PSYCHIATRIC CRISIS REDESIGN IN MILWAUKEE COUNTY

Redesign Planning Team

- Wisconsin Policy Forum
- Human Services Research Institute
- Technical Assistance Collaborative
- Public-Private Advisory Committee

Phase 1: Planning to Date

- Convene a Public-Private Advisory Committee
- Develop basic redesign assumptions
- Conduct environmental scan (review current system, collect & analyze BHD & health system data, stakeholder interviews/focus groups, review national models/best practices)
- Develop environmental scan report
- Develop conceptual models for adults and children; develop adult planning summary report and children's planning internal summary

Phase 2: Continued Planning & Implementation

- Assemble public/private work team and multiple subgroups
- Focus on the development of:
  - *Financial, operational and structural details for each component and the delivery system*
  - *A phased implementation plan*

Key Planning Assumptions

- By statute, Milwaukee County BHD serves as Treatment Director 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.

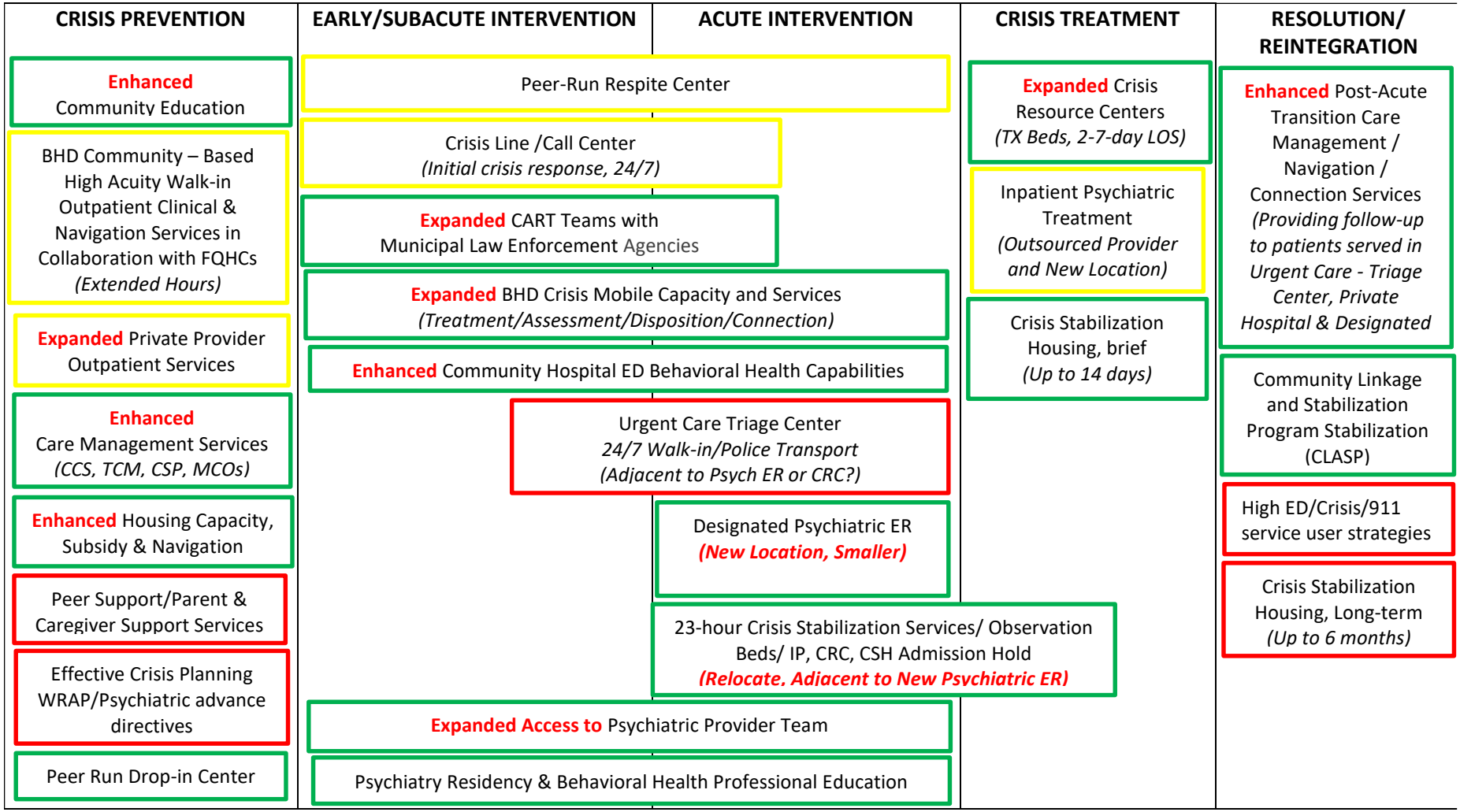
Three Models

1) A centralized system organized around a single large psychiatric emergency facility.

