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Mental Health Crisis Services: Stakeholder Process and Plan

Prepared for Travis County Healthcare District

By Health Management Associates

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Introduction

Austin/Travis County, like many communities across Texas and the nation, is confronting the challenges associated with insufficient mental health crisis services. This is not a new issue for this community. However, with the creation of the Travis County Healthcare District, which convened a Stakeholder Group to help resolve long-standing problems in access to inpatient and crisis mental health care, the community had a new opportunity to identify and implement an appropriate solution.

In recent years there have been great strides in the understanding of mental health and mental illness. It is now well understood that mental health plays a critical role in overall health. With timely and proper treatment, most people who suffer from a mental illness can and do recover. Yet, in spite of the advances in mental health treatment, the mental health system remains under-resourced and not well integrated into the overall healthcare system.

In Austin and Travis County, the element of the mental health services continuum that stands out as most significantly below capacity is the crisis system. Lack of access to appropriate services has a profound impact on people facing a mental illness crisis and their families. The lack of accessible services can result in the exacerbation of symptoms, contacts with the criminal justice system, job loss, homelessness and other negative outcomes. In addition to strains on consumers and family members, lack of appropriate mental health crisis services results in strains on other community systems as well. Law enforcement, emergency medical services, hospital emergency departments, and other social service providers are often enlisted to address crises and the aftermath of unresolved crises.

Additionally, crisis services are the point at which many individuals enter ongoing mental health treatment. As a result, an individual's experience with crisis services often determines whether he or she pursues recommended treatment and his or her attitude toward the mental health system. Clearly, it is critical for the local community to build and maintain a strong system of crisis services.

The stakeholder group convened by the Healthcare District was charged with developing short, interim and long-term solutions to the community's need for mental health crisis services. During a 10 month period, the Stakeholder Group worked to craft a solution to the lack of inpatient beds and crisis mental health services in the community. This report describes that process, documents the consensus solution, and outlines the implementation steps necessary to ensure that the proposed solution is achieved.

Problem Statement and Findings

Problem Statement

The Austin/Travis County community, like others throughout the state and the nation, is facing a challenge in meeting the needs of individuals experiencing mental health crises. While the community has engaged in planning processes before, the problem has persisted. Many community systems (e.g. criminal justice, local hospitals) are impacted by the lack of a broad based community solution to the problem. Forging a solution requires a collaborative community approach.

Current Situation

The need for additional psychiatric inpatient capacity and enhanced mental health crisis services is fueled by a number of factors. The current situation, in terms of available resources and utilization and payer trends, is described below.

Reductions in local inpatient beds

Austin/Travis County, like many other communities has seen the loss of inpatient psychiatric capacity both in the public and private sectors. This reduction in inpatient capacity has occurred during a period of significant population growth in the Austin/Travis County area, further exacerbating the pressure on the mental health system. The loss of private sector beds can largely be attributed to changing payer practices. In the late 1980s, there were three free standing psychiatric hospitals as well as a psychiatric unit in a general hospital in the Austin area. Today there is one free-standing hospital serving privately insured and self pay clients and one psychiatric unit in a general hospital, serving only the elderly population. There are no locally owned psychiatric inpatient beds for indigent patients.

Most of the public sector beds needed by this community have been supplied by the local mental health authority's use of their state allocation for inpatient beds within the State Mental Hospital system. As a result, the Austin State Hospital (ASH) has been used to fill the gap created by insufficient local inpatient psychiatric resources. As treatment philosophies have changed and state funding has been constrained, there has been a steady reduction in the availability of state hospital beds across the State, including those at ASH. Unfortunately, the availability of community based treatment alternatives has not risen to meet the demand

State hospital allocation methodology

Since 2001, Texas has been implementing a rigorous state hospital allocation methodology. The Department of State Health Services allocates to each local mental health authority (LMHA) a "prepaid account" to pay for the treatment of the uninsured patients in a state hospital. The LMHA for Travis County is Austin Travis County Mental Health Mental Retardation Center (ATCMHMRC). Austin/Travis County's FY 2006 allocation for state hospital use is \$6,012,761. The LMHA may use this account to

¹ State Hospital Section, Department of State Health Services, <u>Overview of State Hospital Allocation</u> <u>methodology: Key Responsibilities for State Hospitals and LMHAs (Forms and Instructions), Fiscal Year 2006.</u> Revised 12-23-2005, p.53.

pay for acute care, subacute care and/or child and adolescent services, each of which have a per day cost. Once the LMHA has used its allocation, if it still has patients in the hospital and if it continues to admit patients, it will be responsible for unfunded costs.

An additional factor which can affect whether local mental health authorities are able to provide care within their state hospital budget, is the way charges for state hospital use are calculated. A daily rate has been established for uninsured patients, depending on the type of service used (acute care, sub acute or child and adolescent services). Each admission to the state hospital includes an admission charge, which covers the cost of initial tests and assessments. Thus, the use of the state hospital for crisis services, which typically have short lengths of stays, causes faster depleting of the allocation than use of the state hospital for intermediate or longer lengths of stays.

Use of the state hospital for crisis services

Austin/Travis County typically uses more than its allocated state hospital capacity, risking the potential for the state to demand payback for overuse. For the past three years (Fiscal Years 2004, 2005 and 2006), ATCMHMR has exceeded its State Hospital budget, putting it at risk of having to repay the State the amount of its excess hospital charges. While patients from Travis County could be in any of the State's nine state hospitals, for Austin/Travis County the situation primarily involves Austin State Hospital (ASH). The average daily census at ASH (its "capacity") is 265². Patients from Austin/Travis County use approximately 36% of this capacity.

ASH patients from Travis County typically have shorter lengths of stay than patients from other communities. For example, the entire ASH population with lengths of stay between 1 and 10 days is 48% (including Travis County consumers) compared to 54% of the ATCMHMR admissions with lengths of stay between 0 and 10 days.³ The shorter lengths of stay, coupled with the large number of admissions, cause rapid depletion of ATCMHMR's allocation, and contribute to periodic overcrowding at the state hospital.

Austin State Hospital diversions

The Texas Legislature has funded a limited number of state hospital beds for use by individual communities and for statewide specialty services such as forensics. Because the number of beds is limited, occasionally an individual hospital becomes "full", that is, unable to take additional admissions. When a hospital is full, admissions are diverted to other locations. In these instances, the hospital is referred to as "on diversion".

Between April 1, 2005 and March 31, 2006, ASH was on diversion status 64 times, impacting 123 patients. The number of patients affected by each diversion episode ranged from 1 to 6. Some of the patients were eventually admitted to ASH when ASH went off diversion status.4 While the length of each diversion episode was not tracked, it ranged from only a few hours to a few days.

³ Austin State Hospital, HMA data request, April 2006.

⁴ Austin State Hospital, HMA data request, March 2006.

According to the State's diversion plan, when ASH is full, admissions are made first to the San Antonio State Hospital (SASH), which is 90 miles from Austin, and if SASH is full to another hospital even further away. One consequence of this situation is that law enforcement personnel, who typically provide transportation services, incur the expense and time lost to other duties associated with these transports. This situation potentially presents a public safety issue for the community, since officers involved in lengthy transportation duties are not "on the street." When the crisis is quickly stabilized, law enforcement must then repeat the trip to transport the individual back to this community, occasionally as soon as the next day. An additional consequence of diversions is the clinical distress caused to the individual needing treatment, who is transported in the back of a police car for long distances, often restrained, while in the midst of a mental health crisis.

Under the state's Mental Health Code, a person determined to be in need of involuntary mental health services may be transported by a peace officer to (1) the nearest appropriate inpatient mental health facility; or (2) a mental health facility deemed suitable by the local mental health authority, if an appropriate inpatient mental health facility is not available. In 2005, APD and TCSO made a decision to discontinue transporting clients to other SMHFs when ASH was on diversion citing public safety, staffing and client safety concerns. In response to the local need for appropriate settings to evaluate and hold clients in crisis, ATCMHMR designated the local EDs as the nearest appropriate and available facility when ASH was on diversion. This change from past practice posed the potential for new strains on the local emergency facilities.

State crisis re-design initiative

The Texas Department of State Health Services established a Crisis Services Redesign Committee to develop recommendations for mental health and substance abuse crisis services that are delivered by local mental health authorities. The Committee was charged with making recommendations regarding the necessary elements of crisis services that would be provided by local mental health authorities. The Committee's final report⁶ was published in September 2006 and recommended that the following core services should be the center piece of the mental health system of care for individuals in crisis:

- 1. Crisis Hotline Service
- 2. Psychiatric Emergency Services with extended observation services (23-48 hours)
- 3. Crisis Outpatient Services
- 4. Community Crisis Residential Services
- 5. Mobile Outreach Services
- 6. Crisis Intervention Team/ mental health deputy/ peace officer program.

The Department will request additional funds from the Legislature during the 2007 Legislative Session in order to provide local mental health authorities with funding to

⁵ Texas Department of State Health Services, <u>15th Edition Texas Laws Relating to Mental Health</u>, June 2005.

⁶ Texas Department of State Health Services, *Crisis Services Re-design*, September 2006, available at: http://www.dshs.state.tx.us/mhsacsr/mhsacsr.pdf

expand crisis services. It is also expected that the Department will issues rules that will define the core components of the above crisis services that must be present in order to be eligible for state funding.

Currently available crisis services

Austin Travis County operates the Psychiatric Emergency Services (PES) at the Nadine Jay Center, 56 East Avenue. ATCMHMR reports that demand for services has increased dramatically, and their patient data show that the profile of those seeking services is different from those enrolled in ongoing (*i.e.* non crisis) services. For example, in Fiscal Year 2005:

- 80% of clients served at PES were not currently enrolled in ATCMHMR services at the time they presented at PES
- PES served 599 unduplicated out-of-county residents, almost twice the number of out-of-county clients served in FY 04.⁷

PES includes a telephone hotline that is available 24-hours a day. PES also has the capacity to respond to walk-in clients and clients brought by law enforcement, but only during normal business hours. During evenings and weekends, physicians are "on call" rather than on site. The lack of readily available psychiatric clinical support during evenings and weekends often results in consumers using the state hospital or local hospital emergency rooms for psychiatric emergency services.

Overview of current holes in the local crisis mental health system A comprehensive mental health crisis system includes the following elements:

- Crisis hotline
- 24-hour psychiatric emergency services
- Crisis outpatient services (counseling, medication stabilization, community crisis intervention, continuity of care, case management)
- Crisis inpatient services
- Crisis Respite Services
- Mental Health Deputies / Crisis Intervention Teams
- Mobile crisis teams
- Extended observation ("23 hour" services)

While much of the concern has centered on the availability of crisis inpatient services, beds are only one element of the continuum of crisis services. Equally important are the non-inpatient services such as mobile crisis outreach teams and 24-hour assessment services which support an individual during the crisis period. Finally, a sound mental health crisis system also requires strong connectivity and coordination among the various elements, so patient care can be managed across the continuum of services.

Results of a survey by the Texas Department of State Health Services indicate that no community has an adequate array of every one of these critical elements.⁸ However,

⁷ Austin Travis County MHMR, HMA data request, April 2006.

Austin/Travis County stands out among the metropolitan areas of the state as having significant holes in its crisis system. Comparing Austin's crisis service systems to literature on best crisis practices, as well as to other local systems recognized as having strong crisis services, illustrates fundamental major gaps in the local crisis services system. These gaps include:

- Crisis inpatient beds
- Mobile crisis outreach team
- Respite and housing services
- 24-hour psychiatric emergency services
- Prevention services

Insurance Status

While the lack of inpatient psychiatric resources affects people with and without insurance, it is predominantly an issue for the uninsured. Most of the Travis County residents using crisis services at the Austin State Hospital are uninsured.

Austin State Hospital Clients from Travis County, March 2005-March 2006

	Children (under 21)	Adults (21-64)	Older Adults (65+)
Commercial Insurance	5%	5%	5%
Medicaid	30%	2%	3%
Medicare	<1%	12%	46%
Uninsured (no payer source)	64%	82%	46%

Source: Data Supplied by Austin State Hospital, March 2006

The table above shows that for non-elderly adults, aged 21-64, 82% of ASH patients had no payer source. Commercial insurance accounted for only 5% of the payers, while Medicaid and Medicare combined only paid for 14% of the adult stays at ASH. While third party payers funded a larger proportion of the care for children (Medicaid: 30%) and older adults (Medicare: 46%), uncompensated care costs remained significant.

