Grand Traverse Center for Mental Wellness

Serving Children and Adults

A Community Crisis Center

Business Plan

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Business Plan

Executive Summary

Michigan, like many other states, has seen an increase in demand for behavioral health services. While this has been exacerbated by the global pandemic, issues related to crisis response, inpatient capacity, and effective access have been identified, discussed, and explored for the past eight years and more.

Communities across the country are increasingly challenged by pressures on their healthcare and criminal justice systems from high volumes of persons experiencing behavioral health (BH) crises arising from mental illness, addiction, and related unresolved needs.[1] People suffering from substance use and mental health challenges, or both, often have limited access to health care and face other barriers, contributing to increased utilization of criminal justice and emergency health services.[2] Mental illness and substance use drive a disproportionate number of avoidable emergency department (ED) visits and, at the same time, are recognized as contributing to repeated involvement with the criminal justice system, 911/ emergency response, and other safety net systems.[3,4]

As providers, payers, states, and advocates seek answers and solutions, a consensus has emerged regarding the value of "crisis diversion facilities" as a key piece of the solution. In 2021, the Northwest Community Health Innovation Region, with funding from the Michigan Health Endowment Fund, published the Blueprint for Action: Strengthening Behavioral Health Systems and Promoting Well-Being and Resiliency. This document utilized recommendations from the Northern Michigan Crisis System Assessment Report prepared by tbdSolutions for two northern Michigan CMHs and two northern Michigan health systems. Drawing from this report and the work of a community-based action team, a group of community stakeholders has advanced the concept of a Community Crisis Wellness Center. The primary focus of such a center will include both Crisis Stabilization Unit (CSU) services and Crisis Residential Unit (CRU) services for both adults and youth.

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[1] NAMI. Mental Health by the Numbers, http://www.nami.org/Learn-More/Mental-Health-By-the-Numbers, Accessed January 2019

[2] SAMHSA. About Us. https://www.samhsa.gov/about-us Access January 2019

[3] Moore, B.J., Stocks, C., Owens, P.L. (2017). Trends in Emergency Department Visits, 2006–2014. Statistical Brief #227 Healthcare Cost and Utilization Project Agency for Healthcare Research and Quality. https://www.hcup-us.ahrq.gov/ reports/statbriefs/sb227-Emergency-Department-Visit-Trends.pdf. Accessed January 2019

[4] Nguyen, T., Davis, K. (2016). The state of Mental Health in America 2017. Mental Health America. https://www.mentalhealthamerica.net/sites/default/files/2017%20MH%20in%20America%20Compressed.pdf. Accessed January 2019.

The following pages present an initial business plan concept for consideration by the various key stakeholders in such a community center. It is intended to provide a high-level overview of the concept of a community crisis center, describe the key stakeholders, and discuss the facility and staffing needs for initial core services, as well as estimated costs and revenue potential. It is important to understand that the Michigan Department of Health and Human Services is currently developing certification criteria for crisis stabilization units. Also, the current behavioral health system, both in statute and in existing contractual arrangements, places considerable responsibility for behavioral health crisis response services on the community mental health system. More importantly, Medicaid is the largest single funding source for such services. This makes it essential that the local community mental health services program be involved in the development of the community crisis wellness center.

Introduction

This initial Business Plan is intended to support the ongoing discussion, planning and development of a Community Crisis Wellness Center for Children and Adults. This plan will present the purpose and benefits of a community crisis wellness center, the population to be served and how such a center benefits a community, and services it may provide. It will address initial operational models and staffing needs and considerations, including considerations for a financial plan addressing start-up, ongoing operations and sustainability. Perhaps most importantly, this plan will discuss community involvement, key stakeholders and governance considerations.

Description of Need

The proposed Grand Traverse Center for Mental Wellness (The Community Crisis Center) will serve communities across northern Michigan, increasingly challenged by pressures on their healthcare and criminal justice systems from persons experiencing behavioral health (BH) crises arising from mental illness, addiction, and related unresolved needs. The Community Crisis Center will serve the greater Grand Traverse region. People suffering from behavioral health challenges face barriers to accessing the right level of care at the right time contributing to increased – but potentially avoidable - utilization of emergency and acute health care services and involvement in the criminal justice system. Behavioral health needs, including mental illness and substance use and to a lesser extent intellectual/developmental disabilities, drive a disproportionate number of avoidable emergency department (ED) encounters compared to the general population, and, at the same time, are recognized as contributing to repeated involvement with the criminal justice system, 911/emergency response, and other safety net systems.