2) A decentralized system, with multiple sites providing a diverse array of crisis services (including some capacity for receiving individuals under emergency detention).

3) A dispersed system with vastly enhanced county investment to shift most crisis episodes out of ED into less intensive support services; private health system EDs care for individuals with more complex needs.

Milwaukee County Psychiatric Crisis System Redesign: Modified Model 3



KEY: Current Service Under Development Enhancement or New Service

Care Delivery Philosophy

- Continue transition from a system focused on 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.

Cross-Cutting Functions

- **Air traffic control**: a centralized call center, patient service tracking system, and treatment director disposition system
- **Health information exchange/WISHIN**: to facilitate personal health information accessibility and access to crisis plans
- **Telepsychiatry**: Accessible to all early intervention/subacute, acute crisis intervention programs and providers
- **Transportation strategy**: enhanced, coordinated non-law enforcement transportation
- **Justice system/law enforcement**: buy-in for new overriding philosophy, reformed policies and practices

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 detentions and those with highly complex needs
- BHD retains Treatment Direction function

Dedicated Psychiatric ED

- Details still need to be determined:
  - *Exact mix of joint public-private financial support (for both ED and entire continuum)*
  - *Location*
  - *Capacity*
  - *Governance*
  - *Operations*

Other Key Components

Partnerships with FQHCs

- Early crisis intervention services delivered by embedding BHD resources at two FQHC locations on North and South sides.
- Will include short-term high intensity services, same day walk-in urgent care, navigation services.
- Will deliver fully integrated medical/behavioral health services to county residents at locations closer to their homes.
- Partnerships could be expanded to additional FQHCs in the future.

Other Key Components

Crisis Resource Centers

- Key for early intervention and diversion from EDs and inpatient treatment; step down from these more intensive services
- Currently funded by BHD, provided by contracted community partner
- CRCs provide an array of onsite supportive services including:
  - *Peer support, clinical assessment, access to medication, short-term therapy, nursing, supportive services, recovery services, linkage to ongoing support and services.*
- Planning for expanded capacity and functionality for the CRCs:
  - *Direct admissions from Crisis Mobile Team, CART, and Team Connect*
  - *Control of discharges*
  - *Potential development of additional centers*

Other Key Components

Enhanced Private Hospital ER Behavioral Health Capabilities

- Behavioral health provider education
- Telepsychiatry
  - *Provided by BHD clinicians*
- Psychiatric provider team
  - *Improve capacity to serve voluntary and involuntary clients*
  - *Provide consults, telepsychiatry to help triage and find right disposition*

Other Key Components

Crisis Stabilization Houses

- Licensed Community Based Residential Facilities
- Currently two CSHs operated by a community-based partner in collaboration with the Crisis Mobile Team
  - *16 beds serving people with significant mental health needs; short-term beds with stays of around 14 days and long-term beds with stays up to 6 months*
- CSHs provide a caring, supportive, therapeutic environment to assist people stabilize and meet their individualized needs
- There is a current capacity shortage; could add to existing types of CSH beds or potentially pursue adding new types of “step-down” beds modeled after Hennepin County

Other Key Components

Urgent Care/Triage Clinic

- New 24/7 clinic distinct from outpatient clinics and potentially located adjacent to a CRC or dedicated psychiatric ED; could also be folded into another component of the continuum of crisis services.
- Would serve as an alternative police drop-off site and also could accommodate walk-ins with the primary function of diversion from EDs, inpatient admissions, out-of-home placement, and police custody.
- Would include assessment, diagnosis, and treatment capability (including medication), delivered in a timely manner and leading to stabilization.

