HSRI

Milwaukee Psychiatric Crisis Service Redesign

Phase 1 Adult Services Planning Summary

December 2018

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1. Introduction

For the past decade, the Milwaukee County Behavioral Health Division (BHD) has been engaged in a long-term transition to a more community-based continuum of care for residents needing mental health and substance use treatment and services. As the latest phase of this process, the County has made a decision to close the Milwaukee County Mental Health Complex (MHC) inpatient units and contract with a private provider for inpatient behavioral health services.

The MHC is also the site of the BHD-operated psychiatric emergency department and observation unit (known as PCS). With the shift to contracted inpatient units, it no longer makes programmatic or financial sense for BHD to operate a freestanding PCS at this site. BHD also sees this pending change as an opportunity to redesign the entire psychiatric crisis service system consistent with its continued goal of transitioning to a more community-based system of care. To fully consider an array of models for both psychiatric emergency department and community-based services, BHD has collaborated with the Milwaukee Health Care Partnership to commission an analysis aimed at redesigning the county's full psychiatric crisis service system.

While the timing is not yet certain, it is assumed the redesigned system is to be implemented in full in 2021. A number of preliminary steps need to be taken, including some that are already underway, to build up to the final system.

The redesign project was guided by a team consisting of the Wisconsin Policy Forum (WPF), the Human Services Research Institute (HSRI), and the Technical Assistance Collaborative (TAC). The planning and implementation process consisted of:

1) Convening a public-private Advisory Committee to participate in all aspects of the planning, decision-making, and implementation.
2) Developing a set of basic assumptions to guide the planning process.
3) Conducting an environmental scan, including interviews and focus groups with stakeholders, review of the current system services including functions and utilization rates, and review of national models and best practices.
4) Reporting the results of the environmental scan to the Advisory Committee and presenting decision points, options, and recommendations (reviewed in several meetings during the course of development).
5) Convening an all-day planning meeting with the Advisory Committee to formulate the model for the redesigned system as it pertains to adults. (Held July 16, 2018.)
6) Convening a separate planning meeting to consider the redesigned system for children/adolescents, with a report to be issued separately. (Held September 18, 2018.)

This report summarizes the conceptual redesign plan for the adult psychiatric crisis system developed by the Advisory Committee with the assistance of the project team. A lengthier environmental scan document—containing data findings, results of key informant interviews,

descriptions of national models and best practices, and additional information used by the Committee to help develop and guide the plan—has been published as a separate document accompanying this summary. In addition, a summary of progress to date on the separate planning process for the child and adolescent psychiatric crisis system has been provided to the Advisory Committee by the project team.

The overall approach to the redesign process has been to frame it as an opportunity to design a system from the ground up, and to consider perceived shortcomings as opportunities for improvement. While incorporating lessons learned from past experience and seeking to retain the features of the previous system that were most effective, the goal of the redesign is to address gaps and limitations of that system and introduce forward-thinking innovations that will best serve the residents of Milwaukee County.

The Milwaukee Psychiatric Crisis Service Redesign has occurred as a matter of necessity, compelled by the closure of Milwaukee County's Mental Health Complex. It is occurring at an opportune time, however, as there has recently been a nationwide surge of interest, innovation, learning, and improvement in how psychiatric crisis services are organized and delivered.

2. Overview of the Current BHD Psychiatric Crisis Service System: Components and Utilization

BHD's current psychiatric crisis system for adults consists of the following components, briefly described below. A lengthier description is contained in our accompanying environmental scan document.

Psychiatric Crisis Services - Admission Center (PCS/Observation Unit)

Psychiatric Crisis Services (PCS) is a 24-hour a day, seven days a week psychiatric emergency room. This essential component of BHD's current system provides crisis intervention and face-to-face medical/psychiatric assessment for individuals who are, or who believe themselves to be, in psychiatric emergency and in need of psychiatric assessment, treatment, and/or referral. PCS physicians also provide medical oversight and consultation for all Crisis Mobile Team, Crisis Assessment Response Team (CART), Community Consultation Team (CCT), and Geriatric Crisis Services. All individuals admitted to BHD's inpatient units are evaluated first in PCS, as are individuals brought in on Emergency Detention, under Chapter 51 of the Wisconsin Statutes, by law enforcement.

Crisis Line

The Crisis Line is the community access line for adult crisis services in Milwaukee County. In 2017, IMPACT 2-1-1, a community agency, began answering the first line of calls on the Crisis

Line. IMPACT 2-1-1 handles all calls for resources and triages crisis calls to a clinician on the Crisis Mobile Team for immediate response.

Crisis Mobile Team

The Crisis Mobile Team (CMT) consists of master's level clinicians and nurses who provide community-based crisis services to individuals ages 18 and older. CMT provides crisis response, assessment, linkage to services, and follow-up support to people throughout Milwaukee County 24 hours a day, 365 days a year. Coverage is provided first and second shift by Milwaukee County staff; the third shift is covered by a contracted provider. For the first shift there are two or three teams, and for the second shift and weekends there are one or two teams. BHD is working to increase proactive follow-up to ensure people's needs are being met post crisis. BHD projects that there will be 3,200 CMT contacts in 2018.

Geriatric Crisis Services

Dedicated geriatric psychiatric crisis intervention and stabilization services are available on a mobile outreach basis for individuals age 60+. A designated geriatric psychiatric nurse specialist is also available to connect with people in need.

Crisis Assessment Response Team (CART)

CART is a co-responder program that pairs master's level clinicians with law enforcement officers who have received crisis intervention training (CIT). CART responds to mental health calls that are dispatched through law enforcement or the Crisis Mobile Team, or by proactive response by the officer. Currently, there are five teams, with three teams serving the City of Milwaukee, one team serving West Allis, and one team serving all of Milwaukee County. A sixth team is currently in the process of being developed in collaboration with the Milwaukee County Sherriff's Department. Unlike CMTs, CART services are not available around the clock. The City of Milwaukee teams are available 11am-10pm M-F and 11am-7pm on weekends; the West Allis team is available M-F from 11am-7pm; and the county-wide team is available M-F 9am-5pm.

