Public Investment Plan (PIP)

Name:	Community Mental Health Systems Improvement Through Public-Private Partnerships
Convener:	Metro Public Health Department
Contact:	William S. Paul, MD, MPH, FACP, Director of Health
Mayor's Priority Area :	Mental Health

1. Briefly describe the issue or problem addressed by the investment plan:

Mental illnesses ideally should be treated like other illnesses—by trained providers in an appropriate care setting. No one would, upon suspecting appendicitis, deliver someone to the jail.

Unfortunately, Nashville's "system" for mental health care is fragmented and under-resourced. This means people with mental illness often are routed to the criminal justice system. On any given night, there are now 300-plus seriously and persistently mentally ill people being housed at the County Jail. Their detention is not designed around treatment of illness, so stabilization and continuity of care are addressed poorly--on the margins of the criminal justice system. In recent years the census of the jail has declined, but not the census of mentally ill people in jail. We shouldn't be criminalizing mental illness, and we should expand our ability to manage people with mental illnesses without arrest or incarceration.

A mental health planning workgroup, comprised of key providers of mental health services and criminal justice entities, asked the question:

"What do we need to have in place in the next 3 years to serve our community and improve outcomes for people with mental illness in Metro Nashville/Davidson County?"

Answers fell into 8 agreed-upon focus areas:

1. 24/7 Health Hub (Urgent Care)	5. Processes for Expanded Diversion
2. Backbone Organization/Collective Impact Planning	6. Care Management for Uninsured and Underinsured
3. Data/Outcomes Measurement	7. Expanded Housing Options
4. Citywide Campaign	8. Dedicated Mental Health Funding

The following 3 actions were identified as critical first steps to address the needs:

1. **Close gaps in Nashville's public 24/7 Mental Health Urgent Care hubs (Mental Health Co-op and Nashville General Hospital) to provide realistic alternatives to arrest and incarceration for more patients.**

2. **Create and facilitate a community mental health planning group to monitor the system of services, identify strategic gaps, and mobilize resources and system changes to improve service.**

3. **Support preventive strategies "upstream" in the mental health system by preventing and responding to Adverse Childhood Experiences.**

2. How does the plan solve the stated problem?

1. **Closes gaps in Nashville's 24/7 Mental Health Urgent Care to provide realistic and recognized alternatives to arrest and incarceration for more patients**

While there are many gaps throughout the system, the planning group chose to focus on gaps that cause backups and delays in 24/7 Mental Health Urgent Care.

The Mental Health Cooperative (MHC) is funded to provide triage, crisis intervention, and linkage to care of mental health patients in crisis on a voluntary and involuntary basis. Likewise, the **Nashville General Hospital Emergency Department (NGH-ED)** provides triage and linkage to care, with the majority of these being involuntary commitments. Addressing gaps in existing systems at MCH and NGH-ED for crisis response is a first step in upgrading the 24/7 Mental Health Urgent Care System.

Mental Health Cooperative

MHC will partner with Metro Government to improve service as a 24/7 Mental Health Urgent Care provider.

Issue: Hours of police time spent waiting with clients at MHC. On any given day, there can be multiple officers supervising 3-4 individuals deemed a danger to themselves or others, who are awaiting a bed for crisis stabilization.

Proposed solution: Funded security staff or officers to provide supervision needed for clients waiting for placement. This would allow officers the ability to "drop off" individuals at the walk-in center and get back on patrol. MHC would evaluate the need to modify the facility to allow the ability to minimize security staffing needs and provide the appropriate level of supervision.

Issue: Medical co-morbidities requiring off-site care Often individuals who are in a psychiatric crisis also have chronic medical conditions like hypertension, diabetes, seizure disorder, etc. The current crisis walk-in center has minimal medical coverage (specifically after hours) to manage some of these issues, which often leads to individuals being transported to local ER's.

Proposed Solution: Resources for 24/7 medical coverage, MHC can address more of the issues on site as opposed to having officers and emergency personnel tied up transporting these individuals to emergency rooms.

