ANALYSIS OF ADULT BED CAPACITY

For Milwaukee County Behavioral Health System

Prepared by:

Human Services Research Institute
Technical Assistance Collaborative
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Contents

Section 1
Introduction

The Milwaukee County mental health system has seen several changes over the past few years. A number of stakeholders have recommended a move to a more recovery-oriented and community-focused system of care, one that is more consistent with SAMHSA's vision of "A Good and Modern Addictions and Mental Health System"[1]; this was also the recommendation of a 2010 report produced by the Human Services Research Institute, Technical Assistance Collaborative and the Public Policy Forum (HSRI/TAC/PPF). A decreased reliance on crisis response and inpatient care is another important goal of such a reform.

Between 2011 and 2013, the Milwaukee County Behavioral Health Division (BHD) experienced a 14% reduction in the utilization of Psychiatric Crisis Services (PCS) and a 30% decrease in admissions to its adult inpatient units at the Mental Health Complex. As a result, BHD has begun downsizing its bed capacity with the stated intent of increasing its community-based services. While there is general support for reducing the county's reliance on a hospital-based system, particularly among service recipients themselves, total inpatient admissions across Milwaukee County hospitals remain consistent and questions have arisen about the adult psychiatric inpatient capacity in the county.

This report provides an analysis of adult psychiatric inpatient bed capacity in Milwaukee County. It looks at aspects of the behavioral health system based on available data (inpatient, outpatient, crisis services, case management, evidence-based practices, etc.), recommends adult psychiatric inpatient bed capacity for Milwaukee County based on current utilization, and suggests considerations for determining future inpatient bed need.

These recommendations should be considered in the context of two key points pertaining to mental health system reconfiguration:

- The diverse array of service providers in a given area complicates efforts to view the mental health care delivery network as a "system." In most areas, including Milwaukee, provider organizations represent a variety of organizational and ownership types with differing incentives, constraints, and approaches to strategic planning.
- There is no standard, universally applicable formula for "right-sizing" the components of a behavioral health system. Because of the variability and complexity of the organizational characteristics across mental health systems and the nature of the relationships among their constituent parts, the appropriate allocation of resources differs from one system to another. This is particularly true with respect to the

[1] SAMHSA. (2011). Description of a Good and Modern Addictions and Mental Health Service System. Rockville, MD: Substance Abuse and Mental Health Services Administration.

relationship between inpatient and community-based services, where it is generally assumed that the latter may be substituted for the former to some degree at equal or better quality and cost. Precisely how this balance is to be achieved is difficult to determine, primarily due to the variability in the types, capacity, and effectiveness of available outpatient services. Additionally, population characteristics (including the prevalence of mental disorders, availability or lack of social supports, and barriers of race and poverty, among others) vary by locale.

Given all these variables, comparative data from other systems have limited utility and must be carefully weighed when applied to any particular case, such as that of Milwaukee County. National trends in the supply and utilization of inpatient services and the factors that influence them, as discussed below, may provide a general gauge, but these must be considered in the context of Milwaukee County's particular circumstances. A recent report by the National Association of State Mental Health Program Directors indicated that there is no standard formula to apply when seeking to project or estimate the number of inpatient beds that should exist in a system, and that the unique circumstances within the system should be taken into account when determining what the capacity should be.[2]

Assuming continued progress in the shift to a more community-based system of care, we anticipate that demand for adult beds could further decrease over time. In the final section of this report, we present four configuration scenarios for the County to consider as the system evolves over the next several years to meet the inpatient needs of county residents in the most cost-efficient manner.

[2] National Association of State Mental Health Program Directors Medical Directors Council. *The Vital Role of State Psychiatric Hospitals*. July 2014. http://www.nasmhpd.org/Publications/The%20Vital%20Role%20of%20State%20Psychiatric%20HospitalsTechnical%20Report_July_2014.pdf

Section 2
National Context

Public behavioral health systems play a vital role in ensuring access to a continuum of treatment and services designed to meet a range of needs. Safety net services, such as psychiatric inpatient treatment and crisis intervention, are at one end of this continuum. Inpatient bed need and utilization, as well as interaction with other systems such as criminal justice and homeless service systems, are often contingent on the availability of quality community-based services, including an organized psychiatric crisis response and diversion system. Generally, stronger and more accessible community-based services and a well developed psychiatric emergency response system will result in decreased reliance on costly inpatient care and overutilization of police intervention.[3]

Changes to Milwaukee's behavioral health system can be viewed in the context of what is occurring nationally and in other Wisconsin counties. Understanding Milwaukee County inpatient and systemic issues through the national lens helps to provide context for the current and future planning of inpatient capacity within the county. While there is no valid or reliable standard formula to determine the number of beds needed in a particular system, national context provides a general gauge. National trends in inpatient utilization and capacity have been driven by a variety of issues, including the strength of community services infrastructure, the U.S. Supreme Court's 1999 *Olmstead* decision, reimbursement and payer issues, and the Affordable Care Act (ACA).

Systems across the country are generally evolving in the context of three national trends: 1) decreases in overall psychiatric inpatient capacity; 2) a shift in the provision of inpatient treatment from public hospitals to general acute care hospitals; and 3) growth of community-based alternatives.

2.1 Decreasing Psychiatric Inpatient Capacity and the Provision of Psychiatric Inpatient Treatment

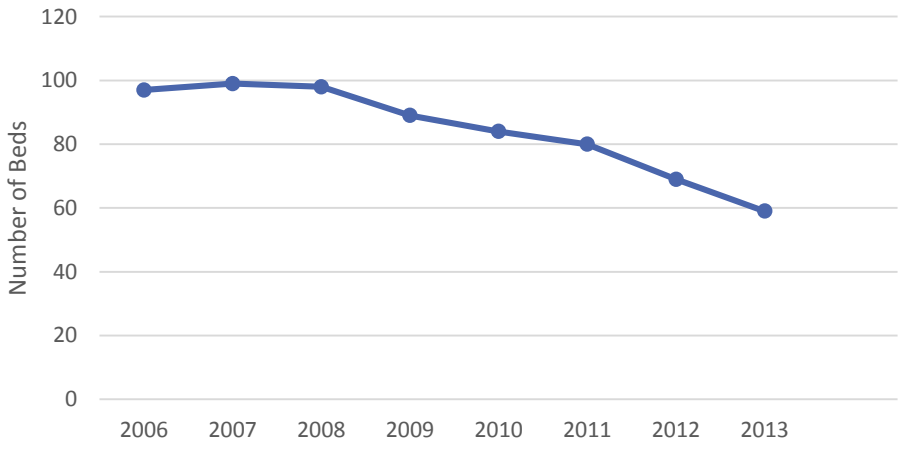
From a high point in the 1950s, the number of psychiatric beds in the United States has declined steadily over the years. Notably, the number of non-psychiatric, acute care beds has also dropped. In 1999, the nationwide average for hospital beds (all types) was 3.0 beds per 1,000 people; in 2009, the average was 2.6 per 1,000—a 13.3% drop. Additionally, lengths of stay are dropping as well.[4]

[3] President's New Freedom Commission on Mental Health (2003) Achieving the promise: Transforming mental health care in America. Rockville, MD.
[4] National Center for Health Statistics (2011). Health, United States, 2010: With Special Feature on Death and Dying. Hyattsville, MD.

In 1950, there were more than 500,000 state/county public psychiatric hospital beds in the United States. As of 2010, there were fewer than 44,000.[5] In 1955, there were 340 public psychiatric beds per 100,000 people; by 2005, this figure was down to 17 beds per 100,000, a 95% reduction.[6] At the same time, the number of psychiatric beds in general hospitals increased from virtually none in the late 1940s to more than 54,000 by 1998 (note: this number has been reduced to about 40,000 today). In the late 1940s, over 94% of psychiatric inpatient care was provided in public mental health facilities; by 1998, almost 50% of such care was provided in general hospital psychiatric units. In addition, the number of private psychiatric facility beds increased from fewer than 15,000 in 1970 to almost 45,000 in 1990,[7] but dropped to 28,000 in 2004.[8]

For the most part, BHD's experience has mirrored these national trends. In 2013, BHD had an average daily census of 59 individuals in its adult inpatient units at the Mental Health Complex,[9] a decline of roughly 39% since 2006, as shown in Figure 1, below.[10] However, among the counties with a county-operated psychiatric hospital, Milwaukee County is the only county in Wisconsin to have experienced an increase in private inpatient beds between 2010 and 2013.[11]

Figure 1. Adult Inpatient Beds at the Milwaukee Mental Health Complex: 2006-2013



[5] Treatment Advocacy Center (2012). *No Room at the Inn: Trends and Consequences of Closing Public Psychiatric Hospitals 2005 – 2010*. July 2012.
[6] Treatment Advocacy Center (Unpublished). *The Shortage of Public Hospital Beds for Mentally Ill Persons*.
[7] Liptzin, B., Gottlieb, G., & Summergrad, P. (2007). The future of psychiatric services in general hospitals. *American Journal of Psychiatry, 164*(10), 1468-1472.
[8] National Center for Health Statistics (2011). Health, United States, 2010: With Special Feature on Death and Dying. Hyattsville, MD. 2011.
[9] Source: BHD
[10] BHD is operating approximately 60 beds as of this report.
[11] Source: Wisconsin Hospital Association

2.2 Reasons for Decreasing Capacity

Nationally, several factors are driving the reductions in psychiatric beds. These include advances in care and treatment, policy direction, budget constraints, and decreasing utilization. Much of the shift was driven by humane and clinical concerns surrounding quality of care and the negative effects of long-term institutionalization on people with mental illness.[12] The Community Mental Health Centers Act of 1963 was expected to be a remedy for long-term institutionalization. The Act was amended over the years to add essential services needed to supplant the multiple functions of institutional care. The introduction of psychotropic medications also allowed many previously hospitalized individuals to function effectively in the community.

In addition, the enactment in 1980 of the Civil Rights of Institutionalized Persons Act (CRIPA) enabled legal challenges to involuntary long-term institutionalization and to inadequate care in large public facilities. CRIPA predated the Americans with Disabilities Act (see below), and resulted in the closure or downsizing of many state hospitals. Finally, the enactment of Medicaid in 1965, with its parallel allowance for inpatient psychiatric care in general hospitals and prohibition of reimbursement for institutions for Mental Disease (IMDs – see below), fostered the development of general hospital alternatives to state-operated inpatient care. The end result of all these complementary forces was to significantly reduce the need and demand for publicly operated inpatient psychiatric care.

2.3 Influence of Olmstead

The 1999 U.S. Supreme Court decision in ***Olmstead v. L.C***. affirmed the right of people with disabilities under Title II of the Americans with Disabilities Act (ADA) to live in the least restrictive setting appropriate to their abilities. Through proactive Olmstead planning, litigation, and/or settlement agreements, states have identified large numbers of individuals who no longer require inpatient or institutional care and are strengthening community capacity to serve people in more integrated settings. A recent federal Department of Justice policy brief lays out the characteristics of such settings:

> Integrated settings are located in mainstream society; offer access to community activities and opportunities at times, frequencies, and with persons of an individual's choosing; afford individuals choice in their daily life activities; and, provide individuals with disabilities the opportunity to interact with non-disabled persons to the fullest extent possible. Evidence-based practices that provide scattered site housing with supportive services are examples of integrated settings. By contrast, segregated settings often have qualities of an institutional nature. Segregated settings include, but are not

[12] Abt Associates and Technical Assistance Collaborative. Massachusetts General Court Mental Health Advisory Committee Report Phase I and Phase II. June 2014

> limited to: (1) congregate settings populated exclusively or primarily with individuals with disabilities; (2) congregate settings characterized by regimentation in daily activities, lack of privacy or autonomy, policies limiting visitors, or limits on individuals' ability to engage freely in community activities and to manage their own activities of daily living; or (3) settings that provide for daytime activities primarily with other individuals with disabilities.[13]

Under *Olmstead*, states have an affirmative obligation to assure that people with disabilities who choose to live in integrated community settings have maximum opportunities to do so consistent with the resources available to the state. The fact that a given state might have resources committed to institutional settings and thereby claim to have insufficient resources to provide community alternatives has been found in many courts to be no defense.

There are 12 states with active *Olmstead*-related mental health settlement agreements or investigations: Arizona, Connecticut, Delaware, Georgia, Illinois, Kentucky, Mississippi, New Hampshire, New Jersey, New York, North Carolina, and Oregon. However, it is important to note that just because a state does not have active Olmstead litigation does not mean that the state is compliant with *Olmstead* and Title II of the ADA.

2.4 Institutions for Mental Disease (IMD) Exclusion and Other Reimbursement Issues

2.4.1 IMD Exclusion

Section 1905(a) of the Social Security Act "prohibits the federal government from reimbursing states under the Medicaid program for services rendered to a Medicaid beneficiary who is a patient in an institution for mental disease (IMD)."[14] In accordance with this statutory prohibition, CMS has defined an IMD as: "a hospital, nursing facility, or other institution that is primarily engaged in providing diagnosis, treatment or care for people with mental disease."[15]

The IMD exclusion does not apply to people 65 and older or to individuals under age 21. Nor does it apply to facilities with 16 or fewer beds. Typically, the IMD exclusion applies to public mental health inpatient facilities, such as Milwaukee County's Mental Health Complex, and to private inpatient psychiatric treatment facilities, such as Rogers Memorial Hospital and Aurora Psychiatric Hospital.

The underlying motivation of the federal government for the development of the IMD rule was to dissuade states from relying on institutions as the primary care settings. The premise was that state and county governments would not unnecessarily utilize institutional settings that

[13] U.S. Department of Justice Civil Rights Division (2011). *Statement of the Department of Justice on Enforcement of the Integration Mandate of Title II of the Americans with Disabilities Act and Olmstead v. L.C.* Washington, DC: U.S. Department of Justice, June 22, 2011.

[14] *Social Security Act §1905*, 42 U.S.C. §1396(d). See also 42 *CFR* §435.1010.

[15] SAMHSA (2013). *Medicaid Handbook: Interface with Behavioral Health Services*, HHS Publication No. SMA-13-4773. Rockville, MD: Substance Abuse and Mental Health Services Administration, August 2013.

are costly and segregated if they were responsible for total costs. Despite the IMD rule, many IMDs still exist today, but, as stated earlier, the trend is to serve individuals in more integrated settings that are also able share costs through federal government programs like Medicaid.

All states in the United States, including Wisconsin, have made serious efforts to shift the cost of mental health services away from state (and county) general fund appropriations and toward Medicaid services that receive at least 50% federal reimbursement. In parallel with quality of care and clinical effectiveness motivations, the IMD exclusion serves as one of the primary reasons for states to shift care away from large publicly operated inpatient facilities. As a practical matter, a decision to operate facility-based care and treatment in an IMD, or a facility that is likely to be treated as an IMD by CMS, is a decision to forego federal reimbursements for services provided to Medicaid-eligible individuals.

2.4.2 Other Reimbursement Issues

In public psychiatric hospitals, underutilization is often cited as a reason for budget reductions and decreases in bed capacity. In fact, during the most recent recession between 2009 and 2012, at least 3,222 state psychiatric hospital beds across the country were eliminated.[16] In light of decreasing utilization, public funders are more likely to reduce underutilized beds than to reduce community-based alternatives such as outpatient treatment, residential programs, and crisis response services.

The availability of reimbursement from Medicaid, Medicaid managed care, and commercial insurance also places a strain on the ability and willingness of private or general acute care hospitals to operate psychiatric inpatient beds. Within states there is a constant tension to reduce the number of publicly operated beds in favor of beds operated by local acute care hospitals and diversion to community-based services, but payer issues for non-public beds often create an unstable bed environment. Sometimes the issue may not be the bed capacity of a certain system but rather who is admitted. With fiscal pressure to keep beds full in private or general acute care hospitals, beds are sometimes occupied by individuals with good payer sources (e.g., private insurance) rather than those who may be a greater priority from a system need perspective.

Consequently, building some flexibility or fluidity into systems to ensure that hospitals are being adequately reimbursed may be a necessity to ensure sufficient psychiatric inpatient capacity at private or general acute care hospitals. This is particularly the case if there is an expectation that more complex patients previously treated in the public hospitals will be pushed to the local acute care system for treatment, possibly longer stays, and discharge to community-based services.

[16] NASMHPD Research Institute. The Impact of the State Fiscal Crisis on State Mental Health Systems: Winter 2011-2012. http://media.wix.com/ugd/186708_c2fd199b2a9f4d04818b889b93c3a884.pdf

2.5 The Affordable Care Act

The 2010 enactment of the Affordable Care Act (ACA) signaled significant changes in health care delivery and financing throughout the United States. Nationally, the ACA has the potential to extend coverage to many of the 47 million nonelderly uninsured people nationwide.

Approximately 566,000 uninsured Wisconsinites could benefit from the insurance mandate and the BadgerCare Reform waiver.[17] In Wisconsin, 70% of uninsured nonelderly people are eligible for financial assistance to gain coverage through either Medicaid or the Marketplaces established by the federal government. Roughly 36% of these individuals are eligible for Medicaid or CHIP (i.e., "Children's Medicaid") as of 2014. An additional third (34%) of those currently uninsured in the state are eligible for premium tax credits to help them purchase coverage in the Marketplace. The remaining 30% of uninsured individuals either have incomes that are too high for subsidized insurance or are ineligible due to their undocumented status.

Wisconsin's BadgerCare Program extends benefits for single adults at 100% of the Federal Poverty Level (FPL).[18] The result is expanded coverage for approximately 99,000 childless adults who are expected to enroll in 2014 with another 5,000 going to the federally subsidized Marketplace. The BadgerCare Reform waiver also expands benefits through the BadgerCare Plus Standard Plan, which is more comprehensive than the previous BadgerCare Plus Core Plan.

It is anticipated that this coverage expansion, stronger mental health parity provisions, standards for Essential Health Benefits and benefit plan changes, and new program features such as the revised 1915(i) Home and Community-Based Services state plan option will provide greater opportunities for individuals to receive behavioral health services. The result of these changes is likely additional individuals seeking treatment and services within the system. However, it is unclear if the level of reimbursement and availability of qualified professionals will be sufficient to meet the potential increase in demand.

2.6 Shift in Provision of Inpatient Treatment

Today, in most states, acute psychiatric inpatient care is provided in general hospitals or private hospitals rather than publicly operated beds, though this does vary by state. The remaining public beds, provided in state or county hospitals and with some variation among states, generally provide forensic services (evaluation, restoration to competency, and long-term commitment for people found not guilty by reason of insanity) and longer term treatment for people not ready for discharge to the community after a short-term acute hospitalization.

There are few remaining county-operated psychiatric hospitals in the country, largely due to trends toward serving individuals in more cost effective, integrated settings. The county-operated psychiatric hospitals that remain are likely to be classified as IMDs and therefore

[17] Kaiser Family Foundation. *Wisconsin's BadgerCare Program and the ACA*. February 2014.
[18] Ibid

ineligible for Medicaid reimbursement, resulting in an increased financial burden on state or county general funds. In states where county hospitals do exist, they have helped fill the need for intermediate-length stays and short-term acute care stays for individuals with more complex needs or who are indigent. For example, other counties in Wisconsin (e.g., Brown County) and in other states (e.g., San Diego) operate county facilities that serve an acute care function with typically short stays. Brown County also performs a regional function and contracts with other counties to meet acute care needs. In other states, like New Jersey, county hospitals have more of an intermediate level of care role; responsibility for shorter lengths of stay is delegated to acute care hospitals and longer lengths of stay to the state hospitals.