Community Consultation Team (CCT)

Specializing in helping individuals with co-occurring intellectual/developmental and mental health needs, the team goes into the community to provide crisis response. CCT also offers ongoing education and consultative services for providers and offers support to family members.

The Access Clinic

The Access Clinic is a short-term stabilization clinic that provides comprehensive assessment, brief term recovery planning, care coordination, peer services, psychotherapy, prescriber services, assertive outreach and follow-up, and referral and linkage to needed services. The Access Clinic primarily serves individuals with no insurance.

Crisis Stabilization Houses

Crisis Stabilization Houses are two licensed Community Based Residential Facilities with 16 beds each serving people with significant mental health needs for up to six months (there are short-term beds with stays of around 14 days and long-term beds with stays up to 6 months). CSH is operated by a community-based partner in collaboration with the Crisis Mobile Team. CSH provides a caring, supportive, and therapeutic environment to assist people to stabilize and to meet their individualized needs. Clinicians and nurses from the Crisis Mobile Team have daily strengths-based interactions with each person to ensure their mental health and physical needs are being met in a strengths-based, trauma-informed, and person-centered manner. Clinicians and nurses coordinate each individual's care, provide short-term crisis therapy (motivational interviewing), facilitate team meetings with the person's care team (comprised of both formal and informal supports), and collaborate with house staff.

Crisis Resource Centers

Crisis Resource Centers (CRCs) provide people who are experiencing a mental health crisis a safe and supportive environment to meet their individualized needs. CRC services are funded by BHD and provided by a contracted community partner. There are two CRCs – one in the northern part of the city of Milwaukee and one on the south side – with a total of 27 beds, including 8 beds that were converted from CSH to CRC beds in 2017 to better meet community needs. Services are wrapped around the individual's full array of needs to support stabilization in a community setting. Onsite supportive services include peer support, clinical assessment, access to medication, short-term therapy, nursing, supportive services, recovery services, and linkage to ongoing support and services. CRCs provide extensive stabilization services to prevent emergency room visits or hospitalization. The average length of stay is 5-7 days. People are directly referred to CRCs through BHD Crisis Services and community agencies; others are self-referrals, either via phone or walk-in.

Community Linkage and Stabilization Program (CLASP)

CLASP is a community-based peer specialist program. People are voluntarily referred to the program through one of the Crisis Services programs (CRC, Crisis Mobile Team, CART, Team Connect, Observation Unit, Inpatient Units, Access Clinic).

Team Connect: Short-Term Follow-Up

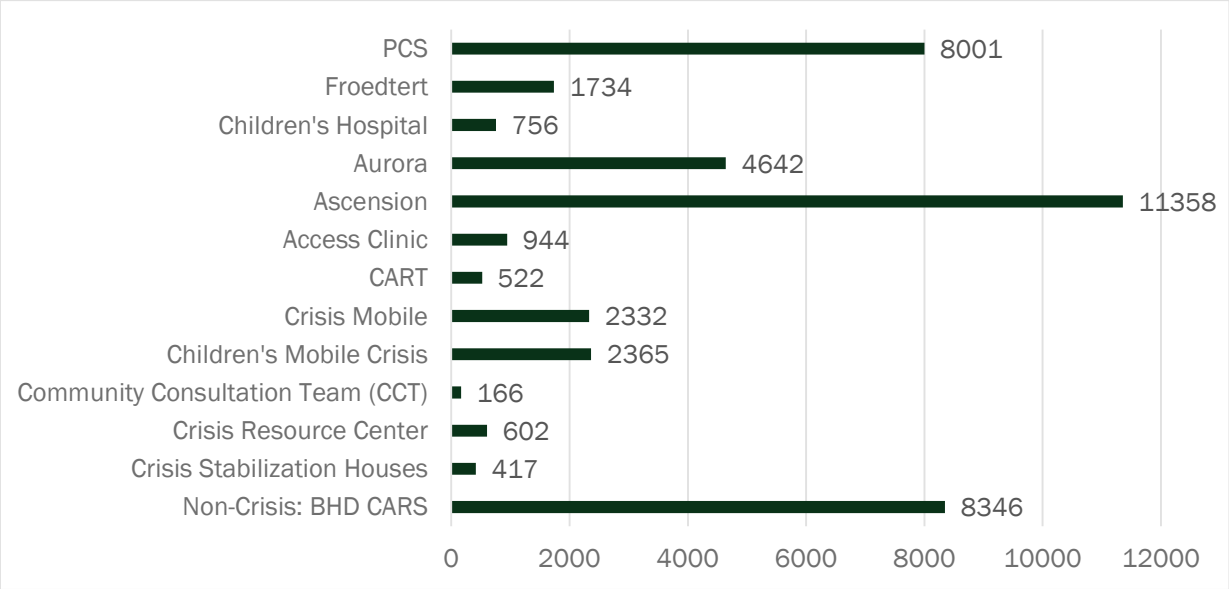
Team Connect consists of master's level clinicians and peer specialists who provide services to individuals who are discharged from PCS, the Observation Unit, or the BHD inpatient units. Team Connect provides additional support via telephone and in person to people as they return to the community to reduce the risk of harm.

Figure 1 shows the number of individuals assessed or served in 2017 in Milwaukee County by the crisis programs directly run or contracted for by BHD and those served by the private health

system emergency departments. To provide a sense of post-crisis capacity, utilization of BHD's Community Access to Recovery Services (CARS) non-crisis services is also shown. The distribution of utilization across both BHD services and private systems demonstrates the importance of joint planning and participation by both public and private stakeholders in a redesigned psychiatric crisis system.

Figure 1

Numbers assessed or served by crisis programs in 2017



Note: The data represent admissions to ERs and BHD programs for persons with a primary behavioral health diagnosis. Legal disposition is not consistently collected in ERs and these data reflect the combined numbers of voluntary and involuntary admissions.

Implications of BHD Psychiatric Crisis Service Utilization for System Redesign

The environmental scan portion of the project involved collection and analysis of utilization data from BHD and private health systems. Detailed consideration of those data is contained in the environmental scan document that accompanies this report.

The data available on the flow of individuals through the system and characteristics of those being served reveal some key considerations for future crisis service design in Milwaukee County. Certain zip codes (e.g., 53215, 53204, 53218, 53209) have a higher concentration of individuals served by some crisis services, suggesting that these areas should be considered as possible priorities for siting of any new crisis (especially diversion) programs.

