The Jefferson Regional Health Alliance Behavioral Health Initiative Mapping Project

March 13 - 16, 2006

Medford, Oregon

participants

ADULT MENTAL HEALTH SERVICES GROUP - SPMIA

Joe Adair - *Manager of Mental Health Services for Josephine County*

Shelly Colclasure - *Nursing Manager, Providence Medford Medical Center*

Marie Hill - *Director of Community Corrections (Parole and Probation) Josephine County*

Brenda Johnson, *Director La Clinica de Valle*

Becky Martin - *Manager of Mental Health Services for Jackson County*

Dianne Sandler - *Police officer, Medford*

Scott Sonenshine - *Nurse Manager, Rogue Valley Medical Center Psych Unit*

PHYSICIANS

Mark Bradshaw - *Medical Director, Jackson County Mental Health*

Ken Buccino - *Director of Emergency Department at Rogue Valley Medical Center*

Dick Phillips - *Psychiatric Director of Rogue Valley Medical Center Psych Unit*

George Schultz - *Internist, Providence Medical Group*

CHILDREN'S MENTAL HEALTH SERVICES - SEDK

Arnie Green - *Director Community Works, a children's mental health outpatient treatment provider*

Tom Gunderson - *Director, Southern OR Child Study and Treatment Center – a day and outpatient children's mental health provider*

Bob Lieberman - *Director, Southern OR Adolescent Study and Treatment Center – a children's residential and outpatient provider*

Donna Lippareli - *Supervisor, Childrens Mental Health Services, Josephine County*

