Considerations for Crisis Services

SJR 41

Study of mental health crises response

New Freedom Commission on Mental Health

- Three obstacles to care:
  - Stigma
  - Unfair treatment limitations and financial requirements placed on mental health benefits in private health insurance
  - Fragmented mental health service delivery system

Council of State Governments: Action Steps

- Access Guarantees to MH services:
  - Require coverage in Medicaid and CHIP
  - Sound clinical practices and prohibit restrictions/limits
  - Equal coverage for MH: parity
- Employment Assistance: transition, protection
- Housing Supports
- MH Quality Improvement State Vendor Initiative: quality goals into provider contracts and require providers to meet specific quality standards

Mental Health Parity

- Relates to treatment limitations and financial requirements
- Options for changes to parity or minimum mandates:
  - Adequacy of definitions (inc. crisis care?)
  - Adequacy of limits
  - Adequacy of coverage in gov’t programs

Secure Crisis Facilities

- Secure means patient can be compelled to remain: requires due process, involuntary commitment.
- BHIF or community commitments statutes in Title 53, chapter 21, MCA.
- Licensure
- Involuntary commitment process

Behavioral Health Inpatient Facilities

- Department and State Hospital-oriented
- Hospital-based
- Department has authority to license, determine number, locations, qualifications, reimbursement rates, and criteria for admissions and transfer
- Department has authority to contract

Policy decisions for Secure Crisis Facilities

- Define the purpose: community incentive or to relieve State Hospital population pressure?
- Court processes and mental health evaluation different from licensure authority.
- Role of SAAs vs. DPHHS?
- Transfer provisions – continuum of care from community to MSH to community

Policy decisions, cont.

- Reimbursement – Medicaid requirements, other reqs?
- Licensing authority and parameters: los, life, health, safety, Medicaid-certification.
- BHIF statutes: hospital and MSH-oriented. Why didn't BHIFs happen?
- Is a community commitment appropriate? What is a 'community facility or program'?

Continuum of Care

- Crisis telephone line – 2-1-1?, CMHC contracts
- Jail Diversion – CIT training, need place to take individual
- On-call, on-site, mobile crisis response by mental health professional for law enforcement or ED
- Need to be accessed by anyone, not just Medicaid, CMHC or MHSP clients
- Mental health professionals & MSH admissions
- Short term intensive services – home health model and peer support, job training

Continuum, cont.

- Community Crisis Stabilization – outpatient, inpatient, secure, nonresidential
- Day treatment
- Recovery homes, safe homes
- Private, hospital-based psychiatric care
- Transportation
- Long-term psychiatric care – Montana State Hospital
- Discharge and transition planning

Other services in other states

- Recovery education programs, action plans, recovery planner (AZ)
- Peer support training and employment (AZ)
- Medicaid-funded peer support services – training and certification (GA)

Other services in other states, cont.

- Non-residential crisis intervention funded by SMHA: AZ, CA, KY, MN, NJ, NM, NY, VT
- Consumer-operated residential services funded by SMHA: CA, NJ
- MN East Metro Children's Crisis Services - enhancement of existing county-based services with initial crisis response and crisis stabilization benefit sets

Adult Behavioral Health Inpatients (From MHA's COMPdata)

- In 2004, 20.4% of all adult patients discharged with a principal or secondary diagnosis of mental illness.
- 3.7% had a primary diagnosis: 2/3 with psychoses, 10% with depressive neuroses
- 71.2% were admitted through the emergency room
- 54.7% were urgent admissions, 32% were emergencies, and 12.9% were classified as elective for admission; 81% were discharged to home

Adult Behavioral Health Inpatients, cont.

- Average total charge for adult mental health inpatients was $6,458 and the average length of stay was 4.9 days.

Emergency Call Issues.

- National survey: 2/3 of ED directors report inadequate on-call specialist –coverage (not just MH)
- AHA survey: 1/3 hospitals pay stipends, or pay Medicare rates for uninsured
  - Perceived risk of malpractice, lack of reimbursement for uninsured, time from practice, late and unpredictable hours
  - On-call coverage traditionally obligation in return for admitting privileges, just relinquish privileges

Emergency Call Issues, cont.

- Rising numbers seek primary care in emergency departments
- Seriously mentally ill strain EDs
  - State budget problems, cuts to MH services, Medicaid, decline in # of inpatient beds, low reimbursement rates
  - Create partnerships between hospitals and mental health centers (e.g. Kalispell and Bozeman).

Emergency Call Issues, cont.

- MSH – no ED, policy requires physical and mental exam within 24 hours, physician employees, extra “on call” pay over 40 hours for nights and weekends, 8 psychiatrists (treat), 2 family practice (consult), on call 1 of each
- EMTALA – all Medicare-participating hospitals with emergency departments must provide a medical screening exam, stabilization, and further care or transfer as needed, regardless of ability to pay

Emergency Call Issues, cont.

- What level of mental health professional needed?
- Team effort: Law enforcement, county attorney, hospital, mental health center, mh professionals
- What continuum of care is necessary for it to work – i.e., transitional residential, inpatient psych, mh prof?
- How does certification as a mental health professional relate?
- How do hospital admitting privileges relate?

Emergency Call Issues, cont.

- Reimbursement issues: employment and income generation
- How do you pay for services at the front-end before you realize savings on the high end?
- Incentives: condition of employment or state contracts, provide additional “call pay”, allow regional variation
- Look at services reimbursed: are these the diagnoses involved in crises, e.g. PTSD, anxiety disorders, psychoses, depressive neuroses

Telemental health services

- Eastern Montana Telemedicine Network – 16 communities (Deaconess – CHC)
- REACH Montana Telemedicine Network – 12 communities, Golden Triangle
- MCTN – St. Patrick's Missoula
- Montana Partners in Health Telemedicine Network – 9 communities in SC Montana
- METNET – 13 sites + connect to others

Telemental health services, cont.

- Judicial Video Network –34 sites: 24 County Courthouses, MSH, 3 detention facilities
- WICHE 1997 focus groups
- Cost, reimbursement, use of existing systems, need psychiatrists on other end.
- Community and consumer oriented (incentives).
- Savings in time, money, transport.
- Concern over use of MSH as “gatekeeper”

Telemental health services, cont.

- Services can include crisis consults for risk of suicide or harm to others
- Mental health treatment
- Personalized substance abuse interventions with students
- Military vets with PTSD on Indian reservations receive treatment via videoconference.
- Palmtop computers for anxiety disorders to receive messages of reinforcement/reminders and to assess levels of anxiety.

Policy Options

- Mental health parity
- Secure Crisis Facility
  - Licensure
  - Involuntary commitment
  - Purpose
  - AMDD, SAA roles
  - Transfer provisions – MSH

Policy Options, cont.

- Continuum of Care, Emergency Call, Telemental:
  - Decide what you want and put resources there.
  - Analyze AMDD EPP proposals with all this information in mind. Does the EPP reflect the communities' and your priorities? Next meeting.
- Structure appropriations or legislation accordingly, place conditions or narrow parameters, contract requirements.