While the number of people in these communities presenting at the emergency department (ED) with mental health emergencies increases, the number of psychiatric inpatient beds is unable to meet the demand, resulting in the ED serving as a holding facility for transition to inpatient psychiatric care; a practice known as psychiatric boarding or ED boarding. Hospital EDs that are intended for acute medical care and not BH crisis or psychiatric emergency typically are not equipped to effectively respond to people in BH crisis, putting pressures on the hospital that drain resources from their primary mission of acute health care. At the same time, persons presenting

in BH crisis at an ED may not get the individualized treatment and support that will be most helpful to resolving their crisis and supporting their ongoing stability in the community. Furthermore, a significant number of people who are currently admitted for inpatient care could have their treatment needs addressed at a lower level of care if that option is available, as proposed for The Community Crisis Center.

In December 2020, TBD Solutions, a behavioral health consulting firm based in Grand Rapids Michigan, was contracted by North Country Community Mental Health (NCCMH), Northern Lakes Community Mental Health (NLCMH), McLaren Health System and Munson Healthcare to assess the current behavioral health crisis system in their shared twelve county region. This analysis reported the need for an additional *6.4 adult Crisis Residential Unit beds and up to 4.8 youth Crisis Residential Unit beds* to serve the NLCMH counties. Further, TBD recommended the establishment of a Crisis Stabilization Unit with 6 adult chairs in the Traverse City area. While the TBD Solutions report did not address child Crisis Stabilization chairs, the increasing demand for youth services supports the development of up to 5 child chairs at the Crisis Stabilization Unit.

There are not enough crisis services, beds and other treatment options in the region to treat those in behavioral health crises. Those that do exist are geographically isolated, downstate, or out-of-state, leaving large portions of the region without easy or prompt access to care in case of a crisis [Crisis Center Abstract}

In 2021, the Grand Traverse County 911 received over 800 mental health or suicide related calls. This has continued into 2022, with nearly 200 such calls in the first quarter of the year. Approximately 35% of these calls were handled by the Traverse City Police Department. During 2021, Grand Traverse County Sheriff responded to 497 mental health or suicide calls, consuming 1023 hours of sheriff staff time. This represents **an increase of 46% over 2020** and an increase of 19% over 2019, with an average of 468 calls and 860 hours per year over the past three years. People in jails with mental health and/or substance use conditions are most likely to be there due to low-level offenses like jaywalking, disorderly conduct, or trespassing. Involvement in the criminal justice system compounds the challenges faced by people with behavioral health issues, interrupting their access to benefits, treatment relationships, and routines and other sources of support and stability, and making them vulnerable to trauma. In most counties across the country the jails are de facto mental health institutions, with a large percentage of detainees experiencing mental health conditions. These targeted counties in Michigan also experience sizable numbers of detainees with behavioral health conditions. Leelanau County jail had an average daily census in 2021 of approximately 14 individuals. This is a total of 4990 days. If even 25% of this is diverted by the Crisis Center, that represents over 1200 jail days. For Grand Traverse County, 1977 individuals entered the correctional facility in 2021. Redirecting even 25% of those individuals would result in a reduction of 494 individuals being admitted to the correctional facility.

Emergency Departments which often receive people experiencing a behavioral health crisis are intended and designed to provide screening and triage for acute medical conditions. This environment is not intended nor designed to be the treatment option for individuals experiencing a behavioral health crisis. Behavioral health crisis needs are often best addressed in a specialized

setting such as the one proposed for The Community Crisis Center, which will include a medical clearance protocol.

Concerns about the growing impact of BH crises on EDs and other acute health care services, and mounting pressures on jail capacity, have led nationally to efforts to generate solutions that are both more cost effective and more conducive to effective treatment. The Community Crisis Center will incorporate this problem-solving approach to help reduce avoidable ED encounters and inpatient admissions as well as recidivism at the county jails and time spent by law enforcement officers responding to BH crises.

Community crisis centers provide an alternative to ED utilization for crises. Hospitals and other acute health care facilities provide assessment and treatment of individuals experiencing acute medical conditions. The Table below shows the increasing numbers of individuals, particularly youth, seen in Munson Healthcare's ED, and the increasing length of time they are there. The proposed Community Crisis Center will offer behavioral health (mental health, substance use disorder and intellectual/developmental disability) screening and assessments, immediate crisis stabilization services and services to triage and stabilize minor medical conditions. Law enforcement officers can divert from EDs and inpatient care to an appropriate lower level of care. Hospitals can save resources for acute care that can only be provided in a hospital to better meet community emergency health needs.