2.7 Growth of Community-Based Alternatives

Many public behavioral health systems across the country have successfully shifted emphasis toward community-based services. With advances in psychiatry and the development of evidence-based practices—including Assertive Community Treatment (ACT), Permanent Supportive Housing (PSH), and peer-delivered supports—community-based services are producing positive outcomes, reducing the need for inpatient care, and reducing costs. These services are known to be effective with individuals with a broad range of needs; ACT, in particular, is known to be successful with individuals who are the hardest to serve and keep out of the hospital. While inpatient care in an IMD could cost over $300,000 per year, evidence-based alternatives like ACT and PSH cost less than $20,000 per year and can be offset by federal financial participation through Medicaid.[19,20]

However, critics in many communities argue that community-based services have not been made sufficiently available or accessible to those who could benefit from them. Reasons for this include limited funding for community services in general as compared with inpatient funding, and eligibility criteria that do not target those with the most complex conditions who are most likely to be hospitalized. The challenge in developing a "good and modern" behavioral health system is achieving the proper balance of a strong, accessible, quality community-based system capable of meeting the diverse needs of individuals and an adequate number of inpatient beds and crisis intervention capacity to ensure a sufficient safety net. Until the science and technology of treating mental illness advances further, some individuals will require an inpatient level of care; however, a strong, accessible community-based system can reduce the frequency and duration of inpatient stays.

Interestingly, some studies have shown that decreases in publicly funded/operated acute and long-term inpatient beds have not resulted in increased negative outcomes such as suicide,

[19] The FY2012 daily rate for Adult Treatment Services in Oregon State Hospital is $945/day, or $345,000/year. http://www.oregon.gov/oha/amh/osh/Pages/cost-of-care.aspx

[20] FY2013 New York State Budget for ACT. https://www.omh.ny.gov/omhweb/spguidelines/case_mngmt_models/2013_Upstate_Downstate_Models.pdf

incarceration, police interactions, decreased level of functioning, or homelessness.[21]
In addition, demand for acute inpatient care appears to be "elastic,"[22] in that capacity was fully used when it was available, but other options were found to meet patients' basic needs when it was no longer available. This suggests that when a person no longer meets inpatient criteria, system partners can maximize the availability of community resources to meet the individual's needs. The ability of community-based providers to piecemeal a package of services together does not justify underfunding the availability of programs known to produce positive outcomes. Rather, it does suggest that the combination of community provider expertise and resource availability can create alternatives to the need for inpatient care for many individuals.

[21] Shumway, Martha, et al. *Impact of Capacity Reductions in Acute Public-Sector Inpatient Psychiatric Services*. Psychiatric Services. February 2012 Vol. 63 No. 2
[22] Ibid

Section 3
Methodology

3.1. Data Sources

Data for this report were obtained by request from the Milwaukee County Behavioral Health Division (BHD) and private hospitals and health systems within the county. Monthly inpatient admissions data were requested from 2011 through the first quarter of 2014, by age and payer source, as well as average length of stay. Annual summaries from 2011-2013 were requested for average 30-day readmission rates, number of admissions by discharge setting, and the percentage of annual admissions with co-occurring medical problems, substance abuse, mental illness and intellectual disability/developmental disability, and legal involvement.

Crisis Services data requested from BHD included: monthly Psychiatric Crisis Services (PCS) admissions by acuity level; number of admissions resulting in admit to BHD and local inpatient facilities; number of discharges to detox and law enforcement; and number of admissions returned/referred back to the community. Monthly admissions to BHD's Access Clinic and Crisis Stabilization services were also requested.

In-person and telephone interviews were conducted with key stakeholders, including senior staff from BHD, the project advisory committee (consisting of officials from BHD and private health systems), and representatives from private hospitals to further understand factors influencing inpatient capacity and bed need in Milwaukee County.

The Wisconsin Hospital Association (WHA) supplied prevalence data and bed numbers across counties, and these were used to compare Milwaukee County to other Wisconsin counties.

3.2. Bed Utilization and Projections

A utilization-based formula was used to determine the estimated number of beds needed in the system now, based on how the system is currently functioning. This approach relies more on the actual experience within the system, and inherently captures factors like prevalence of mental illness in the county. Bed utilization for 2013 was estimated from inpatient admissions and median length of stay, using the following formula:

[Adult admissions * Median Length of stay]/365 = Number of beds utilized

This formula allowed us to translate the number of bed days consumed in the psychiatric inpatient units in the system into an approximate number of beds utilized in the system on an average day. Adult admissions was defined as age 18+. The number of beds utilized was calculated first by hospital then summed across hospitals to estimate the total bed utilization in Milwaukee County.

The total bed utilization across psychiatric inpatient units was considered the base utilization of beds in the county. However, the hospitals made the case that a unit often intentionally operates under capacity to accommodate unique circumstances—patient acuity, gender issues or medical co-morbidity for example—that affect unit milieu. Essentially, the hospitals balance unit census to ensure safety and therapeutic milieu. Based on feedback from the hospitals, we applied an occupancy rate range of 80% to 90% on units to project the maximum bed capacity needed to accommodate utilization and unit environmental circumstances.[23]

Because there are many variables that will influence future bed need, several of which are not quantifiable at this time, we applied a similar utilization-based approach based on admission trends to determine how many beds could be decreased over time in the County, with an underlying assumption that more accessible community-based services will decrease admissions and lengths of stay.

We used the following formula to determine future bed need:

[# of Decreased Adult Admissions * Median Length of Stay]/365 = Number of fewer beds utilized

While this methodology provides data-driven guidance for future decisions on psychiatric bed capacity, we recommend that a trend analysis should occur for any decrease in admissions and that it is sustained for a period of at least six months before any decreases in bed capacity occur across the county.

[23] Based on the American Hospital Association annual survey data, the bed occupancy rate across all hospitals in the U.S. in 2009 was 67.8%. However, hospital officials in Milwaukee County indicated that the 80% to 90% occupancy range was more consistent with where they are operating, and necessary to ensure financial viability.

Section 4
Stakeholder Perspectives

In addition to the meetings with BHD and the project advisory committee, HSRI/TAC/PPF spoke with several stakeholders to inform our understanding of issues that affect the level of need for inpatient beds in Milwaukee County. Stakeholder interviews, particularly with service recipients, help provide additional context that data does not always capture. The following are some of the meetings and telephone interviews conducted for this purpose:

- Mental Health Task Force members; February 11, 2014
- Milwaukee Health Care Partnership Behavioral Health Provider workgroup; April 16, 2014
- A diverse group of stakeholders, including consumers, family members, providers, the public defender's office, and Disability Rights Wisconsin; April 17, 2014
- Area hospital systems; various dates
- Wisconsin Hospital Association

The facilitated discussions covered a range of system topics, including but not limited to:

- Access to inpatient beds and bed capacity
- Access to community services and community services capacity
- The interrelation between community services, crisis systems, and inpatient utilization
- Psychiatric emergency response services, policy involvement and emergency detentions
- Funding issues and priorities
- Consumer/patient needs (housing, co-occurring disorders treatment, medical care, etc.)

All stakeholders brought unique perspectives to the table, and all were genuinely concerned that the "system" should serve people with the right services, in the right place, at the right time. Stakeholders expressed the following sentiments about bed capacity in general in Milwaukee County; no single perspective dominated.

- Some said inpatient bed capacity should continue to decrease.
- Some were indifferent about bed capacity but clearly identified additional community-based services as an area of need.
- Some expressed concern that BHD was downsizing too quickly.
- Some said additional beds are needed (without regard to who operates them).

Many issues about the behavioral health system were voiced during these discussions. Some were anecdotal and hard to substantiate, but several emerged as consistent and overlapping themes. The various themes that stakeholders identified as system issues that may affect bed need were:

- Insufficient community-based capacity

- Lack of accountability to ensure system-wide inpatient capacity
- Consumers with specialized or complex needs
- Role of Milwaukee County in providing inpatient services

A more detailed summary of stakeholder discussions can be found in Appendix B.

Section 5
Findings & Discussion

5.1 Current Inpatient Bed Capacity & Concerns

Based on information provided by BHD and the private hospitals, there are approximately 201 adult inpatient psychiatric beds in Milwaukee County at present, as shown in Table 1. This figure does not include beds at the State hospitals occupied by Milwaukee County residents or at Columbia St. Mary's Ozaukee campus outside the county; however, the Columbia-Ozaukee hospital is able to take voluntary Milwaukee County residents and, according to hospital officials, about one third of its psychiatric admissions do come from Milwaukee County. Of the 201 beds, 135 (67%), are operated by the private hospitals. While there are more beds that are licensed, this capacity considers the beds that are staffed, budgeted, and able to accommodate patients.[24]

Table 1. Psychiatric Inpatient Bed Capacity in Milwaukee County

Hospital	Adult Beds Budgeted 2014	Projected Adult Beds FY2015
BHD	66	60
Private Psychiatric Hospitals		
Rogers Memorial	50	76
Aurora Psychiatric Hospital	40	40
Aurora St. Luke's South Shore (SLSS)	23	23
Wheaton-St. Francis	22	25
Columbia St. Mary's	0	0
TOTAL	**201**	**224**

Note: Rogers Memorial Hospital plans to open 56 additional beds (28 adult beds and 28 child/adolescent beds).

As shown in Table 2, while the median length of stay at BHD is approximately eight days, BHD's current inpatient census includes a group of individuals with very long lengths of stay because a) they continue to meet commitment criteria; or b) they no longer meet commitment criteria but intensive community services appropriate for their needs have not been developed yet. As a result, there is no admissions flow or turnover in these beds. To the extent that intensive

[24] Froedtert Hospital is not included in this table because it does not currently operate inpatient psychiatric beds. Froedtert does provide medical assistance to BHD, however, and does typically serve a number of patients with behavioral health diagnoses on its medical units.

community services can be developed to meet their needs, these beds could otherwise be used to address admission pressures in the system or closed.

Table 2. Patients with Extended Lengths of Stay at BHD

Length of Stay	Number of Patients
30 – 59 days	6
60 – 99 days	7
100 – 199 days	5
200 – 499 days	3
TOTAL	**21**

According to WHA's analysis of inpatient capacity among Wisconsin counties with a county-operated hospital, Milwaukee County was the only county to see an increase in the number of private psychiatric hospital beds between 2010 and 2013.

The steady decline in beds at BHD in recent years—combined with BHD having to activate its "waitlist" policy and divert admissions at various times this year (as shown in Table 3)—has caused concern that the system is at a tipping point for bed capacity.

Table 3. BHD PCS Waitlist Status, Jan-July 2014

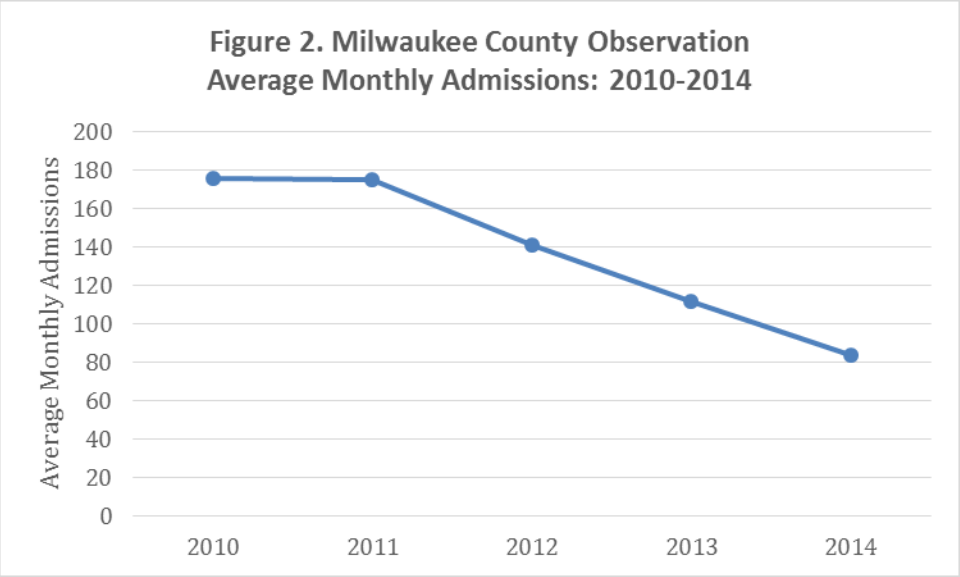
Month	Number of Days on Waitlist	BHD Actual Operating Capacity
January	0	66
February	1	66
March	0	60
April	6	60*
May	14	54
June	4	54**
July	4	66

*Census capacity was 63 for the last two days of April for which there was a waitlist.

** Census capacity for the first nine days of June was 54 beds, and between 60-66 beds for the remainder of the month.

The timing of the BHD bed reductions at the Mental Health Complex and the closure of the 18-bed unit at Columbia St. Mary's at the beginning of 2014 appear to be the primary drivers for the recent strain on the inpatient system. Aurora Psychiatric Hospital also had a temporary reduction of 5 beds in early 2014 due to staffing challenges. BHD saw a roughly 30% decrease in admissions between 2011 and 2013, and it decreased its number of beds as a result. (Factors that have impacted decreased admissions to BHD, such as a decrease in emergency detentions, increased psychiatric mobile response capacity, and some community-based services expansion, are discussed later.) However, as shown in Section 5.2, overall inpatient bed admissions in Milwaukee County remain relatively steady. In other words, the balance of system-wide admissions has shifted, and other hospitals—particularly Aurora Psychiatric Hospital and Rogers—have seen an increase in admissions while BHD's admissions have declined.

Observation beds at BHD (there are currently 18) have been used as an effective diversion to inpatient admission. In fact, data show that nearly 80% of admissions to observation beds result in diversion from inpatient units. However, Figure 2 shows that utilization of observation beds has decreased by approximately 45% between 2010 and 2014. From one perspective, decreased reliance on any type of hospital bed use may be perceived as positive. Despite the fact that there has been decreased pressure in PCS, a significant number of individuals are still admitted to inpatient beds throughout the system. Continued utilization of observation beds could further reduce pressure on inpatient admissions, and BHD should examine the role that observation beds should have in future system-wide inpatient bed capacity decisions.



5.2 Behavioral Health Admissions in Milwaukee County

Total admissions to psychiatric inpatient units (adult and child/adolescent) in Milwaukee County from 2011 through 2013[25] are shown in Table 4, by hospital. Private hospitals accounted for 79% of total admissions in 2011, increasing to 85% in 2013. Accordingly, BHD accounted for a small percentage of admissions from 2011 to 2013, dropping from 21% to 15%. Rogers Memorial had the greatest number of inpatient admissions, representing 35% of total admissions in 2013. This data does not include primary psychiatric admissions to general medical/surgical beds (i.e. not in a designated psychiatric unit) operated by the private hospitals.[26]

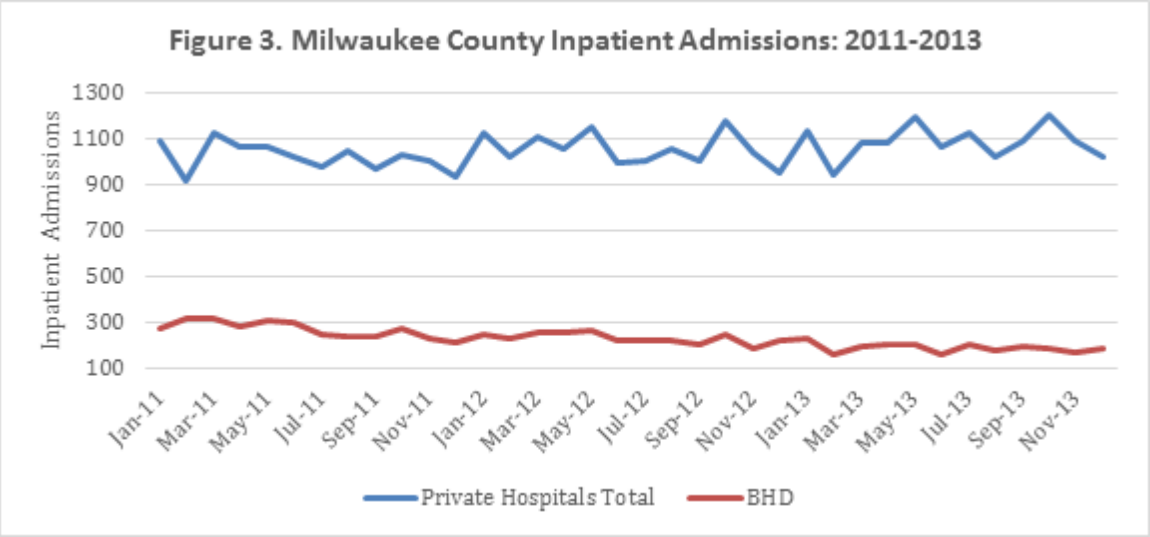
Table 4. Milwaukee County Behavioral Health Inpatient Admissions, N (%)

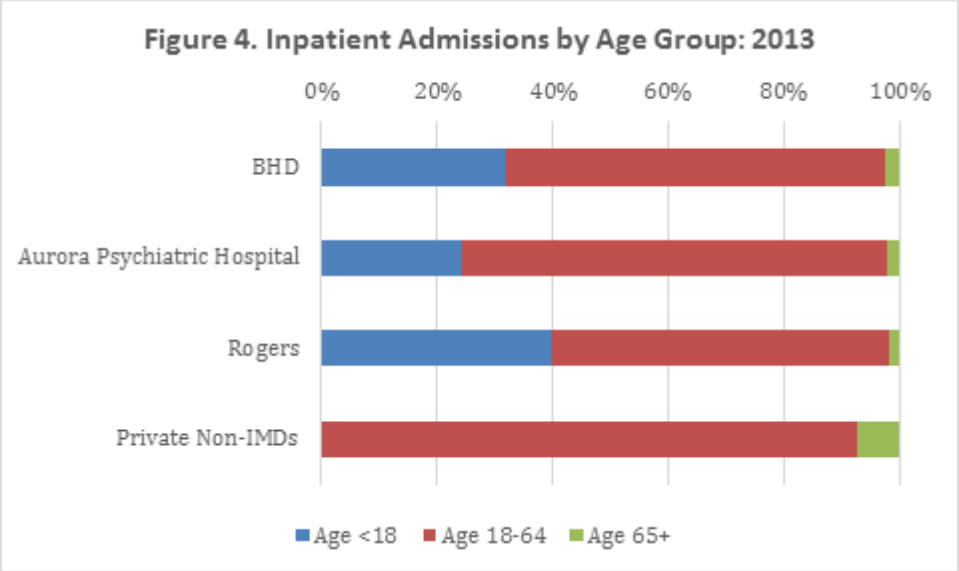
	2011	2012	2013
BHD	3,244 (20.9%)	2,793 (18.1%)	2,285 (14.9%)
Aurora Psychiatric Hospital	3,186 (20.6%)	3,205 (20.7%)	3,470 (22.6%)
Aurora SLSS	1,110 (7.2%)	1,167 (7.5%)	1,255 (8.2%)
Columbia St. Mary's	1,789 (11.6%)	1,975 (12.8%)	1,894 (12.4%)
Rogers Memorial	5,197 (33.6%)	5,341 (34.6%)	5,406 (35.2%)
Wheaton-St. Francis	959 (6.1%)	977 (6.3%)	1,029 (6.7%)
Private Hospitals Total	12,241 (79.1%)	12,665 (81.9%)	13,054 (85.1%)
TOTAL	**15,485**	**15,458**	**15,339**

Sources: BHD Dashboard (includes Adult Acute and CAIS), and data provided by private hospitals.
Note: The percentages above are out of the total admissions for each year, shown in the bottom row. The percentages add to 100% within a given year, not including the Private Hospital Total, which is the sum of all private hospitals not including BHD.

Admissions by facility and age are presented in Figures 3 and 4. In 2013, youth (younger than age 18) accounted for 40% of admissions to Rogers, 32% of admissions to BHD, and 24% of admissions to Aurora Psychiatric Hospital. Adults aged 18 to 64 accounted for 93% of admissions to the non-IMD private hospitals, and for 65%, 74%, and 58% of admissions at BHD, Aurora Psychiatric Hospital, and Rogers, respectively.

[25] We only included data in the table for years we had complete data.
[26] It was reported that the hospitals may admit patients with a primary psychiatric diagnosis to medical/surgical beds at times due to various circumstances. While these admissions add to the total bed days utilized in the system, they do not appear to be as a result of problems accessing designated psychiatric inpatient beds.





