CATALYST
a Haskell Company

Wichita Behavioral Health Community Needs Assessment

Final Report

July 17, 2019

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Executive Summary

Behavioral Health Community Needs Assessment

What We Did

The Catalyst Team developed potential facility programming and operational interventions to augment and fill behavioral health market gaps in the Wichita community. This was based on strategic community needs as well as historical and projected future utilization.

How We Did It

The Strategy Team identified the community's strategic priorities, assessed the current behavioral health landscape, projected the provider and inpatient bed need, and analyzed stakeholder feedback to develop a comprehensive gap analysis and strategic framework for approaching the facility and operational responses. The Planning Team leveraged stakeholder feedback and pulled from other behavioral health case studies to develop a focused scope of facility responses, which were supported by preliminary costs. This allowed leaders to manage capital expectations and projected timeline needs. Additionally, the Strategy Team assessed all non-facility related feedback and created a list of potential operational interventions primarily drawn from national models of care for the Steering Committee to consider.

Strategic Direction

The information gathered and presented to the Steering Committee during the on-site visit served as the baseline for establishing priorities and strategic direction. The ultimate goal of the committee was to emulate a comprehensive co-located community solution similar to a behavioral health model located in Bexar County, TX. While this direction was incorporated into a longer term solution for the Wichita community, Catalyst also pulled from previous client work and other national models of care to offer other options with greater feasibility and lower capital intensive needs in the short term.

Outcomes

Facility and operational options offered in this plan were tiered ranging from basic to long term solutions. This will allow the Steering Committee to choose proposed solutions based on priorities, timing, and funding availability.

Option Development

Basic

Facility

Right-size *existing* facilities

Incorporate BH services within *existing* primary/urgent care setting

Operational

Asset/Team Evaluation

Business Plan/Marketing

Training

Intermediate

Facility

New facility investments in wellness/primary care; housing for violent patients

Operational

New services/ capabilities

Prevention/ Primary Care/ Early Intervention

Transportation

Operational Study

Long-Term

Facility

Community/ comprehensive facility model of co-located resources

Operational

New services/ capabilities

Operational study findings implemented

Continue to next page for explanation.

Option Development (cont.)

Catalyst evaluated facility options that addressed planning priorities based on feedback from the visioning session with service area agencies and community partners. Existing services and programs are housed in different facilities in Sedgwick County, and several are constrained from a space standpoint. This is a real challenge from a facility perspective as it physically limits the scope and reach of their services. The team developed options that correlate to different capital environments, and these options were categorized into three main tiers - Basic, Intermediate, and Long-Term. The range of options can essentially be scaled incrementally across tiers based on community need and funding availability. Enhancing existing resources and exploring new strategies that are not currently readily available to this community were considered. Operationally, high level options were proposed from formalizing team structures and business planning efforts to operationalizing a more proactive behavioral health approach in today's care setting. The extent of adjustment to the existing facility framework and operations will need to be incrementally modified to accommodate growth along this spectrum, until comprehensive or long-term options can be activated to support an ideal state.

Facility Options – Feasibility Evaluation

Key	
Success	🟢
Opportunity	🟡
Challenge	🔴

Each facility option is displayed and rated for its feasibility indicating its potential risk. While many of the more effective options are rated as challenges due to time and cost, they yield more effective outcomes to create a comprehensive behavioral health system in the community.

Feasibility Evaluation	Time	Cost	Availability	Effectiveness	Comments
Basic					
Relocate Call Center; Renovate/Refresh CCC/SACK with technology upgrade	🟢	🟢	🟢	🔴	Increases space in the existing COMCARE Center by only marginal amounts.
Relocate and right-size CCC/SACK in same location (renovation)	🟡	🟡	🟢	🔴	Utilizes existing infrastructure, but still not an effective solution to facilitate future growth.
Right-size CCC/SACK in new location (new construction)	🔴	🔴	🟡	🟡	Must find and purchase real estate to right-size facilities, but still must plan for future growth.
Renovate SCOAP; Refresh with Technology Upgrade	🟢	🟡	🟢	🔴	Minimal costs, but not an effective solution to facilitate future growth.
Expand and Renovate SCOAP into adjacent strip mall with Technology Upgrade	🔴	🟡	🟡	🟡	Must be able to purchase the adjacent strip mall. Efficiency limitations for facilities.
Consolidate CCC/SACK/SCOAP (renovation)	🔴	🔴	🟡	🟢	Improved patient access to care and utilizes existing infrastructure at higher rates of time and cost.
Consolidate CCC/SACK/SCOAP at another location (new construction)	🔴	🔴	🟡	🟢	Improved patient access to care at increased costs and timelines.
Primary Care Provider/Urgent Care Facility Model (renovation and technology upgrade)	🟢	🟢	🟢	🟢	Utilizes existing infrastructure to expand scope of BH care.
Intermediate					
Halfway Housing (8 Beds ea M & F)	🟡	🟡	🟡	🟢	Increases Sedgwick County's behavioral health's scope of care.
Violent Patient Housing (8 beds ea M & F)	🟡	🟡	🟡	🟢	Increases Sedgwick County's behavioral health's scope of care.
Wellness Program Expansion (renovation/addition)	🟡	🟢	🟢	🟢	Uses existing infrastructure and establishes community partnerships.
Wellness Program Expansion (new construction)	🔴	🔴	🟡	🟢	Allows for flexible and unique design for the county's wellness facility at a high rate of cost and time.
Long-Term					
Co-locate Critical Resources (Expand BH services near St. Joseph)	🟡	🔴	🟡	🟢	Utilizes existing infrastructure that Via Christi has already established at a high cost.
Co-locate Critical Resources (Greenfield Site)	🔴	🔴	🟡	🟢	Allows for a BH facility in a secluded location designed uniquely for Sedgewick County.
Homeless Shelter- New Construction	🟡	🔴	🟡	🟢	Must find and purchase real estate large enough to house program and accommodate future growth.

Assessment and Projected Need

Current State

Current State

- Barriers in the Wichita behavioral system are straining resources, especially in the EDs and Jails
- Consolidation of resources and a coordinated community effort will help to address these issues

Background

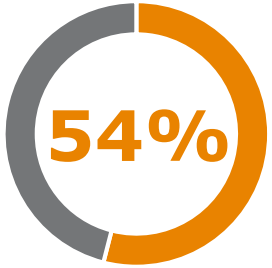
Wichita, Kansas is facing several behavioral health barriers in providing appropriate care to the community. 10 organizations were interviewed by Catalyst to better understand the current state of behavioral health in their community. In doing so, it became clear through stakeholder feedback that the partnership between community organizations, healthcare providers, and the legal system will be critical for implementing a holistic integrated health system. This coordinated effort will help to proactively address the current strain on behavioral health resources, particularly in the ED and Jails.

Findings

Based on stakeholder interviews, key barriers identified were: access to care, lack of care coordination, funding uncertainty, operating within a siloed system, and lack of long term beds. Similar themes were found nationally as well, reinforcing the idea for a better integrated system of care. With the population projected to grow at 0.4% annually over the 10 year horizon, Wichita will need to position itself to accommodate a likely increase in demand for behavioral health services. Currently behavioral health resources are concentrated in the urban core however population growth is expected outside of the metro area. Thus, solutions should consider care model, technology, and facility options to address this outward push.

National Mental Health Barriers

Consolidating resources to improve access and coordinate care is more crucial than ever



Adult patients with **any mental illness** who did not receive mental health services

Americans with a **substance use disorder** who did not receive treatment

Increase in **deaths by overdose or suicide** per 100,000 people from 2005 to 2016

Provider Shortages

- 56% shortage of mental health professionals

Patient Adherence Barriers

- 44% did not know where to go
- 31% thought they could manage without treatment
- 44% could not afford care

Limited Insurance Coverage

- Denial rates of private insurance based on medical necessity criteria:
  - Mental health care- 29%
  - Substance use care- 18%
  - Medical care- 14%

Advisory Board, Population Health Advisor: Overcoming the Behavioral Health Access Challenge

Stakeholder Interview Themes

Key Challenges

Access

- Initial access point
- Ability to pay
- Stigma
- Lack of long-term beds

Care Coordination

- HIPPA Restrictions-record sharing
- Lacking continuum of care and "clean handoffs"
- No designated care coordinators

Funding Uncertainty

- Securing regular funding
- Unreimbursed care
- No crisis funding
- Lean staffing & staffing insecurity

Siloed Approach

- No shared records
- Lacking communication (HIPPA)
- Politics
- No economies of scale

Long-Term Beds

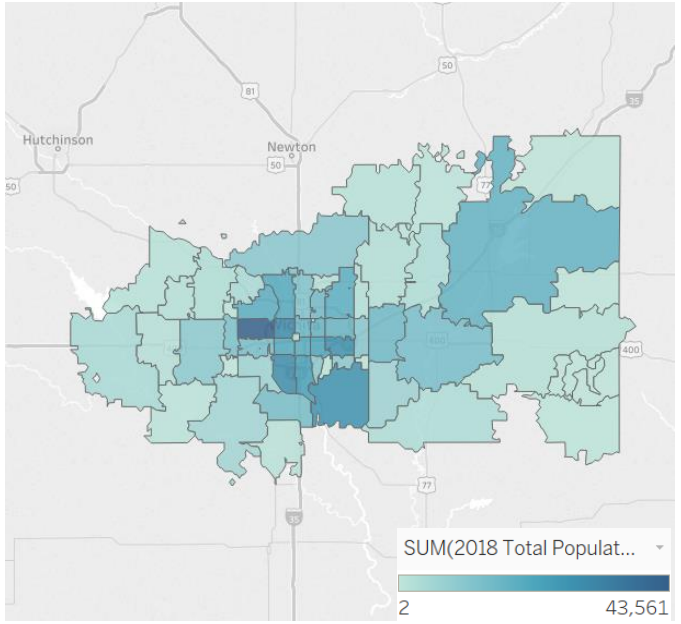
- Lacking state hospital resources
- No/lacking safety net solution
- Jails provide current 'long term care'
- Large proportion of patients needing long term care are turned away from state

Stakeholder organizations interviewed: Ascension Via Christi, Comcare, SACK, GraceMed, MHA – South Central Kansas, Wichita Children's Home, Continuum of Care, Law Enforcement, National Alliance on Mental Illness (NAMI), School District 259

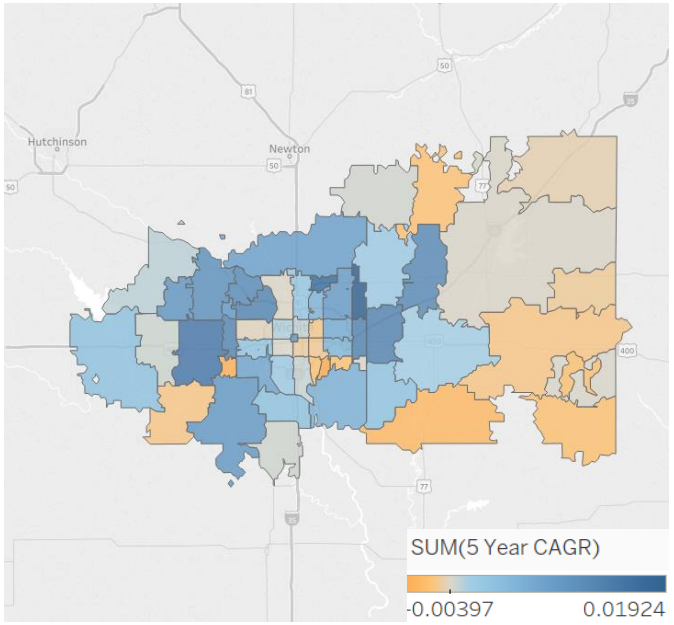
Primary Service Area Population Change

The Primary Service Area (PSA) anticipates a steady population with growth expected outside the metro area.

2018 Population Distribution



2018-2023 Population Growth (CAGR)



Service Area	2018 Pop	2023 Pop	5 Year CAGR
Primary	575,981	587,569	**0.40%**
Whole Market	964,906	973,486	0.18%

Source: Truven/IBM. PSA = Sedgwick and Butler counties.

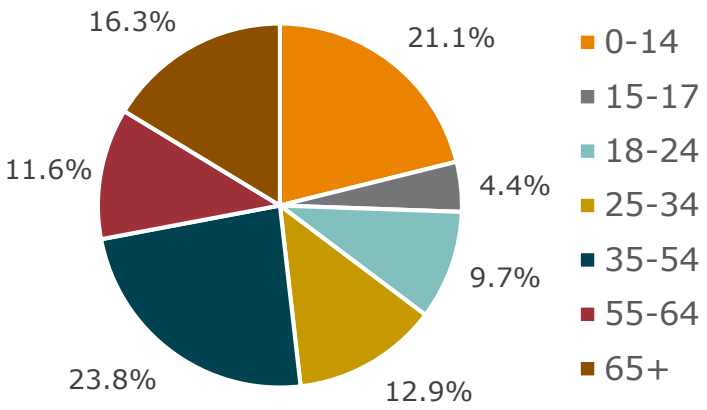
PSA Demographics

Seniors 65+ are the fastest growing age demographic

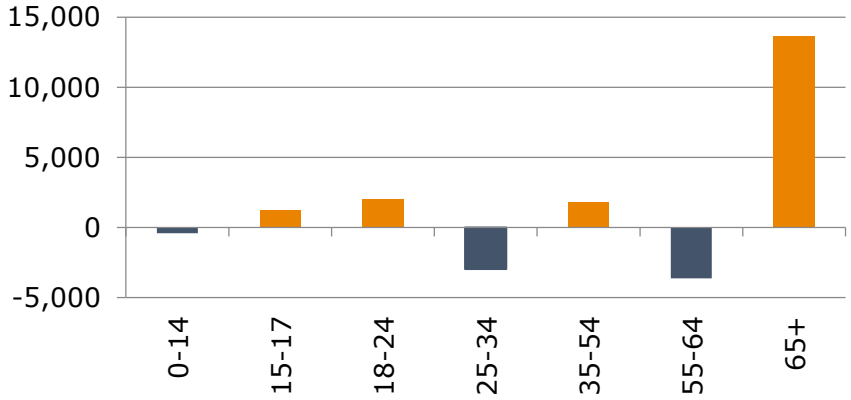
Household income is lower than US average

11% of the PSA is uninsured

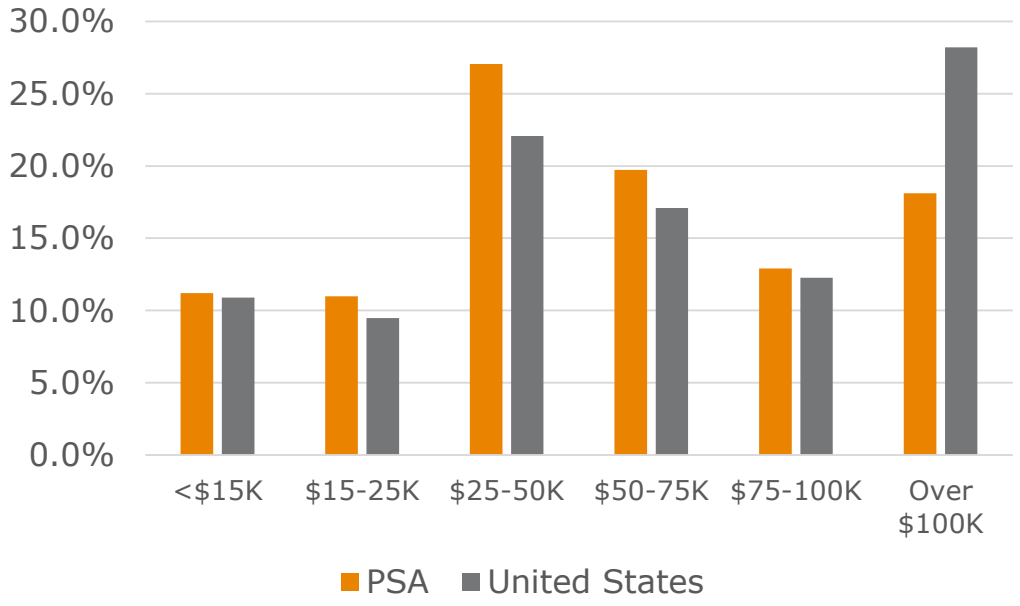
2023 Population by Age Group

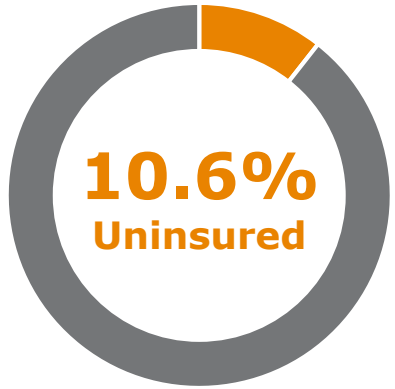


Population Change 2018-2023



2018 Household Income Distribution





Source: Truven/IBM, County Health Rankings

BH Resource Inventory (PSA)

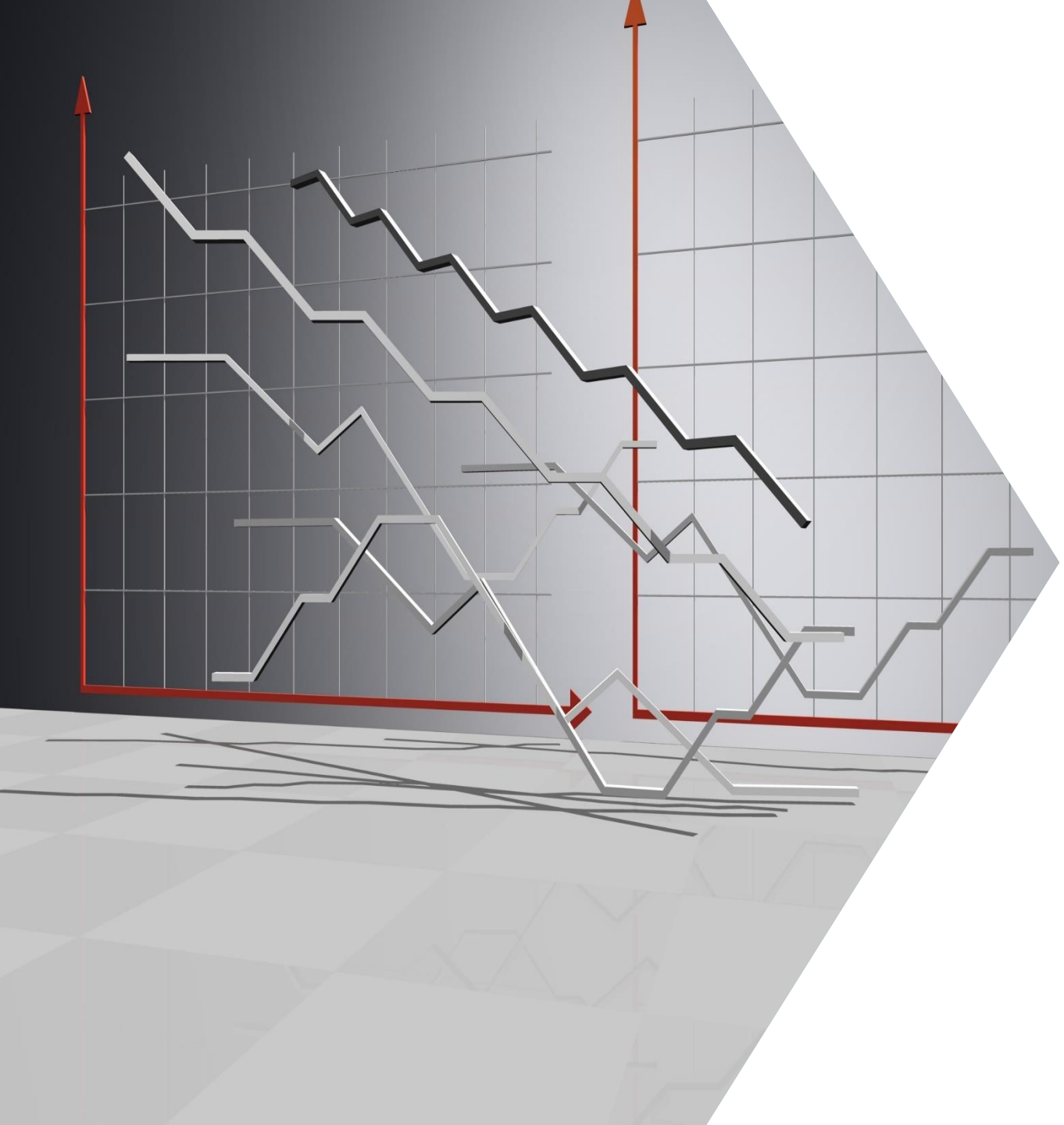
Behavioral Health resources are concentrated in the urban core

With population growth expected outside of the metro area, solutions should consider care model, technology, and facility options to address this outward push

Key Sources: KDADS Mental Health Resources in Kansas, Shelterlistings.org, Psychology Today

Behavioral Health Resources

Interactive Google Map



Projected Need

Projected Need

- Outpatient behavioral discharges are projected to grow at 0.9% annually in the PSA
- This would require a need of *at least* 64 additional mental health providers over the next 10 years

Background

Historic and projected growth rates in the primary service area were analyzed to assess the projected need of behavioral health resources in the market. Inpatient, outpatient, and housing were all evaluated. The assessment focused on quantifying the projected provider need as well as inpatient beds.

Issues

The provider need calculation is directional, as public data was limited and/or not well maintained to understand the current number of behavioral health providers in the service area today. As an alternative, Catalyst leveraged the Sg2 outpatient projections as a baseline for the total behavioral health market. Based on secondary research, we then assumed 60% of mental health "MH" visits go to licensed MH providers, 23% go to psychiatrists, and 17% to other MH staff. The team also assumed psychiatrists see an average of 2,750 visits/provider and all other MH staff see an average of 900 visits/provider. This approach however, does not account for psychiatrist retirement and loan repayment pressures, which would inflate the need.

Findings

Catalyst found that there is a mental health provider shortage in Sedgwick and Butler counties. The outpatient behavioral health service demand is growing within the service area at 0.9% CAGR. To meet this demand the community needs *at least* 64 additional mental health providers. This need is likely to increase with anticipated psychiatrist retirements (the average age of psychiatrists in the community is 52) along with the fact that many are dealing with loan repayment pressures. If the team were to just focus on the outpatient market for Via Christi, Comcare, and SACK to start, the need is projected at a*t least* 15 additional mental health providers. These three organizations were selected as they are already very engaged in this effort and it may take time to gain community wide consensus to work on addressing the larger need.