NGH Emergency Department

The care of the behavioral health patient in the emergency department setting impacts resource utilization and throughput. Mental health patients spend many hours awaiting inpatient placement or disposition to alternative care settings.

Issue: Emergency room staffing and configuration are inefficient and ineffective in treating behavioral health patients. Patients spend many hours waiting for disposition, often with supervision by registered nurses and Metro police. Current average length of stay for behavioral health patients transported by Metro Police is 707 minutes.

Proposed Solution: The implementation of an ED-Based Behavioral Health Unit. The unit would be designed and staffed to facilitate the care of individuals, enabling them to achieve stability to be discharged or transferred to an alternative care facility. Police officers would be released more quickly to the field. Mental Health Assessment Team onsite will provide rapid assessment, evaluation, and management of mental health crisis and referral; expediting care and disposition of patient to alternative patient care setting.

Issue: MHC serves as the state's mandatory prescreening agent for hospital beds in the state system. Due to delays inherent in the mobile crisis response system, patients seen in the hospital EDs experience waits for MHC

mobile crisis teams to fulfill this role. These waits may be increased during peak times.

Proposed solution: Coverage in the NGH–ED with a dedicated Crisis Counselor 24/7 to provide assessments and complete 6404 paperwork.

2. **Creates a community mental health planning body to monitor the system of services, identify strategic gaps, and mobilize resources and system changes to improve services. This planning body is committed to ongoing mental health systems planning and guiding local systems improvement and investment.**

This planning body would be charged with careful assessment of the system and defining and monitoring its metrics, and addressing other agreed upon 3-year priorities/goals.

This will be achieved using a "Collective Impact" framework—a collaborative model that engages stakeholders around a common agenda, shared measurement, mutually reinforcing activities, and continuous communications that is supported by a backbone organization providing overall coordination. MPHD will serve as the convener and backbone organization for this planning body.

3. **Supports prevention and response to Adverse Childhood Experiences which have a lasting impact on the spectrum of mental and physical health. This PIP supports preventive strategies "upstream" in the mental health system by coordinating Metro's strategies for preventing and responding to Adverse Childhood Experiences (ACEs).**

We cannot neglect the importance of prevention—particularly prevention of adverse childhood experiences and of violence that can have a long term impact on mental and physical illness, addiction, productivity and early death. ACEs have been shown to be a driver of long term chronic mental health and medical conditions, poor health outcomes, and shorten lifespan by 10-plus years.

Summary

This proposal addresses both near term and long range needs related to solving the issues noted above. In the near term this PIP seeks to enhance the existing system for both voluntary-and involuntary-based crisis mental health needs. In the longer term this PIP establishes the importance and priority of community planning to address the development and plan for a funded system of long-term treatment and case management.

3. Why is this the right time to implement this plan?

Mental Health emerged as a priority in Nashville's Community Health Improvement Plan and in the Community Health Needs Assessments of both Vanderbilt University Medical Center and St. Thomas Health.

The population of Nashville is growing, and its mental health resources are shrinking. Since 2006, the Davidson County Sheriff's Office (DCSO) has seen a rise in the number of seriously mentally ill individuals entering the local jail system. At the same time, the local emergency rooms have seen a rise in the number of mental health patients who entered their emergency departments and in the length of time it takes to appropriately assess and transfer these patients to other levels of care.

The MHC mental health crisis team has seen an increase in requests for service since 2006 (over 2,000 more crisis assessments in 2015 as compared to 2006). In addition, this region's state psychiatric hospital, Middle Tennessee Mental Health Institute (MTMHI), has seen an increase in referrals and is often at maximum capacity, unable to accept new referrals. When MTMHI is at capacity, individuals in need of acute inpatient admission are put on a waiting list or transferred to the next closest State facility, which is in Bolivar, Tn. In FY 2014-15, MTMHI reported 1,396 referrals from Davidson County. Of those, 385 were on a wait list before they were approved for transport to MTMHI. In 2015, 727 referrals from Davidson County were placed on a wait list for a bed at MTMHI. These individuals were waiting in the

current crisis center or local ERs, and most of the time they required around-the-clock police presence.

