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Wisconsin Department of Health Services

Assessment of the Milwaukee County Behavioral Health System

SUMMARY OF FINDINGS WORKING PAPER

November 25, 2014
Prepared by Deloitte Consulting

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Executive Summary

Introduction

In 2013, the Wisconsin legislature passed Act 203 that requires the Wisconsin Department of Health Services (DHS) to conduct an operational and programmatic audit of the Milwaukee County Mental Health system. The objective of the audit is to evaluate the effectiveness of the Milwaukee County Mental Health system and make recommendations for transition of oversight and operations among the behavioral health division of the Milwaukee County Department of Health and Human Services, the psychiatric hospital of the Milwaukee County Mental Health Complex, and related community based behavioral health programs.

Ultimately, DHS is charged with determining if county-based resources and services can better meet the needs of mental health consumers in a cost-effective, quality manner.

The Act calls for DHS to complete the audit by December 1, 2014, and issue a report to the Department's Secretary that includes recommendations for the State to:

- Assume oversight for emergency detention services and the psychiatric hospital of the Milwaukee County Mental Health Complex;
- Develop a plan to close the complex; and
- Develop a plan for state oversight of a regional facility for delivery of institutional, inpatient, crisis services, and behavioral health services using similar state-operated regional facilities as a model.

In August 2014, the Wisconsin Department of Health Services (DHS) engaged Deloitte Consulting as a contractor to help implement Act 203 by providing recommendations to the Governor and Legislature for improving the cost and quality of delivering publicly-funded behavioral health services in Milwaukee County.

The goal of Deloitte's assessment was to provide DHS with high-level insight and data so that it may develop policy recommendations for the continued care of Mental Health and Substance Abuse (MH/SA) consumers in Milwaukee County, including consumers using inpatient psychiatric and Emergency Detention services, consumers using crisis services, and consumers using community-based services. Between August and October 2014, Deloitte partnered with The Management Group (TMG) to assess several operational and programmatic aspects of the Milwaukee County behavioral health system. The assessment included findings from previously published reports on the system: the analysis of the adult mental health care delivery system completed by the Public Policy Forum and Human Services Research Institute (HSRI) in 2010; the Wisconsin public mental health and substance abuse infrastructure study completed by The Management Group (TMG) in 2009; and HSRI's report on the County's inpatient service capacity.

The project also included interviews with several key stakeholders, including staff of the Milwaukee County Behavioral Health Division; members of the Mental Health Board and Mental Health Task Force Redesign committee; and advocates and consumers groups. Utilization, operational and outcomes data was reviewed to substantiate stakeholder feedback. The scope of the assessment performed by Deloitte Consulting did not include any evaluation of cost, actuarial risk, or the financial aspects of providing services in Milwaukee County.

So that DHS will be able to align State and County policy to support effective treatment for the continued care for mental health and substance abuse consumers eligible for pubic/medical assistance in Milwaukee County, this paper focused on gathering consensus points within four key domains:

- **Inpatient Supply and Demand, Behavioral Health Division (BHD) Operations and Associated Outcomes:** Focuses on BHD's progress in right-sizing the system and its continued role in the broader County health system to serve high-acuity consumers of inpatient care.
- **Inpatient Diversion, specifically Crisis and Community-Based Alternatives and Associated Outcomes:** Discusses crisis and community-based initiatives that support a recovery-oriented, person-centered, trauma-informed system of care and opportunities to explore broader of these Evidence Based Practices as the County behavioral health system evolves. Includes application of principles of quality care and cost efficiency in the inpatient setting.
- **Transition Models:** Describes models for management of emergency detention services and the psychiatric hospital of the Milwaukee County Mental Health Complex.
- **Future Financing and Policy Implications:** Presents new delivery system options, payment/incentives and other policy levers to support the growth of consumer services. Discusses need for a common data infrastructure and sources to measure baseline, statewide comparative and outcomes data to lay track for quality and strategic decision making within the County and at DHS.

The intent is for DHS to use this assessment to develop policy recommendations to the Governor and Legislature.

Introduction and Project Background

Study Purpose and Scope

In 2013, the Wisconsin Legislature passed Act 203 stipulating that the Wisconsin Department of Health Services (DHS) conduct an operational and programmatic assessment of the Milwaukee County Behavioral Health System. The objective of the assessment was to evaluate the effectiveness of the Milwaukee County Behavioral Health System and include recommendations for transition of oversight and operations of the Behavioral Health Division of the Milwaukee County Department of Health and Human Services, the psychiatric hospital of the Milwaukee County Mental Health Complex, and related community-based behavioral health programs.

The goal of this report is to provide Milwaukee County Behavioral Health System with recommendations for the following items:

1. The state assuming oversight responsibility for emergency detention services and the psychiatric hospital of the Milwaukee County Mental Health Complex.
2. The development of a plan to close the complex.
3. The development of a plan for state oversight of a regional facility for delivery of institutional, inpatient, crisis services, and behavioral health services using similar state-operated regional facilities as a model.

Act 203 also requires the Milwaukee County Mental Health Board to arrange for a study to be conducted on alternate funding sources for mental health services and programs including fee-for-service models and managed care models that integrate mental health services by March 1, 2016. This activity is not included in the scope of this current project.

Study Approach and Methodology

The methodology includes three main steps:

1. **Gather data inputs:** Includes research questions based on Milwaukee County Behavioral Health System goals, major literature, relevant utilization and outcome reports, policies and interview results, to help understand patient needs, availability of services, processes, and associated health outcomes.
2. **Analyze current demand, supply, operations, best practices, policy implications and outcomes:** Answers research questions comparing the current state with proposed future transformational system goals using data that has been previously published and is readily available.

3. **Identify findings and insights:** Highlight key observations in the findings, resulting in four Summary of Finding papers:
    a. Inpatient Psychiatric Unit and Emergency Detention Services
    b. Crisis Services
    c. Community-Based Services
    d. Inpatient Transfer Options

Gather data inputs

Deloitte evaluated literature and existing reports to understand current and future strategies to service MH/SA consumers more effectively and efficiently. Similarly, data reports received from the state and county, and stakeholder interviews were assessed to identify reemerging themes. These data sources included:

1. Third Party Studies
    - *Wisconsin Public Mental Health and Substance Abuse Infrastructure Study*. The Management Group, Inc., 2009
    - *Transforming the Adult Mental Health Care Delivery System in Milwaukee County* Human Services Research Institute, 2010
    - *Milwaukee County Service Capacity Report*. Human Services Research Institute, 2014.
2. Milwaukee County Published Documents
    - *Mental Health Redesign Working Forum.* Milwaukee County Mental Health Redesign and Implementation Task Force, 2014
    - *Mental Health Redesign SMART Goals: 2013-2014*. Milwaukee County Mental Health Redesign Task Force, 2013
    - *Milwaukee County Executive's 2013, 2014 and 2015 Budgets.* DHS Behavioral Health Division, 2013
3. Industry Best Practices
    - Mental health and substance abuse interventions
    - Innovative urban-center MH/SA models of care
    - State/county policies around funding, inpatient diversion, behavioral health homes, etc.
4. State of Wisconsin Data Requests
    - Existing reports on Medicaid membership service utilization, , cost and
    - Pre and post-BadgerCare waiver impact on childless adult membership
5. Data Requests to Milwaukee County
    - Existing reports on services needed and those provided in Milwaukee County
    - Existing reports service utilization, payer mix
    - Existing reports quality of care metrics
    - Policies and procedures
    - Stakeholder input

In addition to reviewing existing reports, members of the project team facilitated two stakeholder sessions for behavioral health consumers and advocates at two different Milwaukee locations on September 23, 2014 to gather critical information. The invitation for the stakeholder sessions was distributed by the project team a week prior to the scheduled sessions to:

1. Leadership from Milwaukee Mental Health Task Force
2. Leadership from the Comprehensive Community Services (CCS) Recovery Advisory Committee
3. Consumer representatives on the Mental Health Redesign and Implementation Task Force
4. Representatives of advocacy organizations, including Disability Rights Wisconsin (DRW), the National Alliance for the Mentally Ill (NAMI) Greater Milwaukee, Mental Health of America, and Community Advocates
5. Individuals of peer service organizations used by BHD consumers including Our Space, Grand Avenue Club, La Causa, and Horizon Healthcare – Office of Consumer Affairs

The project team would like to acknowledge the assistance provided by Barbara Beckert of DRW and Sue Gadacz of the Milwaukee County BHD, who provided insights on the distribution list for the focus group invitations and the location of the sessions, and forwarded the invitation broadly to their networks of consumers, peer specialists and/or advocacy representatives. Those receiving the email invitation where also asked to share it with other individuals with lived experience who might be interested in attending the sessions.

In addition, the invitation to the sessions provided contact information for individuals not able to attend but who wanted to provide input. The project team also offered the opportunity for individuals to provide feedback via email to the questions covered during the sessions.

The purpose of the feedback sessions was to hear from individuals—those with lived experience and individuals who advocate on their behalf regarding input on the strengths, progress, challenges, and gaps of the Milwaukee County behavioral health system—in order to gain insights on the broader redesign and system issues, including impact on areas such as access, quality, recovery and best practices.

It should be noted that various community stakeholders provided input to the 2010 study on the adult mental health system in Milwaukee County and the more recent inpatient capacity study this past April. In the stakeholder feedback for this assessment, the project team tried to build on the input from those previous studies to capture any new or updated information on the progress that has been made or issues that have emerged since then.

The project team held two sessions attended by 30 individuals and received input via phone from one individual. Participants at the sessions were told that comments made in the sessions would be shared in aggregate, without identifying the individual(s) making the comments. This

was done to encourage candid, open feedback. Time was built into the focus group schedule to enable individuals to discuss issues/concerns that they did not feel comfortable discussing in a group setting.

Individuals attending the feedback sessions could voluntarily provide their name and affiliation, but individuals were not required to do so. In order to understand the make-up of the audience at each session, the session facilitators asked for a show of hands for individuals. More individuals with lived experience attended the early afternoon session at Grand Avenue Club (GAC) location, and more advocates attended the later afternoon/evening session at the NAMI Greater Milwaukee location.

1. At GAC – 12 of 16 people attending indicated they had lived experience and direct experience with BHD services (75%)
2. At NAMI – 5 of 14 people attending indicated they had lived experience and direct experience with BHD services (36%)

Analyze current demand, supply, operations, best practices, policy implications and outcomes

Deloitte used research questions to help frame the stakeholder interviews and data requests.

Identified findings and insights

Deloitte identified themes that emerged during the assessment of the operational and programmatic aspects of the system.

These included:

1. **Demand and Supply:** Demonstrate need, availability/capacity, and utilization of services.
2. **Operations:** Describe staffing patterns, policies and procedures.
3. **Best Practices:** Identify alignment with evidenced-based practices, innovative models and existence of quality improvement processes.
4. **Outcomes:** Describe impact on Mental Health/Substance Abuse (MH/SA) consumers relative to access, safety, quality and recovery (symptom improvement and improved functioning).
5. **Policy:** Summarize impact of county, state and federal policies related to benefits, coverage, and payment.

Research Questions

The research questions listed below are sample questions and are not an exhaustive list. The topics are specific to each domain and are aligned with the goals of the assessment.

Assessment Area	High Level Question
Inpatient	1. **Supply and Demand:** What IP services are presently provided? 2. **Operations and Outcomes:** How has utilization of beds trended relative to the quality of care? 3. **Operations and Outcomes:** Have staff and services provided adequate care and access? 4. **Best Practices:** Are there opportunities to increase efficiencies and effectiveness of admission, discharge/referral policies and procedures, in order to support principles of community-based recovery, and care in the least restrictive setting? 5. **Best Practices:** Are there evidenced models of care in other communities that can be leveraged? 6. **Policy:** What is the future need for IP services given the available payment constructs?
Crisis Services	1. **Supply and Demand:** What crisis services are presently provided? 2. **Operations and Outcomes:** Do the current crisis services offered meet the needs of Milwaukee County consumers in terms of access/capacity, quality and safety? 3. **Best Practices:** Are there opportunities to increase efficiencies and effectiveness of crisis services? 4. **Best Practices:** Are there evidenced models of care in other communities that can be leveraged? 5. **Policy:** What is the future need for crisis services given the available payment constructs? 6. **Policy:** Are there evidenced models of care in other communities that can be leveraged?

Assessment Area	High Level Question
Community-Based Services	***1.*** **Supply and Demand:** What community services are presently provided? ***2.*** **Operations and Outcomes:** Do the current crisis services offered meet the needs of Milwaukee County consumers in terms of access/capacity, quality and safety? ***3.*** **Best Practices:** Are there opportunities to increase efficiencies and effectiveness of crisis services? ***4.*** **Best Practices:** Are there evidenced models of care in other communities that can be leveraged? ***5.*** **Policy:** What is the future need for crisis services given the available payment constructs? ***6.*** **Policy:** Are there evidenced models of care in other communities that can be leveraged?
Inpatient Transfer Options	***1.*** **Supply and Demand:** What are the future options/models to provide care for consumers requiring inpatient services? ***2.*** **Operations and Outcomes:** Are there implications on access, quality and safety in each of the models? ***3.*** **Best Practices:** Are there evidenced models of care from other communities which MCBHS can leverage? ***4.*** **Policy:** What are the county, state and federal policy considerations of each model?

Limitations

There were several limitations as to the data available for review. Some of the major gaps are noted below; others are shared throughout the Summary of Findings section.

1. The analysis did not include any review of cost, actuarial risk, or the financial aspects of providing services in Milwaukee County.
2. Time and resources did not allow for comparison of Medicaid encounter data to Medicaid FFS data available in the PPS database. Instead, DHCAA provided reports with the populations comingled that allows for the analysis of year-to-year trend but not an analysis of FFS vs. managed care payment or utilization.
3. Neither DHCAA nor DMHSAS collect and report traditional health outcomes data (e.g. HEDIS measures such as follow-up after MH/SA discharge, medication adherence rates, or quality of life study data). Instead, outcomes measures received from the county were derived from a 'Mental Health Statistics Improvement Program (MHSIP) Consumer Satisfaction Survey' and included results from only two years 2010 and 2011.
4. The methodology used to calculate Emergency Detentions, inpatient admissions, readmissions, etc. did not adjust for the acuity of the population. Additionally, Medicaid demographic received data did not contain information regarding the risk of the population. Therefore it cannot be

assumed that the health status of the population is constant; thus the improvement in admission in readmission rates cannot be correlated solely to improved care, community and crisis services, or processes at BHD.

5. The assessment process did not include a comparison of training and credentialing requirements of inpatient, crisis services and community services settings as this information, although it was requested, was not provided to Deloitte.
6. In order to respect individual privacy, the facilitators of the advocate/consumer sessions did not ask people to share what specific services their comments referred to unless they volunteered this information. It should be noted that not knowing what specific services individuals had experienced may be a limitation of the feedback received in the sessions.
7. Some advocates expressed concerns that certain groups of consumers (e.g., consumers with substance use issues and those with hearing impairments) were underrepresented in the focus group sessions due to issues with the location of the sessions or the lack of a session facilitated by an individual who was deaf. The project team provided the opportunity for individuals who expressed concerns and did not attend one of the scheduled sessions to provide written comments in response to the questions via email. In addition, given the limited timeframe and scope of this project, the project team was not able to engage in extensive outreach activities, schedule multi-day focus group sessions, or conduct broad surveys. It should be noted that past studies of the Milwaukee County behavioral health system more broadly solicited stakeholder feedback, with community stakeholder meetings held as recently as April 2014. The summary feedback from those studies was reviewed for consideration in the meta-analysis conducted for this assessment.
8. The assessment was not able to gain access to several Standard Operating Procedures for the Complex, staffing patterns at the Complex or around the system.

Reflection on Milwaukee County's Public Behavioral Health System

Introduction: Milwaukee County Uniqueness

County-Based Behavioral Health System

Like many states, Wisconsin's mental health and substance abuse system is supervised by the state and administered at the county level. Wisconsin's Division of Mental Health and Substance Abuse Services is responsible for allocating state and federal funding for mental health and substance abuse services, in addition to high-level planning, management and oversight of these services in the state. However, what makes Wisconsin unique is the extent to which the 72 counties are responsible for administering mental health and substance abuse services and for providing for the well-being, treatment and care of individuals with mental illness and/or substance abuse problems.1

The counties are responsible for a significant amount of the funding, including the nonfederal share of Medicaid funding, required to provide behavioral health services mandated by the state and federal governments. In addition, the counties are responsible for purchasing most services.2

According to the ***Transforming the Adult Mental Health Care Delivery System in Milwaukee County*** report (2010), some argue that the decentralized county-based system creates disparities in the services that are provided across the state and creates strong budgetary pressures for the counties; behavioral health services must compete for resources with other county priorities. The same report shares a perspective that Milwaukee County government lacks administrative flexibility and independence to effectively govern a behavioral health system that includes psychiatric inpatient units and an emergency department. In addition, it does not properly protect the provision of behavioral health services from shifts in political oversight and funding preferences.[3]

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[1] Wisconsin Public Mental Health and Substance Abuse Infrastructure Study. Prepared for the Wisconsin Department of Health Services by The Management Group, Inc. 2009, December 18. Page 2.

[2] Transforming the Adult Mental Health Care Delivery System in Milwaukee County. Submitted by Human Services Research Institute. October 2010. Page 20.

[3] Transforming the Adult Mental Health Care Delivery System in Milwaukee County. Submitted by Human Services Research Institute. October 2010. Page 20.

Even under these stressed circumstances, Milwaukee County continues to operate its own inpatient psychiatric units. The BHD operates four 24-bed units for short-term inpatient stabilization.[4] BHD's inpatient hospital is categorized as an Institution for Mental Disease (IMD) which, by federal mandate, means it is excluded from pursuing Medicaid reimbursement for care provided to adults, enrolled in Medicaid, that are older than 21 and younger than 65. This creates an additional hardship on an already financially stressed county system.

Demographics

With a population of 956,000 residents, Milwaukee County is the most populous in Wisconsin and accounts for approximately 17% of Wisconsin's population. In addition, the demographics of Milwaukee County are more diverse than the rest of Wisconsin as demonstrated by the table below.[5]

Table 1: Representation of Races in Milwaukee compared to the rest of Wisconsin

Race	Milwaukee County	Wisconsin
White, Non-Hispanic or Latino	53%	83%
Black or African American	27%	7%
Hispanic or Latino	14%	6%
Asian	4%	3%
Two or more races	3%	2%

Milwaukee County also has the largest city in Wisconsin, Milwaukee, and as a result its residents suffer from many of the issues associated with urban poverty[6]:

- 22% of residents live below 100% of FPL, compared to 12% of residents in Wisconsin
- The September 2014 unemployment rate in Milwaukee County is 6.3%, compared to a 4.7% average statewide[7]
- 19% of residents are on Medicaid in Milwaukee County, compared to 12% in Wisconsin
- 10% of Milwaukee County residents have been uninsured all of the past year, compared to 6% in Wisconsin

[4] Transforming the Adult Mental Health Care Delivery System in Milwaukee County.

[5] State & County Quick Facts. United States Census Bureau. http://quickfacts.census.gov/qfd/states/55/55079.html

[6] Wisconsin Department of Health Services, Division of Public Health, Office of Health Informatics, Health Analytics Section. Public Health Profiles,

[7] http://worknet.wisconsin.gov/worknet_info/maps/pdf/uRatesCo.pdf

- The infant mortality in Milwaukee County is 8.1 per 1,000, compared to 5.7 per 1,000 in Wisconsin
- The number of alcohol-related hospitalizations per 100,000 population in Milwaukee county was 1,128, compared to 836 per 100,000 population in Wisconsin[8]

Milwaukee County suffers from a shortage of behavioral health professionals and paraprofessionals to address the problems that so often accompany urban poverty. This shortage directly impacts inpatient bed capacity, which is exacerbated when staff takes vacations or sick leave. In addition, there is a lack of an available and skilled community-based workforce to meet the staffing demand for outpatient programs.[9]
Perhaps, as a result, Milwaukee County residents are much higher utilizers of emergency services compared to the rest of the state; approximately 36% of individuals with serious mental illnesses visited the emergency department in 2013, compared to 20% of individuals in the rest of the state.[10]

Milwaukee County is unique in terms of population, healthcare demands and the behavioral health system. For this reason, it is difficult to compare healthcare outcomes or use state and national benchmarks to drive change in the system.

Emergency Detention Statutory Language and Practice

Chapter 51 of Wisconsin State Statutes establishes procedures and criteria under which an individual with mental illness, drug dependency or developmental disabilities may be involuntarily detained and subsequently committed for treatment. The process of initial involuntary detention is referred to as emergency detention. Only a law enforcement officer may take a person meeting the statutory criteria into custody for emergency detention.

In Milwaukee County, law enforcement brings all emergency detentions, except those requiring medical stabilization, to the 24 hour/7 day a week psychiatric emergency room at the MH Complex, referred to as Psychiatric Crisis Services PCS. PCS provides crisis assessment, treatment and/or referral services. In situations requiring medical stabilization, the person is first taken to a private hospital for medical care. Once a person receives medical clearance, they are transported to PCS. In addition to all law enforcement emergency detentions, all inpatient admissions to BHD are admitted to PCS for evaluation.

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[8] http://www.dhs.wisconsin.gov/publications/P4/P45718-14.pdf

[9] Analysis of Adult Bed Capacity.

[10] Analysis of Adult Bed Capacity.

The emergency detention procedure in Milwaukee County is different from that in other counties. Milwaukee County is the only county in which the treatment director (i.e., licensed BHD or contracted physician or psychologist with clinical responsibility for the provision of emergency service care) must make a detention decision within 24 hours of when the officer brought the person to the detention facility. The treatment director determines whether to release or detain the person for a period not to exceed 72 hours (excluding weekends and holidays) from the time the person was brought to the facility. Apparently, this different statutory procedure for Milwaukee was put in place in the late 1970s at the urging of law enforcement.

As a result of this statutory provision, the treatment director's determination, also known as a Treatment Director Supplement (TDS), is required before the emergency detention statement is filed with the court. The TDS must be done in the first 24 hours that the person has been brought to the facility.

- **Pros**: The requirement to do the TDS within 24 hours is important because the TDS serves to identify individuals who do not fit the emergency detention criteria and should not be detained. Advocates maintain that without the requirement of a TDS within 24 hours, a person could be detained for up to 72 hours or longer (if a weekend and/or holiday is involved) waiting for their probable cause hearing.

- **Cons**: Milwaukee County H&HS has urged elimination of the TDS requirement, and indicated in testimony to the Legislature in 2010 that "the primary concern with TDS is if a patient also requires medical clearance before entering BHD's PCS, the 24-hour TDS time period has likely expired … due to either a pre-existing medical condition or as a result of physical harm they have done to themselves that led to the ED. This can result in some of the most serious cases being dismissed that otherwise would have been addressed."

Two pieces of legislation that went into effect this past spring impacted Milwaukee's emergency detention procedures. The first, 2013 Wisconsin Act 158, was supported by advocacy groups and Milwaukee County, and made several changes to the statutory provisions relating to emergency detention, including:

- Changed the emergency detention statute to make it clear that the purpose of emergency detention "is to provide, on an emergency basis, treatment by the least restrictive means appropriate to the individual's needs", to individuals who meet all the following criteria: (a) are mentally ill, drug dependent, or developmentally disabled; (b) evidence of the statutory standards of dangerousness; and (c) are reasonably believed to be unable or unwilling to cooperate with voluntary treatment.