Projected Need

- Inpatient behavioral discharges are projected to grow at 0.4% annually in the PSA
- No need for additional IP beds

Findings continued

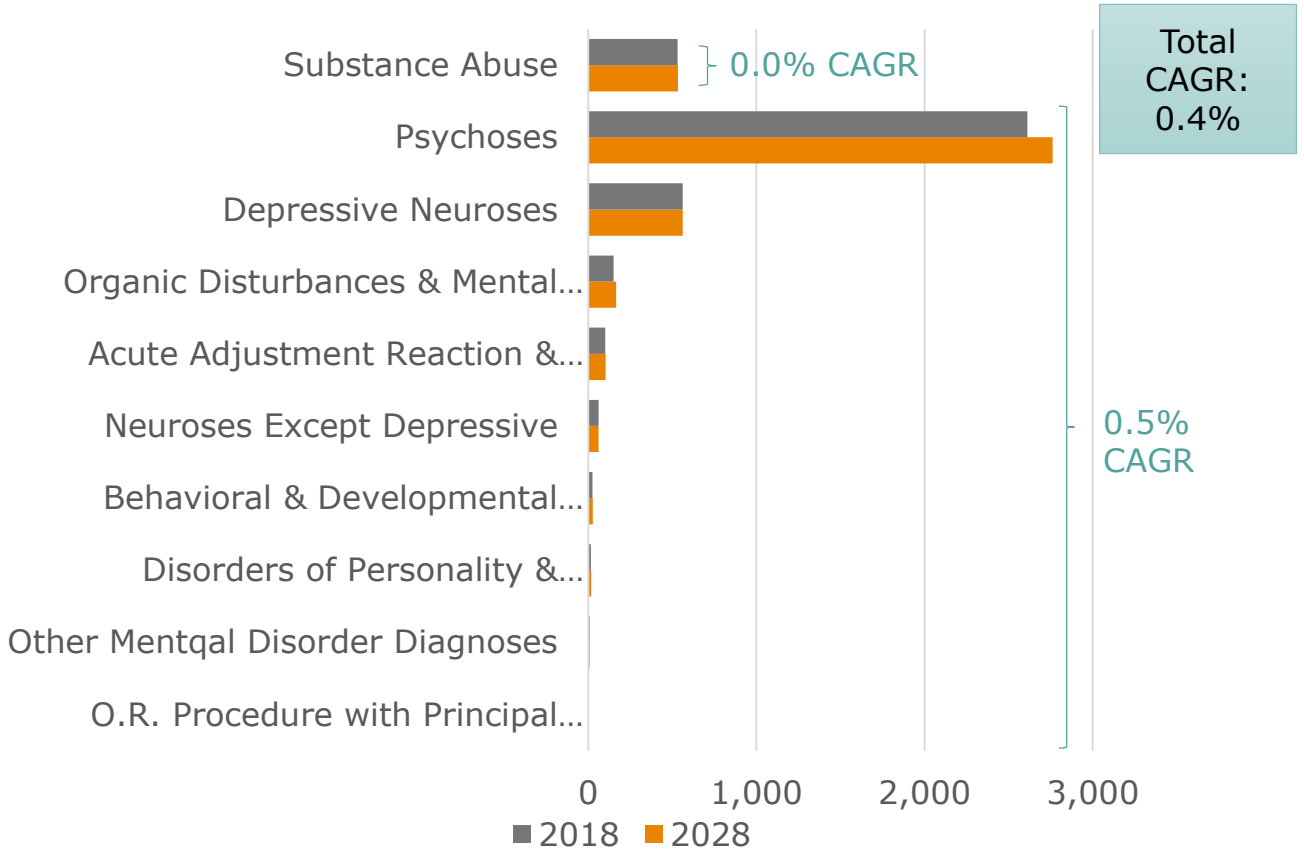
On the inpatient side, there is no need for additional inpatient beds, as the demand is likely to remain steady over the next 10 years growing at 0.4% annually. Via Christi will have 117 beds after the opening of the psych observation unit in the Summer 2019 which accommodates the 111 beds needed over the 10 year horizon.

Based on discussions with key stakeholders, there is also a need for housing within the service area in the forms of emergency shelters or transitional housing. However, the biggest challenge for homeless shelters at least is around staffing constraints.

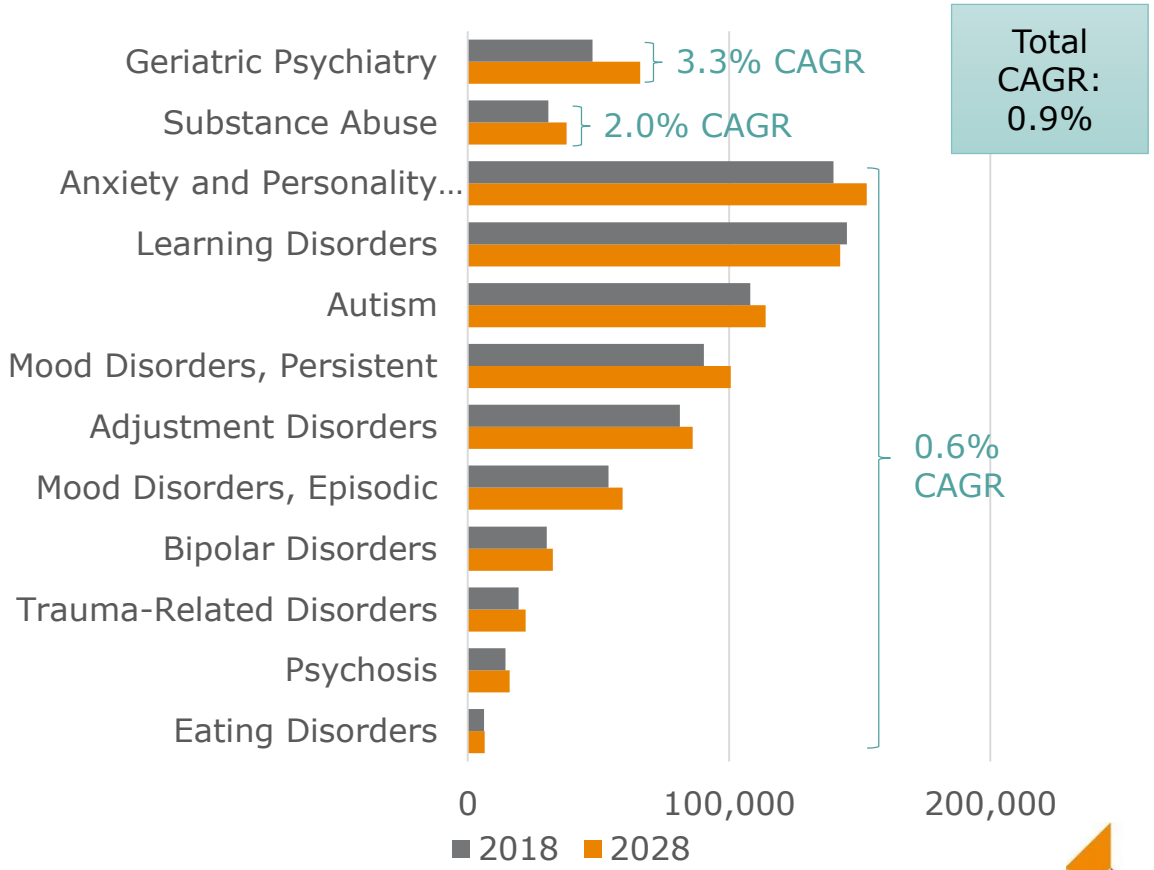
Sg2 10 Year Inpatient and Outpatient Discharge Growth (PSA)

Over the 10 year horizon, IP will remain steady while OP is expected to show positive growth

Sg2 IP Discharge Volume



Sg2 OP Discharge Volume



Source: Sg2 Market Analytics; Data filtered on service area – PSA
Assumptions: Substance Abuse defined as Addiction/Chemical Dependency and Poisonings in Commonly Abused Drugs in Sg2 OP CARE Family and as Addiction/Chemical Dependency in Sg2 IP MS-DRG; Geriatric Psychiatry defined as Dementia and Cognitive Disorders in Sg2 OP CARE Family

Historic Discharges vs. Sg2 Projections

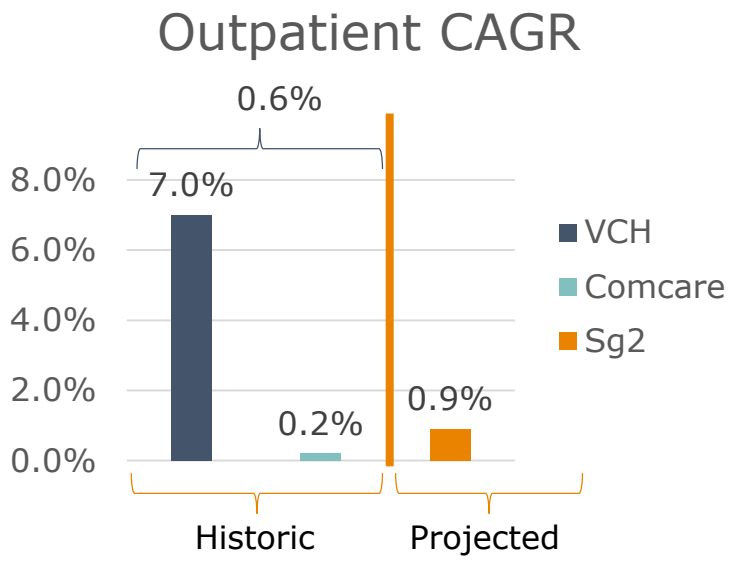
Outpatient growth has remained consistent with Sg2 forecasts

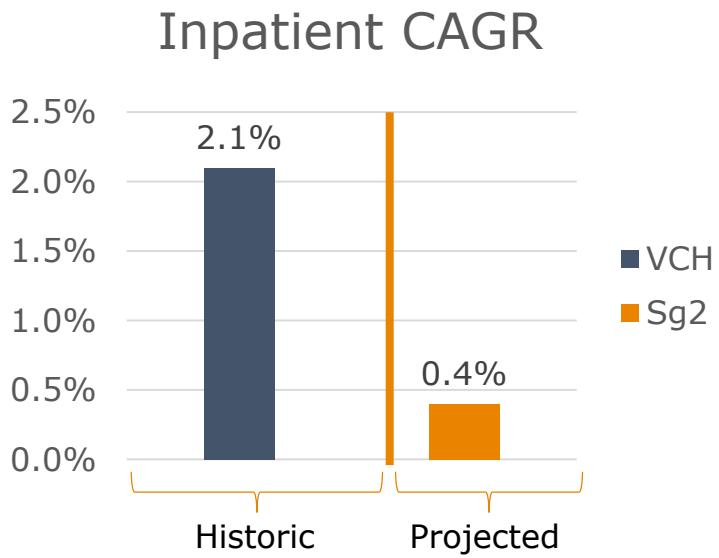
Inpatient growth has outpaced Sg2 forecasts

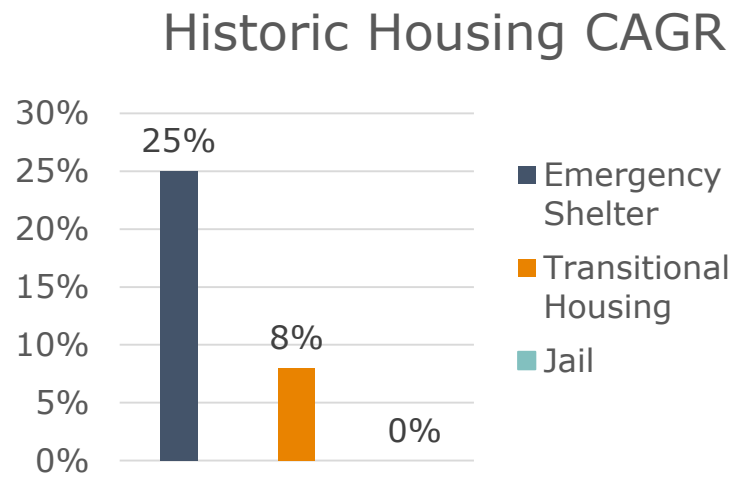
Housing remains a substantial need with considerable historic growth 2016-2018

Note: OP CAGR excludes ED volume. Historic OP & IP CAGRs based on 2017 – 2019; Historic Housing CAGRs based on 2016 – 2018. All Projected CAGRs based on 2018 – 2028.

Source: Log data, Sg2





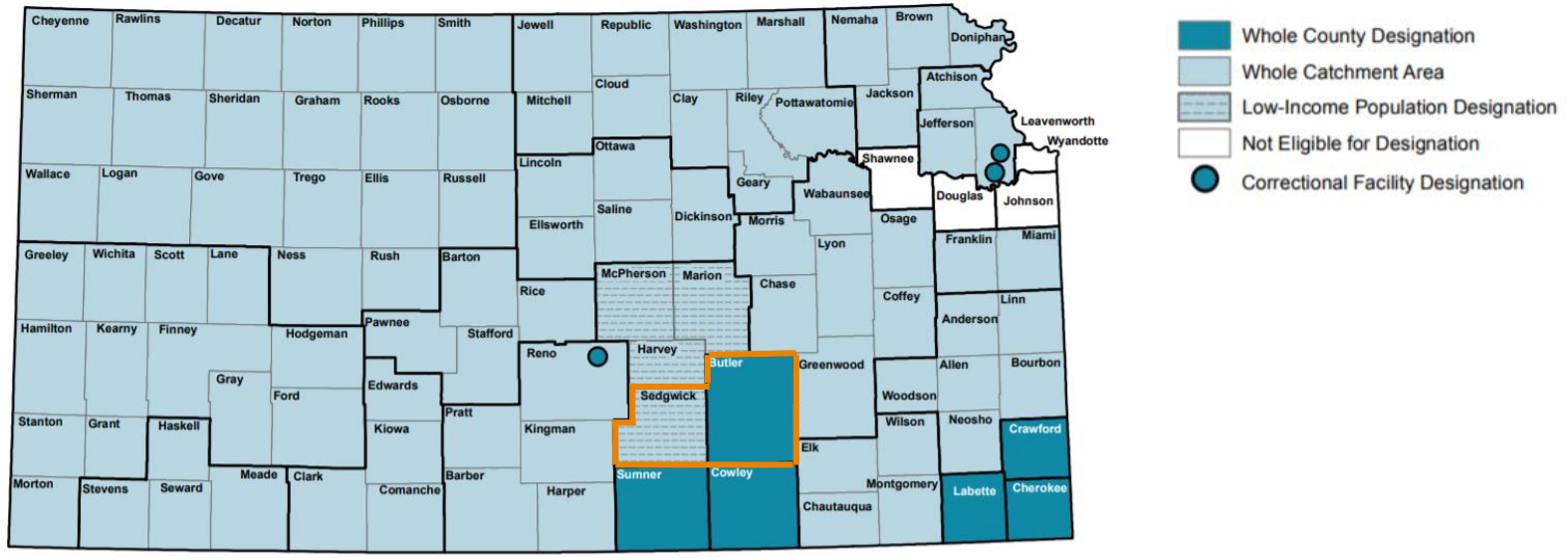


Future Provider Need (PSA)

To meet outpatient demand, it is estimated that *at least* **64 additional** mental health providers are needed

This need is likely higher due to the current shortage of providers in the PSA along with psychiatrist retirement and loan repayment pressures

Federally Designated Mental Health Professional Shortage Areas (HPSAs) in Kansas

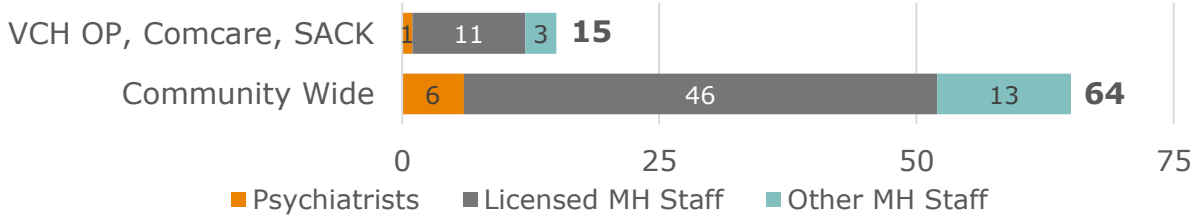


Source: Institute for Policy & Social Research, The University of Kansas; data from the U.S. Department of Health & Human Services.

Estimated Number of Mental Health Providers Needed

	Metric	2018	2028	Change
Community Wide	# of OP Discharges	767,704	836,305	68,601
	# of MH Providers Needed	**719**	**784**	**64**
VCH OP, Comcare, SACK	# of OP Discharges	168,489	184,282	15,793
	# of MH Providers Needed	**158**	**173**	**15**

*OP discharge growth assumes a 0.9% CAGR



1. HPSA Mental Health map source: https://ipsr.ku.edu/ksdata/ksah/vital/mentalcare.pdf
2. MH Provider need calculation: (1) assumes 60% of MH visits go to licensed MH providers, 23% to psychiatrists, and 17% to other MH staff [BMC Health Services Research]; (2) assumes psychiatrists see an average of 2,750 visits/provider [MGMA] and all other MH staff see an average of 900 visits/provider [HRSA - Uniform Data System (UDS) & National Survey on Drug Use and Health]
3. Community Wide Need discharge source: Sg2; VCH OP/Comcare/SACK Need discharge source: log data from each organization

Inpatient Bed Need

VCH will have 117 BH beds after the opening of a psych observation unit Summer '19

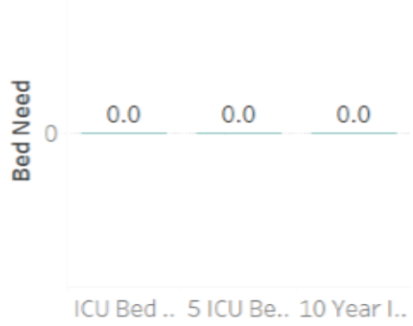
There is no need for additional IP beds over the 10-year Horizon given current market share and ALOS

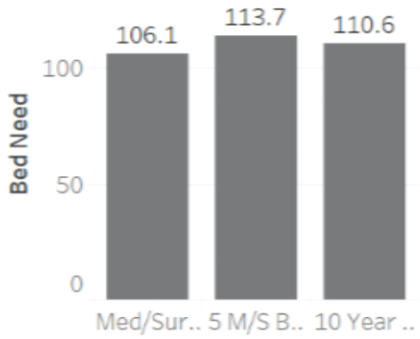
Inpatient Bed Dashboard:

	Current Year	5 Year	10 Year
Population	575,981	587,569	599,390
Current Use Rate	7.1	7.4	7.1
Market Discharges	4,077	4,368	4,248
Out of SA Dischar..	0	0	0
Market Share	96.0%	96.0%	96.0%
Hospital Dischar..	3,914	4,193	4,078
ALOS	7.4	7.4	7.4
Hospital Days	29,050	31,123	30,268
ADC	79.6	85.3	82.9

0-5 Year ..	5-10 Year..	0-10 Year..
1.4%	-0.6%	0.4%

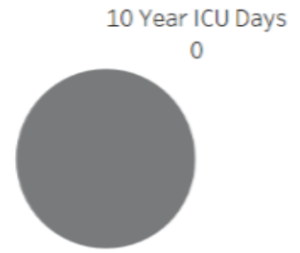
0-5 Year C..	5-10 Year ..	0-10 Year ..
1.4%	-0.6%	0.4%





10 Year Total Days	30,268
10 Year ICU Days	0
10 Year ICU Bed Need	0
10 Year M/S Bed Need	111
% ICU Days	0%

Index1
(All)



Source: Via Christi Inpatient Log, Sg2 Projections

Strategic Direction

Strategic Direction

Over 50 behavioral health gaps identified in the Wichita community

Future industry trends in the behavioral health space and case examples from across the US helped to inform the strategic direction for potential solutions

Background

After evaluating the current state and future projected need of behavioral health in the Wichita community, Catalyst identified and analyzed behavioral health trends in the industry. Not only were industry market solutions assessed, but also specific case examples across the country. A gap analysis was then performed comparing the current state of behavioral health in the community to where the community needed to be. The gap analysis pulled from research to date as well gaps identified during a strategic "visioning session" performed during Catalyst's on-site visit. The visioning session involved presenting the steering committee with 10 profiles of individuals with varying behavioral health needs and asking the committee to walk through their thought process of how that individual might respond and what options for care currently existed today for each particular situation. During this interactive session, the team was able to identify additional gaps.

Issues

The challenge was identifying which market solutions were applicable to the Wichita community and the feasibility of implementing them. Additionally, over 50 gaps were identified during the visioning session. As will be shown later, while most gaps can be addressed through various solutions proposed by Catalyst, there were still some that would require state policy changes or involve funding challenges, both of which were out of scope for the purposes to this assessment.

Findings

The gaps identified generally fell into the following categories: Facility, Access, Community, Resources, Services, Communication, and the Continuum of Care. These designations helped to tailor our potential solutions. In our research, we discovered that there are several market solutions and case examples that address certain components of Wichita's behavioral health gaps. Catalyst found that technology (i.e. telehealth, mobile applications), primary care, and partnerships was the way of the future for behavioral health. We also distilled the multitude of cases out there down to the most applicable models for the Wichita community. These cases addressed incarceration, homelessness, ED, substance abuse, depression, and comprehensive community initiatives.

Industry Trends

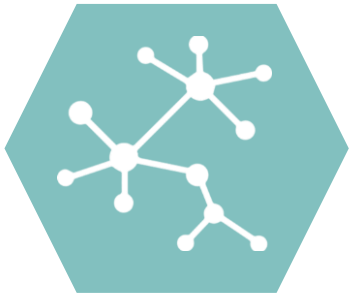
Four Market Solutions to Bridge Care Gaps

Guarantee timely access to urgent psych care

- ED telepsychiatry - equip EDs with on-demand BH experience
- Dedicate environment tailored to BH needs (i.e. crisis stabilization units in ED)
- Establish a transitional care model (link patients to ongoing support, discharge clinic for follow up visits

Prepare PCPs to manage low-to-moderate acuity

- Extend reach of existing mental health care with telepsychiatry and teleconsulting
- Deploy new services to manage substance use disorders (peer support services, medication assisted treatment)



Activate partners to prevent symptom escalation

- Triage patient to right site of care
- Address patients' non-clinical needs
  - Housing support
  - Employment
- Serve as a vehicle for ongoing services
  - Community-based teams

Use IT platforms for between-visit care

- Support self-management (education, community network)
- Extend care team reach (i.e. automated assessments, texting with providers)

Source: Advisory Board

Case Studies

By subject addressed

Incarceration	Homelessness	ED	Substance Abuse	Continuum of Care
Advocates' JDP Model	WellSpace Health's Interim Care Program (ICP)	WellSpace Health's Triage Transport, Treatment (T3) Program	National Alliance on Mental Illness	Denver Health Model
National Alliance on Mental Illness	West End Health Center	Advocates' JDP Model	Ascension Brighton Center for Recovery	Arizona Health Care Cost Containment System (AHCCCS)
The Fortune Society's Better Living Center (BLC)		Atrium Health: Behavioral Health-Davidson, NC		Agency for Community Treatment Services (ACTS)
Changing Lives and Changing Outcomes		Agency for Community Treatment Services (ACTS)		Catalyst Case Example Outpatient Care Center
Agency for Community Treatment Services (ACTS)				

Bexar County BH Model
addresses all of these subjects

Case Studies: Overview

Bexar County CHCS: Restoration Center

- Integrated Mental Health Service Center
  - Sobering Unit
  - Detox Room
  - Extended Observation Unit
- Provides substance abuse treatment programs, job training
- Reduced overcrowded jails and inappropriate incarceration
- Partners with nonprofits to address and reduce the broader causes of homelessness.