Metro-Nashville Government has a strong history of collaboration between systems to develop innovative programs that connect the criminal justice system and the mental health system. This was clear back in 2001 when the Davidson County Mental Health Court was established. This Court would not have had the success it has in assisting mentally ill individuals to live successful lives back into the community if the Court had not had relationships with and support of outpatient community providers. In order to improve emergency crisis services in Nashville, we need to build on the city's history of Metro Departments partnering with local non-profit agencies like MHC in order to develop a more effective, efficient, and innovative program to address the current needs of the city.

4. What current processes address the issue?

The majority of the behavioral health patients seen in the emergency department at NGH-ED are involuntary committals requiring a certificate of need for involuntary admission. The Mental Health Cooperative is designated as a Mandatory Prescreening Agent appointed by the Tennessee Department of Mental Health and Substance Abuse Services. Mental Health Co-op provides crisis stabilization units which are voluntary only. The demand for mobile crisis services is greater than the resources available. The Crisis Stabilization services provided are all on a voluntary basis with limited medical components.

Mental Health Cooperative (MHC) is a 501(c)(3) organization, established in April, 1993, to provide intensive case management, psychiatric/clinic and 24/7 emergency psychiatric services for consumers in Davidson County. MHC has been the designated team for Davidson County by the state Department of Mental Health since 1993. The crisis team employs specialized mental health clinicians who conduct assessments via phone and in person on individuals who are experiencing a psychiatric emergency (e.g., severe depressive symptoms, suicidal ideation, homicidal ideation, paranoia, psychosis). In 2015, the crisis team has received an average of 6,090 calls a month to the 24/7 crisis line from individuals seeking assistance, and the team conducted on average 654 face-to-face assessments per month on individuals who were presenting with acute psychiatric symptoms.

In the late 90's, MHC saw a need for enhanced crisis services in Nashville which led to the creation of the 24/7 crisis walk-in center located in Metro Center. The walk-in center allows individuals who are experiencing a psychiatric crisis to access immediate assessment and intervention in a safe location. In 2015, the walk-in center provided services to an average of 188 individuals a month. When the walk-in center was created, MHC developed a partnership with Metro Nashville Police Department (MNPD) that led to the implementation of General Order No. 10-03 "Interviewing & Transporting Mentally Ill Persons." General Order No. 10-03 outlines the process by which MNPD officers can access services from the Mobile Crisis Team (MCT) or walk-in center if they encounter a citizen who appears to be experiencing a psychiatric emergency. In 2015, MCT saw on average 90 individuals each month at the request of MNPD.

At the same time that the walk-in center was established, MHC created an eight-bed Crisis Resolution Center (CRC). The CRC is staffed with a nurse and resident counselor who are able to monitor and treat individuals in crisis for up to 24 hours. During an individual's stay in CRC, they are seen by a psychiatrist or psychiatric nurse practitioner who evaluate and initiate medication as needed. Prior to discharge from CRC, individuals are connected with follow-up outpatient services. In 2015, CRC admitted an average of 96 individuals each month.

MHC has operated a respite program also known as the Intensive Intervention Center (IIC) since the mid 90's. Today the IIC is operated in an eight-bed unit in Metro Center. IIC is a voluntary unit that provides 24/7 supervision for individuals who need on-going intervention and stabilization to address the issues that led to a crisis episode. Individuals admitted to IIC are able to stay up to three days, during which time they are evaluated by nursing staff for immediate needs. During their stay they are also offered a psychiatric evaluation if needed. Prior to their discharge, a discharge plan for follow-up services is developed for each individual. In 2015, IIC admitted an average of 63 individuals each month.