Munson Healthcare, Traverse City	**Behavioral Health Crises in ED**			
Persons in ED for suicide related diagnosis	2016	2020	2021	Jan-Apr 2022
Ages 6-17	83	80	121	50
Age 18+	900	772	840	236
Average hours in ED waiting placement				
Ages 6-17	14.1	16.0	23.8	28.2
Age 18+	14.7	12.7	28.4	30.1

The COVID-19 pandemic has increased the already significant need for behavioral health services, including for crisis response capacity. According to the Mental Health and Substance Use State Fact Sheet[5], produced by the Kaiser Family Foundation, **over 30% of adults in the US report symptoms of anxiety and/or depressive disorder, up from 11% prior to the pandemic**. **Over 20% of children have experienced worsened mental or emotional health since the pandemic began. In Michigan the level is 29.8% of adults 18 and over.**

[5] Mental Health and Substance Use State Fact Sheets | KFF

The Century Foundation's report *Mental Health Crisis During the COVID-19 Pandemic in 2021*[6] highlights numerous concerns about the negative impact of the pandemic on behavioral health and wellbeing, including:

- During the pandemic, moderate-to-severe anxiety among adults **jumped to 37.3 percent, up from 6.1 percent in 2019**. Moderate-to-severe depression **hit 30.2 percent, four times higher than prior to the pandemic.**
- 43.5 percent of young adults reported moderate to severe anxiety during the pandemic,
- Income is a key indicator of mental health. Households with income less than $25,000 are 20.1 percentage points more likely to report moderate to severe anxiety than a household with income that is $200,000 or more.

Operational Model

The Vision

The proposed Center is intended to be a core component of a coordinated, systemic response, bringing health and service sectors together with law enforcement in a central facility, providing effective BH crisis response, reducing reliance on the public safety net and emergency and acute care, and better supporting and stabilizing vulnerable community members. *The Community Crisis Center development team envisions a behavioral health crisis response that is well-known in the community and easily accessible to meet people in crisis to ensure proper intervention, assessment, and connection to the right resources. The goal is to alleviate behavioral health crises in the most appropriate and least restrictive setting and to avoid unnecessary visits to the emergency department, inpatient psychiatric unit, or jail (*The Community Crisis Center Abstract*)*.

The Community Crisis Center will be developed in alignment with best practices which include the following core components:

- To improve the health and wellbeing of individuals experiencing BH crisis, including those with repeated criminal justice system encounters, by integrating and coordinating supports and health care, law enforcement, criminal justice, and emergency agencies, to improve access to services that reduce reliance on emergency health and public safety response;
- Is a coordinated community approach by stakeholders with key roles and responsibilities in the system of care that leverages multiple funding streams and community investment;
- Is developed in alignment with best practice and evidence-based models for driving a service delivery system that is trauma-informed, person-centered, and recovery-oriented.
    - All services are conceptualized and provided as Person-Centered Care with a commitment to care that is individualized, respectful, compassionate, and based on evidence-based and emerging best practice.
    - Aligns with evidence-based and emerging best practice models for criminal justice system diversion and deflection.
    - A crisis model based on provision of care in the most appropriate yet least restrictive setting possible; and committed to community accountability, data driven decision-making and continuous quality improvement.

[6] Mental Health Crisis during the COVID-19 Pandemic (tcf.org)

Core Components

The core components, that will provide crisis de-escalation, assessment, observation and a short-term place to receive additional necessary services, are the Crisis Stabilization Unit (CSU) and Crisis Residential Services (CRU). These units can serve as a hospital alternative for those who can be appropriately served at a lower level of care but whose needs cannot be met safely in returning to an unsupervised setting; and to address the gap in psychiatric and mental health services across the spectrum in the target area.

