Dane County Crisis Triage Center Implementation Report

Dane County Department of Human Services

Submitted by RI International
October 25, 2021

Contact: Jamie Sellar
Chief Strategic Officer
Phone: 602.292.6130
E-mail: jamie.sellar@riinternational.com

RECOVERY INNOVATIONS, INC (dba RI INTERNATIONAL) | 2701 N. 16TH STREET, SUITE 316, PHOENIX, AZ 85006

Table of Contents

Acknowledgments....3

Executive Summary and Recommendations....4

Introduction and Background....12

SAMHSA's National Guidelines for Behavioral Health Crisis Care....16

Methodology....30

Findings and Analyses....32

Conclusions and Recommendations....61

Crisis Triage Center Implementation.... 72

Appendices

A. Stakeholder Inputs
B. Acronyms
C. Bibliography

Acknowledgements

The RI International (RI) consultant team thanks the many Dane County contributors to this crisis response system assessment and to the Crisis Triage Center (CTC) implementation plan for their time, candor, and willingness to participate in a process to design and establish a sustainable CTC and a robust crisis response system. These contributors consistently demonstrated a passionate commitment to meet the needs of County residents and respectively shared their perspectives regarding the strengths and weaknesses of the current crisis response system and suggestions on how to improve it.

This crisis response system assessment and CTC implementation plan and this final report is the result of a contract between the Dane County Department of Human Services (DHS) and RI. We would like to extend our appreciation to the following individuals whose coordination and support were essential to the entire project:

- Shawn Tessmann, Director — Department of Health Services
- Todd Campbell, Administrator — Adult Community Services Division
- Carrie Simon, Behavioral Health Manager — Adult Community Services Division
- Hannah Whaley, Behavioral Health Program Specialist — Adult Community Services Division
- Jeff Kostelic, Executive Assistant — Office of the County Executive

The RI International, Inc. consultant team that was actively engaged in all facets of this project included:

- Jamie Sellar — Chief Strategy Officer
- Wayne W. Lindstrom, PhD — VP, Business Development and Consulting
- Ken Anderson — Consultant

Executive Summary

RI International (RI) was awarded a contract with the Dane County Department of Human Services (DHS) on June 18, 2021. Under the Scope of Work of that contract, RI was tasked with providing consultation, assessment, analysis, and recommendations to develop a plan for the implementation of a Dane County Triage and Restoration Center that would address the following:

- The capacity to serve as a jail diversion by accepting and safely managing all referrals by law enforcement for individuals who are believed to have urgent mental health or substance use issues;
- The capacity to assess and address the immediate behavioral health need(s) of the individuals referred, provide stabilization, and link the individual with on-going services and supports;
- The capacity to admit individuals on a voluntary or involuntary basis for a time period as determined by medical or health professionals;
- The capacity to serve as a resource for individuals and families seeking assistance in dealing with behavioral health issues; and
- The capacity to address the disparate impact of the criminal justice system on those who are members of our Black, Indigenous, and People of Color (BIPOC) communities

The term, "restoration" in the title for the planned Crisis Triage and Restoration Center should be removed as it implies that one of the purposes of the proposed CTC is to restore the competency of an individual who has been found incompetent to stand trial (IST), and who has been court-ordered to receive competency restoration services. Since the proposed Center is to provide facility-based crisis services with stays of under twenty-four (24) hours, it will not operate as a facility to restore competency. Therefore, throughout the remainder of this Report, the intended facility will be referred to as a Crisis Triage Center (CTC).

Briefly, the scope of work for this project included the following:

- Conducting a study of the existing crisis care continuum available in Dane County;
- Complete a comparative analysis of the current crisis response system against best practices;
- Recommend an implementation plan for the development of the Crisis Triage & Restoration Center;
    - To be located in a safe & accessible location
    - With identification of needs, design elements, costs, timelines, & partnerships needed in order to make the development of this center feasible & sustainable.

Per the expectations of DHS, RI engaged in key stakeholder meetings with members of the local community/municipal/borough crisis services, including: public safety, health, hospitals, behavioral health (BH) treatment providers, housing and homeless service providers, advocates, those with "lived experience," and other key parties and safety net services providers. A representative from DHS facilitated each of these meetings. In each meeting, there was a discussion around the application of the BH crisis care best practices and key service components and standards. These stakeholder engagements also served as an opportunity for participants to have unanswered questions addressed and to share their respective perspectives on the current crisis response system and the proposed Crisis Triage Center. These discussions also served to rally support for crisis system optimization utilizing national best practices as a guide. A crisis response system is a complex and tiered structure comprised of crisis response services

that support anyone, anywhere, and anytime. This system is designed to stabilize those whose safety and health are threatened by BH challenges, including mental illness, developmental disabilities, substance use, and/or overwhelming stressors and begin to guide them towards a path of recovery.

DHS and RI Convened meetings with thirty-nine (39) organizations & over three-hundred and four (304) participants. Below are the general themes that emerged from these stakeholder engagements:

- Support for the Crisis Triage Center (CTC) to fill a recognized service gap in the crisis response system;
- CTC "no wrong door" approach and heavy reliance on peer support are both favorably received;
- Recognition that state barriers to operating & sustaining the crisis response system must be overcome;
- Better coordination of crisis and other care needs to occur;
- Crisis services require culturally competent delivery;
- Rural access to crisis care remains a need; and
- Behavioral health workforce challenges need to be addressed.

It was abundantly clear, within each meeting and across meetings, that there exists a broad consensus and a sense of pride regarding the richness of behavioral service assets within the County. Dane County has all of the components of a crisis response system, as outlined in SAMHSA's National Guidelines for Behavioral Health Crisis Care, with the exception of one - a 23-hour Crisis Triage Center with recliners. According to DHS' Coordination Plan for Emergency Mental Health Services (2020),

> "Dane County's mental health system is characterized as a mature system of care. Journey Mental Health Center (JMHC) has been providing emergency mental health crisis services in Dane County for over 40 years. As an established system of care, the emergency services unit (ESU) has developed and evolved with the community, and it is currently comprised of three components.
>
> 1. Emergency Telephone Services;
> 2. Mobile Crisis Services;
> 3. Crisis Stabilization Services
>
> The ESU also serves as the "hospital gatekeeper" for all voluntary admissions of JMHC clients and it acts as the County funding agent for all voluntary psychiatric inpatient admissions for uninsured individuals. DHS is the source of this funding. The ESU is responsible for conducting mental health assessments for all Emergency Detentions in Dane County.
>
> In addition to the crisis services provided by JMHC, DHS contracts with other provider organizations to provide crisis stabilization services which include: SOAR, Tellurian, Goodwill, Lutheran Social Services, Women in Transition, and others."

However, not all of the crisis service components meet the criteria specified by SAMHSA's *National Guidelines for Behavioral Health Crisis Care,* nor the requirements associated with the implementation of 988 in July of 2022. Therefore, this Report will include an analysis of each of these crisis service

components against these guidelines and requirements and will include in its recommendations, how the entire crisis response system can be optimized.

In order to meet DHS' expectation that RI conduct a comprehensive quantitative and qualitative analysis of Dane County's current resources and conditions for crisis intervention and jail diversion, it was necessary to review existing data sources and reports. This Crisis Report is not intended to replicate any of the resources that have been published (see below) in the past, but they have respectively been used to inform this project.

- *A Hand and a Home: Foundation for Success, 2019-2022 Statewide Action Plan*. Wisconsin Interagency Council on Homelessness. November 2018.
- *Behavioral Health Barometer: Wisconsin, 2015*. HHS Publication No. SMA–16–Baro–2015–WI. Rockville, MD: Substance Abuse and Mental Health Services Administration (SAMHSA), 2015.
- *Client Perception of Care: Dane County Mental Health System: January 1, 2018 – August 31, 2018*. Dane County Department of Human Services. July 2019.
- *Dane County Behavioral Health Needs Assessment*. Public Consulting Group. October 2019.
- *Dane County Department of Human Services Vision: Next 2021 – 2026*. Dane County Department of Human Services. 2020.
- *Differences in Crisis Services and Psychiatric Hospitalizations across Race and Ethnicity*. Wisconsin Department of Health Services. February 2021.
- *Key Performance Indicators Report*. Dane County Department of Human Services. Volume 8, Issue 4. March 2019.
- *Outcome Indicators – Mental Health Summary: July 1, 2017 – December 31, 2017*. Dane County Department of Human Services. March 12, 2018.
- *Plan for Coordination of Emergency Mental Health Services*. Dane County Department of Human Services.
- *2018 Performance Scorecard: Adult Services Division*. Dane County Department of Human Services. May 2020.
- *Sequential Intercept Model Mapping Report for Dane County*. Delmar, NY. Policy Research, Inc. 2018.
- *Service Participant Satisfaction with Mental Health Services*. Wisconsin Department of Health Services. 2015.
- *Report to the Legislature: Mental Health and Substance Use Services and Programs provided by Wisconsin Counties and Regions CY 2016 and CY 2017 Summary Report*. Wisconsin Department of Health Services, Division of Care and Treatment Services. January 2019.
- *Behavioral Health Barometer: Wisconsin, Volume 5: Indicators as measured through the 2017 National Survey on Drug Use and Health and the National Survey of Substance Abuse Treatment Services*. HHS Publication No. SMA-19-Baro-17-WI. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2019.
- *Suicide in Wisconsin: Impact and Response*. Produced in partnership with Wisconsin Department of Health Services, Mental Health America of Wisconsin, and the Medical College of Wisconsin. September 2020.
- Vigna, A.J., Connor, T. *The 2019 Behavioral Health Gaps Report for the State of Wisconsin*. Madison, WI: University of Wisconsin Population Health Institute, October 2020.
- Wahlberg, David. *Psychiatric Hospital in Middleton to Open to Patients Soon*. Wisconsin State Journal. July 6, 2021.

- *Wisconsin Crisis Services and Emergency Detentions Statewide, 2013-2017*. Wisconsin Department of Health Services. November 2019.

This Report builds on the conclusions of this previous body of work, along with other relevant data gathered throughout the process, and on the information gleaned from the wide array of stakeholder engagements.

This information has been synthesized and used to inform the application of specific algorithms when calculating the capacity for the CTC and related components, that appear in the conclusion section of this Report. Most specifically, this Report addresses CTC costs, staffing requirements, facility size, and potential funding mechanisms, and associated system alignment issues, such as facility and provider licensing, Medicaid provider type regulations, and payment structures and rates. This Report assesses the overall cost of CTC implementation against the potential savings that are anticipated to accrue to the entire system. The intent is to offer a staged roadmap for how a high fidelity CTC can be established and sustained within Dane County. In addition, this Report projects the anticipated impact that the CTC will have on the entire crisis response system and suggests the crisis response redesign that will be required to both address this impact and to optimize the system as a whole.

Recommendations

Below is a summary of the recommendations of this Report. For a full explanation of the conclusions and the recommendations that flow from those conclusions, please refer to the full Report. Each recommendation within the Report has been organized within the context of SAMHSA's *National Guidelines for Behavioral Health Crisis Care* balanced against the needs and the strengths of the current crisis response system. In addition, each recommendation, when appropriate, includes specific policy and operational details and resources that outline capacity needs, infrastructure, and costs estimates.

1. Crisis Response System Accountability

Establish a dedicated organizational entity within the Dane County Department of Human Services to be responsible and accountable for the oversight, resourcing, and administration of the County's behavioral health (BH) crisis response system.

Without a clear designation of authority, the responsibility for leadership for BH crisis services becomes diffuse, making it difficult for any one entity to be held accountable for the implementation and management of a crisis system with high fidelity to SAMHSA's *National Guidelines for Behavioral Health Crisis Care.* This need becomes critical to facilitating the planning, financing, and monitoring of BH crisis service adequacy and quality is relevant to the local community.

2. Crisis Response System Redesign

Redesign the Dane County behavioral health crisis response system, as expressed in DMH's Behavioral Health Emergency Coordination Plan, to optimize client flow throughout the crisis care continuum.

The system, as it currently operates, has some barriers that stand in the way of accessing crisis care.

a) Eliminate the need for advance medical clearance prior to admission into the CTC & any facility-based crisis services & the Detox Center;
b) Place the responsibility, on these same crisis facilities, for the placement in and transport to, an appropriate higher level of care;
c) Remove any "gate-keeping" responsibilities by Journey Mental Health Center for voluntary & involuntary admissions into the CTC, but maintain Journey's responsibilities for processing civil commitments;
d) Serve more residents experiencing a behavioral health crisis in their natural environments; &
e) Designate the Crisis Triage Center (CTC) as the "no wrong door" to crisis care.

3. Performance Expectations and Metrics

Establish performance expectations and metrics for each component of the crisis response system and the data systems to collect the information necessary to manage, analyze, and report on the performance of each component and the system as a whole.

SAMHSA published in 2020 a Crisis Service Best Practice Fidelity Review Tool. The Fidelity Review Tool is designed to assist in the implementation of essential crisis service elements, and to assist with the delineation of performance expectations. This will be an important resource to Dane County for establishing performance metrics for the CTC and the other components of the crisis response system.

In addition to monitoring fidelity to the Crisis Service Best Practice Standards, funders, system administrators and crisis service providers should continuously evaluate performance with shared data systems. System transparency and the regular monitoring of key performance indicators supports continuous quality improvement. It is highly recommended that the crisis response system apply shared systems that offer real-time views of agreed-upon system and provider-level dashboards that can also be used to support alternative payment reimbursement approaches that focus on value.

4. Policy and Regulatory Barriers

Advocate for the elimination of statutory and regulatory barriers that impede Dane County's efforts to optimize its BH Crisis Response System to include:

a. Medicaid eligibility expansion under the Affordable Care Act (ACA);
b. Enforcement of Parity Laws, requiring commercial health insurers to pay for BH crisis response as these health plans do for emergency medical response. This should not be the continued responsibility of taxpayers to assume crisis care costs for enrollees with commercial health insurance.

Monitor and implement, as appropriate, Wisconsin's 988 Implementation Plan, which potentially will overcome these system barriers. This Plan is due by January 31, 2022 for submission to

Vibrant Emotional Health and SAMHSA, both of which have national responsibilities for 988 implementation. The Federal Communications Commission (FCC) designated 988 as the new three-digit number for the National Suicide Prevention Lifeline on July 16, 2020. The U.S. Senate passed the National Suicide Hotline Designation Act (S. 2661), establishing 988, in May 2020, and the U.S. House of Representatives passed the legislation in September 2020. The National Suicide Hotline Designation Act of 2020 was signed into law on October 17, 2020. The requirement for phone service providers to transition to 988 as the National Suicide Prevention Lifeline will take effect on July 16, 2022. Recognizing that this expanded scope and greater visibility for the Lifeline would create greater demand and expectation of response, the legislation also allows states to charge fees on phone bills to help fund crisis response services.

5. Crisis Triage Center (CTC) Startup and Operational Costs

Plan for the provision of financial support associated with the CTC site purchase/lease, and its construction/renovation, along with equipment, start-up and operating costs.

Without financial support for construction, equipment, and start-up costs associated with the establishment of the proposed CTC, it will be very challenging for providers to standup these facilities. Most providers to not have the assets necessary to assume these costs and therefore, without capital and initial financial operating assistance, these facilities will most likely not be established. Therefore, Dane County, private foundations, and local health systems should collaborate and explore all available financing options to support the capital and initial operating costs to standup this new facility.

6. Crisis Triage Center (CTC) Implementation

Establish and sustain an adult Crisis Triage Center with 22 recliners, instead of beds, to maximize capacity flexibility, client flow, and an environment that is conducive to meaningful engagement during the initial crisis triage period.

The CTC will operate 24/7, with stays of up to 23 hours and it will provide high acuity care under the “no wrong door” approach, admitting all those who present, whether voluntarily or involuntarily, to include those needing detoxification services or those with intellectual or developmental disabilities; and without requiring medical clearance in advance of admission. This facility will act as a “psychiatric emergency department,” and accept a large percentage of its anticipated 7,085 admissions annually, as diversions from arrest and detention; and from emergency departments and psychiatric hospitalizations. The CTC will have a multi-disciplinary staff to include medical staff, behavioral health clinicians, and peer support specialists.

7. Other Facility-based Crisis Stabilization Services

Dane County should continue to support, but modify, its existing crisis stabilization and detoxification facilities that operate with beds. These units should serve the roughly 30% of CTC admissions that are not sufficiently stabilized in under 24 hours to represent 2,921 anticipated admissions annually. While these facilities are system assets, there are a number of reconfigurations that could be made that will add value in the overall optimization of the crisis response system.

Capacity projections needed for this level of care (LOC) are projected to be 32 beds, serving 2,921 admissions annually, in an optimized crisis response system. Currently, Dane County has 57 crisis and detox beds, with 29 of these for detox in a secure facility. Given that there appears under-utilization associated with the current bed configuration, the County should examine converting the Detoxification Center to a crisis stabilization facility, which could potentially accept voluntary and involuntary admissions, while continuing to provide detoxification services, and serving those with co-occurring disorders, and those requiring BH stabilization.

8. Mobile Crisis Team (MCT) Service

Realign the current mobile crisis service assets with the national crisis care guidelines, which will result in MCTs, comprised of a BH Clinician and a Peer Support Specialist, being dispatched by the crisis call center and intervening 24/7 with anyone, anywhere, and anytime.

MCT capacity projections for Dane County indicate that 5.2 MCTs (each MCT operating for 40 hours per week), would meet this need on a 24/7 basis. Currently, there are 17.9 FTEs dedicated to a non-standardized approach to this service and there has never been 24/7 coverage countywide. By uniformly adopting this approach for MCTs, it is anticipated that the system will realize personnel savings of 7.5 FTEs, who can subsequently be re-deployed to other crisis care service components. If the CIT personnel at Tellurian are taken into account who respond to crises involving those with a substance use disorder (SUD), then the personnel savings are anticipated to be even greater.

9. Rural Crisis Service Adaptations

Planning needs to occur with the more sparsely populated areas of Dane County to create local crisis response solutions, where access to MCTs and facility-based crisis services have historically been inadequate.

As with most metropolitan areas in the country, crisis services have been concentrated in the County's largest city – Madison. Therefore, it is critical that mobile crisis services may need to be modified, to include tele-psych options and transportation, to assure adequate rural access to crisis care.

10. Crisis Care Traffic Control Hub

Continue to enhance the Dane County crisis call center, operated by Journey MHC, so that it continues to function as an integral part of the Wisconsin Lifeline network, which has been operational since August 2020; and that it is adequately resourced to operate as a fully functional Care Traffic Control Hub, under 988 implementation.

Operating as a Care Traffic Control Hub, Dane County's crisis call center will have the ability to dispatch GPS tech-enabled MCTs across Dane County; will possess real-time data on available crisis and psychiatric beds and outpatient BH treatment slots county-wide; and provide text, chat, and peer-to-peer warm line services, also on a 24/7 basis.

11. Care Coordination

Adopt the technological tools and the supports necessary to assure that there is meaningful care coordination across the crisis response system and other adjacent service systems. A consistent message from stakeholders has been that Dane County has a rich array of crisis and other BH services, but that this service array remains largely fragmented. This makes meaningful care coordination challenging.

With the adoption of the Wisconsin Statewide Health Information Network, (WISHIN) by the BH service providers within Dane County, the tools necessary to enable collaborative service planning will be available. More than 2,000 provider organizations currently utilize WISHIN statewide, including BH providers. WISHIN 2.0 is currently under implementation and it will offer new technology platforms to deliver WISHIN Pulse, a community health record, as well as, other enhancements.

Begin transitioning to Alternative Payment Models (APM), which give providers the flexibility to coordinate and manage care. Typical service reimbursements based on price per unit of service delivered, incentivizes providers instead to produce revenue by increasing volume and not value.

Having the tools to effectively and efficiently engage in care coordination is critical, however under the current fee-for-service (FFS) payment methods, service providers have no way to cover the costs associated with meaningful care coordination. Therefore, transitioning to APMs offers service providers payment streams that incentivize providers for coordinating care. Without the financial resources to support care coordination, this critical aspect of care will likely continue to be neglected.

12. BH Workforce Development

Dane County should adopt BH workforce development as a priority. Particular focus should be on attracting and supporting those from Black, Indigenous, and People of Color (BIPOC) and queer and trans BIPOC (QTBIPOC) populations, to careers within BH. Dane County should implement The National CLAS Standards, which are a set of fifteen (15) action steps intended to advance health equity, improve quality, and help eliminate health care disparities.

The web portal *Think Cultural Health* features information, continuing education opportunities, resources, and more for health and health care professionals to learn about culturally and linguistically appropriate services, or CLAS. Launched in 2004, Think Cultural Health is sponsored by the Office of Minority Health at the U.S. Department of Health and Human Services (HHS).

13. Cost Offsets and Reinvestment Opportunities

When Dane County's BH crisis response system is further optimized, analyze the resulting cost offsets and reinvest those cost offsets to further address the BH clinical and support service continuum and the social determinants of health.

It is anticipated that Dane County will experience reductions in arrests, detention, ED, and hospital utilization; and therefore the reinvestment of those savings can further buildout community-based services and supports. This requires providing intensive levels of community-based care, such as peer-run crisis respite, Assertive Community Treatment (ACT) teams, Intensive Outpatient (IOP), and supportive housing, supported education and employment to address the social determinants of health and system inequities. Ultimately, Dane County like every other locality must get upstream to prevent BH conditions and their effects in the first place, rather than always having to pay exorbitant costs on the back end to intervene to treat these conditions. Therefore, it is urged that there be greater investments in primary prevention, such as the highly researched and evidence-based, PAX Good Behavior Game.

14. Peer Respite

Establish peer respite as a component within Dane County's crisis response system. Peer respites are peer-run, voluntary, short-term (typically up to two weeks), overnight programs that provide community-based, non-clinical support for people experiencing or at risk of acute BH crisis.

They operate 24 hours per day in a homelike environment and can provide a "step-down" from facility-based crisis services, where peer navigation services are provided to assist with transition back to the community. Peer respites also allow users to take a break from stressful life circumstances while building a community with peers.

Introduction and Background

RI International (RI) was awarded a contract with the Dane County Department of Human Services (DHS) on June 18, 2021. Under the Scope of Work of that contract, RI was tasked with providing consultation, assessment, analysis, and recommendations to develop a plan for the implementation of a Dane County Triage and Restoration Center that would address the following:

- The capacity to serve as a jail diversion by accepting and safely managing all referrals by law enforcement for individuals who are believed to have urgent mental health or substance use issues;
- The capacity to assess and address the immediate behavioral health need(s) of the individuals referred, provide stabilization, and link the individual with on-going services and supports;
- The capacity to admit individuals on a voluntary or involuntary basis for a time period as determined by medical or health professionals;
- The capacity to serve as a resource for individuals and families seeking assistance in dealing with behavioral health issues; and

- The capacity to address the disparate impact of the criminal justice system on those who are members of our Black, Indigenous, and People of Color (BIPOC) communities

The term, "restoration" in the title for the planned Crisis Triage and Restoration Center should be removed as it implies that one of the purposes of the proposed CTC is to restore the competency of an individual who has been found incompetent to stand trial (IST), and who has been court-ordered to receive competency restoration services. Since the proposed Center is to provide facility-based crisis services with stays of under twenty-four (24) hours, it will not operate as a facility to restore competency. Therefore, throughout the remainder of this Report, the intended facility will be referred to as a Crisis Triage Center (CTC).

Briefly, the scope of work for this project included the following:

- Conducting a study of the existing crisis care continuum available in Dane County;
- Complete a comparative analysis of the current crisis response system against best practices; Recommend an implementation plan for the development of the Crisis Triage & Restoration Center;
- To be located in a safe & accessible location
- With identification of needs, design elements, costs, timelines, & partnerships needed in order to make the development of this center feasible & sustainable.

The Substance Abuse and Mental Health Services Administration (SAMHSA, 2014) define a BH crisis stabilization service, as:

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

Like a physical health crisis, a mental health crisis can be devastating for individuals, families and communities. While a crisis cannot be planned, we can plan how services are structured and organize them to best meet the needs of those individuals who experience a BH crisis. Too often that experience is met with delay, detainment and even denial of service in a manner that creates undue burden on the person, law enforcement, emergency departments and justice systems.

Given the ever-expanding inclusion of the term "crisis" by entities describing service offerings that do not truly function as "no-wrong-door" services, it is important to distinguish what crisis services are and what they are not. Crisis services are for anyone, anywhere and anytime without undergoing a prescreening process or medical clearance in advance of accessing them. Examples of emergency medical response services seen in communities around the country include: (1) 911 accepting all calls and dispatching support based on the assessed need of the caller; (2) law enforcement, fire or ambulance dispatched to wherever the need is in the community; and (3) hospital emergency departments serving everyone that comes through their doors from all referral sources.

Similarly, BH crisis response should include (1) crisis lines accepting all calls and triaging the call based on the assessed need of the caller; (2) mobile crisis teams dispatched to wherever the need is in the community (not hospital emergency departments); and (3) facility-based crisis services that serve everyone that comes through their doors from all referral sources. A simple test regarding whether a service meets this standard definition of a crisis service is to inquire whether there is any screening of referrals by location, acuity, eligibility or other exclusionary criteria; or any limitation of the service based on availability during certain days of the week or hours of the day. If screening exists, the service may still represent an important part of a community's system of care, but the service is not representative of the *SAMHSA's National Guidelines for Behavioral Health Crisis Care*.

There appears to be general agreement, in Dane County and elsewhere, that far too many persons with BH issues are arriving in hospital emergency departments (EDs), or are being charged and transported by law enforcement to detention facilities; and they are not being well served in either setting. In fact, criminal justice settings have been increasingly referred to as, "the de facto BH system." Holding those with BH conditions in EDs has been termed "psychiatric boarding" and is a growing problem most everywhere. Long waits, often for hours or even days, in often-chaotic ED environments, may exacerbate symptoms and trigger trauma responses. In addition, "boarding' consumes hours of law enforcement officers' time, which they commonly refer to as, "wall time." To exacerbate this problem further, EDs typically do not have the appropriate BH personnel onboard to effectively engage and intervene when someone presents in a BH crisis.

Another unproductive dynamic involves BH crisis dispositions by EDs. These have become known as, "streeting." This occurs when those with presenting BH conditions are not appropriately screened and triaged and, as a result, are discharged prematurely usually without appropriate treatment and/or supports. In either case, "boarding" or "streeting" is damaging to not only those in crises, but also frequently the significant others who must endure these dynamics as well. From a cost standpoint, ineffective interventions in EDs or jails are poor uses of resources and they exacerbate costs. They perpetuate the crisis response dynamic of the "revolving door" that saps the resources of health care, law enforcement, the judiciary, incarceration settings, and social services. The ED is an expensive setting and can result in unnecessary and costly admissions for public and private insurers. Likewise, costs associated with 911 dispatch, law enforcement, EMS, and the criminal justice system for those in crisis, are costs that could be better spent and with better outcomes using an adequately resources BH crisis response system.

The underlying issues that impede the appropriate interventions for a person in a BH crisis are complex. For instance, many large service systems may be involved with someone who has complex needs. Each of these intervening service systems have their own respective missions, cultures, competencies, and entry points with rules for accessing services. The BH system has its own complexities and issues with having a dearth of intermediate and intensive community-based treatment options that serve people in their natural environments. Care for these individuals is, left too often, to EDs and hospitals at one end of the care continuum, and routine outpatient services on the other. There are significant legal issues that serve as barriers to accessing BH crisis care, including professional scope of practice laws, facility and service licensing (including ambulance emergency destination restrictions), and protections for those in care, including medical clearance and "certifications for involuntary admissions." Financing of BH treatment services has its own set of challenges, since insurers (public and private) have their own systems, rules, and payment rates that only reimburse certain services operated by only certain facility and provider types. And let's not forget, there are still those who are uninsured and require safety net funding in order to access services

Per the expectations of DHS, RI engaged in key stakeholder meetings with members of the local community/municipal/borough crisis services, including: public safety, health, hospitals, behavioral health (BH) treatment providers, housing and homeless service providers, advocates, those with "lived experience," and other key parties and safety net services providers. A representative from DHS facilitated each of these meetings. In each meeting, there was a discussion around the application of the BH crisis care best practices and key service components and standards. These stakeholder engagements also served as an opportunity for participants to have unanswered questions addressed and to share their respective perspectives on the current crisis response system and the proposed Crisis Triage Center. These discussions also served to rally support for crisis system optimization utilizing national best practices as a guide. A crisis response system is a complex and tiered structure comprised of crisis response services that support anyone, anywhere, and anytime. This system is designed to stabilize those whose safety and health are threatened by BH challenges, including mental illness, developmental disabilities, substance use, and/or overwhelming stressors and begin to guide them towards a path of recovery.

DHS and RI Convened meetings with thirty-seven (37) organizations & over three-hundred and two (302) participants. Below are the general themes that emerged from these stakeholder engagements:

- Support for the Crisis Triage Center (CTC) to fill a recognized service gap in the crisis response system;
- CTC "no wrong door" approach and heavy reliance on peer support are both favorably received;
- Recognition that state barriers to operating & sustaining the crisis response system must be overcome;
- Better coordination of crisis and other care needs to occur;
- Crisis services require culturally competent delivery;
- Rural access to crisis care remains a need; and
- Behavioral health workforce challenges need to be addressed.

A comprehensive and integrated crisis network is the first line of defense in preventing tragedies of public and patient safety, civil rights, extraordinary and unacceptable loss of lives, and the waste of resources. There is a better way. Effective crisis care that saves lives and dollars requires a systemic approach. This Report is intended to guide Dane County on estimating the crisis system resource needs, the number of individuals who can be served within the system, the cost of crisis services, the workforce demands of implementing crisis care, and the expected community-changing impact with the optimization of the crisis response system. This Report will also demonstrate how this approach harnesses data and technology, draws on the expertise of those with lived experience, and incorporates evidence-based suicide prevention practices. Perhaps the most potent element of all is human connection. To be authentic. To be compassionate. RI knows from experience that immediate access to help, hope and healing, saves lives.

Utilizing an analysis of information collected during key stakeholder interviews, related to the utilization of emergency room care, police/fire intervention, arrest, and service waitlists, RI has accomplished the following:

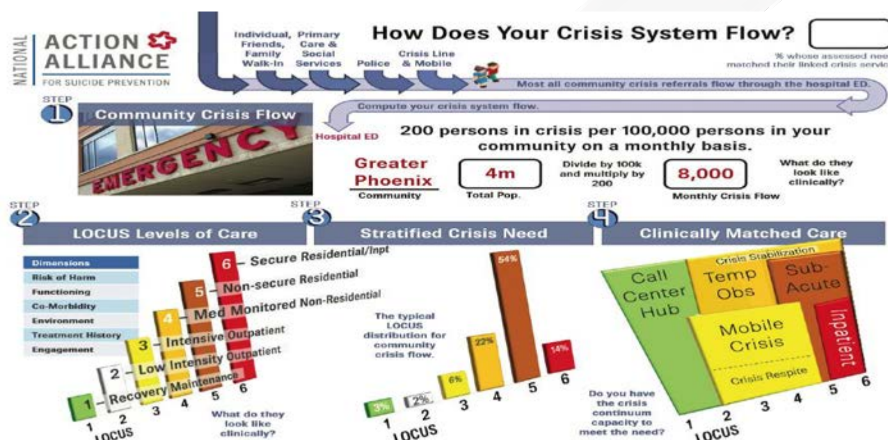
- Identified gaps in services and opportunities for Dane County to include demand, optimization, costs, feasibility, and funding mechanisms;
- Identified opportunities to reduce overall health care costs, psychiatric boarding, law enforcement resources dedicated to addressing BH crises and incarceration of individuals when BH treatment is the preferred intervention;

- Identified areas of overlap and opportunities for efficiency for how to most effectively and efficiency meet the needs of those in crisis on the front end to effectively decrease the need for higher more costly and invasive levels of intervention;
- Provided recommendations on how to align current practices with the crisis practice standard defined within national best practices while optimizing crisis resource design and allocations to most efficiently meet the needs in Dane County; and
- Presented a draft report to key stakeholders for community engagement and implementation planning before finalizing the final report.