The data also show that nearly a third of PCS admissions are walk-ins, possibly indicating a lack of other crisis alternatives available for those individuals.

These data also suggest that for many BHD crisis programs, the predominant way of accessing the service is by way of law enforcement involvement—a potentially traumatizing experience. It

would be useful to know what proportion of emergency detentions were “lifted”, which would indicate potential diversions; however, this information is not collected systematically.

Age ranges are similar for all services, with the exception of PCS, which serves more youth (under 18) and transition age youth (between the ages of 18-25) than others, but fewer individuals age 40 and above. CART also serves a relatively high percentage of transition age youth. These data suggest that crisis models considered should take into account the needs of youth, as more than 1 in 5 individuals currently receiving crisis services through PCS are under 18.

The proportion of African Americans served in the systems is notable, especially in PCS (nearly 60%), as census figures indicate that African Americans comprise 27% of the population in Milwaukee County. These data indicate that cultural competency should be a key consideration in the selection of crisis service options.

Private Health Systems Emergency Utilization

For future crisis service planning purposes, it is also important to understand who is being served by private health systems and how these individuals flow through those systems. Availability of specific data elements varied among facilities reporting. The following is a summary of relevant data highlights based on information provided.

- Ascension: Of the 11,358 individuals assessed for behavioral health issues, about half were male and about half were non-white. More than half were diagnosed with a substance use disorder, and disposition for about 80% was return to home, with fewer than 2% admitted to a private behavioral health inpatient facility.
- Aurora: Of the 4,642 individuals assessed, only 2% were under involuntary status, with three-quarters admitted as walk-ins and the same number given a mental health diagnosis. Approximately 40% were discharged to home and about the same proportion were admitted to a private inpatient psychiatric facility.
- Children’s: Fewer than 2% of the 756 admissions were assessed under involuntary status, about three quarters were walk-ins, and a quarter arrived by ambulance. About half were non-white, and nearly all were under the age of 18, with about a third in the 14-17 age range. About 9% were admitted to private psychiatric inpatient facilities.
- Froedtert: Only about 6% of the 1,734 admissions were under involuntary status and about three quarters were given a mental health diagnosis. About half were male, White and African American individuals were seen in about equal numbers, 16% were admitted to inpatient medical care, and 10% were admitted to private behavioral health inpatient.

These statistics demonstrate that the psychiatric crisis system in Milwaukee County is not limited to BHD services, but also includes extensive use of services provided by private health systems. Consideration of how to improve and enhance the relationship and partnership between BHD and private health systems throughout the psychiatric crisis service continuum was deemed to be a key element of redesign planning.

3. Redesign Plan: Assumptions

Following the completion of the environmental scan and review of the report by the Advisory Committee, the committee engaged in planning to formulate a conceptual approach for the redesigned crisis service system. Planning was guided by the following assumptions developed by the Advisory Committee.

Legal and Regulatory Assumptions

- Under WI statute, Milwaukee County BHD serves as the "Treatment Director" and has the authority to detain individuals who meet certain criteria, including being a risk to themselves or others, under emergency detention. The Treatment Director role is assigned to the BHD Chief Medical Officer or their designee(s).
- Under statute, law enforcement has the responsibility to place individuals they believe meet criteria under emergency detention in the field, and to convey these individuals to the County's designated treatment facility.
- Under statute (Chapter 51), the "Treatment Director must assess and authenticate the legal disposition of individuals placed under emergency detention by law enforcement. In Milwaukee that determination must be made within 24 hours of an emergency detention order."
- In addition to assessing and authenticating the legal status of individuals, the Treatment Director function must ensure for the stabilization, immediate treatment, and safe discharge disposition for individuals placed under detention and connect individuals to the next appropriate level of care.
- Milwaukee County could identify additional "designees" to perform the Treatment Director duties, but there are legal, fiscal, and clinical practice philosophy reasons for the County to maintain exclusive operational responsibility for those duties.
- Under statute, Milwaukee County must provide a place (either itself or via contract with an outside entity) where persons taken into custody by law enforcement officers under Wis. Stat. § 51.15 ("Emergency detention") can be detained, evaluated, diagnosed, and treated.
- Under § 51.15(2), a law enforcement officer who takes a person into custody is required to transport that person to one of the following facilities: "Detention may only be in a treatment facility approved by [Wisconsin DHS] or the county department, if the facility agrees to detain the individual, or a state treatment facility."
- It is unlikely that Chapter 51/emergency detention rules and regulations will change within the next 3 to 5 years.
- Milwaukee County DHHS/BHD can influence law enforcement and court policies and practices, but it will take time and resources to transform the practice philosophy and behaviors of the judiciary and the 20+ municipal law enforcement agencies in Milwaukee County. There is an opportunity to engage law enforcement, particularly if redesign strategies can be shown to reduce time spent by law enforcement addressing individuals in crisis.

Law Enforcement Assumptions

- Law enforcement personnel issue emergency detentions as a mechanism to address complex clinical and behavioral incidents and to efficiently discharge their responsibility for the safety and protection of citizens.
- There will continue to be variation in law enforcement emergency detention practices across the 20+ municipal law enforcement agencies in Milwaukee County, given the sheer number of agencies and personnel as well as the socio-economic diversity of the populations they serve.
- Law enforcement personnel value clear policies and destination protocols for transporting and transferring patients and will continue to want to discharge their legal custody and documentation responsibilities in a timely and efficient manner so they can return to community policing.