Brighton Center for Recovery

- Treats drug and alcohol dependence.
- Equips patients with the tools they need to live clean and sober lives.
- 99 beds
  - 41 Acute Beds
  - 58 Residential
- Traditional halfway housing (16)
- Outpatient services utilize group therapy class/meeting rooms

Atrium Health: Behavioral Health Davidson

- Met the psychiatric bed shortage within the Mecklenburg County and the surrounding area.
- Treats patients both with and without insurance.
- 66 IP Beds
  - 11 Bed Units
  - 2 Stories
  - Future Expansion Zones

See Appendix for further detail on each case

Case Studies: Overview

Denver Health Model

- Integrated safety net institution in Denver, Colorado
- 477-bed acute care hospital
- Patients referred by PCP or through a pharmaceutical audit of anti-depressant prescriptions
- Services:
  - Telephone-based support
  - Counseling sessions via phone

Sacramento WellSpace Health Programs

- Triage, Transport, Treatment (T3) Program
  - Frequent ED users are connected to program that provides comprehensive BH care, housing and social resources through partner organizations
- Interim Care Program (ICP)
  - Homeless IP Patients are discharged to nurse-managed specialized unit in area shelters operated by WellSpace Health.
  - Reduces LOS by 23 for homeless patients.

Advocates Jail Diversion Model

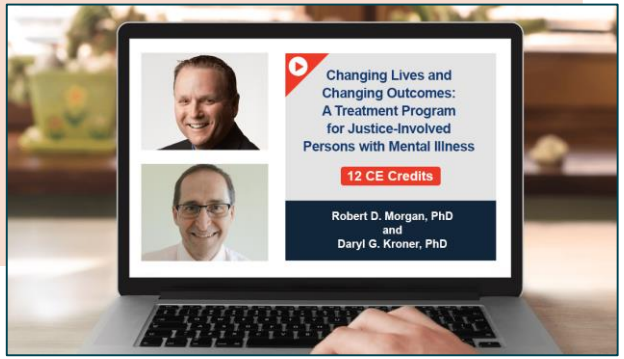
- Pairs police officers with masters-level clinicians on all 911 response calls involving individuals in a mental health or substance-related crisis.
- Dual diversion program- both the ED and incarceration.
- Saved its first county, Farmingham, $3,324,000 in arrest diversions and $2,472,000 in ED diversions.

See Appendix for further detail on each case

Case Studies: Overview

Changing Lives and Changing Outcomes

- Online program to assist with the mentally ill involved with the criminal justice system.
- There are 9 treatment modules covered in 74 online sessions specifically designed to change and recognize the mental illness and criminalness awareness.



The Fortune Society

- Better Living Center- treats anyone with a history of court involvement who present signs of mental illness
- Alternate Incarceration
- On-call 24/7
- Uses alternative incarceration to move people involved in the justice system that are mentally ill.
- Uses a "one-stop" model where previously incarcerated people can have access to resources.
- Provides a smooth transition for previously incarcerated people.

The Fortune Society
BUILDING PEOPLE, NOT PRISONS

Colorado Coalition for the Homeless

- Provides integrated services and temporary shelters for those that are chronically homeless or are below the poverty line.
- Integrated the shelter, primary care, behavioral health, and pharmacies to be provided in one single location.
- 101 supportive housing apartments
  - 50 apts. for chronically homeless
  - 51 apts. for low-wage households.

COLORADO COALITION FOR THE Homeless
Creating Lasting Solutions

See Appendix for further detail on each case

CATALYST
a Haskell Company

Case Studies: Overview

Agency for Community Treatment Services (ACTS)

- Meets the coordination of care need in Hillsborough County.
- Established standardized education and resources for providers caring for patients with mental or behavioral health needs.
- Local partnerships between hospitals, healthcare systems, and county's health department.
- Identifies and addresses high ED and other healthcare resource utilizers, and directs them to the most appropriate form of care.

Arizona Health Care Cost Containment System (AHCCCS)

- Establishes an integrated healthcare model with moth behavioral health and primary care services for adults and children.
- Provides programming for Phoenix's Medicaid population.
- Addresses key demographics:
  - People with a serious mental illness
  - Children in custody of the Department of Child Safety
  - Members of Arizona Long Term Care System with disabilities
- Provides a crisis hotline.

Outpatient Care Center

- A Catalyst Case Example
- Center was experiencing space constraints.
- The center was operating under an integrated model of care where all of the providers come to the patient when the rooms were designed for the patients to move around between providers.
- To improve the integrated model of care Catalyst recommended the following solutions/resources:
  - Remote Resource Management
  - Group Care
  - Virtual Care

Catalyst Case Example

See Appendix for further detail on each case

Gap Analysis

Gaps by Category

Over 50 gaps identified during on-site visioning session

Majority of Gaps are service and resource related:

- Services: 29%
- Resources: 19%
- Continuum of Care: 15%
- Community: 13%
- Access: 13%
- Communication: 6%
- Facility: 4%

Gap	Category	Sub-Category
Incorrect use of crisis center - people transport dementia patients to the crisis center thinking they are having a psychotic break; really it's dementia	Access	Point of Access
Disproportionate concentration of BH patients @ certain EDs	Access	Point of Access
Same day access	Access	Timely care
Follow-up appt/ wait time for appt	Access	Timely Care
Transportation	Access	Transportation
Transport from jail to shelters (fallen through)	Access	Transportation
Transporting youth in crisis from school to crisis center (won't do it)	Access	Transportation
Consistent messaging for services & resources	Communication	Consistency
Education of process/policy/capability (the WHY)	Communication	Education
Communication w/ non-Medicaid patients	Communication	Targeted Audience
Time- teachers (certifications), MH First Aid, Church	Community	Advocate Engagement
Religious connection	Community	Advocate Engagement
Knowing all businesses educate employees	Community	Advocate Engagement
BH campaigns	Community	Advocate Engagement
Employers' acceptance of MH support	Community	Advocate Engagement
Community commitment to address need	Community	Advocate Engagement
Diverse organizations: culture- language, education, etc.	Community	Diversity
Standardizing intake info	Continuum of Care	Information sharing
School direction- Counselor>ED>Crisis Center	Continuum of Care	Process
Ground level collaboration (right now it is mostly among leadership)	Continuum of Care	Process
Coordination with VA	Continuum of Care	Process
Individual practitioners not incentivized to refer or coordinate with other organizations	Continuum of Care	Process
Community Care Transitions	Continuum of Care	Transition of care
Steps after Jail	Continuum of Care	Transition of care
Communication gap on release from judge to coordinating access to care (end up in ED)	Continuum of Care	Transition of care
Facility proximity	Facility	Proximity
Need for more beds/ clinic space across facilities	Facility	Space

Gaps by Category *continued*

Gap	Category	Sub-Category
Education & resources	Resources	Educational
Access or mandate for Police education	Resources	Educational
Resource booklets of options for everyone	Resources	Educational
Training on aggressive behavior & decision making for staff safety	Resources	Educational
Funding for innovative change	Resources	Funding
Live off of grants	Resources	Funding
Opioid vs. meth funding competition	Resources	Funding
Sustainable funding	Resources	Funding
Statewide gap puts pressure on Wichita system	Resources	Gap in care
Turnover time/staffing	Resources	Staffing
Medical Detox	Services	Gap in care
Medical health (Homeless)	Services	Gap in care
Geriatric care & shelters	Services	Gap in care
Time of day/night to stay @ a shelter	Services	Gap in care
Housing for violent patients	Services	Gap in care
Management of violent patients	Services	Gap in care
Policy change- mandatory bookings	Services	Policy barrier
Cops can't enter women's shelters (policy)	Services	Policy barrier
Reactionary instead of proactive	Services	Prevention & Wellness
Rely on a emergency plan rather than early intervention	Services	Prevention & Wellness
Lack of PC screenings	Services	Prevention & Wellness
Need to focus on wellness/preventitive care & self care	Services	Prevention & Wellness
Preventitive medical/ wellness centers/ nutrition	Services	Prevention & Wellness
identify the cause- dig deeper	Services	Prevention & Wellness
Eating disorders	Services	Service offering

Facility and Operational Options

Option Development Approach

A three-tiered system was developed with facility solutions and operational interventions

Background

The market trends and gap analysis ultimately helped to shape the proposed solutions. In alignment with the scope of work, options were primarily focused on potential facility solutions. Operational interventions were also presented at a high level to give the steering committee direction for planning efforts outside of the facility response. In addition to developing a list of facility and operational responses, Catalyst also created a tiered system whereby solutions were grouped into basic, intermediate, and long-term options.

Issues

As mentioned previously, not all gaps could be addressed within the proposed options due to some requiring state policy changes or involved funding challenges, both of which were out of scope for the purposes to this assessment. Sample space programs included are rough space estimates which are derived from similar programs and industry space standards. It must be noted that the cost analysis shown is at a high level to indicate a rough order of magnitude (ROM). Each option is priced based on current market location as well as current anticipated inflation, and generally includes probable building and project costs that are subject to change based on future market conditions, and does not include land or leasing costs, or costs associated with facility condition assessment for any options that suggest expansion through renovation of an existing facility as illustrated on slides 38 through 44. Lastly, to properly scope a facility moving forward, a more detailed study would need to be provided, as the team made broad assumptions on existing facility conditions, space, and needs based on steering committee feedback, so the information included for the purpose of this high-level study should only be used to steer big picture decisions.

Findings

It was found that nearly 80% of the gaps identified could be addressed through basic and intermediate responses. From a capital planning and funding perspective this is significant, as it allows the team time to focus on fundraising and gaining community consensus for the longer term solution while still working to address a majority of the needs.

Option Development Approach (continued)

A three-tiered system was developed with facility solutions and operational interventions

Findings (continued)

At the most basic level, options were developed to right size existing facilities and get organized operationally (i.e. developing business and marketing plans, conducting a thorough assessment of existing assets, etc.). At the intermediate level the focus shifted to developing new facilities primarily in the primary care/wellness space as well as working to introduce new service offerings and proactive interventions operationally. Finally, the long term solution is geared toward the creation of a comprehensive co-located community model. For each of these tiers, national case examples were considered and elements were incorporated into our final responses.

Opinions of Probable Cost

Most people speak in terms of "construction costs" but there are many more costs associated with a project that need to be accounted for

Building Costs + Project Costs = Total Project Costs*

- Building Gross SF $120-450 cost/SF

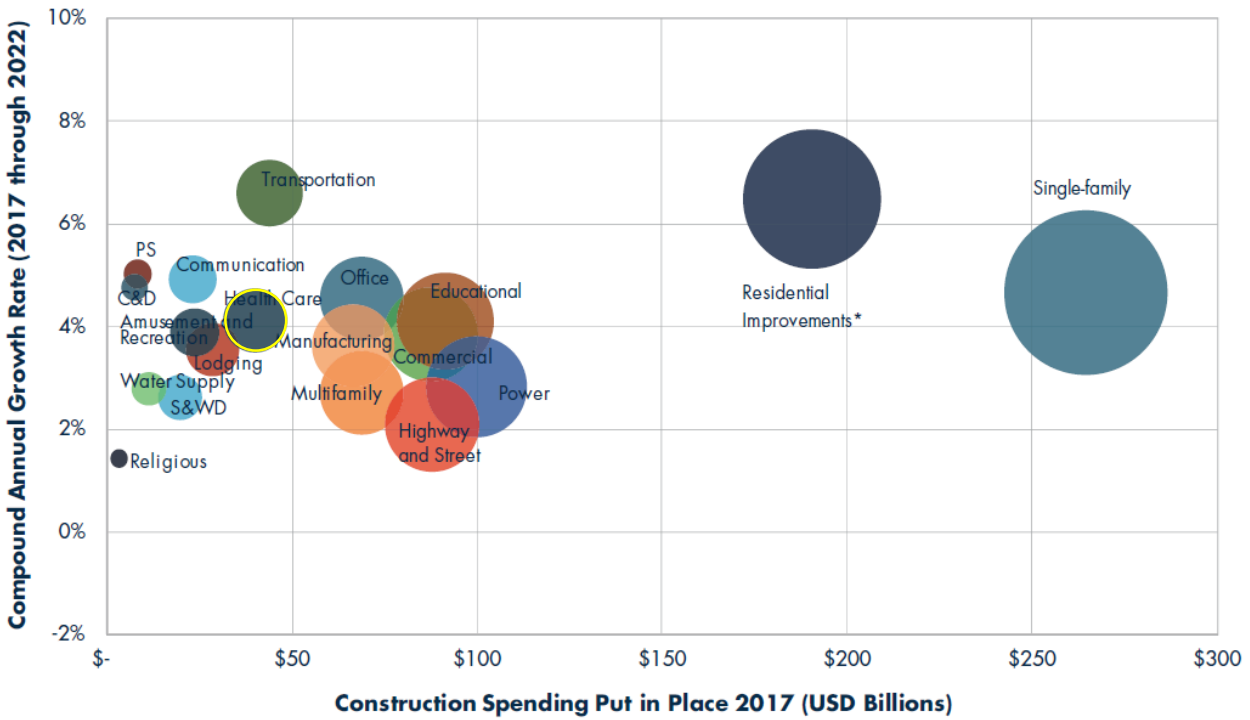
- Site Development
- **Construction Contingency (10%)**
- Equipment
- Furniture
- Signage
- Low Voltage (6%)
- Professional Fees
- **Owner's Contingency (10%)**
- **Escalation (6-9%)**

**Note: Costs assume construction begins this year, will be adjusted as options are selected and phased)*

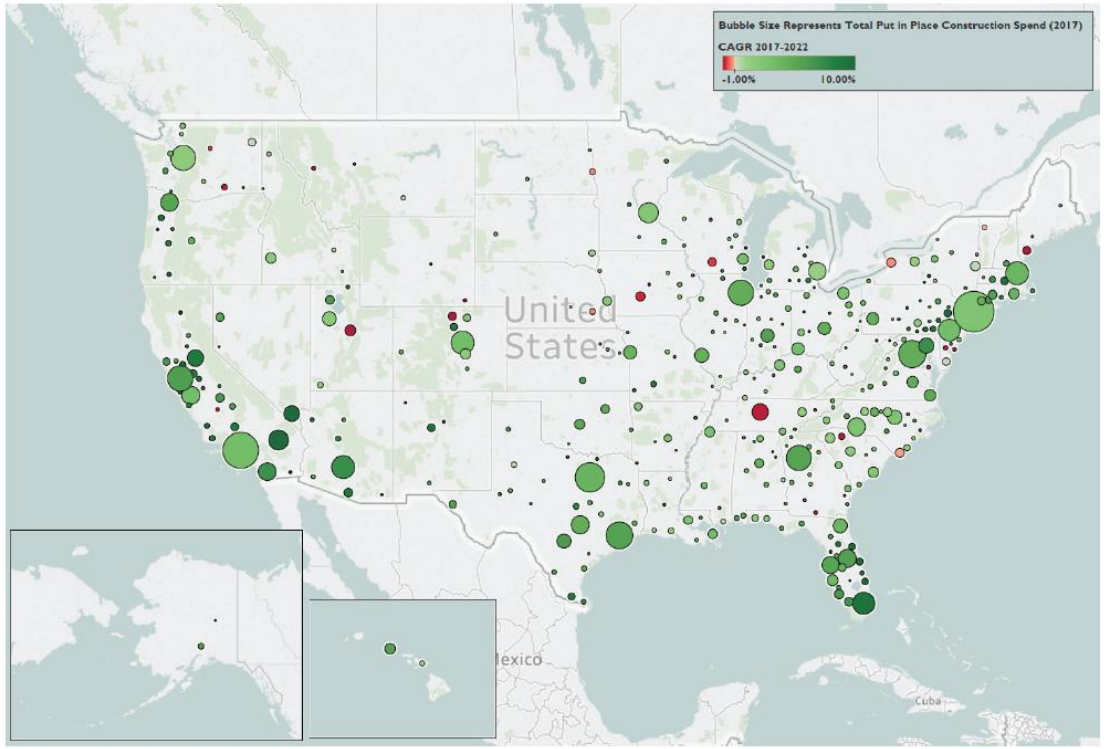
Construction Forecast

Forecasted to increase by 3-5% with concentrated areas and small pockets of declines

Total Construction Spending Put in Place 2017 and Forecast Growth (2017-2022 CAGR) by Construction Segment



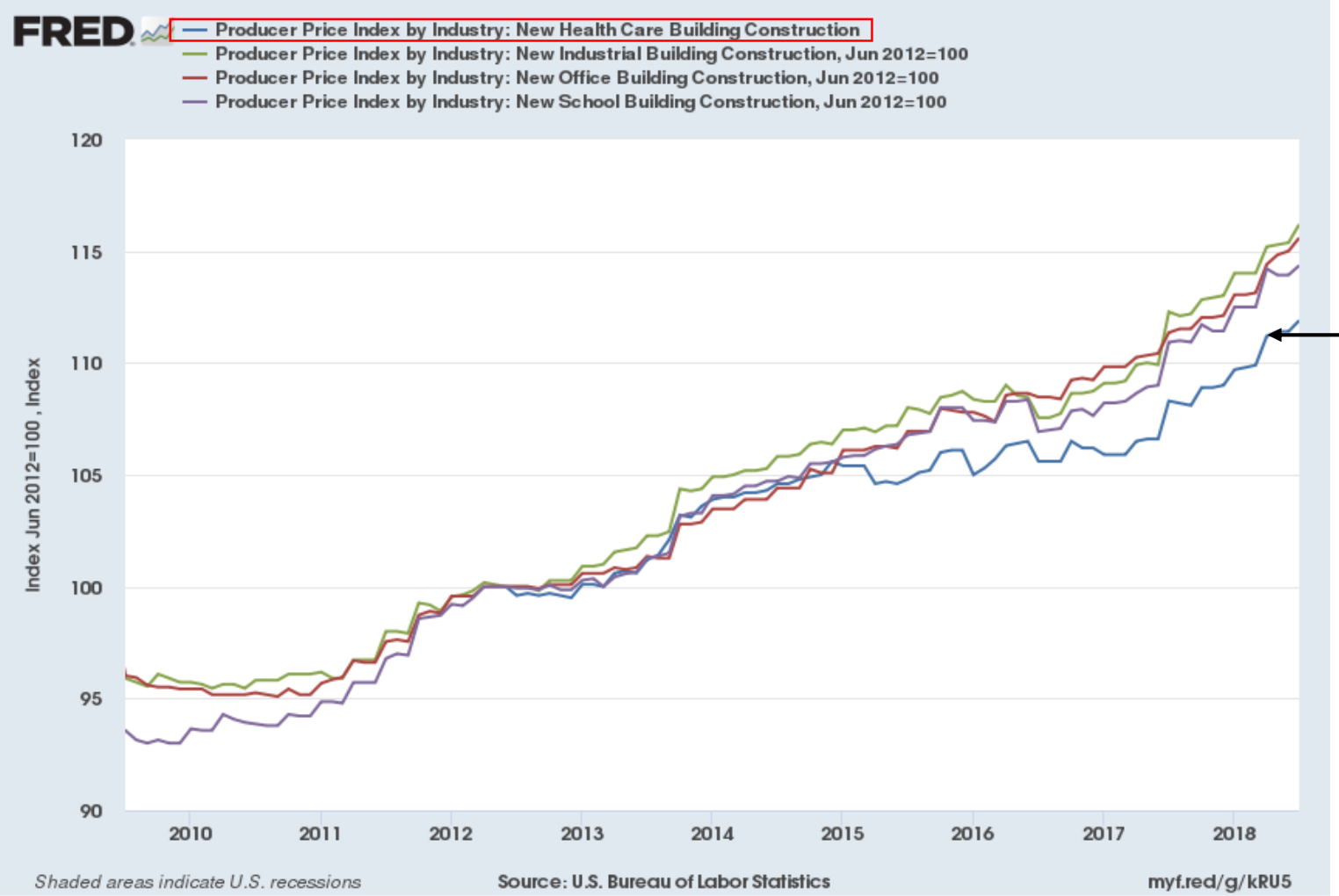
Total Construction Spending Put in Place 2017 and Forecast Growth (2017-2022 CAGR) by Metropolitan Statistical Area