RI operates a continuum of BH crisis and recovery services across the U.S. and in Australia. Included in this continuum are ten (10) Recovery Response Centers (RRC) that would be analogous to a psychiatric emergent level of care. RI has these facilities in Arizona, California, Delaware, Louisiana, New Mexico, North Carolina, and Washington. RI is currently establishing similar facility-based crisis services in Maryland, Ohio, and Virginia. All of RI's crisis services operate in alignment with *SAMHSA's National Guidelines for Behavioral Health Crisis Care* and the components of Dane County's crisis response system have been evaluated against these guidelines; and the recommendations of this report have been framed in terms of them as well.

SAMHSA's National Guidelines for Behavioral Health Crisis Care

According to the paper published by the National Association of State Mental Program Directors (NASMHPD) and co-authored by RI's CEO, David W. Covington, LPC, MBA, *Comprehensive Crisis System: Ending Unnecessary Emergency Room Admissions and Jail Bookings Associated with Mental Illness*, August 2018, individuals in crisis often interface with the justice system, first responders, hospital emergency departments (EDs) and correctional facilities. These resources are essential to supporting a healthy community, but they are not designed to meet the unique needs of individuals experiencing a BH crisis. The diagram below represents potential paths of flow within a crisis response system for individuals experiencing a BH crisis:



It is estimated that for every 100,000 members of a representative population, 200 of those population members will experience a crisis that requires something more than a typical outpatient or phone intervention. Research has resulted in the utilization of data to stratify the service level needs of those individuals; and that data can be applied to design a cost-effective crisis response system.

Timely access to vital acute psychiatric inpatient (hospital) care is frequently unavailable for individuals experiencing the most significant BH crises. A decade of Level of Care Utilization System (LOCUS) assessment data, gathered in Georgia by mobile crisis teams, emergency departments and crisis facilities indicates that 14% of individuals experiencing a crisis who have reached these higher levels of care have a clinical need that aligns with inpatient care (LOCUS level 6). A majority (54%) of these individuals, experiencing a BH crisis have needs that align better with services delivered within a crisis facility and 32% have lower level needs that would benefit from interventions by a mobile crisis team (LOCUS levels 1-4). It is important to note that this LOCUS data set does not include an assessment of individuals who have only contacted the crisis line. Therefore, it is used to only stratify the clinical needs of those engaged by higher levels of care and is not being used to predict crisis line resource needs.

As indicated above, it is expected that 200 individuals per 100,000 will experience a crisis that requires a service level more acute than can be accommodated by outpatient services or a phone intervention. If this ratio were applied to Dane County with a population in 2021 of 546,695, it would be expected that over 13,121 individuals would annually be in need of more intense crisis services. If 54% of these were expected to require admission to a crisis facility, the number of admissions would be 8,345. Similarly, if 32% require a MCT intervention, that annual number is 4,199.

Therefore, the key elements of a comprehensive BH crisis response system as delineated in the National Guidelines are:

1. **Regional or Statewide Crisis Call Centers**. The "front door" of a modern crisis system is a crisis call center that meets National Suicide Prevention Line (NSPL) standards and participates in the national network. Since 2005, SAMHSA has funded multiple research projects to evaluate the critical role of crisis call centers as indispensable resources for suicide prevention. Nationally more than 180 call centers meet the standards of and participate in the NSPL. Such a crisis call center is equipped to connect individuals in a BH crisis to needed care. These programs use technology for real-time coordination across a system of care and leverage big data for performance improvement and accountability across systems every minute of every day. That real-time care coordination requires electronic linkage with every BH inpatient, and residential bed and with every outpatient treatment slot in the service area. At the same time, they provide high-touch support to individuals and families in crisis that adheres to National Suicide Prevention Lifeline (NSPL) standards. In order for Call Centers to be accessible to youth, it is critical that they include the technology and the staffing to support both texting and chat capabilities. The Crisis Call function can be further supplemented by a Peer-to-Peer Warm Line, which is staffed by Certified Peer Support Specialists. This service can provide 24/7 readily accessible support, outreach, and postvention which can prevent the emergence of future crises or re-stabilize an individual who is beginning to feel over-stressed, overcome with drug cravings, or feelings of loneliness, hopelessness, and burdensomeness.

2. **Centrally Deployed Mobile Crisis Teams on a 24/7 Basis**. Mobile crisis services are typically comprised of a two-person (licensed clinician and peer partnerships are common) mobile crisis team (MCT) that offers assessment, outreach, and support where people in crisis are either in the person's home or a location in the community (not a healthcare facility). The two person model is intended to assure greater safety for the teams in their work in the community, to ensure that those served have the best opportunity for engagement, and to allow for the transportation of those served when warranted, eliminating the need for overuse of the police and ambulances for

transportation. Recently, programs have shown greater success by using GPS-enabled technology dispatched from the crisis call center to efficiently connect individuals in crisis with the nearest available mobile team. Programs should include contractually required response times and medical backup. The MCT provides a timely face-to-face response and requires the capacity to intervene quickly, day or night, wherever the crisis occurs. In cases where the person in crisis cannot be stabilized, the MCT assists in transferring this person to a higher-level program and will provide transportation for those that are voluntary when it is safe to do so.

3. **Crisis Observation and Stabilization Facilities**. These facility-based crisis services offer short-term BH crisis care for individuals who need support and observation. Design of these facility-based crisis services may vary, but ideally they will include a medically staffed flexible observation and stabilization area with recliners, instead of beds, (usually limited to less than 24 hours of care); and operate under a "no wrong door" approach. The proposed CTC will operate as crisis observation service. Under this approach walk-ins, law enforcement, and other first responder referrals, are immediately accepted without requiring any form of medical clearance prior to admission. This approach also includes both accepting both voluntary and involuntary admissions. Therefore, it is imperative that the facility is staffed and equipped, to assure the health and safety of everyone within the facility. These centers are typically a high-speed assessment, observation, engagement, and stabilization service. Each admission receives the following services: a psychiatric evaluation by a Licensed Psychiatrist or Psychiatric Nurse Practitioner, that includes a risk assessment and medication evaluation; a brief medical screening, by a registered nurse to ensure that co-occurring medical issues are addressed; Substance Use Disorder (SUD) screening and assessment by a licensed clinician; a psychosocial assessment by a licensed clinician; crisis stabilization services utilizing a high engagement environment with a strong recovery focus and peer support model; and comprehensive discharge planning and community coordination of services.

   These observation stabilization programs are typically paired with a subacute short-term (2-5 day) facility-based crisis program (either inpatient, respite or residential) to offer more than 24 hours of care without escalating to more costly acute inpatient options that would result in longer lengths of stay and higher per diem costs. This facility needs to be licensed to accept involuntary guests and have the licensed ability to offer seclusion and restraint services, if needed. This unit is intended to serve approximately 30% of those admitted to the 23-hour center with recliners, who were not sufficiently stabilized during the 23-hour observation stay.

   Both settings should be designed as inviting non-institutional environments that are enhanced by natural light, and hopeful and inspiring aesthetic features. Common security elements such as uniformed and armed security guards and razor wire fences are not features in these facilities. Program interventions are delivered by both professional (MD, PNP, RN, Clinician) and para-professional (certified peer support specialists) staffs designed to support ongoing recovery, and to engage in comprehensive discharge planning and community coordination of care. Equally important is that this interdisciplinary team creates and sustains an environmental milieu where all "guests" are treated with dignity and respect, are authentically and meaningfully engaged, and when dysregulated, they are allowed the space, time, and support necessary to de-escalate. As a result, these stabilization settings, when appropriately staffed, are able to assure greater safety than normally expected in crisis settings. Seclusion and restraints are available, but rarely applied.

It should be noted that once these core components are in place and operating as intended, there are additional crisis systems service enhancements that can be made. These can include a Peer Navigator service that assists individuals who have accessed crisis services to subsequently navigate health and human services systems in order to access the benefits and services that potentially further stabilize and improve one's quality of life, such as permanent supportive housing, supported employment or education. Another option is a Peer Respite Center that is managed by and staffed with Peer Support Specialists. Crisis Respite is typically a short-term (two-week) residential environment that operates as a transition from crisis stabilization to the community, or as a step up from the community to prevent a potential crisis. Other alternative models are being developed as communities become freer to innovate in meeting identified needs and garner a broader base of practice-based evidence.

Communities that lack a crisis service continuum pay the price in terms of the cost of law enforcement engagement in addressing BH crises, the expense of incarceration, the negative impact on the quality of life for individuals in the community, and ED and hospitalization costs. Those unable to access needed services in a timely manner endure the effects of psychiatric boarding (waiting in an ED for hours or days) and the exacerbation of symptoms and distress. For payers of healthcare, a lack of adequate crisis care translates into paying unnecessary ED bills that are estimated to cost between $1,200 and $2,260. In contrast, 96% of individuals directly referred to a crisis provider do not require an ED visit. Additionally, acute psychiatric inpatient care often comes with a higher per diem rate and a longer average length of stay than crisis facilities. The escalated expenses increase healthcare costs by an estimated 100% of the costs realized within a comprehensive crisis system.

The desired model is to connect individuals to a crisis provider as quickly as possible using a systemic method that is analogous to the healthcare delivery system's approach to medical emergencies. This prototype can also be used as a tool to help model reimbursement for these similar crisis services in a manner consistent with parity expectations. The chart below demonstrates the differences between our 911 medical emergency response system in comparison to our traditional BH crisis response system. The final column illustrates how an optimized crisis response system, can operate on par to our traditional medical emergency response system. In so doing, those with BH conditions in crisis can be subject to life-saving interventions, rather than routinely being endangered and traumatized, or even worse, exposed to deadly force. The table below highlights how the BH crisis response systems are intended to be comparable to emergency medical response systems:

Medical Emergency Response versus a BH Crisis Response			
	Medical System	**BH Crisis System**	**National Guidelines**
Call Center	911	Crisis Line or 911	Crisis Line – 988 in 2022
Community Service	Ambulance / Fire	Police	Mobile Crisis Team
Facility Option	Emergency Dept.	Emergency Dept. Arrest/detention	Acute Crisis Observation & Stabilization Facility
Facility Response	Always Yes	Wait for Assessment	Always Yes

Escalation Option	Specialty Unit (PRN)	Inpatient if Accepted	Crisis Facility or Acute (PRN)

The *Crisis Now Transforming Crisis Services: Business Case* suggests that a comprehensive crisis system is affordable and within reach of most communities. The cost of crisis response services can be further supported by the reinvestment of savings from the decreased spend on hospital-based services and incarceration/detention. In Maricopa County, Arizona for example (which includes the greater Phoenix area), the associated savings of a crisis response system containing all three-core components have experienced the following system efficiencies in 2018:

- 37 full-time equivalent (FTE) police officers' time was spent engaged in public safety, instead of being engaged with BH crises;
- Reduction in ED accumulated boarding time of 45 years annually; and
- Decrease in inpatient hospitalization spend by $260 million.

The escalating costs communities pay for not investing in a comprehensive crisis system are unsustainable; manifesting as demands on law enforcement, other first responders, criminal justice systems, emergency departments, service providers of all types, and public and private payers. These escalating demands in our communities are pushing the limits of what is affordable and sustainable, while resulting in adverse outcomes for those in need of care and the communities within which they reside. The impact to vulnerable and marginalized members of our communities, and their families, is devastating. A comprehensive crisis response system that includes the three core components is essential to all communities. Zero unnecessary admits for BH conditions to emergency departments and jails (where only nuisance crimes have been committed) are attainable goals through the implementation of the *National Guidelines.*

Core Principles and Practices

There are several additional elements that must be systematically "baked into" excellent crisis response systems, in addition to the core structural elements, that are essential for modern crisis response systems. These essential principles and practices are:

- Embracing recovery;
- Significant role for peers;
- Trauma-informed care;
- Suicide safer care;
- Safety/security for staff and consumers; and
- Crisis response partnerships with law enforcement.

Embracing Recovery

Crisis providers must embrace the reality that individuals and families move beyond their BH challenges to lead happy, productive and connected lives, each day. At the 2019 International Initiative for Mental Health Leadership (IIMHL) *Crisis Now* Summit, consumer Misha Kessler ended

his description of his direct experiences with crisis services, “Mental illness is [just] one part of my tapestry.” The fact that recovery is possible and that it means not just the absence of symptoms, but also the development of meaning and purpose in life, has begun to transform mental health care (Anthony, 1993). The President’s New Freedom Commission on Mental Health (Hogan, 2003), recommended that mental health care be “recovery-oriented” and enriched by person-centered approaches, a hopeful and empowering style, and increased availability of support by individuals with lived experience.

The significance of a recovery-oriented approach is critical for those in crisis, and thus for crisis settings. In an outmoded, traditional model, crises typically reflect “something wrong” with the individual. Risk is seen as something to be contained, often by means of an involuntary commitment to an inpatient psychiatric unit. In worst-case scenarios, people end up restrained on emergency room gurneys or in jails. These actions in turn, are traumatizing to those who are subjected to them, and often they further reinforce the likelihood that the person will soon again recycle through this same revolving door of inadequate crisis interventions.

In a recovery-oriented approach to crisis care, the risks of harm to self or others are recognized, but the basic approach is fundamentally different. Crises are viewed as challenges that may present opportunities for growth. When crises are ameliorated in comfortable and familiar settings, people feel less alone and isolated with their feelings of anxiety, panic, depression, and frustration. This creates a sense of empowerment and belief in one’s own recovery, and ability to respond effectively to future crises. The recovery-oriented approach to crisis care is integral to transforming a broken system.

Implementation Guidance

1. *Commit to a “no force first” approach regarding care that is characterized by engagement and collaboration;*
2. *Create engaging and supportive environments that are as free of barrier, as much as possible. This would include eliminating Plexiglas from crisis stabilization facilities and minimal barriers between team members and those being served, in order to support stronger connections;*
3. *Ensure team members engage individuals in the care process during a crisis. Communicate clearly and frequently to those in care regarding all intervention options, and offer materials regarding any processes in writing, in the individual’s preferred language whenever possible;*
4. *Ask the individual served about their preferences and do what can be done to align any actions to those preferences; and*
5. *Work to convert those with an involuntary commitment to voluntary, as soon as practicable, so they become more invested in their own well-being and recovery.*

Significant Role for Peers

One specific, transformative element of recovery-oriented care is to engage the experience, capabilities, and compassion of those who have experienced BH crises. Integrating those “with lived experience” within the components of crisis care has repeatedly demonstrated that they

"take all of [their] experiences; regardless of the pain, and use them to transform [their] life into 'living hope' for others who want to recover" (Ashcraft, Zeeb, & Martin, 2007). This reality has been increasingly substantiated by studies investigating peer services and supports. This body of work has found support for a range of peer support benefits including strengthened hope, relationship, recovery, and self-advocacy skills, and improved community living skills (Landers & Zhou, 2011).

Utilizing peers, especially those who have experienced suicidality and suicide attempts, and learned from these experiences, can provide a safe, authentic, and respectful context within which the feelings of aloneness and burdensomeness, associated with suicidality, can be permeated. Peer intervention in the crisis setting with suicidal individuals is particularly potent in light of the reported 11%-50% range of attempters who refuse outpatient treatment or abandon outpatient treatment quickly following an ED referral (Kessler et al., 2005). Peers support specialists can relate without judgment, can communicate hope in a time of great distress, and can model the fact that improvement and success are possible. This increases engagement, while reducing distress.

The role of peers—specifically survivors of suicide attempts, as well as, survivors of suicide loss—was bolstered when the Action Alliance's Suicide Attempt Survivors Task Force released its groundbreaking report, *The Way Forward: Pathways to Hope, Recovery, and Wellness with Insights from Lived Experience*, in July 2014. The report describes the many ways in which learning from and capitalizing on lived experience can be accomplished.

Implementation Guidance

1. *Hire credentialed peers with lived experience that reflect the characteristics of the community served as much as possible; including, but not limited to, gender, race, primary language, ethnicity, religion, veteran status, lived experiences and age considerations;*
2. *Develop support and supervision that aligns with the needs of the program's peer staff; and*
3. *Emphasize engagement as a fundamental pillar of care that includes peers as a vital part of a crisis program. This would include peers who:*
    a. *Are available for connection with crisis line operations;*
    b. *Serve as one of two mobile team members; and*
    c. *Are one of the first individuals to greet someone upon entrance to a crisis stabilization facility.*

Trauma-Informed Care

The great majority of individuals served with BH services have experienced significant interpersonal trauma. The adverse effects of child trauma may present well into adulthood, increasing the risk for post-traumatic stress disorder (PTSD), mental illness, substance use disorders, and poor medical health (Finkelhor et al., 2005). Persons with a history of trauma or trauma exposure are more likely to engage in self-harm and suicide attempts; and their trauma experiences make them acutely sensitive to how care is provided to them. When crisis care involves a loss of freedom, noisy and crowded environments, and/or the use of force, there is an

exacerbation of presenting symptoms. These situations can actually re-traumatize individuals at the worst possible time, leading to worsened increased agitation or withdrawal, and often followed a genuine reluctance to seek help in the future.

On the other hand, environments and treatment approaches that are safe and calming can facilitate stabilization and healing. Therefore, trauma-informed care is an essential element of crisis treatment. In 2014, SAMHSA posited five guiding principles for trauma-informed care:

1. Safety;
2. Trustworthiness and transparency;
3. Peer Support and mutual self-help;
4. Collaboration and mutuality;
5. Empowerment, voice and choice; and
6. Cultural, historical and gender issues.

These principles should inform treatment and recovery services. When these principles are applied to practice, they become self-evident to staff, clients, and their significant others. The program's culture becomes transformed. All clients are screened for trauma exposure and its impact on overall well-being. Addressing the trauma that family and significant others have experienced is also a critical component that assists stabilization and reduces the possibility for further trauma or crisis.

Developing and maintaining a healthy therapeutic and supportive environment also requires support for staff, who may have a trauma history or may experience post-secondary trauma because of working with other trauma victims. An established resource for further understanding trauma-informed care is provided by SAMHSA (2014): *Trauma-Informed Care in Behavioral Health Services (TIP 57)*. Trauma-informed care is urgently important in crisis settings because of the links between trauma and crisis and the vulnerability of people in crisis, especially those with trauma histories.

Implementation Guidance

1. *Incorporate trauma-informed care training into each team member's new employee orientation with refreshers delivered as needed; and*
2. *Apply assessment tools that evaluate the level of trauma experienced by the individuals served by the crisis program and create action steps based on those assessments.*

Crisis intervention programs have always focused on suicide prevention. This stands in contrast to other health care and BH services, where suicide prevention was not always positioned as a core responsibility. Every crisis provider in the nation must make two transformational commitments:

1. Adoption of suicide prevention as a core responsibility, and

2. Commitment to reductions in suicide among people under care. These changes were adopted and advanced in the revised National Strategy for Suicide Prevention (2012), "Promote suicide prevention as a core component of health care services."

The National Action Alliance for Suicide Prevention created a set of evidence-based actions known as *Zero Suicide* or *Suicide Safer Care* that health care organizations can apply through an implementation toolkit developed by the Suicide Prevention Resource Center (SPRC) at the Education Development Center, Inc. (EDC). The following seven key elements of *Zero Suicide* or *Suicide Safer Care* are all applicable to crisis care:

- Leadership-driven, safety-oriented culture committed to dramatically reducing suicide among people under care, which includes survivors of suicide attempts and suicide loss in leadership and planning roles;
- Develop a competent, confident, and caring work force;
- Systematically identify and assess suicide risk among people receiving care;
- Ensure every individual has a pathway to care that is both timely and adequate to meet his or her needs and that includes collaborative safety planning and reducing access to lethal means;
- Use effective, evidence-based treatments that directly target suicidal thoughts and behaviors;
- Provide continuous contact and support, especially after acute care; and
- Apply a data-driven quality improvement approach to inform system changes that will lead to improved patient outcomes and better care for those at risk.

See more at http://zerosuicide.sprc.org/about

It should be noted that the elements of zero suicide closely mirror the standards and guidelines of the National Suicide Prevention Lifeline (NSPL). NSPL has established suicide risk assessment standards, guidelines for callers at imminent risk, protocols for follow-up contact after the crisis encounter, while promoting collaborative safety planning, reducing access to lethal means, and incorporating the feedback of suicide loss and suicide attempt survivors.

Since comprehensive crisis response systems are the most urgently important clinical service for suicide prevention; and since most parts of the country do not have adequate crisis care, a national and state-level commitment to implementing comprehensive crisis services is foundational to suicide prevention. It is anticipated that health authorities (i.e., payers, plans, state agencies, Medicaid and Medicare) will increasingly require this to an expectation that best practices in suicide care.

Implementation Guidance

1. *Incorporate suicide risk screening, assessment and planning into the new employee orientation for all staff;*
2. *Assign the completion of Applied Suicide Intervention Services Training (ASIST) or similar training to all staff;*
3. *Incorporate suicide risk screening, assessment and planning into crisis care practices;*
4. *Automate the suicide risk screening, assessment and planning process, and associated escalation processes, within the electronic health record (EHR); and*

5. *Commit to a goal of Zero Suicide as a crisis response system.*

Safety and Security

Safety for both guests and staff is a foundational element for all crisis service settings. Crisis settings are also on the front lines of assessing and managing suicidality, an issue with life and death consequences. While ensuring safety for people using crisis services is paramount, the safety for staff is also a priority. People in crisis may have experienced violence or acted in violent ways, they may be intoxicated or delusional, and/or they may have been dropped-off by law enforcement and may present an elevated risk for violence.

Trauma-informed and recovery-oriented care is safe care. Nevertheless, much more than a philosophy is involved. *DHHS's Mental Health Crisis Service Standards (2006)* begin to address this issue, setting parameters for crisis services that are flexible and delivered in the least restrictive available setting, while attending to intervention, de-escalation and stabilization. Keys to safety and security in crisis delivery settings include:

- Evidence-based crisis training for all staff;
- Role-specific staff training and appropriate staffing ratios to number of clients being served;
- A non-institutional and welcoming physical space and environment for persons in crisis, rather than Plexiglas "fishbowl" observation rooms and keypad-locked doors. This space must also be anti-ligature sensitive and contain safe rooms for people for whom violence may be imminent or who may find the crisis environment over-stimulating;
- Established policies and procedures emphasizing "no force first" prior to any implementation of safe physical restraint or seclusion procedures; and
- Strong relationships with law enforcement and first responders.

Ongoing staff training is critical for maintaining both staff competence and confidence, and promotes improved outcomes for those served; and decreases the risk for staff (Technical Assistance Collaborative, 2005). Nationally recognized best practices in crisis intervention such as *CPI* (Crisis Prevention Institute, Nonviolent Crisis Intervention Training) and *Therapeutic Options* (Therapeutic Options, Inc.) are highly effective and instrumental in their utilization of positive practices to minimize the need for physical interventions and re-traumatization of persons in crisis. Such approaches have contributed to a culture of safety for staff and guests in crisis care settings.

RI is currently implementing, Ukeru® which is a safe, comforting and restraint-free crisis management technique developed by and for BH caregivers and educators. Named for the Japanese word, "receive," this award-winning program helps people engage, sense, and feel, and then respond to what someone is trying to communicate through their actions. Ukeru has helped BH providers and schools reduce the use of restraint, seclusion, and injury, while lowering workers' compensation costs and employee turnover.

Adequate staffing for the number and clinical needs of guests under care is foundational to safety. Access to a sufficient number of qualified staff (clinicians, nurses, providers and peer support

specialists) promotes timely crisis intervention and risk management for persons in crisis who are potentially dangerous to self or others (DHHS, 2006).

In some crisis facilities that are licensed or certified to provide intensive services, seclusion and/or restraint may be permitted. Though some practitioners view physical and/or pharmacological restraint and seclusion as safe interventions, they are often associated with increased injury to both guests and staff; and may ultimately re-traumatize individuals who have experienced physical and/or emotional trauma. Therefore, restraint and seclusion are now considered safety measures of last resort, not to be used as a threat of punishment, alternative to appropriate staffing of crisis programs, as a technique for behavior management, or a substitute for active treatment (Technical Assistance Collaborative, 2005).

Crisis providers must engage in person-centered planning and treatment, while assessing risk for violence and collaboratively develop de-escalation and safety plans for individuals served. Debrief staff and individuals involved in those interventions after a seclusion/restraint event to inform policies, procedures, and practices; reducing the probability of the future use of such interventions.

Following the tragic death of Washington State social worker Marty Smith in 2006, the Mental Health Division of the Department of Social and Health Services sponsored two safety summits. The legislature passed into law a bill (SHB 1456) relating to home visits by mental health professionals. These measures should be adopted as policy by every state or jurisdiction.

According to Washington's SHB 1456, the keys to safety and security for home visits by mental health staff include:

- No mental health crisis outreach worker will be required to conduct home visits alone;
- Employers will equip mental health workers who engage in home visits with a communication device; and
- Mental health workers dispatched on crisis outreach visits will have prompt access to any history of dangerousness or potential dangerousness on the client they are visiting, if available.

Ensuring safety for both consumers and staff is the very foundation of effective crisis care. While safety is urgently important in all health care, in crisis care, the perception of safety is also essential. The prominence and damaging effects of trauma and the fear that usually accompanies a psychological crisis.

Implementation Guidance

1. *Commit to a "no force first" approach to care;*
2. *Monitor, report and review all incidents of seclusion and restraint with a goal to minimize the use of these interventions;*
3. *Barriers do not equal safety. The key to safety is engagement and the empowerment of the individual served while in crisis;*

4. *Offer enough space in the physical environment to meet the needs of the population served. A lack of space can elevate anxiety for all;*
5. *Incorporate quiet spaces into the crisis facility for those who would benefit from time away from the milieu of the main stabilization area; and*
6. *Engage team members and those served in discussions regarding how to enhance safety within the crisis setting, make safety truly "Job One."*

Law Enforcement and Crisis Response—An Essential Partnership

Law enforcement agencies have reported a significant increase in police contacts with people with BH conditions in recent years. Some involvement with BH crises is inevitable for police. As first responders, they are often the principal point of entry into emergency care for individuals experiencing a BH crisis.

Police officers are critical to mobile crisis services as well; by either providing support in potentially dangerous situations (Geller, Fisher, & McDermeit, 1995); or by serving as a referral source delivering "warm hand-offs" to crisis mobile teams or facility-based crisis services. Research investigating law enforcement response to individuals with mental illness (Reuland, Schwarzfeld, & Draper, 2009) found police officers frequently:

- Encounter persons with mental illness at risk of harming themselves;
- Often spend a greater amount of time attempting to resolve situations involving people exhibiting mental health concerns;
- Address many incidents informally by talking to the individuals with mental illness;
- Encounter a small subset of "repeat players"; and
- Often transport individuals to an emergency medical facility where they may wait for extended periods for medical clearance or admission.

In many communities across the United States, the absence of sufficient and well-integrated BH crisis care has made local law enforcement the de facto BH mobile crisis system. This is unacceptable and unsafe. The role of local law enforcement to address emergent public safety risk is essential and important. With good BH crisis care in place, MCTs can collaborate with law enforcement, which will improve both public safety and produce better outcomes for those in crisis. Unfortunately, well-intentioned law enforcement responders to a crisis call can often escalate the situation just based on their presence. Police vehicles and armed officers can generate anxiety or agitation for far too many individuals in a crisis.

We now know a good deal about crisis care/law enforcement collaboration. Deane et al. (1999), reporting on partnerships between BH personnel and law enforcement, found the alliance between first responders and BH professionals helped to reduce unnecessary hospitalization or incarceration. Specialized responses to BH crises included specialized police response, police-based specialized BH response, and BH-based specialized BH response. These forms of collaboration share the common goal of diverting people with BH crises from criminal justice settings into BH treatment settings and were rated as "moderately effective" or "very effective" in addressing the needs of persons in crisis.

Specialized police responses involve police training by BH professionals in order to provide crisis intervention and to act as liaisons to the BH crisis system. The Memphis Crisis Intervention Team (CIT) model pioneered this approach. In CIT, training for law enforcement includes educating officers about mental illness, substance use disorders, psychiatric medications, and strategies for identifying and responding to a crisis (Tucker et al., 2008). Lord et al. (2011) found most officers involved volunteered to participate in the training.

Consistent with the findings above, CIT necessitates a strong partnership and close collaboration between the police officers and BH programs (e.g., availability of a crisis setting where police can drop off people experiencing a mental health crisis). CIT has been cited as a “Best Practice” model for law enforcement (Thompson & Borum, 2006). Crisis care programs should engage in ongoing dialogue with local law enforcement agencies to support continuous quality improvement and collaborative problem solving. Optimized crisis response systems report facilitating monthly meetings with aggregate data sharing as a part of their ongoing operations.

Strong partnerships between BH crisis care systems and law enforcement are essential for public safety, suicide prevention, connections to care, justice system diversion, and the elimination of psychiatric boarding in emergency departments. The absence of a comprehensive crisis response system has been the major “front line” cause of the criminalization of those with BH conditions, and a root cause of shootings and other incidents that have left too many people, including police officers, dead. Collaboration is the key to reversing these unacceptable trends.

Implementation Guidance

1. *Have local crisis providers actively participate in CIT training sessions;*
2. *Incorporate regular meetings between law enforcement and crisis providers into the schedule so that these partners can work to continuously improve their practices;*
3. *Include BH crisis provider and law enforcement partnerships in the training for both partner groups; and*
4. *Share aggregate outcomes data, such as: numbers served, percentage stabilized and returned to the community, and connections to ongoing care.*

988 Implementation

The plans by Dane County, to optimize its BH crisis response system and to establish a Crisis Triage Center (CTC), are being intersected by the following national developments:

- August 2018: The National Suicide Hotline Improvement Act (H.R.2345) became law. This initial legislation called on the Federal Communications Commission (FCC) and the Substance Abuse and Mental Health Services Administration (SAMHSA) to report on the feasibility of designating a three-digit dialing code for the National Suicide Prevention Lifeline (“Lifeline,” 1-800-273-8255).
- August 2019: The FCC, in conjunction with SAMHSA, indicated that the 988 dialing code would be the optimal three-digit number for the Lifeline and that additional resource would be necessary to support crisis call centers responding to 988 callers.

- October 2019: The National Suicide Hotline Designation Act (S.2661) was introduced to support the designation and implementation of the 988 dialing code and strengthen local crisis response capacity to meet 988-service demand. Local crisis call centers are chronically underfunded and under-resourced; many localities are not equipped to respond to current crisis call volume, much less, any projected increases once 988 becomes widely available.
- July 2020: The FCC officially designated 988 as the three-digit dialing code for the Lifeline — to be nationally available by July 2022.
- September-October 2020: During September Suicide Prevention Month, the National Suicide Hotline Designation Act passed through Congress unanimously. The President signed it into law in October 2020. Legislation will be required in all 50 states and D.C. to support 988 implementation and establish a sustainable funding mechanism for the 988-crisis response system as allowed for in federal law.
    - The (federal) National Suicide Hotline Designation Act included language allowing each state to pass their own legislation funding 988 the same way as 911, through state-managed monthly customer service fees.
    - The federal law allows for the revenue generated by these fees to go toward funding local crisis centers and supporting the development and implementation of wraparound crisis care services. Current 911 fees vary by state, between $0.25 - $5.00; some state fees are charged on a percentage basis.
    - Ideally, fees will be collected across all wireless and wireline providers in each state.
- January 2021: States receive 988 Implementation Planning Grants from Vibrant (Vibrant) Emotional Health, administrators of the National Suicide Prevention Lifeline (Lifeline). Through this grant opportunity U.S. states, territories, and Lifeline centers received grant awards and are expected to:
    - Develop clear roadmaps for how they will address key coordination, capacity, funding and communication strategies that are foundational to the launching of 9-8-8, which will occur on or before July 16, 2022.
    - Plan for the long-term improvement of in-state answer rates for 9-8-8 calls.

The 988-crisis response system is expected to consist of:

- Well-resourced crisis call centers in communities across the country that are able to answer callers quickly and effectively in-state 24/7/365 and follow up as needed.
- Mobile crisis outreach teams and crisis stabilization centers in all 50 states and the District of Columbia that work together with crisis call centers to provide the full continuum of crisis care.
- Flexible and sustainable funding options — including federal appropriations, state appropriations, grants, and service fees that ensure standard quality and delivery of services across the country.
- Public education and awareness campaigns that promote the new 988 number and the availability of crisis services and that encourage and normalize seeking help for mental health and suicide crises.
- Robust administration and reporting of 988 services. Oversight of services provided and populations served will facilitate greater understanding of the 988 crisis care continuum and support a quality, standardized service for callers in need.