Harriet Saturen - *Supervisor, Childrens Mental Health Services, Jackson County*

SYSTEM USERS AND ADVOCATES GROUP

Al Ames - *NAMI - Jackson*

Peter Buckley - *State Representative, Ashland*

Caren Caldwell - *mother of a severely mentally ill adolescent*

Pat Garoutte - *NAMI - Josephine*

Donna Giacolini - *consumer of mental health services*

Chris Hince - *consumer of mental health services*

REPORT BACK TO CEOS – NEXT STEPS

Hank Collins, *Director, Jackson County Mental Health*

Tom Hannenberg, *CEO, Providence Hospital*

Barry Kast, *Best Practices Researcher*

Mark Marchetti, *Ashland Hospital* **Roy**

Vinyard, *CEO, Asante Hospital*

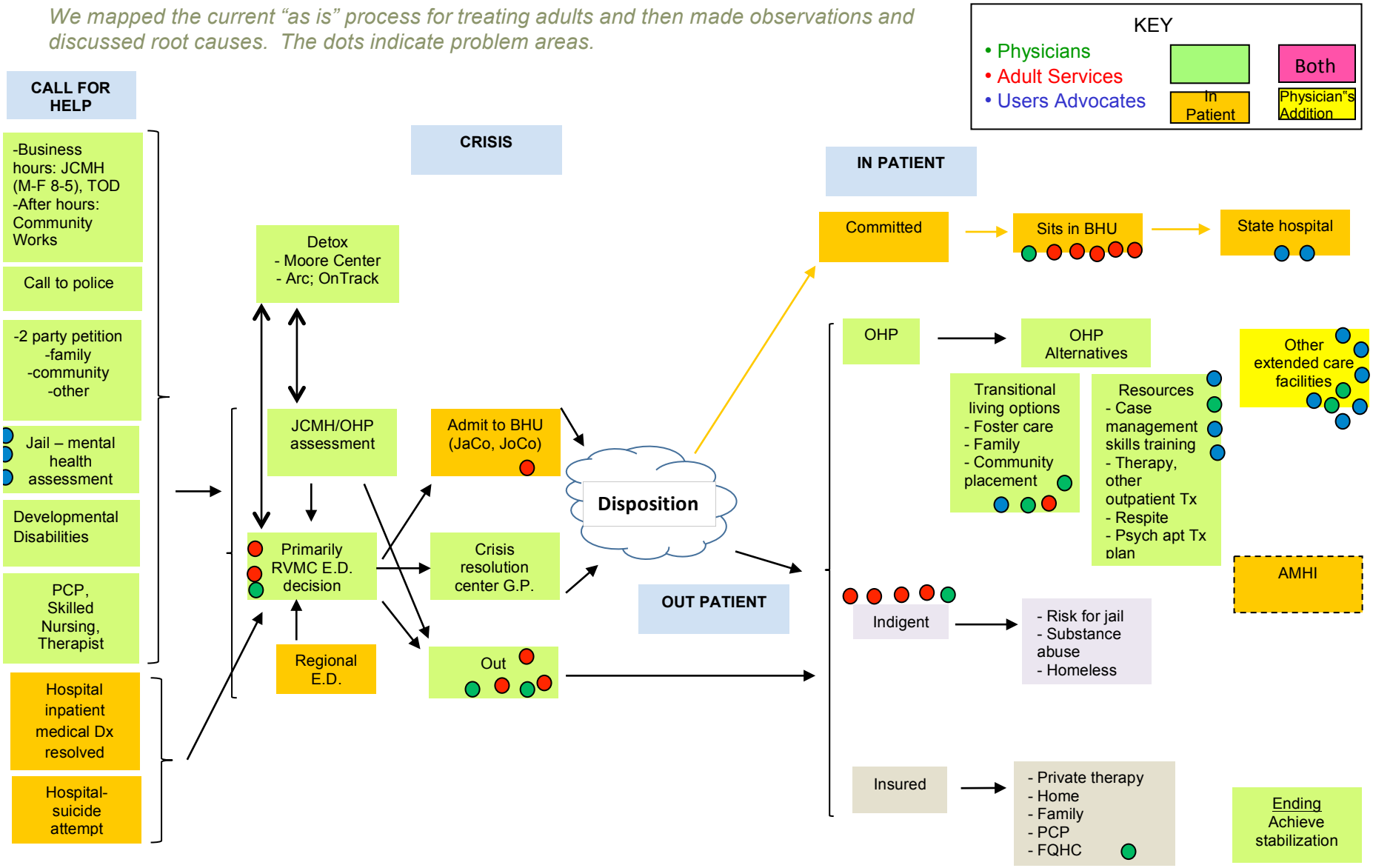
FACILITATION

Barbara Cecil
Reola Phelps

contents

adult mental health services group • SPMIA: process map (updated 1-29-13)

We mapped the current "as is" process for treating adults and then made observations and discussed root causes. The dots indicate problem areas.



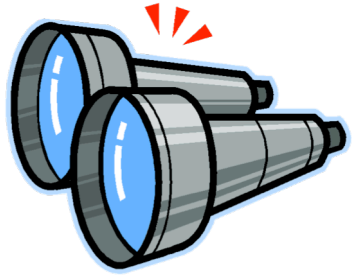
Disposition: what happens?

- 14-day hold – two doctors to hold
  - Commitment process
    1. PCI Pre-Commitment Investigation: decided by day 3 to go to court, be released, signed in voluntary at the CRC, or signed in 14 day commitment at the BHU or CRC
    2. Civil commitment hearing
    3. Committed for 180 days
    4. BHU (2 North then to community placement on conditional release via ED) or state hospital
    5. Stable
    6. Back to county and community placement
       - Step down facility: Hazel center, Hugo Hills, Carniham
       - Foster care or family

observations & root causes

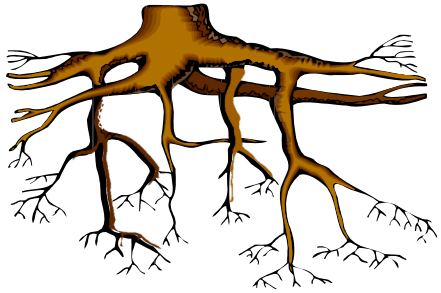
Observations

- People being released at all points of the system when they need more help.
- Release from the E.D. is a big decision point.
- Eligibility interface – hospitals treat everyone, then discharge. Then your ability to pay determines care.
- Patients in BHU staying in the wrong place too long.
- Further out in the system you get, the less recycling loops and more intervention. Also more hospital interventions that are costly.
- Got to jail → lose benefits – no medical insurance. People lose ground and get worse.
- Need shared incentives.
- Straightening out the system is good financially – saves money.
- Screening should not be done at E.D. – cost of an E.D. visit sucks money out of the process.