The lack of availability of third party payers is even more pronounced in the payer mix for Psychiatric Emergency Services provided at the Nadine Jay Center. ATCMHMR reported that Medicaid paid for just over 3% of the services for individuals served in the crisis respite beds at the Inn at the Nadine Jay Center, while Medicare paid for less that .5%. The vast majority of care provided (over 96%) had no third party payer source and was therefore paid for with state and local funds. ¹⁰

The low percentage of Medicaid clients and reimbursements indicates that many of the clients using existing crisis and public inpatient services are not Medicaid eligible or have not been able to successfully negotiate the Medicaid eligibility process. While

¹⁰ Source: Austin Travis County MHMR Center, April 2006.

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⁸ Texas Department of State Health Services Community Mental Health and Substance Abuse Services, <u>FY</u> 2006 Crisis Services Review Report, February 2006.

⁹ Interview with Steven Shon, MD, DSHS Medical Director for Behavioral Health Services, and Cindy Hopkins, Special Assistant to the Medical Director for Behavioral Health Services, April 6, 2006.

approximately 32% of ATCMHMR's clients are Medicaid eligible, it appears that the clients entering the system because they are in crisis are less likely to receive Medicaid. Other communities have confirmed that their crisis systems are also heavily used by the uninsured and that Medicaid eligible clients make up a very small portion of those served.

The low reliance on Medicaid to finance crisis services lessens the need to structure future crisis services to maximize Medicaid reimbursement. If Medicaid reimbursement appeared to be a significant funding source for crisis services, the local community would want to develop services that are eligible for Medicaid reimbursement. In particular, this would mean providing those inpatient services in a facility of 16 or fewer beds or within a unit of a general hospital, since Medicaid prohibits reimbursement of inpatient services to non-elderly adults in psychiatric facilities of 16 or more beds.

Community impact

Crisis services are a critical component of a community's mental health services continuum. The failure to provide adequate crisis services can lead to unnecessary incarceration, hospitalization, disruption and separation of families and the costly involvement of various community services, such as law enforcement, the courts and social services. In particular populations, the relationship between the presence of mental illness and the impact on the community is pronounced. A recent review of services provided to Austin's homeless population showed that approximately 39% report some form of mental illness and 50% have a co-occurring mental health and substance abuse disorder. The most compelling indicator of the community's weak crisis services infrastructure may be the area's suicide rate. Travis County has the highest suicide rate of any major Texas county. Is

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¹¹ Texas Department of State Health Services Community Mental Health and Substance Abuse Services, FY 2006 Crisis Services Review Report,

¹² Community Action Network, Frequently Asked Questions About Mental Health, August 2005.

¹³ Ibid.

Approach

From December 2005 – September 2006, the Travis County Healthcare District convened an ad hoc group, known as the Psychiatric Services Stakeholder Committee, to develop short, mid and long-term solutions to the need for more comprehensive and connected mental health crisis services for Travis County. This Stakeholder Group built on the existing work of the community, including the recommendations in the Mayor's Mental Health Task Force and the Jail Diversion committee, to develop a plan to strengthen local mental health crisis services. Minutes from the Stakeholder Group's meetings are attached as **Appendix G**.

Organizations participating on the Stakeholder Group and their principal representatives are listed below:

- Travis County Health Care District: Clarke Heidrick, Board Chair; Trish Young, President and CEO
- Austin / Travis County Mental Health and Mental Retardation Center: David Evans, Executive Director; Dr. Jim Van Norman, Medical Director
- Seton Health Care Network: Diana Resnik, Senior Vice President of Operations; Jesus Garza, Chief Operating Officer
- St. David's Hospital: Richard Hammett, Senior Vice President for Strategic Planning and Development; Caroline Murphy, Division, Ethics and Compliance Officer
- St. David's Community Health Foundation: Dick Moeller, President and CEO
- Travis County Commissioner's Court: Judge Sam Biscoe; Commissioner Margaret Gomez
- Travis County Probate Court: Judge Guy Herman
- City of Austin: Chief Mike McDonald, Acting Assistant City Manager
- Austin City Council: Mayor Pro Tem Betty Dunkerley, Council Member; Lee Leffingwell

At various meetings, other individuals representing the above organizations attended the stakeholder group to provide input.

The Healthcare District retained Health Management Associates to work on behalf of the Stakeholder Group to assist in the development of short, mid-term and long-term solutions to the community's need for mental health crisis services. HMA's contract

began in February, 2006. HMA's scope of work on behalf of the District and the Stakeholder Group included: facilitating stakeholder meetings, reviewing existing mental health services to identify gaps in care, analyzing recent financial and utilization data related to crisis mental health services, developing suggested solutions to enhance crisis services and recommending various metrics/performance measures to be used to evaluate and monitor future crisis services. In addition, HMA monitored the State's efforts to redesign the requirements for state-funded crisis services to help ensure that the Stakeholder Group's work would be aligned with the new State requirements.

Stakeholder Group Charge/Focus

The Stakeholder Group agreed that the focus of its efforts would be to create a stronger, more viable mental health crisis system for the Austin / Travis County community. While the Stakeholder Group acknowledged the importance of a comprehensive and coordinated system of care to both address and prevent mental health crises, they defined mental health crisis services as those services essential to assist individuals negotiate a crisis event, which may take 2-3 weeks to resolve to the point where the individual could transition to traditional (non-crisis oriented) mental health services. Specifically, the Stakeholder Group defined mental health crisis services as:

- <u>Crisis Hotline</u> A round the clock (24 hours per day, 7 days a week) telephone access to crisis counseling or referral to services.
- <u>Mobile Crisis Outreach Services</u> A mobile crisis outreach team provides temporary services to the individuals in the community who need psychiatric treatment but who will not or cannot use the traditional system to access care.
- <u>24-hour Psychiatric Emergency Services</u> The essential elements of this service include immediate access to assessment and treatment for people in crisis.
- Observation Beds Observation beds offer a safe and structured environment for individuals whose care needs are still being assessed.
- <u>Inpatient Crisis Services</u> Inpatient services are necessary for patients who have a high risk of harm or severe functional impairment.
- <u>Crisis Intervention Teams/ Mental Health Deputy Program</u> These programs involve trained law enforcement officers who respond to calls involving individuals who have or are suspected of having a mental illness.
- <u>Crisis Respite Beds</u> Respite beds assist clients who don't have high enough risk or functional impairment to meet criteria for inpatient care, but who require a brief period in a structured environment. Respite beds can be used as either a step up or step down from inpatient services.

Proposed Solution

Short-Term Solution

As a short-term solution to the need for more inpatient beds for clients experiencing a mental health crisis, the Travis County Healthcare District, Austin Travis County MHMR Center and Seton Health Care Network entered into a temporary agreement to place uninsured psychiatric patients in Shoal Creek Hospital, a free-standing psychiatric hospital which is part of the Seton Health Care Network. The District will fund the care for uninsured clients needing inpatient services during periods when Austin State Hospital is at capacity and therefore unable to accept additional patients. As part of the agreement, ATCMHMR is responsible for placing patients and providing follow up care once patients leave Shoal Creek Hospital.

This short-term solution was anticipated to be in place for approximately one year, to provide necessary additional inpatient capacity while a longer-term solution was implemented. The contract between the District, Seton and ACTMHMR took effect on May 20, 2006.

Mid-Term Solution

In developing proposed solutions, the Stakeholder Group focused most closely on the mid-term solution, which was understood to cover a period of the next 3-5 years. The Stakeholder Group developed a proposal to strengthen certain existing mental health crisis services that are currently unable to meet the needs of the Austin / Travis County residents and to develop certain new crisis services that are not currently available.

The mid-term solution addresses the components of crisis services that are currently unavailable or not at sufficient capacity. Specifically, the mid-term solution develops or increases crisis services in the following areas:

• Psychiatric Inpatient Services: Supported by funding from the Travis County Healthcare District, Seton Healthcare Network will bring up to 16 additional beds on line in the Seton Shoal Creek facility to expand local inpatient care capacity for clients experiencing a mental health crisis. Funding by the Healthcare District will allow for approximately 8 of these beds to be used for indigent (i.e. uninsured) clients needing inpatient treatment. A portion of renovation costs will be paid for by ATCMHMR and Seton will cover various expenses associated with administering the additional beds. The Travis County Hospital District will consider a capital contribution to the cost of renovations if all other capital funding sources have been evaluated and deemed insufficient.

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¹⁴ The Stakeholder group had initially planned to increase inpatient care capacity by creating a Crisis Stabilization Unit within Seton Shoal Creek Hospital. However, due to the specific licensing criteria required for a CSU, the consensus was that expanding hospital capacity without creating a separate CSU was the most practical alternative for the mid-term.

- Mobile Crisis Outreach Team: The Travis County Commissioners Court approved \$400,000 for the 2007 Fiscal Year to fund a mobile mental health treatment team. This team will be managed by ATCMHMR and will provide services to individuals unable or unwilling to seek treatment in the clinic environment.
- <u>Housing</u>: The City of Austin approved \$1 million to fund transitional housing for people with mental illnesses. Additionally, the City put forward a \$55 million housing bond (which was approved by voters on November 8, 2006), from which a portion of the funds will be dedicated to housing for people with mental illnesses.
- 24-Hour Psychiatric Emergency Services The current PES services do not provide physician coverage on evenings or weekends, other than on an "on call" basis. In order to provide true 24 Hour Psychiatric Emergency Services, ATCMHMR made a commitment to increase physician coverage and associated staffing within PES to provide appropriate services in the evenings and weekend hours.
- Prevention Services. While prevention services are not a specific component of crisis services, they do play a critical role in alleviating the need for these services. A number of new programs and/or funds were made available to support prevention services. These included: \$812,000 in grants by St. David's Foundation for various prevention programs such as integrated mental health services in primary care settings and school-based mental health services; a three percent increase City's budget for social services; and an increase in funding by the Travis County Healthcare District to expand the E-merge program, an integrated behavioral healthcare program in the community health clinics.

Appendix B outlines the commitments made by various entities to support enhanced crisis services for the mid-term.

Long-Term Solution

A long-term solution, defined by the Stakeholder group as approximately five years out from the present, was discussed in broad terms. In general, the need for a long-term solution was driven by the following factors:

- The need for a facility in the community capable of treating medically complex clients in the crisis/inpatient psychiatric setting.
- The need to eventually develop inpatient/crisis capacity which would be capable of receiving Medicaid reimbursement. While the payer mix for existing inpatient and crisis services makes it appear that Medicaid is unlikely to be a significant payer, the Stakeholders were interested in developing a long-term solution that maximized all available funding sources.
- The acknowledgement that Seton's use of and need for the Shoal Creek facility may change over time and they may need flexibility in the long-term to revise the way the facility is structured.

The issues that the Stakeholders agreed would be important elements of a long-term solution to the need for inpatient crisis services included:

- The ability of the facility providing inpatient services to be eligible to receive Medicaid reimbursement
- The ability of the facility to accept medically complex patients
- The accessibility of the facility to law enforcement i.e. central location, space for officers to complete paperwork, minimal waiting time for law enforcement.
- Maximizing co-location of services to bring as many of the components of crisis services within the same location as possible. Of specific interest to the stakeholders was the desire to have a long-term solution in which Psychiatric Emergency Services, 23-hour Observation beds, and a Psychiatric Emergency Residential facility were all available and co-located.

Implementation Steps

Crisis Services Implementation Team

In June, 2006, a subgroup of the Stakeholders' Group began meeting to begin implementation of a key features of the psychiatric crisis services plan, including creating additional inpatient psychiatric capacity for people in a mental crisis. This group, referred to as the "Implementation Team" is comprised of the Travis County Healthcare District, Austin Travis County MHMR Center, the Seton Health Network and the Austin Medical Education Program. The Team has met at least monthly from June to September 2006 to shepherd the implementation of this part of the plan.

On August 30, the Implementation Team representatives and other community partners, along with other key stakeholders, met in all day session to further their shared vision for crisis emergency services and for implementation of the "mid-term" solution of inpatient services at Seton Shoal Creek Hospital. The group's work remains ongoing.

