Northwest (HHS Region 10)

MHTTC Mental Health Technology Transfer Center Network

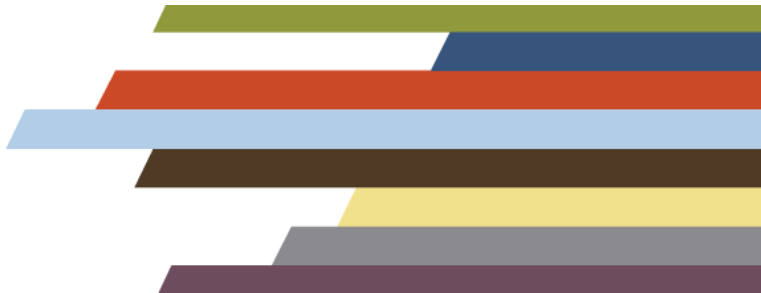
Funded by Substance Abuse and Mental Health Services Administration

Implementing New Crisis Services: *The View from the Ground Up*

Michael Flaum, MD
Iowa City, Iowa

April 15, 2020

SAMHSA
Substance Abuse and Mental Health Services Administration

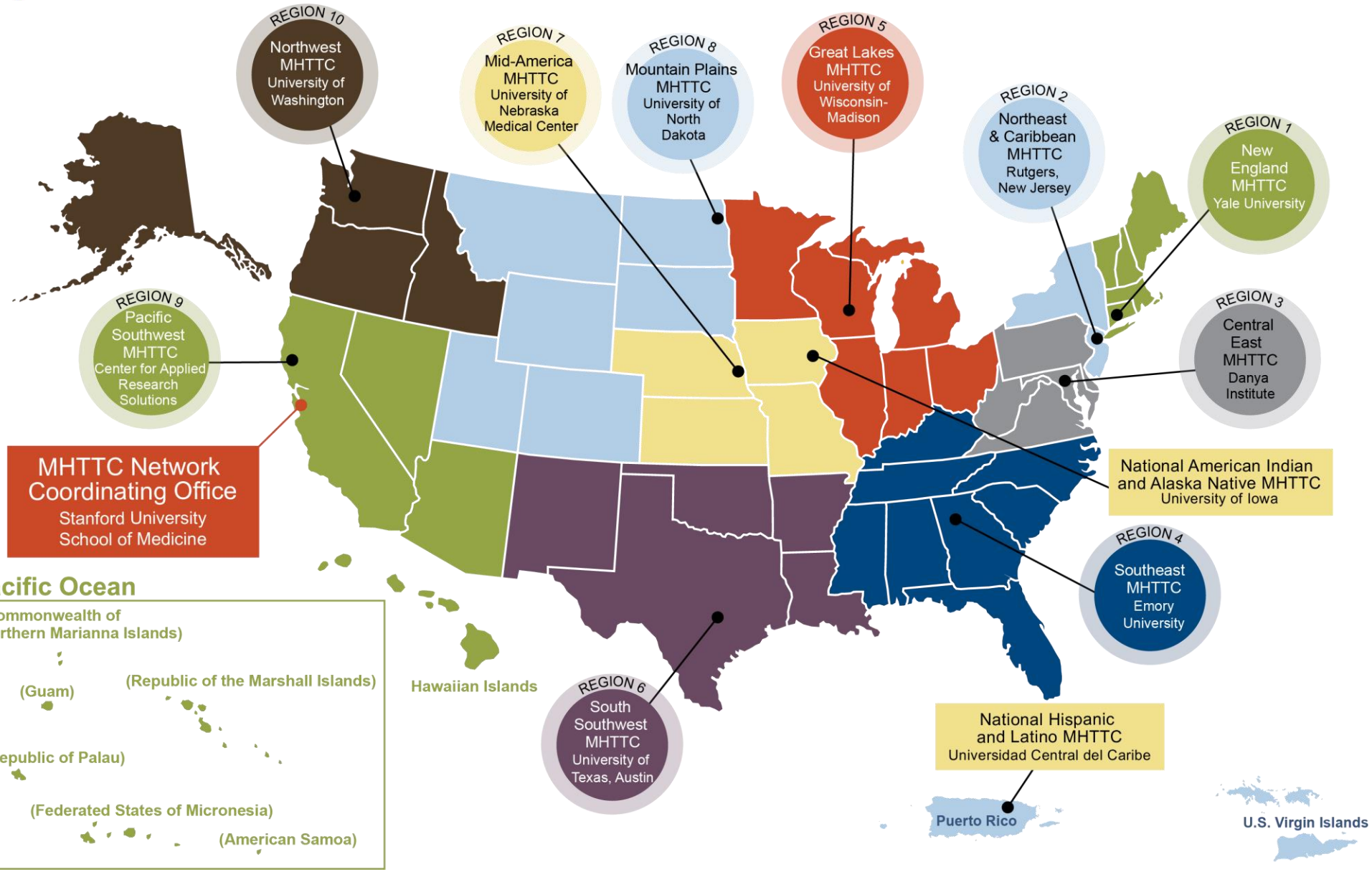


MHTTC

Mental Health Technology Transfer Center Network

Funded by Substance Abuse and Mental Health Services Administration

MHTTC Network



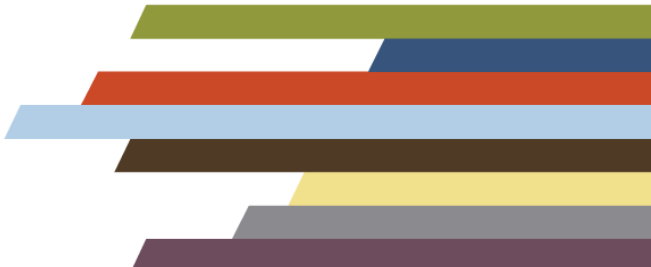
Northwest Mental Health Technology Transfer Center

Our Role

Provide training and technical assistance (TA) in evidence-based practices (EBP) to behavioral health and primary care providers, and school and social service staff whose work has the potential to improve behavioral health outcomes for individuals with or at risk of developing serious mental illness in SAMHSA's Region 10 (Alaska, Idaho, Oregon, and Washington).

Our Goals

- Heighten awareness, knowledge, and skills of the workforce addressing the needs of individuals with mental illness.
- Accelerate adoption and implementation of mental health-related EBPs across Region 10.
- Foster alliances among culturally diverse mental health providers, policy makers, family members, and clients.



The use of affirming language inspires hope and advances recovery.

LANGUAGE MATTERS.

Words have power.

PEOPLE FIRST.

The MHTTC uses affirming language to promote the promises of recovery by advancing evidence-based and culturally informed practices.

Today's Trainer

- **Michael Flaum, MD**
- Emeritus Professor of Psychiatry at the University of Iowa Carver College of Medicine
- the author or co-author of more than 100 publications (mostly reflecting his collaborative clinical research in schizophrenia in the 1990s)
- Assumed directorship of the Iowa Consortium for Mental Health in 1999; its mission is to bring the academic resources of Iowa's Universities to benefit the state's public mental health system
- President of the American Association for Community Psychiatry

Northwest (HHS Region 10)
MHTTC
Mental Health Technology Transfer Center Network
Funded by Substance Abuse and Mental Health Services Administration