Root Causes

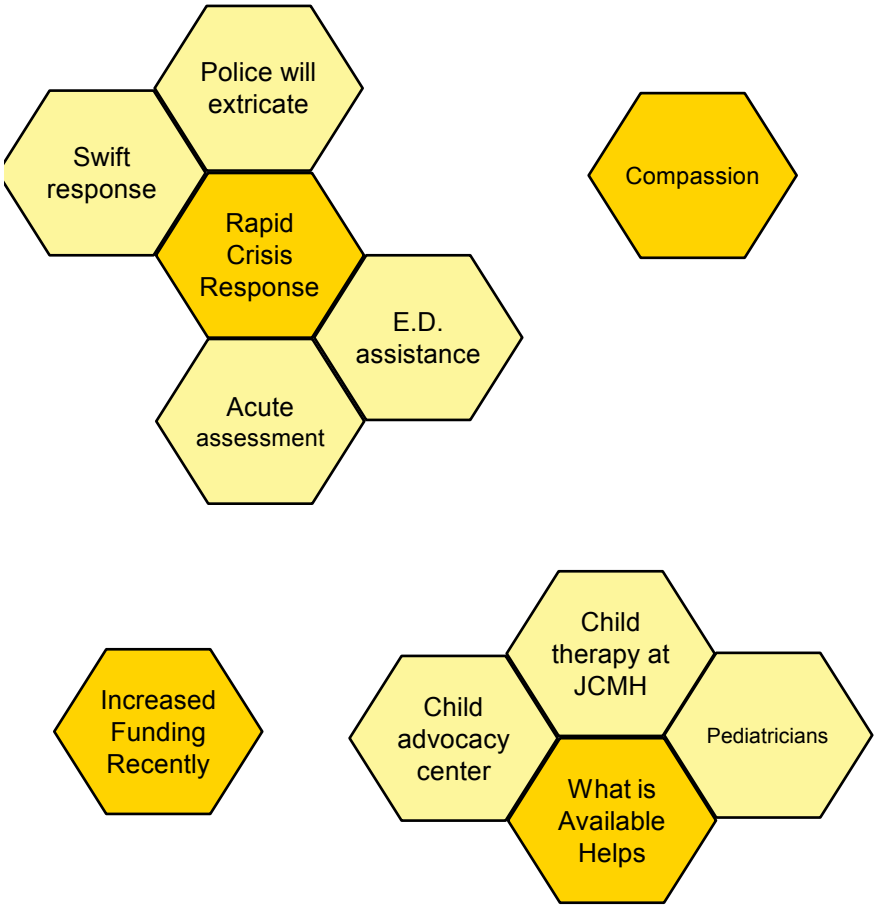
- Inadequate medical coverage – a political issue.
- Mental health is not seen as part of the system.
- Social problems – no place to go – not really medical or psychiatric.
- Interest of society in these problems decreasing. Responsibility down.
- Expectations of society to fix the problems high. Sense of entitlement.
- ECMU rules regarding BHU.