In 2007, MHC opened a Crisis Stabilization Unit (CSU) for the Middle Tennessee region. The CSU is a voluntary unit that accepts referrals from Davidson and surrounding county crisis teams. The CSU is not considered an inpatient psychiatric unit; however, the services offered by the CSU are comparable to many of the services offered on an inpatient unit. The CSU is voluntary and maintains a staff to patient ration of 1:5. The average length of stay in the CSU is two to three days with the maximum length of stay being five days per licensure regulations. A registered nurse is on the unit 24/7 and each day a psychiatrist and/or psychiatric nurse practitioner conduct rounds on the unit. Individuals are encouraged to attend group treatment daily and individual treatment is offered as needed. Prior to discharge, a comprehensive discharge plan is developed for each patient that connects them with follow-up community based services. In 2015, the CSU admitted on average 160 individuals each month.

5. What problems and inefficiencies have been identified with the current processes?

- Mobile Crisis is under-resourced, resulting in increased waiting times for patients in EDs who need assessment.
- State funding has been continually cut and beds reduced at state institutes.
- Changes in TennCare's structure have resulted in ineligibility for many with severe mental illness.
- Emergency rooms have become the default waiting area for those in need of an admission to the state mental health institute.
- The community has worked in silos and has not been incentivized to work collectively across departments and community agencies resources.
- There is a lack of treatment and case management resources so that those who have been stabilized can continue treatment.
- For State Mental Health Facilities and TennCare Recipients a Mandatory Prescreening agent is required; Mobile Crisis is the only MPA available in the county and it is under-resourced.
- There is often difficulty placing patients for inpatient hospitalization as the demand outweighs the available resources.
- MNPD officers are sitting at the MHC Walk-in crisis center or in the NGH-ED for extended periods of time-- sometimes over multiple shifts-- if a person is being assessed for emergency psychiatric treatment by the crisis team. If the individual is deemed a danger to self or others and in need of inpatient treatment, law enforcement is often involved to maintain the individual's safety until an appropriate treatment resource can be secured. This results in multiple officers being off regular patrol duties.
- Individuals who are experiencing a psychiatric emergency frequently have medical co-morbidities. As stated previously, there are programs like the Crisis Resolution Center (CRC) and Crisis Stabilization Unit (CSU) run by MHC that are able to appropriately treat the psychiatric issues of individuals experiencing a psychiatric emergency. These services are more cost-effective than inpatient psychiatric treatment, and are able to provide a high level of care to individuals in a less restrictive environment than inpatient psychiatric treatment. In 2015, the MHC Walk-in center provided services to 2,240 individuals, the Crisis Resolution Center served 1,138, and the Crisis Stabilization Unit admitted 1,711 individuals.
- The MHC was able to provide services to over 5,000 individuals in crisis and is confident it could treat many more with enhanced medical services on site. Currently MHC is not be able to admit individuals to the CRC or CSU because they have complicated medical issues that exceed the capabilities of the service. If MHC is able to enhance its staff at the walk-in center and CRC with higher trained medical staff, we believe they could increase the number of individuals served in this type of setting. That could prevent unnecessary trips to local emergency rooms, and would divert more individuals from local emergency rooms to this level of care. Currently if an individual presents at the walk-in center with medical issues that exceed what the current system can address, MHC refers them to NGH-ER for treatment. If the current crisis triage center had more medical staff on-site 24/7, many costly trips to the ER could be avoided. In addition, with enhanced medical staff on site, the enhanced crisis triage center would be able to get those who initially present at an ER into lower levels of care quicker through direct consult and collaboration with the ER medical staff.

6. List all proposed participants including:

- **Internal Partners**
- **External Partners (Nonprofits, Non-Government Organizations, Community Organizations)**

Internal: MPHD; Nashville General Hospital; DCSO; Public Defender; Police; Courts; Metro Social Services

External: Mental Health Cooperative; Centerstone; Elam Mental Health Center; Meharry Department of Psychiatry; National Alliance on Mental Illness; Vanderbilt Medical Center; St. Thomas Health