Implementing New Crisis Services:
The View from the Ground Up

Michael Flaum, MD

Iowa City, Iowa

April 15, 2020

Introductions: A bit about me

UNIVERSITY OF IOWA HOSPITALS & CLINICS

GROUP for the ADVANCEMENT of PSYCHIATRY

AACP
American Association for Community Psychiatry

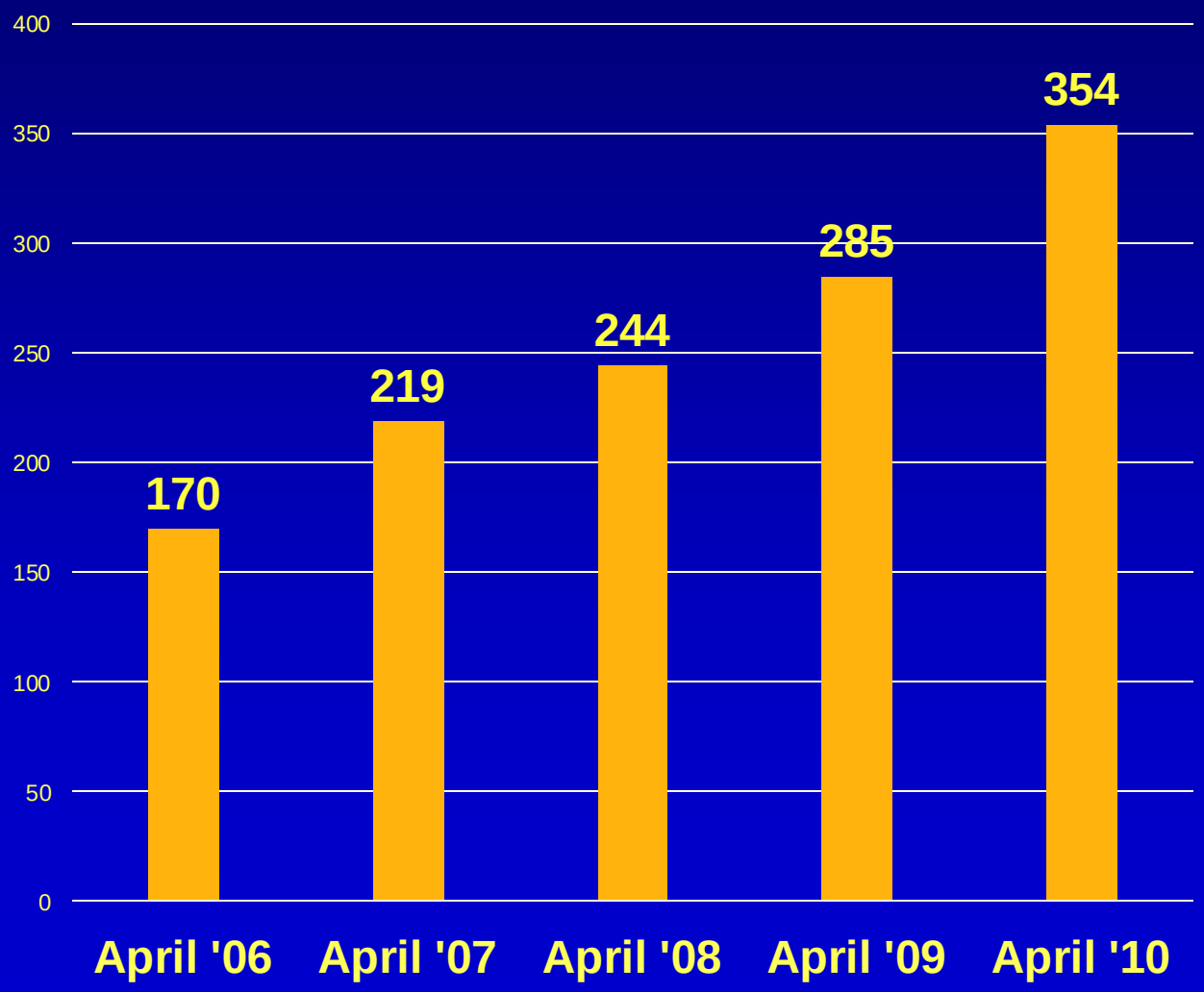
Introductions: A bit about you

4 poll questions

Overview

- Describe two types of BH crisis programs that our local community is in the process of rolling out:
  - Hospital-Based "Crisis Stabilization Unit" (Psych ER)
    - Opened October 2018
  - Community-based Behavioral Health Crisis/Access Center
    - Scheduled to open Fall 2020
- Background
  - Long process to get where we are
- Progress and Challenges

Origins: ER visits for Behavior Health at UIHC 2006-2010



- >100% increase over 5 yrs
  - Overall ER visits increased by ~30%
- Unclear why
  - Similar trends nationally
  - Multifactorial
- Long ER “boarding times”
- Perception of inpatient bed shortage

"Functional Shortage" of Inpatient Psych Beds

- We were admitting >50% of these people to inpatient psychiatry units → Inpatient psych beds often full
- Lots of consequences for both BH and all ER patients
  - Long ED boarding for BH patients
  - Transferring BH patients to distant hospitals
  - Increased "Left Without Being Seen" for general patients
- Perceived shortage of inpatient beds
  - State Task force in 2009 on need for more inpatient psych beds
  - "How many inpatient psych do we need in Iowa?"

MHI Task Force Meeting

Des Moines, IA

Nov 9, 2009

"The footbone's connected to the shinbone, and the shinbone's connected to the.."

Michael Flaum, MD

Director, Iowa Consortium for Mental Health

Division of Public and Community Psychiatry

University of Iowa Carver College of Medicine

Inflow and Outflow Issues

"Front Door"

Acute Hospital Bed

"Back Door"

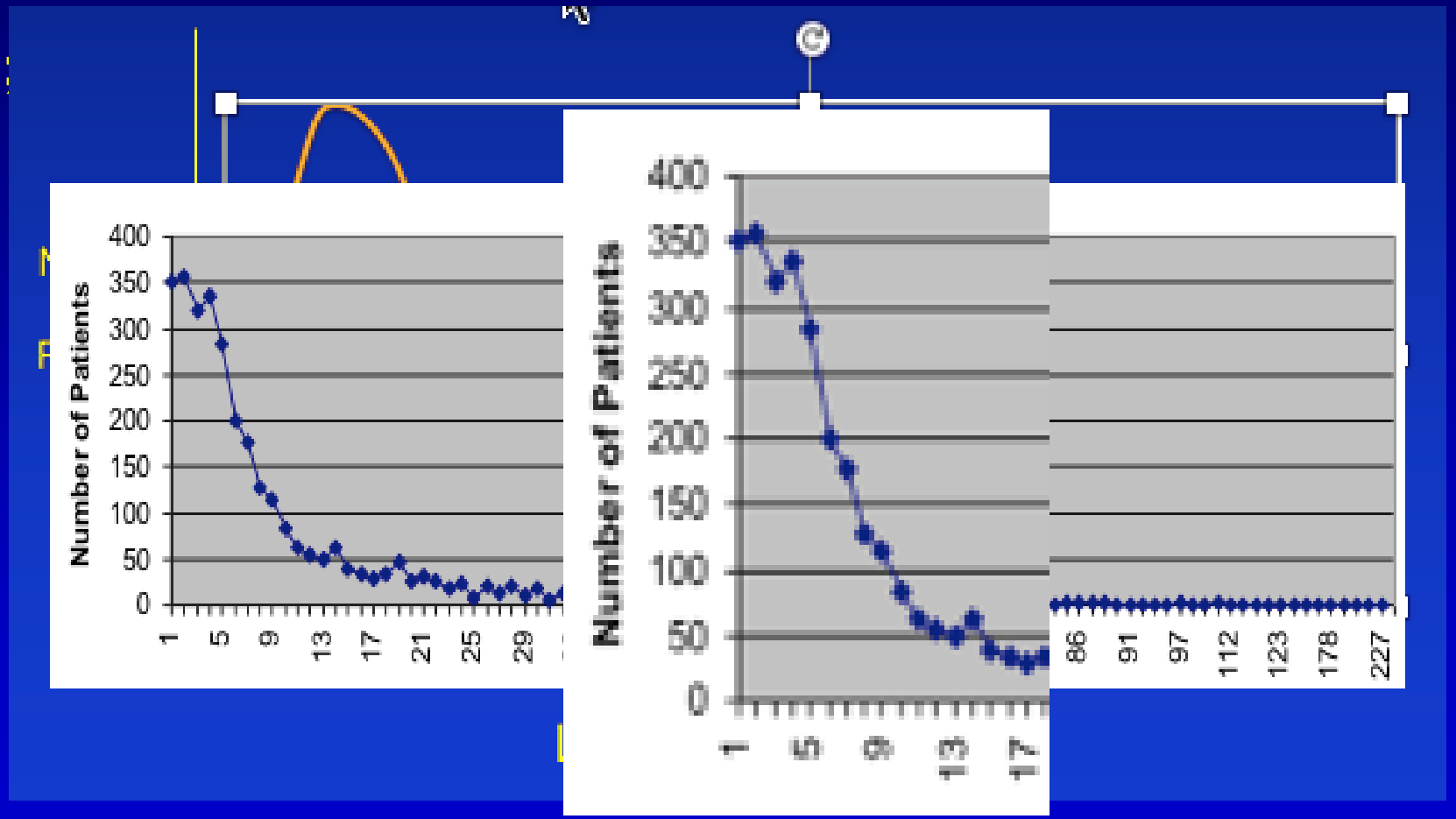
UIHC: Length of Stay (9/08 – 10/09)
All Psychiatric Inpatient Units N= 3,173