Other Key Components

Crisis Mobile Teams & Crisis Assessment Response Teams

- Expand CMTs and redefine functions from primarily assessing for involuntary holds to crisis resolution in the community and follow-up to ensure stabilization
  - *Addition of more peer specialists to CMTs also an important goal*
- Expand functionality of CARTs to ensure CART clinicians play a greater role in providing “warm hand-off” to care coordinators

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.*
  - *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)*

Strategies for Reducing Volume

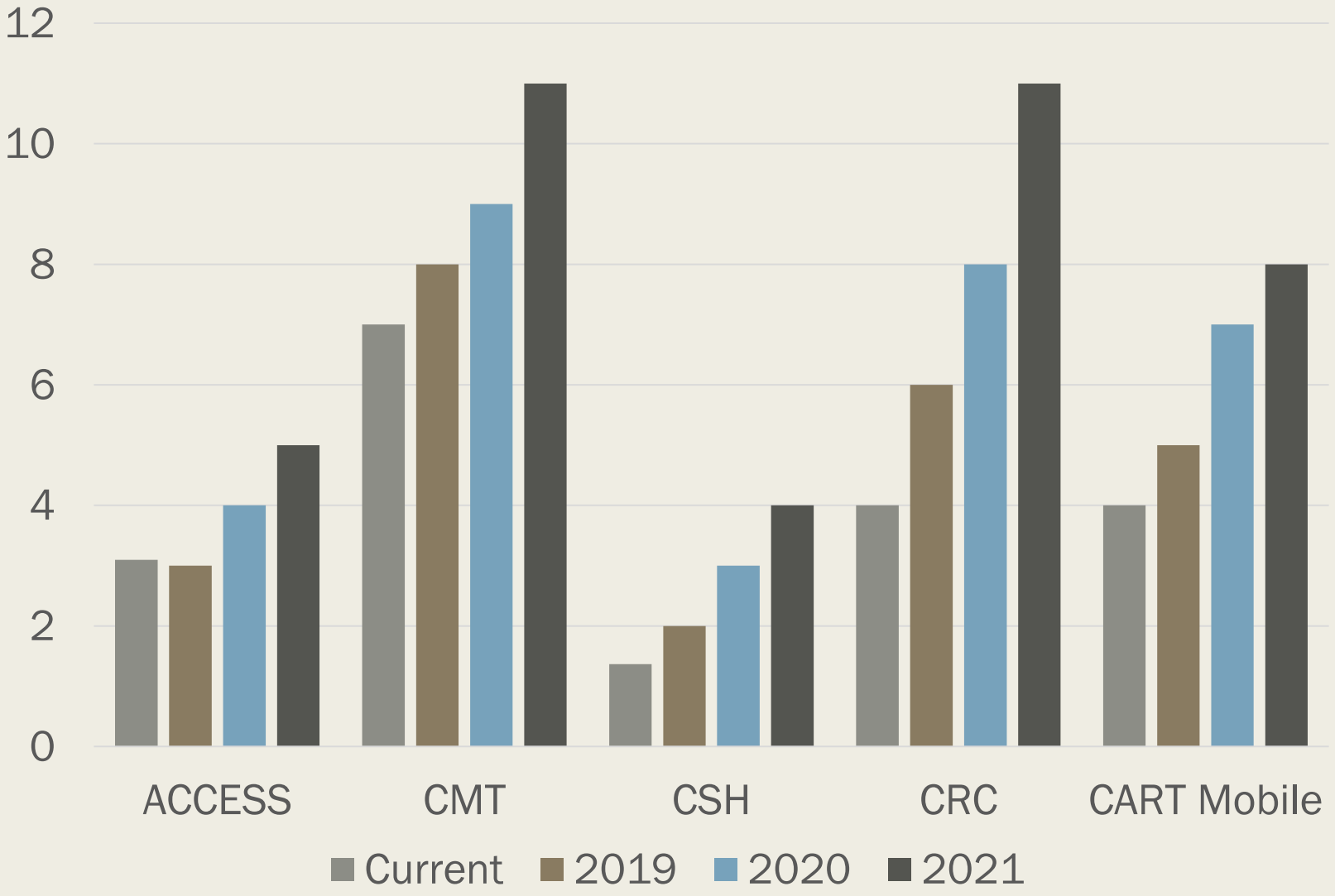
- Individual level: Prevention (enhanced competencies of community providers at advanced planning, anticipating crisis, preemptive intervention and support)
- Episode level: Diversion (identification and care planning for high utilizers)
- Admissions: Early resolution in less intensive crisis services, increased coordination and communication (among crisis services and between crisis services and community providers, including HMOs)