Source: FMI Forecast

Price Index By Industry
National

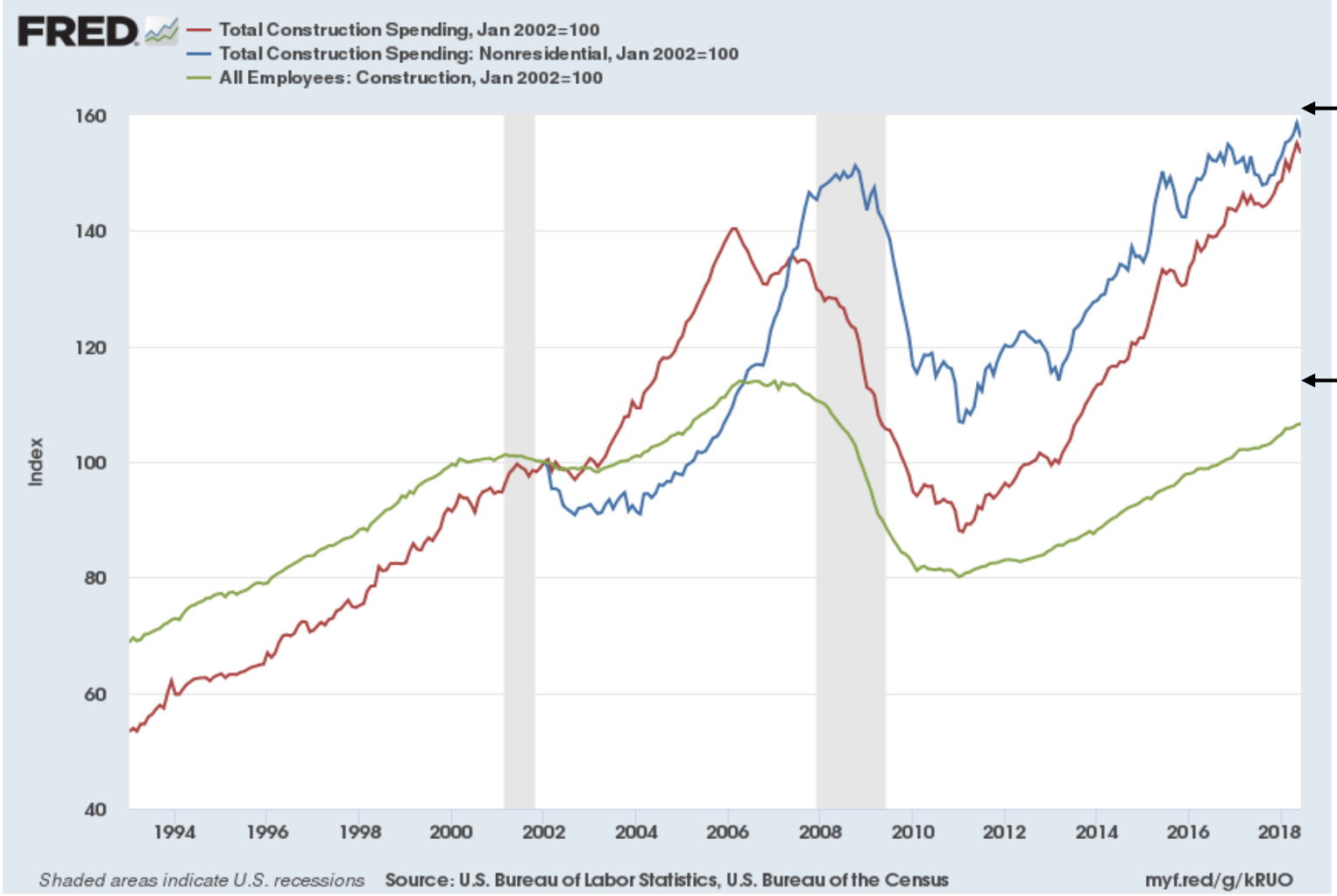
The price index for healthcare increased at a slower rate in 2015 but is now increasing similar to other markets



Healthcare Market

Index Construction Spending v. Construction Labor National

After 2010, growth in construction labor is less than growth in construction spending, indicating a shortage in construction labor

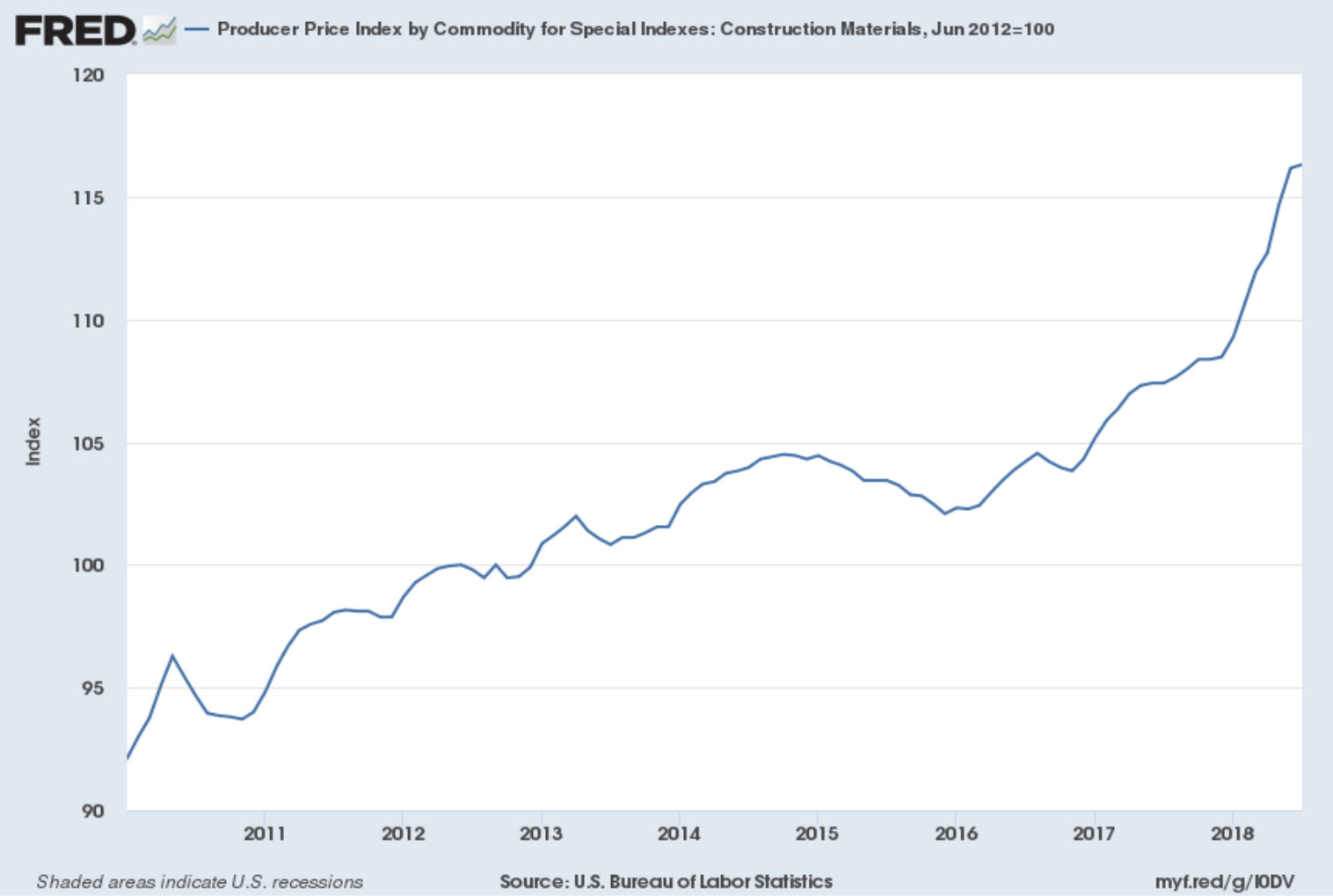


Non-residential Markets

Construction labor

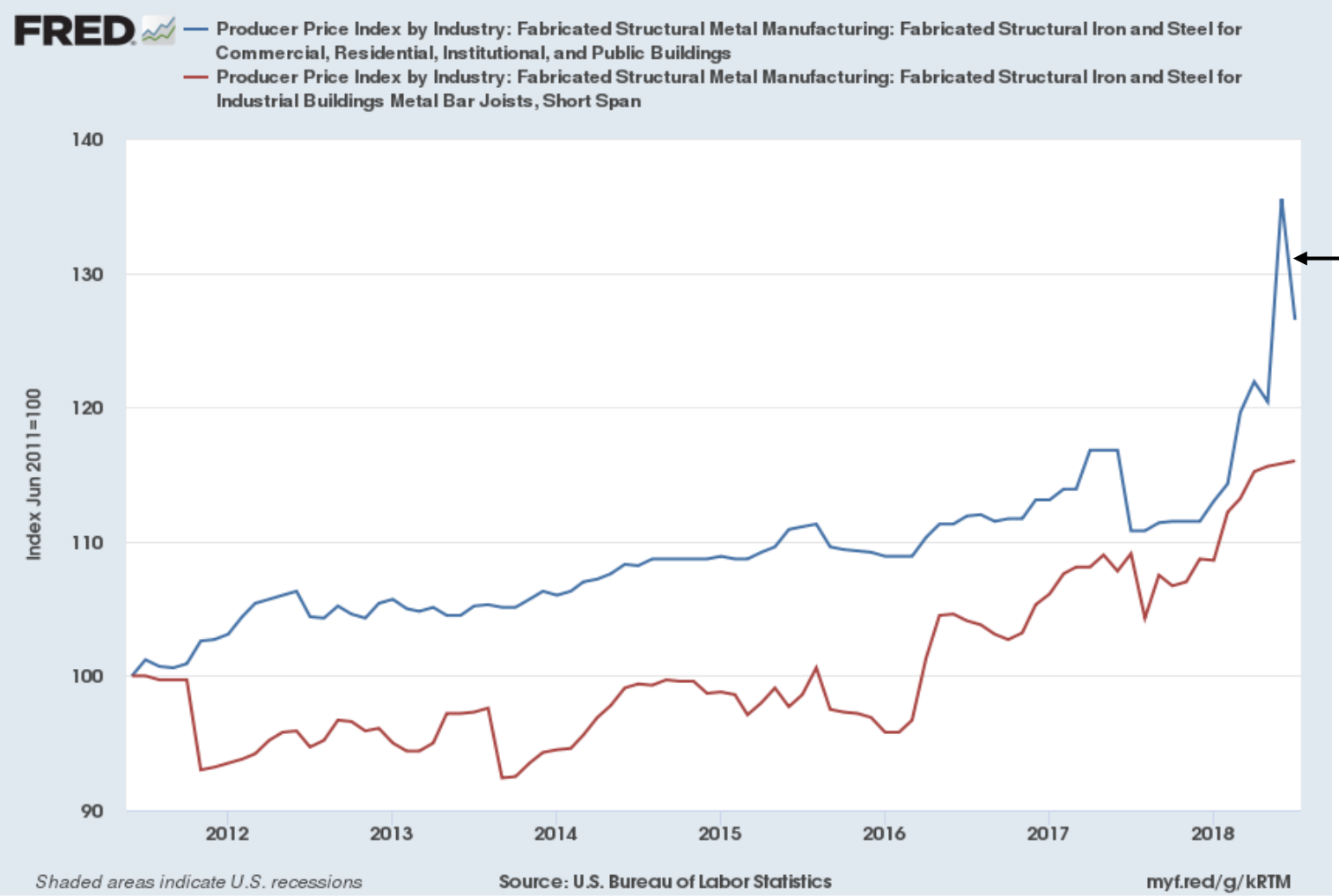
Materials Price Index
National

Material Prices have increased 12% over the past 18 months



Price Index
National

The price of steel has increased dramatically over the past 12 months



Institutional Market

Construction Cost Index Factors

01 **Increased labor costs**

02 **Labor shortage**

- Lack of skilled labor
- Stricter immigration policies
- Cant recruit younger generations

03 **Natural disasters and diversion of resources**

04 **Construction increase in the region**

05 **Project type and materials used**

06 **Increased cost of crude oil**

Expected to stabilize

Overview of Approach

A Tiered Approach

~80% of gaps identified can be addressed through basic and intermediate responses

X%: Cumulative % of gaps addressed by Tier

37%
Basic

Facility	Operational
Right-size *existing* facilities Incorporate BH services within *existing* primary/urgent care setting	Asset/Team Evaluation Business Plan/Marketing Training

79%
Intermediate

Facility	Operational
New facility investments in wellness/primary care; housing for violent patients	New services/ capabilities Prevention/ Primary Care/ Early Intervention Transportation Operational Study

92%
Long-Term

Facility	Operational
Community/ comprehensive facility model of co-located resources	New services/ capabilities Operational study findings implemented

See appendix for list of gaps and corresponding facility and/or operational response solutions

Case Studies

By Tier

Basic	Intermediate	Long-Term
National Alliance of Mental Illness	WellSpace Health's Triage, Transport, Treatment (T3) Program	WellSpace Health's Interim Care Program (ICP)
Denver Health Model- Emphasizes PCP	Changing Lives and Changing Outcomes	West End Health Center
Catalyst Case Example Outpatient Care Center	Advocates JDP Model	The Fortune Society's Better Living Center
	Arizona Health Care Cost Containment System (AHCCCS)	Bexar County Behavioral Health Model
		Atrium Health: Behavioral Health- Davidson, NC
		Ascension Brighton Center for Recovery
		Agency for Community Treatment Services (ACTS)

Facility Response

Facility Options- Overview

- Lack of access and availability state psychiatric beds
- Lack of space to serve the increasing BH population
- Facilities are spread out throughout the county serving as a barrier to BH care

Background

The city of Wichita is experiencing an increasing need for Behavioral Health (BH) services, much like many communities around the nation. There is a lack of state beds that those living in the service area can utilize or have access to. Hospital Emergency Departments (EDs) are overcrowded and unable to handle the increased need for BH patients, as this has generally been the most frequently used and burdened resource. Geographically, the services that BH patients need are spread out throughout the county making it more difficult for high-need patients to access. Many people with BH conditions are incarcerated partly due to the complexity of needs and issues that are associated with this population in general, and the correctional system does not have the capacity, nor is the appropriate environment to adequately handle their care. Improved services, conditions, and/or facilities must be considered in order to meet the BH needs of Sedgwick County.

Issues

Visioning sessions with stakeholders yielded gaps and variables that the community BH system has been unsuccessful in addressing. This crisis must be resolved in order to better address the growing BH needs of the county. Proximity to services and the need for increased space were the main gaps of concern voiced by stakeholders from a facilities perspective. In order to address these main gaps, the 3-tiered approach described above will be used.

Findings

To address the community's BH needs, it is critical that action be taken in order to address the facility needs where those limitations serve as barriers to care for those most in need. The co-location of resources is encouraged where possible, in order to not only improve economies of scale, but to decrease the number of access points BH patients must be processed through in order to receive the holistic care they may need. Additionally, the suggested increases in facility size and resources will support efforts to appropriately meet the growing needs of the BH community in Sedgwick County.

Basic Tier

Facility Options - Basic

- Rightsize COMCARE Programs
- Consolidate Crisis Center, SACK, and SCOAP
- Primary Care/Urgent Care Setting

Background

The proposed facility responses in the basic tier addresses the items that can be addressed at the most basic level to tackle the community's most immediate needs. The two organizations identified has having the greatest physical capacity constraints were COMCARE and SACK. Due to the increasing need for these services, there must be immediate improvements from a facility standpoint, to enable this program to continue to address and meet current and future needs of Sedgwick County. The expansion of an integrated healthcare system into the primary care market will allow for earlier detection, effective treatment and improved outcomes for the segment of the population with behavioral health needs.

Issues

Limited square footage at the COMCARE facilities has led to the facility and corresponding resources being unable to accommodate the need of the community that grew by approximately 40% from 2016-2017. 485 cases were denied from the Crisis Center/SACK during that period. Services provided by COMCARE are offered at two different locations, but could be more effective and efficient from the consumer and operational perspective, if they were operated from within the same facility as an example.

Findings

Consolidating COMCARE Crisis Center/Substance Abuse Center of Kansas and the Sedgwick County Offender Assessment Program allows for patients needing a wider range of BH services to have one access point. Additionally, integrating more BH services provided in the primary and urgent care settings will allow for increased preventative measures to be put into place. The suggested options in the basic tier propose changes that if implemented, would address the shortages of space and lack of coordination of care between the facilities to varying degrees.

Sources:

WSU 2018 Report (Public Policy and Management Center)

Basic (Existing)

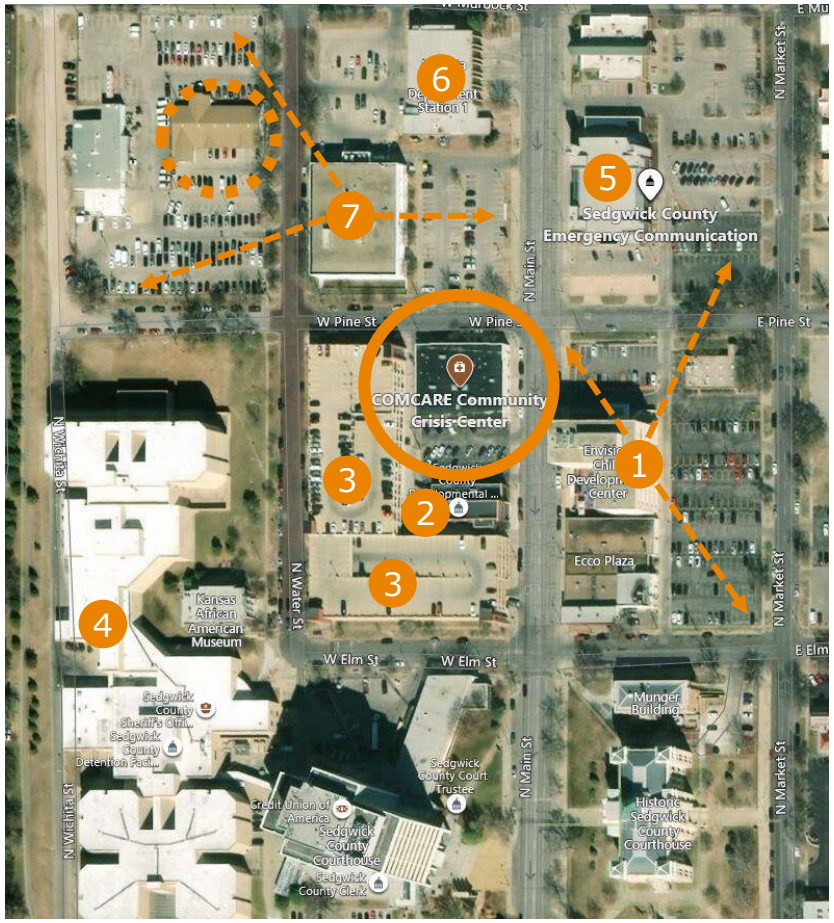
Right-size COMCARE Programs:

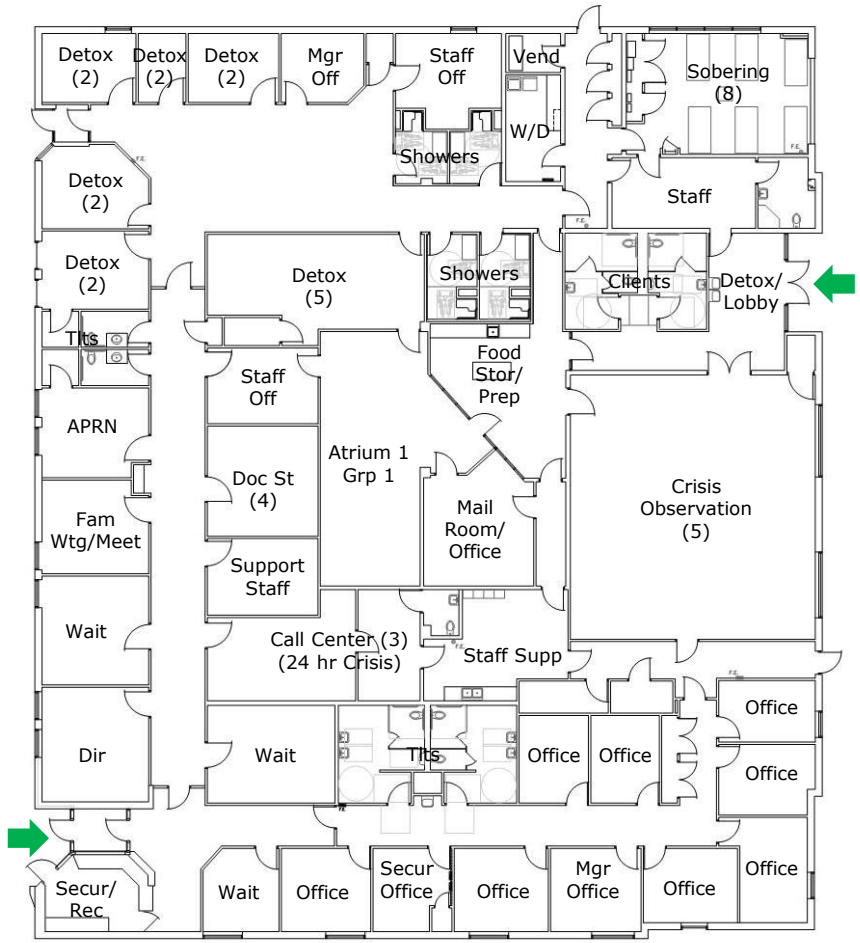
Crisis Center/SACK (Detox/Sobering Unit)
14,694 BGSF *(estimate)*

- Provides care for Alcoholism, Opioid Addiction, Dual Diagnosis, Mental Health and Substance Abuse, and provides Group Therapy

Land Use/Ownership Key:

1. Envision Child Development Center
2. Sedgwick County Development
3. Parking Deck
4. Sheriff/Courthouse/Detention Center
5. Emergency Communication Center
6. Fire Department
7. Red Cross





Existing COMCARE – CCC/SACK

- Pregnant Women/Women with children/Diagnosed with HIV/Social and Rehab Services (SRS) referrals and those meeting SRS income eligibility
- Alcohol & Drug Assessment
- Referral/Monitoring of Treatment Services/ Placement
- Educational Presentations
- Case/Professional Consultation/Management
- Involuntary Commitments

Basic (Proposed)

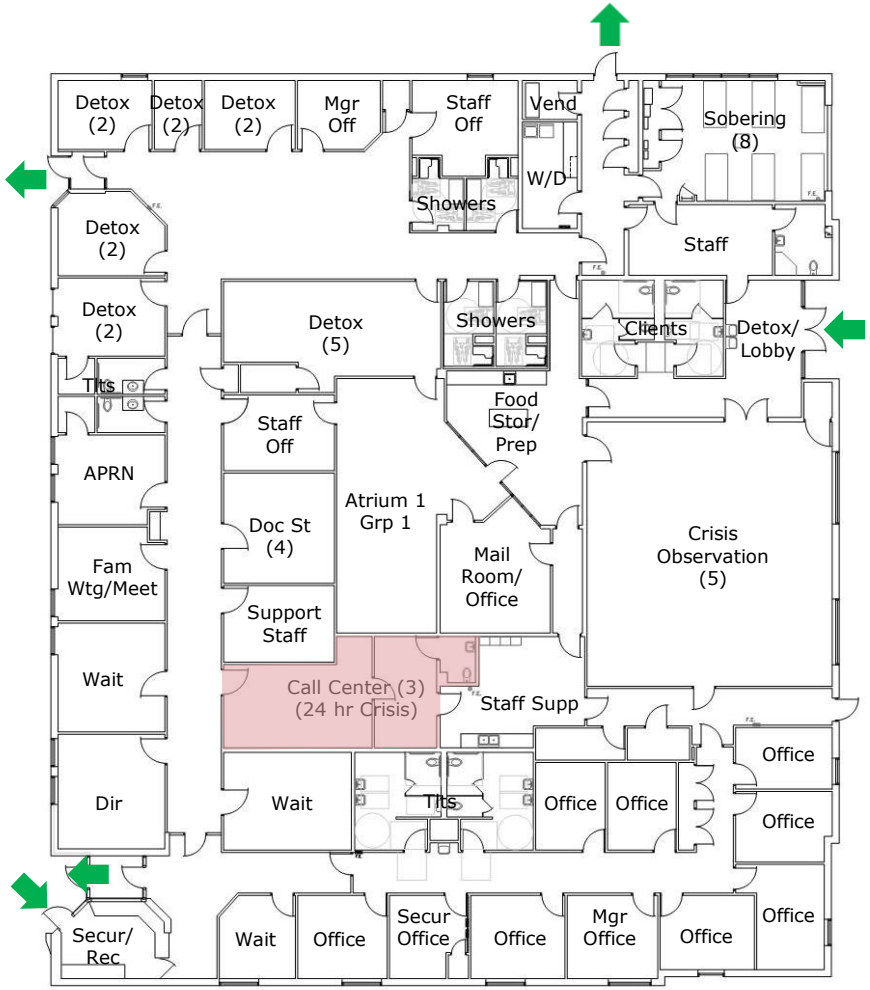
Right-size COMCARE Programs:

