WHA
Behavioral Health Task Force
White Paper

EXECTUTIVE SUMMARY

In late 2008, the Wisconsin Hospital Association established the WHA Behavioral Health Task Force (the "Task Force"). The Task Force was formed in response to hospitals' growing concerns regarding the treatment of patients with severe and acute behavioral health issues brought to hospital emergency rooms. A too frequent lack of a coordination between county mental health services, law enforcement, physicians, and hospitals, combined with inconsistent interpretations of Wisconsin's sometimes confusing mental health laws and scarce behavioral health resources has meant that in many cases patients' and communities' needs were not being satisfactorily met. The charge to the task force was to:

- Identify barriers to accessing behavioral health services in Wisconsin.
- Develop a set of recommended goals and actions for improvement.

The Task Force focused on four areas in its analysis:

- Access to behavioral health services
- The laws relating to the financing and delivery of services
- The scope and severity of emergency detention problems in hospitals, and
- The counties' statutory responsibility to provide certain mental health services

Task Force membership included behavioral health professionals and representatives of hospitals, a county-based agency providing behavioral health services, and the Wisconsin Division of Mental Health and Substance Abuse.

Conclusions Regarding Emergency Detention Problems in Hospitals

The Task Force used several data sources for its analysis, starting with a survey of hospital emergency room personnel in 2009. The survey revealed the following impressions by these personnel:

- 60 percent of all respondents indicated experiencing chronic administrative difficulties relating to emergency detention issues.
- 59 percent indicated that at least once a year a patient that should be under an emergency detention is delivered to the ER without an emergency detention.
    - In 38 percent of those cases, patients left against medical advice.
    - In 37 percent of those cases, patients waited in the emergency department for at least 12 hours.

Other findings and conclusions included the following:

- There is a wide variation across counties in their interpretation and application of Wisconsin's mental health laws which sometimes leads to confusion among providers trying to resolve the multiple jurisdictional interpretations.

- There is no state-wide correlation between the level of county funding and perceived problems with the provision of emergency mental health services.
- Some counties and regions have found collaborative ways to effectively deal with emergency detention situations.

The Task Force also identified issues relating to access to mental health services that may be exacerbating the need for emergency detentions in some counties. Surveys of hospital emergency department personnel revealed that:

- 42 percent of respondents felt that mental health services were nearly unavailable or generally inaccessible for patients with Medicaid coverage; and 60 percent had the same impression regarding individuals with no insurance coverage.
- 49 percent of all respondents and 35 percent of critical access hospitals (CAHs) responded YES to whether consult services were available in the ER.
- 22 percent of all respondents answered YES to whether a psychiatrist was on call for the emergency department, only 6 percent of CAHs.
- 74 percent of all respondents indicated that a psychiatrist was available within 25 miles of the hospital.

Task Force Recommendations

Based on the findings and conclusions, the Task Force made the following recommendations:

To address the shortage of resources:

Recommendation #1: Behavioral health provider shortages should be added to the Wisconsin Council on Medical Education and Workforce's (WCMEW's) list of priorities. Additionally, telemedicine should be explored as one method to leverage and extend existing behavioral health work force.

Recommendation #2: Work with Wisconsin's Congressional delegation to address CAH rules that discourage rural psychiatric units.

To make mental health laws more understandable and workable for hospitals:

Recommendation #3: Develop and provide education program(s) for hospitals regarding Chapter 51 requirements.

Recommendation #4: Explore the option of amending state law to allow hospitals to initiate emergency detentions.

Recommendation #5: Explore the option of amending state law to explicitly include hospital representation on county s.51.42 behavioral health boards.

To take advantage of and encourage more of what is currently working well:

Recommendation #6: Encourage collaboration between hospitals and counties; Inform hospitals of examples of successful collaborations between counties, hospitals, law enforcement, and others.

Recommendation #7: Allocate state funding to counties on a regional basis, which would force counties to regionalize their Chapter 51 services. Funding would also be tied to a more rigorous

Chapter 51 plan that shows collaborative relationships and treatment across the full scope of services.

<u>Recommendation #8</u>: Support efforts to find effective, lower-cost emergency detention and treatment options such as Community-Based Residential Facilities (CBRFs).

To encourage accountability and improvement in the system:

<u>Recommendation #9</u>: Develop quality improvement goals for the regions/counties relative to Chapter 51 responsibilities. Develop measures for these goals and monitor, using the measures as one basis for funding.

<u>Recommendation #10</u>: In the long term, support adequate funding for the treatment of individuals with severe mental illness.

<u>Recommendation #11</u>: WHA should become more strategically active in selected state-level mental health workgroups such as the Wisconsin Crisis Network.

<u>Recommendation #12</u>: WHA should collaborate with the Division of Mental Health and Substance Abuse Services and the Wisconsin Counties Association to help resolve the issues outlined in this report.