- Changed the emergency detention statute to include that a law enforcement officer must have reason to believe … "that taking a person into custody is the least restrictive alternative appropriate to the person's needs."

- Changed the 24-hour provision unique to Milwaukee County that requires a treatment director's supplemental statement (i.e., the TDS) to include any delays specific to the evaluation or stabilization of a person's non-psychiatric medical conditions to be excluded from the 24-hour calculation. In this way, any required medical clearance will not count toward the 24-hour time period for determining whether or not the person should be detained for up to 72 hours or released.

The second piece of legislation, 2013 Wisconsin Act 235, was supported by Milwaukee County but opposed by advocacy groups. It created a two-year emergency detention pilot program only in Milwaukee County to expand the authority of who, in addition to law enforcement, can initiate an emergency detention.

- Act 235 authorizes a treatment director or their designee (i.e., licensed mental health professional) to take a person into custody for emergency detention if the person meets all the criteria for detention. This expanded authority for emergency detentions went into effect in Milwaukee County on April 10, 2014 and expires May 1, 2016.

- After the pilot has expired, the Legislative Audit Bureau is required to conduct a performance evaluation audit of the pilot that includes a survey of emergency detention procedures and outcomes before and during the pilot, as well as an evaluation of the feasibility of making the pilot permanent in Milwaukee County and expanding it to other counties.

Emergency detention practices in Milwaukee County are strikingly different from the rest of Wisconsin. The following table outlines the key differences between Milwaukee and Wisconsin's other 71 counties.

Table 2: Comparison of Milwaukee County ED Practices to Other Wisconsin Counties

Milwaukee County	Other Wisconsin Counties
Law enforcement can determine who will be brought in on a potential emergency detention and is required by state law to sign a statement of emergency detention and deliver it to the detention facility with the individual (Wisconsin Stats. 51.15(4)(4)). **There is no similar approval by the county mental health authority required before a potential emergency detention is initiated and a person is delivered to the detention facility.**	Law enforcement needs approval from the county department of community programs (i.e., mental health authority) to initiate the emergency detention process and transport a person for detention (Wisconsin Stats. 51.15(2)(2)). In addition, the county may approve the detention only if the county reasonably believes the individual will not voluntarily consent to evaluation, diagnosis and treatment.
Doctors have 24 hours, not including delays due to medical clearance, from the time a person is brought to PCS at the Mental Health Complex to determine if an individual meets criteria for emergency detention and, if that determination is not made, the person is required to be released. This determination by the doctor at the detention facility is referred to as the Treatment Director Supplement (TDS). ***"Upon delivery of the individual, the treatment director of the facility, or his or her designee, shall determine within 24 hours, except as provided in par. (c), whether the individual shall be detained"***	*No 24 hour requirement and doctors in other counties are not required to complete a TDS.*

Milwaukee County	Other Wisconsin Counties
A Chapter 51 court case is started and the necessary documents are filed with the court when a treatment director determines the person brought to the MH Complex by law enforcement should be detained. ***"The law enforcement officer or other person shall deliver, or cause to be delivered, the statement to the detention facility upon the delivery of the individual to it. […]If the individual is detained, […] the treatment director or designee shall then promptly file the original statement together with any supplemental statement and notification of detention."*** [2]	A court case is started when an officer detains an individual *"The statement of emergency detention shall be filed by the officer or other person with the detention facility at the time of admission, and with the court immediately thereafter."*
From April 10, 2014 to May 1, 2016, a statutory pilot program authorizes licensed mental health professionals, who are employees of, or on contract with, the Milwaukee County BHD to also initiate detentions.	No other counties are statutorily allowed to participate in the 2013 Wisconsin Act 235 Emergency Detention Pilot Program.

Structure, Roles and Responsibilities, Service Delivery Model

Budget and Payers

According to Wisconsin Act 203, the Milwaukee County Mental Health Board (MCMHB) is responsible for proposing an annual budget to the county executive. The proposal outlines how much of the budget will come from community aids funding, county tax level, patient revenue and other sources (including grants). The county tax levy must be between $53 million and $65 million; this amount can only be increased if additional mental health programs and services are transferred to MCMBH.

In 2015, approximately $183,500,000 was allocated to Milwaukee County's Behavioral Health Department; $67,400,000 from direct revenue, $54,000,000 from intergovernmental revenue and $62,000,000 from tax levy. The direct revenue includes an additional $500,000 in expected Medicaid reimbursement as a result of expanded access to BadgerCare Plus, Wisconsin's Medicaid program for low income families and people without dependent children.

The County recommended BHD budget is approximately 14% of the county's annual budget. This includes an increase in revenue expenditures of $3,699,353 to support the following:

- Increasing fringe benefit costs
- A strengthened inpatient staffing model to support the higher acuity patient load seen in the inpatient psych units over the past several years
- Expanding community-based crisis services focus on crisis services to divert patients from unnecessary hospitalization

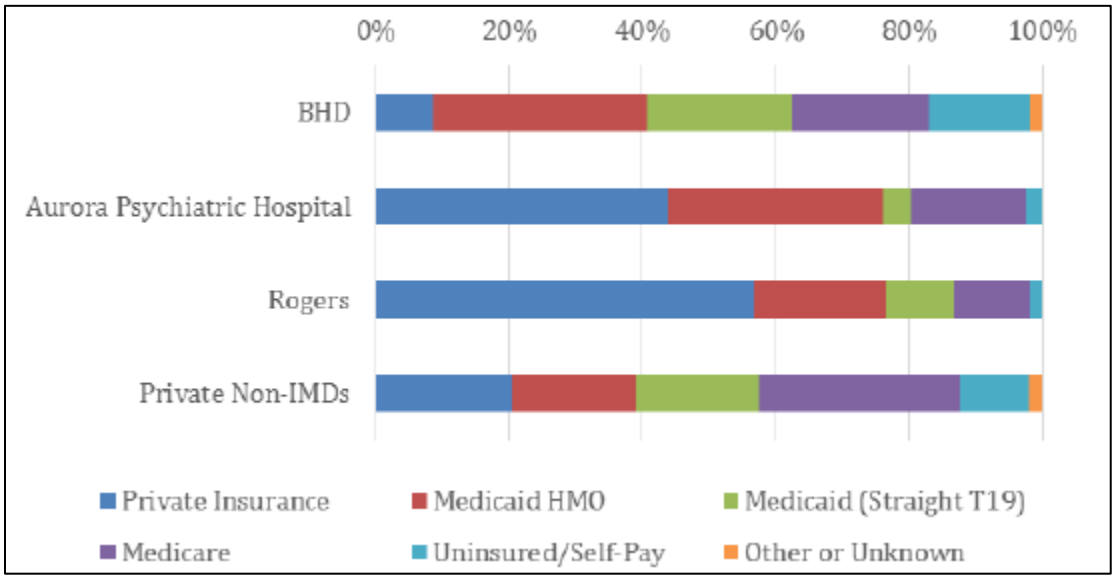
Despite plans to close both long-term rehabilitation facilities by the end of 2015, Milwaukee County must continue to maintain the facilities in compliance with State and Federal regulations until the facilities are fully closed. Subsequently, even though several FTEs will be eliminated, there are still significant overhead costs associated with operating the facilities.

Wisconsin Behavioral Health Department Payer Profile

As in many places throughout the country, the Milwaukee County BHD takes on the role of "Safety Net" and treats many of the Medicaid and uninsured residents of Milwaukee County. In 2013, only 9% of admissions had private insurance. Medicaid was the most common payer, with 32% of admissions covered by Medicaid HMO and 22% of admissions covered by Medicaid

fee for service. The graph below compares this payer mix with the payer mix at other IMDs and Non-IMDs in Milwaukee County.[11]

Graph 1: Inpatient Admissions by Payer Source, 2013



Source: Analysis of Adult Inpatient Capacity (2014)

BHD Operated Services and Facilities

BHD operates four 24-bed inpatient adult psych units, two long-term care facilities and several community, crisis services. The number of adult and pediatric inpatient beds in 2015 has increased to 60 adult beds and 11 children's beds, in large part due to the following two factors:[12]

- The unexpected closures of inpatient beds at private hospitals
- Higher-acuity patients who require longer inpatient stays to stabilize

[11] Analysis of Adult Bed Capacity.

[12] Milwaukee County 2015 Recommended Operating and Capital Budgets. http://county.milwaukee.gov/ImageLibrary/Groups/cntyDAS/PSB/Budgets/2015-Budget/2015-CEX-Budget/2015CountyExecutiveRecommended.pdf

In addition to inpatient care, Milwaukee County provides community-based services directly and through contracts with community-based services. The services that are currently provided include:

- Community Support Program
- Targeted Case Management
- Community Residential
- Outpatient Treatment
- Day Treatment Partial Hospitalization Program

For those without direct access to community-based services, crisis services are a vital source of support. These services include[13]:

- Psychiatric Crisis Services
- Observation Unit
- Crisis Line
- Mobile Crisis Teams
- Geriatric Psychiatric Services
- Crisis Assessment Response Team
- Community Consultation Team
- Access Clinic
- Crisis Stabilization Houses
- Crisis Resource Centers
- Community Linkages and Stabilization Program

Coordination and Partnership with Private Systems

BHD is not the only provider of inpatient psychiatric services. In Milwaukee County, there are approximately 225 adult inpatient psychiatric beds projected to be available in 2015; 165 of those beds are at private hospitals.

[13] Transforming the Adult Mental Health Care Delivery System in Milwaukee County.

Table 3: Psychiatric Inpatient Facilities in Milwaukee County[14]

Hospital	IMD Status	2013 % Inpatient Admissions
BHD	✓	14.9%
Rogers Memorial	✓	35.2%
Aurora Psychiatric	✓	22.6%
Aurora St. Luke's South Shore		8.2%
Wheaton-St. Francis		6.7%
Columbia St. Mary's (closed the inpatient psych unit in 2014)		12.4*
TOTAL		**100%**

According to BHD, over the past six to seven years, it has been a major focus to transfer as many appropriate individuals as possible into the private system. This allows BHD to manage census much more proactively. "Wait List Status"—which occurs when there are five beds or fewer in the BHD system, (acute and observation beds combined)—is seen as a significant indicator of system performance.

BHD reports that it has had Memorandums of Understanding (MOU) with Aurora Psychiatric Hospital, Aurora St Luke's Southshore, Rogers Memorial, and St. Francis to be detention facilities (i.e. inpatient psychiatric facilities) for a number of years in an effort to prevent such occurrences as Wait List Status. Patients are transferred directly from BHD Psychiatric Crisis Service to them. Transfer data shared later in the document validates the percentage of individuals transferred to community partners.

Change in Governance

Over the past several years, it has been widely discussed that Milwaukee County faces severe challenges in carrying out its mandate to provide behavioral health services to its residents. As a result, in 2014, Wisconsin Act 203 was signed into law and changed the oversight of Milwaukee County's behavioral health system, transferring control from the Milwaukee County Board of Supervisors to a newly created Milwaukee County Mental Health Board (MCMHB). The MCMHB will directly manage behavioral health care in Milwaukee County, including inpatient care, system-wide bed capacity, and the capacity and quality of community-based services.[15]

[14] Analysis of Adult Bed Capacity.

[15] Analysis of Adult Bed Capacity.

The MCMHB will be made of 11 active members and 2 representatives from academia serving in *ex-officio* positions. The proposed board composition is as follows:[16]

- Two psychiatrists or psychologists
- A representative of the community who is a consumer of mental health services
- A psychiatric mental health advanced practice nurse
- An individual specializing in finance and administration
- A health care provider with experience in the delivery of substance abuse services
- An individual with legal expertise
- A health care provider representing community−based mental health service providers
- An individual who is a consumer or family member representing community−based mental health service providers
- The chairperson of the county community programs board in Milwaukee County under s. 51.42 (4), or his or her designee who is not an elected official as community programs board in Milwaukee County is an elected official, the chairperson shall designate a member of the county community programs board who is not an elected official to be a member under this subdivision.
- The chairperson of the Milwaukee Mental Health Task Force, or his or her designee.
- A health care provider who is an employee of a higher education institution suggested by the Medical College of Wisconsin.
- A health care provider who is an employee of a higher education institution suggested by the University of Wisconsin—Madison.

The MCMHB has the following responsibilities:

- Oversee the provision of mental health services in Milwaukee County;
- Work with DHS to recommend and establish policies for inpatient mental health treatment facilities and related services in Milwaukee County;
- Allocate funds for mental health services, functions and programs in Milwaukee County
- Establish and adopt policies regarding mental health in Milwaukee County;
- Perform all mental health functions in Milwaukee County that were previously the responsibility of the county board of supervisors; and
- Attempt to achieve cost savings.

[16] http://docs.legis.wisconsin.gov/2013/related/acts/203

Other Policy Considerations and Impact

Redesign and Reform Efforts

In response to decreased utilization of inpatient psychiatric services, seen in Milwaukee and experienced across the country, Milwaukee County launched an effort to downsize its inpatient bed capacity and increase its community-based services.

In 2010 Health Services Research Institute (HSRI) published their findings on the planning efforts to redesign Milwaukee County's mental health care system. This report was initiated by the Milwaukee Health Care Partnership, the Medical Society of Milwaukee County and the Milwaukee County Behavioral Health Division and was completed in partnership with the Public Policy Forum and Technical Assistance Collaborative, Inc.

Their recommendations were as follows[17]:

- Continue to downsize and redistribute inpatient capacity
- Encourage private health systems to expand capacity of their behavioral health services
- Reorganize crisis services and expand alternatives
- Reduce emergency detentions through improved emergency provider and law enforcement trainings
- Promote recovery through person-centered approaches and peer supports
- Expand housing supports
- Ensure cultural competency
- Ensure trauma-informed care
- Develop quality initiatives throughout the system

BHD has implemented several initiatives to meet these recommendations[18]:

- Increased mobile crisis response capacity, which has decreased inpatient admissions, police interventions and emergency department visits
- Utilization of observation beds to decrease inpatient admissions; 80% of admissions to observation beds result in diversion from inpatient units
- Allocated additional resources to crisis residential beds, peer support services, supported housing assistance

[17] Transforming the Adult Mental Health Care Delivery System in Milwaukee County. HSRI

[18] Analysis of Adult Bed Capacity.

Summary of Findings

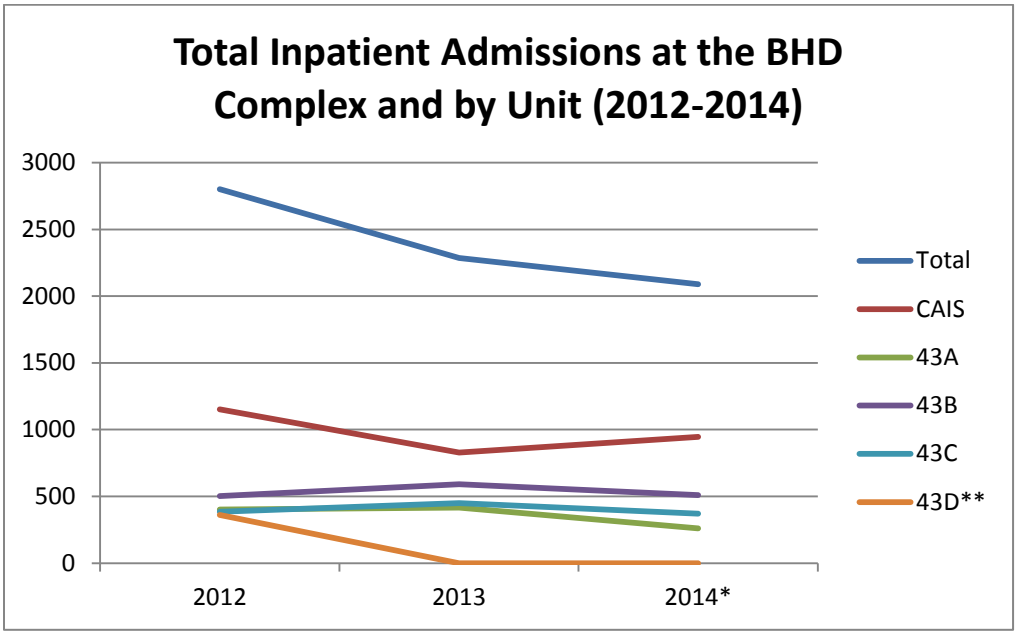
Inpatient Supply and Demand, Behavioral Health Division (BHD) Operations and Associated Outcomes

Background on the Reduction in Inpatient Beds

The Milwaukee County Behavioral Health Division (BHD) has pursued several initiatives to align with the recommendations posed in the 2010 study "Transforming the Adult Mental Health Care Delivery System in Milwaukee County." First and foremost, in an effort to rebalance the County's behavioral health system away from inpatient to community-based services, BHD has downsized inpatient bed capacity at the Milwaukee Mental Health Complex (the Complex) from nearly 100 beds in 2006 to 60 in 2013. This is a reduction of roughly 39%. [Source: 2014 Analysis of Adult Bed Capacity]. This is a reduction in *staffed* beds. BHD reported that its four adult inpatient units are licensed at 24 beds each and that one of those units is empty. BHD did not relinquish the license for that unit so as to remain flexible in the use of the space.

The reduction in beds is accompanied by decreasing utilization at the Complex. BHD has experienced dramatic decreases in inpatient admissions from 2010 to 2014: a 46% decrease in the average number of acute adult admissions per month and a 40% reduction in the average number of child and adolescent admissions per month. The table below demonstrates the trend over the last three years.

Graph 2: Total Inpatient Admissions at the BHD Complex and by Unit



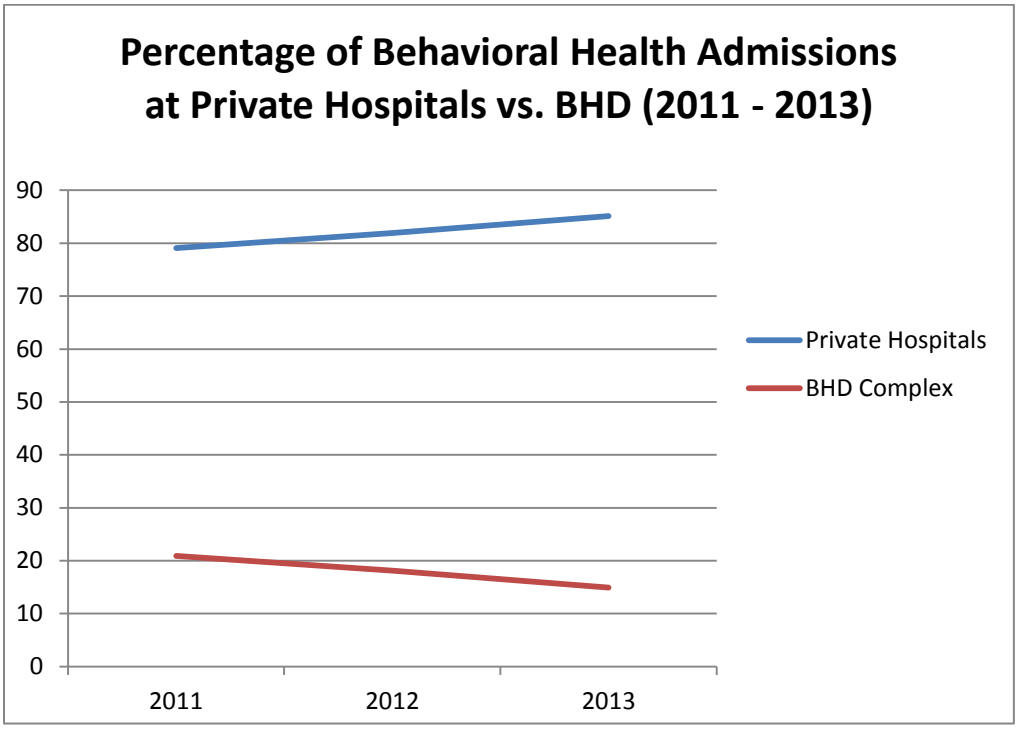
Year	Total	CAIS	43A	43B	43C	43D**
2012	2802	1152	401	502	386	361
2013	2285	829	416	590	450	0
2014*	2088	946.5	261	510	370.5	0

Source: Milwaukee County Behavioral Health Division

*2014 projects is based on eight months of data, therefore a completion factor of 1.5 was applied to calculate a total projected inpatient admission rate.
**Acute Adult Unit 43D was a mixed Acute Adult Inpatient Unit that closed December of 2012. Prior to 2013, Acute Adult Inpatient Service had four (4) units: 43A (ATU), 43B (Gero), 43C (ATU), and 43D (ATU). Between December 2012 and February 2013, Acute Adult Units were reconfigured to: 43A – Intensive Treatment unit (ITU), 43B - Acute Treatment Unit (ATU), and 43C – Women's Treatment Unit (WTU).

It appears that the number and percentage of individuals requiring inpatient care in Milwaukee County is decreasing based on the data available. According to data reporting in the 2014 *Analysis of Adult Bed Capacity* report, behavioral health inpatient admissions at Milwaukee's private hospitals increased 6% over the last three years—from 12,241 admissions in 2011 to 13,054 admissions in 2013. The graph below depicts the percentage of admissions at the private hospitals compared to those at BHD.

Graph 3: Percentage of Behavioral Health Admissions at Private Hospitals vs. BHD Complex



Note, the 2014 *Analysis of Adult Bed Capacity* reports 3,244 admissions to BHD in 2011 and 2,793 admissions in 2012. The date received from BHD for this study did not include 2011 data and 2,802 admissions in 2012, which is still roughly 18% of admissions. Both sources reported 2,285 admissions in 2013.

Census

BHD tracks licensed capacity, operating capacity and average daily census as the table below demonstrates.

Table 4: PCS**, Observation and Inpatient Bed Metrics

Program	2010			2011			2012			2013			2014		
	Licensed Beds	Operating (Staffed) Capacity	Average Daily Census (ADC)	Licensed Beds	Operating (Staffed) Capacity	ADC	Licensed Beds	Operating (Staffed) Capacity	ADC	Licensed Beds	Operating (Staffed) Capacity	ADC	Licensed Beds	Operating (Staffed) Capacity	ADC
Adult															
PCS*	N/A	N/A	36.8	N/A	N/A	36.4	N/A	N/A	34.8	N/A	N/A	31.4	N/A	N/A	29.3
Observation	18	18	9.8	18	18	10.6	18	18	10.6	18	18	6.3	18	18	7.6
Acute Inpatient	96	96	84.4	96	96	79.7	96	79	67.2	96	66	58.5	96	66	55.9
Total Adult (Acute & OBS)	114	114	94.2	114	114	90.3	114	97	77.8	114	84	64.8	114	84	63.5
Child/ Adolescent															
PCS	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Observation	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Child/ Adolescent Inpatient	24	12	10.4	24	12	8.4	24	12	6.3	24	12	8.0	24	12	8.5
Total Children	24	12	10.4	24	12	8.4	24	12	6.3	24	12	8.0	24	12	8.5
Total Adults & Children	138	126	104.6	138	126	98.7	138	109	84.1	138	96	72.8	138	96	72.0

*PCS average daily admissions

**According to BHD, there are no licensed beds per se attached to PCS. "Capacity is somewhat subjective and highly contingent on the milieu. From a square footage and space perspective we typically see capacity in PCS as around 18 Patients. However that is not a hard and fast number, PCS cannot admit more Patients at any given time than it has the capacity to adequately care for (this is the same for any emergency room setting). So it is conceivable that when there are less than 18 Patients but the acuity of the Patient mix is high, PCS reaches capacity. So the PCS numbers below will only reflect overall numbers of Patients coming to PCS. It is simply not possible to use that as a numerator over capacity, because capacity in this setting is so variable. Also of note is that during the course of 2012 and 2013 the census caps changed several times during the course of the year. The number submitted is the average census caps for the year."