5.3 Additional Factors That Influence Psychiatric Inpatient Admissions & Demand in Milwaukee County

There are many variables that impact the capacity, availability, demand for, and utilization of psychiatric inpatient services in behavioral health systems—even beyond the national trends discussed in Section 2. Because of this variability, there is no single, reliable formula that can be applied across systems to determine the number of psychiatric beds needed. An often-cited report suggests 50 beds per 100,000 individuals;[27] however, this figure oversimplifies the variables in each unique system and may reflect a period of time when there was more reliance on treatment in inpatient settings rather than in the community. While there may be

[27] Treatment Advocacy Center. The Shortage of Public Hospital Beds for Mentally Ill Persons. http://www.treatmentadvocacycenter.org/storage/documents/the_shortage_of_publichospital_beds.pdf

innumerable variables that influence bed capacity and demand in Milwaukee County, several with particular relevance are discussed below.

5.3.1 Patient Characteristics

People with mental illness often have other diagnoses or complicating issues that affect the type of treatment, support, and supervision needed within inpatient settings. In fact, this is more likely the case than not. The most commonly associated factors include individuals with:

- Medical diagnoses that need attention, ranging from less serious issues to significant issues that require intensive medical oversight
- Forensic involvement due to criminal behavior as a result of mental illness
- Behavior management issues, including individuals who are assaultive or have disruptive behaviors
- A co-existing intellectual or development disability, or a substance use disorder

Because the hospitals do not currently collect the types of information needed to produce system-level data on patient characteristics and acuity, our ability to analyze patient characteristics and acuity specifically in Milwaukee County was limited.[28] Functionally, the hospitals appear to address these characteristics by categorizing beds as low/moderate or high acuity. There does not seem to be an operational definition for each of these categories, but we have interpreted these for purposes of this report.

Generally, the inpatient system of care in Milwaukee County has relied on BHD for inpatient treatment for individuals with more symptomatology and complexity—such as individuals who are highly treatment-resistant or are exhibiting assaultive and aggressive behavior—and those who are more likely to have a longer length of stay. Aurora Psychiatric Hospital did open a higher acuity unit in 2013, but continues to refer the highest acuity patients to BHD. Those with low/moderate acuity—individuals who are more likely to benefit from shorter inpatient length of stay and tend to present with fewer risks—tend to be admitted to private hospitals. Absent an organized approach to the county's inpatient system of care, this issue places pressure on BHD's bed capacity and utilization.

It is unrealistic to think that there can be dedicated beds designed to meet the needs of all possible patient diagnoses or characteristics. Rather, individual hospitals (including state, county, private, and general acute) each should maintain or contract for clinical capacity to meet the unique, diverse needs of individuals who require access to different types of specialty care on units (for example, general medical practitioners, addiction specialists, and behaviorists). For private hospitals to work with more complex patients, they will likely need to

[28] It is recommended that a standardized assessment of level of functioning and treatment needs that impact bed placement (e.g., medical needs, criminal justice status, behavioral-related issues) be jointly adopted by BHD and the private hospitals to provide an improved data source for future bed need planning.

increase professional and para-professional expertise and coverage to ensure safe, therapeutic environments.

Based on the current functional configuration of beds in the system, Tables 5 and 6 show the average open beds by acuity between January and October 2013. While the 2013 data in both tables appear to show open capacity that can accommodate admissions pressures, patient acuity or other related factors can affect the unit milieu, impacting a hospital's ability to fully utilize beds. At times, hospitals make decisions to keep bed occupancy lower to ensure a safer, more therapeutic environment; thus, vacant beds do not necessarily mean there is additional or underutilized capacity. In addition, the loss of capacity through closure of the Columbia St. Mary's unit in January 2014 has increased bed utilization in the other hospitals.

Table 5. Average Open Low– to Moderate-Acuity Beds by Hospital, Jan-Oct 2013

Month	Rogers	Aurora Psychiatric Hospital	Columbia St. Mary's	Wheaton-St. Francis	Aurora SLSS	TOTAL
Jan	6	6	2	2	--	**16**
Feb	5	6	3	2	--	**16**
Mar	3	6	1	2	4	**16**
Apr	3	4	1	1	2	**11**
May	4	5	4	1	4	**18**
Jun	3	6	2	2	4	**16**
Jul	2	3	2	0	3	**10**
Aug	2	4	1	1	1	**9**
Sep	5	5	1	1	1	**13**
Oct	6	5	3	3	3	**20**

Source: BHD dashboard

Table 6. Average Open High-Acuity Beds, Jan-Oct 2013

Month	Aurora Psychiatric Hospital-Adult Unit 4	43A Intensive Treatment Unit	43B Acute Treatment Unit	43C Women's Treatment Unit	TOTAL
Jan	4	1	1	1	**7**
Feb	5	1	1	2	**9**
Mar	4	5	3	2	**14**
Apr	3	2	4	3	**12**
May	4	1	2	8	**15**
Jun	4	2	1	2	**9**
Jul	4	2	3	8	**17**
Aug	3	2	2	4	**11**
Sep	3	2	2	2	**9**
Oct	4	2	2	2	**10**

Source: BHD dashboard

5.3.2 Medicaid and Other Payer Issues

As discussed in the National Context section, reimbursement issues affect system-wide bed capacity. While patient characteristics and acuity are a primary factor in the ability and willingness of private hospitals to admit patients, hospitals are also challenged to ensure that reimbursement meets budget expectations. Most individuals who are admitted to hospitals have some type of insurance. Hospitals and managed care companies enter into contracts to ensure some access to beds for members at negotiated rates. This results in a complicated balancing act for hospitals as they work across contracts to ensure maximum occupancy.

Because they are classified as IMDs, however, BHD, Aurora Psychiatric Hospital, and Rogers Memorial do not receive Medicaid fee-for-service reimbursement for individuals between the ages of 22 and 64. Consequently, these individuals, as well as those without insurance, are usually referred to BHD, which has traditionally assumed the role of "public safety net" for the Medicaid fee-for-service and indigent populations despite the fact that it holds the same IMD classification as the other two hospitals.

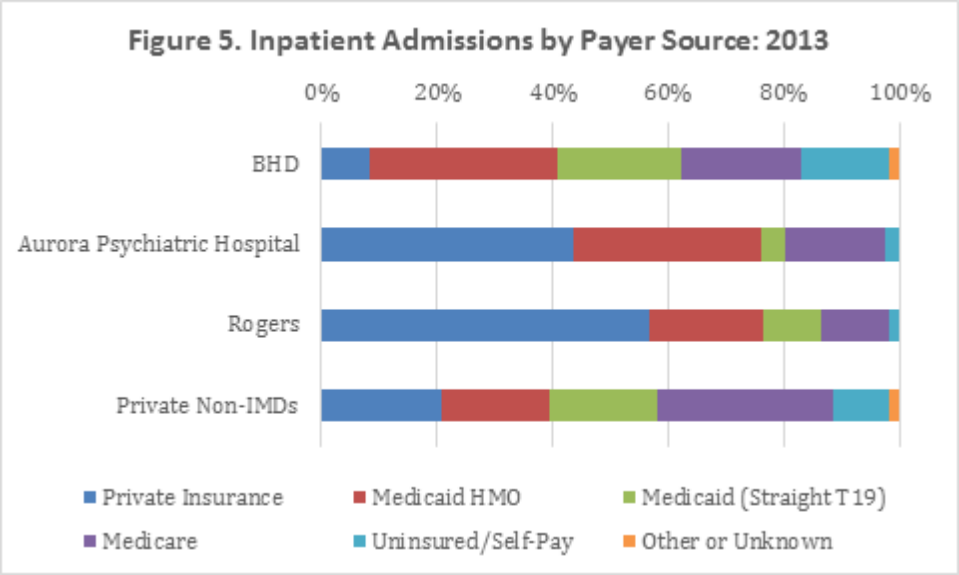
Milwaukee County is not unique in assuming this safety net role. Indeed, the public system in other states also often assumes the financial burden and admits indigent individuals in the 22- to 64-year-old age group to public hospitals. It is important to recognize, however, that if additional psychiatric units within private hospitals that are not classified as IMDs existed in the county, like the existing psychiatric units at Aurora SLSS and Wheaton-St. Francis, individuals with less complex conditions could be successfully treated there at a lower cost because Medicaid reimbursement would be possible.

While non-IMD private hospitals can accept individuals with traditional Medicaid and receive reimbursement on a fee-for-service basis, they face other reimbursement challenges. Reimbursement is based on a Diagnosis-Related Group (DRG) system that basically pays a predetermined, set rate based on the patient's diagnosis. The shorter the stay, the greater the financial incentive; the hospital could lose money if the stay is too long. Individuals who are likely to have longer lengths of stay are often referred to BHD due to the financial impact to the hospital. To the extent that the private, non-IMD hospitals are able to serve individuals with Medicaid or other insurance, however, the lower the burden on public, non-Medicaid matched funds.

A sizable subset of the population that is enrolled in Medicaid in Wisconsin receives services under a managed care approach from "Medicaid HMOs." For those individuals, reimbursement for hospital care is provided directly from the health maintenance organization (HMO). Since Medicaid funding cannot be used to pay for services in an IMD, the IMD services covered by HMOs are substitutes for covered acute inpatient days. This does not represent the use of Medicaid funds for long-term IMD services and enables the Medicaid HMOs to pay for care in the IMDs. However, individuals with longer stays are often converted to non-Medicaid HMO status, and the cost of care in the IMD becomes the responsibility of public funds.

Figure 5 illustrates the greater reliance of the private hospitals on managed care (including Medicaid HMO); in contrast, BHD bears a greater responsibility for individuals who are without insurance or eligible payer sources. Notably, 57% of admissions to Rogers had private insurance compared to 9% at BHD. Medicaid was the most common payer source of BHD patients: 32% had Medicaid HMO and 22% Medicaid fee for service (T19).[29]

[29] It is important to note that because of data limitations, Figure 5 reflects inpatient admissions for all age groups, and not just adults. The inclusion of children and adolescents may paint a slightly different picture than would be the case if only adults were considered. For example, the figure shows a higher percentage of Straight T19 admissions at BHD than exists only for the adult population.



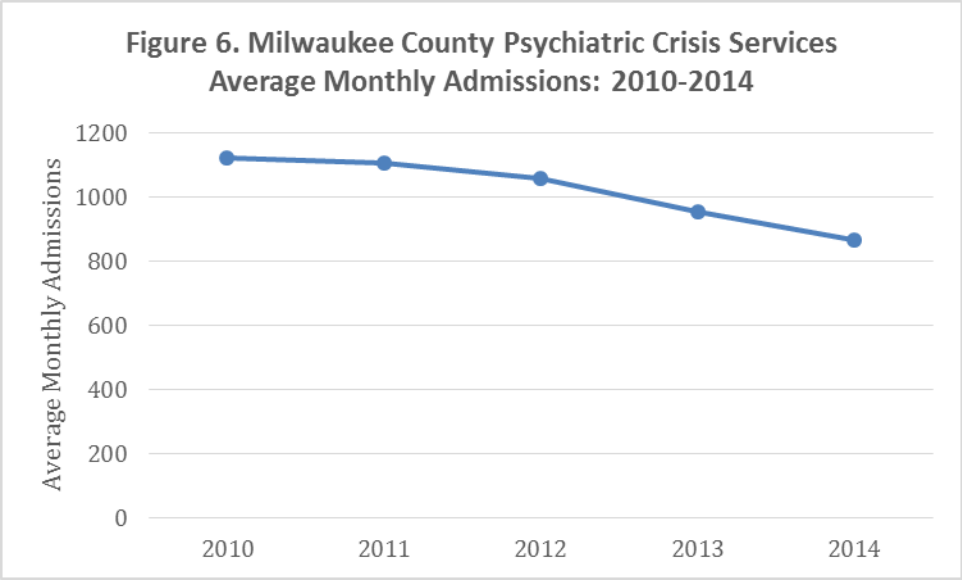
One issue to consider is the potential financial impact to private hospitals if they take on higher-acuity patients. Patients with serious mental illness are potentially more likely to be readmitted than individuals with lower acuity. Managed care organizations may structure rates based on performance measures such as readmission rates. As hospitals negotiate rates with managed care organizations, hospitals could be faced with lower reimbursement as a result of higher readmission rates if working with higher-acuity patients. While readmission rates are an indicator of the quality of discharge planning by the hospital, much of this is contingent on the ability of the community services system to meet consumer needs.

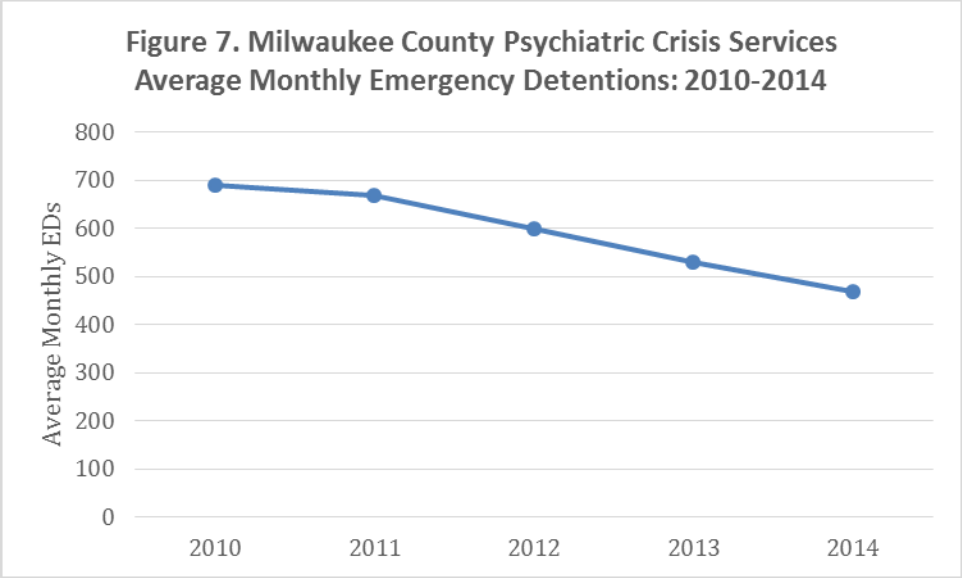
The Public Policy Forum is conducting a separate review of the expenses and revenues of operating the BHD Mental Health Complex and community-based services; this review—available later this year—should further inform inpatient capacity planning.

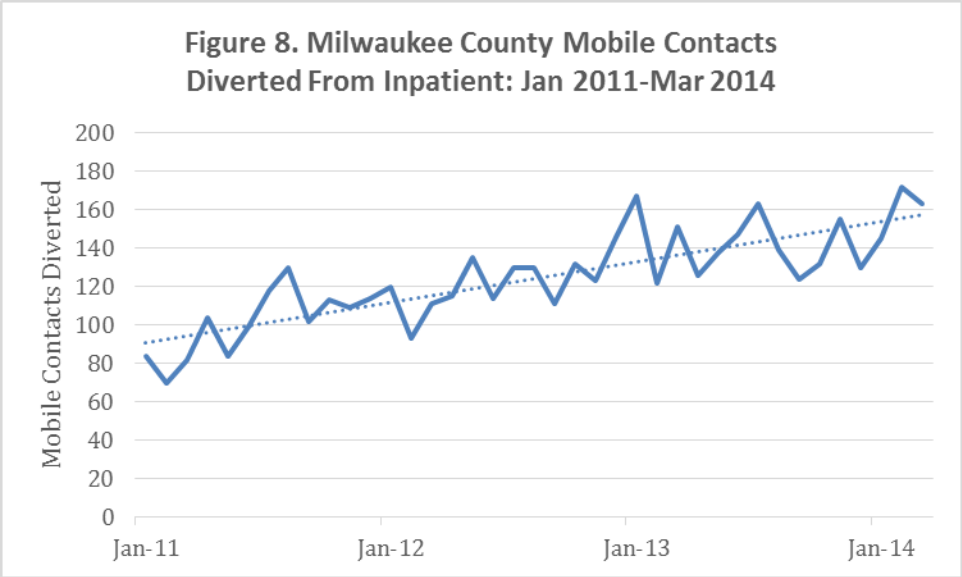
5.3.3 Increased Crisis Diversionary Activity

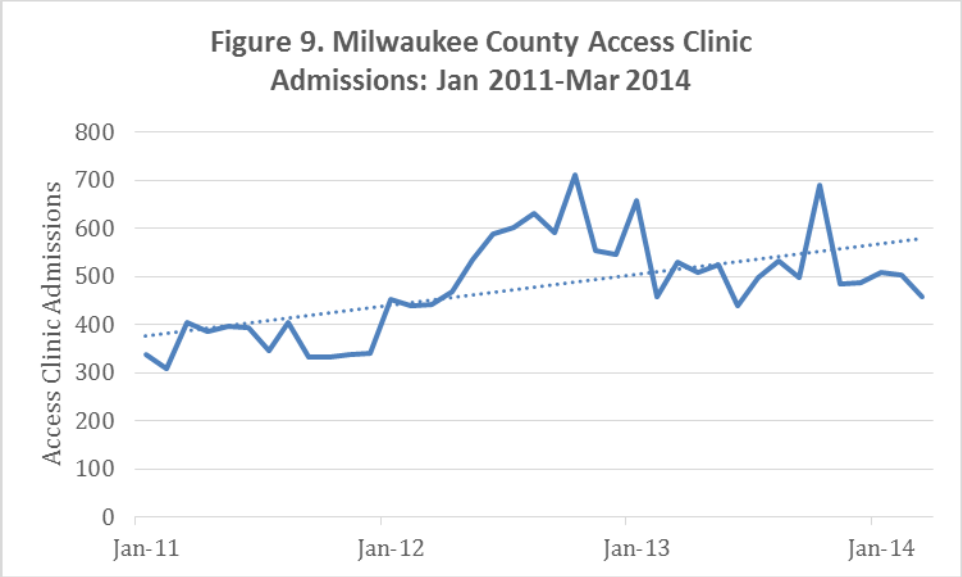
By focusing attention on the front door of the inpatient system, BHD appears to have decreased the need for hospitalization for those likely to need high acuity inpatient care. This is evidenced by the shift in admissions to private hospitals and reduced utilization of crisis services, including a decrease in PCS admissions (Figure 6) and emergency detentions (Figure 7), and increased use of mobile response. Most notably, it appears that expansion of mobile crisis response capacity has increased the number of individuals diverted from inpatient (Figure 8) and is related to decreased utilization of police intervention, emergency room visits, and admissions to BHD. Between 2011 and 2013, BHD data show the number of emergency detentions and crisis admissions in Milwaukee decreased by 21% and 14%, respectively. Increased use of the Access Clinic (which provides a variety of outpatient clinical services) by those who are indigent may have also contributed to decreased utilization of emergency detentions and BHD admissions

(Figure 9). Note: An additional Access Clinic site is now being added which should increase the number served.









Despite the real progress discussed above, there is evidence to suggest that Milwaukee County's behavioral health system still relies too heavily on crisis services in emergency rooms or crisis clinics. Data prepared by the Wisconsin Hospital Association (WHA) for this report show that when adjusting for poverty, an estimated 36% of individuals with serious mental illness in Milwaukee County had an emergency room visit in 2013, compared with a state average of approximately 20%. Additionally, the use of police interventions and emergency detentions remains high. For comparison, Houston's population of 2.1 million is more than

twice that of Milwaukee County, yet in 2011 Houston had 2,259 emergency detentions,[30] or about 28% of the number of emergency detentions in Milwaukee County (8,109).[31]

WHA data also suggest that when comparing the inpatient penetration of individuals with serious mental illness (SMI) who are in poverty, an estimated 17% of individuals with SMI in Milwaukee County had an inpatient discharge for mental illness in 2013, ranking it 11th out of 20 counties it compared data with.[32] While emergency detentions remain problematic, this data suggests that Milwaukee County residents with SMI who are in poverty are less likely to be admitted as compared with other counties.

5.3.4 Access to and Availability of Community-based Services

While use of crisis diversion services such as mobile response and the Access Clinic are important, the strength, quality and accessibility of non-crisis oriented, community-based services is equally or perhaps even more critical. The 2010 HSRI/TAC/PPF report highlighted the voice of stakeholders in the system calling for a more recovery-oriented, higher quality, accessible community-based system that is less reliant on crisis-oriented, emergency, and inpatient treatment service. One of the challenges to this inpatient bed need analysis was to understand the extent to which the increase in community-based services that has occurred since that time has lessened demand for inpatient services and the use of emergency detentions.

