

## **REVIEW OF CRISIS SERVICES**

The purpose of this report is to determine the compliance of the Department of Behavioral Health and Developmental Disabilities (DBHDD) with the requirements for crisis services as described in the State of Georgia's Settlement Agreement with the Department of Justice. In addition, this report offers an assessment as to how well the different components of the crisis requirements are integrated to form a comprehensive crisis service system for individuals with behavioral health needs and/or developmental disabilities.

### **Introductory Comments**

In developing this report, I reviewed the Settlement Agreement between the State of Georgia and the Department of Justice, had an opportunity to meet with the leadership and senior managers of DBHDD, reviewed Departmental data reports and visited a number of programs around the State. Specifically, I met twice with Commissioner Berry and his Chief of Staff Judy Fitzgerald. I also met a number of senior managers individually or in group settings. All of these meetings were in person with the exception of a phone conversation with Ms. Atkins. The following are the members of the Department I met with:

- Dr. Emile Risby, Chief Medical Officer
- Ms. Monica Parker, Director of Behavioral Health
- Dr. Chris Gault, Director of Performance Management and Quality Improvement
- Dr. Terri Timberlake, Director of Adult Mental Health Services
- Mr. Dan Howell, Director of Developmental Disabilities
- Mr. Eddie Towson, Developmental Disabilities Quality Management Director
- Mr. Mark Baker, Director of Recovery and Transformation
- Mr. Charles Fetner, Region 1 Coordinator
- Ms. Debbie Atkins, the newly appointed Director of Crisis Services.

I also visited the following programs around the State:

- GCSS's Crisis Respite Home in Rome; I met with their mobile crisis staff
- Highland Rivers Community Service Board's Assertive Community Treatment Team where I met with members of the ACT Team
- Benchmarks Human Services's mobile crisis team where I met with their regional manager and members of the mobile crisis team
- The Georgia Crisis and Access Line (GCAL) where I met with their Executive Director
- Grady Health Systems' main site; I toured their Emergency Department and short-term inpatient unit and met with the Executive Director of their mental health services and his staff
- McIntosh Trail Community Service Board's Behavioral Health Crisis Centers (BHCC); I met with staff and observed their admission process and crisis stabilization unit
- Advocates in a meeting convened by legal advocates.

I am grateful to Pamela Schuble, Director Settlement Services, for her assistance in providing me with a number of documents that described the various crisis services as well as data reports on service utilization. In addition, Ms. Schuble was very helpful in arranging my various meetings and visits throughout the State.

## Findings

### **Developmental Disabilities**

#### 1. Mobile Crisis Teams for individuals with Developmental Disabilities

(A) By July 1, 2012, the State will have six mobile crisis teams for persons with developmental disabilities.

The State does have six crisis teams, one for each region of the state, which are operated by four providers. In FY'15, the mobile crisis teams provided 1,128 episodes of care to 556 individuals. The data provided indicated that just over 80% of the mobile crisis calls resulted in crisis stabilization and that 225 or 20% of the interventions led to a referral for inpatient services. All of the developmentally disabled individuals admitted to an inpatient setting had a co-occurring psychiatric diagnosis.

2. By July 1, 2014, the State will have established twelve Crisis Respite Homes with four beds each. These forty-eight beds will provide respite services to persons with developmental disabilities and their families.

The purpose of the Crisis Respite Homes is to offer time-limited services to an individual due to their need for support and protection. Homes are required to have capacity for four or less individuals and each individual is to have their own bedroom. The Crisis Respite Homes are designed to offer a stay of up to seven days. If an individual requires a longer length of stay, the Regional Office can provide authorization for an extended stay.

In my review of the data for the Crisis Respite Homes, there are concerns about utilization of these beds. The State only established eleven Crisis Respite Homes and is not in compliance with this Provision of the Agreement. Therefore, the Crisis Respite Homes have a total of forty-four beds that are to provide an average length of stay of up to seven days. I have calculated the annual capacity of the Crisis Respite Homes by using the following methodology:

Dividing 365 by 7, each bed can have 52 admissions; however, there will be reasons such as an extended length of stay or other reasons that a bed will not be available. Therefore, I have used a 75% expected utilization rate which would equal 39 admissions/per bed/year and multiplying that by 44 would provide a capacity of 1,721 admissions per year.

