SAMHSA
Substance Abuse and Mental Health Services Administration

Expert Panel on

Comprehensive Community Crisis Services: Structure and Standards

Substance Abuse and Mental Health Services Administration
July 9-10, 2018

The Southern Arizona Crisis System

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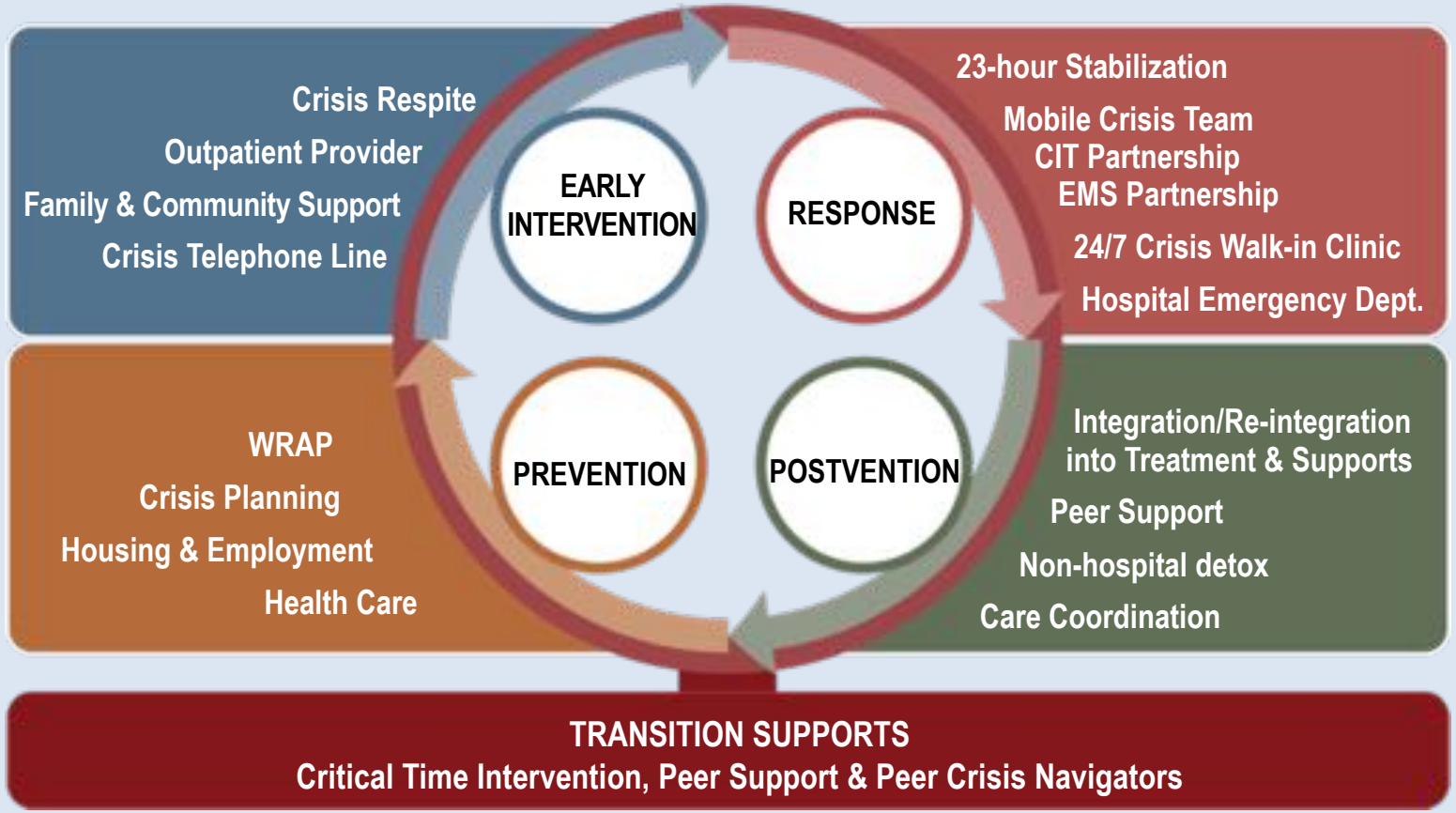
SYSTEM
vs. Services

A crisis system is **more than a collection of services**.

Crisis services must all **work together** as a coordinated system to achieve **common goals**.

And be **more than the sum of its parts**.

A crisis system needs a robust **continuum of services** to meet the needs of people in various stages of crisis.



Adapted from: Richard McKeon (Chief, Suicide Prevention Branch, SAMHSA). Supercharge Crisis Services, National Council for Behavioral Health Annual Conference, 2015.

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3 Key Ingredients for a SYSTEM

Accountability

- Who is *responsible* for the system?
- Governance and financing structure
- System values and outcomes
- Holding providers accountable

Collaboration

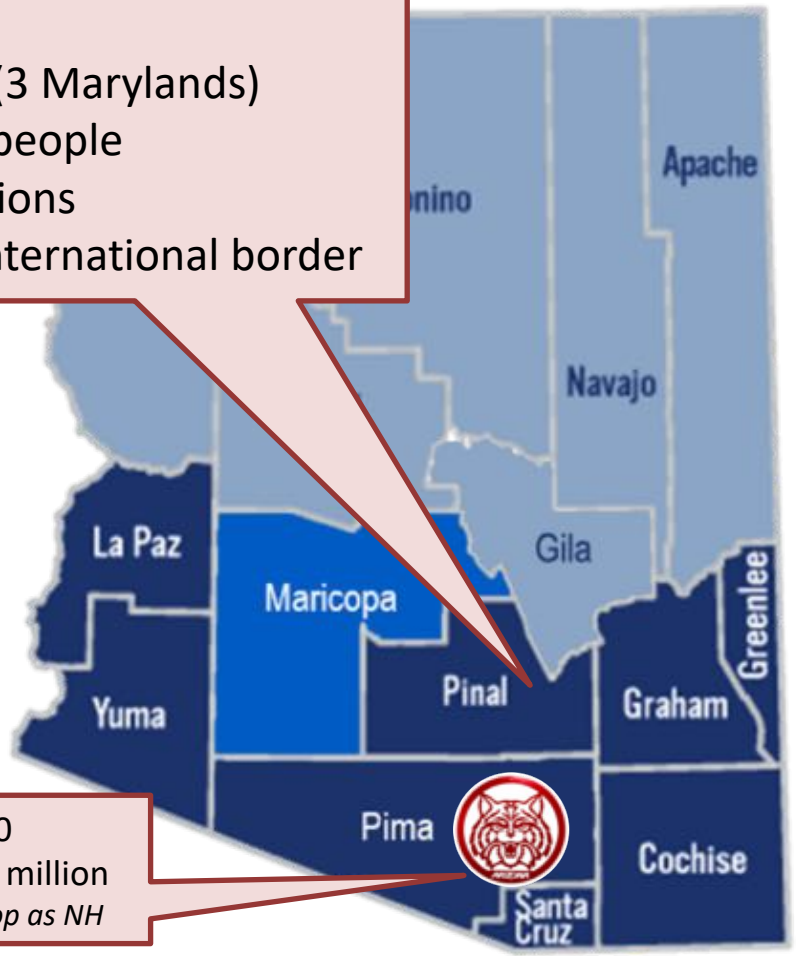
- Broad inclusion of potential customers, partners, & stakeholders
- Alignment of operational processes & training towards common goals
- Culture of communication & problem solving

Data

- Are we achieving desired outcomes?
- Performance targets & financial incentives
- Continuous quality improvement
- Data driven decision making

Arizona Behavioral Health System Structure

Southern Arizona Region:
8 counties
38,542 mi^2 (3 Marylands)
1.8 million people
6 Tribal Nations
378 mi of international border



Tucson: 530,000
Pima County: 1 million
Similar size and pop as NH

AZ Medicaid

AHCCCS
Arizona Health Care Cost Containment System

Other state funds

Regional Behavioral Health Authorities (RBHAs)

Health Net
CENPATICO INTEGRATED CARE
arizona complete health
Starting October 1, 2018

Counties

Hospitals, Crisis Facilities, Clinics, etc.

The **financing & governance** structure supports **accountability & oversight** of the crisis system.

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What this means for the crisis system

- Centralized **planning**
- Centralized **accountability**
- **Alignment** of clinical & financial goals

Regional Behavioral Health Authority

Performance metrics and payment systems that **promote common goals**

Decrease	**Increase**
• ED & hospital use • Justice involvement	• Community stabilization • Engagement in care

These goals represent <u>both</u>
good clinical care & fiscal responsibility.

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Example of strategic service design

State says: Reduce criminal justice costs for people with SMI.

AHCCCS contracts with regional Medicaid MCOs/RBHAs and includes requirements targeted at reducing criminal justice involvement.

RBHA (which is at risk) uses contract requirements/VBP to incentivize subcontracted providers to implement services and processes targeted at reducing justice involvement.

Targeted Services and Processes:
Law Enforcement as a "preferred customer"

CRISIS LINE
- Some 911 calls are warm-transferred to the crisis line
- Dedicated LE number goes directly to a supervisor

MOBILE TEAMS
- **30 minute response time** for LE calls (vs. 60 min routine)
- Some teams assigned as **co-responders** (cop + clinician)

CRISIS CENTERS
- **24/7** crisis facility
- **Quick & easy drop-off** for law enforcement
- **No wrong door** – LE is never turned away

911: WHAT'S YOUR EMERGENCY?