Since the release of the HSRI/TAC/PPF report on Milwaukee's mental health system, the county has allocated additional resources to community-based services and made progress in several areas. Budgeted initiatives since 2011 have included expansion of crisis residential beds, peer support services, supported housing assistance, and mobile crisis response services. As shown in Appendix C, the current 2014 budget allocates a significant investment of approximately $4.8 million to expand a range of community services. It is important to note that BHD has begun piloting more intensive community-based supports that resemble Assertive Community Treatment (ACT). The implementation and projected expansion of Community Recovery Services (CRS) 1915(i) Medicaid state plan services will provide a good platform to meet the needs of individuals, but these will take time to phase in and achieve positive outcomes. CRS is initially being used to transition people from community-based residential facilities (CBRFs) to lower levels of care, making room for those who need more intensive support. Meanwhile, the phase-in of Comprehensive Community Services (CCS) during the remainder of 2014 and projected growth in 2015 will provide an opportunity for more persons who are receiving case

[30] Houston Police Department, Mental Health Unit. 2011 Annual Report: Success through collaboration. 2011. http://www.houstontx.gov/police/department_reports/MHU_2011_Annual_Report.pdf

[31] The process for counting the number of Emergency Detentions (ED's) for Milwaukee and Houston is comparable. After recognizing problems with the number of ED's, the Houston Police Department and the Mental Health Mental Retardation Authority of Harris County implemented a series of reforms to reduce the use of ED's and improve access to care. http://www.houstoncit.org/history/

[32] Wisconsin Hospital Association. Data analysis provided July 9, 2014.

management services to receive a more comprehensive array of support. The use of CCS can be intensive, and BHD is seeking to develop ACT-like[33] services through this mechanism.

However, many of these newer services are budgeted for implementation during 2014 and expansion in 2015, and have yet to be sufficiently established to the point where they lessen existing demand for inpatient capacity across the system. While BHD's bed utilization is down, the overall admissions throughout the county have generally remained consistent for the past three years, and the reliance on police as the frontline for psychiatric emergency services in Milwaukee County, evidenced by the persistently high number of emergency detentions, remains problematic.

In addition, while most individuals in inpatient care have lengths of stay of roughly one week, there is a group of individuals at BHD with very long lengths of stay that occupy beds. These individuals have complex situations such that they: a) continue to meet commitment criteria; or b) they no longer meet commitment criteria but intensive community services appropriate for their needs have not been developed yet. An argument can be made that if appropriate services could be developed in the community for these individuals, then the beds that they currently occupy would not be needed. One explanation for the system's admissions and discharge challenges may be the system's historic reliance on less-intensive services with limited access, such as Targeted Case Management, compared to other better-performing jurisdictions that utilize services like ACT, intensive case management, and peer-delivered supports.

Table 7 shows the various types of community-based services offered by the County prior to this year (when CRS and CCS were added and an ACT pilot was initiated) and changes in the number of individuals served since 2011. Projected increases by BHD in the number of individuals that could be served between 2015 and 2017 with continued growth of community-based services could reduce inpatient demand further. Appendix A has a more detailed description of each service.

[33] Assertive Community Treatment is an evidence-based practice with established fidelity standards. ACT should not be confused with services that are intensive but do not adhere to fidelity standards.

Table 7. Milwaukee County Behavioral Health System Services: 2011-2014

	2011	2012	2013	2014 YTD*	2014 Projected
Targeted Case Management					
Capacity	1234	1234	1252	1292	1292
# served	1314	1378	1439	1370	1505
Length of stay (Years)	3.6	5.6	3.5		
# with PCS encounter	362	399	356		
# with inpatient stay (BHD)	101	144	149		
# with inpatient stay (Self-reported)	331	351	329		
Community Support Program					
Capacity	1315	1310	1340	1340	1340
# served	1408	1384	1352	1337	1392
Length of stay (Years)	10.0	7.7	9.7		
# with PCS encounter	396	360	363		
# with inpatient stay (BHD)	121	133	125		
# with inpatient stay (Self-reported)	334	319	255		
SAIL[34]					
New Clients Requesting Services	432	470	568	199	600
Total Approved Requests	1348	1297	1619		
Denied Requests	427	499	649		
CLASP					
Capacity	n/a	75	150	150	150
# served	n/a	59	248	158	243
Length of stay (Months)	n/a	2.0	3.2		
# with PCS encounter	n/a	52	182		
# with inpatient stay (BHD)	n/a	36	120		
Recidivism rate	n/a	8.5%	8.3%		
Partial Hospital					
Capacity	24	24	24		
# served	65	63	63	38	54
# with PCS encounter	39	30	26		
# with inpatient stay (BHD)	14	14	14		
# with inpatient stay (Self-reported)	33	30	31		
Community-Based Residential Facility (CBRF)					
# of beds	136	136	136		
# with PCS encounter	42	52	51		
# with inpatient stay (BHD)	31	24	20		
# with inpatient stay (Self-reported)	17	29	30		
Outpatient					
# served	998	978	657	464	988
# with PCS encounter	459	440	141		
# with inpatient stay (BHD)	134	109	93		

Source: BHD

*2014 YTD is 01/01/2014 – 04/30/2014

[34] The Service Access to Independent Living (SAIL) program makes assessments and referrals to programs and is not a direct service program. It is shown here to reflect increased demand for services.

5.3.5 System-wide Inpatient Bed Planning and Management

Because Milwaukee County operates its own inpatient and long-term care facilities, it rarely sends consumers to the state hospitals. In most states, as well as in those Wisconsin counties without a county hospital, consumers who require longer lengths of stay tend to be admitted to state facilities either after a short-term admission at a local hospital or directly if no beds are available locally.[35] State psychiatric hospitals admit individuals with the most complex conditions only after they have been served in a local, private hospital unit.[36,37]

The balance of inpatient care is managed by private hospitals at the local acute care level. In 26 states,[38] the availability of psychiatric beds is regulated through a Certificate of Need process to ensure bed availability and that clear requirements exist for things like admissions and discharge criteria, minimum staffing and clinical expertise, and the types of services that should be provided. Absent a Certificate of Need process for psychiatric inpatient services (or a similar oversight, regulatory or coordination process), challenges could emerge with regard to access to care, system coordination, and fragmentation.

In Milwaukee County, the lack of such clear guidelines to govern psychiatric inpatient bed capacity and responsibility is problematic. For example, the ability of individual providers to open and close beds unilaterally and on short notice—and sometimes solely in response to psychiatrist vacations or absences—can negatively impact overall system capacity in ways that cannot be anticipated and effectively addressed by other providers. The lack of formal system criteria with regard to admissions is also problematic, as individual providers can establish their own criteria that are determined by variables such as patient acuity or payer factors. Payer factors may become an increasing concern as private hospitals engage in managed care and create accountable care networks that will drive bed capacity.

Overall, the lack of system-wide coordinated planning between BHD and its partners (e.g., private hospitals, providers, and stakeholders) and resulting uncertainty regarding bed capacity, availability, and access remains a significant system issue, despite the real progress that has been made in recent years to implement a public-private provider working group and to establish contractual relationships between BHD and certain providers. A high-level review of data shows a slight decrease in admissions to inpatient settings overall. However, bed planning

[35] National Association of State Mental Health Program Directors Medical Directors Council. *The Vital Role of State Psychiatric Hospitals*. July 2014.

[36] Despite this, state hospitals are typically not equipped to treat individuals with serious medical conditions and individuals are often treated in private, acute care hospitals with mental health staff providing supervision in the medical setting.

[37] There are some situations where patient acuity of circumstances are so complex that private hospitals are precluded from serving individuals. Examples include court-ordered or otherwise forensic situations, or severe risk of dangerousness.

[38] According to the National Conference of State Legislatures, 26 states, excluding Wisconsin, have a Certificate of Need process for psychiatric inpatient bed capacity. http://www.ncsl.org/research/health/con-certificate-of-need-state-laws.aspx#Regulated

should not occur in a vacuum. The admission trends suggest that beds could be reduced at BHD, but several factors should be considered, including the future plans of individual hospitals and the impact of community services expansion.

The role of the State of Wisconsin also must be clarified. For example, like the County, the State is also considering strategies to reduce census in its facilities at Mendota and Winnebago. While such action is consistent with national efforts from economic and community integration perspectives, it could be detrimental to BHD's downsizing efforts; an inability to send additional consumers to state hospitals could preclude an important option for certain patients served by Milwaukee County.

5.3.6 Closure of Rehab Hilltop and Rehab Central

In February 2013, the Milwaukee County Executive announced the County's intent to close the long-term care rehabilitation units at the Mental Health Complex. The stated intent was to provide residents living at Rehab Hilltop and Rehab Central the opportunity to live in the least restrictive environments and more integrated settings consistent with *Olmstead*. Rehab Hilltop has operated as a 72-bed intermediate-care facility for individuals with intellectual and developmental disabilities and co-occurring mental illness, and it is scheduled for closure at the end of 2014. Rehab Central has operated as a 70-bed skilled nursing facility/home for individuals with complex physical, mental and behavioral needs, and its closure is slated for December 2015.

As of August 2014, there were 38 individuals in Hilltop and fewer than 35 in Rehab Central. Both facilities have 24-hour supervision and are highly structured environments with comprehensive treatment and supports. As a result, it is reported by BHD that there has been low utilization of psychiatric inpatient beds by the Hilltop and Rehab Central residents. As residents are moved into community-based settings, however, there is some possibility that there will be an increase in psychiatric inpatient utilization if services do not meet individuals' needs, creating a new pressure point. In addition, individuals who otherwise would have been admitted to either of these facilities could also remain on BHD inpatient units for a longer period of time if sufficient community-based options do not exist.

According to BHD, two former residents were admitted to BHD once, and another individual was admitted twice, since downsizing of the two facilities began. While there have been few admissions to BHD of former residents of Rehab Central and Hilltop since downsizing began, the number of inpatient bed days consumed is long, with one presently exceeding 425 days. Over time, it is likely that some of these individuals, and individuals with similar needs, will need inpatient treatment, and BHD should track this issue to understand the impact to bed demand and the need to deliver more enhanced services to those individuals in community settings.

5.3.7 Workforce

Consistent with workforce challenges experienced nationally, Milwaukee is experiencing a shortage of behavioral health professionals and paraprofessionals. Most directly, this impacts inpatient bed capacity at BHD and the other hospitals. Hospitals struggle to recruit and retain qualified staff, and these difficulties are compounded by the typical staffing challenges associated with vacations and sick leave. When hospitals are at the staffing margin, any staff vacancies directly reduce bed capacity.

Area hospitals have made limited use of nurse practitioners for prescribing. Nurse practitioners have been used successfully in some states, not as a replacement for psychiatrists but as a complement to the milieu. While there is little research on differences in quality of care, nurse practitioners are able to prescribe in Wisconsin and could—at minimum—play a role in helping to ensure that existing bed capacity is staffed and can be fully utilized. A key issue in Wisconsin is a decided lack of certified psychiatric mental health nurse practitioners.

It appears common in Milwaukee County for bed capacity to fluctuate depending on staffing. While the availability of workforce is a documented issue in Milwaukee and other parts of the country, it was surprising to hear about the frequency of fluctuations in bed capacity caused by temporary staff vacancies. While clinical care and safety must not be compromised by high caseloads, there could be greater efforts to ensure consistent staffing to ensure consistent bed capacity (for example, shared professionals, use of APNs, and locum tenens).

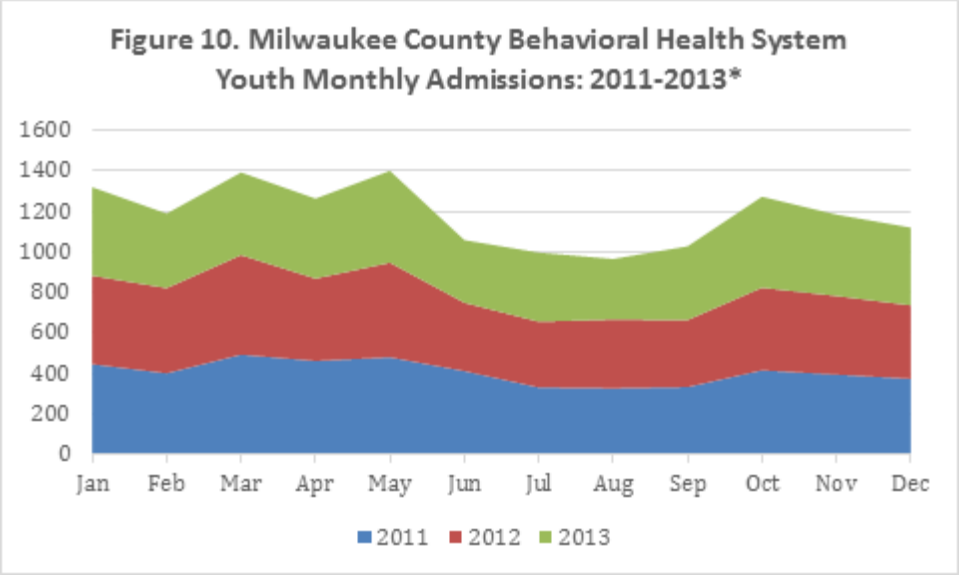
Key informants also expressed concern about the lack of available and skilled community-based workforce to meet demand, including staff for program services such as Assertive Community Treatment and licensed clinical professionals like psychiatrists and therapists to meet clinical outpatient demand. That issue also could impact inpatient bed capacity but it is beyond the scope of this report to quantify it; the issue will be addressed, however, by an outpatient capacity analysis that will be initiated shortly after the release of this report.

It was suggested by some providers that the hospitals should consider a joint approach to meeting the skilled workforce needs across the inpatient system. This model would include sharing treatment professionals such as psychiatrists or other licensed professionals with expertise in various areas to meet the needs of individuals with complex conditions. This could enhance the ability and willingness of the private hospitals to admit some patients who might otherwise be admitted to a more restrictive setting at BHD. This idea merits discussion among the hospitals, including BHD.

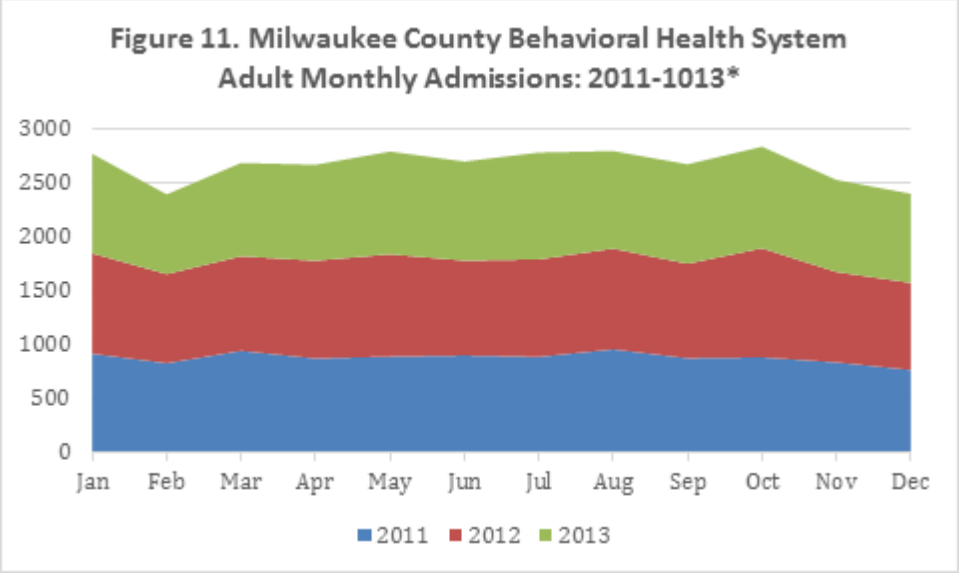
5.3.8 Seasonality

During this project, the notion of seasonal effect on admissions was raised by various stakeholders. A review of the data for the past three years shows significant fluctuations in total admissions (i.e., adult and child/adolescent) on a monthly basis each year. A closer look at the data—as displayed in Figures 10 and 11—indicates that for children and adolescents

(younger than age 20), there seems to be a decrease in admissions during the summer months. For adults over 20, however, there seems to be general consistency of admissions throughout the year.



*Includes private hospital admissions for persons age <21, and CAIS admissions to BHD.



*Includes private hospital admissions for persons age ≥21, and Adult Acute admissions to BHD.

For adults, it appears that any strain on inpatient capacity is unrelated to seasonality. However, given the current number of adult beds in the county, it appears that there is enough capacity to accommodate any minor, temporary fluctuations that arise due to seasonality or other

issues, and hospital systems should be prepared to staff up accordingly. It is cost prohibitive to maintain additional staffed bed capacity for short-term spikes in demand.

While it does not appear that seasonality is a major issue for adult inpatient demand, it is important to point out that admissions that may be related to seasonality are not necessarily indicative of a greater clinical need during these months. Many experts in the County agree that seasonal variations could be partly weather-related; for example, people who are homeless are more likely to be admitted for sheltering reasons due to extreme cold despite the fact that this is not consistent with commitment criteria. However, our data do not show an increase in adult admissions in the winter months. If such a situation should occur, greater attention to community service needs would be more appropriate than utilizing costly inpatient beds as shelter.

5.3.9 Transfer of Authority

Recently passed state legislation that provides for a different means of oversight of Milwaukee County's behavioral health system will affect how psychiatric inpatient care is approached and managed in the county. Until recently, per the Wisconsin state statutes, the county board of supervisors in all counties had "the primary responsibility for the well-being, treatment and care of the mentally ill, developmentally disabled, alcohol and other drug dependent citizens residing within its county and for ensuring that those individuals in need of such emergency services found within its county receive immediate emergency services."

However, this authority in Milwaukee County was recently changed by state lawmakers and assigned to a new Mental Health Board (MHB). Effective July 1, 2014, the new Mental Health Board assumed responsibility for the oversight and direction of Milwaukee's behavioral health system. Details of this role can be found in Chapter 51 (i.e., 51.41) of the State Alcohol, Drug Abuse, Developmental Disabilities and Mental Health Act. While the Mental Health Board is just beginning its work, it will have a direct role in how the system evolves, including BHD's role in inpatient care, system-wide bed capacity, and the capacity and quality of community-based services.

Section 6
Recommendations

The purpose of this analysis is to understand the demand for adult psychiatric inpatient beds and the capacity that should exist in Milwaukee County. As stated earlier in the report, much of the demand and capacity for inpatient beds depends on multiple variables, including the overall community-based services infrastructure. We reviewed several of these variables in making our recommendations. It is important to point out, however, that a detailed assessment of outpatient capacity (e.g., community-based programs and licensed treatment professionals)—which will be a key determinant of the inpatient capacity needed in Milwaukee County—is beyond the scope of this project. An analysis of outpatient treatment capacity is planned as a second phase that will begin after the completion of this report.

6.1 Short-Term Demand and Need for Adult Psychiatric Beds

Recommendation: Based on the current capacity and composition of the overall adult mental health system in Milwaukee, adult inpatient bed capacity should be in the range of 167 to 188 beds.

Currently, among both public and private hospitals, we calculate that there are approximately 201 adult psychiatric beds in the system; of these, roughly 150 beds are utilized. These utilization figures are based on 2013 admissions trends and lengths of stay, and they capture seasonality and other factors. As discussed in the Methodology section, however, hospital psychiatric units often intentionally operate under capacity to accommodate unique circumstances—patient acuity, gender issues or medical co-morbidity for example—that affect unit milieu. Essentially, the hospitals balance unit census to ensure safety and a therapeutic environment. As a result, the system needs more beds than are utilized to account for these variables.

Based on feedback from the hospitals, we applied a lower and upper occupancy rate and calculated the range of beds that should exist in the current system to accommodate actual utilization. This means that the psychiatric units will generally operate at 80% to 90%[39] of capacity to meet inpatient demand. In Milwaukee County, there should be approximately 167 to 188 beds to meet the current utilization rate of 150 beds. Given that there are 201 beds budgeted among all of the hospitals in the County (with 23 more planned for 2015), we believe there is enough total capacity to meet current demand.