Average LOS = 10.4 days

Median LOS = 5 days

Modal LOS = 2 days, followed by 1 day

i.e., Could likely have been diverted



Implications

- Recognition of increased need for crisis services
  - “Front Door” - Diversion
- Increased need for “sub-acute services”
  - ”Back Door” – Step down
- The right service at the right time
  - Expand the array

Who were in our inpatient psych beds?

- People in crisis – not necessarily people with “serious mental illness”
  - People who have multiple, co-occurring, often chronic problems including:
    - Substance abuse
    - Criminal justice issues
    - Trauma (often complex and multigenerational)
    - Homelessness
    - Joblessness / underemployment

Hitting the wall

- When people “hit the wall”, they go to the ER
- From there, the majority wind up in acute inpatient units
  - …go to Midas, get a muffler
  - If a hammer is the only tool you have, you tend to see most problems as nails

The Crisis in Psychiatric Hospital Care: Changing the Model to Continuous, Integrative Behavioral

Alex Clarke, M.D., and Ira D. Glick, M.D.

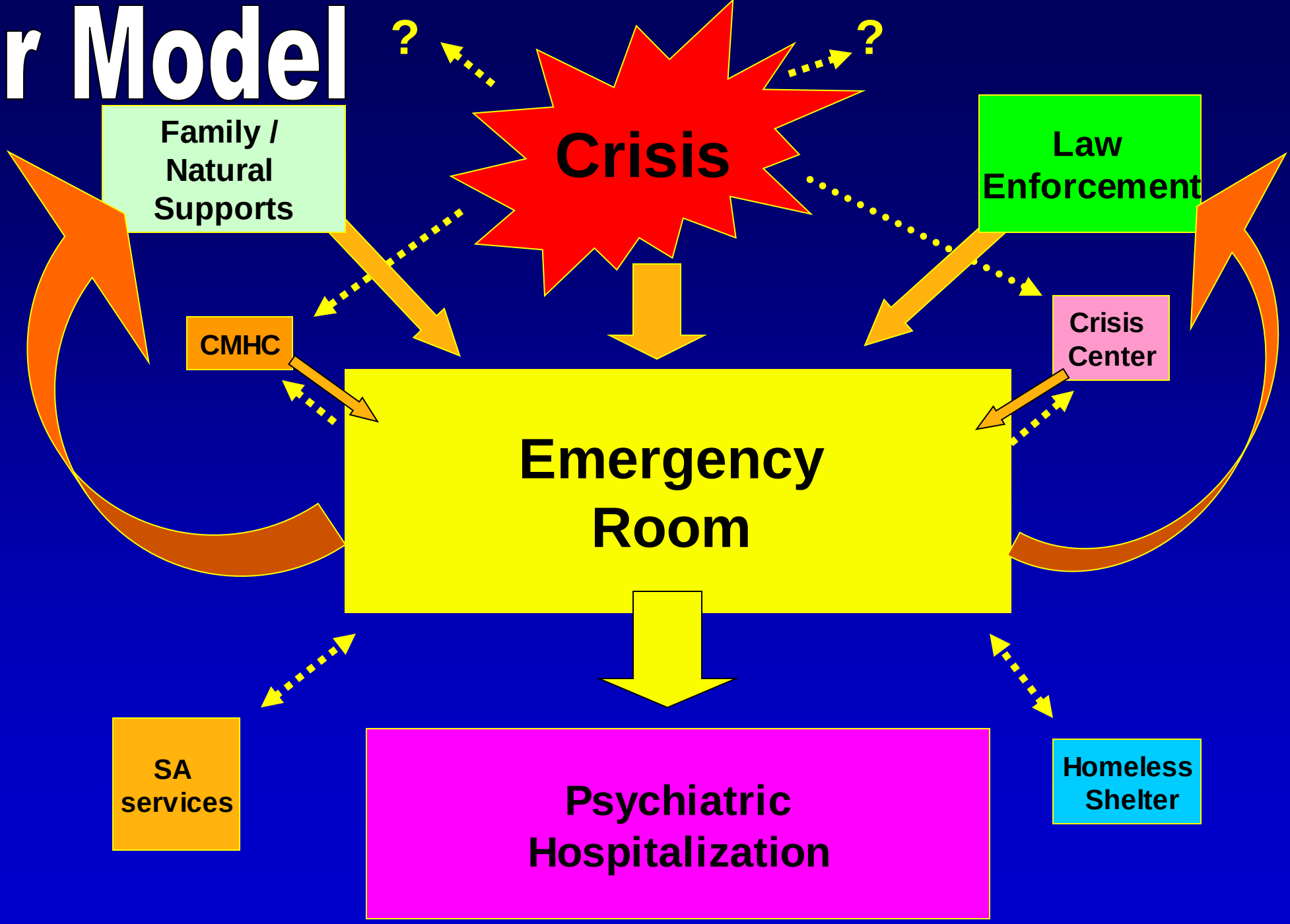
Inpatient psychiatric hospital services, as they currently exist, have little to no evidence base. Deficits in the current sys-

tied to a comprehensive, individualized treatment plan tailored to address a patient's lifetime course of illness. A structured approach can ultimately improve care quality and continuity by allowing for rigorous testing of each aspect of