"I'm having chest pain."

"I'm suicidal."

Law Enforcement's Contribution

Training for first responders

- 100% MHFA training
- 80% *voluntary* CIT training
- With support from RBHA and community stakeholders (NAMI, providers, etc.)

A unique, specialized Mental Health Support Team (MHST)

- Select group 12 officers and detectives
- Dedicated to mental health
- Focus on high risk individuals
- Preventing people from falling through the cracks

Collaborative Processes

- 911 calls transferred to crisis line
- Co-responder teams: cop + clinician
- Investment in building relationships

7

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Centralized Crisis Line + Mobile Teams

LEAST Restrictive
LEAST Costly

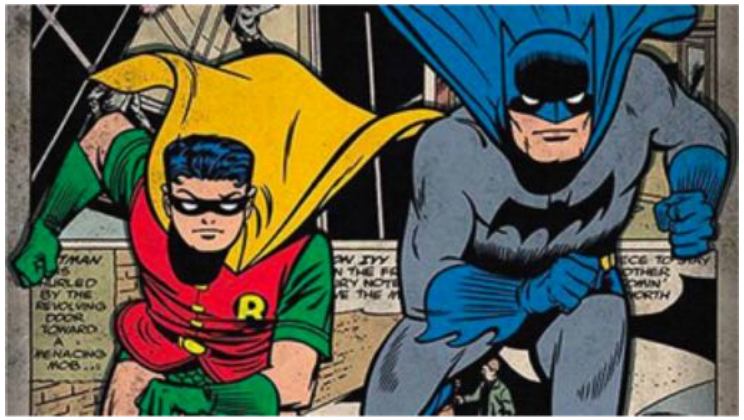
Person in crisis

911 EMERGENCY

Crisis Line

80% resolved on the phone

Mobile Teams



72% resolved in the field

Per month:

- **10,450 calls**
  - Crisis counseling
  - Care coordination
  - **550** follow-up appts scheduled

- **1,779 activations**
  - **34 minute** response time
  - **18%** law enforcement initiated
  - **12** mobile teams and co-responder teams

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Co-Responder Teams

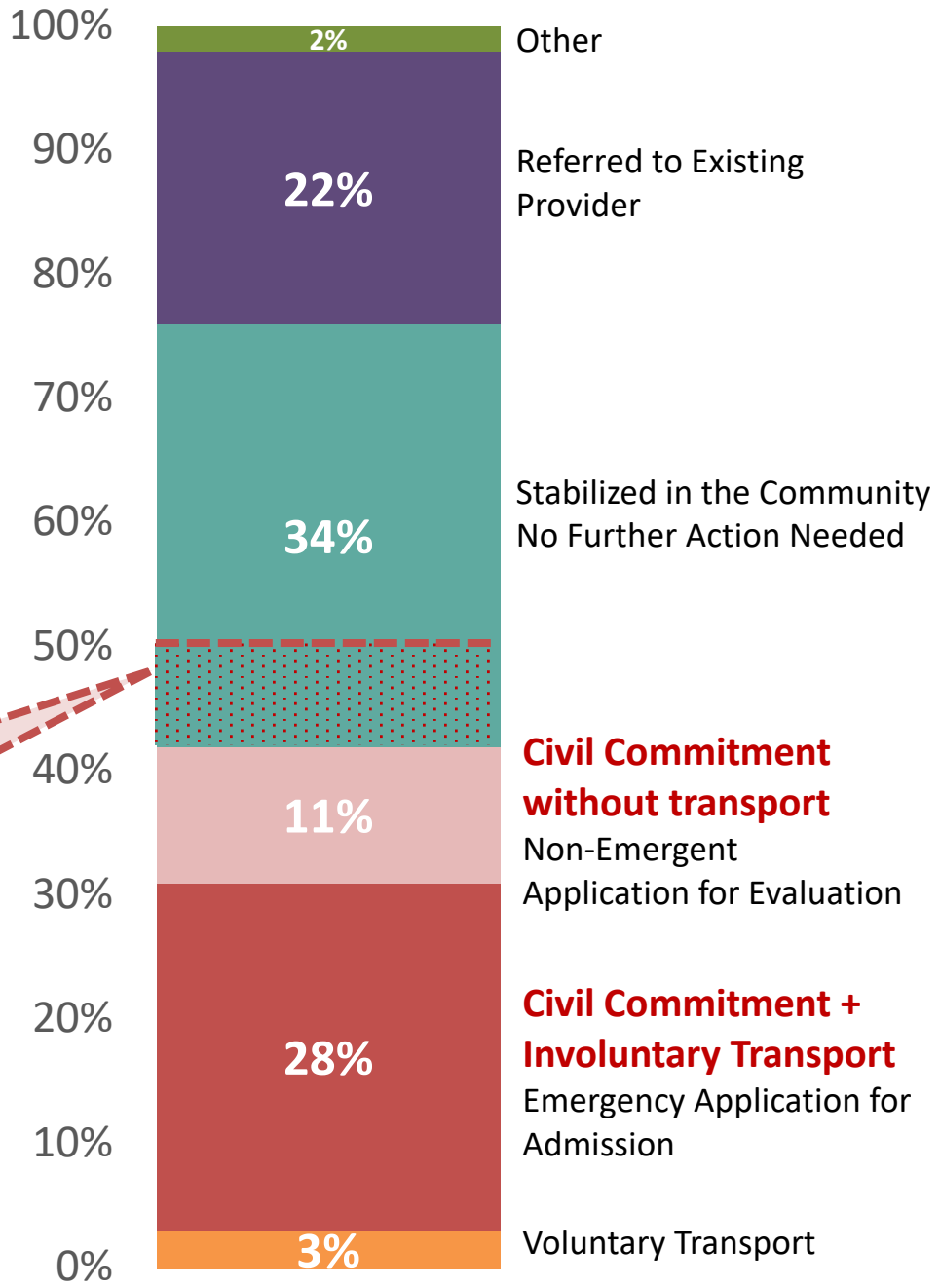
Tucson Police Department Mental Health Support Team (MHST) Detective

+ Mobile Team Clinician

- Clinician helps police respond to cases with mental health nexus
- Officer helps clinicians respond to higher-acuity calls

RESULT: More people get their needs met in the least restrictive setting.

Prior to the co-responder model, over 50% of MHST Detectives cases resulted in civil commitment and/or transport to a facility.



Feb-Apr 2018. Courtesy Johnnie Gaspar, Cenpatico

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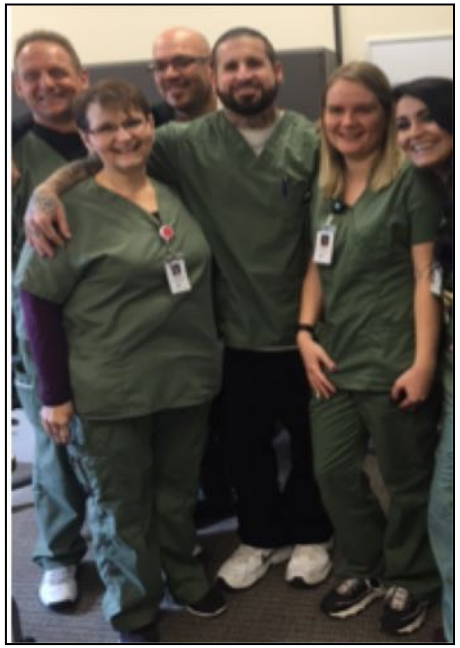
The Crisis Response Center

- Built with Pima County bond funds in 2011
  - Alternative to jail, ED, hospitals
  - Services financed by the RBHA
  - 12,000 adults + 2,400 youth per year
- **Law enforcement receiving center with NO WRONG DOOR**
  (no exclusions for acuity, agitation, intoxication, payer, etc.)
- 24/7 urgent care, 23-hour observation, short-term inpatient
- 24/7 staffing with MDs, Nurses, Techs, Peers, Social Work
- Space for co-located community programs
  - Including peer-run post-crisis wraparound program
- Adjacent to
  - Banner University Emergency Department (Level 2 Trauma Center)
  - Crisis call center
  - Inpatient psych hospital for civil commitments
  - Mental health court

Crisis Response Center in Tucson, AZ
ConnectionsAZ/Banner University Medical Center

23-Hour Observation Unit

- Staffed 24/7 with MDs, NPs, PAs
- Medical necessity criteria similar to that of inpatient psych (danger to self/other, etc.)
- Diversion from inpatient:
  - **60-70% discharged to the community the following day**
  - Early intervention
    - Median door to doc time is ~90 min
  - Interdisciplinary team
    - Including peers with lived experience
  - Aggressive discharge planning
  - Collaboration and coordination with community & family partners
  - Assumption that the crisis can be resolved



Peers with lived experience are an important part of the interdisciplinary team.

"I came in 100% sure I was going to kill myself but now after group I'm hopeful that it will change. Thank you RSS members!"

The Crisis Response Center

"We address any behavioral health need at any time."