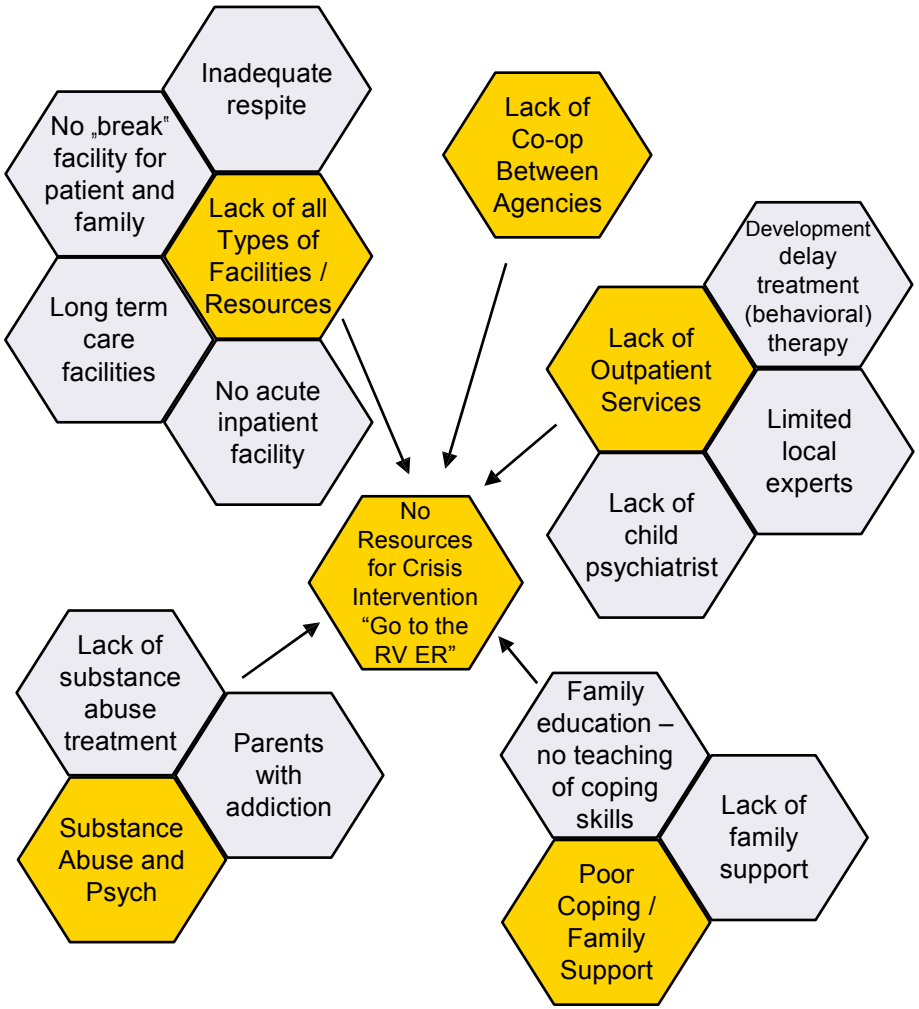
physicians: what works? • where are the gaps for children?

We looked at the map for adult services, added to it and dotted where we believed some of the most serious problems are. We also gave our observations and root causes. We then turned our attention to the services for children and mapped out what is working and where the current gaps are.

Collectively, what do we do well?



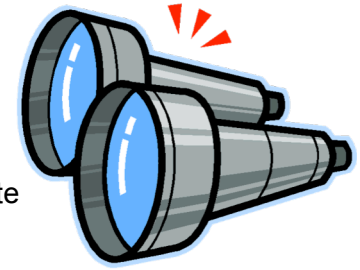
Collectively, where are the gaps?



physicians: observations & root causes

Observations

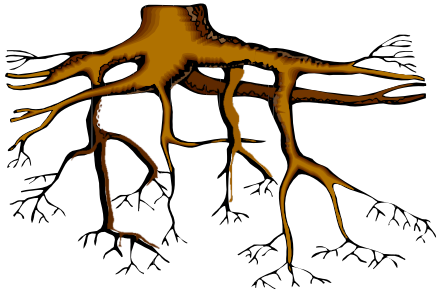
- No urgent assessment (emergency) that is separate from the emergency room – need a psychiatric emergency room.
- Huge pressure on E.D. So many arrows point to E.D. – should not be the center of psychiatric care. We are not the right people to "call their bluff."
- People sent to us who should go to jail – stay in jail. If mention "suicide," system identifies as Mental Health.
- Studies show therapy works to reduce recycling (stillpoint working). Too much reliance on medication – cuts in case management and therapy. Poor care if medication is seen as the answer.
- Funding – when people leave OHP it is a real problem we can't ignore. Expected to be "doing everything with nothing."
- Lack of communication / adequate assessment between JCMH and E.D. – hand-off a problem.



- Not enough capacity in respite – acutely intoxicated can't go to respite.
- Not realistic to separate substance abuse and mental health.
- Problem to release after civil commit hearing.
- When "hold" dropped, we have "frequent fliers."
- Missing step down.