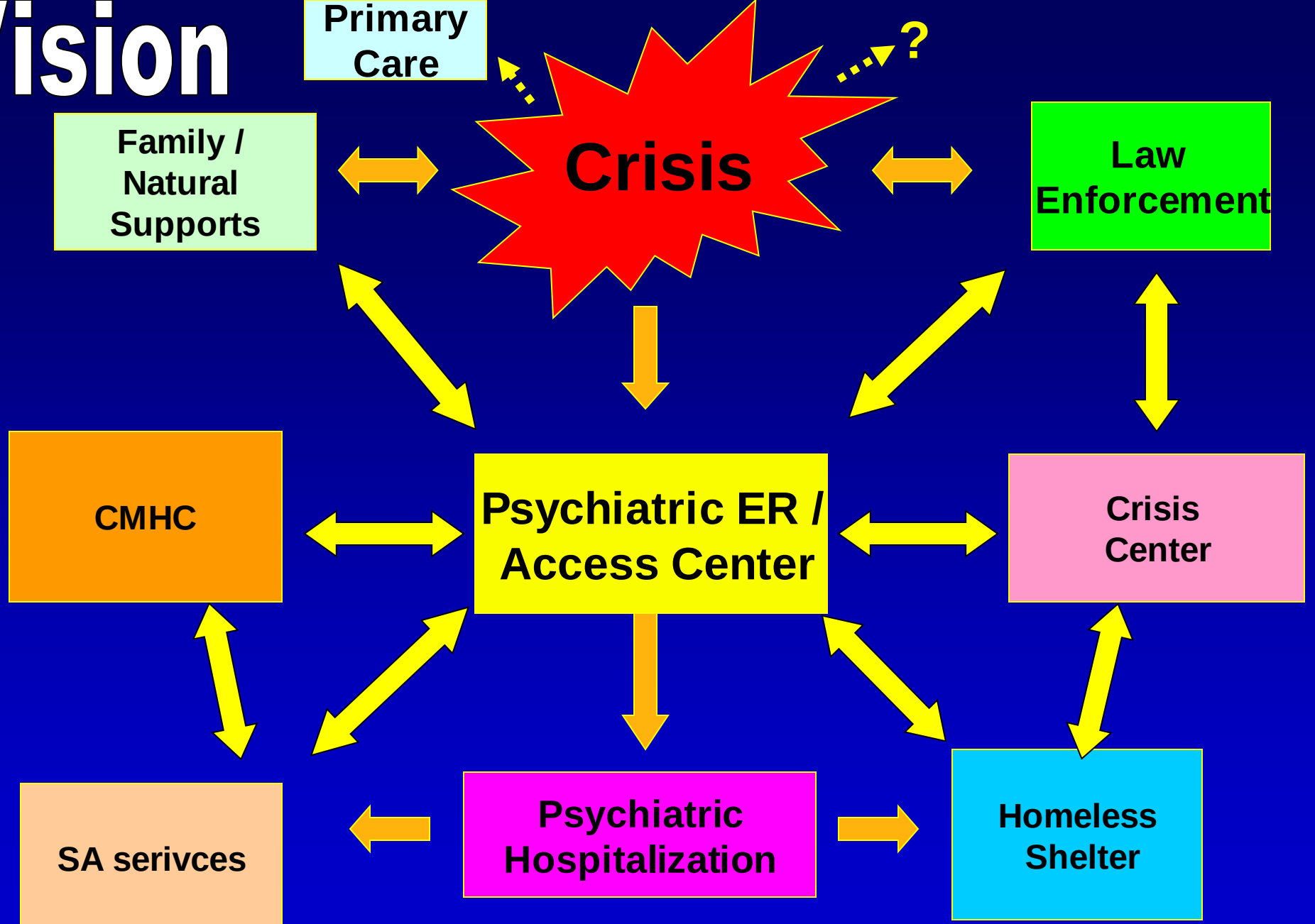
chiatric care, the authors describe a new model, called the S.E.T.U.P. approach.

Psychiatric Services 71:2, February 2020

Prior Model


?
?
Crisis
Family / Natural Supports
Law Enforcement
CMHC
Crisis Center
Emergency Room
SA services
Psychiatric Hospitalization
Homeless Shelter

Vision


Primary Care
?
Family / Natural Supports
Crisis
Law Enforcement
CMHC
Psychiatric ER / Access Center
Crisis Center
SA serivces
Psychiatric Hospitalization
Homeless Shelter

Strategy # 1:
Hospital-Based Psychiatric Emergency Treatment Center: Crisis Stabilization Unit at UIHC

Opened Oct 2018

(after almost a decade of planning)

University of Iowa Crisis Stabilization Unit challenges convention

Hillary O
, Iowa City Press-Citizen

Published 4:24 p.m. CT April 12, 2019

A view into the Crisis Stabilization Center. *(Photo: Special to the P*

A new unit specialized to serve acute psychiatric needs in Iowa City has reduced the wait time for patients seeking intensive care by 80 percent since it opened in October.

Officials from the University of Iowa Hospitals and Clinics also found that about 75 percent of patients who would typically be admitted to the hospital are instead able to go home after seeing a provider.

Known as the Crisis Stabilization Unit, the space has a capacity of up to 12 adult patients and was designed off a model known as emPATH units. The units help address the issue of patients with acute mental health issues waiting long hours in emergency departments across the country.

READ: Five weeks in, Crisis Stabilization Unit shows promise

A new unit specialized to serve acute psychiatric needs in Iowa City has reduced the wait time for patients seeking intensive care by 80 percent since it opened in October.

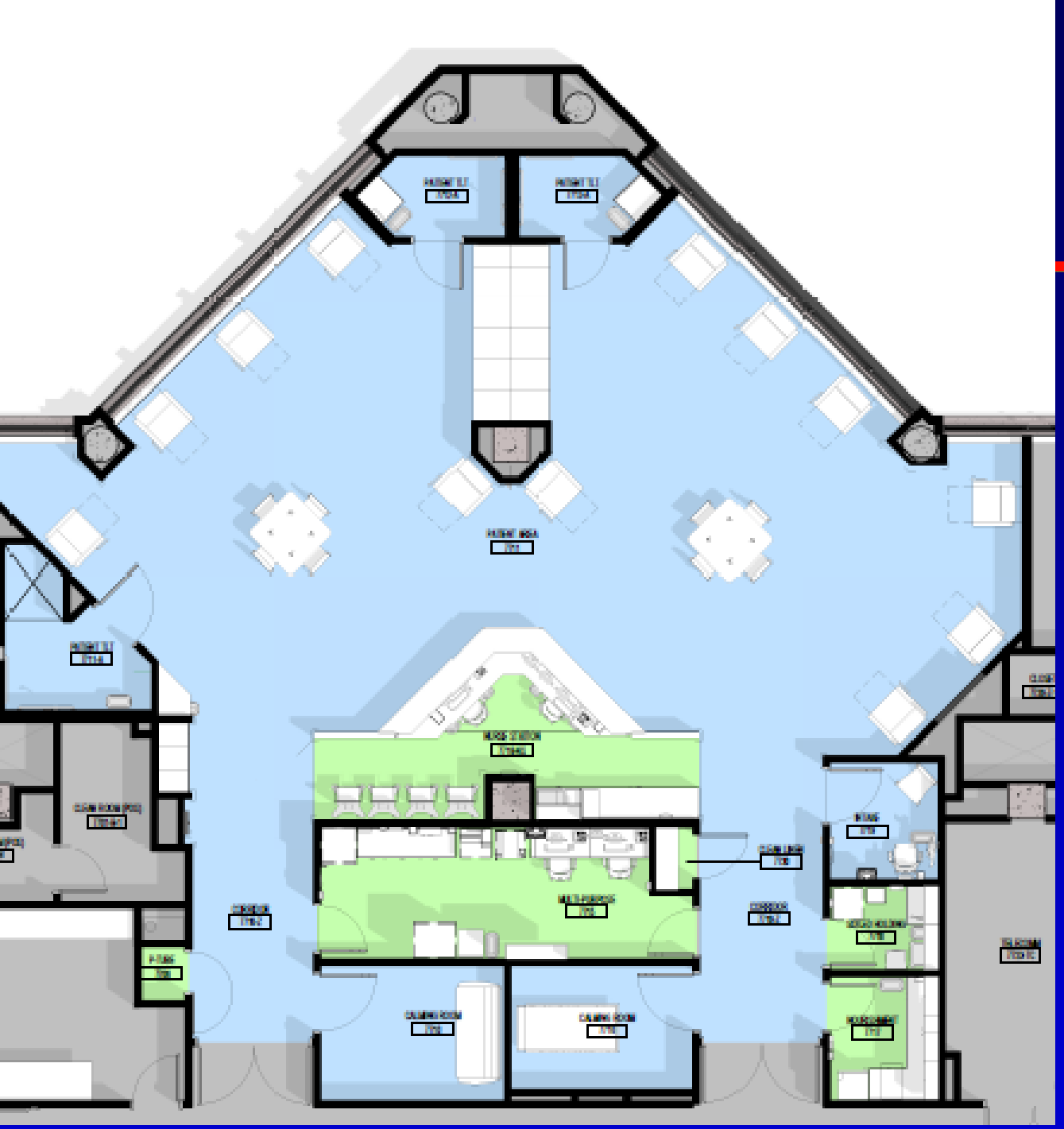
Officials from the University of Iowa Hospitals and Clinics also found that about 75 percent of patients who would typically be admitted to the hospital are instead able to

Sidekick Coffee & Books now open in U Heights

Sept. 27, 2019, 9:21 a.m.