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I. INTRODUCTION

Life-threatening cracks are emerging in Wisconsin's system for treating mental health care and the result is that physicians, hospitals, and most concerning of all, patients with severe mental illness, are increasingly finding themselves in situations where medicine and Wisconsin's mental health laws conflict. The reasons for the emergence of these cracks are multi-fold, but the impacts of Wisconsin's sometimes fractured and conflicting mental health system are illustrated in the three increasingly common scenarios below.

Vignette #1 – Law enforcement refuses to initiate an emergency detention

Joe, a young adult, is brought to a community hospital's emergency department by his family after making threats at home to kill himself. Dr. Smith, the on-call physician, evaluates Joe and in his professional judgment determines that Joe is competent, but depressed, and evidences a substantial probability of physical harm to himself. Joe rejects all treatment options proposed by Dr. Smith and insists on going home. Concerned that Joe would kill himself if he left the hospital without immediate stabilization, Dr. Smith recommends that law enforcement be called to initiate a mental health emergency detention under Chapter 51 to stabilize Joe. A law enforcement officer arrives at the emergency department, but the officer disagrees with Dr. Smith's conclusion that Joe evidences a substantial probability of harm to himself and refuses to initiate an emergency detention under Chapter 51.

Joe and Dr. Smith are now in a very difficult position: Dr. Smith's diagnosis is that Joe needs immediate help, but Joe will not voluntarily agree to treatment and law enforcement will not initiate an involuntary emergency detention to stabilize Joe.

What is Dr. Smith to do?

Vignette #2 – Corporation counsel refuses to pursue a probable cause hearing

Sam, an adult, is a patient voluntarily admitted to a community hospital's inpatient psychiatric unit to treat severe depression after coming to the hospital following a deliberate medication overdose. During the admission Sam generally refuses most treatment and after two days seeks to leave the unit against medical advice. Dr. Johnson, a psychiatrist and treatment director for the unit, concludes that given Sam's recent suicide attempt, lack of treatment progress since that attempt and desire to leave to the unit against medical advice, Sam has a substantial probability of imminently attempting suicide if Sam leaves the hospital. Under Chapter 51, the treatment director may initiate an emergency detention for a patient if the patient was admitted voluntarily to the inpatient unit, thus Dr. Johnson files the appropriate paper work with the court to initiate an emergency detention of Sam. By law, an emergency detention must end when any of the following occurs: (i) The treatment director believes that the grounds for Sam's detention no longer exist, (ii) 72 hours pass (excluding weekends and holidays), or (iii) a probable cause hearing, which can only be pursued by the county's corporation counsel, is held to begin court-ordered involuntary detention and treatment.

72 hours pass, and the emergency detention ends after the county corporation counsel refuses to pursue a probable cause hearing for Sam. Sam refuses further care and insists on leaving the hospital, but Dr. Johnson's diagnosis is that Sam remains suicidal and needs treatment.

What is Dr. Johnson to do?

Vignette #3 – County crisis unit refuses to approve an emergency detention

Sid, a young adult male with bipolar disorder, is brought by his family members to a community hospital emergency department after he became increasingly manic and began threatening family members. Dr. Miller, an on-call psychiatrist at the hospital, evaluates Sid and in his professional judgment determines that Joe is competent, but manic, and evidences a substantial probability of physical harm to his family unless he receives immediate treatment. However, Sid refuses to consent to any treatment. Concerned that Sid would harm his family if he did not receive immediate stabilization, Dr. Miller recommends that law enforcement be called to initiate a mental health emergency detention under Chapter 51 and to take Sid to a properly equipped treatment facility that could stabilize Sid. Law enforcement arrives and agrees to place Sid under an emergency detention. However, pursuant to Chapter 51, law enforcement cannot transport Sid to a treatment facility for detention unless the county's department of community programs approves the need for detention. Law enforcement calls the county department of community programs and recites Sid's situation and the officer's rationale for the need for the detention. However, the county department of community programs refuses to approve the detention based on its judgment that Joe is not evidencing a substantial probability of harm others. Receiving the news, Dr. Miller contacts the county department of community programs and explains his rationale for the need to have Sid emergently detained and transported to a treatment facility for stabilization. The county department of community programs continues to refuse to approve the need for detention.

Without approval to detain and transport Sid to an appropriate treatment facility, law enforcement asserts they cannot continue to hold Sid. Sid insists he does not want treatment and wants to leave the hospital, but Dr. Miller's diagnosis is that Sid remains a danger and needs treatment.

What is Dr. Miller to do?

II. BACKGROUND

During 2008, the Wisconsin Hospital Association (WHA) was informed of an increasing number of incidents where hospital staff dealt with mentally ill patients at or coming to the hospital who were a danger to themselves or others and in need of immediate, involuntary stabilization through an emergency detention. Lack of dedicated resources, inconsistently interpreted laws, and a too frequent lack of coordination between local law enforcement, the counties, and the hospital meant that in many cases, patients' and community needs were not being met.

