NORTHERN MICHIGAN CRISIS SYSTEM ASSESSMENT

June 2021

tbdSolutions

Contents

Executive Summary

In December 2020, TBD Solutions was contracted by North Country CMH and Northern Lakes CMH to assess the behavioral health crisis system in their shared 12-county region in northern lower Michigan.

The CMHs and their key community hospital partners Munson Hospital and McLaren Health Care met with TBD Solutions five times over the six-month assessment period, and all four partners engaged in data sharing and individual meetings facilitated by TBD Solutions.

TBD Solutions engaged a variety of methods for the behavioral health crisis system assessment, soliciting input from key stakeholders and persons served to better contextualize the needs and wishes of the community.

Based on the evaluation of the current system, review of data, input from key stakeholders, and consideration of best practices for an effective crisis continuum, TBD Solutions makes the following recommendations:

1. Develop and/or expand crisis services to include a crisis stabilization unit, psychiatric urgent care, adult crisis residential, and additional child and adult psychiatric inpatient beds.
2. Assure crisis services are available to all payer types.
3. Develop a collaborative crisis metrics portfolio to monitor and continuously improve system performance.
4. Develop Access Solutions that Minimize Reliance on First Responders.

Introduction

In December 2020, TBD Solutions contracted with North Country CMH and Northern Lakes CMH to assess the behavioral health crisis system in their shared 12-county region in northern lower Michigan. The region has a combined population of over 350,000 people.[1]

Munson Healthcare and McLaren Health Care were active and collaborative partners in the project. The system assessment was conducted between December 2020 and June 2021.

Considerations

- Data collected about the region's crisis system originated from two primary sources: the CMHSP Sub-element Cost Report,[2] and self-report information from a data inquiry of the two CMHs and the two health care systems in the region.
- While efforts were made to include persons with lived experience with the region's crisis system in every phase of the project, these individuals were primarily represented through the community survey and focus groups.

Persons Served

Individuals receiving behavioral health treatment are referred to by many different names, including patient, client, consumer, resident, guest, individual, and person served. This report is predicated upon the foundation of recovery-oriented principles in mental health treatment and choosing the least stigmatizing language. While we understand the potential breadth and diversity of this report's audience, we have chosen to use the words "client" or "person served" when referring to a person receiving services as it is universally understood while being less stigmatizing than words like "patient" or "consumer."

About TBD Solutions

TBD Solutions (TBDS) is a consulting, training, and research firm specializing in behavioral health crisis system design, function, and performance. Formed in 2011, TBD Solutions is committed to the values of high-quality, cost-effective, and client-centered care that effectively meets the urgent and ongoing needs of individuals receiving services and their communities.

Methods

To assure a thorough understanding of the region's crisis system functions and most pressing needs, TBD Solutions engaged a multi-faceted series of quantitative and qualitative research that

[1] U.S. Census Bureau (2021). County Population Totals: 2010-2020, Vintage 2020. Retrieved from https://www.census.gov/programs-surveys/popest/technical-documentation/research/evaluation-estimates/2020-evaluation-estimates/2010s-counties-total.html.

[2] https://www.michigan.gov/mdhhs/0,5885,7-339-71550_2941_4868_4902-256889--,00.html At the time of this report, MDHHS had only published Medicaid claims data through FY2019 (October 2018-September 2019).

included crisis providers, administrators, persons served, law enforcement, first responders, and other stakeholders. These methods included:

- Community Meetings
- National Research
- Community Survey
- Focus Groups
- Structured Interviews
- Metrics Analysis

Findings

Community Meetings

TBD Solutions facilitated five community meetings over 6 months to introduce the critical components of effective crisis systems, walk project participants through the steps of the assessment process, report findings from the stakeholder feedback interventions, and provide initial recommendations based on findings. Leaders from North Country CMH, Northern Lakes CMH, Munson Healthcare, and McLaren Health Care participated in these meetings.

National Research

Community-based behavioral health crisis services boast a 40+ year history of achieving Triple Aim health care objectives of strong clinical outcomes, high client satisfaction, and low costs compared to its medical/inpatient contemporaries.

Crisis Residential Research

Over 30 articles dating back to the 1970's support the efficacy and cost-effectiveness of Crisis Residential Programs (CRPs).[3] In a 2009 study, clients reported higher satisfaction compared to inpatient psychiatric hospitalization.[4]

UNDERSTANDING CRISIS STABILIZATION

Short-term crisis stabilization programs offer viable alternatives to Emergency Departments and psychiatric hospitals for people experiencing a behavioral health crisis.

Crisis stabilization programs go by many different names, sometimes informing their function.

Psychiatric Urgent Care Centers (PUCCs) are typically unlocked and community-based, open 8-12 hours per day, up to 7 days per week.

Crisis Stabilization Units (CSUs) typically operate in a secured setting, serving people for up to 23 hours, although some offer treatment for up to 72 hours.

EmPATH Units are similar to CSUs but are operated in hospital settings.

[3] To view a research overview of alternatives to hospitalization from 1973-2013, visit https://www.crisisresidentialassociation.org/crisis-residential-research-summary.html

[4] Adams, C. and El-Mallakh, R. "Patient Outcome After Treatment in a Community-Based Crisis Stabilization Unit." Journal of Behavioral Health Services, July 2009.

By keeping their average length of stay at or below the level of inpatient psychiatric hospitals, CRPs keep total treatment costs lower.[5] Cost savings are also actualized by utilizing CRPs as stepdowns from inpatient hospitalization, shortening the length of stay for treatment.[6] According to the Michigan Medicaid Provider Manual, criteria for crisis residential admission is almost identical to psychiatric inpatient criteria, only distinguished by the ability to contract for safety in an unlocked environment and care for one's Activities of Daily Living (ADLs).

Despite the unlocked and homelike environment, CRPs have even demonstrated the ability to effectively serve individuals receiving court-ordered treatment.[7]

Crisis Stabilization/Psychiatric Urgent Care Research

Research specific to alternatives to the Emergency Department is limited but promising. Psychiatric emergency services like Crisis Stabilization Units and Psychiatric Urgent Care centers have been shown to reduce ED boarding time and reducing the need for inpatient psychiatric hospitalization.[8] Research also indicates improvements in symptom severity, stress, psychosocial functioning, and satisfaction with care.[9]

Rural Considerations

"Rural" is defined by several governmental bodies and based on diverse standards. For example, the U.S. Census Bureau considers anything area that is "not urban" to be rural. Urban clusters consist of at least 2,500 individuals, therefore any area with less than 2,500 individuals is considered rural.[10] Conversely, the Office of Management and Budget defines rural as non-metro, meaning less than 10,000 individuals.[11] Federal Office of Rural Health Policy (FORHP) grant programs utilizes components of each definition when determining a classification for a geographic region. The Rural Health Clinics (RHC) Program requires a location to be outside an urbanized area as defined by the U.S. Census Bureau.

Based on these definitions all twelve counties within the North Country and Northern Lakes Community Mental Health regions are considered rural.

In rural communities, collaboration is essential to bringing excellent crisis care to individuals served in addition to being essential for the sustainability of the services themselves. Collaboration and

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[5] Fenton, W. et al. "Cost and Cost-Effectiveness of Hospital vs Residential Crisis Care for Patients Who Have Severe Serious Mental Illness." Archives of General Psychiatry, 2002.
[6] Budson, R. "Community residential and partial hospital care: low-cost alternative systems in the spectrum of care." The Psychiatric Quarterly, 1994.
[7] Greenfield, T. "A Randomized Trial of a Mental Health Consumer-Managed Alternative to Civil Commitment for Acute Psychiatric Crisis." American Journal of Community Psychology, September 2008.
[8] Zeller, S., et al, A. Effects of a Dedicated Regional Psychiatric Emergency Service on Boarding of Psychiatric Patients in Area Emergency Departments. Western Journal of Emergency Medicine. Feb. 2014
[9] Sunderji, et al. Urgent Psychiatric Services: A Scoping Review. Canadian Journal of Psychiatry. Sept. 2015.
[10] Rural America (census.gov)
[11] Defining Rural Population | Official web site of the U.S. Health Resources & Services Administration (hrsa.gov)

true partnership throughout the community includes a shared vision of the desired outcomes and goals. Consultations, warm hand-offs, conferences, team meetings, and case management are cited to be critical to the success of healthcare services in rural communities.[12]

The unique qualities of rural communities often magnify access as a major barrier to receiving care. Shared infrastructure, staffing, and training can all be effective measures to mitigate a lack of accessibility. First responders who are cross-trained in detecting signs of a behavioral health crisis or technology solutions that link a clinician or peer support to people in remote parts of a county or region help to bridge some of these service and access gaps.