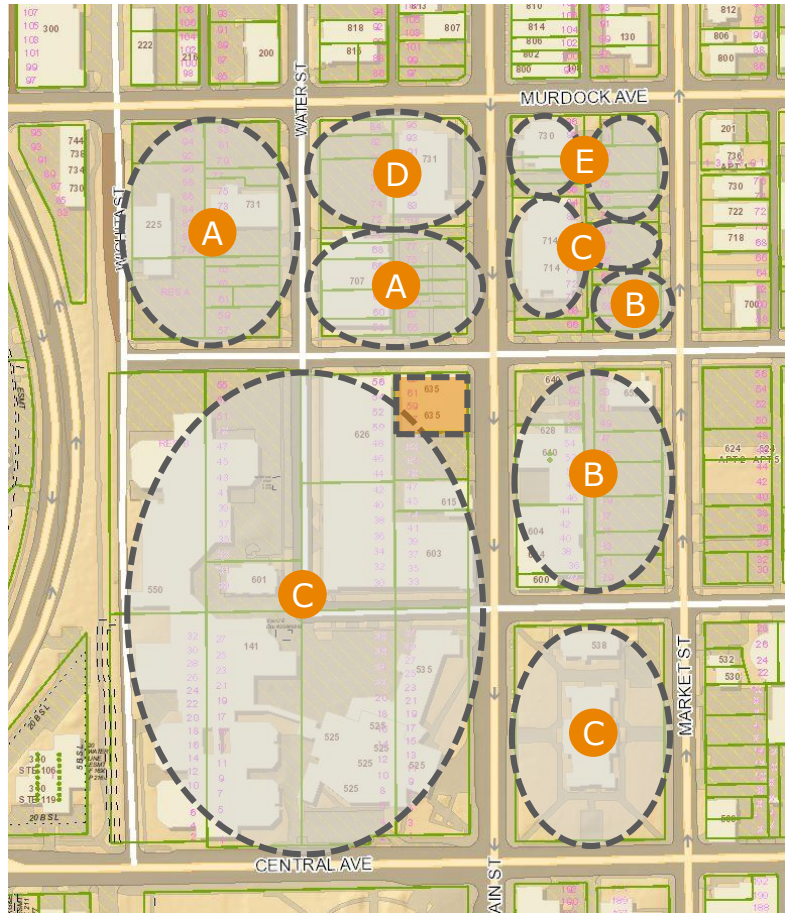
Crisis Center/SACK (Detox/Sobering Unit)
~14,694 BGSF *(estimate)*

- 40% growth in SACK services (1,156-1,635) from 2016-2017
- 485 beneficiaries declined due to limited capacity

Land Use/Ownership Key:

- A Red Cross
- B Envision Child Center
- C Sedgwick County
- D City of Wichita
- E Wichita Area Builders Association





OPTION A

- Relocate Call Center to adjacent E911 Center
  - ~ 462 NSF*
- Enhance technology infrastructure for expanded CCC/SACK capacity

OPTION B

- Relocate and right-size CCC/SACK in another location (existing office space/property)
  - Projected need: 20,572 SF* – 28,801 BGSF*
- Relocate and right-size CCC/SACK to new site
  - Projected need: 28,801 BGSF*
  - To increase bandwidth of service offerings for beneficiaries of all ages ranging from children to adults

Basic (Existing)

Right-size Comcare Programs:

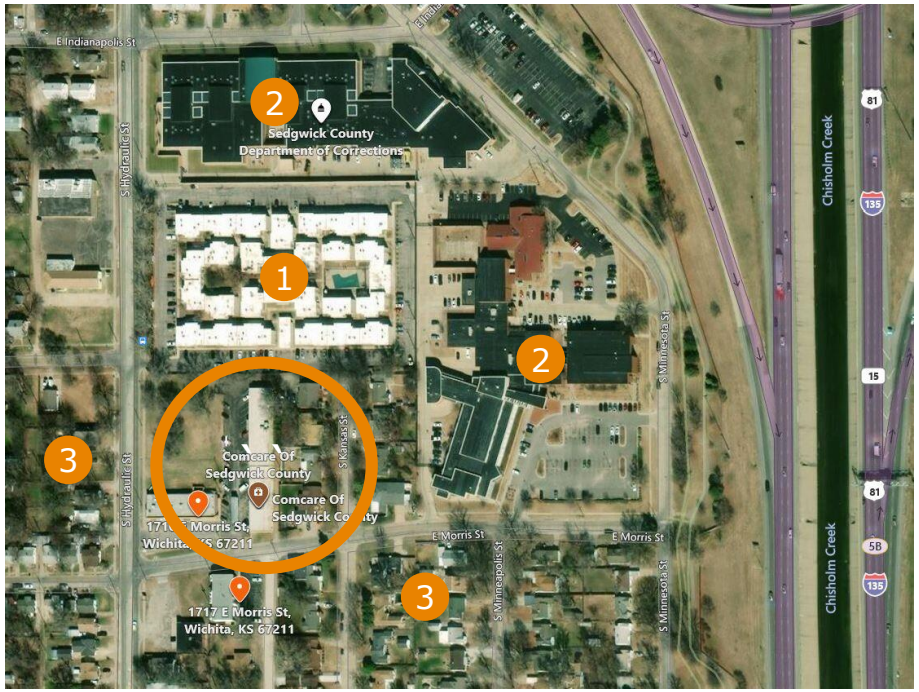
Sedgwick County Offender Assessment Program (SCOAP)

~6,527 BGSF *(estimate)*

- Mental Health Assessment, Intensive Case Management, Crisis Intervention, Medication Management

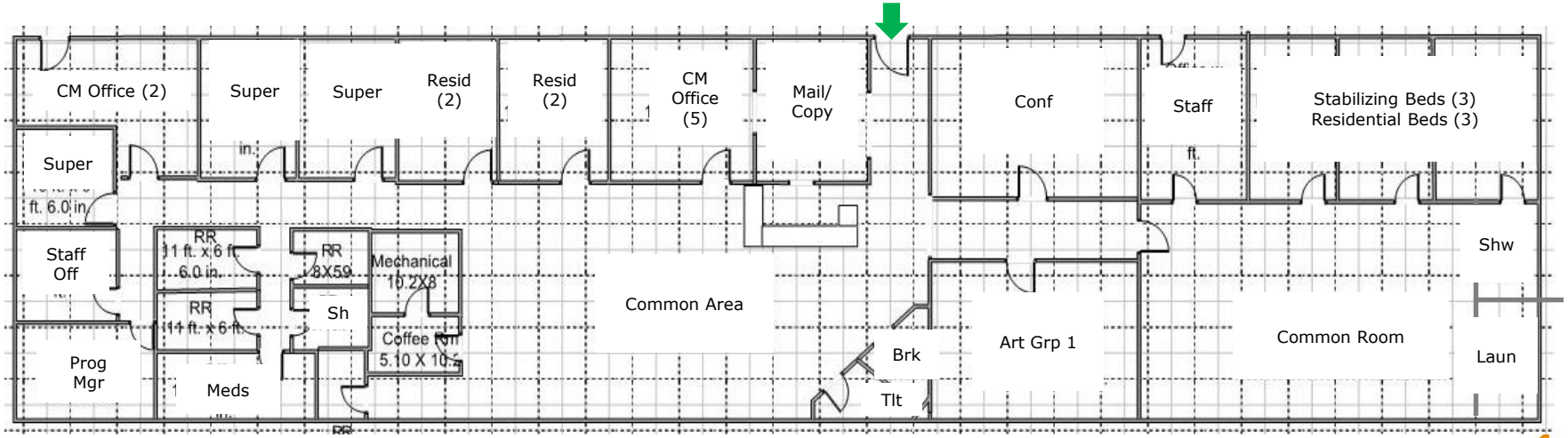
Land Use/Ownership Key:

1. Subsidized Apartment/Housing
2. Department of Corrections
3. Single Family Residences



Existing COMCARE – SCOAP

- 18+ or older with diagnosable mental illness who come into contact with the Criminal Justice system
  - Crisis Intervention Team
  - SCOAP
  - Mental Health Court



Basic (Existing)

Right-size Comcare Programs:

Sedgwick County Offender Assessment Program (SCOAP)

~6,527 BGSF *(estimate)*

- Directly adjacent to Liquor store and take-out restaurant
- Surrounded by residences with subsidized housing to the immediate North
- The County Detention Centers are to the North and East

COMCARE/SCOAP

Potential Expansion Zone

Option A – Renovate SCOAP

- SCOAP building occupies 2 parcels
  - (2 Owners: "A" & "B").
- Future program expansion may be achieved at this location if adjacent building/parcels can be available to COMCARE
  - Increased opportunity to increase the bandwidth of service offerings for beneficiaries of all ages ranging from children to adults.

Basic (Proposed)

Right-size Comcare Programs:

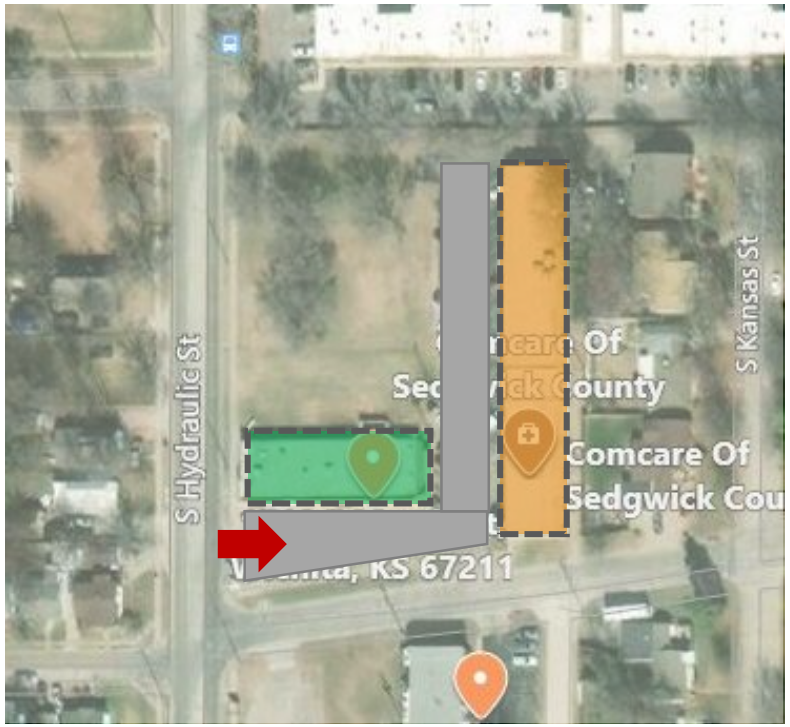
Sedgwick County Offender Assessment Program (SCOAP)
~6,527 BGSF *(estimate)*

- Space need assuming 40% growth from 2017-2019, similar to Crisis Center/SACK
  - 2018: 9,138 BGSF
  - 2019: 12,793 BGSF

SCOAP

Liquor Store/Restaurant

Source: WSU 2018 Report (Public Policy and Management Center)



Existing SCOAP

Proposed SCOAP

Option A	Option B

• Renovate SCOAP
  • ~6,527 BGSF*
• Enhance technology infrastructure for expanded SCOAP capacity
	• Expand SCOAP by capturing adjacent strip mall building area and connected space
	  • ~13,000 BGSF*
	  • ~6,527 NSF Renovation
	  • ~6,473 BGSF Addition
	• Enhance technology infrastructure for expanded SCOAP capacity

Basic (Proposed)

Right-size Comcare Programs:

- Projected 2018 CCC/SACK+ SCOAP need: ~29,710 BGSF *(estimated, assuming 40% growth from 2017-2018)*
- Projected 2019 CCC/SACK+ SCOAP need: 41,594 BGSF *(assuming 40% growth from 2018-2019)*
  - *Includes Adult and Children's Crisis Programs and Medical Detox*

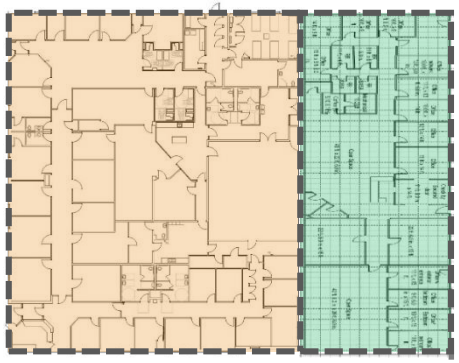
SCOAP (6,527 BGSF*)

CCC/SACK (14,649 BGSF*)

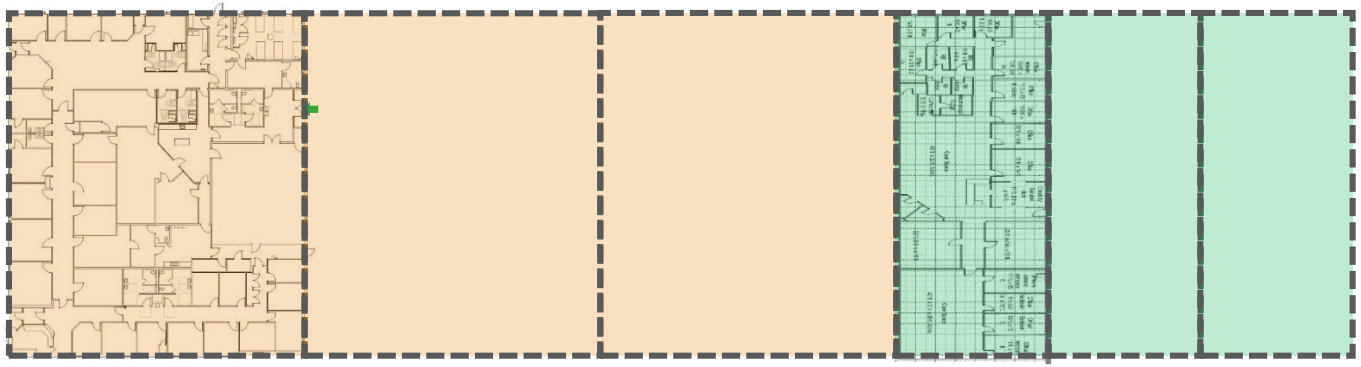
* Estimated

Option A & B – Consolidate CCC/SACK/SCOAP SCOAP Site or Greenfield Location

- To increase the bandwidth of service offerings for beneficiaries of all ages ranging from children to adults, the following assumptions were made:
  - Existing and adjacent properties can be acquired
  - Adjacent strip mall with liquor store and take out restaurant can be relocated
  - SCOAP to temporarily operate in existing space
  - Build new multistory facility for COMCARE Programs (CCC/SACK + SCOAP)



Existing CCC/SACK + SCOAP:**21,221 BGSF** (14,694+6,527)



Projected CCC/SACK + SCOAP (@ 40% increase: 2017-2018)
2018: **20,572 BGSF** (14,694+5,878) + **9,138 BGSF** (6,527+2,611) = **29,710 BGSF**
2019: **28,801 BGSF** (20,572+8,229+) + **12,793 BGSF** (9,138+3,655) = **41,594 BGSF**

Basic (Proposed)

Primary Care Provider Facility Models:

- Accommodate BH Clinicians, Social Workers, Therapists, Tele-psych within Clinics

- Increased BH capacity in Urgent Care Centers

- Co-locate/Integrate BH services with Primary care clinics
  - Program space within clinics/for virtual platforms
  - Mobile Crisis teams
- Leverage virtual platforms: space for tele-psych/remote consulting
  - Reliability, timely access for at-risk patients

- Additional BH capacity at Urgent Care Centers
  - Suites within Unit, BH Providers and Crisis Response teams

Basic Tier: Option/Cost Summary

CATALYST a Haskell Company	Renovate- Low	New Construction- Low	Renovate- High	New Construction- High
Basic				
Relocate Call Center; Renovate/Refresh CCC/SACK with technology upgrade	$ 0.2	$ 0.2	$ 0.2	$ 0.2
Relocate and right-size CCC/SACK in another location (renovation)	$ 18.1			
Right-size CCC/SACK in new location (new construction)		$ 29.6		
Renovate SCOAP; Refresh with Technology Upgrade	$ 3.9			
Expand and Renovate SCOAP into adjacent strip mall with Technology Upgrade		$ 10.9		
Consolidate CCC/SACK/SCOAP (renovation)			$ 25.0	
Consolidate CCC/SACK/SCOAP at another location (new construction)				$ 45.4
Primary Care Provider Facility Model (renovation and technology upgrade)	$ 0.1	$ 0.1	$ 0.1	$ 0.1
TOTAL	**$ 22.3**	**$ 40.8**	**$ 25.3**	**$ 45.7**

CATALYST a Haskell Company Basic	Total Project Cost Range ($ Millions)		2018	2019	2020	2021	2022	2023	2024	2025	Average Total Project Cost ($ Millions)
Relocate Call Center; Renovate/Refresh CCC/SACK	$0.2	$0.2		$0.0	$0.2						$0.2
Relocate CCC/SACK to another location (Renovation)	$17.2	$19.0		$0.3	$6.5	$11.4					$18.1
Right-size CCC/SACK in new location (New Construction)	$28.2	$31.1		$0.4	$8.0	$18.0	$3.2				$29.6
Renovate SCOAP; Refresh with Technology Upgrade	$3.7	$4.0		$0.1	$3.7						$3.9
Expand and Renovate SCOAP into adjacent strip mall with	$10.3	$11.4		$0.1	$2.9	$6.6	$1.2				$10.9
Consolidate CCC/SACK/SCOAP at SCOAP Site (Renovation)	$23.7	$26.2		$0.4	$6.6	$15.2	$2.8				$25.0
Consolidate CCC/SACK/SCOAP at another location (New	$43.2	$47.7		$0.6	$12.4	$27.6	$4.8				$45.4
Primary Care Provider Facility Model Renovation and Technology Update	$0.0	$0.1		$0.0	$0.0						$0.1

Basic Tier: Feasibility Evaluation

Feasibility Evaluation	Time	Cost	Availability	Effectiveness	Comments
Basic					
Relocate Call Center; Renovate/Refresh CCC/SACK with technology upgrade	🟢	🟢	🟢	🔴	Increases space in the existing COMCARE Center by only marginal amounts.
Relocate and right-size CCC/SACK in same location (renovation)	🟡	🟡	🟢	🔴	Utilizes existing infrastructure, but still not an effective solution to facilitate future growth.
Right-size CCC/SACK in new location (new construction)	🔴	🔴	🟡	🟡	Must find and purchase real estate to right-size facilities, but still must plan for future growth.
Renovate SCOAP; Refresh with Technology Upgrade	🟢	🟡	🟢	🔴	Minimal costs, but not an effective solution to facilitate future growth.
Expand and Renovate SCOAP into adjacent strip mall with Technology Upgrade	🔴	🟡	🟡	🟡	Must be able to purchase the adjacent strip mall. Efficiency limitations for facilities.
Consolidate CCC/SACK/SCOAP (renovation)	🔴	🔴	🟡	🟢	Improved patient access to care and utilizes existing infrastructure at higher rates of time and cost.
Consolidate CCC/SACK/SCOAP at another location (new construction)	🔴	🔴	🟡	🟢	Improved patient access to care at increased costs and timelines.
Primary Care Provider/Urgent Care Facility Model (renovation and technology upgrade)	🟢	🟢	🟢	🟢	Utilizes existing infrastructure to expand scope of BH care.

Key	
Success	🟢
Opportunity	🟡
Challenge	🔴

Intermediate Tier

Facility Options - Intermediate

- Half-way Housing
- Violent Patient Housing
- Wellness Program Expansion

Background

The community lacks housing areas or zones for accommodating segments of the population that can benefit from half-way or violent patient housing. This is an ideal setting for patients transitioning out of the inpatient care environment. Additionally, Sedgwick County does not currently offer services typically provided through a wellness program.

Issues

Half-way and violent patient housing is often sited in a transitional zone where patients that are transitioning out of the inpatient setting, but are unable to function fully independently can utilize this type of housing as they incorporate lifestyle changes to propel them towards a healthier, productive and balanced life. This helps decrease length of stay (LOS) in the inpatient setting and, therefore, costs for the patient and the facility, as well as increase the volume of patients who can be assisted from a patient volume standpoint. Wellness programs will allow the county to partner with community organizations to reduce cost and increase effectiveness within the community, as well as offer education, training, coping tools and resources to empower the at-risk population, all in an effort to fully care of beneficiaries at the various stages in their journey to recovery.

Findings

Sedgwick County can implement half-way and violent patient housing in a transitional zone in order to expand the scope of services it offers in the appropriate care setting, as well as the scope of patients it is able to serve. Additionally, partnering with a community organization or building its own wellness center increases the spectrum of BH services those in Sedgwick County can utilize. This will improve the overall population health of the county where preventative approach is more effective than a reactionary one, as is common following the incidence of a crisis.