Continued Downsizing

According to its Proposed 2015 Budget Narrative[19], BHD plans to retain 60 inpatient beds at the Complex, for acute inpatient needs, amid the 2014 closure of Hilltop and November 2015 closure of Rehab Central. BHD leadership shared that plans to downsize the Complex to one or two 16-bed units are under consideration as well.

A representative from the Mental Health Redesign Task Force cautioned against down-sizing the number of beds too quickly, as it could overwhelm the entire County behavioral health system. In addition, the perspective was shared that capacity is not a static number and that staffing and consumer acuity impacts capacity on a daily basis. Given these factors, strategies to reduce the volatility of the system, specifically related to behavioral health workforce stability, needs to be studied and planned before any additional inpatient reductions occur at the Complex. The pace of bed reduction must also align closely with ensuring adequate access to step-down and wraparound services in the community as well as the provision of high quality inpatient care.

Below are findings based on an assessment of inpatient rebalancing initiatives reflecting supply and demand, current and future operating paradigms and measured improvement in outcomes.

Finding 1: BHD has developed a standard data set to measure the quality of care of inpatient services delivered at the Complex. There is a significant opportunity to enhance the collection and reporting of quality and cost outcomes data that would allow BHD to measure itself against comparable facilities and agencies. Joint Commission accreditation, specifically alignment with the Hospital-Based Inpatient Psychiatric Services (HBPIS), will accomplish this.

Impact on System and Quality of Care

One goal of this assessment is to understand the level of quality of care that is delivered at the Complex in the context of declining beds and inpatient admissions. BHD collects several outcome metrics that policy researchers commonly accept as measures of quality that was, in turn, relied upon to assess performance of the Complex. For example, outcome metrics, such as the rate of 30-, 60-, and 90-day readmissions correlate to a provider's ability to successfully discharge individuals from its facility into the community. In the case of a behavioral health

[19] http://county.milwaukee.gov/ImageLibrary/Groups/cntyHHS/BHD/Mental-Health-Board/BudgetNarrative2015.pdf

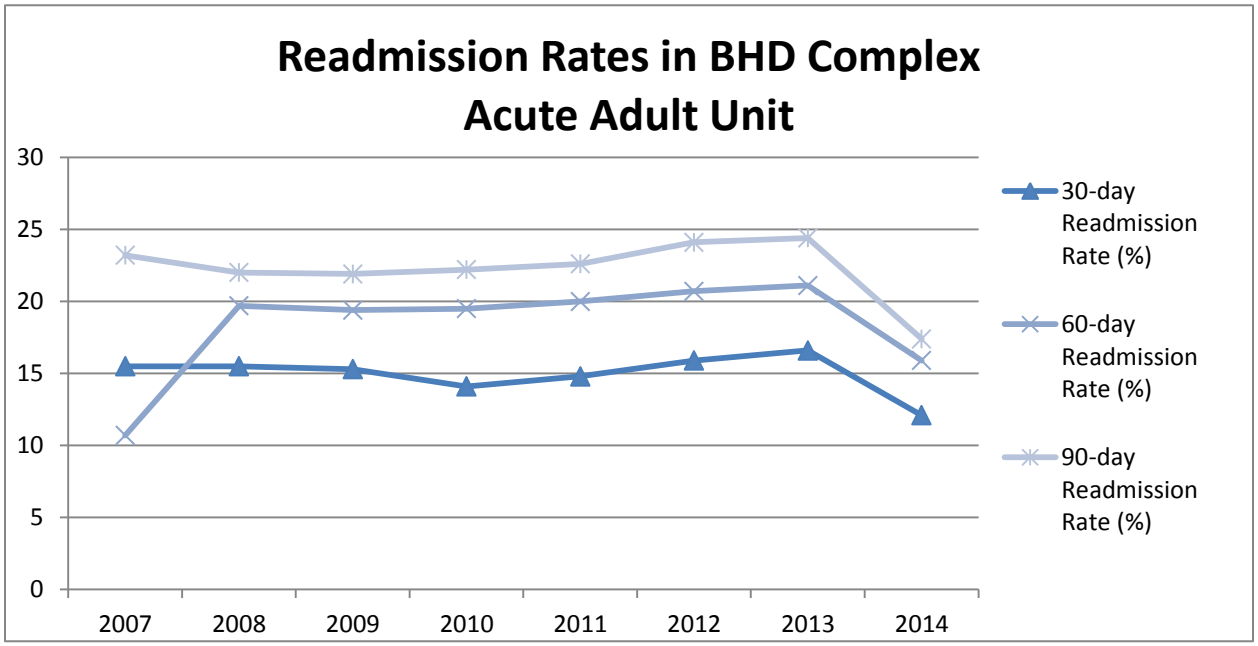
system, it also is indicative of the continuum of services within the community available to behavioral health consumers for recovery-oriented support.

Data collected from BHD demonstrates a decreasing readmission rate in the adult inpatient units at the Complex:

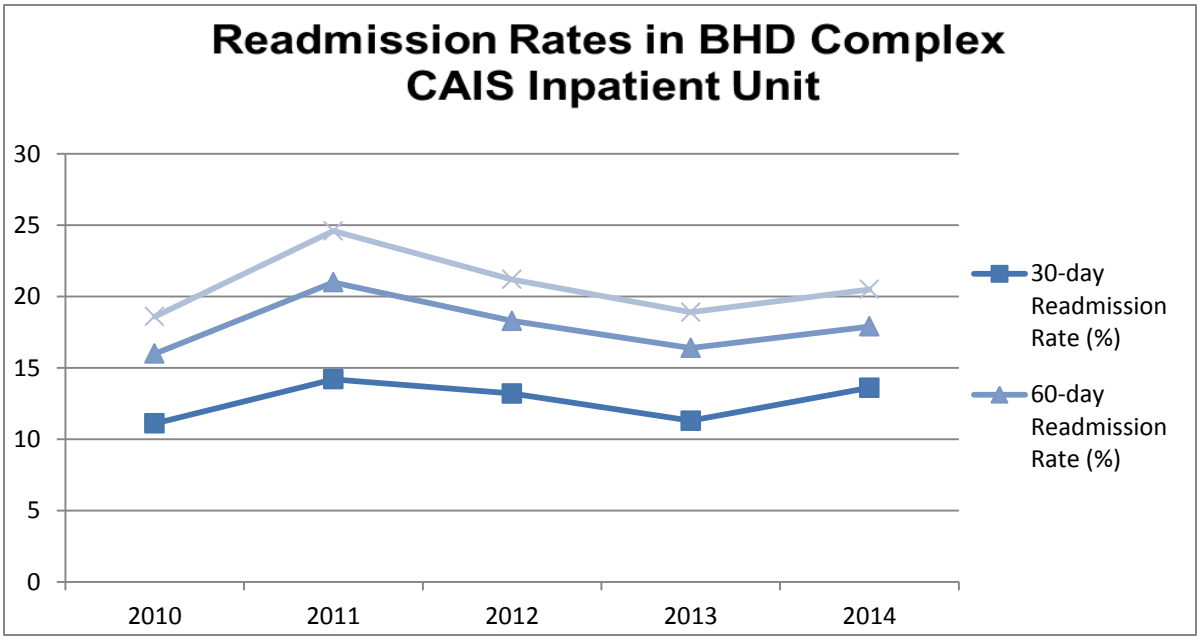
- The percentage of clients returning to Psychiatric Crisis Services (PCS) within 90 days has decreased from 32% in 2012 to 31% as of June 30, 2014. The rate of return in 2013 was 33%.
- The percentage of adult readmissions within 30 days of a discharge from the Complex that resulted in a readmission to BHD decreased 2% overall from 14.1% in 2010 to 12.1% in 2014 while 60-day and 90-day readmission rates decreased 4% and nearly 5%, respectively.
- Conversely, within the child and adolescent inpatient unit, 30-, 60-and 90-day readmission rates increased slightly from 2010 to 2014. There was a 2.5% increase in admissions that resulted in a readmission within 30 days of a discharge over the four-year period and nearly 2% increase in 60-day and 90-day readmissions.

Data to track whether specific consumers admitted originally to the Complex were later readmitted to a private hospital is not available; neither were aggregated readmission rates for behavioral health diagnoses within the private system. The graphs below reflect readmission rates within the adult and child/adolescent (CAIS) units.

Graph 4: Readmission Rates in BHD Complex Acute Adult Unit



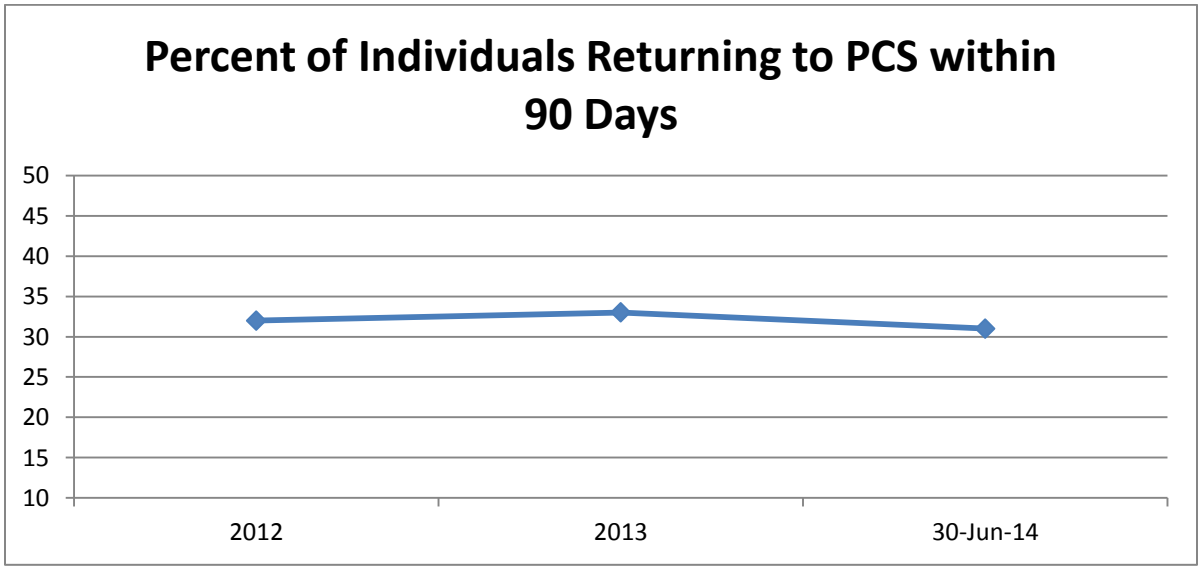
Graph 5: Readmission Rates in BHD Complex CAIS Inpatient Unit



NOTE: The rate of readmissions was calculated by BHD using a numerator defined as the count of consumers having less than, or equal to, 30 days between an Acute Adult admission and a past discharge from Acute Adult (within a specific time period); the denominator is the total Acute Adult Admissions (within a specific time period). The rate for 2014 reflects readmission rates from January 1, 2014 – September 28, 2014.

Additional outcomes reported by BHD as measures of inpatient treatment and discharge effectiveness include readmissions to Psychiatric Crisis Services. The graph below depicts a relatively steady trend over the past three years.

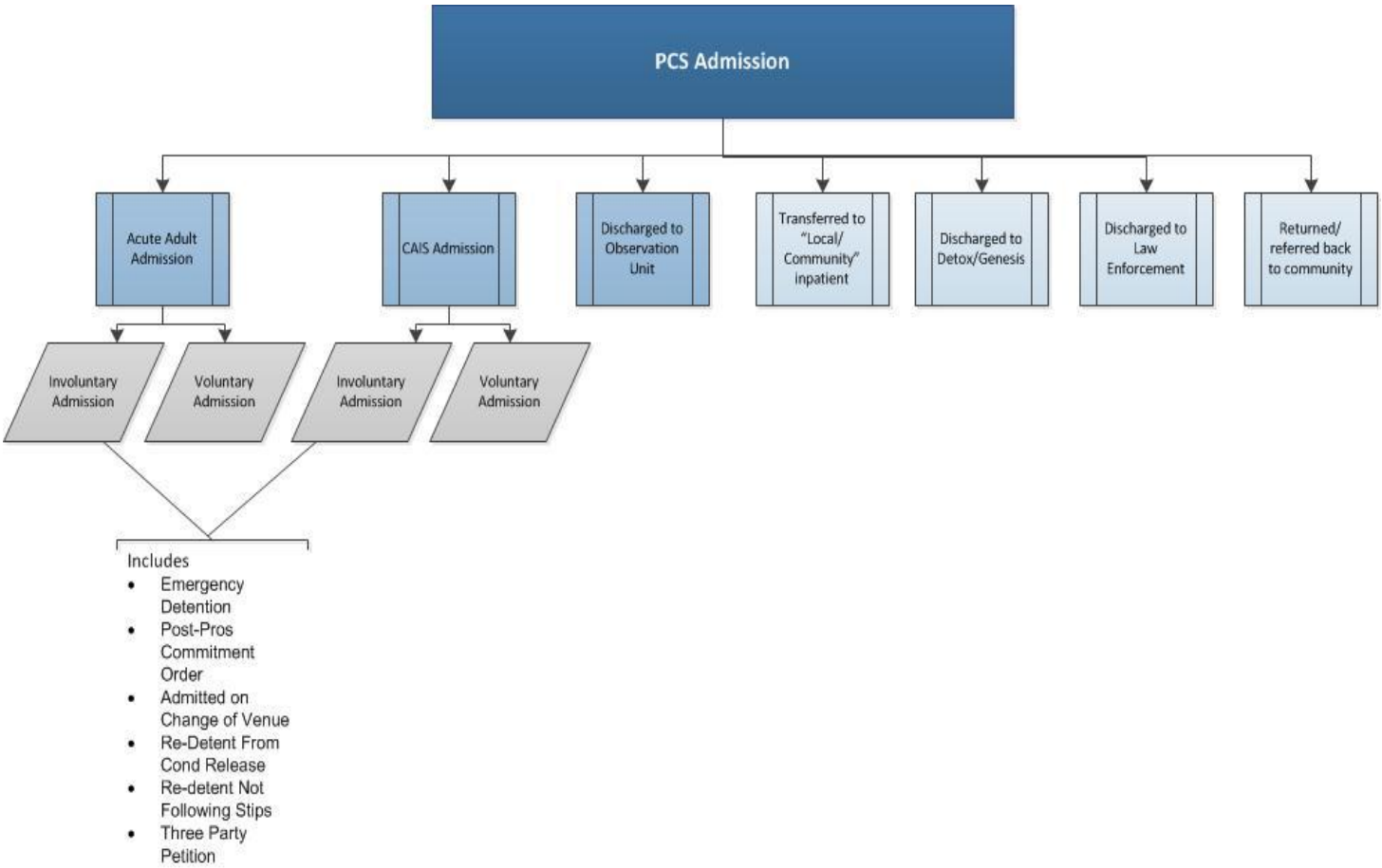
Graph 6: Percent of Individuals Returning to PCS within 90 Days



Disposition of Individuals to Inpatient Levels of Care or Community/Home

After an individual is assessed at PCS and a level of care is determined, s/he can be either voluntarily or involuntarily admitted to the Complex's adult or CAIS inpatient units, discharged to the Observation Unit, transferred to a private hospital for inpatient care or discharged back into the community for appropriate services (detox, justice or outpatient community services). The graphic below depicts these options.

Chart 1: Disposition of Individuals Assessed through PCS



The success with which BHD has partnered with private systems to identify and transfer appropriate individuals is demonstrated in the metrics around the use of PCS, including the disposition of consumers to private hospitals. The percentage of involuntary admissions as a percentage of PCS admissions is depicted as well. The bullets below provide context to these outcome metrics reflected in the following graphs and table.

Graph 7: Percentage of PCS Admissions Transferred/Discharged to Inpatient Levels of Care and Community/Home

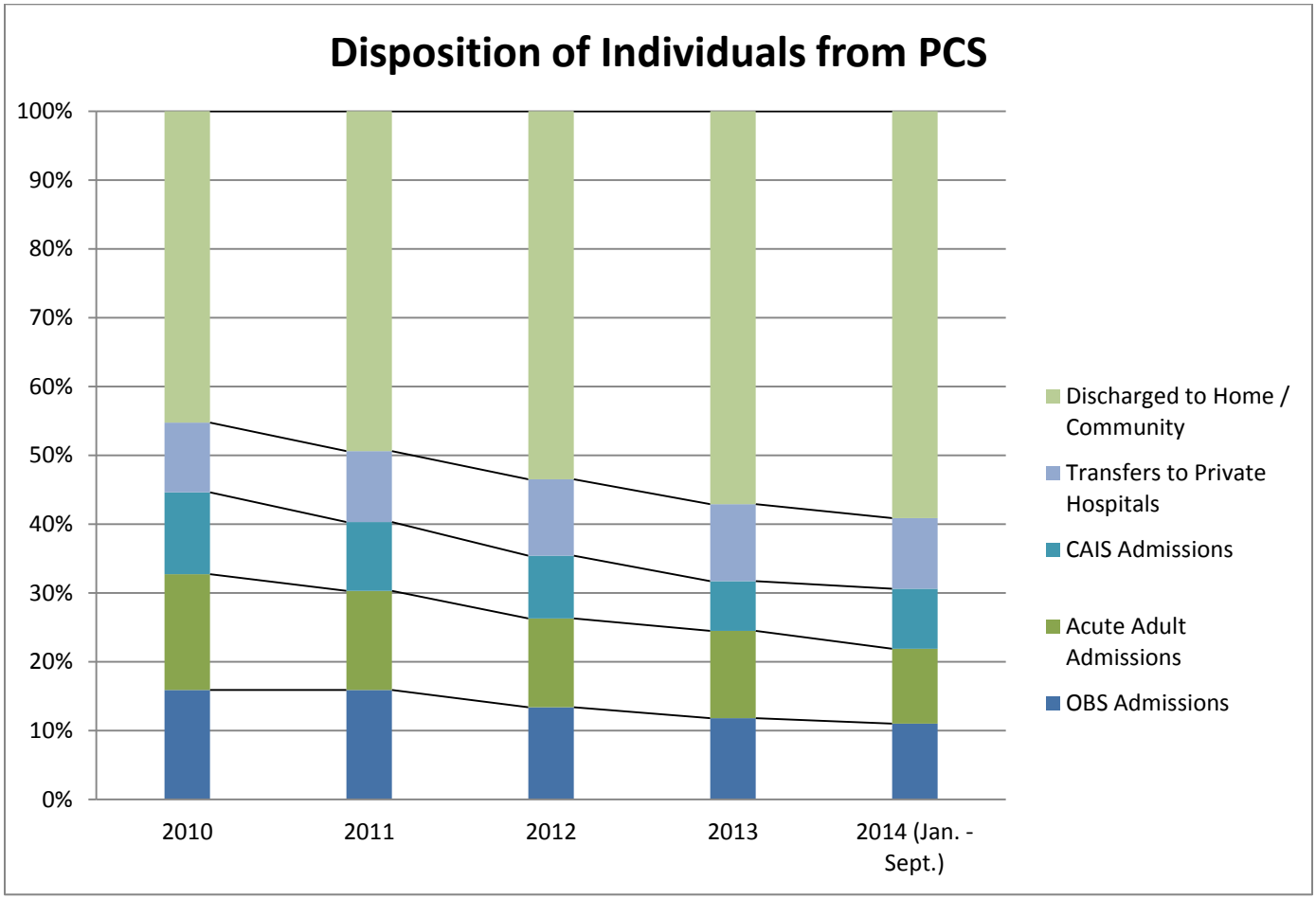


Table 5: Disposition of Individuals from PCS to Inpatient Levels of Care and Community/Home

Year	Month	PCS Admissions	OBS Admissions		Acute Adult Admissions		CAIS Admissions		Transfers to Private Hospitals		Discharged to Home / Community		Total	
2010	Jan	1,129	184	16.3%	197.0	17.4%	133	11.8%	98	8.7%	517	45.8%	1,129	100%
	Feb	1,093	175	16.0%	203.0	18.6%	117	10.7%	102	9.3%	496	45.4%	1,093	100%
	Mar	1,226	168	13.7%	215.0	17.5%	169	13.8%	121	9.9%	553	45.1%	1,226	100%
	Apr	1,100	163	14.8%	196.0	17.8%	138	12.5%	83	7.5%	520	47.3%	1,100	100%
	May	1,243	168	13.5%	185.0	14.9%	163	13.1%	93	7.5%	634	51.0%	1,243	100%
	Jun	1,129	168	14.9%	177	15.7%	113	10.0%	110	9.7%	561	49.7%	1,129	100%
	Jul	1,135	208	18.3%	198.0	17.4%	120	10.6%	120	10.6%	489	43.1%	1,135	100%
	Aug	1,136	204	18.0%	202.0	17.8%	107	9.4%	131	11.5%	492	43.3%	1,136	100%
	Sep	1,113	170	15.3%	180.0	16.2%	135	12.1%	136	12.2%	492	44.2%	1,113	100%
	Oct	1,054	167	15.8%	190.0	18.0%	137	13.0%	131	12.4%	429	40.7%	1,054	100%
	Nov	1,040	176	16.9%	168.0	16.2%	135	13.0%	113	10.9%	448	43.1%	1,040	100%
	Dec	1,046	192	18.4%	143.0	13.7%	134	12.8%	124	11.9%	453	43.3%	1,046	100%
	Total	**13,444**	**2,143**	**15.9%**	**2,254**	**16.8%**	**1,601**	**11.9%**	**1,362**	**10.1%**	**6,084**	**45.3%**	**13,444**	**100%**
2011	Jan	1,075	183	17.0%	153.0	14.2%	122	11.3%	123	11.4%	494	46.0%	1,075	100%
	Feb	1,093	175	16.0%	203.0	18.6%	117	10.7%	102	9.3%	496	45.4%	1,093	100%
	Mar	1,179	207	17.6%	174.0	14.8%	142	12.0%	143	12.1%	513	43.5%	1,179	100%
	Apr	1,107	181	16.4%	149.0	13.5%	131	11.8%	135	12.2%	511	46.2%	1,107	100%
	May	1,187	181	15.2%	172.0	14.5%	136	11.5%	129	10.9%	569	47.9%	1,187	100%
	Jun	1,108	184	16.6%	174.0	15.7%	122	11.0%	117	10.6%	511	46.1%	1,108	100%
	Jul	1,103	180	16.3%	147.0	13.3%	97	8.8%	118	10.7%	561	50.9%	1,103	100%
	Aug	1,155	175	15.2%	157.0	13.6%	84	7.3%	115	10.0%	624	54.0%	1,155	100%
	Sep	1,069	156	14.6%	149.0	13.9%	93	8.7%	112	10.5%	559	52.3%	1,069	100%
	Oct	1,127	177	15.7%	157.0	13.9%	120	10.6%	99	8.8%	574	50.9%	1,127	100%
	Nov	1,035	153	14.8%	144.0	13.9%	91	8.8%	86	8.3%	561	54.2%	1,035	100%
	Dec	1,051	159	15.1%	135.0	12.8%	75	7.1%	91	8.7%	591	56.2%	1,051	100%
	Total	**13,289**	**2,111**	**15.9%**	**1,914**	**14.4%**	**1,330**	**10.0%**	**1,370**	**10.3%**	**6,564**	**49.4**	**13,289**	**100%**