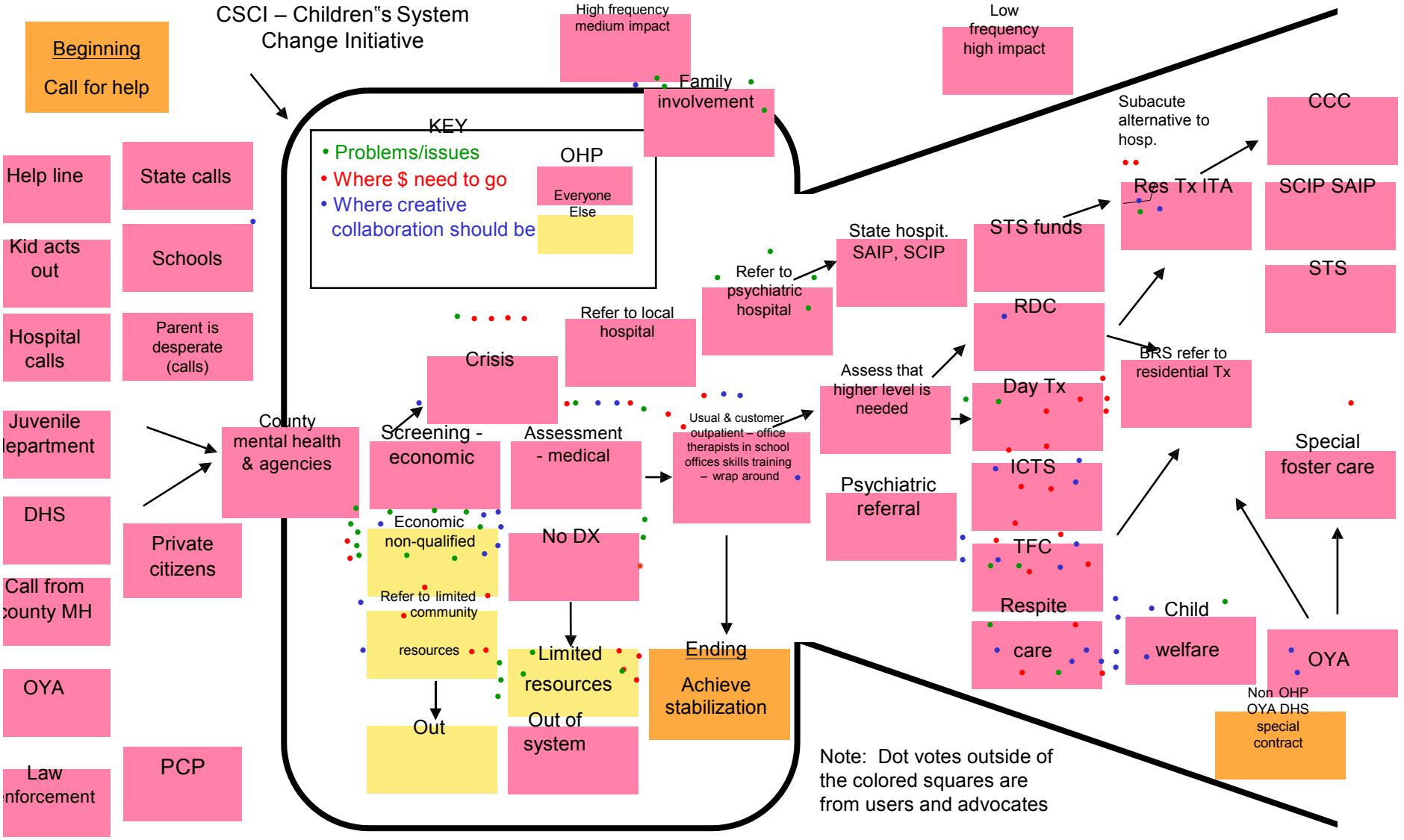
Root Causes

- The decision making process is not right at E.D. Doctors can't make good decisions about where people should go – they are not trained to do this.
- Lack of therapy for personality disorders.
- Lack of support and community services for acute psychiatric patients.
- No facility for acutely intoxicated patients – no sobering up center.
- Eligibility for OHP +.



children's mental health services • SEDK: process map for children

We began by mapping the current process for services for children and giving our own observations and root causes. We then looked at and discussed the work the physician's had done regarding children's services. ***PLEASE SEE ATTACHMENT FOR UPDATED VERSION.***



observations & root causes

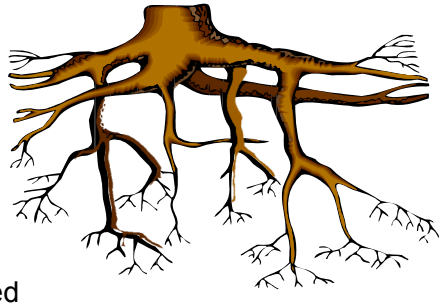
Observations

- We know how to serve kids in both the "ball" and the "horn." Where we need focus is the linkage between the two.
- Our goal is to keep kids at home, in school, out of trouble, with friends.
- Resources to serve kids are inadequate.
  - Outside OHP.
  - Inside OHP.