Community Survey

In January and February 2021, TBD Solutions conducted an open survey across the region. **686 individuals responded**, representing a diverse group of stakeholders, including community residents (134 responses), behavioral health providers (102), family members of individuals served (96), CMH/PIHP[13] staff (90), crisis responders (85), physical health providers (76), persons with lived experience (62) and SUD providers (41). Participation was evenly split between the NLCMH and NCCMH regions (49%).

Themes of the community survey included:

- Improvements in coordination of care are needed throughout the system, including formal education for providers within the emergency department specific to behavioral health resources and a general understanding of level of care criteria
- A strong preference is expressed for community-based and mobile treatment
- Improvements in treatment for individuals with substance use disorders and/or behavioral challenges are needed, particularly when presenting at the emergency room
- Reduction in need for medical clearance at an emergency room prior to admission to treatment

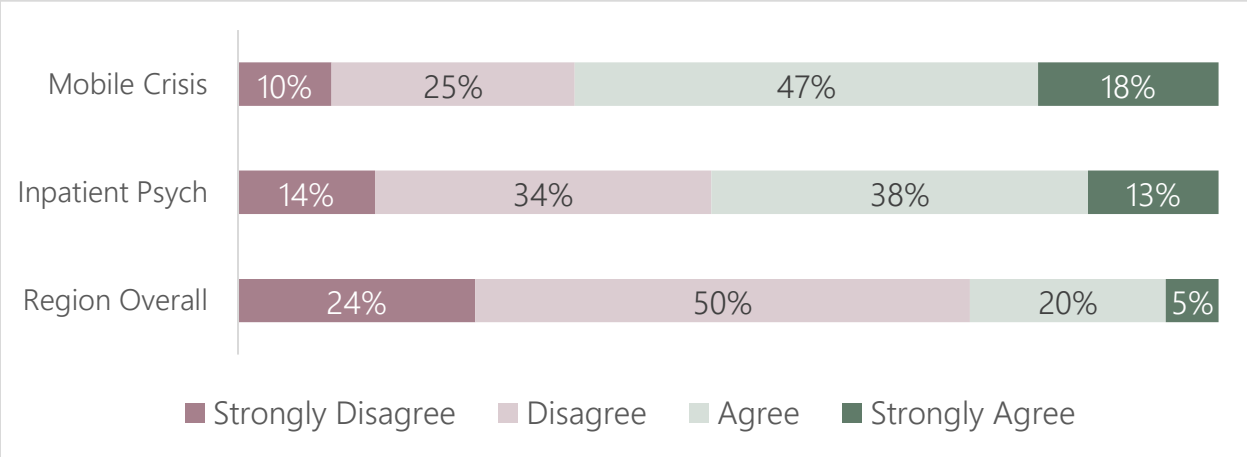
Selected survey results and findings are provided below, including feedback on family involvement in treatment and perspectives from persons served and/or their family members on crisis system priorities. The full survey results were shared at the March Northern Michigan Crisis System Consortium meeting.

[12] Rural Community Health Toolkit (ruralhealthinfo.org)

[13] Prepaid Inpatient Health Plan, the public behavioral health plan for persons with Medicaid.

Figure 1. Survey Results on Family Involvement

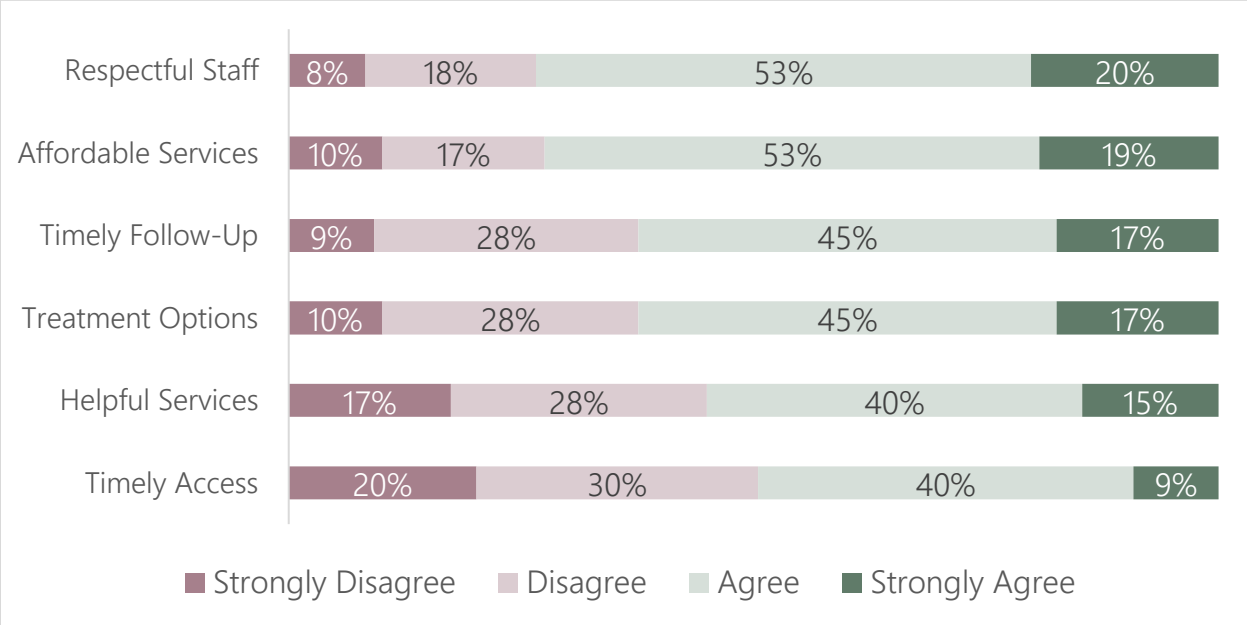
"*[Service] appropriately encourages family involvement in treatment*" (All respondents)



Nearly 2/3 of respondents (65%) agree that mobile crisis services appropriately encourage family involvement in treatment, while 51% of respondents reported the same about psychiatric inpatient and even fewer (25%) reported that the region overall appropriately encourages family involvement in treatment.

Figure 2. Survey Results of Priorities

"*If you or a family member received treatment in a behavioral health crisis facility or provider in the past two years, how would you rate the following aspects of treatment*" (Only respondents identifying as people with lived experience or family members of those with lived experience)



Out of all survey respondents, 109 individuals reported that they or a family member had received behavioral health crisis services in the past two years. Characteristics of treatment that received the

strongest levels of agreement[14] were: respectful staff (74%), affordable services (73%), timely follow-up (63%), and treatment options (61%).

Below are quotes from those with recent experience with the crisis system:

- *"Everyone was very helpful and answered all my questions. they always called back and if they didn't have the answer they found it for me. I appreciate them all and are thankful they are there."*
- *"My family member has received services over the years for SUD … He has had mixed experiences re: Mental Health Services from excellent to in his opinion limited options… it seems to add an extra challenge for him having both mental health concerns (anxiety, OCD, depression) and a substance use disorder."*
- *"ER nurses treated him as if it was a bother and did not care about the basic needs other patients get addressed. Holding cell with little or no interaction. Feels like he is a criminal in jail. Is talked to as if mental illness is something that is his fault."*

Focus Groups

TBD Solutions facilitated three focus groups open to survey respondents and selected stakeholders in March 2021. Approximately 50 individuals participated in the 90-minute sessions, and their feedback was arranged into ten categories, organized by frequency of comments related to each theme.