Intermediate (Proposed)

Transitional Housing Violent and Non-Violent patients

- Behavioral Health Homes
- 8 or 16 Bed Units (M & F)
  - Reliability, timely access for at-risk patients
  - Half-way housing
  - Non-Violent patients
  - Violent patients

Intermediate: Transitional Housing

		Conceptual Planning Space Program - Half-Way Houses (8 Bed Unit)				
		Quantity	Net Area	Total Net Area	Gross Area	Comments
Building NTG	1.15 net to gross				7,460 BGSF	New Construction- Half-Way House (8 Bed)
Departmental NTG multiplier, Non-Clinical	1.20 net to gross					
TOTAL DEPARTMENTAL GROSS AREA				5,406 dgsf	6,487 dgsf	
1.0 MEN'S HALF-WAY HOUSE	8 People			2,703 nsf	3,244 dgsf	Assume 2-story
2.0 WOMEN'S HALF-WAY HOUSE	8 people			2,703 nsf	3,244 dgsf	Assume 2-story

		Conceptual Planning Space Program - Half-Way Houses (16 Bed Unit)				
		Quantity	Net Area	Total Net Area	Gross Area	Comments
Building NTG	1.15 net to gross				11,407 BGSF	New Construction- Half-Way House (16 Bed)
Departmental NTG multiplier, Non-Clinical	1.20 net to gross					
TOTAL DEPARTMENTAL GROSS AREA				8,266 dgsf	9,919 dgsf	
1.0 MEN'S HALF-WAY HOUSE	16 People			4,133 nsf	4,960 dgsf	Assume 2-story
2.0 WOMEN'S HALF-WAY HOUSE	16 people			4,133 nsf	4,960 dgsf	Assume 2-story

Intermediate (Proposed)

Wellness Center

Community/Social Services and Partnerships:

- Community Health Centers Church Groups, Work Groups, Gyms, School Programs, Correctional/ Institutional Facilities involvement.
- Facility components:
  - Public/ Areas
  - Education
  - Wellness Clinic
  - Staff & Building Support

Intermediate: Wellness Center

Building NTG	1.15 net to gross		7,789 nsf	New Construction- Wellness Center
Departmental NTG multiplier	1.20 net to gross			
TOTAL DEPARTMENTAL GROSS AREA		**5,644 nsf**	**6,773 nsf**	
1.0 PUBLIC AREA		**1,060 nsf**	**1,272 dgsf**	
2.0 EDUCATION & EXERCISE		**2,656 nsf**	**3,187 dgsf**	
3.0 WELLNESS CLINIC		**1,180 nsf**	**1,416 dgsf**	
4.0 STAFF SUPPORT		**748 nsf**	**898 dgsf**	
5.0 BUILDING SUPPORT		**1,420 nsf**	**1,704 dgsf**	

Intermediate Tier: Option/Cost Summary

CATALYST a Haskell Company	Renovate- Low	New Construction- Low	Renovate- High	New Construction- High
Intermediate				
Halfway Housing (8 Beds ea M & F)	$ 5.2	$ 5.2	$ 5.2	$ 5.2
Violent Patient Housing (8 beds ea M & F)			$ 5.6	$ 5.6
Wellness Program Expansion (renovation/addition)	$ 1.7		$ 1.7	
Wellness Program Expansion (new construction)		$ 7.0		$ 7.0
TOTAL	**$ 6.9**	**$ 12.2**	**$ 12.5**	**$ 17.8**

CATALYST a Haskell Company Intermediate	Total Project Cost Range ($ Millions)		2018	2019	2020	2021	2022	2023	2024	2025	Average Total Project Cost ($ Millions)
Transitional Housing: Half-Way	$4.9	$5.5		*$0.1*	*$1.5*	*$3.6*					$5.2
Transitional Housing: Violent BH Patients	$5.4	$5.9		*$0.1*	*$1.6*	*$3.9*					$5.6
Wellness Center Expansion (Renovation/Addition):	$1.6	$1.8		*$0.0*	*$0.0*	*$1.6*					$1.7
Wellness Center (New Construction)	$6.7	$7.4		*$0.1*	*$0.2*	*$2.7*	*$3.2*	*$0.8*			$7.0

Intermediate Tier: Feasibility Evaluation

Feasibility Evaluation	Time	Cost	Availability	Effectiveness	Comments
Intermediate					
Halfway Housing (8 Beds ea M & F)					Increases Sedgwick County's behavioral health's scope of care.
Violent Patient Housing (8 beds ea M & F)					Increases Sedgwick County's behavioral health's scope of care.
Wellness Program Expansion (renovation/addition)					Uses existing infrastructure and establishes community partnerships.
Wellness Program Expansion (new construction)					Allows for flexible and unique design for the county's wellness facility at a high rate of cost and time.

Key	
Success	
Opportunity	
Challenge	

Long-Term Tier

Facility Options - Long-Term

- Homeless Shelter
- Co-locate critical Behavioral Health resources

Background

A completely integrated Behavioral Health system of care will allow the community to operate in the most efficient way. Behavioral Health models that have been established in Bexar County (TX), Brighton (MI), and Davidson (NC) provide guidance in the development of a completely integrated and co-located behavioral health services model.

Issues

Due to the location of services being spread out through the service area, many processes and services are being duplicated, making it challenging for patients to conveniently access needed resources where they need it. Also, there is a high incidence for continued treatment and follow up for beneficiaries in many instances, where they may encounter obstacles that are not conducive to their transition and progression through the recovery continuum based on different variables. Many BH patients in Sedgwick County are dealing with homelessness as well. Additionally, a single location or campus allows for all the needed, frequently used and inter-related programs to be provided in a one-stop-shop style. This concept has been successfully implemented to varying levels in the case studies mentioned above, and further detailed in the appendix. By partnering with existing homeless shelters and/or by establishing a county-owned shelter, agencies and other stakeholders will be successful in directing BH patients away from the ED or jails, and into programs that can better assist this population in a sustainable fashion.

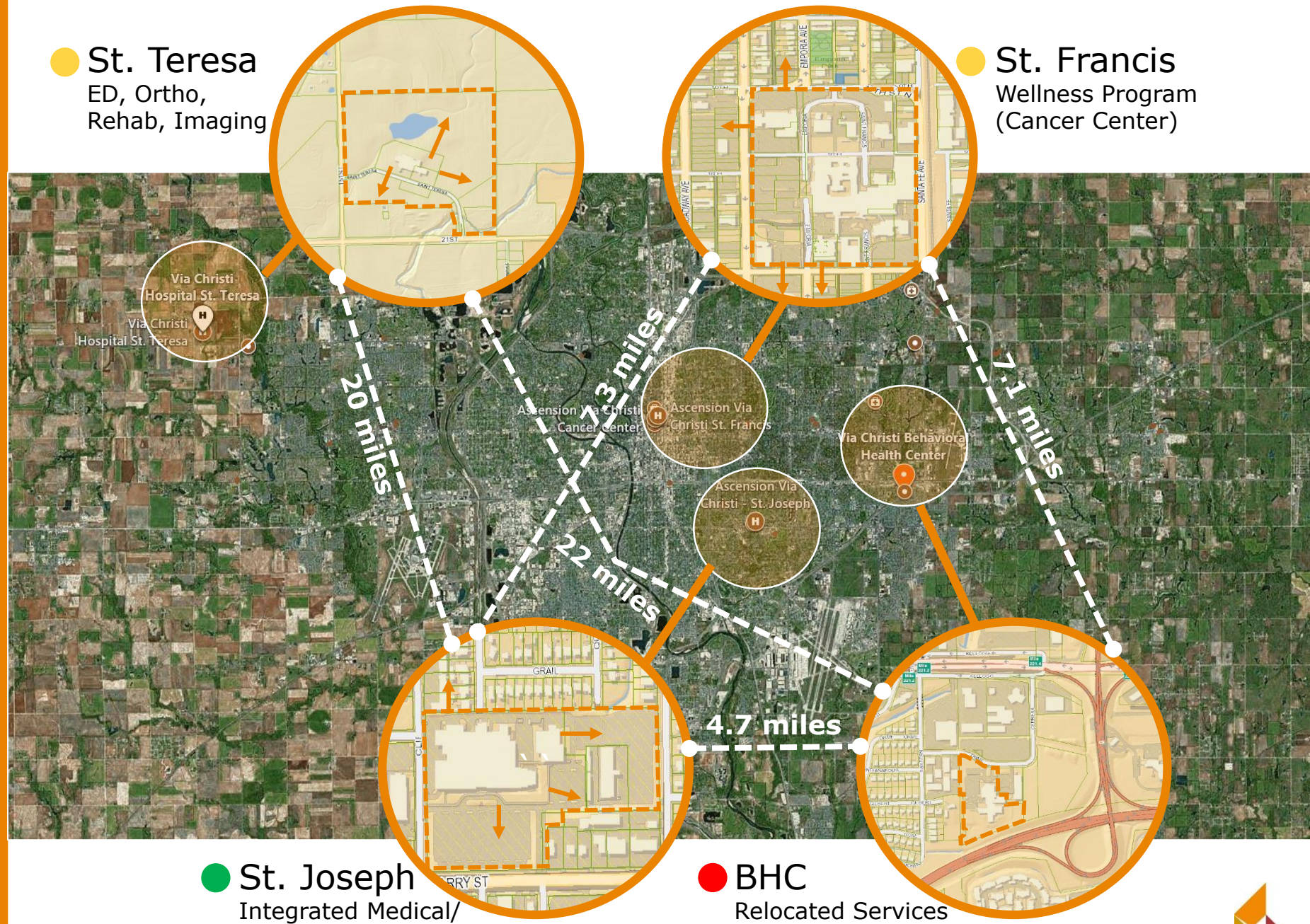
Findings

There are two options to co-locate behavioral health resources and services: a greenfield site, leveraging new construction, or expansion(combination of renovation and new construction) of the existing and well-established program at St. Joseph's to facilitate the co-location of BH resources at this campus. This concept assumes the availability of real estate through future land acquisition or partnerships with surrounding property Owners. While the costs of establishing a homeless shelter will be great, there will be downstream savings for the ED and correctional facilities, as the community can more effectively direct patients to utilize the proper BH services.

Long-Term (Existing)

Co-location of Critical Resources

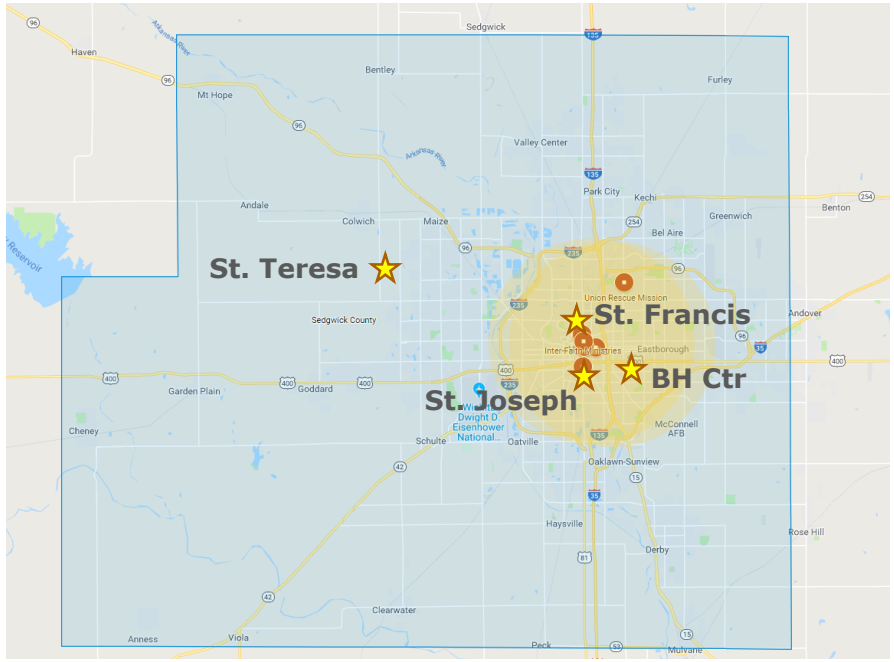
- Existing program in place at St. Joseph (VC), including relocated programs from the BHC (DCCCA)
  - 2019 Expansion at St. Joseph Hospital
- Available real estate at St. Teresa, St. Francis, and potentially at St. Joseph (Catholic Diocese)
- Potential to expand Wellness program at St. Francis (currently Cancer Center related)



Long-Term (Existing)

Co-location of Critical Resources

- Sedgwick County Shelters and Substance Abuse Centers are concentrated towards the downtown area and within close proximity to Via Christi Hospitals

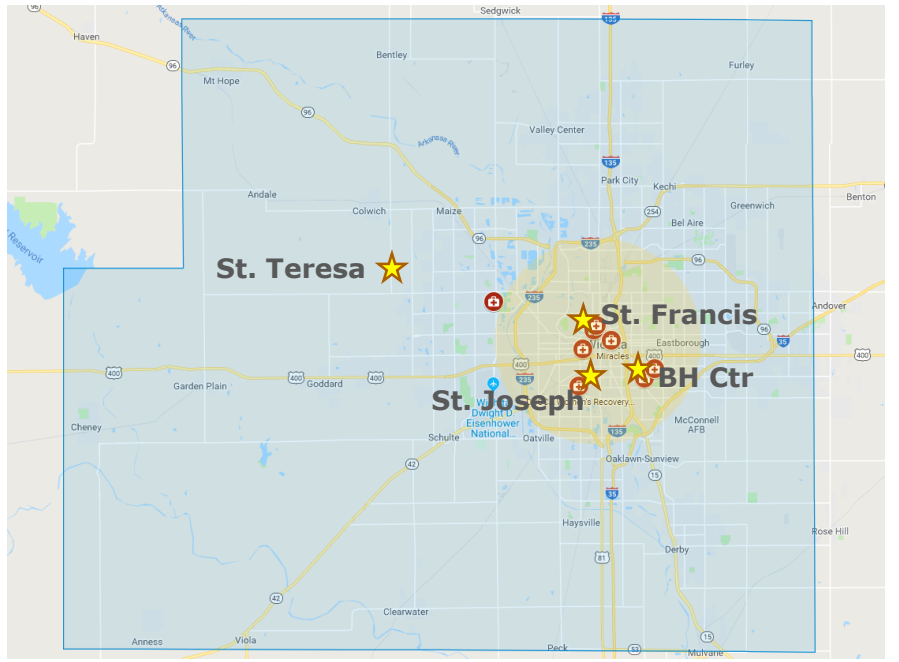


Homeless Shelters

Legend:

Wichita Hospital/BH Center

Wichita Homeless Shelter



Substance Abuse Centers

Legend:

Wichita Hospital/BH Center

Wichita Substance Abuse Centers

Case Examples Explained

The following case examples represent three types of behavioral health interventional facility designs. While, Bexar County represents an all-encompassing behavioral health model. Brighton, MI and Davidson, NC represent

Davidson, NC

Represents a greenfield inpatient and outpatient co-location option for Sedgwick County to consider if deciding to build a co-located greenfield site with space for future growth.

Brighton, MI

Represents a co-located option in which it houses inpatient, outpatient, and transitional facilities within zones for substance abuse treatment.

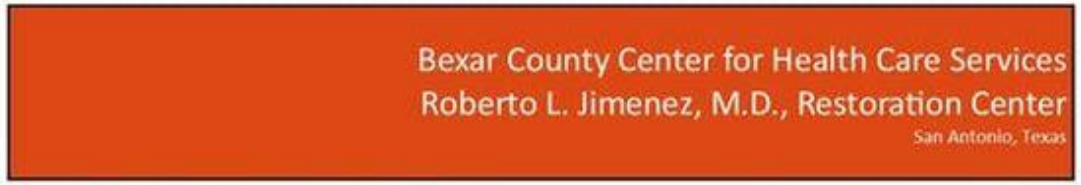
Bexar County

Represents a full, comprehensive behavioral healthcare model in which the facilities house both behavioral health services in addition to community resources, such as homeless shelters.

Case Example 1 (Bexar County, TX)

Co-location of Critical Resources

- Bexar County CHCS: Restoration Center
  - Sobering Unit
  - Detox Room
  - Extended Observation Unit (EOU)



- 18,500 SF (4,000 SF + 14,500 SF)
  - Center for Health Care Services (CHCS)
  - University Health System (UHS)
  - Homeless Shelter
- Sobering Unit
  - Peak times are 11am-6pm & 11pm-6:00 am
- Detox Room
  - 28 Beds
- Extended Observation Unit (EOU)
  - 16 Beds (3 dedicated to UHS)

Case Example 2A (Brighton, MI)

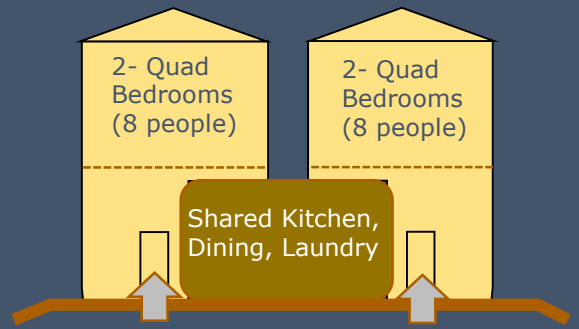
Co-location of Critical Resources

- Brighton Center for Recovery (Campus expansion option)
- +24 New Beds
- 99 Existing Beds
  - 41 Acute Beds
  - 58 Residential Beds
    - 22 Rehab
    - 29 Partial
    - 7 Detox
    - 123 Proposed Beds
  - Outpatient
    - Group Therapy
    - Support Classrooms
  - Halfway Housing
    - 32-44 Beds (M & F)

Case Example 2B (Brighton, MI)

Co-location of Critical Resources

- Brighton Center for Recovery (Greenfield Option)
- 123 Beds (+24)
  - OP: Admin, Classrooms, Call Center, Offices, Group Therapy, Meeting/Classrooms
  - 1 Bed M & F Units



Each House sized for 8 people, quad-bedrooms (1-male, 1-female). 2-story town-house layout to break down scale, with central shared support located on the first floor.

Case Example 3 (Davidson BH, NC)

Co-location of Critical Resources

- Atrium Health: BH Davidson
  - 66 Beds
    - 11 Bed Units
    - 2 Stories
    - Future Expansion

Long-Term

Co-location of Critical Resources

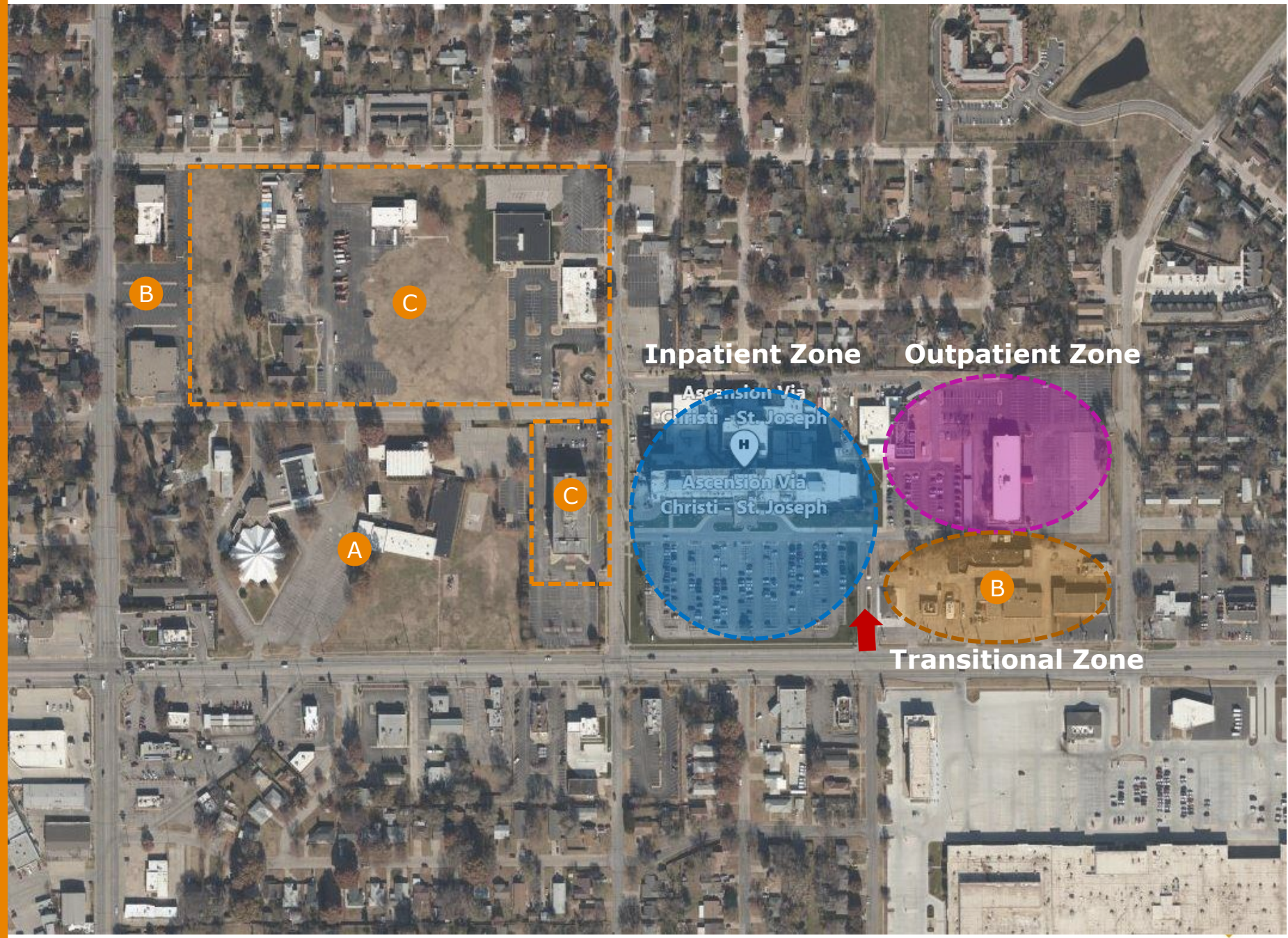
- Potential Zoning at Via Christi - St. Joseph Hospital (Integrated Medical/BH for Seniors)
- Expansion to include:
  - Outpatient Center
  - Wellness Center
  - Primary Care Provider Facility Models
  - Transitional Housing: Violent/Non-violent patients

Land Use/Ownership Key:

A Catholic Diocese (potential partner)

B Others

C Via Christi Owned



Long-Term (Proposed)

Co-location of Critical Resources

Expansion of BH Services at St. Joseph Campus

- Existing BH Services
- Transitional Housing
  - Violent/ Non-Violent Patients
- Outpatient Center
  - Public Areas, Patient Support, Clinical Treatment, Clinical Support, Staff Support, Building Support
  - Includes Adult and Children's Crisis Programs, and Medical Detox
- Wellness Center
  - Public Areas, Education & Exercise, Wellness Clinic, Staff & Building Support

Long-Term: Co-located Resources (Expansion)

TOTAL BUILDING GROSS AREA					**11,407 BGSF**	**New Half-Way House Construction**
					24,469 BGSF	**New Outpatient Center Construction**
Departmental NTG multiplier, Clinical	1.50 net to gross				**35,876 BGSF**	**Total, Campus Expansion New Construction**
Departmental NTG multiplier, Non-Clinical	1.40 net to gross					