7. Briefly define the individual roles of each participant in each year of the project

- **MPHD** would develop data committee to define and gather data needed to evaluate the effectiveness of this program in getting individuals quicker access to treatment and providing a viable alternative to booking and incarceration. Existing data analyst will be assigned from MPHD. MPHD will serve as convener and facilitator for the Community Mental Health Planning Group and Prevention components.
- **Metro-Nashville Police Department** would be consulted regarding their safety/security protocols for individuals they transport to the MHC Walk-in Crisis Center, and work in collaboration with Metro and community partners to consider alternate staffing scenarios to address these needs. MNPD will participate in the Community Mental Health Planning Group and advise from the MNPD perspective.
- **Metro-Nashville General Hospital** would work in collaboration with the Mental Health Cooperative psychiatric and medical team to develop criteria for those individuals whose medical conditions could be treated on site at the walk-in center. MNGH would also be the receiving hospital for those individuals whose medical conditions exceed what can be safely treated at the walk-in center.
- **Metro-Nashville General Hospital** would initiate capital project to build a 6-8 bed Behavioral Health Unit in Emergency Department. Personnel would be hired to staff unit.
- **Davidson County Sheriff's Office** will participate in the Community Mental Health Planning Group and advise from the DCSO perspective; integrating DCSO mental health diversion with this PIP for a holistic approach.
- **Office of the Public Defender** will participating in the Community Mental Health Planning Group and advise from the Public Defender's perspective.
- **Office of the Courts** will participate in the Community Mental Health Planning Group and advise from the Courts perspective.
- **Metro Social Services** will participate in the Community Mental Health Planning Group and advise from the Homelessness Commission perspective.
- **Mental Health Cooperative** (MHC) would enhance their existing walk-in center services to include more on-site medical coverage. MHC would expand their existing walk-in center in order to increase capacity. MHC would authorize or provide specialized training to the security personnel officers assigned to work within the crisis unit. MHC would provide consistent data to the Metro Health Department regarding number of admissions, services provided, etc. in order to assist in the evaluation of the program. In addition, MHC would develop marketing material to increase awareness of these services throughout the community.
- **MHC:** As the program develops and is evaluated, the need for additional services (e.g., additional crisis stabilization unit beds) may be identified. MHC would work with MPHD to identify these needs and additional resources to fund these services.
- **Centerstone, Inc.** will participate in the Community Mental Health Planning Group and advise from the Community Mental Health Center perspective.
- **Elam Mental Health Center** will participate in the Community Mental Health Planning Group and advise from the Community Mental Health Center perspective.
- **Meharry Department of Psychiatry** will participate in the Community Mental Health Planning Group and advise from the psychiatric provider perspective.
- **National Alliance on Mental Illness (NAMI)** will participate in the Community Mental Health Planning Group and

advise from the mental health consumer perspective.

- **Vanderbilt Medical Center and St. Thomas Health** will participate in the Community Mental Health Planning Group and advise from the emergency room, inpatient and outpatient perspectives. As non-profit hospitals they also have both prioritized mental health as part of their Community Health Needs Assessment and may find opportunities to address community gaps using public benefit resources.

8. Total Length of Project in Years

Three years for initial implementation and evaluation; ongoing to implement best practices to meet needs of community

9. Provide a brief explanation below of the actions that will be taken to implement the project in each year

Year 1

NGH

- Configure Behavioral Health Unit in the NGH Emergency Department for 6-8 beds.
- Establish Mental Health Assessment Team to serve as a 24/7 Mental Health Urgent Care hub for behavioral health patients.
- Include mechanisms to release a police officer back to the field expeditiously.
- Establish partnerships with community resources for alternative care settings.
- Coordinate care of patients seen at Nashville General through the Patient Centered Medical Home to reduce recidivism and enhance the quality of care for this patient population.
- Submit Certificate of Need Application for Inpatient Psychiatric Hospitalization Unit at Nashville General Hospital
- MPHD would work with NGH and MNPD to develop data tracking needed from each organization so that the effectiveness of the program could be evaluated.

