adolescent: crisis, substance abuse
- Employed, low income, no insurance
- Co-occurring diagnoses (see special section)
- Drug offenders (specifically mentioned: methamphetamine & heroine addictions)
- Elderly population (specifically mentioned: nursing homes, recovery homes)
- Spanish speaking
- Gay/lesbian
- Homeless

Quality

- Adopt holistic, strengths based approach
- * Staff quality: caring, patient, trained, knowledgeable, responsive
- * Training & technical assistance to enhance quality

Ancillary Needs

Housing

Recovery/halfway houses

Shelter care

Jobs

Interpretation (bilingual)

Transportation costs (for organizations, for consumers)

NEBH seeking better Medicaid reimbursement for emergency transportation

Community-wide Coordination

Protocols

* Planning

* Coordination between all planning groups & initiatives (mental health and substance abuse)

* Involve policy makers, consumers, staff

Add faith community, private sector, CSU to current discussions

Continuous communication between services, and with consumers

Share successes

Build in incentives, including incentives for private providers, for collaboration

Community Resource Distribution

* Determine if resources can be better spread with restructuring

* Establish pool of \$\$ for most costly and complicated situations

Can we make better use of CSU in working on mental health and substance abuse issues?

Resource Issues

Child welfare projected to be over budget

* Child welfare cuts in rates of great concern to providers

* Lowest Medicaid (mental health) reimbursement rate in state

Many eligible for Medicaid are not enrolled

Most resources, best access in criminal justice system

Private insurance very limited in MH and SA funding

Substance abuse funding less than mental health funding

Poudre School District lowest per pupil rate in the area

Consider fee sharing (2 or more organizations share cost of one client)

Need to find less traditional sources of funding (e.g., profit feeder organizations)

Collaborate fundraising (grants, etc.)

Inform funders (funders group discussion, etc.): local, state

Jacob Center working to become Medicaid provider for MH services in 7 counties

Recruit retired professionals to help fill gaps (need incentives such as malpractice, liability waiver)

Create political action group to raise money and have political voice

Policy Changes (see separate document)

Common Themes Among Most Providers

“My organization is doing more than its share”

“Demand is higher than we have the funds to meet”

Kudos to (what we're doing well)

LCMH, Mountain Crest: Using clinical nurse specialists with prescriptive authority

LCMH: after hours crisis response improving

Mountain Crest community/continuing education program

Healthy Kids Club: preventive approach

Workforce center/HUB: services on site, creativity

Therapist Referral: helps people find help in dealing with life issues

Pro Bono Project: likelihood of getting someone into system prior to crisis point is high

Namaqua: diversified services and funding sources

Detention Center: good services; 2 week academy & 4 hour annual training

Namaqua, LCMH, Poudre School District partnership

Ethic of interagency cooperation in Ft. Collins (at least people are talking)

Early childhood system (integrated, shared responsibility, objective coordinating unit –
RAFT –interagency policy council)

Drug court for juveniles

Foothills Gateway (comprehensive integrated system)

Challenge Experienced by Staff

Financial and data information not kept in consistent manner; compiling accurate
community-wide picture very difficult

* = mentioned very often

Appendix K

Policy Issues Impacting Delivery of Mental Health and Substance Abuse Services

Issues Uncovered in the Community-wide Mental Health and Substance Abuse Planning
Process
September 1999 to June 2000