> *Crisis "Chairs" for CSU and Crisis Residential Beds for CRU - Crisis "chair" is the name given to the furniture/accommodation used for short-term, up to 3-day crisis care in a CSU. Crisis residential beds are used for longer term care, up to 14 days, used in a CRU. Crisis Residential Units are licensed as foster care with specialized treatment. Both types of care require that adults be separate from children but may be under the same roof.*

The Community Crisis Center will pursue creating the CSU and CRU in a physical facility that serves as a hub for the service area's crisis continuum of care. The operational model is intended to effectively prevent and respond to BH crises and support engagement in ongoing mental health and substance use disorder treatment and support services for long term stability. Additional BH crisis services integral to the crisis continuum that can **be either co-located at the facility, or be integrated via systematic coordination include**:

- 24-hour Crisis Line with assessment (work with existing NLCMH, MiCAL and 988 structures), screening, triage, preliminary counseling, and information and referral services;
- Walk-in Crisis Services, that offer immediate attention and services to the community on a walk-in basis and drop-off center for law enforcement to reduce unnecessary arrests.
- Mobile Crisis Teams, available to provide 24/7 community-based de-escalation and assessment in conjunction with law enforcement, crisis hotlines, and hospital emergency personnel.

Services

The Community Crisis Center will provide a systemic response, bringing health and service sectors together with law enforcement in a central facility, providing effective BH crisis response and resolution options to individuals experiencing a behavioral health crisis. This includes youth and adults with mental health needs, substance use disorder needs and intellectual/developmental disability needs. Services to be developed include:

- **Walk-In Crisis Services.** In many instances, individuals experiencing or at risk of a behavioral health crisis, simply need a safe place to go, people to talk with, and perhaps some therapy. The Crisis Center will provide this service for individuals who wish to see someone to prevent reaching crisis stage or to resolve a crisis. Peers can be particularly

effective in this role and offer a strategic alternative to a traditional mental health workforce for which there is a deficit.

- **Drop-off for Law Enforcement.** It is well documented that law enforcement are often the primary responders to behavioral health crisis situations. The Community Crisis Center will provide an alternative to jail or the ED, when appropriate.
- **Screening and Assessment, Diagnosis, Treatment Initiation.** When fully functional, The Community Crisis Center will employ or share clinical staff to provide capacity for assessment, diagnosis, and limited clinical treatment as appropriate. The Community Crisis Center is not intended to be the primary provider of BH services; however, it will have the capacity to provide services to individuals in or at risk of crisis to support stabilization and tenure in the community versus requiring acute health care or emergency safety net response. This will include psychiatric consultation, medication review, and health screenings in coordination with a patient's existing BH care provider. The Community Crisis Center will be staffed to complete the Mi-SMART medical clearance required for inpatient screening.
- **Support and Education Services for Families and Natural Supports**. Support persons are an essential element of long-term recovery. This service will be provided by organizations such as NAMI.
- **Introduction to and Education about Healthy Lifestyles and Holistic and Traditional Healing Therapies.** These services will most likely be volunteer-led.
- **Referral and Follow-Up.** Successfully linking individuals to appropriate services is a critical role in crisis response. The Community Crisis Center will employ peer specialists and trained volunteers to facilitate and follow-up on patient well-being and referrals to services.
- **Coordination with Crisis Lines and Mobile Crisis Teams.** Michigan is currently implementing the Michigan Crisis and Access Line (MiCAL) and National 988 Crisis Lifeline. The Community Crisis Center will coordinate with all active crisis lines and mobile crisis services in the region as appropriate to create a smooth, seamless crisis response capacity.

Governance and Structure

Determining the proper governance structure for the Community Crisis Center is dependent on several variables such as: determining funding sources, identifying providers, involving community organizations, and including those governmental operations with responsibilities impacted by The Community Crisis Center. These groups are critical to the development, service provision, referrals and dispositions and overall success of The Community Crisis Center.

Factors essential to development that may inform the governance structure already in place include a primary revenue source: specialty behavioral health Medicaid which flows from the State of Michigan to the Northern Michigan Regional Entity (NMRE) as the prepaid inpatient health plan. The NMRE passes the Medicaid mental health and intellectual disabilities funding for Medicaid recipients to the CMHs within its region. The NMRE passes SUD funding directly to

service providers such as Munson and ATS. As such, the NMRE and local CMH are responsible for paying for most behavioral health crisis services for Medicaid beneficiaries.

The local CMH and/or the NMRE will collaborate with Action Team Co-Chairs under the direction of the Project (Planning) Director to determine the governance of the Wellness Center. It is essential, that The Community Crisis Center have input from and be responsive to the various community stakeholders necessary to create a successful crisis center. This will include Munson Health Care, primary care providers, other BH providers, law enforcement, judicial, advocates and service recipients. To ensure this much-needed guidance and direction, the Project Director has been tasked with helping create a Community Advisory Board for the Crisis Center. This advisory board will likely have 8-10 members representative of the key stakeholder groups. Significant funders may have permanent positions on this board. The advisory board will have rules or bylaws that specify the board's membership, terms, committee structure, meeting frequency and authority.
Legal entity status of The Community Crisis Center is to be determined.