Figure 3. Focus Group Results by Theme

Theme	Details
Access to Services	• CMH services are not perceived as visible or easy to access • Services are inconsistently available based on acuity (i.e. Individuals who are perceived as violent have nowhere to get services) • Service hours are limited • Wait times to access appointments are long, especially psychiatry and outpatient therapy • Services are limited for those with mild-to-moderate • Services are limited for those with private insurance • Early access services are limited; people reported not being able to access services where they first engage the system or before they went into crisis
Coordination of Care/ Aftercare Services	• Individuals discharging from higher levels of care need more support post-discharge • Recovery would be supported with stronger aftercare service availability and reduce the need to re-enter higher levels of care • Aftercare services could look like wrap-around services • Medicaid deactivation (post jail incarceration) creates barrier to aftercare • Providers are not consistently coordinating care between one another

[14] Agreement is defined as an item response of Agree or Strongly Agree

	• People recalled having to "retell" their story and felt "bounced around" from provider to provider • Appointments were missed because persons served did not know the provider they were being referred to (e.g., An individual is referred to a primary care provider from their case manager) • There was a perceived lack of partnership and sharing of desired outcomes among providers • Service navigators would be a helpful addition to the system
Community Education	• Community members do not know the services that organizations provide and/or who they serve • Community members do not know the difference between levels of care (e.g., hospital and community services) • The community needs to know when to use the ER or other services • Mental health stigma prevents people from getting services
Partner Education	• Providers, hospital systems, law enforcement, and housing support organizations do not have good awareness of service providers and who they each serve • There is a perceived lack of communication between partners and providers (including law enforcement and hospital systems) • The emergency department was described as not being prepared or equipped to work with an individual with a behavioral health need
Co-Occurring Services	• There is a need for services to meet both SUD and mental health needs • SUD services exist but they are isolated and not integrated into other types of care (MH, physical health, etc.)
Mental Health "Facility"	• There is a need for a "facility" or center similar to partial inpatient programs, psych ER/BH Urgent Care models, mobile crisis services, and walk-in services
Provider Shortage	• There is a perceived shortage of providers, specifically respite services for families
Support for Families	• Support for families is critical and needs to be considered when developing innovative solutions • Families being involved in care and prepared for transitions between care would better support individual's recovery • Care located closer to the community would improve family involvement and recovery outcomes
Funding	• Services need to be expanded and financially supported regardless of payer
Helpful Services	• The jails provide helpful services to those who need it • Hope Not Handcuffs was a great resource • Telehealth allowed for better access to services

Structured Interviews

TBD Solutions conducted ten interviews with behavioral health clinicians, administrators, law enforcement, and community partners. Their responses are summarized below.

Improving Access by De-Centralizing Care

- The crisis systems should rely less on psychiatrists and more on other behavioral health providers—clinicians, peer supports, and nurses.
- Meeting people where they are at in communities (i.e. mobile crisis) is a better solution than expecting people to drive to multiple locations to receive care
- Ambu-cab was tried in the past but the volume wasn't there to pay for itself

New Crisis Services

- Crisis Residential Units
    - CRUs truly help divert people from psychiatric hospitals.
    - The region's loss of CRUs has been felt over the past few years.
    - People are being sent to psychiatric inpatient when they don't need to be, or they are sent home when a better solution used to be available.
- Crisis Stabilization Unit/Psychiatric Urgent Care
    - Consensus that a Crisis Center/CSU/PUC would be a welcome improvement to the region's crisis system
    - Services in a CSU/PUC should be more welcoming an inviting than status quo psychiatric hospital treatment, with more attention given to freedom and choices in treatment
- Peer Respite
    - Would be a welcome addition to the region.

Referrals & Care Coordination

- Psychiatric Hospitals
    - Selective admission criteria by psychiatric hospitals makes placement difficult for law enforcement and referring clinicians
- Medical Clearance
    - One CMH requires medical clearance for all individuals
    - Medical clearance expires after 72 hours and must be completed again
    - Consistent protocols between Emergency Departments are needed for BH patients
- After-Hours Clinical Phone Coverage
    - The addition of ProtoCall as after-hours clinical phone support has reduced system workload but added some layers of complexity for assessment and psychiatric inpatient admission
- Criminal Justice & Mental Health
    - Without bed availability, law enforcement reports people with mental illness are going to jail who don't belong there.

Education and Community Awareness

- Community members have been conditioned to go to the Emergency Department for any behavioral health emergency or crisis
- Mental Health system trainings are needed for law enforcement

- Law enforcement awareness training are needed for behavioral health clinicians
- Visuals of system design and throughput would help first responders of all experience levels to improve clarity of function and communication

Co-Occurring Treatment for Mental Health & Substance Use Disorders

- Multiple reports of limited SUD capacity
- Some people are considered too acute for both SUD and MH programs

Metrics

In February and March 2021, TBD Solutions requested a bevy of metrics from key partners on behavioral health crisis system utilization, referrals, and quality, including emergency departments (EDs), psychiatric hospitals, and crisis residential units (CRUs) as primary service components. There are eight Emergency Departments in the 12-county region as follows:

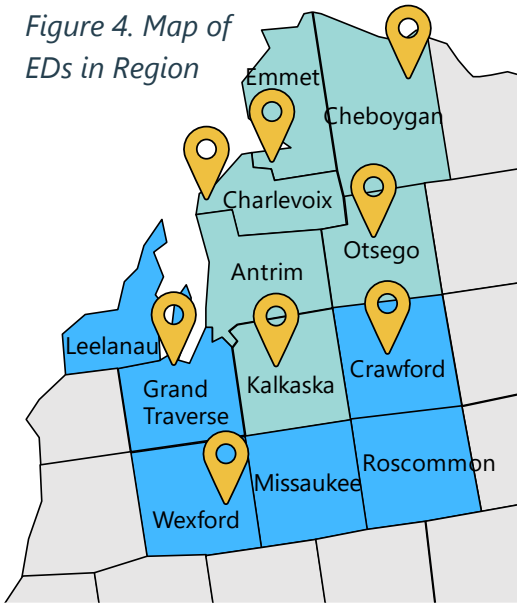


Figure 4. Map of EDs in Region

North Country CMH Region

- McLaren Northern MI—Petoskey
- McLaren Northern MI -Cheboygan[15]
- Kalkaska Memorial Health Center
- Munson Healthcare Charlevoix Area Hospital
- Munson Healthcare Otsego Memorial Hospital

Northern Lakes CMH Region

- Munson Medical Center in Traverse City
- Munson Healthcare Grayling Hospital
- Munson Healthcare Cadillac Hospital.

Munson Traverse City also operates a 17-bed adult psychiatric hospital unit, the only psychiatric hospital beds in the 12-county region. Data was reported for Calendar Years 2017-2019. TBD Solutions requested over 1,500 combined data elements and shared the results in a comprehensive report.

In order to better understand the feasibility of a shared metrics portfolio for crisis services, CMHs and hospitals were asked to report on their current practices in crisis metrics by answering questions related to current functionality, clinical processes and current reports using particular data elements. The tables below provide a summary of the level of comprehensive crisis metrics collection and utilization reported by each organization.

[15] McLaren Northern Michigan Cheboygan ED was the only ED not to report their data.

Figure 5. CMH Metrics Feasibility

Metrics Feasibility: CMHs								
○=EMR field exists ◐=EMR field exits + Data used regularly ●=EMR + Data used regularly + Existing reports	North Country CMH				Northern Lakes CMH			
	Crisis Res		Psych Inpatient		Crisis Res		Psych Inpatient	
	Adult	*Youth*	*Adult*	*Youth*	*Adult*	*Youth*	*Adult*	*Youth*
Total Persons Served	●	●	●	●	●	●	●	●
Total Visits	●	●	●	●	●	●	●	●
Total Bed Days	○	○	●	●	●	●	●	●
Total Cost	○	○	●	●	●	○	●	●
Average Cost/Person	N/A							
Average Cost/Visit	○	○	●	●	●	○	●	●
Average Cost/Bed Day	○	○	●	●	●	○	●	●
Average Hours/Client	○	○	●	●	●	●	●	●
Average Units/Person	N/A							
Readmission to <u>same</u> facility: 7 days	○	○	●	●	●	●	●	●
Readmission to <u>same</u> facility: 30 days	○	○	●	●	●	●	●	●
Readmission to <u>same</u> facility: 90 days	○	○	○	○[16]	●	●	●	●
Readmission to same <u>type</u> of facility: 7 days	○	○	●	●	●	●	●	●
Readmission to same <u>type</u> of facility: 30 days	○	○	●	●	●	●	●	●
Readmission to same <u>type</u> of facility: 90 days	○	○	○	○[16]	●	●	●	●
Aftercare Linkage Rate	○	○	○	○	○	○	○	●
Inpatient Hospitalization Rate	N/A							
Client Satisfaction Rate	○	○	○	○	○	○		

[16] North Country CMH responded "no" to "Are people using this data/measure regularly?" and "yes" to "If yes, do you have reports/queries that use this data?", so this was recorded as "EMR field exists", an open circle.