- Referrals from:
  - Law enforcement
  - Crisis Mobile Teams
  - Walk-ins
  - Transfers from EDs
  - Foster Care
- Studies show this model:
  - Critical for pre-arrest diversion[2]
  - Reduces ED boarding[3,4]
  - Reduces hospitalization[3,4]

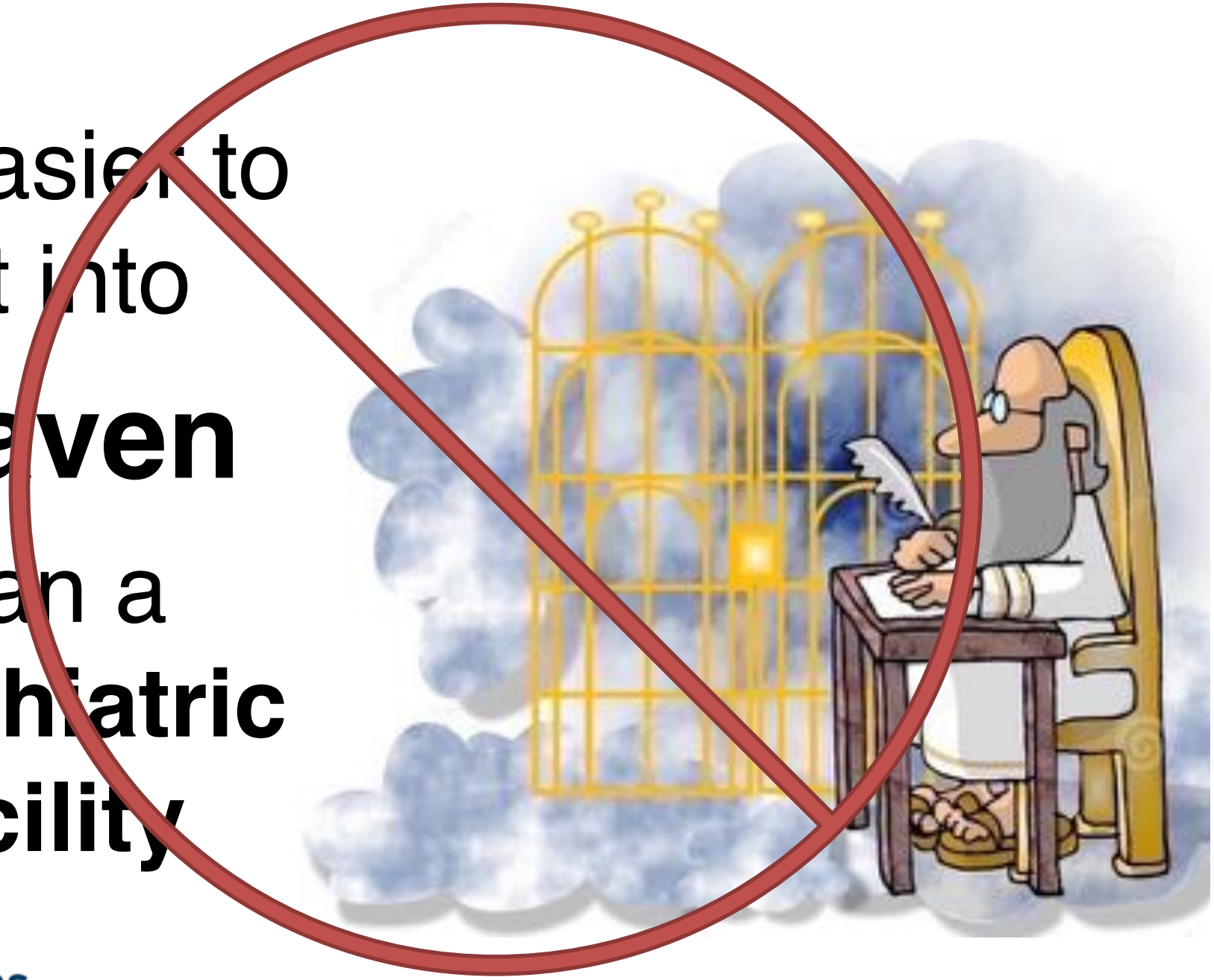
These 2 are the hardest to do well

CIT Recommendations for Mental Health Receiving Facilities[1]

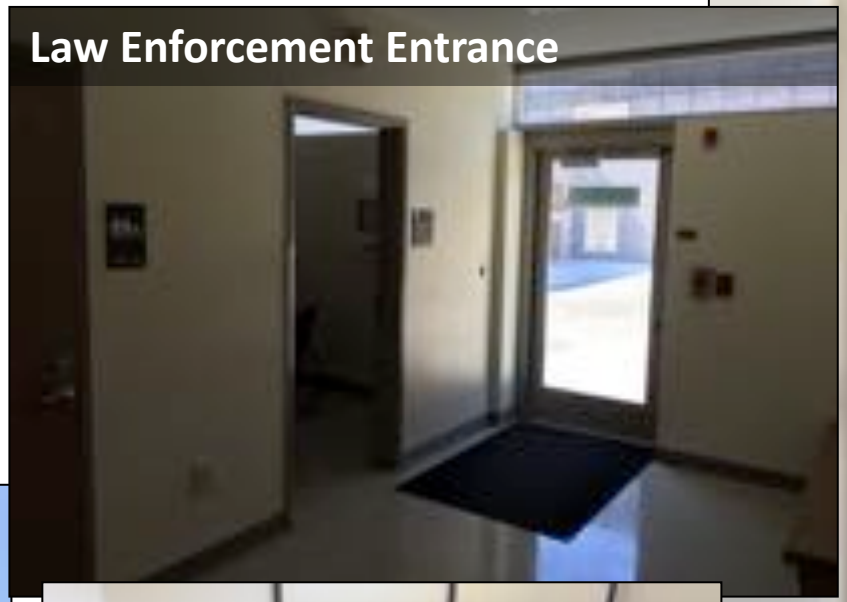
1. Single Source of Entry
2. On Demand Access 24/7
3. **No Clinical Barriers to Care**
4. **Minimal Law Enforcement Turnaround Time**
5. Access to Wide Range of Disposition Options
6. Community Interface: Feedback and Problem Solving Capacity

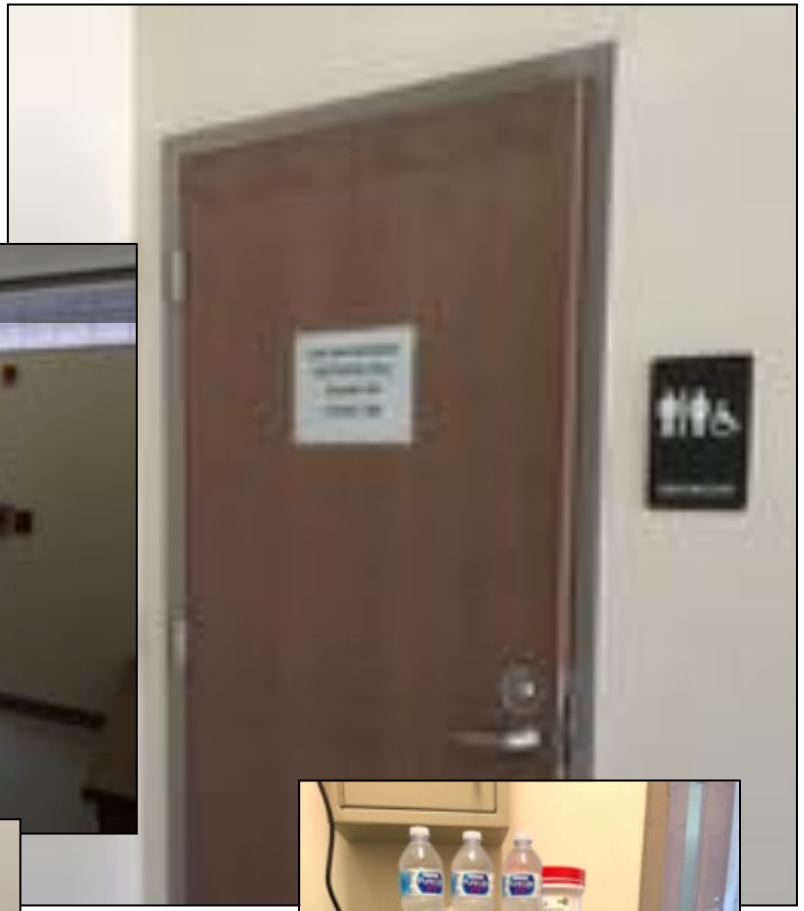
1. Dupont R et al. (2007). Crisis Intervention Team Core Elements. The University of Memphis School of Urban Affairs and Public Policy
2. Steadman HJ et al (2001). A specialized crisis response site as a core element of police-based diversion programs. Psychiatr Serv 52:219-22
3. Little-Upah P et al. (2013). The Banner psychiatric center: a model for providing psychiatric crisis care to the community while easing behavioral health holds in emergency departments. Perm J 17(1): 45-49.
4. Zeller S et al. (2014). Effects of a dedicated regional psychiatric emergency service on boarding of psychiatric patients in area emergency departments. West J Emerg Med 15(1): 1-6.