DHHS/BHD Operating Assumptions

- Milwaukee County DHHS/BHD will outsource inpatient care for county residents under emergency detention to Universal Health Systems and will not continue to operate a psychiatric emergency department at the Milwaukee County Mental Health Complex. (Estimated closure date: 2021).
- As the outsource inpatient provider, Universal will assume responsibility for being the primary receiving facility for inpatient care for all County residents placed under emergency detention; either directly or under transfer agreements with private behavioral health inpatient providers.
- Under the DHHS/BHD contract, Universal will ensure timely inpatient access for all county residents under emergency detention who require hospitalization or BHD will need to arrange for stabilization or inpatient care at private health systems or State institutions. BHD will be responsible for ensuring the safety and clinically appropriate care for patients waiting for inpatient admission, should an inpatient bed not be readily available.
- Universal will have responsibility for transition care planning for inpatients prior to discharge, though it is in BHD's best interest to ensure that such planning be effective. BHD will likely assist in such planning to prevent emergency crisis or inpatient readmissions.
- Universal has indicated that it will not operate a psychiatric emergency department, though it may be willing to operate an admission/intake center. BHD will retain the duties of the "Treatment Director" function including responsibility for the stabilization, clinical and behavioral assessment, immediate crisis treatment, discharge disposition determination, and transition care management (navigation and linkage) for patients under emergency detention; serving as the "gatekeeper" to ascertain involuntary status, inpatient admissions, and/or community-based service and care management connections.
- Milwaukee County will not invest additional property tax levy, above the amount currently expended, on the psychiatric crisis continuum of services, and BHD would like to reduce its total expense for its psychiatric crisis services operations.

- The current BHD psychiatric crisis system experiences some cost efficiencies associated with the cross coverage of psychiatrists and behavioral health professional and support staff across the current continuum of psychiatric crisis services (PCS, Observation Beds, Access Clinic, and Mobile Crisis and Team Connect transition care management). The redesigned system will retain this characteristic.
- But BHD also currently experiences higher operating expense and revenue shortfalls due to County overhead and legacy expenses, the cost of ancillary and support services, current facility design and maintenance expenses, HIT limitations, and billing inefficiencies. These will change under the new model, with the potential for additional gains in efficiency.

Private Provider Operating Assumptions

- Private health care providers have responsibility for the assessment, stabilization, treatment, and transition care management for individuals with mental health and substance use disorders who are NOT placed under emergency detention; be that in emergency department, inpatient, or outpatient settings.
- Under EMTALA, private health system providers are also responsible for providing medical services and medical clearance for patients under emergency detention who are in their emergency departments.
- There is variation in the clinical capabilities among private health systems to effectively care for patients with mental health and substance use disorders in ER, outpatient, and inpatient settings. These variable capabilities are exacerbated by behavioral health provider workforce turnover and shortages.
- The health systems recognize the need to enhance their capabilities, and some are already actively working to address this.
- Private health systems benefit from having a dedicated psychiatric emergency department which has the clinical expertise, physical environment/milieu, legal acumen and personnel, and efficient Treatment Director stabilization, assessment, disposition, and transition care management functions. Private hospitals and Milwaukee County DHHS/BHD would not be able to replicate these services in multiple ER settings cost-effectively, given the unique expertise and treatment setting required; this is compounded by significant behavioral health professional workforce shortages.

Medicaid Managed Care Assumptions

- The majority of individuals in a psychiatric crisis who are placed under emergency detention are covered by Medicaid and are enrolled in a BadgerCare, SSI, or Family Care Medicaid managed care organization (MCO), given the State's expanded Medicaid managed care system.
- The 10 Medicaid MCOs serving Medicaid beneficiaries in Milwaukee County are accountable for ensuring positive health outcomes, per contract and pay-for-performance incentives, and for ongoing member care management. They are also financially incentivized to reduce avoidable health care utilization and associated cost. DHS is also creating new contractual

requirements and incentives for MCOs to enter into Alternative Payment Models (APMs) with providers to improve outcomes and member satisfaction and lower costs.

Integrated (Public/Private) Delivery System Assumptions

- There are gaps in behavioral health prevention, early intervention, outpatient, and non-emergency crisis resources for individuals with mental health and substance use disorders. These gaps in access are particularly acute for uninsured, underinsured, and Medicaid beneficiaries and influence the rates of emergency incidents and detention placements.
- Treatment gaps may be linked, in part, to the fact that individuals are not always aware of and do not seek care in non-emergency settings.
- Low Medicaid reimbursement rates contribute significantly to gaps in provider participation and access to outpatient or alternative and non-emergency crisis services.
- Behavioral health provider workforce shortages further exacerbate gaps in access and result in delays in treatment and increased crisis incidents.
- Increasingly, telemedicine and teleconsultation services are being implemented to address workforce shortages and ensure timely, clinically appropriate, and more cost-effective care.
- There are significant gaps in the exchange of demographic, health care, and care plan information within and across providers and care management organizations, including managed care organizations/issuers. WISHIN is evolving as a multisector tool for clinical and care plan information exchange.

Consumer and Advocate Input

In addition to the above assumptions reflecting various perspectives on the redesign, input provided by consumers and advocates in focus groups held by the project team was used to inform redesign planning. A detailed description of consumer and advocate input is included in the environmental scan report.

4. Redesign Plan: Recommendations

After developing these overriding assumptions, the Advisory Committee turned to three models suggested by the project planning team as part of the environmental scan process to guide its decision-making process (a full description of those models, including pros and cons of each, is contained in the environmental scan document):

1. A centralized system organized around a single large psychiatric emergency facility, having arrangements with hospital emergency departments to receive individuals who have been medically stabilized. It may or may not be hospital-adjacent and may or may not be hospital-operated/staffed.
2. A decentralized system, with multiple sites providing a diverse array of crisis services including some capacity for receiving individuals on petitions. This array of smaller sites could be adjacent to or affiliated with other types of facilities such as shelters or FQHCs and

would be strategically located in the community to provide accessible crisis walk-in services. Sites could be a mix with some providing voluntary services only and others accepting involuntary admissions.

3. A dispersed system with county investments largely in non-emergency department settings, with an intention of shifting the bulk of crisis episodes out of the ED. In this model, private health system emergency departments would focus their attention on a smaller group of individuals with more complex healthcare needs who essentially need to be served at this level of care.

The Advisory Committee recommends a system that generally adheres to Model 3, with the proviso that the system include some form of dedicated psychiatric ED. That facility is envisioned, however, to serve a much smaller number of persons than the current PCS and a narrower population largely limited to individuals on petitions and those who require highly specialized, intensive care for their complex needs. This conceptual approach was selected with the understanding that the precise structure of the system would depend on a variety of contingencies and questions of feasibility, some of which have been addressed in initial planning and others of which will require further consideration.