Figure 6. Emergency Department Metrics Feasibility

Metrics Feasibility: Emergency Departments							
○=EMR field exists ◐=EMR field exits + Data used regularly ●=EMR + Data used regularly+ Existing reports	North Country CMH Region				Northern Lakes CMH Region		
	Munson Charlevoix	McLaren N. MI-Petoskey[17]	Munson Otsego	Kalkaska Memorial	Munson Grayling	Munson Cadillac	Munson Traverse City
Total Persons Served	●	●	●	●	●	●	●
Total Visits	●	●	●	●	●	●	●
Total Bed Days		N/A					
Total Cost	●	○	●	●	●	●	●
Average Cost/Person	●	○	●	●	●	●	●
Average Cost/Visit	●	○	●	●	●	●	●
Average Cost/Bed Day		N/A					
Average Hours/Client	○	●	○	○	○	○	○
Average Units/Person		N/A					
Readmission to same ED: 7 days	○	○	○	○	○	○	○
Readmission to same ED: 30 days	○	○	○	○	○	○	○
Readmission to same ED: 90 days	○	○	○	○	○	○	○
Aftercare Linkage Rate		N/A					
Inpatient Hospitalization Rate	○	●	●	●	●	●	●
Client Satisfaction Rate	○	○	○	○	○	○	○

Crisis Standards

There are currently no established, broadly accepted national standards for behavioral health crisis services. While some HEDIS measures assess timely access to outpatient care or Initiation and Engagement in certain types of treatment, local communities are left to develop and adopt their own crisis standards, and many choose not to. This is a cause for concern, as communities measure what they care about, and a lack of crisis practices standards and outcomes indicates that these services are not a priority.

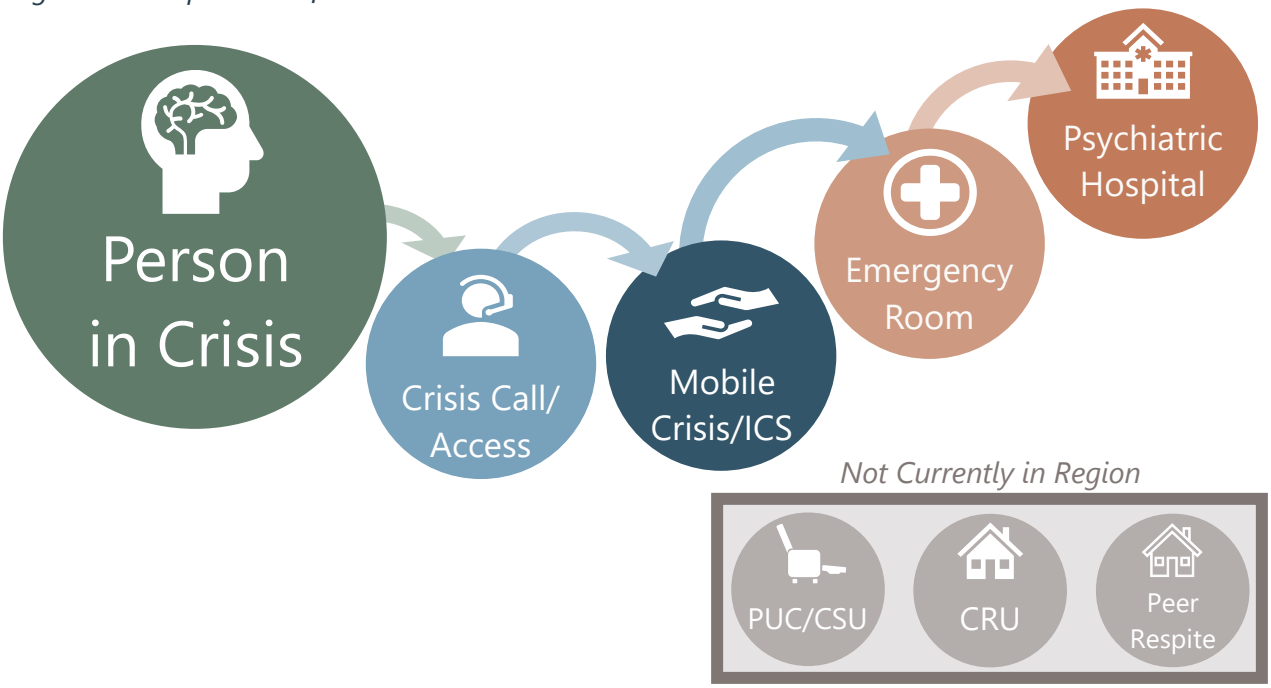
Some examples of clinical practice standards include symptom rating scales measured at intake and discharge, client satisfaction ratings, readmission rates to any emergency behavioral health service, and care coordination after discharge.

[17] McLaren Northern Michigan—Petoskey relies on North Country CMH and their data for behavioral health screening and admissions.

Network Adequacy

Currently, the region's crisis continuum includes two Access Centers (operated by the CMHs), two mobile crisis teams (operated by the CMHs), eight Emergency Departments (5 operated by McLaren, 3 operated by Munson), and one inpatient psychiatric unit (operated by Munson).

Figure 7. Components of the Current Crisis Continuum



In 2018, the Michigan Department of Health and Human Services (MDHHS) established regional network adequacy standards for crisis residential units. The standards state that every population of 500,000 or more must have 16 adult CRU beds and 8-12 youth CRU beds.

Based on these requirements and current population data, the North Country CMH region needs at least 4.8 adult CRU beds and 2.5-3.7 youth CRU beds, and the Northern Lakes CMH region needs at least 6.4 adult CRU beds and 3.2-4.8 youth CRU beds.

Crisis Services Previously Operated in Region

Prior to 2018, the Northern Lakes CMH and North Country CMH regions each had a crisis residential unit; both units have since closed, in part due to utilization/occupancy issues. However, the Northern Lakes CRU showed some of the highest utilization relative to psychiatric inpatient hospitalization of any CMH in the state. Similar levels of utilization would help CRUs to thrive in both regions.

Commitment to the crisis residential model by operators, referral sources, and funders is critical to program success, as is adherence to clinical best practice established at the state and national level. Psychoeducational and therapeutic groups should be offered multiple times daily, with agency and choice revered in the client treatment experience.

Recommendations

1. Expand Crisis Services and Capacity

To assure timely access to high-quality services, TBD Solutions recommends the addition of the following crisis services:

Crisis Stabilization Unit

Build a 6-chair Crisis Stabilization Unit in Traverse City to divert individuals from the Emergency Department and avoid unnecessary hospitalizations. The CSU should be secured and serve most people in 23 hours or less, with the ability to serve people for up to 72 hours. This program will primarily serve people living in the Northern Lakes CMH region but will be open to individuals in other neighboring counties and regions.

A daily rate of $800 is recommended, with a minimum average utilization of 8 people per day, 365 days per year. The recommendation of a 6-chair program assumes that 2/3 of patients will leave within 12 hours, allowing the provider to turn most beds over daily.

The availability of additional staff may allow for medical clearance within a Crisis Stabilization Unit, but previous instances of medical issues ascertained from the medical clearance process of people presenting to emergency services in a behavioral health crisis. The MI-SMART[18] form is a recently developed tool for standardizing the medical clearance process with behavioral health clients in mind.

The specifications of this service are still in development by MDHHS.

Crisis Residential

Build a 6-bed adult Crisis Residential Unit in Traverse City, co-located with the Crisis Stabilization Unit and Peer Drop-In Center. Assure that the service operator demonstrates competencies and passion for the crisis residential model and the referring doctors and clinicians are well-versed in the ability of the program to accept most people who meet psychiatric inpatient criteria.