Operating Costs, Capital Costs and Revenues

Staffing needs will expand as the service array grows. Initial staffing requirements will be for the CSU, the CRU, a Center Director, reception, administration, IT, security and building operations. Staffing for this service array will require at a minimum:

CSU

Staffing includes 2 Peer Specialists/Psych Techs at all times for both adult and child operation, a Licensed Masters Degreed Clinician and Registered Nurse at all times, serving both adult and child operation, a CSU Manager and a consulting, on-call psychiatrist. First year estimates:

Adult Staffing

Position	Number of FTE	Cost
Peer Specialist/Psych Tech	9.0	$471,744[7]
Masters Clinician-shared	2.5	269,500[8]
RN-shared	2.5	269,500
Psychiatry-on call	0.1	40,400[9]
Manager-shared	0.5	38,500[10]

[7] $18/hour and 40% benefits
[8] $77,000 salary and 40% benefits
[9] $286,000 salary and 40% benefits
[10] $55,000 salary and 40% benefits, split between adult and child

Subtotal		$1,089,644

Child Staffing

Position	Number of FTE	Cost
Peer Specialist/Psych Tech	9.0	$471,744
Masters Clinician-shared	2.5	269,500
RN-shared	2.5	269,500
Psychiatry-on call	0.1	40,400
Manager-shared	0.5	38,500[11]
Subtotal		**$1,089,644**

Reception and Admin Staffing

Position	Number of FTE	Cost
Receptionist	4.5	$196,560[12]
General Support	2.0	87,360
Records/Billing/Admin	1.5	65,520
Subtotal		**$349,440**
CSU STAFFING TOTAL ESTIMATE **(Numbers expected to increase due to recruiting during workforce shortage)**		**$2,528,728**

CSU Total (Estimate)[13]

Category	Expense
Staffing	$2,528,728
Rent or Property Tax, Utilities	36,000
Facility Supplies	10,000
Facility IT	3,000

[11] $55,000 salary and 40% benefits, split between adult and child
[12] $15/hour and 40% benefits
[13] Estimated cost based on operation of CSU

Maint, Equip, & Furniture	15,000
Patient Food	24,000
Vehicle Expense	4,500
Other- Security	2,400
CSU INITIAL TOTAL COST ESTIMATE	**$2,623,628**

CRU

The Adult and Youth Crisis Residential Units may be operated in one of two ways:
Option 1: CRUs are co-located with CSU to maximize staff and facility sharing
Option 2: CRUs are separate from the CSU in AFC-type homes
Cost estimates for each will be determined more specifically by our Project (Planning) Director in September-October, 2022.

Staff includes Residential Aides at all times, Nursing onsite one hour per day per resident, a Manager for the adult and child CRUs. A miscellaneous position is split between both CRUs and psychiatric consultation as needed.

Adult Staffing

Position	Number of FTE	Cost
Residential Aides	9.0	$471,744
Mental Health Professional	1.0	107,800
RN (1 hr/resident/day)	1.0	107,800
Psychiatry-on call	0.1	40,400
Manager-may be shared	1.0	77,000[1]
Miscellaneous-shared	0.5	23,296[2]
Subtotal		$828,040

Child Staffing

Position	Number of FTE	Cost
Residential Aides	9.0	$471,744
Mental Health Professional	1.0	107,800

RN (1 hr/resident/day)	1.0	107,800
Psychiatry- on call	0.1	40,400
Manager-may be shared	1.0	77,000[14]
Miscellaneous-shared	0.5	23,296[15]
Subtotal		$828,040

Costs per CRU Unit

Staffing	$828,040
Rent, Utilities, Property Tax	17,500
Facility Supplies	4,800
Facility IT	1,500
Maint, Equip, & Furniture	12,500
Resident Food	13,500
Vehicle Expense	4,500
Other	2,400
CRU Costs per Unit	**$884,740**

CRU Total (Estimate)

Position	Number of FTE	Cost
CRU Costs Child and Adult	$884,740x2	$1,769,480
Receptionist	4.5	$196,560[16]
General Support	2.0	87,360
Records/Billing/Admin	1.5	65,520
CRU INITIAL TOTAL COSTS ESTIMATE		**$2,118,920**

