County of Milwaukee
Inter-Office Communication

DATE: July 5, 2011

TO: Supervisor Peggy Romo West, Chairperson, Committee on Health and Human Needs

FROM: Geri Lyday, Interim Director, Department of Health and Human Services
Prepared by: Jim Kubicek, Director of Crisis Services, Behavioral Health Division

SUBJECT: **From the Interim Director, Department of Health and Human Services, submitting an informational report regarding a crisis bed analysis to determine the number of crisis beds needed in Milwaukee County to alleviate strain on the Psychiatric Crisis Services Admission Center in the Behavioral Health Division**

Background

The 2011 Behavioral Health Division (BHD) Budget included an amendment directing BHD to conduct a Crisis Bed analysis to survey the need for crisis beds in Milwaukee County to alleviate strain on the Psychiatric Crisis Services (PCS) Admission Center and build capacity for stabilization and linkages to services in the community. In the amendment, BHD was also directed to explore the possibility of developing a Crisis Resource Center in the northern portion of Milwaukee County. BHD was directed to provide quarterly reports to the Board and this is the second quarterly update and includes a review of specific indicators regarding the need for additional Crisis Bed capacity.

Discussion

The first quarter report reviewed the historical context regarding crisis services in Milwaukee County including current capacity (16 crisis respite beds in the community and seven crisis resource center beds) and program design. This report addresses the following key measures, that were included as next steps in the previous Board report:

1. Determine the existing Crisis programs impact on recidivism.
2. Determine the existing Crisis programs impact on emergency detentions.
3. Determine specific indicators regarding community need, i.e. numbers of consumers turned away due to capacity issues, number of days at capacity etc.
4. Investigate law enforcement interest in North side location.
5. Identify impediments to direct law enforcement referrals.
6. Examine other possible funding sources that would provide ongoing programmatic sustainability.
7. Further exploration of revenue options at the State level for this level of care.

Impact on Recidivism

An analysis of recidivism data for PCS was conducted using a review of a sample of 100 BHD patients who were referred to the Crisis Resource Center (CRC) in 2010. The focus of the analysis was to assess whether or not the CRC had an actual impact on the frequency of PCS visits or BHD inpatient admissions and bed days.

The specific measurement strategy utilized was to first determine the date the BHD patient was referred to CRC and then review the number of BHD contacts each patient had with BHD for services six months prior and six months post referral. For these 100 patients, in the six months after the CRC referral, there was a:

- 40% reduction in PCS usage
- 39% reduction in inpatient admissions
- 46% reduction in inpatient bed days

Impact on Emergency Detentions

Since the Crisis resource centered opened in 2007 the overall number of emergency detentions in Milwaukee County has increased by approximately 2%.

2007	8,092
2008	8,249
2009	7,861
2010	8,274

While the number of emergency detentions has been fairly consistent, the ability of the system to adequately manage the numbers of patients detained has improved substantially. The utilization of crisis beds has contributed significantly to this effect.

In terms of CRC's impact on Emergency Detentions, a similar analysis was conducted on the same 100 patients referred to CRC in 2010. Each patient's frequency of emergency detentions were reviewed six months prior and six months post referral. There was a 35% reduction in emergency detentions for these 100 patients after a referral was made to CRC.

The CRC has a positive impact in reducing the number of emergency detentions for the population that it serves, however, given the its relatively small clinical capacity, the impact on the entire system is not significant.

Determine Specific Indicators Regarding Community Need

Through June 2011, there have been 120 patients that met CRC admission criteria but who were not accepted due to capacity issues. Typically the CRC is at their maximum capacity three out of seven days per week, or approximately 40% of the time. At this point the CRC does not track where these individuals go who cannot be admitted. BHD will be requesting that this information be collected, when possible, in the future.

CRC provides aftercare support to an average of 30 clients each month; this number does not include approximately 30 individuals who use the CRC as a support network in order to keep them in the community. These individuals are not formally admitted to the program but are able to use it when they feel as though they are in need.

BHD continues to be the single largest referral source for the CRC accounting for approximately 37% of their total admissions. Approximately 10% of CRC admissions come from other inpatient psychiatric facilitities. Another 10% come from a variety of medical settings including Emergency rooms and private Hospitals. The remaining Patients are referred from a variety of community based settings. It could be reasonably assumed that a significant percentage of individuals that were referred by either medical facilities or community settings would have been referred to BHD for services had CRC not been an option.

Investigate Law Enforcement Interest in North Side Location and Identify Impediments to Direct Law Enforcement Referrals.

A survey of Crisis Intervention Team (CIT) officers from the City of Milwaukee was conducted by the Milwaukee Police Department. There were 68 respondents out of approximately 200 surveys that were distributed. Ninety percent (90%) of the officers who responded were familiar with the Crisis Resource Center. Of those, however, only 51% responded that they had attempted a referral to the CRC. Eighty percent (80%) of the officers who attempted a referral to the CRC stated that the patient was accepted. The remaining 20% were not accepted for two main reasons: either because the CRC had a full census or was unable to admit on the night shift. Ninety-two percent (92%) of the officers who responded believed that there was a need for an additional North Side crisis intervention facility. Of those officers who believed there should be a North side location 81% believed they would be more likely to use it if it was there.

The main obstacle identified by the officers to referring directly to the CRC was the CRC's inability to accept a patient that had higher risk behaviors. Also, 87% of the officers responded that the facility was either too small or too far away.

Examine Other Possible Funding Sources

BHD provides $200,000 per year in funding to the CRC, which accounts for approximately 36% of their overall budget. In addition the CRC is able to generate approximately 28% of their budget through revenue. The remaining 32% in of their budget is funded through various grants. These grants are all expiring as of the end of 2011. At this time, BHD is not aware of a viable sustainability plan that has been identified and is, in large part, dependent on negotiations between the CRC and the State of Wisconsin.

Further Exploration of Revenue Options at the State Level

Approximately 50% of the individuals currently using the CRC are members of Medicaid (Title 19) HMOs. These HMOs have indicated that they want to use the CRC as an alternative to

inpatient hospitalization and emergency care but, unfortunately the CRC level of care is not a covered service within the HMO capitated rate from the State. Therefore, the HMOs cannot claim patients getting services at the CRC and in many cases the CRC does not receive payment for these services, which results in a sizable amount of unrecognized revenue.

The current State mental health service continuum lacks an intermediate/sub acute level of care. This impacts a large number of patients who do not require inpatient psychiatric or emergency room services, but who are not stable enough to be sustained with only outpatient services. This missing level of care drives clinical inpatient placement and emergency room costs, when less restrictive and more cost effective care could be provided.

Next Steps

BHD will continue to work on this intiative and return to the Board in the third quarter with an updated report, including exploring other options to enhance crisis services such as peer specialist programming and expansion of the crisis mobile team. In addition, BHD will work with the Crisis Resource Center to try and negotiate with the State regarding sustainable funding for the existing CRC and the possibility of funding for expansion. Specifically, BHD hopes to increase the Medicaid rate for the crisis stabilization per diem to a level capable of sustaining sub acute residential care in an environment that is less restrictive than inpatient care and inappropriate emergency room care and also identify a new Medicaid code for acute residential care that would allow the T19 HMOs to include clients served under this code in the T19 HMO contract revenue reimbursement.

Recommendation

This is an informational report. No action is necessary.

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