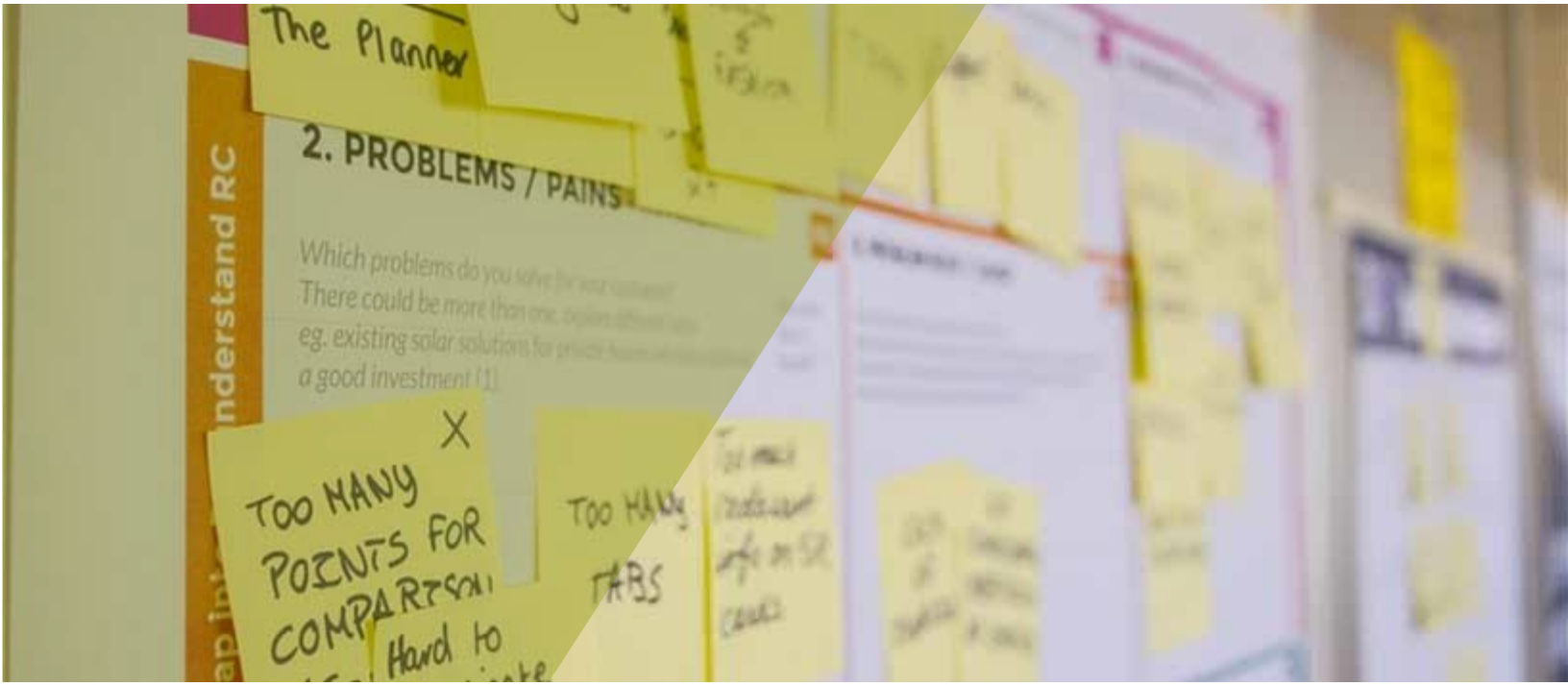
Environmental Scan

Milwaukee Psychiatric Crisis Service Redesign
December 2018

Table of Contents

Introduction & Background



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 the Human Services Research Institute (HSRI), the Technical Assistance Collaborative (TAC), and the Wisconsin Policy Forum (WPF) under the direction of a five-person project Advisory Team. That team consisted of the BHD administrator, the Milwaukee Health Care Partnership director, the Milwaukee Department of Health and Human Services director, the president of Aurora Behavioral Health Services, and the chair of the Medical College of Wisconsin's Department of Psychiatry and Behavioral Medicine.

The project sponsors established the following conditions at the start of the project:

- The design will consider the current and future continuum of BHD psychiatric crisis services.
- The design will address the current and future role of both public (county and state) and private providers.
- The design will consider the County's legal and regulatory responsibilities.
- If a psychiatric emergency department is among the recommendations for the new system, it would not be operated by BHD or located in the current BHD facility.
- The new design will consider the County's current property tax levy expenditures on psychiatric emergency services and seek to reduce the amount of those annual expenditures.
- The redesigned system must be implemented on or before the date of outsourcing and relocation of BHD inpatient services, which is slated for late 2020 or early 2021.

Approach

The project team views the redesign process as an opportunity to design a system from the ground up. While incorporating lessons learned from past experience and seeking to retain the features of the previous system that were most effective, the goal is to address gaps and limitations of that system and introduce forward-thinking innovations that will best serve the residents of Milwaukee County.

To gain as much information as possible about the size and characteristics of the population that is currently served by the crisis service system, we collected and analyzed data on crisis service utilization provided by BHD, private health systems, and the Wisconsin Hospital Association. The resulting information is presented in the section titled "Utilization of Current Crisis Services."

Interviews and focus groups with a wide range of stakeholders were the primary source of information for identifying current system strengths and opportunities for improvement. The key themes that emerged are presented in a subsequent section, under the heading "What We Heard from Milwaukee County Stakeholders."

As a third source of information to inform the redesign decision-making process, we drew from published literature and sought input from experts to identify varieties of

models and practices around the country, with a focus on innovative and exemplary practices that might feasibly be applied to Milwaukee County. These are presented in the section titled "National Models for Consideration."

Background

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

- In general, a widespread recognition of the need to transform psychiatric crises services to being less restrictive and more therapeutic.
- The need to plan for and comply with the Americans with Disabilities Act (ADA) Integration Mandate following the *Olmstead* ruling; cities, counties, and states are building community-based crisis systems of care to prevent avoidable institutionalization.
- The critical need to address factors that contribute to reduce "boarding" of individuals with behavioral health crises in emergency departments.
- The need to reduce the practice of using 911 as a way to initiate crisis care and to avoid using law enforcement officers in any aspect of behavioral health crisis delivery (including compelling treatment, initiating involuntary evaluation orders, carrying out court orders for evaluation, transportation, supervision/guarding in emergency departments).
- The need to view effective psychiatric crisis services as an essential aspect of state or local initiatives to reduce community violence.
- A desire to apply evidence-based practices that are trauma-informed, person/family-centered, and recovery-oriented in the delivery of crisis services.
- A rise of peer-inclusive interdisciplinary treatment teams and peer-operated crisis service models that have challenged conventional thinking of what helps in a crisis.
- An overarching desire by many healthcare thought leaders to change the care experience of individuals with behavioral health conditions and their families—as has been done in other medical disciplines.
- The desire to deliver services that are empowering and promote whole-health activation.

Overcrowding of hospital emergency rooms with those needing psychiatric care, increasing numbers of psychiatric ER visits, and boarding of ER patients with psychiatric disorders are widespread national problems caused by a relatively

common set of circumstances. These circumstances should be considered in any crisis service planning process and include:

- **Lack of less-restrictive, walk-in, or rapid mobile response resources**. This gap means that, in a crisis, ERs are used as a first choice rather than a last resort. These avoidable visits contribute to overcrowding. Often this also signals a need to enhance the crisis competencies of outpatient treatment providers in crisis prevention and early intervention response and to increase the competency of professionals in other systems that have frequent or even daily interaction with individuals who have mental health conditions (i.e., schools, criminal/juvenile justice systems, social services providers, homelessness/housing services) to reduce stigma, increase knowledge, and build effective, trauma-informed engagement skills.
- **Lack of service specialization**. Emergency department teams often lack sufficient specialized knowledge of how to treat individuals experiencing behavioral health crises, starting with how to empathically engage and offer calming and soothing support. The absence of these skills can create a care experience in which a person feels marginalized and stigmatized.
- **Lack of treatment initiation**. Without the introduction of relieving treatment, symptoms generally persist or worsen. Whether by default (and related to a lack of service specialization) or design (for example, purposefully limiting the role of the ER team to assessment and referral), a lack of treatment initiation can increase the length of stay and delay symptom relief.
- **Under-defined roles**. Whereas emergency departments often have clear protocols for other health care conditions, their protocols for behavioral health conditions may be less defined, leaving team members unclear about whether, when, and how to proceed in a meaningful way. There are multiple, competing priorities in an emergency department, and in the absence of clearly defined roles, team members may gravitate to the work that is most clear and familiar; in this way, care of the individual in crisis may be placed on the back burner or passed along to the next shift.
- **Early use and overuse of involuntary treatment**. An emergency department physician can be reticent to release an involuntary hold even if a patient has improved—particularly if this is outside the physician's area of specialty. Sometimes the decision to initiate a hold occurs prior to transport to an ER, and sometimes a hold is initiated in an emergency department. These practices are worthy of close scrutiny with an eye toward pushing the decision downstream, focusing on early, voluntary, and person-centered engagement and shared decision-making, and eliminating the use of holds when they are avoidable (for example, when the hold is being used more for the benefit of the system than the needs of the person).
- **Lack of a trauma-informed environment.** Emergency departments are challenged every day to assure the safety of patients and staff. The approaches they use to ensure safety can create settings that are experienced as

traumatizing for individuals with behavioral health conditions. For example, these environments may include staff who are not welcoming; barren rooms; a locked treatment area; the presence of police officers, guards or sitters; restrictions on clothing and personal belongings; and the threat of restraints. These approaches are often iatrogenic in the sense that they can serve to escalate rather than calm, shame rather than instill feelings of acceptance and hope, inhibit rather than promote active participation and candor, and reduce rather than increase treatment adherence/follow-up. In a crisis, individuals often are experiencing an absence of safety, comfort, control, agency, choice, connection, and understanding; providing an environment that offers these experiences can deescalate a crisis and help preserve dignity.

> **Emergency room experiences can be undermining and countertherapeutic for people experiencing behavioral health crises.**
>
> **Environments that offer comfort, control, agency, connection, and understanding can help prevent trauma and preserve dignity.**

- **Inadequate supply (or access to supply) of outpatient treatment resources**. It is very common to find a significant disconnect between private hospital emergency departments and community behavioral health systems. Emergency department teams may believe the community lacks outpatient resources to assure adequate treatment; because of this, they may assume the safest course of action is to admit a person to an inpatient treatment unit where the sense of the available service is better known. Community mental health systems that are not well connected to emergency departments often lack the supply of urgent slots necessary for timely follow-up with post-ER discharges—even for their current clients. Emergency departments operate 24/7/365, and the most efficient systems figure out mechanisms to offer firm appointments at the time of discharge rather than simply offering a list of agencies and phone numbers for the patient to call.

- **Lack of systemic strategies for individuals with specialized needs.** Strategies for individuals with specialized needs have to be built one by one, in partnership with subject matter experts and stakeholders. Such individuals include those who:
  - Are experiencing homelessness
  - Are uninsured
  - Have criminal justice involvement
  - Have a comorbid medical or substance use issues
  - Have an intellectual or developmental disability
  - Display/have a history of extreme aggression
  - Are child protective services involved

For developing strategies for special needs individuals, the use of data and a shared commitment for a good outcome go a long way when developing memorandums of understanding, service pathways, 24/7/365 telephonic consultation models, etc. Without well-developed person-centered strategies for these individuals, episodes of psychiatric crisis episodes are more frequent and more drawn out, which is overwhelming for patients, family members, and treatment teams, and exposes all parties to avoidable risk.

Components of Psychiatric Crisis Service Systems Nationally

Modern Crisis Service Systems

Modern crisis systems have evolved well beyond a collection of programmatic parts into systems that are highly planned, dynamic, and driven by real-time data. The best functioning systems are decidedly cross-sector in nature with macro-level oversight, data analytics, and systems improvement capability.

The Crisis System Community Coordination and Collaboration Continuum describes five levels of maturation (see Figure 1 on the following page). Each subsequent level represents a greater advancement of a crisis system's functionality. For a crisis service system to provide Level 5 integrated care, "it must implement an integrated suite of software applications that employ online, real-time, and 24/7 ability to communicate about, update, and monitor available resources in a network of provider agencies" (National Action Alliance for Suicide Prevention: Crisis Services Task Force, 2016).

Figure 1

Levels of Coordination and Collaboration

Crisis System of Care Framework

Individuals in crisis often "touch" multiple systems (schools, social services, criminal justice, primary care, etc.). For example, in the course of just one crisis episode, a person may move through or touch law enforcement, an emergency department, a mobile crisis team, and an inpatient treatment team. Moreover, crises impact individuals across the socioeconomic spectrum, the age spectrum, and of all races and cultures; and only a portion of individuals in crisis are known to community mental health providers prior to the crisis. To meet the health and safety needs of a diverse community—and to impact both those who seek traditional treatment and those who do not—a public health lens is essential.

Unless purposefully developed, general hospital emergency departments (and inpatient psychiatric treatment units) tend to function in isolation from community outpatient treatment systems. Individuals presenting with psychiatric crises are assessed, medically cleared, and either admitted for inpatient treatment or discharged back to the community. In the absence of dependable plans for treatment continuity and assuring community safety, this often leads to "erring on the side of safety" and hospitalizing an individual; in many instances, such hospitalization is involuntary.

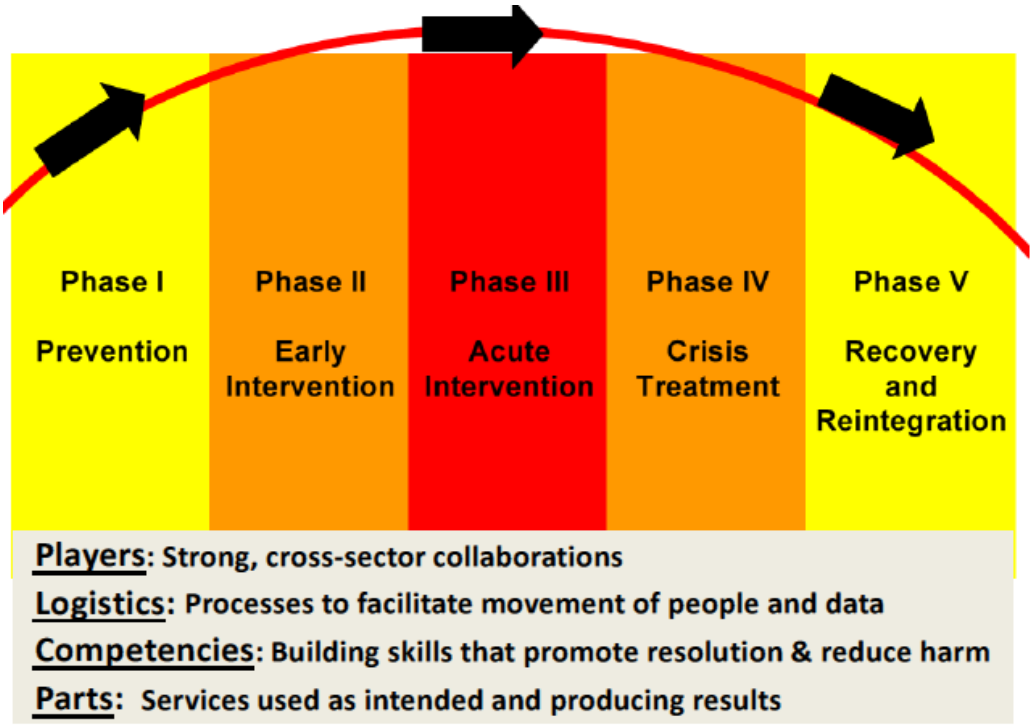
The relationship between the crisis system and the larger service system may be well-planned and well-built, in which case the result will be care that is coordinated, integrated, and efficient; or the relationship may be unplanned, underdeveloped, and/or ad hoc, in which case there will likely be default reliance on 911, law enforcement, and emergency departments, as well as frequent disruptions and inefficiencies in care.

In Milwaukee County, we find considerable efforts at building a crisis system of care, significant system investment in new models and services, and considerable opportunity to do more and do it better—a perception widely supported by the informants we interviewed. As many of those informants emphasized, the most important consideration for the redesign is that it presents an opportunity for careful planning for coordination and integration with the broader behavioral health system and cross-sector stakeholders.

The Crisis System of Care framework (Figure 2) offers a way to conceptualize the whole of the organized crisis system for a particular community and to determine opportunities to invest across five "phases of crises": prevention, early intervention, acute intervention, crisis treatment, and recovery/reintegration. Often, attention and

money are focused narrowly on the "acute intervention" without attending to upstream/downstream opportunities.

Figure 2
Crisis System of Care Framework



Source: Madenwald & Day, Technical Assistance Collaborative

In addition, effective crisis systems attend to four key crisis system components: Players, Logistics, Competencies, and Parts. Often, communities focus solely on adding more "parts" and bemoan that there aren't resources to pay for the parts, when in fact it is development of the players, logistics, and competencies (often low-cost investments) that promotes return on investment, improved care experience, and system efficiency.

We recommend that Milwaukee County and its stakeholders consider investment opportunities in each of the elements of the Crisis System of Care framework. Upstream, this can include increasing the competency of treatment providers to support individuals in crisis planning and the capacity to provide same-day appointments for clients in crisis. Downstream, this can include improving "back door" movement out of emergency departments, crisis beds, and inpatient units by enhancing service coordination, increasing the supply of urgent appointments, and increasing collaboration with managed care companies and key partners (for example, in homelessness/housing services, schools, and child protective services).

Regardless of the specific service array, Milwaukee County can consider a cross-cutting philosophy of care and a set of core competencies so that as individuals progress through a crisis episode, there is a commonality of approach to care—preferably one that is trauma-informed, strengths-based, person-centered, and resolution-focused.

There is significant opportunity to improve system logistics, including how people, resources, and data move through the system and across entities in ways that are HIPAA-compliant but also service user–friendly.

Traditional Psychiatric Crisis System Parts

Crisis service systems across the country vary in their management, organizational structure, relative allocation of resources to different types of services, and prevailing culture; however, most (at least in urban settings like Milwaukee County) provide a fairly standard array of service parts, briefly described as follows:

Regional or Statewide Crisis Call Centers

Crisis call centers are often well positioned to serve as the intelligence hub for a community's crisis system, providing telephonic support, authorizing and/or dispatching services, coordinating care (including transportation), performing bed searches or insurance preauthorization, facilitating transfer of records, and capturing real-time data.

The premier model for a crisis call center operates an "air traffic control" level of connectivity. An example of this approach is the Georgia Crisis & Access Line, which employs state-of-the-art technology, including an integrated software infrastructure capable of tracking individuals at a statewide level, providing built-in insurance of consistent triage, level of care protocols, and warm hand-offs to the appropriate crisis service teams across the state (Covington 2016).

These are programs that adhere to National Suicide Prevention Lifeline (NSPL) standards, provide support to individuals and families in crisis using technology for real-time coordination across a system of care, and leverage data for performance improvement and accountability.

BHD currently maintains a crisis line and recently expanded its functionality through a partnership with IMPACT/211.

Walk-In Crisis Centers

Walk-in crisis centers vary greatly in terms of staffing models, hours of operation, and capacity. Many are freestanding (Massachusetts has 21 freestanding, regional walk-in crisis centers) while others are hospital-adjacent (in Philadelphia, for example). Some communities co-locate 23-hour observation and/or crisis stabilization beds with walk-in crisis centers (Columbus, Ohio).

For Milwaukee County, 24/7/365 accessibility is essential. Currently, PCS serves as the County's primary walk-in crisis center, but it is questionable whether a similar center would be the optimal approach in the redesign. An alternative would be establishment of one or more comfortable, walk-in treatment settings that are less restrictive than an emergency department but that maintain some capability to screen for and manage some medical needs, as well as the ability to accept individuals on involuntary holds. Expansion of walk-in crisis centers is currently being planned by BHD.

Free of some of the regulations that govern emergency departments, walk-in crisis centers can be designed to provide a flexible and person-specific service based on expressed needs and preferences. Walk-in crisis centers often are a great resource for crisis intervention teams who seek to connect individuals with a crisis treatment program.

Mobile Crisis Teams

Since the 1970s, community-based mobile crisis services have been a core component of crisis care systems. Many communities have specialized mobile teams for specific populations such as older adults, children, or individuals with intellectual or developmental disabilities. Some mobile crisis teams offer one-time interventions; other teams offer follow-up crisis support services over the course of several days or even weeks.

A brief period of follow-up crisis support in certain circumstances can be quite effective in diverting people from higher levels of care, assuring care continuity, or for sufficiently resolving a crisis such that no further treatment is needed.

