COUNTY OF MILWAUKEE
Behavioral Health Division Administration
INTER-OFFICE COMMUNICATION

DATE: May 1, 2011

TO: Chairman Lee Holloway, County Board of Supervisors

FROM: Geri Lyday, Interim Director - Department of Health and Human Services
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SUBJECT: **INFORMATIONAL REPORT FROM THE INTERIM DIRECTOR, DEPARTMENT OF HEALTH AND HUMAN SERVICES, PRESENTING A PROPOSAL FOR A PILOT PROJECT IN THE COMMUNITY TO PROVIDE SPECIALIZED SERVICES FOR A SPECIFIC POPULATION OF BEHAVIORAL HEALTH DIVISION CLIENTS**

BACKGROUND

On February 3, 2011 the County Board Adopted a Resolution (File No. 11-81/11-49) directing the Interim Director, Department of Health and Human Services (DHHS), to develop a report describing the details of a pilot project creating a model for the managed care system with small facilities located in the community to be included in a Request for Proposals. Since that time, DHHS and the Behavioral Health Division (BHD) convened a work group to discuss and develop a plan to move forward on this initiative. This report presents the recommendations of the work group.

DISCUSSION

The BHD staff welcomed an opportunity to create an innovative addition to our current community support programs. After looking at data and discussing various options with clinical experts at BHD, the workgroup decided to pursue a pilot project for a specific target population and approach this design in two phases.

The first phase proposes to develop an in-home intensive treatment model called ACT. The second phase establishes a 15-20 bed specialized residential treatment program utilizing managed care principles. This approach is being recommended because the goal is not only to pilot the 16-bed facility, but also provide stabilization services and crisis intervention to a small

group of individuals currently living in their own home. These individuals are frequent users of the Mental Health Complex whom we are currently not receiving any reimbursement for.

Below is a detailed summary of each aspect that was discussed at the work group and information for review.

Identification of Target Patient Population

BHD conducted a review of the Psychiatric Crisis Service (PCS) data, which revealed that there are 40 individuals with a Developmental Disability (DD)/Mental Illness (MI) diagnosis who each had four or more PCS encounters in 2010. Further review of these individuals revealed that they have a total of 294 or almost 3% of the total PCS admissions. Additional relevant information was collected related to this group of clients to help BHD determine if it was an appropriate group to consider for this initiative. This opportunity to focus on a specific group of high users is also a way to pilot craft an original solution.

After further review, BHD determined that 54% of this population lived in a structured living or home situation. This is exactly the group that BHD hopes to find ways to maintain in their environment and out of higher cost care. It is also interesting to note that only 10.5 percent of the visits resulted in actual admission to the hospital indicating that their PCS encounter was more of a crisis or short-term destabilization.

From a purely fiscal perspective, these consumers are the heaviest users of the most expensive resources. More importantly, they personally experience the most extreme and devastating consequences of having a serious mental illness. Traditionally, the mental health system has not been successful in engaging these consumers in effective treatment. However, some teams, specifically ACT which is discussed later, can successfully help consumers who have extensive needs to live safely and autonomously in the community.

Managed Care Approach

Managed care is a term utilized in health care financing to describe an approach of shifting risk. Managed care works best when the managed care organization focuses on assisting the client towards wellness with a focus on prevention and primary care and avoiding high cost "illness" care, which occurs in hospitals. At this point, most managed care organizations do not utilize their fundamental approach towards wellness to mental health care. Instead, most seek to limit their risk by limiting out-patient visits and hospital stay days.

By targeting the above-mentioned population, the proposed program seeks to shift the paradigm of mental health to a wellness model of care. BHD proposes to engage in a newly

defined level of community support for clients with co-occurring Mental Health and Development Disabilities diagnoses.

Co-Occurring Disorders: Core Values

Since the specific population that BHD plans to serve is a specialized group with a co-occurring disorder, the workgroup looked at the best practices for this specific group. According to the Substance Abuse and Mental Health Services Administration (SAMHSA), there are six guiding principles that serve as fundamental building blocks for programs in treating clients with co-occurring disorders:

1. Employ a recovery perspective
    a) Develop a treatment plan that provides for continuity of care over time
    b) Devise treatment interventions that are specific to the tasks and challenges faced at each stage of the co-occurring disorder recovery process
2. Adopt a multi-problem viewpoint
3. Develop a phased approach to treatment
4. Address specific real-life problems early in treatment
5. Plan for the client's cognitive and functional impairments
6. Use support systems to maintain and extend treatment effectiveness
    a) Building community
    b) Reintegration with family and community

Treatment and Support in the Community

Utilizing the concepts of managed care with a focus on prevention and primary care, BHD would like to plan care based on the Assertive Community Treatment (ACT) model that would work towards keeping this high PCS utilization group in the community and out of BHD. This is not an approach we currently have in place.

ACT is for a relatively small group of consumers who are diagnosed with serious mental illness, experience the most intractable symptoms, and, consequently, have the most serious problems living independently in the community. Because of the severe and recalcitrant nature of their symptoms, these consumers are more likely to frequently use emergency and inpatient medical and psychiatric services.

ACT is a way of delivering comprehensive and effective services to consumers who have needs that have not been well met by traditional approaches to delivering services. ACT teams directly deliver services to consumers instead of brokering services from other agencies or providers. For the most part, to ensure that services are highly integrated, team members are cross-trained in one another's areas of expertise. ACT team members collaborate on

assessments, treatment planning, and day-to-day interventions. Instead of practitioners having individual caseloads, team members are jointly responsible for making sure that each consumer receives the services needed to support recovery from mental illness.