At the same time, hospitals were closing inpatient psychiatric beds, continuing a long-term trend that has eliminated access to inpatient psychiatric care in all but 19 of Wisconsin's 72 counties. At the same time, fewer mental health professionals were choosing to practice in rural parts of the state.

In response to these and other disturbing trends impacting the behavioral health safety net, the WHA Board formed the Behavioral Health Task Force, and gave it the following charge:

- Identify barriers to accessing behavioral health services in Wisconsin.
- Develop a set of recommended goals and actions for improvement.

The Task Force decided to focus on four areas in their analysis:

- Access to behavioral health services
- The laws relating to the financing and delivery of services
- The scope and severity of emergency detention problems in hospitals, and
- The role of counties

III. ANALYSIS

A. History of Wisconsin's County-based Mental Health Systems

Prior to the 1970's the state maintained responsibility for providing acute care services for persons with severe and persistent mental disorders. Primarily, state care involved institutionalization in state-owned facilities. Early in Wisconsin's history, counties also sought to establish their own facilities to care for the mentally ill, and in 1881, Wisconsin law was changed to permit counties to establish such facilities. Many counties did so, and by 1900, thirty-two counties operated hospitals, then known as county asylums.

Responsibility for caring for the state's mentally ill substantially shifted away from the state to individual counties in the 1970's. In 1971, the state made local mental health boards responsible for funding adult inpatient services in state institutes, and authorized the creation of community mental health boards (51.42 boards). By 1974, the statutes *required* counties to establish 51.42 boards in order to continue receiving state aid. Furthermore, responsibility for most care of persons with mental illness was shifted from the state to the 51.42 boards. At that time, counties received approximately 60 percent of their mental health budgets from state funds.

Responsibility for caring for the mentally ill changed significantly again in the 1995 state budget bill. Still in effect today, the law specified that while each county would remain responsible under state law to provide for the needs of persons with mental illness, including emergency care, the budget bill change qualified that responsibility by specifying that counties were only responsible "within the limits of available state and federal funds and of county funds required to be appropriated to match state funds."

During this same time and up to the present, the number of inpatient psychiatric beds has declined sharply. This decline reflects both the trend toward more outpatient treatment of mental health disorders, and the reduction in funding that was taking place. In 1970, there were 13,234 public psychiatric beds. By 1985 there were only 1,135 public psychiatric beds, a 91-percent drop from 1970's total. In 2007, there were only 726 public psychiatric beds statewide, and only 1,601 public and private beds in total.

B. Hospital Survey on Mental Health Services

In March 2009 the Task Force surveyed emergency department professionals in all WHA member hospitals. The purpose of the survey was to gain an understanding of issues related to the accessibility of mental health services, trends in county-provided mental health services, and trends in emergency detention/involuntary admission issues.

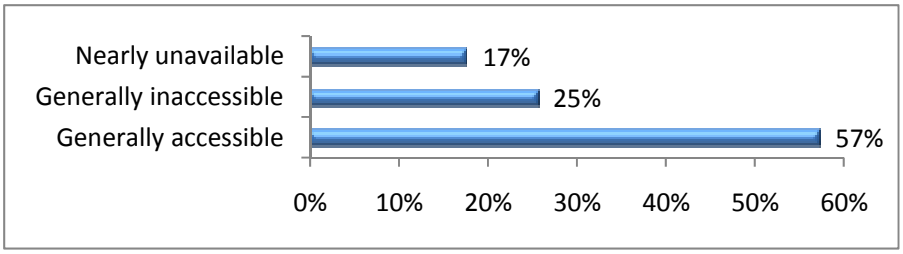
Sixty-three (50 percent) of the 127 hospitals surveyed submitted a response. Thirty-four (54 percent) of the respondents were CAHs. Survey questions and responses are discussed below.

1. *Accessibility of Mental Health Services*

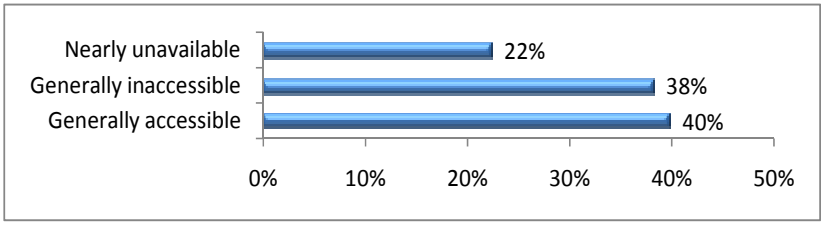
Without access to treatment, a person's mental health condition can worsen to a point where costly emergency stabilization or inpatient care becomes necessary. Lack of accessible services also makes it difficult for hospitals to direct patients to services for follow up care necessary to avoid future hospitalizations and visits to the emergency department. Thus, one of the focuses of the emergency department personnel survey was on their perceptions of the accessibility of mental health services in Wisconsin.

The survey results illustrated below show discrepancies in availability between patients with commercial insurance, Medicaid and no insurance, and also show that county-funded outpatient services were less accessible than private outpatient services.