The Wisconsin Department of Health Services (DHS) received the Vibrant 988 Implementation Planning Grant of $171,701 in January of 2021. As Wisconsin prepares for this transition, a 988 Planning Coalition

has been formed to advise WI DHS on issues related to coordination across call centers and other services (examples 211 and 911), capacity, funding, and marketing. This group has been meeting since April 2021. The Interim Report on Wisconsin's 988 Implementation Plan is due by September 30, 2021 and its Plan must be submitted to Vibrant and SAMHSA by December 31, 2022.

Before Dane County DHS invests further in establishing a CTC and other improvements to its crisis response system, it will be necessary to assure that such planning aligns with any Wisconsin statutory, regulatory, and financing changes in support of 988 implementation.

Methodology

The over-arching purpose of this project was to create a CTC implementation plan and determine how to align current crisis practices within Dane County to the practice standards for BH crises care as defined within the *National Guidelines*. In addition, the intention of this project is to optimize crisis resource design and allocations to meet local needs; and to find opportunities to reduce overall health care costs and those costs associated with psychiatric boarding, law enforcement interventions, and the incarceration. In order to implement and sustain a comprehensive BH crisis response system that is in fidelity to the *National Guidelines*, RI examined available information regarding Wisconsin's alignment of facility certification standards, Medicaid administrative rules and payment rates, and regulations governing involuntary placements.

Lastly, RI applied the pertinent data that was gleaned throughout the assessment process, to its algorithmic formulations to determine the general crisis capacity needs for the County. The results of these calculations were subsequently modified to accommodate the unique permutations of client flows within Dane County's crisis response system and the impact on that flow with the operationalization of the proposed CTC. The results were then analyzed against current crisis service assets and strengths to develop a set of concrete recommendations on how to best develop and implement a staged approach to achieving these aims. RI implemented the following methodology and management plan to accomplish the scope of services in meeting DHS's objectives for this project.

- **Pre-Planning:** Virtual stakeholder meetings were planned with DHS to discuss the project schedule, scope of work, deliverables, and to receive input regarding BH crisis care in Dane County, and respond to questions.
- **Assessment:** RI initially gathered information on Dane County's existing crisis response system, which included an examination of substantiated needs, an inventory of existing crisis services, and an analysis of the gaps in the crisis services provided. This was completed through a review of existing publicly available records and data. Each of these sources is listed in the Reference Appendix of this Report. Additionally, RI's consultant team conducted stakeholder interviews from July to mid-September 2021.

  These stakeholder engagements were determined and scheduled in consultation with DHS, and included representatives from the following organizations:
    - BadgerCare MCO - Centene

- BadgerCare MCO – MHS Health
- BadgerCare MCO – United Health Care (UHC)
- Behavioral Health Resource Center Workgroup
- Behavioral Health Subcommittee, Criminal Justice Committee
- Collaborative Stabilization Coalition
- Dane County Administrator
- Dane County Board of Supervisors Chair
- Dane County Comprehensive Community Service Directors
- Dane County Crisis Providers
- Dane County DHS and JFA Institute
- Dane County DHS Leadership
- Dane County District Attorney
- Dane County Forensic Meeting
- Dane County Health and Human Need/Public Protection and Judiciary, Joint Meeting
- Dane County POS providers
- Dane Hospital Quarterly Meeting
- Dane County NAMI Executive Director
- Dane County Sheriff
- Developmental Disabilities Coalition
- Hmong Institute
- Homeless Outreach Service Providers
- Homeless Shelter Providers
- Journey Crisis Services
- Journey MHC Executive Director
- Latinx Mental Health Coalition
- Madison Homeless Services
- Madison Mayor
- Madison Municipal Judge
- MOSES (Madison Organizing in Strength, Equality and Solidarity)
- Peer Support Network
- Public Defender for Dane County
- Recovery Coalition of Dane County
- SE Asian Healing Center
- Tellurian Executive Director
- Wellpath Behavioral Health Lead
- Wisconsin DHS

- **Analysis and Draft Report, and Implementation Plan Development:** RI analyzed the assessment results to identify gaps and opportunities. This was followed by an analysis of service demand, crisis system optimization, costs, feasibility, and a review of financing methodologies and rates. Subsequently, RI developed an implementation plan, balancing all of these elements and reviewed it with DHS.

- **Community Engagement:** RI engaged current and potential future stakeholders to rally support for crisis system optimization. Virtual stakeholder forums were convened to further to build consensus within the community. Invitees for this forum were determined by working with DHS.

- **Final Report and Plan:** This Report is the project's final work product, which is intended to be a roadmap for the development and implementation of the CTC that builds on the current crisis care assets within Dane County while maximizing system efficiencies whenever possible. This Report contains all of the substantive information acquired in the course of the project and will be publicly shared by DHS. This Report includes:
  - An overview of project, lessons learned, and recommendations for the future;
  - A brief description of Dane County's crisis response system (call center, mobile teams, facility-based crisis services and other crisis care assets) with recommendations for needed capacity or system redesign.
  - A recommended plan to best incorporate existing crisis care assets into an optimized crisis response system, which will include the implementation of a 23-hour CTC with recliners. This Report addresses CTC costs, staffing requirements, facility size, and potential funding mechanisms. This Report also assesses overall cost impact of the implementation of recommendations balanced with potential savings to the system.

- **Wrap-Up Meeting:** The goal of this meeting was to the review the Report, answer questions and determine actionable next steps. This involved one (1) two-hour collaborative teleconference meeting between representatives from DSH, and RI's consultant team.

Findings and Analyses

Dane County and its various service entities have done a commendable job of chronicling BH needs, inventorying related existing service capacity, completing gaps analyses; issuing recommendations for providing a more comprehensive response to better meet BH-related needs, and completing a sequential intercept-mapping project. This body of work has included analyses and recommendations related to needed public policy to support crisis service system enhancements. The following reports were reviewed in preparation of this Report, and the relevant information from the respective findings and recommendations, have been integrated within this Report:

- *Dane County Behavioral Health Needs Assessment*. Public Consulting Group. October 2019.
- *Investigating Solutions to Racial Disparities and Mental Health Challenges in the Dane County Jail and throughout Dane County's Criminal Justice System.*" September 2015.
- *Sequential Intercept Model Mapping Report for Dane County*. Delmar, NY. Policy Research, Inc. 2018.
- *The 2019 Behavioral Health Gaps Report for the State of Wisconsin*. Madison, WI: University of Wisconsin Population Health Institute, October 2020.

A Crisis Triage and Restoration Center in Dane County was first proposed in the report, *Investigating Solutions to Racial Disparities and Mental Health Challenges in the Dane County Jail and throughout Dane*

County's Criminal Justice System in 2015. Subsequently, the potential of establishing a Crisis Triage and Restoration Center appeared to gain momentum. That momentum was reinforced by the findings from the *Sequential Intercept Model Mapping Report for Dane County*, completed in 2018. While the idea for a Crisis Center was not specifically mentioned in this report, the first recommendation referenced developing a crisis continuum of care and expanding crisis care treatment interventions. The Report's second recommendation encouraged the development of "alternatives to detention and pre-adjudication diversion options for people with mental health disorders. Most recently, *The Dane County Behavioral Health Needs Assessment,* conducted by the Public Consulting Group, in 2019, added more weight in support of such a Center. One of the Assessment's recommendations was, "Create a roadmap to implement a facility with 23-hour observation beds, 24/7 crisis care, dedicated law enforcement drop off for crisis care, and programs that more fully integrate co-occurring substance use and mental health treatment."

In direct response to that recommendation, the Dane County Executive added an initiative to the 2021 County Budget Proposal to study the feasibility of developing a Behavioral Health Crisis Triage and Restoration Center. The vision put forth in the County Executive's budget message was that "such a center would represent another bold step at improving mental health care in Dane County, while offering an innovative service that would be another step toward reforming the criminal justice system." In order to continue to move this initiative forward, the County determined that it required an implementation plan.

At its meeting in September of 2020, the Dane County Community Justice Council (CJC) endorsed the planning and development of a Crisis Triage and Restoration Center to serve as an alternative for those who do not require inpatient or emergency department care or jail. The CJC further directed the Behavioral Health Subcommittee of the CJC to take the lead in planning efforts for a Crisis Triage and Restoration Center, to include developing a concept plan regarding services, a space plan, and identification of costs and resources. The CJC-Behavioral Health subcommittee membership includes the following representatives: Dane County District Attorney, Department of Human Services, Office of the Public Defender, NAMI Dane County, Madison Police Department, Dane County Sheriff's Office, Corporation Counsel, and the 911 Center.

In February of 2020, the Dane County Department of Administration's Purchasing Division issued a Request for Proposal (RFP) to procure a Crisis Triage Restoration and Triage Center Planning Consultant. RI International responded to this RFP with a proposal submission and RI was awarded the contract to serve in this role. As envisioned by Dane County, a Crisis Triage Center would address:

- The capacity to serve as a jail diversion by accepting and safely managing all referrals by law enforcement for individuals who are believed to have urgent mental health or substance use issues;
- The capacity to assess and address the immediate behavioral health need(s) of the individuals referred, provide stabilization, and link the individual with on-going services and supports;
- The capacity to admit individuals on a voluntary or involuntary basis for a time period as determined by medical or health professionals;
- The capacity to serve as a resource for individuals and families seeking assistance in dealing with behavioral health issues; and
- The capacity to address the disparate impact of the criminal justice system on those who are members of our Black, Indigenous, and People of Color (BIPOC) communities

One of the critical components and expectations for this review of data and the analysis of need was the gathering of inputs from key stakeholders, including people with "lived experience." To accomplish this, the RI consultant team worked closely with DHS leadership to set up and convene a series of stakeholder meetings that began in early July and continued through mid-September 2021. Most of these engagements were meetings setup to focus exclusively on the potential establishment of the CTC and its anticipated impact on the County's crisis response system and those it serves; and for some other engagements, the CTC focus became an agenda item as part of a regularly scheduled meeting for a particular group or organization. The significant majority of these discussions were for an hour. A few of these groups followed up by providing notes, comments and questions in writing. One or more of DHS staff proctored all of these meetings. Attached to this report is a flyer that was widely distributed to garner interest and participation in these meetings. Also attached, is a sample presentation document used by RI to kick--off the meetings, with an overview of RI's credentials and the specifics regarding this project.

During this period, stakeholder engagements occurred with thirty-nine (39) separate organizations and over three-hundred and four (304) participants. The common themes that emerged from these encounters are delineated below:

- Support for the Crisis Triage Center (CTC) to fill a recognized service gap in the crisis response system;
- CTC "no wrong door" approach & heavy reliance on peer support are both features that were favorably received;
- Recognition that state barriers to operating & sustaining the crisis response system must be overcome;
- Better coordination of crisis & other care needs to occur;
- Crisis services require culturally competent delivery;
- Rural access to crisis care remains a need; &
- Behavioral health workforce challenges need to be addressed.

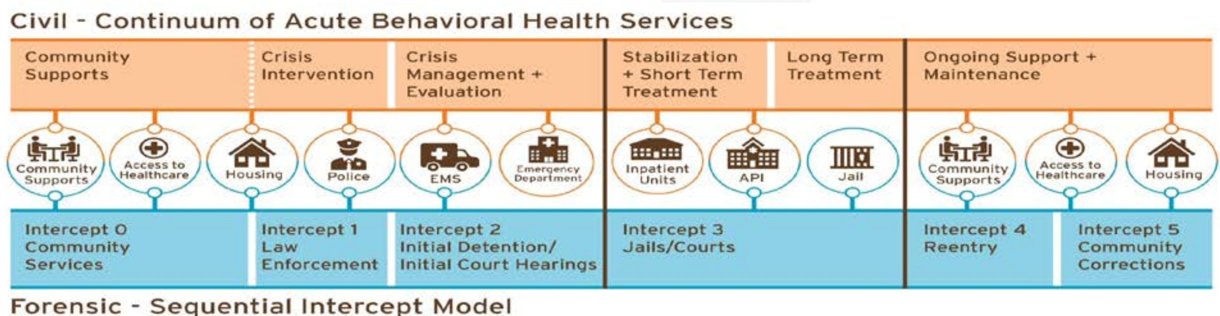
For a more detailed breakdown of stakeholder inputs, please see the appendix to this report that inventories this rich source of information. A synopsis of these takeaways have been divided into three focus areas: 1) need, 2) operations, and 3) impact. In addition, these inputs will be woven throughout the appropriate sections of this report.

When asking questions about the crisis response system, it was not uncommon to hear, "Overall Madison and Dane County are well-resourced when it comes to BH services." Others were more nuanced in their replies and identified components of the crisis response system that could be improved. It was indicated that too frequently, people attempt to access care and are turned away without sufficient connections to the "right" resource. In addition, there were several comments that the current crisis response system needs to be more comprehensive, more robust, and better coordinated; that there are challenges and gaps in mobile crisis services and community interventions. Specific needs that were perceived to not be adequately addressed include:

- Several families expressed frustration at not receiving a desired response at hospital emergency departments for loved ones seeking care, which has resulted in deteriorating BH conditions, suicide attempts, and even arrests.

- A number of comments were offered regarding the need for a similar CTC designed for children and youth; and it was suggested that the currently planned CTC function as a resource for transitional age youth (18 to 24).
- Concerns were expressed about the possibility of people cycling through the CTC frequently and not engaging in follow-up community services. It was recognized that there are a number of "known" people who make "inappropriate" use of services.
- Several comments were received from groups and individuals representing services, programs, and needs for individuals of ethnic and cultural groups (Latinx, Hmong, and LGBTQ). While they see value in a CTC serving their communities, they remain concerned about the makeup of staff at the CTC, so people can relate to another person of similar culture and ethnicity. In several instances, there exist needs for service staff to speak other languages (i.e., Spanish and Hmong). It was identified that there are very few professional staff from minority ethnic and cultural groups.
- Apparently, there are a number of service providers who are reluctant to call law enforcement. The concern expressed was that a law enforcement intervention might result in an arrest or worse. Some wanted to know what resources and processes will be available so that people can access a CTC without law enforcement engagement.
- There were several concerns expressed about what happens when people are stabilized and ready to leave the CTC, because of the limited choices for community placement, inadequate housing options, and for people with special needs(such as IDD), there may not be an available supervised setting.

In preparing the recommendations for this Report, the RI consultant team became firmly convinced that the CTC holds tremendous promise for Dane County. Implementation of the CTC, along with the other recommendations of this Report, have the potential of meeting the BH crisis-related recommendations from the reports previously cited and the needs identified by other sources. This perhaps can best be illustrated by the diagram below on the, *Civil + Forensic Psychiatric Continuums of Care*. It illustrates the BH continuum of care in conjunction with the Forensic Sequential Intercept Model. The CTC and the redesign of the crisis response system provides for a set of community-based BH crisis intervention and stabilization facilities and services that effectively and efficiently meet the community needs associated with Intercept Levels 1, 2, and much of 3. Once established, the CTC will divert the overwhelming majority of individuals experiencing BH crises from EDs and the County Detention Center.



Each of the reports reviewed have built the case using incidence, prevalence, utilization, and other data to substantiate the need for a CTC. Because of this archival of documented data, RI will not be replicating what already has been thoroughly documented.

Dane County, of course, exists within a larger context – the State of Wisconsin. In October of 2020, the University of Wisconsin Population Health institute published *The 2019 Behavioral Health Gaps Report for the State of Wisconsin.* This gaps analysis resulted in ranking crisis intervention and stabilization services as the second highest gap in mental health (MH) services statewide; and integrated mental health and substance use disorders (SUD) services as the highest-ranking gap for SUD services; and third for MH services. While there appeared to be a consensus that Wisconsin suffers from a dearth of crisis stabilization and diversion services, service providers voiced considerable frustration over the quality of the limited county crisis services that do exist. As a result, they called for "increased state monitoring of county crisis programs - unannounced audits/site visits and chart reviews, verification of supervision, staff and supervisor credentials, solicit client and other agency/provider feedback." Providers also expressed frustration with current triage practices that negated individuals gaining access to crisis services. Views were expressed that "[crisis] services are often denied to people who cannot prove their crisis is life or death." One survey respondent wrote, "The system fails those in acute crisis. Unfortunately, a person in a MH crisis must hurt themselves or somebody else, before the area crisis system will connect to the MH system." In addition, many providers reported difficulty getting crisis staff to conduct an assessment.

This evaluation indicated an urgent need for innovation in public safety interventions for individuals facing a BH crisis, and that developing alternatives to policing, is an important step toward decreasing the disproportionate criminalization of individuals with BH issues, particularly from Black and Brown communities. Survey respondents suggested, "Changing the statute so that law enforcement would be barred from involvement, unless the person is actively dangerous and then law enforcement involvement should be limited."

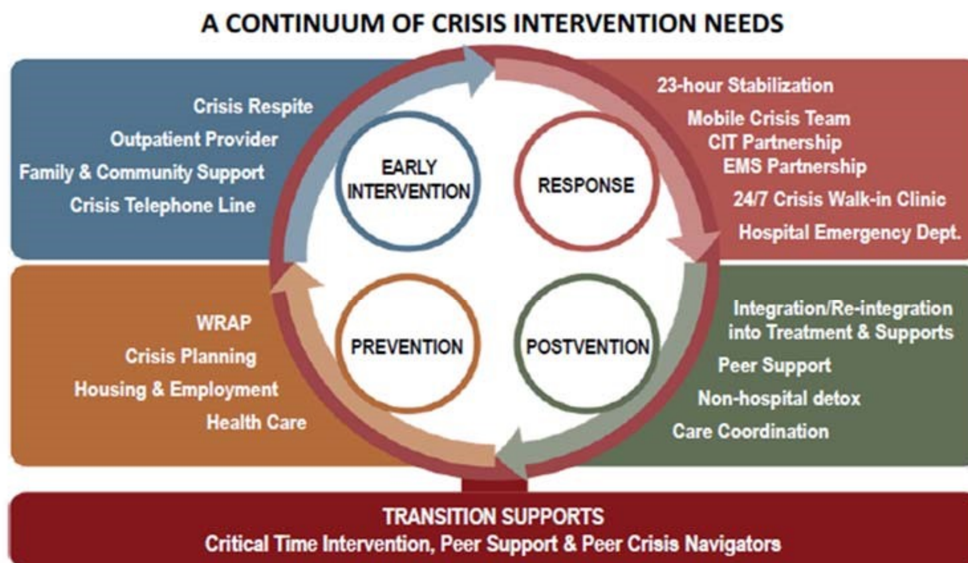
Dane County has all of the components of a crisis response system, as outlined in *SAMHSA's National Guidelines for Behavioral Health Crisis Care*, with the exception of one - a 23-hour Crisis Triage Center with recliners. This gap was clearly identified in PCG's Gaps Analysis recommending that Dane County consider "creating a roadmap to implement 23-hour observation beds, 24/7 crisis care, dedicated law enforcement drop off for crisis care, and programs that more fully integrate services for co-occurring MH and SUD."

However, not all of these crisis service components meet the criteria specified by in the National Guidelines, nor the requirements associated with the implementation of 988 in July of 2022. In addition, PCG's capacity analysis showed significant variability in utilization among these services and this was further validated during the course of this project. In fact, each of PCG's recommendations to improve Dane County's BH care system are equally pertinent to its BH crisis response system:

1. Maximize capacity through better facility and provider coordination,
2. Establish formal partnerships between providers and facilities,
3. Develop additional services to reduce gaps in care,
4. Improve access to care for underserved populations,
5. Increase diversion options,
6. Extend crisis care to rural areas,
7. Develop infrastructure for cross sector data-driven decision making.

Therefore, this Report will include an analysis of each of the core crisis service components, against these guidelines and will include in its recommendations, how the entire crisis response system can be optimized.

A depiction of SAMHSA's Continuum of Crisis Intervention Needs, which is more extensive than the three core crisis service components, is shown in the figure below:



The point to be made here is that while the proposed CTC will overcome a major gap in Dane County's crisis response system, it will improve access for those in crisis, including under-served populations, and will increase diversion options. It will not however in and of itself, overcome the other identified system-wide issues, nor will it be able to sustain a "no wrong door" approach, without the full continuum of crisis-related services that are contained within the diagram above.

According to DHS' Coordination Plan for Emergency Mental Health Services (2020),

> "Dane County's mental health system is characterized as a mature system of care. Journey Mental Health Center (JMHC) has been providing emergency mental health crisis services in Dane County for over 40 years. As an established system of care, the emergency services unit (ESU) has developed and evolved with the community, and it is currently comprised of three components.
>
> 1. Emergency Telephone Services;
> 2. Mobile Crisis Services;
> 3. Crisis Stabilization Services
>
> The ESU also serves as the "hospital gatekeeper" for all voluntary admissions of JMHC clients and it acts as the County funding agent for all voluntary psychiatric inpatient admissions for uninsured individuals. DHS is the source of this funding. The ESU is also responsible for conducting mental health assessments for all Emergency Detentions in Dane County.

> In addition to the crisis services provided by JMHC, DHS contracts with other provider organizations to provide crisis stabilization services which include: SOAR, Tellurian, Goodwill, Lutheran Social Services, Women in Transition, and others."

DHS' Coordination Plan for Emergency Mental Health Services also reports that about 85% of the individuals utilizing ESU services are from the Madison area and 15% from areas that are more rural. This Plan indicates that this may suggest that the rural areas are under-served, but that the majority of the people in Dane County living with severe and persistent mental illness (SPMI) live in Madison and its immediate vicinity. It is RI's conclusion however, that both points have validity. Those with SPMI do appear to be concentrated in Madison given the high correlation between poverty and BH conditions. Moreover, given that BH related services are also concentrated in the most densely populated areas, it is true that those in rural areas do not have the same access to services as those the urban core – in this case, Madison.

Out of the 4957 people who received ESU services in 2017, only 65% identified their race when providing other demographic information. This may be because, about a quarter of the ESU contacts, received crisis care solely from the County's crisis call center which does collect any identifying information, unless needing to escalate services to a higher level of care. Of the 65% individuals for which race was recorded, 69% identified as White Non-Hispanic, 19% identified as Black/African American, 5% identified as Hispanic, 3% identified as being bi/multi-racial, and 1% identified as Asian. The Plan interprets this as an obvious racial disparity, when comparing the population ESU serves to the population of Dane County in which the 80% of Dane County residents identify as white, 6% identify as non-white Hispanic, 6% Asian, and 5% as Black.

DHS' Coordination Plan references the 2018 article, *Wisconsin's African American Poverty Rate is Three to Four Times Higher than White Poverty Rate* (Johnson, 2018), within which it was reported that "the black poverty rate is more than two-and-a-half times the overall Wisconsin poverty rate, and three to four times the white poverty rate. " Simon, Beder and Manseau's report in the June 2018 edition of Psychiatric Times Journal identifies that "poverty is one of the most significant social determinants of health and mental health". There is likely a direct correlation between those seeking/receiving mental health emergency services and those living in poverty in Dane County. This may very well account for the disproportionate number of Black people getting services through the ESU.

In RI's experience, we would expect that as the CTC becomes operational and the overall crisis response system becomes further optimized, that there will be an even greater disproportionate share of marginalized people in BH crisis care, but it is our contention that this should be viewed as a positive development. This increase in BIPOC participation in crisis care will be attributable to the fact that the barriers to crisis care access will increasingly cease to exist. In addition, those most in need of crisis services will have immediate access to crisis care, via either call, text, or chat, intervention and support in their natural environments, or facility-based crisis services. With the CTC operating as the front door to facility-based crisis services, there will be no exclusionary criteria to exclude them; and with the elimination of the requirement for medical clearance in advance of admission, there will be no delays in accessing care. In addition, with the use of new technological tools, there will be meaningful care coordination resulting in better outcomes for those with BH conditions who also suffer health inequities. The proverbial revolving door dynamic of people repeatedly cycling through service systems will also end because of being supported and sustained in the community.

Up to this point in time, Journey MHC has served as "the front door" for accessing crisis services. This central "gate-keeping" model has been utilized by BH service systems across the country to standardize and improve the quality of assessments and diagnostics, while appropriately assigning those assessed to the most appropriate and least restrictive level of care (LOC). This methodology also has been typically designed to put the interests of those needing care above the interests of any given service provider. This structure was designed and implemented long before the advancement of the *National Guidelines for Behavioral Health Crisis Care*. We now know that BH crisis intervention and stabilization, per se, is not a treatment service. When someone is experiencing a crisis, conducting a diagnostic assessment and developing a treatment plan are inappropriate and unwarranted. Assessing imminent risk is, of course, key, but stabilizing a crisis is "a direct service that assists with de-escalating the severity of a person's level of distress and/or need for urgent (or emergent) care, associated with a substance use or mental health disorder" (SAMHSA, 2014). The Wisconsin criteria used to determine whether a person is appropriate for services, is based on State Statutes Chapter 34. Under this provision, "crisis" is a situation caused by an individual's apparent mental disorder, which results in a high level of stress or anxiety for the individual, persons providing care for the individual, or the public, which cannot be resolved by the available coping methods of the individual or by the efforts of those providing ordinary care or support for the individual. A person under such circumstances is deemed appropriate for emergency mental health services.

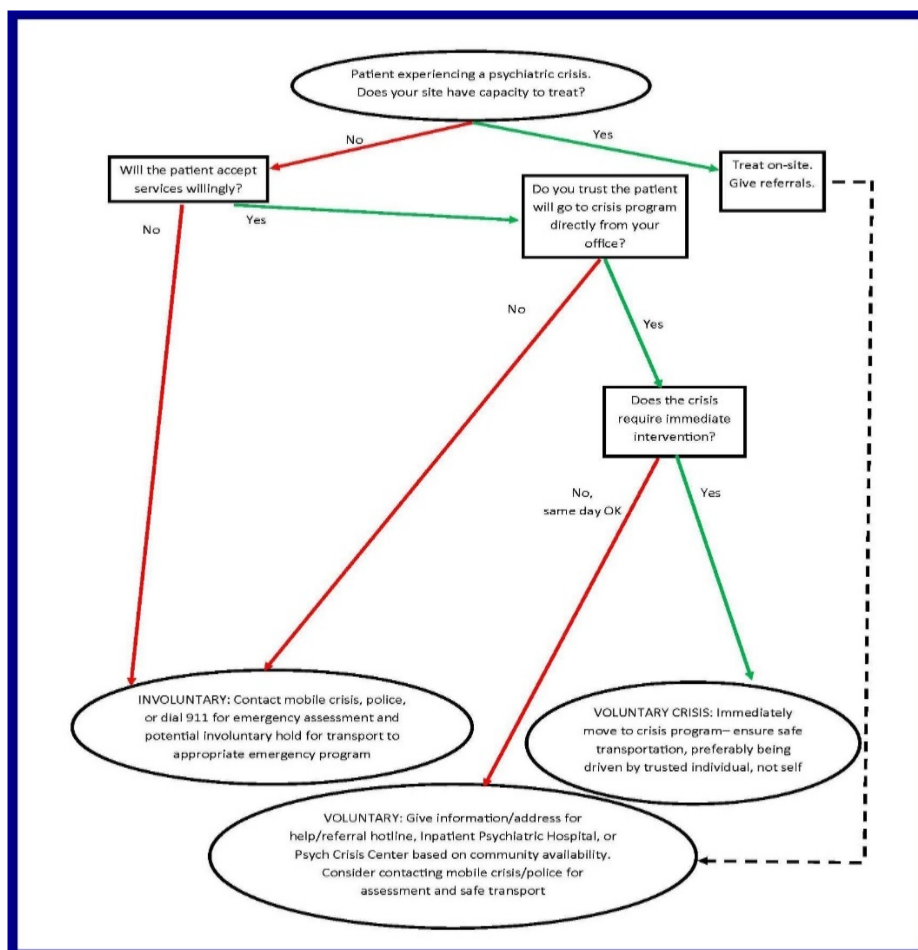
The Dane County Emergency Services Unit (ESU) provides emergency responses to those that are experiencing a BH crisis. Requests for ESU assessment and intervention come from significant others, hospitals, law enforcement, and from members of the community. Anyone can call the crisis unit 24 hours a day/7days a week. The Emergency Telephone Services (ETS) staff triages calls and connects the caller with a crisis response resource if the caller needs assistance beyond telephonic intervention. ETS staff conduct risk assessments, brief support and phone counseling, as well as, safety planning.

The ESU oversees all voluntary admissions of Journey MHC clients. It also works with the police to provide the BH assessments required for all Emergency Detentions, seeking to avoid involuntary admissions whenever possible. However, when emergency protective placements are initiated under Chapter 51, either Emergency Detention or three-party Petition, and converted to Chapter 55 proceedings at the Probable Cause hearing, the ESU is involved in all of these cases at the outset. Once the ESU is involved in hospitalizing a person, ESU staff monitors the course of that hospitalization, and develops and implements discharge plans. The ESU monitors the cases of those people involuntarily committed, or those leaving the hospital under Settlement Agreements.

The ESU is also responsible for coordinating with Tellurian's Community Intervention Team (CIT) when a resident needs to be evaluated for an Alcohol Commitment or Mental Health/Drug Commitment. CIT is responsible for providing supervision of the individuals under commitment for SUD; and they coordinate with ESU when a person is out of compliance with the commitment order and needs to be escalated to a higher level of care. Under these circumstances, the ESU will coordinate with law enforcement to facilitate the transfer. In the event that an individual is both intoxicated and suicidal, the individual will be placed with the Tellurian Detox Center until they are no longer intoxicated. If he or she remains suicidal at that point, the ESU may need to re-evaluate and plan for an alternative disposition.

The figure below appears in *Understanding Crisis Services: What They Are and When to Access Them* (Zeller, 2020). Since a BH crisis can surface anywhere—in public, in the home or work environment, or in any number of clinical settings, this diagram focuses on the considerations when an apparent crisis arises

when an individual is under a clinician's direct care. However, a similar process needs to be followed regardless of the setting within which the crisis occurs. Moreover, the process should be as safe, humane, expedient, easy to navigate, and accessible as possible; and without barriers associated with admission, eligibility, or authorization criteria or with an inability to pay.



In Dane County currently, the process for accessing crisis care can be disrupted at a number of points:

- Those seeking or being referred for voluntary admission for facility-based crisis services, do not have immediate access to crisis care, because the crisis response system requires that an ESU assessment and a medical clearance occur in advance of any admission. This results in delaying crisis care, while potentially exacerbating the crisis. In addition, these practices require unnecessary ED onboarding time, which can tie up law enforcement and family members for hours and produce unfavorable outcomes for the person in crisis.
- For those in crises, but who require invoking involuntary status, only law enforcement can initiate a 72-hour hold, which subsequently requires a court order. As PCG reported in its Dane County Gap Analysis Report, only two states in the U.S., Wisconsin and Kansas, limit invoking emergency detention holds to law enforcement and not to other professionals. This practice, along with the requirement of a court order, not only takes an inordinate amount of time, it also severely limits the opportunity for diversion from law enforcement. According to the *Sequential Intercept*

Model Mapping Report for Dane County prepared by Policy Research, Inc., "emergency detention can take eight hours or more, crossing between law enforcement officers' shifts, and averages 17 total officer hours per detention". In addition, emergency detentions can be more time consuming for law enforcement, because the subject must remain in the custody until they are admitted into a psychiatric inpatient facility. This means that officers must remain with the subject through all psychiatric testing, assessments, and labs until the facility grants admission to the subject. In 2018, the Madison Police Department reported two-hundred and fifty-two (252) Emergency Detentions for the year.

- Under Chapter 51: State Alcohol, Drug Abuse, Developmental Disabilities, and Mental Health Act, Section 51.15 (2)(d) Emergency detention specifies, "Detention under this section may only be in a treatment facility approved by the department or the county department, if the facility agrees to detain the individual, or a state treatment facility." Under this provision, it appears that the designation of the CTC as a treatment facility that can accept involuntary admissions is under the purview of Dane County DHS. As a result, with the implementation of the CTC, those in police custody with a BH condition, will be able to be transported to the CTC directly and thereby avoid any onboarding issues in an ED.
- PCG reported that those who are supported by DHS are more likely to be transported to Winnebago Mental Health Institute, which is over 100 miles away, which represents more time and expense. Research has demonstrated that CTCs and MCTs are far less likely to result in expensive psychiatric IP care than EDs; and these community-based crisis services can cost nearly three times less to operate.

