PSYCHIATRIC CRISIS REDESIGN IN MILWAUKEE COUNTY

Mental Health Board Update
August 22, 2019
Re- Cap of Phase 1 – Psych Crisis Redesign

**Catalyst for Initiative**
- Outsourcing of Milwaukee County Behavioral Health inpatient care (Target Date: 7/2021)
- Support BHDs and private health systems concurrent efforts to continuously improve current psychiatric crisis services

**Planning Team**
- Wisconsin Policy Forum
- Human Services Research Institute & Technical Assistance Collaborative
- Public-Private Advisory Committee
- Multi-Stakeholder engagement over 9 months – County, Health Systems, Physicians, Courts, Law Enforcement, Advocates/Consumers

**Phase 1 Planning Process/Desired Outcome**
- Develop redesign assumptions
- Conduct environmental scan
- Design conceptual models for adults and children delivery systems
Key Planning Assumptions

■ By statute, Milwaukee County BHD serves as Treatment Director for patients who are legally detained (involuntary status) and there are legal, fiscal, & clinical reasons for BHD to maintain exclusive operational responsibility for those duties.

■ 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.

■ Milwaukee County will not invest additional property tax levy, above the amount currently expended, on the psychiatric crisis continuum of services.

■ There is variation in the private health systems’ clinical capabilities to effectively care for patients with behavioral health disorders in ER, outpatient, and inpatient settings; 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 ED and would not be able to replicate these services in multiple ER settings cost-effectively, given the unique expertise and treatment setting required and significant workforce shortages.

■ The county’s 10 Medicaid MCOs are accountable for ensuring positive health outcomes and financially incentivized to reduce avoidable health care utilizations and costs.
**Milwaukee County Psychiatric Crisis System Redesign: Modified Model 3**

<table>
<thead>
<tr>
<th>CRISIS PREVENTION</th>
<th>EARLY/SUBACUTE INTERVENTION</th>
<th>ACUTE INTERVENTION</th>
<th>CRISIS TREATMENT</th>
<th>RESOLUTION/REINTEGRATION</th>
</tr>
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<tbody>
<tr>
<td><strong>Enhanced</strong> Community Education</td>
<td>Peer-Run Respite Center</td>
<td>Crisis Line /Call Center <em>(Initial crisis response, 24/7)</em></td>
<td><strong>Expanded</strong> Crisis Resource Centers <em>(TX Beds, 2-7-day LOS)</em></td>
<td><strong>Enhanced</strong> Post-Acute Transition Care Management / Navigation / Connection Services <em>(Providing follow-up to patients served in Urgent Care - Triage Center, Private Hospital &amp; Designated)</em></td>
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<tr>
<td>BHD Community – Based High Acuity Walk-in Outpatient Clinical &amp; Navigation Services in Collaboration with FQHCs <em>(Extended Hours)</em></td>
<td></td>
<td><strong>Expanded</strong> CART Teams with Municipal Law Enforcement Agencies</td>
<td>Inpatient Psychiatric Treatment <em>(Outsourced Provider and New Location)</em></td>
<td>Community Linkage and Stabilization Program Stabilization <em>(CLASP)</em></td>
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<td><strong>Expanded</strong> Private Provider Outpatient Services</td>
<td></td>
<td><strong>Expanded</strong> BHD Crisis Mobile Capacity and Services <em>(Treatment/Assessment/Disposition/Connection)</em></td>
<td>Crisis Stabilization Housing, brief <em>(Up to 14 days)</em></td>
<td>High ED/Crisis/911 service user strategies</td>
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<tr>
<td><strong>Enhanced</strong> Care Management Services <em>(CCS, TCM, CSP, MCOs)</em></td>
<td></td>
<td><strong>Enhanced</strong> Community Hospital ED Behavioral Health Capabilities</td>
<td></td>
<td>Crisis Stabilization Housing, Long-term <em>(Up to 6 months)</em></td>
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<tr>
<td><strong>Enhanced</strong> Housing Capacity, Subsidy &amp; Navigation</td>
<td></td>
<td>Urgent Care Triage Center 24/7 Walk-in/Police Transport <em>(Adjacent to Psych ER or CRC?)</em></td>
<td></td>
<td><strong>Enhanced</strong> Post-Acute Transition Care Management / Navigation / Connection Services <em>(Providing follow-up to patients served in Urgent Care - Triage Center, Private Hospital &amp; Designated)</em></td>
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<tr>
<td>Peer Support/Parent &amp; Caregiver Support Services</td>
<td></td>
<td>Designated Psychiatric ER <em>(New Location, Smaller)</em></td>
<td></td>
<td>Community Linkage and Stabilization Program Stabilization <em>(CLASP)</em></td>
</tr>
<tr>
<td>Effective Crisis Planning WRAP/Psychiatric advance directives</td>
<td></td>
<td>23 hour Crisis Stabilization Services/ Observation Beds/ IP, CRC, CSH Admission Hold <em>(Relocate, Adjacent to New Psychiatric ER)</em></td>
<td></td>
<td>High ED/Crisis/911 service user strategies</td>
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<tr>
<td>Peer Run Drop-in Center</td>
<td></td>
<td></td>
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<td>Crisis Stabilization Housing, Long-term <em>(Up to 6 months)</em></td>
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**KEY:** Current Service  Under Development  Enhancement or New Service
WPF/HSRI Recommends a Dedicated Psychiatric ED