While we find the current county-wide budgeted bed capacity sufficient and that demand for inpatient beds appears to be lessening throughout the county, recent data shows a “tipping

[39] Based on the American Hospital Association annual survey data, the bed occupancy rate across all hospitals in the U.S. in 2009 was 67.8%.

point" where the system appeared to have sufficient bed capacity but then suffered a strain when that capacity was diminished earlier this year. In 2013, there were approximately 223 beds operating (66 at BHD and 157 among the private hospitals) compared to 201 in 2014. With admissions in the county remaining relatively stable, the strain on capacity appears to stem largely from the reductions in beds at both Columbia St. Mary's and at BHD. It is important to keep in mind that fluctuations in staffed bed capacity at BHD and the private hospitals due to vacations and other leave time add to this strain.

This data also does not include admissions to medical/surgical beds operated by the private hospitals. It was reported that the hospitals may admit patients with a primary psychiatric diagnosis to medical/surgical beds at times due to various circumstances. While these admissions add to the total bed days utilized in the system, they do not appear to be as a result of problems accessing designated psychiatric inpatient beds. BHD should monitor the extent of such admissions to ensure that it does not underestimate psychiatric inpatient bed need.

Several private hospitals have increased their admissions in the past three years, particularly Aurora Psychiatric Hospital and Rogers. However, the closure of Columbia St. Mary's 18-bed unit in Milwaukee seems to have added pressure on bed capacity throughout the county.[40] In 2013, Columbia St. Mary's admitted 1,892 adults and had an average daily census of approximately 12 individuals who were there involuntarily or voluntarily. That loss of capacity--combined with a reduction in beds operated by BHD from 66 to 54 earlier this year—placed added pressure on the system. Consequently, it is reasonable to suggest that for short-term planning, the number of beds needed now in Milwaukee County should be based on recent experience and utilization, which suggests the range of 167 to 188 beds.

This does not suggest that the 167 to 188 bed range needed now is ideal for the longer term. Instead, it reflects the need based on the current capability and capacity of Milwaukee County's overall behavioral health system. We found that new investments made in mobile response, for example, have helped lessen the pressure on PCS and inpatient demand at BHD; however, these investments have not significantly improved access to community-based services. Ideally, Milwaukee County and the new Mental Health Board should emphasize the development of the types of accessible, community-based services that could reduce the demand for inpatient beds.

[40] It is important to note that several other health systems in Milwaukee also have closed psychiatric inpatient beds during the past several years. Our discussion of this closure is not meant to single out the Columbia-St. Mary's system, but simply reflects the timing of this specific reduction in beds and its relevance to the consideration of near-term inpatient capacity.

6.2 Type and Configuration of Beds

Recommendation: Using the upper range of beds needed in the system to meet demand (188 beds), 54 to 60 adult inpatient beds should be maintained to serve high-acuity and/or indigent patients and roughly 128 to 134 beds should be maintained to serve low– to moderate-acuity patients.

Current data shows that most admissions can be accommodated by the private hospitals and tend to be low to moderate in acuity. As discussed earlier, functionally, the county appears to categorize beds as low/moderate or high acuity. Generally, individuals with low to moderate acuity tend to be admitted to the private hospitals. These individuals are more likely to benefit from shorter inpatient lengths of stay and tend to present with fewer risks, such as assaultive behavior. As the inpatient system is currently configured, those with more complex presentations—such as individuals with dual diagnosis, co-occurring disorders, and assaultive behaviors—and those who are more likely to have a longer length of stay tend to be referred to BHD for inpatient treatment. In addition, BHD is more likely to serve those enrolled in Medicaid fee-for-service and the indigent population as uncompensated care.

As discussed earlier, private hospitals handled 79% of the behavioral health admissions in the county in 2011; this percentage increased to 85% in 2013. Accordingly, we can broadly assume that in 2013, roughly 85% of admissions were for patients with low to moderate needs, and 15% were to BHD for higher acuity (though we acknowledge that payer source also impacts BHD admissions). Because BHD admits higher-acuity patients and has longer lengths of stay, however, it is clear that based on the current demand/capacity approach, BHD should operate far more than 15% of the total beds. The data suggest that 54 to 60 beds is the needed capacity for high-acuity and/or indigent patients who historically have been served by BHD, and that roughly 128 to 134 adult beds should be available for patients with low/moderate acuity who historically have been served in the private hospitals.[41] However, as discussed above, the ability of BHD and the hospitals to cooperatively gauge and plan needed bed capacity on an ongoing basis will be important to maximize beds and ensure a seamless system.[42]

In the near future, it is likely that BHD's inpatient beds will continue to serve patients with higher acuity and/or those who are indigent unless agreements are worked out with private hospitals to admit higher-acuity patients and use public funds to reimburse those hospitals for uncompensated care. Based on beds in operation at the beginning of 2014, bed capacity at the private hospitals appears mostly stable, aside from the closure of beds at Columbia St. Mary's Milwaukee. In fact, Rogers Memorial is adding 56 new beds, which will result in an additional

[41] BHD is budgeting for 60 adult beds for CY2015.

[42] The private hospitals have no legal obligation to provide beds to meet recommended county-wide need. Therefore, we do not feel it is appropriate to recommend a per hospital allocation of beds. However, we feel it is in the hospitals' and county's interest to coordinate how best to meet the system's bed need.

28 beds for adults and 28 beds for children and adolescents. Rogers also anticipates adding additional intensive outpatient and partial hospital capacity.

As discussed earlier in the report, there is some risk of relying on the private hospitals to maintain capacity, and the county and private hospitals should engage in regular joint planning to meet the inpatient needs of county residents. Prior to 2009, there was very little interaction among the hospitals and BHD. However, over the past few years there have been efforts to improve coordination. The newly constituted Mental Health Board should consider how best to ensure active coordination and planning among BHD and the hospital providers.

6.3 Planning for Future Bed Capacity

Recommendation: BHD should expand community-based services that have been shown to promote recovery and decrease the need for hospitalization. Future decreases in bed capacity should be based on inpatient and community-based services metrics that demonstrate a sustainable decrease in demand for inpatient beds.

Strategies to decrease admissions to the private hospitals and BHD will be essential to enabling further decreases in bed capacity. If the goal of Milwaukee County/MHB is to decrease reliance on inpatient bed utilization, then the enhancement of the community-based system must take place. As previously mentioned, inpatient bed demand is contingent on the foundation of the community-based system of care. BHD should enhance its efforts to expand the availability of community-based services that have been shown to decrease inpatient admissions.

While we found that the County has expanded some community-based services, and that this expansion has reduced activity at PCS and helped to successfully accommodate the reductions in bed capacity that have occurred to date, the increase has not been sufficient to further decrease bed capacity at this time. To some degree, the overall coordination and organization of the system, including the need to establish a culture built on community support and diversion (as compared to a “get sick first” system), is as important as simply expanding services.

There is solid evidence to suggest that more available and accessible community-based services can decrease the demand for inpatient care. For Milwaukee County, this would require further investment (new or reallocated resources) to improve access to community-based services targeted to those most likely to utilize crisis and inpatient services. Among these are efforts to increase mobile response activity or other interventions aimed to divert and reduce police interventions and emergency detentions; intensive and flexible services such as Assertive Community Treatment and supportive housing strategies; increased access to peer-delivered supports; and increased access to prescribers.

BHD should utilize SAMHSA’s *Description of a Good and Modern Addictions and Mental Health Service System* as a reference for the continuum of services that should be available to

Milwaukee County residents. BHD should also refer to emerging best practices on the integration of behavioral health and primary healthcare. Critical to the outcomes, BHD should evaluate how individuals are assessed and matched to services. Individuals with the highest needs and who are most at risk for hospitalization should have access to the most intensive community-based services; those who are further along in recovery and present with lower risk should have access to less intensive but flexible supports. As part of this process, BHD should identify performance metrics to evaluate whether the services that individuals are receiving are having a desired impact on hospitalizations and other recovery-oriented outcomes (e.g., employment, quality of life).

Similarly, system-wide and hospital-specific metrics should be utilized when changing inpatient bed capacity and considered in the context of the community-based performance indicators. Community-based performance indicators that demonstrate an expansion of services that demonstrate desired outcomes such as fewer crisis episodes, stable housing, and engagement in meaningful activities (employment and positive social relationships, among others) will likely result in fewer hospital admissions. The ability of the system to correlate these metrics will provide a data-driven justification for additional decreases to inpatient bed capacity.

Hospital admissions data is another source of information that could be carefully tracked and used to determine how many beds could be decreased in the system. We applied a utilization-based approach based on admission trends to estimate the number of beds that could be decreased over time in the county, with an underlying assumption that more accessible community-based services metrics will support decreasing admissions and lengths of stay.

Based on current lengths of stay, we estimate, based on our bed calculation methodology, that for every 225 BHD admissions (median length of stay of 8 days) that the system can divert and sustain, roughly five fewer high-acuity beds are needed in the system. For every 450 admissions to the private hospitals (median length of stay of 4 days) the system can divert, roughly five fewer low/moderate acuity beds are needed in the system. However, before these estimates are actually used to decrease bed capacity across the county, we recommend that a trend analysis occur for community metrics described above and any decrease in admissions, and that the decrease is sustained for a period of at least six months before any bed capacity is reduced. This is important since there are many variables that will affect future bed need, several of which are not quantifiable at this time.

These estimates depend on several factors, and the numbers above should be used as a guide. Some beds have patients with very long lengths of stay, essentially resulting in limited utilization of those beds. Consequently, the less efficient the hospitals and system are at managing lengths of stay, the greater the likelihood that bed capacity will need to remain higher.

Recommendation: The private hospitals should continue to increase their role in meeting the psychiatric inpatient needs of Milwaukee County residents. BHD should collaborate with and assist the private hospitals to successfully treat individuals with complex situations and seamlessly facilitate their discharge back into the community.

We also think that much of the inpatient care provided at BHD can be provided by the private hospitals, especially if the community-based services are increased and providers are equipped to work with consumers who have more challenging behaviors. It is likely there will still be a need for beds to serve a higher level of acuity, but BHD does not necessarily have to be the entity to operate those beds. This decision ideally should be determined by which party can provide those beds in the most cost-effective and clinically proficient manner.

The private hospitals have expressed concerns about their ability and willingness to assume this responsibility, including finding appropriate community settings to which patients can be discharged and additional financial risks they would incur for delayed discharges if community resources are unavailable or nonexistent. The County, and possibly the State, will need to consider the roles that they might play in appropriately addressing those and related concerns. Another alternative would be for the State to assume the responsibility for those limited instances when higher-acuity beds for the most complex patients are needed.

Much of the bed capacity in Milwaukee County is driven by the private hospitals and market factors, such as demand and payer sources, and is beyond the control of the County. Similar to third party insurance payers, the County/MHB should determine what inpatient bed capacity is needed in Milwaukee County, especially with regard to beds capable of serving patients with high acuity, and devise strategies to ensure that capacity exists. While providing appropriate high-acuity capacity itself is one option for the County, procuring it through private hospitals is another.

It was difficult for us to determine the private hospitals' precise future plans for inpatient bed capacity, and the feedback we did receive from hospital officials about future bed capacity can only be considered speculative. However, Rogers Memorial's expansion to a second site will result in roughly 28 additional adult beds in the county, and BHD should be engaging Rogers Memorial for bed planning purposes.

It also is difficult to predict the impact that the BadgerCare expansion will have on inpatient need, and this data should be regularly reviewed. We expect it is more likely that this will result in increased pressure on outpatient services as people will be more likely to seek services. Since inpatient care is emergency-based, we believe this population already accessed inpatient treatment when brought in through emergency detentions or other means.

It is possible, however, that greater access to community services will positively impact the system in that some people who were previously uninsured and admitted to inpatient treatment will instead access outpatient services and be less likely to be admitted in crisis. The

impact to inpatient and outpatient services through this newly insured group should be tracked. Increased insurance coverage could be a factor in increased emergency department pressure, as some other states have experienced.[43] However, this does not necessarily mean that this pressure should result in increased admissions to psychiatric inpatient units, and there should be some leveling off as newly insured individuals engage in and learn to navigate outpatient services.

[43] Taubman, Sarah, L., et al. Medicaid Increase Emergency Department Use. Evidence from Oregon's health insurance experiment. Science Express. January 2, 2014; Page 1 / 10.1126/science.1246183

Section 7
Concluding Thoughts

Our analysis has found that based on the current adult mental health system in Milwaukee County, there will be a continued need for inpatient beds for consumers with higher acuity and lack of insurance to pay for care. It is reasonable that demand for these beds could further decrease if certain types of community-based services are increased. In the near term, however, individuals with higher acuity and Medicaid fee-for-service or no insurance will likely continue to be admitted to BHD rather than to Aurora Psychiatric Hospital or Rogers Memorial due to lack of reimbursement and other factors discussed throughout this analysis.

Given that the private hospitals currently handle approximately 85% of all admissions to inpatient care, however, a major consideration for the longer term is at what point it becomes economically inefficient for the County to continue to provide care at the Mental Health Complex. BHD could negotiate a rate to pay for Medicaid-eligible or uninsured individuals at the private hospitals, or work with non-IMD private hospitals to admit more individuals with Medicaid to reduce the burden on public funds.

To accommodate a reduced but continued need for high-acuity beds and the reimbursement issues discussed throughout this report, we suggest that four scenarios exist:

- BHD continues to operate a smaller number of high-acuity beds at the Mental Health Complex or in a smaller facility.
- BHD purchases high-acuity capacity at a private hospital or hospitals.
- Milwaukee County residents with high-acuity, longer term needs are referred to a State-operated hospital.
- BHD or the State operates a regionalized facility that serves Milwaukee County residents and residents from surrounding counties who otherwise would have been referred to a State hospital for longer term care.

Each scenario is discussed briefly below and will require additional examination as the Mental Health Board considers the future role of the Mental Health Complex.

Scenario I: BHD continues to operate a smaller number of high-acuity beds at the Mental Health Complex or in a smaller facility.

Over time, the number of consumers admitted to the Mental Health Complex has decreased as community capacity increased and psychopharmacological treatments became more effective. Despite this progress, there will still be a need for some longer term, high-acuity beds to serve Milwaukee County residents. We believe, however, that if there is willingness to devote sufficient resources to the types of community-based services described in the previous

section, then the number of such beds can be reduced substantially below the 54 to 60 that currently are required.

In many states, the public authority (mostly at the state level) charged with this responsibility continues to provide this service. For Milwaukee County, the efficiency of operating this service at the current Mental Health Complex or providing the service in a more cost-efficient setting is at issue.

At some point the cost to provide services to relatively few individuals in a larger facility becomes inefficient, particularly when that facility is classified as an IMD and when it exists as part of a county government structure that allocates centralized costs to the Mental Health Complex as if it is a regular county department (as opposed to a health care facility). If the MHB determines that the County should continue providing inpatient services, then it should consider the point at which it provides the service in a smaller setting at a different location. One consideration could be to secure space to provide one or more 16-bed units, which might not be considered IMDs and would therefore be eligible to receive Medicaid reimbursement. Discussions would need to occur with the state Medicaid office, however, to determine whether the site or sites would be IMDs. Notwithstanding the IMD consideration, there may be other cost savings that could be realized if the county operated its inpatient beds at a different location in a smaller facility.

Scenario II: BHD purchases high-acuity capacity at a private hospital.

BHD could get out of the business altogether and purchase capacity from private hospitals or other private behavioral health providers. Historically, BHD has taken responsibility for providing inpatient and emergency care of indigent individuals with mental health and substance abuse disorders. However, there are examples across the country where the public system purchases that capacity from private hospitals. It is likely there will still be instances when a patient's situation is so complex (for example, forensic involvement, extreme risk for violence, history of sexual offense) that the public system will need to play a role. In this scenario, in those limited instances, the state hospital system typically provides treatment. Despite the fact that BHD currently transfers very few county residents to the state hospitals, the State hypothetically could be asked to play a greater role in accepting such patients, though state officials obviously would have to be open to that idea and heavily involved in this planning process.

Scenario III: Milwaukee County residents with high-acuity, longer term needs are referred to a state-operated hospital.

Unlike the previous scenario, in which the state hospitals would play a greater role solely with regard to the most complex patients, in this scenario they would be expected to serve all Milwaukee County residents with high-acuity and longer term needs. This scenario assumes an increased ability of the private hospitals to serve more individuals, thereby resulting in a lower

number of individuals who would be referred to the state hospitals. Most systems across the nation, including other counties in Wisconsin, do not have county-operated hospitals. In these systems, patients who cannot be served well in local acute care hospitals are served in the state hospitals. While state systems are working to reduce their census, they continue to play a role in serving individuals with the most complicated situations. As in Scenario II, the state may reject any additional pressure on its state hospital beds, and this scenario would need to be discussed and negotiated with state officials. A separate fiscal analysis by the Public Policy Forum will be released later this year, and this analysis will be helpful in comparing the actual costs of operating beds at the Mental Health Complex against potential charges for state hospital beds.

Scenario IV: BHD or the State operates a regionalized facility.

Instead of seeking to move to a smaller facility, BHD could use the excess capacity at the Mental Health Complex that has been (and will continue to be) created from decreasing utilization of high-acuity beds to provide beds to adjacent counties. As the State seeks to decrease its census in the state hospitals, it could utilize the Mental Health Complex, or a facility in an alternate location, in a regional capacity to serve out-of-county residents who need higher-acuity beds, rather than referring them to the state hospitals. Reimbursement arrangements with sending counties would need to be made. While it would be logical for the County to run such a regionalized facility, its operation also potentially could be turned over to the State. Either way, the facility would continue to be an IMD, and other cost factors, such as capital costs for the aging complex, remain an issue.

Appendix A: Description of Community-Based Services

SAIL: Within the BHD, the Service Access to Independent Living (SAIL) unit within the Community Services Branch centrally manages access to long-term community-based services. Eligibility for long-term community-based services, initiated through the SAIL program, is restricted to persons who are most in need of services and who have not been adequately served through traditional outpatient services. Behavioral and medical providers must initiate a referral to SAIL. Referrals involve a psychiatric evaluation, two psychiatric hospital discharge summaries, and a SAIL assessment. The purpose of this lengthy assessment process is to determine that community services are being delivered to those most in need.

CARS: Community Access to Recovery Services (CARS) is a BHD program that provides recovery-oriented services to people with severe and persistent mental illness and/or issues with substance use disorder.

Community Support Program: The CSP is based on the Assertive Community Treatment (ACT) model of case management, although it is not a true ACT program. It is the most intensive case management service available in Milwaukee County.

Targeted Case Management: TCM is a less intensive case management program designed to involve fewer contacts with clients and a focus on ongoing monitoring and service coordination.

CLASP: Community Linkages and Stabilization Program (CLASP) provides post-hospitalization extended support and treatment designed to support an individual's recovery, increase ability to function independently in the community, and reduce incidents of emergency room contacts and re-hospitalizations through individual support from Certified Peer Specialists under the supervision of a clinical coordinator.

Day Treatment Partial Hospitalization Program: A structured non-residential treatment service consisting of regularly scheduled sessions of various modalities such as counseling, case management, group or individual therapy, medical services and mental health and substance abuse services, as indicated, by interdisciplinary providers for a scheduled number of sessions per day and week.

Community-Based Residential Facility (CBRF): Residential treatment is available in varying intensities in community-based residential facilities and transitional housing programs.

Outpatient: Services available through outpatient treatment include medication management and individual and group psychotherapy.

Comprehensive Community Services (CCS): CCS programs provide psychosocial rehabilitation services to consumers who have needs for ongoing, high or low-intensity services resulting from mental health or substance use disorders but who are not in need of Community Support Program (CSP) services. Psychosocial rehabilitation includes medical and remedial services and

supportive activities provided to or arranged for a individual by a comprehensive community services program authorized by a mental health professional to assist individuals with mental disorders and/or substance use disorders to achieve the individual's highest possible level of independent functioning, stability and independence and to facilitate recovery. CCS programs use a wraparound model that is flexible, consumer directed, recovery oriented, as well as strength and outcome based.