In this model, BHD would function as Treatment Director and would oversee and coordinate a continuum of crisis services, delivered primarily through contracted providers. It is likely that implementation would take place over a multi-year period with gradual scaling up of some services and possibly some pilot projects to assess effectiveness and costs.

Implementation of the redesign would proceed on two levels: a program planning level and an organizational philosophy level. Programmatically, the redesign emphasizes a broadly collaborative community-based approach described in more detail below. Philosophically, there is a commitment to continue shifting toward a person-centered approach that emphasizes resolution of crises and rapid stabilization instead of disposition decision-making and overreliance on involuntary holds.

Additionally, there is consensus that to the maximum extent possible, crisis resolution should occur “upstream”—that is, the system should emphasize and invest in crisis prevention and resolution at earlier stages of a crisis, before more intensive, costly, and potentially restrictive interventions are required. There was agreement that this philosophical commitment needs to extend beyond direct behavioral health care stakeholders and that considerable effort must be undertaken to also extend it to law enforcement, justice system leaders, and the broader community.

As widely reported by stakeholders, BHD has made great strides in transforming its approach to crisis interventions in recent years. It was emphasized in the planning process that these efforts should continue and even be accelerated in the redesign. Central to BHD’s role in the redesigned system is oversight and support to ensure ongoing commitment to the principles cited above—prevention, crisis resolution rather than disposition, person-centered and trauma-informed care, coordination and collaboration throughout the system. Some possible activities for BHD in this area are to facilitate collaboration protocols and MOUs among service providers,

hold regular service system meetings to review problems and formulate solutions, and provide trainings to promote the use of person-centered care in crisis services.

5. The Redesign Model

The programmatic model recommended by the Advisory Committee emphasizes upstream prevention and early intervention, increased crisis competency, expanded and enhanced access to community-based crisis services (such as crisis mobile teams and telepsychiatry), and improved post-crisis recovery/reintegration services.

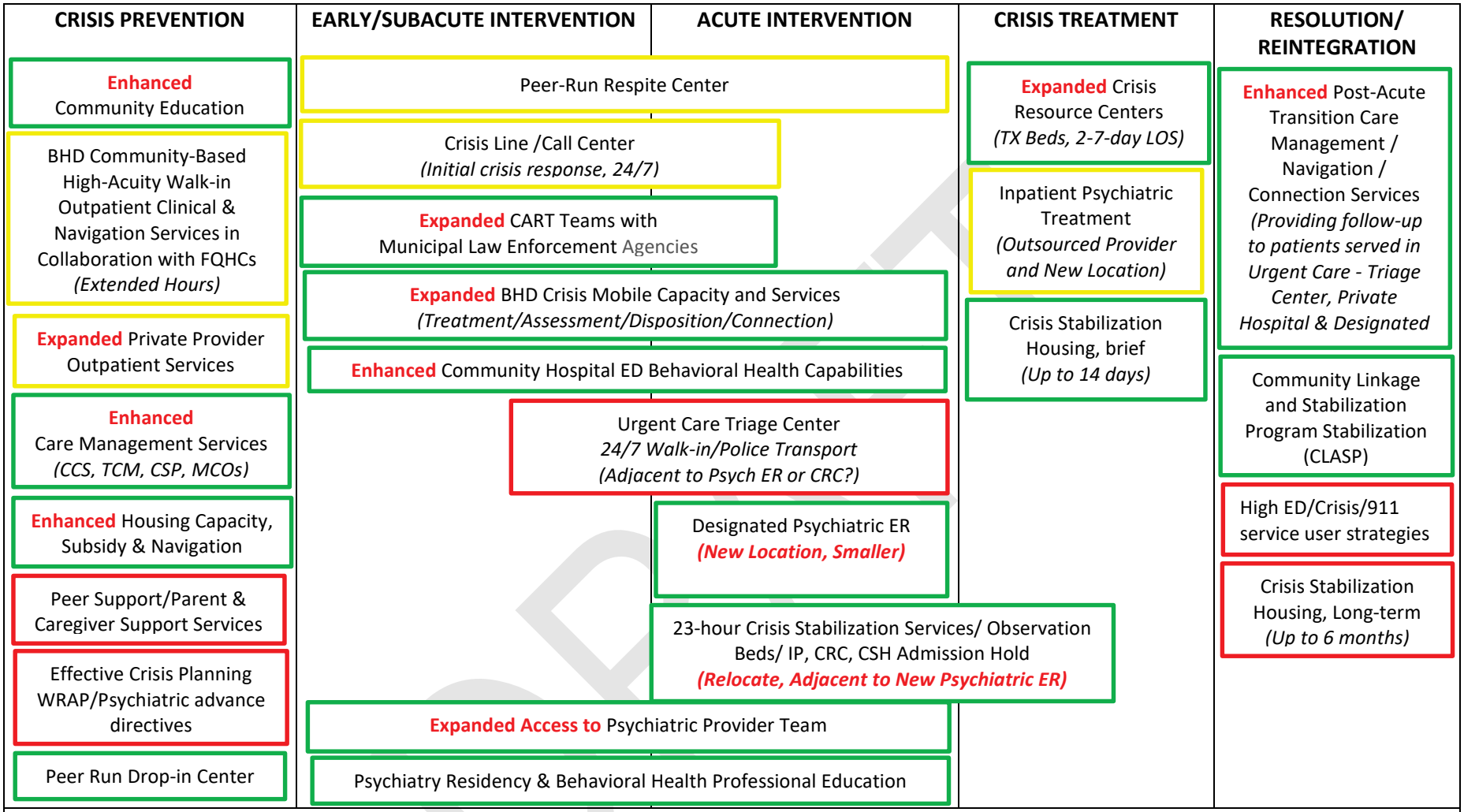
With the closure of PCS, some shift in service episodes to private hospital emergency departments is likely and some expanded behavioral health crisis expertise and capacity in those departments is anticipated; however, better front-door triaging and back-door coordination should reduce overall volume and lengths of stay in the emergency department and improve care continuity. In addition, transporting individuals from the emergency department to a separate facility for evaluation will be avoided by successfully resolving more crises in the ED.

Finally, the model recognizes that while some form of dedicated psychiatric emergency facility is still required, that facility should operate on a much smaller scale than the existing PCS and its usage should be limited to those individuals with the most highly complex needs.