- Despite increased investment in all other continuum components, a dedicated psychiatric emergency department will be needed.

- Dedicated psychiatric ED must include appropriate clinical expertise, physical environment/milieu, and legal acumen.

- Much smaller population with narrower focus - mainly individuals under emergency detention with complex clinical and social needs.

- BHD retains Treatment Direction function.

- Details to be determined:
  - Volume projections
  - Exact mix of joint public-private financial support (for both ED and entire continuum)
  - ED Location, Licensure, Governance, Operations
BHD Psych ED Utilization – CY2018

- BHD ED served ~7400 patients; ~60% of ED patients were involuntary upon presentation
  - ~20% children/adolescents
  - Private Hospitals reported serving 27,000 patients with a primary BH diagnosis in their EDs in 2018

- CY2019 BHD ED Visits Trending Up: Projecting 7800 visits based on the first half of 2019, Private health systems also report an increase.

<table>
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<tr>
<th>Year</th>
<th>Child/Adolescent PCS Visits (Aged 4-17)</th>
<th>Adult PCS Visits (Aged 18+)</th>
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<tbody>
<tr>
<td></td>
<td>Voluntary</td>
<td>Involuntary</td>
</tr>
<tr>
<td></td>
<td>Visits</td>
<td>% of Total Child/Adol Visits</td>
</tr>
<tr>
<td>2015</td>
<td>273</td>
<td>13.8%</td>
</tr>
<tr>
<td>2016</td>
<td>235</td>
<td>14.3%</td>
</tr>
<tr>
<td>2017</td>
<td>274</td>
<td>15.6%</td>
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<tr>
<td>2018</td>
<td>243</td>
<td>15.7%</td>
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Care Delivery Philosophy

■ For 10 years, BHD has led a transition from a system focused on institutionalization, emergency detentions and disposition decisions to one informed by principles of prevention, diversion, person-centered care, dignity, recovery, and crisis resolution.

■ This philosophy must be embraced by all private providers involved in the continuum, as well as justice system and community stakeholders.

■ Other Values:
  
  - Provide care in the least restrictive, most therapeutic environment
  
  - Locate prevention/early intervention/urgent care-walk in services closer to affected population
  
  - Leverage scarce professional resources
  
  - Consider role of law enforcement in emergency detention process
  
  - Cost-effective care
Changing Utilization

Utilization will be changed in two ways:

- Shifting from intensive, restrictive, and facility-based services to those that are more person-centered, supportive, and community-based (Community Health Center Partnerships, Mobile, Crisis Resource Center expansion in scope and service, Peer Services, etc)
- Reduce volume overall

Reduction in volume occurs at three levels:

- Individuals (# individuals entering crisis service system)
- Episodes (# crisis episodes per individual)
- Admissions (# admissions to different crisis services per episode)
Cross-Cutting Functions

■ “Air Traffic Control”: a centralized call center, patient service tracking system, and treatment director navigation and disposition system

■ Health Information Exchange/WISHIN: to facilitate transfer of health information and crisis plans

■ Telepsychiatry/Teleconsultation: Accessible to all early intervention/subacute, acute crisis intervention programs and providers

■ Transportation Strategy: enhanced, coordinated non-law enforcement transportation
Phase 2: Fiscal Analysis, Detailed Design & Implementation Plan

■ Phase 1 Review and Conceptual Approval
  - Presentations to Key Stakeholders, including MHB 12/2018 - 1/2019

■ Phase 2 Deliverables:
  - Develop financial, operational and structural details for each component of the delivery system, including Psychiatric ED
  - Develop a phased implementation plan
  - Complete Design of Child and Adolescent Delivery Model
Phase 2.1: Wipfli Fiscal Analysis

Three Components

1. Develop Operating Assumptions and conduct Fiscal Analysis of a Centralized Psychiatric ED

2. Compare Fiscal Analysis to a Decentralized ED Model of Care

3. Determine the amount of County Tax Levy available to support the full continuum of Psychiatric Crisis Services, including emergency services.