Implementation Timeline

At the first meeting of the implementation team, an aggressive initial timetable was proposed. The timeline was refined at the August 30th meeting. The following outlines the initial timeline to develop inpatient crisis services at Seton Shoal Creek Hospital, with a preliminary operational target of May of 2007. However, much of the timetable is dependent on the time needed for asbestos abatement and renovation of the Seton Shoal Creek facility and the timeline will be modified as additional information becomes available.

Activity	Target Date for Completion
Develop Operating Plan, and Staffing Pattern	November 1, 2006
Finalize Operation Budget	December 1, 2006
Establish Relationships and Protocols for Major Collaborators	January 1, 2007
Complete Building Renovations	February 1 2007
Develop Community Awareness Plan	February 15, 2007
Training for Law Enforcement	March 15, 2007
Begin Operation of Inpatient Crisis Services	May 1, 2007

Implementation of other components of the crisis services continuum will follow different timelines. For example, the city's commitment to affordable housing is dependent on voter approval in November and the implementation of the Mobile Crisis

Outreach Team is dependant upon final Commissioners Court approval to release designated funds for those services.

Role of the Stakeholders Group

As implementation becomes the focus of the crisis services initiative, the role of the Stakeholder Group will change. The Stakeholder Group agreed to ongoing quarterly meetings during which the Group will monitor the progress of the implementation activities associated with the mid-term plan and will receive data and metrics designed to measure the effectiveness of the newly developed or expanded crisis services. A joint public announcement of the outcomes of the initial work of the Stakeholder Group i.e., the mid-term solution will be undertaken. The Healthcare District agreed to coordinate the announcement with ATCMHMR.

In the future, the quarterly meetings of Stakeholder Group may include other designated representatives of the key stakeholders. The group's purposes will be:

- Monitor the status of funding and implementation of the commitments made by the stakeholder organizations
- Develop and monitor metrics to track impact of the plan
- Collaborate with the Code Red group to work for a regional solution
- Monitor and work to enhance linkages between key elements of the mental health crisis system
- Educate the community, commissioners' court and city officials about the needs and solutions.
- Lay the foundation for developing a long-term solution.

The first quarterly meeting of the Stakeholders' Group is slated for December 11, 2006.

Proposed Metrics

The Stakeholder Group identified the need for objective measures to monitor the effectiveness of the newly developed or expanded crisis services. These measures will be necessary both to justify the expenditure of public funds to create new services and to inform program management and improvement activities.

The following metrics associated with the newly developed crisis services are proposed by Health Management Associates for consideration by the Stakeholder Group and the various entities managing the crisis services. While these measures should be discussed and reviewed by the Stakeholder Group to ensure that the data necessary to track the measure is available, it will be important to identify key indicators of the crisis service system's performance in order to monitor effectiveness and demonstrate to existing and potential funding sources the value these services provide to the community. The proposed metrics may also be useful as "early warning signs" for larger systemic problems, such as inadequate coordination and communication across the various elements of the crisis system. As with most performance indicators, these measures should be tested to determine if they adequately answer the intended question and to

ensure that the data used to derive the measure are accurate and comprehensive prior to using the metric to judge the efficacy of a particular program.

An additional consideration in collecting and using performance metrics for program monitoring and improvement is the degree to which the performance metrics are made available to the public. Public reporting not only provides transparency and education to the public, it is, in and of itself, a performance improvement tool. To paraphrase the National Committee on Quality Assurance, that which is measured improves, and that which is measured and *publicly reported* improves *faster*.

The process for selecting and refining the measures should also include an agreement within the Stakeholders Group regarding how the measures are to be used, including with whom they will be shared. As part of this discussion, team members should consider whether these measures could be publicly reported as part of any larger "health care report card" efforts being developed by the Community.

Proposed Metric	Desired Direction & Explanation	Benchmark
Access Measures:	Ехріанаціон	
ASH Diversion Status - Number of Days ASH is on Diversion	Reduced The availability of inpatient crisis services should reduce the need for ASH services that are currently being provided in lieu of crisis services. Once inpatient crisis capacity exists in the community, the amount of time ASH is on Diversion should be reduced.	Average number of days per month ASH was on diversion for the corresponding month in 2005.
Use of Brackenridge ER for MH Crisis Patients	Reduced The expansion of crisis services, specifically the new availability of the mobile crisis outreach team and additional inpatient services, should translate into fewer consumers using the Brackenridge ER for crisis services.	The average number of patients per month that were seen in the Brackenridge ER in 2005 with a primary mental health diagnosis.
Percentage of clients in jail	Reduced	2005 average percentage of

known to have a mental illness	Many individuals with mental illness are jailed for minor crimes (e.g. trespassing) related to untreated mental illnesses. The availability of a more robust crisis services system, and in particular, a mobile crisis outreach team, should result in fewer people with mental illness being sent to jail.	people in Travis County Jail with a mental illness.
Percentage of APD and TCSO calls which are designated as "welfare checks"	One of the key factors in the creation of the enhanced crisis service system and in particular the Mobile Crisis Outreach Team, was the expectation that it would lessen the burden on regular patrol officers who are asked to intervene in issues mainly driven by untreated mental illnesses. Frequently, this takes the form of law enforcement being asked to conduct "welfare checks" on individuals. Enhanced crisis services should lower the occurrence of regular officers being asked to perform this function.	2005 average percentage of welfare checks being conducted by regular (i.e. non-mental health deputy) law enforcement.
Quality Measures:		11 2
Restraint/Seclusion Usage in Crisis Inpatient Services	Usage of restraint or seclusion can be reduced by appropriate staff training in de-escalation techniques and other preventive measures. Increases in	Average monthly rate for the first year of operation.

	restraint or seclusion or high use of restraint and/or seclusion can indicate potential problems in staff training, ratio of staff to clients or other issues.	
Re-admit to Crisis Inpatient Services within 30 days of discharge	A high or increased rate of readmission could indicate a number of deficits in the system, including: that clients have not be appropriately stabilized before release, that discharge planning was not adequate or that follow up care in the community was not sufficient.	Average rate per first year of operation.

Appendix A – Project Interview List

Sam Biscoe

County Judge

Travis County Commissioners Court

Patrick Crocker, MD

Chief, Emergency Medicine

Brackenridge and Children's Hospital

Aaron Diaz

Program Administrator

Crisis Care Center

Center for Health Care Services

Betty Dunkerley

Mayor Pro Tem

Austin City Council

David Evans

Executive Director

Austin Travis County MHMR

Leon Evans

Executive Director

Center for Health Care Services

Jesus Garza

Chief Operating Officer

Seton Healthcare Network

Richard Hammett

Senior Vice President

Strategic Planning and Development

St. David's Hospital

Jim Hargrove

Executive Director

Housing Authority of the City of Austin

Larry Hauser, M.D.

Chief of Psychiatry

Brackenridge Hospital

Patricia Hayes

Chief Operating Officer (outgoing)

Seton Healthcare Network

Clarke Heidrick

Chair, Board of Managers

Travis County Healthcare District

Sergeant Kitty Hicks

Mental Health Deputy Program Travis County Sheriff's Office

Guy Herman

Probate Judge

Travis County

Nancy Hohengarten

Judge

Travis County Court of Law, No. 5

Cindy Hopkins

Director, Office of Consumer Affairs

Department of State Health Services

Chief Mike McDonald

Acting Assistant City Manager

City of Austin

Rosie Mendoza

Board of Managers

Travis County Healthcare District

Dick Moeller

President and CEO

St. David's Community Health

Foundation

Roger Morin

Community Liaison

Center for Health Care Services

Caroline Murphy

Division Ethics and Compliance Officer St. David's Hospital

Dick Rathgaber

Private Developer

Diana Resnik

Senior Vice President of Operations Seton Healthcare Network

Ellen Richards

Senior Planner Travis County Healthcare District

Carl Schock

Superintendent Austin State Hospital

Steve Shon

Medical Director Behavioral Health Services Department of State Health Services

Susan Stone

Private Consultant Mayor's Mental Health Task Force Monitoring Committee

Mike Turner

Austin Police Department/ Crisis Intervention Team

Stacy Wilson

Assistant County Attorney Travis County

Jim Van Norman

Medical Director Austin Travis County MHMR

Mildred Vuris

Director of Governmental and Community Relations Austin Travis County MHMR

Paul Whitelock, M.D.

Medical Director Seton Shoal Creek

Kari Wolf, M.D.

Program Director Austin Psychiatric Residency Program

Patricia Young

CEO, President Travis County Healthcare District

Tom Young

Board of Managers Travis County Healthcare District

Appendix B – Proposed Commitments

September 18, 2006
Psychiatric Crisis Elements Not Currently Available or in Need of Enhancement in Austin / Travis County

Inpatient Crisis Services	Mobile Crisis Outreach Team	Housing Respite / SRO	PES Additional	Prevention Services
			Physician and other Staffing	
 TCHD Commitments: \$1 million in baseline budget to fund a portion of the operation costs and is prepared to handle up to \$1.5 million in operations to cover any overage. Prepared to make one-time capital contributions when all other capital funding sources have been evaluated. Conditions of Participation: Additional staffing to provide 24/7 coverage of PES must be assured. MCOT must be in place or in process. Seton Commitments: Operating costs of assessment team In-kind donation of floor space to be allocated for proposed solution. Costs associated with management & implementation oversight Costs associated with unfunded medical diagnostic texts & treatment Contribution of Health Plan for oversight and preauthorization	Travis County Commitments: Funding (\$400,000) approved by Commissioner's Court. Conditions of Participation: Baseline data available to determine impact of MCOT on jail utilization by people with mental illnesses.	City of Austin Commitments: • \$55 million housing bond – a portion of which will be dedicated to people w/ mental illness. • \$1.3 million proposal to Council for FY 07 budget to fund transitional housing for people with mental illness (funds from operating budget). Conditions of Participation: • None identified	ATCMHMR Commitments: Conduct efficiencies assessment to reallocate staffing to prioritized PES functions. Reallocate funding for 1 FTE physician (pending board approval). Conditions of Participation: PES must continue to comply with state requirements for crisis services. Structured transition plan to promote continued knowledge base.	St. David's Foundation • \$812,000 in prevention grants TCHD • Board will consider further enhancement of the E-Merge program beyond FY07 budget. City of Austin • Increasing social services budgets by 3%.

Inpatient Crisis Services		
inpatient Crisis Services		
Seton (continued)		
Conditions of Participation:		
Additional staffing to provide 24/7 coverage of PES		
needs to be assured.		
• Commitment needs are a mid-term (3-5 years) solution.		
ATCMIMD		
ATCMHMR Commitments:		
One-time capital from sale of "Helping Hand Home"		
one and captum nome and of Troiping Haile Home		
Conditions of Participation:		
Investment must reduce state hospital usage.		
CSU must be JCAHO Accredited		
Successful sale of designated property.		
CSU able to meet DSHS requirements		
 Utilization Management provided by ATCMHMR. 		

Appendix C – Payer Information

Summary Information on Payer Mix for Austin / Travis County Residents

Austin State Hospital Clients from Travis County - March 2005-March 2006:

	Children (under 21)	Adults (21-64)	Older Adults (65+)
Commercial Insurance	5%	5%	5%
Medicaid	30%	2%	3%
Medicare	<1%	12%	46%
Uninsured (no payer source)	64%	82%	46%

Source: Data Supplied by Austin State Hospital, March 2006

Austin Travis County MHMR Center, Revenue

Inn – Crisis Respite Beds Medicaid – 3.11% Medicare - 0.39% DSHS (uninsured/no payer) - 96.34%

Source: Data Supplied by Austin Travis County MHMR Center, April 2006

Summary of Analysis:

The low percentage of Medicaid clients and reimbursements indicates, on a preliminary basis, that many of the clients using existing crisis and public inpatient services are not Medicaid eligible. While approximately 32% of ATCMHMR's clients are Medicaid eligible, it appears that the clients entering the system because they are in crisis have much lower level of Medicaid eligibility. If this is confirmed to be the case, there is less of financial rational for ensuring that the crisis services are structured to maximize Medicaid.

Additionally, when payer mix and revenue is considered in combination with service utilization, it appears that if crisis service beds, in a CSU or other type of psychiatric emergency facility were available, then the community's need for inpatient beds for longer (14 plus) lengths of stay will be substantially reduced.