[14] $55,000 salary and 40% benefits
[15] $16/hour and 40% benefits, split adult/child

[16] $15/hour and 40% benefits

CSU & CRU Grand Operational Total Estimate

Item		Cost
GRAND OPERATIONAL TOTAL CSU AND CRU (not including capital costs)		**$4,742,548**

Facility Capital Costs

There are many decisions yet to be made that may have significant impact on the facility needs and costs associated with the Community Crisis Center. The location must be in Traverse City, preferably close to Munson Medical Center for easy access and transfers between the various levels of behavioral health, ED and medical care. This environment has significant therapeutic and healing qualities as well.

Current estimates of construction costs for a new build are as follows:
$8,250,000 = $5,250,000 (15,000 sq ft x $350) building + 2,000,000 furniture/equipment + 1,000,000 land.

Potential Revenue

Payment for services provided will include new revenues as well as some redirected revenues. Currently, NLCMH provides, either directly or contractually, crisis response and preadmission screening services. These services are covered by Medicaid for Medicaid beneficiaries and by State General Fund dollars for non-Medicaid individuals, to the extent that there is limited or no insurance coverage. Some commercial insurance carriers reimburse for mental health and substance use disorder services, including crisis response, but do not cover preadmission screening. Similarly, crisis residential services are a covered benefit for Medicaid beneficiaries, but there is limited coverage beyond that. Approximate revenue from these services can be projected based on current payer mix. It is important to consider that the payer mix will be impacted by the end of the public health emergency, which will reinitiate annual Medicaid eligibility determinations, and by the expanded reach of The Community Crisis Center.

MDHHS is currently developing certification standards for CSUs. Reimbursement models are not yet determined. While projections based upon similar centers currently in operation can be helpful, there is not currently a defined CSU payment structure in Michigan's Medicaid program.

Based on what is known, potential revenue through service reimbursement may be:

CSU 12 Chairs total, (16 per day, $800/day)	**$4,672,000**[17]
CRU 11 beds total, 80% occupancy (3213 days @$500)	**$1,606,500**
Total potential revenue, including redirection from CMH	**$6,278,500**

It is expected that it will take 24-36 months to reach full revenue potential for The Community Crisis Center. CRU will undoubtedly see greater utilization sooner, with the CSU building more slowly.

[17] TBD report suggested 6 chairs, utilization of 8/day at $800/day, double for 12 chairs

In order to fully understand the potential revenue, it is necessary to understand the current expenditure by NLCMH for services that would become part of the Crisis Center. NLCMH currently performs about 800 Pre-Admission Screenings per year in Grand Traverse County. Also, the Crisis Residential is a diversion from inpatient, and represents a reduction of a current expenditure.

Crisis Intervention and Pre-Admission Screening CMH Saving)	$ 480,000[18]
CRU savings vs. Inpatient 3213 days @ $250 Savings)	$ 803,250[19]

Additionally, not all individuals served at the Crisis Center will be from Grand Traverse or Leelanau Counties, or even from the current NLCMH catchment area.

Facility Selection and Design

There are several decisions pending which will impact facility needs. These include:

- Service Array – initial services are determined, but the facility should accommodate expected expansion of the service array.
- Staffing – again, initial services are identified, with potential staffing needs, but staffing requirements for potentially expanded services will impact facility needs.
- Capacity – current plans are for 12 CSU chairs and 12 CRU beds. The targeted number of persons served for walk-in, crisis intervention less than CSU, pre-admission screening, and other potential services must be considered.

The following paragraphs explore the facility needs for the initial services.

There are many possible approaches for the physical structure of the Crisis Center. Important considerations include both location and building design. It is desirable to have all related services easily accessible, even co-located. However, certain services, such as Crisis Residential, may be located in a separate building, depending on availability. Crisis Residential settings should have a comfortable residential feel, with private or shared bedrooms, community space (living room, kitchen, dining room) and office space. Crisis Stabilization does not have separate bedrooms but should have the ability to offer quiet spaces and privacy, while allowing observation as appropriate.