Mobile crisis teams are increasingly pairing clinicians (generally master's prepared, but this differs by the licensure/service requirements in each state) with adult peer specialists (examples include Southern AZ, Southwest WA) or parent peer support specialists on children's teams (examples include Massachusetts, Philadelphia).

Another variation of the mobile crisis team model is creation of co-responder teams composed of a master's level clinician and a law enforcement officer, the latter of whom typically has received Crisis Intervention Training (CIT). Milwaukee's model of that approach consists of five Crisis Assessment and Response Teams (CART), with three teams dedicated serving the City of Milwaukee, one team serving West Allis, and one team serving all of Milwaukee County.

The function of mobile crisis teams must be carefully considered to prevent them from becoming narrow in scope. Optimally, the goal of a mobile crisis team is to deliver resolution-oriented crisis intervention and support designed to ameliorate the crisis and promote community tenure.

Since the mid-2000s, many metropolitan area mobile crisis programs have used GPS programming to identify the location of teams by GPS signal and determine which team can arrive the soonest at the site of a person in crisis.

BHD currently has a crisis mobile team that provides 24-hour, 365-day service.

Peer-Delivered Services

According to SAMHSA (2009), mental health crisis services:

> . . . should afford opportunities for contact with others whose personal experiences with mental illness and past mental health crises allow them to convey a sense of hopefulness first-hand. This can include but is not limited to staff members that serve as peer specialists. Recruiting individuals with personal experience is key to shifting culture in organizations that have been operating in a traditional provider-driven care model.

There are examples of peer specialists working in virtually every behavioral health crisis setting—including but not limited to hospital emergency departments, inpatient psychiatric units, crisis stabilization units, mobile crisis teams, and crisis call centers. In addition, there are an increasing number of peer-operated crisis programs, including Living Room model programs described in more detail later in this report.

BHD staff describe a significant commitment to peer involvement and the division is planning considerable expansion, which is described in detail in the following section.

Crisis Stabilization Facilities

Crisis stabilization facilities vary in title, licensure, intensity, staffing model, and locale. Generally, however, they are described as bed-based services that are less-restrictive than, and serve as a diversionary alternative to, inpatient treatment units. In a review of nationwide crisis services, SAMHSA (2014) defined crisis stabilization as:

> A direct service that assists with deescalating the severity of a person's level of distress and/or need for urgent care associated with a substance use or mental health disorder. Crisis stabilization services are designed to prevent or ameliorate a behavioral health crisis and/or reduce acute symptoms of mental illness by providing continuous 24-hour observation and supervision for persons who do not require inpatient services. Short-term crisis residential stabilization services include a range of community-based resources that can meet the needs of an individual with an acute psychiatric crisis and provide a safe environment for care and recovery.

In general, evidence reviewed by SAMHSA suggests a high proportion of people in crisis who are evaluated for hospitalization can safely be cared for in a crisis facility. The same evidence suggests the outcomes for these individuals are at least as good as hospital care, and the cost of crisis care is substantially less than the cost of inpatient care. (SAMHSA, 2014.)

Crisis stabilization beds are effective only in so far as they are available at the time of the crisis. We have seen far too many examples of laborious admission processes, long lists of admission "exceptions," beds used for shelter/housing, beds being used for hospital stepdown rather than diversion, and poorly managed discharge practices leading to extended lengths of stay. In some communities, the front door and even the back door of crisis stabilization units is largely managed by crisis teams.

Milwaukee County's psychiatric crisis system currently includes two crisis resource centers and two crisis stabilization houses operated by contracted providers. While generally receiving praise from key informants for the role they serve in offering an alternative to PCS, private hospital emergency rooms, and inpatient units, areas for improvement also were identified.

Extended observation or 23-hour beds

Extended observation units (EOUs) and 23-hour beds are designed for consumers who may need short, fairly intensive treatment in a safe environment that is less restrictive than a hospital and when it is expected that the acute crisis can be resolved in less than 24 hours. Services include medication, meeting with extended family or significant others, and referral to more appropriate services (Technical Assistance Collaborative, 2005). Additionally, these facilities may be suitable for patients in substance-induced states, while they return to sobriety.

Milwaukee County currently has 18 observation beds housed at PCS. This resource is used when it is likely that a period of brief stabilization or treatment initiation can sufficiently resolve the crisis.

Transportation

Transportation resources are essential for well-functioning crisis systems, but issues with transportation are not necessarily easy to solve. Engaging law enforcement officers for the purpose of transportation should be minimized. Some communities use peer specialists, ambulettes, taxi cabs, family members, and/or mobile teams for transportation. Minimizing the need to transport is useful as well. Providing services in the community where an individual lives will reduce transportation needs.

According to 2017 data, two thirds of the admissions to Milwaukee County's PCS were by police transport. BHD's Team Connect and Care Coordination Teams also transport individuals and, additionally, BHD has a contract with a transportation company to provide transports.

It should be noted, however, that the crisis system in Wisconsin is law enforcement-based by statute, and barring a significant change in the law (which most observers consider unlikely at least in the short term), law enforcement will continue to have a

significant role in transport. A key emphasis in the redesign planning, therefore, is a less direct approach to reducing the role of law enforcement—by enhancing capacity for prevention and diversion as alternatives to psychiatric ED admission. That said, law enforcement will continue to be the principal means of transport to a dedicated psychiatric ED, as that is determined by the Chapter 51 process.

Current Milwaukee County Psychiatric Crisis Services, Utilization, and Stakeholder Feedback

Summary of Current Milwaukee County Psychiatric Crisis System Services

In this section, we provide an overview of the components that comprise the current Milwaukee County psychiatric crisis service system. Please refer to Appendix B for additional information on the current crisis system services.

Crisis Line

The Crisis Line (257-7222) is the community access line for adult crisis services in Milwaukee County. Individuals and family members who are experiencing a psychiatric crisis can speak with someone directly to obtain crisis response and resources. In May 2017, IMPACT/211, a community agency, began answering the first line of calls on the Crisis Line. IMPACT/211 is a call center that specializes in taking crisis, shelter, resources, and general information calls. IMPACT/211 handles all calls for resources and triages crisis calls to a clinician on the Crisis Mobile Team for

immediate response. The partnership with IMPACT/211 has increased the ability of the Crisis Mobile Team clinicians to respond to calls in the community by reducing time spent staffing the Crisis Line. In 2017, the Crisis Line consistently received over 3,000 calls a month.

BHD is a call center for the National Suicide Prevention Lifeline.

Crisis Mobile Team

The Crisis Mobile Team (CMT) is composed of master's level clinicians and nurses who provide community-based crisis services to individuals 18 years 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. Responses are individualized to meet the person's unique needs and in the setting most convenient to the individual (home, work, school, etc.). Milwaukee County employees cover the first and second shifts of the day; a contracted partner, La Causa, covers the third shift. BHD is currently 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.

Children's Mobile Crisis Team

The Children's Mobile Crisis team is similar in structure to the CMT but focused on off-site assessment for children and adolescents (under 18 years of age).

Community Consultation Team

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

Crisis Assessment Response Team

The Crisis Assessment Response Team (CART) is a co-responder program that consists of paired teams of master's level clinicians and law enforcement officers. Participating officers go through Crisis Intervention Training (CIT) and additional extensive training with Milwaukee County Crisis Services, and the teams respond to calls for service for individuals with significant mental health or co-occurring needs that require a mental health and law enforcement response.

CART responds to mental health calls that are dispatched through law enforcement, the Crisis Mobile Team, or proactive response by the officer. CART clinicians provide the immediate stabilization, linkage to services, and follow up with the people served.

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.

Access Clinic

The Access Clinic is a short-term stabilization clinic located at the Mental Health Complex 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 primary population served is individuals with no insurance, and the clinic functions as a walk-in alternative to the PCS. Once the Complex closes, BHD plans to partner with two Federally Qualified Health Centers to provide walk-in clinic options.

Crisis Stabilization Houses

Crisis Stabilization Houses are two licensed Community Based Residential Facilities comprised of 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.

Peer-Run Respites (Planned)

Milwaukee County's first peer-run respite is set to open in 2019. The Peer Run Respite is a short-term respite consisting of 4-5 beds for individuals with mental health needs and in need of additional support in a safe and accepting environment. People coming to the Peer Run Respite are looking to strengthen their recovery and proactively address any need they may be experiencing. Programming will be self-directed and will use a strengths-based holistic approach. People will be offered wellness opportunities through one-on-one or group peer support. A stay at the Peer Run Respite will begin with a potential guest speaking directly with staff about what they are experiencing, their hopes and needs, and how a temporary stay would be beneficial to their recovery. Peer Run Respite programming is person-centered and recovery-focused, and activities are strictly voluntary.

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. Crisis Resource Center (CRC) services are funded by BHD and delivered by a contracted community-based provider. The two CRCs, located in the northern part of the city of

Milwaukee and on its south side, provide people who are experiencing a mental health crisis a safe and supportive environment to meet their individualized needs. There are currently 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 to support stabilization in a community setting through the CRC's array of onsite supportive services, including 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 at the CRCs is 5-7 days. People are directly referred to CRCs through BHD Crisis Services, hospital EDs, and community agencies; others are self-referrals, either via phone or walk-in. In the redesign, as discussed in the Planning Summary, the emphasis of CRC admissions will shift from ED step-down to ED diversion.

Community Linkage and Stabilization Program

The Community Linkage and Stabilization Program (CLASP) is a community-based peer specialist program. Individuals 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). The peer specialists utilize their own unique recovery experiences to engage people who are beginning their recovery. The CLASP team provides individualized care and planning in the community at the location that best serves the person's needs. CLASP has been able to successfully engage people who have traditionally not engaged in services. CLASP focuses on stabilizing the crisis, partnering with the person to meet their needs, and developing strong support systems to prevent crisis. Duration of service is generally 6 months but is based on the individual's needs. Services are provided under contract by La Causa, Inc. There is currently capacity for a caseload of 80 people program-wide. It is hoped that expanding funding sources through HMOs and other revenue streams will increase capacity and the ability to serve more people.

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

Psychiatric Crisis Services (PCS) is a 24-hour, seven days per week psychiatric emergency room. This essential component of the County's current system of crisis services 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, CART, Community Consultation Team, and Geriatric Crisis services. Individuals who come in either voluntarily or involuntarily can be seen immediately. All inpatient admissions to the Behavioral Health Division are evaluated first in the Psychiatric Crisis Services, as are individuals brought in on Emergency Detention, under Chapter 51 of the Wisconsin Statutes, by law enforcement. There were 8,001 individuals seen in PCS in 2017 (7,194 for whom legal status is known and demographic information is available, and about one quarter of whom were children).

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.

Team Connect: Short-Term Follow Up

Team connect is comprised 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. Contact is made or attempted with the person within 24 hours or the next business day of discharge. The team provides linkage to services in the community, supports engagement in post discharge care, and community-based crisis response. Team Connect was implemented in 2017 and continues to evolve. The team will continue focusing on engaging people post discharge from BHD Mobile Crisis, private EDs, and inpatient to ensure their needs are being met and to reduce PCS visits, BHD readmissions, and overall crisis episodes. Going forward, additional emphasis will be placed on Care Coordination. Expanding services to HMOs for people being discharged from private hospitals is also being considered.

Utilization of Current Psychiatric Crisis Services

The preceding section provides context on the basic characteristics of the psychiatric crisis service system in Milwaukee County. In this section, we provide more granular context by summarizing utilization data and information provided by BHD, private health systems, and the Wisconsin Hospital Association (WHA).

BHD provided summary information on the number and characteristics of people receiving crisis services and assessments through PCS, Crisis Mobile, and CART teams in 2017 (the most recent full year for which data were available), as well as numbers served for the Access Clinic, Crisis Stabilization Houses, Crisis Resource Centers, Community Consultation Team, and Children's Crisis Mobile (formerly known as MUTT). Ascension, Aurora, Froedtert, and Children's health systems provided numbers and characteristics of individuals presenting in their EDs for behavioral health problems.

The data requested focused on the flow of individuals through the system, such as how they accessed crisis or ED services and where they live; the individuals who are being served according to various demographic characteristics; and information on their disposition (where they went after assessment).

The aggregate data received from BHD and the private health systems are summarized below. Data provided by WHA and analyzed separately is presented in Appendix D. It is important to note that there were some inconsistencies in data collection and reporting among the different systems that result in some imprecision and gaps. For example, BHD (PCS, Crisis Mobile, CART) and Froedtert were able to distinguish legal status within their records, and BHD provided data for those with a known legal status. Aurora and Children's assumed anyone arriving via law enforcement was involuntary, and Ascension was unable to distinguish legal status.

It also should be noted that the purpose of this summary is not to compare different systems, but rather to provide a picture of the overall population of persons receiving crisis services as they are distributed across various facilities in Milwaukee County and the volume of services provided. These organizations differ in structure, populations served, and functions within the overall Milwaukee County health care system, and it should not be expected that they would be comparable with respect to crisis services and patients.

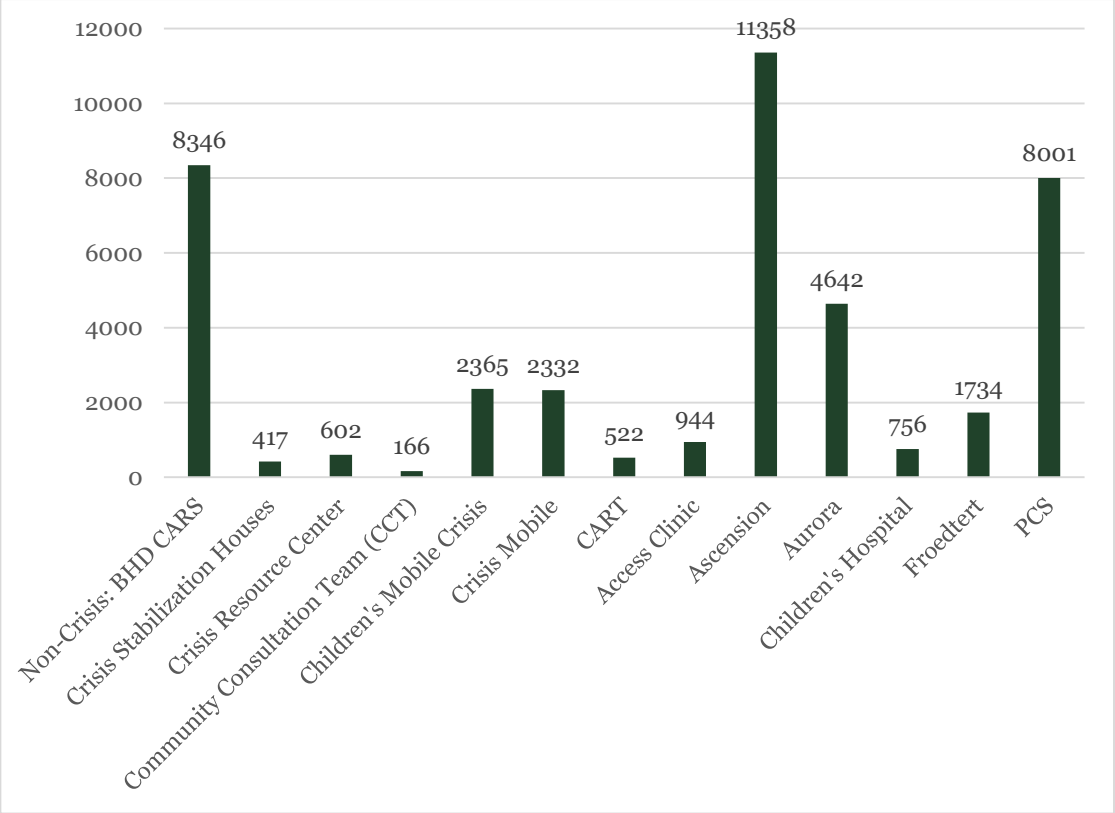
Finally, while each program or system provided unduplicated counts of individuals served, it is possible that some individuals were counted under multiple programs or systems if they received services from multiple programs or systems in 2017. As such, it is important to realize that the data presented represent the best estimates available for our purposes, but there is likely to be more error than with alternate approaches that can be employed when individual-level data are available.

Psychiatric Crisis Service Clients Served

To understand the need for potential changes or expansion to various components of the current psychiatric crisis service system, it is important to understand the utilization of existing crisis programs. Figure 3 shows an overall view of the number of individuals assessed or served in 2017 by the various crisis programs directly run or contracted for by BHD as well as by BHD's Community Access to Recovery Services (CARS) non-crisis services (to give a sense of post-crisis capacity). We also show the collective number of individuals assessed for behavioral health reasons at the emergency departments of hospitals in the Ascension, Aurora, Froedtert, and Children's Hospital health systems in Milwaukee County.

Figure 3

Number of Individuals Assessed or Served by Program/System, 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.

For future crisis service planning purposes, it is also important to understand who is being served by each of the crisis programs and their flow through those programs. For example, where do they come from, who are they, and where do they go after they are assessed or have received services?

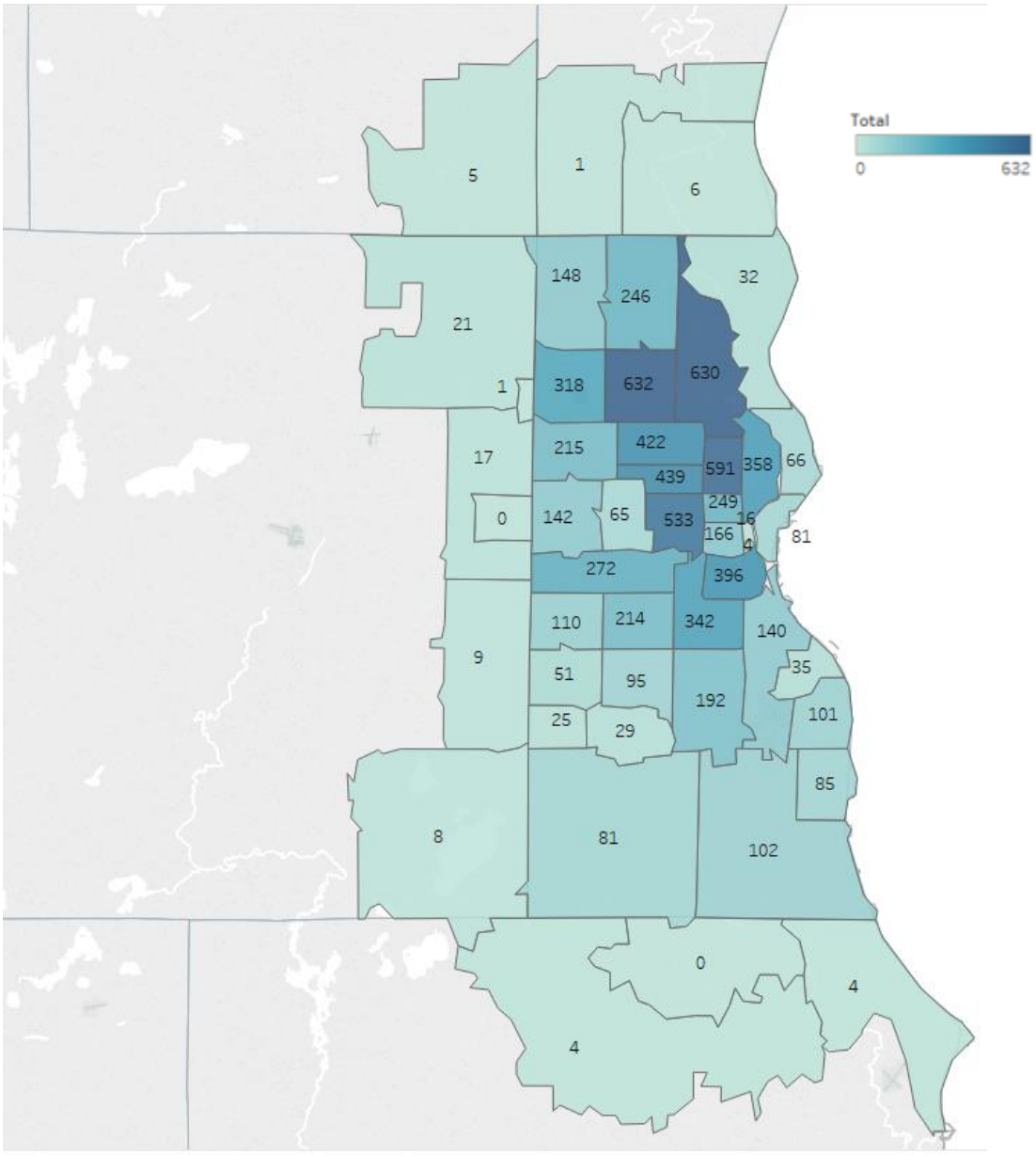
We were not able to obtain data summarizing user characteristics for all programs; consequently, characteristics of those served are only summarized for those programs for which data were available. Characteristics summarized include admission status (voluntary or involuntary when available), geographical distribution, mode of access, demographic information (age, gender, race, and ethnicity), diagnosis, payment source, and disposition once the psychiatric assessment or crisis service was provided.