Community Recovery Services (CRS): CRS provides three (3) specific services: Community Living Supportive Services, Supported Employment, and Peer Supports, under the umbrella of psychosocial rehabilitation. The goal of CRS is to enable people with mental illness to live with maximum independence within the community, while at the same time offering these members more control over designing the services they receive.

Appendix B: Stakeholder Perspectives

Capacity

By far, the concern expressed most was that the system does not have sufficient community-based capacity or psychiatric emergency response services to divert people from inpatient settings. There was some acknowledgement of new funding (for example, CLASP, mobile response), but the concern was raised that it is insufficient and has not been implemented in advance of inpatient downsizing.

Several people commented that access to psychiatrists is limited, that long waitlists jeopardize stability, services are not intensive enough or aligned with the types that are needed (for example, ACT, PSH), that too many individuals are discharged to homeless settings, shelters or other substandard housing, and that there are not enough treatment options for substance abuse or co-occurring disorders. Several felt that because of BHD funding, it is easier to get access if a person is indigent and without insurance than it is for a person with Medicaid coverage due to rate reimbursement issues and a shortage of providers that accept Medicaid. Several noted that the inclusion of Recovery Case Management was good, but that new case management capacity was not actually added to the system. Concerns about waitlists for case management were expressed.

Regarding crisis services, participants acknowledged the decrease in emergency detentions, but they were critical that police intervention as a frontline to psychiatric crisis response services is fundamentally flawed. The increase in mobile response capacity has been seen as beneficial, but there was criticism that the response time is inadequate.

Stakeholders liked the concept of Comprehensive Community Services (CCS) and Community Recovery Services (CRS), but expressed some skepticism that the services would be implemented in a manner that will meet the needs of consumers. The lack of affordable, supportive housing was also identified as a significant gap.

Regarding inpatient capacity, several felt that resources would be better spent on strengthening the community system of care. However, others felt that there must be bed capacity to serve as the safety net when needed.

Stakeholders felt strongly that any funding saved from BHD downsizing should be reallocated to community services.

Accountability

Several stakeholders expressed concern with a lack of accountability over psychiatric inpatient capacity in the system. While BHD has a mandate to address the acute care needs of Milwaukee residents, stakeholders felt that some of these issues were beyond the control or

authority of BHD. Even if there was a formula to determine the optimal number of beds for the county, there is no incentive or leverage to ensure that capacity is developed or maintained.

There is a perception that the local hospitals are not doing all they can to meet the behavioral health needs of Milwaukee County, and that they should step up. There is a perception that there is no real admission/exclusionary criteria, that hospitals refuse admissions indiscriminately, and that situations default to BHD. Absent any authority, contractual or regulatory, it is difficult for BHD to have a planned inpatient system.

Specialized/Complex Needs

Concerns were expressed that hospital and community-based providers do not do a good job working with consumers with complex needs, and that this results in consumers being unnecessarily pushed into deeper levels of care. Some qualified this, stating that the intent is good on the part of providers, but that providers' workforce shortages and lack of training are the issue. Stakeholders identified co-existing medical conditions, co-occurring mental illness and substance use disorders, and severe symptomatology and behaviors as needing more specialized expertise in inpatient and outpatient settings. In inpatient settings, stakeholders expressed that hospitals should be able to work with patients with more complex conditions. In community-based settings, some stakeholders expressed that community providers could work with more challenging individuals, but need adequate levels of reimbursement to provide more services such as Assertive Community Treatment, supportive housing, and peer supports.

Stakeholders also expressed concern about the closure of the Hilltop and Rehab Central facilities. There was general support for the closures themselves; however, there was concern that the level of community supports being made available to individuals being discharged may be inadequate to meet their needs. There were also concerns that these individuals may place additional pressure on inpatient bed capacity.

Also, some individuals commented that some patients at BHD need a longer length of stay prior to being ready for discharge back to a community setting. However, there was recognition that this would result in some congestion in bed capacity and flow.

Roles

Roles came up in several discussions with stakeholders. Several comments were made regarding whether BHD should be in the business of providing and operating inpatient and crisis services or whether those functions should be delegated through contracts. Participants also expressed that there should be increased clarity on the role of the hospital systems in meeting the psychiatric inpatient needs of county residents. This further called into question the role of the State in providing inpatient care to those with the most complex needs.

Other questions involved the role of the new Mental Health Board going forward

Appendix C: Community Investments

BEHAVIORAL HEALTH DIVISION (6300) BUDGET

DEPT: Behavioral Health Division UNIT NO. 6300
FUND: General - 0077

Appendix Table

2014 Budget - Community Investments (DHHS and BHD)

January 1, 2014

Expand BHD's partnership with the Milwaukee Police Department for the **Crisis Mobile Team**, by adding one clinician to work directly with law enforcement in serving as first responders to ED calls with the goal of reducing involuntary Emergency Detentions.	$	115,327
Start a **Peer Run Drop in Center** that will operate on evenings and weekends to increase the existing peer services contracts.	$	278,000
Add **quality assurance staff** - which includes one position dedicated to Crisis Services in January.	$	81,214
Continue implementing the **Community Recovery Services (CRS)** program, which is a co-participation benefit for individuals with a severe and persistent mental illness that connects clients to necessary recovery services, such as supported employment and housing, to promote independence. This includes the creation of three positions.	$	275,000
Continue the **expanded case management**, including additional TCM slots.	$	125,000
Maintain funding for **Families Moving Forward**, focusing on the African American community.	$	150,000
Invest in a new partnership with the **UCC/16th street clinic** to focus on the Latino community.	$	45,000
Add resources specifically for clients moving out of **Rehab-Centers Central**, including 20 additional CSP slots, more group home beds and other additional supports such as adult family homes and other needed services.	$	793,174
Add **ACT/Integrated Dual Disorder Treatment (IDDT)** models, which are evidence based, to the existing CSP programs to improve and expand services for clients enrolled in that program.	$	416,800
Include a **cost of living adjustment** for all CSP providers that have been level funded since 2000. BHD will continue to review and consider COLA increases for other service areas in future years.	$	738,731

July 1, 2014

Open a **Southside Access Clinic** in July 2014 to help meet increased demand and also to address community needs by having a second location for services that individuals can more easily access.	$	250,000
Apply for funds to implement **Comprehensive Community Services (CCS),** which is a Medicaid psychosocial rehabilitation benefit.	$	-

BEHAVIORAL HEALTH DIVISION (6300) BUDGET

DEPT: Behavioral Health Division UNIT NO. 6300
FUND: General – 0077

Phased in over 2014

In partnership with the Division of Housing, BHD plans to offer a new **housing pilot program** specifically aimed at AODA clients, to provide a safe living environment coupled with Targeted Case Management (TCM) services for individuals who are in the early stages of recovery from a substance use disorder.	$	100,000
Expand the capacity to **provide mobile assessments to individuals in the community to 24 hour coverage**. If any call was deemed to be emergent, requiring immediate assessment, the BHD staff would then dispatch two on-call clinicians. This on call service would be provided by a contracted vendor. The vendors' Clinical staff would receive the full BHD Clinician training. Each member of the Mobile Crisis Team will receive additional training in related to address the behavioral health, medical and cognitive needs of elderly individuals in Milwaukee County.	$	200,000
The Housing Division's **Pathways To Permanent Housing** program is funded on an annual basis and provides transitional housing including intensive care management and the presence of a robust level of peer specialist resources and expertise in 2014. $276,250 is transferred from BHD to Housing and an additional $70,000 in increased tax levy is invested.	$	70,000
The Housing Division plans to implement a new initiative to create **40 permanent supportive housing scattered site units** to serve BHD consumers. The Housing Division will work with existing landlords to secure these units and the service model will include peer specialists to supplement the work of case managers.	$	400,000
Establish a **Community Consultation Team** specifically for individuals dually diagnosed with both a developmental disability and mental health issue. This includes the creation/transfer of 5 positions throughout 2014.	$	247,452
BHD and DSD will develop a **Crisis Resource Center** that will be available to individuals with Intellectual/Developmental Disabilities and a co-occurring mental illness. The primary goal of this program is to provide intensive support to assist an individual in acquiring the necessary skills to maintain or return to community living following behavioral or symptoms changes leading to crisis destabilization.	$	250,000
To assist BHD clients moving into the community, BHD will provide **prescriber availability** as a part of the Day Treatment program. This service will help provide continuity and outpatient services for individuals who are relocated from Hilltop and Rehab Central in order to avoid more intensive services. This will be a short-term initiative to help clients move to the community and allow time for a prescriber base to be developed.	$	65,578
An evening and weekend on-call **Crisis Response Team (CRT)** for individuals with ID/DD and MH clients is created through a partnership with the agency selected to run the DSD CRC. The main responsibilities of the on-call workers will be to answer crisis calls, provide support and guidance, and on-site assessment and intervention if needed.	$	154,544
The Housing Division will also fund **two case managers** to provide services to approximately 50 veterans who are disabled and homeless.	$	100,000
TOTAL INVESTMENT IN 2014	**$**	**4,855,820**

Appendix D: Data Tables

Table D1. Aurora Psychiatric Hospital Inpatient Admissions 2011-Q1 2014

Month-Year	Total	By Age					By Payer Source							Length of Stay (Days)		
		≤12	13-17	18-20	21-64	≥65	Private Insurance	Medicaid HMO	Medicaid (T19)	Medicare	Dual Medicaid/Medicare	Self -Pay	Other or Unknown	Mean	Median	Mode
Jan-11	284	23	50	14	194	3	139	85	12	33	7	8	0	4.8	4	4
Feb-11	249	20	54	15	155	5	125	74	11	33	1	5	0	5.2	4	3
Mar-11	311	29	64	23	191	4	144	107	10	38	8	4	0	4.5	4	3
Apr-11	294	23	52	27	187	5	163	74	9	39	5	4	0	4.7	4	3
May-11	268	23	50	14	178	3	142	81	10	28	2	5	0	4.7	4	3
Jun-11	232	11	33	20	163	5	121	72	4	26	5	4	0	4.9	4	3
Jul-11	247	6	28	16	193	4	122	75	4	35	6	5	0	4.5	4	3
Aug-11	249	8	23	17	191	10	120	77	4	36	4	8	0	4.5	4	3
Sep-11	255	15	40	20	176	4	118	92	2	31	8	4	0	4.4	4	3
Oct-11	275	18	46	16	191	4	132	96	14	25	5	3	0	5.0	4	3
Nov-11	280	16	60	15	186	3	149	81	12	30	5	3	0	4.6	4	2
Dec-11	242	10	49	18	161	4	116	69	12	34	4	7	0	5.0	4	3
Jan-12	293	19	46	16	207	5	144	100	10	31	6	2	0	5.1	4	4
Feb-12	267	23	51	16	174	3	120	91	14	32	5	5	0	4.7	4	3
Mar-12	309	36	59	28	181	5	149	98	19	26	13	4	0	5.4	4	4
Apr-12	299	19	48	25	203	4	154	91	9	32	8	5	0	5.0	4	4
May-12	308	28	54	19	200	7	138	95	20	38	11	6	0	4.8	4	3
Jun-12	232	13	38	15	164	2	112	71	10	24	5	10	0	4.7	4	3
Jul-12	254	8	36	17	190	3	108	93	5	32	8	8	0	5.3	4	4
Aug-12	261	17	40	10	193	1	134	71	18	26	10	2	0	5.0	4	4
Sep-12	237	23	36	10	161	7	104	78	12	32	8	3	0	4.8	4	3
Oct-12	282	15	42	24	194	7	134	76	11	46	8	7	0	5.3	4	3
Nov-12	253	12	48	12	175	6	136	63	11	31	7	5	0	5.2	4	3
Dec-12	210	11	44	17	134	4	104	51	17	27	5	6	0	5.0	4	4
Jan-13	296	13	48	14	214	7	146	66	20	41	14	9	0	5.4	4	3
Feb-13	236	13	52	19	148	4	115	67	19	28	4	3	0	5.3	4	3
Mar-13	300	19	56	24	197	4	152	94	12	31	11	0	0	4.9	4	4
Apr-13	255	10	55	16	169	5	103	89	8	37	8	10	0	5.1	4	3
May-13	308	18	52	24	212	2	141	106	3	41	9	8	0	5.0	4	4
Jun-13	274	13	40	8	207	6	103	100	8	48	5	10	0	4.3	4	3
Jul-13	246	12	38	12	178	6	101	78	10	51	1	5	0	5.2	4	4
Aug-13	249	15	30	15	183	6	94	88	4	47	5	11	0	4.5	4	3
Sep-13	289	11	53	19	200	6	129	81	11	53	5	10	0	5.1	4	4
Oct-13	355	20	88	20	223	4	151	120	18	49	7	10	0	4.8	4	4
Nov-13	344	21	82	26	205	10	149	126	16	39	8	6	0	5.1	4	3
Dec-13	318	23	59	22	204	10	132	111	12	51	8	4	0	5.5	4	4
Jan-14	335	13	75	25	219	3	146	121	15	35	6	12	0	5.3	5	4
Feb-14	351	22	95	23	202	9	158	114	20	47	4	8	0	5.1	5	5
Mar-14	349	29	79	35	197	9	152	111	19	57	3	7	0	5.3	5	3
2011 Total	**3186**	**202**	**549**	**215**	**2166**	**54**	**1591**	**983**	**104**	**388**	**60**	**60**	**0**	**4.7**	--	--
2012 Total	**3205**	**224**	**542**	**209**	**2176**	**54**	**1537**	**978**	**156**	**377**	**94**	**63**	**0**	**5.0**	--	--
2013 Total	**3470**	**188**	**653**	**219**	**2340**	**70**	**1516**	**1126**	**141**	**516**	**85**	**86**	**0**	**5.0**	--	--

Table D2. Aurora St. Luke's South Shore Inpatient Admissions 2011-Q1 2014

Month-Year	Total	By Age					By Payer Source							Length of Stay (Days)		
		≤12	13-17	18-20	21-64	≥65	Private Insurance	Medicaid HMO	Medicaid (T19)	Medicare	Dual Medicaid/Medicare	Self -Pay	Other or Unknown	Mean	Median	Mode
Jan-11	90	0	0	8	74	8	17	23	14	29	4	3	0	5.0	5	3
Feb-11	75	0	0	1	64	10	19	12	9	25	7	3	0	5.4	4	3
Mar-11	100	0	0	2	91	7	13	24	20	29	8	6	0	4.9	4.5	4
Apr-11	97	0	0	1	88	8	21	31	14	20	10	1	0	4.8	4	3
May-11	111	0	0	4	101	6	24	21	19	38	7	2	0	4.4	4	3
Jun-11	96	0	0	1	90	5	19	25	12	27	10	3	0	4.7	4	2
Jul-11	88	0	0	1	83	4	16	20	15	23	11	3	0	4.7	4	3
Aug-11	113	0	0	2	104	7	21	37	13	29	9	4	0	4.2	4	3
Sep-11	93	0	0	4	83	6	14	26	18	27	7	1	0	4.7	5	5
Oct-11	85	0	0	2	77	6	20	10	18	27	6	4	0	4.4	4	3
Nov-11	75	0	0	2	72	1	10	26	16	19	3	1	0	5.1	5	4
Dec-11	87	0	0	1	74	12	9	23	18	29	5	3	0	5.0	5	4
Jan-12	89	0	0	2	78	9	12	20	17	30	6	4	0	5.0	4	3
Feb-12	86	0	0	4	79	3	19	16	20	21	8	2	0	5.2	5	5
Mar-12	106	0	0	1	97	8	24	21	19	36	5	1	0	4.9	4	3
Apr-12	100	0	0	2	89	9	29	19	22	16	12	2	0	4.6	4	4
May-12	107	0	0	5	97	5	26	22	18	20	19	2	0	4.3	4	3
Jun-12	86	0	0	4	74	8	16	15	24	15	14	2	0	4.9	4	4
Jul-12	90	0	0	7	81	2	23	14	14	25	12	2	0	5.0	5	4
Aug-12	102	0	0	2	98	2	14	19	27	19	16	7	0	4.4	4	4
Sep-12	100	0	0	0	93	7	25	25	14	21	15	0	0	4.3	4	3
Oct-12	105	0	0	6	93	6	26	19	15	20	19	6	0	4.6	5	5
Nov-12	105	0	0	3	100	2	16	14	37	17	14	7	0	4.9	4	4
Dec-12	91	0	0	2	86	3	13	13	31	15	14	5	0	4.8	4	4
Jan-13	104	0	0	5	94	5	21	16	25	16	18	8	0	4.8	5	5
Feb-13	75	0	0	4	68	3	9	19	25	12	7	3	0	4.4	4	5
Mar-13	101	0	0	5	90	6	11	25	20	20	20	5	0	4.9	4	4
Apr-13	100	0	0	2	94	4	28	20	16	19	14	3	0	4.4	4	3
May-13	113	0	0	3	107	3	21	24	27	18	20	3	0	4.1	4	4
Jun-13	119	0	0	2	112	5	22	30	24	17	21	5	0	4.1	3	3
Jul-13	135	0	0	4	128	3	29	43	25	15	15	8	0	4.1	4	4
Aug-13	96	0	0	3	90	3	24	17	20	20	13	2	0	4.7	4	3
Sep-13	101	0	0	1	95	5	19	21	28	15	13	5	0	4.8	5	6
Oct-13	120	0	0	3	111	6	17	26	24	19	27	7	0	4.5	4	4
Nov-13	95	0	0	4	84	7	17	19	20	22	11	6	0	4.6	4	3
Dec-13	96	0	0	8	82	6	24	23	12	17	11	9	0	4.1	4	3
Jan-14	100	0	0	4	93	3	19	17	28	18	16	2	0	4.9	4	6
Feb-14	80	0	0	1	73	6	12	22	11	21	9	5	0	4.5	4	4
Mar-14	96	0	0	6	87	3	22	16	21	18	14	5	0	4.7	4	4
2011 Total	**1110**	**0**	**0**	**29**	**1001**	**80**	**203**	**278**	**186**	**322**	**87**	**34**	**0**	**4.7**	**--**	**--**
2012 Total	**1167**	**0**	**0**	**38**	**1065**	**64**	**243**	**217**	**258**	**255**	**154**	**40**	**0**	**4.7**	**--**	**--**
2013 Total	**1255**	**0**	**0**	**44**	**1155**	**56**	**242**	**283**	**266**	**210**	**190**	**64**	**0**	**4.4**	**--**	**--**