With the implementation of the CTC, with the optimization of the crisis response system, and with the removal of State barriers to that optimization, Dane County and its residents will experience a crisis response system that is truly responsive by immediately responding to anyone, anywhere at any time who is experiencing a crisis. Nevertheless, as previously indicated, the CTC will be a key component of that system but will be dependent on an entire BH crisis response continuum of services. In particular, the CTC will need to rely on Dane County's established facility-based crisis stabilization services with beds, since approximately 30% of those admitted to the CTC will require a longer length of stay to stabilize.

Tellurian Crisis Assessment, Recovery and Empowerment (CARE) Center portends to offer crisis stabilization services for adults as either a diversion or as a step-down from state hospitals through ten (10) contracted beds with DHS. This facility is a community-based residential rehabilitation facility that is intended to be an alternative to institutional or hospital placements. Referrals to the CARE Center are often initiated by the ESU and the Madison Police Department when responding to a crisis in the community. Tellurian also operates the Detoxification Center, which is a 29-bed facility that has a variance from the State to accept involuntary admissions. These two centers provide DHS with thirty-nine (39) beds, however not all beds can be considered equal. The CARE Center is not actually a facility-based crisis service, but instead a residential treatment setting. It does not operate as a high-acuity crisis stabilization facility and it is neither designed, staffed, nor equipped to operate as such. It does have a useful place in the overall continuum of BH care, but it should not be considered a crisis care resource. The Detoxification Center, however could potentially take on an expanded role as a crisis stabilization center with beds and this will be further examined in the recommendations section of this report.

Journey MHC offers several intensive levels of BH services, that are for the most part adjacent services to crisis care. One of these, Resource Bridge is a short-term case management/treatment program, which provides a bridge to ongoing services, with an ALOS of 90 days. Journey MHC readily promotes Resource

Bridge as connecting individuals who have been hospitalized, utilized emergency services, or a care center, after a mental health crisis. Recovery House is a facility-based subacute step down service, with an ALOS of under 14 days and with maximum stays of up to 60 days. Recovery House is co-located with Bayside Care Center, which operates as a residential treatment center (same level of care as Dane County Care Center). Bayside is intended as an alternative to a psychiatric hospitalization, typically for seven (7) days or as a step-down program. Bayside Care Center is for individuals under acute stress due to emotional, behavioral, social and/or family problems. Not unlike, the Care Center, Bayside is another BH treatment asset, but it too operates as another residential treatment center, and not a crisis stabilization center, as defined in the *National Guidelines*.

Crisis Stabilization Programs

Since the Scope of Work for this project is specifically related to developing a CTC implementation plan, the next phase of analysis is focused on facility-based crisis services, beginning with a further delineation of why such facilities are so critical to communities in the U.S. and around the globe. Many individuals in crisis brought to hospital EDs for stabilization, report experiencing increased distress and worsening symptoms due to noise and crowding, limited privacy in the triage area, and being attended to by staff who had little experience with psychiatric disorders. All of this increases frustration and agitation (Clarke et al., 2007). Agar-Jacomb and Read (2009) found individuals who had received crisis services preferred going to a safe place, speaking with peers and trained professionals who could understand what they were experiencing, and interacting with people who offered respect and dignity to them as individuals, an experience they did not have at the hospital. In such an alternative setting, psychiatric crises could be de-escalated.

In its review of crisis services, SAMHSA (2014) defined crisis stabilization as:

> "A direct service that assists with de-escalating the severity of a person's level of distress and/or need for urgent care associated with a substance use or mental health disorder. Crisis stabilization services are designed to prevent or ameliorate a behavioral health crisis and/or reduce acute symptoms of mental illness.

Facility-based crisis services are usually provided in relatively small structures. The exception to this is when an entire spectrum of crisis services are provided under one-roof. Often these facilities are more home like than institutional. They are staffed with a mix of professionals and para-professionals. They may operate as part of a community mental health center, in affiliation with a hospital, or a stand-alone facility operating by a non-profit provider organization. Crisis stabilization facilities function best when the facilities:

- Function as an integral part of a regional crisis system serving a whole population, rather than as an offering of a single provider;
- Operate in a home-like environment;
- Utilize peers as integral staff members; and
- Have 24/7 access to psychiatrists and/or Master's-level BH clinicians.

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

> "The current literature generally supports that crisis residential care is as effective as other longer psychiatric inpatient care at improving symptoms and functioning. It also demonstrates that the satisfaction of these services is strong, and the overall costs for residential crisis services are less than traditional inpatient care. For the studies examined in this review, the populations range from late adolescence (aged 16 to 18 years) through adulthood. Regarding mental health and crisis residential, a recent systematic review examined the effectiveness of residential alternatives to hospital inpatient services for acute psychiatric conditions (Lloyd-Evans, et al., 2009). This review included randomized control trials or studies that provided specific quantitative comparisons of effectiveness of alternatives to standard acute inpatient care. The authors concluded that there is preliminary evidence to suggest residential alternatives may be as effective as and potentially less costly than standard inpatient units."

Home-like crisis facilities are a necessary core element of a crisis system of care. To maximize their usefulness, crisis facilities should function as part of an integrated crisis response system within the county. Access to the program should be facilitated through the Care Traffic Control Hub, which monitors the trajectory of crises throughout the service area; and by MCTs that have determined that a given crisis in the community requires an escalation into facility-based crisis services. In this way, those that ultimately need the benefits associated with facility-based care can readily access it. Access is also readily available to first responders, such as law enforcement and EMS. But, in order for EMS to be reimbursed for transport to a crisis facility, Dane County should consider applying for a CMS Emergency Triage, Treat, and Transport (ET3) Model pilot project https://innovation.cms.gov/innovation-models/et3 .

Safety for both guests and staff is a foundational element for all crisis service settings. Crisis settings are also on the front lines of assessing and managing suicidality, an issue with life and death consequences. Moreover, while ensuring safety for people using crisis services is paramount, the safety for staff cannot be compromised. People in crisis may have experienced violence or acted in violent ways, they may be intoxicated or delusional, and/or they may have been brought in by law enforcement, and thus may present to the facility at an elevated risk for violence. Trauma-informed and recovery-oriented care is safe care. Nevertheless, much more than philosophy is involved. It is understood that Wisconsin is beginning to address this issue by potentially setting new parameters for crisis services that are flexible and delivered in the least restrictive available setting while attending to intervention, de-escalation, and stabilization. The keys to safety and security in crisis facilities include:

- Evidence-based crisis training for all staff.
- Role-specific staff training and appropriate staffing ratios to number of guests being served.
- A non-institutional and welcoming physical space and environment for persons in crisis, rather than Plexiglas “fishbowl” observation rooms and keypad-locked doors. This space must also be anti-ligature sensitive and contain safe rooms for people for whom violence may be imminent or find the common areas overly stimulating.
- Established policies and procedures emphasizing “no force first” prior to implementation of safe physical restraint or seclusion procedures.
- Pre-established criteria for crisis system entry.
- Strong relationships with law enforcement and first responders.

Ongoing staff training is critical for maintaining both staff competence and confidence, and promotes improved outcomes for persons served and decreased risk for staff (Technical Assistance Collaborative, 2005). Nationally recognized best practices in crisis intervention such as CPI (Crisis Prevention Institute, Nonviolent Crisis Intervention Training) and Therapeutic Options (Therapeutic Options, Inc.) are highly effective and instrumental in their utilization of positive practices to minimize the need for physical interventions and re-traumatization of persons in crisis. Such approaches have contributed to a culture of safety for staff and clients in the crisis setting.

Adequate staffing for the number and clinical needs of consumers under care is foundational to safety. Access to a sufficient number of qualified staff (clinicians, nurses, providers, peer support professionals) promotes timely crisis intervention and risk management for persons in crisis who are potentially dangerous to self or others (DHHS, 2006).

In some crisis facilities, that are licensed or certified to provide intensive services, seclusion and/or restraint may be permitted. If the facility is to operate under a “no wrong door” approach, it is imperative that the crisis facility be able to accommodate involuntary admissions. Though some practitioners view physical and/or pharmacological restraint and seclusion as safe interventions, they are often associated with increased injury to both guests and staff; and often end up re-traumatizing individuals who have experienced physical and emotional trauma. Therefore, restraint and seclusion are now considered safety measures of last resort, not to be used as a threat or act of punishment, alternative to staffing shortages or inadequacies, as a technique for behavior management, or a substitute for active treatment (Technical Assistance Collaborative, 2005).

The National Association of State Mental Health Program Directors (NASMHPD) (2006) has postulated a set of core strategies for mitigating the use of seclusion and restraint. These include employing BH leadership that sets seclusion and restraint reduction as a goal, oversight of all seclusion/restraint for performance improvement, and staff development and training in crisis intervention and de-escalation techniques.

Person-centered approaches and the use of assessment instruments to identify risk for violence are also critical in developing de-escalation and safety plans. Other recommendations include collaborating with the guest and his or her family in service planning, as well as, debriefing staff and guests after a seclusion/restraint event, to inform policies, procedures, and practices to reduce the probability of repeat episodes that result in the use of such interventions.

Ensuring the safety of both guests and staff is the very foundation of effective crisis care. While safety is urgently important in all of health care, in crisis care, maintaining a safe and welcoming environment is essential. The prominence and damaging effects of trauma and the fear that usually accompanies psychological crisis make safety truly “Job One” in all crisis settings.

Ashcraft (2006) and Heyland et al. (2013) describe an alternative crisis setting called “the living room,” which uses the recovery model to support an individual’s stabilization and return to active participation in the community. Key elements include a welcoming and accepting environment, which conveys hope, empowerment, choice, and higher purpose. Individuals in crisis are admitted as “guests” into a pleasant, home-like environment designed to promote a sense of safety and privacy. A team of “crisis competent” professionals, including peers with lived experience, engages with the guest. Risk assessment and management, treatment planning, and discharge goals are set. A peer counselor is assigned to each guest to discuss the guest’s strengths and coping skills that can be used to reduce distress and empower the guest on his or her recovery journey.

Preferably, these facilities are available for direct drop-off by law enforcement and/or EMS. This advanced practice can avoid both criminalization of crisis-induced behavior, as well as, the costs and potential trauma associated with hospitalization and/or incarceration. If it is determined, a guest continues to pose a safety threat to self or others, he or she may be subject to seclusion and restraint, but only as a last resort. Rarely, is a guest transferred to a more intensive level of care. Likewise, upon medical screening, roughly 4% on average require a medical transfer, which the facility arranges with the expectation that the guest return upon the completion of medical intervention.

“No Wrong Door,” has become the motto for these facilities since everyone that presents, whether a walk-in or a police drop-off, whether actively psychotic, violent on methamphetamines, or suicidal, is admitted. There is no need for medical clearance in order to be accepted. There is no “diversion,” which seems to be a common practice among the EDs in the three communities, when their respective capacities have been overwhelmed, often by BH crises. In addition, law enforcement is not called back to the facility after drop-off because the facility has been unsuccessful at de-escalation. The entire milieu of the facility is designed to assure that guests and staff are kept safe. This extends from the design of the facility, the staffing ratio, the teamwork culture, and the use of “milieu specialists” who are “bulked-up” peers who engage guests who are being challenged with self-regulation. They serve as an alternative to security guards whose mere presence can escalate situations.

The average length of a CTC is only seven to ten (7-10) hours in an optimized crisis response system. It is anticipated to be at least ten to twelve hours (10-12) initially for Dane County. This is again possible because of the milieu and the culture of this "living room" approach. The CTC has no beds, but instead recliners and they are arranged to facilitate interaction with other guests and with staff. With 20 - 22 recliners instead of beds, the CTC is a high-speed assessment, observation, engagement, and stabilization service. Each guest admitted receives the following services: a psychiatric evaluation by a Licensed Psychiatrist or Psychiatric Nurse Practitioner that includes a risk assessment and medication evaluation; a brief medical screening by a registered nurse to ensure that co-occurring medical issues are addressed; Substance Use Disorder (SUD) screening and Assessment by a licensed clinician; a psychosocial assessment by a licensed clinician; crisis stabilization services utilizing a high engagement environment with a strong recovery focus and peer support model; and a comprehensive discharge and coordination of care planning.

Often under the same roof as the 23-hour CTC, Crisis Stabilization Centers (also known as short-term crisis stabilization units, crisis triage centers, and crisis response centers or recovery centers) are home-like environments that address BH crisis in a community-based BH provider setting or in some instances are affiliated and operated by a hospital. These are bedded units that range from 6-16 beds and are staffed by licensed and unlicensed peer support specialists, as well as, clinical and non-clinical professionals. (SAMHSA, 2014; Mukherjee & Saxon, 2017). Services typically consist of assessment, diagnosis, abbreviated treatment planning, observation and engagement, support, individual and group therapy, skills training, prescribing and monitoring of psychotropic medication, referral, and linkage to community resources. Services are provided on a 24-hour basis to address immediate safety needs, to develop resiliency, and to create a plan to address the cyclical nature of BH challenges. The National Alliance for Suicide Prevention (2016) considers Crisis Stabilization Centers to be a "core element" of BH crisis systems. Different from the Living Room Model and the 23-Hour Crisis Observation Unit, Crisis Stabilization Centers offer services to individuals who are unable to be stabilized in under 24 hours and whose conditions may be exacerbated by co-morbidity and complex social needs. In RI's experience, Crisis Stabilization Centers have an ALOS of 2-3 days, but stays of 5-7 days is probably more the norm. This service is available in Dane County, but it will require significant re-design to align with the *National Guidelines*.

Many communities have only two basic options available to those in crisis, and they represent the lowest and highest end of the continuum: outpatient versus inpatient treatment. However, for those individuals who can best benefit from crisis care, outpatient services lack the intensity to meet their needs, and inpatient services tend to be too clinically focused. The focus should be on determining with the guest, what precipitated the crisis and how to best return this individual to his or her baseline functioning in the community. Crisis stabilization facilities offer an alternative that is less costly, less intrusive, designed to feel like home, and relies on peers for meaningful engagement.

Crisis Call Center

Care Traffic Control Hub Model

The keystone of the *National Guidelines* and the *Crisis Now Model* is a 24/7 Crisis Call Center. When equipped with the technology to support Care Traffic Control, 90% of crisis calls can be stabilized and resolved without further intervention. Dane County's crisis call center, operated by Journey MHC, is a major crisis response resource for residents of the County. As a National Suicide Prevention Lifeline Affiliate and as one of five (5) Wisconsin network crisis call centers, it is well positioned to serve as the foundation upon which 988 can be implemented within Dane County.

Learning from Air Traffic Control Safety

The keys to advancements in aviation safety are simple. Two vitally important objectives make it impossible to avoid tragedy:

1. Always know where the aircraft is – in time and space – and never lose contact; and
2. Verify the hand-off has occurred and the airplane is safely in the hands of another controller.

In the Air Traffic Control example, technological systems and clear protocols ensure that there is absolute accountability at all times, without fail. When an air traffic controller has the responsibility for any given plane… unless and until they seamlessly hand the responsibility to someone else, who then assumes the same level of care and attention. They simply do not allow an airplane to be unsupported and left on its own. These objectives easily translate to BH. We should always know where the individual in crisis is, and verify that the appropriate hand-off has occurred. Yet these seemingly simple objectives are missing from most public sector BH crisis systems. Individuals and families attempting to navigate the BH system, typically in the midst of a BH crisis, should have the same diligent standard of care that air controllers provide.

In 2006, the Georgia Crisis and Access Line was launched. The goal was to have an "air traffic controller's view" of individuals currently navigating the crisis system. This goal was accomplished through state-of-the-art technology, including an integrated software infrastructure that tracks individuals at a statewide

level, with built-in assurance of consistent triage, level of care protocols, and warm hand-offs to the appropriate MCTs across the state. This is very different from traditional systems and can reduce the number the failures facing current the crisis response systems across the country. This approach does not imply a belief that human beings can be routed like objects, nor is it an effort to force a one-size-fits-all approach on unique geographies, demographics, funding streams, and BH care systems. Rather, it ensures no individual gets "lost" in the system.

Making the Case for a Close and Fully Integrated Crisis Services Collaboration

In 2010, the Milbank Memorial Fund published the landmark *"Evolving Models of Behavioral Health Integration in Primary Care,"* which included a continuum from "minimal" to "close to fully integrated." This established the gold standard for effective planned care models and changed the views of what is acceptable community partnership and collaboration. Prior to this, coordination among BH and primary care providers had frequently been minimal or non-existent and it would have been easy to accept any improvement as praiseworthy.

In fact, the Milbank report portrayed close provider-to-provider collaboration (evidenced by personal relationships of leaders, MOUs, shared protocols, etc.) at the lowest levels of the continuum and deemed them insufficient. They described these community partnerships and their coordination as minimal or basic, citing only sporadic or periodic communication and inconsistent strategies for care management and coordination. They called for frame-breaking change to the existing systems of care, and their report continues to reverberate throughout the implementation of integrated care.

Required Elements of a Statewide Crisis Services "Air Traffic Control System"

The Milbank collaboration continuum (original citation Doherty, 1995) for the purposes of evaluating crisis system community coordination and collaboration (see the graphic below).

In this model, the highest level requires shared protocols for coordination and care management that are "baked into" electronic processes, not simply add-ons. For a crisis response system to provide Level 5 "Close and Fully Integrated" care, it must implement an integrated suite of software applications that employ online, real-time, and 24/7:

- Status Disposition for Intensive Referrals: There must be shared tracking of the status and disposition of linkage/referrals for individuals needing intensive service levels, including requirements for service approval and transport, shared protocols for Medical Clearance algorithms, and data on speed of accessibility (Average Minutes Till Disposition).

- 24/7 Outpatient Scheduling: Crisis staff should be able to schedule intake and outpatient appointments for individuals in crisis with providers across the state, while providing data on speed of accessibility.
- Shared Bed Inventory Tracking: Intensive services of bed census tracking is required, showing the availability of beds in crisis stabilization programs and 23-hour observation beds, as well as, private psychiatric hospitals, with interactive two-way exchange (individual referral editor, inventory/through-put status board).
- High-tech, GPS-enabled Mobile Crisis Dispatch: MCTs should use GPS-enabled tablets or smart phones to quickly and efficiently determine the closest available teams, track response times, and ensure clinician safety (time at site, real-time communication, safe driving, etc.).
- Real-time Performance Outcomes Dashboards: These are outwardly facing performance reports measuring a variety of metrics such as call volume, number of referrals, time-to-answer, abandonment rates and service accessibility performance. When implemented in real-time, the public transparency provides an extra layer of urgency and accountability.

In addition, the crisis response system should provide electronic interconnectedness, in the form of secure HIPAA-compliant, and easy-to-navigate web-based interfaces and community partner portals. This functionality supports communication between service and support organizations (including emergency departments, social service agencies, and community mental health providers) with intensive service providers (such as acute care psychiatric inpatient, community-based crisis stabilization, inpatient detoxification, and mobile crisis response services).

One of the advantages that Dane County has in this regard is the statewide implementation of The Wisconsin Statewide Health Information Network – WISHIN 2.0. WISHIN has partnered with Velatura to power WISHIN's HIE infrastructure, data ingest, and automated delivery using its multi-transport, multi-protocol Intelligent Query Broker (IQB), and KPI Ninja to deliver WISHIN Pulse (community health record), analytics, patient activity reports, and NCQA certified supplemental data. The unified and hybrid environment will be delivered in the trusted and HITRUST certified Amazon Web Services (AWS) cloud, allowing WISHIN additional flexibility and scalability to respond to emerging trends and increase valuable service offerings for health care delivery organizations, payers and publicly funded health programs, regardless of their size or technical sophistication. This technological tool will enable a level of "care traffic control" that has never before been possible in Dane County.

The Georgia Crisis & Access Line utilizes sophisticated software to help the crisis professional assess and engage those at risk and track individuals throughout the process, including where they are, how long they have been waiting, and what specifically is needed to advance them to service linkage. Their names display on a pending linkage status board, highlighted in green, white, yellow, or red depending on how long they have been waiting.

When a person contacts the Crisis Line, they have metaphorically put their hand out and the crisis team has taken it. The answering clinician will continue holding the caller's hand until there is confirmation that someone else has successfully taken hold. A warm hand-off is not deemed successful until there is verification that the caller successfully engaged with another entity that has accepted the clinical responsibility for the caller's care and support. This verification process is applicable to referrals to MCTs, law enforcement, or an ED. These approaches also apply for those with routine needs, who turn out not to be in crisis, but have been engaged by a MCT or the crisis call center. The staff of the Crisis Line follows

up with everyone, 100% of the time. As a result, despite increasing numbers of referrals flowing through the system, individuals are being accepted into care faster and more effectively.

Optimizing Dane County's Crisis Call Center to Become the County's Care Traffic Control Hub

Even organizations that maintain numerous close relationships with other service and support organizations can be extremely inefficient and ineffective when they are dependent on referral protocols that rely on telephonic coordination of care (voice mails, phone tag, etc.). Many, if not most, crisis referrals fall through these proverbial cracks in the system. The time has passed for having to continue to rely on these antiquated processes. The current crisis response system failures, have been receiving national attention. Crisis response systems must take seriously the need to avoid both near misses and tragedies. Community collaboration in support of Level 5 crisis systems are the 988 implementation solutions. If the National Transportation Safety Board settled for a 99.9% success rate on commercial flights, there would be 300 unsafe take-offs and/or landings per day! Air traffic controllers only settle for 100% success, and Dane County residents deserve no less.

Known as the Wisconsin Lifeline, the new Wisconsin call center is managed by Family Services of Northeast Wisconsin under a $2 million annual grant. It accepts calls originating from communities not covered by one of four existing Wisconsin-based call centers in the National Suicide Prevention Lifeline (NSPL) network. One of these is the Dane County crisis call center operated by Journey MHC's ESU. All of the call centers accept calls 24 hours a day, seven days a week.

In 2019, there were 29,402 Lifeline calls from Wisconsin, but only 30% could be answered in Wisconsin. NSPL is a network of more than 170 call centers around the country. Callers are routed to a member call center near them based on their phone number. In most cases, calls that are not answered by a local call center roll over to a national backup system. However, in Wisconsin, the Wisconsin Lifeline now serves as backup to the four locally funded call centers; further ensuring that calls are answered by Wisconsin-based counselors.

The Wisconsin Lifeline began answering calls in August of 2020. In its first week of operation, the percent of Wisconsin calls to the NSPL that were answered in-state, climbed to 85%, well above the current national benchmark of 70%, which will become 90% with the launch of 988 next year. Prior to the inception of the Wisconsin Lifeline, Wisconsin's in-state answer rate was only 30% because of the large volume of calls coming from areas outside of the responsibility of the four locally funded call centers.

The Wisconsin Lifeline network, which includes Dane County's crisis call center, places Wisconsin in a good position to handle the predicted surge in calls when 988 becomes the new nationwide BH crisis call number to be operated by NSPL's parent organization, Vibrant Emotional Health (Vibrant) effective July 16, 2022. Individual State Reports on volume and in-state answer rate can be found at https://suicidepreventionlifeline.org/lifeline-state-reports/.

Wisconsin received a 988 Implementation Planning Grant and it submitted its six (6) month interim report regarding that plan on September 30, 2021, with a final report due by January 31, 2022. Congress has given all states on October 17 of last year, the authority to implement 988 and to levy phone surcharges for crisis care. Vibrant and Mental Health America (MHA) have constructed a Model Bill for Core State

Behavioral Health Crisis Services Systems and it is available from MHA at: https://mhanational.org for states to consider as enabling legislation for 988 implementation. Other crisis care implications for Dane County to consider with 988 implementation include the following:

- Any phone surcharge fee revenue should supplement, not supplant existing funding;
- Resources must be dedicated to scale multi-channel services fully;
- Must meet needs of at-risk groups, including youth, rural populations, BIPOC communities, and LGTBQ+ individuals;
- Dispatch mobile crisis teams, rather than police or EMS and have involuntary police drop-offs;
- 988 & call centers must be technology enabled;
- Crisis response centers should have PSAP Designation (public safety answering points);
- Vibrant will cover the initial and ongoing costs of a "988 Hub" to be implemented in every 988 crisis call center in the nation; and
- It will provide a hosted technology platform in the cloud that is omni-channel (handles calls, chats, texts, & emails).

So, as Dane County proceeds with optimizing its crisis response system, it will be propelled in this endeavor by all of the attributes associated with 988 implementation. It is advised that Dane County become an active participant in Wisconsin's 988 implementation and become well versed regarding this initiative. The best-case scenario is that Dane County will have the financial resources, the technology, and "the bureaucratic skids greased" to realize its vision for crisis care.

Dane County has a number of specialized Helpline services. This is an opportune time to conduct a cost benefit analysis to determine what benefits might accrue from the integration of these resources. Chief among these are:

- Recovery Dane is county-funded for Dane County residents dealing with BH conditions. It had been the focal point for referrals for assessments, providing non-crisis access point to Dane County resources. Recovery Dane's role as a referral/access point has shifted to the Behavioral Health Resource Center (BHRC), but it continues to serve as the hub for development of certified peer specialists; and now offers 1:1 peer support, support groups, and wellness activities.
- Solstice Warm line is a state-funded 24/7 non-clinical, non-emergency service staffed by certified peer specialists, a program of the Solstice House.

Mobile Crisis Teams (MCT)

Community-based mobile crisis is an integral part of a crisis response system. Mobile crisis interventions provide individuals with less restrictive care in a more comfortable environment that is likely to produce more effective results than hospitalization or an ED visit. When collaboration exists with hospitals, medical and BH providers, law enforcement, and other social services, community-based MCT is an effective and efficient way of resolving BH crises and preventing future crises.

MCTs typically use face-to-face professional and peer intervention teams, deployed in real time to the location of a person in crisis, in order to achieve the needed and best outcomes for that individual. Since

the mid-2000s many metropolitan area MCTs have used GPS programming for dispatch in a fashion similar to Uber, identifying the location of teams by GPS signal and then determining which MCT can arrive at the location of an individual in crisis the quickest.

MCTs, under the National Guidelines, are comprised of both professional and para-professional staff, for example, a Master's- and Bachelor's-level clinician with a peer support specialist. The MCT should have the backup of psychiatrists, psychiatric nurse practitioners, and/or Master's-level clinicians. Peer support specialists often take the lead on engagement and may assist with continuity of care by providing support that continues past the crisis period.

In many localities, a co-responder model is used. In this model, a law enforcement officer is paired with a BH professional. RI operates co-responder teams in both WA and NC. The Institute for Social Research at the University of New Mexico conducted a literature review on MCTs in 2016, which compared these two models. The Institute distinguished these two models as civilian MCTs and officer/civilian MCTs:

- Both models of civilian MCTs and officer/civilian MCTs are effective in fulfilling the main goals of diversion and on-site crisis stabilization/intervention.
- Civilian MCTs are more equipped to deal with on-site treatment and swift evaluation, but may not have the training and resources to deal with potentially violent situations.
- Officer/civilian MCTs are more equipped to deal with potentially violent situations, but have less on-site treatment options because of the composition of the team.
- Civilian MCTs are proven able to take calls from law enforcement and respond to crises, stabilize/intervene, and divert citizens.
- If violent calls are received by civilian MCTs, they most likely originate from law enforcement; but if the community civilian MCTs are dispatched to a violent situation, they can contact law enforcement to intervene.
- The officer/civilian MCTs are proven to effectively deal with persons who have acute and severe mental illness, and a high potential of violence.
- The research for civilian MCTs has not conclusively shown how they deal or can deal effectively with persons of violent potential or if they even, need to deal with violent individuals at all.

There are two factors that favor the professional/peer MCT model. These have to do with the efficacy of peer engagement and with the fact that the operational costs associated with these teams are significantly less than the co-responder model. The use of a peer specialist, as opposed to an armed uniformed officer, in responding to crises on the ground is, in itself, de-escalating. The mere presence of a law enforcement officer on the other hand, can result in an escalation of agitation by someone in crisis because his or her fears are triggered. A peer specialist is a non-threatening presence. Respectfully and authentically sharing ones, lived experience, of "having been there," has a calming influence that often serves to de-escalate the crisis and hence lower the risk of violence. Hence, dealing with violent situations becomes less of a concern with these MCTs.

The co-responder model typically pairs a BH professional with a law enforcement officer. The pay and benefits to support a law enforcement officer are substantially more than for a peer support specialist and the costs associated with the development of a police officer is substantially more as well. Given these realities and the fact that the professional/peer model has demonstrated its efficacy, and in addition, RI having experience with both models, RI stands by its recommendation of the

professional/peer model. The co-responder model can take on different permutations, as it has in Madison where an Emergency Medical Technician (EMT) is paired with a BH clinician as members of a CARE Team. This type of co-responder MCT does not integrate peer support, but it does provide more competency around a medical intervention and is far less threatening than a patrol car and an armed officer, and significantly less expensive.

According to SAMHSA's report on crisis care (2014):

> The main objectives of mobile crisis services are to provide rapid response, assess the individual, and resolve crises that involve children and adults who are presumed or known to have a behavioral health disorder (Allen et al., 2002; Fisher, Geller, and Wirth-Cauchon, 1990; Geller, Fisher, and McDermeit, 1995). Additional objectives may include linking people to needed services and finding hard-to-reach individuals (Gillig, 1995). The main outcome objective of mobile crisis teams is to reduce psychiatric hospitalizations, including hospitalizations that follow psychiatric ED admission.

MCTs exist in the majority of states, but few have statewide coverage. While terms describing mobile crisis care differ, these programs share common goals:

- To help individuals experiencing a crisis event to experience relief quickly and to resolve the crisis situation when possible;
- To meet individuals in an environment where they are comfortable; and
- To provide appropriate care/support while avoiding unnecessary law enforcement involvement, ED use, and hospitalization.

Studies that were identified in the *Crisis Now* monograph suggest that MCTs are effective at diverting people in crisis from psychiatric hospitalization, effective at linking suicidal individuals discharged from the ED to services, and better than hospitalization at linking people in crisis to outpatient services. In addition, another study from the year 2000, analyzed the effectiveness and efficiency of a MCT by comparing it to regular police intervention. The average cost per case was $1,520 for MCTs, which included $455 for program costs and $1,065 for psychiatric hospitalization. For a regular police intervention, the average cost per case was $1,963, which consisted of $73 for police services and $1,890 for psychiatric hospitalization. In this study, MCTs resulted in a 23% lower average cost per case. These findings did not account for the array of savings associated with diversions from EDs, hospitalization, and incarceration.

Triage and Screening

The essential functions of MCTs should include triage/screening, along with explicit screening for suicidality; assessment; de-escalation/resolution; peer support; coordination with medical and BH services; and crisis planning and follow-up. As most mobile crisis responses are initiated via a phone call to a hotline or provider, the initial step in providing MCT services is to determine the level of risk faced by the individual in crisis and the most appropriate intervention to employ. In discussing the presenting situation with the caller, a decision needs to be made whether or not other emergency responders should be involved.

For example, if the person describes a serious medical condition or indicates that he or she poses an imminent threat of harm, the MCT should coordinate with emergency responders. The MCT can meet emergency responders at the site of the crisis and work together to resolve the situation. Explicit attention to screening for suicidality, using an accepted, standardized suicide-screening tool should be a part of the triage.

Assessment

The BH professional on the MCT is responsible for completing an assessment. Specifically, he or she should address:

- Causes leading to the crisis event, including psychiatric, substance use, social, familial, and legal factors;
- Safety and risk for the individual and others involved, including an explicit assessment of suicide risk;
- Strengths and resources of the person experiencing the crisis, as well as, those of family members and other natural supports;
- Recent inpatient hospitalizations and/or current relationship with a mental health provider;
- Medications and adherence; and
- Medical history.

As indicated earlier, following the tragic death of a Washington State social worker in 2006, the legislature passed into law a Bill relating to home visits by BH professionals. Provisions within the Bill include the following:

- No BH crisis outreach worker will be required to conduct home visits alone;
- Employers will equip BH workers, who engage in home visits, with a communication device; and
- BH practitioners dispatched on crisis outreach visits will have prompt access to any history of dangerousness or potential dangerousness on the client they are visiting, if available.

Given that MCTs intervene with individuals in their natural environments, including their homes, these types of safety protocols require MCT adherence.

De-escalation and Resolution

Community-based MCTs engage individuals in counseling throughout the encounter and intervene to de-escalate the crisis. The goal is not just to determine a needed level of care to which the individual should be referred, but to stabilize the individual so that a higher level of care is not necessary.