PSYCHIATRIC CRISIS SERVICES

The 53218, 53209, 53206, and 53208 zip codes had the highest numbers of individuals served, with these four zip codes alone accounting for 33% of PCS users in 2017. Figure 4 shows the number served for each zip code in Milwaukee County and abutting zip code boundaries, with darker shades indicating a higher number of individuals served. Similar maps for other BHD services and for private health systems are included in Appendix C.

Figure 4

GIS map of home zip codes of individuals using Psychiatric Crisis Services



Other notable characteristics of those served by PCS:

- Of the 7,194 individuals with known legal status assessed in 2017, 59% were at PCS under involuntary status.
- 69% of individuals served were under the age of 40, including 23% under age 18.
- Those served were most likely to be male (58%) and African American (59%).
- 72% of those served had a mental health (as opposed to a substance use) diagnosis.

- The majority of individuals served were covered by Medicaid (59%) or Medicare (21%).
- The most common disposition after assessment was a return home with community services (58%), though 16% experienced a BHD inpatient stay and 8% experienced an inpatient stay at a private hospital.

CRISIS MOBILE

- Of the 2,332 individuals assessed by Crisis Mobile in 2017, 60% were assessed under involuntary status.
- The 53218, 53209, 53204, and 53215 zip codes accounted for 31% of individuals served (see Appendix C for map).
- About a third (33%) of those served were in the 26-39 age range, with the 18-25 range the next highest at 19%.
- Individuals served were split evenly between males and females.
- Of those served by Crisis Mobile, 51% were white and 43% were African American.
- Most of those served were covered by Medicaid (49%) or Medicare (27%). About 12% had no insurance source.
- After being assessed by Crisis Mobile, the most likely disposition was return home with community services (59%), with 10% experiencing an inpatient stay in a private behavioral health facility. Fewer than 1% experienced an inpatient stay at the BHD complex.

CART

- Of the 522 individuals assessed by CART in 2017, 22% were assessed under involuntary status.
- The 53218, 53209, and 53208 zip codes accounted for 26% of individuals served, with another 22% residing in the 53204, 53206, and 53216 zip codes (see Appendix C for map).
- 32.8% of those served were in the 26-39 age range and 23% in the 18-25 age range.
- 58% were male and 53% were Black/African American.
- The majority were covered by Medicaid (49%) or Medicare (30%); 12% were classified as having no insurance or were self-pay.
- The most frequent disposition was return to home with community services (57%), while 15% were admitted to a private behavioral health facility. Fewer than 1% were admitted to a BHD inpatient bed.

ASCENSION

- Of the 11,358 individuals assessed for behavioral health issues in Ascension emergency rooms, the most frequently reported home zip codes were 53215, 53204, and 53210, accounting for 24% of individuals served (see Appendix C for map).
- 25% of those served were in the 26-39 age range, and 22% were in the 50-59 age range.
- 55% were male, and of the one third for whom data on ethnicity was reported, 52% were White.
- 59% were given a substance use diagnosis.
- The majority were covered by Medicaid (53%) or Medicare (24%).
- The most frequent disposition was return to home with community services (81%); fewer than 2% were admitted to a private behavioral health inpatient facility.

AURORA

- Of the 4,642 individuals assessed in Aurora emergency departments, 2% were under involuntary status.
- 31% lived within the 53215, 53204, 53208, 53214, and 53219 zip codes (see Appendix C for map).
- The majority (74%) accessed Aurora EDs as walk-ins; 24% arrived by way of ambulance; and 2% arrived by way of law enforcement.
- Most were in the 26-39 age range (32%) or the 40-49 age range (22%).
- 55% were male and 65% were White.
- 76% were given a mental health diagnosis.
- The majority were covered by Medicaid (55%) or were dual eligible for Medicaid and Medicare (19%).
- The most frequent disposition was return to home with community services (44%), though a nearly identical proportion (43%) were admitted to a private behavioral health inpatient facility.

CHILDREN'S

- Fewer than 2% of the 756 individuals assessed in Children's ED in 2017 were assessed under involuntary status.
- Most individuals served by Children's lived within the 53209, 53218, 53216, 53215, and 53206 zip codes, accounting for 27% of the total individuals served (see Appendix C for map).

- The majority (71%) accessed Children's ED as walk-ins; 26% arrived by ambulance; and fewer than 2% arrived by way of law enforcement.
- Most of those served were in the 14-17 age range (36%), with all but a few under the age of 18.
- 57% were male, 46% were White and 42% were African American.
- The majority were covered by Medicaid (66%) or private insurance (31%).
- 9% were admitted to a private behavioral health inpatient stay.

FROEDTERT

- Fewer than 6% of the 1,734 individuals assessed in Froedtert's ED in 2017 were under involuntary status.
- Most of those served by Froedtert lived within the 53218, 53226, 53208, 53209, and 53225 zip codes, accounting for 33% of individuals served (see Appendix C for map).
- Most of those served were in the 26-39 age range (34%) or the 40-49 age range (20%).
- 56% were male, 48% were White, and 42% were African American.
- Most had a mental health diagnosis (72%).
- The majority were covered by Medicaid (31%) or Medicare (26%).
- The most frequent disposition (65%) was discharge to something other than BHD inpatient: private behavioral health inpatient, medical inpatient, home with community services, or unknown. 16.5% were admitted to inpatient medical care, and 10% were admitted to private behavioral health inpatient care.

Other data

The data summarized above were collected from programs and systems using a template that made use of common variables and response categories, focused only on the most recent full calendar year, so that information was available for the same time period in a comparable way across programs. Appendix C provides additional data displays for the information summarized above, showing the information for all response categories across all programs and health systems for which the data were available.

Key Data Takeaways

These data points 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 continuum was deemed to be a key element of redesign planning.

Overall, the data available on the flow and characteristics of those being served impart some key considerations for future crisis service design in Milwaukee County.

Service Areas: Figure 4 and Appendix C indicate there are certain zip codes (e.g., 53215, 53204, 53218, 53209) with higher numbers of individuals served by some crisis services, suggesting that these areas be considered as possible priorities for siting of any new crisis programs.

Access method: 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.

Age groups: Age ranges are similar for all services, with the exception of PCS, which serves more under 18 and 18-25 than others, but fewer age 40 and above. CART also served a relatively high percentage of transition-aged youth. It is unclear if these programs have targeted such youth in some way, or if this may be an artifact of the fact that PCS and CART had the largest proportion of individuals accessing the services via law enforcement, and individuals in these age ranges are the most likely to have some sort of police contact (Eith & Durose, 2011). 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.

Race: 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 choosing of crisis service options.

Substance use disorders: Ascension appeared to be serving more individuals with some sort of substance use disorder, with nearly 60% of individuals having this type of diagnosis, roughly 2-3 times the amount seen in the other programs and health systems. It is not clear if this is related to the characteristics of the Ascension system or possibly to the way in which the data were collected and drawn from data systems. If not a data-related anomaly, this might suggest Ascension as a natural fit for any crisis service models more attuned to co-occurring or substance use disorders.

Disposition: Finally, and perhaps most notably, a very large proportion of emergency service admissions, and even those at PCS, do not result in an admission

to inpatient behavioral health services. While desirable with respect to avoiding unnecessary hospitalization, this also suggests there is potential to divert greater numbers of individuals from emergency departments via more extensive use of "front end" crisis stabilization services such as walk-in crisis centers and respite programs. These functions will be addressed in the next phase of the redesign planning process.

What We Heard from Milwaukee County Stakeholders

Milwaukee County and its taxpayers have made significant investment in the delivery of psychiatric crisis services, inpatient psychiatric hospital treatment, law enforcement crisis intervention training, and a number of other service components described throughout this report. BHD staff described a number of these improvements, especially in the last year and a half, and particularly with regard to providing greater care through mobile teams in the community and less in hospitals.

The number of community mobile teams has increased, and there has been increased focus on follow-up contacts and connecting people to community-based services. Some other areas of recent enhancement include the previously noted partnership with IMPACT 2-1-1, which is now answering the crisis line. Also, changes have been made to make it easier to refer to Crisis Stabilization Houses, and direct admissions to Crisis Resource Centers have been added.

However, a common and recurring theme voiced by the wide range of stakeholders we interviewed is that elements of the crisis system have functioned in discordant fashion rather than as part of a coordinated whole. This lessens the return on the County's investment and produces avoidable costs for other providers and those in crisis.

We also heard that for many, "crisis services" connotes "involuntary treatment." Too many crisis experiences involve law enforcement, and that has an impact on how individuals with mental health conditions view themselves, how they think others view them, and how they view the mental health system and the treatment they receive (particularly if it is compelled). Too few crisis care experiences include meaningful peer support and service delivery models and care informed by those who live with mental illness. And too much crisis work is occurring in bubbles across the community—with daily missed opportunities for communication, care continuity, and collaboration.

We conducted semi-structured interviews and focus groups to gain insight into what features of the current system are most effective and should be retained and what is lacking or less effective that might be improved. Additional key themes that emerged are summarized below.

It should be noted that this section represents the perceptions of a diverse group of stakeholders who vary in their experience and familiarity with all aspects of the crisis service system in Milwaukee County. BHD staff have offered corrections or clarifications about some statements of fact related to features of the crisis systems, which are noted in the relevant passages. The original stakeholder comments have

been retained, however, as it will be important for the redesign communication strategy to address these apparent misperceptions on the part of some members of the community. As noted in the comments from BHD staff below, many improvements have occurred only in the past year and half, and it may be that some of these improvements have yet to be recognized or experienced by some community members.

Quality of Services. Although informants cite significant shortcomings and limitations in the current system that they hope will be addressed in the redesign, they also cite great improvement in the crisis service system in recent years, which they generally attribute to positive leadership.

- Mobile Crisis Service: The mobile crisis teams were frequently discussed in connection with the quality of the current system. They are highly valued, but limited capacity is described as a problem that results in long wait times and poor communication. Also, there is a desire to expand the functions of mobile crisis teams. There is a perception, indicated by consumers, family members and other stakeholders, that Chapter 51 assessments are the primary activity of these teams, more so than providing treatment and crisis resolution. Some informants from the private hospitals stated that the teams come into the hospital EDs to evaluate but do not coordinate treatment or communicate with staff, which most informants attribute to lack of capacity. It is clear that the mobile crisis service should be an important focus of the redesign planning.
- PCS is generally regarded as having improved significantly in recent years, and representatives of private health systems noted the value as a training site. Some suggested there is still room for improvement, however, particularly in regard to treating patients with dignity and focusing more on crisis resolution in addition to assessing for commitment. Some felt there has been excessive concern about safety and liability, at the expense of regard for the well-being of patients. While it is not entirely clear whether these views reflect current practices or past experience, these issues of philosophy and culture are certainly important for consideration in planning the redesign.
- Crisis resource centers are also valued, including by managed care organizations (MCOs). Some identified limitations such as requirements for stable housing and health insurance to be eligible for the service. Some consumers noted that the CRCs tend to have an overly directive/bordering on coercive, provider-driven orientation (e.g., requiring medications be taken) that can be at odds with community programs' approach of person-centered care. In response, however, BHD states that there is no insurance requirement for eligibility nor is there a requirement for medications. Some consumers also expressed the view that CRCs are located in "unsafe" sections of town.
- The Access Clinic is valued and there is hope that it can at least be preserved if not expanded. Consumers and other stakeholders identified a need for walk-in

crisis services as a means of diversion, and the Access Clinic provides rapid, voluntary services in a minimally restrictive setting.

Preferred models. Informants, including consumers, widely endorsed a community-based system with a continuity of services of multiple levels of intensity, beginning with prevention and continuing through early crisis resolution; the use of respite and crisis resource centers for diversion from the ED; and, when an ED visit becomes necessary, a smooth transition afterward that includes step-down services and coordination with outpatient care. Some suggested there needs to be a redefinition of what constitutes "crisis"; too often, individuals are only viewed as being in crisis when it gets to a point that involuntary commitment is an option being considered. Not all crises involve lethality risk or psychosis; narrowing access to crisis services in this manner leaves out too many individuals who are suffering. In addition, if crisis services are delivered earlier (before symptoms are most acute), there is more flexibility in service delivery and post-crisis services and safety planning.

The wider use of crisis respite, crisis resource centers, and peer supports are seen as necessary for a system supporting this broader view. The call for increased flexibility and availability of the mobile crisis service was also identified with this orientation, as was increased accessibility by location of crisis prevention services where people live. BHD and FQHCs have been actively planning a partnership that is expected to be in place within the next six months. The partnership will be beneficial in multiple ways: FQHCs are community-based, offer better reimbursement, and are already integrated with health care. Shelters also are an important point for heading off crises and increased co-location of services and collaboration would beneficial.

At the same time, some emphasized the complexity of needs for individuals experiencing crises, including medical comorbidity, substance use disorders, homelessness, and developmental disability, with the recommendation that this not be underestimated in the redesign. We believe, based on knowledge of model systems, that these two considerations—preventing or resolving crises early and attending to individuals in crisis with complex needs—are not incompatible, and we recommend that the planning process take into account both scenarios.

Communication and coordination. Lack of communication among health systems, crisis services, community outpatient treatment providers, and MCOs was widely cited as a longstanding and seemingly intractable problem. Representatives of MCOs identified a challenge in communicating with BHD staff mid- and post-crisis. Although this situation has improved, the MCOs feel they have a lot to offer in stabilizing an individual in crisis, but often they don't even know when one of their members is in the ER or is receiving post-discharge case management. BHD has responded by acknowledging this shortcoming in the current system and the importance of addressing it in the redesign, noting that coordination and communication are two-way processes, and it will be important for both parties to engage in making improvements in this area.

The fragmentation of services throughout BHD and in the community was emphasized. The system was said to be an overwhelming maze to navigate even for professionals embedded within it; consumers and advocates noted that it is even more challenging for individuals and families. When asked why this situation had persisted, stakeholders had no definitive explanations; however, one stakeholder mentioned that competition among agencies for clients and funding contributes to a lack of willingness to collaborate. It is also possible, based on our observations, that the individual components of the system are so strained that there is little capacity to reach out and build relationships.

Long waiting periods in hospital emergency rooms were identified as a common quality of care issue. These waits may be due to a variety of factors, such as finding an open bed, organizing community social services when that is the need rather than hospitalization, varying emergency room expertise/specialized staffing models, and delays in response by mobile crisis teams who may be occupied with other cases. Hospital EDs have limited staffing to attend to patients while awaiting disposition. This is a common national problem, as noted in our preceding discussion of ED boarding; however, hospitals around the country have developed practices for reducing the frequency and duration. One means of improving both communication and efficiency, mentioned by a number of informants, is the increased use of telepsychiatry—for example, to provide consultation to hospital EDs.

We strongly recommend that the planning process address not only the various services that make up the system but also the mechanisms for ensuring that these services are interconnected and coordinated with other providers and community services.

Law enforcement. There was a widespread view, especially among consumers and advocates, that the functions of law enforcement, though an essential and valued adjunct to crisis services, ought to be limited to those functions that cannot be performed safely in any other way. Representative of this issue is the current legislation authorizing only law enforcement, and not hospital doctors, to determine Chapter 51 status; one informant described this practice as “archaic, iatrogenic and inefficient.” The stigmatizing nature of having law enforcement respond for psychiatric crisis was emphasized by many. Prior traumatic experiences with law enforcement can lead people to avoid reaching out to crisis services when in need—particularly when law enforcement is intertwined with crisis response. BHD staff note that making major changes in the role of law enforcement will be a large-scale, complex, and long-term policy issue. Yet they also report that much progress has been made in cooperation with law enforcement agencies, affecting how crises are addressed and relations with crisis service providers, as evidenced by the expansion of CART and CIT.

There is a view that while the understanding of mental health issues and crises have improved in recent years, there is still room for progress. For example, consumer focus group members reported that the default response to veterans experiencing crisis is often to dispatch a SWAT team because of concerns of the possible threat an individual may pose to police because of his or her military training. Informants

suggested there is a need for more de-escalation training, and one informant indicated that the way CIT training is provided lacks fidelity to the evidence-based model.

National Models for Consideration

With a basic understanding of the characteristics of those accessing psychiatric crisis services in Milwaukee County and where they are accessing those services—as well as a basic grasp of the various services offered in the county and how those compare to national norms—we now turn to consideration of system enhancements and improvements. In this section, we offer examples of national best practices in the different psychiatric crisis service areas.

Examples of Best Practice: System Components

The following are descriptions of best practices for some services to be combined in a seamless continuum of psychiatric crisis care.

emPATH

Dr. Scott Zeller, whom we interviewed for this project, has designed a model for psychiatric crisis facilities known as emPATH (emergency Psychiatric Assessment, Treatment & Healing). While still connected to or in proximity of hospital emergency departments, the most recent replications of this model are smaller and less restrictive; they provide an open, comfortable, shared treatment space; help-yourself access to food and beverages; and blankets and restful spaces. They use intuitive care models—with staff following the patient's lead in terms of what the patient needs throughout their stay—that are focused on engagement and delivery of crisis

treatment. Peer specialists are embedded in the program and deliver supportive interventions.

Dr. Zeller describes programs that have virtually eliminated the use of restraints and greatly reduced the need for inpatient hospitalization—particularly on an involuntary basis. He cautions that the programs must have minimal "exceptions" with regard to whom they will treat (have high tolerance for some medical symptomatology, individuals brought by police, individuals on involuntary holds) while providing care that is trauma-informed and person-centered.

The following is a description of a new emPATH program that opened in April 2018 in Billings, Montana:

> Using the Alameda Model, also referred to as an emPATH (emergency Psychiatric Assessment, Treatment & Healing) Unit, psychiatric patients once medically cleared are directed to a dedicated space with specially trained providers, away from the noise, hectic activity, flashing lights, and other norms of a traditional emergency care setting. Like many other medical emergencies, psychiatric emergencies can often be resolved in less than 24 hours when prompt, skilled care is available. Compared to emergency departments, the emPATH setting is calmer, more home-like, and offers a supportive environment for patients in psychiatric crisis. This setting decreases patient agitation and reduces the need for coercive measures (like restraints). In the large, comfortable central room are recliners and stations where patients can access snacks and beverages. There are opportunities to read, watch TV, play board games, or visit privately with a therapist or counselor. The design is safer for patients and more cost effective than building a separate emergency room. (Helmsley Charitable Trust)

The emPATH model involves a general shift in organizational and system culture, a redefinition that the primary intent of each and every crisis service—from the first call to the crisis line to a course of inpatient treatment—is resolution rather than problem identification and referral. As opposed to completing screening tools or a series of assessments, the focus instead is on the delivery of relieving interventions (not limited to medication) that reduce or ease the sense of crisis and the discomforting symptoms; reduce actual risks of harm; are change-promoting; activate coping skills and problem solving; offer support and information to caregivers; and lead to collaborative development of person-specific care strategies.

The "Living Room" Model

The Living Room model was first developed by Recovery Innovations (now Recovery International). The organization has now established 10 Living Room programs in five states and has influenced the practice of many other programs that have sent teams to train at Recovery International's Arizona headquarters. Living Room programs use a recovery model to support stabilization and return to active participation in the community. Individuals in crisis are admitted as "guests" into a pleasant, home-like environment designed to promote a sense of safety and privacy.

The programs employ teams consisting of doctors, nursing staff, and peers with lived experience to engage with the guest. Risk assessment and management, treatment planning, and discharge goals are set, and a peer counselor is assigned to the guest to discuss crisis and coping skills that can be used to reduce distress and empower the individual. In some communities, "living rooms"/crisis respite facilities are available for direct drop-off by trained law enforcement teams. The programs make every effort to eliminate seclusion and restraint and to serve all people regardless of level of acuity without resorting to physical interventions.

Walk-In Centers: Colorado

Six previously established mental health care organizations operate a network of seven walk-in centers in Colorado. Anyone can be treated at the walk-in clinics, which are open around the clock. Many of those using the service are directed to them by crisis hotline operators or a mobile crisis team. The center's professional staff work with patients to determine a personalized treatment plan and connect them with outpatient services. Patients may remain in the center for up to 24 hours.

Community Crisis Response Teams: Netcare (Columbus, Ohio)

Netcare's Community Crisis Response provides immediate, on-the-scene response to traumatic events. These teams work with the Red Cross, police, and fire departments to assist citizens in the community who are impacted by traumatic events such as homicides, suicides, unexpected deaths, motor vehicle accidents, fires, and other events where significant physical trauma or death is involved.