Crisis Stabilization Unit at UIHC

Opened 10/15/2018



CSU Floorplan

- Used existing space
- Open plan
- 12 recliners
- Some open staff space
- Some private staff space
- Two “calming rooms”

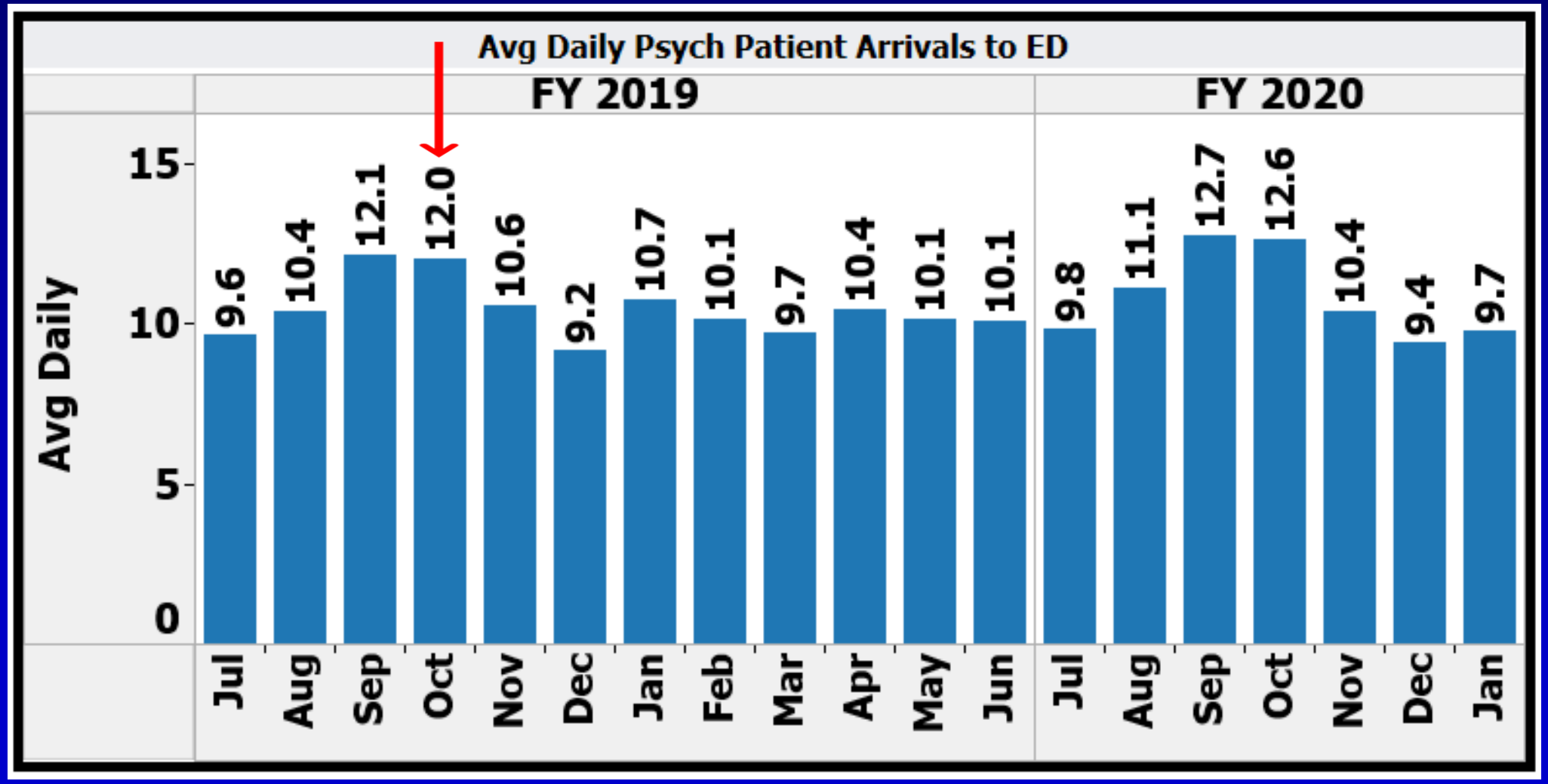
Staffing: High Staff to Patient Ratio (1:3)

24/7 Staff

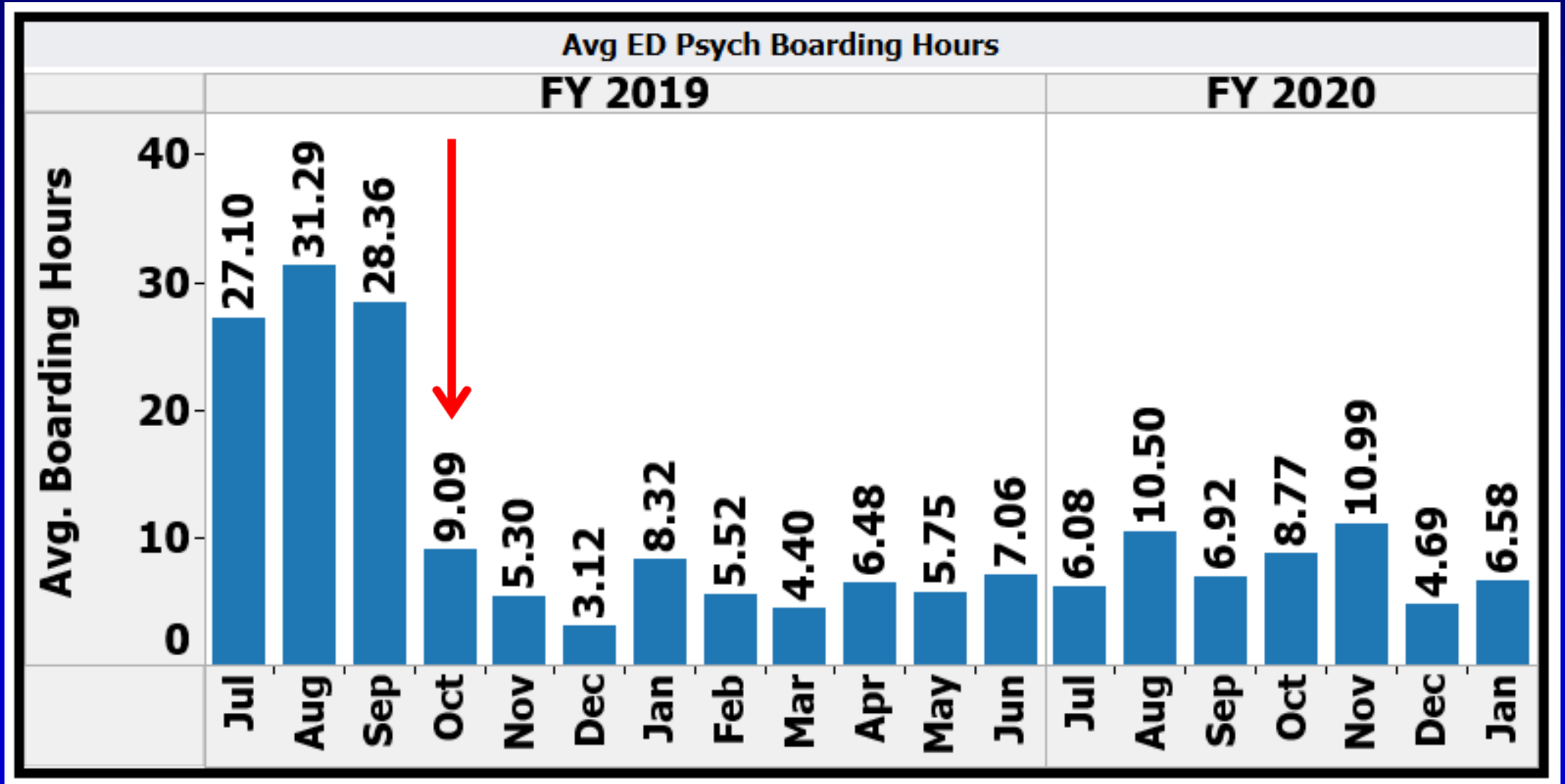
- 2 Registered Nurses
  - 1 Psychiatric Nursing Assistant
  - 1 Crisis Stabilization Officer (plain clothes)
  - 1 clerk

