

Joint Select EXHIBIT 4
Committee March 17, 2005
on Mental Health SB 499

MONTANA COUNCIL OF
COMMUNITY MENTAL HEALTH CENTERS

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TO: Select Committee on SB 499

FR: Kathy McGowan

RE: Crisis Services in Montana

In response to Senator Esp's request I have gathered information from each of the community mental health centers in regard to what crisis services they provide and what they are or are not reimbursed for those services. What is most clear is that we have no crisis **system** Montana. On the other hand every region of the state has fashioned crisis response services of some kind and this has depended largely upon what the folks in those areas have identified as their priorities and what they could afford.

You've already heard from the Department that in past years the four Community Mental Health Centers had contracts with DPHHS to provide emergency crisis telephone services in their respective regions. The figure used was a total of \$147,000 per year. Most recently the crisis telephone function was rolled into the MHSP (Mental Health Services Plan) contracts.

Before I describe specifically what crisis services look like in the individual regions I will take the liberty to identify what we see as the challenges and/or overriding issues:

- What is a "crisis?" Discussion generally revolves around serious mental illness but, in fact, community mental health centers respond routinely to crises where the individual/situation neither meets the SDMI criteria nor the financial criteria in terms of reimbursement.

•Who ultimately is responsible to ensure that crisis services are available in Montana?

•Who ultimately will be responsible for the cost of crisis services? What will be Montana's policy in regard to the 50% who have no payment source?

•How (or will we) address the fact that neither private insurance nor Medicare have participated in any meaningful way in terms of stepping up to the plate to assume responsibility for individuals with mental illness, thus accounting for at least some of the 50% with no payment source?

I will give you an overview of what crisis services look like in all the Regions but the Western Montana region, which Paul Meyer will describe.

Eastern Montana Community Mental Health Center, based in Miles City

EMCMHC is responsible for a huge expanse in eastern Montana. Crisis response differs from county to county, depending upon what has been planned with the other stakeholders in the individual counties. For instance, in Rosebud County, crisis calls go to the Sheriff's Office. In Sidney and Glendive they go to the hospital. They, in turn, call the MHC crisis worker on-call. In some of the other counties, the satellite staff are on call all the time. Crisis telephone numbers are published in the yellow pages of local telephone directories under Mental Health.

- Crisis response situations take precedence over all other services.
- Crisis responders are in all cases clinical employees.
- Crisis responders are never further than 1 - 1/2 hours away.
- Crisis responders will not answer a call to a home, motel, or similar place without being accompanied by a law enforcement officer.

Critical incident debriefing is one kind of crisis service we haven't discussed in this committee. Some examples of critical incident debriefing where EMCMHC was summoned are:

- Small rural community. Individual shot and killed three residents, then fled. Community was frightened, in grief.
- Hospital. Hospital staff required debriefing after a twin baby fell behind a couch, was brought to the hospital and subsequently died.

•First responders at a truck stop. Woman and child traveling through the state were run over and killed by a truck. The husband and other child, witnesses, and employees of the truck stop required help in dealing with the tragic situation.

EMTCMHC looks to Deaconess Hospital, Billings, 3 hospitals in North Dakota, and limited beds in Glendive when it is necessary to hospitalize. This can be a time-consuming and frustrating experience because hospital beds are at a premium.

What it costs, what is not paid: It costs a lot. Very often the incidents are very time-consuming. It is not uncommon to "pull an all-nighter." Hostage situations, threatened suicides, community tragedies, are complex. The Center is not reimbursed for any of the critical incident situations. It is not reimbursed, except on a rare occasion, by the 50% with no resources. If the person happens to be Medicaid eligible or have private insurance, the Center submits a claim for the actual face-to-face but cannot recoup travel costs. Because a crisis is put ahead of everything else, a nonpaying crisis call may bump a paying customer.

The Center does not tabulate its "losses" on crisis because it is a part of their traditional mission and their communities and county commissioners expect that they will respond.

As you've already heard, the former crisis telephone money was rolled into the MHSP contracts, which are seriously underfunded.

Golden Triangle Community Mental Health Center, based in Great Falls

Similarly, crisis response provided by GTCMHC varies from community to community, depending upon other resources and what has been worked out with other stakeholders. In communities where they have offices a therapist is available for walk-in crises from 8:00 a.m. to 5:00 p.m.. From 5:00 p.m. to 8:00 a.m, and on weekends an all-call therapist is available, backed up by an on-call psychiatrist. GT also depends upon county law enforcement, hospitals, and the like to be part of the solution, particularly in its most rural counties.

GTCMHC reiterated that going out on a call without the aid of a law enforcement officer is a thing of the past for them.

GTCMHC has a long standing, good relationship with Deaconess Hospital, a key component to a successful crisis system. In Helena the lack of hospital support has been disappointing and presented a lot of challenges.

GTCMHC is not often involved in critical incident debriefing. Whereas EMCMHC must be all things to all people because of their isolation, the other Centers have the "luxury" of other community resources to provide some of those services.

What it costs, what is not paid: The answer was similar. If they have a billable person who was seen face-to-face, the Center bills Medicaid, for instance, for an outpatient visit. Medicaid reimbursement is \$51+ but the actual cost is \$85-\$90/hour. Again, what is a "crisis?" If a client is kicked out of his/her apartment and the Center pays for a motel room until another housing situation is located, would you consider that part a crisis cost? PACT teams have been instrumental in alleviating some crises situations. Would that be considered a crisis cost?

South Central CMHC, based in Billings

Third verse, same as the first. Much of what they do is consistent with what the other Centers do. The principles are the same and they plan their delivery based upon community desires and resources. Crisis always comes first. Every satellite office has a local number to call. There is an 800 number in Billings. In Lewistown, for instance, the Center contracts with two physician groups to take the crisis calls, and they, in turn, work with the crisis response person.

South Central likewise has a good hospital in its region. However, as you've heard, Deaconess can't keep up with the demand either. If Deaconess is on divert, and the Center requires a hospital bed, then they begin to explore beds in other parts of the state. Randy Vetter at the State Hospital is a big help with this.

What it costs, what is not paid: Same, same. There is no expectation of being reimbursed by anyone for much of the crisis work.