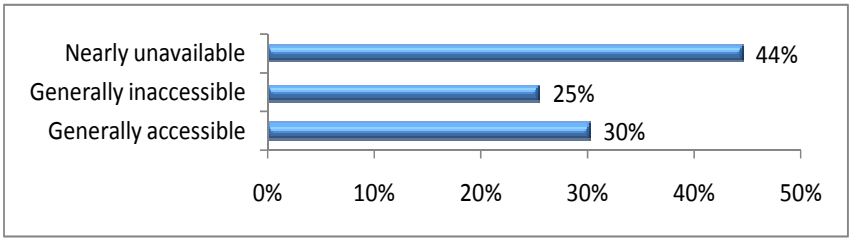
Accessibility of MH Services for Individuals with Commercial Insurance



Accessibility of MH Services for Individuals with Medicaid



Accessibility of MH Services for Individuals with No Insurance



Nearest Available Private Outpatient Services

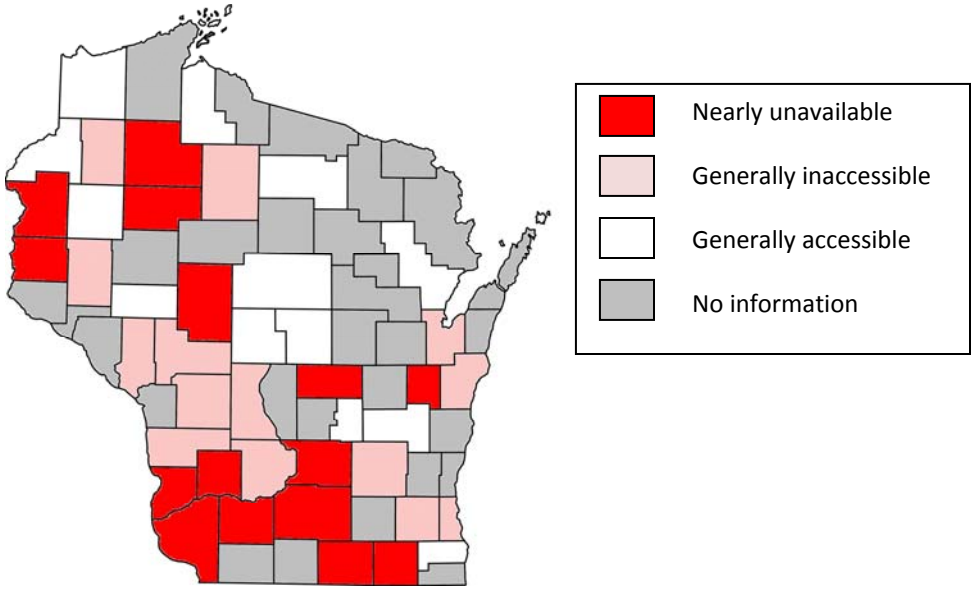
	All respondents	CAH respondents
In hospital	24%	18%
Off-campus	13%	6%
Within 25 mi	33%	32%
Within 50 mi	25%	41%
Within 100 mi	5%	6%
Over 100 mi	0%	0%

On Nearest Available County Funded Outpatient Services

	All respondents	CAH respondents
In hospital	6%	9%
Off-campus	0%	0%
Within 25 mi	62%	50%
Within 50 mi	17%	21%
Within 100 mi	10%	15%
Over 100 mi	0%	0%

While 62 percent responded that county-funded outpatient services were available within 25 miles, the results vary widely across Wisconsin. The map below illustrates the variation.

Accessibility of MH Services for Individuals with No Insurance By County



The survey's questions on accessibility also focused on whether consult services were available in hospital emergency departments. 49 percent of all respondents and 35 percent of CAHs responded YES. However, when asked whether a psychiatrist was on call for the emergency department, only 22 percent of all

respondents answered YES, and only 6 percent of CAHs. 74 percent of all respondents indicated that a psychiatrist was available within 25 miles of the hospital.

2. *Emergency Detention*

Each county has responsibility under Chapter 51 for the well-being, treatment and care of the mentally ill, developmentally disabled, and alcohol and other drug dependent citizens residing with the county, and for ensuring that those individuals in need of such emergency services found within the county receive immediate emergency services.

The survey also sought to identify the scope of emergency detention concerns in Wisconsin hospitals. Responses to the baseline question found that a majority of hospitals identified chronic difficulties relating to emergency detention and/or involuntary admissions.

Is your hospital experiencing chronic administrative difficulties relating to emergency detention/involuntary admission issues?

	All respondents	CAH respondents	Respondents with Inpatient Psychiatric Unit
Yes	60%	65%	67%
No	40%	35%	33%

The results indicate serious and long-standing problems of hospitals and county agencies not being able to coordinate services for patients with mental health conditions. As was stated in the Background section, this issue is one of the most critical for hospitals.

