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

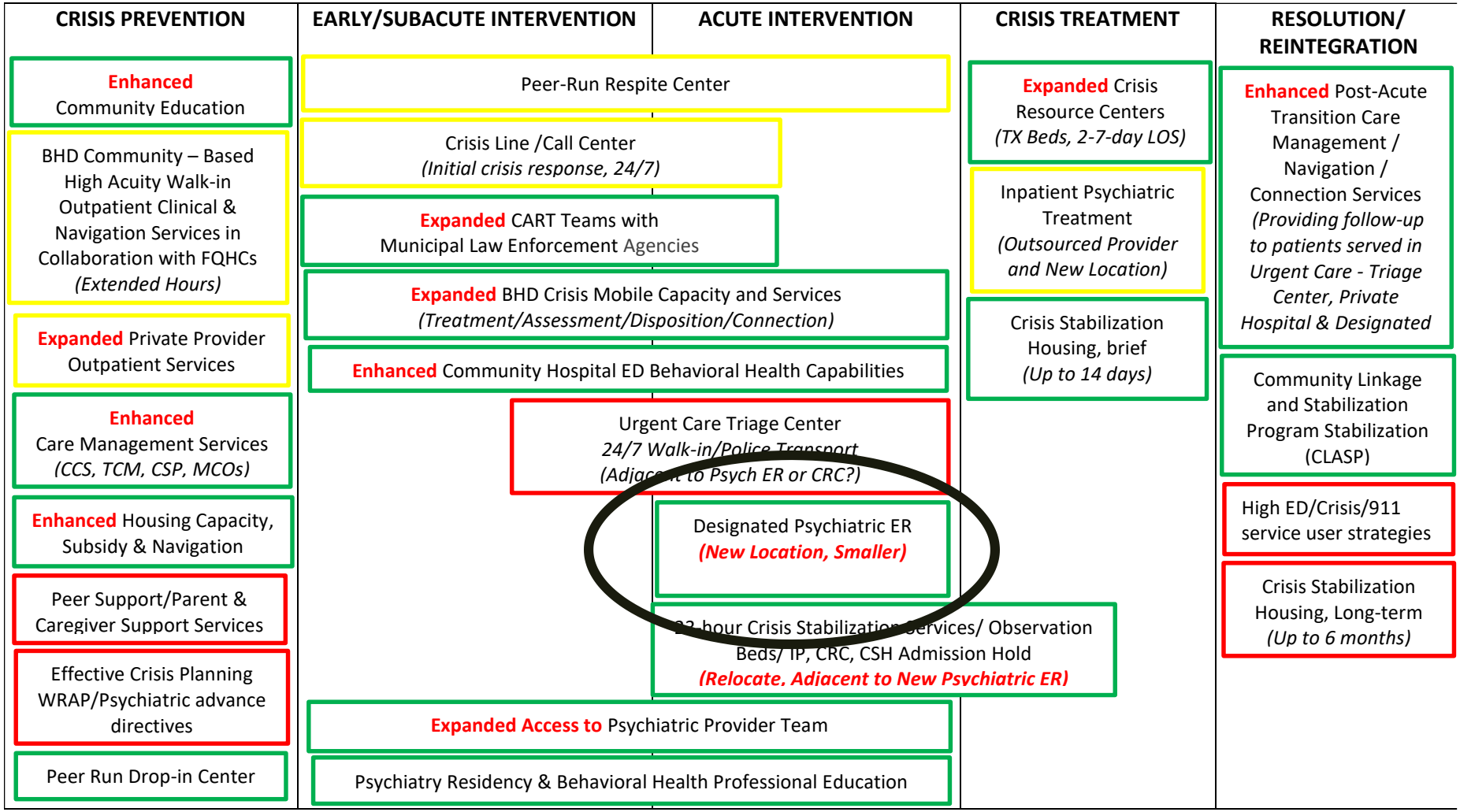
Phase 1 Planning Process/Desired Outcome

- 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



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.

2015-2018 BHD PCS Visits by Age Group and Legal Status

Year	Child/Adolescent PCS Visits (Aged 4-17)						Adult PCS Visits (Aged 18+)						Total PCS Visits
	Voluntary		Involuntary		Total		Voluntary		Involuntary		Total		
	Visits	% of Total Child/Adol Visits	Visits	% of Total Child/Adol Visits	Visits	% of Total PCS Visits	Visits	% of Total Adult Visits	Visits	% of Total Adult Visits	Visits	% of Total PCS Visits	
2015	273	13.8%	1,701	86.2%	1,974	19.4%	3,965	48.4%	4,234	51.6%	8,199	80.6%	10,173
2016	235	14.3%	1,406	85.7%	1,641	19.8%	3,376	50.8%	3,269	49.2%	6,645	80.2%	8,286
2017	274	15.6%	1,480	84.4%	1,754	21.9%	3,214	51.4%	3,033	48.6%	6,247	78.1%	8,001
2018	243	15.7%	1,306	84.3%	1,549	21.0%	2,715	46.6%	3,111	53.4%	5,826	79.0%	7,375

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*
  - *County Executive and Market Leaders Conceptual Approval. Chartered Phase 2 Work 2/2019.*
- **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.