- There is money, but it is divided among agencies.
- Can't rob from one to give to another.
- Have the right number of beds – need to use money more wisely.
- Doctors have misconception about the new funding.
- Intensive community-based services need beefing up.
- Not good services for eight and under.
- Need alternatives to psychiatric hospitals.
- Need to hear from parents.
- Level of complexity is great! Need interconnections, interdependence.
- What are ways to really get families involved?
- Focus on do-able things.

Root Causes

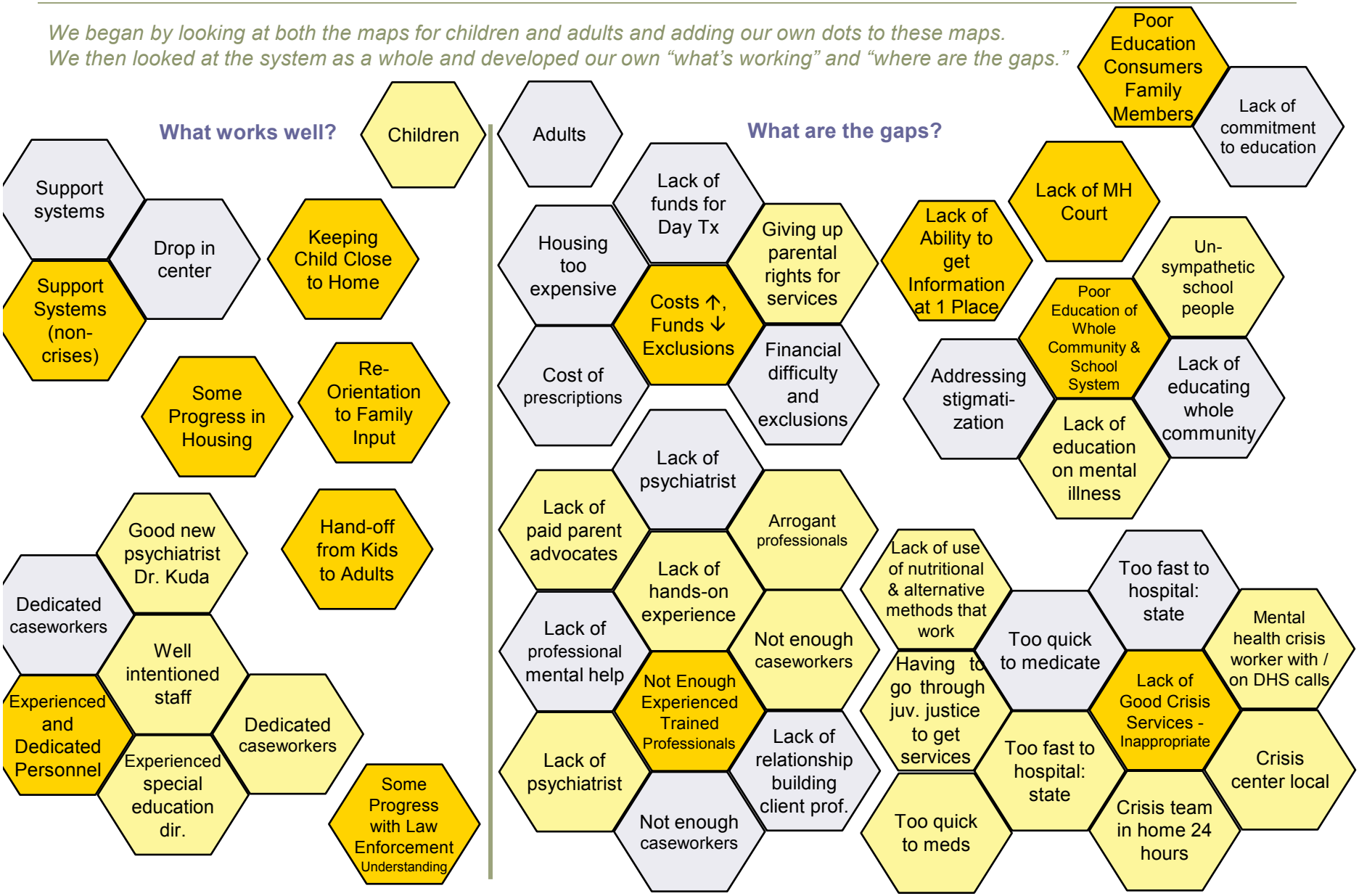
- Structural barriers between agencies causes lack of flexibility. Difficulty in working with the state and funding. Could put together a blended financial package with the right waivers in place. Do away with entrenchment of agencies through political will.