One of the most-often cited examples of this lack of coordination is when a patient, exhibiting a substantial probability of physical harm to self or others, is delivered to the ER under custody of law enforcement but not pursuant to a s. 51.15 emergency detention.

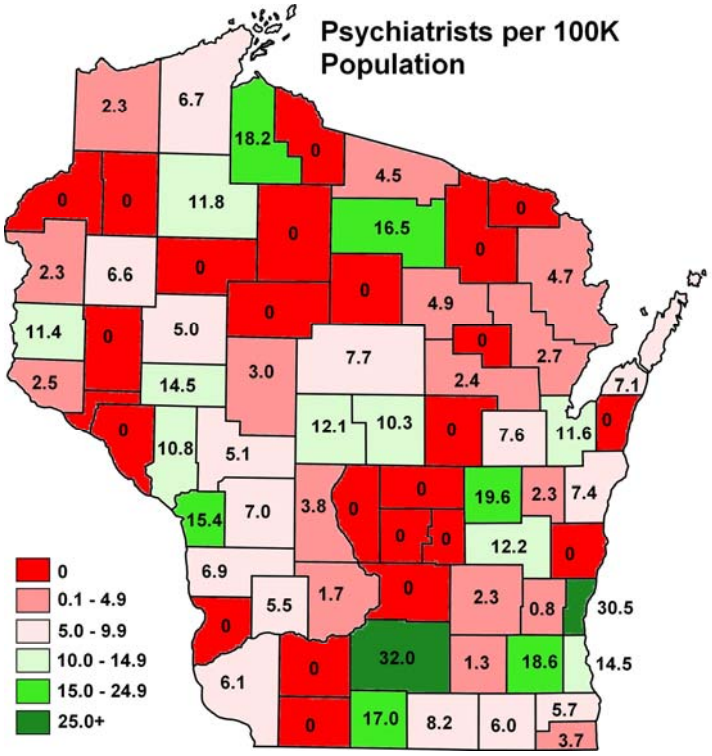
- Over half of the respondents to the survey (37 out of 63) indicated that this occurs **at least once a year**; with a third saying it happens **at least once a month**.
- Of those same respondents, 38 percent indicate that such patients leave against medical advice - **a circumstance that potentially puts the patient and/or the public in danger.**
- In many cases (37 percent of the time), the patients delivered by law enforcement **must wait more than 12 hours in the emergency room** while an appropriate resource - in many cases an inpatient bed - is located for them.
- Ultimately, if the patients are transferred to another hospital, law enforcement in many cases will transport the patient. **The result is that already limited local law enforcement resources are expended on patient transportation.**

WHA's survey of emergency department managers also showed that, while emergency detention problems do exist, the problems are not state-wide. No discernable geographic pattern of emergency detention problems was identified, and, as discussed later, there is a lack of state-wide correlation between county funding and reported emergency detention problems.

While the problem is not state-wide, for those hospitals that are facing emergency detention problems, the concerns are very real. Some emergency department managers are particularly concerned that counties are routinely failing to emergently detain potentially dangerous persons who arrive in a hospital emergency department. In addition, they are concerned that someone may argue that a hospital may be liable for allowing such persons to voluntarily leave the hospital.

C. Distribution of Mental Health Resources

The map below shows the distribution of psychiatrists per 100,000 people. The distribution of psychiatrists across the state is uneven, with higher concentrations in the more populated counties, although some rural counties have a comparatively good supply of psychiatrists.



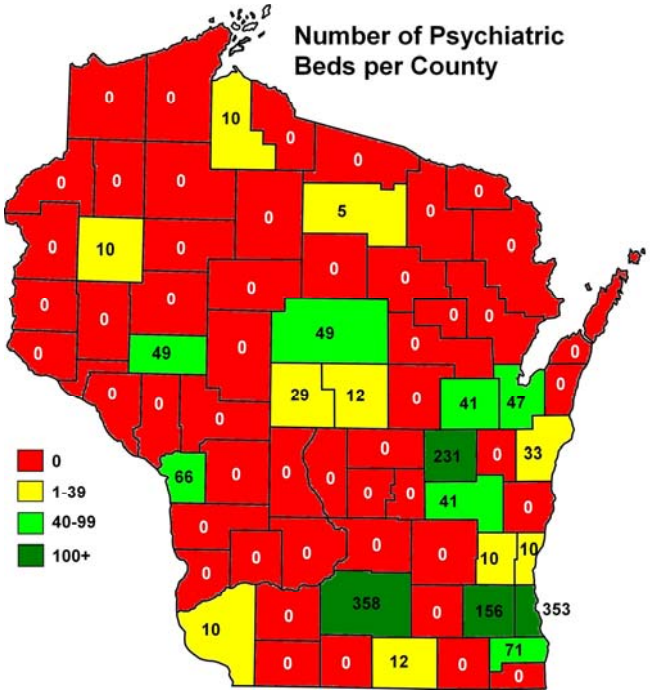
Overall, a review of Wisconsin's mental health workforce shows that Wisconsin:

- Has about the national average number of psychiatrists per 100,000 people.
- Ranks high in the number of psychologists, (seventh in the country).
- Has about the national average umber of social workers, ranking 23rd.