Community Mental Health Clinic Outreach Team

Boudreaux, Crapanzano et al. (2016) describe a component of a service system that combines a Mental Health Emergency Room Extension (MHERE) with a community mental health outreach team. The MHERE is a psychiatric observation unit and annex of the ED, located in a building adjacent to the ED that holds patients who were having a psychiatric emergency after they receive medical clearance and triage services. The community mental health clinic provides an outreach team that comes to the ED, Monday through Friday, to meet with patients who are being referred to their agency for follow up to discuss their needs and to educate them about the available services at the outpatient clinic. The team also obtains contact information and assists with obtaining transportation to the clinic. After discharge, team members make phone contact to remind the client of the appointment.

Transportation

The Carolinas HealthCare System, one of the largest freestanding psychiatric emergency departments in the country, was prompted to explore transportation options other than law enforcement because of the increasing number of patients presenting in crisis and the desire to decrease the number who are involuntarily committed. They contracted with a company that uses unmarked vehicles with drivers wearing non-police-type uniforms. They allow the patient to choose the music that is

played in the vehicle, and they do not use any type of restraints (Rachal, Sparks et al., 2017).

Southern Arizona uses non-ambulance transportation services often staffed by peer specialists who are dispatched by a centralized crisis line (also responsible for dispatching mobile crisis teams).

Minnesota has developed various alternatives to police and ambulance transportation. Allina Health, which owns Abbott Northwestern and 11 other hospitals statewide, keeps an unmarked Ford Escape among its fleet of ambulances at its emergency medical base, which community paramedics use for visiting recently discharged patients or transporting them to outpatient follow-up appointments. Yellow Medicine County Sheriff's Department in southwest Minnesota uses an unmarked Chevrolet Malibu to transport psychiatric patients from the hospital emergency room to mental-health facilities across the region.

The main obstacle to alternative forms of transportation is that insurance companies and government-funded programs such as Medicaid reimburse people for ambulance trips but not for private security guard transports. As of 2014, the Minnesota Legislature had taken steps to address the problem by creating a special class of nonemergency transports under state law, and advocacy groups were asking the legislature to include nonemergency transport as a reimbursable expense under Medicaid (Serres, 2014).

Telepsychiatry

Technological solutions to improve the efficiency and quality of care are receiving increasing emphasis. The American Psychiatric Association has recently published a book on the subject. The book is a comprehensive guide for psychiatrists, psychologists, and other mental health clinicians to use for care delivered in whole or in part by technological devices and applications (Yellowlees & Shore, 2018).

The Carolinas HealthCare System, mentioned above, sees around 1,000 patients per month across 21 EDs; it has made telepsychiatry a central element in its operations (Rachal, Sparks et al., 2017). The process for telepsychiatry begins with an initial interview by licensed clinical staff (licensed professional counselor, licensed clinical social worker, or a registered nurse [RN]), similar to the initial evaluation completed by RNs in the psychiatric emergency service. The psychiatrist then reviews this information and contacts the medical ED to set up the virtual evaluation, where the patient is interviewed over secure, HIPAA-compliant video and audio lines. The assessment is documented, and recommendations for further treatment are provided to the medical ED physician. An automatic alert notifies the medical ED when the consultation is complete and the assessment and recommendations are in the chart for their review.

If a patient requires inpatient treatment but cannot immediately be admitted—an unfortunate but common occurrence—the patient is boarded until a psychiatric bed becomes available. While held in the ED, patients are started on medications right away for their psychiatric treatment. The consulting psychiatrist places these

medication orders after evaluating the patient. Patients are visited by a member of the licensed clinical team daily, and the psychiatrist or psychiatric nurse practitioner rounds on patients at least every 48 hours. Whereas nearly every patient was admitted prior to implementation of this system, now 35% to 40% are discharged.

Respite Care: Colorado

Colorado's system has extensive capacity for respite care. The walk-in centers and Crisis Stabilization Units have the option of referring clients to respite care services, which provide therapy management, medication management, and inpatient mental health treatment for up to 14 days. Separate respite services exist for adults and children/adolescents. Adult respite services connect patients to designated beds in the community, where they can remain for up to 14 days. Respite care locations offer counseling and medication management as well as support for families and caregivers. Children can stay in respite care for two consecutive nights on the weekend, and for several additional hours during the week. Child-specific respite services specialize in supporting the family in its efforts to care for the child and in developing a multi-generational, in-home treatment plan.

Volunteers are recruited and trained by Colorado Crisis Services to provide respite care. Respite vouchers provide funds for respite care to family caregivers across the state of Colorado, serving all ages and special health care needs. This program offers a resource for unserved and underserved family caregivers who have limited access to respite care and/or other supports through current systems. The program is intended to act as a payer of last resort. Vouchers are for services by approved providers, and families may receive up to $2,000 a year. The system is supported by a coalition of numerous provider organizations and advocacy groups.

Virtual Care Coordination

The Carolinas HealthCare System has implemented a "virtual care coordination model" that uses audio-video technology to provide remote assistance to patients in medical EDs over a large geographic area in order to get appropriate outpatient care. The virtual care coordinators perform the same functions as an on-site coordinator, such as setting up follow-up appointments and ensuring they are able to get medications to last until the next appointment to prevent another emergent visit just for refills. They also are able to assist with issues related to social determinants that pose barriers to the patient staying well (Rachal, Sparks et al., 2017).

Resource Directories: Colorado

Rocky Mountain Crisis Partners in Colorado maintains an online resource directory that includes over 5,000 different providers, assistance programs, and support resources throughout the community. The platform uses Google translation capabilities for non-English speaking users, allows for search by provider, type of problem or illness and location, and utilizes an automatic update system to ensure the correct contact information.

Enhancement of Psychiatric Crisis Treatment in Medical EDs

As an alternative to transferring persons in psychiatric crisis to a specialty service, medical EDs may increase capacity to treat some subset on site (Zun, 2016). This requires enhancing the competency of medical ED staff to assess, manage, and treat patients presenting with psychiatric symptoms, such as agitation. To promote this enhancement of medical EDs, the American Society of Emergency Physicians has developed a consensus statement on the management of agitation that includes recommendations for the use of various mechanisms for enhancing capacity for EDs, including the use of psychiatric triage scales, a psychiatric medical clearance checklist, suicide and homicide risk assessment, and protocols for psychopharmacological treatment (Wilson, Currier et al., 2012).

Next Steps for Milwaukee County

In this section, we identify best practice strategies that stakeholders in Milwaukee County should consider. We also outline a decision framework highlighted by three potential models. These concluding observations are based on feedback from key informants, our analysis of utilization data, and our review of national models and exemplary practices.

What "best practice" strategies do we lack that we should consider?

Milwaukee County has a reasonable number of crisis system parts—and this will continue to be the case once key decisions are made about repurposing existing resources in a redesigned system. However, the county system is missing sufficient structures to tie all of the core crisis parts together into a functional whole. In addition, there is significant opportunity to assess and strengthen services that address other phases of the crisis continuum. Strategies to consider:

- Develop an overarching structure for managing the crisis system of care that is either managed by the county or procured. A centralized call system can be a key part, but additional elements are required to maintain appropriate oversight of a crisis system; assure daily function; assure service continuity for each person in crisis; formalize partnerships, processes, and collaborations; perform cross-sector outcomes evaluation; and promote continuous

improvement. The development of a crisis system of care is never complete; it requires continual attention, evaluation, refinement, and advancement.

- Develop a crisis system of care plan that addresses the mental health and related public safety needs of the whole community. Addressing the regulatory responsibilities of BHD and the service components that are funded by BHD are a key part but should not constitute all of the plan.
- Seek a high level of transparency across the crisis system of care. Real-time data is the most important data for a crisis system. With high-quality data, all players' decisions are better informed, performance is better honed, and interpretation of outcomes is more accurate throughout the entire system of care.
- Involve individuals with lived experience (including parents of children who have used crisis services) as consultants in the crisis system redesign. This would build on the involvement of peers in the BHD Crisis Executive Team and redesign planning over the past 11 years.
- Invest in peer-delivered services and peer-infused treatment teams.
- Proceed with implementation of the Zero Suicide model, which is currently in process. Zero Suicide is an approach developed by the National Action Alliance to Prevent Suicide that embeds suicide prevention into the standard practices and culture of behavioral health systems.
- Implement the No Force First model, which consists of a set of practice and cultural changes, in this case aiming to reduce the use of coercive measures.
- Develop a working consensus document that explains the crisis system, its philosophy, and its operations. This document becomes a transparent go-to resource for all sectors. This should be a focus of the next phase of the redesign planning process.

A Path Forward

Based on our understanding of Milwaukee County's health and behavioral health needs and assets, the utilization patterns of the current psychiatric crisis service system, the characteristics of the community, and consideration of modern principles and national best practice models, we have identified three general adult crisis system models for Milwaukee County to consider. It is important to note that we have not yet addressed issues of cost and have not completed a fiscal analysis of the three models.

We suggest that this consideration be made with the following questions in mind:

- What is the intended purpose of the future crisis system of care?
- How could the system, as a whole, best be organized?
- What are its core programmatic components?

- What is it expected to deliver?
- What are the principles by which it will operate?
- What cross-cutting core competencies are necessary to achieve delivery objectives?
- And, critically, how should the system be experienced by the adults, children and their families who use it?

The three models are as follows:

1. A centralized system organized around a single large psychiatric emergency services program.
2. A decentralized system, with multiple sites providing a diverse array of crisis services, including some capacity for receiving individuals on petitions.
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.

These three models are described in Figure 5, with a starter set of pros and cons to consider for each model.

It should be noted that this typology actually represents a continuum with some flexibility in the boundaries of each. That is, depending on the relative allocations to different components of the system and the ways in which these components are coordinated, elements of two or all three models could be incorporated in a final redesign strategy.

That said, we recommend moving as far toward a decentralized and multi-faceted crisis system of care model as is reasonably feasible and sustainable. This kind of model would necessarily alter the utilization patterns that characterize the current system. While that would be disruptive, it is also most likely to improve patients' experience of care.

Figure 5

Potential Adult Psychiatric Crisis Models for Consideration by Milwaukee County

Model 1 Single centralized magnet psychiatric emergency department	**Model 2** Decentralized crisis walk-in/drop-off system (multiple sites around the county)	**Model 3** Enhance competency/capacity of existing emergency departments combined with an expansion of early intervention and post-crisis recovery/reintegration services
Select a single large site that serves as a psychiatric ER for the county and has arrangements with hospital emergency departments to receive individuals who have been medically stabilized. The psychiatric ER may or may not be hospital-adjacent and may either be operated/staffed by a private health system or by BHD. Provides: • Large receiving facility for individuals on petitions • Voluntary crisis treatment services • Crisis treatment services (not limited to assessment) • Peer support services • Treatment and support services linkage	Establish an array of smaller sites strategically located in the community offering crisis walk-in services. This could be accomplished by repurposing some or all of the existing crisis system components. Could be a mix of distributed sites, some providing voluntary services only, others accepting involuntary admissions. Sites could be adjacent to or affiliated with other types of facilities such as shelters or FQHCs.	Enhance competency/capacity of existing private hospital emergency departments to better serve individuals in crisis. The number of such individuals would shrink via investment in: • Expanded crisis prevention and early intervention capacity (urgent cares, open access treatment sites, effective crisis planning, harm reduction models); • Less restrictive acute crisis intervention and treatment services (mobile crisis, brief crisis stabilization/detox beds); • Post-crisis capacity (e.g., back door coordination of services from EDs, inpatient units, crisis beds, bridge services, peer support and engagement, brief intensive 30-60 day service programs to divert from high-intensity services).
PROs: Single centralized site • Simple decision making for system, law enforcement, hospitals • Some logistic simplicity—smaller number of sites to coordinate/manage • There may be a financial advantage if adjacent to a general hospital emergency department • Close proximity to a general hospital emergency room may permit inclusion of individuals with more complex health needs	**PROs:** • A balanced system that provides some of the benefits of each of the two alternative models with an array of sites offering various levels of service intensity • Individual sites embedded in the community, attuned to neighborhood needs and characteristics, more culturally competent • Flexible—allowing for adjustment to meet changing or unanticipated needs by changing mission or expanding/shrinking components • Brings more treatment providers and system stakeholders under the crisis continuum umbrella—opportunity to have more competent providers	**PROs:** • Broadest approach—investing in all phases of the crisis system of care framework rather than primarily focused on acute crisis response • Less restrictive: Primarily focused on engagement in voluntary services • Improved broad, systemic competency in crisis prevention and early intervention—reducing need for acute intervention, hospitalization, petition initiation • Improved broad, systemic competency in post-crisis support, reintegration • Brings broad group of treatment providers and system stakeholders under the crisis continuum umbrella—opportunity to have many more competent providers

Model 1 Single centralized magnet psychiatric emergency department	Model 2 Decentralized crisis walk-in/drop-off system (multiple sites around the county)	Model 3 Enhance competency/capacity of existing emergency departments combined with an expansion of early intervention and post-crisis recovery/reintegration services
CONS: Single centralized site • Limits choice for individuals • Location may be a deterrent or barrier to service and family participation • If ED-adjacent, may reduce flexibility in service model • Longer transport from EDs, longer transport for MPD coming from all parts of the city • Have to work hard to minimize use of coercion (petitions, restraints, restrictions, security…) • May be viewed as panacea, limiting efforts to implement more challenging system culture changes • Over time may become overused and a place where people get stuck • More difficult to provide culturally informed and linguistically competent care for diverse community • Preserves an approach where there is a small pool of providers/clinicians with crisis expertise • Might require substantial capital investment in a new site if not contained within an existing facility	**CONS:** • More complex to implement and manage • Requires greater system logistics • Not ED-adjacent so there may be more limits as to who can be seen in these sites due to co-occurring medical conditions • Might entail siting challenges and/or greater capital investment in multiple sites	**CONS:** • It is the most complex to implement and manage • Requires well developed logistical processes • Requires greater transparency across the system • Requires maximum buy-in by diverse and cross-sector set of systems/organizations
Comparison to this model: **Unity Center in Portland, OR** Unity Center in Portland is an example of an emPATH program (described previously) that provides a hospital ER-adjacent centralized psychiatric receiving facility for the city. It is a collaboration between four health care systems. Other hospitals can medically clear individuals and transport to Unity Center for comprehensive assessment and treatment. In addition, Unity	**Comparison to this model:** **Massachusetts example** Massachusetts has developed a state-wide system of 17 emergency services programs (ESPs), each of which has a walk-in crisis site along with crisis line services, mobile crisis teams for children and adults, and co-located crisis stabilization beds. The vast majority of ESP sites are not emergency department–adjacent. All private nonprofit service providers. Crisis system procurement/oversight by an MCO	**Comparison to this model:** **Southern Arizona example** Southern Arizona has very low use of emergency departments and inpatient psychiatric treatment. The region has made very high investments in smaller, primarily voluntary, community-based walk-in sites, some of which provide detox services. There is a high expectation for peer embedded models. The system is tied together by a sophisticated regional call and dispatch center that is affiliated and works closely

Model 1 Single centralized magnet psychiatric emergency department	Model 2 Decentralized crisis walk-in/drop-off system (multiple sites around the county)	Model 3 Enhance competency/capacity of existing emergency departments combined with an expansion of early intervention and post-crisis recovery/reintegration services
Center is a police drop-off site for individuals on petitions.	that coordinates with the other MCOs on provision of crisis services. ESP teams employ adult peer and parent peer support specialists. **Franklin County, Ohio example (Columbus and vicinity).** Franklin County operates a county-level crisis system (Netcare) consisting of two community-based walk-in crisis agencies, each with 23-hr observation beds. The walk-in sites are receiving facilities for individuals on petition; they coordinate admission to state hospital beds when unavoidable. In addition, crisis stabilization unit is adjacent to one of the walk-in sites and there is a freestanding sub-acute, brief crisis respite program. The County recently added a brief bed-based program as a pathway to permanent supported housing. Netcare also provides a mobile petition pre-screening service. There is high coordination transparency across the network of private hospital emergency department and inpatient units, Netcare, the county, and the state hospital to maximize the flow of individuals throughout an episode of care; and a well-evolved collaboration with criminal justice/law enforcement.	with the regional behavioral health authority (RHBA). The call center dispatches crisis teams and transportation resources, authorizes and activates follow-up services, reconnects with service users to assure continuity, uses real-time dashboards and GPS tracking systems for mobile teams, and uses advanced data analytics. Arizona has achieved high participation in county-specific crisis system of care collaboratives and developed mutual care protocols.

Appendix A: Key Informant Interview Guide

1. What is your role/relation to the crisis services?

2. How are people currently accessing crisis services and where are they located? How often is law enforcement involved?

3. What are the characteristics of individuals who may need psychiatric inpatient care?

4. Why are people presenting for crisis services? What happens during crisis services?

5. How are people experiencing crisis services? How about family members?

6. What role do peers have in the crisis response system now? What role do you think peers should have in the crisis response system?

7. What have been the major strengths of the existing crisis service system? Major limitations?

8. What features of the existing crisis service system do you think are important to retain?

9. What features could or should be dispensed with?

10. What opportunities do you see for the redesign to improve the crisis services?

11. Do you know of models in other communities that you think would work well in Milwaukee County?

12. What services are most important to help avoid the need for crisis services? What is the provider capacity to address emerging crisis issues? What is the capacity after hours or on weekends?

13. What services are available post crisis now? What are most important to have available?

14. Which of the following crisis-related services do you think are most important?

    - Psychiatric ER Services
    - 24-Hour Crisis Telephone Lines (including Warm Lines)
    - Walk-In Crisis Services
    - Mobile Crisis Services
    - Respite programs
    - Individual crisis services
    - Crisis Stabilization Units

15. What will be the major challenges in the design?

16. Are there other issues that are important to consider in the redesign that we did not touch on today that you think are important related to redesigned crisis services?

Appendix B: Crisis Service Information Sheets

Crisis System Element: Crisis Line

If section is N/A for this element, leave blank

Service Description: **The Crisis Line (257-7222) is the community access line for adult crisis services in Milwaukee County. Individuals and family members who are experiencing a mental health or co-occurring crisis can speak with someone directly to obtain crisis response and resources. In May 2017, Impact/211, a community agency, began answering the first line of calls on the Crisis Line. Impact/211 is a call center that specializes in taking crisis, shelter, resources, and general information calls. Impact/211 handles all calls for resources and triages crisis calls to a clinician on the Crisis Mobile Team for immediate response.**

FUTURE VISION: **The partnership with Impact/211 will allow the Crisis Mobile Team clinicians to respond to calls in the community and reduce staffing on the Crisis Line. The partnership will lead to all calls being answered, additional community contacts, and allow clinicians to be in the community doing clinical work.**

CURRENT INFORMATION	ACTUAL or ESTIMATE	QUESTIONS/NOTES
Operator of Service and Service location(s)	Impact/211	
Hours of Operation	24 hours per day and 365 days per year	
Current Service Volume	All calls on the Crisis Line	Added efficiencies to allow additional face-to-face contacts in the community
Current Service FTEs	Contracted Agency Staff	
Target Population	Adults and caregivers/loved ones of people experiencing a mental health crisis	
Referral Source	Self-referral	
Expected Future Volume		
Funding Source(s)	County Tax Levy	
Funding model (FFS, Block, Case rate, etc)	County Tax Levy-Purchase of Service Contract	
Peer Involvement	No peers currently	
MODIFICATIONS REQUIRED?	**DESIRED RESULT**	**QUESTIONS/NOTES**
• physical plant modifications (None, Minor, Moderate, Major)		
• Required programmatic modifications (None, Minor, Moderate, Major)		
• Required Competencies		
CONSIDERATIONS	**DESIRED RESULT**	**QUESTIONS/NOTES**

• NIMBY issues?		
• Acceptance of Emergency Petitions?		
• Exceptions to services at this level of care		
• Consider co-location of mobile crisis teams to these sites		

Crisis System Element: Crisis Mobile Team

If section is N/A for this element, leave blank

Service Description: The Crisis Mobile Team (CMT) master's level clinicians and nurses who provide community-based crisis services to individuals 18 years of age and older. CMT provides crisis response, assessment, linkage to services, and follow-up support to people throughout Milwaukee County. Responses are individualized to meet the person's unique needs and in the setting most convenient to the individual (home, work, school, etc.) Coverage is provided first and second shift by Milwaukee County employees; third shift is covered by a contracted partner, La Causa, Inc. **FUTURE VISION: Focus on increasing community-based contacts to stabilize people in the community and reduce emergency detentions. Increase proactive follow-up to ensure people's needs are being met post crisis.**		
CURRENT INFORMATION	**ACTUAL or ESTIMATE**	**QUESTIONS/NOTES**
Operator of Service and Service location(s)	Milwaukee County BHD	
Hours of Operation	24 hours per day, 365 days per year	
Current Service Volume and number of teams (if applicable)	2,332 (2017) First shift=2-3 teams 2nd shift and weekends=1-2 teams 3rd shift=1 team	
Current Service FTEs	20	6 Nurses, 12 Clinicians, and 2 Psychologists
Target Population	Adults with mental health and co-occurring needs	
Referral Source	Community	Anyone needing crisis mental health services
Expected Future Volume	3,200 in 2018	Over 1,500 contacts through June 2018 and projecting 3,500 contacts in 2019
Funding Source(s)	Medicaid and County Tax Levy	
Funding model (FFS, Block, Case rate, etc)	Medicaid FFS and County Tax Levy	Working toward developing insurance contracts with HMOs
Peer Involvement	No peer specialists currently	In the planning process of adding peer specialists in 2019 to CMT like other areas of Crisis Services. CMT connects people to peer specialist programs including CLASP.
MODIFICATIONS REQUIRED?	**DESIRED RESULT**	**QUESTIONS/NOTES**
• physical plant modifications (None, Minor, Moderate, Major)		
• Required programmatic modifications (None, Minor, Moderate, Major)		
• Required Competencies		

CONSIDERATIONS	DESIRED RESULT	QUESTIONS/NOTES
• NIMBY issues?		
• Acceptance of Emergency Petitions?		
• Exceptions to services at this level of care		
• Consider co-location of mobile crisis teams to these sites		

Crisis System Element: Crisis Assessment and Response Team

If section is N/A for this element, leave blank

Service Description: **CART is a co-responder program of teams composed of a master's level clinician and a law enforcement officer. The law enforcement officer is CIT trained and goes through extensive training with Milwaukee County Crisis Services. CART responds to mental health calls that are dispatched through the law enforcement agency, the Crisis Mobile Team, or proactive response by the officer through law enforcement's CAD system. Calls for service are for individuals with significant mental health or co-occurring needs that require a mental health and law enforcement response. CART clinicians provide the immediate stabilization, linkage to services, and follow up with the people served. Currently, there are five teams with three teams dedicated serving the City of Milwaukee, one team serving West Allis, and one team serving all of Milwaukee County.**

FUTURE VISION: **Continued focus on increasing utilization, increasing awareness and consultation with law enforcement officers, and further expanding on the success of the program. Data has shown that a CART response results in people being stabilized in the community and connecting with VOLUNTARY treatment options. A sixth team is currently in the process of being developed in collaboration with the Milwaukee County Sherriff's Department.**

Future state would have CART in the community responding to as many calls for service as possible to prevent emergency detention. The CART Clinician would provide a warm hand off to a Care Coordinator to develop a crisis plan, plan of care, and coordinate services for the individual. In addition, future state would have law enforcement dispatch contact CART or the Crisis Mobile Team for mental health calls.