Potential admissions diverted from the crisis system & EDs

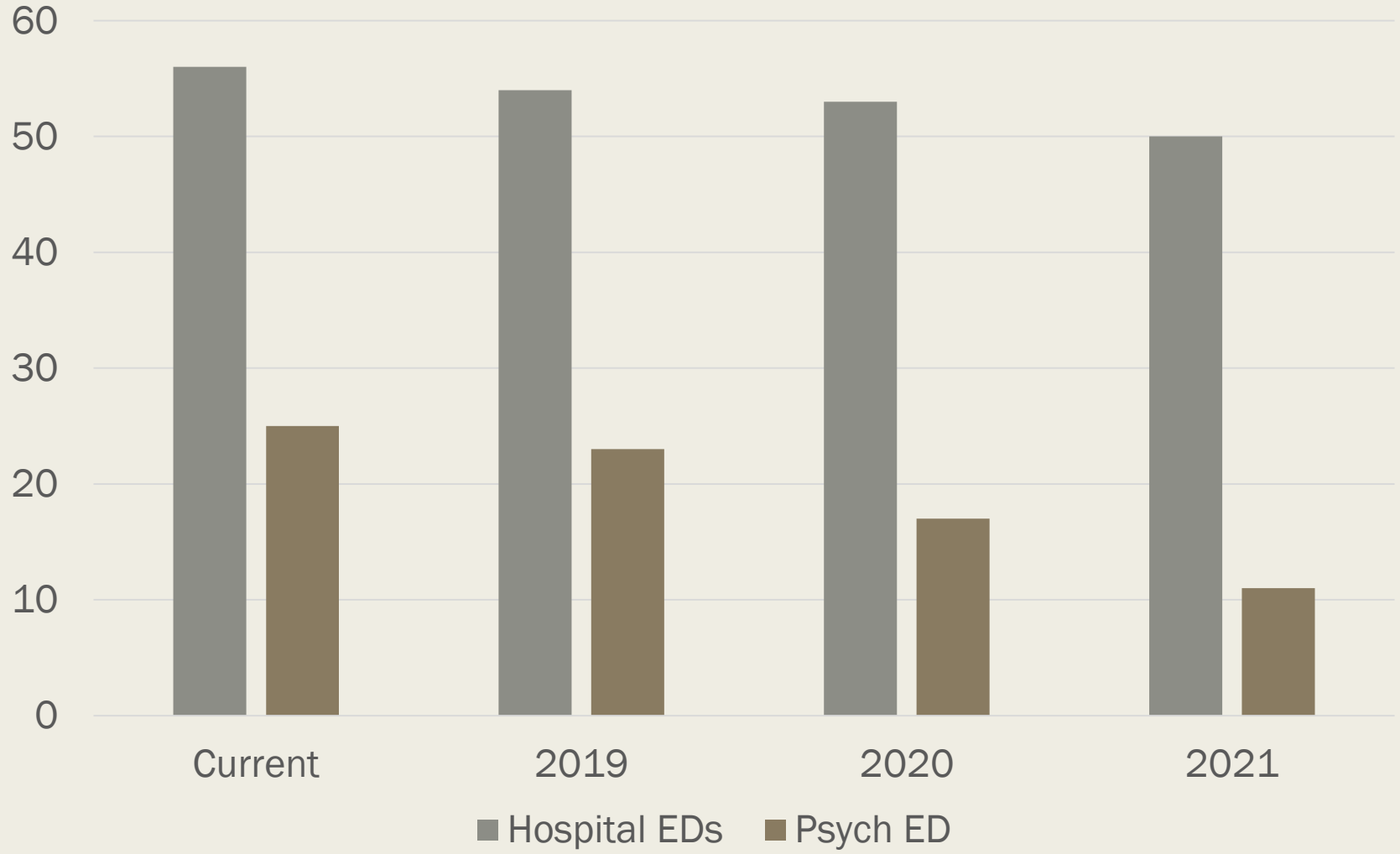
Year	N	%
2019	750	2
2020	2,250	7
2021	3,350	10

	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

Change in Community-Based Crisis Service - % of Admissions



Change in Facility-Based Crisis Services - % of Total Admission



Next Steps

- Review Phase 1 Adult Conceptual Model with Key Stakeholders
  - Mental Health Board
  - Health System ER and Behavioral Health Leaders
  - Community Justice Council
  - Mental Health Task Force
  - State DHS
  - BHD Leaders
- Integrate Feedback and Finalize Phase 2 Planning Process
- Concurrently Implement Enhancements to Existing Psychiatric Crisis Continuum, such as:
  - Service Enhancements (Mobile Crisis, CART, Team Connect…)
  - BHD/FQHC Community Access Centers
  - CRC Expansion

Next Steps

- Support Ongoing Communication/Redesign Process Tracking
  - Phase 1 Communication Themes
  - Oversight Structure to be developed

- Begin Phase 2
  - Develop and Test Alternative Psychiatric ER Business Models
  - Conduct Fiscal, Operating and Implementation Analysis of All Other Components of the Adult Continuum
  - Complete Phase 1 Model for Child and Adolescent Psychiatric Crisis Services