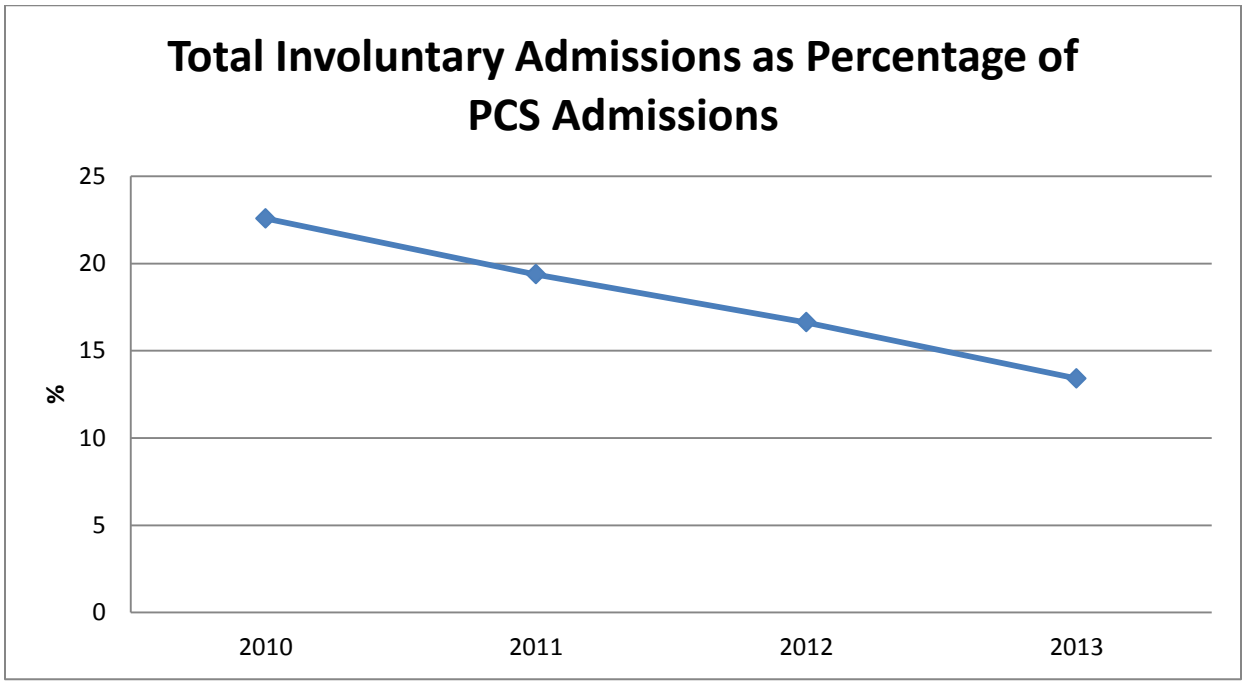
Year	Mon-th	PCS Ad-missions	OBS Admissions		Acute Adult Admissions		CAIS Admissions		Transfers to Private Hospitals		Discharged to Home / Community		Total	
2012	Jan	1,130	166	14.7%	136.0	12.0%	112	9.9%	142	12.6%	574	50.8%	1,130	100%
	Feb	989	127	12.8%	127.0	12.8%	103	10.4%	128	12.9%	504	51.0%	989	100%
	Mar	1,115	140	12.6%	130.0	11.7%	131	11.7%	152	13.6%	562	50.4%	1,115	100%
	Apr	1,101	151	13.7%	152.0	13.8%	104	9.4%	155	14.1%	539	49.0%	1,101	100%
	May	1,150	152	13.2%	139.0	12.1%	129	11.2%	131	11.4%	599	52.1%	1,150	100%
	Jun	1,058	137	12.9%	142.0	13.4%	84	7.9%	109	10.3%	586	55.4%	1,058	100%
	Jul	1,085	152	14.0%	156.0	14.4%	70	6.5%	119	11.0%	588	54.2%	1,085	100%
	Aug	1,078	146	13.5%	142.0	13.2%	79	7.3%	104	9.6%	607	56.3%	1,078	100%
	Sep	1,014	131	12.9%	114.0	11.2%	87	8.6%	92	9.1%	590	58.2%	1,014	100%
	Oct	1,004	125	12.5%	152.0	15.1%	95	9.5%	104	10.4%	528	52.6%	1,004	100%
	Nov	943	123	13.0%	119.0	12.6%	72	7.6%	98	10.4%	531	56.3%	943	100%
	Dec	1,031	153	14.8%	131.0	12.7%	87	8.4%	78	7.6%	582	56.5%	1,031	100%
	Total	**12,698**	**1,703**	**13.4%**	**1,640**	**12.9%**	**1,153**	**9.1%**	**1,412**	**11.1%**	**6,790**	**53.5%**	**12,698**	100%
2013	Jan	975	148	15.2%	134.0	13.7%	97	9.9%	81	8.35	515	52.8%	975	100%
	Feb	923	125	13.5%	120.0	13.0%	42	4.6%	110	11.9%	526	57.0%	923	100%
	Mar	1,017	127	12.5%	122.0	12.0%	70	6.9%	123	12.1%	575	56.5%	1,017	100%
	Apr	986	97	9.8%	122.0	12.4%	79	8.0%	94	9.5%	594	60.2%	986	100%
	May	986	110	11.2%	122.0	12.4%	87	8.8%	106	10.8%	561	56.9%	986	100%
	Jun	937	126	13.4%	112.0	12.0%	52	5.5%	115	12.3%	532	56.8%	937	100%
	Jul	978	128	13.1%	149.0	15.2%	60	6.1%	103	10.5%	538	55.0%	978	100%
	Aug	956	117	12.2%	117.0	12.2%	63	6.6%	73	7.6%	586	61.3%	956	100%
	Sep	974	104	10.7%	119.0	12.2%	75	7.7%	94	9.7%	582	59.8%	974	100%
	Oct	1,017	97	9.5%	119.0	11.7%	66	6.5%	132	13.0%	603	59.3%	1,017	100%
	Nov	838	87	10.4%	105.0	12.5%	66	7.9%	125	14.9%	455	54.3%	838	100%
	Dec	877	86	9.8%	115.0	13.1%	72	8.2%	125	14.3%	479	54.6%	877	100%
	Total	**11,464**	**1,352**	**11.8%**	**1,456**	**12.7%**	**829**	**7.2%**	**1,281**	**11.2%**	**6,546**	**57.1%**	**11,464**	100%
2014	Jan	888	80	9.0%	110.0	12.4%	85	9.6%	111	12.5%	502	56.5%	888	100%
	Feb	835	89	10.7%	99.0	11.9%	80	9.6%	92	11.0%	475	56.9%	835	100%
	Mar	882	84	9.5%	95.0	10.8%	75	8.5%	83	9.4%	545	61.8%	882	100%
	Apr	914	91	10.0%	100.0	10.9%	88	9.6%	94	10.3%	541	59.2%	914	100%
	May	940	118	12.6%	75.0	8.0%	91	9.7%	91	9.7%	565	60.1%	940	100%
	Jun	916	114	12.4%	99.0	10.8%	70	7.6%	84	9.2%	549	59.9%	916	100%
	Jul	831	100	12.0%	94.0	11.3%	68	8.2%	74	8.9%	495	59.6%	831	100%
	Aug	935	120	12.8%	88.0	9.4%	74	7.9%	99	10.6%	554	59.3%	935	100%
	Sep	891	90	10.1%	112.0	12.6%	70	7.9%	98	11.0%	521	58.5%	891	100%

The table and graphs below depict the rate of involuntary admissions (Emergency Detention, Post-Pros Commitment Order, Admitted on Change of Venue, Re-Detent from Conditional Release Re-Detent Not Following Stipulations, Three Party Petition). While Emergency Detentions make up the majority of involuntary admissions, there is a small percentage (between 7-15% of Adult Acute involuntary admissions and less than 1% of CAIS involuntary admissions) of admissions categorized as third party petitions and Treatment Director's holds). Consideration of these other admissions round out the picture of individuals under involuntary commitment in Milwaukee County.

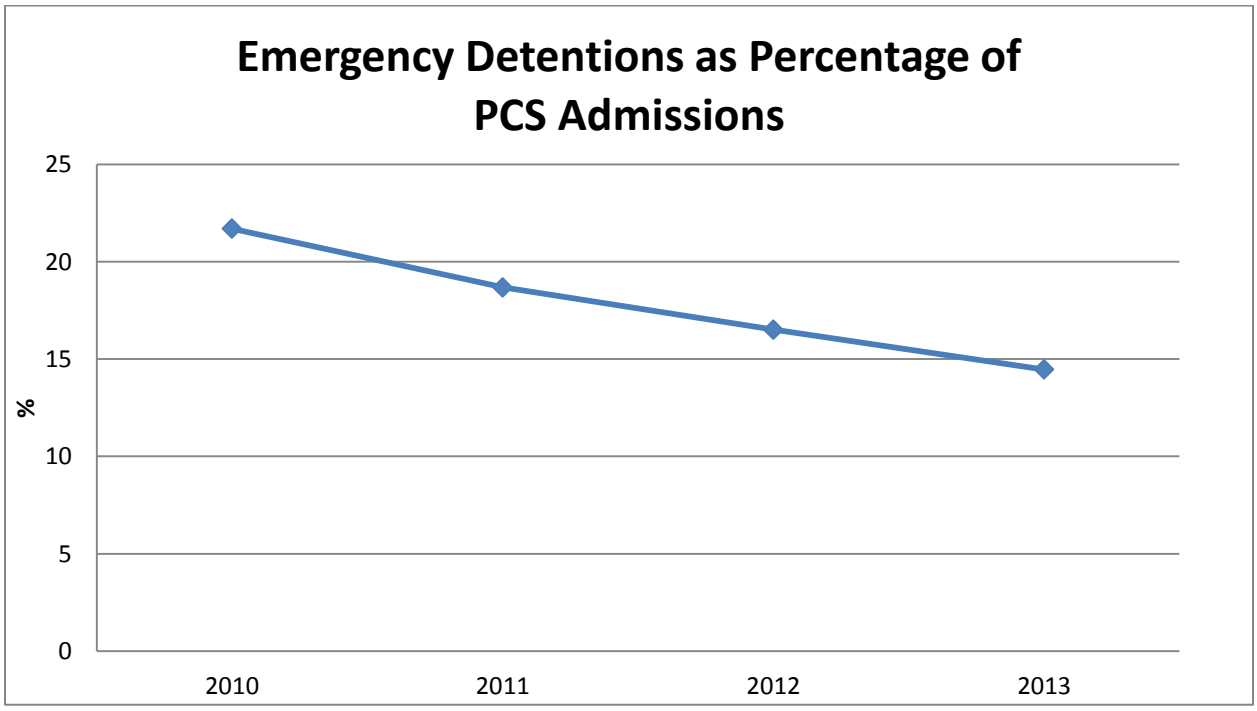
Year	Acute Adult Unit					
	Acute Adult Total Admits	Acute Adult ED Admits	Acute ED Admit%	Additional Involuntary Admits	Total Acute Adult Involuntary Admits	Acute Involuntary Admit%
2010	2,254	1,518	67.3%	118	1,636	72.6%
2011	1,914	1,291	67.5%	123	1,414	73.9%
2012	1,640	1,089	66.4%	138	1,227	74.8%
2013	1,456	960	65.9%	137	1,097	75.3%
2014 (Jan. 1 – Nov. 16)	1,163	779	67.0%	133	912	78.4%

Year	CAIS Unit					
	CAIS Total Admits	CAIS ED Admits	CAIS ED Admit%	Additional Involuntary Admits	Total CAIS Involuntary Admits	CAIS Involuntary Admit %
2010	1,601	1,399	87.4%	-	1,399	87.4%
2011	1,330	1,191	89.5%	-	1,191	89.5%
2012	1,153	1,008	87.4%	-	1,008	87.4%
2013	829	698	84.2%	7	705	85.0%
2014 (Jan. 1 – Nov. 16)	935	833	89.1%	3	836	89.4%

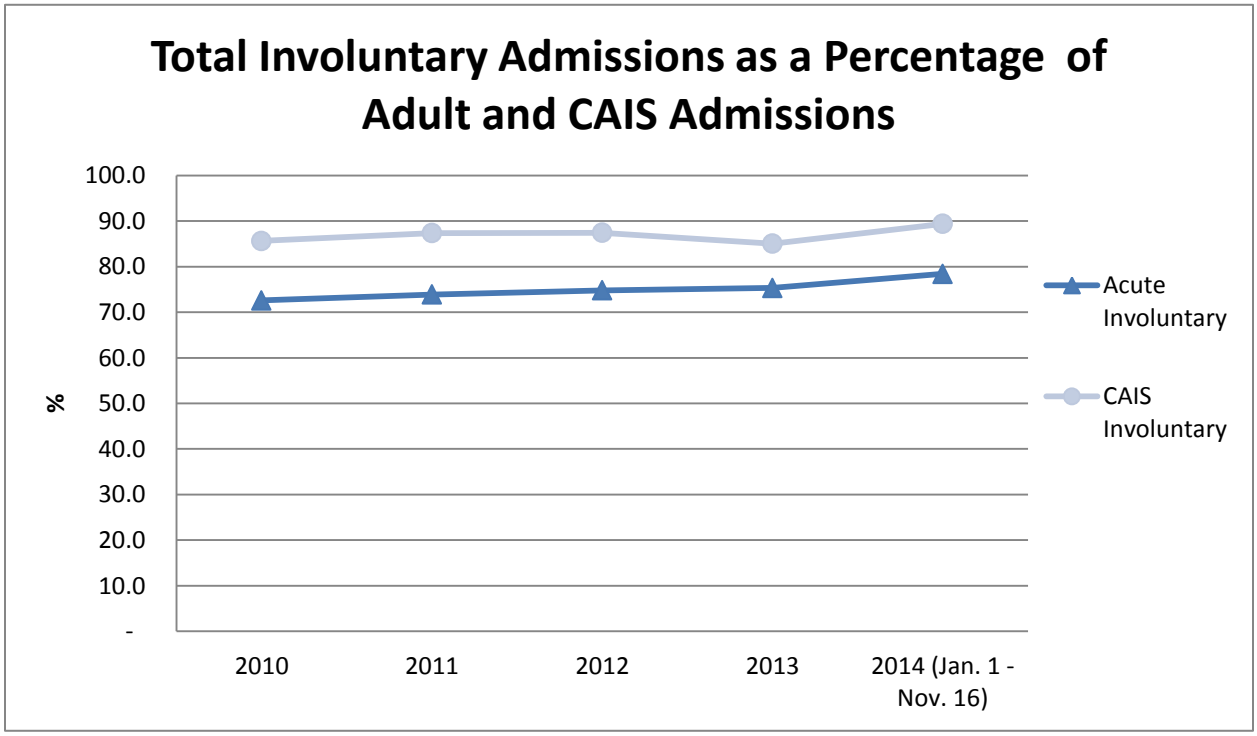
Graph 8: Total Involuntary Admissions as a Percentage of PCS Admissions



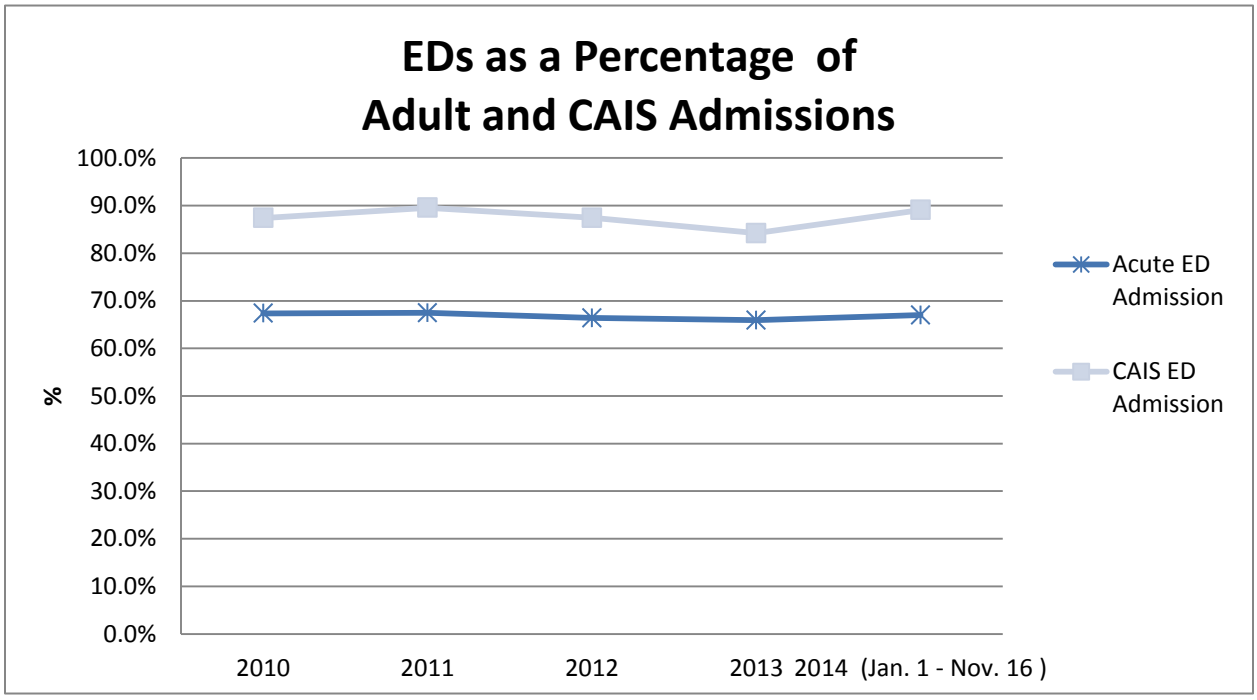
Graph 9: ED Admissions as a Percentage of PCS Admissions (Subset of Total Involuntary Admissions)



Graph 10: Involuntary Admissions as a Percentage of Total Adult Acute and CAIS Admissions



Graph 11: Emergency Detentions as a Percentage of Adult Acute and CAIS Admissions



Note, BHD projects that the rate of PCS admissions resulting in EDs in 2014 to be 54%.

- **Declining rates of Psychiatric Crisis Service (PCS) admissions and emergency detentions**. According to the 2010-2014 Q1 Milwaukee County Behavioral Health Division Utilizations Trends report, the average number of PCS admissions per month has decreased 23% from 2010 to 2014. Similarly there has been seven-point decrease in the number of emergency detentions as a percentage of PCS admissions. BHD believes the reduction in emergency detentions are driving the reduction in PCS admissions overall. Finally, the percentage of PCS admissions transferred to community hospitals has increased slightly from 10.1% (in 2010) to 11.2% (2013).

- **Declining frequency with which the Complex invokes wait list and diversion status to community providers.** BHD reports that its partnership efforts have led to a significant reduction in Wait List Status. In 2007, BHD was on Wait List Status 48% of the time; in 2013 that number reduced to below 3%. Thus far in 2014, the numbers have increased to 6.7%.

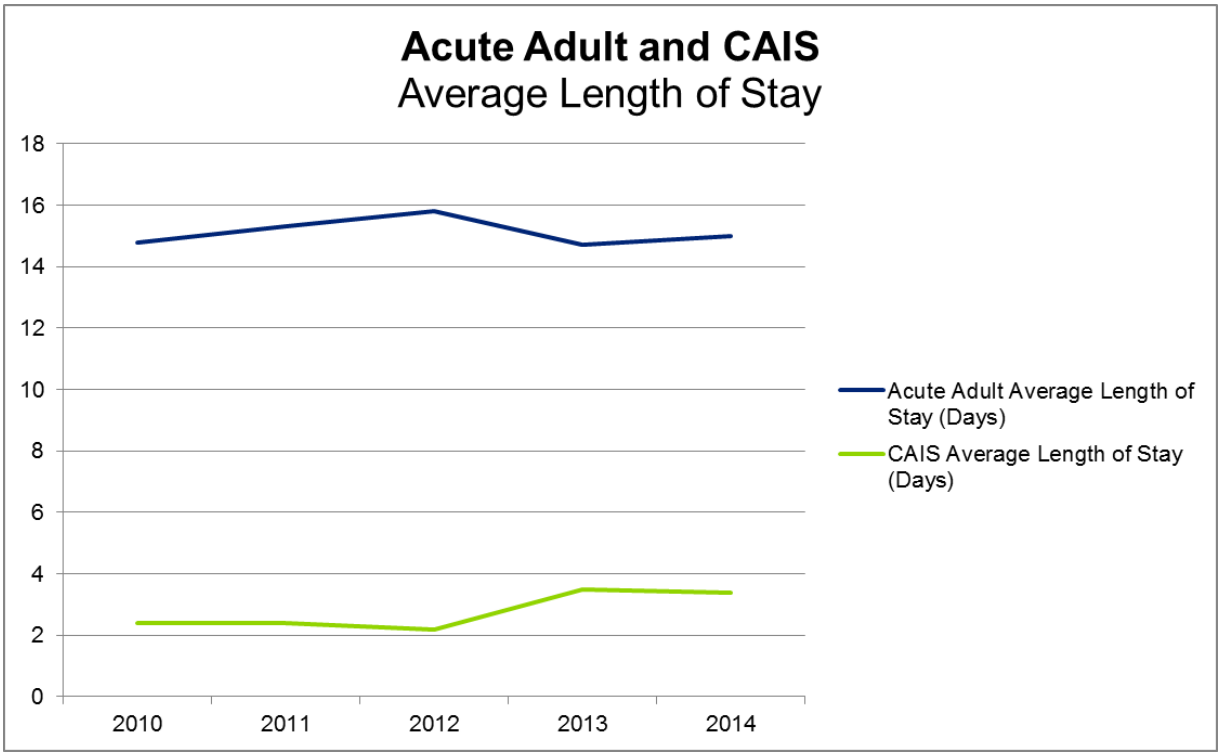
  According to BHD, Observation beds are another absolutely essential element in minimizing the frequency and duration of Wait List events. The Complex enters Wait List Status when there are five beds or fewer in the BHD system, (Acute and Observation beds combined). Typically it is available Observation beds that allow BHD to avoid Wait List Status. The unit is staffed with a full clinical team, however it is seen as either a rapid stabilization unit or a unit that is used when more time is required for disposition decisions.

  When on Wait List Status any individual requiring transfer from a private hospital setting must wait to send the individual to BHD until beds open up. If Observation Beds, Inpatient Beds and PCS all are filled to capacity, then BHD moves to Full Diversion Status. When on full diversion, essentially PCS closes and individuals must be seen at a private hospital emergency. BHD reports that full diversion status is extremely rare, "[we] have not had to go on diversion in several years, but we have been close recently."