- Lack of money.
- Our problems reflect society's lack of value on children. How can we shift this in our community?
- We must get away from a victim mentality. Our organizations get traumatized just like our kids.

system users & advocates group: what's working? where are the gaps?

We began by looking at both the maps for children and adults and adding our own dots to these maps. We then looked at the system as a whole and developed our own "what's working" and "where are the gaps."



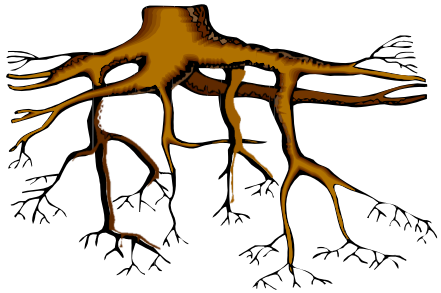
system users & advocates group: observations & root causes

Observations

- Merry Go Round – vicious cycle – release with nowhere to go. No long-term plan or follow-up.
- Model for treating should be long-term stabilization. But the percentage of people who can recover is higher than we think – especially kids.
- No long-term care facilities so recycling.
- Need more community involvement.
- Need dialogue among professionals – integration of knowledge – respect for families-data-experience.
- Old belief that cause of mental illness is the parent – no!
- Lack of a coordinated mental health system – need integration.
- Not enough help / intervention in the schools.
- Need for non-OHP people to get in the system – nowhere to go.
- Treatments may not be working – need alternatives – need research into causes and treatments.
- The diagnosis fits the professional"s model.
- Police are the crises team – they don"t want to be and try not to be – money in the jails.
- Lack of housing stigma.