The State reported a total of 109 admissions for 88 individuals to the Crisis Respite Homes for FY'15 which would be 6% of the admissions capacity. Another way to look at the Crisis Respite Home utilization is to analyze the bed occupancy rates:

The 44 beds have the capacity to offer 12,045 bed days, which was determined by multiplying 44 beds x 365 days x 75%.

In FY'15, the State reported that there were 9,045 bed days used in crisis beds or 75% of the capacity bed days. The reason for the difference between admissions and bed utilization is that there are a number of individuals who are staying in the Crisis Respite Homes for long periods of time, some for years. The average length of stay for all admissions in FY'15 was sixty-eight days. There were sixteen individuals who had more than one admission. (Dr. Heick has documented a more in-depth review of six of these individuals.) The data were also analyzed to get an understanding of how the utilization of the beds compared to the intended goal of a 7 to 10 day stay. The data were presented in a manner that only allowed for an accurate analysis of length of stay per admission episode for individuals with just one admission. The one admission population represented the majority of users as they were 72 or 82% of the 88 individuals who used the crisis beds. The analysis of the data found the following:

- 9 of the individuals or 12.5% had stays of 250 days or more
- 30 of the individuals or 42% had stays of 90 days or more
- 55 of the individuals or 76% had stays of more than 10 days

Therefore, less than a quarter of those admitted to the crisis beds had stays within the intended use of the service. This data should encourage the State to review the intended purpose of the crisis beds to determine the reason(s) for the extended stays and determine if there is a need for a different type of service to better serve the relatively small number of individuals using the crisis beds.

Other components of the crisis system for individuals with development disabilities do not appear to be serving a significant number of individuals. In-home services for individuals served by the mobile team and who did not require a crisis home admission accounted for 58 individuals who received 138 in-home services during the course of FY'15.

## **Mental Health**

3. Crisis Service Centers (CSCs) are to provide walk-in services, staffed by clinicians, 24 hours per day, 7 days per week to serve individuals in crisis, including individuals with co-occurring illness. The obligation is that the State will have six CSCs in operation by July 1, 2015.

CSCs are now known as Behavioral Health Crisis Centers (BHCCs). As of June 30, 2015, the State had six BHCCs opened. They are:

- River Edge Crisis Service Center      opened 4/12
- Bradley Center                              opened 7/1/13
- Aspire    opened 8/1/13
- Georgia Pines                                opened 1/17/14
- BHS of South Georgia                    opened 1/17/14
- McIntosh Trail                                opened 6/4/15
- Pathways                                        opened 6/30/15

The BHCCs are all operated by a Community Service Board (CSB) provider and are full service crisis centers that provide assessments for individuals who voluntarily walk-in as well as for individuals brought by law enforcement for an involuntary evaluation; provide observation beds; and offer short-term (7-10 day) crisis stabilization beds.

In addition to the development of the BHCCs, the Department is making a concerted effort to improve the system's ability to serve, in an outpatient clinic setting, individuals experiencing a behavioral health urgent need. In early FY'15, the Department contracted with MTM services to provide year-long technical support to both Regional staff of the Department as well as Community Service Boards (CSBs). An aspect of the technical assistance was training on both clinical and financial strategies for the CSBs to offer open and timely access to the residents in their community seeking immediate services. To support this commitment of expanding same day services, the State's policy encourages the CSBs to have open access as stated in Policy 01-201 "DBHDD strongly encourages same day access to services."

In addition to the open access initiative, the State tracks the time it takes for an individual referred for Assertive Community Treatment (ACT) to be admitted to an ACT program. The goal is 70% or more should be admitted within three days. The State's performance exceeds this expectation. In the first three quarters of FY'15, approximately 73% of the referrals were accepted into the program within three days.

