

Community Forum #52: Local Service Redesign Plan

October 2, 2007, 5:45 p.m., Large Training Room

91 Attendees

In compliance with state planning efforts, the Austin Travis County Mental Health Mental Retardation Center has created the following transcription of Community Forum #52 to share attendee comments and feedback.

Input and Response		Responsible Staff
<p>1. Input</p> <p>Response</p>	<p>What is your turnaround time when a call comes into the hotline/crisis center? Is the State mandating a certain amount of time/response as it does with EMS?</p> <p><i>The standards for the certification will give us more definitive guidelines, but the definitive concept is that if an individual calls our hotline or walks into our Psychiatric Emergency Services Center, the response will be immediate. In practical terms, "immediate" would mean around 15-20 minutes in a walk-in situation, and 30 seconds on a hotline. In any managed care setting a rapid response is very important. Also, the fact that we want to collocate and closely link with Crisis Services should help to increase our responsiveness.</i></p>	<p><i>Jim Van Norman</i></p>
<p>2. Input</p> <p>Response</p>	<p>I would like to suggest creating a VOICE committee specifically for the personnel because turnover is so high and new people are coming in all the time.</p> <p><i>We will take that into consideration and appreciate the continued volunteer service of many fine citizens in the mental health field.</i></p>	<p><i>Jim Van Norman</i></p>
<p>3. Input</p> <p>Response</p>	<p>What has DSHS done to implement the equity demanded by the legislature?</p> <p><i>The State decided there would be a per capita or even funding across the state to implement crisis hotline and mobile crisis outreach services. The State will also fund centers that were not getting their basic allocation of funds per person in that specific community. Travis County and several other Centers don't have a spending per person equal to some of the rural counties, but funding will be shifted</i></p>	<p><i>Jim Van Norman</i></p>

	<p><i>as there is a move towards an even approach across the state. Travis County is still below the average,, but there was funding toward that equity in both the \$1,073,000 and the \$1.66 million.</i></p>	
<p>4. Input</p>	<p>What is the relationship between MHMR and the private managed-care system? How do we surf between these different entities and make sure our loved ones are getting care?</p>	
<p>Response</p>	<p><i>There is no short answer to this question. ATCMHMR is a provider for the managed care entities within Medicaid managed services but it is a fragmented system. We are doing our best through this Crisis Redesign to bridge those gaps and serve as a local solution, rather than having consumers have to navigate the system on their own. This is a certainly a challenge.</i></p>	<p><i>Jim Van Norman</i></p>
<p>5. Input</p>	<p>Laura DeWitt: What systems will be in place to measure consumer satisfaction, how well the services are serving the needs, the quality of the service delivered and how effective and safe are they?</p>	
<p>Response</p>	<p><i>First, we will have a local program evaluation component in our local implementation so that we can monitor and understand the impact on consumers and on the community. We are moving toward that goal by working with the Travis County Healthcare District and analyzing the data across hospitals, jails, courts, the community health clinic and PES. In addition, the State – in cooperation with A&M University – is also implementing a system to report back to the legislature where all the money was used.</i></p>	<p><i>Jim Van Norman</i></p>
<p>6. Input</p>	<p>When consumers get out of detox or a rehabilitation program, they often have to wait months to receive mental health services because it is not considered a “crisis.” Is there mention in your crisis plan of access to services for other community providers?</p>	
<p>Response</p>	<p><i>There really is not. This first wave of funding from the Legislature is allocated to improving and strengthening crisis services. However, in previous meetings, everyone recognized that you build a crisis-driven system if you only fund crisis services without an expansion of outreach of services. The Department of State Health Services and the</i></p>	<p><i>Jim Van Norman</i></p>