Appendix D – Utilization Information

Summary Information on Utilization of MH Services for Austin / Travis County Residents¹⁵

Diversion Episodes at Austin State Hospital*:

From April 1, 2005 – March 31, 2006:

- ASH was on Diversion 64 times.
- A total of 123 patients were affected by the Diversion some were directed to another hospital. Others may have been held until the diversion was lifted.
- The number of patient affected by each diversion episode ranges from 1 -6. Some of those patients were likely eventually admitted to ASH when ASH went off of diversion.
- The length of each diversion episode is not tracked, it can range from a few hours to a few days.

Source: Austin State Hospital, HMA data request, March 2006

Length of Stay at Austin State Hospital for Consumers from Austin/Travis County*

(ATCMHMR accounts for about 36% of the ASH census)

Percent 0-5 days - 31.54%

Percent 6-10 days - 22.68%

Percent 11-15 days - 12.63%

Percent 16-20 days - 6.22%

Percent 21-25 days - 4.97%

Percent 26 - 30 days - 3.23%

Percent over 30 days. – 18.73%

- ATCMHMR consumers with an LOS of 0-10 days 54.22 %
- The entire ASH population with LOS of 0-10 days 48%, a portion of which is driven by the shorter LOS from ATCMHMR consumers

Source: Austin State Hospital, HMA data request, April 2006

ATCMHMR Psychiatric Emergency Services (PES):

- In FY 05 80% of the clients served at PES were not currently enrolled in ATCMHMR services at the time they presented at PES.
- In FY 05 PES served 599 unduplicated out-of-county residents, almost twice the number of out of county clients served in FY 04.

Source: Austin Travis County MHMR, HMA data request, April 2006

Summary of Analysis:

The number of diversion episodes at the Austin State Hospital indicates that the lack of crisis services is placing stress on hospital emergency departments and law enforcement. Relatively

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¹⁵ Some of these indicators could serve as metrics to measure the effect of future crisis services – these are noted with an *.

short lengths of stay indicate that the state hospital is, in the absence of other crisis beds, being used as the provider of crisis services which is not in the best financial interest of the community or the clinical interest of the patient.

Appendix E – Crisis System Components

Crisis Hotline

- Crisis response/intervention
- Crisis prevention
- 24/7/365 availability
- Trained, seasoned responders
- Phone triage
- Access to information, appointments
- Phone counseling ("warm line")

Mobile Crisis Outreach

- Provide care in individual's environment
- Crisis resolution, linkage to crisis services, family support
- Extensive availability
- Trained, seasoned staff
- Coordination with law enforcement (e.g. CIT)
- Collaboration with a range of community providers

24-hour Emergency Psychiatric Service

- Crisis counseling
- Medication stabilization
- Continuity of care/referral/follow up
- Case management

Extended Observation

- 23 hour observation
- Clarification of needs
- Divert inappropriate admission
- Voluntary/involuntary
- Address environment issues
- Linkage to other services

Crisis Respite

- Settings: apartments, group homes, consumers' own homes
- Voluntary; not imminent risk of harm
- Respite from stressful situation

Psychiatric Emergency Facilities

- Crisis stabilization units
- Urgent care
- Voluntary or involuntary
- Short lengths of stay
- Intensive treatment/Linkage to community services

Appendix F – Case Study

Name of Program: NeuroPsychiatric Center (NPC)

Location: Houston, Texas (Harris County)

Brief Overview:

Decreases in funding for Harris County Psychiatric Center, fewer beds available at Rusk State hospital, and fewer mental health benefits for many residents of Harris County highlighted the need for a comprehensive psychiatric emergency program and contributed to the development of NPC. County funds make up a significant source of the financing for NPC and were made available based on the belief that a comprehensive psychiatric emergency program would lower the use of inpatient and emergency care by the indigent/uninsured, and therefore provide an offset to the county's contribution and a benefit for the overall health care capacity of the community.

Components of the NPC program:

<u>Psychiatric Emergency Services (PES):</u>

A 24-hour a day psychiatric emergency room, which serves both children and adults and has the ability to serve both voluntary and involuntary consumers. Approximately 31% of clients are brought in by law enforcement.

Capacity:

10,882 Harris County residents were served in the past 12 months, 53% of which were uninsured or indigent.

Method of Finance:

County funds, state general revenue which is allocated to MHMRA, Medicaid and Commercial Insurance reimbursement¹⁶.

Outcomes:

Of the almost 11,000 consumers served in by NPC, 78% of the adults and 71% of the children returned to the community without incurring the cost of inpatient hospitalization.

23-Hour Observation:

This is a psychiatric intensive care unit within PES (i.e. is not within a separate space, and referrals come from admissions to PES) that is designed to treat and stabilize acutely mentally ill consumers who upon admission meet full criteria for psychiatric hospitalization. Many of the consumers treated in this program are brought in by law enforcement on an involuntary basis. The program is assertive in its use of pharmacological interventions. ALOS is 13.6 hours.

Capacity:

961 Harris County residents were served in the past 12 months.

¹⁶ Medicaid and Commercial reimbursement are pursued, but according to program officials, it is a time consuming, labor intensive process for minimal reimbursement.

Outcomes:

Of the consumers served in the 23 hour observation program, 70% returned to the community without incurring the cost of inpatient hospitalization.

Crisis Stabilization Unit (CSU)

The 16 bed CSU provides hospital-like services in a less costly, less stigmatizing and less restrictive setting than inpatient hospitalization. The program is designed to serve *voluntary* consumers who can be stabilized and linked to community supports within three to five days.

Capacity:

1,582 Harris County residents were served in the past 12 months, an average of 132 consumers per month are served in the unit, with an average length of stay of 3.4 days.

Method of Finance:

The cost of a CSU bed is approximately \$307.00 per day (vs. approximately \$500 per day for inpatient care), inclusive of medications and physician services. The CSU is paid for primarily with county funds. Medicaid financing was not pursued because the majority of clients (60%+), are uninsured or indigent. While some may be eligible for Medicaid, they are usually too unstable in their mental health and housing situations to be able to complete the Medicaid eligibility process.

Outcomes:

The number of voluntary adult admissions at Harris County Psychiatric Center has decreased to less than 40 consumers per month, freeing up bed capacity for uninsured consumers needing involuntary treatment.

Mobile Crisis Outreach Team (MCOT)

MCOT provides emergency and urgent crisis outreach and follow-up by traveling to locations and evaluating adults and children in the community who cannot or will not access traditional psychiatric emergency room care. Services provided by MCOT include triage, assessment, rehabilitation and counseling, medication/nursing, and monitoring and linkage. Inpatient hospitalization is avoided through the use of preventative medicine, reducing the likelihood that a person will become dangerous to self or others. Follow up visits are provided to insure linkages into outpatient services. The program interfaces and complements the Crisis Intervention Team by intervening with those consumers who do not warrant detention or before emergency detention become necessary. MCOT staff carry a client on their caseload until the client is linked into services or the crisis is resolved – usually about 4-6 weeks. The average caseload is about 4-6 clients per staff member.

Capacity:

2,352 Harris County residents were served in the past 12 months - an average of 196 persons are served per month, with an average of six services provided per consumer.

Method of Finance:

County funds

Outcomes:

42% of those served by MCOT were linked into MHMRA outpatient services, 3% to substance abuse programs, and 22% to other agencies or providers. 4% required linkage to inpatient hospitalization.

Crisis HelpLine

The helpline is a 24-hour-a-day telephone service providing crisis hotline and information and referral services to all Harris County residents needing emergent or urgent psychiatric services. For many consumers, it is the first source of contact. HelpLine staff work with the caller to determine the next steps and make referrals to services.

Capacity:

2,250 crisis calls per month were received in the past 12 months

Outcomes:

The Crisis HelpLine helps decompress the NPC and Ben Taub psychiatric emergency services by triaging non-emergent problems to routine outpatient treatment centers.

Crisis Residential Unit (CRU)

The 18 bed CRU¹⁷ is designed to serve voluntary consumers who are judged to be able to be stabilized and linked to community services within 7 -14 days of treatment while living in the CRU. Average length of stay is 10-14 days. Therapeutic interventions include cognitive behavior therapy, psycho social rehabilitation, Good Chemistry (a nationally recognized program for alcohol and drug addiction) skills training and individual therapy. The program targets homeless, dually diagnosed, indigent consumers, those clients that are "frequent flyers" within the community's emergency rooms. A Crisis Counseling Unit (CCU) is operated in conjunction with the CRU to provide timelimited outpatient therapies (the cost of crisis counseling is included in the cost of the crisis respite beds, with CRU staff providing the services.) The CCU averages four visits per consumer, at a cost of approximately \$150.00. Emphasis is placed on the definitive resolution of a crisis.

Capacity:

Approximately 44 consumers are served per month in the CRU, with an average length of staff of 11.2 days.

Method of Finance:

Method of Finance:

County funds pay for the CRU.

¹⁷ CRUS are well established nationally as effective alternatives for many consumers experiencing a psychiatric emergency who do not need the more restrictive settings of a CSU or inpatient facility.

Outcomes:

51% of the consumers served were linked to an MHMRA clinic, 19% were linked to substance abuse treatment, and 9% were linked to Harris County hospital district clinics or medical treatment. Program staff believe that the CRU has been moderately successful in preventing hospitalizations, but this has been difficult to document with current data systems.

Information Sources:

- 1. Handout provided by NPC to State Crisis Redesign Team, *NPC Accomplishments*, 2005.
- 2. Presentation by Dr. Avrim Fishkin to State Crisis Redesign Team, April 11, 2006.

Appendix G – Minutes of Psychiatric Services Stakeholder Group

Psychiatric Services Stakeholder Meeting

December 14, 2005 – 4:00–6:00 p.m. Cesar Chavez Building (1111 East Cesar Chavez) **MEETING NOTES**

Attendees:

Clarke Heidrick

Trish Young

Rosie Mendoza

Jesus Garza

Pat Hayes

Mike McDonald

Guy Herman

Richard Hammett (for Jon Foster)

Dick Moeller

Carol Clark

Betty Dunkerley

Tom Coopwood

David Evans

Jim Van Norman

Toby Futrell

Edith Moreida (for Margaret Gomez)

Ellen Richards

Clarke Heidrick, Chair of the Travis County Hospital District facilitated the meeting.

Meeting Summary

The Travis County Hospital District (TCHD) is working to identify its role in addressing the issues of individuals with mental health needs and recognizes that the issue of inpatient psychiatric services is a priority for this community. TCHD also recognizes that, as a single entity, it cannot solve the issues alone.

The stakeholders brought together for this meeting are tied to the issue of mental health services in some way. The purpose of bringing the group together is to identify a collaborative approach for addressing the needs around inpatient psychiatric services.

Mr. Heidrick asked each stakeholder present to discuss the issue from his/her perspective and identify his/her interests related to the issue. Following is a brief summary of the issues and interests.

• Develop a solution within a six month timeframe that everyone can support. Ensure that solution is clearly defined and can be implemented.

- Public safety concern for staff and visitors in hospitals when individuals experiencing psychiatric crisis are brought to emergency room.
- When officers are transporting individuals in crisis to other counties, this presents challenges related to providing adequate back-up for the police department.
- Crisis prevention and adequate, timely community based services are important pieces to maintaining people in the community. More effective and available community based services can save money in other parts of the system (e.g. less time in jail). Ensure availability of a continuum of care that is based on best practices.
- Develop local bed capacity within Travis County.
- Agree to work together to address issues beyond the current crisis.
- Identify opportunities for new partnerships to creatively address the issue (e.g. City/County partnering to provide housing for the mentally ill).
- Maintain the economic viability of Brackenridge Hospital.

Proposal by TCHD:

- Meet monthly
- Hire an independent consultant to help the group develop possible solutions
- Stakeholder group provided opportunity to comment on the statement of work sent to potential consultants.

Proposal approved.