BHD tracks additional performance metrics that demonstrate mixed results. For example, the rate of incidents per patient days demonstrates a decreasing rate of elopements, patient falls (falls and falls with injury), adverse medication events causing harm and suicide attempts. The Complex has experienced an increasing rate of contraband, aggression (patient-to-patient and patient-to-employee), medical emergencies, self-inflicted injuries and sexual contact.
BHD also reports that average length of stay at the Complex is steadily increasing. The average length of stay within the acute adult units increased slightly from 2010-2014 from 14.8 days to 15 in the acute adult inpatient unit. The median increased from 7 to 9 days in that same time

period. For children and adolescents, the average has increased roughly 40% from 2.4 days to 3.4 days.

Graph 12: Acute Adult and CAIS Average Length of Stay (2010-2014)



Additional Considerations of Finding #1

1) **Outcomes measurement strategy aligned with Hospital-Based Inpatient Services (HBIPS)**. BHD tracks the rate of individuals discharged on multiple antipsychotic medications and the percentage of individuals discharged on multiple antipsychotic medications with appropriate justification. Antipsychotic polypharmacy is an example of core performance measures for HBIPS developed by the Joint Commission and the National Association of Psychiatric Health Systems (NAPHS), the National Association of State Mental Health Program Directors (NASMHPD) and the NASMHPD Research Institute, Inc. (NRI). As BHD continues to pursue Joint Commission accreditation for the Complex, it will be required to use the HBIPS core measure set for free-standing psychiatric hospitals, use a Joint Commission-listed vendor and submit data to the Joint Commission on all applicable measures that comprise the HBIPS core measure set[20].

[20] http://www.jointcommission.org/assets/1/6/HBIPS.pdf

BHD can integrate HBIPS measurement into its evolving Quality Management and Electronic Medical Record (EMR) roll-out plan for 2015. Since the core set is an industry-accepted measurement of quality, achievement rates can be shared transparently with community, state and federal stakeholders. It will also allow for the comparison of the Complex with other free-standing psychiatric hospitals in Wisconsin such as Aurora, Rogers and the state mental health facilities.

2) **Adjustment of utilization metrics by consumer population risk/acuity/health status.** There are challenges in attributing reductions in inpatient admissions, readmissions and EDs directly to improved access to care and quality services when the acuity/health status of the consumer population is not understood and tracked. Currently, the declining rate of admission and readmission suggests that consumer health status/acuity remains constant. Yet, BHD makes the assumption that its inpatient population is growing more complex, based on clinical experience on the increasing length of stay. Confounding this contradiction is the lack of a standardized method to determine health status in individuals with mental illness and substance use/abuse.

BHD, itself reports,

> At this time, there are no widely accepted, validated global measures of acuity in psychiatry. Conceptually, attributes of acuity are severity, intensity and the pairing of acuity measurements with another concept such as level or location or care provision, medical versus psychological co-morbidity, degree of engagement, severity of dangerous behaviors, etc. Thus far (BHD has] operationalized two measures or processes. [BHD uses] the Broset Violence Checklist (BVC), this is a validated, reliable, easily administered measure that is accurate in predicting likelihood of short-term violence and have paired this with a functional screen of risk factors including presence of complex, difficult-to-manage patient symptoms that the private hospital exclude such as pica or psychogenic polydypsia, complex risk/legal issues that private hospitals exclude such as recent arson, sexual offender status or criminal commitment conversion, recent aggressive or violent behavior, and history of documented repeated treatment failures at that facility.[21]

Nevertheless, it would benefit BHD to explore using surrogate measures of risk/acuity/health status such as comparisons between admission and discharge diagnosis or integrating a case mix algorithm (i.e. Johns Hopkins Adjusted Clinical Groupers or 3M's Clinical Risk Groupers) as it gains more functionality within the EMR system and potentially through its Joint Commission accreditation process. A further

[21] Follow-up Questions and Clarifications of Data Requests. BHD to Deloitte Team.

exploration of the concept of population risk/acuity/health status is discussed later in this assessment.

3) **Leverage the quality management process to measure the extent to which outcomes, such as length of stay (LOS), correlate to the level of integration between acute and community setting.** The average LOS at the Milwaukee County Complex hovers around 15 days. A study published by Psychiatric Services (2012)[22] examining the extent to which hospital and regional characteristics correlate to LOS for patients with serious mental illness found that the average LOS was 10.0 ± 3.0 day. In addition, the presence of housing resources funded by county mental health programs was found to be associated with variations in length of hospitalization. The study points out the need to study the impact of interventions performed in inpatient setting, i.e. post-discharge planning and care coordination with community providers and HMOs on quality outcomes.

4) **To accomplish the capture and measurement of member-level outcomes, additional effort will be required on the part of BHD for cross-program, cross-payer alignment and data availability/exchange.** A discussion of the IT and data infrastructure needs are discussed in Finding #11.

Finding 2: The Mental Health Complex serves a unique role within the Milwaukee community by virtue of the high-acuity population it serves. It's clear that the private hospitals rely on BHD to care for this more complex group of consumers; they in turn, have a role in serving low-moderate acuity individuals. There are processes in place to identify low-moderate individuals appropriate for care in private hospitals; yet, given the low rate of transfers of these consumers there may be opportunities to strengthen the intake and referral policies, payment incentives, etc. in order to better optimize high-acuity bed capacity at the Complex.

[22] http://ps.psychiatryonline.org/doi/abs/10.1176/appi.ps.201100412?url_ver=Z39.88-2003&rfr_id=ori%3Arid%3Acrossref.org&rfr_dat=cr_pub%3Dpubmed

Role of Safety Net Provider

When applying the definition of safety net provider adopted by the Institute of Medicine23—meaning those providers that deliver a significant level of health care to uninsured, Medicaid, and other vulnerable consumers—the Mental Health Complex meets that criteria more so than other private providers in the County. Supporting this notion is the broad consensus among Milwaukee County stakeholders that the Complex plays an important role as an inpatient provider for highly complex consumers who have diagnoses, histories, socioeconomic factors, care coordination needs and payment considerations that make treatment in a private hospital less conducive to their recovery. It was even noted by one stakeholder that treatment of a higher acuity population requires clinicians with a special type of expertise and passion, and that private providers may not meet physical or clinical capacity requirements to serve higher acuity individuals with complex social needs.

Inpatient Bed Capacity at the Complex

There is general agreement among stakeholders the methodology used in the inpatient study for determining appropriate inpatient capacity is strong. Findings from the 2014 *Analysis of Adult Bed Capacity* determined that a range of 54-60 beds is needed to serve the highest acuity individuals and that 128-134 beds provide adequate capacity to serve low to moderate acuity individuals. BHD leadership reported agreement with the range put forth by the *Analysis of Adult Bed Capacity* Report and noted that BHD would be operating at 54 beds if not for the loss of beds at Columbia/St. Mary's and Aurora.

Intake and Referral of Low-Moderate Acuity Consumers

BHD reports that over the past six to seven years, there has been a major focus to transfer as many individuals as possible into the private system. This allows BHD to manage census much more proactively and maintain its role of a high-acuity provider. According to BHD, it has established MOUs with Aurora Psychiatric Hospital, Aurora St Luke's Southshore, Rogers Memorial, and St. Francis to be detaining facilities (i.e. inpatient psychiatric facilities). According to the 2014 *Analysis of Adult Bed Capacity*, private hospital systems now operate 68% of the psychiatric beds and account for 85% of total psychiatric admissions.

BHD has developed a methodology to screen individuals for possible transfer to private hospitals, excluding any individual that exhibits complex, difficult to manage symptoms (i.e., pica or psychogenic polydipsia), complex risk/legal issues such as recent arson, or sex offender status. This intake and referral process demonstrated in Appendix 1 also has a dedicated transfer coordinator to procure beds at a partner MOU facility (individuals on emergency detention) or any in-network provider for individuals admitted on a voluntary basis. Despite this, Wisconsin State Statute 51.15(2) allows for private hospitals to refuse to detain the patient.

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[23] **AMERICA'S HEALTH CARE SAFETY NET INTACT BUT ENDANGERED. Institute of Medicine. 2000. Retrieved from:** http://iom.edu/~/media/Files/Report%20Files/2000/Americas-Health-Care-Safety-Net/Insurance%20Safety%20Net%202000%20%20report%20brief.pdf

The table below demonstrates historical acceptance rates at each of the private providers, including an aggregate analysis on T-19 (non-IMD) facilities and non T-19 (IMD) facilities. Note that for the first half of 2014, 68% of the time that an attempt was made to transfer an individual to a T-19 Hospital, the facilities were at capacity and 10% of the time, they were not accepted for other reasons.

Table 6: Acceptance Rates for Private Hospitals from PCS (Representative Sample from January – June 2014)*

Hospital	Individuals eligible for transfer for particular hospital (denominator)	Accepted	Declined	No Bed Available
*Aurora	257	67%	5%	28%
Aurora SLSS	211	15%	7%	78%
*Rogers	147	60%	7%	33%
St. Francis	221	30%	10%	60%
Columbia St. Mary's	5	20%	80%	0%
*VA Facilities	2	50%	50%	0%
TOTAL	843	42%	8%	50%

Hospital Type	Individuals eligible for transfer for particular hospital type	Accepted	Declined	No Bed Available
Non-IMD ("T19" Hospitals)	437	22%	10%	68%
*IMD ("non-T19" Hospitals)	406	64%	6%	30%

* IMD ("non-T19") Hospitals

Note that numbers listed above do not represent the entire universe of individuals referred to the private hospital system, they are a representative sample. This data is only tracked during hours when there are staff in the emergency room dedicated to transferring individuals. In addition, this assessment was not able to clarifying with BHD if private hospitals have different criteria for which they will accept transfers—noted by differing denominators for each hospital.

Of the 843 low-moderate risk/acuity individuals eligible for transfer to a private hospital from January – July 2014, only 42% were accepted by private hospitals.

Current referral patterns suggest that the private hospitals don't accept referrals of low-moderate acuity consumers (those that meet criteria) 100% of the time. So as a result, BHD uses beds for these lower risk consumers. Perhaps if there were financial incentives, standardized methods of gauging acuity across the system, etc. then the bed at the Complex would be available for the high-acuity individuals that are excluded from being referred elsewhere.

Additional Considerations of Finding #2:

1) **More rigorous processes and agreements with private system providers to assume responsibility for low-moderate acuity consumers.** BHD has an opportunity to engage members of the Mental Health Board to establish a system-wide transfer criterion to allow for objective, timely, seamless and person-centered transfer of individuals to private hospitals. The 2014 *Analysis of Adult Bed Capacity* report describes attributes a lack of clear guidelines around inpatient bed capacity and responsibility. "The lack of formal system criteria with regard to admissions is [also] problematic, as individual providers can establish their own criteria that are determined by variables such as patient acuity or payer factors. Payer factors may become an increasing concern as private hospitals engage in managed care and create accountable care networks that will drive bed capacity."

   Common, transparent view of consumers through a system-wide tool for consumer intake, referral and patient management across the system that eliminates subjectivity when determining eligibility and responsibility for transfer. There may be opportunities for DHS, BHD and private hospital partners to create a more transparent view into bed availability that would better inform referral processes and determine appropriate staff and overall system reconfiguration to support individual transitions to private hospitals in a sustainable manner.

2) **Explore incentives.** Multiple stakeholders noted that there are currently no financial incentives for private providers to accept a higher percentage of referrals/transfers. In fact, it was reported that the inadequacy of outpatient and housing resources creates disincentives for private providers to accept transfers as this may result in longer inpatient stays. There are opportunities to pursue strategies for more stringent

contracting and provision of financial incentives for private systems to accept transfer of low-moderate acuity individuals.

3) **Initiate care coordination process with HMOs as part of initial discharge planning.** Discharge planning is an essential process in order to prevent recurrent readmission to inpatient psychiatric care. Although this assessment was not able to gain access to discharge planning protocols within the Complex, it is assumed that, at a minimum, linkages with community services including supportive housing, psychosocial rehabilitation, peer supports and specialized behavioral health services are coordinated in the early stages of inpatient stay. During this process, Complex staff should prioritize outreach to the individual's HMO in the case they are insured by Wisconsin Medicaid. BadgerCare and SSI HMO plans are required to involve and engage consumers in selecting providers and treatment options to ensure access to culturally competent providers, culturally appropriate treatment and to make sure their medical needs are met. As Complex staff provides similar planning, best practices would indicate teaming with HMO staff to coordinate care.

4) **Strategic planning predicated on the Complex's continued role as a safety net behavioral health provider and in alignment with future capacity needs for high acuity consumers.** BHD's development and memorialization of a plan that reflects its understanding of overall financing alternatives should be central to this current/future strategic planning and decision making. A plan should include:
    - Role and implications of the Complex as a safety net provider.
    - State and Federal funding mechanisms to support payment of indigent populations and Medicaid-covered individuals not eligible for transfer to private hospital (for example, emergency detainees, etc.).
    - Policies and procedures/Standard Operating Procedures reflective of highly complex indigent and forensic populations—such as refined staffing models and levels—and in alignment with Joint Commission accreditation standards.
    - Treatment modalities used in inpatient units that differentiate BHD from private systems in the approach it takes to serve high acuity individuals.
    - Infrastructure improvements to create staff efficiencies, capture and report outcomes data, better predict resource needs based on consumer; acuity/risk/health status and minimize volatility that occurs as a result of staff vacancies.
    - Training to lesson workforce volatility, including recruiting and staff performance incentives.

- Identification of specific areas for additional resources and investments to be made; process changes to further reduce inpatient use.

Please note that this assessment discovered numerous gaps in the information received from BHD specific to staffing patterns, detailed levels, training, etc. that limited the ability to evaluate the program.

Inpatient Diversion: Crisis and Community-Based Alternatives and Associated Outcomes

BHD is gradually decreasing the number of inpatient beds; it is seeking to increase access to crisis services and community-based services for those discharged from the hospital or requiring more intensive alternatives to inpatient care. *Transforming the Adult Mental Care Delivery System in Milwaukee County* report (2010) provided recommendations to develop peer-run crisis respites, educate law enforcement and consumers about the Crisis Resource Center and ensure funding for the retention of CRC. The study suggests that funding for crisis alternatives can be found in cost-savings associated with ED and crisis inpatient services and that county funding should be directed toward these resources.

The narrative below provides detail around BHD's investment in crisis and community services.

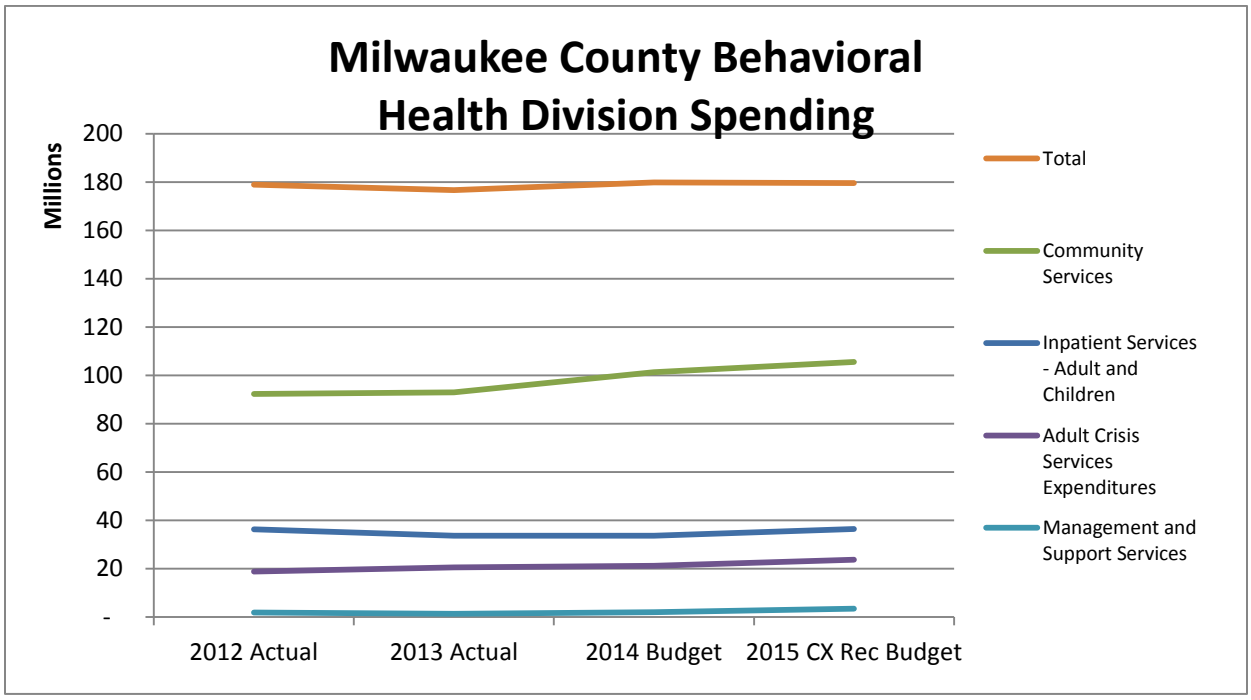
Spending on inpatient services at the BHD Complex (excluding the Hilltop and Central facilities) remained flat from 2013 and 2014, but increased 8% from 2014 to 2015 by $2.7M. Prescription medication expenditures accounted for 24% ($633,998). Professional service contracts accounted for 33% of the increase due to contract and temporary staff at the Complex.

The 2014 BHD recommended budget narrative[24] reports that the savings from downsizing inpatient facilities will be reinvested into community services; however, there didn't appear to be an account of the costs to maintain legacy inpatient infrastructure. The 2014 and 2015 budgets do not specifically list or mention capital costs. It could be included in the $10.5 million budgeted to run Hilltop and Central in 2015, but there is not enough detail to evaluate.

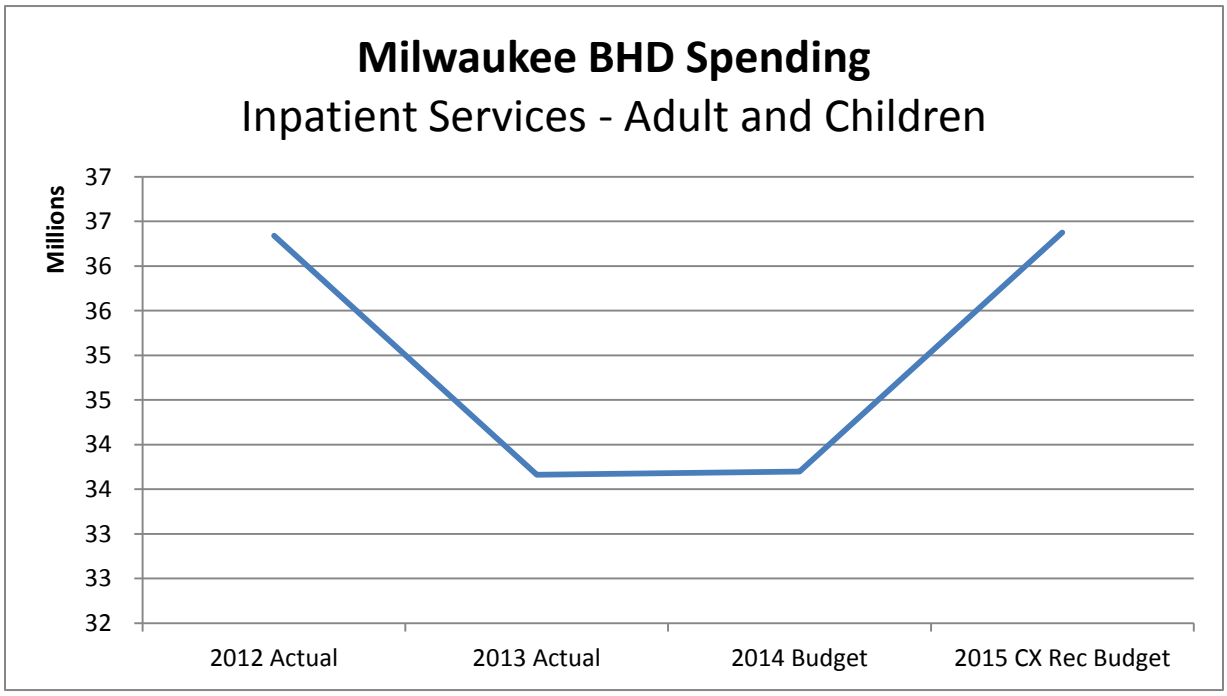
[24] http://county.milwaukee.gov/ImageLibrary/User/bpariseau/2014-Budget-/2014FinalRevisedCEXOperating.pdf

Spending on community services increased 9% from 2013 to 2014, and another 4% from 2014 to 2015. The graphs below depict spending trends.

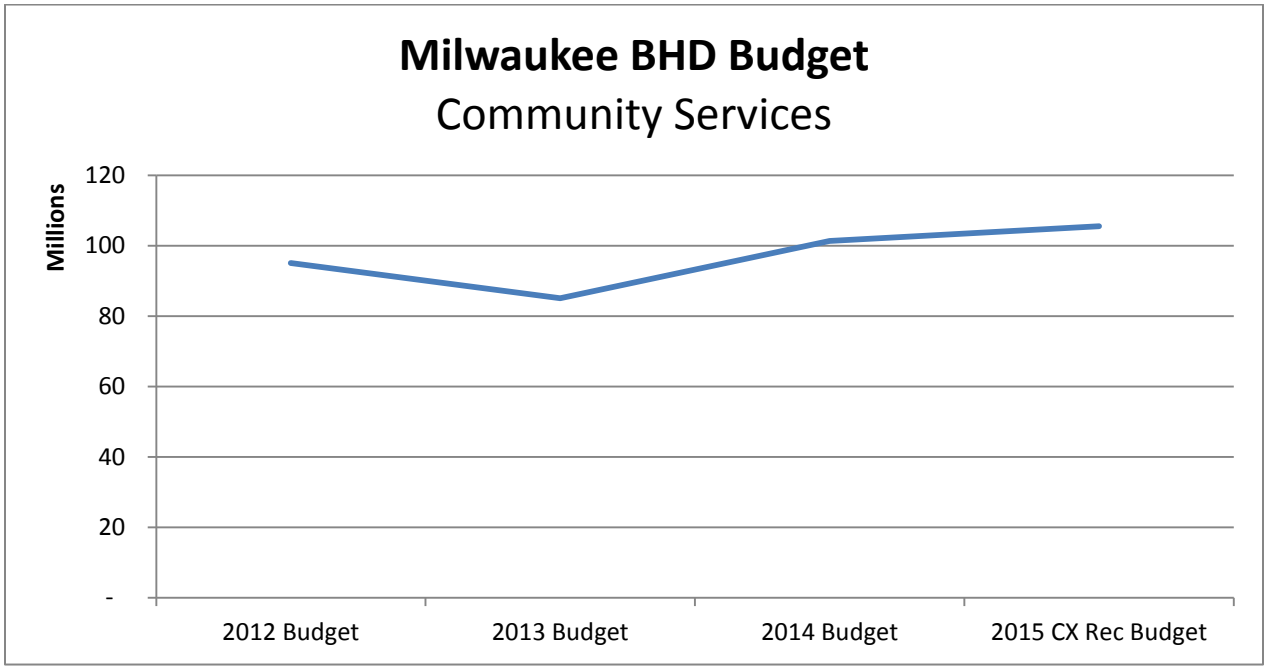
Graph 13: Milwaukee County Behavioral Health Division Spending (2012-2015)



Graph 14: Budget Trend for Inpatient Services Spending (2012-2015)



Graph 15: Budget Trend for Community Services Spending (2012-2015)



The 2014 budget increase included plans to make investments in the following (not an exhaustive list):

- Expanding the Crisis Mobile Team.
- Starting a peer-run drop-in center.
- Continuing to implement the Community Recovery Services program.
- Adding ACT/IDDT models to the existing CSP programs.
- Opening a Southside Access Clinic.
- Creating 40 permanent supportive housing units to serve BHD consumers.
- Developing a Crisis Resource Center for individuals with intellectual/developmental disabilities and a co-occurring mental illness.