- 1-2 Psychiatric care providers (MD/NP/PA)
  - Weekdays 8am-8pm
  - Weekends 8am-1pm; 8pm - midnight
  - Residents cover other times
- LISW (2-3) Mon-Fri 8am-5pm
- Weekends (1) 8am – 1pm

N of patients coming to ED for MH/SA is stable



Marked Decrease in ED Boarding Time
29 hrs to ~7 hrs



Safety: Better than might be expected so far

- "Code Greens": 31
- Seclusion and restraint use: 0
- Assaults
  - 1 patient - patient (no injury)
  - 2 patient – staff – 1 minor injury
- Patent self injury; 2
  - superficial cutting, swallowing

Who is admitted to the CSU?

Inclusion Criteria

- Adults (>/= 18)
- Capacity: 12 beds
- Mental illness present
- Medically stable
- Dementia
- ID with comorbid MI
- Patients that are discharged from jail
- Patients on furlough from prison (furlough paperwork with them)

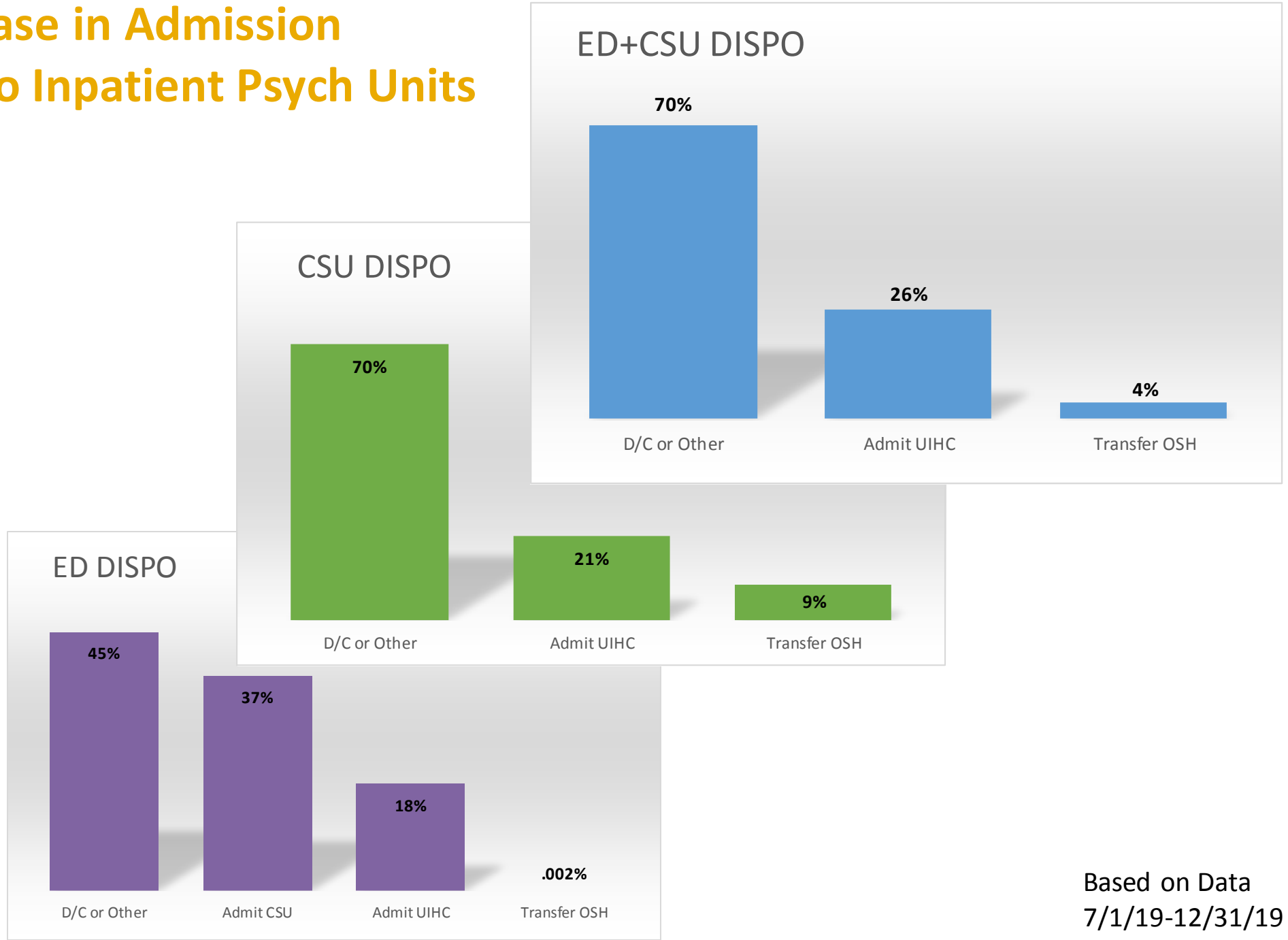
Exclusion Criteria

- Medically unstable
- Delirious
- Actively Violent
- Prisoners currently in state custody (i.e. wearing orange with guards)
- Acutely intoxicated (clinical)
- History of complicated withdrawal

Satisfaction

- Satisfaction surveys have been excellent
- Main complaint: lack of visitors

Decrease in Admission Rate to Inpatient Psych Units



Based on Data
7/1/19-12/31/19

Length of Stay- Longer than we hoped

Average 46 hours

CSU Median LOS by Discharge Month																
	2018			2019											2020	
	Oct	N..	Dec	Jan	Feb	Mar	Apr	M..	Jun	A..	Sep	Oct	Nov	Dec	Jan	Feb
Grand Total	33	40	36	46	48	48	48	46	44	50	56	48	49	48	53	49

Financials

- CSU loses money
- ED makes money
  - ~$150K/month or
  - $1,800,000 annually
- More than covering CSU losses

- How does the ED gain revenue?
  - Decrease in boarding time, LWBS rate, transfers
  - Increased med/surg hospitalizations

Hospital-based CSU: Looking back on 18 months in

- The ED loves us!
- Surprisingly few calamities so far
  - Patients appear generally calmer and more respectful than they were in ED
- Staff intensive
  - Can't have too much social work staff
  - Need the "right" people at all levels
  - Security staff / unit clerks
- Spirit is key
  - The only firm rule is that there are no firm rules

Hospital based CSU (cont.)

- We seem to be doing most of what we did in a week or so of inpatient, in ~ one day.
  - It feels like that at the end of a day sometimes
- Not a panacea-still need to connect people to services in a timely manner – which often are not available, i.e, “Back-door” issues
  - Started a follow-up walk-in clinic, staffed by CSU docs
- Still admitting ~30% of patents to acute inpatient

Changing the Culture:
Moving away from the hospital when possible

Strategy #2:

Development of Community-based Behavioral Health "Access Center"

Community-based "Access Center" Origins

- Long Process; ~ 12 years so far
- Formation of a local (county level) "system of care" group
  - Voluntary participation – monthly meetings; no clear agenda at first
  - UICH Psychiatry, Hospitals, Shelter, Substance Use, Police, Sheriffs, CMHC, SCL providers, peer and family advocacy groups
- All sharing a common population
  - FUSE project (Frequent User Service Enhancement)
- Many, many unfunded grants

Access Center
What and Why?