Peer Support

According to SAMHSA (2009), mental health crisis services "should afford opportunities for contact with others whose personal experiences with mental illness and past mental health crises allow them to convey a sense of hopefulness first-hand. In addition, peers can offer opportunities for the individual to connect

with a supportive circle of people who have shared experiences—an option that may have particular relevance given feelings of isolation and fear that may accompany a mental health crisis." This is equally valid for those with substance use disorders (SUD).

Including peers on the MCT can add complementary qualifications to the team so that individuals in crisis are more likely to engage with crisis intervention and support services. Peers should not attempt to replicate the role of clinicians, but instead establish rapport, share experiences, and strengthen engagement with individuals experiencing a crisis. They may also engage with the family members of (or other persons significant to) those in crisis relative to self-care and ways to provide support.

Coordination with Medical and Behavioral Health Services, and Community Supports

MCTs, as part of an integrated crisis system of care, should focus on linking individuals in crisis to the appropriate medical, BH, and human services in an attempt to preclude the types of precipitating and destabilizing events that could stimulate another crisis. These services may include treatment in the community, but are more likely to address the social determinants of health such as housing and food security and social connectedness.

Crisis Planning and Follow-Up

SAMHSA stresses that responding to crisis, must include prevention. "Appropriate crisis response works to ensure that crises will not be recurrent by evaluating and considering factors that contributed to the current episode and what will prevent future relapse. Hence, an adequate crisis response requires measures that address the person's unmet needs, both through individualized planning and by promoting systemic improvement." (SAMHSA, 2009). During a mobile crisis intervention, the BH professional and the peer support specialist should engage the individual in a crisis planning process, which can result in the creation or update of a range of planning tools including a safety plan.

When indicated, the MCT should follow-up to determine, if the service or services to which they were referred, was provided in a timely manner and is meeting the person's needs. For example, a follow-up call within 48 hours continues to ensure support, safety, assistance with referrals and/or follow-up until the person is sufficiently stabilized in the community or the individual is linked to other services and supports.

Police-Mental Health Collaborations (PMHCs)

In April 2019, the Bureau of Justice Assistance under the U.S. Department of Justice and the Justice Center of The Council of State Governments published the brief, *Police-Mental Health Collaborations: A Framework for Implementing Effective Law Enforcement Responses for People Who Have Mental Health Needs.* This brief stipulated the following:

> Understanding a need for greater collaboration, many law enforcement and behavioral health agencies have begun taking important steps to improve responses to people who have mental health needs. These efforts have led to improvements in practices, such as providing mental health training to law enforcement workforces and including mental

> health, crisis intervention, and stabilization training as part of law enforcement training standards. (Stabilization training refers to tactics used to defuse and minimize any harmful or potentially dangerous behavior an individual might exhibit during a call for service.) Some of these communities also designate officers to serve as part of specialized teams to respond to mental health-related calls for service. However, while these steps are commendable and signify widespread acknowledgment of the need to improve law enforcement's responses to people who have mental illnesses, they also underscore the need for more comprehensive, cross-system approaches.
>
> Communities are learning that small-scale or standalone approaches—such as just providing mental health training or having a specialized team that is only available on certain shifts or in certain geographical areas—are not adequate to achieve community-wide and long-lasting impacts. They have also learned that even the most effective law enforcement responses cannot succeed without mental health services that provide immediate crisis stabilization, follow up, and longer-term support.
>
> Moreover, when there are limitations in data collection and information sharing, law enforcement leaders have a difficult time understanding whether the investments they have made in training or programs are working, because success is being defined by anecdotes, impressions, or even by the media's coverage of isolated, high-profile incidents instead of concrete measures and outcomes.

To address these challenges, some law enforcement agencies, such as Madison PD, have invested in comprehensive, agency-wide approaches and partnerships with the BH system. These cross-system approaches, which the brief refers to as Police-Mental Health Collaborations (PMHCs), are intended to build on the success of BH training and specialized teams by layering multiple types of response models—e.g., Crisis Intervention Teams (CIT), co-responders, and MCTs—and implementing one or more of these models as part of a comprehensive approach. PMHCs are distinguished by a commitment to integrating responses to people who have BH conditions into the day-to-day functions of all officers. In PMHCs, law enforcement executives have included the initiative in their agency mission, instead of just assigning it to the exclusive domain of a specialized unit. They result in formal partnerships with community-based BH providers and organizations representing people living with BH conditions and their families; quality training on BH and stabilization techniques that is provided to all officers and 911 dispatchers; and written procedures that are clear and adhered to by staff.

RI has found that PMHCs are critical to the development and implementation of a comprehensive crisis system approach. For jurisdictions that are seeking to implement a new PMHC, the U.S. Department of Justice's Bureau of Justice Assistance provides additional background on PMHCs and the different PMHC response models in the Police Mental Health Collaboration Toolkit which is available at the following link: https://pmhctoolkit.bja.gov/ .

During the course of preparing for this Report, there were expressions by various stakeholders that crisis service efforts to date have not been adequate or sufficiently coordinated to achieve community-wide and long-lasting impacts. As a result, there have been efforts to find crisis response solutions, which has resulted in the layering of multiple types of response models, and facility types, which is apparent

throughout this Report. These efforts have occurred in the absence of a comprehensive and well-coordinated approach Countywide.

Current MCT Operations

Journey MHC's ESU has as many as twenty (20) crisis staff who respond to calls 24/7, but a portion of personnel function in a mobile crisis role and respond in the community for emergency detentions, home visits, hospital funding evaluations, and risk assessments. They also complete face-to-face assessments at the ESU and conduct risk assessments on the crisis call center phone. According DHS, these staff worked a total of 55,058 hours between August 1, 2018 – August 1, 2019, and 35,474 total contacts for this same period. Of those, 3865 contacts, or 10.1%, involved law enforcement.

ESU's mobile crisis service consists of Master's level BH professionals. These staff are available for on-site and mobile crisis services 16 hours/day 7 days a week, between 8am and 12pm, with plans to expand 24/7. Position vacancies have been the limiting factor in consistently staffing overnight mobile crisis capability. Currently, Journey MHC reports that approximately four (4) out of every seven (7) nights a week are covered utilizing a mobile crisis clinician. It should be noted that if the emergency phone clinician who scheduled for the night shift is unexpectedly absent, the mobile crisis clinician could not be dispatched for mobile response. As for staffing levels, the most recent data from Q2 2021 indicates the following:

- 8.063 FTE allocated for emergency phone response (with 2.533 FTE vacant as of 6/30/21);
- 11.9 FTE allocated for mobile response (with 1.8 FTE vacant as of 6/30/21);
- 4.0 FTE allocated for law enforcement embedded positions (with 1.2 FTE vacant as of 6/30/21); and
- 2.0 FTE allocated for the new CARES mobile response service (both positions filled).

During the hours in which crisis staff is not on-site, both an on-call crisis worker and a clinical supervisor are available for consultation to the ESU. The ESU has the capacity to facilitate inpatient admissions as appropriate or to engage in a crisis intervention through ongoing follow-up, which can include telephone support, frequent face-to-face contacts, medication evaluation and the dispensing of psychotropic medications, and short-term, intensive crisis case management. If an individual has been assessed to be at risk of harming himself or herself, or someone else, but does not require a secure placement, they may be referred to one of Dane County's crisis stabilization services. Subsequently, the individual is connected to services and resources that will provide ongoing support to reduce the likelihood of experiencing another crisis. Crisis staff engage individuals, their families, and other natural supports in the creation of a safety plan that outlines interventions that can be used to regain and maintain stability. When the BH crisis has subsided, connections are made for ongoing care and support. For individuals under a civil commitment or settlement agreement, the ESU monitors compliance with the outpatient treatment court orders.

The Madison PD has its own mental health unit that provides a dedicated and specialized response to crises within the community. This unit consists of both Mental Health Officers and Mental Health Liaisons. Mental Health Officers are dedicated, full-time, police officers who have specialized training responding to crises. There are six (6) full-time officers (one per district) and three (3) crisis staff, who are provided by Journey MHC, join them. Mental Health Liaisons, who are law enforcement volunteers, and who assist

with crisis responses when available, complement this unit. Additionally, the Liaisons are responsible for identifying barriers regarding access to services, coordinating services, serving as points of contact, and providing individualized follow up.

Much of this work within the Madison PD is attributable to the Department's participation in the Law Enforcement-Mental Health Learning Sites Program sponsored by the Council of State Governments (CSG). The CSG Justice Center, with support from a team of national experts and the U.S. Department of Justice's Bureau of Justice Assistance (BJA), began the program in 2010 as a way to help public safety personnel implement effective responses to people with mental health needs. Since then, the program has continued to expand and regularly deliver assistance and training to law enforcement and mental health practitioners nationwide. The program is engaged with following tasks within Dane County:

- Collects comprehensive data and shares non-protected information with line-level officers;
- Provides training for all officers using "scenario-based" approaches;
- Features a multi-layered approach with officers trained to be mental health liaisons;
- Employs a full-time mental health team of sworn officers and in-house crisis workers;
- Facilitates a Crisis Intervention Team (CIT) training program for outside agencies; and
- Includes a behavioral health data analyst as part of the team.

The Dane County Sheriff's Office (DCSO) have dedicated deputies whose focus is to make referrals for services, however, they are not a fully dedicated BH unit. Additionally, there is a crisis clinician from Journey MHC assigned to support the Sheriff's Office with BH crises. The Sheriff's Office and the Madison PD are strong proponents in the adoption of Crisis Intervention Teams (CIT). In addition to these two major law enforcement agencies, the following Dane County police departments and public safety entities have available CIT personnel:

- Capitol Police
- Cottage Grove Police Department
- Cross Plains Police Department
- Dane County Public Safety Communications
- Dane County 911 Call Center
- Deforest Police Department
- Fitchburg Police Department
- Madison Area Technical College-Protective Services Division
- McFarland Police Department
- Middleton Police Department
- Monona Police Department
- Oregon Police Department
- Stoughton Police Department
- Sun Prairie Police Department
- Town Of Madison Police Department
- UW Madison Police Department
- Verona Police Department
- Village Of Shorewood Hills Police Department
- Waunakee Police Department

CIT is designed to improve the outcomes of interactions between law enforcement and those with mental illness. CIT officers work to divert those in crisis to appropriate services and supports, rather than to the criminal justice system. CIT officers focus on preventing crises and de-escalating a crisis when it occurs, without the unnecessary use of physical force. CIT programs provide 40 hours of training for law enforcement and corrections officers and Crisis Intervention Partner (CIP) is a 16-hour training modeled after the CIT curriculum, but is designed for a wider-ranging audience, including emergency personnel, hospital staff, teachers, social workers, and more. In 2020, 50 first responders were trained in Crisis Intervention Team (CIT) and Crisis Intervention Partner (CIP) programs in Dane County. This level of CIT and CIP participation is most commendable and is a firm foundation upon which to build a network of PCMHs across the County, which was advocated in the PCG Report.

Recently a CARES Team pilot program was launched which consists of two co-responder MCTs each consisting of a Madison Fire Department paramedic and a BH clinician from Journey MHC. CARES stands for Community Alternative Response Emergency Services. Though the plan is to operate the program 24/7 throughout Dane County, the teams are initially responding, on a limited basis, to nonviolent 911 BH crisis calls Monday through Friday from 11 a.m. to 7 p.m. in downtown Madison. During this initial phase, CARES will operate from 11 a.m. to 7 p.m. on weekdays. The CARES Team members wear a more casual uniform than other emergency responders do, but they do visibly display their credentials. They are being dispatched using a grey Chrysler Pacifica minivan branded with the CARES logo.

The CARES Team will address an immediate crisis that is occurring in the community and will identify any resources the individual may need. Of the four staff members who have been hired, three of the four are people of color, and one is fluent in Spanish. CARES will work out of Fire Station #3 on Williamson Street. The 911 Call Center, which is operated by Dane County, will dispatch calls to the CARES Team. If the CARES Team is unavailable to respond to a person in crisis, law enforcement will be dispatched to respond. CARES will be able to transport people to places other than a hospital. According to State law, only ambulances are only allowed to transport people to emergency rooms. The CARES pilot program does not have a prescribed duration, but the future of the program is contingent on funding and results.

It is evident that in the absence of a comprehensive and well-coordinated BH crisis response system, various organizations have taken the initiative to fill some of the gaps in crisis services. Others are actively working on plans to implement new or additional components of crisis care, but often these plans are developed within a context of having to address a specific need or population. Too often, this can result in a duplication of effort that does not adequately address the crisis needs of the entire County. For example, the inadequacy of crisis response in rural areas of the County was a common refrain in stakeholder meetings. Another outcome is the establishment of a fragmented grouping of services that

results in inefficiencies, service gaps, and with questionable results. Despite these well intended efforts, no one organization has the resources to adequately do the job, and as result, there is a seeming patchwork quilt of services that have no way of tracking and monitoring services to individuals from one organization to another. In Care Traffic Control terms, "there is no way to ensure that everyone in crisis will have a safe landing."

With the expected enhancements to the Dane County crisis line, operated by Journey MHC, to become a 988 Care Traffic Control Hub, that is technologically enabled to dispatch and track MCTs countywide, Dane County would continue to have the means to offer 90% of its residents with an appropriate, immediate, and urgent stabilizing response. With the restructuring of its current MCT assets, the call center would be able to centrally dispatch MCTs 24/7, countywide. These dispatches would be for the 10% of callers who could not be stabilized on the phone. Based on the current population of the County, 4,199 MCT 988 dispatches should be expected per year and 30% of these, 1260 individuals, would need to be escalated to the CTC, assuming the CTC was able to take voluntary and involuntary admissions. A small percentage of these, roughly 4%, would require dispositions by public safety responders. Given these projections, Dane County would be expected need 5.2 MCTs. Assuming the *National Guidelines* will be guiding policy decisions, it would be expected that each MCT would be comprised of a BH clinician and a peer support specialist. Each MCT would be expected to be engaged in three (3) crisis episodes per day at an annual operating cost of $1,406,485. This amount is significantly less than current expenditures for MCT services, particularly when considering the costs associated with co-responder teams that include police officers.

The total number of BH personnel currently assigned to mobile crisis functions is 17.9 FTEs. Of these, 11.9 FTEs are attached to the ESU, 4.0 FTE to law enforcement co-responder teams and 2.0 to the new CARES co-responder teams, each comprised of a clinician and a para-medic. By following the National Guidelines, it would be expected that Dane County would realize a net savings of 7.5 FTEs, and these personnel could be re-deployed to other crisis response services that have been experiencing workforce shortages.

CMS State Planning Grants for Qualifying Community-Based Mobile Crisis Intervention Services

CMS, through the Center for Medicaid and CHIP Services (CMCS), awarded $15 million in planning grants to twenty (20) State Medicaid Agencies for the purpose of developing a state plan amendment (SPA), section 1115 demonstration application, or section 1915(b) or 1915(c) waiver request (or an amendment to such a waiver) to provide qualifying community-based mobile crisis intervention services. Wisconsin is one of the states that received this planning grant.

The American Rescue Plan (ARP) Act, enacted on March 11, 2021, establishes this state option to provide community mobile crisis intervention services for a five-year period beginning in April 2022. As an incentive to state adoption, the law provides for an 85% enhanced federal matching rate for qualifying services for the first three years of state coverage. Currently, funding for state crisis response systems is pieced together across funding sources and payers. Funding is also largely inadequate to sustain the crisis system using a "firehouse model," which refers to mobile crisis services providers who are "on-call" and able to be dispatched at all times to anyone in crisis regardless of insurance status – similar to other emergency services like fire departments. Medicaid can reimburse for crisis services delivered to Medicaid covered individuals only. Many private insurers may not cover crisis services. Taken together, these factors force states and localities to subsidize crisis services for insured and uninsured individuals using

limited state and local funds, which inhibit the access and availability of mobile crisis services across Wisconsin and in Dane County.

The state option for qualifying community mobile crisis intervention services represents a promising opportunity for Wisconsin to better leverage federal funds to sustain its crisis response systems and crisis providers. States that have expanded Medicaid will be able to claim 90% federal matching funds to support mobile crisis intervention services. However, Wisconsin will be able to claim 85% enhanced federal match on these services for the first three years of the option, and in addition, Wisconsin should consider developing or enhancing crisis provider reimbursement rates to reflect the cost of making "on call" mobile crisis services available to Medicaid enrollees. Should Wisconsin choose to do so, Dane County will experience significant relief from assuming the majority of MCT costs; and its crisis providers will experience a financing model that makes this service highly sustainable.

Conclusions and Recommendations

Each recommendation within this Report is organized within the context of SAMHSA's *National Guidelines for Behavioral Health Crisis Care* balanced against the needs and the strengths of the current Dane County crisis response system. In addition, each recommendation, when appropriate, includes specific policy and operational details associated with optimizing Dane County's BH crisis response system and most specifically, establishing a Crisis Triage Center.

1. Crisis Response System Accountability

Establish a dedicated organizational entity within the Dane County Department of Human Services to be responsible and accountable for the oversight, resourcing, and administration of the County's behavioral health (BH) crisis response system.

Without a clear designation of authority, the responsibility for leadership for BH crisis services becomes diffuse, making it difficult for any one entity to be held accountable for the implementation and management of a crisis system with high fidelity to the *National Guidelines for Behavioral Health Crisis Care*. This need becomes critical to the planning, financing, and monitoring of BH crisis service adequacy and quality is relevant to the local community.

RI made this first recommendation preliminarily to DHS and by September 27, 2021, the County Executive was already announcing $10 million in additional monies that are included in the County Executive's 2022 budget proposal for the establishment of the Crisis Triage Center and for the creation of a Behavioral Health Division within DHS. It is anticipated that this new Division will be responsible, in part, for overseeing Dane County's BH Crisis response system.

2. Crisis System Redesign

Redesign the Dane County behavioral health crisis response system, as expressed in DMH's Behavioral Health Emergency Coordination Plan, to optimize client flow throughout the crisis care continuum.

The system, as it currently operates, has some barriers that stand in the way of accessing crisis care.

a) Eliminate the need for advance medical clearance prior to admission into the CTC & any facility-based crisis services & the Detox Center;
b) Place the responsibility, on these same crisis facilities, for the placement in and transport to, an appropriate higher level of care;
c) Remove any "gate-keeping" responsibilities by Journey Mental Health Center for voluntary & involuntary admissions into the CTC, but maintain Journey's responsibilities for processing civil commitments;
d) Serve more residents experiencing a behavioral health crisis in their natural environments; &
e) Designate the Crisis Triage Center (CTC) as the "no wrong door" to crisis care.

https://www.thenationalcouncil.org/wp-content/uploads/2021/03/031121_GAP_Crisis-Report_Final.pdf?daf=375ateTbd56

3. Performance Expectations and Metrics

Establish performance expectations and metrics for each component of the crisis response system and the data systems to collect information necessary to manage, analyze, and report on the performance of each component and the system as a whole.

SAMHSA published in 2020 a *Crisis Service Best Practice Fidelity Review Tool*. The Fidelity Review Tool is designed to assist in the implementation of essential crisis service elements, and to assist with the delineation of performance expectations. These elements are summarized below:

1. Regional or statewide crisis call centers coordinating in real time:
   a. Operate every moment of every day (24/7/365);
   b. Staff with clinicians overseeing clinical triage and other trained team members to respond to all calls received;
   c. Answer every call or coordinate overflow coverage with a resource that also meets all of the minimum crisis call center standards defined in this toolkit;
   d. Assess risk of suicide in a manner that meets NSPL standards and danger to others within each call;
   e. Coordinate connections to crisis mobile team services in the region;
   f. Connect individuals to facility-based care through warm hand-offs and coordination of transportation as needed;
   g. Incorporate caller ID functioning;
   h. Implement GPS-enabled technology in collaboration with partner crisis mobile teams to more efficiently dispatch care to those in need;
   i. Implement real-time regional bed registry technology to support efficient connection to needed resources; and
   j. Schedule outpatient follow-up appointments in a manner synonymous with a warm handoff to support connection to ongoing care following a crisis episode.

2. Centrally deployed, 24/7 mobile crisis:
    a. Include a licensed and/or credentialed clinician capable to assessing the needs of individuals within the region of operation;
    b. Respond where the person is (home, work, park, etc.) and not restrict services to select locations within the region or particular days/times;
    c. Connect individuals to facility-based care through warm hand-offs and coordinating transportation as needed;
    d. Incorporate peers within the mobile crisis team;
    e. Respond without law enforcement accompaniment unless special circumstances warrant inclusion; supporting true justice system diversion;
    f. Implement real-time GPS technology in partnership with the region's crisis call center hub to support efficient connection to needed resources and tracking of engagement; and
    g. Schedule outpatient follow-up appointments in a manner synonymous with a warm handoff to support connection to ongoing care.
3. 23-hour crisis observation and stabilization facilities:
    a. Accept all referrals without pre-screening;
    b. Do not require medical clearance prior to admission but will assess for and support medical stability while in the program;
    c. Design their services to address mental health and substance use crisis issues;
    d. Employ the capacity to assess physical health needs and deliver care for most minor physical health challenges:
    e. Staff at all times (24/7/365) with a multidisciplinary team capable of meeting the needs of individuals experiencing all levels of crisis in the community; including:
        i. Psychiatrists or psychiatric nurse practitioners (telehealth may be used)
        ii. Nurses
        iii. Licensed and/or credential clinicians capable of completing assessments in the region; and
        iv. Peers with lived experience similar to those of the population served.
    f. Offer walk-in and first responder drop-off options;
    g. Be structured in a manner that offers capacity to accept all referrals at least 90% of the time with a no reject policy for first responders;
    h. Screen for suicide risk and complete comprehensive suicide risk assessments and planning when clinically indicated;
    i. Function as a 24 hour or less crisis receiving and stabilization facility;
    j. Offer a dedicated first responder drop-off area;
    k. Incorporate some form of intensive support beds into a partner program (could be own program or another provider) to support flow for individuals who need additional support;
    l. Include beds within the real-time regional bed registry system operated by the crisis call center hub to support efficient connection to needed resources; and
    m. Coordinate connection to ongoing care.

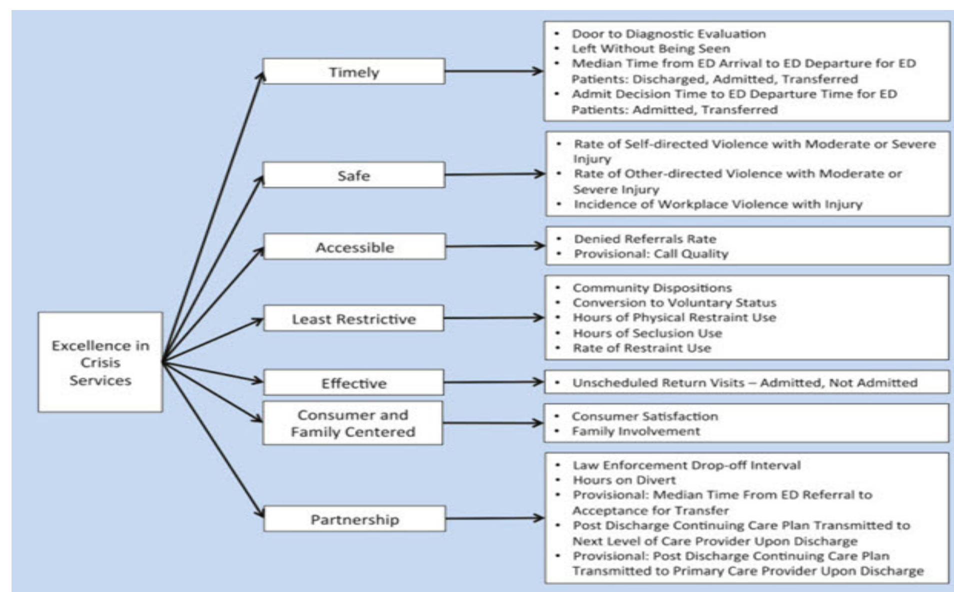
In addition to monitoring fidelity to the *Crisis Service Best Practice Standards*, funders, system administrators and crisis service providers should continuously evaluate performance with shared data systems. System transparency and the regular monitoring of key performance indicators supports continuous quality improvement. It is highly recommended that the crisis response system apply shared systems that offer real-time views of agreed-upon system and provider-level dashboards that can also be used to support alternative payment reimbursement approaches that focus on value. Performance metrics include the following:

- **Crisis Call Center Services**:
  - Call volume,
  - Average speed of answer,
  - Average delay,
  - Average length of call,
  - Call abandonment rate (should be very low),
  - Percentage of calls resolved by phone (should be over 90%),
  - Number of mobile teams dispatched,
  - Number of individuals connected to a crisis or hospital bed, and
  - Number of first responder-initiated calls connected to care.
- **Crisis Mobile Services:**
  - Number served per 8-hour shift,
  - Average response time,
  - Percentage of calls responded to within 1 hour… 2 hours,
  - Longest response time, and
  - Percentage of mobile crisis responses resolved in the community (should be around 70% - hospital/crisis facility diversion)
- **Crisis Observation and Stabilization Facilities:**
  - Number served (could be per chair daily),
  - Percentage of referrals accepted (should be 100%),
  - Percentage of referrals from law enforcement (should be substantial – hospital and jail diversion),
  - Law enforcement drop-off time (should be under 5 minutes because all referrals are accepted),
  - Percentage of referrals from all first responders (including law enforcement – hospital and jail diversion),
  - Average length of stay (throughput matters – support increased capacity within a limited resource),
  - Percentage discharge to the community (target high percentage of crisis resolved and transition back home – hospital diversion),
  - Percentage of involuntary commitment referrals converted to voluntary (this is 75% in Maricopa County, AZ in support of diversion from longer inpatient stays and individual engagement in care),
  - Percentage not referred to emergency department for medical issues/ assessment (should target over 95% to divert from ED costs and boarding),
  - Readmission rate,
  - Percentage completing an outpatient follow-up visit after discharge,

- o Total cost of care for crisis episode,
- o Guest service satisfaction, and
- o Percentage of individuals reporting improvement in ability to manage future crisis.

For further guidance on developing a framework for developing crisis performance, see Dr. Margie Balfour's journal article, *"Crisis Reliability Indicators Supporting Emergency Services (CRISES): A Framework for Developing Performance Measures for Behavioral Health Crisis and Psychiatric Emergency Programs,"* Community Mental Health Journal, 2015, (available at: https://www.ncbi.nlm.nih.gov/pubmed/26420672) which includes the outcomes model below:

Crisis Reliability Indicators Supporting Emergency Services Framework



4. Policy and Regulatory Barriers

Remove any statutory and regulatory barriers that impede Dane County's efforts to optimize its BH Crisis Response System to include:

a) Statutes and regulations that will permit involuntary admissions to crisis stabilization facilities, including the CTC;

Chapter 51 of the Wisconsin Mental Health Act provides legal procedures for voluntary and involuntary admission, treatment and rehabilitation of individuals affected with mental illness, developmental disability, drug dependency or alcoholism. Chapter 51.15 (2)(c) designates the facilities for detention, transport, and approval. According to this section, the county may approve the detention of someone who has undergone a crisis assessment; agrees with the need for detention; and reasonably believes the individual will not voluntarily consent to evaluation, diagnosis, and treatment necessary to stabilize the individual, and remove the substantial probability of physical harm, impairment, or injury to

himself, herself, or others. The crisis assessment may be conducted in person, by telephone, or by telemedicine or video conferencing technology.

Sub-section (2)(d) of this provision requires that detention may only occur in a treatment facility approved by the (state) department or the county department, if the facility agrees to detain the individual. In addition, under sub-section (3), an individual is in custody when the individual is under the physical control of the law enforcement officer, but upon arrival at the facility under sub. (2), custody of the individual is transferred to the facility. In addition, under DHS 34.22 (4)(a)(4)(c) The county department of the local county may designate a stabilization site as a receiving facility for emergency detention under s. 51.15, Stats., provided that the site meets the applicable standards under this chapter; under sub-paragraph (7), counties may choose to operate emergency service programs which combine the delivery of emergency mental health services with other emergency services, such as those related to the abuse of alcohol or other drugs; and under (3)(c), the CTC meets all of the requirements to provide crisis walk-in services. It appears therefore, that under the provisions cited above, that the County has the discretion to designate the CTC and its other contracted crisis stabilization facilities as appropriate for involuntary admissions.

Moreover, under Section (5), when, upon the advice of the treatment staff, the director of a facility specified in sub. (2)(d) determines that the grounds for detention no longer exist, the facility director can discharge the individual detained under this section. Unless a hearing is held under s. 51.20 (7) or 55.135, the individual cannot be detained by the law enforcement officer or other person and the facility for more than a total of 72 hours after the individual is taken into custody for the purposes of emergency detention, exclusive of Saturdays, Sundays, and legal holidays. Therefore, the CTC and other crisis stabilization facilities would be able to revoke involuntary status as appropriate. Given that Wisconsin has involuntary status provisions and processes that fall within a prescribed commitment process, it will be necessary for Dane County to establish appropriate notification requirements when involuntary status is revoked by the CTC or another crisis stabilization facility.

b) Certification rules that permit Medicaid and other third-party reimbursement for involuntary admissions to the CTC and other facility-based crisis services;

Wisconsin, under Chapter DHS 34: Emergency Mental Health Service Programs has one of the most comprehensive set of provisions in support of BH crisis response systems in the U.S. Under these provisions, there do not appear to be any prohibitions against the proposed CTC being eligible for State certification. In addition, under Subchapter III — Standards for Emergency Service Programs Eligible for Medical Assistance Program or Other Third Party Reimbursement, DHS 34.20 Applicability:

> (1) A county may operate or contract for the operation of an emergency mental health services program that is eligible for medical assistance program reimbursement or eligible for third-party payments under policies governed by s. 632.89, Stats., and

> (2) An emergency mental health services program eligible for medical assistance program reimbursement or eligible for third-party payments under policies governed by s. 632.89, Stats., that is operated by a county or under contract for a county shall comply with subchapter I and this subchapter.

Therefore, the CTC under the provisions cited above, would be eligible for Medicaid reimbursement.

Given that the CTC will apparently be setting a precedent as a new type of emergency mental health service in Wisconsin, should there be any resistance to the certification of this facility and/or payment by Medicaid, Dane County should exercise the Waiver provisions specified under DHS 34.04, Wisconsin DHS may grant a waiver of any requirement, "if an alternative to a rule, including a new concept, method, procedure or technique, new equipment, new personnel qualifications or the implementation of a pilot project is in the interests of better participant care or program management."

c) Medicaid payment rates and types of reimbursement that make a robust crisis system sustainable in the long term;

Approaches to fund BH crisis services vary widely from state to state. In many cases, it is cobbled together, often inconsistently supported and ultimately inadequate to sustain these services. One of the greatest factors contributing to these funding challenges is the inconsistent expectations around crisis service delivery; allowing providers to staff and operate in very different ways and yet utilize the same crisis stabilization service coding and rates. If a given crisis service provider commits to align its practices to the *National Guidelines*, then that provider is poorly positioned to negotiate reimbursement rates with respective payers. Each health plan knows that this provider is committed to accept all of its health plan member referrals, even if the level of reimbursement is inadequate to cover the cost of care. In these cases, it is often local jurisdictions, such as Dane County, that are paying to make up for the payment shortfall of health plans, including Medicaid. Wisconsin should create a Medicaid rate structure that sustains delivery of crisis services that align with the *National Guidelines*, and secure funding for residents who remain uninsured.

We should be using the same logic to fund BH crisis response services as we do emergency medical and public safety response services. The vision of 988 implementation is that every county within the U.S. will have a BH crisis response service that is on par with emergency medical and public safety services. It is revealing to compare BH crisis care to other first responder systems like firefighting or emergency medical services (EMS). There are striking similarities:

- The service is essential and may be needed by anyone in the community;
- The need for it is predictable over time, but the timing of individual crises events is not; and
- Effective crisis response is lifesaving and much less expensive than the consequences of inadequate care.

For EMS, its effectiveness can be measured in terms of lives saved, because of timely interventions for individuals with acute care needs. For BH crisis response, the impact of comprehensive approaches requires measurement in terms of lives saved from suicide and other tragic fates. It would be unthinkable for any community, except perhaps in the frontier, to go without its fire department. Because this is known to be an essential public expenditure, fire fighters, EMS personnel, fire stations, fire trucks, and ambulances are made available. This ongoing public commitment persists even though only about 3% of the time available is spent actually fighting fires.