It's easier to get into **heaven** than a **psychiatric facility**

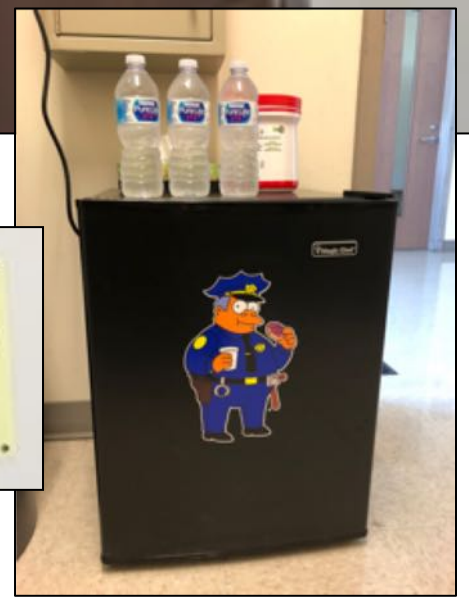


Law Enforcement is a "Preferred Customer"


Law Enforcement Entrance




Gated Sally Port
Crisis Response Center - Tucson AZ



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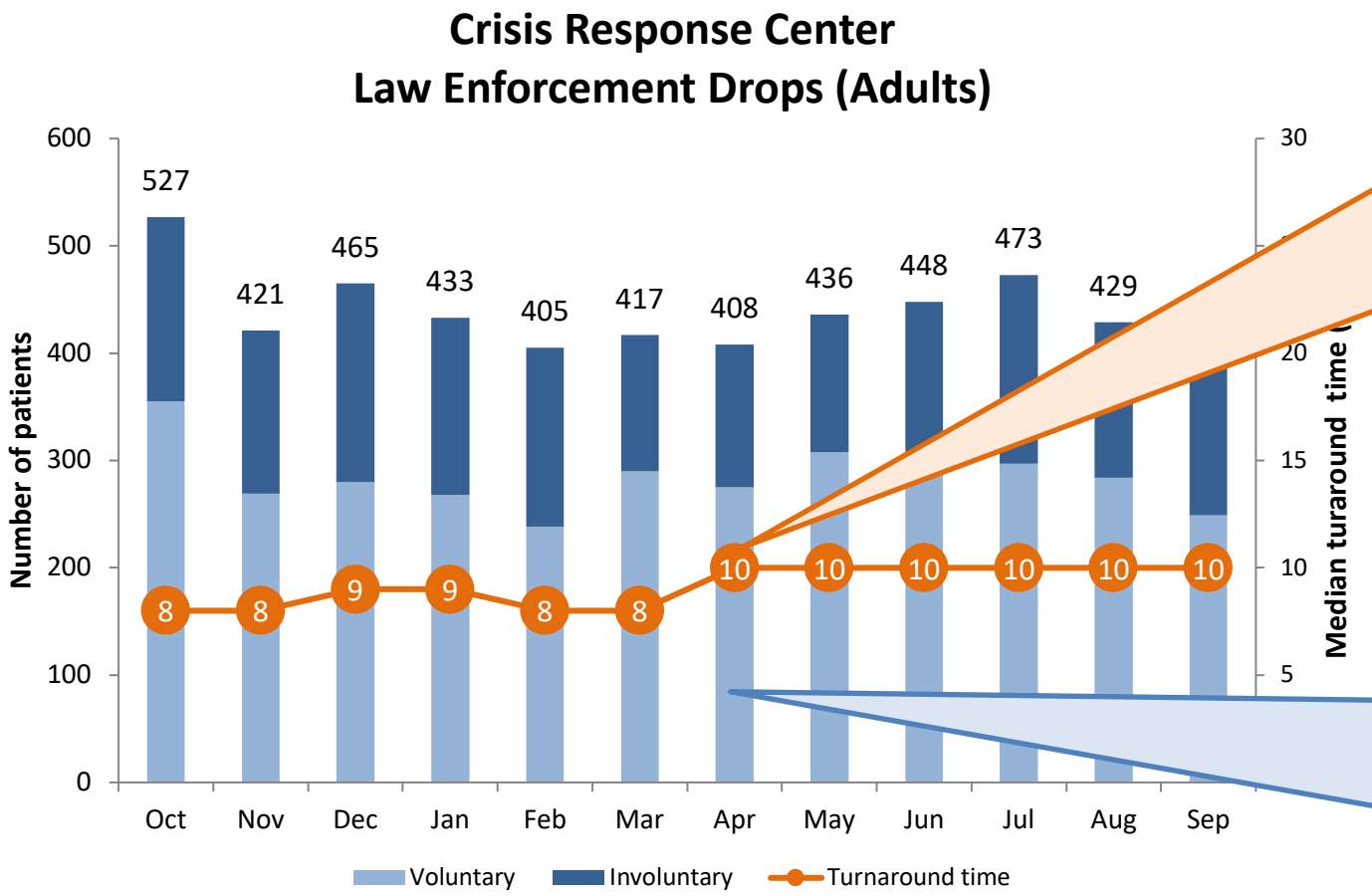
More **Law Enforcement Engagement** = More People in **Treatment Instead of Jail**

Cops are super busy and have crimes to fight. Therefore **crisis services need to be QUICK & EASY to access** so that cops prefer to drop off at crisis centers instead of taking the person to jail or the ED.

NO WRONG DOOR means never turn the cops away. If they brought the patient to the "wrong" place, we'll handle it.



It takes 20 min to book someone into jail, so we must get the cops back on the street even FASTER.

Most LE drops are VOLUNTARY, meaning that the officers are engaging people into treatment.

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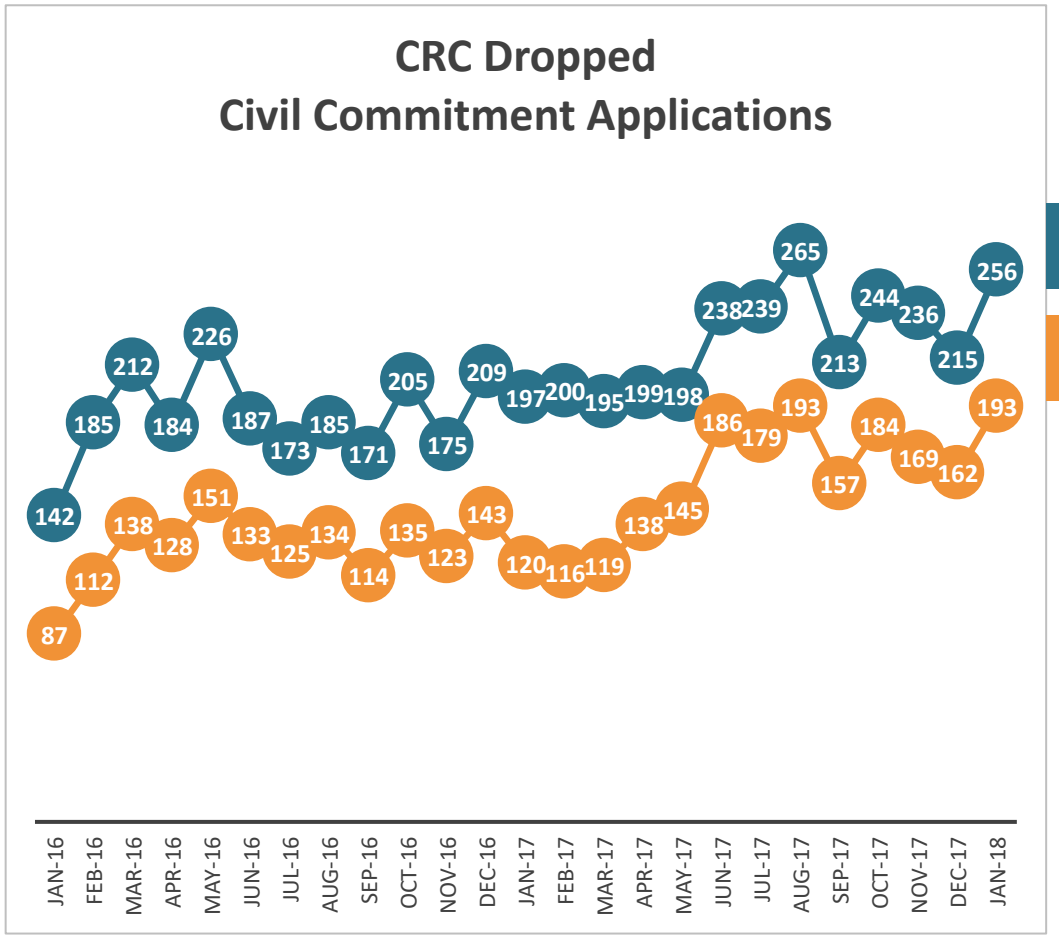
Crisis Stabilization Aims for the **Least-Restrictive** Disposition Possible

65%
Discharged to Community (Diversion from Inpatient)

- People admitted to the 23-hour observation unit who are discharged to community-based care instead of inpatient admission.
- Most can be stabilized for community dispositions with early intervention, proactive discharge planning, and collaboration with families and other community supports



70%
Converted to Voluntary Status

People under involuntary hold who are then discharged to the community or choose voluntary inpatient admission

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Many options for law enforcement to **divert people to treatment instead of jail** all with a culture of **NO WRONG DOOR**

Crisis Hotline
- Info, care coordination
- Direct line for LE
- Some co-located at 911

NurseWise

Law Enforcement Training
- Supported by RBHA & multiple community partners
- Tucson PD and Pima Co Sheriff are 100% MHFA & 80% CIT trained

Mental Health First Aid USA

International CIT Crisis Intervention Team

Crisis Response Center
- 24/7 Crisis Center for Adults and Youth
- <10 minute LE drop-off time
- Law enforcement never turned away
- Adjacent to ED, Court, Inpatient psych
- Clinic, 23 hour obs, initiation of Opiate MAT

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Banner University Medical Center

PIMA COUNTY

Mobile Crisis Teams
- Masters level clinicians
- On-site crisis intervention
- 30-min response time for LE

Community Health Associates

CBI Community Bridges, Inc.