- Wanted a third option for people in behavioral health crisis in addition to:
  - Hospital Emergency Room
  - Jail
- Wanted one central campus to integrate services for the highest utilizers
  - (e.g., emergency, behavioral health, housing, criminal justice)
  - Diversion from higher cost, less effective services
- De-medicalize; decriminalize

Johnson County ACCESS Center
Key Elements (circa 2015)

INFLOW

- Law Enforcement Drop Off
- ER / Hospital
- Walk-in
- Mobile Crisis
- Community Agencies

OUTFLOW

- Longer SA Treatment
- ER / Psych Hospital
- Community-based behavioral health services
- Primary Care
- Jail / Criminal Justice
- Natural Supports
- Shelter House
- Transitional or other housing

Evaluation Capacity
Psych PA, BSN/MSW

Sobering Unit
~ 10 beds

Detox Unit
~ 10 beds

Medical
- Urgent care
- Primary Care

Case Management
(Short term)

23-46 hr. obs. beds
~ 8 beds

Crisis Stabilization Beds (~8) < 1 week

Security

Food

Low Barrier Shelter
(~ 40 “bed” capacity)

Projected Costs

- Projected initial capital costs: $5 - 10 M
- Projected annual operating budget: ~$4 M
- Projected revenue from traditional health care reimbursement: ~$2.5 M
- Projected additional revenue required: ~$1.5 M

Funding

- Current Project Capital Cost Estimate: $10M
- Current Capital Funding:

Source	Fiscal Year	Amount
Johnson County	2018	$1,400,000
Johnson County	2019	$600,000
MH/DS East Central Region (Johnson Co. Fund Balance)	2019	$877,141
University Heights	2019	$5,000
MH/DS East Center Region (Iowa Co. Fund Balance)	2019	$100,000
MH/DS East Central Region (Johnson Co. Fund Balance)	2020	**$2,050,000
Iowa City	2020	$2,500,000
Coralville	2020	$250,000
North Liberty	2020	$250,000
Tiffin	2020	$10,000
Hills	2020	$2,000
Coralville	2021	$250,000
North Liberty	2021	$250,000
Total		**$8,544,141**

Core Services: (and maximum capacity)

- **Crisis Observation (10)** Prompt evaluation and/or stabilization of individuals presenting with acute symptoms or distress, up to 23 hours.
- **Crisis Stabilization: (10)** Admitted to the Crisis Stabilization unit from the Crisis Observation unit when it is determined treatment needs will last beyond 24 hours (up to 5 days).
- **Sobering: (10)** offers an alternative to arrest of public intoxicants by providing a medically safe environment and offers direct access to additional treatment.
- **Detox:** (10) Medically-supervised place to withdraw from drugs or alcohol and stabilize before engaging in a treatment program

Services Continued

- Additional Services On Site:
  - **Mobile Crisis Outreach:** 24/7 program that covers Johnson and Iowa Counties. Dispatch mental health counselors to places where a mental health crisis is occurring.
  - **Low Barrier Winter Shelter:** December through March. Barriers to entry such as sobriety, participation in programs, and other requirements are removed. Open for shelter guests from 5:00 p.m. to 8:00 a.m.

Putting the pieces together

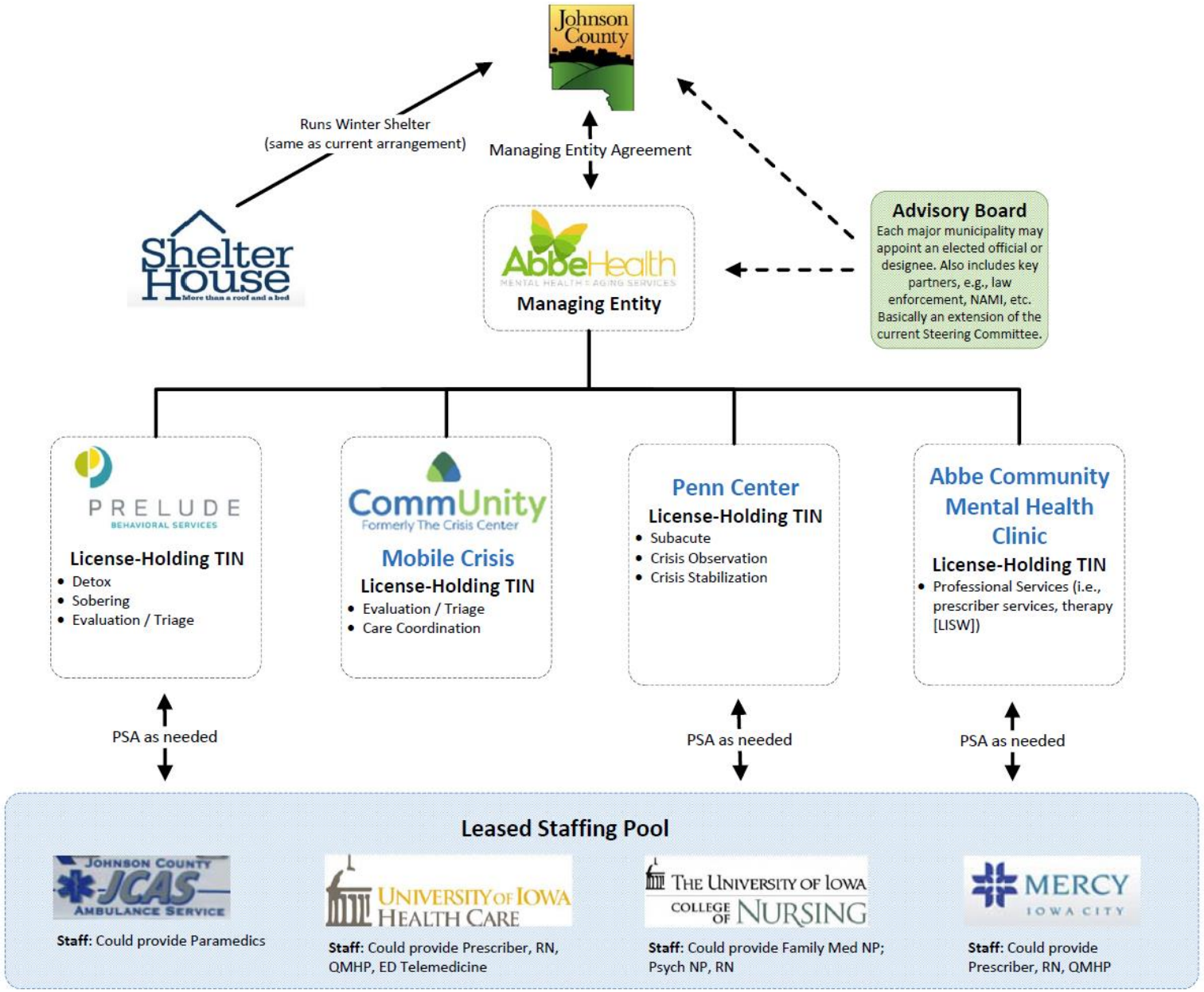
Floor Plan


EXTERIOR COURTYARD
SERVICE AREA
PARKING
SHED
FIRST RESPONDERS
SHELL
QUIET
COORDIN.
WORK ROOM
BREAK RM
DIRECTOR
DAYROOM
SLEEPING
INTERVIEW
MECH
SHELL
IT
STAFF RR
MEETING
EXAM
MOBILE CRISIS
SECURITY
SECRETARY
CUST
SERVING
LOCKERS
DAYROOM
NURSE
CRISIS OBS
MED. STOR
SHOWER
MTG.
SOBERING
LAUNDRY
INTAKE
HAZARDOUS WASTE BINS
SALLY PORT
LOW BARRIER SHELTER
STOR.
SHELL
STOR.
TRIAGE
RR
LOBBY
PATIENT QUIET
MEETING
VEST.
PATIO
URGENT CARE ENTRANCE
SALLY PORT ENTRANCE
SHELTER ENTRANCE
PARKING
PARKING
PARKING

Location


HIGHWAY 6 E
HOLLYWOOD BLVD
BOYRUM ST
STEVENS DR
S GILBERT ST
WATERFRONT DR
OLYMPIC CT
SOUTHGATE AVE

Organizational Structure



Site Image and Branding

GuideLink Center

IMMEDIATE ACCESS TO MENTAL HEALTH AND SUBSTANCE USE CARE

Recent Timeline

- September, 2019: Awarded construction contract
- January, 2020: Managing entity agreement signed
- June, 2020: Service provider agreements in place
- July – September 2020: Staff hired and training conducted
- October 2020: Grand opening

What are some of the things keeping me up at night about this?