It is important that The Community Crisis Center be in a location that is easily accessible, ideally within Traverse City. It must also facilitate pedestrian and vehicle access. Given that Michigan Public Health Code Regulation R 325.22112 requires that “An ambulance operation, both ground and rotary, shall transport an emergency patient only to an organized emergency department…….” it is recommended that it be located near Munson Medical Center. This will facilitate, if necessary, transfer from an ED to the CSU for those transported as an emergency patient. Additionally, the

[18] GT county about 800 Per year @ $600 each, now part of CSU Charges

[19] This number is savings based on all CRU being a diversion from inpatient, so savings would be to home CMH program, not necessarily local CMH

CSU must have a separation between the adult area and the youth area. It could have central reception and offices, but the "chairs" area must be separated.

Additionally, in order to facilitate law enforcement drop off, it is essential to have a separate entrance for them. This should include space to meet with CSU staff, space for officers to complete paperwork, and a separate bathroom for officers to use.

Ideally, the various community partners should have input into the ultimate location and design of the facility. This should include, at a minimum, service recipients and families, law enforcement, clinical staff, and the service providers. Site location and square footage must accommodate future needs as well. While the initial services will be walk-in and drop-off crisis response, crisis screening, CSU and CRU, the intent is to expand the services. The facility must be adequate for these planned expansions.

Sustainability

Key elements in developing and sustaining an effective BH crisis facility include intentionally addressing and overcoming fragmentation and gaps in the service delivery system with alignment and integration. The model crisis facility does not exist in a vacuum. It serves as the hub for the crisis continuum of care and structured care coordination with community-based services to support recovery and stability. It is important to consider that many people presenting in a BH crisis have co-occurring substance use disorders.

It is intended that all people accessing the crisis center will be served, regardless of ability to pay or insurance coverage. The majority of individuals accessing The Community Crisis Center are expected to be Medicaid beneficiaries. Medicaid coverage for CRU, Crisis Intervention, and Pre-admission screening is clear and calculable. Commercial insurance and Medicare coverage is less clear. While most commercial plans include some behavioral health benefits, and Medicare typically covers acute care services, reimbursement and coverage is less comprehensive than Medicaid. There are also opportunities to explore value-based payment arrangements with specific payors, since the model proposed for the Community Crisis Center can demonstrate impact on reducing costs and improving outcomes for persons served.

> The Community Crisis Center will be available 24/7/365 to all ages and all people. Insurance status will not matter; walk-ins will not require prior clearance. Care and support will be available to all persons with the focus on de-escalating the crisis and helping the person initiate or resume a path to well-being via the most clinically appropriate level of care including, as appropriate, referral to crisis residential beds, psychiatric inpatient, partial hospitalization, and outpatient aftercare. The environment will be safe, welcoming, comfortable and trauma informed. There will be two independent major components to The Community Crisis Center: a Crisis Stabilization Unit (CSU) and a Crisis Residential Unit (CRU). [Crisis Center Abstract]

Sustainability will rely on participation by various community partners that have a vested interest in the Community Crisis Center. This will include, among others, local law enforcement, local ED providers and the local CMH. It is possible to

develop reliable revenue and expenditure patterns for the initial service array, but additional stakeholder participation will be required to plan for expansion and support ongoing sustainability.

The Michigan Department of Health and Human Services is currently developing certification criteria for CSUs. Reimbursement rates and methodologies are not yet developed. These may include alternative payment arrangements intended to support the 24/7 operation model as opposed to a traditional fee for service payment structure.

Ultimate sustainability will be impacted by future decisions regarding service array, delivery model, and care coordination relationships. Below are elements of model comprehensive BH crisis facilities that may be considered:

- Crisis Stabilization
- Crisis Respite
- Medical Triage/Physical Health Clearance
- Primary Care (urgent care model; or onsite FQHC or similar partnership for providing routine/non-acute care)
- Comprehensive social services/case management/legal support
- Provision of or direct connection to:
    - Outpatient behavioral health treatment
    - Mental health intensive outpatient
    - Transitional supportive housing
    - Permanent supportive housing
    - Employment training
- Continuum of SUD Treatment and Services – Provision of or Direct Connection to:
    - Withdrawal Management
    - Inpatient SUD
    - Intensive Outpatient SUD
    - Outpatient SUD

Considerations Moving Forward…

The visions and goals of the community, as expressed through The Community Crisis Center business plan, forms the foundation for investment in The Community Crisis Center. To attract support from community partners, we must assure that there is a clear messaging regarding the structure, governance, resources, and benefits of this venture. To the greatest extent possible, data should be presented to support not just the need, but the benefits, answering these questions: ***Why is it important we do this? How will it benefit persons served; key partners; the public? How will we know we are being successful? Who will be served?***

The planning group needs to have clear consensus on a communications/marketing plan, informed by data, that provides answers to these questions to assure consistent messaging to garner support and to inform all implementation planning. The group must "speak with one voice" in presenting this. This is also the basis for developing measures and outcomes that tell the story of the facility's progress to generate initial, and continued, investment and support.