CURRENT INFORMATION	ACTUAL or ESTIMATE	QUESTIONS/NOTES
Operator of Service and Service location(s)	Milwaukee County BHD and Law Enforcement Agencies (Milwaukee Police Department, West Allis Police Department, and District Attorney Investigator's office)	
Hours of Operation	MPD: 7 days per week 11-7, 1-9, or 2-10 (weekend coverage 11-7) West Allis: Monday-Friday 11-7 County Wide CART: Monday-Friday 9-5	
Current Service Volume and number of teams (if applicable)	502 (2017)	
Current Service FTEs	5 Clinicians 5 Law Enforcement Officers	
Target Population	Adults in mental health crisis requiring law enforcement intervention	
Referral Source	Crisis Mobile Team and Law Enforcement Dispatch	

Expected Future Volume	1,200 in 2018	590 people served through June 2018 (more people were served in 6 months of 2018 compared to all of 2017). Projecting over 1,500 face-to-face contacts in 2019.
Funding Source(s)	Medicaid, Grant Funding, County Tax Levy	
Funding model (FFS, Block, Case rate, etc)	Medicaid Fee for Service, Grant Funding, County Tax Levy	
Peer Involvement	No peer specialists Currently	CART Clinicians connect people to peer specialist programs including CLASP
MODIFICATIONS REQUIRED?	**DESIRED RESULT**	**QUESTIONS/NOTES**
• physical plant modifications (None, Minor, Moderate, Major)		
• Required programmatic modifications (None, Minor, Moderate, Major)		
• Required Competencies		

Crisis System Element: The Access Clinics

If section is N/A for this element, leave blank

FUTURE VISION: ***A Short-Term Stabilization Clinic that provides comp. 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 Clinics (2) will be located at a North and South location, will be integrated with two partner Federally Qualified Health Centers, and will focus on service to individuals who have had recent psychiatric emergencies (PCS/Obs admission, Crisis Mobile contacts, IP Hospitalization). The expectation will be that clients will be served for a short term, approximately 2-6 months of time. Service intensity would vary based on client need, but clients open to care would be seen at least weekly by LCSW/LPC, care coordinators and peers (all three staff weekly); in addition, clients will see prescribers bi-weekly for the first month or two, then as needed.***

The Program will have the ability to divert willing clients from higher levels of care; however, the exact impact is difficult to determine.

CURRENT INFORMATION	ACTUAL or ESTIMATE	QUESTIONS/NOTES
• Operator of Service and Service location(s)	BHD; current plans call for one clinic on the North Side of Milwaukee and one on the South Side; both clinics are planned to be collocated (then integrated with two Federally Qualified Health Centers)	
• Hours of Operation	Hours will be consistent with the current FQHC clinic hours.	
• Current Service Volume	YTD 2018 is showing: 50 walk-ins per month (visits with BHESC) 126 prescriber sessions per month (initial and med check) Access staff provide approximately 30 "outreach phone calls" per week "Teams" is not an appropriate term per current clinic design. See staffing below.	
• Current Service FTEs	1.0 Director 2.0 FTE BHESC 1.0 RN 1.56 FTE Prescriber (1.0 APNP; .56 MD) 1.0 Receptionist	

• Target Population	Adults, 18+. Clients will be assessed and then referred to the right service per need and desire.	
• Referral Source	Walk-ins, Crisis Mobile Team, PCS/OBS, Crisis Case Management (Care Coordination Team), CARS Intake Team	
• Expected Future Volume	The Access Clinics are planned to include 1.0 Director 5.0 FTE BHESC 2.0 MD/APNP 2.0 peers 2.0 BA Level Care Coordinator The two clinics should be able to serve approximately 3,000 clients per year	
• Funding Source(s)	Medicaid, Medicare, Private Insurance, County Levy; working to partner with FQHC and get PPS rate for clients with Medicaid	
• Funding model (FFS, Block, Case rate, etc)	Fee for Service	
• Peer Involvement	No peers currently; future plan calls for use of peers to complete Health Navigation, Outreach, and Care Coordination	
MODIFICATIONS REQUIRED?	**DESIRED RESULT**	**QUESTIONS/NOTES**
• physical plant modifications (None, Minor, Moderate, Major)		
• Required programmatic modifications (None, Minor, Moderate, Major)		
• Required Competencies		
CONSIDERATIONS	**DESIRED RESULT**	**QUESTIONS/NOTES**
• NIMBY issues?		

• Acceptance of Emergency Petitions?		BHD Team and FQHC partners discussed that at this time they would not be including voluntary clients who would be dropped off by law enforcement.
• Exceptions to services at this level of care		
• Consider co-location of mobile crisis teams to these sites		Crisis Mobile, Crisis Stabilization Clinic (Access) and FQHC services will be co-located.

Crisis System Element: Crisis Stabilization Houses (CSH)

If section is N/A for this element, leave blank

Service Description: **Crisis Stabilization Houses are two licensed Community Based Residential Facilities comprised of 16 beds 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 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 persons care team (both formal and informal supports), and collaborate with house staff.**

FUTURE VISION: **Continued focus on ensuring beds are being utilized and people's needs are being met prior to discharge.**

CURRENT INFORMATION	ACTUAL or ESTIMATE	QUESTIONS/NOTES
• Operator of Service and Service location(s)	Bell Therapy (CBRF) Crisis Mobile Team (clinical and nursing services)	
• Hours of Operation		
• Current Service Volume and number of teams (if applicable)	16 beds	In 2017, 8 CSH beds were converted to Crisis Resource Center (CRC) beds to meet the needs of the community.
• Current Service FTEs	2 locations • Contracted Vendor Operates CSH and provides house staff • Milwaukee County provides clinicians and nurses from the Crisis Mobile Team	
• Occupancy Rate	16	
• Target Population	Adults with mental health and co-occurring needs. Either hospital step down or crisis placements	
• Referral Source	Hospitals, crisis teams, community partners (case management agencies).	
• Expected Future Volume	16 beds	
• Funding Source(s)	Medicaid and County Tax Levy	
• Funding model (FFS, Block, Case rate, etc.)	Medicaid Fee for Service, Medicaid Daily Per Diem, and County Tax Levy	
• Peer Involvement	Peer specialists provide daily services to the individuals residing	In 2018, the use of peer specialists was expanded within CSH. Peer specialists are at the houses daily.

	in CSH. This includes individual and group peer support.	
MODIFICATIONS REQUIRED?	**DESIRED RESULT**	**QUESTIONS/NOTES**
• physical plant modifications (None, Minor, Moderate, Major)		
• Required programmatic modifications (None, Minor, Moderate, Major)		
• Required Competencies		

Crisis System Element: The Parachute House (Peer Run Respit

If section is N/A for this element, leave blank

Service Description: **The Peer Run Respite, scheduled to open in 2019, will be a short-term respite consisting of 4-5 beds for individuals with mental health needs and in the need of additional support in a safe and accepting environment. People coming to Peer Run Respite are looking to strengthen their recovery and proactively address any need they may be experiencing. Programming is self-directed and uses a strengths-based holistic approach. People are offered wellness opportunities through one-on-one or group peer support. A stay at the Peer Run Respite begins with a potential guest speaking directly with staff about what they are experiencing, their hopes and needs, and how a temporary stay would be beneficial to their recovery. Peer Run Respite programming is person-centered and recovery-focused, and activities are strictly voluntary.** **FUTURE VISION: Milwaukee County's first Peer Run Respite is set to open in 2019. BHD Crisis Services will continue partnering with the contracted agency, Our Space, to successfully implement services.**		
CURRENT INFORMATION	**ACTUAL or ESTIMATE**	**QUESTIONS/NOTES**
• Operator of Service and Service location(s)	Our Space	Location to be determined, but in the City of Milwaukee
• Hours of Operation	24 hours per day, 365 days per year	
• Current Service Volume	4-5 beds scheduled to open in 2019	Our Space was awarded the Peer Run Respite contract in 2018 through a competitive RFP process. BHD Crisis Services is working closely with Our Space to implement services in 2019.
• Current Service FTEs		
• Occupancy Rate	4-5 adults	
• Target Population	Adults with mental health and co-occurring needs	
• Referral Source	Self-Referral	
• Expected Future Volume	4-5 person capacity per day	
• Funding Source(s)	County Tax Levy	
• Funding model (FFS, Block, Case rate, etc)	County Tax Levy-Purchase of Services Contract	
• Peer Involvement	Program is completely peer run	Crisis Services has also coordinated peer specialist training, funded by BHD, to expand the number of peer specialists in Milwaukee County
MODIFICATIONS REQUIRED?	**DESIRED RESULT**	**QUESTIONS/NOTES**
• physical plant modifications (None, Minor, Moderate, Major)		
• Required programmatic modifications (None, Minor, Moderate, Major)		
• Required Competencies		
CONSIDERATIONS	**DESIRED RESULT**	**QUESTIONS/NOTES**
• NIMBY issues?	Potential issues related to zoning	

• Acceptance of Emergency Petitions?	No	
• Exceptions to services at this level of care		
• Consider co-location of mobile crisis teams to these sites	No	

Crisis System Element: Crisis Resource Center (CRC)

If section is N/A for this element, leave blank

Service Description: **CRC services are funded by BHD and provided by a contracted community partner: the Whole Health Clinical Group at theMilwaukee Center for Independence. CRC provides people who are experiencing a mental health crisis a safe and supportive environment to meet their individualized needs. Services are wrapped around the individual to support stabilization in a community setting through the CRC's array of onsite supportive services including: peer support, clinical assessment, access to medication, short-term therapy, nursing, supportive services, recovery services, and linkage to ongoing support and services. CRC provides extensive stabilization services to prevent emergency room visits or hospitalization. The average length of stay at the CRC is 5-7 days. People are directly referred to CRC through BHD Crisis Services or community agencies, or they are self-referrals via phone or walk-in.**

FUTURE VISION: **Continued planning and focus on direct admissions from BHD Crisis Services including PCS, Crisis Mobile Team, CART, and Team Connect.**

Future state, CRC would directly admit individuals being served through crisis services to divert people from ERs and hospitals. Utilizing CRC as a step down from hospitalization is reducing the capacity for crisis admissions (pre ER and hospital). Prioritizing CRC beds for Crisis Services, reducing barriers to direct admissions, and CMT controlling CRC admissions and discharges is essential to Crisis Redesign efforts. HMOs currently have contracts with CRC which is reducing crisis services capacity. CRCs in future state could act as service hubs where people can walk in for services. **Getting to a system where the Crisis Mobile Team/Crisis Services controls admissions and discharges is an essential part of redesign efforts.**

CURRENT INFORMATION	ACTUAL or ESTIMATE	QUESTIONS/NOTES
• Operator of Service and Service location(s)	Whole Health Clinical Group at the Milwaukee Center for Independence	
• Hours of Operation	24 hours per day and 365 days per year	
• Current Service Volume and number of teams (if applicable)	27 beds	Expanded to 27 beds in 2017 with 8 Crisis Stabilization House beds being converted to CRC beds to meet needs of the community.
• Current Service FTEs	Contracted Service	
• Target Population	Adults experiencing a mental health and co-occurring crisis	
• Referral Source	BHD crisis services, self-referral, HMO	
• Expected Future Volume	27 beds	
• Funding Source(s)	Medicaid, HMO Contracting, County Tax Levy	Provider Agency has contracts with various HMOs. Any future expansion would be through insurance contracts/revenue. HMO utilization is taking away from crisis services direct admission opportunities.
• Funding model (FFS, Block, Case rate, etc)	Medicaid Fee for Service, Medicaid Daily Per Diem, and Tax Levy	Future state needs to advocate for increase in Medicaid rates (rates need to be comparable to HMO rates) to increase capacity. BHD looking at fee for service agreement for the future.

		2018-increased revenue due to Medicaid professional service billing
• Peer Involvement	peer specialists are a key component of the treatment team	
MODIFICATIONS REQUIRED?	**DESIRED RESULT**	**QUESTIONS/NOTES**
• physical plant modifications (None, Minor, Moderate, Major)		
• Required programmatic modifications (None, Minor, Moderate, Major)		
• Required Competencies		
CONSIDERATIONS	**DESIRED RESULT**	**QUESTIONS/NOTES**
• NIMBY issues?		
• Acceptance of Emergency Petitions?		
• Exceptions to services at this level of care	Hospital step downs in future state	CRC needs to be used for crisis services direct admission and diversion from hospitals and ERs when appropriate
• Consider co-location of mobile crisis teams to these sites		There's potential for including additional crisis services at CRC to create additional walk-in crisis clinics and services.

Crisis System Element: Community Linkages and Stabilization P (CLASP)

If section is N/A for this element, leave blank

Service Description: CLASP is a community-based peer specialist program where 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). The peer specialists utilize their own unique recovery experiences to engage people who are beginning their recovery. The CLASP team of peer pecialists provides individualized care and planning to provide the strength and hope that recovery is possible. CLASP provides peer support in the community at the location that best serves the person's needs. CLASP has been able to successfully engage people who have traditionally not engaged in services. CLASP focuses on stabilizing the crisis, partnering with the person to meet their needs, and developing strong support systems to prevent crisis. Duration of service is generally 6 months but is based on the individual's needs. Services are provided by BHD contracted partner La Causa, Inc.

FUTURE VISION: Continue to increase the utilization of CLASP by making appropriate referrals to the program. Expanding funding sources through HMOs and other revenue streams will add to increased capacity and the ability to serve more people. Future state, CLASP could be part of the team serving the individual through a Care Coordination model. Continued and increased access to CLASP for individuals who struggle to engage in traditional services (TCM, CSP, etc.) is essential. Adding other referral streams through additional funding provided through HMOs and health systems would provide the opportunity to serve more people.

CURRENT INFORMATION	ACTUAL or ESTIMATE	QUESTIONS/NOTES
• Operator of Service and Service location(s)	La Causa, Inc. 804 W. Greenfield Ave. Milwaukee WI 53204	CLASP office is on the South Side of Milwaukee but the peer specialists provide services in the community at locations convenient to the person being served by the program (home, etc.).
• Hours of Operation	Monday-Friday 830 AM-5PM	
• Current Service Volume and number of teams (if applicable)	CLASP has the capacity to serve a caseload of 80 people	
• Current Service FTEs	1.0 Supervisor 1 Clinician 7 peer specialists	
• Target Population	Adults with mental health and co-occurring needs	
• Referral Source	Crisis Services Programs (CRC, Crisis Mobile Team, CART, Team Connect, Observation Unit, Inpatient Units, Access Clinic)	
• Expected Future Volume	80 people when fully staffed	
• Funding Source(s)	Medicaid and County Tax Levy	
• Funding model (FFS, Block, Case rate, etc)	Medicaid FFS and Tax Levy	Increased funding through HMOs and/or health systems would support expansion of the service.

• Peer Involvement	CLASP is a community-based peer specialist rogram composed of the equivalent of 7 full-time peer specialists	Crisis Services has also coordinated peer specialist training funded by BHD to expand the number of peer specialists in Milwaukee County
MODIFICATIONS REQUIRED?	**DESIRED RESULT**	**QUESTIONS/NOTES**
• physical plant modifications (None, Minor, Moderate, Major)		
• Required programmatic modifications (None, Minor, Moderate, Major)		
• Required Competencies		
CONSIDERATIONS	**DESIRED RESULT**	**QUESTIONS/NOTES**
• NIMBY issues?		
• Acceptance of Emergency Petitions?		
• Exceptions to services at this level of care	People who are on commitments	
• Consider co-location of mobile crisis teams to these sites	Possibly relocating CLASP to walk-in clinic sites with Care Coordinators	

Crisis System Element: Psychiatric Crisis Services (PCS)

If section is N/A for this element, leave blank

Service Description: *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 of crisis services 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. Individuals who come in either voluntarily or involuntarily can be seen immediately. All inpatient admissions to the Behavioral Health Division are evaluated first in the Psychiatric Crisis Service, as are individuals brought in on Emergency Detention, under Ch. 51 of the Wisconsin Statutes, by law enforcement.*

FUTURE VISION: *Continue to be recognized as a national best practice standard model that other communities are currently replicating while expanding behavioral health/social services directly from the ER to include expansion of mobile capability and medical oversight of mobile services. Continue to be a collaborative partner with law enforcement, emergency medical services (EMS), and private healthcare systems in Milwaukee County to coordinate care and services for individuals receiving voluntary or involuntary psychiatric care.*

CURRENT INFORMATION	ACTUAL or ESTIMATE	QUESTIONS/NOTES
• Operator of Service and Service location(s)	BHD; 9455 Watertown Plank Road	
• Hours of Operation	24/7 365 days/year	
• Current Service Volume and number of teams (if applicable)	8,001 individuals seen in PCS in 2017 1,428 individuals managed as part of waitlist protocols	PCS physicians also provide medical oversight and consultation for all Crisis Mobile Team, CART, CCT and Gero RN mobile teams
• Current Service FTEs	• 1.0 FTE Medical Director • 8.25 FTE physicians • Hourly physician coverage for remaining shifts • 25.0 FTE RNs • 4.0 Pool RNs • 3.5 RN II UR Transfer Coordinators • 5.0 Psych Techs • 15.0 FTE CNAs • 8 Pool CNAs3.5 Unit Clerks • Contracted 24/7 security/public safety presence in PCS -- stationed at the intake bay	• Physician staffing provides services/coverage to PCS, OBS, Access Clinic, and medical oversight for CMT, CART, CCT, and Crisis Stabilization Houses. • RN, Psych Tech, and CNA staff provide services/coverage for PCS and OBS.