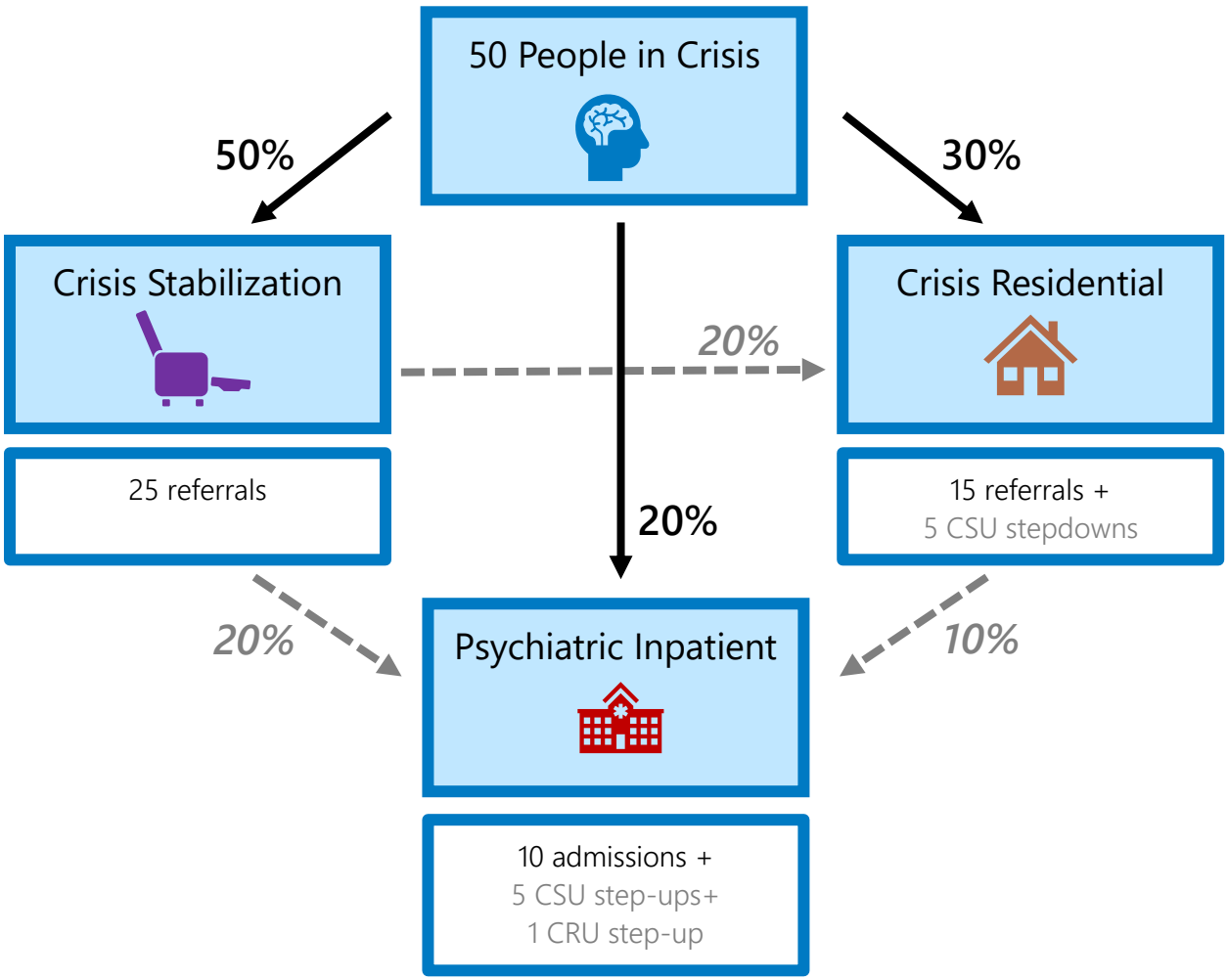
Service specifications are provided in the Michigan Medicaid Provider Manual.

While new services are being built, work with the current CRU referral destinations in Grand Rapids, Oscoda, and other CMH regions to relax their medical clearance requirements if the MI-SMART form is used and other protocols are followed by the referral source.

The table below shows the potential monthly throughput of the Northern Lakes CMH region's crisis services with the addition of both a CSU and CRU. In this model, less than one third of the people presenting in crisis and prospectively meeting criteria for psychiatric inpatient hospitalization actually need to be referred to the hospital.

[18] https://www.mpcip.org/mpcip/mi-smart-psychiatric-medical-clearance/

Figure 8. Northern Lakes Region Potential Future State with CSU & CRU (monthly)



Psychiatric Urgent Care

Build a 6-chair Psychiatric Urgent Care Center (PUCC) in Petoskey to divert people from the Emergency Department and avoid unnecessary hospitalizations. The PUCC should be unlocked and open 8-12 hours per day, providing timely access to care while diverting people from the Emergency Department and, in some cases, the psychiatric hospital.

A daily rate of $400 is recommended, with a minimum average utilization of 7 people per day, 365 days per year. The recommendation of a 6-chair program assumes that 2/3 of clients will leave within 12 hours, allowing the provider to turn half of the beds over during a 12-hour day.

Psychiatric Inpatient

Build a 16-bed inpatient psychiatric unit on the Cheboygan Hospital campus. To address the service gaps for adults and youth, design the facility as a 10-bed adult unit and a 6-bed youth unit. In the Certificate of Need application, indicate a plan to create "swing beds" that allow the youth beds to flex up to 8 beds while reducing the adult unit census to 8 beds during those times.

The graphic below shows the estimated monthly throughput of the North Country CMH region's crisis services with the addition of a psychiatric urgent care center and adult and youth psychiatric inpatient beds. In this model, less than half of the people presenting in crisis and prospectively meeting criteria for psychiatric inpatient hospitalization actually need to be referred to the hospital.

Figure 9. North Country Region Potential Future State with PUC & CRU (monthly)

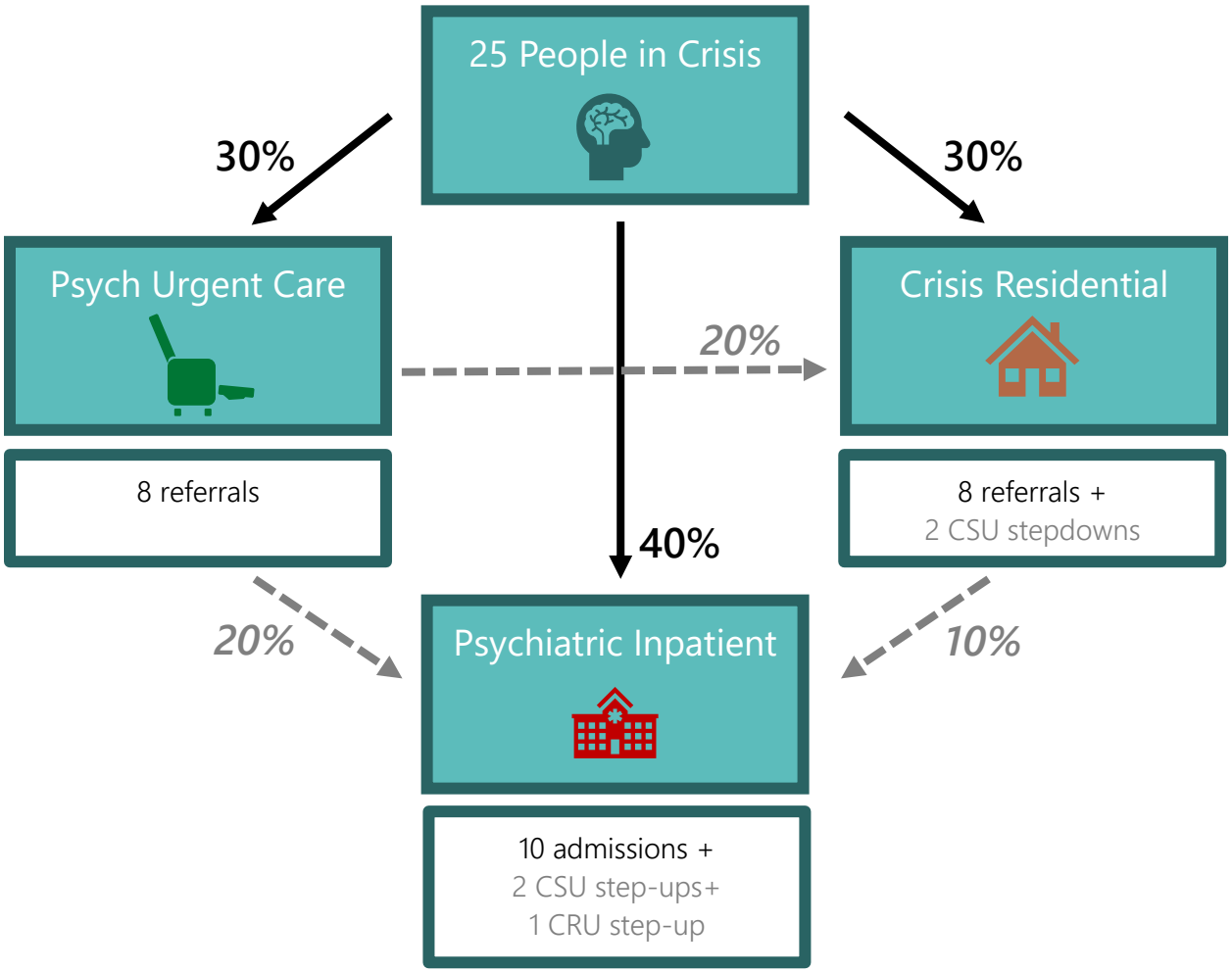


Figure 10. Behavioral Health Crisis Facility Recommendations

Recommendations for Northern Michigan Crisis System			
Facility	**# of Beds/ Chairs**	**Staffing**	**Notes**
Crisis Stabilization Unit 	6 chairs	Prescriber, Nurse, Clinician, Peer Support, Psych Tech	Locate in Traverse City, co-locate with CRU and outpatient services; police drop-off, up to 72-hour LOS.
Psychiatric Urgent Care 	6 chairs	Prescriber, Nurse, Clinician, Peer Support, Psych Tech	Locate in Petoskey, 8-10 hours/day, 7 days/week
Psych Inpatient-Adult & Youth 	10 adult beds 6 youth beds	Prescriber, Nurse, Clinician, Peer Support, Psych Tech	Locate on Cheboygan Hospital campus
Adult Crisis Residential 	6 beds	Prescriber, Nurse, Clinician, Peer Support, Psych Tech	Co-locate with CSU in Grand Traverse County (6-bed with co-occurring enhanced status)

With an enhanced crisis services continuum that includes the services listed above, both the North Country CMH and Northern Lakes CMH regions will produce more timely access to care, with fewer people being boarded in the Emergency Department or referred outside their collective region for crisis services.