Sometimes users may pay a fee for service calls and some fire departments are staffed by volunteers, but the station and the equipment that support the service are available to anyone in need, regardless of ability to pay. By comparison in most communities, BH crisis response services "take a back seat" due historic inequities and due to the lack of coverage or reimbursement for this type of care. Health care coverage (e.g., Medicaid) will typically pay for professional fees associated with crisis care, but few entities pay sufficiently to cover the costs of the infrastructure and capacity required of a crisis response system.

Fire and/or an ambulance services respond quickly to deliver emergent care. If they assess a need for further support, they may transport to the nearest ED for care. They may even rely on a medical helicopter transport to a Level I Trauma Center. In the subsequent weeks, bills or invoices are submitted to the person's insurance for payment or to the individual if they are without coverage. These payment submissions total thousands of dollars in most cases. These expenses represent the higher cost of offering emergent care that is available and accessible to everyone, everywhere and every time. Wisconsin, where appropriate, should consider modeling its crisis response system reimbursement structure after that of emergency medicine.

24/7 Crisis Care Traffic Control Center Hub

Dane County's crisis call center service, operated by Journey MHC 24/7, extends to the entire County in a manner similar to 911. Although there is some ability to verify certain eligibility information regarding a crisis caller by phone, many callers prefer to remain anonymous and/or are unable to provide any health plan enrollment information at the time of the call. Therefore, reimbursement from health insurers, cannot financially sustain a crisis call center. Arizona however, has chosen to allow Medicaid billing for eligible enrollees who access this service and uses HCPCS code H0030 - Behavioral Health Hotline Service. Currently Dane County's crisis call center is supported mostly by County funds, but it does bill Medicaid whenever possible. Data elements such as member phone numbers of Medicaid enrolled or privately insured individuals can be combined with caller ID technology to support such billing efforts.

Another alternative for Wisconsin, under 988 implementation, would be to begin utilizing the Medicaid Administrative Match of 50% to support call center services. New Mexico, for example offsets about 25% of the cost of its statewide

crisis call center in this way. Wisconsin could utilize a population-based funding stream to support a service that originates from an assessment on phone usage. This is a funding option to states authorized by the National Suicide Hotline Designation Act of 2020, which allows states to levy fees for local 988-related services on wireless/IP carrier bills, including crisis outreach, stabilization, & other mental health services responding to 988 callers.

Mobile Crisis Teams (MCT)

Crisis mobile response services are analogous to fire and ambulance responses for medical emergencies. As such, funding should align so that adequate capacity can be in place to serve the entire County on a 24/7 basis. Given that service demand is not completely predictable, each MCT will experience periods of low utilization. Hence, reimbursement rates must be set at a level to maintain the service, while the payer can still realize value, which will largely accrue from the ensuing reductions in ambulance, ED, inpatient, and detention expenses. If commercial health insurance and Medicaid reimburse for this service at a reasonable rate, funding required by the County will be significantly reduced.

MCT services, when provided by BH staff should be billed using the nationally recognized HCPCS code of H2011: Crisis Intervention Service per 15 Minutes. By limiting the use of this code to MCTs, funders will be better positioned to set a reimbursement rate that represents the actual cost of delivering this safety net service. When applicable, MCT transportation services, for voluntary transports, should be billed separately from crisis intervention services. In some states, this is allowable under Medicaid as a medical transport. If crisis intervention services continue during the transport, then this time can become billable and serve to defray transportation expenses if they are not billable.

Another payment option to consider is an episodic rate that is sufficient to cover the total costs associated with delivering this service. Doing so significantly reduces the administrative burden associated with 15-minute intervals of billing under FFS.

Up to this point in time, the County has been assuming the BH capacity costs of MCTs, but this may not be the case for much longer. Wisconsin recently was one of twenty (20) states that were awarded a CMS grant for the purpose of developing a state plan amendment (SPA), section 1115 demonstration application, or section 1915(b) or 1915(c) waiver request (or an amendment to such a waiver) to provide qualifying community-based mobile crisis intervention services. If Wisconsin's plans are successful, it will qualify for Medicaid matching funds of 85% to support MCT services statewide, thereby taking much of the burden for financing these services from local communities, including Dane County.

CTC and Crisis Stabilization Facilities

CTC and crisis stabilization facilities are analogous the acuity found in a psychiatric ED. Nevertheless, when it comes to reimbursement rates, they typically fall under a crisis intervention claims coding system within Medicaid that offers

payment via hourly and/or per diem reimbursement that is not adequate to compensate for this high acuity level. Most states struggle with how to best categorize these facilities within existing Medicaid facility and provider type structures. CTC services should be billed using the HCPCS Code of S9484: Crisis Intervention Mental Health Services per Hour. Fortunately, Wisconsin Medicaid uses this coding structure and uses code modifiers to distinguish between the provider types (professional disciplines) delivering the service. In a review of the rates associated with reimbursing for professional services in the CTC, these rates are generally adequate. However, neither nursing staff nor care managers are recognized under Medicaid's emergency mental health provisions, as being eligible for reimbursement. As a result, if Medicaid reimbursement of CTC services were possible, its regulations do not conform to *National Guidelines* and would not support these additional professionals necessary to operate under "no wrong door."

HCPCS Code S9485: Crisis Intervention Mental Health Services per diem, can be used to reimburse for services delivered by a crisis stabilization facility with beds. Medications, radiology, laboratory, and professional evaluation and treatment services should be billed separately or bundled into the per diem rate. This service language is out of Forward Health's (WI Medicaid) billing manual. The CTC will not be conducting radiology or laboratory services. Currently, the Medicaid per diem is $139.54, which is an inadequate rate to sustain this high acuity service.

For crisis stabilization centers with beds, professional fees are usually billed in addition to a per diem, but could be billed as a bundled service if this option were made available. The benefit of separate billing for professional services is that most third-party payers currently reimburse for professional services, while few outside of Medicaid recognize crisis facility reimbursement. Getting some of the expense covered by these payers is better than none.

Given the limitations of the current payment system for crisis care, it is hoped that Wisconsin will remedy this situation with new policies, regulations, and financing to support county crisis response systems throughout the State under 988 implementation, which is scheduled for July 16, 2022.

d) Medicaid eligibility expansion under the Affordable Care Act (ACA);

From a recent, review of Dane County financial reconciliation reports, Medicaid reimbursements to support BH facility-based crisis services over the course of year, average around 41%. Since Wisconsin's Medicaid FMAP is 66.08%, Wisconsin only has to spend $.34 for every dollar that Medicaid pays for these services. In RI's experience working with Medicaid expansion states, the average percentage paid by Medicaid for facility-based crisis services hovers around 70%. If Wisconsin were to expand Medicaid, then Medicaid would assume an additional 34% of these costs, and the costs to Wisconsin for that additional 34%, would only be $.10 for every dollar expended, as opposed to $.34. The financial implications for Dane County are huge, as it would only be assuming approximately 30% of the costs for facility-based crisis care as opposed to 59%.

If commercial health insurance were required for facility-based crisis care, then Dane County's share would drop to 20%.

e) **Enforcement of Parity Laws, requiring commercial health insurers to pay for BH crisis response as these health plans do for emergency medical response. This should not be the continued responsibility of taxpayers to assume crisis care costs for enrollees with commercial health insurance.**

In addition to federal requirements related to parity, the State of Wisconsin has its own legislation that guides the coverage of mental health and SUD services by insurance carriers. Wis. Stats. §632.89 addresses coverage of "mental disorders, alcoholism, and other diseases." Group health plans, under this statute, are required to cover inpatient, outpatient, and transitional treatment for both mental health and SUD. Transitional treatment includes services like day treatment programs, community support programs, and intensive outpatient programs for SUD. Wisconsin state law also requires that restrictions on qualitative and quantitative aspects of care be no more restrictive for mental health/SUD treatment than for all other coverage under the plan.

The Office of the Commissioner of Insurance (OCI) includes requirements around mental health and SUD coverage in their administrative code language. INS §3.36 pertains specifically to coverage of autism spectrum disorders, the required levels of care, and minimum dollar values for coverage that plans must provide. INS §3.37 includes requirements on transitional services and what types of transitional services should be covered under a health insurance plan. INS §3.375 provides further clarification on coverage requirements for mental health and SUD services, similar to those provided for by federal law.

The question becomes whether or not crisis services can fall under the definition of transitional services and therefore be eligible for reimbursement for those with commercial health insurance. It is recommended that the WI Commissioner of Insurance take this under advisement.

5. Crisis Triage Center (CTC) Startup and Operational Costs

Plan for the provision of financial support associated with the CTC site purchase/lease, and its construction/renovation, along with equipment, start-up and operating costs.

Without financial support for construction, equipment, and start-up costs associated with the establishment of the proposed CTC, it will be very challenging for providers to standup these facilities. Most providers to not have the assets necessary to assume these costs and therefore, without capital and initial financial operating assistance, these facilities will most likely not be established. Therefore, Dane County, private foundations, and local health systems should collaborate and explore all available financing options to support the capital and initial operating costs to standup this new facility.

Some states have capital allocations available for constructing and equipping facilities that serve to benefit the well-being of residents. The methods for accessing such funds

is variable and often competitive. At the local level, where county and/or city governments have levy authority, dedicated measures have been passed to better meet local BH needs, including the construction of new facilities. Often these funds have been intended to overcome local gaps in services and to fund services and programs that are not funded by Medicaid. The County is urged to seek similar financing measures.

Some counties pass specific measures with allocations to provide social safety net funding to support the uninsured and to cover the cost associated with needs that are not included in health care benefits, including Medicaid. The methods for accessing such funds is variable and often competitive. At the local level, where jurisdictions have levy authority, dedicated measures have been passed to better meet local BH needs. Often these funds have been intended to overcome local gaps in services and to fund services and programs that are not funded by Medicaid. Dane County has been using its taxing authority to generate indigent care funds.

The capital, startup, and ramp up costs for establishing the CTC are delineated in the CTC implementation, which follows.

6. Crisis Triage Center (CTC) Implementation

Establish and sustain an adult CTC with 22 recliners to maximize capacity flexibility, client flow, and an environment that is conducive to meaningful engagement. The CTC will operate 24/7, with stays of up to 23 hours and it will provide high acuity care under the "no wrong door" approach, admitting all those who present, whether voluntarily or involuntarily, to include those needing detoxification services or those with intellectual or developmental disabilities; and without requiring medical clearance in advance of admission.

Capacity

This facility will be accepting individuals into care who have the same acuity level as those who commonly present to "psychiatric emergency departments," and accept a large percentage of its anticipated 7,085 admissions annually, as diversions from arrest and detention; and from emergency departments and psychiatric hospitalizations. As a result, the CTC will require a multi-disciplinary staff to include medical staff, behavioral health clinicians, and peer support specialists. It also requires a high staffing ratio to ensure clinically appropriate crisis care, while maintaining safety for both guests and staff. RI used its Crisis Resource Need Calculator to project the staffing capacity needs of the CTC and the entire crisis response system.

The innovative Crisis Resource Need Calculator offers an estimate of optimal crisis system resource allocations to meet the needs of the community. It also calculates the impact on healthcare costs associated with the incorporation of those resources. The calculator analyzes a number of data elements that includes population size, average length of stay in various system beds, escalation rates into higher levels of care, readmission rates, bed occupancy rates, and local costs for those resources. In communities in which these resources do not currently exist, figures from comparable communities can be used to support planning purposes.

The calculations are based on data gathered from several states and the *Crisis Now Business Case* that explains the rationale behind the model. A video can be seen on NASMHPD's www.crisisnow.com, which delineates this methodology. Quality and availability of outpatient services also influences demand on a crisis system so the Crisis Resource Need Calculator should be viewed as a guide in the design process. True assessment of system adequacy must include a look at overall functioning of the existing system. Signs of insufficient resources will include, but are not limited to, psychiatric boarding in EDs and incarceration for misdemeanor offenses when connection to urgent care is the preferred intervention. The calculator's algorithms are built in part on an analysis of the distribution scores on over one million Level of Care UTILIZATION System for Psychiatric and Addiction Services (LOCUS) score assignments.

The Crisis Resource Need Calculator demonstrates the cost savings that can be realized by implementing mobile crisis and facility-based crisis services in a given community. Using the calculator, the population for Dane County of 546,695 was entered. The algorithms built into the Calculator will indicate that those with LOCUS level scores of five (5), 68% of them would be expected to be referred to inpatient care. The Calculator has also projected the number of psychiatric beds that would be needed, based on the inpatient ALOS of 8.80 for Dane County.

The average per diem inpatient rate of $980 for Dane County was also be entered which tabulates as a total inpatient spend. After applying an ED cost for the area per admission to an inpatient bed (medical clearance and assessment), the total estimated cost escalates further. For the 32% of individuals with LOCUS levels scores of 1-4, no cost or service is included in the calculations, since in reality it is unlikely that any actual cost would be incurred. When MCT and facility-based crisis services are included in optimal ratios, total costs drop in the projections. This is despite engaging the entire appropriate LOCUS scored individuals. This means that the more individuals who are served with programs that align better to their unique level of clinical need, will result in lowered costs by a calculated percentage. Additionally, alignment of clinical level need to the service delivered improves from a low of 14% to as high as 100% in an optimized crisis response system under the National Guidelines.

The algorithm also utilizes key crisis performance indicators from current community crisis providers to predict the capacity needed to serve the expected number of crisis events that a community would experience over the course of a year. In utilizing this algorithm for Dane County, it is important to note that not all used data points came from current County crisis providers. Dane County currently does not offer certain services whose data points could be used to inform the model. In these cases, the consultants used data points from high functioning crisis programs as a proxy. The final set of Calculator results for Dane County appear below:

Crisis Now Crisis System Calculator Advanced		
	No Crisis Care	**Crisis Now**
# of Crisis Episodes Annually *(200/100,000 Monthly)*	13,121	13,121
Short-Term Inpatient Crisis Beds		
# Referred to Crisis Bed From Stabilization Chair	-	2,994
# of Short-Term Beds Needed	**-**	**33**
Total Cost of Short-Term Beds	**$ -**	**$ 10,269,897**
Crisis Receiving Chairs/Recliners		
# Initially Served by Crisis Stabilization Facility	-	7,085
# Referred to Crisis Facility by Mobile Team	-	1,470
Total # of Episodes in Crisis Facility	-	8,555
Involuntary Estimates - To be taken out of total numbers		500
# of Crisis Receiving Chairs Needed	**-**	**22**
Total Revenue of Crisis Receiving Chairs (Medicaid)	**$ -**	**$ 4,045,465**
Mobile Outreach Teams		
# Served Per Mobile Team Daily	4	3
# of Mobile Teams Needed	**-**	**5.21**
Total # of Episodes with Mobile Team	-	4,199
Total Cost of Mobile Teams	**$ -**	**$ 1,406,485**
# of Unique Individuals Served	**8,922**	**13,121**

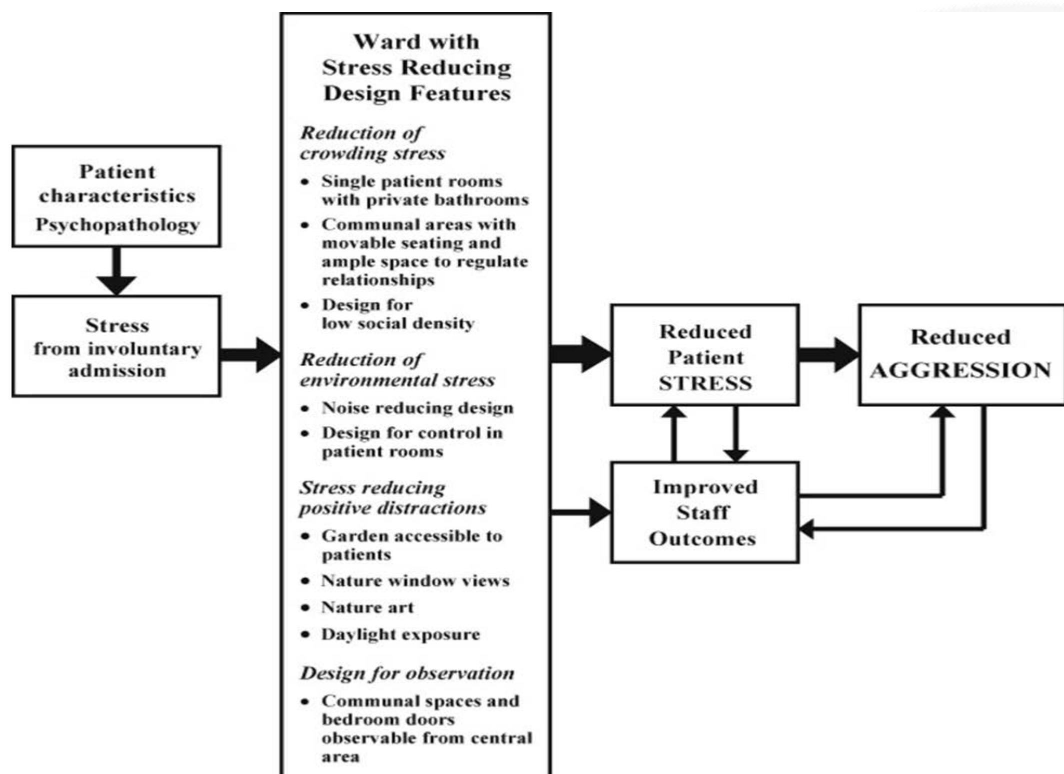
The Calculator indicates that Dane County can expect 13,121 BH crisis episodes per year. Out of these, 8,555 CTC episodes of care would be expected, if the CTC operates under "no wrong door," and accepts voluntary and involuntary admissions. In this scenario, the CTC would need 24 recliners, but with involuntary admissions in question, 22 recliners was projected by the Calculator because 500 fewer admissions can be expected annually if the CTC is not able to admit those on involuntary status. For construction purposes, the County should plan to construct a facility that at a minimum can accommodate 25 recliners. There are other relevant Calculator projections for County planning purposes that can be applied to the crisis response system as a whole, but only those that are relevant to establishing the CTC have been elaborated upon here.

As indicated earlier, the calculator projects that 8,555 people will be served in the CTC annually. 7,085 of these will be a mix of first responder drop-offs and community and self-referrals, while the balance of 1,470 will be MCT transports. The calculator also indicates that each MCT will intervene on average with three (3) crisis episodes per day, which will total 4,199 episodes over the course of a year.

Facility Planning

While BH facilities have some of the same general needs as other medical facilities, they also require planning to assess and address their specialty needs. That is more valid now than ever, since we are moving toward more person-centered approaches to BH treatment and support. A controlled research project on a design conceptual model that proposed that aggression in psychiatric facilities can be reduced by designing the physical environment with ten evidence-based stress-reducing features. The model was first tested in a newer psychiatric hospital in Sweden. Data, on two clinical markers of aggressive behavior, compulsory injections and physical restraints and was subsequently compared with data from an older facility that had only one stress-reducing feature. Another hospital with one feature, which did not change during the study period, served as a control.

The proportion of patients requiring injections as a chemical restraint declined ($p < 0.0027$) in the new hospital compared to the old facility, but did not change in the control hospital. Among patients who received such injections, the average number of injections declined marginally in the new hospital compared to the old facility, but increased in the control hospital by 19%. The average number of physical restraints (among patients who received at least one) decreased 50% in the new hospital compared to the old. These findings suggest that designing better psychiatric buildings using well-reasoned theory and the best available evidence can reduce the major client and staff safety threat posed by aggressive behavior. (Ulrich, 2018) These findings are portrayed in the diagram below:



The design elements, that were determined in this study to reduce violent behavior, are consistent with the principles of the *National Guidelines*, and are featured below:

1. Single patient rooms with private bathrooms, which require patients to be continuously monitored, however, in the case of CTC, an open floor plan is optimal;
2. Communal areas with movable seating, (but incapable of being weaponized) and ample space to regulate relationships;
3. Design for low social density;
4. Reduction of environmental stress;
5. Noise reducing design;
6. Design to foster personalization and control in patient rooms;
7. Stress reducing positive distractions;
8. Garden accessible to patients;
9. Nature window views;
10. Nature art;
11. Daylight exposure
12. Design for observation of and engagement with patients; and
13. Good visibility of communal areas.

However, when it comes to facility standards for the CTC, RI follows those of The Joint Commission. When planning for new, altered, or renovated space, the applicable standard is EC.02.06.05. The Joint Commission expects organizations to assess building design and construction requirements based on local, state, and federal regulations and codes. Typically, the controlling authority for this issue is the state health department licensing entity. When these entities are silent on a particular design criterion, The Joint Commission recognizes the 2018 Facility Guidelines Institute (FGI) Guidelines for Design and Construction of Hospitals for new construction and renovation.

The FGI allows requirements at the time of construction to be used, so the edition of the FGI applicable at the time of construction would be used for existing construction. If the current requirements are stricter than the building codes at the time of construction, The Joint Commission would expect the organization to perform a gap analysis to validate that adequate patient and staff safety, and process integrity can be maintained. A read only copy of the Guidelines is available at https://fgiguidelines.org/guidelines/purchase-the-guidelines/read-only-copy/.

The Dane County CTC will have space requirements of approximately 16,000 square feet with 50 to 60 parking spaces. It will need to be a relatively open floor plan with no hallways to accommodate up to twenty-five (25) recliners and an eating area. Given that the ALOS will be 10-12 hours, the utilization of a catering service is preferable to building out a kitchen and having to employ food preparation staff. Additionally the following spaces would need to be designed and incorporated into the building plans:

- 3 intake rooms
- 1 small lobby and reception space

- 2 quiet rooms
- 1 seclusion and restraint room
- 1 sally port
- Eating area and food storage
- 3 dayroom restrooms
- 1 sally port restroom
- 1 staff breakroom with staff lockers
- 1-2 family visitation areas
- 2-3 multi-purpose conference/training rooms
- 2-3 consultation rooms
- 1 nursing station/medication dispensary with sink, refrigeration, and OmniCell pharmacy unit
- IT closet
- Janitorial closet with roof access
- 3-4 staff offices
- Ample space to accommodate multiple washers and dryers
- Storage space for guest belongings and clothes pantry

The CTC building plans should be of professional quality, prepared and stamped by a licensed architect. The following plans are typical of the minimum required for all facilities in new and /or renovated construction:

1. Site plan: showing the location of the building on a site/plot plan to determine surrounding conditions, driveways, all walks and steps, ramps, parking areas, handicapped and emergency vehicle spaces, accessible route to the main entrance, secure yard for clients, any permanent structures, including notes on construction materials used.
2. Life safety and code compliance plan: noting applicable code requirements and compliance data, locations of rated firewalls, smoke partitions (if any), exit paths & distances, fire extinguishers locations. The design of the CTC should be to the specification s of a secure psychiatric facility and include anti-ligature features throughout.
3. Floor plans: showing location use of each room and all other pertinent explanatory information addressing the requirements in applicable regulations.
4. Dimensioned floor plan: showing all exterior and interior dimensions of all rooms, spaces, and corridors, etc.
5. Exterior building elevations: noting all building heights, locations of exterior doors, and any operable and fixed windows (sill heights).
6. Building and wall sections: showing at least one building or wall section showing an exterior and interior wall construction section including the material composition of the floor, walls, and ceiling/roof construction.
7. Schedule sheets: room finish: noting all room finishes, (e.g., carpet, tile, gypsum board with paint, etc.); door schedule; noting door sizes/thickness, door types & ratings; window schedule, noting sizes, type and operation; skylight schedule, noting size, type.

8. Special systems plan: location of fire extinguishers, heat and smoke detectors, nurse call systems, and operational elements of alarm system.
9. Mechanical plans: noting location of heating units, furnaces, hot water heaters, and fuel type and source; all heating, ventilating and air conditioning/cooling systems including locations of fire dampers.
10. Plumbing plan: noting all plumbing fixture locations, fixture types.
11. Electrical plan: noting power and lighting layouts, exit lighting, emergency lighting fixtures, emergency power systems (if any), electrical panel information.
12. Other plans: As necessary (i.e. phasing plan) to describe compliance with the other requirements in applicable regulations.

Site Selection

In meeting with Dane County facility management, the RI consultant team learned that the County does not currently own any vacant real estate upon which the CTC could be built, nor any vacant facilities that could be re-purposed to serve the facility needs of the CTC. Based on that information, RI did an environmental scan to identify parcels suitable for the CTC. Prime among the criteria for potential site selection was that it would have to be located in the central area of the City of Madison, in proximity to interstate highway intersections, in order to facilitate first responder drop-offs to the CTC, and near public transformation to facilitate walk-ins into the CTC. Three of the four parcels met this criterion, while one of them was not accessible via public transportation. Another consideration, if plausible, would be to locate the CTC near existing crisis facilities in order to make transfers between programs less arduous.

Three potential sites were therefore identified, upon cursory examination, to be potentially suitable. One of the parcels was on the market, while the other two were not. Further investigation will have to be made regarding the status of the properties that are not currently being marketed. Bottom line is that there does appear to be options for siting the CTC.

Project Management

The selected CTC management entity should be expected to present a project plan that clearly explains how it will manage and control all proposed implementation activities including timelines. It should explain how the management and administrative processes function to ensure that the appropriate levels of supervision are provided to monitor and oversee all proposed activities and the resulting timetable. When a provider organization is awarded a contract by Dane County to operate the CTC, it should forge a project implementation team for this project. This team should be comprised of members that are representative of functional areas across the organization. This approach offers several benefits by focusing on integrating, aligning and linking processes and organizational functions effectively to achieve the planned goals and objectives for the opening and ongoing operations of the CTC.

Collaborating, with the County, at the outset to pinpoint the necessary requirements to implement the project correctly the first time will have a positive domino effect, with bottom line impact. The resulting deliverables will include a more efficient requirement gathering

process, fewer plan modifications, improved staging of project milestones, heads-up planning that minimizes risk, and ultimately, timely project implementation. This will assure that all work is properly performed, and that all milestones are met as proposed.

State Certification

In order for the CTC to operate, it would have to be certified as an Emergency Mental Health Service Program by the Department of Health Services under Wisconsin Administrative Code Chapter DHS 34. If the CTC as a new facility type is deemed by the Department to not fall within existing certification requirements, then a variance under these provisions should be requested. The Emergency Mental Health Service Program Initial Certification Application is available at https://www.dhs.wisconsin.gov/regulations/mh/emergency-services.htm. On receipt of an application for initial certification or renewal of certification, WI DHS will do all of the following:

1. Review the application and its supporting documents.
2. Designate a representative to conduct an on-site survey of the program, including interviewing program staff. The certification survey will be used to determine the extent of the program's compliance with the standards. Within 60 days after receiving a completed application for initial certification or renewal of certification, WI DHS will do one of the following;
    a. Certify the program, if all requirements are met, or
    b. Deny certification, if one or more major deficiencies are found. Certification decisions are based on a reasonable assessment of the program.

The annual cost for maintaining certification is $550.00.

Payer Contracting

Prior to becoming an eligible provider organization to qualify for reimbursement from Medicaid and non-Medicaid funding opportunities payer agreements, BH provider organizations must apply for and receive a ten-digit National Provider Identifier (NPI) number through the National Plan and Provider Enumeration System (NPPES) of the Centers for Medicare and Medicaid Services (CMS). Further information about the NPI system and application materials is available on the CMS website.

Most publicly funded BH providers intend to serve both Medicaid-eligible individuals and those who qualify for funding from non-Medicaid sources such as federal block grants, state general funds, or discretionary grants. In order to be reimbursed for eligible services delivered to eligible recipients from these different funding sources, providers must complete the respective applications, and registration and credentialing processes.

Medicaid is the major payer of publicly funded BH services nationally. Therefore, Medicaid would normally be expected to be the major payer for services rendered by the CTC. This is particularly true in states that have chosen to expand Medicaid. Nevertheless, in Dane

County, Medicaid represents just 41% of the funding in support of BH services currently. Therefore, the County will assume the majority of the financing of the CTC. There was receptivity expressed in meeting with BadgerCare MCO's to exploring contract and payment options related to CTC services, primarily due to the significant diversion potential for ED and psychiatric inpatient utilization.

Staffing

The CTC must be staffed every hour of every day without exception, so that it will be equipped to accept any admission. To fulfill this commitment, a multi-disciplinary team is essential. It should be stressed, because of the high acuity of those being admitted, a high staff to client ratio is required along with the professional personnel necessary to manage the acuity levels of those admitted. Therefore, this is an expensive service to render. In order to be able to financially support this level of staffing for 24/7, there needs to be sufficient referrals into the CTC. To achieve this requires a sufficient population base, and collaborative working relationships with law enforcement, EMS, hospitals, BH providers, and the community. The staffing configuration for the proposed CTC to operate 24/7 is presented below for 42.15 full-time equivalents (FTE) that would operate in two (2) twelve (12) hour personnel shifts per day. The composition of the staffing plan is presented below:

Position	Hours per Shift	FTE	Count FT	Count PT	Rate
Medical Director	NA - not shift worker	0.2	0.2	0	155
Program Director	NA - not shift worker	1	1	0	58
Program Supervisor	NA - not shift worker	1	1	0	34
Billing Specialist III	NA - not shift worker	1	1	0	24
Office Manager	NA - not shift worker	1	1	0	25
Nurse Manager	NA - not shift worker	1	1	0	60
NP / Psych Worked		3.5	4	2	107.11
Nurses Only	12	5.6	5	1	46
Nurse - LPN	12	4.2	4	0	28
Shift Supervisor - MHP	12	4.2	4	0	32
Peer Support Specialist	12	8.4	8	0	17
Mileau Specialist	12	4.2	4	0	22
Customer Service Specialist	8	2.8	2	2	18
Admin/Discharge Coordinator	12	2.625	1	1	21
Transport Specialist	8	1.4	1	1	17
TOTALS		42.125	38.2	7	

Unfortunately, nursing is not a recognized discipline as appropriate for WI Medicaid reimbursement for emergency mental health services, as nursing will be a critical function in the operation of the CTC.

Technology Needs

Electronic Health Record (EHR)

The CTC will need to negotiate and execute provider agreements with each payer, whether Medicaid-related or commercial health insurance. However, it anticipated that a Medicaid provider agreement would have to be held in abeyance until Medicaid reimbursed for CTC services. The CTC will need to determine who is eligible for any given health plan benefit, document financial eligibility, record clinical and demographic characteristics, generate appropriate invoices/claims and effectively bill appropriate third-party payers. CTC management will need to become well versed on the nuances of each benefit plan, to include its eligibility criteria and member enrollment processes. The CTC should be expected to retain a Medicaid enrollment expertise to assist with eligibility determination and with enrollment of clients who are eligible for Medicaid, but who have not enrolled. The CTC should be expected to utilize the State's web portal to check eligibility at the time of services and document the payer in the EHR.

Demographic information should be collected upon admission, and entered into the EHR. Reverification of payer status should be determined within each episode of care. Billing should be completed at least weekly through a claims clearinghouse on a two-week lag timeframe to allow time for internal claim scrubs to occur and be corrected prior to billing, i.e. missing member ID. Internet resources such as Avidity can be used to identify other potential health insurance coverage. Primary insurance needs to be billed prior to Medicaid, when covered billing codes exist within a covered code set. While there will be those that are admitted to the CTC with Medicare coverage, Medicare does not have a benefit plan that includes coverage for BH crisis services.

The CTC will benefit from utilizing an EHR that is specifically designed for organizations that provide BH treatment services in community-based, residential and inpatient programs. Preferably, it should offer a recovery-focused suite of solutions that leverage real-time analytics and clinical decision support to drive decision-making. The ideal platform should streamline workflows, making client information quickly accessible with user-friendly dashboards. It should also offer a whole-person integrated care model with a comprehensive set of features that support all CTC clinical and management functions, from front desk staff and clinicians, to billing administrators and executive management. This level of functionality will result in improved operational, clinical and financial workflows the CTC.

The EHR clinical features should include supporting scheduling and workflows for group appointments and treatments, detoxification and any outpatient care; monitoring of treatment adherence while alerting clinicians to needed information; and supporting documentation for different treatment workflows such as crisis stays and recovery supports. In terms of financial management, it should provide automated electronic remittance processing and efficient denial management workflow while managing complex billing requirements, intensive episodes of care, including wrap-around services and Medicare pharmacy billing. Particularly important in today's complex healthcare environment, it should support complex billing models, including value-based reimbursement payments, shadow

billing and non-profit grant funding. Operationally, it should track key performance indicators to measure meaningful use compliance, revenue and other organizational goals, while monitoring system status and optimization utilizing modeling tools.