		Conceptual Planning Space Program - Half-Way Houses				
		Quantity	Net Area	Total Net Area	Gross Area	Comments
Building NTG	1.15 net to gross	32 people			**11,407 BGSF**	**New Construction- Half-Way Houses**
Departmental NTG multiplier, Non-Clinical	1.20 net to gross					
TOTAL DEPARTMENTAL GROSS AREA					**9,919 dgsf**	
1.0 MEN'S HALF-WAY HOUSE	**16 people**			**4,133 nsf**	**4,960 dgsf**	Assume 2-story
2.0 WOMEN'S HALF-WAY HOUSE	**16 People**			**4,133 nsf**	**4,960 dgsf**	

		Conceptual Planning Space Program - Outpatient Center				
		Quantity	Net Area	Total Net Area	Gross Area	Comments
Building NTG multiplier	1.20 net to gross				**24,469 BGSF**	**New Construction- Outpatient Center**
Departmental NTG multiplier, Non-Clinical	1.40 net to gross					
TOTAL DEPARTMENTAL GROSS AREA				**14,565 nsf**	**20,391 dgsf**	
1.0 CLASSROOM				**6,450 nsf**	**9,030 dgsf**	
2.0 CLINICAL OFFICES & SUPPORT				**3,415 nsf**	**4,781 dgsf**	
3.0 ADMIN OFFICES & SUPPORT				**4,700 nsf**	**6,580 dgsf**	

Long-Term (Proposed)

Co-location of Critical Resources

Replacement Hospital at Greenfield Site

- Replacement Hospital
  - Inpatient Units (64 Beds)
- Transitional Housing
  - Violent/ Non-Violent Patients
- Outpatient Center
  - Public Areas, Patient Support, Clinical Treatment, Clinical Support, Staff Support, Building Support
  - Includes Adult and Children's Crisis Programs, and Medical Detox
- Wellness Center
  - Public Areas, Education & Exercise, Wellness Clinic, Staff & Building Support
- Homeless Shelter
  - Intake, Community/Client Services, Medical Clinic, Staff Support, Building Support

Long-Term: Co-located Resources (Greenfield)

TOTAL BUILDING GROSS AREA				80,800 BGSF	New Replacement Hospital Construction
				11,407 BGSF	New Half-Way House Construction
				17,062 BGSF	New Outpatient Center Construction
				7,789 BGSF	New Wellness Center
				37,431 BGSF	New Homeless Shelter Construction
Departmental NTG multiplier, Clinical	1.50 net to gross			154,489 BGSF	Total, Campus Replacement New Construction
Departmental NTG multiplier, Non-Clinical	1.40 net to gross				

Conceptual Planning Space Program - Replacement Hospital					
	Quantity	Net Area	Total Net Area	Gross Area	Comments
TOTAL DEPARTMENTAL GROSS AREA			41,148 nsf	59,852 dgsf	861 dgsf/bed
					Excludes Public and Therapy Spaces; Target 375-400 SF/Bed
1.0 PUBLIC ENTRY & SUPPORT			1,070 nsf	1,498 dgsf	
2.0 TRIAGE/IP ENTRY			849 nsf	1,274 dgsf	
3.0 INPATIENT THERAPY & SUPPORT SP			11,304 nsf	15,826 dgsf	
4.0 MAIN CLINICAL TREATMENT AREA(s			16,220 nsf	24,330 dgsf	
5.0 CLINICAL SUPPORT SPACE			5,375 nsf	8,063 dgsf	
6.0 OUTPATIENT THERAPY & SUPPORT S			3,380 nsf	4,732 dgsf	
7.0 STAFF SUPPORT AREAS			2,950 nsf	4,130 dgsf	
8.0 BUILDING SUPPORT			8,320 nsf	11,648 dgsf	

Conceptual Planning Space Program - Half-Way Houses					
	Quantity	Net Area	Total Net Area	Gross Area	Comments
Building NTG	1.15 net to gross			11,407 BGSF	New Construction - Half-Way Houses
Departmental NTG multiplier, Non-Clinical	1.20 net to gross				
TOTAL DEPARTMENTAL GROSS AREA				9,919 dgsf	
1.0 MEN'S HALF-WAY HOUSE	16 People		4,133 nsf	4,960 dgsf	Assume 2-story
2.0 WOMEN'S HALF-WAY HOUSE	16 people		4,133 nsf	4,960 dgsf	Assume 2-story

Long-Term (Proposed)

Co-location of Critical Resources

Replacement Hospital at Greenfield Site

- Replacement Hospital
  - Inpatient Units (64 Beds)
- Transitional Housing
  - Violent/ Non-Violent Patients
- Outpatient Center
  - Public Areas, Patient Support, Clinical Treatment, Clinical Support, Staff Support, Building Support
  - Includes Adult and Children's Crisis Programs, and Medical Detox
- Wellness Center
  - Public Areas, Education & Exercise, Wellness Clinic, Staff & Building Support
- Homeless Shelter
  - Intake, Community/Client Services, Medical Clinic, Staff Support, Building Support

Long-Term: Co-located Resources (Greenfield)

		Conceptual Planning Space Program - Outpatient Center				
		Quantity	Net Area	Total Net Area	Gross Area	Comments
Building NTG multiplier	1.20 net to gross				17,062 BGSF	New Construction - Outpatient Center
Departmental NTG multiplier, Non-Clinical	1.40 net to gross					
TOTAL DEPARTMENTAL GROSS AREA				10,156 nsf	14,218 dgsf	
1.0 PUBLIC AREA				2,012 nsf	2,817 dgsf	
2.0 PATIENT SUPPORT SPACE				3,140 nsf	4,396 dgsf	
3.0 CLINICAL SUPPORT SPACE				1,714 nsf	2,400 dgsf	
4.0 STAFF SUPPORT AREAS				3,290 nsf	4,606 dgsf	
5.0 BUILDING SUPPORT				460 nsf	644 dgsf	

		Conceptual Planning Space Program - Wellness Center				
		Quantity	Net Area	Total Net Area	Gross Area	Comments
Building NTG multiplier	1.15 net to gross				7,789 BGSF	New Construction - Wellness Cneter
Departmental NTG multiplier, Non-Clinical	1.20 net to gross					
TOTAL DEPARTMENTAL GROSS AREA				5,644 nsf	6,773 dgsf	
1.0 PUBLIC AREA				1,060 nsf	1,272 dgsf	
2.0 EDUCATION & EXERCISE				2,656 nsf	3,187 dgsf	
3.0 WELLNESS CLINIC				1,180 nsf	1,416 dgsf	
4.0 STAFF SUPPORT				748 nsf	898 dgsf	
5.0 BUILDING SUPPORT				1,420 nsf	1,704 dgsf	

Long-Term (Proposed)

Co-location of Critical Resources

Replacement Hospital at Greenfield Site

- Replacement Hospital
  - Inpatient Units (64 Beds)
- Transitional Housing
  - Violent/ Non-Violent Patients
- Outpatient Center
  - Public Areas, Patient Support, Clinical Treatment, Clinical Support, Staff Support, Building Support
  - Includes Adult and Children's Crisis Programs, and Medical Detox
- Wellness Center
  - Public Areas, Education & Exercise, Wellness Clinic, Staff & Building Support
- Homeless Shelter
  - Intake, Community/Client Services, Medical Clinic, Staff Support, Building Support

Long-Term: Co-located Resources (Greenfield)

		Conceptual Planning Space Program - Homeless Shelter				
		Quantity	Net Area	Total Net Area	Gross Area	Comments
Building NTG multiplier	1.15 net to gross				37,431 BGSF	New Construction - Homeless Shelter
Departmental NTG multiplier, Non-Clinical	1.20 net to gross					
TOTAL DEPARTMENTAL GROSS AREA				27,124 nsf	32,549 dgsf	
1.0 INTAKE/PUBLIC AREA				4,040 nsf	4,848 dgsf	
2.0 COMMUNITY/CLIENT SERVICES				18,640 nsf	22,368 dgsf	
3.0 MEDICAL CLINIC				2,220 nsf	2,664 dgsf	
4.0 ADMIN/STAFF SUPPORT				2,224 nsf	2,669 dgsf	
5.0 BUILDING SUPPORT				3,440 nsf	4,128 dgsf	

Long-Term: Option/Cost Summary

CATALYST a Haskell Company	Renovate- Low	New Construction- Low	Renovate- High	New Construction- High
Long-Term				
Co-locate Critical Resources (Expand BH services near St. Joseph)	$ 39.7	$ 39.7		
Co-locate Critical Resources (Greenfield Site)			$ 127.7	$ 127.7
Homeless Shelter- New Construction		$ 5.2		$ 5.2
TOTAL	**$ 39.7**	**$ 39.7**	**$ 127.7**	**$ 127.7**

CATALYST a Haskell Company Long-Term	Total Project Cost Range ($ Millions)		2018	2019	2020	2021	2022	2023	2024	2025	Average Total Project Cost ($ Millions)
Co-locate Critical Resources (Expand BH services near St.	$37.7	$41.7		$0.5	$1.0	$15.2	$18.3	$4.7			$39.7
Co-locate Critical Resources (Greenfield Site)	$121.3	$134.1		$1.7	$3.3	$48.8	$58.9	$15.0			$127.7
Homeless Shelter (New Construction)	$4.9	$5.5		$0.1	$0.1	$2.4	$2.6				$5.2

Long-Term Tier: Feasibility Evaluation

Feasibility Evaluation	Time	Cost	Availability	Effectiveness	Comments
Long-Term					
Co-locate Critical Resources (Expand BH services near St. Joseph)					Utilizes existing infrastructure that Via Christi has already established at a high cost.
Co-locate Critical Resources (Greenfield Site)					Allows for a BH facility in a secluded location designed uniquely for Sedgewick County.
Homeless Shelter- New Construction					Must find and purchase real estate large enough to house program and accommodate future growth.

Key	
Success	
Opportunity	
Challenge	

Facility Response Cost Summary

(cost in millions)

Facility Response Options				
CATALYST a Haskell Company	Renovate- Low	New Construction-Low	Renovate- High	New Construction-High
Basic				
Relocate Call Center; Renovate/Refresh CCC/SACK with technology upgrade	$ 0.2	$ 0.2	$ 0.2	$ 0.2
Relocate and right-size CCC/SACK in another location (renovation)	$ 18.1			
Right-size CCC/SACK in new location (new construction)		$ 29.6		
Renovate SCOAP; Refresh with Technology Upgrade	$ 3.9			
Expand and Renovate SCOAP into adjacent strip mall with Technology Upgrade		$ 10.9		
Consolidate CCC/SACK/SCOAP (renovation)			$ 25.0	
Consolidate CCC/SACK/SCOAP at another location (new construction)				$ 45.4
Primary Care Provider Facility Model (renovation and technology upgrade)	$ 0.1	$ 0.1	$ 0.1	$ 0.1
TOTAL	**$ 22.3**	**$ 40.8**	**$ 25.3**	**$ 45.7**
Intermediate				
Halfway Housing (8 Beds ea M & F)	$ 5.2	$ 5.2	$ 5.2	$ 5.2
Violent Patient Housing (8 beds ea M & F)			$ 5.6	$ 5.6
Wellness Program Expansion (renovation/addition)	$ 1.7		$ 1.7	
Wellness Program Expansion (new construction)		$ 7.0		$ 7.0
TOTAL	**$ 6.9**	**$ 12.2**	**$ 12.5**	**$ 17.8**
Long-Term				
Co-locate Critical Resources (Expand BH services near St. Joseph)	$ 39.7	$ 39.7		
Co-locate Critical Resources (Greenfield Site)			$ 127.7	$ 127.7
Homeless Shelter- New Construction		$ 5.2		$ 5.2
TOTAL	**$ 39.7**	**$ 39.7**	**$ 127.7**	**$ 127.7**
GRAND TOTAL	**$ 68.9**	**$ 92.7**	**$ 165.5**	**$ 191.2**

Facility Options – Feasibility Evaluation

Key	
Success	🟢
Opportunity	🟡
Challenge	🔴

Feasibility Evaluation	Time	Cost	Availability	Effectiveness	Comments
Basic					
Relocate Call Center; Renovate/Refresh CCC/SACK with technology upgrade	🟢	🟢	🟢	🔴	Increases space in the existing COMCARE Center by only marginal amounts.
Relocate and right-size CCC/SACK in same location (renovation)	🟡	🟡	🟢	🔴	Utilizes existing infrastructure, but still not an effective solution to facilitate future growth.
Right-size CCC/SACK in new location (new construction)	🔴	🔴	🟡	🟡	Must find and purchase real estate to right-size facilities, but still must plan for future growth.
Renovate SCOAP; Refresh with Technology Upgrade	🟢	🟡	🟢	🔴	Minimal costs, but not an effective solution to facilitate future growth.
Expand and Renovate SCOAP into adjacent strip mall with Technology Upgrade	🔴	🟡	🟡	🟡	Must be able to purchase the adjacent strip mall. Efficiency limitations for facilities.
Consolidate CCC/SACK/SCOAP (renovation)	🔴	🔴	🟡	🟢	Improved patient access to care and utilizes existing infrastructure at higher rates of time and cost.
Consolidate CCC/SACK/SCOAP at another location (new construction)	🔴	🔴	🟡	🟢	Improved patient access to care at increased costs and timelines.
Primary Care Provider/Urgent Care Facility Model (renovation and technology upgrade)	🟢	🟢	🟢	🟢	Utilizes existing infrastructure to expand scope of BH care.
Intermediate					
Halfway Housing (8 Beds ea M & F)	🟡	🟡	🟡	🟢	Increases Sedgwick County's behavioral health's scope of care.
Violent Patient Housing (8 beds ea M & F)	🟡	🟡	🟡	🟢	Increases Sedgwick County's behavioral health's scope of care.
Wellness Program Expansion (renovation/addition)	🟡	🟢	🟢	🟢	Uses existing infrastructure and establishes community partnerships.
Wellness Program Expansion (new construction)	🔴	🔴	🟡	🟢	Allows for flexible and unique design for the county's wellness facility at a high rate of cost and time.
Long-Term					
Co-locate Critical Resources (Expand BH services near St. Joseph)	🟡	🔴	🟡	🟢	Utilizes existing infrastructure that Via Christi has already established at a high cost.
Co-locate Critical Resources (Greenfield Site)	🔴	🔴	🟡	🟢	Allows for a BH facility in a secluded location designed uniquely for Sedgewick County.
Homeless Shelter- New Construction	🟡	🔴	🟡	🟢	Must find and purchase real estate large enough to house program and accommodate future growth.

Operational Planning

Operational Options

Operational interventions were developed at a high level by tier to inform planning efforts

Background

As stated previously, operational interventions were presented at a high level to give the steering committee direction for planning efforts outside of the facility response. These also followed the tiered system of basic, intermediate, and long term options.

Findings

At the basic level, operational interventions largely focused on evaluating current assets, reorganizing the team into task force groups, developing a business and marketing plan, and increasing training efforts for select community groups. The intermediate tier suggests operationalizing medical detox and eating disorder service offerings, incorporating proactive interventions operationally (specific case examples highlighted), creating more robust transportation, and initiating an operational study to assess processes and hours. Longer term, we suggest continuing to build out service offerings from an operational perspective (specifically for the geriatric and homeless populations) and implementing any adjustments that come out of the operational study.

Operational Interventions

High Level Planning by Tier

Basic

Asset/Team Evaluation
- Comprehensive existing asset assessment
- Organize into task force groups

Business Plan/Marketing
- Create a business plan and proforma
- Targeted campaign
- Centralized website or consistent messaging across individual websites
- Centralized phone number (i.e. "311")
- Resource booklet

Training
- Police
- Schools
- IP/OP safety

Intermediate

New services/capabilities
- Medical detox
- Eating disorders

Prevention/Primary Care/Early intervention
- Inpatient *(Bon Secours Hampton Roads "Life Coach Program")*
- ED *(WellSpace Health 'T3' Program)*
- Primary Care *(Providence Health Oregon)*

Transportation
- Shuttle system
- Mobile Crisis services

Operational Study
- Assessment of current operations (i.e. hours of operation, intake/post discharge processes, etc.)

Long-Term

New services/ capabilities
- Healthcare for homeless population
- Geriatric care shelters

Operational study findings implemented

Appendix

Outpatient Behavioral Health Staffing Needs (PSA)

OP growth requires at least 64 additional mental health providers to accommodate demand

Assumptions:

Provider Type	% of Visits to Provider[3]	Avg. # of Visits per Provider[4]
Psychiatrists	23.3%	2,750
Licensed MH Provider[5]	59.9%	900
Other MH Staff[5]	16.8%	*900*

Provider Need:

		# of Discharges				# of Providers Needed			
	OP Grouping[2]	Total[1]	Psychiatrists	Licensed MH Providers	Other MH Staff	Total	Psychiatrists	Licensed MH Providers	Other MH Staff
Current (2018)	Geriatric Psychiatry	47,807	11,139	28,636	8,032	45	4	32	9
	Substance Abuse	30,861	7,191	18,486	5,185	29	3	21	6
	Mental Health	689,036	160,545	412,733	115,758	646	58	459	129
	Total	**767,704**	**178,875**	**459,855**	**128,974**	**719**	**65**	**511**	**143**
Projected (2028)	Geriatric Psychiatry	65,976	15,372	39,520	11,084	62	6	44	12
	Substance Abuse	37,780	8,803	22,630	6,347	35	3	25	7
	Mental Health	732,549	170,684	438,797	123,068	686	62	488	137
	Total	**836,305**	**194,859**	**500,947**	**140,499**	**784**	**71**	**557**	**156**
Δ		**68,601**	**15,984**	**41,092**	**11,525**	**64**	**6**	**46**	**13**

1. Total Discharges source: Sg2, filtered on PSA service area
2. OP Grouping assumptions: Geriatric Psychiatry = Dementia and Cognitive Disorders. Substance Abuse = Addiction/Chemical Dependency. Mental Health = all other CARE Family Services not included in Geriatric and Substance Abuse.
3. % of Visits by Provider Type source: Burke, Bridget Teevan et al. "A needs-based method for estimating the behavioral health staff needs of community health centers." *BMC health services research* vol. 13 245. 2 Jul. 2013.
4. Mean Visits per Provider source: Psychiatrists – MGMA; Licensed MH providers - HRSA - Uniform Data System (UDS) & National Survey on Drug Use and Health. Other MH Staff – assumes same source as Licensed providers
5. Licensed MH Provider = psychologists, licensed clinical social workers, and other licensed mental health professionals. Other MH Staff = unlicensed individuals, incl. "certified" individuals who provide counseling, treatment, or support services related to MH professionals.

Behavioral Health Resources in the Wichita Community

Primary Service Area

Outpatient

- SACK
- Comcare
- Comcare Community Crisis Center
- Wichita Family Crisis Center
- Miracles Inc.
- Prarieview (East, West Wichita)
- DCCCA
- Hunter Health Clinic
- HealthCore Clinic
- Ascension Via Christi OP BH/Partial-Day Program
- Wichita Child Guidance Center
- Mayflower Clinic
- Center for Health and Wellness
- Soma Recovery
- Psychiatric & Addiction Services
- South Central MH Counseling Center (El Dorado, August, Andover)
- Andover Family Counseling
- Flinthills Wellness
- GraceMed

Residential Care

- Comcare Crisis Stabilization Unit
- DCCCA
- Wichita Children's Home
- Fieldview at Holland
- Valley Hope Treatment Center
- A Clear Direction Wichita

Associations, Advocacy, Other BH Support

- Mental Health Association of South Central Kansas
- Families Together
- Kansas Consumer Advisory Council for Adult MH
- NAMI – Sedgwick County
- St. Francis Ministries
- Continuum of Care
- Project Independence of Sedgwick County
- Sedgwick County Department on Aging
- Alzheimer's Association – Adult Care Connection

State Hospitals

- Osawatomie State Hospital
- Larned State Hospital

General Hospitals

- Ascension Via Christi (St. Teresa, St. Joesph, St. Francis)
- Robert Dole VA Medical Center
- Kansas Medical Center
- Wesley Medical Center
- Susan B Allen Memorial Hospital

Homeless Shelters, Transitional Housing

- Step Stone Wichita
- Salvation Army Homeless Services
- Mennonite Housing Rehab
- United Methodist Open Door
- Wichita Housing Authority
- Sisters of St. Joseph Dear Neighbor Ministries
- Community Housing Services
- Inter-Faith Ministries
- Catholic Charities (St. Anthony Family Shelter, Harbor House)
- Wichita Children's Home emergency shelter
- YWCA Wichita (women's crisis center)
- Berkley House
- Wichita House
- First church of the Nazarene – butler Homeless Initiative
- St. Anthony Family Shelter
- Family Life Center of Butler County
- Wichita Homeless Mission Messiah's Branch

Psychiatric Hospitals

- KVC Adolescent Psych Hospital (*summer 2019*)
- St. Anthony's Senior Care Hospital

Advocate's JDP Model

Pairs police officers with masters-level clinicians who ride alongside officers on all calls involving individuals in a mental health or substance-related crisis.

Tier Addressed	Long-Term
Subject Addressed	Incarceration, ED Overcrowding
Population Addressed	Incarcerated Population
Services Provided	Behavioral Health clinicians to deescalate mental health or substance abuse crises.
Funding Source	Short-term local philanthropic support and the Massachusetts Department of Mental Health
Location	Farmingham, MA
Source Link	https://www.advocates.org/services/jail-diversion

Dual-Diversion Program

Incarceration + Unnecessary ED Visits

$3,324,000 in Arrest Diversion Savings

$2,472,000 in ED Diversion Savings

The Fortune Society

Better Living Center: Alternative Incarceration

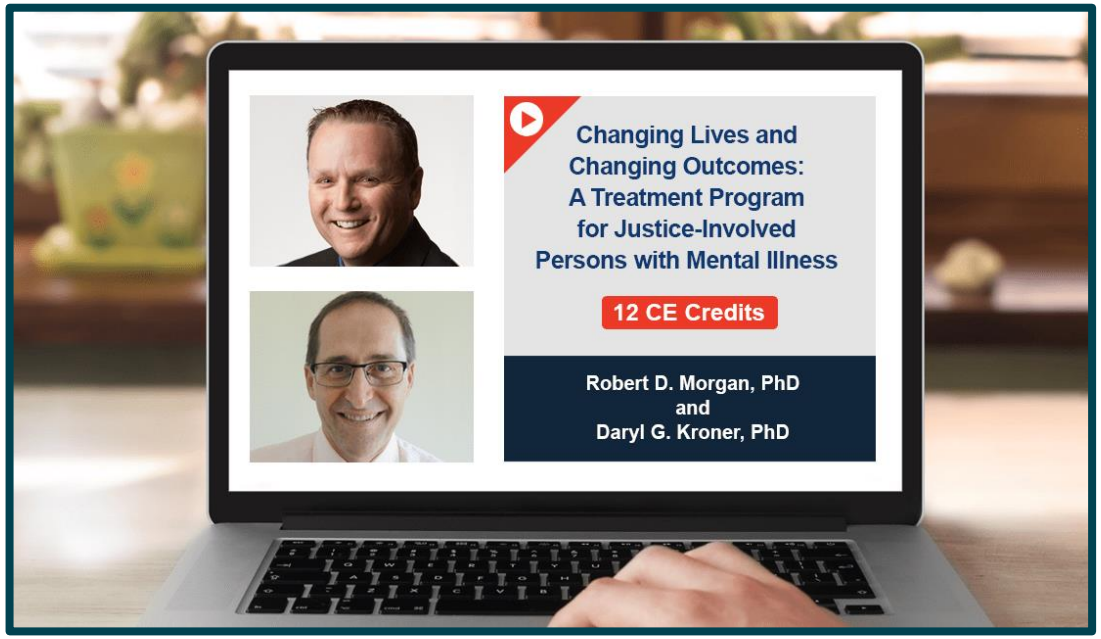
Better Living Center treats any person with a history of court involvement who presents with signs of mental illness.