• Target Population	All individuals (adult and children) experiencing a psychiatric crisis and/or in need of behavioral health services	PCS must assess, treat, and stabilize any individual presenting for services to PCS regardless of place of residence and/or ability to pay as per emergency department standards
• Referral Source	Any source	
• Expected Future Volume	2018 Projection=7,431 individuals seen in PCS 2018 Projection=929 individuals managed as part of waitlist protocols	
• Funding Source(s)	Medicaid/Medicare; all insurances billed for services; tax levy	
• Funding model (FFS, Block, Case rate, etc)	Insurance billing and tax levy	
• Peer Involvement	None at this time	
MODIFICATIONS REQUIRED?	**DESIRED RESULT**	**QUESTIONS/NOTES**
• physical plant modifications (None, Minor, Moderate, Major)	Major: Similar-sized emergency department in a freestanding location on the north side of Milwaukee; or co-location with physical care ED on the north side of Milwaukee; smaller size Observation Unit	
• Required programmatic modifications (None, Minor, Moderate, Major)	Moderate: Need a social service/service navigator presence in PCS along with connection to peer services; decreased RN/CNA presence due to decreased Observation status	
• Required Competencies	Competencies as per board certifications, state licensure, and credentialing/privileging in addition to DHS 34 Emergency Mental Health Services	
CONSIDERATIONS	**DESIRED RESULT**	**QUESTIONS/NOTES**
• NIMBY issues?	No	Healthcare/ED partners supportive of services.
• Acceptance of Emergency Petitions?	Yes	

• Exceptions to services at this level of care	Individuals experiencing medical emergencies need to have medical conditions stabilized at a medical ED	
• Consider co-location of mobile crisis teams to these sites	Yes	

Crisis System Element: Team Connect

If section is N/A for this element, leave blank

Service Description: **Team Connect is composed 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. Contact is made or attempted with the person within 24 hours or the next business day of discharge. The team provides linkage to services in the community, supports engagement in post discharge care, and provides community-based crisis response.**

FUTURE VISION: **Team Connect was implemented in 2017 and continues to evolve as a program. The team will continue focusing on engaging people post discharge to ensure their needs are being met and reduce PCS visits. Additional emphasis will be placed on Care Coordination. Expand services to HMOs for people being discharged from private hospitals.**

Future state, will look comprehensively at the continued impact of Team Connect services and transitioning Team Connect resources to a Care Coordination model. Team Connect follow-up has been successful at engaging people being discharged from inpatient units. Expanding services to individuals discharged from inpatient care throughout the system with HMO and other revenue streams could further support the redesign efforts. Embedding social workers or crisis staff in area emergency rooms would lead to additional coordination of services, increase discharge planning, quicker Emergency Detention reviews and assessments (dropping EDs, safety planning, connection to resource) and support crisis redesign efforts.

CURRENT INFORMATION	ACTUAL or ESTIMATE	QUESTIONS/NOTES
• Operator of Service and Service location(s)	Milwaukee County BHD	
• Hours of Operation	Sunday-Friday 8 AM – 7 PM	
• Current Service Volume and number of teams (if applicable)	All people being discharged from PCS, BHD Inpatient, and Observation Unit Currently 5 teams (shared peer specialist resources)	Additional peer specialist time would be beneficial to further engage people. Service could be provided with expanded use of peer support and reduction in the number of clinicians.
• Current Service FTEs	5 Clinicians 2 peer specialists	
• Target Population	Adults with mental health and co-occurring needs being discharged from BHD inpatient, observation unit, or PCS	
• Referral Source	BHD inpatient, observation unit, and PCS	
• Expected Future Volume		
• Funding Source(s)	Medicaid and Grant Funding	Grant Funding through STR

• Funding model (FFS, Block, Case rate, etc)	Medicaid FFS, Grant Funding, County Tax Levy	HMO contracting to provide additional services to people being discharged from private hospitals would further support redesign efforts
• Peer Involvement	peer specialists are part of the team	Crisis Services has also coordinated peer specialist training funded by BHD to expand the number of peer specialists in Milwaukee County
MODIFICATIONS REQUIRED?	**DESIRED RESULT**	**QUESTIONS/NOTES**
• physical plant modifications (None, Minor, Moderate, Major)		
• Required programmatic modifications (None, Minor, Moderate, Major)		
• Required Competencies		

Crisis System Element: "Air Traffic Control" Crisis Resources (P

If section is N/A for this element, leave blank

Strategy

FUTURE VISION: Adopt an electronic surveillance and scheduling solution that will allow Crisis Staff, contracted providers, and others with need to know to utilize real time surveillance and access to crisis resources. Crisis staff, future care managers, partners and providers will be able to see available resources needed by clients in crisis. Resources will include: hospital and diversion beds, care management intake slots, psychotherapy and prescriber appointments, Peer services appointments, and other ancillary services. Will support real-time, same-day access to care and will fully utilize available resources.		
CURRENT INFORMATION	**ACTUAL or ESTIMATE**	**QUESTIONS/NOTES**
• Operator of Service and Service location(s)	BHD Managed/TBD	
• Hours of Operation	24/7	
• Current Service Volume		See estimates provided for Crisis Services.
• Target Population		Individuals who are experiencing a psych crisis; resources may also support individuals with lack of access to services to help them avoid a psychiatric crisis.
• Referral Source		Services that are connected to the Milwaukee County BHD Crisis Service would utilize this model.
• Current Service FTEs		
• Expected Future Volume		
• Funding Source(s)		
• Funding model (FFS, Block, Case rate, etc)		
• Peer Involvement	N/A	
MODIFICATIONS REQUIRED?	**DESIRED RESULT**	**QUESTIONS/NOTES**
• physical plant modifications (None, Minor, Moderate, Major)		
• Required programmatic modifications (None, Minor, Moderate, Major)		Will lead to great improvement in teamwork and will spur major system change.
• Required Competencies		Will require all providers to join and allow admission based on set criteria. Considerable training needed re: admission criteria and least restrictive use of resources.
CONSIDERATIONS	**DESIRED RESULT**	**QUESTIONS/NOTES**
• NIMBY issues?		Not expected to be a problem
• Acceptance of Emergency Petitions?		Yes.
• Exceptions to services at this level of care	Acute medical emergency	

• Consider co-location of mobile crisis teams to these sites		

Crisis System Element: Crisis Services Care Coordination (Plan

If section is N/A for this element, leave blank

FUTURE VISION: Provide a short-term (up to 6 months) Care Management model for clients with recent psych emergencies, contacts with Crisis Mobile, ER or walk-in clinic. The Program utilizes crisis assessment, develops a Plan of Care with the consumer, and authorizes peer services, prescriber services, psychotherapy, and other services per client need and agreement. Plan is comprised of SMART output and outcome-focused goals designed to improve client safety, health, wellness, improve symptoms. The model will require close supervision of staff, management and oversight of ancillary providers, and electronic system change to allow proper data collection and management (development of dashboards, improved communication across providers, consumer use of record/portal.		
CURRENT INFORMATION	**ACTUAL or ESTIMATE**	**QUESTIONS/NOTES**
• Operator of Service and Service location(s)	BHD has Crisis Case Management Team in place; discussions have identified this team be built into Care Coordination Team	
• Hours of Operation	Will use the Access Clinic Hours, consistent with FQHC Partners; will consider a few weekdays per week with later evening options.	
• Current Service Volume and number of teams (if applicable)	1.0 FTE Crisis Coordinator (Team Leader); 7.0 FTE Care Coordinators; 2.0 FTE Peers will also provide service in this model; if each Care Coordinator can serve 15 clients, then 105 clients will be served concurrently within this program	
• Current Service FTEs	1.0 FTE Crisis Coordinator (Team Leader); 7.0 FTE Care	

	Coordinators; 2.0 FTE peers will also provide service in this model	
• Target Population	Adults 18+ who have had recent psych crisis contacts and are determined to be higher risk (multiple ER/IP admissions, failure at Outpatient Level of care, recent suicidal planning, behavior, difficulties adhering to recommended treatment	
• Referral Source	Crisis Mobile, CART, PCS/ER, IP, Walk in, FQHC	
• Expected Future Volume	105 clients served concurrently	
• Funding Source(s)		
• Funding model (FFS, Block, Case rate, etc)		
• Peer Involvement	N/A	
MODIFICATIONS REQUIRED?	**DESIRED RESULT**	**QUESTIONS/NOTES**
• physical plant modifications (None, Minor, Moderate, Major)		Space required for Care Management staff in phase one; could be contracted to high-performing agency.
• Required programmatic modifications (None, Minor, Moderate, Major)		Major system change. Will need to build a new team and thoroughly train staff. Current staffing, credentials of staff, and training plan may not serve new model.
• Required Competencies		
CONSIDERATIONS	**DESIRED RESULT**	**QUESTIONS/NOTES**
• NIMBY issues?		Not expected to be a problem
• Acceptance of Emergency Petitions?		Yes.
• Exceptions to services at this level of care	Acute medical emergency	

• Consider co-location of mobile crisis teams to these sites		

Appendix C: GIS Maps of Home Zip Codes of Those Receiving Crisis Services by BHD Program or Health System ED