Psychiatric Services Stakeholder Meeting

January 18, 2006 – 4:00–6:00 p.m. Cesar Chavez Building (1111 East Cesar Chavez) **MEETING NOTES**

Attendees:

Clarke Heidrick

Trish Young

Jesus Garza

Pat Hayes

Chief Michael McDonald

Richard Hammett

Dick Moeller

Carol Clark

Caroline Murphy

Judge Guy Herman

Jim Van Norman

David Evans

Commissioner Margaret Gomez

Councilmember Lee Leffingwell

Stacy Wilson

Clarke Heidrick, Chair of the Travis County Hospital District, facilitated the meeting.

Meeting Summary

Mr. Heidrick introduced new participants and reviewed key points from the first meeting:

- The City of Austin can play a role by providing intermediate and long-term facilities for people with mental health needs.
- David Evans from ATCMHMR pointed out that the community has all the plans we need and the next step is action.
- Key now is to focus and do something, not talking and doing nothing.
- We are now dealing with the consequences of inadequate investments in mental health.
- No one participant was willing to take on the whole thing but everyone was willing to play a role by at least providing expertise.
- Group agreed to get proposals from consultants, which we accomplished since the last meeting. Reason for getting the consultant was to gather facts in a neutral, independent document with proposed solutions.

General discussion expanding on the last meeting continued:

Jesus Garza from Seton put forth the idea that sustainable funding solutions for mental health include governmental bodies maintaining their current commitments to mental health so that funds contributed by the District is new money, not replacement monies that have been taken out by other bodies.

Chief McDonald anticipates that the City of Austin will maintain the position that it has taken in the past, which is to maintain the current funds dedicated to mental health.

Mr. Heidrick reiterated that while the group needs to clarify roles, the current need is to focus on the issue at hand, what's right for the community, and then address how to fund identified solutions.

Trish Young reviewed the process for securing the mental health consultant. Varying opinions were expressed about the background of the consultant to be chosen. Affirmation that the contract requires disclosure of previous relationships.

Discussion from previous meeting about the significance of Medicaid reimbursement of services was addressed. St. David's and Seton researched the issue in the interim. A clear answer to the question was not available but key issues were identified:

- Need clarification of the population to be served and the expected financial need.
- Individuals 21 and younger can receive some type of Medicaid reimbursement. Individuals older than this cannot receive reimbursement in a free standing hospital.
- Opportunity exists for DRG payments for older patients.
- Reimbursement opportunities expand if the inpatient facility is managed under an acute care facility license.
- Need to understand patient mix from other facilities in Texas.
- Medicaid reimbursement will not be significant enough to solely determine the direction of the process at hand.

Discussion about proposals to make available additional inpatient beds on an interim basis at ASH and/or Shoal Creek was discussed. Key issue seems to be identifying a payor source for additional beds as capacity sometimes exists within the community. Both proposals are based on the premise that cost is only incurred if a bed is used. St. David's Pavilion will also take clients that are appropriate for program if there is a payor source. Lengthy discussion ensued regarding the specifics of these proposals. Specific question was expressed as to whether beds at ASH would create new capacity or just a payor source for people being accepted by ASH currently. Discussion about Shoal Creek and how staffing levels determine available capacity – when they don't have sufficient staff they stop accepting patients. Beds at Shoal Creek would definitely create new capacity as long as persons placed there are not patients that could be served at ASH. District and ATCMHMR will move forward with getting more information about the proposals and to answer questions posed during discussion.

Discussion of whether another option would be to find a way to purchase transportation services so that if hospitals in Travis County are on diversion there is an option to transport to another county. This could be one piece of a broader solution.

Question regarding current protocols at Psychiatric Emergency Services (PES) and whether these can be changed in some way to accommodate more patients so that individuals in need are not using acute care hospital beds unnecessarily. General discussion occurred regarding whether the current PES service array could be enhanced or adjusted to provide more short-term intervention that would avoid hospitalization.

Lengthy discussion about how Travis County is using the current state allotment for beds at ASH – current allotment is approximately 58 beds/day but Travis County is using 70-75 on average. The policy is for state to charge the local mental health authority for using beds over the allotment. However, this policy was suspended for the first quarter while the state conducts a review of the current situation – a significant number of communities are over their allotment. Discussion revealed that other large urban counties are not using their allotments at the same rate as Travis County and insufficient service array in Travis County results in unnecessary hospitalization.

General discussion about activities at the state level – a statewide committee has been established to review crisis services statewide. Eduardo Sanchez appears committed to trying to secure additional funds for mental health services.

Point made that as the group moves beyond an interim solution it is important to carefully evaluate the data to see if the solution is more beds or something else. Additional service needs exist beyond inpatient beds and emergency services. A mapping effort is currently underway to identify the current array of services and how they are funded.

The District asked its attorney to identify if there are obligations or preclusions around how mental health services can be provided. Assistant County Attorney, Stacy Wilson, believes that the issue is not clearly defined in law – local entities can come up with their own arrangements to fund mental health. Districts can provide mental health services but are not required to do so. The same applies to other local entities. Additionally, the law does not clearly define mental health services nor the components within the array of mental health services that are considered medical services. An amendment to the State Constitution says that cities and counties are not precluded from providing mental health services where there is a hospital district and the district provides such services.

Final discussion occurred around what impacts an entity and its ability to commit resources to the issue. Flexibility indicates that we can voluntarily come together to address the mental health service needs of the community. Some members expressed a preference to take a flexible, voluntary route than be directed by a specific law.

Psychiatric Services Stakeholder Meeting

February 27, 2006 – 4:00–6:00 p.m. Cesar Chavez Building (1111 East Cesar Chavez) **MEETING NOTES**

Attendees: Stakeholders

Clarke Heidrick Trish Young Bobbie Barker David Evans Jim Van Norman Richard Hammett

Richard Hammett

Carol Clark

Judge Biscoe

Judge Herman

Jesus Garza

Councilmember Lee Leffingwell

Councilmember Betty Dunkerley

Chief Mike McDonald

Attendees: Health Management Associates

Therese Ruffing Kim McPherson Karen Hale Barbara Edwards

Attendees: Staff Ellen Richards

Mr. Heidrick welcomed everyone and started the meeting by saying that he needed a remedial lesson on what issue the group is addressing even though it was discussed at the first meeting. Sometimes he thinks it is inpatient beds, sometimes crisis stabilization services, but that it is not always clear because it is a complex issue that the group is tackling.

Mr. Heidrick recalled the first meeting at which the group agreed to hire a consultant that is neutral, can present the facts, develop solutions and price options. He indicated that the consultant had been selected and asked Trish Young to introduce the consultant.

Ms. Young reviewed the process for hiring the consultant:

- Six proposals were submitted in response to the RFS all of which were reviewed by a review team of District staff
- The review team sent follow-up questions to four proposers
- The review team, plus Trish Young and Mildred Vuris from ATCMHMR, conducted interviews with three of the proposers

The review team selected Health Management Associates because they bring both national and local perspectives to their work and bring team members with significant financial experience. This group was also selected by the District to conduct their strategic plan development and it is expected the overlap of the projects will provide economies of scale. Ms. Young introduced the four members of the consulting team present for the meeting: Karen Hale, Kim McPherson, Therese Ruffing and Barbara Edwards.

Ms. Young reminded the group of the discussion at the last meeting about two short-term proposals to make beds available at ASH and/or Shoal Creek. Since the last meeting, a group met with Shoal Creek to get more details on the proposal. A similar meeting with ASH was canceled due to illness of one of the participants. Shoal Creek is a viable option for creating some additional bed availability but it cannot be predicted in advance – the availability depends on the census of Shoal Creek on any given day. ATCMHMR would manage the use of the beds in terms of screening, approving admissions, utilization management, etc. This option could be made available fairly quickly provided an agreement is established without too much difficulty. The value of Shoal Creek is that admissions and discharges are easier to complete and the doctors conduct rounds every day so patients do not stay longer than necessary. Shoal Creek can only accommodate voluntary commitments and their ability to take a patient is dependent upon the mix of patients on any given day.

It is possible that a combination of both options will create the best solution. The mental health committee of the District Board has engaged in initial discussions about the proposals. Ms. Young will be identifying how much funding the District could dedicate. A proposal will go forward to the District Board in March.

Judge Herman asked for clarification on the purpose of the solution.

Ms. Young replied that the intent is to create a short-term solution to the inpatient bed issue while the group explores more permanent solutions. The short-term option would provide some additional capacity when it is needed, such as when ASH is on diversion and could also help to divert admissions so that ASH does not go on diversion.

Lengthy discussion about over use of beds at ASH -- because of the lack of availability of services that are less intensive and/or preventative in nature, individuals end up in the state hospital in crisis.

The Shoal Creek proposal could accommodate individuals who get sent to ASH because there is no payor source. The proposal could also address voluntary commitments.

Lengthy discussion around who goes where and who pays that cannot be answered at this time. Additionally, each stakeholder grapples with different challenges around this issue. There are a number of questions that need to be answered about how individuals are handled at ASH depending on how they get there – by walking in the door versus being brought by a peace officer, etc. Stakeholders interacting with individuals in crises face

challenges with how to handle these patients, their specific situations and who will accept them for inpatient services.

Judge Herman does not believe that there is a crisis currently related to inpatient bed availability – he stated that only two people have been dropped off at the ER since the change in September.

Issue raised concerning the mental health needs among veterans returning from Iraq. Is there a possibility to work with the VA or the feds to address these needs.

Question about additional state funds for mental health and whether those funds will help the local situation. According to Dr. Van Norman, the additional state funds will mean additional forensic beds at ASH which will help the situation at the jail. There will be 24 additional beds total but we will get 18-20 of those.

HMA joined the stakeholders at the table to begin dialogue with stakeholders around the issues as they seem them. HMA is directed to come up with a plan that has an immediate focus of how to make permanent expansion in inpatient bed capacity. They are to focus on the crisis issue but within the context of the larger issue/need.

Additional introduction of HMA. Firm was founded by former State Medicaid directors that wanted to continue in the health policy arena but not by working on the issues as part of state systems. The team is Austin based but brings benefits of national best practices and creative financing strategies used around the country. The team includes Barb Edwards from Ohio as well as two finance people from out of state, Dave Ferguson and Jane Longo.

A simple diagram of the continuum of mental health services for adults was presented and discussed.

HMA is interested in hearing from the stakeholders how they define the needs in the community.

Jim Van Norman described psychiatric emergency services as an ambulatory urgent emergent clinic that cannot hold people involuntarily. This highlights a gap in the system when ASH is on diversion and the CITs will not drive people out of town. When ASH is on diversion we have no place to hold people. From his perspective, the community needs short stay inpatient beds that provide an alternative to ASH in appropriate circumstances and provides an option for Law Enforcement when transporting. Need to create a balanced system so that we don't create a crisis driven system. We would like to see an expansion of outpatient services to help prevent crises and support the reintegration into the community of people coming out of ASH or other inpatient facilities.

Challenge for the County is people who are in the jail and identified as seriously mentally ill. The County has created a court system that tries to help people with mental illness

but when people are released and there are no services in the community, they wind up back in jail. Issue raised about how the police handle people who have committed an offense – they charge these folks and take them to jail rather than evaluating whether they have a mental health condition. This creates more pressure on the jail. When individuals are incarcerated and no one is aware they have a mental health issue – they don't get the services they need and some commit suicide or attempt suicide.

Chief McDonald indicated that he would look into the matter with how the police department is handling cases.

Discussion about how patients are handled when ASH is on diversion. Lengthy discussion/explanation about the Crisis Intervention Teams and how they function. Opinion expressed that it is a public safety issue when patients in crisis are dropped at the local ERs.

Chief McDonald agrees that if someone commits a crime such as assault and has a mental illness then the public safety issue needs to be considered when deciding where to take the individual.

Discussion of how the current mental health system in Travis County evolved and whether it should look like the systems in other communities.

Need to investigate the utilization of ASH – does Travis County over use beds at ASH, who ends up at ASH and are these appropriate referrals, etc. Need a full understanding of how the current system works, the challenges and barriers to treatment.

Need to fully explore what the role of the various entities around the table will be with regard to mental health. Improvements in the system and additional investments could help reduce the cost and strain on other parts of the system such as jails and law enforcement. Interest expressed in understanding what is working in other communities – successful interventions and effective relationships amongst funders. Need to clearly understand options for financing including funds from every level of government.

Mr. Heidrick proposed that at a future meeting the group have a discussion about roles and responsibilities that is facilitated by a professional.