MHC

- Mental Health Cooperative**,** MNPD, and safety experts will assist in review of the current physical layout of the crisis center to provide input for consideration of changes to be recommended by MHC to increase capacity of the unit and provide a more secure setting for those who require direct observation while waiting on placement.
- MHC will hire additional medical staff (Registered Nurses) to conduct crisis assessments and provide on–site medical coverage and intervention under the direction of MHC's Chief Medical Officer.
- MHC will hire additional 24/7 Crisis Counselors to be stationed in the NGH-ED.
- NGH would be the designated ER that MHC would collaborate with if an individual who is at the crisis center is in need of emergency medical intervention. MHC and NGH would collaborate and develop protocols for interagency transfers. MHC would conduct training for NGH staff on emergency psychiatric interventions and if needed would provide a training site for Meharry psychiatric residents. NGH would provide consultation to MHC clinical staff as needed regarding acute medical issues.
- MPHD would work with MHC and MNPD to develop data tracking needed from each organization so that the effectiveness of the program could be evaluated.
- In the first three months of Year One, MHC would initiate a marketing campaign to educate the community on the resources offered by the enhanced crisis walk-in center.

MPHD

- Hire Facilitator for planning Group.
- Identify and engage additional community partners that align with work
- Create structure for work of group
- Use existing epidemiology staff to identify and create shared data and measurement parameters
- Hire ACE Coordinator; Collaborate with ACE Nashville Initiative and State ACE Initiative regarding focus on Public Health Prevention; train appropriate staff in trauma-informed care, disseminate best

	practices in nonprofit, government, and education sectors.
Year 2	**NGH:** On-going implementation and evaluation to determine the program effectiveness in providing greater access to emergency crisis services and decreased MNPD manpower hours waiting with mentally ill individuals who are on wait list for services. Begin planning and construction for Inpatient Hospitalization Unit at Nashville General Hospital **MHC:** On-going implementation and evaluation to determine program effectiveness in providing greater access to emergency crisis services and decrease MNPD manpower hours waiting with mentally ill individuals who are on wait list for services. **MPHD:** Collaborative planning body assesses system performance and makes recommendations for new investments
Year 3	**NGH:** Implement Inpatient Hospitalization Unit at Nashville General Hospital **MHC:** On-going implementation and evaluation to determine program effectiveness in providing greater access to emergency crisis services and decrease MNPD manpower hours waiting with mentally ill individuals who are on wait list for services. **MPHD:** Evaluate and refine Planning and Prevention components; the Community Mental Health Planning Group would make recommendations for new investments; Build on work of years 1 and 2 to advance initiatives
Long Term	Create plan and strategies addressing gaps in services, build on successes, capitalize on funding and program opportunities to improve systems for meeting mental health needs of vulnerable Nashvillians

10. Please explain why this collaborative approach more effectively addresses the identified issue compared to existing individual efforts

There is no Mental Health ***system*** in Nashville! Our facilitated consensus workshop was the first time the major players had been in the room to address systemic issues in a decade, and the consensus was that a system with a framework and accountability to the community needs to be established.

The mental health system lost resources to support the uninsured 10 years ago, and since then, the criminal justice system has become a more familiar and visible, if not effective, way of managing mental illness than community mental health services.

There are interdependencies between MHC, emergency providers, law enforcement, the jail, and other system players. Without collaborative problem solving, gaps in the system are never addressed and people suffer.

11. Briefly summarize the additional resources (funding, staffing, training, etc.) needed by all participants in order to

successfully implement the plan.

NGH's cost estimate for ED Based Behavioral Health Unit is $ 400,000 in capital investments for construction, including materials, equipment and labor.

The MHC would need $378,765 per year to provide the additional medical staff and non-personnel funding needed at the walk-in center. This would include around-the-clock nursing coverage, weekend psychiatric provider coverage, and additional medical supplies. If MHC employs officers from Metro Police Department's Secondary Employment Unit, the yearly cost would be $350,400 (based on hourly cost of $40). Coverage in the NGH –ED with Crisis Counselor 24/7 to provide assessments and complete 6404 paperwork and associated costs is $264,605. MHC would be able to provide the estimated $22,000 cost for the build-out of the existing walk-in center location as an in-kind contribution. Current funding supporting Davidson County for MHC Mobile crisis and walk in center services is $4,384,856. This funding is from the state Department of Mental Health and Substance Abuse Services and the state TennCare Managed Care Organizations. This includes funding to operate adult mobile crisis services and children and youth crisis services for Davidson County.