Co-Responder Teams
- MHST Detective
- Mobile Team Clinician

MHFA or CIT trained officer/deputy

Access Point
- 24/7 Detox/Crisis for Voluntary Adults
- <10 minute LE drop-off time
- Transitions to substance use tx/MAT

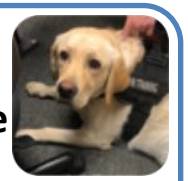
CBI Community Bridges, Inc.

Regional Behavioral Health Authority
- First Responder Liaisons
- Responsible for the network of programs and clinics

CENPATICO INTEGRATED CARE

Mental Health Support Teams (MHST)
- In addition to CIT
- Unique specialized team specializing in civil commitment, challenging cases, and follow-up
- Officers/Deputies & Detectives

Crisis Response Canine



"LEO"

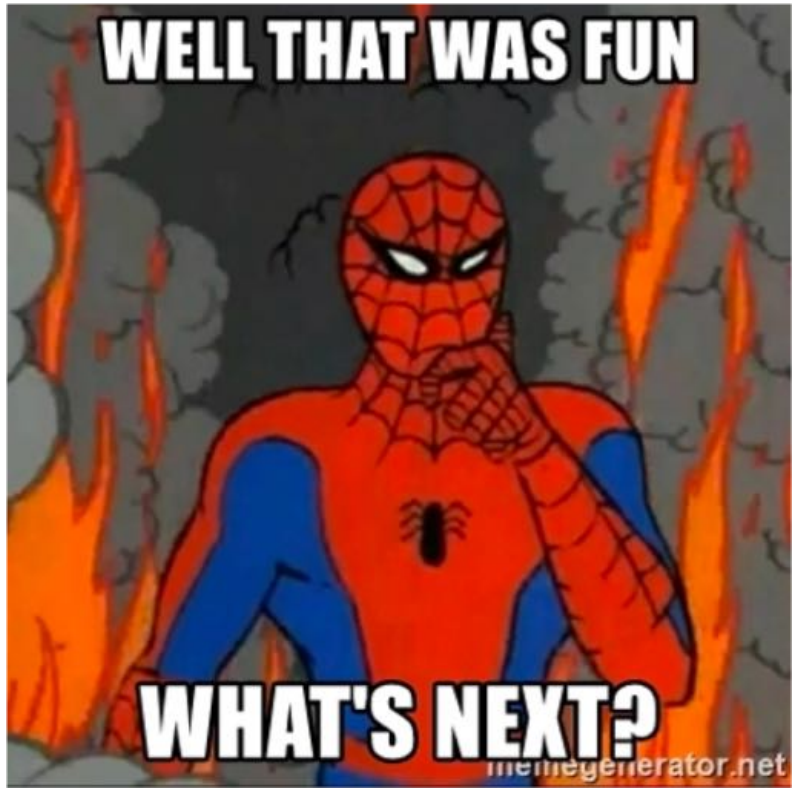
BH Services at the Jail
- Instant data exchange with MH history
- Risk screening
- Diversion programs, specialty courts, etc.

HOPE Incorporated

PIMA COUNTY

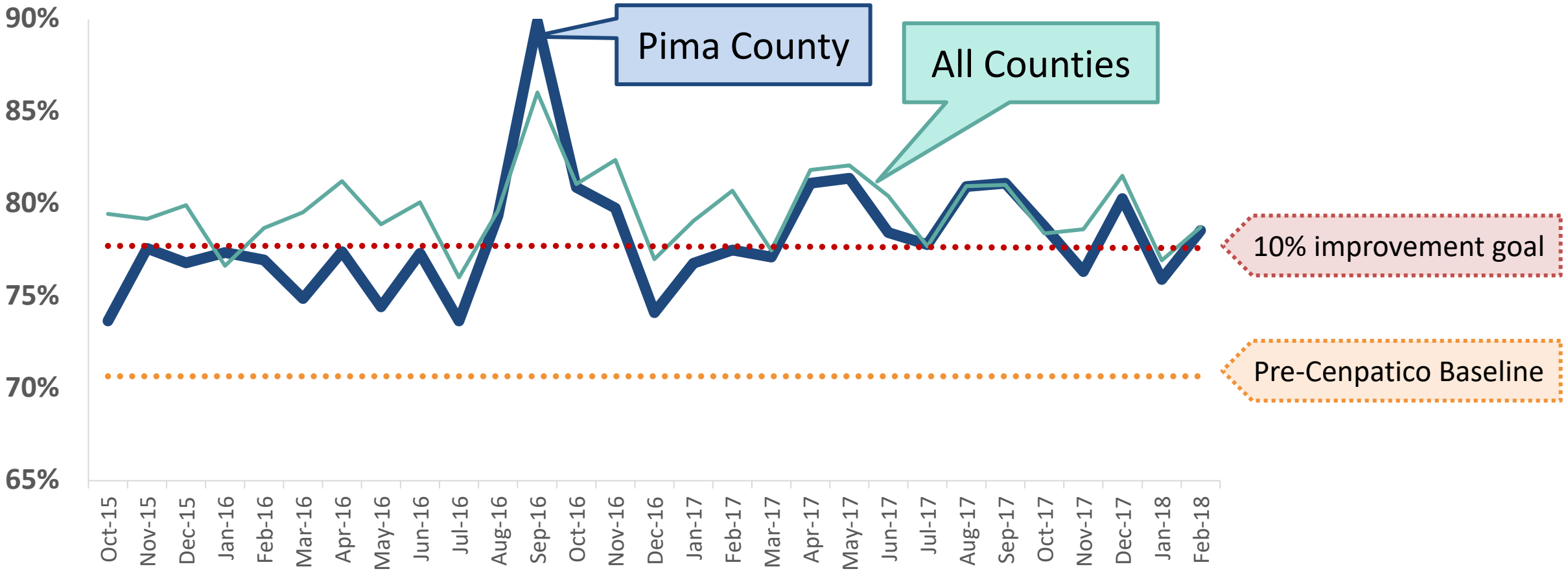
After the crisis…

- **Step-down programs**
  - Crisis Residential
    (in AZ called “Level 2” or “Brief Intervention Programs”)
  - Residential/outpatient substance use treatment
- **Post-crisis follow-up**
  - “Second Responders” including:
    - 45 days post-crisis peer services: peer support, transportation to appointments, picking up meds, getting benefits, etc.
    - Assistance with housing, children’s services, etc.
  - Follow-up phone calls and welfare checks
- **Outpatient services**
  - Behavioral health homes and specialty providers
- **Special plans** for “familiar faces” (high utilizers)



Continued Stabilization

Percent of Mobile Team Encounters with NO Inpatient Admission After 45 Days



Courtesy Johnnie Gaspar, Cenpatico

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Continuous Improvement via **collaboration and data sharing**

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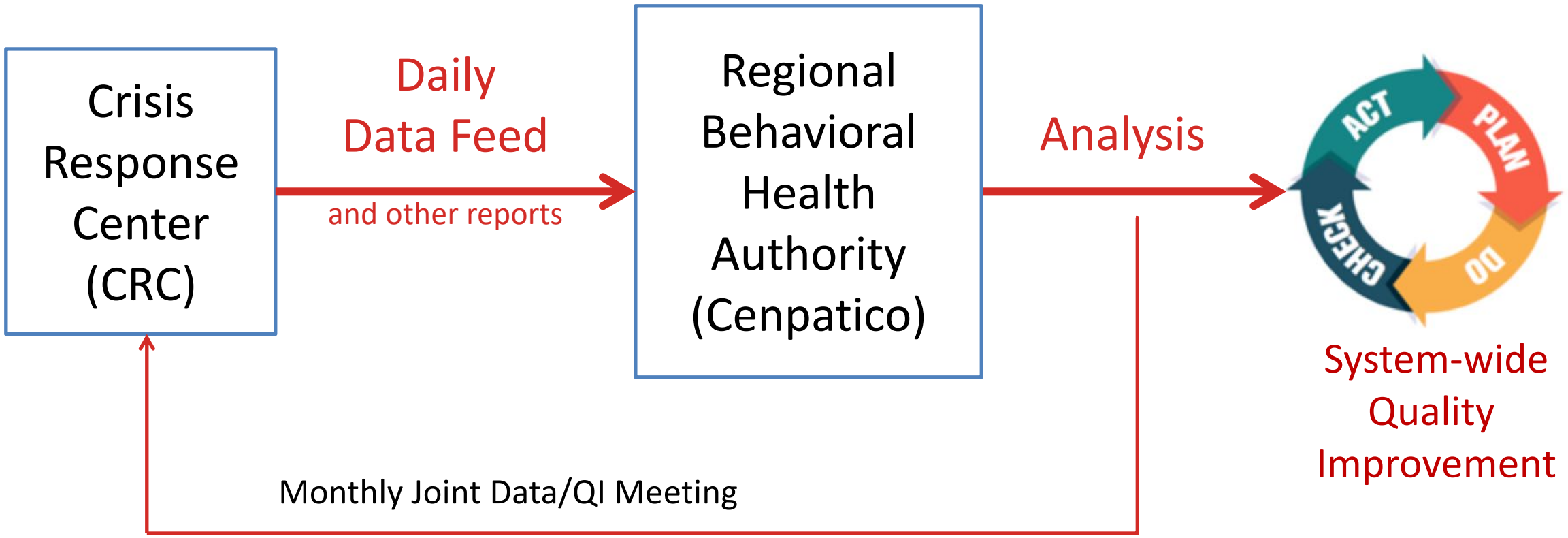
Provider + Payer Partnerships