The EHR should be used for all documentation of clinical care, service delivery, claim submission, and reporting. Any electronic documents should have discrete data capture fields that can be modified for contract requirements. Hardcopy client records need to be scanned into the system for ease of access and chart review. The EHR should also have batch transaction capability for transmission and reception for organizations that can accept HIPAA compliant 837 transactions. The EHR 837 templates should be created based on CMS and funder companion file requirements. It should also accommodate claims transmission through a payer portal, if preferred or required. In order for the CTC to sustain a high success rate in clean claim submission and subsequent appropriate payment, the CTC will have to engage in the rigorous working of internal claim rejections, clearinghouse rejections, and 835 denials, as well as, vetting back end reports for accurate contract amounts, etc. These denial reviews need to be completed on a daily, weekly, and monthly basis.

The EHR must secure storage of protected health information, as well as, generate reports from the data to conduct continuous quality improvement analyses that should include:

- Referral outcomes;
- Average wait time to completion of critical assessment and treatment planning;
- Average transition time for law enforcement handoffs;
- Reason for referral;
- Average length of stay;
- Disposition at discharge;
- Involuntary to voluntary conversion percentage;
- Readmission percentage/recidivism rates;
- Linkage to community resources;
- Customer Satisfaction Survey;
- 72-hour follow-up calls to monitor stabilization and connection to care;
- Incidence of sentinel events;
- Incidence of seclusion/restraints, if applicable.

Most EHRs have a Report Library that contains a host of standardized reports often including those related to Client Management; Provider Practice; Scheduling; Billing Management; Diagnoses; Active Client List; Missing Progress Notes; Client Satisfaction, and Services by Client Demographics. However, reporting requirements should be considered a collaborative effort with contracted authorities and payers of service. Customized reporting requirements to multiple entities is possible via Secure File Transfer Protocol (SFTP) delivery. Any pre-determined templates can be built into an EHR for specific data capture and delivered on any delivery schedule. Specific forms and outcome reports can be customized for service recipients using an Application Designer who can further modify existing forms and reports based on the changing needs of customer(s). CTC management must possess the necessary competencies related to its EHR and its application to meet various performance measurement requirements.

Telehealth

Telehealth or tele-psych involve the use of mobile and web platforms that brings BH care directly to the person. By enabling the distribution of virtual clinical services, these capabilities can expand the reach of BH care during times of crisis. Improved care outcomes can be achieved with the timely access to high-demand practitioners, such as psychiatry and after-hours access to physicians. It offers the potential to improve health outcomes and lower costs by allowing the CTC to access specialty and assessment expertise, often 24/7 that might not be otherwise available on-site, hence making this expertise available and affordable. In addition, telehealth provides the ability to follow-up with discharged clients and thereby facilitate ongoing care coordination.

The features commonly available with a telehealth platform are:

- Schedule initial intake or ongoing appointments with existing clients;
- Access and launch a telehealth session from the EHR;
- Document treatment and services, and seamlessly bill for services;
- Available on an Android or iOS device; and
- Dedicated tablets can connect individuals with specialists for consultations and assessments.

Telehealth platforms now offer integration with an EHR, enabling the scheduling and launching of virtual appointments, creating dedicated virtual practices, while providing strict compliance with industry safety and security standards.

Technology Assisted Care (TAC)

The SAMHSA Treatment Improvement Protocol 60 (TIP), *Using Technology-Based Therapeutic Tools in Behavioral Health Services,* provides an overview of current technology-based assessments and interventions (including treatment, recovery support, relapse prevention, and prevention-focused interventions) targeting BH, and it summarizes the evidence base supporting the effectiveness of such interventions. It also examines opportunities for technology-assisted care (TAC) in the BH arena—particularly in improving early access to care, client engagement in and commitment to treatment and recovery, client education, specific treatment interventions, relapse prevention and recovery management, extended recovery, community engagement, MH promotion, and SUD prevention, among other areas.

This particular TIP addresses how BH service providers can use Web sites, telephone and telehealth resources, smartphones, and other portable devices and electronic media for education, outreach, and direct client services. It emphasizes use of TAC with clients who might not otherwise receive treatment or whose treatment might be impeded by physical disabilities, rural or remote geographic locations, and lack of transportation, employment constraints, or symptoms of mental illness. While this TIP emphasizes the use of TAC with those who might not seek treatment in conventional settings and/or who have personal

preferences that limit access to conventional services, including crisis services, it has application to the full crisis care continuum.

In short, evidence-based TAC has the potential to reach more clients and help engage and retain them in services in a cost-effective manner. This TIP provides treatment and prevention staff in the BH arena with the resources they need to use various technologies in clinical practice; and to recognize the limits and ethical considerations involved in using them. It also provides BH program administrators with the need to integrate and expand the use of technologies in their systems of care. This TIP 60 is highly recommended as a resource for the implementation of the Dane County CTC and in the further development of a more robust crisis continuum of care. However, more importantly, is the adoption and sound execution of an EHR, which will be critical to the operational success of the CTC.

Additional Technology

Below is a listing of additional technology that the CTC will require. The associated costs appear in the operating budget:

Server	Server computer, temperature monitor and software
	UPS
	Network switch
	Cables
	Rack and patch panel
	Wiring data/voice jacks each
Electronic Bed Board	Electronic Bed Board & cabling
Group Printer	Group printer
RSA Laptop	Laptop with bag, docking station, monitor, licenses, webcam & speakers
	Power strips & cables
Basic Laptop or Desktop	Laptop with bag
	Licenses
	Power strips & cables
Desktop	Desktop
	Licenses
	Power strips & cables
Billing	1 scanners
	add dual video card and one monitor
WIFI	Wireless Access Point
Security Camera System	Security Camera System

Legal and Accounting

CTC management will eventually face legal questions and challenges. The CTC will require legal counsel to mitigate risk and ensure legal and regulatory compliance. Below, are reasons why legal counsel should be retained by the CTC:

1. Corporate law and governance
   One of the biggest hurdles for nonprofits (NPO) generally is governance. A strong nonprofit business attorney can help ensure that the CTC corporate structure, practices, and procedures always remain in legal compliance.

2. Taxes
   Legal counsel will help ensure compliance with all regulations and requirements with regard to maintaining the CTC's nonprofit tax-exempt status.
3. Intellectual property
   The CTC may need to protect any intellectual property. NPO status does not; in and of itself protect any innovative ideas and practices. Legal counsel will help to protect intellectual property through trademark and copyright law.
4. Contracts
   As with intellectual property, a business attorney can help create concrete contracts to protect the CTC's interests whenever possible.
5. Employment
   The CTC will face many of the same labor and employment related issues that traditional businesses do, but with even more complications due to the CTC may make use of volunteers and interns. There are many ways to be in jeopardy when utilizing unpaid labor. Legal counsel can help ensure that all hiring and labor practices are fair and legal.
6. Liability
   Because of the nature of its work, the CTC can be subject to malpractice allegations.
7. Fundraising
   A business attorney can assist to maintain legality in any fundraising practices. Missteps in fundraising can jeopardize the CTC's tax-exempt status.
8. Lobbying
   Nonprofits are not permitted, under law, to engage in lobbying. However, it is often necessary for a NPO to engage in advocacy. A business attorney can assist with limiting the any advocacy activities to operating only within prescribed legal parameters.

The bottom line is that there are numerous reasons why CTC management should utilize experienced legal counsel. It should have an attorney on its Board of Directors or retain an attorney who understands the intricacies of the CTC and BH-related legal matters.

Increased requests for transparency and accountability in financial reporting, has NPO financial managers continually reviewing their programs and processes. In the age of digital communications, social media, and the 24-hour news cycle, perceived violations of public trust offer NPOs little chance to recover from financial mistakes. In the headlights of this increased focus on integrity and accountability are the chief financial officer, accounting staff, and finance director. They are each, increasingly being asked to anticipate problems and suggest solutions, to articulate timely financial results and decisions, and to provide leadership in a dynamic health care provider marketplace.

Unfortunately, traditional accounting systems are ill equipped to help health care financial officers meet these challenges. Managing unique revenue streams such as donations, membership dues, program revenues, grants, and investment income requires accounting systems tailored to meet these needs. Operational systems that are not designed to automate these specific business processes and reporting needs, cost organizations time, energy, and effort. A solution that provides the highest levels of transparency and accountability is necessary to help CTC management make solid, strategic decisions and avoid violating the

public's trust. A major solution toward that aim is for CTC management either to have an accountant on its Board of Directors or to retain one. Another solution is to have an accounting system that can generate the information necessary for the organization's finance team and accountant to manage the CTC's finances.

Quality Management

The Quality Management Program (QMP) for the CTC should extend beyond traditional Quality Assurance and instead embrace a Continuous Quality Improvement (CQI) process that involves monitoring and evaluating clinical, management, and support services provided to internal and external customers and identifies and assigns priority to problems and/or opportunities for improving departmental and overall organizational performance. The basic tenets of the QMP should include:

1. Quality is every employee's job;
2. A belief that optimal quality results from a close partnership between the provider of services and the participants;
3. Quality problems that result in inefficiencies or substandard services frequently stem from faulty processes and systems, rather than individual performance;
4. Accessible, reliable and current data is vital to organizational decision-making;
5. Quality problems can be resolved, and service continually improved;
6. Poor quality is costly; and
7. Education, training, and retraining are critical to quality, and to facilitating improvement in job performance.

The Director of the CTC should be designated with the responsibility for assuring the quality and effectiveness of care and services provided by its medical, professional, and support staff. The Director should actively and visibly support and lead Quality Management efforts by establishing priorities for the QMP consistent with the CTC's mission and directives; and by modeling his/her ongoing commitment to CQI. The responsibility of designing, planning, implementing, and evaluating the QMP should fall to the Quality and Compliance function, that works collaboratively with the Director and the management team in striving for excellence in all aspects of the organization's clinical, management and support services.

The QMP should define quality improvement targets and initiatives based on established priorities; reviewing and recommending indicators for measuring individual and organizational functions, processes and outcomes; analysis and assessment of findings; identification and resolution of known or suspected opportunities for improvement; making recommendations for formulation of Performance Improvement Teams; and ensuring appropriate follow-through on quality improvement action items. The QMP should also plan for the review of statistical data and findings on Customer Satisfaction, Seclusion and Restraint, Qualitative Record Reviews, Utilization Management, Critical Incidents, Customer Complaints and Grievances, Risk Management, Periodic Cultural Assessments, and Health and Safety. The information reviewed and any recommendations regarding the QMP should be readily available to Dane County, regulators, and payers.

Employees from all levels of the within the CTC should participate in teams created to improve a specific process or outcome, as appropriate. Teams may be Functional (created from within one department, work area, or discipline), or Cross Functional (members from two or more departments, work areas or disciplines which share ownership of the issue discussed). Representation of individuals from outside the organization who have special knowledge or expertise may participate as team members, as appropriate. All teams should have a designated Team Leader and Facilitator and utilize the **F**ind, **O**rganize, **C**larify, **U**nderstand, and **S**elect – **P**lan, **D**o, **C**heck, and **A**ct (FOCUS- PDCA) model, or a modified version of this model, for performance improvement activities. FOCUS-PDCA is a management method, developed in the healthcare industry that is used to improve processes.

The QMP should become operational through a Quality Management Work Plan, which includes an annual evaluation of QMP; Quality Management Plan and Work Plan; Utilization Management Program; Utilization Management Plan; Policies and Procedures and Forms; and The Joint Commission (TJC) Training and Education Program, or other accrediting body. In addition, a quarterly evaluation, should be conducted, of Customer Satisfaction Surveys, Infection Control Report, Environment of Care Report, Quality Record Reviews, and Sentinel Event Report; and on a monthly basis, there should be an evaluation of the Patient Complaint and Grievance, and Seclusion and Restraint Reports.

The CTC 23-hour crisis observation and stabilization service should be expected to achieve the following expectations:

- Accept all referrals without pre-screening;
- Does not require medical clearance prior to admission, but will assess for and support medical stability while in the program;
- CTC services to address SMI, SUD, and IDD crisis-related conditions;
- Employ the capacity to assess physical health needs and deliver care for most minor physical health challenges;
- Staff at all times (24/7/365) with a multi-disciplinary team capable of meeting the needs of individuals experiencing all levels of crisis in the community.
- Offer walk-in and first responder drop-off options;
- Be structured in a manner that offers capacity to accept all referrals, with a no reject policy for first responders;
- Screen for suicide risk and complete comprehensive suicide risk assessments and planning when clinically indicated;
- Function as a 24 hour or less crisis receiving and stabilization facility;
- Offer a dedicated first responder drop-off area;
- Incorporate some form of intensive support beds into a partner program (could be own program or another provider) to support flow for individuals who need additional support;
- Have access in real-time to the bed registry system operated by the crisis call center hub to support efficient connection to needed resources; and
- Coordinate connections to ongoing care.

For CTC performance metrics, see **Recommendation 3. Performance Expectations and Metrics**.

Competency in Serving Persons with Intellectual and Developmental Disabilities

Individuals with intellectual and developmental disabilities (PWIDD) are at high risk for co-occurring mental health conditions, with the incidence of psychiatric disorder estimated to be more than three times higher in the IDD population compared to the general population. One of the challenges in providing mental health services for these individuals in all age groups is in addressing their broader spectrum of unique needs. The vulnerabilities faced by these individuals are pronounced and can lead to catastrophic consequences, including, pronounced rates of victimization, lack of access to appropriate treatment with multiple transitions in care that can create regression, the potential for criminalization of behavior as an unfortunate result of miscommunication, and other challenges. Therefore, the CTC staff and all those that are part of the crisis response system must develop the requisite competence to serve PWIDD.

The National Association of State Mental Health Program Directors' (NASMHPD) Technical Assistance Coalition White Paper Assessment #7 from August 2017, entitled, *The Vital Role of Specialized Approaches: Persons with Intellectual and Developmental Disabilities in the Mental Health System,* makes a number of recommendations that would be beneficial for DHS to consider, among them:

- Policymakers should work to develop cross-agency guidelines for greater intersystem collaboration, recognizing that PWIDD will and do appear in the mental health service system. The development of these collaborative efforts should include input from a variety of stakeholders and examine collaboration across all ages, including persons served in the child/adolescent, adult, and older adult sectors. Perspectives of persons served, their families, and representative advocacy organizations will be critical in the development of guidelines. Examples of important areas for these guidelines to address include:
  - Development of shared data to understand total numbers of individuals served across systems and those denied services because of overlap issues, and the development of planning based on those data;
  - Development of approaches to handle requests for services for people that do not neatly fit into administrative lines for particular services and the development of approaches for reviewing individual cases where overlapping needs are present but are not being met;
- Foster leadership to develop methods through blended and braided funding streams for continuum of care services that address the dual need populations;
- Establish intersystem partnerships, such as with law enforcement and jail diversion programs, to include interventions for persons with both IDD and SMI;
- Establish mutual workforce development;
- Systemic data collection must be done to better identify population prevalence and needs across systems.

- Prioritize the ability to develop self-directed and person-centered care planning, focusing on the PWIDD's strengths, capabilities, and potential to contribute to their community.
- Partner with IDD agencies overseeing services for these persons, and together there should be interagency outreach and collaboration with law enforcement, courts, and corrections to provide skilled de-escalation, diversion approaches, cross-discipline education, and linkages to services; and guidance in developing greater supports to accommodate persons with disabilities in justice and forensic systems, as well as, build bridges to programs reflecting alternatives to incarceration. Partner in cross-agency activities and policy development to strengthen appropriate services for the IDD population within corrections and offer strategies to advance improved conditions of confinement targeting this sub-population's needs.

Recommendations for practitioners include the following:

- Co-occurring challenges such as psychiatric disorders, other neurodevelopmental disorders, hearing loss, and other sensory challenges, are important to take into account among the PWIDD population across the continuum of care and support services. There is much heterogeneity in the population, so generalizations and cookie-cutter approaches are risky.
- Rates of trauma and victimization are alarmingly high in PWIDD. Safeguards, self-scrutiny, and monitoring are of ongoing critical importance.
- All behavior reflects some type of communication. An individual's limited ability to verbally communicate anxiety, mood issues, or a psychotic disorder may manifest in aggression or externalizing behaviors, which can often result in missed diagnoses or opportunities for treatment. Always ask, "What is the communication or behavior trying to achieve?"
- Given the limited guidance on helpful medication strategies for PWIDD in the literature, the evidence for psychopharmacology should be case-specific, data-informed rather than anecdotal, coming from behavioral evidence and comprehensive contextual information (e.g., behavior tracking reports) for the specific individual.
- Gather information from all sources, especially direct service professionals, who can provide a wealth of information to inform program and planning. Peer partners, provider treatment networks, and an emphasis on environmental precipitants to behavioral challenges should be helpful.
- Secure access to current policy and regulatory guidance in your state governing the provision of services to persons with co-occurring IDD and MH conditions. The guidance would include coverage and reimbursement guidelines, as well as criteria for case reconciliation carried out by interagency health and human services bodies designed to parse eligibility, and clinical and financial responsibility, for complex cases crossing multiple agency lines.
- Current practitioners should update their skills in working with PWIDD through continuing education activities. Trainees must be instructed in best practices in the appropriate biopsychosocial approach to psychiatric diagnosis and treatment of PWIDD.

This publication is available at https://www.nasmhpd.org/content/ta-coalition-assessment-working-papers-vital-role-specialized-approaches-persons. Another issue paper on this topic is, *Findings of Joint NASMHPD/NADD/NASDDDS Roundtables on Supporting Individuals with Co-Occurring Mental Health Support Needs and Intellectual/Developmental Disabilities* which can be accessed at https://www.nasmhpd.org/content/findings-joint-nasmhpdnaddnasddds-roundtables-supporting-individuals-co-occurring-mental-0 .

Utilization Management

The Level of Care Utilization System (LOCUS) was developed, for psychiatric and addiction services for adults, by the American Academy of Community Psychiatry to help guide level of care decisions. This tool is recommended for use by the CTC. It can be programmed into the Electronic Health Record (EHR), within which key assessment concepts and tools can be integrated. For example, SAMHSA's Suicide Risk Assessment Standards (SRAS) can be a tool available within the EHR, using the LOCUS methodology for determining the level of care assignment for any given admission. These software-driven clinical decision support tools should be integrated into the EHR and be reauthorized on an ongoing basis by the Medical Director. The Clinical Institute Withdrawal Assessment (CIWA) can also be integrated for use with individuals with severe SUD and potential withdrawal symptoms, along with elements of the Columbia Suicide Scale to assess for suicidality.

Capital, Startup, and Ramp-up Costs

Capital

The capital cost estimate for the CTC, based on the current market, is without site selection or civil engineering work estimates. A CTC with 22 recliners and 2-4 beds would require a facility of 16,000 total square feet. If the intention were to construct a facility to accommodate 25 or more recliners, the square footage required would have to be adjusted accordingly. For a building procurement by Dane County, the capital cost estimates are as follows:

	Item	Cost
1.	Ground purchase and prep:	$ 3,500,000
2.	Design and engineering:	$ 684,000
3.	Construction	$ 7,200,000
4.	Equipment, internal	$ 346,250
	Total	$11,730,250

There are of course other options available to the County that could significantly lower the costs. Should the County choose to lease a facility for 10 to 20 years, and have the facility renovated to CTC standards, the costs could be built into the terms of the lease and amortized over the course of the term. There exist other building finance options as well.

Startup

Costs associated with the startup of the CTC have to with the initial period following contract execution and/or facility occupancy permitting, for a provider organization to operate the CTC. This period of 60 days involves the recruitment, hiring, and onboarding/training of staff, while at the same time gaining State CTC certification and meeting other necessary requirements. Because there will be no services delivered during this period, there will be no revenue to offset these startup costs which equal two months of CTC expense budget which equates to $120,107.

Ramp-up

The ramp-up period is the period from when the CTC becomes operational and begins accepting admissions until the CTC generates sufficient revenue to meet its expenses. It is expected that the CTC will have a 35% occupancy rate in the first month of operation and it is anticipated to reach 85% by the ninth month. Without a resource to make up for the shortfall in revenue during the first eight months, a provider operating the CTC would take on a significant operating loss during the first year. Ramp-up funds are intended to compensate the CTC provider for these losses. In this circumstance, it appears that the County will be the CTC's primary funder and during the first year of operation, the CTC provider can be reimbursed for the services delivered, and the County could choose to cover the balance of expenses for this period only. For the first eight months of operation, the CTCF would not have sufficient occupancy to meet expenses, therefore it would experience a shortfall of $1,729,443 during this ramp-up period.

Operating Expense Budget

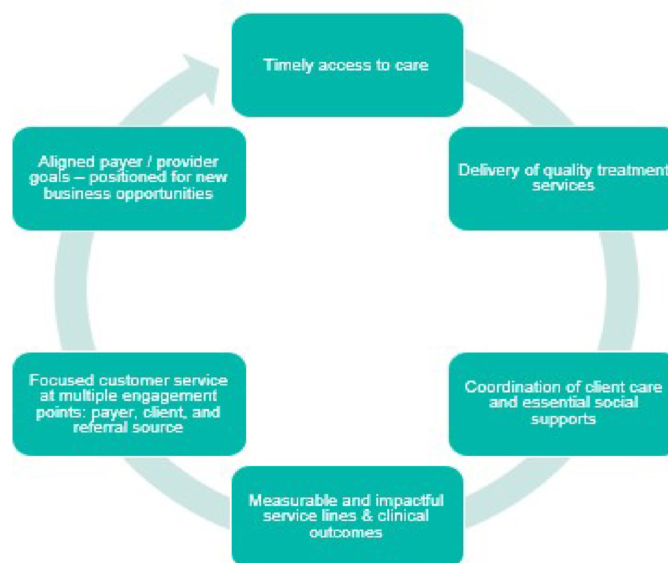
OPERATING EXPENSES	
Salary & Wages	3,579,745
Registry Services	125,000
Employee Benefits	720,643
Total Employee Expenses	**4,425,388**
Travel	2,730
Office Occupancy (Facility)	524,436
Client Occupancy	-
Program Services	136,161
Program Supplies	143,008
Office Supplies & Equipment	31,980
Insurance	102,407
Telephone	51,010
Other Expenses	7,750
Property Management (RI Properties)	-
Recovery Connections Line	-
Local Shared Services	-
Capital Expenditures	-
Net Operating Expenses, excluding Direct Allocations	**5,424,869**
Direct Allocation Expenses	306,679
Operating Expenses, including Direct Allocations	**5,731,549**
Indirect Allocation Expenses	489,448
Total Expenses	**6,220,997**

Revenue

If the CTC were to receive a bundled episodic rate of reimbursement, it would need to be a rate of $973.00. If the County chooses to reimburse on a FFS basis, then the individual services billed would need to equate to a comparable rate, in order for the CTC to be sustainable over time. On pages 69-71 of this Report, an analysis of Medicaid payment coding and rates was presented which indicated that current Medicaid rates are inadequate to financially sustain the CTC.

Promotion

The key to the ongoing sustainability of the CTC is dependent on a steady flow of referrals and their successful stabilization and reintegration into the community. It is not dependent on a competitive analysis, target market research, nor brand identity and positioning. Therefore, promoting the CTC requires a pragmatic approach that is typified by the Referral Development Planning Process that is diagrammed below:



If the CTC adheres to the *National Guidelines* to the extent that current WI statutes and regulations allow, then the CTC will provide ongoing timely access to crisis stabilization services and it will be delivering consistently effective and efficient care. However, the next three components of this process involve adopting what appeared earlier in this Report regarding Level Five (5) of Care Coordination.

In this model, the highest level requires shared protocols for coordination and care management that are "baked into" electronic processes, not simply add-ons. For a crisis service system to provide Level five, "Close and Fully Integrated Care", it must implement an integrated suite of software applications that employ online, real-time, and 24/7 functionality, as indicated in the diagram below:

It would be ideal if the Dane County crisis call center adopted the "Care Traffic Control" connectivity technology and practices as outlined in this Report to achieve this level of care coordination. In addition, DHS is strongly encouraged that to collaborate with its BH and health care providers within Dane County adopt and maximize the care coordination functionality of WISHIN 2.0.

7. Other Facility-based Crisis Stabilization Services

Dane County should continue to support, but modify, its existing crisis stabilization and detoxification facilities that operate with beds. These units should serve the roughly 30% of CTC admissions that are not sufficiently stabilized in under 24 hours to represent 2,921 anticipated admissions annually. While these facilities are system assets, there are a number of reconfigurations that could be made that will add value in the overall optimization of the crisis response system.

Capacity projections needed for this level of care (LOC) are projected to be thirty-two (32) beds, in an optimized crisis response system. Currently, Dane County has fifty-seven (57) crisis and detox beds, with twenty-nine (29) of these for detox in a secure facility. Given that there appears to be under-utilization associated with the current bed configuration, the County should examine converting the Detoxification Center to a crisis stabilization facility, which could potentially accept voluntary and involuntary admissions, while continuing to provide detoxification services, and serving those with co-occurring disorders, and those requiring BH stabilization.

Given that, the Detox Center bed capacity exceeds the Institution of Mental Disease (IMD) exclusion, which limits beds to under sixteen (16), a Center for Medicaid and Medicare (CMS) IMD Waiver by the State would be required in order for this facility to operate as a crisis stabilization center. Another potential option would be to reconfigure the facility to operate as two crisis stabilization units with separate addresses and entrances if this would be permissible under state certification. Since this detox facility already operates under a state variance to permit involuntary admissions, it may be possible to maintain the variance assigned to this program should it take on an expanded role as a Crisis Stabilization Center that also provides detoxification services.

The ten (10) beds that DHS currently contracts for at the CARE Center could continue to be used as a step-down service for higher levels of care. Under these circumstances, the ten (10) beds in question should be designated as transitional care and not as crisis care. Given that these beds are under-utilized, the County should re-evaluate the potential of reducing the number of beds contracted. Ultimately, the County should be able to reduce its stabilization/detox beds by twenty-five (25) when the crisis response system is fully optimized.

Miramont Behavioral Health in Middleton began accepting patients into its new 72-bed psychiatric hospital in August of this year, which will bring Dane County's psychiatric bed capacity total to 172. It has been reported that it will be offering free crisis assessments as an apparent loss leader to increase admissions. If the ALOS for psychiatric inpatient admissions is from five (5) to seven (7) days, then the Crisis Now Capacity Calculator projects that Dane County needs a total acute psychiatric bed count between 138 and 193, if operating without an optimized crisis response system. With the establishment of the CTC and the optimization of the County's crisis response system, the County's psychiatric bed capacity needs will be reduced to between 40 and 56 beds. In this scenario, the County would be over-bedded by 116 beds or more when considering adult crisis care only, but appropriate adjustments would have to be made to account for the beds needed for children and adolescents.

8. Mobile Crisis Team (MCT) Service

Realign the current mobile crisis service assets with the national crisis care guidelines, which will result in MCTs, comprised of a BH Clinician and a Peer Support Specialist, being dispatched by the crisis call center and intervening 24/7 with anyone, anywhere, and anytime.

MCT capacity projections for Dane County indicate that 5.2 MCTs (each MCT operating for 40 hours per week), would meet this need on a 24/7/365 basis. It is expected that on average, there will be three (3) crisis dispatches per day, per MCT. If an additional dispatch is needed while the MCT is already occupied with a crisis intervention in the community, it would be expected that the call center, based on an appropriate triage, would either continue with the crisis caller via phone, text, or chat, until the MCT was available; or a 911 dispatch would be initiated.

Any co-responder model of MCT that is dispatched by 911 will be expected to have far more crisis episode dispatches per 24 hours, then what the two-person behavioral health team model will experience during the same period. The CARES Team, for example, is directly dispatched by 911, which offers no crisis intervention service to stabilize the caller. With crisis call center dispatch, 80-90% of calls are stabilized without further intervention. Hence, only 10-20% of crisis calls will result in a MCT dispatch and as a result, the crisis episodes per day, that require a MCT response, will be far less.

Currently, there are 17.9 FTEs dedicated to a non-standardized approach to this service and there has never been 24/7 coverage countywide. By uniformly adopting this approach for MCTs, it is anticipated that the system will realize personnel savings of 7.5 FTEs who would be available for redeployment to other crisis care service components. If the CIT personnel at Tellurian are taken into account, who respond to crises involving those with a substance use disorder (SUD), then the personnel savings are anticipated to be even greater.

Since Dane County also has co-responder MCTs operating, it may be useful to consider the Literature Review that the University of New Mexico's Institute for Social Research completed on MCTs. It provides a summary of the research literature that compares what

it calls the “civilian model” of MCT to the co-responder model, which it terms a “civilian/police model.”

https://isr.unm.edu/centers/center-for-applied-research-and-analysis/behavioral-health-initiative-reports/summarized-literature-reviews/mobile-crisis-team.pdf

9. Rural Crisis Service Adaptations

Planning needs to occur with the more sparsely populated areas of Dane County to construct local crisis response solutions, where access to MCTs and facility-based crisis services have historically been inadequate. As with most metropolitan areas in the country, crisis services have been concentrated in the County’s largest city – Madison. Therefore, it is critical that mobile crisis services may need to be modified, to include tele-psych options and transportation, to assure adequate rural access to crisis care.

The National Association of State Mental Health Program Directors (NASMHPD) issued a Technical Assistance Brief in 2020 entitled, *Strategies for the Delivery of Behavioral Health Crisis Services in Rural and Frontier Areas of the U.S.* This paper is divided into seven sections. The first five sections discuss the challenges and opportunities related to particular barriers to crisis service delivery in rural areas, including workforce, distance to travel and transportation, sustainability, and the use of technology and broadband access. These sections are followed by a section discussing the additional effects the COVID-19 pandemic is having on the delivery of BH crisis services in rural and frontier communities, and the implications each of these challenges and opportunities have for policy makers. This publication should be of assistance in finding ways to deliver crisis responsive care to rural areas: https://nasmhpd.org/sites/default/files/2020paper10.pdf

More recently, SMI Advisor, which is a clinical support system for serious mental illness, released the report, *Improving Behavioral Health Services for Individuals with SMI in Rural and Remote Communities.* This publication involved a partnership between SMI Advisor, NASMHPD, and the NASMHPD Research Institute (NRI), and it is designed to offer strategies and key lessons for developing, implementing, financing, and sustaining BH services for individuals who have SMI and live in rural and remote communities. There is a chapter dedicated to “Increasing Access to Crisis Services.” A copy can be downloaded here: https://smiadviser.org/wp-content/uploads/2021/09/Improving-Behavioral-Health-Services-for-Individuals-with-SMI-in-Rural-and-Remote-Communities-Full-Report-September-2021.pdf

10. Crisis Care Traffic Control Hub

Continue enhance the Dane County crisis call center, operated by Journey MHC, and so that it continues to function as an integral part of the Wisconsin Lifeline network, which has been operational since August 2020; and that it is adequately resourced to operate as a fully functional Care Traffic Control Hub, under 988 implementation.

Operating as a Care Traffic Control Hub, Dane County’s crisis call center will have the ability to dispatch GPS tech-enabled MCTs across Dane County; will possess real-time data on available crisis and psychiatric beds and outpatient BH treatment slots county-wide; and provide text, chat, and peer-to-peer warm line services, also on a 24/7 basis.

Achieving this capability will be facilitated by Wisconsin's 988 implementation planning. Vibrant Emotional Health (Vibrant), which is overseeing 988 implementation nationally and is SAMHSA funded, has announced that it will be rolling out, in phases, a unified technology platform for crisis call centers across the country. It is estimated that approximately 10-15% of current 911-call volume will shift to the 988-call center. This will increase the volume of communications to the Dane County crisis call center. In addition, with the adoption of text and chat, roughly three times the current staffing levels will be required. Since 988 will be operational in July 2022, work should begin now to increase call center capacity and negotiate communication transfer protocols between 988 and 911. More information is available at https://www.vibrant.org/988/.

Based on the call volume projections, provided by Vibrant, and on Dane County's current population, the table below projects both the anticipated call volume for Dane County's Crisis Call Center and its associated costs over the course of five years beginning in July 2022:

988 Volume and Cost Projections		
	Volume	Expense
Implementation	15,323	$ 1,407,379
Full Year 1	26,649	$ 1,732,158
Full Year 2	30,370	$ 1,974,054
Full Year 3	33,560	$ 2,181,394
Full Year 4	36,750	$ 2,388,733
Full Year 5	39,940	$ 2,596,072

Behavioral Health Link (BHL), which operates the Georgia Crisis and Access Line and is a strategic partner of RI's, is the innovator of the Care Traffic Control applications to crisis call centers. The start-up cost modeling below, is a rough estimate provided by BHL of the anticipated start-up costs to transition the Dane County Call Center to a 988 Crisis Care Traffic Control Hub. Basically BHL uses two months of operating expenses to ballpark an estimation of start-up costs.