State

Legislative

- Rate for Medicaid mental health lowest in state
- Lowest per pupil rate in area (schools)
- Colorado one of very few states without Medicaid for substance abuse
- Medicaid reimbursement levels too low--apparently don't cover costs
- State trying to control Medicaid growth—second largest budget item
- TABOR limits options
- DYC receives no state funding for MH services for kids, so they are held in detention for safety, but receive no services and are housed with criminals
- Need dollars for treatment when person is court ordered (committee working on policy & sanctions for people in criminal justice system in need of treatment)
- Child welfare: services for kids available only if parents are neglectful or abusive or if child is at risk of being placed out of home; no early intervention
- Co-occurring diagnosis: between mental health and substance abuse, each requires the other issue to be addressed first
- Places like Harvest Farms and Spectrum bring people from outside our community & tax already limited services (can money follow consumers?)
- Volunteers unable to provide services due to high costs of liability and malpractice insurance
- Need analysis of HB 99-1116 "Services for Mentally Ill Children" and 00-1119 "Exchange of Juvenile Information"
- Judicial system punitive, not early intervention-oriented—could we use corrections dollars earlier in the intervention cycle?
- Must have data and outcomes to demonstrate needs to Legislators

Regulatory

- Health Care Policy and Finance (HCPF) taking on more direct management of Medicaid mental health expenditures
- HCPF moving to integrate Medicaid mental health into primary care managed care system
- Important that state understand the risk of losing safety net infrastructure to get lowest bid
- General fund mental health dollars for the indigent (non-Medicaid) inadequate
- New Human Services Department matrix management: will it coordinate services or confuse things more?
- Family coordinator required for Medicaid, but not non-Medicaid eligibles
- Very low reimbursement funds for pregnant women in need of substance abuse treatment... which has severe long-term implications for future needs of child
- HCPF considering cutting home health Medicaid \$\$ and redirecting to SA
- Medicaid paying for medical detox only, when non-medical is cheaper

- Need blending of MH & SA at state level
- Alcohol and Drug Abuse Division (ADAD) Request for Proposals RFP for prevention & intervention issued separately
- Information sharing regulations (need to be able to share information to coordinate care)
- Hard to get someone into Pueblo; once get there, very short length of stays
- Illegal to detox chronic pain patients
- Medicaid managed care, MH, DA, DD, Child welfare all very different plans, "from different planets"
- Diverse paperwork requirements waste time (e.g., Compass, Signal, state)
- Requirement to complete evaluation including write-up delays treatment
- Multiple diagnosis: fights over who will fund
- Requirements for psychiatric resident supervision
- Waiver possibilities: co-mingling money, determining locally which funds get used first (co-occurring diagnoses), etc.
- State may support us in piloting new approaches:
- "MHS job is to make good things happen at the local level." - George Kawamura

Federal

- Have medically underserved area designation, but not medically underserved population, so can't hire J1 visa physicians
- Medicare won't pay for someone with cognitive disorders to be admitted to psychiatric hospital
- Grant psychologists prescribing authority (clinical nurse specialists can get it)

Insurance

- Won't cover detox at psychiatric facility
- \$5,000 limit on detox; may need more than once
- Every insurance company has own policy on evaluation, admits, and treatment
- Limited benefits, high copays mean early intervention may not happen
- Limited inpatient days results in decreased patient & staff safety, issues inadequately addressed, medications not stable upon discharge
- Patients change insurance regularly; providers must adjust
- Dictates types of medications that can be prescribed
- Some companies don't cover preventive mental health services (e.g. marriage & family counseling)

Local

Resources

- Request waiver to allow for co-mingled money
- Ballot initiative/mill levy (add on to Foothills Gateway?)

Schools

- Zero tolerance in schools can lead to criminalizing kids with MH issues
- Lack of mental health personnel on site; lack of coordination
- Confusion over who pays (school or parent)
- When schools (paying source) are the ones diagnosing, may be disincentive to diagnose certain conditions
- Counseling services in schools not mandated

Other

- Can we save local dollars by having PVHS bill Medicaid for inmates instead of county?
- Company policies moving towards zero tolerance for substance abuse
- Approval required from LCMH before criminal justice system can send to Pueblo
- OSHA and AOA policy discrepancies
- Direct to consumer marketing of medications

Unsure of jurisdiction

- TANF benefits tied to child being “enrolled,” not attending school
- 27-10 procedure time consuming (police trying to figure out where to go with person in need of services)
- Courts must put criminal charges on hold for hospital to admit
- Medicaid and ADAD: overlap and/or gaps in responsibilities