The previously referenced research on cost savings of Crisis Residential Programs can be replicated when CRUs are utilized as often as the top four most utilized CRUs in Michigan. Appendix A provides a pathway towards saving $1 million or more annually by utilizing CRUs as a diversion from psychiatric inpatient hospitalization.

Co-locating Crisis Services

Co-locating crisis services creates a multi-service access point for clients while creating efficiencies in shared staffing and care coordination. The Traverse City campus recommendations include co-located peer drop-in center, Access Center, Crisis Stabilization Unit, and adult Crisis Residential Unit.

2. Assure Crisis Services are Available to All Payer Types

Building on the knowledge of current contracts and pilot programs between commercial health plans and crisis providers, develop relationships with health plans to propose a pilot and lobby for parity in the coverage of behavioral health crisis services at the state and federal level. Partner with

organizations like the CMH Association of Michigan and the Michigan Association of Health Plans to bring equitable access to behavioral health crisis services as people with commercial insurance do not currently have access to most evidence-based crisis services discussed in this report.

When meeting with commercial payers, be prepared with data on efficacy and cost-effectiveness of crisis services with an emphasis on return on investment compared to treatment as usual in Emergency Departments and psychiatric hospitals.

While commercial health plan coverage is the focal point of this recommendation, explore the paneling and advocacy necessary to also contract with TriCare, Medicare, and other payer types.

3. Develop a Collaborative Crisis Metrics Portfolio to Assess System Performance

Community crisis systems need three components to use data to drive improvements in treatment: *ability* to measure, *use* of data, and *reporting* of the data. The participating CMHs and hospital systems showed considerable promise in their ability to produce numerous data points, but more work needs to be done to build a comprehensive and dynamic metrics portfolio, including increased measurement of client satisfaction and readmission rates to various types of facilities.

The collaborative and transparent spirit of crisis data sharing in the region is very promising, as other communities experience this is as a primary barrier to understanding the performance of the crisis system. Next steps should include designing a metrics portfolio based on shared community values and a method to measuring, choosing 4-5 measures to collect for the first 6-12 months, and sharing these outcomes on a consistent basis.

4. Develop Access Solutions that Minimize Reliance on First Responders

Crisis service solutions require locations where the services will be utilized optimally, either by the host CMH regions or the neighboring counties and regions. Based on transportation solutions of those offered in other states for non-emergency medical transport (NEMT),[19] explore solutions with current and prospective providers that rely on personnel like retired law enforcement, retired military, and peer supports & recovery coaches.

Lobby for the passing of House Bill 6452,[20] and in accordance with the proposed goal, establish a county mental health transportation panel. Also, monitor the results of the Emergency Triage, Treat, and Transfer (ET3)[21] pilot from the Center for Medicare and Medicaid Services (CMS), and advocate for EMS to get reimbursed by Medicaid for drop-offs to non-hospital behavioral health treatment facilities.

In addition to building new services, de-centralizing access to crisis care may also mean more home visits and telehealth visits from an optimized workforce of clinicians, peer support specialists, nurses, and paraprofessionals. If workforce capacity and utilization challenges limit the number of

[19] For information on Wisconsin's NEMT, visit https://www.dhs.wisconsin.gov/nemt/index.htm.
[20] http://www.legislature.mi.gov/documents/2019-2020/billintroduced/House/pdf/2020-HIB-6452.pdf
[21] https://innovation.cms.gov/innovation-models/et3

mobile crisis teams available, mobilize peer support specialists and trained paraprofessionals from the CSU or PUC campuses to engage in outreach, urgent care, or telehealth visits.

Impact of Crisis Service Development on Utilization

Of the four recommended new crisis services, only adult psychiatric inpatient currently exists in the region. Utilization projections of these services must be made cautiously with consideration of how one service can impact the utilization of other services.

For example, Crisis Stabilization Units, Psychiatric Urgent Care Centers, and Crisis Residential Units can each divert people from psychiatric hospitals. With the prospective addition of all three services to the 12-county region *plus* additional inpatient psychiatric beds, effects could include:

- Reduced referrals to crisis services outside of the region
- Limited utilization of new crisis services as clinicians utilize what they are familiar with
- Unused psychiatric inpatient beds as the new crisis service negate the need for the expanded beds

Future Crisis Service Considerations

Once the initial set of recommendations have been enacted, TBD Solutions recommends assessing the impact of new services on system cost, access, and outcomes. Assessment should be executed collaboratively with providers, administrators, and most importantly, the users of the crisis services and their families. Once the assessment is complete, explore the additional services identified below.

Figure 11. Future Behavioral Health Crisis Facility Considerations

Facility	Description	Issues / Considerations
EmPATH Unit 	Stands for "Emergency Psychiatric Assessment, Treatment & Healing" Unit. An extension of a hospital Emergency Department dedicated to serving patients experiencing a psychiatric emergency, with a focus on empathic care as opposed to coercive care	• Keeps services in the hospital instead of the community • Not a solution for youth—typically no visitors and easy to compromise milieu • Most do not use peer support specialists
Adolescent Detox 	Substance use treatment provided within a psychiatric hospital or in a freestanding facility for adolescents with a medical	• Assess the utilization to assure sustainability • Co-location may help with overhead costs through staff sharing
Youth Crisis Residential Unit 	A home-like alternative to psychiatric hospitalization serving as a diversion or a stepdown. In Michigan, youth CRUs operate under a Child Caring Institution (CCI) license.	• Assess access and utilization one year after opening youth inpatient beds before exploring additional crisis services

Facility	Description	Issues / Considerations
		• Assess utilization of neighboring CMHs • Difficult to support youth under current licensing guidelines (no physical intervention allowed) • Place in rural area
Partial Hospitalization Program 	An intensive day treatment program serving adults and youth in a behavioral health crisis. Often used as a stepdown from inpatient psychiatric hospitalization and located on the same campus.	• Community based care solution allows people to go home but decreases milieu supervision • Clients whose environment is contributing to their crisis/ stressors will not benefit as much by remaining at home
Peer Respite 	An early intervention for people experiencing emotional distress or a mental health crisis. Staffed entirely by peer support specialists and recovery coaches.	• Built on the premise that crisis is user-defined, so no rigorous admission criteria and minimal paperwork • Not funded by Medicaid-- $400k-$600k in annual operating costs for a 4-bed peer respite must come from alternative sources

Whether an EmPATH unit is opened in the region or not, the principles of empathic, non-coercive, and person-centered treatment should be instilled into those treating people at the Emergency Departments across the region. This is a critical first step in standardizing care for people in a behavioral health emergency presenting to the ED.

It cannot be understated that the behavioral health workforce must be able to absorb these additions to sustain multiple new programs. Creative solutions, such as co-location and policy reform,[22] must be pursued in order for these services to be build and sustained.

[22] In June 2021, MDHHS proposed changes to the Peer Support Specialist Certification eligibility that would allow more people to qualify for their certification training, potentially expanding the available peer workforce in Michigan. View the proposed changes here: https://www.michigan.gov/documents/mdhhs/2103-BHDDA-P_726874_7.pdf

Additional Considerations

While the assessment revealed many strengths of the northern Michigan crisis system and opportunities for improvement, additional work is necessary to solidify a dependably plan for sustainability. This includes finding the answers to critical operational questions, such as:

1. Who will be responsible for assessing the function and quality of the entire regional crisis system, not just Medicaid-funded services? And how will the system users and their families be involved?
2. How will your community define success in crisis services? For example, will a crisis program that operates at a loss be considered successful if it prevents iatrogenic harm, improves clinical outcomes, and saves money for other components of the health care system?
3. What clinical risk is your system willing to bear in exchange for the reward promised by bearing that risk? Issues such as medical clearance, psychiatric inpatient diversion, and use of non-traditional professional staff must all be considered and addressed. For example, when is it acceptable to employ a Nurse Practitioner where a Psychiatric was previously utilized, or a Bachelors-prepared case manager where a Master's-prepared clinician was previously utilized?