Total new funding: $993,770
Total In-Kind and funding from other sources: $4,384,856

MPHD would need $193,945 in year 1, with salary increases and funding for non-personnel costs in subsequent years to support the staffing for the Mental Health Planning and Prevention Components and associated non-personnel costs.

It is anticipated that additional funding will be requested in future years based on the recommendations of the Mental Health Workgroup's long term planning.

12. If applicable, briefly describe how your proposed project will achieve cost savings, revenue gains and/or service improvements? Please provide detailed financial data in the attached spreadsheet.

Enhancing Nashville's existing 24/7 Mental Health Urgent Care hubs at NHG and the MHC will more effectively meet the needs of patients with mental health emergencies who are being seen on either primarily a voluntary basis at the Mental Health Cooperative or primarily involuntary basis at NGH-ED. The needs of both of these patient groups will be more effectively served because they will be receiving a comprehensive, timely set of services tailored to their similar but unique needs. Having both medical and mental health treatment readily available in both facilities with appropriate levels of security and reducing structural delays to needed services will increase capacity for patients to be treated in the least restrictive and most cost effective environment.

NGH would realize an annual net savings in RN salary of $ 137,804.76 by repurposing these positions as Mental Health Technicians. To staff the Behavioral Health Unit NGH would need to facilitate the hiring and recruiting of 8.4 FTE's for Mental Health Technicians (MHT). The median salary for MHT's according to the Bureau of Labor Statistics is $14.97 per hour; resulting in annual salary expense of $261,555.84.The number of Nurse FTE's NGH would be able to repurpose with the implementation of the Behavioral Health Unit is 6.0 RN FTE's at $399,360.00 annual salary expense. This repurposing will result in annual net savings in RN salary of $ 137,804.76. With proposal for MHC t to provide an on-site 24/7Crisis Counselor, NGH would still need 2.4 RN FTE's to support this unit (to provide medications and patient care as needed). Additional NGH cost savings would be realized due to the decreased the level of care required for this patient population in the emergency department. There should also be a reduction of Metro Police officer's utilization in the Emergency Department.

The Community Mental Health Planning Group will develop infrastructure and system improvements designed by those who know it best, stakeholders that cross government, health care and nonprofit sectors and includes the mental health consumer perspective. This can lead to reduced incarceration, more efficient use of resources and improved mental health and health outcomes as individuals are receiving the appropriate service at the appropriate

time and receive the community supports that are currently lacking.

The Prevention component will interface with existing ACE initiatives and coordinate Metro's strategies for preventing and responding to ACEs.

13. How will success be measured and in what years of the project will it become measurable?

Year 1: Increase in number of individuals who are receiving services in walk-in center. Reduction in volume of higher cost services like local emergency rooms. Decrease in MNPD officer hours dedicated to supervising individuals who are waiting on a psychiatric placement.

Years 2 and 3: Decrease in number of mentally ill misdemeanants who are in DCSO Custody. NGH will see decreased average Length of Stay (LOS) patients with Metro Police mode of arrival and decreased average LOS of patients with psychiatric symptoms/chief complaints (current average nearly 15 hours)

14. How many citizens will this project impact?

MHC estimates this plan would result in a minimum of 25% increase in the number of walk-in assessments at the walk-in center. Based on 2015 figures this would result in approximately 2,820 individuals served in a year.

The number of individuals impacted at NGH is to be determined as a new service structure is being implemented.

15. What benefits or improved services will the citizens of Davidson County receive as a result of the plan?

Davidson County community would benefit from this service in multiple ways.