Crisis System Start-Up Cost Modeling			
	Methodology	Rationale	Amount
Call Center	2 Month's Expenses	Sup/Equip/Staff	$ 411,388

As indicated in the body of this Report, Care Traffic Control's aim is to assure that everyone experiencing a BH crisis has "a safe landing." To learn more about this approach and its associated technologies, the following link connects you to BHL: https://behavioralhealthlink.com/.

This Erlang C Calculator estimates the number of staff that Dane County will need to manage the call volume associated with the implementation of 988. The three values below will need to be entered enter three values into the Erlang C Calculator:

1. Calls per hour: the number of inbound calls to the call center receives;
2. Duration: the average duration of those calls, in seconds; and
3. Average delay: the average delay of all calls that are designated as a standard.

Once this information is entered into the Calculator, it will tabulate the number of staff required to answer the anticipated increased volume of calls. The Calculator can be accessed at https://www.callcentrehelper.com/tools/erlang-calculator/.

11. Care Coordination

Adopt the technological tools and the supports necessary to assure that there is meaningful care coordination across the crisis response system and other adjacent service systems. A consistent message from stakeholders has been that Dane County has a rich array of crisis and other BH services, but that this service array remains largely fragmented. This makes meaningful care coordination challenging.

The Agency for Healthcare Research (AHRQ), since 2011 has developed and updated what it terms, the *Care Coordination Measures Atlas*, which includes relevant research, a coaching manual, quality measures, and a safety net toolkit. According to AHRQ, "The main goal of care coordination is to meet a person's healthcare needs and preferences in the delivery of high-quality, high-value health care. This means that the patient's needs and preferences are known and communicated at the right time to the right people, and that this information is used to guide in the delivery of safe, appropriate, and effective care." *The Care Coordination Measures Atlas* contains a Care Coordination Measurement Framework that diagrams the key domains of care coordination that are important to facilitating meaningful care coordination and this framework and its associated resources should assist Dane County in improving care coordination. This information is available at https://www.ahrq.gov/ncepcr/care/coordination/atlas/chapter3.html.

With the adoption of the Wisconsin Statewide Health Information Network (WISHIN) by the BH service providers within Dane County, providers will have the tools necessary to enable collaborative service planning. More than 2,000 provider organizations currently utilize WISHIN statewide, including BH providers. WISHIN 2.0 is currently under implementation and it will offer new technology platforms to deliver WISHIN Pulse, a community health record, as well as, other enhancements. To learn more about these developments, access this link: https://www.wishin.org/Home.aspx

Begin transitioning to Alternative Payment Models (APM), which give providers the flexibility to coordinate and manage care. Typical service reimbursements based on price per unit of service delivered, incentivizes providers instead to produce revenue by increasing volume and not value.

The Health Care Payment Learning & Action Network (LAN), the CMS Alliance to Modernize Healthcare (CAMH), the federally funded research and development center (FFRDC) operated by the MITRE Corporation, were all tasked by the Centers for Medicare

& Medicaid Services (CMS) to convene a national initiative to create an alternative payment model (APM) framework to advance payment reform. The group readily acknowledges that population-based payments (including bundled payments for clinical episodes of care) can offer providers the flexibility to invest in delivery system resources with the greatest return, to treat patients holistically, and to facilitate care coordination. Therefore, Dane County should consider transitioning toward shared-risk and population-based models. The updated APM Framework will be useful to establishing a pathway forward. https://hcp-lan.org/workproducts/apm-refresh-whitepaper-final.pdf

12. Behavioral Health Workforce Development

Dane County should adopt BH workforce development as a priority. Particular focus should be on attracting and supporting those from Black, Indigenous, and People of Color (BIPOC) and queer and trans BIPOC (QTBIPOC) populations, to careers within BH. Dane County should implement The National CLAS Standards, which are a set of fifteen (15) action steps intended to advance health equity, improve quality, and help eliminate health care disparities.

Communities across the nation are challenged by a limited workforce to meet the needs of individuals with BH needs. The workforce problems in BH are numerous, complex, and challenging to address. It is common for policymakers, agency leaders, and program managers to become somewhat confused and overwhelmed about how to assess the many problems and subsequently set workforce development priorities. Drawing on the national *An Action Plan on Behavioral Health Workforce Development*, which was created with federal support, the Annapolis Coalition has developed and disseminated *The Annapolis Framework for Workforce Planning in Behavioral Health*. It identifies three broad areas for planning, and three essential goals within each area. The Framework provides a conceptual road map for understanding the elements of the workforce crisis in behavioral health and the opportunities for intervention. The Annapolis Coalition is a non-profit organization dedicated to improving the recruitment, retention, training and performance of the BH prevention and treatment workforce. Its resources are available at https://annapoliscoalition.org/

Workforce development is more than assuring a diverse BH workforce, it also requires assuring a culturally competent workforce. Dane County should implement The National CLAS Standards, which are a set of fifteen (15) action steps intended to advance health equity, improve quality, and help eliminate health care disparities by providing a blueprint to implement culturally and linguistically appropriate services.

Principal Standard

1. Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.

Governance, Leadership and Workforce

2. Advance and sustain organizational governance and leadership that promotes CLAS and health equity through policy, practices, and allocated resources.
3. Recruit, promote, and support a culturally and linguistically diverse governance, leadership, and workforce that are responsive to the population in the service area.
4. Educate and train governance, leadership, and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis.

Communication and Language Assistance

5. Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.
6. Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.
7. Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.
8. Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area.

Engagement, Continuous Improvement, and Accountability

9. Establish culturally and linguistically appropriate goals, policies, and management accountability, and infuse them throughout the organization's planning and operations.
10. Conduct ongoing assessments of the organization's CLAS-related activities and integrate CLAS-related measures into measurement and continuous quality improvement activities.
11. Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery.
12. Conduct regular assessments of community health assets and needs and use the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area.
13. Collaborate with the community to design, implement, and evaluate policies, practices, and services to ensure cultural and linguistic appropriateness.
14. Create conflict and grievance resolution processes that are culturally and linguistically appropriate to identify, prevent, and resolve conflicts or complaints.
15. Communicate the organization's progress in implementing and sustaining CLAS to all stakeholders, constituents, and the public.

The web portal *Think Cultural Health* features information, continuing education opportunities, resources, and more for health and health care professionals to learn about culturally and linguistically appropriate services, or CLAS. Launched in 2004, *Think Cultural Health* is sponsored by the Office of Minority Health at the U.S. Department of Health and Human Services (HHS). https://thinkculturalhealth.hhs.gov

In the October 5, 2021 issue of Open Minds, Monica Oss stated that the big question regarding BH workforce shortages is, "What to do right now? She and her senior advisors have built a seven-part planning playbook for addressing the workforce crisis with seven key strategies—including strategies for service lines, compensation, licensing, technology, talent acquisition, volunteers, and becoming an "employer of choice." (See The Open Minds Playbook for Optimizing Workforce Recruitment & Performance is available at https://openminds.com/market-intelligence/editorials/the-open-minds-playbook-for-optimizing-workforce-recruitment-performance/. A subscription is required to access the Playbook.

13. Cost Offsets and Reinvestment Opportunities

When Dane County's BH crisis response system is fully optimized, analyze the resulting cost offsets and reinvest those cost offsets to further address the BH clinical and support service continuum and the social determinants of health.

It is anticipated that Dane County will experience reductions in arrests, detention, ED, and hospital utilization; and therefore the reinvestment of those savings can further buildout community-based services and supports. This requires providing intensive levels of community-based care, such as peer-run crisis respite, Assertive Community Treatment (ACT) teams, Intensive Outpatient (IOP), and supportive housing, supported education and employment to address the social determinants of health and system inequities. Ultimately, Dane County like every other locality must get upstream to prevent BH conditions and their effects in the first place, rather than always having to pay exorbitant costs on the back end to intervene to treat these conditions. Therefore, it is urged that there be greater investments in primary prevention, such as the highly researched and evidence-based, PAX Good Behavior Game.

McKinsey & Company, in its publication in February of 2021 entitled, *Unlocking Whole Person Care through Behavioral Health,* stated,

> "Individuals with behavioral health conditions often face difficulty accessing treatment, high out-of-pocket costs, non-guideline-based care, and multiple forms of discrimination, leading to meaningful disparities in healthcare outcomes and affordability. In addition, in both government and commercially insured populations, around 60% of healthcare spend is attributable to the roughly 23% of the population diagnosed with behavioral health conditions."

McKinsey goes on to propose major strategies to address the overall lack of access to BH services. Among them, McKinsey recommends the expansion of community-based BH crisis services which is among a set of actions to improve the quality of care and experience for those with BH conditions. Taken together, McKinsey projects an overall reduction in healthcare spending of $185 billion annually. To realize this saving requires an additional incremental investment of $65 billion which overtime will result in three (3) times return on investment (ROI).

The actions delineated in this Dane County Report will increase access to crisis care, provide guideline-based crisis care, and reduce health inequities, while at the same time Dane County is making increasing investments in BH, that include increasing allocations for crisis response services, i.e. the establishment of the CTC. These investments will result in a positive return that can be re-invested to improve the BH system. https://www.mckinsey.com/industries/healthcare-systems-and-services/our-insights/unlocking-whole-person-care-through-behavioral-health.

In optimizing Dane County's crisis response system, there is the potential for a forty-one percent (41%) reduction in healthcare spending related to ED and psychiatric inpatient utilization, according to the Crisis Resource System Calculator. This translates to potential annual saving of $28, 341,102, while serving approximately forty-two percent (42%) more people annually. In terms of the potential diversion impact of an optimized crisis response system on the Dane County Detention Center, JFA Institute reports that there are roughly 125 misdemeanor offenders in the booking area on any given day and that most these are individuals with BH conditions that have been charged with a nuisance crime. The majority of these are detained for seventy-two hours which translates to 45,625 bed days annually and 15,208 individuals diverted. At the time of this Report, the authors did not have the daily costs to detain these individuals and therefore, the total annually savings could not be calculated.

14. Peer Respite Center

Establish peer respite as a component within Dane County's crisis response system. Peer respites are peer-run, voluntary, short-term (typically up to two weeks), overnight programs that provide community-based, non-clinical support for those experiencing or at risk of an acute BH crisis.

Peer respite facilities operate 24/7 in a homelike environment and can provide a "step-down" from facility-based crisis services, where peer navigation services are provided to assist with transition back to the community. Peer respites also allow users to take a break from stressful life circumstances, while building a community with other peers.

Peer respites are designed as psychiatric hospital diversion programs to support individuals experiencing or at-risk of a BH crisis. The premise behind peer respites is that psychiatric emergency services can be avoided, if less coercive or intrusive supports are available in the community. Peer respites engage guests in mutual, trusting relationships with peer staff. Peer support involves a process of mutual helping based on the principles of respect and shared responsibility. Peer support includes interactions in which individuals help themselves and others through fostering relationships and engaging in advocacy to empower people to participate in their communities.

All individuals in program management positions have "lived experience" associated with BH conditions and are engaged in active recovery. Often, they are certified peer support specialists. The peer respite center either is operated by a peer-run organization, or has an advisory group with 51% or more of its members having "lived experience."

This web portal, at the link below, was created by Live & Learn, Inc. to provide the public access to resources about peer respites in the United States. The resources available include the criteria and definition of a Peer Respite, the Peer Respite Directory (updated in 2018), and the *Guidebook for Peer Support Program Self-Evaluation*, and reports from the Peer Respite Essential Features Surveys, which document nationwide trends in organizational characteristics and policies. This resource now serves as an archive for work that was completed prior to 2019, and it hosts a repository of research on peer respite programs. https://www.peerrespite.com/.

Dane County currently has one peer operated, peer respite center, Solstice House, which is operated by Soar Case Management Services, Inc. The Crisis Resource Capacity Calculator does not have the capability to project the level need for this service, but occupancy level trends at Solstice House would be a good place to start in an attempt to determine the need for this service. As Dane County begins to reconfigure optimal bed capacity, there may be an opportunity to repurpose some of the existing access bed capacity for peer respite. https://soarcms.org/programs/solstice-house .

Appendix A: Stakeholder Inputs

The input, questions and comments from the stakeholder sessions can be grouped into the following general categories: Need, Operations, and System Impact.

Need

- A recognition that the City of Madison and Dane County are fairly diverse and well-resourced for behavioral health services. Although there is some concern about access to services in rural communities and how people outside of Madison may access the CTC;
- General expression and recognition that a CTC could result in fewer inpatient admissions and use of Emergency Departments for behavioral health needs/crises.
- The construct of "No Wrong Door" was well received. Voiced that too frequently people attempt to access care and are rejected, without sufficient connection to the "right" resource. A number of comments and concerns regarding how this relates to people on involuntary or civil commitment. There is a recognized need to serve those individuals, but not a clear path from a state regulatory perspective that would allow admission in a non-hospital setting.
- Several comments that the current crisis response system needs to be more comprehensive and robust and better coordinated. There are observed challenges and gaps with mobile crisis services and community interventions. While many of the current services are provided through Journey MHC, some other resources are not well connected and some of these are underutilized.
- Currently Journey MHC has had challenges fully staffing the MCTs and may not always be able to conduct community outreach after hours. A well-functioning crisis response system and appropriate use of the CTC, will require a more robust MCT response.
- Journey MHC currently has a mental health professional (crisis worker) stationed with the Dane County Sherriff and another with the Madison PD. At least one other community police agency is interested in a similar model. There is a recently launched CARES Team which has a mental health professional (crisis worker) paired with an EMT. There is need for these to be well-coordinated, linked to crisis call lines and shared record systems to ensure appropriate response and use of community resources. The CTC would serve as an important resource to serve people served by these community outreach programs to ensure stabilization through a crisis and reduce use of EDs and inpatient care.
- Law Enforcement currently takes a number of acute involuntary hospital admissions to Winnebago Mental Health Institute, a 2-hour drive. A local CTC would greatly reduce the use of law enforcement making those transports out of county.
- Several families expressed frustration at not receiving a desired response at EDs for loved ones seeking care. This resulted in deteriorating mental health conditions, suicide attempts, and arrests. It is their hope that access to a CTC will be a more expedient and responsive service.
- There is a frequent need for people who may be referred to Homeless Shelters who require a BH assessment/intervention and stabilization prior to integrating into a shelter environment. There is hope that the CTC will be an appropriate first step into receiving these services.
- There is a lot of community support and interest in the newly established BHRC as a point of entry to needed services. It was stressed that a good relationship between the CTC and BHRC will facilitate both admissions, as well as, discharges to the community. Rapid access to a community stabilization program is seen as a positive.

- BadgerCare MCOs see the need and value of a CTC to reduce unnecessary use of EDs, inpatient care, and hospital based detox. No clear commitment has been made regarding the funding for CTC services, given that crisis care Systems is perceived to be outside their mandate.
- Several comments were made about need for a similar CTC level of care for children and youth. It was suggested that the CTC could be a resource for transition age youth (18 to 24).
- Need to locate the CTC near or accessible to public transportation. It needs to be centrally located in the county to be readily accessible by Madison PD and the Sheriff.
- Many positive comments were shared about the CTC serving individuals with mental illness, substance use and co-occurring disorders.
- Several comments were made that it would be a positive if the CTC reduced the number of jail bookings for people experiencing a BH crisis. A couple of comments phrased this as also important to addressing equity in terms of access to health care for certain groups who may be underserved but over responded to by law enforcement.

Operations

- Current WI Code and Regulations do not seem to allow a non-hospital community setting to provide care for individuals on involuntary or civil commitment status.
- WI requires the arrest and charges for people involved in a Domestic Violence situation, even when BH-related issues are significant. Could the CTC accept and manage such individuals?
- Concern about the cost of developing and operating a CTC. Counties are responsible for funding community-based crisis services. BadgerCare MCOs pay for hospital based inpatient care. Can MCOs be expected to pay for their members served by the CTC?
- If it is established that the CTC can accept people recently certified for a civil commitment, there need to be processes for evaluating the need for that hold and if transferred to another program/facility recognition of the timelines for the Probable Cause Hearings.
- Questions about accepting and serving people who are unhoused (on the street or in a shelter) and how they will be connected to community resources upon stabilization and release.
- Many community service providers are reluctant to call law enforcement out of concern for possibly escalating a situation or it resulting in an arrest. They want to know, what resources and processes will be available so that people can access a CTC without law enforcement engagement? Multiple questions and comments were offered about accepting people without law enforcement engagement or transportation. They want CTC to be able to accept referrals and admissions at all hours and on a voluntary basis.
- Concerns were expressed about the possibility of people cycling through the CTC frequently and not engaging in follow-up community services. This was expressed several times along with the recognition there are any number of "known" people who make "inappropriate" use of services.
- A number of positive comments were made about the significant role of Peer Specialists at the CTC. This is seen as a strength. The perception was shared that there will be an adequate labor pool of people with "lived experience" and trained as a Peer Specialist to become part of the CTC staff.
- It was noted that several programs, including the Journey MHC Crisis Teams, have had significant difficulty recruiting and retaining professional behavioral health staff. Concern that this labor shortage (which is national as well) will impact CTC hiring and operations.
- Several questions were expressed about how the CTC would coordinate with hospitals and EDs; how it would accept referrals from EDs for people who do not require a hospital admission; and

for those transferring from the CTC due to medical needs or who are so acute they do need a hospital admission.
- Several comments were offered from groups and individuals representing services, programs and needs for individuals of ethnic and cultural groups (Latinx, Hmong, LGBTQ) who see value in a CTC serving their communities. But concerns were expressed about makeup of staff at the CTC so people can relate to an other person of similar culture and ethnicity. In several instances, the need for staff to speak other languages (i.e., Spanish and Hmong) was brought up. Also, several expressed the need to engage and incorporate family relationships as part of the service and supports provided. It was identified that there are very few professional staff from other ethnic and cultural groups represented in the ranks of BH providers.
- There were a number of offers from individuals and organizations to be part of a comprehensive staff training effort. This could be about community resources, specific ethnic communities and their unique needs, trauma informed care, access to health care, IDD, Dementia, etc.
- Several questions were offered about the use and access to video supports at the CTC. This could be useful for probable cause hearings, connections with family members, and even possibly as part of a welcome message for individuals reluctant to come to the facility.
- There were many questions about how large the CTC would be, how many recliners, how many beds and how it would be staffed given a fluctuating census.
- For people who are served at the CTC but also receiving services in the community, the need was stressed for care coordination.

System Impact

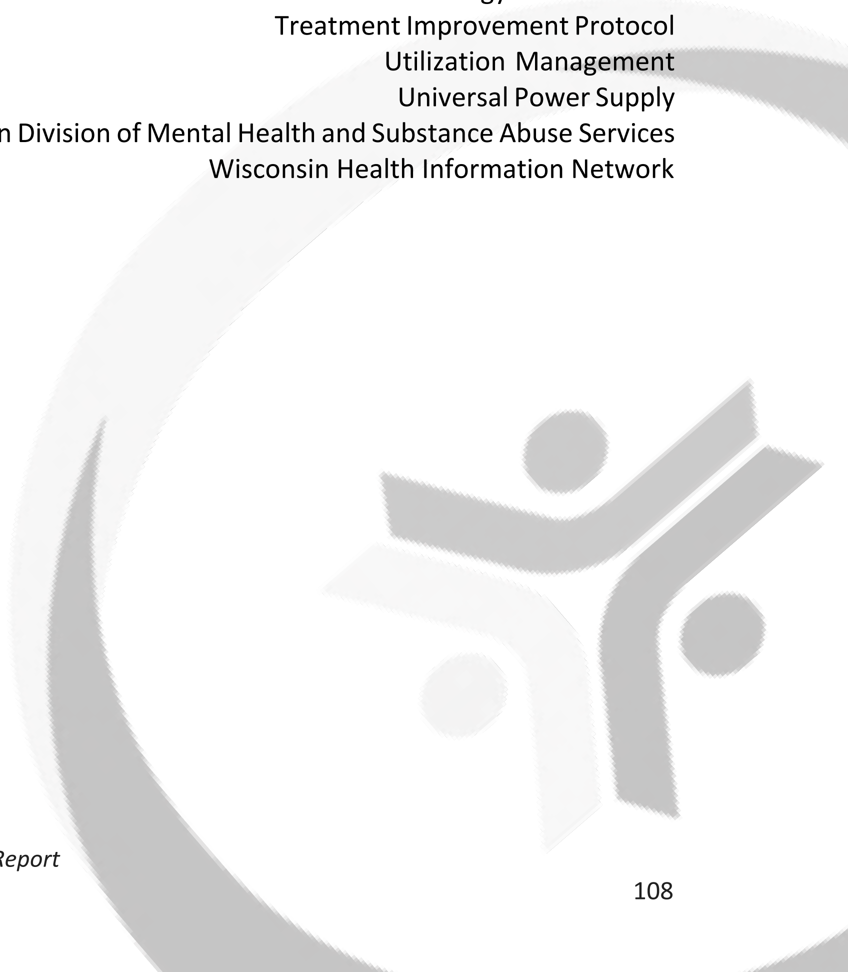
- The following question was asked a number of times, “Will the CTC reduce the number of people with significant BH needs currently being booked into the County Jail?”
- It was expressed that there are a number of people with misdemeanor offenses that are released from the Jail who could benefit from services through a CTC.
- Inquiries were also made about whether or not the CTC could serve as a reentry service for those released from county detention?
- Journey MHC currently operates Bay Side and Recovery House residential programs and has not been able to establish a regular practice of law enforcement drop-offs. Apparently, the majority are taken to an ED first. It was suggested that an effective CTC with active law enforcement use could change the role of the these programs to become post CTC placements.
- There is currently a Detox program in the community operated by Tellurian. It can management people in a secure setting. The CTC will also accept and serve people needing detox, as well as, continued services for SUD. A question was raised about how this will impact the use of the Detox Center. It was suggested that the CTC could increase the requests/referrals for residential SUD treatment.
- Residential SUD treatment for Medicaid enrollees has recently transferred to the BadgerCare MCOs. It will be critical for the MCOs to be linked with the CTC.
- There were several concerns about what happens when people are stabilized and ready to leave the CTC. Numerous comments were made regarding the limited choices for community placement and for supportive housing. There were also concerns expressed for people with special needs (such as IDD), who may not be able to locate an available supervised setting.
- There were a number of questions about what service provider, including the County, would operate and manage the CTC? And, how that would the CTC connect with the other network of providers?

- It was suggested that it would be important to gain buy-in for the CTC from hospitals, EDs, as well as, BadgerCare MCOs.
- It was also suggested that there be a process for on-going and regular communication with key stakeholders as CTC progress moves forward and continues once it is operational.
- Several groups asked for the opportunity to review and comment on a draft report/plan before it is finalized and adopted.

Appendix B: Acronyms

ACT	Assertive Community Treatment
ADD	Attention Deficit Disorder
ADHD	Attention Deficit Hyperactivity Disorder
AHCCCS	Arizona Healthcare Cost Containment System
AHRQ	Agency for Healthcare Research and Quality
ALOS	Average Length of Stay
ASO	Administrative Services Organization
BH	Behavioral Health
BHRC	Behavioral Health Resource Center
BHL	Behavioral Health Link
CAQH	Council for Affordable Quality Healthcare
CCSS	Comprehensive Community Support Service
CFR	Code of Federal Regulations
CIP	Crisis Intervention Program
CIT	Crisis Intervention Team
CLAS	Culturally and Linguistically Appropriate Services
CLWA	Clinical Institute on Withdrawal Assessment
CMHC	Community Mental Health Center
CMS	Centers for Medicare and Medicaid
CPI	Crisis Prevention Institute
CQI	Continuous Quality Improvement
CRISES	Crisis Reliability Indicators Supporting Emergency Services
CSG	Council of State Governments
CTC	Crisis Triage Center
DCSO	Dane County Sheriff's Office
DHS	Department of Health Services
ED	Emergency Department
EHR	Electronic Health Record
EMS	Emergency Medical Services
EMT	Emergency Medical Technician
FAQ	Frequently Asked Questions
FFS	Fee-for-Service
FGI	Facility Guidelines Institute
FMAP	Federal Medical Assistance Percentages
FOCUS-PDCA	Find, Organize, Clarify, Understand, Select - Plan, Do, Check, and Act
FTE	Full Time Equivalent
GPS	Global Positioning System
HIPAA	Health Information Portability and Accountability Act
IP	Inpatient
IPS	Individual Placement and Supports
IOP	Intensive Outpatient Program
IMD	Institute of Mental Disease
LOCUS	Level of Care Utilization System
MAT	Medication Assisted Treatment
MCO	Managed Care Organization
MCT	Mobile Crisis Team

MH	Mental Health
MHPAEA	Mental Health Parity and Addiction Equity Act
MOU	Memorandum of Understanding
NASMHPD	National Association of State Mental Health Program Directors
NPI	National Provider Identifier
NPPES	National Plan and Provider Enumeration System
NPO	Non-Profit Organization
OP	Outpatient
OUD	Opioid Use Disorder
PHP	Partial Hospitalization Program
PHS	Permanent Supportive Housing
PMCH	Police-Mental Health Collaboration
PSH	Permanent Supportive Housing
PTSD	Post-Traumatic Stress Disorder
QMP	Quality Management Plan
RI	RI International
RSA	Recovery Services Administrator
SAMHSA	Substance Abuse and Mental Health Services Administration
SE	Supported Education
SFTP	Secure File Transfer Protocol
SMI	Severe Mental Illness
SOW	Scope of Work
SRAS	Suicide Risk Assessment Standards
SUD	Substance Use Disorders
TAC	Technology Assisted Care
TIP	Treatment Improvement Protocol
UM	Utilization Management
UPS	Universal Power Supply
WDMHSAS	Wisconsin Division of Mental Health and Substance Abuse Services
WISHIN	Wisconsin Health Information Network



Appendix C. References

A Comprehensive Crisis System: Ending Unnecessary Emergency Room Admissions and Jail Bookings Associated with Mental Illness. (Assessment Paper No. 5). National Association of State Mental Health Program Directors. August 2018.

A Hand and a Home: Foundation for Success, 2019-2022 Statewide Action Plan. Wisconsin Interagency Council on Homelessness. November 2018.

Alternative Payment Model: APM Framework. Produced by The Health Care Payment Learning & Action Network (LAN), The CMS Alliance to Modernize Healthcare (CAMH), the Federally Funded Research and Development Center (FFRDC) operated by the MITRE Corporation, and funded by the Centers for Medicare & Medicaid Services (CMS). 2017.

Angela Alei, and Caroline Pierotti. *Literature Review: Mobile Crisis Services*. Institute for Social Research, University of New Mexico. August 5, 2016.

Balfour, Margaret E. at al. *Crisis Reliability Indicators Supporting Emergency Services (CRISES): A Framework for Developing Performance Measures for Behavioral Health Crisis and Psychiatric Emergency Programs*. Community Ment Health J. 2016. 52(1):1-9

Behavioral Health Barometer: Wisconsin, 2015. HHS Publication No. SMA–16–Baro–2015–WI. Rockville, MD: Substance Abuse and Mental Health Services Administration (SAMHSA), 2015.

Beyond Beds: The Vital Role of a Full Continuum of Psychiatric Care. National Association of State Mental Health Program Directors (NASMHPD) and Treatment Advocacy Center. October 2017.

Client Perception of Care: Dane County Mental Health System: January 1, 2018 – August 31, 2018. Dane County Department of Human Services. July 2019.

Coe, Erica et al. *Unlocking Whole Person Care Through Behavioral Health.* McKinsey & Company. February 24, 2021.

Dane County Behavioral Health Needs Assessment. Public Consulting Group. October 2019.

Dane County Department of Human Services Vision: Next 2021 – 2026. Dane County Department of Human Services. 2020.

Differences in Crisis Services and Psychiatric Hospitalizations across Race and Ethnicity. Wisconsin Department of Health Services. February 2021.

Emergency Mental Health Service Programs: Chapter DHS 34. Wisconsin State Legislative Reference Bureau. December 2010.

Findings of Joint NASMHPD/NADD/NASDDDS Roundtables on Supporting Individuals with Co-Occurring Mental Health Support Needs and Intellectual/Developmental Disabilities. NASMHPD Publications. 2021.

Hoge, M. A., Morris, J. A., Daniels, A. S., Stuart, G. W., Huey, L. Y., & Adams, N.: *An Action Plan on Behavioral Health Workforce Development*. Cincinnati, OH: The Annapolis Coalition on the Behavioral Health Workforce, 2007.

Hoge M., Morris J., Stuart G., Huey L., Bergeson S., Flaherty M., Morgan O., Peterson J., Daniels A., Paris M., Madenwald K. *A National Action Plan for Workforce Development in Behavioral Health*. Psychiatric Services, 60 (7): 883-7, 2009.

Journey Mental Health Center Annual Report. 2019.

Key Performance Indicators Report. Dane County Department of Human Services. Volume 8, Issue 4. March 2019.

Medicaid Provider Manual. MHS Health Wisconsin. February 2018.

National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care. U.S. Department of health and Human Services, Office of Minority Health. 2015.

National Guidelines for Behavioral Health Crisis Care – A Best Practice Toolkit. Substance Abuse and Mental Health Services Administration (SAMHSA). 2020.

Neylon, K.A. (2020). *Strategies for the Delivery of Behavioral Health Crisis Services in Rural and Frontier Areas of the U.S.* Alexandria, VA: National Association of State Mental Health Program Directors (NASMHPD).

Outcome Indicators – Mental Health Summary: July 1, 2017 – December 31, 2017. Dane County Department of Human Services. March 12, 2018.

Plan for Coordination of Emergency Mental Health Services. Dane County Department of Human Services.

2018 Performance Scorecard: Adult Services Division. Dane County Department of Human Services. May 2020.

Rate Information for Billing for Services Provided by the Mental Health Institutes. Wisconsin Department of Health Services. August 30, 2021.

Sequential Intercept Model Mapping Report for Dane County. Delmar, NY. Policy Research, Inc. 2018.

Service Participant Satisfaction with Mental Health Services. Wisconsin Department of Health Services. 2015.

Report to the Legislature: Mental Health and Substance Use Services and Programs provided by Wisconsin Counties and Regions CY 2016 and CY 2017 Summary Report. Wisconsin Department of Health Services, Division of Care and Treatment Services. January 2019.

Roadmap to the Ideal Crisis System: Essential Elements, Measurable Standards and Best Practices for Behavioral Health Crisis Response. Authored by Committee on Psychiatry and the Community for the Group for the Advancement of Psychiatry and published by the National Council for Behavioral Health. March 2021.

Substance Abuse and Mental Health Services Administration. *Crisis Services: Effectiveness, Cost Effectiveness, and Funding Strategies.* HHS Publication No. (SMA)-14-4848. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2014.

Suicide in Wisconsin: Impact and Response. Produced in partnership with Wisconsin Department of Health Services, Mental Health America of Wisconsin, and the Medical College of Wisconsin. September 2020.

The Consolidated Appropriations Act, 2021 was enacted as Section 203 of Title II of Division BB of the Appropriations Act and amended Mental Health Parity and Addiction Equity Act (MHPAEA), on December 27, 2020.

The Justice Reinvestment Initiative: A Guide for States. U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Assistance. May 2021.

The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA). 2008.

The Vital Role of Specialized Approaches: Persons with Intellectual and Developmental Disabilities in the Mental Health System. NASMHPD Publications. 2017.

Therapeutic Transportation Program. Los Angeles County of Mental Health. October 2020.

Vigna, A.J., Connor, T. *The 2019 Behavioral Health Gaps Report for the State of Wisconsin*. Madison, WI: University of Wisconsin Population Health Institute, October 2020.

Wahlberg, David. *Psychiatric Hospital in Middleton to Open to Patients Soon*. Wisconsin State Journal. July 6, 2021.

Wisconsin Crisis Services and Emergency Detentions Statewide, 2013-2017. Wisconsin Department of Health Services. November 2019.

Wisconsin Medicaid Maximum Allowable Fee Schedule for Crisis Intervention Services. Wisconsin Department of Health Services, Division of Health Care Financing. October 2003.