Outline of Data Plan: Key Components

- Data that tells the story of challenges people in BH crisis in the service area face;
- Data that shows that change is needed;
- Data that shows cost savings to the ecosystem or redirection to more efficient and appropriate points of care;
- Establish agreements for sharing data; and
- Integrate data across systems to understand the magnitude of cross-system utilization and key characteristics of cross-system utilizers.

Telling the Story to Make the Case

Data, both qualitative and quantitative, reflect the issues and challenges of the target service area and helps make the case for the imperative to support a model facility to better serve community members with BH conditions. This data informs the plan for The Community Crisis Center**.** A simple dashboard, including items such as:

- Jail bed days for individuals with MH or SUD issues, with costs
- Numbers and LOS for ED Boarding, with costs
- Total Psychiatric Inpatient Days and Potential Diversion to CRU, with cost savings

Intersection with Justice System

- Jail bed census compared to jail capacity
- Numbers of persons in jail with a diagnosed BH condition (and/or number or cost of psychotropic medications)
- Recidivism rate of individuals with a diagnosed BH condition
- Number of MH warrants served and where individuals under warrant receive crisis intervention
- Law enforcement officer/deputy response to BH crisis
    - Number of responses

    - Average time spent until disposition of BH crisis
- Costs associated with
    - Jail bed days, including for one: ones and other expenses for detainees with BH conditions
    - Booking costs for individuals with BH conditions
    - Law enforcement officer BH crisis response time (includes wait time for screening/disposition in hospital)

Intersection with Health Care System

- Reduction in Avoidable ED encounters
- Reduction in Avoidable Inpatient encounters

APPENDIX

Service Array Example Descriptions from "Gold Standard" Facilities

Exemplar Facility 1:

- Behavioral health services provided to adults and children/adolescents 24 hours a day/7 days per week/365 days per year.
- For Adults, 24/7 walk-in clinic, 34 observation chairs, and 15 subacute beds with full clinical staffing MDs, Nurses, Techs, Peers, Social Work;
- For children/adolescents (ages 0 - 17), 24/7 walk-in clinic, and 10 observation chairs with full clinical staffing
- Provides communities with alternatives to arrest, emergency department utilization, and inpatient psychiatric care. Disposition planning includes financial eligibility screening, crisis follow up, and transitional case management services that connect individuals with treatment and other services to prevent reemerging crisis.
- Peer run program co-located at the Crisis Center; Provides 45 days of post-crisis wraparound services, including peer support, transportation for appointments and picking up medications, help getting ID/completing application for benefits.

Exemplar Facility 2:

- Behavioral health services provided to adults 24 hours a day/7 days per week/365 days per year.
- For adults 24/7 walk in clinic with access to up to 40 observation chairs, 16 co-ed inpatient detox beds, 16 subacute psychiatric beds
- Referrals accepted from but not limited to Crisis Mobile Teams, Emergency Departments, Law Enforcement, Walk-in, and outpatient assignment.
- Functions as outpatient office and holds group services on site
- Can provide community pickups for admission and service provision via crisis transportation
- 24/7 access to Medication Assisted Treatment (e.g. buprenorphine induction) accessible for law enforcement drop-off
- Onsite or through partnership with community SUD provider for real time/hot hand off access:
    - 24/7 MAT access for people with high acuity co-occurring mental health needs
    - 24/7 access to MAT services in an outpatient clinic setting
    - Connection to ongoing MAT treatment at multiple outpatient agencies
    - Residential SUD beds provided for outpatient referral for long term stays accessible during business hours
    - Outpatient SUD treatment provided by partner providers including but not limited to groups, therapy and care management.
    - Residential Crisis SUD beds accessible 24/7 by crisis mobile teams, Observation Units, and outpatient providers. These are approved under the Brief Intervention Program for 5-10 day stays with the ability to transfer to residential services
- Second Responder Teams:
    - Community outreach and engagement and case coordination with individuals challenged by chronic homelessness, mental illness and/or substance use.
    - 45 days post crisis peer services: peer support, transportation to appointments, picking up meds, getting benefits, etc.
    - Assistance with housing, children's services, etc.
      Follow up phone calls and welfare checks