4. By July 1, 2014, the State was to establish a total of three additional Community Stabilization Programs (CSPs). As of July 1, 2015, there are twenty agencies that provide 448 CSP beds. All CSPs are operated by CSBs and six of the programs are contained within a BHCC. A major goal of the CSPs is to offer community-based services as an alternative to the use of a state hospital.

A critical component of the CSPs is their ability to accept involuntary admissions. In many states, general hospitals provide acute psychiatric care for both voluntary and involuntary admissions. In Georgia, there appears to be a minimum number of acute psychiatric units within general hospitals. While there are a number of private psychiatric hospitals in the State, their capacity to provide acute inpatient care to Medicaid recipients is limited by the Institutions for Mental Diseases (IMD) restrictions, as IMDs are prohibited from receiving Medicaid reimbursements for individuals aged twenty-two to sixty-four. Therefore, the CSPs perform many of the functions that you would find in a general hospital and the average length of stay of just fewer than eight days is very similar to acute general hospital length of stays.

5. As of July 1, 2011, the State shall retain funding for thirty-five beds in non-State community hospitals.

The vast majority of the thirty-five contract beds are used in Region 1 and they provide on average 2,200 episodes of care and a length of stay of just around six days.

It appears that the use of the CSPs and State contracts with hospitals have been successful in shifting the locus of acute care from the state hospital to the community. Using data from Region 1 as an example, as capacity of the CSPs and community hospital beds has increased, state hospital admissions declined. Region 1 reported: "In FY'10, of the people who needed inpatient level of care or that of a CSU, 25% were served in a state hospital. In FY'15, less than 2% of the Region 1 people were admitted to a State Hospital."

6. The State shall establish a statewide Crisis Call Center that shall be staffed by skilled professionals.

Such a call line exists and is operated by Behavioral Health Links (BHL) and known as the Georgia Crisis & Access Line (GCAL). GCAL receives on average between 20,000 and 25,000 calls per month. GCAL is well known among the behavioral health providers in the State and is an essential component of the Georgia crisis system. GCAL publishes regular reports on its website ([www.behavioralhealthlink.com](http://www.behavioralhealthlink.com)) that document the reasons for calls, time of the call, demographics about the callers, locations of the callers, and the timeliness of services, including the number of business days for a scheduled appointment. GCAL and the providers have established procedures that allow GCAL staff to schedule appointments at the most appropriate Community Service Board location. In addition, GCAL deploys the mental health mobile crisis teams and the teams stay in close contact with GCAL during their response and report back to GCAL when the crisis situation is resolved. This allows GCAL to report on the amount of time it takes for a crisis episode to be resolved and to provide telephonic assistance to the team. GCAL is well integrated into Georgia's public behavioral health system and, as of July 1, 2015, GCAL is a component of Georgia's new Administrative Services Organization (ASO) contract.

7. By July 1, 2015, the State shall have mobile crisis services within all 159 of its counties and the teams should have an average response time of one hour or less.

The data for the first eleven months of FY'15 indicate that the State has met this objective. The data through May 2015 indicate the following:

- There is an average of just over 1,500 mobile crisis deployments per month.
- The average response time in FY'15 was 55 minutes with only one month having an average response of more than 60 minutes, which was 73 minutes for the first month of the fiscal year. Between December and May of this past fiscal year, the average response time was slightly above fifty-one minutes, which would be a 30% improvement from July of 2014.
- Regions 2 and 3 represent 46% of all mobile crisis responses.

8. By July 1, 2015, the State will establish a total of eighteen crisis apartments with the capacity to serve two individuals with Serious and Persistent Mental Illness (SPMI) at a time.

Based on reporting from the State, there are nineteen apartments that provide thirty-seven beds. In FY'15, 313 individuals accessed these beds. Based on a one day survey for June 30, 2015, twenty of the thirty-nine beds were occupied.