The map below shows the number of inpatient beds by county. It reveals an uneven distribution of psychiatric inpatient beds across state. Fifty-one of Wisconsin's 72 counties have no inpatient beds.

As stated above, the number of psychiatric inpatient beds has been declining, and that decline continues. The most frequently cited reasons for the decline are:

- Lack of adequate payment
- Difficulty finding psychiatric staff
- CAH bed limit of 10 for psychiatric beds



There is no consensus on the ideal number of beds an area should have, but the map above shows that residents of some areas in Wisconsin are a considerable distance from the nearest psychiatric bed. By combining this map with the map above showing a lack of psychiatrists in a number of counties, one can conclude that some counties have very little in the way of mental health resources.

D. Mental Health Laws and Regulations

While providing care for individuals with severe mental health needs can be especially medically complex for hospitals and physicians, Wisconsin's mental health laws contained in Chapter 51 create additional challenges for such providers that are not present for other types of health care services.

For example, if an individual that comes to a hospital emergency department with injuries from a car crash, the treatment the individual receives is generally dictated by the judgment of the treating physician. However, because of the regulatory layers in Chapter 51, if an individual comes to an emergency department with a severe mental health problem, the treatment the individual receives is often dictated by interpretations of Chapter 51 by law enforcement, county agencies, county attorneys, and others.

Unfortunately, inconsistent interpretations of Chapter 51, especially those provisions governing the obligations of counties to provide care, further add to the complexity of mental health care in Wisconsin and result in inconsistent mental health care treatment across the state. In the course of its review, the Task Force found that county agencies across Wisconsin (and sometimes agencies within the same county) have differing interpretations on their obligations to individuals in need of mental health services under

Chapter 51. As a result, the treatment an individual gets can vary by county, due only to how the county interprets its obligations under the law.

Because of the multiple interpretations of Chapter 51, those health care providers that deal with multiple jurisdictions often find it especially difficult to resolve each jurisdiction's separate interpretations of the law. The Task Force heard interest in resolving some of these inconsistencies through an administrative rule process, however, the Department of Health Service's Division of Mental Health and Substance Abuse Services has been unwilling to clarify or to provide a more uniform interpretation of the mental health laws through guidance or the promulgation of rules.

E. Role of County Governments

1. *County Funding*

There is much variability among counties in reported county-agency funding for mental health services. Counties bear a much higher share of the cost for inpatient mental health services (79 percent) than for mental health services overall (32 percent). Again, there is wide variation between the counties in the amount of funding.

Perhaps more importantly, **analysis shows no state-wide correlation between the level of county funding and difficulties relating to emergency detentions reported in the Task Force's survey of hospitals,** as the table below illustrates.

Response	All responding hospitals in county reported ED difficulties	Some responding hospitals in county reported ED difficulties	No responding hospitals in county reported ED difficulties
Per-Capita Spending	$9.93	$10.89	$8.48

2. *Best Practices*

Regardless of the real and perceived problems – underfunding, inconsistent interpretation of mental health laws, and lack of cooperation among various local organizations – a number of counties and regions have been able to develop systems that have been successful in dealing with behavioral health issues - emergency and otherwise.

Best practices are emerging in some counties. They typically involve:

- Collaborative relationships between hospitals, county crisis services, and law enforcement
- Alternatives to inpatient emergency detention facilities
- Multi-county collaborations

Following are three examples of these success stories.

North Central Health Care – A Unique Multi-County Collaboration

North Central Health Care (NCHC) is an example of multiple counties pooling their resources together to better serve community needs to provide appropriate treatment for residents with mental health and alcohol and other drug problems. Established in the 1970's, Marathon, Langlade, and Lincoln counties jointly fund and operate NCHC, whose main site is located in Wausau, with additional offices located in Antigo, Merrill and Tomahawk.

NCHC serves the three counties through a comprehensive set of services, including a 16 bed psychiatric hospital (one of only 5 county-owned inpatient psychiatric units in Wisconsin), outpatient services, and 24/7 mobile crisis stabilization services, including emergency detention services. An eight-bed Community Based Residential Facility (CBRF) designated as an emergency detention site is the newest service offered by NCHC. Created to offer a less expensive alternative to a scarce inpatient psychiatric bed, the CBRF is designed to serve individuals who do not have symptoms/situations that indicate the necessity for hospitalization but whom are not deemed safe to return to their home.

Local hospitals have also partnered with NCHC to provide specialized psychiatric services at their hospital. Aspirus Wausau Hospital has contracted with NCHC to manage its 11-bed inpatient psychiatric unit, as well as to provide specialty mobile crisis services that includes a dedicated crisis hotline, guaranteed onsite crisis response times, and full coordination of service referrals. NCHC also contracts with Riverview Hospital in Wisconsin Rapids to provide its specialty mobile crisis services.