The 2015 Budget passed by Mental Health Board increase includes investment in the following (not an exhaustive list):

- Partial-year funding of community placements for Rehab Central clients.
- Contracting of two eight-bed CBRFs.
- Fully implementing the Comprehensive Community Services program.

Below is a table of the Crisis Diversion and Community Based Services for which BHD has made investments in development and growth.

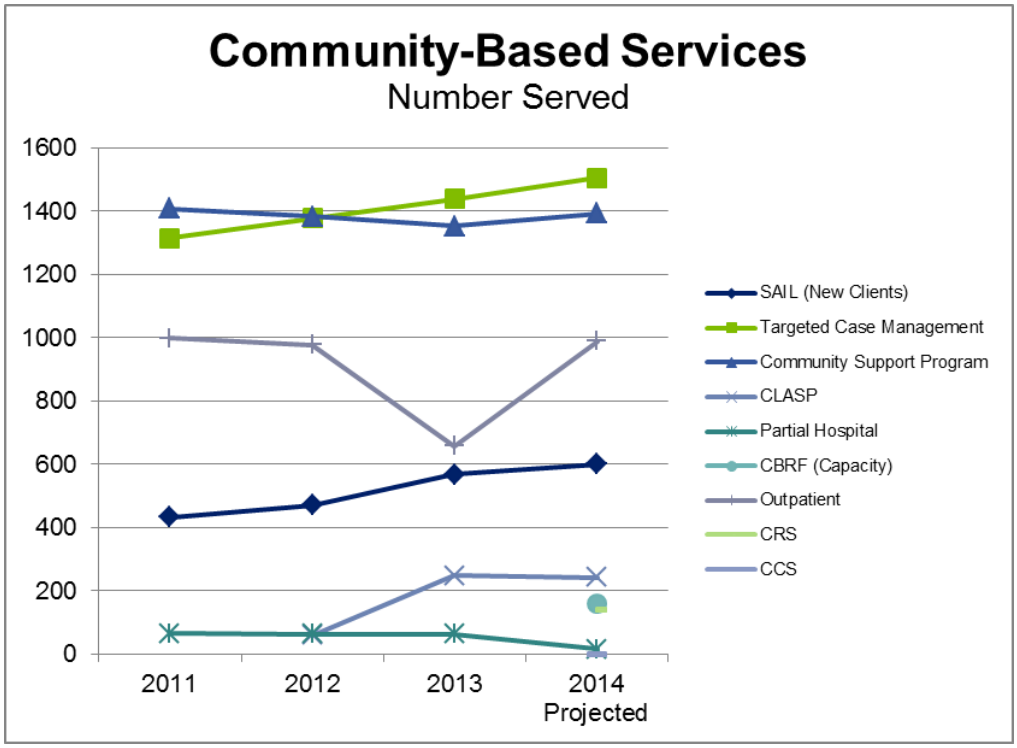
Table 7: Milwaukee County Crisis and Community Based Services

Program	Start Date	Alignment with Transforming the Adult Mental Care Delivery System in Milwaukee County report (2010)	Outcome Metrics Collected	Relevant Notes from BHD 2015 Budget
Targeted Case Management	Pre-2011, expanded in 2014	HSRI Rec 5: Expand & reorganize community-based services	• Consumer satisfaction • Percent in private residence or household • Percent homeless or in shelters • Percent with any kind of employment • Percent with competitive employment • Percent with no criminal involvement in last 6 months • Percent with arrest/incarceration in last 6 months • Percent kept medical care appointment or needed no care • Percent kept dental care appointment or needed no care • Percent kept vision care appointment or needed no care • Percent with activity or other respected status • Percent with no educ, social, or other activity • Percent with high potential for suicide • Percent with no risk factors for suicide • Average psychiatric bed days in past 6 months • Average number of PCS episodes in past 6 months	
CLASP	2012	HSRI Rec 3: Reorganize crisis services & expand alternatives	• Consumer satisfaction • Utilization of inpatient hospitalization; • Frequency of emergency detentions; • Utilization of medical emergency rooms; • Utilization of Psychiatric Crisis Service; • Frequency and type of linkages to community resources; • Maintenance of stable housing.	
MHOP	Pre-2011, expanded in 2013	HSRI Rec 3: Reorganize crisis services & expand alternatives	n/a	
Community Recovery Services	2014	HSRI Rec 5: Expand & reorganize community-based services	n/a	
Comprehensive Community Services	2014	HSRI Rec 5: Expand & reorganize community-based services	Mandated by DHS	

Program	Start Date	Alignment with Transforming the Adult Mental Care Delivery System in Milwaukee County report (2010	Outcome Metrics Collected	Relevant Notes from BHD 2015 Budget
SAIL	Pre-2011		• Approved requests - new clients	
Wiser Choice	Pre-2011		• Consumer satisfaction • Abstinent alcohol 30 days • Abstinent drugs 30 days • Permanent housing • Employed, full or part time • Employed OR Enrolled in school/training • Arrested in past 30 days • Arrested in past 6 months • No supportive family, friend, or group	
Community Support Program	Pre-2011		• Consumer satisfaction • Percent in private residence or household • Percent homeless or in shelters • Percent with any kind of employment • Percent with competitive employment • Percent with no criminal involvement in last 6 months • Percent with arrest/incarceration in last 6 months • Percent kept medical care appointment or needed no care • Percent kept dental care appointment or needed no care • Percent kept vision care appointment or needed no care • Percent with activity or other respected status • Percent with no educ, social, or other activity • Percent with high potential for suicide • Percent with no risk factors for suicide • Average psychiatric bed days in past 6 months • Average number of PCS episodes in past 6 months	$4,418 average dollars expended per CSP slot. BHD will outsource the caseload currently covered by BHD's Community Support Program (CSP) – Downtown and Southside locations and have all 290 caseloads assumed by community providers through purchase of service contract.
Partial Hospital	Pre-2011			
CBRF	Pre-2011		Consumer satisfaction	
Outpatient	Pre-2011			

Just as BHD tracks outcome metrics on the performance of the inpatient system, it gathers and monitors a set of metrics for crisis and community based services to inform policy and practice changes. Among them is utilization of community-based services—as depicted in the graph below. For the majority of services, BHD predicts that it will serve more individuals in 2015 than what was budgeted for in 2014. Actual 2014 utilization was not available.

Graph 16: Number of Consumers Served through Milwaukee County BHD Community-Based Services (2011-2014)



	2011	2012	2013	2014 Projected
SAIL (new clients)	432	470	568	600
Targeted Case Management	1314	1378	1439	1505
Community Support Program	1408	1384	1352	1392
CLASP	n/a	59	248	243
Partial Hospital	65	63	63	16
CBRF (Capacity)	n/a	n/a	n/a	158
Outpatient	998	978	657	988
CRS	n/a	n/a	n/a	140
CCS	n/a	n/a	n/a	92
Access Clinic (new clients)*	1,387	2,283	2,214	TBD

*Not represented in the graph above.

Perhaps the most valid measure of the expansion of access is presented through the number of new individuals served in the SAIL program—the central access point for Milwaukee County residents requiring long term community support such as case management, day treatment, group home placements, and outpatient services. Clients screened and placed through SAIL have increased steadily over the past several years.

Finally, the 2015 BHD budget narrative attributes the decreases in PCS admissions and EDs to increased use of community-based crisis services such as the Crisis Mobile Team and the Crisis Assessment Response Team. BHD reports the ED rate for consumers who receive crisis services at the time of the initial request has dropped from 57.2% in 2012 to 54.1% in 2014.

Additionally, the rate of emergency detention from January 1, 2013 – October 1, 2014 for individuals who are recipients of crisis services more than once in is only 3.7%. Baseline or historical trended data was not available for this assessment.

Finding 3: It does not appear that BHD has fully explored partnerships with community Federally Qualified Health Centers and approaches to integrating care.

While BHD has made progress in developing programs and initiatives specified by the *Alignment with Transforming the Adult Mental Care Delivery System in Milwaukee County* report (2010), it appears that developing partnerships with Federally Qualified Health Centers (FQHCs) has not been fully explored. There are at least seven FQHCs serving Milwaukee and surrounding communities[25] that potentially have co-located behavioral health with physical health services. These providers who offer care coordination and disease management services, should be a close partner with BHD in inpatient discharge planning and with community services as a wraparound clinical service provider.

[25] https://www.dhs.wisconsin.gov/forwardhealth/pdf/fqhc.pdf

Finding 4: Transformation towards a trauma-informed, recovery-oriented, person-centered system is still ongoing within the operations and culture of BHD and provider agency operations.

According to BHD, it is committed to providing "person-centered, trauma informed and culturally competent inpatient services" and has implemented numerous initiatives to align system transformation with this approach. For example it has expanded its use of peer supports and launched a project in 2011 to educate all staff about trauma-informed care.

Yet, additional changes are needed to in order for BHD to embed the approach into every aspect of its operations and culture. At a high-level, there are two community programs being launched for Medicaid eligible members. With the addition of these programs, it appears that the service continuum is fairly complete. It will take time to determine if these investments meet the needs of the population.

Additional Considerations of Finding #4

- While Milwaukee County has greatly increased the number of peer specialists and included them across inpatient and community-based program areas, the current crisis response system does not include involvement of peer specialists.

- It appears that law enforcement in Milwaukee County determines when crisis intervention is activated and this, in turn, has an impact on the setting in which individuals are initially triaged and screened (in the community vs. at the Complex). Media coverage points to lack of training of the law enforcement officials. DHS and/or BHD should consider an analysis to determine the equity—unintentional bias that may occur when the police are determining response—and potential risk of denying civil liberties and its implications for creating a recovery-oriented, person-centered system of care.

- The emergency detention statute requires that consumers in Milwaukee County are brought to the Complex to be evaluated. This can induce additional stress/crisis, stigma, etc.

- Based on stakeholder feedback gathered during this assessment, it is possible that the practice of detaining an individual who initially entered an IPU voluntarily and was later determined to be at-risk based on a physician's decision, presents a significant deterrent to individuals seeking services and potentially violates civil liberties. Also, individuals are held in emergency detention and not released, due to a lack of beds at BHD; this is not person-centered.

- Finally, consumer and advocate feedback reflected a lack of care coordination of services, especially for individuals with more complex needs such as those who have had involvement with the criminal justice system.

Finding 5: Fifty-percent of the evidence based practices (EBP) were initiated on or after 2013; this indicates that provider agencies are at varying stages of fidelity with the EBP models.

The rapid rate of deployment of new Evidence-Based Practices may create some change management challenges that BHD needs to anticipate and manage. Rapid change across the system without a clear strategic plan in place to anticipate and mitigate issues and risks as they arise may create a "reactive" model of management, rather than a "proactive" model. Additionally, as new skills, processes and policies are adopted, a period of learning and adjustment will occur. When many sectors of the system are undergoing this period at the same time a sense of instability may occur.

Additional Considerations of Finding #5

- Investment in community programs should be guided by the fidelity measures and specific outcomes for the types of services being provided. The System Evaluation Program at University of Maryland provides a framework for collaboration in developing and measuring robust statewide community programs.

- There appears to be only one source of crisis services for children and adolescents that also includes children and adolescents with intellectual and developmental disabilities. This gap may result in a higher rate of restraint use, commitments and use of the criminal justice system. The State of Oklahoma has developed a system of care in which children who are identified with more complex behavioral health concerns are monitored by a community board and managed by a case manager who works closely with the board, the family, the child and their service providers. Additionally, SAMSHA offers numerous evidence-based practices for treatment of children.

- Community involvement is currently being measured by a lack of negative events, compliance to treatment, housing and employment. Outcomes should instead reflect a shift to more strength-based engagement in the community such as clubs, sporting activities, community/religious-based memberships that reflect quality of life.

Transition Models

Act 203 calls for an analysis of the possible models for the continued management of an inpatient facility to serve Milwaukee County residents.

Finding 6: Four models have emerged for the continued provision of inpatient care to the highest acuity population. These models are informed, in part, by the *Wisconsin Public Mental Health and Substance Abuse Infrastructure Study* (2009), options put forth in Act 203, and recently by the Analysis of Adult Inpatient Capacity (2014).

The table below frames the potential models and provides insight into considerations.

Table 8: Models for Oversight of Inpatient Facility Serving Milwaukee County Residents

Scenario	Description	Considerations
BHD maintains oversight responsibility with local operations	BHD continues to oversee and operate Psychiatric Crisis Services (ED services) and high-acuity beds at one or more smaller facilities	• BHD demonstrated outcomes in unique role serving high acuity consumers. • At same time, private hospitals have little incentive to provide care for complex consumers who are often uninsured and have long lengths of stay. • Opportunities for improving delivery of care exist. • Least structural change to current delivery of MH/SA services. • General consensus that high operating cost of the large Complex building is a barrier to efficiency. • Possibilities include securing smaller setting at different location. • Analysis of future population and funding sources requisite to inform decisions. • Possibility for BHD to contract with experienced BH Administrative System Organization to manage the Complex operations and reduce administrative burden to County.

Scenario	Description	Considerations
BHD assumes oversight responsibility with regional operations	BHD operates a regionalized facility that serves Milwaukee County residents and residents from surrounding counties who would otherwise be referred to a state hospital	• Stakeholders shared that surrounding communities may not be amenable to partnership with Milwaukee County. • Requires structural change to current delivery of MH/SA services, including contracting with surrounding counties to become payers. • Payment agreements would need to be established with surrounding counties. • Implications of IMD status and managed care reimbursement would need to be studied. • Future of operating inpatient unit at large Complex building remains an issue, but if excess capacity (resulting from reduction in high-acuity beds once dedicated to Milwaukee County residents) were to be populated by consumers from around the region, an additional revenue stream would be gained. However, this only partially addresses the sustainability of the Complex. The capital cost per patient will actually grow as portion of total cost given the infrastructure aging. For this scenario to be viable, inpatient payment rates and consistent benefit coverage policies will need to be considered.
Public-private partnership for oversight, management of operations	BHD purchases high-acuity at private hospital or hospitals	• Leverages the large scale operations of a private system, including administrative functions such as accounting and staffing as well as quality management, IT and reporting. • Private hospitals not presently equipped to care for the highest acuity consumers with forensic histories or those who current meet exclusionary criteria. • Significant investments in infrastructure and staff would be required as would financial incentives on the part of the County, State and Federal government. • Possibility exists for BHD to transfer only the most complex (forensic history/involvement, extreme risk for violence) to state hospital setting. • Requires more robust negotiation and contracting, likely payment model would need to include financial incentives. • Cultural shift and training required for law enforcement in Milwaukee County to modify crisis and ED response. • Statute requiring a designated treatment director to examine individuals within 24 hours becomes significant issue when accounting for individuals at the five private hospitals that accept involuntary individuals.

Scenario	Description	Considerations
State-managed	BHD refers all high-acuity, longer-term need individuals to other institution(s)	• Possible locations can include existing state hospitals or newly developed facilities in the region • Removing individuals from home communities is not necessarily supportive of person-centered, recovery-based, trauma-informed care. • Puts greater responsibility on private hospitals for caring for low and moderate acuity consumers and emphasizes need for more seamless and transparent referral process between BHD and private system. • Places additional pressure on state facility inpatient capacity.

Additional Consideration of Finding #6

- **Cost analysis pending.** The Public Policy Form is writing a fiscal report that will analyze the actual costs to operate inpatient beds at the Complex and it will also model different scenarios for BHD in 2017, in terms of its mix of inpatient vs. community-based services. As part of that, PPF will show the cost of running a 32-bed or a 16-bed facility.

Future Financing and Policy Implications

Current and Future Payer Sources

This paper has already discussed the current role of the Complex as a safety net provider. Case in point: the 2014 *Analysis of Adult Bed Capacity* report demonstrated that in 2013 BHD admitted a higher percentage of uninsured/self-pay individuals and those covered by Wisconsin Medicaid compared to other private providers. Medicaid paid for 54% of inpatient admissions at BHD (the most common payer source); the majority of individuals admitted to Aurora Psychiatric Hospital and Rogers were privately/commercially insured. The majority of individuals seen at the remaining private hospitals were paid for by private/commercial insurance and Medicare.

Medicaid is a major purchaser of behavioral health services provided by BHD in Milwaukee County, including fee-for-service (FFS) and managed care inpatient and outpatient services.

The table and graphs below demonstrate the population of Medicaid beneficiaries with access to mental health and substance abuse services in Milwaukee County and their use of such services with the following caveats:

- Data reflects residents of Milwaukee County who are enrolled in Wisconsin Medicaid full-benefit plans in years 2010-2013; the data does not include information on children enrolled in the Milwaukee Wraparound integrated mental health and substance abuse program for Severally Emotionally Disturbed (SED) youths.

- Both fee-for-service claims and managed care encounter claims are aggregated within the analysis. The significant time and resources required to analyze fee-for-service and managed care populations separately was not available given the Assessment project's timing and scope.

- Behavioral health (mental health and substance abuse) services used by Milwaukee County residents are reflected in several tables. The methodology in which claims/encounters are filed allows for a beneficiary to receive care in multiple places of service/settings during the same visit. For example, services billed during one visit could be reflected as an IMD claim/encounter and as an inpatient claim/encounter. An IMD claim/encounter could also reflect nursing facility services. Similarly, services billed under an outpatient clinic visit could also be billed as an outpatient hospital visit, depending on the services provided. Therefore, comparing the number of IMD services to inpatient hospital visits is not a valid exercise. Rather, analysis of the trend from 2010-2013 that demonstrates growth or decline in a particular setting can provide insight.

- Detailed analysis, such as a comparison of Emergency Department visits for Mental Health for Substance Abuse diagnoses at inpatient hospitals vs. IMDs, can be performed if additional time and resources need are dedicated to the project.

Table 9: Milwaukee County Medicaid plans with access to mental health and substance abuse coverage

Plan	Description of Eligibles[1]	Major MH/SA Benefits	Avg. Age[2]	Average Months of Eligibility[2]
BC+ Standard Plan	● Children under 19 ● Pregnant women, with income up to 300% FPL ● Parents/Caretaker Relatives of children under 18, with income up to 100% FPL ● Childless adults ages 19-64, with income up to 100% FPL	● Full coverage (not including room and board). ● $0.50 to $3 copayment per service, limited to the first 15 hours or $825 of services, whichever comes first, provided per calendar year. ● Copayments are not required when services are provided in a hospital setting.	16.30	10.32
Medicaid	● People who are age 65 or over, or disabled or blind, with income at or below monthly limits	●Inpatient hospital services other than services in an institution for mental disease. ●Inpatient hospital, skilled nursing facility, and intermediate care facility services for patients in institutions for mental disease who are under 21 years of age, under 22 years of age and received services immediately before reaching age 21 or 65 years of age or older. ●Intermediate care facility services, other than services at an institution for mental disease. ●Mental health and medical day treatment. ●Mental health and psychosocial rehabilitative services, including case management services provided by the staff of a certified community support program.	59.02	9.58

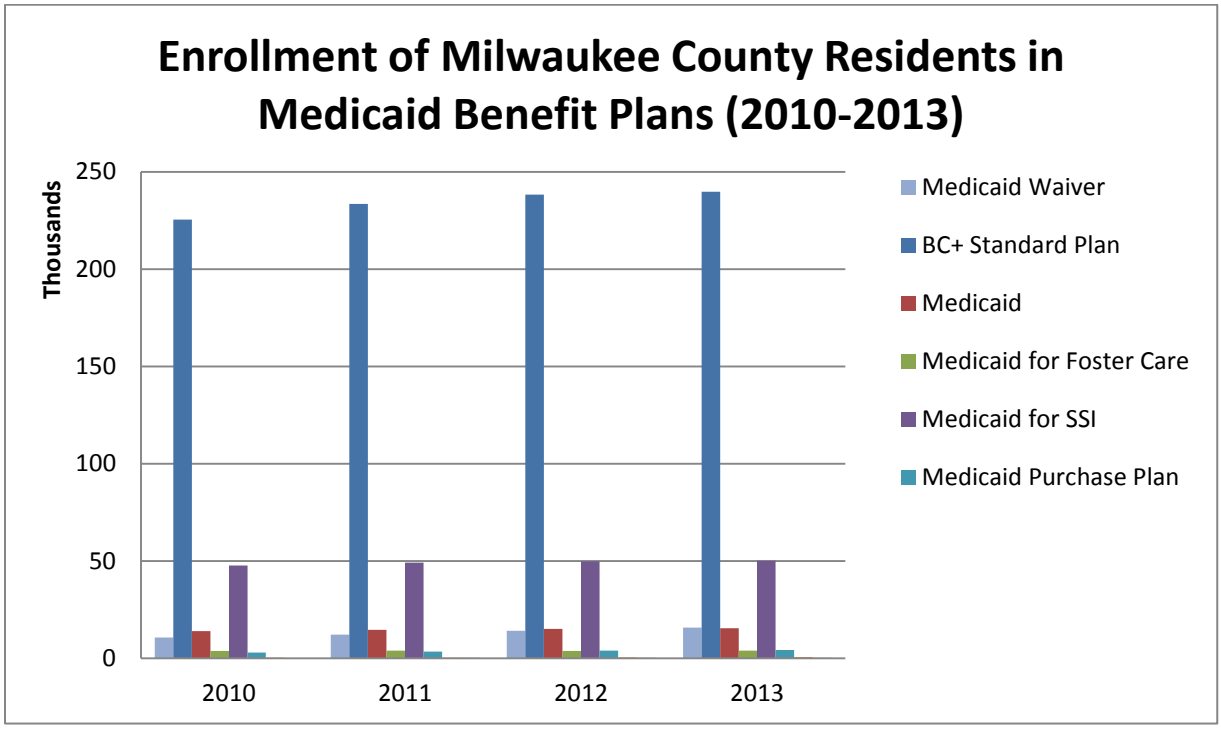
Table 9 continued

Plan	Description of Eligibles[1]	Major MH/SA Benefits	Avg. Age[2]	Average Months of Eligibility[2]
Medicaid for Foster Care	● All youths placed in Foster Care, subsidized guardianship, or court-ordered Kinship Care	● Full coverage (not including room and board). ● $0.50 to $3 copayment per service, limited to the first 15 hours or $825 of services, whichever comes first, provided per calendar year. ● Copayments are not required when services are provided in a hospital setting.	8.15	10.64
Medicaid for SSI	● People who are age 65 or over, disabled, or blind, who qualify for federal SSI payments	Full Benefit Medicaid Services	39.18	11.46
Medicaid Purchase Plan	● Disabled adults who are working or interested in working	Full Benefit Medicaid Services	54.88	10.39
Medicaid Purchase Plan Waiver	● Disabled adults who are working or interested in working	Full Benefit Medicaid Services	53.55	11.44
Medicaid Waiver	● People who are age 65 or over, disabled, or blind, with income at or below monthly limits	Full Benefit Medicaid Services	60.17	11.24
Wisconsin Well Woman Medicaid	● Women who have been diagnosed and are in need of treatment for breast or cervical cancer	Full Benefit Medicaid Services	49.58	9.57