Table D3. Columbia-St. Mary's Inpatient Admissions 2011-Q1 2014

Month-Year	Total	By Age					By Payer Source*							Length of Stay (Days)		
		≤12	13-17	18-20	21-64	≥65	Private Insurance	Medicaid HMO	Medicaid (T19)	Medicare	Dual	Self-Pay	Other/Unknown	Mean	Median	Mode
Jan-11	144	0	0	15	114	15	33	27	25	38	n/a	13	8	3.9	3	1
Feb-11	133	0	0	7	105	21	44	28	7	39	n/a	8	7	5.6	4	3
Mar-11	153	0	0	3	137	13	59	21	16	41	n/a	10	6	4.7	3	2
Apr-11	158	0	1	5	138	14	36	32	19	50	n/a	14	7	4.3	4	1
May-11	146	0	0	18	116	12	44	32	15	41	n/a	10	4	4.3	3	2
Jun-11	151	0	0	8	123	20	37	34	12	44	n/a	8	16	5.2	4	2
Jul-11	151	0	0	11	129	11	44	33	11	42	n/a	12	9	4.5	3	1
Aug-11	147	0	0	7	126	14	38	27	13	48	n/a	14	7	4.2	4	1
Sep-11	143	0	0	8	119	16	41	27	8	42	n/a	13	12	4.5	4	2
Oct-11	156	0	0	12	135	9	47	28	21	38	n/a	10	12	3.9	3	2
Nov-11	156	0	0	7	133	16	40	30	13	54	n/a	12	7	4.5	4	2
Dec-11	151	0	0	10	118	23	41	32	15	46	n/a	12	5	4.3	3	1
Jan-12	167	0	0	4	149	14	42	31	19	53	n/a	15	7	3.9	3	3
Feb-12	148	0	0	9	124	15	42	30	25	33	n/a	12	6	4.7	4	2
Mar-12	161	0	0	8	143	10	43	28	24	45	n/a	15	6	4.8	3	2
Apr-12	147	0	0	9	125	13	32	36	19	42	n/a	11	7	5.2	4	2
May-12	200	0	0	9	174	17	46	43	30	55	n/a	18	8	4.4	4	2
Jun-12	162	0	0	2	146	14	41	28	17	55	n/a	11	10	4.1	3	2
Jul-12	161	0	1	7	142	11	33	33	24	40	n/a	25	6	4.2	3	3
Aug-12	163	0	1	1	147	14	44	29	16	48	n/a	18	8	4.4	3	3
Sep-12	162	0	0	4	137	21	28	20	19	57	n/a	23	15	4.0	3	3
Oct-12	183	0	0	7	169	7	54	29	22	40	n/a	27	11	4.0	3	2
Nov-12	157	0	0	7	136	14	46	20	22	44	n/a	17	8	3.7	3	2
Dec-12	164	0	0	9	136	19	49	14	30	44	n/a	18	9	4.6	3	2
Jan-13	151	0	0	7	119	25	43	19	19	42	n/a	25	3	5.0	4	2
Feb-13	143	0	0	7	125	11	43	17	19	39	n/a	20	5	5.4	3	3
Mar-13	156	0	0	5	139	12	38	25	22	43	n/a	21	7	4.8	4	2
Apr-13	175	0	0	9	154	12	41	32	31	44	n/a	17	10	4.1	3	2
May-13	175	0	1	10	149	15	40	20	31	54	n/a	28	2	4.2	3	1
Jun-13	163	0	0	8	139	16	48	20	28	32	n/a	26	9	4.1	3	3
Jul-13	185	0	1	6	165	13	58	24	22	50	n/a	25	6	5.0	3	2
Aug-13	170	0	0	3	152	15	47	24	19	51	n/a	23	6	4.6	4	1
Sep-13	160	0	0	10	131	19	38	21	17	51	n/a	23	10	4.8	3	3
Oct-13	144	0	0	7	121	16	39	26	19	37	n/a	19	4	4.2	3	2
Nov-13	142	0	0	11	120	11	38	18	23	33	n/a	23	7	4.2	3	2
Dec-13	130	0	0	3	114	13	26	13	19	41	n/a	24	7	4.5	3	2
Jan-14	116	0	0	7	97	12	33	14	14	33	n/a	18	4	5.4	4	2
Feb-14	107	0	0	5	92	10	32	17	11	24	n/a	22	1	4.8	4	4
Mar-14	109	0	0	13	84	12	39	17	8	20	n/a	17	8	3.7	3	2
2011 Total	**1789**	**0**	**1**	**111**	**1493**	**184**	**504**	**351**	**175**	**523**	**--**	**136**	**100**	**4.5**	--	--
2012 Total	**1975**	**0**	**2**	**76**	**1728**	**169**	**500**	**341**	**267**	**556**	**--**	**210**	**101**	**4.3**	--	--
2013 Total	**1894**	**0**	**2**	**86**	**1628**	**178**	**499**	**259**	**269**	**517**	**--**	**274**	**76**	**4.5**	--	--

*Private insurance includes Commercial/Indemnity and Managed Care/NON-CAP; Medicaid HMO includes Medicaid MGD CARE CAP and Medicaid MGD CARE NON-CAP; Medicare includes Medicare Traditional, Medicare MGD CARE CAP, and Medicare MGD CARE NON-CAP; Other or Unknown includes Other Government, Workers Comp, and Unknown.

Table D4. Froedtert Hospital Inpatient Admissions 2011-Q1 2014

Month-Year	Total	By Age					By Payer Source							Length of Stay (Days)		
		≤12	13-17	18-20	21-64	≥65	Private Insurance	Medicaid HMO	Medicaid (T19)	Medicare	Dual	Self -Pay	Other or Unknown*	Mean	Median	Mode
Jan-11	11	0	0	0	8	3	1	5	1	4	n/a	0	0	5.7	n/a	n/a
Feb-11	15	0	0	1	9	5	2	2	2	7	n/a	2	0	4.3	n/a	n/a
Mar-11	11	0	0	2	8	1	0	3	4	1	n/a	3	0	3.1	n/a	n/a
Apr-11	12	0	0	0	9	3	1	4	1	4	n/a	1	1	3.5	n/a	n/a
May-11	14	0	0	0	12	2	1	3	3	4	n/a	3	0	4.0	n/a	n/a
Jun-11	17	0	0	0	16	1	3	4	2	3	n/a	4	1	5.7	n/a	n/a
Jul-11	16	0	0	0	11	5	1	4	2	7	n/a	2	0	2.5	n/a	n/a
Aug-11	17	0	0	1	11	5	2	3	3	6	n/a	2	1	4.1	n/a	n/a
Sep-11	15	0	0	0	13	2	0	4	1	5	n/a	5	0	4.3	n/a	n/a
Oct-11	11	0	0	0	11	0	4	2	0	0	n/a	2	3	3.0	n/a	n/a
Nov-11	5	0	0	0	5	0	1	0	1	1	n/a	1	1	3.0	n/a	n/a
Dec-11	6	0	0	0	6	0	0	0	2	0	n/a	4	0	1.8	n/a	n/a
Jan-12	14	0	0	0	13	1	1	1	5	4	n/a	3	0	4.8	n/a	n/a
Feb-12	11	0	0	0	9	2	2	1	2	3	n/a	1	2	3.3	n/a	n/a
Mar-12	10	0	1	0	7	2	1	4	1	3	n/a	1	0	1.8	n/a	n/a
Apr-12	10	0	0	1	7	2	0	1	2	2	n/a	4	1	5.0	n/a	n/a
May-12	10	0	0	0	9	1	1	2	2	2	n/a	3	0	3.1	n/a	n/a
Jun-12	14	0	0	0	13	1	4	1	3	2	n/a	4	0	4.1	n/a	n/a
Jul-12	12	0	0	0	12	0	0	1	4	1	n/a	6	0	5.6	n/a	n/a
Aug-12	10	0	0	0	9	1	2	2	1	2	n/a	3	0	6.4	n/a	n/a
Sep-12	8	0	0	0	6	2	1	0	2	3	n/a	2	0	6.4	n/a	n/a
Oct-12	12	0	0	0	9	3	1	1	1	4	n/a	4	1	5.4	n/a	n/a
Nov-12	9	0	0	0	8	1	4	0	0	3	n/a	2	0	3.7	n/a	n/a
Dec-12	7	0	0	0	5	2	2	0	2	3	n/a	0	0	3.3	n/a	n/a
Jan-13	12	0	0	0	9	3	4	0	0	5	n/a	3	0	4.0	n/a	n/a
Feb-13	10	0	0	0	10	0	2	3	1	1	n/a	3	0	5.4	n/a	n/a
Mar-13	7	0	0	0	5	2	0	0	1	2	n/a	3	1	2.6	n/a	n/a
Apr-13	15	0	0	0	13	2	0	2	3	2	n/a	7	1	3.5	n/a	n/a
May-13	17	0	0	1	12	4	3	0	2	7	n/a	5	0	4.1	n/a	n/a
Jun-13	6	0	0	0	4	2	3	0	1	2	n/a	0	0	4.8	n/a	n/a
Jul-13	9	0	0	0	6	3	0	1	2	4	n/a	1	1	6.3	n/a	n/a
Aug-13	20	0	0	0	14	6	5	0	1	8	n/a	5	1	5.4	n/a	n/a
Sep-13	11	0	0	0	11	0	1	2	3	2	n/a	2	1	10.6	n/a	n/a
Oct-13	16	0	0	0	13	3	2	1	2	6	n/a	4	1	5.1	n/a	n/a
Nov-13	7	0	0	0	7	0	1	1	2	2	n/a	1	0	4.3	n/a	n/a
Dec-13	19	0	0	0	19	0	2	3	0	4	n/a	9	1	3.1	n/a	n/a
Jan-14	17	0	0	2	11	4	4	1	1	4	n/a	7	0	3.3	n/a	n/a
Feb-14	14	0	0	0	12	2	2	1	0	5	n/a	6	0	2.9	n/a	n/a
Mar-14	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
2011 Total	**150**	**0**	**0**	**4**	**119**	**27**	**16**	**34**	**22**	**42**	**--**	**29**	**7**	**3.9**	**--**	**--**
2012 Total	**127**	**0**	**1**	**1**	**107**	**18**	**19**	**14**	**25**	**32**	**--**	**33**	**4**	**4.4**	**--**	**--**
2013 Total	**149**	**0**	**0**	**1**	**123**	**25**	**23**	**13**	**18**	**45**	**--**	**43**	**7**	**4.9**	**--**	**--**

*The Other or Unknown category is other government insurance.

Table D5. Rogers Memorial Inpatient Admissions 2011-May 2014†

Month- Year	Total	By Age					By Payer Source*							Length of Stay (Days)		
		≤12	13-17	18-20	21-64	≥65	Private Insurance	Medicaid HMO	Medicaid (T19)	Medicare	Dual	Self -Pay	Other or Unknown	Mean	Median	Mode
Jan-11	504	62	111	41	276	14	253	116	49	73	n/a	13	0	6.7	5	4
Feb-11	395	48	104	35	192	16	213	83	30	60	n/a	9	0	6.3	5	3
Mar-11	456	66	123	39	221	7	238	114	38	56	n/a	10	0	6.1	5	3
Apr-11	423	62	115	39	199	8	228	106	39	44	n/a	6	0	6.2	6	3
May-11	461	74	122	38	214	13	234	120	40	55	n/a	12	0	5.9	5	6
Jun-11	447	66	112	37	223	9	232	104	37	61	n/a	13	0	6.0	5	5
Jul-11	411	60	79	31	224	17	215	90	35	64	n/a	7	0	6.0	5	3
Aug-11	441	65	83	38	244	11	207	111	51	63	n/a	9	0	5.8	5	3
Sep-11	395	49	75	28	233	10	202	96	34	54	n/a	9	0	5.9	5	3
Oct-11	432	71	95	32	224	10	240	93	36	55	n/a	8	0	6.3	5	3
Nov-11	432	65	107	29	223	8	238	112	36	39	n/a	7	0	6.4	6	4
Dec-11	400	66	110	36	180	8	209	119	31	37	n/a	4	0	5.7	5	3
Jan-12	498	72	120	43	258	5	274	108	53	54	n/a	9	0	6.6	5	3
Feb-12	434	70	102	38	218	6	245	88	39	57	n/a	5	0	6.8	6	7
Mar-12	460	70	113	46	221	10	248	107	41	57	n/a	7	0	6.0	5	3
Apr-12	431	63	105	31	227	5	213	108	45	59	n/a	6	0	6.1	5	4
May-12	435	74	107	41	208	5	220	124	38	47	n/a	6	0	6.4	6	6
Jun-12	435	71	81	26	250	7	222	114	41	49	n/a	9	0	6.3	5	3
Jul-12	425	68	75	34	244	4	199	119	33	62	n/a	12	0	6.8	6	4
Aug-12	442	67	74	48	241	12	230	108	37	63	n/a	4	0	6.2	5	3
Sep-12	421	61	79	28	246	7	227	110	29	43	n/a	12	0	6.2	6	7
Oct-12	511	62	125	31	284	9	289	112	43	58	n/a	9	0	6.5	6	3
Nov-12	440	66	124	44	200	6	232	87	67	44	n/a	10	0	6.8	6	4
Dec-12	409	45	116	28	213	7	234	50	56	59	n/a	10	0	6.1	5	5
Jan-13	504	77	135	38	243	11	306	68	60	58	n/a	12	0	7.0	6	7
Feb-13	426	78	124	28	189	7	248	62	61	45	n/a	10	0	6.6	6	7
Mar-13	445	70	123	33	204	15	235	79	58	63	n/a	10	0	7.6	6	7
Apr-13	470	54	128	39	245	4	290	79	39	50	n/a	12	0	7.0	6	3
May-13	517	74	145	38	246	14	320	92	45	55	n/a	5	0	6.9	6	5
Jun-13	413	62	95	26	224	6	224	94	44	46	n/a	5	0	8.0	6	7
Jul-13	469	65	105	38	252	9	256	98	53	49	n/a	13	0	6.6	6	7
Aug-13	436	60	83	26	256	11	236	86	44	58	n/a	12	0	7.1	5	3
Sep-13	441	39	121	34	243	4	238	102	30	57	n/a	14	0	6.4	5	4
Oct-13	478	65	138	41	233	1	258	116	46	54	n/a	4	0	7.0	6	3
Nov-13	413	48	109	32	219	5	242	89	38	42	n/a	2	0	7.1	6	3
Dec-13	394	46	117	30	191	10	217	103	30	40	n/a	4	0	6.5	6	3
Jan-14	481	41	159	37	236	8	277	103	30	62	n/a	9	0	8.2	6	4
Feb-14	430	47	128	25	226	4	254	100	30	42	n/a	4	0	7.1	6	7
Mar-14	419	38	120	37	219	5	227	111	29	47	n/a	5	0	6.4	5	3
Apr-14	462	72	126	35	218	11	242	124	41	50	n/a	5	0	7.4	6	4
May-14	463	56	145	43	210	9	228	113	58	53	n/a	11	0	7.6	6	4
2011 Total	**5197**	**754**	**1236**	**423**	**2653**	**131**	**2709**	**1264**	**456**	**661**	**--**	**107**	**0**	**6.1**	**--**	**--**
2012 Total	**5341**	**789**	**1221**	**438**	**2810**	**83**	**2833**	**1235**	**522**	**652**	**--**	**99**	**0**	**6.4**	**--**	**--**
2013 Total	**5406**	**738**	**1423**	**403**	**2745**	**97**	**3070**	**1068**	**548**	**617**	**--**	**103**	**0**	**7.0**	**--**	**--**

†Includes Oconomowoc and Milwaukee sites; *Private Insurance category includes HMP/PPO, UBH, Value Options, Anthem BCBS, Commercial Misc. and Health EOS; Medicare category includes Medicare HMO and Medicare

Table D6. Wheaton Hospital Inpatient Admissions 2011-Q1 2014

Month- Year	Total	By Age					By Payer Source*							Length of Stay (Days)		
		≤12	13-17	18-20	21-64	≥65	Private Insurance	Medicaid HMO	Medicaid (T19)	Medicare	Dual	Self -Pay	Other or Unknown	Mean	Median	Mode
Jan-11	70	0	0	1	63	6	9	27	11	18	0	4	1	6	4	2
Feb-11	63	0	0	1	59	3	8	17	13	23	0	2	0	6	5	3
Mar-11	105	0	0	3	97	5	13	28	18	40	0	6	0	5	4	4
Apr-11	87	0	1	6	77	3	12	29	10	31	0	5	0	5	3	3
May-11	81	0	0	2	71	8	10	25	18	25	0	3	0	6	5	2
Jun-11	95	0	0	3	89	3	17	29	12	33	0	4	0	6	4	4
Jul-11	82	0	0	3	74	5	7	25	16	27	0	7	0	4	3	3
Aug-11	98	0	0	1	82	15	8	25	17	39	0	9	0	6	5	3
Sep-11	85	0	0	2	72	11	12	19	11	34	0	9	0	5	4	2
Oct-11	79	0	0	5	64	10	13	17	15	31	0	3	0	6	5	4
Nov-11	59	0	0	4	51	4	9	21	8	17	0	4	0	5	4	4
Dec-11	55	0	0	0	48	7	10	13	9	22	0	1	0	7	4	2
Jan-12	73	0	0	3	62	8	9	17	16	25	0	6	0	5	4	2
Feb-12	82	0	0	5	72	5	15	26	14	20	0	6	1	5	4	2
Mar-12	72	0	0	0	65	7	5	21	14	25	0	7	0	6	4	3
Apr-12	81	0	0	1	73	7	10	23	10	30	0	8	0	6	5	3
May-12	98	0	0	1	85	12	12	21	9	46	0	10	0	6	4	4
Jun-12	77	0	0	4	66	7	11	18	15	25	0	8	0	5	4	2
Jul-12	74	0	0	2	64	8	11	17	14	25	0	7	0	5	4	3
Aug-12	85	0	0	1	74	10	17	16	15	30	0	7	0	4	4	3
Sep-12	86	0	0	3	78	5	14	21	20	24	0	7	0	4	4	4
Oct-12	91	0	0	1	86	4	7	12	27	41	0	4	0	5	4	4
Nov-12	79	0	0	0	68	11	10	13	18	29	0	9	0	5	4	5
Dec-12	79	0	0	4	70	5	7	16	23	27	0	6	0	7	4	4
Jan-13	74	0	0	3	65	6	15	20	14	22	0	3	0	5	4	3
Feb-13	65	0	0	1	60	4	8	12	17	24	0	4	0	6	4	3
Mar-13	80	0	0	3	71	6	15	17	18	26	0	4	0	5	4	1
Apr-13	84	0	0	3	76	5	7	18	25	29	0	5	0	5	4	2
May-13	84	0	0	2	79	3	9	23	21	24	0	7	0	5	4	3
Jun-13	95	0	0	3	81	11	12	25	19	36	0	3	0	5	4	2
Jul-13	87	0	0	0	81	6	4	25	18	32	0	8	0	5	4	2
Aug-13	73	0	0	1	66	6	10	18	16	24	0	5	0	5	5	5
Sep-13	101	0	0	1	89	11	14	26	24	31	0	6	0	5	4	2
Oct-13	109	0	0	1	103	5	15	27	27	33	0	6	1	5	4	2
Nov-13	92	0	0	3	85	4	7	19	27	31	0	8	0	5	4	3
Dec-13	85	0	0	4	74	7	10	17	15	34	0	9	0	5	4	3
Jan-14	87	0	0	0	82	5	9	16	19	31	0	11	1	6	5	5
Feb-14	77	0	0	2	73	2	5	23	19	26	0	4	0	7	5	2
Mar-14	98	0	0	5	83	10	14	19	24	30	0	11	0	6	5	3
2011 Total	**959**	**0**	**1**	**31**	**847**	**80**	**128**	**275**	**158**	**340**	**0**	**57**	**1**	**5.7**	**--**	**--**
2012 Total	**977**	**0**	**0**	**25**	**863**	**89**	**128**	**221**	**195**	**347**	**0**	**85**	**1**	**5.2**	**--**	**--**
2013 Total	**1029**	**0**	**0**	**25**	**930**	**74**	**126**	**247**	**241**	**346**	**0**	**68**	**1**	**5.1**	**--**	**--**

Table D7. BHD Inpatient Admissions 2011-2013

Month-Year	Adult Acute	CAIS	TOTAL
Jan-11	153	122	275
Feb-11	203	117	320
Mar-11	174	142	316
Apr-11	149	131	280
May-11	172	136	308
Jun-11	174	122	296
Jul-11	147	97	244
Aug-11	157	84	241
Sep-11	149	93	242
Oct-11	157	120	277
Nov-11	144	91	235
Dec-11	135	75	210
Jan-12	136	112	248
Feb-12	127	103	230
Mar-12	130	131	261
Apr-12	152	104	256
May-12	139	129	268
Jun-12	142	84	226
Jul-12	156	70	226
Aug-12	142	79	221
Sep-12	114	87	201
Oct-12	152	95	247
Nov-12	119	72	191
Dec-12	131	87	218
Jan-13	134	97	231
Feb-13	120	42	162
Mar-13	122	70	192
Apr-13	122	79	201
May-13	122	87	209
Jun-13	112	52	164
Jul-13	149	60	209
Aug-13	117	63	180
Sep-13	119	75	194
Oct-13	119	66	185
Nov-13	105	66	171
Dec-13	115	72	187
2011 Total	1914	1330	3244
2012 Total	1640	1153	2793
2013 Total	1456	829	2285