Works with judges, prosecutors, and defense attorneys to identify and divert defendants out of the criminal justice system and into a community treatment program.

Tier Addressed	Long-Term
Subject Addressed	Incarceration, Homelessness
Population Addressed	Incarcerated Homeless Population
Services Provided	Community-based treatment
Funding Source	Began with private funders and funds until it was able to gain accreditation from state funds
Location	New York
Source Link	http://gallery.mailchimp.com/ae6555fac44e3d725bead12cb/files/BLC_Report.pdf

Changing Lives and Changing Outcomes

Online program to assist with the mentally ill involved with the justice system



Tier Addressed	Intermediate
Subject Addressed	Incarceration
Population Addressed	Incarcerated Population
Services Provided	Online treatment modules
Location	Online Program
Source Link	https://capitol.texas.gov/tlodocs/83R/handouts/C2102014102010001/ae5656a0-d309-48f1-b568-c79852f7be53.PDF

9 treatment modules are covered in **74** sessions specifically designed to change and recognize the mental illness and criminalness awareness.

Colorado Coalition for the Homeless

West End Health Center

Provides integrated services and temporary shelters for those that are chronically homeless or below the poverty line.

The Center contains primary care, behavioral health, and pharmaceutical services all within the one location.

Tier Addressed	Long-Term
Subject Addressed	Homelessness
Population Addressed	Homeless and low-income populations
Services Provided	Housing, primary care, behavioral health, pharmaceuticals
Funding Source	Public and private grants, foundation awards for homeless service providers, Medicaid, Colorado Indigent Care Program
Location	Denver, CO
Source Link	https://www.coloradocoalition.org/sites/default/files/2017-01/CCH.SIM_.2013.pdf

WellSpace Health: Interim Care Program (ICP)

Coordinates the placement of homeless patients out of the inpatient setting that typically have long LOS's to ensure appropriate medical needs are met and reduce the chance of readmission, to a nurse-managed specialized unit.

- Units are operated by WellSpace Health within the Salvation Army or other area shelters.
- The program uses case managers to coordinate transportation, assist with housing placements, and coordinate with other community programs once they are released.

Decreased average inpatient LOS for the homeless by **23 days**.

WELLSPACE HEALTH
Comprehensive care since 1953

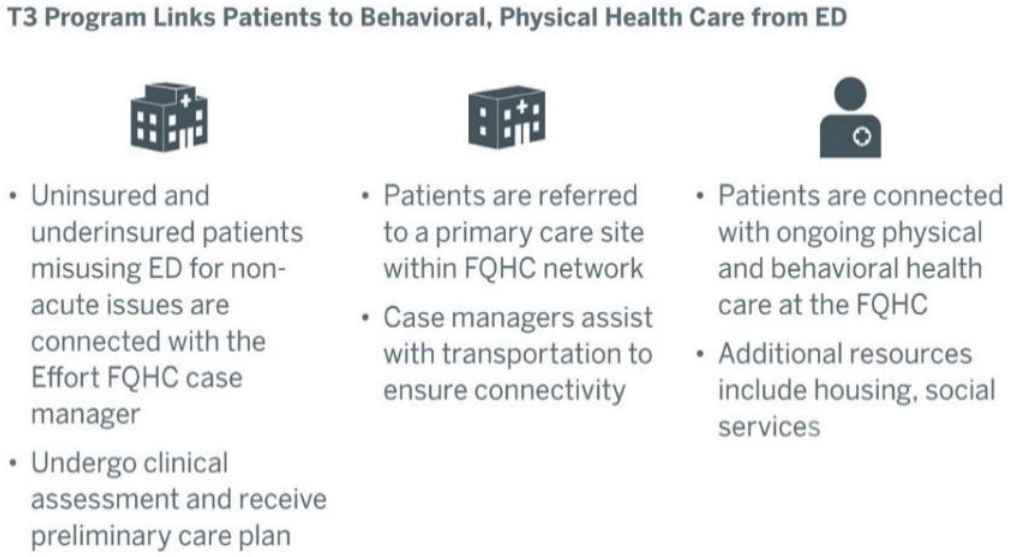
Tier Addressed	Intermediate
Subject Addressed	ED Overcrowding, Homelessness
Population Addressed	The Homeless
Services Provided	Shelter, care coordination,
Funding Source	Dignity Health, Sutter Health, Kaiser, and UC Davis Medical Center
Location	Sacramento, CA
Source Link	https://www.wellspacehealth.org/for-medical-professionals/health-access-referral-and-treatment-hart-programs

WellSpace Health: Triage, Transport, Treatment (T3) Program

Sacramento, CA

Tier Addressed	Intermediate
Subject Addressed	ED Overcrowding, Homelessness
Population Addressed	Frequent ED users
Services Provided	Case management, care planning, transportation, additional resources (i.e. connections to housing, social services, etc.)
Funding Source	Dignity Health, Sutter Health, Kaiser, and UC Davis Medical Center
Location	Sacramento, CA
Source Link	https://www.wellspacehealth.org/for-medical-professionals/health-access-referral-and-treatment-hart-programs

Every $1 spent
on the program
returns a savings of $10
in ED Costs.

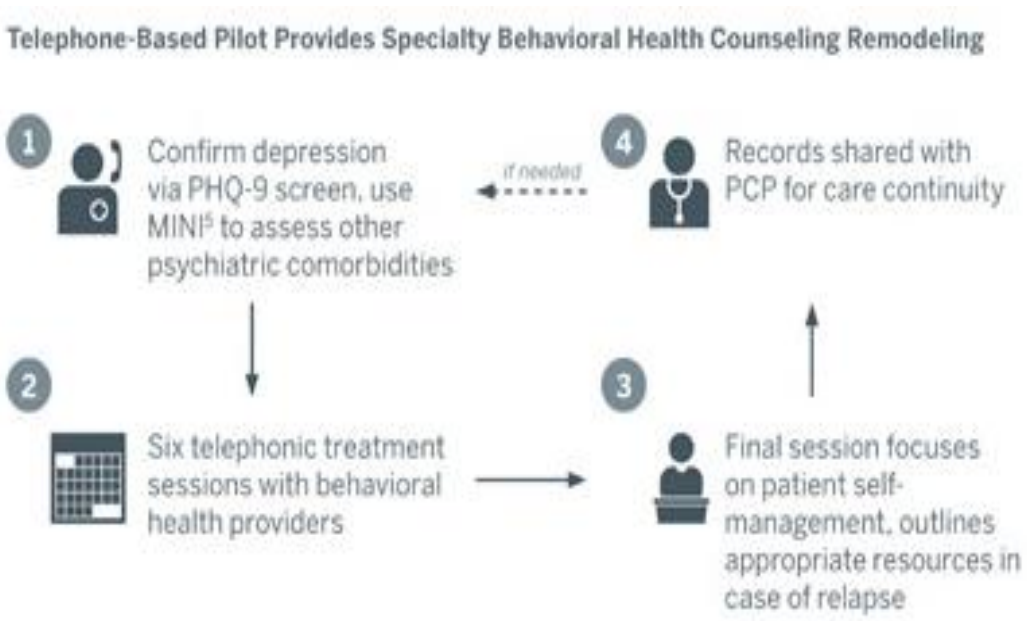


Denver Health Model

Targets depression by partnering with PCPs

Tier Addressed	Basic
Subject Addressed	Depression
Population Addressed	Depressed populations and those using anti-depressants outside of normal limits
Services Provided	Partners with PCPs to identify those that are at risk of depression and the overuse of anti-depressants. Uses telephone treatment to
Funding Source	Hospital funding
Location	Denver, CO
Source Link	https://www.advisory.com/research/health-care-advisory-board/studies/2013/proactive-behavioral-health-management

DENVER HEALTH™
est. 1860
FOR LIFE'S JOURNEY



Ascension Brighton Center for Recovery

Targets substance abuse

- **99 beds**
  - 41 Acute Beds
  - 58 Residential
- Traditional halfway housing (16)
- Outpatient services utilize group therapy class/meeting rooms

Tier Addressed	Long-Term
Subject Addressed	Substance Abuse
Population Addressed	Substance abusers
Services Provided	IP and OP substance abuse treatment and services, halfway housing
Funding Source	Ascension
Location	Brighton, MI
Source Link	https://healthcare.ascension.org/Locations/Michigan/MIDET/Brighton-Ascension-Brighton-Center-for-Recovery

Atrium Health: Behavioral Health- Davidson, NC

Reduce pressure off of inner-city IP BH Hospitals, addressing long wait times and overcrowding in the ED.

Tier Addressed	Long-Term
Subject Addressed	IP BH Bed Shortage
Population Addressed	IP and OP BH Patients
Services Provided	IP and OP BH Services
Funding Source	Atrium Health (formerly Carolinas Healthcare System)
Location	Davidson, NC
Source Link	https://www.charlotteobserver.com/living/health-family/article9110381.html

66 Beds

- 11 Bed Units
- 2 Stories
- Zoned for future expansion as the BH need increases.

Bexar County Behavioral Health

Co-located BH resources, targeting previously incarcerated populations

Tier Addressed	Long-Term
Subject Addressed	Incarceration, substance abuse, ED, homelessness
Population Addressed	Mentally ill, especially the previously incarcerated, homeless, etc.
Services Provided	Holistic services to the mentally ill, especially for those who were recently incarcerated
Funding Source	CHCS, Clarity, University Health System, 1115 Waiver DS-RIP Projects
Location	Bexar Behavioral Health
Source Link	https://www.bexar.org/192/The-Department-of-Behavioral-Health

Bexar County's Path:

- ❑ Deputy Mobile Outreach Team established
- ❑ Jail Diversion Planning Advisory Committee meet for one year
- ❑ Mental Health Docket is expanded
- ❑ Jail Diversion Over-sight Committee is established
- ❑ Bexar County Diversion Model is approved by the JDPAC
- ❑ 78th Legislature in session/reorganization in process for the Jail Diversion Law
- ❑ Crisis Intervention Training for all public safety officials continues
- ❑ Adult Crisis Services and medical clearance 24/7 establish a central location
- ❑ County/City wide consolidation of crisis services and medical triage in process
- ❑ Data on ER utilization and jail admission for misdemeanors tracked and treading down
- ❑ Jail diversions increase
- ❑ Expansion of pre- and post-diversion programs

The Bexar County Model

The Problem

Lack of state beds and adequate community based mental health services

Hospital EDs and the criminal justice system were left to be the safety net providers

Geographically scattered mental health services, each working in siloes

Key Sources: National Association of Counties (NACO) "Blueprint for Success – The Bexar County Model"; CHCS Bexar County Diversion Program Cost Avoidance Report

Building a Nationally Recognized Jail Diversion Program

The key to the program is diverting individuals *early*. There are 46 distinct intervention points throughout the arrest and detention processes, divided into 3 phases:

Before Incarceration

redirect to appropriate care

- Community Crisis Hotline
- Mobile Crisis Teams to provide field assessment
- Crisis trained officers
- Crisis Care Center to allow for fast "drop-off"

During Incarceration

seek alternative treatments to jail

- Offenders who meet certain program criteria may be released and stepped down into long term residential treatment
- Judge may involuntarily commit individuals to an intensive outpatient program

After Incarceration

reintegration back into community

- Genesis re-entry program, which provides more intensive community based treatment

- More than 100k people have been diverted from jail or emergency rooms since the program's inception in 2003
- As of 2017, a total of $96m in cost savings ($78m in Bexar County, $18m in San Antonio)
- Overcrowding in the county jail now routinely has a surplus of ~800 beds
- Jail stays for mentally ill detainees has been significantly reduced due to rapid access to treatment and better access to appropriate services

The Bexar County Model

A Co-Located Campus

The Center for Health Care Services (CHCS) in Bexar County created one centralized complex, the Roberto L. Jimenez Restoration Center, conveniently located across the street from San Antonio's state of the art 22 acre homeless shelter, Haven for Hope. Key service offerings across both entities include:

CHCS Restoration Center

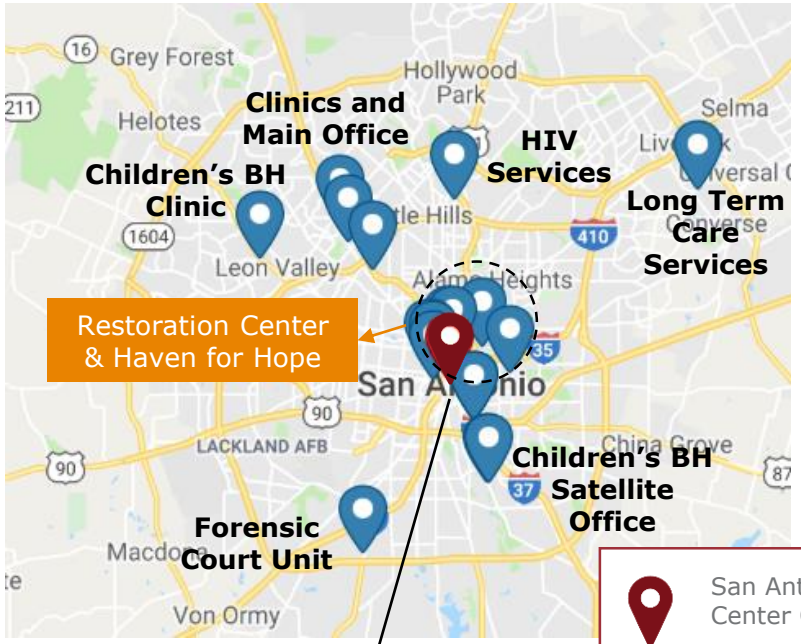
- Crisis Care
- Sobering Unit
- Injured Prisoners medical clinic
- Residential Detox
- Outpatient Substance Abuse
- Drug Court Outpatient Program
- Female Substance Abuse Program
- Opioid Addiction
- Mobile Crisis Outreach Team
- Primary Care Clinic
- In-house recovery Program

Haven for Hope

- The Courtyard – low barrier, emergency shelter program
- Short-term residential housing
- Substance abuse and mental health treatment
- Employment services
- Education Services
- Life-Skills training
- Legal Services
- Childcare
- Healthcare
- Animal Kennel
- Housing

140 partners **300** services

Additional CHCS Services



Remaining Services near City Center

- Children's BH Campus
- Adult BH Clinic
- Mental Health and Specialty Programs
- HIV Prevention, Intervention, & Outreach
- Veteran's Services
- Harvard Place Clinic

Key Sources: Kaiser Health News "Wrestling with a Texas County's Mental Health System"; chcsbc.org; havenforhope.org

Agency for Community Treatment Services (ACTS)

Tampa, FL

ACTS was created to meet the need for coordination of care model in Hillsborough County to address high-utilizers and address them. The program provides a communitywide protocol and education around resources for providers addressing patients with mental or behavioral health needs.

Partnership between:
- Florida Department of Health in Hillsborough County
- BayCare Health System
- Tampa General Hospital

Tier Addressed	Long-Term
Subject Addressed	ED, Incarceration
Population Addressed	Mentally ill using multiple resources, high ED utilizers
Services Provided	Crisis Care, residential services, OP, Housing services, care coordination, jail diversion program
Funding Source	First started the program through grants.
Location	Hillsborough County, Florida
Source Link	http://hillsborough.floridahealth.gov/newsroom/2018/07/behavioral-health-services.html

Arizona Health Care Cost Containment System (AHCCCS)

Phoenix, AZ

Tier Addressed	Intermediate
Subject Addressed	Primary Care
Population Addressed	Mentally ill, high utilizers
Services Provided	Behavioral health services integrated into Medicaid plans to cover recipients in a more holistic manner
Funding Source	SAMHSA Grants and Non-TXIX/XXI Funded services
Location	Phoenix, AZ
Source Link	https://www.azahcccs.gov/

Addresses Phoenix's most vulnerable populations and provides them with behavioral health needs **integrated** throughout the healthcare **continuum**.

Provides programs to ensure access to behavioral health programs to Phoenix's **MEDICAID** population

Outpatient Care Center
Catalyst Case Example

Center was experiencing space constraints

Client seeking to create a primary care model of the future

Options were developed to limit amount of new construction, realign functional space to match clinic needs, and leverage existing space in the center

Current State

The client is currently operating under an integrated model of care where all the providers come to the patient. The clinics were originally intended to have Physicians see patients in the exam room and then the patient would move to a consult room if there were any additional discussions needed (i.e. Behavioral Health, Social Work, etc.).

The Problem

The current physical design does not support this model as there are a lack of exam rooms for the number of providers to maintain sufficient throughput. The primary patients are indigent and are not compliant and miss or don't come back for later appointments if additional care is needed.

Model of Care

The integrated model should be continued as it resulted in higher patient compliance and population health management. To compensate for space needs, the adoption of technology solutions and additional resources should be considered:

- *Group Care* – Behavioral Health, Disease-state management, etc.
- *Virtual Care* such as telehealth, telemedicine, remote monitoring, etc.
- *Remote resource management*

- Wearable Devices to collect real time data

- Patients will increasingly control their medical charts

- No waiting rooms – waiting rooms act more as a "pass through"

- Direct primary care model- cutting out the middle men. Modified FQHC

- Up to 35% of visits will happen virtually – or not at all
- Primary care nurse 24/7
- Remote monitoring chronic diseases (i.e., diabetes)

- Virtual Pharmacy

Gap Analysis by Tier

% of gaps addressed

- Basic: 37%
- Basic + Intermediate: 79%
- Basic + Intermediate + Long Term: 92%

Gaps	Category	Sub-Category	Basic		Intermediate		Long-Term	
			Facility	Ops	Facility	Ops	Facility	Ops
Time- teachers (certifications), MH First Aid, Church	Community	Advocate Engagement						
Religious connection	Community	Advocate Engagement		X				
Knowing all businesses educate employees	Community	Advocate Engagement		X				
BH campaigns	Community	Advocate Engagement		X				
Employers' acceptance of MH support	Community	Advocate Engagement						
Community commitment to address need	Community	Advocate Engagement		X				
Consistent messaging for services & resources	Communication	Consistency		X				
Diverse organizations: culture- language, education, etc.	Community	Diversity						
Education of process/policy/capability (the WHY)	Communication	Education		X				
Education & resources	Resources	Educational		X				
Access or mandate for Police education	Resources	Educational		X				
Resource booklets of options for everyone	Resources	Educational		X				
Training on aggressive behavior & decision making for staff safety	Resources	Educational		X				
Medical Detox	Services	Gap in care				X		
Medical health (Homeless)	Services	Gap in care						X
Geriatric care & shelters	Services	Gap in care						X
Time of day/night to stay @ a shelter	Services	Gap in care				X		
Housing for violent patients	Services	Gap in care			X			
Management of violent patients	Services	Gap in care		X				
Standardizing intake info	Continuum of Care	Information sharing				X		
Incorrect use of crisis center - people transport dementia patients to the crisis center thinking they are having a psychotic break; really it's dementia	Access	Point of Access				X		

Gap Analysis by Tier *continued*

% of gaps addressed

- Basic: 37%
- Basic + Intermediate: 79%
- Basic + Intermediate + Long Term: 92%

Gaps	Category	Sub-Category	Basic		Intermediate		Long-Term	
			Facility	Ops	Facility	Ops	Facility	Ops
Reactionary instead of proactive	Services	Prevention & Wellness			X	X		
Rely on a emergency plan rather than early intervention	Services	Prevention & Wellness			X	X		
Lack of PC screenings	Services	Prevention & Wellness			X	X		
Need to focus on wellness/preventative care & self care	Services	Prevention & Wellness			X	X		
Preventitive medical/ wellness centers/ nutrition	Services	Prevention & Wellness			X	X		
Identify the cause- dig deeper	Services	Prevention & Wellness			X	X		
School direction- Counselor>ED>Crisis Center	Continuum of Care	Process		X				
Ground level collaboration (right now it is mostly among leadership)	Continuum of Care	Process		X		X		X
Coordination with VA	Continuum of Care	Process		X		X		
Individual practitioners not incentivized to refer or coord with other organizations	Continuum of Care	Process		X		X		
Facility proximity	Facility	Proximity					X	
Eating disorders	Services	Service offering				X		
Need for more beds/ clinic space across facilities	Facility	Space	X					
Communication w/ non-Medicaid patients	Communication	Targeted Audience		X				
Same day access	Access	Timely care				X		X
Follow-up appt/ wait time for appt	Access	Timely Care						X
Community Care Transitions	Continuum of Care	Transition of care						X
Steps after Jail	Continuum of Care	Transition of care						X
Communication gap on release from judge to coordinating access to care (end up in ED)	Continuum of Care	Transition of care						X
Transportation	Access	Transportation				X		

Gap Analysis by Tier *continued*

% of gaps addressed

- Basic: 37%
- Basic + Intermediate: 79%
- Basic + Intermediate + Long Term: 92%

Gaps	Category	Sub-Category	Basic		Intermediate		Long-Term	
			Facility	Ops	Facility	Ops	Facility	Ops
Transport from jail to shelters (fallen through)	Access	Transportation				X		
Transporting youth in crisis from school to crisis center (won't do it)	Access	Transportation				X		
Funding for innovative change	Resources	Funding						
Live off of grants	Resources	Funding						
Opioid vs. meth funding competition	Resources	Funding						
Sustainable funding	Resources	Funding						
Disproportionate concentration of BH patients @ certain EDs	Access	Point of Access			X	X	X	X
Statewide gap puts pressure on Wichita system	Resources	Gap						
Policy change- mandatory bookings	Services	Policy barrier		X				
Cops can't enter women's shelters (policy)	Services	Policy barrier		X				
Turnover time/staffing	Resources	Staffing				X		X