Identified next steps for HMA:

- --finalizing interim temporary solution in March
- --definition and strengthening of crisis services and impact on inpatient utilization by June
- --review of the entire community and array of services including a permanent inpatient solution by October

HMA will keep the group informed as they move forward so that the stakeholders will have an opportunity to give input and feedback. HMA wants to test any assumptions with the stakeholder group.

Issue raised that two public forums have occurred at which the solution presented is beds at Brackenridge. If this process is going to work then we need to agree to refrain from identifying solutions prematurely. There are varying points of view. Request that if we are still trying to figure out what to do, then we should not be airing issues/solutions prematurely in public.

April meeting – facilitator to begin roles and responsibilities conversation.

Psychiatric Services Stakeholder Meeting

March 27, 2006 – 4:00–6:00 p.m. Cesar Chavez Building (1111 East Cesar Chavez) **MEETING NOTES**

Attendees:

Stakeholders

Jim Van Norman

David Evans

Clarke Heidrick

Trish Young

Tom Young

Bobbie Barker

Lee Leffingwell

Betty Dunkerley

Chief Michael McDonald

Dick Moeller

Jesus Garza

Diana Resnik

Judge Biscoe

Judge Herman

Consultants

Barb Edwards

Kim McPherson

Carla Penny

Staff

Ellen Richards

Edith Moreida for Commissioner Gomez

Discussion

Clarke Heidrick opened the meeting and reviewed the agenda – focus for the meeting is a presentation from HMA. Mr. Heidrick introduced Carla Penny, a facilitator that will assist with future meetings. Ms. Penny provided information on her background – 20 years experience with change consulting and 15 years working in mental health arena.

Trish Young gave an update on the interim proposal to purchase additional inpatient bed capacity. The District Board approved funding to purchase beds at Shoal Creek for voluntary admissions. ATCMHMR will coordinate the use/access to the beds. The possibility of buying beds at ASH fell through because of additional funds allocated by the State for services at ASH which meant that ASH will not have unused capacity. In recent months the average number of voluntary commitments has been 16. This funding will allow these individuals to receive services at Shoal Creek and will hopefully prevent ASH from going on diversion. District Manager Bobbie Barker requested that the District track who is being served with these funds.

Presentation by HMA

Kim McPherson indicated that HMA would cover two areas in the presentation: evidenced based practices and Medicaid financing. These two pieces of information can help inform the decision making process as the group moves forward with a review of the system and the components that are needed.

Presentation and discussion was as follows:

Critical Components of a mental health system

- No wrong door system is accessible via multiple points of entry
- Use of evidenced based practices programs that have demonstrated positive outcomes in controlled research and real world application. Includes Assertive Community Treatment, Supported Employment, Medication Algorithms, Integrated Mental Health and Substance Abuse Services, Family Psycho Education and Illness Recovery and Management.
- *Crisis Services* Key components include 24/7 response capability, on-site intervention, triage and short-term crisis facilities, strong connection to outpatient services, and continuum of care including outpatient services. Examples include Green Oaks Hospital in Dallas.
- Interagency Collaboration Smooth interactions between agencies and even blended funding are critical for providing seamless services patients who cross multiple systems. Example includes Wraparound Milwaukee in Wisconsin.
- Criminal Justice partnerships and programs Significant overlap between individuals interacting with both mental health and criminal justice systems.
 Programs need to recognize and address this. Example includes Bexar County Jail Diversion Program.
- Resource Management Helps ensure that resources are maximized and that patients have access to the services of the proper intensity and duration.

HMA will be looking at the current service system in place in Travis County to identify if the key components identified are in place. The key to the effectiveness of evidenced based practices is ensuring proper intensity and duration in order to achieve the documented outcomes.

Success, in part, may depend upon addressing co occurring mental health and substance abuse issues.

In reference to the Green Oaks model (crisis services), concerns about NorthStar (privatized Medicaid managed care system in North Texas) were raised. HMAs reason for using Green Oaks as a possible model is that it appears to have components that are effective, particularly, strong connections to community based providers. Additionally, both public and private payors are interested in the program.

Individuals with mental health issues who enter the jail system are going to consume more resources than those who are diverted so diversion programs are important to maximize resources.

Presentation by HMA -- Best Practices and Medicaid Considerations

Medicaid is based on a medical model so certain types of services are not covered such as housing outside of an institution.

Medicaid – *What is Covered:*

- Prescriptions
- Physicians (including psychiatrists)
- Allie mental health professionals (counseling)
- Rehabilitation services (skills training, counseling) for seriously mentally ill
- Targeted case management for seriously mentally ill
- Inpatient psychiatric services in a general hospital

Medicaid – What's not Covered

- Housing
- Any benefits for people who are incarcerated
- Substance abuse counseling for adults
- Any benefits for adults ages 22-64 who are residing in an institution for mental disease (IMD)

Medicaid – Who is Covered

Must be a poor legal resident and fit into one of the following major categories:

- Aged
- Blind
- Disabled
- Minor child
- Parent of a minor child
- Pregnant

Medicaid – Program Structure

- Jointly funded by State and Federal governments
- Federal reimbursement tied to certain rules:
 - Services cannot be restricted to certain localities must be available statewide
 - o Same level of service must be available to all clients
 - o Client must be allowed to go to any Medicaid provider
 - States must provide reasonably sufficient services in terms of amount, duration and scope
- Waivers allow states to amend these rules but must be approved by State Medicaid agency and Federal Government

IMD Definition and Exclusion

• A hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment or care of persons with mental diseases, including medical attention, nursing care and related services.

- Federal prohibition against Medicaid refinancing of state hospitals.
- Medicaid payments still available for those under age 22 if receiving active psychiatric services and those aged 65 and older

Medicaid – Options to Consider

- Maximize Medicaid revenue for inpatient psychiatric admissions from Travis County
- Assure Medicaid eligible beneficiaries are effectively reconnected with Medicaid coverage for follow-up services at discharge

Discussion about Medicaid and other financing:

Option to consider is to try and maximize Medicaid revenue as long as it is in line with where we want to go as a community.

Dispro is designed to reimburse hospitals for services they provide for people who are not covered by Medicaid. It's an exception to Medicaid.

1115 Waiver allows broad authority to waive certain requirements. Has to be budget neutral to federal government. Waivers serve as pilots that are then implemented across the state.

Psychiatric beds in a hospital can be covered by Medicaid as long as they do not constitute more than 50% of the total hospital beds (based on who is covered). Medicaid will cover individuals in a freestanding psychiatric hospital that is licensed under an acute care license.

Medicaid is over half of all the public dollars in the mental health system. ATCMHMR bills \$1.2m in Medicaid a year. The total in TC for all Medicaid is \$250 million so mental health is a small piece of the total.

Lengthy discussion about the difficulties around financing. Waivers are political in Texas. The feds are reviewing state claiming for Medicaid – states were too creative and feds think that states are overclaiming. Feds are going to clarify the definitions in some areas which will likely result in cutbacks in Medicaid reimbursement.

Discussion turned to the next meeting and next steps. Group agreed that a discussion about roles and responsibilities at the next meeting would be premature. Want to understand what services and system components are being considered before discussing roles and responsibilities. Governmental entities are beginning their budget processes and will need something definitive to propose in the upcoming budget year (October 2006 to September 2007). The group will focus on the priorities they identify amongst those proposed by the consultant at the next meeting.

The group agrees that next steps should be carefully considered so that investments made are effective at addressing the problem and do not create unintended consequences. Support overall for a balanced system that helps address and prevent crises.

Key Questions/Requests

How are the resources currently being spent in Travis County so that we can understand what's happening now?

What are the components of a system and what are best practices within those components and who normally funds those components?

What is the identified need that we are trying to address? Based on the interviews conducted thus far by HMA – unmet need is being defined differently. Most commonly identified need is crisis beds. Also hearing concerns that there are not sufficient services that would prevent crisis or help people when they get out of the hospital. This is a challenge even for people with a payor source.

Can we get an analysis of who is going to into state hospital now? What is the payor source?

Psychiatric Services Stakeholder Meeting

April 24, 2006 – 4:00–6:00 p.m. Cesar Chavez Building (1111 East Cesar Chavez) **MEETING NOTES**

Attendees
Trish Young
Tom Coopwood
David Evans
Jim Van Norman
Caroline Murphy
Clarke Heidrick
Mike McDonald
Jesus Garza
Diana Resnik
Dick Moeller

Consultants
Carla Penny
Barb Edwards
Karen Hale
Kim McPherson

Staff Ellen Richards

Clarke opened the meeting. Introduced Carla Penny to facilitate the meeting. Postponed role and responsibilities conversation. Group has a lot of substantive issues to discuss and it made sense to have Carla facilitate this meeting. Need to discuss the role of the District in behavioral health. District doesn't want to hold itself out as a second MHMR – the District's natural role is one of facilitating and funding discrete pieces of the continuum of care as determined by the District Board. When the District Board agreed to fund \$500K for inpatient psych beds, there was discussion that the piece the District is engaging in could be so big that it is unable to make a significant impact and it will dedicate all of its resources to one issue.

Carla opened the discussion to look at the graphic provided by HMA. Two concentric rings. Inner ring is crisis services. Outer ring is supporting services. What services do people need to get through the first week or two of a crisis event? What are the services that are tied to those immediate needs? There are additional service needs obviously but are outside the scope. The two to three week period is the entire time someone may need help getting through.

Is everyone in agreement? Question:

Before additional resources are committed, need to know if there are dollars being spent inefficiently that can be redirected or is it new money. Are we oversubscribed in some places and not others? Need to know this before committing additional resources.

If the group agrees that this is the range of services that we need, how we get there is the next question.

To adequately address the middle you will need a tax increase, then who is going to step up and ask for a tax increase. Where do you get the dollars? If we have more needs then funds, then we have to go look at what we are funding now.

If we can decide what we want in the system and what we are missing and agree that we want to address them and then we can look at the financing.

Point brought up that the State is looking at crisis services. We've learned that we need to look at the system to see if we can identify better ways to allocate funds currently in the system from various places.

We have to assume that there will be new funds, we cannot just reallocate.

District's objective is to use dollars available and ensure that they add to any existing expenditures, not supplant.

City perspective. In the upcoming budget year, it will have issues that are going to impact its ability to continue to do what it does now. It is going to have to cut significantly from social services to cover other needs. Will probably delay bond package among other things.

Want to make sure everyone is on the same page about what it is that we are talking about addressing, so we are using common language.

The Group is not the only ones addressing this issue – State redesign efforts are underway– identifying what are best practices in crisis services, what pieces need to exist and what are the standards for care. They plan to complete their work by mid summer. This will be used to make a legislative appropriations request. How can our local effort have synergy with other efforts? In our local process we need to be in alignment with what the State is doing. State says that there is not a community in Texas that has all the services that they need in crisis services. Inpatient beds is not the only issue, there are a number of other services that are important.

Review of crisis system components - handout

Hotlines – Need to be available 24/7 and handled by trained seasoned professionals ATCMHMR does provide a hotline with a live person that answers phone. Could be strengthened.

Mobile crisis outreach – teams that address people's needs in the environment where they are – at home, on the street, in the ER, etc. Expect extensive availability. Important collaboration with law enforcement and community based providers. It's a clinical response. Can proactively check with individual over next couple of weeks. In some

communities it can prevent the need for law enforcement. Short term, carry a caseload, intended to resolve crisis and get client linked to other services.

TC does not have this currently. Previously had the service. ATCMHMR agrees this is a gap in our service. Here some law enforcement are doing wellness checks which takes the time of law enforcement this could be done by a mobile crisis outreach team.

Clarification on what happened previously – ATCMHMR will provide info on what we had with state funding and then what happened once it was lost. Not available to the general population. There are assertive community outreach teams but these are for the sickest of the sick, small portion of the population. Very expensive, highly intense. Key difference with MCO – available to anyone and not necessarily staffed by as high a level of professional. Perception is that when we had it, it was helpful.

Emergency psychiatric services – place where people in crisis can go or be taken. Brief counseling from clinicians, medication stabilization, access to other services e.g. case management. Outpatient services designed for extensive availability. Can also include extended observation capabilities. Can have more extended observation – more time. This can prevent hospitalization, sometimes delay hospitalization so that length of stay is shorter when hospitalization is necessary. Need good connection to medical services. ATCMHMR operates Psychiatric Emergency Services. It has three 23 hour beds – all voluntary. This number of beds is not sufficient. There is not a doctor there 24/7, but is available on call - and this limits capabilities certain times of day. State may change standard and require urban areas to have a doctor 24/7 on site. Issue that PES is only voluntary – no capacity to hold anyone against their will.