Figure 2, on the following page, shows a diagram of the redesigned adult crisis system, as envisioned by the Advisory Committee. The system components have been color-coded based on their status within the current system at this point in time and represent the continuum from prevention to reintegration. Elements that support a continuum of care model are listed at the bottom of the diagram. Below, we summarize how current services and programs would be impacted by the redesign model:

Crisis Resource Centers: BHD funds two CRCs. These Centers serve as a key component for early intervention and diversion from EDs and inpatient treatment and are a step-down from these more intensive services. The redesign plan envisions a significant expansion of capacity and functionality for the CRCs. Expanded capacity would include greater allocation of beds for BHD consumers and increased functions would include providing for direct admissions from Crisis Mobile Team, CART, and Team Connect, as well as control of discharges.

Figure 2- Milwaukee County Psychiatric Crisis Redesign Adult Care Delivery Model



Federally Qualified Health Centers (FQHCs):

BHD is in the process of establishing a care delivery partnership with two Federally Qualified Health Centers (FQHCs) to expand community-based access to mental health and substance use disorder treatment services. By capitalizing on the current array of FQHC services and their favorable reimbursement structure, BHD will provide upstream prevention and early crisis intervention services to historically underserved communities that have generated significant psychiatric emergency department admissions both at PCS and private EDs. The initial phase of the project would expand immediate capabilities at the FQHCs by embedding BHD resources at two FQHC sites on the North and South sides. These services would provide short-term high intensity behavioral health services, same-day walk-in urgent care, and navigation services to the full continuum of BHD and community mental health and substance use services.

The current Access Clinic outpatient resources combined with other existing community-based services – including Crisis Case Management, Comprehensive Community Services (CCS), CLASP, Team Connect, Certified Peer Specialists, and other BHD care coordination programs – will support BHD's and the FQHCs' shared goal of delivering fully integrated medical/behavioral health services to Milwaukee County residents in locations that are more proximate to their home. Additionally, the expanded outpatient and navigation services co-located at FQHCs should reduce avoidable and costly emergency detentions, ER visits, and inpatient admissions. The co-located service also will provide access for behavioral health patients to the broader array of primary care, dental, and social support services offered by FQHCs. If successful, partnerships with other Milwaukee FQHCs could also be considered in the future.

Urgent Care/Triage Clinic: This would be a new component of the system, distinct from outpatient clinics, that could be located either adjacent to a CRC or the dedicated Psychiatric ED. It would operate 24/7 for walk-in and police drop-off with the primary function of diversion from EDs, inpatient admissions, out-of-home placement, and police custody. The service would assist with the de-escalation of a person's clinical behavioral health crisis by providing 24/7 access to a safe environment with assessment, diagnosis, and treatment capability (including medication), delivered in a timely manner and leading to stabilization. The clinic would serve in coordination with outpatient services if currently being received, or if not, as an entry point to long-term, ongoing service delivery and care. Anyone experiencing a mental health and/or substance-related crisis would be eligible for acceptance.

Crisis Mobile Teams (CMTs): Expansion of the CMTs and some redefinition of their functions are also important considerations in the redesign. Recent improvements in productivity and efficiency have already resulted in increased capacity, and BHD believes there are opportunities for additional improvements. A key issue for CMTs in the redesign is to redefine their function, from primarily assessing for involuntary holds in hospital EDs to crisis resolution in the community and follow-up to ensure stabilization. Addition of more peer specialists to CMTs would also be an important goal in the redesign.

Crisis Assessment Response Team (CART): CART is a co-responder program that pairs master's level clinicians with law enforcement officers. Currently, CART serves 10% of crisis volume and could expand its function to include transporting people to community caregivers. The redesign will continue to focus on increasing utilization of CART, through consultation with law enforcement and increasing awareness of this service in the community. The goal is to ensure that CART clinicians play a greater role in providing a "warm hand-off" to a care coordinator to develop a crisis plan and plan of care, and to coordinate services for the individual.

Peer-Run Respite: Milwaukee County's first Peer Run Respite is set to open in 2019. The Peer Run Respite is a short-term respite that consists of 4-5 beds. It provides individuals with mental health needs with additional support in a safe and accepting environment. BHD will continue partnering with the contracted agency, Our Space, to successfully implement services. Assuming sufficient demand and positive outcomes associated with this initial service, the redesign will include expanded or additional Peer Run Respite facilities.

Crisis Stabilization Houses: The redesign envisions either expanded CSH capacity or addition of a new component in the crisis system that would be similar to the Hennepin County (MN) model. This is a residential step-down program for individuals with complex needs who would benefit from longer-term (30-day) transitional support. This non-hospital based intermediate rehabilitation level of care provides specialized support for individuals who are experiencing a mental health crisis; it could also be utilized for individuals on an involuntary commitment and who require a medically managed care plan. This model is a treatment alternative for individuals who require a medically managed service.

Community Linkages and Stabilization Program (CLASP): CLASP is a community-based peer specialist program to which people are voluntarily referred through one of the Crisis Services programs. In the redesigned system, CLASP could be part of the team serving individuals through a Care Coordination model. This is a model developed for the treatment of chronic conditions that provides a framework for communication and shared goals among multiple providers and the patient. Adding referral streams to CLASP through additional funding provided through HMOs and health systems would provide the opportunity to serve more people. This peer service provides a particularly important function of navigation, which could be expanded in the redesign.

Crisis Line: Through the Crisis Line, individuals and family members who are experiencing a mental health crisis or co-occurring crisis can speak with someone directly to provide crisis response and resources. The redesign model envisions continued operation of the crisis line through a partnership with IMPACT 2-1-1. This arrangement has freed up Crisis Mobile Team clinicians to respond to more calls in the community, consistent with the goal of the redesign.

Team Connect: Team Connect consists of master's level clinicians and peer specialists who provide services to individuals who are discharged from PCS, the Observation Unit, or the BHD inpatient units. The team provides linkage to services in the community and supports engagement in post-discharge care. In the redesigned system, Team Connect may be

transitioned to a Care Coordination model. This model might also entail embedding social workers or crisis staff in area emergency rooms for additional coordination of services, improved discharge planning, and quicker Emergency Detention reviews and assessments.