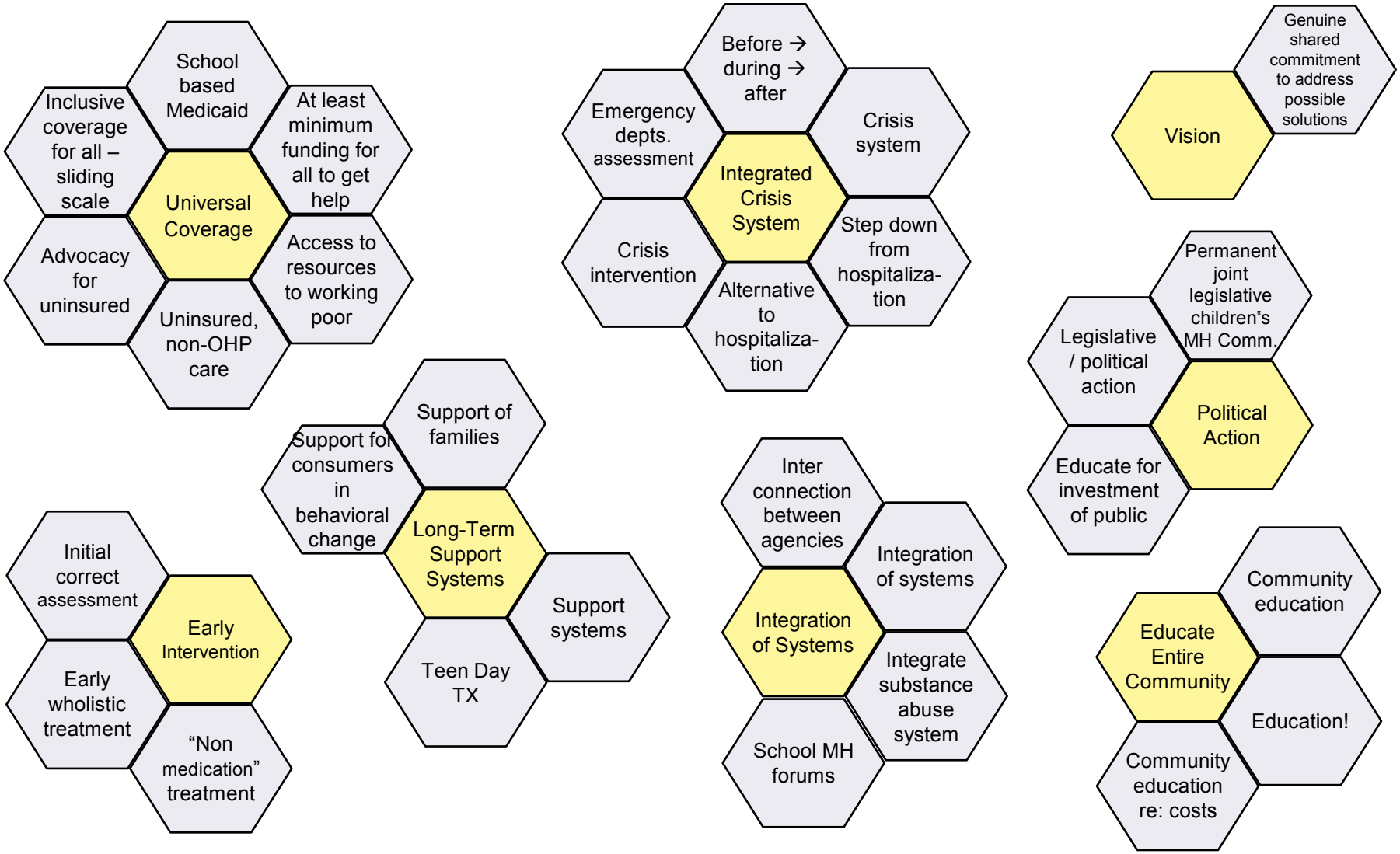
Root Causes

- Kids lack early, correct diagnosis and treatment close to home.
  - Lack of thorough assessment – blood, nutrition.
- Field seen as "emotionally disturbed" when should be "mentally ill" – a difference.
- Not enough money for thousands who get no assessment or treatment.
- Spend money early – up front.



key leverage areas

All of the participants from the entire week gathered and began by doing a Gallery Walk, looking at all of the maps and the output of the various groups. To summarize, we then created these Key Leverage Areas – places where a bit of energy will create significant change in the mental health system.



report back to CEO's: next steps

The CEOs met, reviewed and discussed all of the output of the week and mapped out the next steps.

Road Map

Mapping Week / Key Leverage Areas

CEO decisions/ actions

- Vision, overall commitment
- Facilities
- Structural / organization integration

Areas addressed by participants / stakeholders

- Planning team
- Solution building session(s)
- Solutions approved
- Implementation quick hits
- Institutionalized

What Works

- Planning Team:
  - Small (8-10 people).
  - Stakeholder groups represented.
  - Time frame required – number days in solution building.
  - Who are decision makers.
  - Participants and topic – gather data – Best Practices
- Establish criteria for solutions, e.g., implement in six months, no new funding.
- Concentrated problem solving and decision making.
  - 2-3 continuous days.
  - Recommendations presented at end to decision makers.
  - As rapid as possible decisions – go / no go.

NEXT STEPS

CEO Group

- Add more people / practitioners to this group.
- Pay attention to the left column.
- The expanded group will think through the actions / steps on the left column.

Planning Team

- Create a Planning Team – 8 – 10 people from different areas who participated this week.
- This team will be focused on the right column.
- They will develop a set of criteria for choosing areas to work on.
- They will choose 3-4 areas from the Key Leverage Areas on which we can make some progress.
- They will develop a set of criteria for potential solutions.
- The Planning Team will meet with the CEO Group to present the above and get approval to move forward on trying to develop solutions for the 3-4 areas they choose.