Crisis Respite – variety of services in a variety of settings. Travis County has this.

Psychiatric emergency facilities – place – crisis stabilization units, can be beds in a general hospital or a psychiatric hospital. Generally short stay (10 days or less). Linkages to ongoing treatment. Every system defines it differently in terms of number of hours or days.

Don't currently have this. Because we don't have local ability to hold patients involuntary, we are using the state hospital for this purpose – it's serving as a crisis stabilization unit so we have a short length of stay. This is the most easily identifiable gap.

Services need to be well coordinated with one another – good linkages. For example, if an individual stays in a crisis stabilization unit, after stay, a mobile crisis team may go out to visit once individual has moved home or to other setting.

We have a number of these services but as funding has been decreased or stretched, the intensity or quality of services has declined. Service intensity is thin and it's easy for clients to fall through.

Explanation of ATCMHMR situation – requirements by the state are intensive and if services are not provided according to the state stipulations, the mental health authority is

sanctioned. So while state resources are available they come with strings attached and aren't available for crisis services. Not much flexibility. People who come to ATCMHMR in crisis, if they don't meet state definition for service, then they don't get helped beyond immediate crisis.

Harris Co. puts in over \$7/capita for mental health. Dallas Co. puts in over \$1/capita. Don't know what Travis Co. does. Don't know what cities are doing.

Is there any information available to demonstrate the efficiency of these services discussed, e.g. money in hotline reduces need for inpatient psychiatric services. Information like this helps prioritize – if we make investments in certain places it will save money elsewhere.

HMA will provide some response to this question.

Question: what role do the hospitals play in other communities?

Response: public hospitals in other communities have on call psychiatric services within

their ERs. Additionally, they have psychiatric beds within their hospitals.

Question: what is the payor source for services in other communities?

Diversions from ASH: 64 times impacting 123 patients (double check these numbers)

Length of Stay for Travis County clients: 1/3 released within 5 days, most are released within 10 days. If we had crisis stabilization beds then admissions to ASH would likely decrease. Most of the cost is in the first day. It's costly and this money could be used more effectively elsewhere with better outcomes.

Sometimes people who show up at ASH are not admitted because the ASH staff determine there is an overriding medical need that should be addressed and these people are taken to the ER. Once medical need is treated, psychiatric need may no longer meet admission criteria at ASH. If an officer picks someone up and cannot determine which need is greater, they may bring them to the ER. Also, people with medical issues may be inpatient for several days receiving medical care but no psychiatric care. So patient takes up space at the hospital and then needs to be admitted for further inpatient care for psychiatric issues. Need better connectivity between medical and mental health services so that if someone is coming out of medical hospital, they are connected to services.

State trust fund for state hospital costs are not available for other purposes.

Clients accessing PES – lots of them are new to system. 80% are not currently enrolled with ATCMHMR but could've been served in the past. Decreasing options for patient in crisis as psychiatrists in community are less likely to take people who are in crisis or who have previously been admitted.

What is total unduplicated patients accessing PES (county residents): 6,400

Medicaid is a relatively small portion of the patients receiving services at ASH. Need to build something that works for community, not something that is focused on Medicaid reimbursement. 10-15% of total. What is the dollar amount for this total amount of reimbursement? ASH may not be tracking this carefully as they receive no reimbursement from Medicaid. What about the people at other urban area inpatient services?

Request for more information about respite care and how it connects with the other services and impacts usage of those services.

What are the options for what we can do? Can HMA lay out the options. For example, what can we do for dual diagnosis – e.g. medical and mental health. What are facility driven decisions, what needs to be collocated, and how does this impact the options. Request for sizing information – how many beds. What is Houston's current budget? Who is paying for the services?

Need to clarify function first and then discuss funding.

What's the role of the residency program?

What's the Buick option not Mercedes.

Look at where are monies are going today versus what the ideal system looks like and the cost. What are the percentages – how could it be reallocated, what's the shift that needs to occur.

May meeting will address evaluation of options. Need to schedule a meeting two weeks after May 22nd.

Psychiatric Services Stakeholders Meeting

June 5, 2006 4:00- 6:00 p.m. Cesar Chavez Building (1111 E. Cesar Chavez) **MEETING NOTES**

Present at this meeting:

Judge Sam Biscoe - Travis County

Commissioner Margaret Gomez - Travis County

Judge Guy Herman - Travis County

Mayor Pro Tem Betty Dunkerley - City of Austin

Councilmember Lee Leffingwell – City of Austin

Chief Michael McDonald - Assistant City Manager, City of Austin

David Lurie - Director, Austin/Travis County Health and Humans Services Department, City of Austin

David Evans - Executive Director, ATCMHMR

Mildred Vuris - Director of Governmental & Community Relations, ATCMHMR

Jesus Garza – Chief Operating Officer, Seton Healthcare Network

Diana Resnik – Senior Vice President, Community Care, Seton Healthcare Network

Dick Moeller – President and Chief Executive Officer, St. David's Community Health Foundation

Richard Hammett - Senior Vice President, Planning and Development, St. David's HealthCare

Clarke Heidrick – Chair, TCHD Board of Managers

Rosie Mendoza – TCHD Board of Managers

Tom Coopwood, TCHD Board of Managers

Tom Young, TCHD Board of Managers

Patricia A. Young Brown - President and CEO Travis County Hospital District

- Interim plan for making progress in the next years task: costs and how to approach organizations about solutions and a more permanent solution what it would look like.
- Update for plans for CSU at Seton Shoal Creek Diana Resnik
 - o 1st Meeting between MHMR and Shoal Creek have asked consultants for timeline and establishing numerous subcommittees; Dr. Van Norman and Dr. Wolf (heads up the residency program) and Dr. Paul Whitelock will get together to talk about provider staffing (physicians + nurses = run-rate will be determined as far as cost)
 - o Architects about the look of the intake area
 - Dr. Van Norman will look at volumes and what kind of capacity need to make room for—all of these will require architect to determine cost of renovating
 - Definition of short term that type of investment would require more than a plan for a six-month period
 - o Dr. Van Norman law enforcement concerns about where to take somebody for appropriate treatment setting; concerns and worries about

psych. Patients being in the E.R.; medical issues raised – med psych units where patients also treated medical problems –area of expertise for Dr. Wolf. Very interesting for residents as opportunity to train in med psych

• Question about architect – at the very least need to do an asbestos abatement.

Law enforcement will need to be consulted on implementation planning once major building blocks are "in place".

Commitments of support for crisis services continuum by stakeholder group members:

- 1. Trish Young Travis County Hospital District has the potential to provide support for crisis stabilization unit/inpatient beds which are considered medical services. Efficient and effective if have investments in all other components laid out in grid are made. In order to bring it to the District Board as a proposal for on-going operating investment for the beds (and as it may require a one-time capital investment) all other components need to be committed to by other members of the Stakeholders Group.
- 2. Betty Dunkerley for City of Austin

Commit to protecting existing investments—a minimum of 3.5% increase in MHMR and social service contracts; main role in housing component (Single Room Occupancy models) in partnership with Foundation Communities. Provide counseling services to MHMR to free up moneys. Multi-year conversation. Whatever cooperation APD can do with County Sheriff's office.

Question from Judge Herman – as to whether money from drug seizure revenue could be used to fund MH services. Answer. Can't use it to supplant budget item but can be used for emergency or one-time use.

Population would want to target are recidivists – what is that number of the most critical population that need to target – type of support services that are unique to this population of recidivists.

Chief Mike McDonald – SRO recent projects – how to leverage funds. Need education on whether better to have one unit or a mix for special needs like 20% of each project.

- 3. ATCHMHR working to obtain additional grants housing for dual diagnosis; are continuing conversion of housing units to 40-year HUD housing; working with City of Austin and Travis County to have more section 8 certificates; Rehabilitation Services for people that can receive Medicaid in supportive housing.
- 4. St. David's Healthcare Foundation Is engaged in a nine-month long process to develop strategy for Mental Health Releasing \$800,000 to safety net clinics and are funding intervention and counseling services in middle schools and high schools. Focused on integrated behavioral health services in the physical health services setting particularly, People's Community Clinic (working with MHMR) and Lone Star in Williamson County.

Have committed to a \$20,000 evaluation model to see which approaches are the most efficient methodologies for intervention.

No commitments in regards to:

Mobile crisis unit - \$365,000/year for a team of one MD, 2 licensed professional staff and 1 nurse

Respite Bed expansion -

Benefit management services

PES additional physician staffing – ATCHMHMR + Medical Education

Prevention Services

Memorialize what's been tentatively been put out in the group, share figures, and come to agreement considering that there are commitments only if the entire plan is funded.

Judge Biscoe -County has made commitments but wants to see figures attached to commitments.

Next steps and implementation:

- Summarize components: who is doing what and what amount of monetary commitment is being made to each component of the system.
- Chief McDonald needs data from HMA in order to be able to give to council members prior to their going on hiatus.
- Meet one-on-one with individual stakeholders and tailor approach as to what is needed to close the gaps in the proposed plan --HMA and TCHD to conduct one-on-ones.

Question: as to what is new money and what is redistribution of funds.

Need one more meeting – does not make sense to meet on June 26—better to reschedule meet on July 17^{th} 4 – 6 p.m.

HMA will: refine grids, talk about commitments that have moved forward; price tag; send to the City of Austin the number of recidivist clients, model for best practices.

Collective Interests of the Group in the Proposed Solution

Can meet medical needs

Law enforcement can drop off

Patient focus (better care)

Improve community perception of services availability

Use \$ efficiently – infrastructure, benefit management – integrated system of care Best Practice Focused

Psychiatric Services Stakeholders Meeting

July 17, 2006

MEETING NOTES

Present at this meeting:

Judge Sam Biscoe - Travis County

Commissioner Margaret Gomez - Travis County

Judge Guy Herman - Travis County

Chief Michael McDonald - Assistant City Manager, City of Austin

David Lurie - Director, Austin/Travis County Health and Humans Services Department, City of Austin

David Evans - Executive Director, ATCMHMR

Mildred Vuris - Director of Governmental & Community Relations, ATCMHMR

Diana Resnik – Senior Vice President, Community Care, Seton Healthcare Network

Dick Moeller – President and Chief Executive Officer, St. David's Community Health Foundation

Richard Hammett - Senior Vice President, Planning and Development, St. David's HealthCare

Clarke Heidrick - Chair, TCHD Board of Managers

Rosie Mendoza - TCHD Board of Managers

Tom Coopwood, TCHD Board of Managers

Tom Young, TCHD Board of Managers

Patricia A. Young Brown – President and CEO Travis County Hospital District

Absent:

Mayor Pro Tem Betty Dunkerley Councilmember Leffingwell

Report from Diana Resnik and Dr. Jim Van Norman – Diana reported, Dr. Van Norman was not present at the meeting.

- Can report good progress, have had 4 admissions up to date with Shoal Creek—working on expediting administrative process.
- Planning is taking place for bigger effort. Seton staff had a very productive meeting with Mildred Vuris and Dr. Van Norman of ATCMHMR as well as staff from Shoal Creek to see what volume and space will be needed.
- The plan is to not to just reconfigure the hospital floor but also the admitting process. There will be a special entrance to the unit, a place for assessment to take place near admitting, and an elevator to the floor.
- There will be a need to collaborate with MHMR for wrap around services.
- David Evans, other ATCMHMR staff and Seton staff will meet in late August for a one-day redesign – looking at how would respond in case of different scenarios. Run through various scenarios and what role of each person would be at that meeting.

 A clinical mobile team at the ER is also envisioned. Well-trained team with appropriate assessment forms will be great opportunity to seamlessly organize the process. Dr. Van Norman has a flowchart of activities. Include PES, short-term and long term crisis stabilization units. Clinical mobile team would be part of residency program that offers psychiatric support services to all ER's – starting at Brackenridge E.R.