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Balfour ME, Zinn T, Cason K, Fox J, Morales M, Berdeja C, Gray J; Provider-Payer Partnerships as an Engine for Continuous Quality Improvement; *Psychiatric Services;* 2018;69(6):623-625; https://doi.org/10.1176/appi.ps.201700533

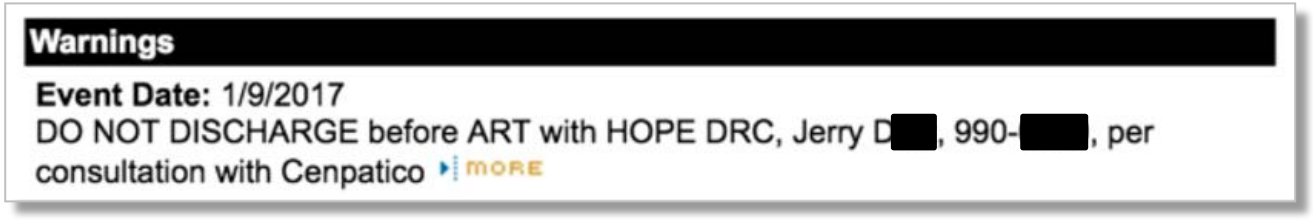
“Familiar Faces” Project

1. **DATA REPORTING:** The CRC sends a monthly rolling frequent utilizer report to Cenpatico.

Last name	First name	dob	ICC	T19 status	rbha	payer	Clinic Only	Obs	Total	Visit this month?
			LA FRONTERA	SMI T19	Cenpatico	AHCCCS only	9	10	19	Y
			LA FRONTERA	SMI T19	Cenpatico	AHCCCS only	0	4	4	Y
			COPE	SMI T19	Cenpatico	AHCCCS & Medicare	0	4	4	Y
			LA FRONTERA	SMI T19	Cenpatico	AHCCCS only	0	6	6	Y
			COPE	SMI T19	Cenpatico	AHCCCS only	1	4	5	Y

2. **MULTI-AGENCY TEAM MEETINGS** with CRC, Cenpatico, clinic staff to discuss the patient’s needs and develop improved crisis and service plans. The goal is at least 3 staffings per patient regardless of whether they are at the CRC that day.

3. **CHARTS FLAGGED** at the CRC with information about the new crisis plan and who to contact so that the new plan can be implemented.



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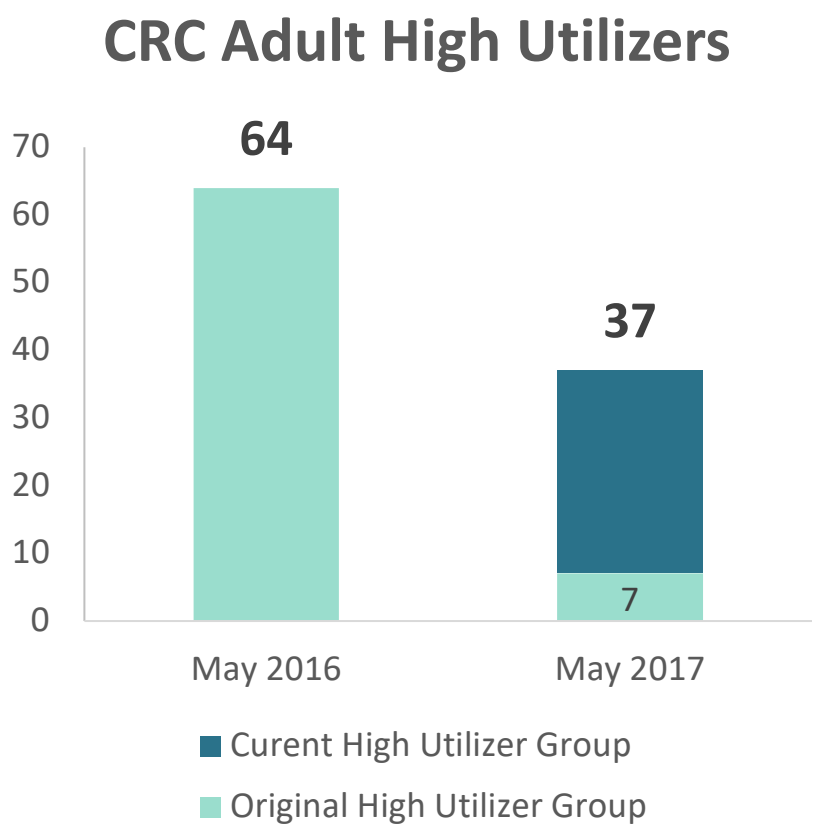
Results: Fewer "Familiar Faces"

There were 64 individuals on the original list of high utilizers. One year later, only 7 of the original 64 remain high utilizers, and only 37 meet the high utilizer definition.



Case Example: Ms. X becomes lonely during the weekend, which is a trigger for feeling overwhelmed and suicidal and coming to the CRC. She has a partner who is also enrolled in services.

Individualized Plan:

- The outpatient provider will do welfare checks on nights and weekends to help plan for boredom and other triggers that historically result in CRC visits.
- The team will explore working with her partner's team (with consent) in order to assist both in recovery together.
- The CRC will call her Peer Support Specialist immediately upon arrival to reinforce the relationship with her outpatient team and help connect her more quickly with outpatient support.

Results: CRC visits **decreased from 14** in 2016 Q1 **to only 1** during the same time frame in 2017.

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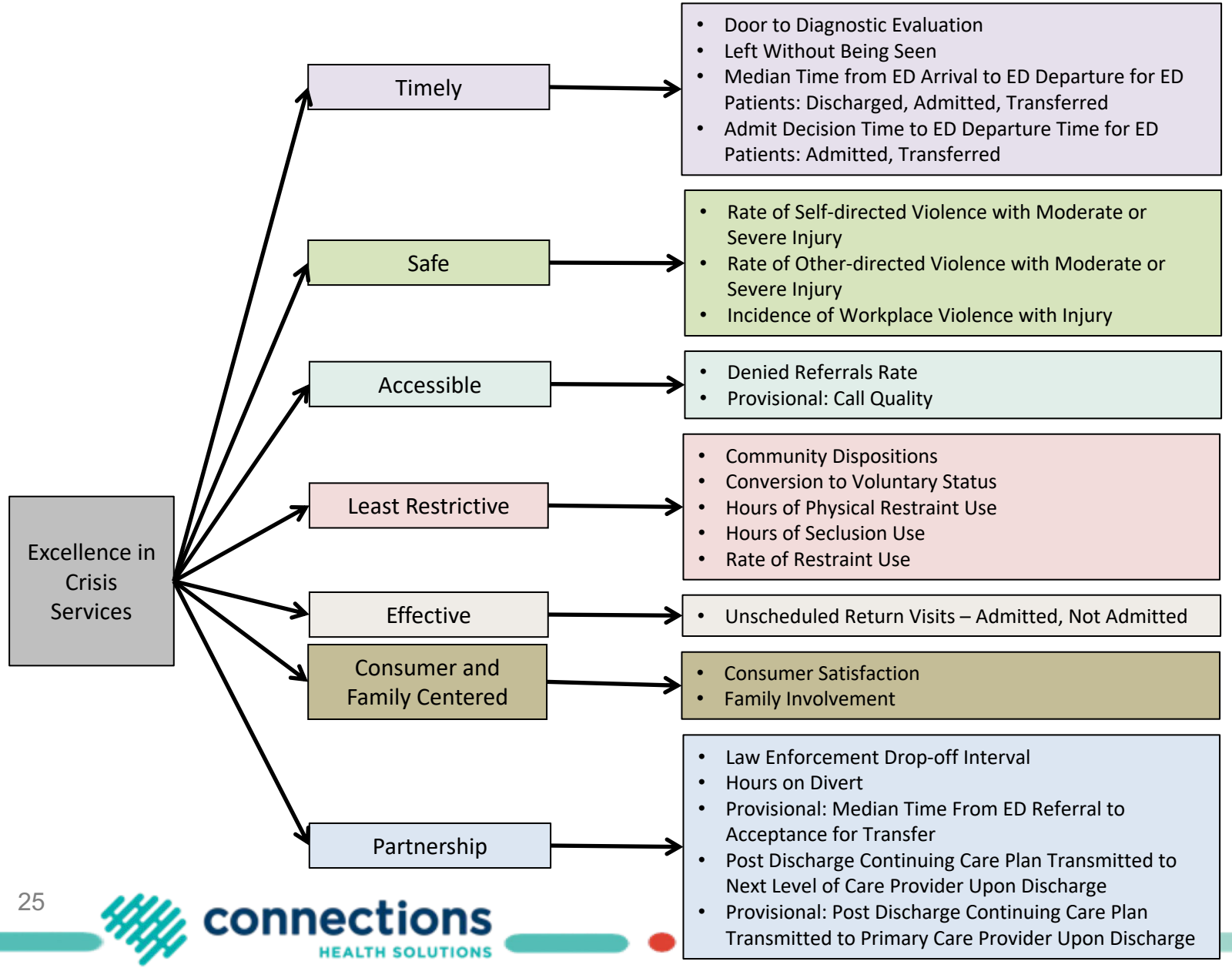
Balfour ME, Zinn T, Cason K, Fox J, Morales M, Berdeja C, Gray J; Provider-Payer Partnerships as an Engine for Continuous Quality Improvement; *Psychiatric Services;* 2018;69(6):623-625; https://doi.org/10.1176/appi.ps.201700533

