

HB-1032 Stakeholder Meeting
Fort Logan Auditorium, Denver, CO - 4/15/11
Summary Report

Attendees: 45

Agenda:

- 1- Welcome
 - Overview of HB-1032
 - Purpose and process of statewide meetings
- 2- Current service structures
 - Review survey results-to-date
 - Record observations and provide missing information
- 3- Visioning the future of crisis response
 - Developing consensus in small groups on priorities for a future crisis response system
 - Share out top priority with the larger group
- 4- Wrap up
 - Models for consideration
 - Next steps in HB-1032 process
 - Thank you for being here

Meeting Summary:

Current Service Structures

In reviewing segments of the online survey report, meeting participants were in agreement on a number of observations. Overall they reported that:

- Current crisis response services are inadequate.
- Service providers often view the system differently than consumers, potentially overstating what exists or is truly functional.
- While services may be in place, there is lack of awareness of services as well as poor collaboration to connect consumers into the service continuum.
- Payer source has a great impact on access to services, noting that uninsured consumers have drastically fewer options than consumers with Medicaid or private insurance.
- Initial crisis response after hours and on weekends is often by law enforcement or the hospital emergency room, and this is not ideal.
- Follow up services are also inadequate to support consumers through stabilization and to prevent them from continuing to cycle through the crisis system.

Feedback on the survey tool and report centered around five themes:

- 1- Concern about low consumer response.

- 2- Request for results should be filtered by region to better understand rural and urban resource differences.
- 3- Concern that the survey represents subjective reporting and should be balanced out with quantitative data.
- 4- Belief that the survey needs to include payer/funding source information.
- 5- Request to include definitions and explanations to ensure consistent interpretation of services (ex. define what we mean by “24 hour access”)

Note: Some of the above requests, such as filtering by region or profession, are built into the current survey but were not made available in the report that participants received. Other suggestions indicate a need to revisit the purpose and value of the survey in this larger process. If the survey is going to be valuable in to this study it may need to be revised and more broadly distributed.

Visioning the future for Crisis Response – Responses from small group activity

IDEAL	FEASIBLE	WHAT WOULD IT TAKE?
<ul style="list-style-type: none"> + Statewide warm response system + Good transition plans post-crisis and community follow-up to avoid future crisis + Crisis response centers in metro Denver and statewide + Response teams who can address crisis real-time, on-site + Family supports for those around person in crisis + Qualified MH staff in hospitals to do MH evaluations + Peer/family navigators embedded in crisis response teams + Improved DRGs for psychiatric admissions + Standardized MH assessment + Encourage partnerships with existing BH agencies to utilize current resources better + Need a centralized navigation system for crisis response, a system to look up a contact person at a particular agency for disposition purposes, in real-time + Max collaboration during the evaluation, when sharing information/getting history and then during the disposition + Is there a way to enact Emergency Medicaid for crisis situations so people aren't sitting hospital ER for days? DBH partner with Urgent Care hospitals? + Attach a MHW to a CIT officer to go to the person's home in the field – don't take person to the hospital + State resources need to be collaborative, on the same page + Need a standard for medical clearance on BAL/drugs + Getting people with medical issues into inpatient psychiatric beds, also people with DD/MR – remove the state system that requires our state institutes to NOT pay the medical costs. Eliminate cost-shifting + Need collaboration around stabilization and post-discharge services + System that is easily identifiable to all consumers. Everyone knows how to get crisis services + Triage model response and comprehensive assessment if 	<ul style="list-style-type: none"> ➔ Statewide warm response system – may be possible with volunteers, donations, grants ➔ Good transition plans post-crisis and community follow-up to avoid future crisis ➔ Standardized MH assessment (currently being worked on by a variety of organizations) ➔ Encourage partnerships with existing BH agencies to utilize current resources better (Is this possibly a fit for BH Transformation Council work?) ➔ Examine the cost-shifting with Medicaid denials from the institutes ➔ A collaborative case management and peer support services approach ➔ CIT trained police officers ➔ Build emergency services through RCCOs statewide ➔ Widely available 24/ telephone support ➔ Standardized crisis assessment process and credentials ➔ Central “bed management” system statewide - Know where beds are and manage rotation of indigent care 	<p><i>Advocacy at state and federal funding levels</i></p> <p><i>Resource allocation to transitional housing, employment to reduce expenditures in correctional system and BH crisis system</i></p> <p><i>Supporting families keeping children in home with community-based services</i></p> <p><i>Training/education of judiciary re: BH and expanding MH and drug courts</i></p> <p><i>Streamline licensing process for sub-acute levels of care</i></p> <p><i>New Legislation</i></p> <p><i>Access to funding</i></p> <p><i>Bridging “territorial” boundaries (silos)</i></p>

<p>needed</p> <ul style="list-style-type: none"> + System that provides for needs of children and seniors + Assessments available regardless of location of crisis + Standardization of assessments across the board + System that supports linkage of multiple services. + System that begins within minutes and lasts for days until stabilization links are made + Behavioral health stabilization first + No wrong door to get into appropriate services + System that provides for follow through on links, assist client in establishing connection + Cannot be a state-wide model as state is too diverse + Should be set of minimum requirements in each community, pertinent to its needs + Adequate resources – especially hospital beds for the high need and less acute levels of care + Capacity for clients with multiple challenges (co-occurring, mh, dd, physical health, SUD) + Community-based, lower-level intervention services (respite) + Intervention/prevention for children before crisis evolves + Keeping crisis services client-directed and individualized + MH services in correctional system + “One-stop shop” + Culturally relevant + Involves family members and loved ones + Change the BH stigma for diverse communities and change perception that services are attached to power systems (police, welfare, etc) + Peer driven + Follow up is culturally sensitive + Triage regardless of payer source 	<p>→ One-stop benefits acquisition process</p> <ul style="list-style-type: none"> → Requirement that clients have crisis plan → Clearly defined agency policies (preparedness) → Resource allocation for lower levels of care, thus reducing cost at higher levels → Incentivize lower level of care in reimbursement systems → Family-based treatment system → System integration to support persons with all forms of co-occurring issues. Reduce silo concept of funds → Integrated licensing for crisis response entities → Expanded use of technology → Multiple triage centers featuring multicultural staff → Marketing with funding from hospitals, private sources, and grants → Utilize juvenile and adult justice system → Tele-psychiatry/intervention → Urgent Care 	
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