SUD Considerations

In 2017 it was found that of the 20.3 million adults in the U.S. diagnosed with a substance use disorder (SUD), 37.9% of individuals were also diagnosed with a mental illness. Of the 42.1 million adults with a mental illness, 18.2% were also diagnosed with an SUD.[23] Nationally, less than 10% of individuals with co-occurring diagnosis receive treatment for both their mental illness and substance use needs. In the North Country Community Mental Health catchment area, 46.9% of adults who engaged in a crisis screen were dually diagnosed, and 12.2% of adolescents had a dual diagnosis, according to self-report by North Country CMH.

Integrating SUD harm reduction principles within traditional mental health programming allows for better access to care, addressing all components of the crisis episode while reducing stigma.

Co-occurring enhanced crisis residential units (COECRU) allow crisis residential units in Michigan to be dually licensed as MI and SUD treatment facilities and Michigan Department of Health and Human Services (MDHHS) certified to deliver withdrawal management treatment. The addition of nursing 24-hours a day enhances the medical capabilities of formally offering this care to a group of individuals that are likely already receiving their mental health care in the crisis residential setting.

Peer Support Specialists and Recovery Coaches are often already a component of successful crisis residential programs. Recovery Coaches are individuals with lived experience of substance use recovery, with the ability to become certified through the state as a coach. Enhancing any

[23] Comorbidity: Substance Use and Other Mental Disorders | National Institute on Drug Abuse (NIDA)

treatment center with a Recovery Coach allows for the person served to connect with a professional in a way that is not typically encouraged with other disciplines.

Hiring Recovery Coaches and providing education on ASAM levels of care will enhance SUD competencies within psychiatric inpatient settings. Using recovery focused language to assist a client in navigating their treatment options empowers an individual to seek treatment, reducing stigma and promoting recovery. Knowledge of the ASAM levels of care and services available within the community allows for informed recommendations, avoiding further confusion and frustration for everyone involved. Psychiatric inpatient facilities can also be licensed to provide detox and withdrawal management services, increasing access further to those in need.

Finally, maintaining a supply of Naloxone (opioid antagonist available by prescription to reverse opioid overdose and saves lives by reversing respiratory depression) on site with simple training for staff allows for life-saving measures to be used as needed while continuing to destigmatize substance use disorders and recovery.[24]

Youth Service Considerations

Just as crisis services should be available to all payer types, they must also be available persons of all ages. The development of any youth services must come with unique considerations related to programming, family involvement, and milieu.

The addition of a child psychiatrist to the staffing model is necessary for any programs that wish to serve both adults and youth, as their specialized training is critical to assure high-quality access to care. A national shortage of child psychiatrists[25] may impact the region's ability to offer youth-specific services or at least require limited hours or telehealth interventions. Due to the shortage of providers, it is also recommended to be clear on the intended purpose of a child psychiatrist in settings such as crisis stabilization units or psychiatric urgent care and base schedules on projected, and later actual, utilization.

Layout and design considerations must also be informed by unique youth needs. If services are co-located and thoughtfully separated, the two age-specific services can be integrated with ease. However, for staff sharing roles, providing crisis stabilization unit or psychiatric urgent care in the same (not separated) areas can assist with shared staffing. If adult and adolescent services are provided in the same open space, consider layouts that are therapeutic to both age groups.

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[24] Green, T.C., Case, P., Fiske, H., Baird, J., Cabral, S., Burstein, D., Schwartz, V., Potter, N., Walley, A.Y., Bratberg, J. (February 2017). Perpetuating stigma or reducing risk? Perspectives from naloxone consumers and pharmacists on pharmacy-based naloxone in 2 states, *Journal of American Pharmacists Association*, 57(2) Supplement S19-S27.E4. doi: http://dx.doi.org/10.1016/j.japh.2017.01.013.

[25] Axelson, D. (April 2020). Beyond A Bigger Workforce: Addressing the Shortage of Child and Adolescent Psychiatrists. *Pediatrics Nationwide*, Spring/Summer 2020, p.32-33. Accessed via: http://pediatricsnationwide.org/wp-content/uploads/2021/02/W154476_Pediatrics-Nationwide-Spring_Summer-2020-Single-Pages.pdf

Conclusion

A community's ability to develop and maintain a high-functioning behavioral health crisis system is predicated on two major factors: collaborative, humble relationships between the public and private behavioral health providers and a shared vision for excellence. The region's health care providers and community mental health centers have demonstrated a desire to work together to achieve shared goals while keeping the persons in crisis at the center of the treatment experience. The quality of these working relationships can save years in the planning process.

As public and private dollars are infused into the region's behavioral health care system through donations, grants, and expanded Medicaid services, the impetus for accountable behavioral health crisis care will become more apparent. Providers and payers must work together to define an effective system while assuring that risk is managed in a way that still serves the client's best interests. This includes alternative funding models besides fee-for-service while incorporating progressive, value-based contracts that incentivize favorable treatment and outcomes.

More efforts must be made to bring users of the behavioral health crisis system and persons with lived experience with mental illness and/or substance use disorders to the planning table as valued stakeholders.

Lastly, additions to the crisis system will push existing providers to reimagine their identity in the crisis continuum. Just as medical urgent care centers challenged the status quo of Emergency Department treatment for nonemergent treatment decades ago, CSUs and Psychiatric Urgent Care Centers may require Emergency Departments and psychiatric hospitals to embrace a new vision for their place in the community's system of behavioral health care.

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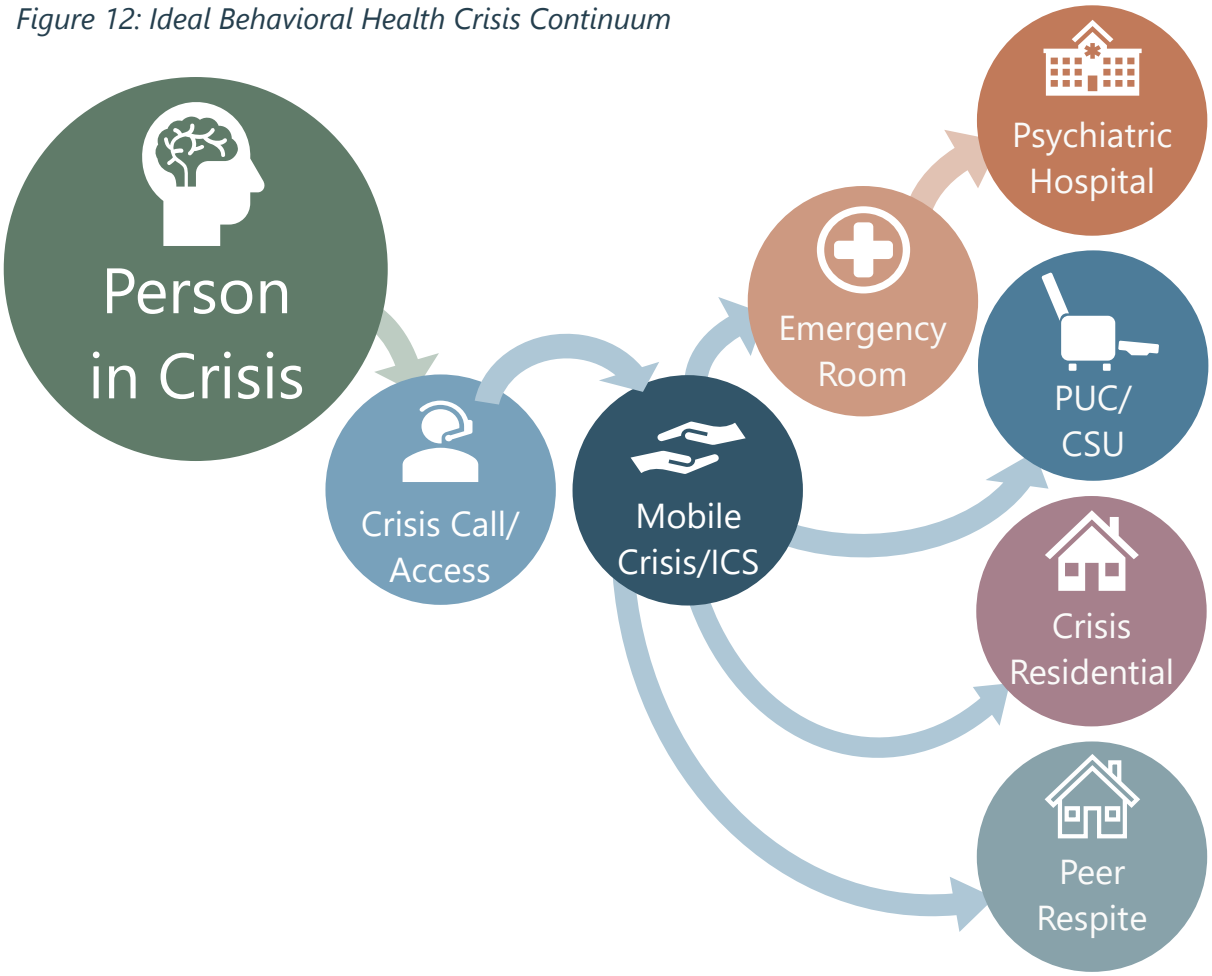
Appendix A: Crisis Continuum Terms

Figure 12: Ideal Behavioral Health Crisis Continuum



Crisis Call Center: Often referred to as a suicide prevention hotline, a crisis call center helps individuals experiencing a behavioral health emergency through emotional support and referrals to appropriate care. In some communities, crisis call centers can dispatch mobile crisis teams or access next-day scheduling of therapy appointments.