Building Dashboards

Defining outcome metrics for facility-based crisis services



Because there aren't any standard outcome measures for crisis services, Connections developed a measure set for the CRC, using a Critical to Quality (CTQ) Tree.

*A **Critical-To-Quality (CTQ) Tree** is a quality improvement tool used to **translate values into discrete measures***

- *Broadly, what value are you trying to accomplish?*
- *Then what are the key attributes that make up that value, from the perspective of the customer?*
- *Then define measures that reflect each attribute*

CRISES: Crisis Reliability Indicators Supporting Emergency Services
Balfour ME, Tanner K, Jurica PS, Rhoads R, Carson C.; *Community Mental Health Journal*. 2015;52(1):1-9 .http://link.springer.com/article/10.1007/s10597-015-9954-5

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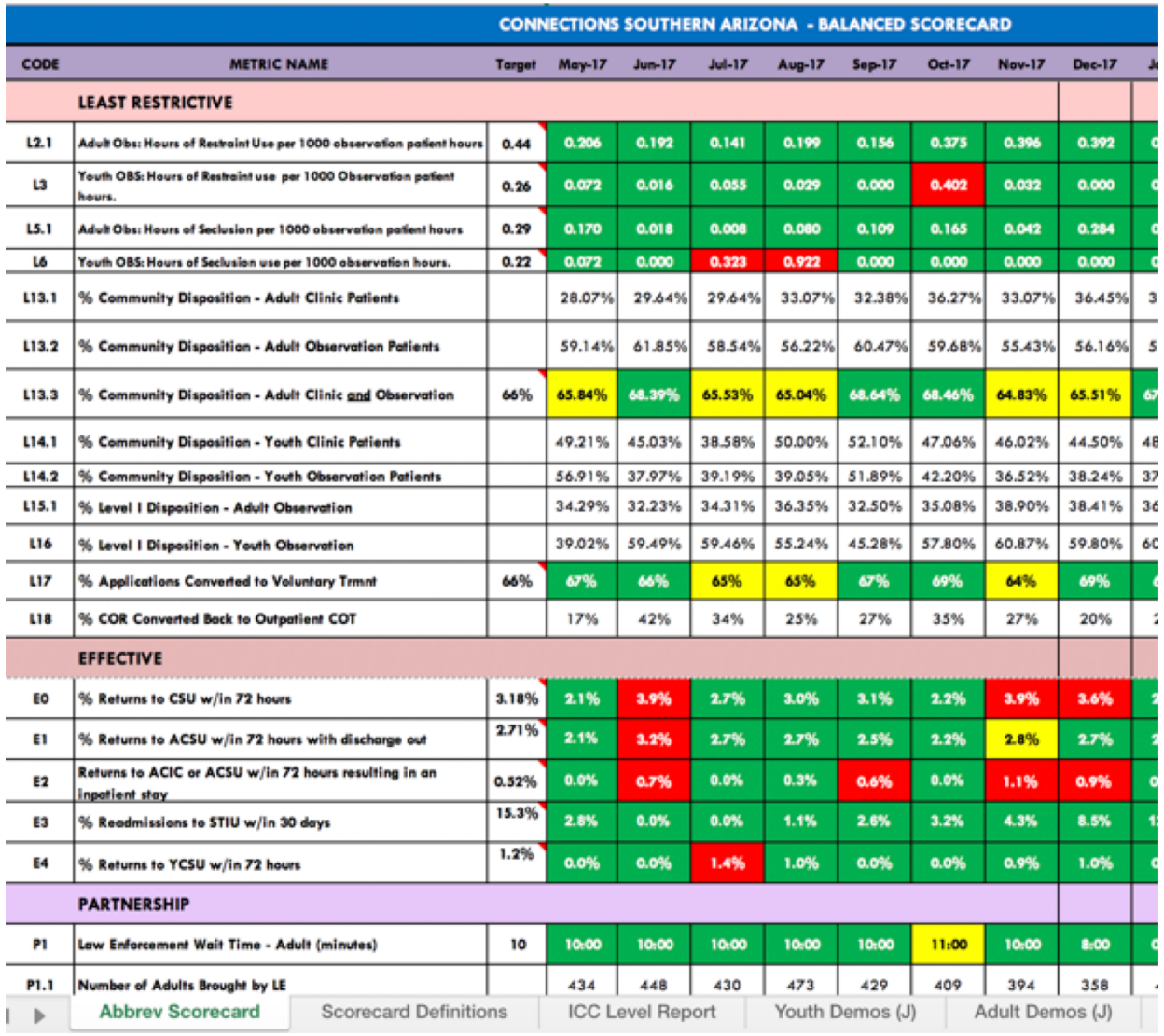
Consistent scorecards for all 24/7 crisis

The RBHA uses this as a common framework to measure outcomes across the 24/7 crisis centers in the network.

- Monthly data review:
  - Insight into volume trends
  - Bed capacity and throughput
  - Community acuity and engagement
  - Ensure accountability and proper discharge planning



CONNECTIONS SOUTHERN ARIZONA - BALANCED SCORECARD

CODE	METRIC NAME	Target	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	J
	LEAST RESTRICTIVE										
L2.1	Adult Obs: Hours of Restraint Use per 1000 observation patient hours	0.44	0.206	0.192	0.141	0.199	0.156	0.375	0.396	0.392	
L3	Youth OBS: Hours of Restraint use per 1000 Observation patient hours.	0.26	0.072	0.016	0.055	0.029	0.000	0.402	0.032	0.000	
L5.1	Adult Obs: Hours of Seclusion per 1000 observation patient hours	0.29	0.170	0.018	0.008	0.080	0.109	0.165	0.042	0.284	
L6	Youth OBS: Hours of Seclusion use per 1000 observation hours.	0.22	0.072	0.000	0.323	0.922	0.000	0.000	0.000	0.000	
L13.1	% Community Disposition - Adult Clinic Patients		28.07%	29.64%	29.64%	33.07%	32.38%	36.27%	33.07%	36.45%	3
L13.2	% Community Disposition - Adult Observation Patients		59.14%	61.85%	58.54%	56.22%	60.47%	59.68%	55.43%	56.16%	5
L13.3	% Community Disposition - Adult Clinic and Observation	66%	65.84%	68.39%	65.53%	65.04%	68.64%	68.46%	64.83%	65.51%	67
L14.1	% Community Disposition - Youth Clinic Patients		49.21%	45.03%	38.58%	50.00%	52.10%	47.06%	46.02%	44.50%	48
L14.2	% Community Disposition - Youth Observation Patients		56.91%	37.97%	39.19%	39.05%	51.89%	42.20%	36.52%	38.24%	37
L15.1	% Level I Disposition - Adult Observation		34.29%	32.23%	34.31%	36.35%	32.50%	35.08%	38.90%	38.41%	36
L16	% Level I Disposition - Youth Observation		39.02%	59.49%	59.46%	55.24%	45.28%	57.80%	60.87%	59.80%	60
L17	% Applications Converted to Voluntary Trmnt	66%	67%	66%	65%	65%	67%	69%	64%	69%	
L18	% COR Converted Back to Outpatient COT		17%	42%	34%	25%	27%	35%	27%	20%	2
	EFFECTIVE										
E0	% Returns to CSU w/in 72 hours	3.18%	2.1%	3.9%	2.7%	3.0%	3.1%	2.2%	3.9%	3.6%	
E1	% Returns to ACSU w/in 72 hours with discharge out	2.71%	2.1%	3.2%	2.7%	2.7%	2.5%	2.2%	2.8%	2.7%	
E2	Returns to ACIC or ACSU w/in 72 hours resulting in an inpatient stay	0.52%	0.0%	0.7%	0.0%	0.3%	0.6%	0.0%	1.1%	0.9%	
E3	% Readmissions to STIU w/in 30 days	15.3%	2.8%	0.0%	0.0%	1.1%	2.6%	3.2%	4.3%	8.5%	1
E4	% Returns to YCSU w/in 72 hours	1.2%	0.0%	0.0%	1.4%	1.0%	0.0%	0.0%	0.9%	1.0%	
	PARTNERSHIP										
P1	Law Enforcement Wait Time - Adult (minutes)	10	10:00	10:00	10:00	10:00	10:00	11:00	10:00	8:00	
P1.1	Number of Adults Brought by LE		434	448	430	473	429	409	394	358	