- Increase awareness of and access to emergency psychiatric services, especially for uninsured.
- More comprehensive services will be available on-site at the walk-in center.
- More efficient use of MNPD resources and fewer barriers to pre-arrest diversion.
- An organized framework for a mental health service system will be built, allowing informed decision making regarding community needs, capacity and resource allocation.
- Increase awareness of ACEs and the value of prevention strategies versus sole focus on intervention strategies.

Public Investment Plan (PIP)

Name of Collaboration: Mental Health

		FY2017			FY2018			FY2019			FY17-FY19 GRAND TOTALS		
	Dept. Name	Operating PIP	FTE PIP TOTAL	Capital PIP TOTAL	Operating PIP	FTE PIP TOTAL	Capital PIP TOTAL	Operating PIP	FTE PIP TOTAL	Capital PIP TOTAL	Operating PIP	FTE PIP TOTAL	Capital PIP TOTAL
Department/External Partner A:	Public Health	193,945	2.00	-	199,763	2.00	-	199,938	2.00	-	593,646		-
Department/External Partner B:	Nashville General H	-	-	400,000	-	-	-	-	-	-	-		400,000
Department/External Partner C:	Mental Health Coop	993,770	9.33	-	1,019,505	9.33	-	1,020,520	9.33	-	3,033,795		-
Department/External Partner D:		-	-	-	-	-	-	-	-	-	-		-
Totals:		**1,187,715**	**11.33**	**400,000**	**1,219,268**	**11.33**	**-**	**1,220,458**	**11.33**	**-**	**3,627,441**		**400,000**

Current Level of Funding (Operating and Capital)

	Dept. Name	Fund	Budget Category	Budgeted Positions/ FTE	Budgeted FTEs	Operating Amount	Capital Budget	Capital Resolution Number
Department/External Partner A:	Public Health	10101						
Department/External Partner B:	Nashville General Hospital							
Department/External Partner C:	**Mental Health Coop**					4,384,856		
Department/External Partner D:								
Totals:				**0**	**-**	**4,384,856**	**-**	

Requested Level of Funding For Fiscal Year 2017 (Operating and Capital)

	Dept. Name	Fund	Budget Category	Requested Positions	Requested FTEs	Operating Funding Request	Capital Funding Request	
Department/External Partner A:	Public Health	10101	Salaries/Benefit/Supplies/ Travel	2	2.00	193,945	-	
Department/External Partner B:	Nashville General Hospital						400,000	
Department/External Partner C:	**Mental Health Coop**		Salaries/Benefits/Supplies	9	9.33	993,770	-	
Department/External Partner D:								
Totals:				**11**	**11.33**	**1,187,715**	**400,000**	

Requested Level of Funding For Fiscal Year 2018 (Operating and Capital)

	Dept. Name	Fund	Budget Category	Requested Positions	Requested FTEs	Operating Funding Request	Capital Funding Request	
Department/External Partner A:	Public Health	10101	Salary increases	2	2.00	199,763	-	
Department/External Partner B:	Nashville General Hospital			0	-	-		
Department/External Partner C:	**Mental Health Coop**		Salary increases	9	9.33	1,019,505		
Department/External Partner D:								
Totals:				**11**	**11.33**	**1,219,268**	**-**	

Requested Level of Funding For Fiscal Year 2019 (Operating and Capital)

	Dept. Name	Fund	Budget Category	Requested Positions	Requested FTEs	Operating Funding Request	Capital Funding Request	
Department/External Partner A:	Public Health	10101	Salary increases	2	2.00	199,938		
Department/External Partner B:	Nashville General Hospital			0	-	-		
Department/External Partner C:	**Mental Health Coop**		Salary increases	9	9.33	1,020,520	-	
Department/External Partner D:								
Totals:				**11**	**11.33**	**1,220,458**	**-**	

Potential Revenue Generated from Collaboration

	Dept. Name	Fund	Revenue Category(OA)	Revenue Source	Revenue Amount	Fiscal Year Collected
Department/External Partner A:	Public Health	10101	0	0	-	0
Department/External Partner B:	Nashville General Hospital					
Department/External Partner C:	**Mental Health Coop**					
Department/External Partner D:						
Totals:					**-**	