The initial thought/idea is to fund the clinical mobile team from Shoal Creek – as incubator – to help Brackenridge deal with who psychiatric patients for which they are providing care. If, and when expansion of the clinical mobile team is indicated, can look for other funds to support the team.

Diana Resnik – Brought in consultants knowledgeable in psych facilities planning. The consultants will have recommendations by end of August as to what to do with the facility as well as how much can afford to be contributed toward the proposed solution for public psych emergency services, will look at use of residency program and how to maximize reimbursement, use of the facility, and investment in the community.

TCHD has also met with these consultants to give them background.

Estimate on capital cost to do renovation—have devised several scenarios but have not come up with finals numbers prior to the scheduled one day redesign with MHMR. A large investment may be required.

Guy Herman asked who will be in the redesign meeting. Suggested Kitty from CIT, Sheriff's office—people on the ground level doing the work be included. Next step is to develop flowchart for comments.

CSU size needs to be developed could be 8 beds or more.

TCHD

- Prepared to include estimated operational expense of \$1.1 to 1.5 M in budgetary process, amount above \$1m included as an enhancement
- Commitment to fund Seton Shoal Creek contract as it exists today (\$1M)
- Discussion on capital contribution need to know all sources of capital sources for renovation for TCHD funds, MHMR funds. TCHD needs to see what all sources for capital contribution are because they want to leverage funds in order for everyone to be able to stretch their dollars.
- Commitment from others is a necessary step of PES as well as a commitment to fund an MCOT—need to protect investment and thus have to avoid overloading PES as well as try to reduce jail population

Seton

- Cost of assessment team for the first year of operation to determine whether good investment
- Conditions for participation same as the District value in kind contribution of the floor and redesign as well as other services that would be there.

- Definition of short term vs. long term—short term is 3-5 years, don't know what will happen to capacity in this community, whatever Shoal Creek does don't want to be held to it for eternity.

MHMR

- Sale of property at Avenue B to Capital Home. MHMR Board willing to apply those dollars to the renovation of Shoal Creek.
- Wants to be payer of last resort on capital investment.
- Total amount of revenue from that sale would go into this process.
- July 27 work session and evening board meeting to approve total center budget. MHMR anticipates contributing \$1.34\$M for PES program, also one additional MD. MHMR expects the other 5 physicians are to be taken on by AMEP.
- Reallocation of monies already used for existing PES. Not proposing to add new monies, but rather perhaps getting more efficiency from contracting with Seton Shoal Creek which may free up some resources.
- Certain functions are required inside PES in order for Center to maintain contract obligations like a call center.

TC Government – Questions from Judge Sam Biscoe

- Would investing in more psychiatrists for MHMR be better than investing in MCOTS?
- Who takes care of individuals released from jail?
- Will agree to propose MCOT funding to Commissioners Court in a voting session on August 1 along with Commissioner Gomez.

St . David's

- Improve integrated behavioral health capacity in clinics – if working well, spread that program to all safety net clinics they are working with.

COA Housing - Chief Mike McDonald

- Two-pronged approach transitional housing model and SRO—Problem with recidivism taking place. Data received from MHMR between 9/1 and 5/31 1355 people were seen. 935 were from TC. 208 admitted more than once. 58 of those were responsible for 225 visits—to ASH or to other facilities.
- In transitional housing model have beds, case management, rent spaces for this facility using bond dollars. To manage that 58 would need a facility that would house 10-15 beds, need more data to take to Healthcare Subcommittee (Leffingwell and Dunkerley) purchase facility and have MHMR in charge of wraparound services.
- SRO's single room occupancy Integrated model is considered best practice. Would be looking at utilizing housing department to leverage private investment—different population—not as intensive. Need Mobile Crisis Outreach Team to respond to any problems that arise.
- COA dollars no idea yet on facility costs.
- Will have \$\$ amount they could share mid-late August.

- 3% increase to social services – MHMR is currently receiving approximately \$2M.

Next steps:

- Request from Judge Biscoe if get other commitments from partners, will stick it on agenda and will back up Commissioner Gomez.
- Trish will submit request for agenda item to present to Commissioners Court; August 1^{st.}
- Next meeting September 18, 4-6 p.m.
- Important- want measurable outcomes, performance data how impacted community and met expectations that had when initially met include this with agenda item as well as stakeholder roles and responsibilities.
- In the future, need talking points for media.

Psychiatric Services Stakeholder Meeting

September 18, 2006 – 4:00–6:00 p.m. Cesar Chavez Building (1111 East Cesar Chavez) **MEETING NOTES**

Present at this meeting:

Judge Sam Biscoe - Travis County

Judge Guy Herman - Travis County

David Evans - Executive Director, ATCMHMR

Jim Van Norman, MD – Director of Medical and Clinical Management Services,

ATCMHMR

Mildred Vuris - Director of Governmental & Community Relations, ATCMHMR

Martha Diaz, Chair, ATCMHMR Board

Toni Inglis, ATCMHMR Board

Jesus Garza – Chief Operating Officer, Seton Health Network

Diana Resnik – Senior Vice President, Community Care, Seton Healthcare Network

Kari Wolf, M.D. – Austin Medical Education Program

Clarke Heidrick - Chair, TCHD Board of Managers

Bobbie Barker, TCHD Board of Managers

Tom Coopwood, TCHD Board of Managers

Patricia A. Young Brown – President and CEO Travis County Healthcare District

Absent:

Commissioner Margaret Gomez - Travis County Mayor Pro Tem Betty Dunkerley Councilmember Lee Leffingwell

Present for:

Commissioner Margaret Gomez – Edith Moreida Councilmember Lee Leffingwell – Kelley Brault

HMA:

Karen Hale

Kim McPherson

1. Welcome and review of the agenda by Clarke Heidrick.

There have been several positive developments, several organizations have come through budget wise.

2. Update on Psychiatric Emergency Services Implementation – Diana Resnik and Dr. Jim Van Norman – Handout – *The Austin Travis County Crisis Services System Community Collaborative*

August 30th – Seton Shoal Creek, Austin Medical Education Program, APD, Travis County Sheriff's Office, and ATCMHMR staff met and discussed and defined ideal state of Psychiatric Emergency Services which is a medical model based emergency department.

Steve Rosenberg, a consultant hired by Seton, helped identify several issues in terms of implementing a psychiatric emergency department at Shoal Creek. There is significant risk to Shoal Creek due to EMTALA requirements that any and all patients be accepted and admitted in to the hospital regardless of payor source.

Question that came out of redesign – EMTALA is applicable when the psychiatric emergency department is located in a licensed acute-care hospital i.e., it must operate as a true medical model with each patient assessed by a physician. The Physician and EMTALA requirements are different for Shoal Creek than for the current PES at the Nadine Jay center which operates under a "social services" model using a mix of behavioral health and nursing staff along with physicians. The medical model is more expensive model due to the increased need for physicians. Developing a true psychiatric emergency center at Shoal Creek would have required an additional \$3M in funding to staff adequately. Funds are not available to sustain that level of cost. Putting in a psych emergency room ½ mile from another emergency room seems duplicative. Additionally, creating the idealized psychiatric emergency department at Seton Shoal Creek would have required significant remodeling of space and parking and transportation posed challenges.

Given the idealized design is not possible at this time and interim plan is proposed:

- Continue using PES at Nadine Jay increasing staffing to offer adequate services during evening and weekend hours.
- Create a 16 bed unit (roughly) at Seton Shoal Creek for involuntary admissions through remodeling and abatement
- Option of holding commitment court at Shoal Creek instead of just ASH. Need to follow up with Judge Guy Herman on this question.
- APD and Sheriff's office would phone PES to determine whether patient should be taken to Shoal Creek). Would avoid trip to PES when unnecessary.

Rationale for continuing use of Nadine Jay PES versus co-located in Seton Shoal Creek – only 25% of patients that come into PES need to be seen by a physician and 75% of people that show up do not usually need to see a physician. At Shoal Creek all people that show up would have to be seen by a physician as legal requirement, increasing the need for physician coverage and thus increasing cost.

Two consequences from maintaining PES at Nadine Jay:

- 1. PES staffing will need to be increased
- 2. Work will need to continue with law enforcement to establish appropriate process for determining where to take detainees

3. Discussion of updated grid

Proposed MCOT design to bolster PES. Scope of Services are as follows:

- a. Timely field response for assessment and intervention of psychiatric crisis following an established call prioritization.
- b. Intervention with individuals in psychiatric distress who do not warrant detention or before emergency detention is necessary, providing monitoring and intervention until the individual is linked into services or the crisis is resolved.
- c. Medication evaluation, intervention, and follow-up when it is safe and necessary to do so in the field.
- d. Coordination with the CIT, PES, and other entities in arrangement of hospitalization or crisis respite.
- e. Transportation of cooperative and medically stable individuals to PES, the Inn, or other needed locations.
- f. Follow-up contact with individuals who are non-compliant with medication, service/treatment referrals, or housing referrals.
- g. Follow-up and location of individuals who have recently been discharged from inpatient hospitalization but have not become engaged in scheduled aftercare.
- h. Intervention as necessary with individuals on outpatient commitments to assist their compliance with the orders of commitment.
- i. Assistance on request of the CIT and law enforcement during extraordinary events (hostage situation involving psychotic individual or self barricade situation of known mental health consumer, etc.)

Notes on future additional components to mental health services system: Expansion of Brackenridge ER – may provide targeted area for Psych Emergencies Mobile medical assessment teams of providers to service ERs

Report on use of Seton Shoal Creek Hospital under the existing contract:

Had expected a large number of walk-ins which, has not occurred. Rather, when a patient is at Seton or St. David's as is ready to be discharged, and needs psychiatric care – for psychiatric care in ASH the consumer has to be involuntarily committed – now can go to Seton Shoal Creek as voluntary admission. People show up at PES that need inpatient care (POEC – involuntary – can get into Shoal Creek—people on border of voluntary/involuntary—can divert these groups to Seton Shoal Creek). Voluntary beds are not the biggest need in our community. The higher need is for involuntary commitments – locked and safe environment for the patient.

4. Discussion of Gaps in Services and Funding and Notes on progress made:

MCOT approved

Commitment to SRO's by COA

What MHMR and Seton are proposing does move the ball forward.

Question: How will we know that we are improving on the mental health status of the community? There is a need for measurable outcomes (metrics)

Seton Shoal Creek – cost saving is presence of the residents there—staffing costs go to about \$6M run rate without the use of the residents

Question: Whether to commit to plan as is and go forward?

Interim commitments – mid-term plan life of 3-5 years

The interim plan under discussion will hopefully have a positive impact on jails, court system and ASH. The investments in the proposed services are transferable—not a wasted investment. Investment of \$1.5M in capital renovations for Seton Shoal Creek for the next 3-5 years—does not carry-over to another longer term solution but may be the most economical investment for this time period in order to move the ball forward and make progress towards closing the gaps in services.

Important to note that the Stakeholder Group is building incremental investment in a long term solution.

Question: What would be the cost to build, renovate and operate another facility? How much cost to run ideal model? This will need to be evaluated as part of the continuing work of the Group.

5. Future Role for Stakeholder Group

Suggestions: Clarke Heidrick – Motion: Proceed on lines Jim Van Norman outlined Group meets quarterly—to see how interim plan evolves,

Continue to discuss and plan for long-term solution

Legislative impact – need to work together in legislature with Code Red group, to work for regional solutions

Amendment by Judge Herman - Interim solution – needs to be big and timeline shooting for – 5 years, educate community and commissioners court and city Vote taken – all stakeholders voted for supporting and moving forward

Next Steps:

Long-term discussion about working with V.A. to have a joint facility

Trish Young: There will be a sub-group – with monthly meetings as well as a communications group to educate and inform the community about the work and plans of the stakeholders group

The quarterly meetings will take on such issues as: Metrics

Next meeting is scheduled for December 2006

Next steps:

- MCOT presentation to Commissioners Court
- MHMR enhanced PES function needs rapid cycle development and deployment
- Healthcare District Board will need to take final approval action on interim plan, funding has been designated in the FY07 budget for support of inpatient services, specifically continuation of current contract with Shoal Creek until new solution developed.
- Develop communications plan including press release of outcomes of stakeholder group activities. District willing to take lead on this. Report back to group at next meeting.
- Next meeting will be in December.

Appendix H – Crisis Services Diagram