These cumulative efforts are showing positive outcomes. The most recent statistics show that Marathon County had the 12th fewest hospital emergency visits for mental health problems per capita in 2008, and had the 17th lowest county-agency spending on inpatient mental health services per capita in 2007. Regarding emergency detentions, no hospitals in the counties served by NCHC reported chronic administrative difficulties regarding emergency detention to the WHA survey of hospitals.

Milwaukee County – Multiple Stakeholders Coordinating to Improve Care

Between 2005 and 2008, emergency department visits for mental health diagnoses in Milwaukee County are **down** 6.6%. During that same time, the rest of Wisconsin saw emergency department visits for mental health diagnoses go **up** 12.5%. Milwaukee County's remarkable result appears to be a result of a unique and close partnership of all key partners in the provision of mental health care in Milwaukee County.

Multiple stakeholders have unique roles to play in the complex provision of mental health services in Milwaukee County. Thus, representatives from the Milwaukee County Mental Health Complex, the five private hospital systems in Milwaukee, city and county law enforcement agencies, county-level decision-makers, the state Department of Health Services, patient advocacy organizations, and others routinely gather together to discuss problems and solutions relating to the provision of mental health services in the county.

As a result of the work of the partnership over the last few years, the partnership has enabled multiple achievements. These have included establishing a mobile crisis center to reduce emergency department backups, creating two private eight-bed respite units to supplement the Milwaukee County Mental Health Complex, and establishing the law enforcement Community Intervention Program to provide tools to law enforcement when dealing with individuals that may need to be emergently detained for mental health reasons.

Building on past successes, the partners are looking toward even closer collaboration in the future. Currently, the partners are working together with the Human Resources Services Institute in Boston to develop strategies to reduce fragmentation, enhance access, maximize funding options, and coordinate regulatory policies. With such collaborative strategies in place, the partners believe improvements to Milwaukee County's mental health care system can be maximized.

Dane County – Working Together to Develop a "Win-Win" Strategy for Better and More Efficient Care

In 2009, Dane County formed the Mental Health Crisis Stabilization Task Force to identify ways to treat adults with mental health needs who are in crisis and currently seek help through emergency departments. A specific goal of the Task Force was to identify and propose strategies for better and more efficient care that would be a "win-win" for hospitals, physicians, and the county.

This collaborative Task Force brought together County Executive Falk with representatives from county-based mental health services, hospitals, physician groups, law enforcement, the Mendota Mental Health Institute, the Dane County Department of Human Services, and the United Way. Bringing together each of their respective expertise and experience, the Task Force studied current mental health care assets in Dane County and proposals for improvement.

As a result of its work, the Task Force recommended to County Executive Falk that Dane County create a new 24- hour Crisis Stabilization Center. This Center, which was included in Dane County's budget, will include 12 CBRF beds designed for individuals at risk of psychiatric hospitalization. The Center is indeed a win-win-win, as the Center should improve response to crisis situations, provide care in a least restrictive setting, and also provide an alternative to the County to costly admissions to the Mendota Mental Health Institute.

These types of collaborative relationships between hospitals, county crisis services, and law enforcement are leading to better services and fewer problems.

- North Central Health Care
  - Marathon County had the 12th fewest Emergency Department visits for mental health diagnoses per capita in 2008.
- Milwaukee County partnerships
  - Emergency Department visits for mental health diagnoses in Milwaukee County are down 6.6 percent between 2005 and 2008.
  - By contrast, such visits in the rest of the State are up 12.5 percent.

Multi-county collaborations are producing better services. Alternatives to inpatient emergency detention facilities are focused on reducing costs and increasing capacity. One example is the use of less expensive CBRF beds for some emergency detentions.

IV. Recommendations

The Task force has identified three areas where improvements need to be made in order to address the problems outlined in this report: (1) additional resources for providing behavioral health services; (2) changes in and better understanding of Wisconsin's mental health laws; and (3) changes in the ways that counties are funded and interact with the behavioral health system.

A. Access

The Task Force concluded that shortages exist in rural Wisconsin counties for both providers of behavioral health services - psychiatrists and other caregivers - and for inpatient psychiatric beds. The causes for each of the shortages are different but related.

In the case of behavioral health professionals, the issue is part of the overall workforce shortage problem in rural counties identified in other WHA studies. To address this issue, WHA helped form the Wisconsin Council on Medical Education and Workforce (WCMEW), which has been instrumental in addressing Wisconsin's physician workforce shortages. Up to this point, the focus has been on primary-care providers. Additionally, the Task Force identified telemedicine as an additional option to extend existing resources into areas of Wisconsin with a shortage of behavioral health workforce.

Recommendation #1: Behavioral health provider shortages should be added to WCMEW's list of priorities. Additionally, telemedicine should be explored as one method to leverage and extend existing behavioral health work force.