Data for these maps were provided by the services

Figure A1: Total Assessed/Served Across Programs & Private Health Systems

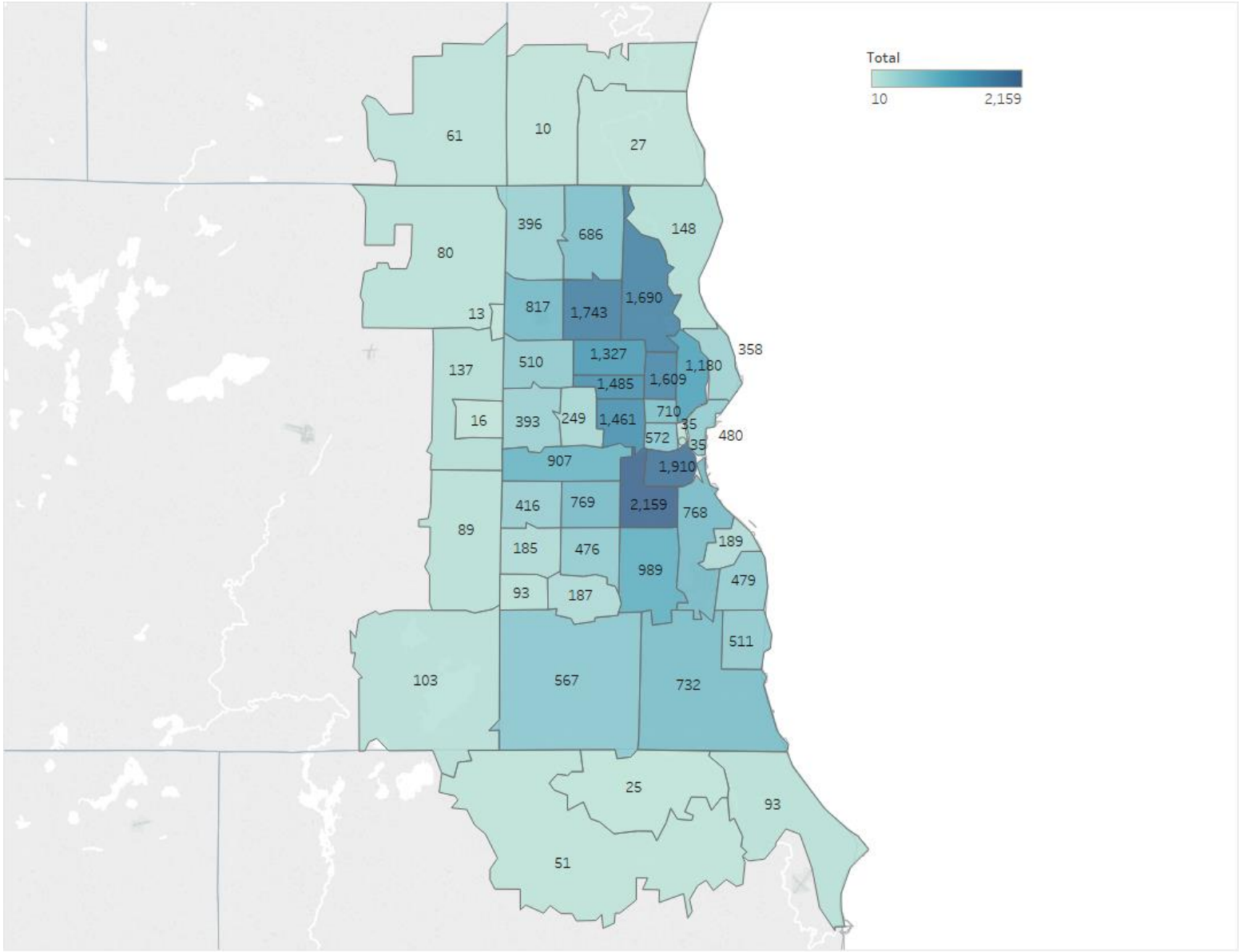


Figure A2: Crisis Mobile Service

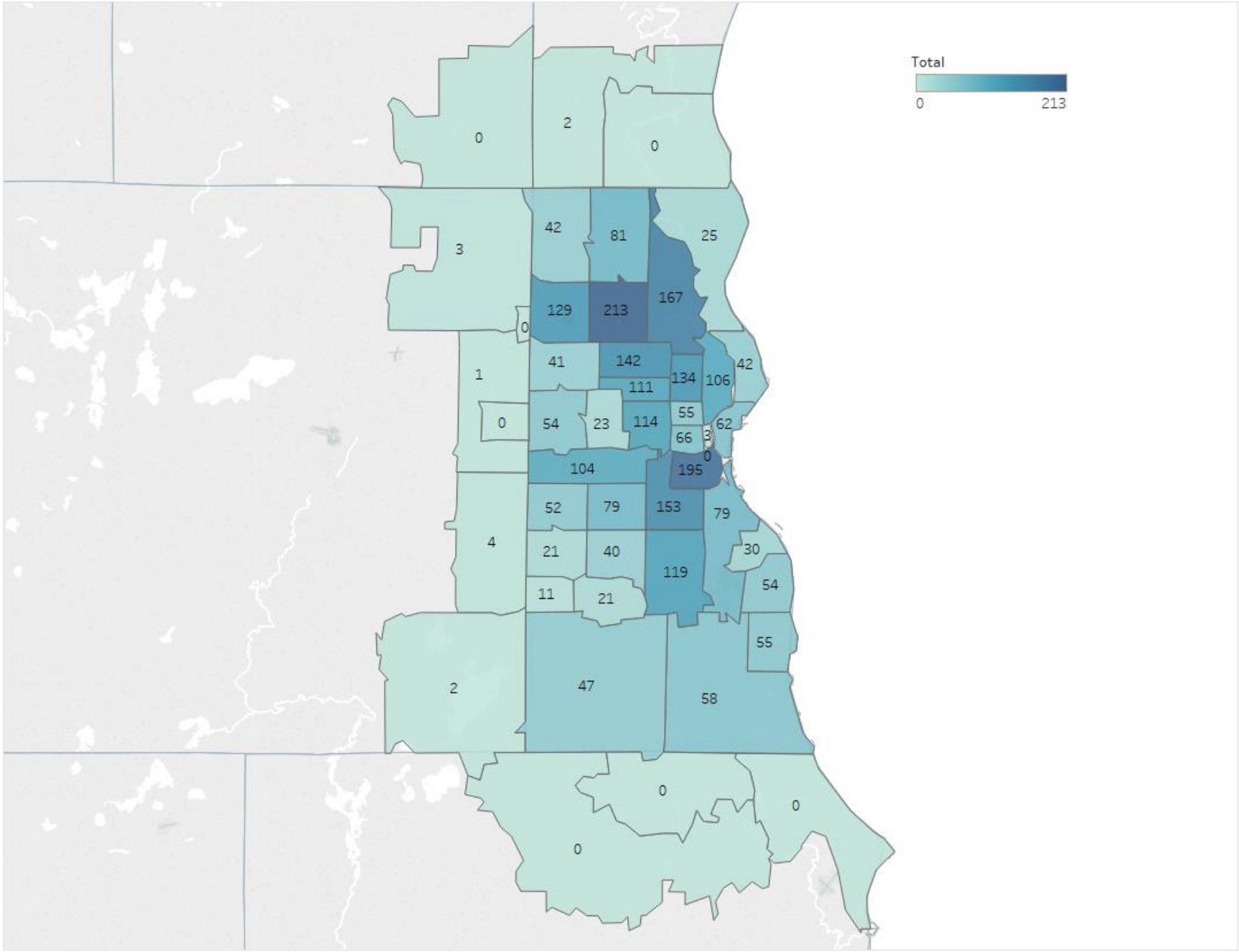


Figure A3: CART

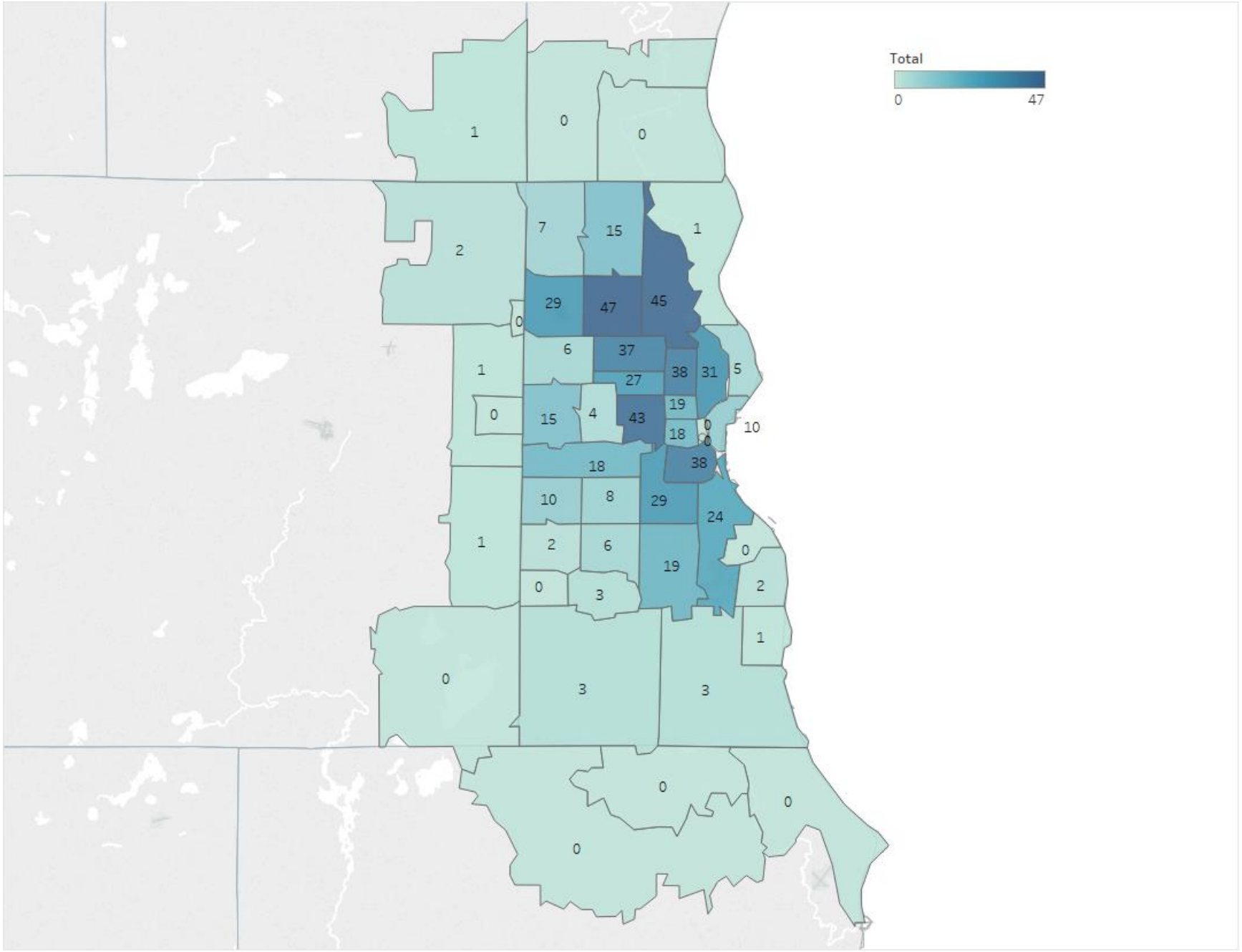


Figure A4: Ascension

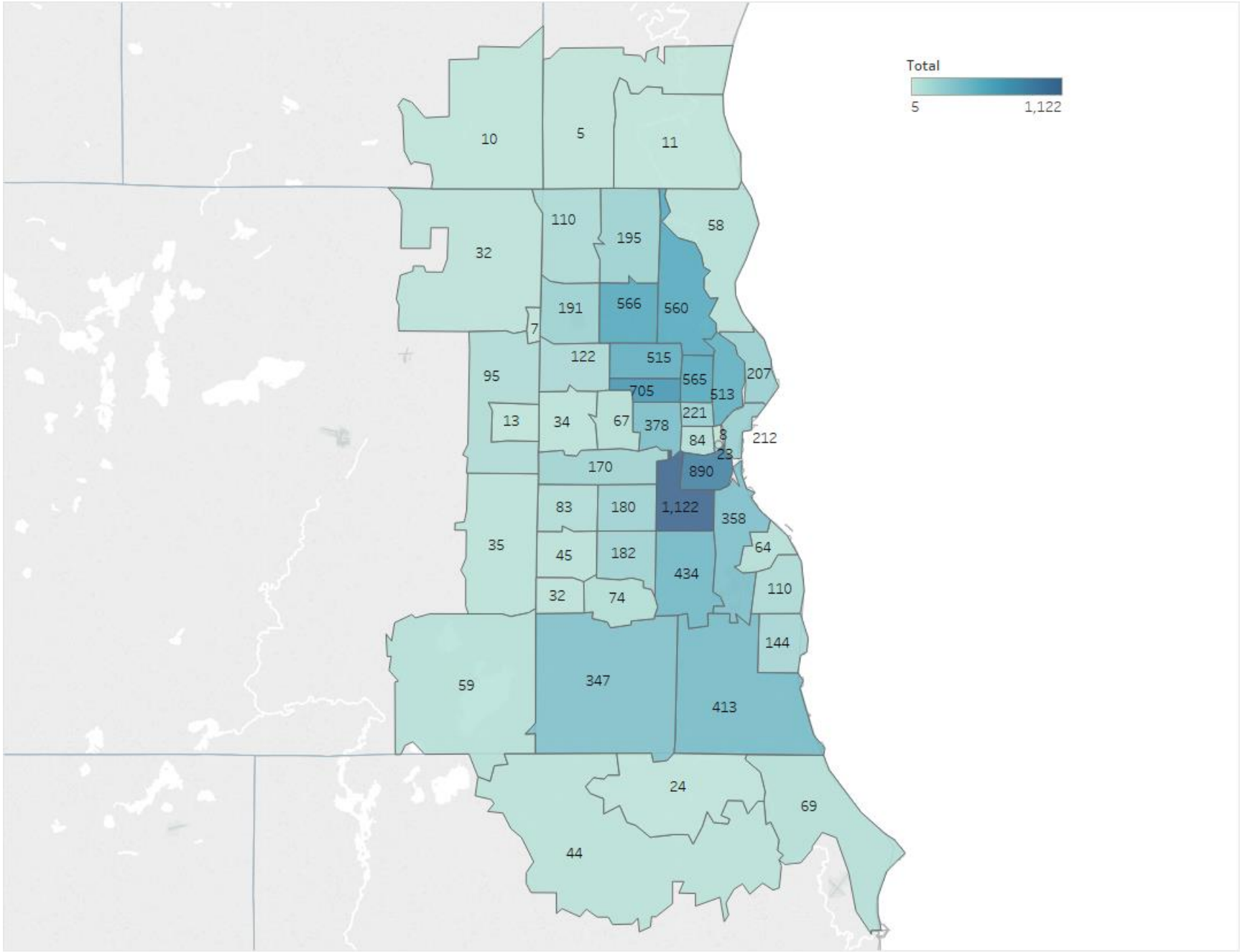


Figure A5: Aurora

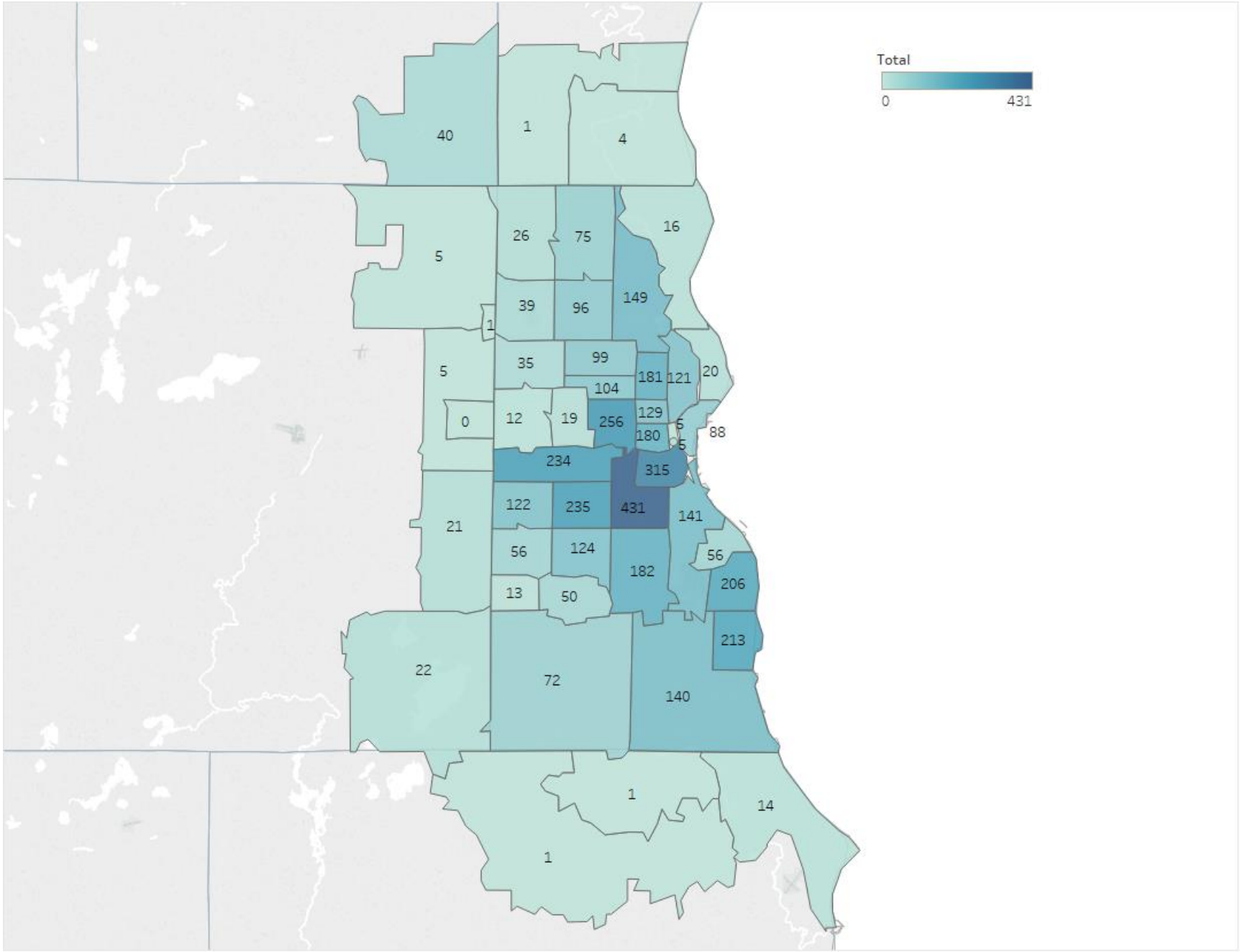


Figure A6: Children's

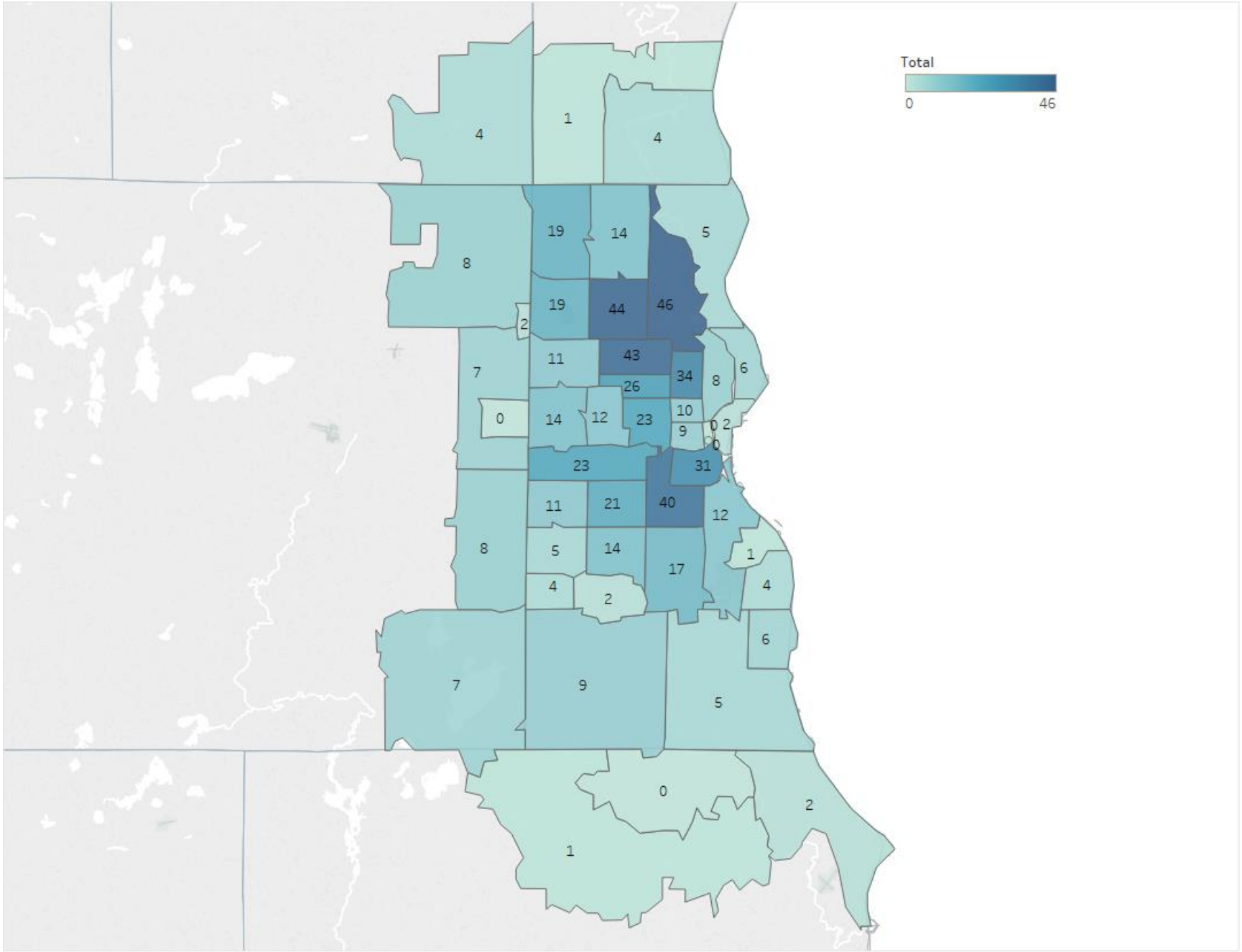
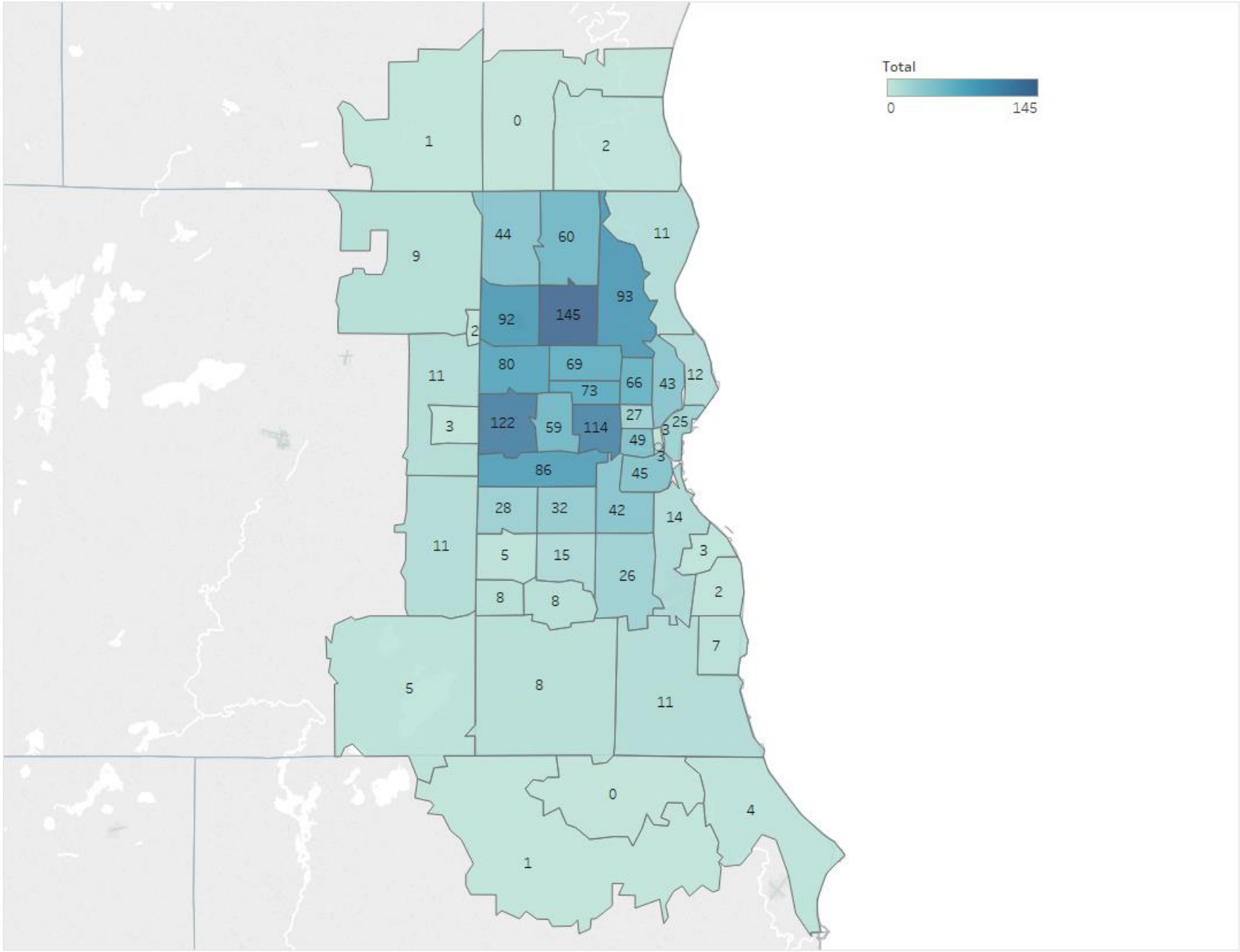


Figure A7: Froedtert



Appendix D: Data Displays for Key Variables by Program/Health System

To assess the implications of the redesign for the overall health care system, we analyzed trends in utilization using data provided by the Wisconsin Hospital Association (WHA). These data involve various aspects of ED and inpatient utilization by Milwaukee County hospitals, including the PCS and BHD inpatient units. (NOTE: Totals from WHA in these tables differ to some extent from those cited elsewhere in the report, which were obtained from the health systems and BHD. This occurs frequently with data drawn from different information systems and may be due to a variety of factors, including differences in coding, variation in consistency of data entry, and data extraction criteria. In this case, the most likely explanation is that the data reported by WHA include a primary mental health diagnosis in the extraction criteria, resulting in a more restricted population. Consequently, each total should be considered only in the context in which it is presented rather than applying across contexts; in these tables, for example, the questions of interest are 1) the changes in the volume of visits over the 5-year period; and 2) changes in the relative proportion of the volume served by PCS and the total crisis system including private health system EDs.

Table A1 presents trends for the past five years in the number of ED visits with a primary mental health diagnosis (PMHD) for all Milwaukee County EDs, including PCS. The portion of total visits represented by those with a primary mental health diagnosis is relatively small and has declined over the past five years to less than 5% in 2017. PCS's portion of total PMHD visits—which represents the number that will be redistributed in the redesigned system once PCS closes—has also declined, even more rapidly, to slightly over one quarter of the total PMHD admissions.

Table A1: PMHD visits, crisis system total including hospitals and PCS portion, 2013-2017

	2013	2014	2015	2016	2017
Total system PMHD ED visits	23,023	24,316	32,216	25,178	24,565
PMHD as % of total ED visits	5.6	5.2	5.4	5.0	4.8
PCS PMHD visits	9,614	9,053	11,027	7,400	6,795
PCS % of total PMHD visits	41.8	37.2	34.2	29.4	27.7

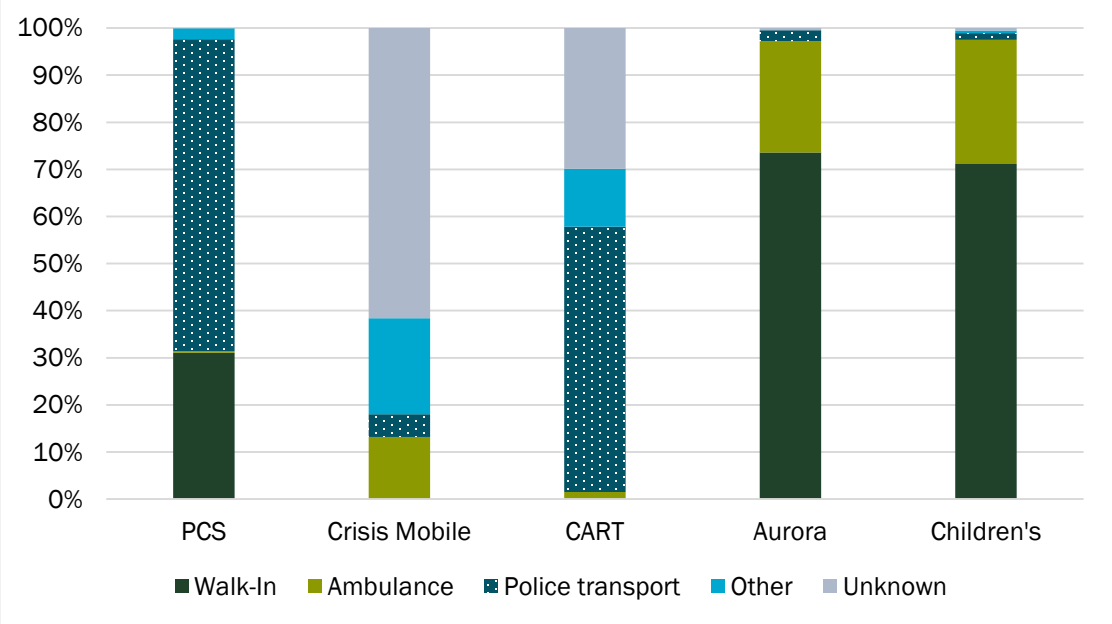
Individuals discharged with a PMHD from inpatient units represent a population at risk of crisis and readmission, thereby requiring step-down and transitional support services. Table A2 presents total PMHD discharges from Milwaukee County inpatient units including the Mental Health Complex (MHC) and the portion of the total represented by MHC. The pattern is again one of decline by nearly half, consistent with the downsizing of the facility over the five-year period.

Table A2: System including hospitals total PMHD discharges and Mental Health Complex (MHC) portion of PMHD discharges, 2013-2017

	2013	2014	2015	2016	2017
Total PMHD inpatient discharges	10,803	10,548	11,157	12,301	13,326
Total MHC PMHD discharges	2,060	1,942	1,790	1,227	1,267
MHC % of total PMH discharges	19.1	18.4	16.0	10.0	9.5

The figures on the following pages of this appendix show detailed breakdowns by health system for a variety of characteristics. These displays are based on the self-report data from BHD and the private health systems.

Figure A8: Mode of Access to Crisis Services



Note: Data unavailable from Ascension; data for Crisis Mobile and CART are incomplete and an error in Froedtert data was discovered in the analysis.