Mobile Crisis & Crisis Intervention Teams: Mobile crisis teams provide behavioral health crisis response in the community to people experiencing a behavioral health emergency. Consisting of at least one clinician and sometimes a police officer, peer support, or nurse, mobile crisis teams meet individuals where they are at—home, school, grocery store, workplace, etc.—with the goal of stabilizing the crisis and diverting people from higher levels of care.

Crisis Intervention Team (CIT) Officers have completed a 40-hour training in mental health education and intervention. These officers often accompany clinicians as part of a mobile crisis team or serve as the first responder to people experiencing a mental health emergency.

Psychiatric Urgent Care/23-hour Crisis Stabilization Unit: This level of care represents a facility resembling an emergency department for individuals in a psychiatric crisis. These units can be locked or unlocked depending on the acuity of the individuals served. Units located on the campus of a hospital are often called Psychiatric Emergency Departments, Psychiatric Emergency Services (PES), or EmPATH Units, while freestanding units or units co-located with other behavioral health services are called Psychiatric Urgent Care or Crisis Stabilization Units. Psychiatric Urgent Care Centers typically serve people 8-12 hours per day, 7 days per week, while CSUs operate 24/7.

Peer Respite: A short-term residential stabilization program operated or staffed by individuals with lived experience with mental illness. Most homes range in size from 2 to 6 beds, participation in programming is voluntary, and no medical staff are on-site, so individuals are responsible for their own medications. The first peer respite opened in 1995, and approximately 60 peer respite programs exist in the U.S.

Crisis Residential Programs: Referred to by many different names, this level of care represents a residential alternative to psychiatric hospitalization. Over 800 Crisis Residential Programs exist across the United States, serving as both a diversion and a stepdown from inpatient hospitalization. Average length of stay can vary from 3 days to 21 days.

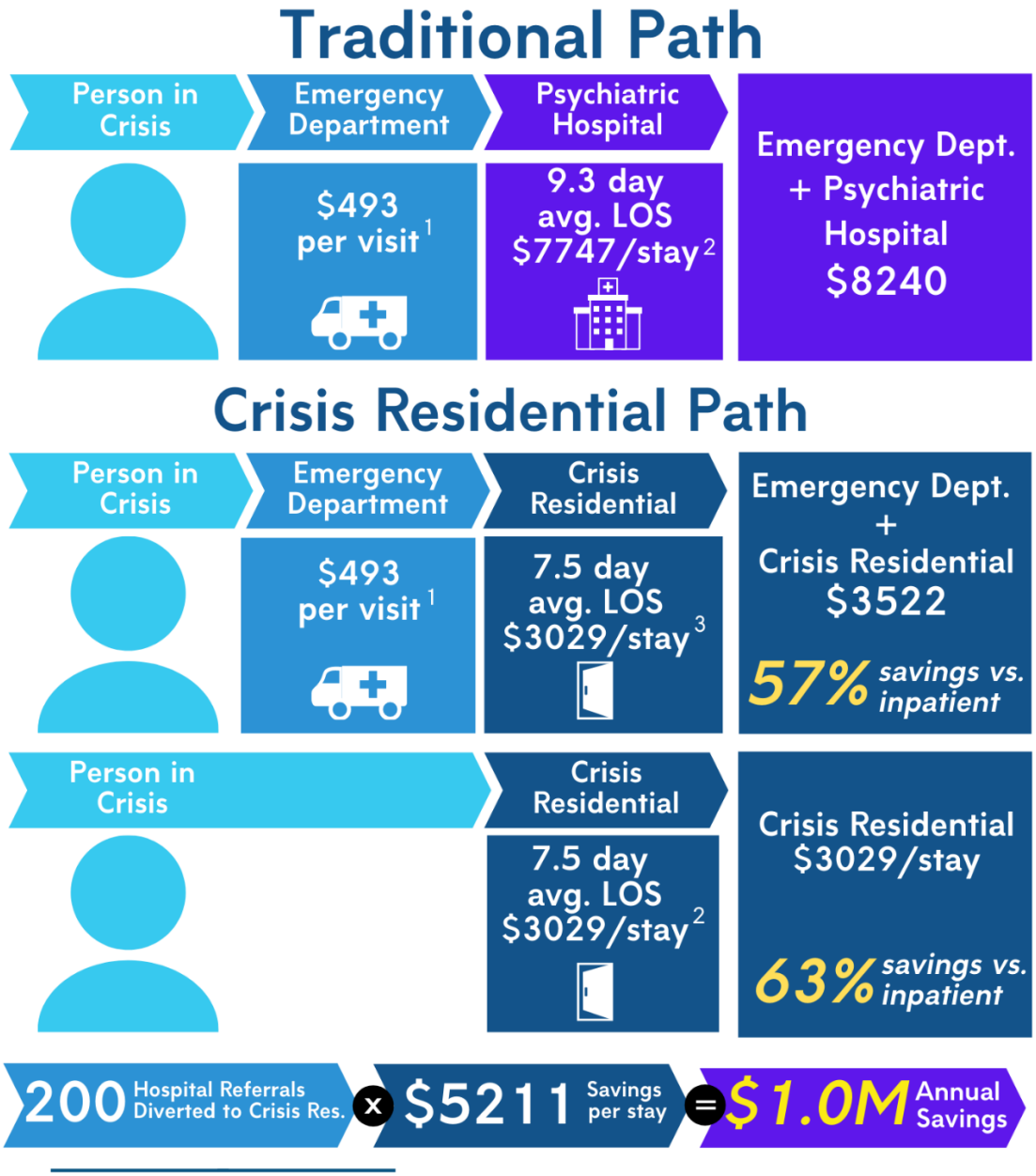
Emergency Department: Since the 1950's Emergency Departments have been the de facto point of access to hospitals for medical emergencies. As individuals experiencing psychiatric emergencies have often utilized the same resources as those designed for medical emergencies (such as 911 and ambulances), 7-10% of all ED visits are for psychiatric emergencies. Individuals needing medical clearance are often routed through the ED before being placed in psychiatric treatment. Mobile crisis teams often meet with individuals in the community to divert ED utilization, as studies show that people in psychiatric crisis that present to the ED have a much higher chance of being admitted to the psychiatric hospital than those accessing other parts of the crisis system. There are approximately 5,200 EDs in the U.S.

Psychiatric Hospital: Psychiatric hospitals represent the highest level of care in the crisis system. Private psychiatric hospitals provide treatment in short-term intervals (typically 3-14 days), while state psychiatric hospitals are for individuals with more severe and persistent mental illness, with lengths of stay ranging from weeks to several years. Both types of hospitals are restrictive and costly. Restrictions placed on facilities by the Institute for Mental Disorders (IMD) keep some private psychiatric hospitals under 16 beds. There are approximately 700 private psychiatric hospitals in the U.S., and approximately 200 state psychiatric hospitals.

Appendix B: Crisis Residential Cost Savings

This infographic delineates a pathway of considerable cost savings--$1 million annually—when using crisis residential units in partnership with other crisis services to divert individuals from both the Emergency Department and the psychiatric hospital. Figures are based on actual utilization and cost data from the northern Michigan region.

Figure 13: Behavioral Health Crisis Cost Savings by Service Pathway



[1] Based on median cost per visit from seven ED's reporting data from CY19 in northern Michigan.

[2] Based on FY2019 MDHHS 404 Data for North Country and Northern Lakes psychiatric inpatient utilization.

[3] Based on FY2019 MDHHS 404 Data for statewide crisis residential utilization.