[1] Eligibility as of April 1, 2014

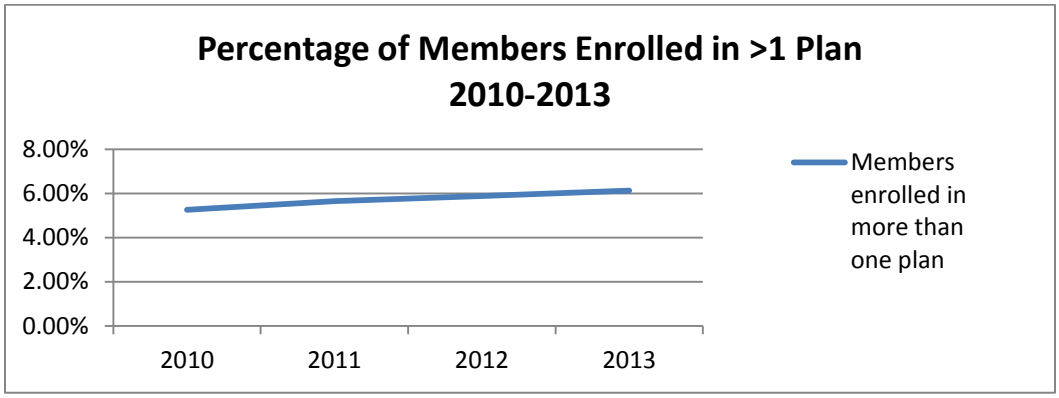
[2] Based on 2013 data, provided by Wisconsin DHS Division of Health Care Access and Affordability

Graph 17: Enrollment of Milwaukee County Residents in Medicaid Benefit Plans (2010-2013)

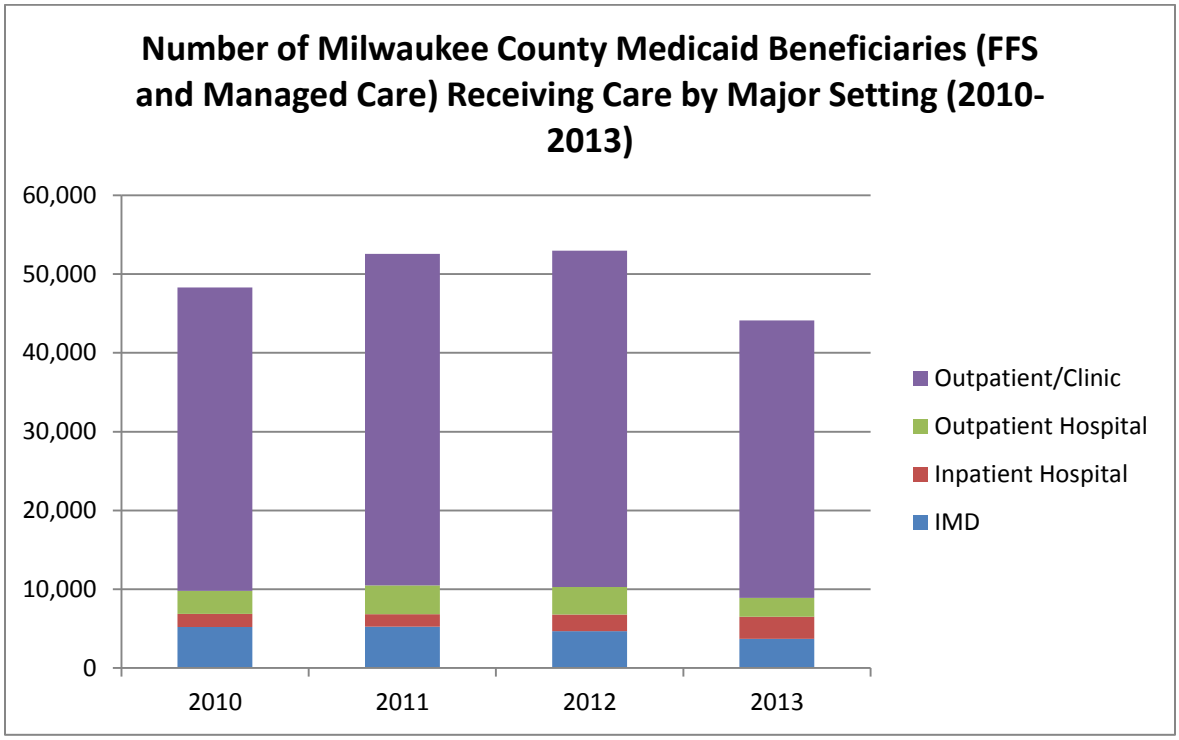


Year	BC+ Standard Plan	Medicaid	Medicaid for Foster Care	Medicaid for SSI	Medicaid Purchase Plan	Medicaid Purchase Plan Waiver	Medicaid Waiver	Wisconsin Well Woman Medicaid
2010	225492	14065	3835	47696	2901	285	10679	244
2011	233598	14686	3951	49117	3466	392	12250	263
2012	238399	15131	3762	49905	4030	549	14096	300
2013	239840	15404	3913	50096	4303	697	15860	319

Graph 18: Percentage of Milwaukee County Residents Enrolled in More than One Benefit Plan

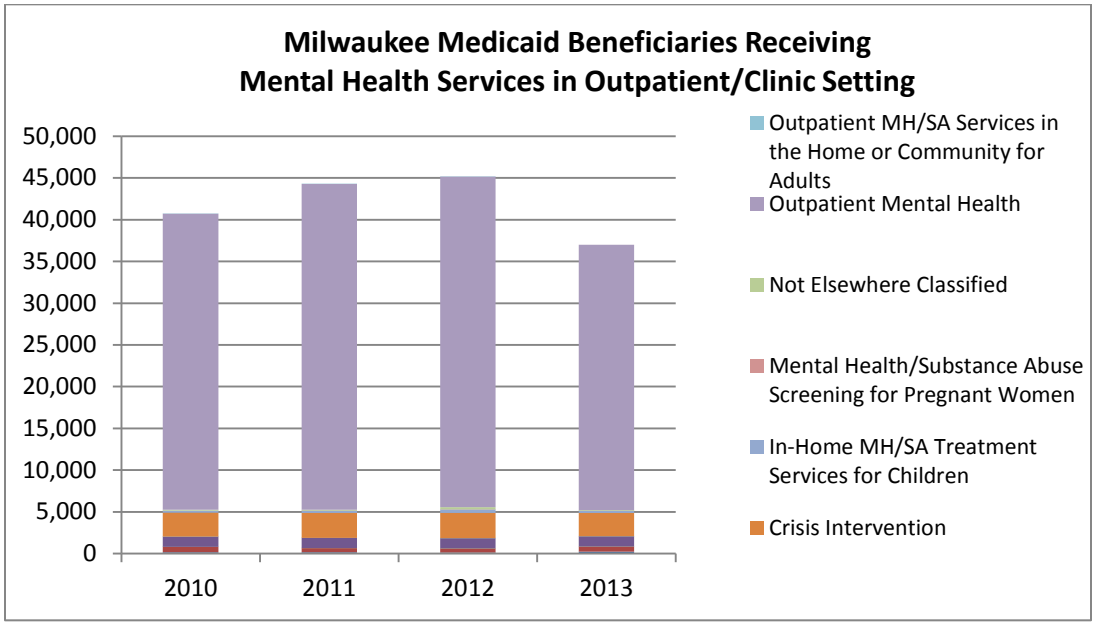


Graph 19: Milwaukee County Medicaid Beneficiaries Receiving Care by Major Setting

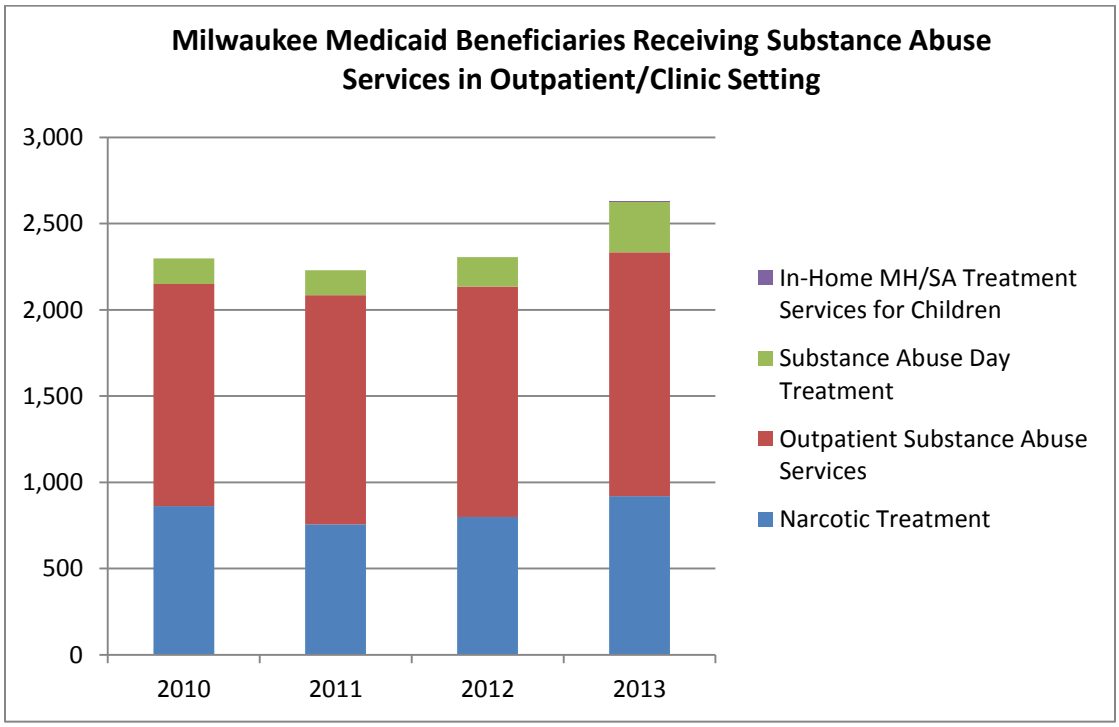


Care Setting	2010	2011	2012	2013
IMD	5,212	5,269	4,708	3,731
Inpatient Hospital	1,668	1,563	2,105	2,774
Outpatient Hospital	2,930	3,675	3,495	2,418
Outpatient/Clinic	38,497	42,050	42,669	35,205

Graph 19: Milwaukee County Medicaid Beneficiaries Receiving Mental Health Services in Outpatient/Clinic Setting



Graph 20: Milwaukee County Medicaid Beneficiaries Receiving Substance Abuse Services in Outpatient/Clinic Setting



Finding 7: The Federally-mandated IMD exclusion is a critical variable in the payment of behavioral health services for Medicaid beneficiaries. It is also a primary decision point for private hospitals considering acceptance of an eligible consumer from BHD. However, given the expansion of managed care in Milwaukee County in 2014 and the opportunity to encourage enrollment in Medicaid SSI HMO, the impact on the County and its partners is potentially shifting.

Exclusion for Institutes for Mental Disease (IMD)

Section 1905(c) of the Social Security act prohibits Wisconsin Medicaid from paying for services provided to certain Medicaid beneficiaries while in a public mental health facility or private psychiatric inpatient treatment facility. BHD, Aurora Psychiatric and Rogers Memorial qualify as Institutes for Mental Disease (IMD) and are thereby impacted by this provision. There are certain populations of Medicaid beneficiaries who are exempt from the IMD exclusion—individuals 65 and older and those under age 21. In addition, it appears that in Wisconsin, IMD facilities can contract with the Medicaid HMOs for the payment of member hospitalizations that would have normally been uncompensated due to the IMD exclusion. This includes both BadgerCare (which now encompasses a richer behavioral health benefit for childless adults, parents and caretakers) and SSI plans that cover aged, blind, disabled individuals who elect to participate in an SSI HMO. BHD reports that it has contracts and/or agreements with many, if not all, of the HMO plans serving SSI beneficiaries.

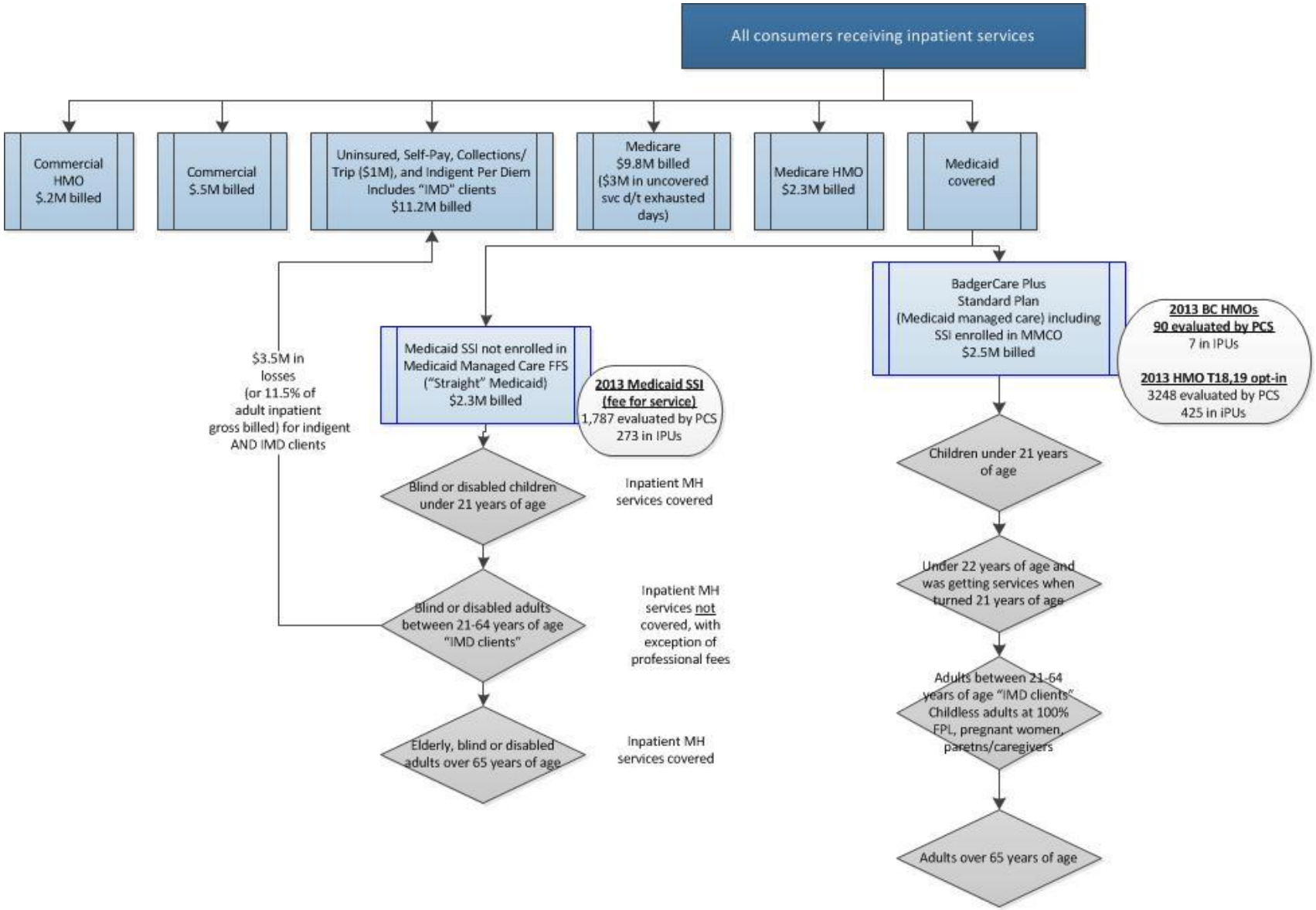
Beneficiaries between the ages of 22-64 eligible for Medicaid due to age, blindness or a disability, whose benefits are reimbursed through fee-for-service payments, remain subject to the IMD exclusion; BHD refers to this population as T19/Straight Medicaid, also known as Medicaid fee for service (FFS). Moreover, BHD asserts that the complexity of this population (variable to non-compliance, high grade disease burden, and treatment refractory despite high service utilization) predicates them to emergency detention/involuntary holds that creates exclusionary criteria preventing transfer to private partners.

Thus, despite having a robust menu of Medicaid contracts and relationships in which BHD receives reimbursement, it reports serving a disproportionate share of Medicaid FFS beneficiaries.

Conversely, Disability Rights Wisconsin (DRW), in written comments in reaction to the 2014 *Analysis of Adult Bed Capacity* provided to the Mental Health Board on September 23, 2014, maintains that a minority of consumers hospitalized at IMD is in FFS Medicaid and are impacted by the IMD exclusion.

The graphic below depicts the Medicaid populations subject to IMD exclusion and an analysis of impacted populations using 2013 data provided by BHD. In summary, there were 97 BadgerCare HMO members evaluated and admitted to BHD in 2013. There were more than 3,600 members of SSI HMOs evaluated and admitted to BHD in 2013. This accounted for approximately $3.7M in inpatient gross billings for adults. There were approximately 2,000 blind or disabled adults between 21-64 years of age evaluated and admitted to BHD in 2013 of which BHD incurred ~$3.5M in losses or 11.5% of adult inpatient gross billed.

Chart 2: BHD Consumer Populations Impacted by IMD Exclusion



According to a technical report[26] published by the National Association of State Mental Health Directors, the Affordable Care Act authorized CMS to fund a 3-year demonstration project under which selected non-government inpatient psychiatric hospitals could be exempted from the IMD exclusion for psychiatric emergencies provided to Medicaid enrollees aged 21 to 64 who have an acute need for treatment. The potential legislation as a result of the pilot, authorized through December 31, 2015, may provide another vehicle for private hospitals to receive payment for traditional IMD exclusions.

Additional Considerations of Finding #7

- **Legal and policy analysis on interpretation of IMD, emergency detention, etc.** Federal IMD exclusion criteria are a complex set of rules that require careful consideration. There is complexity in the interpretation of the facility bed count, location, and organizational structure. Analysis of the Federal and State implications should be further studied to determine specific requirements and exceptions to allow for payment of inpatient services in an IMD setting.

- **Population and funding impacts require further study.** According to BHD, the IMD exclusion represents a loss of nearly 12% of the inpatient gross billed amount. However, growth in the BadgerCare population and the potential to contract with additional Medicaid HMOs is not fully understood. DRW maintains, "Only with this data, can we understand the true scope of this concern, and how it should factor into any capacity planning. Any explorations of developing 16 bed units in order to gain reimbursement under the IMD exclusion…are premature without having this data. Given that the vast majority of individuals are enrolled in Medicaid Managed Care, this may not be a major issue."

  Further analysis of enrollment trends of BadgerCare in Milwaukee County needs to be pursued as well as the trends in enrollment of Aged, Blind or Disabled adults between 21-64 years of age in order to understand the future implications of the IMD exclusion on revenue and loss projections for the Complex.

- **Mandatory SSI Managed Care in Milwaukee County.** BHD shares its experience that many consumers with severe and persistent mental illness (SPMI) are difficult to engage, clinically complex, and generally higher service utilizers. It believes that these factors cause an individual to opt-out of his/her HMO and receive benefits in the FFS setting. This assessment was limited in its ability to substantiate the statement.

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[26] http://www.nasmhpd.org/Publications/The%20Vital%20Role%20of%20State%20Psychiatric%20HospitalsTechnical%20Report_July_2014.pdf

However, if selection of an HMO in Milwaukee County were required for individuals eligible for SSI benefits (an SSI HMO), this would improve the opportunity for payment of IMD services.

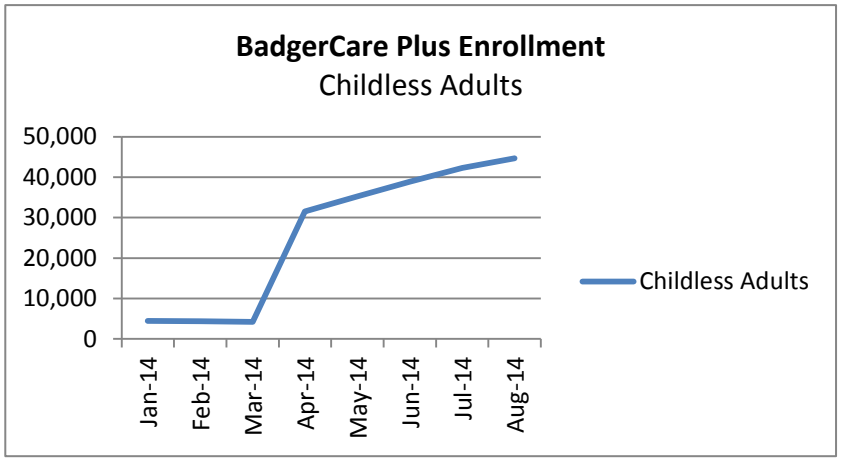
Finding 8: There is consensus on the part of stakeholders around the need to explore new delivery system options, payment/incentives and other policy levers to support the growth and development of a recovery-oriented, person-centered behavioral health service delivery system.

Growth in BadgerCare Childless Adult Population

Further analysis is needed to understand the impact of Medicaid expansion and coverage initiatives on payment, access and capacity. In addition to the growth of Medicaid managed care shifting the impact of IMD exclusion on BHD, it is not yet understood if the new Medicaid benefits and plans will result in significantly increased access, or provide merely a different funding stream for consumers in Milwaukee County already seeking behavioral health services, or a mixture of both.

Also not well understood is the risk/acuity of these newly covered individuals. BHD will need to develop a framework to scale up its programs, as well as contract with HMOs that are required to enroll the childless adults and serve additional consumers that could result from the expanded BadgerCare coverage. Specifically, consideration should be given to completing a needs analysis to determine which services may be required, which services are effective and the infrastructure needed to successfully increase and/or develop services to meet the identified needs.

Graph 22: Trend in Enrollment of Milwaukee County Childless Adults (2014)



Anticipated Changes to Family Care Waiver

It was noted in the 2009 final report of the *Wisconsin Public Mental Health and Substance Abuse Infrastructure Study* that Family Care Managed Care Organizations (MCO) has no incentive to review the total behavioral health needs of the consumer and provide comprehensive care management and care coordination, because the Family Care benefit does not cover inpatient and crisis services. This was listed as the cause of problems with care coordination and timely discharge planning; it was also identified as a major system flaw. The proposed carve-in of these services into Family Care and expansion of services in BadgerCare may provide incentives to MCOs to provide quality, comprehensive care planning that follows the person regardless of service setting. BHD leadership views the proposed carve-in positively from a funding and care coordination standpoint.

Lack of Incentives

There is general consensus around the lack of incentives and payments for private providers and Wisconsin Medicaid HMOs to invest in behavioral health infrastructure, thereby improving outcomes. Some of the feedback captured during this assessment included:

- Acute facilities struggle to financially manage outpatient facilities, and at this point, behavioral health outpatient clinics lose money. There is a lack of alignment between community services that prevent readmissions and funding.
- HMO contracts require adequacy of services; however, many HMOs list the same network of behavioral health providers. Along with the complexity of Medicaid-insured individuals, private providers have difficulty serving this population due to the low provider payment rate (Stakeholders note that the State of Wisconsin has the biggest gap between commercial and Medicaid provider payments).