	<i>Legislature see a long-term incremental process, first to develop crisis services and then to begin to improve outpatient services and expand them so that there is better access and coordination.</i>	
7. Input	Is this crisis redesign addressing the needs of adolescents and their need for longer lengths of stay to stabilize inpatient needs?	
Response	<p><i>Yes, in our crisis redesign we specifically address strategies to meet the needs of children and adolescents as well as adults. Inpatient resources are scarce and particularly scarce for children and adolescents. At this point, we mostly rely on the State Hospital, which is serving a significant portion of the state with only 38 beds. We are hopeful that the collaboration with the residency program, AMEP, Shoal Creek, the Healthcare District and ATCMHMR will improve access to some crisis centers, but it is a definite need.</i></p> <p><i>An additional note on privatization and serving the youth population: A new plan has come out that allows the Center as well as private providers to better serve children in the foster care system. As the Center here is the public safety net managing all the resources, we're trying to coordinate and put out a clear message, but the foster care program and the children it serves will have a complex set of relationships with the Superior Health Plan as the Medical Home and the child placement agencies work on payments and coordination. The date has been pushed back to April to implement this new method of seeing that children in foster care are addressed via the health plan.</i></p>	<p><i>Jim Van Norman</i></p> <p><i>David Evans</i></p>
8. Input	What is being done to train and recruit staff?	
Response	<i>We have a continued commitment to recruiting and training staff, and are working to implement the idea of peer support/ peer counselors –DBSA offers this kind of training. There will be a much sharper focus on training and assessing the competencies and capacities of staff.</i>	

<p>9. Input</p> <p>Response</p>	<p>Do you show an interest in students who are currently at state universities and will be coming into this field?</p> <p><i>We always try to cultivate our relationships with the University training programs – social work, nursing, and counseling-- to engage people in and keep them in the region. Certainly with the residency training program we try to recruit people to stay in the community and be interested in community mental health.</i></p>	<p><i>Jim Van Norman</i></p>
<p>10. Input</p> <p>Response</p>	<p>Are there an adequate number of psychiatrists who are well qualified to replace the number of people who are now working in this field?</p> <p><i>There are not an adequate number of adult psychiatrists and there is a woefully scarce number of child/adolescent psychiatrists available for this kind of work. While I cannot speak to the capacity and need of social work and therapists, most of us feel the pinch in trying to obtain psychiatric services. The residency program currently run by Seton, and soon to be part of UTMB, is working to expand its services and we try to work closely with them as a training site to encourage students to stay in the community.</i></p> <p><i>Austin does not have a psychiatric ward in a major public hospital, which is a shame for such a progressive city. That may be part of the problem in attracting and retaining new psychiatrists.</i></p>	<p><i>Jim Van Norman</i></p> <p><i>Toni Inglis,</i></p>
<p>11. Input</p> <p>Response</p>	<p>Is there adequate funding for 24-7 prescription providers?</p> <p><i>We do have psychiatrists who are on-call 24-7, but not on-site, which means there is a psychiatrist available to consult. We would like to build a tight relationship with Texas Medical Education Program – the residents, which are a rich and relatively inexpensive resource to provide 24 hour staffing by people who can prescribe medications. It may be a three to five year window to find the right setting and location, but ideally we would like to expand this and have more on-site hours than we currently do.</i></p>	<p><i>Jim Van Norman</i></p>

<p>12. Input</p> <p>Response</p>	<p>Will there be an opportunity to provide public feedback via the internet?</p> <p><i>We will definitely have an easily accessible area on the new MHMR web site where comments or suggestions can be submitted – either anonymously or by name.</i></p>	<p><i>Iliana Gilman</i></p>
<p>13. Input</p> <p>Response</p>	<p>I work for the Austin/Travis County Suicide Prevention Coalition and we often refer people in crisis to PES, but it is difficult to explain how to get to the downtown location when there is limited signage at the site. Is there funding for signage?</p> <p><i>There is a need for an in-depth communication plan that would include signs and the internet as well as other ways to communicate about where we are and how to reach us. That is a good suggestion and we will see what can be done on that front.</i></p> <p><i>There is some signage, but we had some restrictions with the Neighborhood Association. Maybe it is time to revisit that debate because we also get a lot of calls from people who are frustrated and cannot find the PES facility.</i></p>	<p><i>Jim Van Norman</i></p> <p><i>Sherry Blythe</i></p>
<p>14. Input</p> <p>Response</p>	<p>What kinds of facilities are you considering for the future of your 24-7 plan? In other cities, it is helpful to have them located in a hospital so that doctors are readily available for a consult.</p> <p><i>Ideally, we would be in a hospital facility with access to the appropriate lab settings. As of now, there are really no hospitals that have the capacity for that kind of program. We are discussing the long-term possibility of moving into some of the buildings that are very close to Brackenridge Hospital, but this may or may not be possible. Our ultimate goal is to provide the highest amount of medical support that's practical if we cannot have access to a psych emergency room.</i></p>	<p><i>Jim Van Norman</i></p>