Dedicated Psychiatric Emergency Department: The redesigned system will continue to feature a dedicated psychiatric ED that will replace the current PCS, but in a modified form. It is envisioned that financial responsibility for the new ED will be shared between the County and the private health systems, with possible joint governance. The facility would serve a smaller volume than the current PCS—as shown in Table 2 on page 18, estimated to be approximately 3,200 admissions, down from the current volume of about 8,000.

It was determined that at least in the short to medium term, developing enough crisis alternatives to divert *all* of the current volume of PCS episodes was not feasible for a variety of reasons. Those include the length of time that would be required to implement many new or expanded services, which will be complicated by workforce challenges and the need to determine contractual and financial frameworks.

Nevertheless, we do believe that a significant reduction of PCS volume within the next three to five years is achievable. Much of this reduction will be accomplished by redirecting many of the approximately one-third of current admissions that are voluntary walk-ins to other services, including private hospital EDs. These less-challenging cases will be diverted through the emphasis of the redesign on increased use of less intensive "upstream" services and the expanded capacity of private hospital EDs. The new facility will serve a narrower population, which is envisioned by the Advisory Committee and other stakeholders to consist exclusively of those individuals currently served by PCS who need more specialized psychiatric crisis treatment services than private hospital EDs will be equipped to provide.

At the same time, it is envisioned that the new facility will maximize measures to support a therapeutic environment such as availability of peer specialists and avoidance of restraints. The facility will also provide more behavioral health and social services directly (rather than by referral) and provide medical oversight of mobile services. It will continue to be a collaborative partner with law enforcement, EMS, and private health care systems. Issues that need to be determined include the location of the facility, whether it will be administered and staffed by BHD or a private entity or entities, and details of how it will intersect with the 120-bed inpatient facility to be operated by BHD's new contracted inpatient service provider (Universal).

Proposed New Services

In addition to the enhanced and modified services described above, the Advisory Committee agreed that several new enhancements to the redesigned system should be explored. As with the dedicated psychiatric ED and the expanded services delineated above, questions regarding the mix of potential public and private resources to support these new services – as well as service delivery, administration, and governance – will need to be determined in the next phase of planning.

"Air Traffic Control": Implementation of an electronic surveillance and scheduling solution would allow crisis staff, contracted providers, and others to know and utilize real-time surveillance and access to crisis resources. Crisis staff, future care managers, partners, and providers would be able to see available resources needed by clients in crisis. Resources would include: hospital and diversion beds, care management intake slots, psychotherapy and prescriber appointments, peer services appointments, and other ancillary services. Such a system would support real-time, same-day access to care and help ensure full utilization of available resources.

Crisis Services Care Coordination (CSCC): CSCC would provide for short-term (up to 6 months) Care Management for clients with recent psychiatric emergencies, including those who have had contacts with Crisis Mobile, ER, or walk-in clinic. The program would utilize crisis assessment and development of a plan of care with consumers, and would authorize peer services, prescriber services, psychotherapy, and other services. The model would entail close supervision of staff, management and oversight of ancillary providers, and electronic system change to allow proper data collection and management (e.g., development of dashboards, improved communication across providers, consumer use of record/portal).

Long-term Crisis Stabilization Housing: This proposed addition to the continuum of crisis services would serve those who need more intensive and extended step-down support, such as those with complex medical co-morbidities.

High Crisis Service User Strategies: This would be a data-driven process of identifying individuals who are frequent users of crisis services, conducting outreach and further assessment to identify unmet needs, and developing treatment plans that would provide alternatives to use of crisis services.

Telepsychiatry: Increased provision of telepsychiatry by BHD is considered to be an important aspect in the redesign, particularly to support the expanded role of hospital EDs. Telepsychiatry consultation can provide specialized support and expand the range of services available within hospital EDs.

WISHIN: The Advisory Committee considered this shared data system as a potential resource for managing the crisis system. One limitation is that it has an opt-out option, which may reduce representativeness, though the opt-out rate is currently only 2%.

Transportation: Developing a system or modes of transportation apart from law enforcement would be a cross-cutting feature of the redesign.

Support and reform of legal, court and law enforcement policies and practices: Though not a service per se, a comprehensive review of the role of the courts and law enforcement in the psychiatric crisis system would advance the goals of the redesign.

6. Utilization Changes in the Redesigned Model

As preparation for the implementation phase of the redesigned crisis system, the project team developed illustrative modeling to show how the distribution of services across the system ideally would be changed. In developing estimates for the numbers to be served by each of these components, three considerations are important.

First, it should be emphasized that it would not be appropriate to simply transfer capacity from one component to its equivalent replacement in the redesign (e.g., the individuals currently served by PCS to private hospital emergency departments). Instead, estimates should take into consideration the greater emphasis on "upstream" intervention, such that some transfers will occur to components higher "up" in the system—i.e., diversion and resolution services—as well as laterally.

