Crisis Solution Coalition

Meeting #8

December 15, 2014

Comments /Questions for the Provider Survey Results. Considerations for next version.

1. Did anyone capture First Responder data? Was that singled out or identified? (no)
2. A survey for consumers may be helpful: asking “what helps you stay out of the hospital, or helps you from utilizing the ER?”
3. Limit or Don’t limit the survey to only one person at a provider agency?
4. Was the data separated out by Medicaid vs. non- Medicaid consumers? (no)

BH Urgent Care – comments for the workgroup’s consideration

1. The issue of Medical Clearance is very important for non-hospital based workers/facilities. There is the need to establish a criteria and perhaps a partnership with a PCP or Psych RN for this.
2. Can we track if consumers have an identified first responder, ie enhanced services?
3. Tracking Recidivism?
4. How much are the medical issues manifesting in a psychiatric issue? Many people use the ER for lab work purposes. What are the alternatives?
5. Must address the 23 hr chair
6. Durham Center Access allows the consumer to stay at the Access Center while they send over the lab work to the ER for processing.
7. Cost analysis on the Access Center use?
8. Early intervention can decrease recidivism, and peer specialists can assist with the engagement piece, Crisis Risk assessments need to be done and utilize Trauma Informed practices
9. Could IVC’s generated in the community be sent to the Access center? (Tier IV) Is there a list of the Current Tier IV sites?
10. Medical expenses: can the Health Dept. share in some of the expense?
11. What is follow up like? Some follow up is occurring in some areas: needs improvement
12. Advocacy for high risk consumers is needed: more accountability for ACTT, advocacy for supported housing
13. How does Mobile Crisis work with Access? Can they transport consumers to the BH Urgent Care?
14. Is the consumer’s crisis plan available for the staff?
15. Coalition endorsed the Tier I – IV naming and descriptions recommended
16. Coalition endorsed the use of the new data sheet ASAP, with future tweaks possible based on notes above

Mobile Crisis Management – comments on current service definition and recommendations for consideration by DMA & DMH/DD/SAS for revised definition

1. Mobile crisis response time of 2 hrs is problematic. Need a shorter response time
2. Training for mobile crisis providers needs to be uniform/standardized
3. Strengthen the role of the psychiatrist on the team
4. New service definition needs to maximize this resource into urgent care model
5. Increase communication between mobile crisis and providers
6. Safety for the mobile crisis providers going into homes is an issue as well as permission/trespassing issue
7. Need a team approach to mobile crisis staffing to include law enforcement.
8. Education needed to work with IDD population
9. How often are psychiatrists involved in the calls? Do they ever go out?
10. Frustration expressed when the mobile crisis provider is attempting to find placement at a facility only to be told by facility staff that they do not need the service
11. Are mobile crisis providers being called by enhanced service providers: yes, sometimes they are
12. Does the workgroup have a consumer survey evaluating mobile crisis?
13. Would a tracer model be helpful? Trace the consumer through the process to identify gaps