- For the most part, Wisconsin Medicaid HMO contracts[27] require plans to perform traditional insurance administration functions; however, there are minimal requirements for care coordination and case management interventions. Requirements are limited to utilization management, coordination of benefits, education about benefits, and efforts to reduce missed appointment reduction, health education and disease prevention.
- Case management requirements exist for SSI HMOs; however, they are very broad and do not specifically require plans to identify and stratify members with co-occurring substance abuse or those with comorbid physical health conditions. Nor do they prescribe specific evidence based interventions, such as medication management.
- In addition, sanctions are imposed related to a plans' failure to provide medically necessary services, submitting data in required form/format, removal of erred encounter records without Department approval, and failure to perform administrative functions. However, there are no incentives/disincentives around performance/achievement of quality outcomes,

Additional Considerations of Finding #8

- **Accountability for outcomes assigned to community partners.** The system can be further strengthened by assigning accountability to community partners for improving outcomes and incentivizing achievement of outcomes. Naturally, this implies providers and Wisconsin HMOs, but also includes exploration of incentive-based performance with law enforcement in Milwaukee County, community mental health centers, etc.

- **Although it would be significant departure from the current operational and funding structure in Milwaukee County, DHS has the opportunity to establish new contracts and develop accountability mechanisms with Milwaukee County HMOs to provide integrated behavioral and physical health benefits to Medicaid beneficiaries.** Over half of all Medicaid beneficiaries with disabilities are diagnosed with a mental illness. For those with common chronic conditions, health care costs are as much as 75% higher for those with mental illness compared to those without a mental illness and the addition of a co-occurring substance use disorder results in two- to three-fold higher health care costs.[28] There exists opportunities within managed care delivery systems to

[27] https://www.forwardhealth.wi.gov/WIPortal/Tab/42/icscontent/Managed%20Care%20Organization/Providers/providerContracts.htm.spage

[28] http://www.medicaid.gov/state-resource-center/medicaid-state-technical-assistance/health-homes-technical-assistance/downloads/bh-briefing-document-1006.pdf

integrate behavioral and physical benefits and care in an effort to reduce fragmentation, provide case management and care coordination, offer enhanced benefits to members and offer fiscal predictability to Medicaid agencies.

States with mature managed care markets similar to Wisconsin are already pursing widespread use of these models. The Arizona Health Care Cost Containment System (AHCCCS) offers a plan for Medicaid and Medicare Eligibles (MMEs) or Dual Eligibles integrating physical and behavioral healthcare within a Medicare Advantage dual Special Needs Plan. First piloted in Maricopa County (Phoenix) a few years ago, the state is expanding the program statewide in 2015. The New York State Department of Health plans to fully integrate behavioral health and physical health managed care services. In 2015, HMOs will be required to develop specialized Health and Recovery Plans (HARPs) for individuals with significant behavioral health needs. For adults 21 and older, this change will go into effect April 2015 in New York City (NYC) and October 2015 in the rest of New York State (NYS). The transformation for children's services will begin January 2016.

A 2011 brief by CMS describes existing and emerging options that are being used or considered by states[29]. In addition to delivery systems leveraging capitated care through HMOs, a recent issue brief from Kaiser Family Foundation, Integrating Physical and Behavioral Health Care: Promising Medicaid Models (2014)[30], describes other strategies that DHS can explore:

- Universal Screening. Encourage HMO plans and FFS providers to screen patients for conditions in addition to the ones they present for.
- Navigators. Train peer supports and HMO care coordinators to become "navigators" to help Medicaid beneficiaries navigate the health care system. Navigators' functions can range from simply helping individuals to seek care, to interacting with their health care providers on their behalf, to improving home and community-based support for their clients. Navigators also foster patient engagement.
- Co-location. Foster relationships with integrated FQHCs, Community Mental Health Centers. Medicaid's system of prospective, cost-based payment for health centers supports this model because the costs of licensed behavioral

[29] http://www.medicaid.gov/state-resource-center/medicaid-state-technical-assistance/health-homes-technical-assistance/downloads/bh-briefing-document-1006.pdf

[30] http://www.integration.samhsa.gov/integrated-care-models/Kaiser_brief_on_integrated_health_2014.pdf

health practitioners can be included in the calculation of health centers' prospective rates.
  - Health Home. Explore Integrated Care Medicaid "health home" option for mental health and substance abuse consumers through ACA Section 2703. Community mental health centers are one natural choice to be designated health home providers for Medicaid beneficiaries with serious mental illness.
  - System-level integration. Explore system-level integration—one that that directly provides and is at financial risk for the entire complement of acute physical and behavioral health services covered by Medicaid.

- **Maximize Funding Sources.** BHD has an opportunity to maximize funding sources to support additional system investments and improvement. These strategies include a reinvestment of savings from reduction in inpatient beds. The County's [2014] budget for inpatient services decreased $10 million or 15% since 2012. [53] The County plans to close Hilltop facility by the end of 2014. According to BHD, the savings from the closure, calculated by BHD to be $758,863, will be invested in community services.[53] One premise of system redesign was that savings from both inpatient downsizing (see 2010 *Transforming the Adult Mental Health Care Delivery System in Milwaukee County* report recommendation 5.2 – "Shift resources from inpatient to community-based services") and transition to a community-based model of service delivery (see county resolution, RES 11-516 adopted by the Milwaukee County Board and signed by the County Executive in October 2011) would be reinvested to expand community-based services. Some of these savings would potentially result from, and include, the future use of Medicaid reimbursement for inpatient and/or community-based services.

  In addition, it appears that there is an opportunity to maximize the county property tax levy, if necessary. Wisconsin Act 203 authorizes the Milwaukee County Mental Health Board (MCMHB) to propose a budget to the County Executive that includes a county property tax levy amount of at least $53 million but not more than $65 million, unless a different amount is agreed to by the MCMHB, County Executive and County Board or additional programs and services are transferred to the oversight of the MCMHB. The mental health levy becomes part of Milwaukee County overall property tax levy that is subject to state imposed levy rate limits. The proposed mental health levy is approximately $62 million, leaving about $3 million available for mental health services and other county-funded services.

Finding 9: Additional study is needed to quantify in total, or by program, the financial investment on the part of the county, state, federal government or private sector.

The complexity of current County behavioral health accounting and financing does not allow BHD to fully quantify in total, or by program, the financial investment on part of the County, State, Federal government or private sector in behavioral health services. The approach limits the ability for BHD to tie expenditures directly back to programs. It also limits analysis of indirect costs and the ability for BHD to accurately predict revenue, specifically when considering growing managed care enrollment, interpretation of IMD exclusion, etc.

The Public Policy Form is writing a fiscal report that will analyze the actual costs to operate inpatient beds at the Complex and it will also model different scenarios for BHD in 2017, in terms of its mix of inpatient vs. community-based services. As part of that, PPF will show the cost of running a 32-bed or a 16-bed facility.

However, additional analysis is needed to understand the specific (quality or cost) impact of each BHD investment as it develops a strategy for future investment in crisis and community services.

Additional Consideration of Finding #9

- **Lack of connectivity of data systems between the state, counties, providers and plans limits the ability to create a population and system-wide view and to measure the extent to which investments have made a difference in outcomes**. Lack of precise accounting within Medicaid managed care encounter data also prevents DHS from fully understanding investments/expenditures it makes on behalf of behavioral health consumers.

  As discussed earlier in the paper, the Psychiatric Services (2012)[31] study examining the lengths of stay (LOS) for patients with serious mental illness points to the need to correlate improved inpatient outcomes with community investments. It points to the need to study whether the availability of housing programs leads to shorter hospital stays for those in crisis and to determine whether longer stays are the result of differences in hospital practices.

- **BHD Complex Move.** BHD Leadership noted that overhead costs amount to $8M annually. There is wide consensus due to the fact that the current building housing the Complex is not safe or cost-effective and that an alternative site needs to be explored if BHD continues to

[31] http://ps.psychiatryonline.org/doi/abs/10.1176/appi.ps.201100412?url_ver=Z39.88-2003&rfr_id=ori%3Arid%3Acrossref.org&rfr_dat=cr_pub%3Dpubmed

operate the inpatient psychiatric unit. One stakeholder suggested that a move to urban Milwaukee presents an opportunity to change the culture within the Complex but also create much-needed jobs in urban Milwaukee.

Finding 10: The differences in population demographics and statutory requirements of the emergency detention process in Milwaukee County prevent the ability to compare Milwaukee to other counties around the state. Yet, there may be opportunities to explore a broader interpretation of the statute to allow for more provision of care in the least restrictive setting.

In Milwaukee County, law enforcement is required to bring all emergency detentions, except those requiring medical stabilization, to the 24 hour/7 day a week psychiatric emergency room located at the MH Complex, referred to as Psychiatric Crisis Services PCS. In situations requiring medical stabilization, an individual is first taken to a private hospital for medical care and once s/he receives medical clearance, is transported to PCS. In addition to all law enforcement emergency detentions, all inpatient admissions to BHD are referred to PCS for evaluation.

The emergency detention procedure in Milwaukee County is different from other counties in that the treatment director (i.e., licensed BHD or contracted physician or psychologist with clinical responsibility for the provision of emergency service care) must make a decision as to whether to detain an individual within 24 hours of when the officer arrives with the individual at the facility. The treatment director is required to complete a Treatment Director Supplement (TDS) within the first 24 hours that the person has been detained.

Advocates support the TDS requirement because they believe it serves to identify individuals who do not fit the emergency detention criteria and should be released. Advocates maintain that without the requirement of a TDS within 24 hours, a person could be detained for up to 72 hours or longer (if over a weekend and/or holiday) awaiting their probable cause hearing.

Conversely Milwaukee County DHS has urged elimination of the TDS requirement, and indicated in testimony to the Legislature in 2010 that "the primary concern with TDS is if a patient also requires medical clearance before entering BHD's PCS, the 24-hour TDS time period has likely expired … due to either a pre-existing medical condition or as a result of physical harm they have done to themselves that led to the ED. This can result in some of the most serious cases being dismissed that otherwise would have been addressed."

In the spring of 2014, two pieces of legislation went into effect impacting Milwaukee County's ED procedures. The first, 2013 Wisconsin Act 158, was supported by advocacy groups and BHD,

and made several changes to the statutory provisions relating to emergency detention emphasizing treatment by the least restrictive means and in the least restrictive setting. In addition, Act 158 modified the 24-hour TDS provision to exclude delays specific to the evaluation or stabilization of a person's non-psychiatric medical conditions from the 24-hour calculation. In this way, any required medical clearance will not count toward the 24-hour time period for determining whether or not the person should be detained for up to 72 hours or released.

The second piece of legislation, 2013 Wisconsin Act 235, was supported by Milwaukee County but opposed by advocacy groups. It created a two-year emergency detention pilot program only in Milwaukee County to expand the authority of whom, in addition to law enforcement, can initiate an emergency detention. The pilot (in effect April 10, 2014 - May 1, 2016) authorizes a treatment director or their designee (i.e., licensed mental health professional) to take a person into custody for emergency detention if the person meets all the criteria for detention. After the pilot expires, the Legislative Audit Bureau is required to conduct an evaluation of the pilot, as well as an evaluation of the feasibility of making the pilot permanent in Milwaukee County and expanding it to other counties. Unfortunately, the unique statutory requirements for Milwaukee County emergency detentions do not allow for a reasonable comparison of Milwaukee County rates to the rest of the state, or the rest of the nation for that matter.

Additional Considerations of Finding #10

- **Detention Period**. The 2013 Wisconsin Act 158 excludes the time delays that result from stabilizing the medical condition of a person on an emergency detention from the 24-hour requirement for a treatment director's determination. While BHD officials indicate that this has provided some relief, they feel the TDS requirement should be eliminated entirely. This would bring the statutory provisions for emergency detention for Milwaukee County in line with Wisconsin's other 71 counties. BHD officials cite the administrative burden and redundancy the TDS requirement poses to BHD staff, and do not believe that the TDS requirement serves a clinical purpose. They envision a scenario where an individual on an ED, after being medically cleared, can be admitted to a private inpatient facility without BHD providing a TDS.

- **Who May Detain**. Various stakeholders expressed concerns that Wisconsin's ED statute makes law enforcement the first response in emergency treatment. BHD officials expressed support for statutory changes authorizing master's level behavioral health professionals to initiate emergency detentions and place individuals on an emergency basis. BHD officials indicated that Act 235 pilot is just starting and early data is not yet available. It was suggested that one metric of success for the pilot may be the percentage of emergency detentions that can be handled at private hospitals, without being referred to the PCS at BHD.

- **Evaluation Procedures**. Best practice and the ED statute call for treatment, including emergency treatment, in the least restrictive environment. BHD has increased the use of crisis intervention to divert individuals from inpatient. The Crisis Mobile Team and CART assist law enforcement, provide evaluation services in the field and support use of voluntary treatment whenever possible. Incorporating these mobile approaches and moving away from the current model of bringing emergency detentions to the PCS at the MH Complex for evaluation will better align emergency detention procedures with best practice. Like Milwaukee County, communities that have adopted a more effective crisis response, have seen decreases in the number of ED and inpatient admissions. In addition, consideration can be given to other public behavioral health systems that have moved away from models to evaluate emergency detentions at sites that are co-located with inpatient facilities.

- **National ED Policy Trends.** According to a report on 2013 State legislative trends[32], themes and best practices in state mental health legislation, the National Alliance for Mental Health (NAM) reported that lawmaking on involuntary inpatient and outpatient commitment was common in 2013. A few examples included:
    - Iowa's SF 406 expanding the scope of providers qualified to authorize inpatient admission from examining physicians to physician assistants and psychiatric advanced registered nurse practitioners.

    - Washington's bills strengthening rights of people with mental illness during civil commitment and criminal incompetency procedures, requiring providers to consider history of symptoms or behavior when making a civil commitment decision, and improving planning and care coordination associated with discharge from inpatient civil commitment.

    - In Nevada, Hawaii and Virginia, outpatient treatment can be ordered for individuals not deemed dangerous to self or others.

[32] http://www.nami.org/Content/NavigationMenu/State_Advocacy/Tools_for_Leaders/2013StateLegislationReportFinal.pdf

Finding 11: There is a need for the County and/or State to invest in an interoperable IT and data infrastructure to assist in behavioral system planning and performance.

The significant number of gaps in data and limitations of analysis discovered through this assessment process (and shared by stakeholders) point toward the inability for DHS, BHD and its private system partners to gain a comprehensive view of the behavioral health system in Milwaukee County. Lack of clarity around operating costs and outcomes is discussed earlier in this paper. Additionally, lack of data to measure and track the acuity/risk/health status of consumers across the system was discussed. Transparency into consumer-referral and use patterns (for example, monitoring specific consumers admitted originally to the Complex who were later readmitted to a private hospital is not available) and bed capacity across all facilities was explored. These factors limit the ability for the State, County and private provider to understand what's truly happening on a population basis, as well as on an individual consumer basis, and to plan for their care.

However, there are opportunities for BHD and DHS to fully understand the needs and impact of mental health and substance abuse consumers in Milwaukee County, enable coordinated care amongst BHD services, private partners, payers and plans, and to make stakeholders accountable for outcomes, through a common data infrastructure that links, collects and analyzes data throughout the system. A few examples are listed below:

- BHD has an opportunity through the implementation of its Electronic Medical Records (EMR) and burgeoning Quality Management program to establish a rigorous methodology to measure the success of its programming including its Return on Investment,
- Creating linkages with Wisconsin's Health Information Exchange can provide a patient-centered system wide view of consumer histories, care plans and needs to support coordinated care and better health outcomes.
- Developing functionality that analyzes population size, acuity, prevalence of comorbid physical and behavioral health conditions, functional status and service use would allow DHS to analyze scenarios of delivery system reform, i.e. coverage and benefits within integrated behavioral and physical health plans, medical homes, etc., as well as support budgetary planning, and predict resources needs.

Finding 12: Consumers and advocates recognize investments made by BHD to rebalance the County's behavioral health system while citing wide variation in the responsiveness, quality and recovery-orientation consumers' experience.

The Division of Mental Health and Substance Abuse Services reports that according to a 2010 survey, 65.0% of consumers in Milwaukee County were overall satisfied with the services they received, compared to 76.4% consumer satisfaction statewide. In 2011, 63.4% of consumers in Milwaukee County were overall satisfied with the services they received, compared to 74.9% consumer satisfaction statewide. Consumers and advocates surveyed through this assessment process shared insight around different levels of satisfaction with the system as it currently exists. They provided a broad range of feedback on what is working well, progress that has been made, as well as issues and challenges that need to be addressed. These comments are summarized in the Summary of Feedback section. The questions that were used to guide the discussion at the focus group sessions can be found in the appendices.

Since this assessment was conducted as a meta-analysis, whenever applicable, the summary of feedback references similar stakeholder feedback included in the 2010 study, *Transforming the Adult Mental Health Care Delivery System in Milwaukee* County and the 2014 study, *Analysis of Adult Bed Capacity for the Milwaukee County Behavioral Health System*. Both of those studies were prepared by the Human Services Research Institute (HSRI), the Technical Assistance Collaborative (TAC) and the Public Policy Forum (PPF), but will be referred to in the Summary of Feedback section as the 2010 or 2014 HSRI studies.

Progress and Improvements

- There was general recognition of the investments made by Milwaukee County in community-based services to rebalance the behavioral health system, as well as specific mention of services and initiatives that are viewed as particularly beneficial, such as peer-run services, increased access and crisis services, peer specialist services, and community intervention specialist services to connect people with housing and appropriate community resources. However, it was stated that the results from the recent initiatives are not yet known, and that it may be too early to see the impact of the investments on systems change.

- There was recognition of the collaborative approach of the Mental Health Task Force and the value of the Task Force to raise important issues. Efforts of the MC3, Milwaukee Co-Occurring Competency Cadre, were also lauded, as was the work of the Mental Health Redesign and Implementation Task Force on the SMART goals for the behavioral health system. Additionally, the effectiveness of the Milwaukee Wraparound approach

for children with severe emotional disturbances (SED) was noted and as was the possibility of expansion of a similar wraparound model to the adult population.

- It was stated that the experiences of some advocate and provider stakeholders with BHD leadership have been positive and responsive, and that leadership supports community-based services. It was also stated that leadership's view and approach may not reflect what consumers experience in their interactions with BHD.

Issues and Challenges

- Stakeholder feedback indicated there is a wide variation in the responsiveness, quality and recovery-orientation consumers experience with the service delivery system.
    - Consumers and advocates shared experiences they or other individuals have had with providers and case managers who do not listen to the person, or do not treat the person with dignity or as capable of making choices about what s/he needs to promote his/her own recovery. It was stated that all involved in a person' treatment need to believe that recovery is possible and support a person's recovery in everything they do.
    - Several individuals mentioned the lack of choice consumers have in selecting care managers, services providers and services to meet their needs.
    - Stakeholders noted long wait times or large workloads for some community-based services, such as the Community Support Program (CSP) and Target Case Management (TCM), and lack of available outpatient therapy services. *(Note: Concerns about service access and capacity were also identified themes from the stakeholder interviews in the 2010 and 2014 HSRI studies.).*
    - Timely access to behavioral health services for individuals age 60 and older who must first be referred to the County's Department of Aging for a Long-Term Care Functional Screen was identified as an area in need of improvement.
    - Stakeholders expressed the concern that individuals need to "fail" before they receive the services they need, or that it is difficult for people to get an effective plan of care and connect to the right services that meet their needs. *(Note: Concerns about an adequate continuum of care and appropriate services for consumers with specialized and complex needs were also identified themes from the stakeholder interviews in the 2010 and 2014 HSRI studies.)*

- Stakeholders identified areas for enhancing the recovery-orientation of the behavioral health system, and the improvements needed to achieve this. These areas include:

    - The development of a common understanding of what is meant by recovery-orientation to include all aspects important to a person's recovery, well beyond the treatment of their mental illness or addiction. *(Note: This was also an identified theme from the stakeholder interviews in the 2010 HSRI study.)*

    - The implementation of the philosophy and principles of recovery and a person-centered approach throughout the entire behavioral health system, including all County and provider agency personnel. *(Note: This was also an identified theme from the stakeholder interviews in the 2010 HSRI study. That study further noted the need for education about recovery to "both clarify the vision of the BHD leadership and elicit buy-in from all system stakeholders." In particular, the 2010 study noted the need for more recovery education of providers and case managers, in particular, and the use of peer specialists in providing education for consumers about available resources.)*

    - The provision of culturally competent services and more bilingual services. *(Note: This was also an identified theme from the stakeholder interviews in the 2010 HSRI study.)*

    - The development of a more comforting, person-centered front door access to inpatient and mobile crisis services. *(Note: An identified theme from the stakeholder interviews in the 2014 HSRI study was that "police intervention as a frontline for psychiatric crisis response is fundamentally flawed.")*

    - Greater and more meaningful involvement of consumers in the design of new initiatives before they are launched. *(Note: More active and influential consumer involvement was also an identified theme from the stakeholder interviews in the 2010 HSRI study.)*

- Many said further investments in the system are needed, but several stressed it is also important to target dollars to the best possible use and invest in what is working. Specific areas include:

    - Peer-run services (e.g., Grand Avenue Club, Our Space): Stakeholders stated that these services provide a sense of purpose and belonging within a community of people that understands consumers and cares. One individual shared that the biggest obstacle to their own wellness and recovery is feeling isolated and alone. *(Note: The importance of peer-run services was also an identified theme from the stakeholder interviews in the 2010 HSRI study.)*

- Peer specialist services: Stakeholders felt that trained specialists with lived experience can effectively support individuals in their recovery. While past investments in this area are seen very positively, some questioned how peer specialists are being used in areas in which they are not trained or in which are outside the scope of the expectations for the position. Several advocated for an expanded role of peer specialists in mobile crisis services to make those services more effective and less focused on a primary law enforcement response. *(Note: The importance of peer specialist services was also an identified theme from the stakeholder interviews in the 2010 HSRI study.)*

- Community intervention specialist services: Stakeholders noted that this position in County's housing division helps with discharge planning so people are connected to the right services.

- Housing: Stakeholders expressed the need for more supportive housing and independent apartments that are integrated (i.e., scattered housing as opposed to segregated housing for MH/SA consumers) and where individuals feel safe. *(Note: The lack of affordable, supportive housing was also an identified theme from the stakeholder interviews in the 2014 HSRI study.)*

- Diversion from the criminal justice system: Stakeholders pointed to the need for better care coordination and services to address the needs of people who are falling between the cracks and cycle through the criminal justice system, noting that the county jail is not an appropriate setting for individuals with behavioral health treatment needs. Some indicated that they feel mental illness has been criminalized by making law enforcement (and not mental health professionals and peers) a first response in crisis calls.

- Resources upon discharge: Stakeholders commented on the need to ensure wraparound services, care coordination and sufficient support for people being discharged from inpatient settings. Stakeholders shared experiences of individuals being discharged to the community before they are stabilized, and without necessary services, housing and/or medications. *(Note: The importance of adequate community supports for individuals being discharged from BHD's long-term care facilities (i.e., Hilltop and Rehab Central) was an identified theme from the stakeholder interviews in the 2014 HSRI study. In addition, stakeholder perspectives from the 2014 study pointed to the need of some BHD consumers for a longer inpatient length of stay before being ready for discharge back into the community.)*

- Integrated services: Stakeholders felt a system that provides better coordinated care in the community to address a person's physical and behavioral health needs would provide better quality care and reduce costs. *(Note: This was also an identified theme from the stakeholder interviews.)*