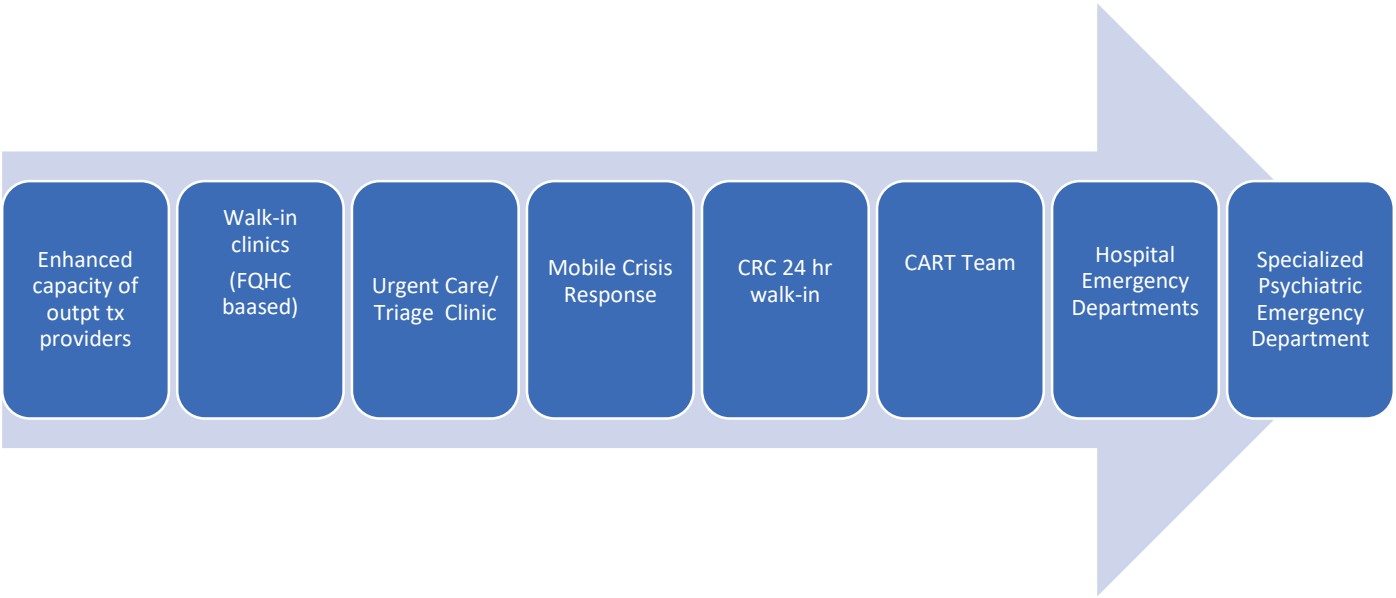
Second, historically there has been a fair amount of duplication among at least three key crisis system components (private hospital EDs, PCS, and Crisis Mobile), meaning in the course of a single crisis episode an individual might be served by two or even all three of the services. Because of the emphasis on treatment and resolution in the redesign, some reduction in movement between system parts is anticipated. Indeed, reduction in movement is a key quality indicator to monitor.

A third consideration is that this redistribution will not occur immediately, as it will depend on changes in practice patterns, community awareness, and the aforementioned continuing evolution of organizational philosophy. BHD has indicated the likely need for piloting and staging some services, which will allow refinement and readjustment of these numbers. Accordingly, estimates of capacity should reflect this staged implementation process, showing changes in the distribution over periods of time.

Figure 3 represents the direction for changes in utilization patterns of the redesigned systems. The arrow represents the range of crisis services proceeding from least restrictive and intensive on the left to most restrictive and intensive on the right. The expectation is that the changes would involve reductions in the services on the right and increases in ones on the left. However, reductions on the right would be greater than increases on the left, because the expectation is that the overall number of persons entering the crisis system would be reduced (by more effective outpatient intervention, etc.). Also, transfers from one service to another are expected to be reduced, which will influence percentages in each service.

Figure 3

Direction of Changes in Utilization Patterns



While it is not possible to project with certainty how utilization patterns would change under the redesigned system, Tables 1 and 2 offer a model of how utilization could shift across the spectrum of psychiatric crisis services as implementation of the redesign proceeds, leading up to 2021. We emphasize that these shifts should not be considered as "hard" targets against which success should be measured, but rather as cautiously optimistic projections based on our knowledge about the population currently receiving services and the anticipated impacts of system improvements. For example, we know that a substantial proportion of current PCS admissions are walk-ins; in our tables, this group is represented as shifting to less intensive services in accordance with assumptions of the redesign plan.

Overall, these projections are intended to illustrate how the redesign plan is intended to change utilization through investment in non-ED prevention services and "upstream" crisis resolution services—first, by diverting some number of persons from the crisis system entirely through prevention, and then by shifting numbers from more intensive, facility-based services to less-intensive, community-based services.

Somewhat arbitrarily, we specify these time periods as years, although it may turn out that the shifts may be achieved more rapidly or more slowly, in which case the distribution presented here will need to be adjusted. For example, the planned expansion of some diversion services may require more time than is currently anticipated, or the programs' ability to absorb the increased caseload may take longer. Alternatively, these processes may occur more rapidly than expected.

Reflecting the fact that initiatives are already underway to modify these utilization patterns (with expanded service capacity, efficiencies, etc.), the shifts represented in the tables reflect changes beginning with the present as baseline and leading up to full implementation in 2021.

BHD has indicated that some piloting and staging of implementation may be desirable, in which case the trends leading up to implementation may be expected to continue beyond 2021.

Table 1 shows annual potential diversions from the crisis system from 2019-2021, while Table 2 shows potential changes in utilization for specific crisis system components for the same period. These projections are presented to illustrate how investment in "upstream" and non-ED crisis services may positively impact the entire continuum based on three considerations:

- First, we drew upon information obtained in the environmental scan and input from the Advisory Committee on recent trends and expectations for the redesigned system (e.g., recent improvements in the efficiency of mobile crisis teams, and plans for expanded services by FQHCs).
- Second, we based expectations for diversion and substitution (for example, expanded clinics substituting for ED visits) on the experience of the project team with similar crisis system redesign initiatives.
- Third, we conducted a brief survey of research on crisis respite centers, peer support programs, mobile crisis teams and CART-like co-responder teams focusing on their impact on the overall service system, such as reducing ED and inpatient utilization.

Table 1

Estimates of potential diversion from the continuum of psychiatric crisis care by year

Year	N	%
2019	750	2
2020	2,250	7
2021	3,350	10

Table 2

Estimated potential changes in volume in the continuum of psychiatric crisis care by year

	ACCESS		CMT		CSH		CRC		CART Mobile		Hospital EDs		Psych ED		Total Minus Diversion	
Year	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Current	940	3	2310	7	400	1	1270	4	1230	4	18000	56	8100	25	32250	100
2019	1000	3	2400	8	600	2	1800	6	1600	5	17000	54	7100	22	31500	100
2020	1100	4	2700	9	800	3	2400	8	2000	7	16000	53	5000	16	30000	100
2021	1600	6	3000	10	1000	3	3000	10	2300	8	14000	48	4000	15	28900	100

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7. Next Steps

The information presented in this summary represents the findings of the adult crisis redesign planning group, or “Phase 1” of the proposed redesign. “Phase 2” would consist of assembling a public/private work team and multiple subgroups that will focus on the development of financial, operational, and structural details for each component and the delivery system, as well as a detailed, phased implementation plan