Workforce

- Who is going to do this work?
- Need the right people, the right spirit, the right leadership
  - If we are are able to recruit – can we retain?
  - i.e., burnout issues
- Peer support is key
- Cross training

Financial stability

- We were able to cobble together capital costs
- But we are expected to be solvent based upon 3rd party funding
  - Crisis rates lower than hospital rates
- Already talking about cutting back proposed staff positions

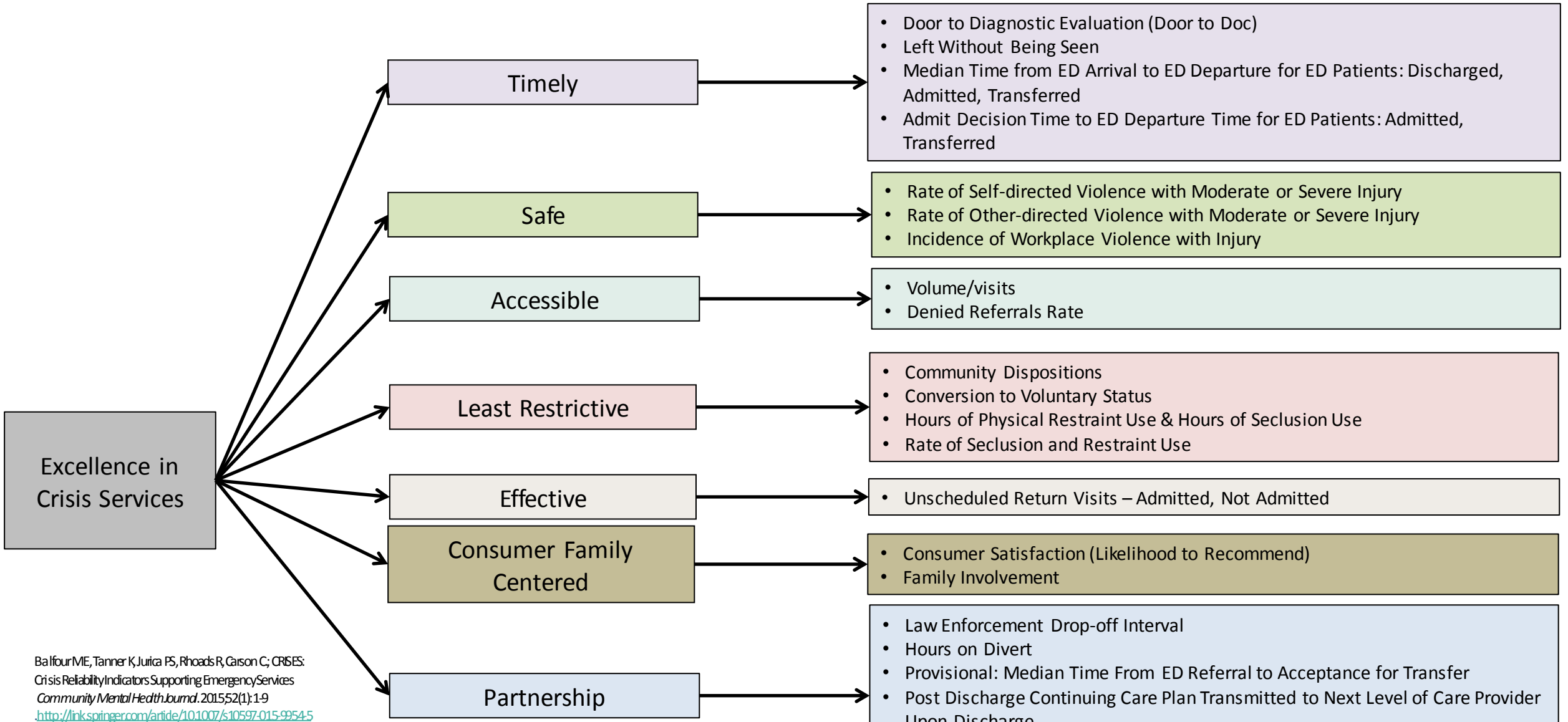
Balancing safety and risk

- If we don’t take “difficult” people, we won’t be viable
  - Police won’t waste there time with us
- But… In our hospital-based ED or crisis stabilization unit, if I call a “code green”, I have 15 people including security there almost immediately
- No seclusion and restraint capacity
- Police called for unmanageable agitation/violence
- Still working out policies regarding involuntary patients

Documentation

- This is a collaboration between four different organizations
  - Triage and initial evaluation: Mobile Crisis
  - Crisis Observation (23 hr beds): CMHC
  - Sobering and Detox: SA treatment providers
  - Crisis Stabilization: Residential treatment provider
- Each uses a different HER
  - Now in the process of figuring out how to integrate these
  - Avoid redundancies
  - Track key performance metrics and outcomes

Outcome metrics for facility-based crisis services



Balfour ME, Tanner K, Jurica PS, Rhoads R, Carson C; CRISES: Crisis Reliability Indicators Supporting Emergency Services *Community Mental Health Journal*. 2015;52(1):1-9 .http://link.springer.com/article/10.1007/s10597-015-9954-5

connections HEALTH SOLUTIONS

Other risks

- Starting up too quickly – rather than phasing in
- One early clinical calamity
  - Like high profile accident of self-driving cars
- Regulatory fiasco, e.g., Is someone going to decide we are an IMD?
- Premature attempts to replication our model in other parts of the state
  - before we've figured out what we are doing
  - without adequate attention to what is unique to our community
  - state has already mandated development of six Access Centers statewide

Hopes and dreams

- Culture shift:
  - No more voicemails on MH offices that say “go to your nearest emergency room”
  - BH Crisis is less medicalized
- Meaningful diversion from criminal justice systems for MH and SA problems
  - No more bond issues for bigger jail
- Use inpatient psychiatric units more appropriately
  - At high risk for imminently dangerous behaviors
  - Medically fragile or complex

Hopes and Dreams (Cont.)

- Access Center becomes a magnet for multi-disciplinary training
  - People from different areas that share a social justice service mission
- Thoughtful, slow replication and adaptation
  - Core components vs. local needs
- Community empowerment:
  - Each community goes through a process
  - National standards of best practice, locally adapted as appropriate

Thank You!
Questions, Comments?

- Feel free to contact me at: michael-flaum@uiowa.edu

Access Center construction site 4/10/20

Northwest (HHS Region 10)
MHTTC Mental Health Technology Transfer Center Network
Funded by Substance Abuse and Mental Health Services Administration

Q&A

SAMHSA
Substance Abuse and Mental Health Services Administration

Get in Touch!

Visit us online:
www.mhttcnetwork.org/northwest


Follow us on social media:
@NorthwestMHTTC

Email us:
northwest@mhttcnetwork.org

Find out about:

- Upcoming trainings
- New online trainings
- Resources and Research Updates

Thank You!

Northwest (HHS Region 10)

MHTTC Mental Health Technology Transfer Center Network

Funded by Substance Abuse and Mental Health Services Administration