Source: BHD Dashboard

Table D8. BHD Inpatient Admissions by Characteristic Dec 2012-Mar 2014

Month- Year	Total	By Age						By Payer Source						Length of Stay (Days)		
		<18	18-25	26-39	40-54	55-64	≥65	Private	Medicaid HMO	Medicaid (T19)	Medicare	Self -Pay	Other*	Mean	Median	Mode
Dec-12	217	55	66	39	41	12	4	29	58	56	37	30	7	9.8	4	2
Jan-13	213	68	44	36	42	19	4	13	76	46	42	31	5	8.5	5	1
Feb-13	165	29	35	35	44	19	3	10	53	34	38	26	4	9.6	6	6
Mar-13	187	59	39	38	28	19	4	26	58	36	29	29	9	8.2	5	3
Apr-13	205	70	22	41	37	24	11	20	56	51	47	28	3	9.8	5	3
May-13	209	79	32	39	35	22	2	18	77	45	38	28	3	9.7	6	2
Jun-13	162	46	20	45	38	9	4	9	54	35	33	29	2	9.6	5	2
Jul-13	210	57	35	57	40	18	3	14	68	49	40	36	3	8.7	5	2
Aug-13	180	60	32	33	33	18	4	12	51	49	34	31	3	10.7	5.5	5
Sep-13	196	68	26	33	37	24	8	23	61	37	50	21	4	10.0	5	3
Oct-13	183	60	34	27	39	16	7	15	58	40	42	26	2	10.2	5	4
Nov-13	172	62	19	50	22	16	3	13	55	38	36	28	2	9.7	5	4
Dec-13	187	67	31	36	34	13	6	21	64	31	39	30	2	9.3	5	3
Jan-14	195	84	24	44	27	13	3	19	69	43	25	38	1	9.6	5	3
Feb-14	179	79	26	30	28	11	5	21	55	44	23	34	2	8.2	5	2
Mar-14	170	74	27	30	21	16	2	19	62	29	26	31	3	8.2	5	4
2013 Total	2269	725	369	470	429	217	59	194	731	491	468	343	42	**9.5**	--	--

*Other includes Military and Family Care

Source: BHD by request

Table D9. BHD Psychiatric Crisis Services (PCS) Admissions 2011-Q1 2014

Month-Year	Total PCS Admits	Number Resulting in Admit to Acute Adult	Number Resulting in Admit to CAIS	Number Resulting in Admit to Local In-patient	Discharge to Detox/ Genesis	Discharge to Law Enforcement	Discharge to Obs. Unit	Number Returned/ Referred Back to Community	Number Mobile Contacts Returned/ Referred Back to Community
Jan-11	1075	153	122	123	132	21	183	341	84
Feb-11	1093	136	131	102	119	27	175	403	70
Mar-11	1179	173	142	143	139	40	207	335	82
Apr-11	1107	149	131	135	131	16	181	364	104
May-11	1187	172	136	129	135	25	181	409	84
Jun-11	1108	174	121	117	117	20	184	375	99
Jul-11	1103	147	97	118	165	3	180	393	118
Aug-11	1155	157	84	115	156	13	175	455	130
Sep-11	1069	149	93	112	164	7	156	388	102
Oct-11	1127	157	120	99	161	6	177	407	113
Nov-11	1035	144	91	86	136	6	153	419	109
Dec-11	1051	135	75	91	148	3	159	440	114
Jan-12	1130	136	112	142	168	34	166	372	120
Feb-12	989	127	103	128	145	33	127	326	93
Mar-12	1115	130	131	152	155	21	140	386	111
Apr-12	1101	153	104	155	147	35	151	356	115
May-12	1150	139	129	131	135	34	152	430	135
Jun-12	1058	142	84	109	126	34	137	426	114
Jul-12	1085	156	70	119	121	34	152	433	130
Aug-12	1078	142	79	104	150	41	146	416	130
Sep-12	1014	114	87	92	135	28	131	427	111
Oct-12	1004	152	95	104	139	27	125	362	132
Nov-12	943	119	72	98	125	34	123	372	123
Dec-12	1031	102	79	244	111	31	145	574	146
Jan-13	975	87	81	241	103	38	142	527	167
Feb-13	923	99	39	248	115	44	127	492	122
Mar-13	1017	103	68	255	134	51	124	540	151
Apr-13	986	102	78	206	126	37	96	563	126
May-13	986	103	83	230	129	36	111	533	138
Jun-13	937	100	47	238	109	46	115	506	147
Jul-13	978	126	58	238	117	38	124	518	163
Aug-12	956	97	60	206	121	41	120	553	139
Sep-13	974	102	73	203	122	35	99	562	124
Oct-13	1017	102	66	246	113	28	95	574	132
Nov-13	838	90	63	220	87	28	86	437	155
Dec-13	877	96	70	222	117	19	88	465	130
Jan-14	888	107	85	206	105	25	81	465	145
Feb-14	835	86	78	193	105	17	87	462	172
Mar-14	882	81	77	190	110	22	84	513	163
2011	**13,289**	**1,846**	**1,343**	**1,370**	**1,703**	**187**	**2,111**	**4,729**	**1,209**
2012	**12,698**	**1,612**	**1,145**	**1,578**	**1,657**	**386**	**1,695**	**4,880**	**1,460**
2013	**11,464**	**1,207**	**786**	**2,753**	**1,393**	**441**	**1,327**	**6,270**	**1,694**

Source: BHD by request

Table D10. BHD Admissions to Access Clinic or Crisis Resource Center 2011-Q1 2014

Month-Year	Total Access Clinic Admissions	Number Sent to PCS	Number Sent to Community Provider
Jan-11	339	4	339
Feb-11	309	1	309
Mar-11	404	3	404
Apr-11	385	5	385
May-11	397	1	397
Jun-11	395	4	395
Jul-11	345	1	345
Aug-11	404	1	404
Sep-11	332	2	332
Oct-11	333	1	333
Nov-11	337	1	337
Dec-11	340	0	340
Jan-12	452	7	452
Feb-12	439	11	439
Mar-12	442	7	442
Apr-12	468	4	468
May-12	535	7	535
Jun-12	588	4	588
Jul-12	601	4	601
Aug-12	632	6	632
Sep-12	592	3	592
Oct-12	711	8	711
Nov-12	555	7	555
Dec-12	545	6	545
Jan-13	659	9	659
Feb-13	457	3	457
Mar-13	530	1	530
Apr-13	508	7	508
May-13	524	2	524
Jun-13	440	2	440
Jul-13	498	2	498
Aug-12	532	4	532
Sep-13	499	6	499
Oct-13	690	3	690
Nov-13	485	3	485
Dec-13	488	2	488
Jan-14	508	2	339
Feb-14	504	3	309
Mar-14	459	2	404
2011	**4,320**	**24**	**4,320**
2012	**6,560**	**74**	**6,560**
2013	**6,310**	**44**	**6,310**

Source: BHD by request

Table D11. BHD Admissions to Crisis Stabilization 2011-Q1 2014

Month-Year	Number Admitted by Community as Diversions	Number Admitted by BHD or Local Inpatient as Step-downs	Number Discharged to Community Provider
Jan-11	2	21	5
Feb-11	5	16	6
Mar-11	8	23	5
Apr-11	4	17	9
May-11	5	23	5
Jun-11	12	26	1
Jul-11	3	27	5
Aug-11	5	30	4
Sep-11	3	30	9
Oct-11	4	29	6
Nov-11	5	18	5
Dec-11	10	10	10
Jan-12	5	25	3
Feb-12	1	21	4
Mar-12	5	17	9
Apr-12	4	26	3
May-12	7	22	6
Jun-12	3	14	6
Jul-12	5	22	5
Aug-12	3	19	6
Sep-12	4	20	6
Oct-12	4	24	1
Nov-12	5	15	2
Dec-12	2	18	3
Jan-13	7	29	1
Feb-13	4	21	4
Mar-13	1	22	5
Apr-13	4	18	6
May-13	2	14	6
Jun-13	7	20	3
Jul-13	10	16	7
Aug-12	7	29	5
Sep-13	6	19	4
Oct-13	3	24	6
Nov-13	5	12	4
Dec-13	2	16	5
Jan-14	4	26	5
Feb-14	3	16	9
Mar-14	4	14	2
2011 Total	**66**	**270**	**70**
2012 Total	**48**	**243**	**54**
2013 Total	**58**	**240**	**56**

Source: BHD by request

Table D12. BHD Admissions to Observation Dec 2012-Q1 2014

Month-Year	Total OBS Admissions	Number Resulting in Admit to Local Inpatient	Number Discharge to Detox/ Genesis	Number Discharge to Acute or CAIS	Number Returned/Referred Back to Community
Dec-12	153	15	2	22	115
Jan-13	148	14	4	21	106
Feb-13	125	9	4	20	94
Mar-13	127	10	4	10	103
Apr-13	97	5	4	17	73
May-13	110	7	3	16	85
Jun-13	126	7	1	16	102
Jul-13	128	8	2	17	102
Aug-13	117	9	2	14	93
Sep-13	104	10	5	11	81
Oct-13	96	8	5	15	72
Nov-13	86	8	0	11	64
Dec-13	85	6	1	18	60
Jan-14	80	9	2	6	64
Feb-14	89	9	3	12	68
Mar-14	84	10	1	13	60

Source: BHD by request

Table D13. Private Hospitals' Average 30-Day Readmission Rates for Behavioral Health Admissions

	2011	2012	2013
Aurora	9.7%	11.0%	12.1%
Aurora SLSS	6.4%	10.0%	9.4%
Columbia St. Mary's	3.2%	3.0%	3.7%
Rogers*	10.0%	7.0%	8.0%
Wheaton	8.5%	8.9%	9.2%

*Transfers back to inpatient from RMH programs not included

Table D14. BHD Average 30-, 60-, and 90-Day Readmission Rates

	2011	2012	2013
Average 30-day readmission rate			
PCS	21.3%	22.5%	22.7%
Acute Adult	14.9%	15.9%	16.6%
CAIS	14.2%	13.2%	11.3%
Average 60-day readmission rate			
PCS	28.1%	28.7%	29.0%
Acute Adult	20.0%	20.7%	21.1%
CAIS	21.0%	18.3%	16.4%
Average 90-day readmission rate			
PCS	31.4%	32.2%	32.5%
Acute Adult	22.6%	24.1%	24.4%
CAIS	24.6%	21.2%	18.9%

Source: BHD by request

Multi-County Comparative Data from the Wisconsin Hospital Association[1.]

Table D15. Estimates of Prevalence of Mental Illness Adjusted for Poverty Levels

County[2]	Total population (2013)	Total population under 200% FPL[3]	% of population under 200% FPL	How much higher is MKE[4] County's rate of poverty (200% FPL)?	Projected number under 200% FPL with serious psych. distress based on CDC data*	Estimated % of population with serious psych. distress based on CDC data*, adjusted for poverty	How much higher is MKE County's estimated % of population with serious psych. distress based on CDC data*, adjusted for poverty?
Milwaukee County	**822,532**	**358,195**	**43.5%**	**0.0%**	**47,282**	**8.1%**	**0.00%**
Dane County	435,998	117,318	26.9%	61.8%	15,486	6.5%	23.12%
Waukesha County	326,877	45,727	14.0%	211.3%	6,036	5.4%	50.06%
Brown County	216,374	63,055	29.1%	49.4%	8,323	6.8%	19.42%
Racine County	163,400	50,252	30.8%	41.6%	6,633	6.9%	16.88%
Outagamie County	154,159	37,795	24.5%	77.6%	4,989	6.3%	27.35%
Lincoln, Langlade, Marathon 51.42 Board	151,552	44,688	29.5%	47.7%	5,899	6.8%	18.86%
Kenosha County	143,945	44,089	30.6%	42.2%	5,820	6.9%	17.07%
Winnebago County	138,018	39,400	28.5%	52.5%	5,201	6.7%	20.38%
Rock County	134,950	45,759	33.9%	28.4%	6,040	7.2%	12.21%
Washington County	112,361	20,071	17.9%	143.8%	2,649	5.7%	40.82%
La Crosse County	95,984	30,736	32.0%	36.0%	4,057	7.0%	14.95%
St. Croix County	94,750	26,384	27.8%	56.4%	3,483	6.6%	21.54%
Walworth County	85,759	26,939	31.4%	38.6%	3,556	7.0%	15.87%
Fond du Lac County	83,039	22,668	27.3%	59.5%	2,992	6.6%	22.46%
Eau Claire County	82,937	28,787	34.7%	25.5%	3,800	7.3%	11.08%
Sheboygan County	75,008	14,442	19.3%	126.2%	1,906	5.9%	37.78%
Ozaukee County	70,812	9,684	13.7%	218.4%	1,278	5.3%	50.86%
Jefferson County	69,726	18,962	27.2%	60.1%	2,503	6.6%	22.63%
Dodge County	69,196	18,593	26.9%	62.1%	2,454	6.5%	23.19%
Wisconsin	4,777,110	1,471,755	30.8%	41.4%	194,272	6.9%	16.79%

Notes:

1. Source: Wisconsin Hospital Association and WHA Information Center

*http://www.cdc.gov/nchs/data/hus/hus11.pdf See Table 59. CDC estimates that 13.2% of individuals below 200% FPL and 4.1% of individuals above 200% FPL had serious psychological distress in 2010-2011

2. The counties compared in this table are the Top 20 highest populated counties in Wisconsin.

3. FPL stands for Federal Poverty Level.

4. MKE stands for Milwaukee.

Table D16. Comparison of Emergency Department Visits with Mental Health Diagnosis in 2013[1]

County	Total ER visits (all dx)[2]	ER visits with primary MH dx	% of ER visits with primary MH dx	ER visits with primary MH dx per capita	How much higher is MKE County's ER visits per capita?	ER visits with primary MH dx per projected number with serious psych. distress based on CDC data*, adjusted for poverty	How much higher is MKE County's MH ER visits per projected number with serious psych. distress based on CDC data*, adjusted for poverty
Milwaukee County	**431,269**	**23,794**	**5.52%**	**2.89%**	**0.0%**	**35.9%**	**0.0%**
Dane County	125,180	6,416	5.13%	1.47%	96.6%	22.5%	59.7%
Waukesha County	91,029	3,345	3.67%	1.02%	182.7%	19.0%	88.4%
Brown County	99,345	2,393	2.41%	1.11%	161.6%	16.4%	119.0%
Racine County	79,170	3,400	4.29%	2.08%	39.0%	30.2%	18.9%
Outagamie County	54,310	2,673	4.92%	1.73%	66.8%	27.4%	31.0%
Lincoln, Langlade, Marathon 51.42 Board	57,818	1,512	2.62%	1.00%	190.0%	14.7%	143.9%
Kenosha County	74,600	2,801	3.75%	1.95%	48.7%	28.3%	27.0%
Winnebago County	52,731	2,707	5.13%	1.96%	47.5%	29.3%	22.5%
Rock County	69,396	2,530	3.65%	1.87%	54.3%	26.1%	37.5%
Washington County	29,587	1,292	4.37%	1.15%	151.6%	20.1%	78.6%
La Crosse County	27,227	2,478	9.10%	2.58%	12.1%	36.8%	-2.5%
St. Croix County	17,509	697	3.98%	0.74%	293.2%	11.1%	223.6%
Walworth County	33,556	1,144	3.41%	1.33%	116.9%	19.2%	87.2%
Fond du Lac County	29,276	1,226	4.19%	1.48%	95.9%	22.4%	60.0%
Eau Claire County	29,821	1,942	6.51%	2.34%	23.5%	32.3%	11.2%
Sheboygan County	32,084	1,979	6.17%	2.64%	9.6%	45.1%	-20.4%
Ozaukee County	19,624	858	4.37%	1.21%	138.7%	22.7%	58.3%
Jefferson County	25,950	774	2.98%	1.11%	160.6%	16.9%	112.5%
Dodge County	31,538	1,036	3.28%	1.50%	93.2%	22.9%	56.8%
Wisconsin	1,978,954	66,573	3.36%	1.39%	34.5%	20.2%	77.7%

Notes:

1. Source: Wisconsin Hospital Association and WHA Information Center

*http://www.cdc.gov/nchs/data/hus/hus11.pdf See Table 59. CDC estimates that 13.2% of individuals below 200% FPL and 4.1% of individuals above 200% FPL had serious psychological distress in 2010-2011

2. dx stands for diagnosis.

Table D17. Comparison of Inpatient Discharges with Mental Health Diagnosis in 2013

County	Total inpatient discharges (all dx)	Inpatient discharges with primary MH dx	% of inpatient discharges with primary MH dx	Inpatient discharges with primary MH dx per capita	How much higher is MKE County's MH inpatient discharges per capita?	Inpatient discharges with primary MH dx per projected number with serious psych. distress based on CDC data*, adjusted for poverty	How much higher is MKE County's MH inpatient discharges per projected number with serious psych. distress based on CDC data*, adjusted for poverty
Milwaukee County	**127,186**	**11,517**	**9.1%**	**1.40%**	**0.0%**	**17.4%**	**0.0%**
Dane County	45,138	3,412	7.6%	0.78%	78.9%	12.0%	45.3%
Waukesha County	40,192	3,069	7.6%	0.94%	49.1%	17.5%	-0.6%
Brown County	24,868	1,869	7.5%	0.86%	62.1%	12.8%	35.7%
Racine County	25,141	2,045	8.1%	1.25%	11.9%	18.1%	-4.3%
Outagamie County	16,127	1,829	11.3%	1.19%	18.0%	18.7%	-7.3%
Lincoln, Langlade, Marathon 51.42 Board	19,523	1,368	7.0%	0.90%	55.1%	13.3%	30.5%
Kenosha County	17,990	1,647	9.2%	1.14%	22.4%	16.6%	4.5%
Winnebago County	15,193	1,632	10.7%	1.18%	18.4%	17.7%	-1.6%
Rock County	17,506	1,481	8.5%	1.10%	27.6%	15.3%	13.7%
Washington County	12,862	955	7.4%	0.85%	64.7%	14.8%	17.0%
La Crosse County	10,359	1,287	12.4%	1.34%	4.4%	19.1%	-9.2%
St. Croix County	11,058	1,231	11.1%	1.30%	7.8%	19.6%	-11.3%
Walworth County	9,881	650	6.6%	0.76%	84.7%	10.9%	59.4%
Fond du Lac County	9,754	999	10.2%	1.20%	16.4%	18.3%	-5.0%
Eau Claire County	10,043	1,086	10.8%	1.31%	6.9%	18.0%	-3.7%
Sheboygan County	3,486	340	9.8%	0.45%	208.9%	7.7%	124.2%
Ozaukee County	8,488	667	7.9%	0.94%	48.7%	17.6%	-1.5%
Jefferson County	7,181	563	7.8%	0.81%	73.4%	12.3%	41.4%
Dodge County	9,142	627	6.9%	0.91%	54.5%	13.8%	25.4%
Wisconsin	451,447	39,140	8.7%	0.82%	70.9%	11.9%	46.3%

Source: Wisconsin Hospital Association and WHA Information Center

*http://www.cdc.gov/nchs/data/hus/hus11.pdf. See Table 59. CDC estimates that 13.2% of individuals below 200% FPL and 4.1% of individuals above 200% FPL had serious psychological distress in 2010-2011

Table D18. Percent of the County's Inpatient Mental Health Discharges Made from Private Hospitals

County	2010	2011	2012	2013
Brown	50.0%	51.1%	59.7%	64.9%
Dane	91.6%	91.8%	91.4%	90.6%
Fond du Lac	52.9%	47.9%	50.2%	49.3%
Lincoln, Langlade, Marathon Combined 51.42 Board	45.7%	37.1%	34.0%	30.0%
Milwaukee	70.6%	74.7%	78.1%	80.4%
Waukesha	67.7%	70.2%	72.9%	72.3%
Wood	55.0%	44.3%	47.3%	39.6%

Notes:

1. Source: Wisconsin Hospital Association and WHA Information Center
2. This table includes all of the counties that have a county-owned psychiatric hospital (like Milwaukee).
3. Dane County is included because it is the most similar to Milwaukee County in terms of population.