<p>15. Input</p> <p>Response</p>	<p>Are we waiting for hospitals to make psychiatry a priority or can the Center support this action?</p> <p><i>We are having ongoing discussions with the hospital systems with the role that psychiatry plays. For a community this size we do not have the amount of inpatient resources we need, but we hope to continue to make psychiatry a priority in hospital settings.</i></p>	<p><i>Jim Van Norman</i></p>
<p>16. Input</p> <p>Response</p>	<p>At Seton Shoal Creek, we have been discussing ways to streamline the movement of patients from medical and behavioral health facilities in our community. I am interested in creating some kind of standardized language and format for patient forms so that in a time of crisis we can move patients quickly into the most appropriate treatment center.</p> <p><i>Thank you for that suggestion.</i></p>	<p><i>Jim Van Norman</i></p>
<p>17. Input</p> <p>Response</p>	<p>In this crisis plan, is there room for some kind of intermediate facility for those who have gone through the criminal justice system but have to wait months after they get out of jail to get a bed at an appropriate treatment facility?</p> <p><i>There is another stream of funding still to come related to psychiatric crisis services, the hub, psychiatric emergency department and outpatient restoration and competency. We intend to apply for outpatient restoration and competency funding. We agree that there are people tying up bed days at the State Hospital and using up Center resources, could really be treated on an outpatient basis while they are waiting to return to jail for their trial dates</i></p>	<p><i>Jim Van Norman</i></p>
<p>18. Input</p> <p>Response</p>	<p>I am from Indigent Care Collaboration and would like support for strengthening psychiatric services particularly for crisis cases. Our statistics show 25% of women and 35% of men using the ICC have some type of behavioral health diagnoses. These individuals are not getting into other types of services to address their needs from a primary care standpoint.</p> <p><i>Thank you for your support.</i></p>	

<p>19. Input</p>	<p>NAMI Austin: The overall crisis services redesign has a great sensitivity to the needs of families and consumers and we hope the MHMR program will have that same sensitivity. We would like to express our support for transparent accountability and believe that it is important that these funds be accounted for so we know where they go and who they serve.</p> <p>Questions:</p> <ul style="list-style-type: none"> • Will you compare the current numbers served with the proposed numbers so we can predict the number of people who would be served in the future? <p>External providers: There is an option for the agency to service the provider of the last resort – to contract with providers - It is challenging to select a provider and receive services.</p> <ul style="list-style-type: none"> • How will ATCMHMR choose providers and set up a system of supervising them/ holding them accountable? • What is your plan for helping consumers choose providers and then coping with conflicts as they arise? • We are aware of the need for additional respite resources and support the funding of these programs. How do you intend to provide space and services to children in this area as several of the “second-tier” services offer? 	
<p>Response</p>	<p><i>We have an internal work group that’s looking at the network development that the state is requiring to look into external providers.</i></p> <p><i>The network development plan is due July 2008 so in the interim there will be plenty of opportunity for stakeholder input and response.</i></p> <p><i>For respite care, it is complicated because the parent has to stay on site, which becomes very hard in an operational sense. However, in-home service and in-home respite are definitely services we want to look into and possible expand.</i></p>	<p><i>Jim Van Norman</i></p> <p><i>Louise Lecher</i></p> <p><i>Jim Van Norman</i></p>

<p>20. Input</p> <p>Response</p>	<p>I would like to suggest that we record the voice of support shown at this meeting so that it can be acknowledged on the internet.</p> <p><i>Thank you for your suggestion.</i></p>	
<p>12. Input</p> <p>Response</p>	<p>I'm concerned that we are moving towards medicating and not providing psychosocial interventions. We need to have an eye on civil rights and advocacy/protection. Also I want to know about the empowerment and recovery model where consumers are in charge.</p> <p><i>The Center does have a consumer rights advocate, Phyllis Wolf, who is always there to help consumers remove barriers, connect them to services, or help their voice be heard. She can be reached by phone or email at the Center.</i></p>	<p><i>Phyllis Wolf</i></p>
<p>13. Input</p> <p>Response</p>	<p>We love to see recovery and restoration in the local community. What has actually been done in the following two areas: Peer support shown in your research model and the apartment/hotel model where people are kept in the community? Are we waiting until the July 08 plan comes out?</p> <p><i>We've already implemented some peer-support services and would like to continue to strengthen those. We are not waiting until July 08. Once we've completed the required standards we will use funds to work on improving the peer-support services.</i></p>	<p><i>Jim Van Norman</i></p>