ACT is characterized by:

- A team approach — Practitioners with various professional training and general life skills work closely together to blend their knowledge and skills
- In vivo services — Services are delivered in the places and contexts where they are needed
- A small caseload — An ACT team consists of a staff-to-consumer ratio of approximately 1 to 10
- Time-unlimited services — A service is provided as long as needed
- A shared caseload — Practitioners do not have individual caseloads; rather, the team as a whole is responsible for ensuring that consumers receive the services they need to live in the community and reach their personal goals
- A flexible service delivery — The ACT team meets daily to discuss how each consumer is doing and the team members can quickly adjust their services to respond to changes in consumers' needs
- A fixed point of responsibility — Rather than sending consumers to various providers for services, the ACT team provides the services that consumers need and if using another provider cannot be avoided (e.g., medical care), the team makes certain that consumers receive the services they need
- 24/7 crisis availability — Services are available 24 hours a day, 7 days a week. However, team members often find that they can anticipate and avoid crises

Core ACT services include:

- Crisis assessment and intervention;
- Comprehensive assessment;
- Illness management and recovery skills;
- Individual supportive therapy;
- Substance-abuse treatment;
- Employment-support services;
- Side-by-side assistance with activities of daily living;
- Intervention with support networks (family, friends, landlords, neighbors, etc);
- Support services, such as medical care, housing, benefits, transportation;
- Case management; and
- Medication prescription, administration, and monitoring.

In addition to this level of care management, we would propose to work with the Disability Services Division and the Department of Family Care to develop a facility that would provide crisis and respite care to these clients and others like them. In looking at models in Madison, this type of facility is designed for a short stay with intensive stabilization. It remains the goal

of returning the client to the community as soon as possible in a stabilized state with a plan for the future. We also have antidotal information that families do not have reasonable access to respite and resort to the emergency department to provide that care.

We would initially have discussions, in partnership with the Disability Services Division and Family Care, with community providers to develop the challenges and opportunities and then release a RFP for a community agency to create and manage this advance in our network of care.

Proposal

As a pilot, BHD proposes to first plan for an approach to care in the community for:

- An ACT approach to care treatment in the community for the target population
- Development of a quality monitoring plan to evaluate the pilot approach
- Document savings in unreimbursed care
- Identify challenges and opportunities in working with focused population that represents a high utilization of resources

Second, based on our current experience and learning from the pilot:

- Development of crisis/respite facility, specifically for the Developmentally Disabled population with mental illness or behavioral issues. For the second phase, we would work with DSD and Family Care to develop a model DD crisis/respite facility for 15-20 clients.
- The facility would provide short stay support for those in crises and for those families who need a respite occasionally.
- Care of the clients related to medical records and development of safety, respite and behavioral plans will be key to ensure a smooth continuity of care within the overall network.

Fiscal

In order to make this a sustainable component of the BHD system, funding needs to be reviewed especially in light of the shifting state and federal budget decisions. BHD is currently getting more data and information to help define and clarify funding sources for these clients.

BHD has reviewed the fiscal information for these clients from prior years. During 2010, across all clients, there were 2,254 acute inpatient admissions and 31,087 inpatient bed days. This patient group accounted for 31(1%) of these admissions and 682 (2%) of the bed days. BHD charges are based on cost. The inpatient per diem cost/charges in 2010 for this group of clients was $688,675 for which payments of $194,892 were received.

On the Observation Unit, there was a total of 2,143 admissions that accounted for 3,596 bed days. This group had 124 (6%) of the Observation Unit admissions and 557 (15%) of the bed days. Per diem rates for Observation are generally not reimbursed, although we do receive some payment for professional services. In 2010, the cost/charges for the Observation Unit for this client group were $800,662 for which we were paid $130,313.

In total, for the Emergency Room, the Observation Unit and inpatient care, BHD provided $1,164,132 in non-reimbursed care and unrecognized revenue for this group of clients during 2010. This revenue gap only stands to increase as costs/charges have risen. The BHD cost of an emergency room visit in 2011 is $604 and the cost of an acute inpatient day for an adult age 21-64 is $1364, yet Medicaid pays only $323 per visit/day.

The fiscal effect of such a change for BHD is difficult to quantify. Although these clients represent a significant number of visits to PCS each year, they would likely be replaced with other clients. It is almost impossible to know what type of clients with what payer source these additional clients would have.

BHD will continue to look at fiscal data to try to quantify the avoidance of PCS encounters and determine funding sources for these clients, the amount BHD could pay per client per month for this level of support and what agencies would be charged for any PCS visit.

NEXT STEPS AND RECOMMENDATION

BHD hopes to move forward with this initiative by:

1. Conducting a survey of families to better define the need and determine if they would be likely to utilize such a facility/resource. It is possible that other families would also utilize such a facility and that might allow them to care for their loved one in their home for a longer period of time.

2. Obtain more financial data, including working with Family Care and the Disability Services Division, to help determine the available funding sources for these clients and an appropriate per member rate.
3. Develop an approach to ACT in the community.
4. Draft a Request for Proposals to solicit bids for this population and return to the Board for approval.
5. Work with the Disability Services Division to develop the model that encompasses principles for both persons with developmental disability and mental illness.

This is an informational report so no action is necessary. BHD and DSD will return to the Board with a draft RFP and an updated report by the July board meeting.

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