Grady Health Systems plays a major role in providing acute care and crisis services to residents of Fulton and Dekalb Counties. In FY'13, its comprehensive services provided almost 40,000 episodes of care to a population that is either uninsured (65%) on Medicaid (30%) or Medicare (5%). The majority of the behavioral health clients served through Grady enter care through the emergency room, brought by either the Emergency Medical Service (EMS), law enforcement or voluntarily walk-in. In any given month, approximately 700-800 individuals are seen in the emergency room and about 40% are diverted to a more appropriate level of care. Grady also operates a thirty-two person capacity short-term unit (up to 72 hours) that serves between 400-

500 episodes of care per month and operates its own twenty four bed inpatient unit. In addition, Grady Health Systems operates very active outpatient services that include same day urgent care access, Assertive Community Treatment (ACT) teams as well as psychosocial rehabilitation and peer support programs. Since there is no CSB in Fulton County, Grady Health Systems works directly with the State's regional structure.

### **Recommendations**

1. The management of crisis services has been dispersed throughout the Department and there has not been a single person whose job is to manage and help develop a crisis system. The Department's senior management is aware of these issues and has recently created a new position to manage all of the crisis services. This new hire began her employment the first week of July 2015 and, hopefully, with the right support, she will be able to provide the much needed leadership and organization of the crisis system. There is a wealth of data available as well as a number of significant activities taking place to ensure that Georgia residents have access to timely quality crisis services. It is now up to the Department leadership to ensure that there is a robust comprehensive crisis system in place that produces regular data reports that are widely shared; that the reports measure the critical components of the system including, but not limited to, timely access to care and the utilization of community based crisis services; that problems are identified in a timely manner and addressed; and that roles and responsibilities for problem solving are well known throughout the Department, with other State agencies, as well as with family members, advocates, law enforcement and other key stakeholders.
2. Addressing the crisis service needs for individuals with a developmental disability must be a priority.
  - Based on the relatively small number of individuals seen more than once by the mobile crisis teams (556) as well as the number of individuals staying far more than the initial seven day limit of the Crisis Respite Homes, a process needs to be put place for formal planning and problem solving for individuals with developmental disabilities who have complex needs and challenges that must be addressed in order for them to have a positive quality of life in the community.
  - While recognizing the geographic challenges of a large state such as Georgia, the State should evaluate if it is offering the right range of services to meet the crisis and immediate needs demands of individuals with developmental disabilities. The State should re-evaluate the way it offers services to see what services are missing and what should be retained. For example, is it cost effective to offer forty-eight beds through the Crisis Respite Homes that have such low utilization rates or are there more efficient ways to utilize these resources that could better address the needs of individuals with developmental disabilities.

3. The Department should continue to support the CSBs to provide open access. The State should determine if it should strengthen its current policy of strongly encouraging same day access to services and, if it does, the State needs to understand the fiscal impact to CSBs as well as the possible return on this investment to the State on using less costly ambulatory services that have some potential to reduce more expensive services offered by BHCCs, CSPs, or other acute inpatient service.

4. The State should determine the number of CSP beds needed statewide and also review if there is any potential revenue from third-party payers that may be available to CSPs.

5. Finally, I also want to note that in meeting with about fifteen individuals representing providers, family members, law enforcement, advocates and interested parties there was an overwhelming negative sentiment expressed about challenges related to access to care, the lack of data available and the perceived absence of a formal process for problem solving. A number of the participants noted that if they reached the right person in the Department that the immediate concern would get addressed but reported not being aware of formal problem solving processes. It would be very beneficial for the Department to address these concerns about access and information and develop viable ways of sharing data about the use of crisis services and their effectiveness with the larger community.

Based on my review of the crisis system, it appears that there has been significant progress made on meeting the mental health objectives established by the Settlement Agreement. The locus of care has undergone a major shift from the state hospital to community services; the range of community-based services has greatly expanded; and the State has a structure in place to track the critical components of a crisis system. However, there is still much work to be done for individuals with a developmental disability. Hopefully, with the establishment of the new Director of Crisis Services, there will be a focused and intensive effort to most effectively address the needs of the developmentally disabled individuals who are in need of a community based crisis service.

Stephen T. Baron

Consultant to the Independent Reviewer

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