Figure A9: Age Distribution: BHD Crisis Services and Health System EDs

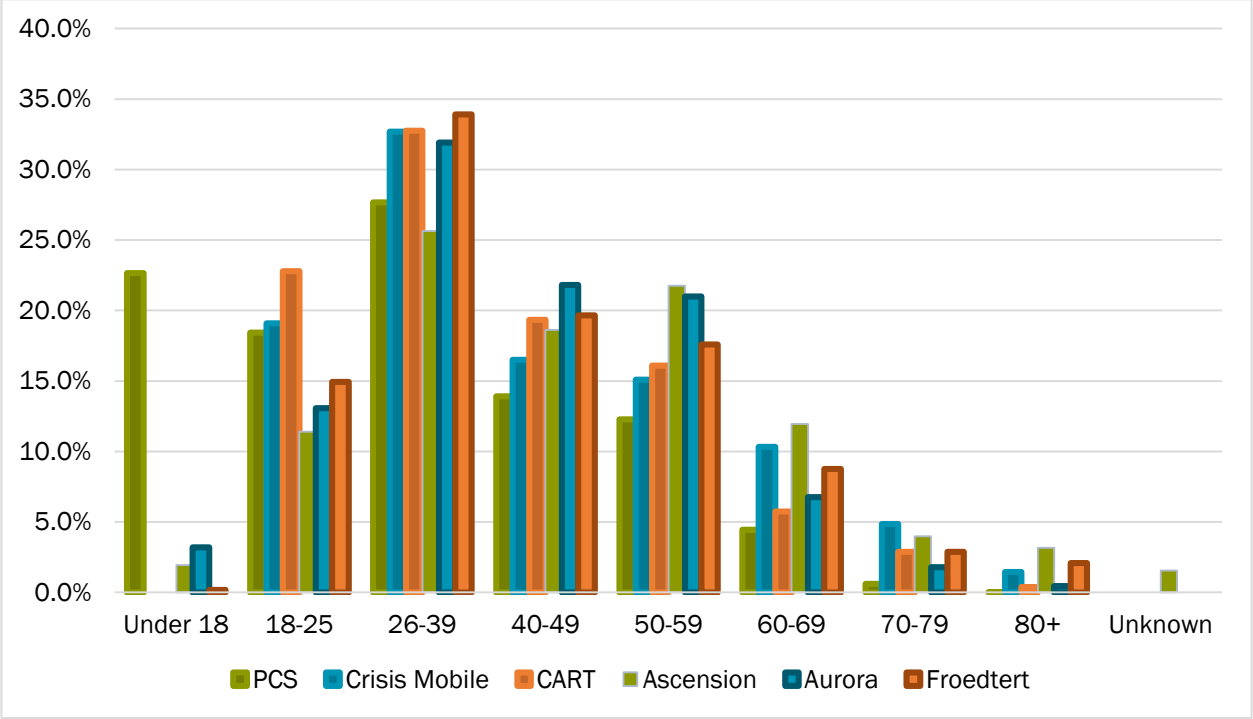


Figure A10: Age Distribution: Children's Hospital ED

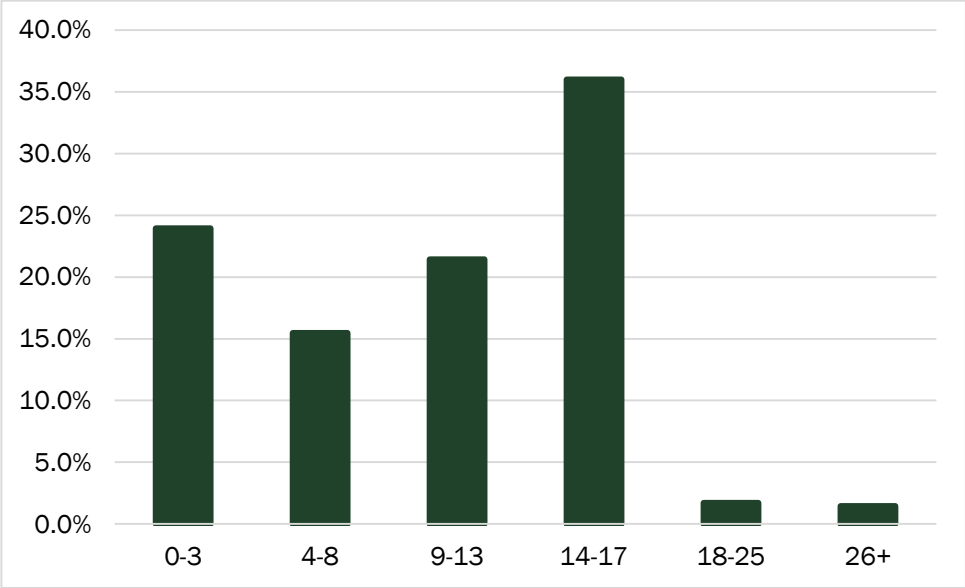


Figure A11: Gender: BHD Crisis Services and Health System EDs

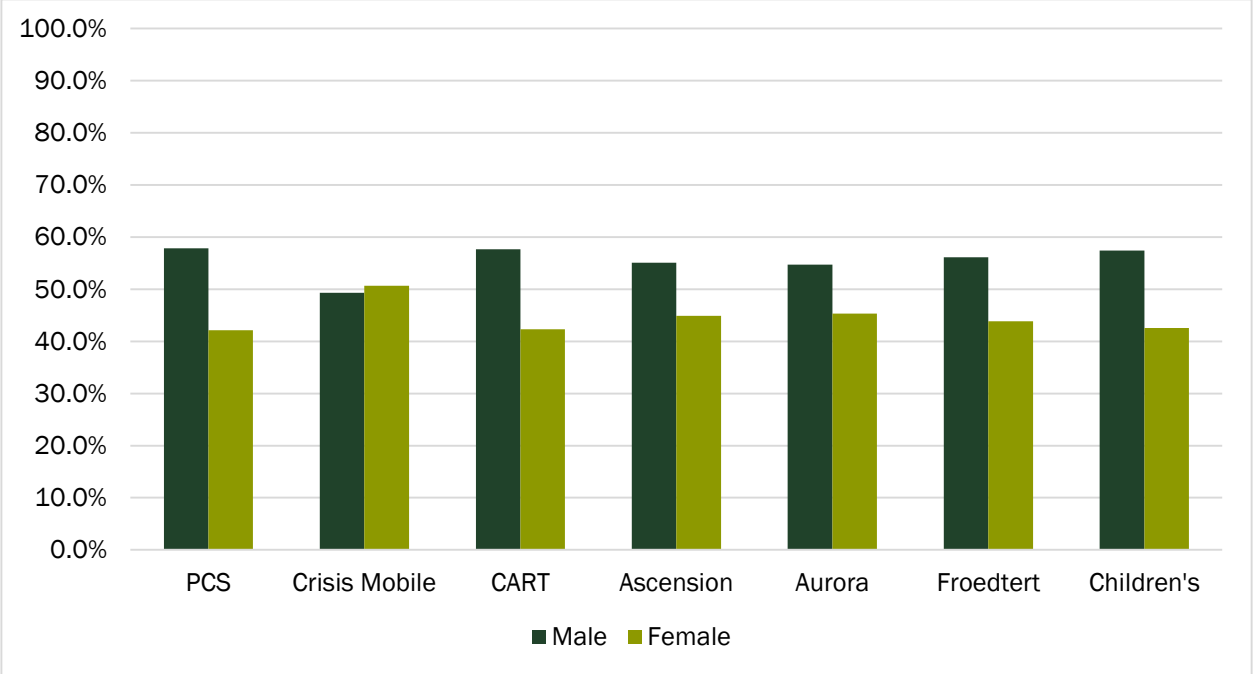
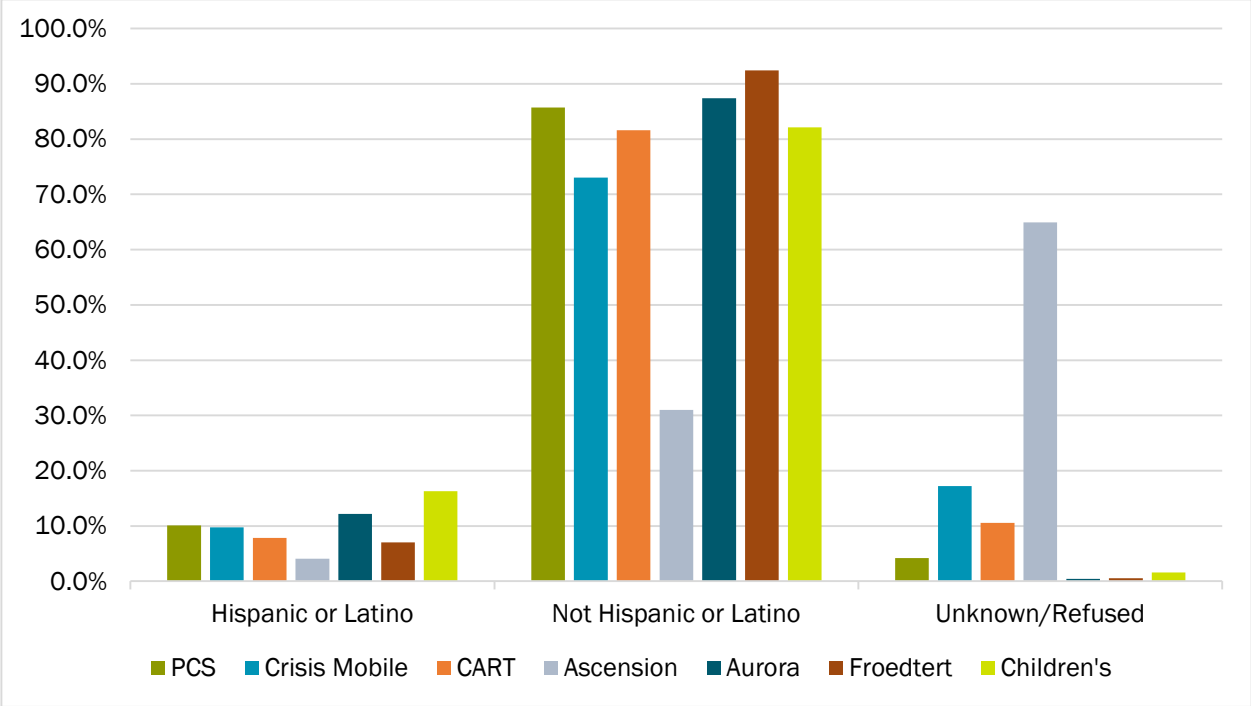


Figure A12: Race and Ethnicity: BHD Crisis Services and Health System EDs



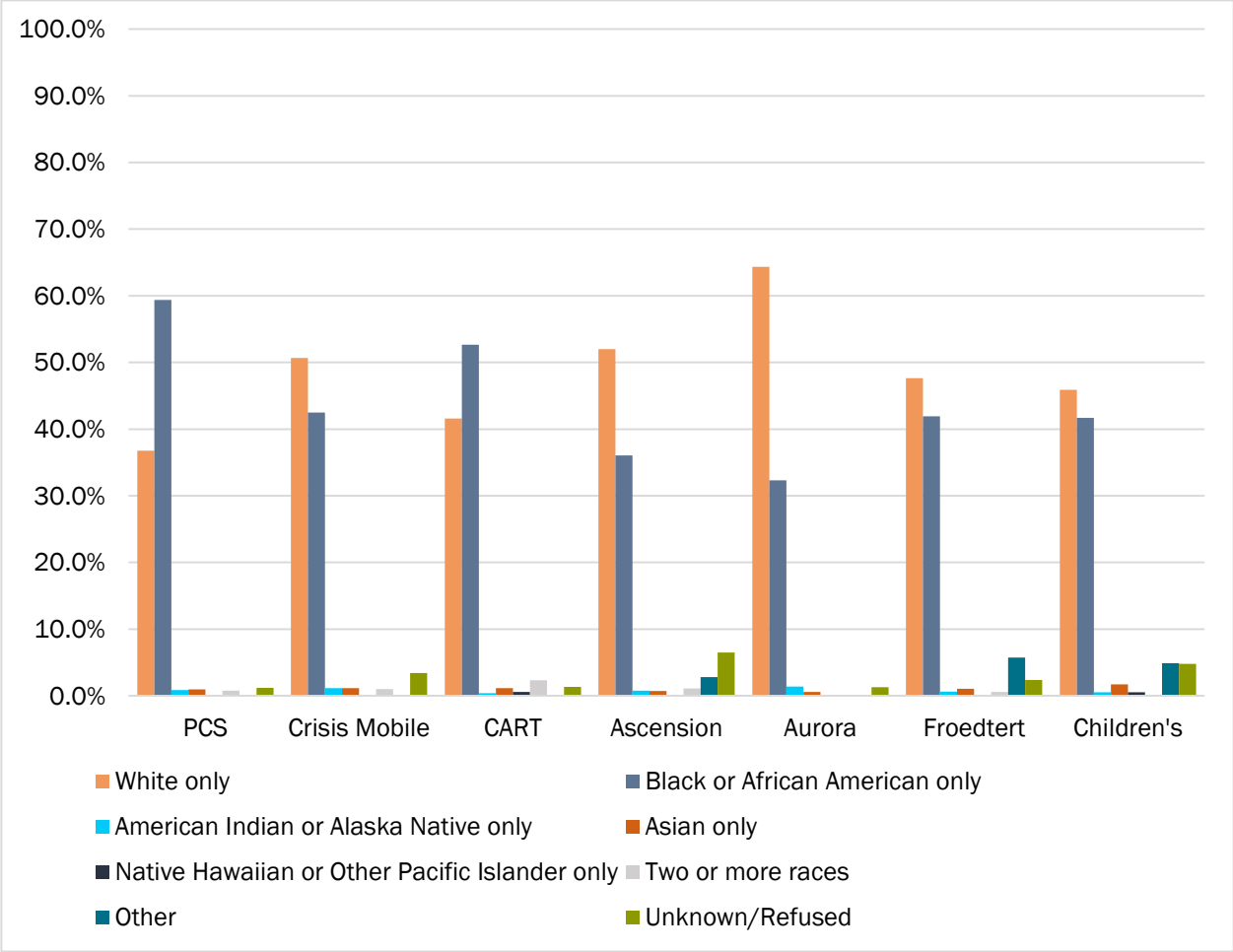
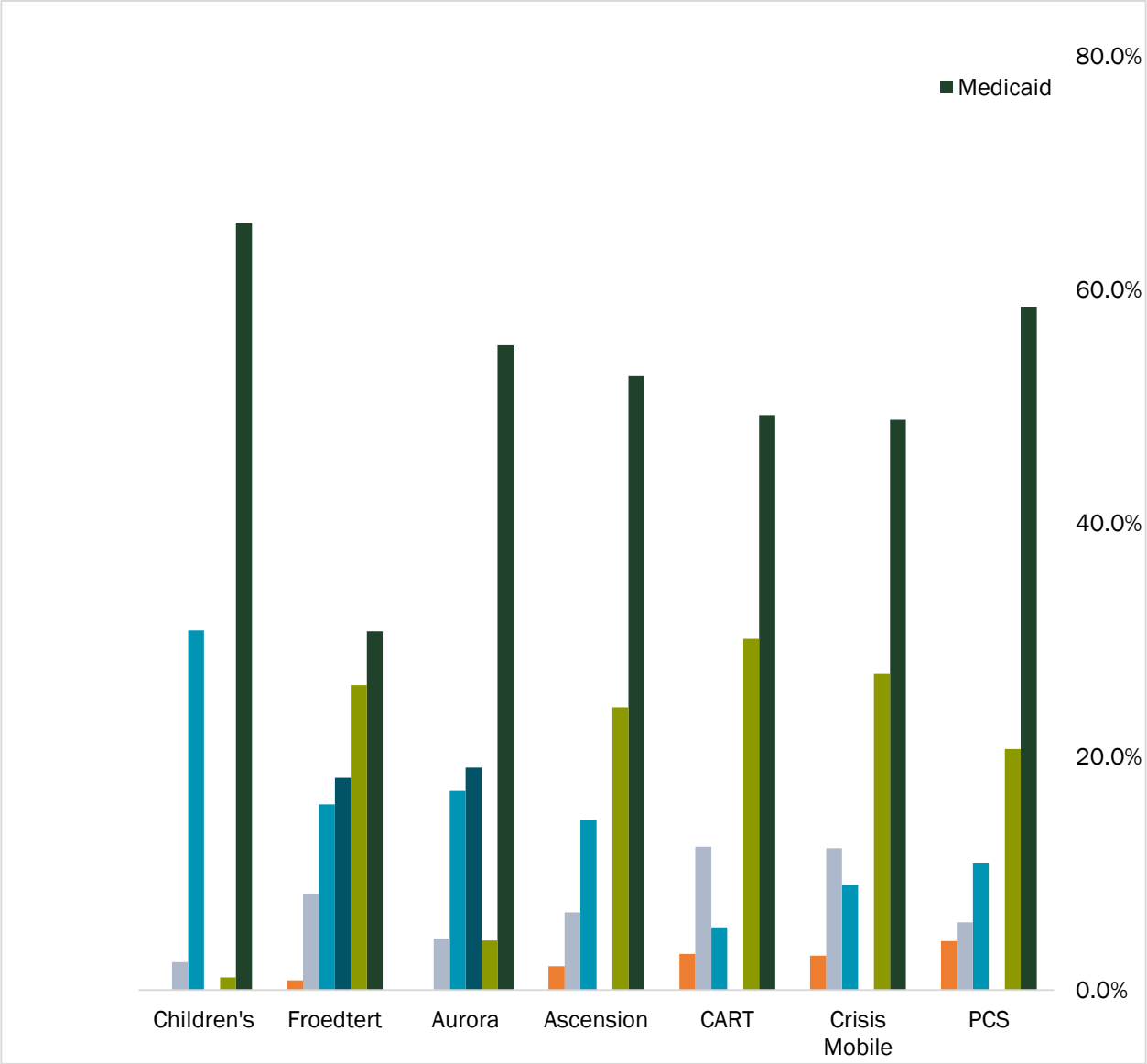


Figure A13: Mental health (MH) and substance use disorder (SUD) diagnosis BHD Crisis Services and Health System EDs

Type of diagnosis	PCS	Crisis Mobile[1]	CART[1]	Ascension	Aurora	Froedtert	Children's[2]
MH only	72.4%	1.4%	3.8%	39.5%	76.3%[3]	71.8%	-
MH only but SMI/SPMI	52.9%	1.3%	3.8%	39.5%	-	13.9%	-
AODA/SUD only	17.6%	0.3%	0.2%	59.1%	18.3%	28.2%	-
Unknown	10.0%	98.3%	96.0%	1.5%	5.4%	0.0%	-
Total N	7,194	2,332	522	11,358	4,642	1,753	-

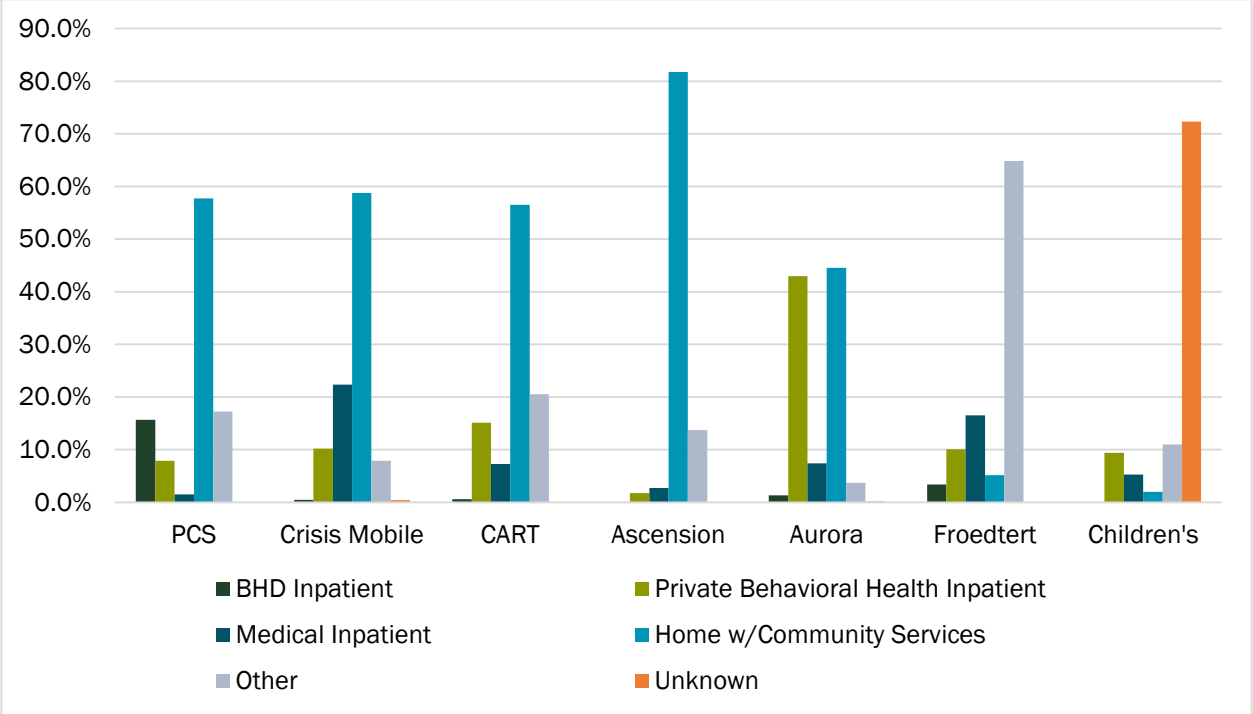
[1] Extensive missing data
[2] Data on diagnosis unavailable
[3] Includes 758 individuals with a dual diagnosis of MH and SUD; SMI/SPMI count unavailable

Figure A14: Payment Source



Note: PCS, Crisis Mobile, CART, Ascension, Children's were unable to distinguish if someone had both Medicaid and Medicare.

Figure A15: Disposition After Assessment



Appendix E: References

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