The other component of the shortage is in the number of available inpatient psychiatric beds. As stated previously in this report, the number of such beds has declined significantly statewide over the last several decades. The causes are mainly due to lack of adequate payment for behavioral health services and changes in delivery of services from the inpatient to the outpatient setting.

But for rural counties, regulatory constraints have led to significant shortages. In 51 Wisconsin counties there are no inpatient psychiatric beds. For the most remote counties, this means that patients needing inpatient treatment must be transported considerable distances for treatment. Prior to the last decade, those counties could rely on a number of rural hospitals that provided inpatient mental health services on a regional basis. But those same hospitals converted to critical access hospital (CAH) status. A federal requirement of obtaining that status was to limit psychiatric beds to 10. Most of these rural regional providers had a bed complement of 16, which allowed for greater volume and revenue to spread over their fixed costs. The lower volume resulting from CAH status meant that in many cases, providing inpatient behavioral health services became financially unviable. This led to most of these regional providers - now CAHs - to cease providing these services altogether.

Recommendation #2: Work with Wisconsin's Congressional delegation to address CAH rules that discourage rural psychiatric units.

B. Mental Health Laws (ch.51)

Chapter 51 of the Wisconsin statutes guides the provision of behavioral health services by counties. There is wide variation in interpretation of those statutes by the counties, which leads to inconsistent care that frequently is dictated by county agencies. Health care providers that deal with multiple jurisdictions also often find it difficult to resolve the multiple interpretations of the law.

The Task Force made three recommendations regarding Chapter 51:

<u>Recommendation #3</u>: Develop and provide education program(s) for hospitals regarding Chapter 51 requirements.

<u>Recommendation #4</u>: Explore the option of amending state law to allow hospitals to initiate emergency detentions.

<u>Recommendation #5</u>: Explore the option of amending state law to explicitly include hospital representation on county 51.42 behavioral health boards.

C. Emergency Detention Concerns /Role of Counties

While there are significant existing impediments to delivering behavioral health services to individuals with acute needs, a number of areas in the state have found ways for counties and health providers to collaboratively work through barriers to effectively and compassionately treat these vulnerable populations. Three examples of these success stories were highlighted above in this report. The question becomes how to make them more widespread across Wisconsin. The Task Force had several recommendations in this regard:

<u>Recommendation #6</u>: Encourage collaboration between hospitals and counties; Inform hospitals of examples of successful collaborations between counties, hospitals, law enforcement, and others.

<u>Recommendation #7</u>: Allocate state funding to counties on a regional basis, which would force counties to regionalize their Chapter 51 services. Funding would also be tied to a more rigorous Chapter 51 plan that shows collaborative relationships and treatment across the full scope of services.

<u>Recommendation #8</u>: Support efforts to find effective, lower cost emergency detention and treatment options such as CBRFs.

D. General Recommendations

Finally, the Task Force made several broader recommendations:

<u>Recommendation #9</u>: Develop quality improvement goals for the regions/counties relative to Chapter 51 responsibilities. Develop measures for these goals and monitor, using the measures as one basis for funding.

<u>Recommendation #10</u>: In the long term, support adequate funding for the treatment of individuals with severe mental illness.

<u>Recommendation #11</u>: WHA should become more strategically active in selected state-level mental health workgroups such as the Wisconsin Crisis Network.

<u>Recommendation #12</u>: WHA should collaborate with the Division of Mental Health and Substance Abuse Services and the Wisconsin Counties Association to help resolve the issues outlined in this report.

APPENDIX A

Task Force Members

Chair: George Kerwin, CEO, Bellin Hospital
Jim Mugan, Vice President for Patient Services, Agnesian HealthCare
Gareth Steiner, CEO, Vernon Memorial Healthcare
Pete Carlson, CEO, Aurora Psychiatric Hospital
Jeff Martin, Central Region CEO, Ministry Health Care
Paul Mason, Vice President Clinical Services, WFH-All Saints
Bill Henricks, Rogers Memorial Hospital
Phylis Fritsch, CEO, Upland Hills Health
Gary Bezucha, CEO, North Central Health Care Facilities
Mary Ann Clark, Chief Nursing Officer, Cumberland Memorial Hospital and ECU
John Easterday, Director, Bureau of Mental Health and Substance Abuse Services, DHS
Melissa Huggins, Meriter Hospital
Lois Klay, Division Manager, St. Joseph's Hospital, Chippewa Falls
Joy Tapper, Milwaukee Health Care Partnership
Rick Paul, Integrated Behavioral Health, St. Mary's/Duluth Clinic Health System
Jerry Halverson, M.D., UW-Madison School of Psychiatry; Psychiatrist, Meriter Hospital
Tim Size, Rural Wisconsin Health Cooperative

Staff to the Task Force

George Quinn, WHA Staff
Matthew Stanford, WHA Staff
Bill Bazan, WHA Staff
Laura Leitch, WHA Staff
Charles Shabino, MD, WHA Physician Consultant