Abbrev Scorecard | Scorecard Definitions | ICC Level Report | Youth Demos (J) | Adult Demos (J)

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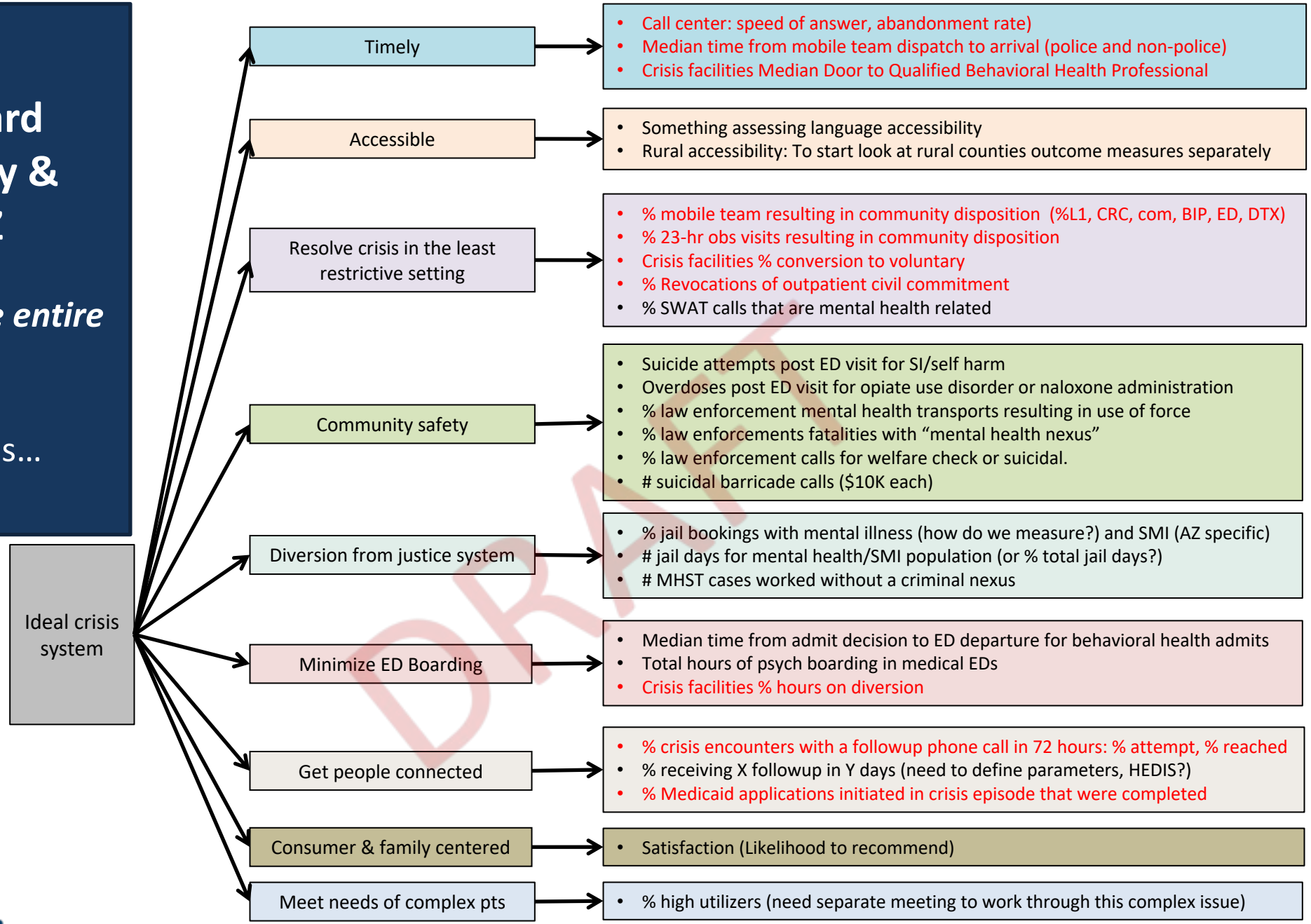
Thinking BIGGER…

SYSTEM
Crisis Dashboard for Pima County & Southern AZ

Goal is to capture the entire crisis system

A work in progress…



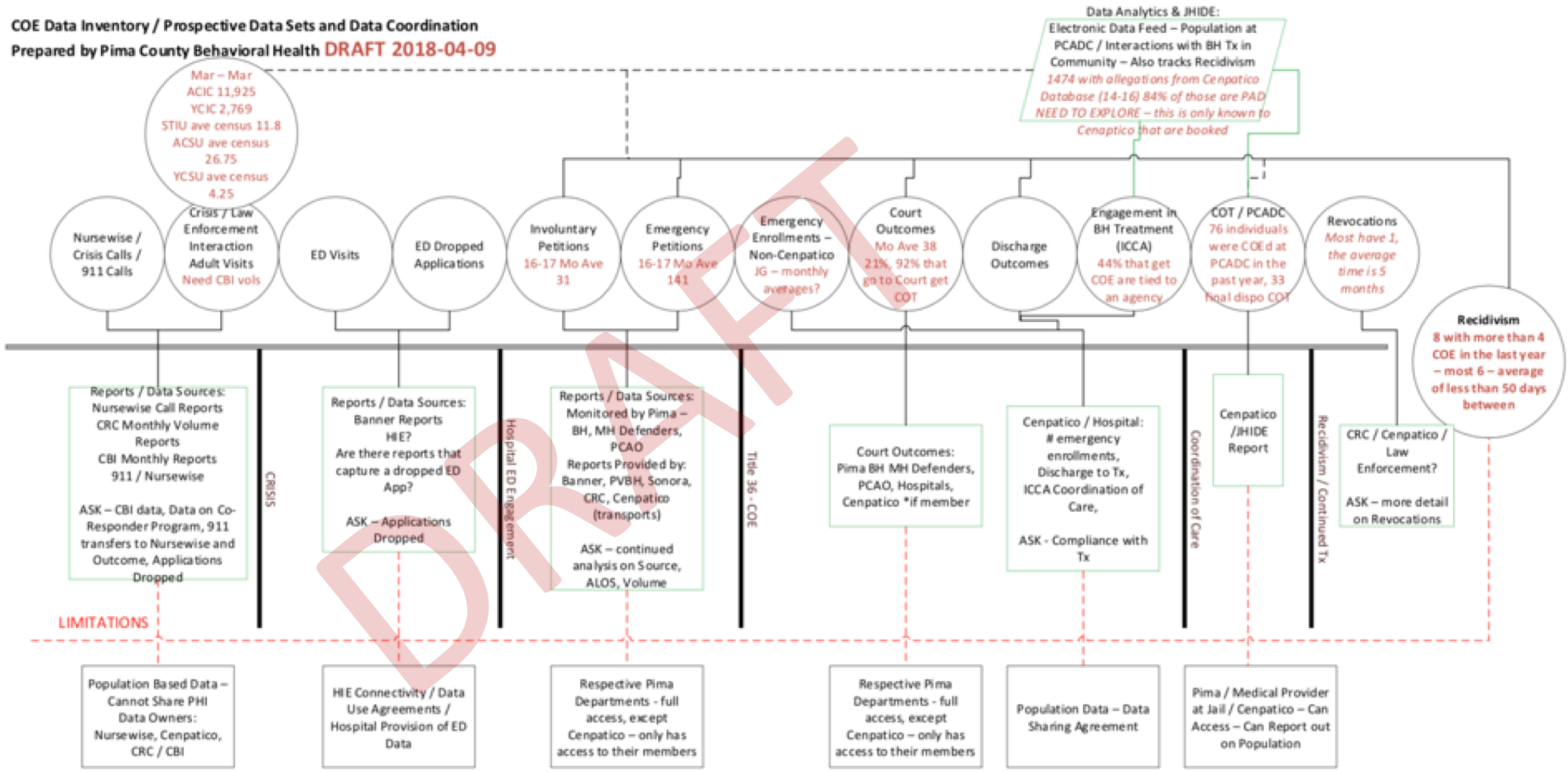
Adapted from methodology outlined in Balfour ME, Tanner K, Jurica PS, Rhoads R, Carson C. (2015) *Community Mental Health Journal*. 52(1): 1-9. http://link.springer.com/article/10.1007/s10597-015-9954-5

Pima County Title 36 (Civil Commitment) Data Map

All of the points a patient encounters along the civil commitment path.

What metrics should we be looking at and who has the data?

How can we collaborate to improve outcomes?



Courtesy Sarah Davis, Pima County

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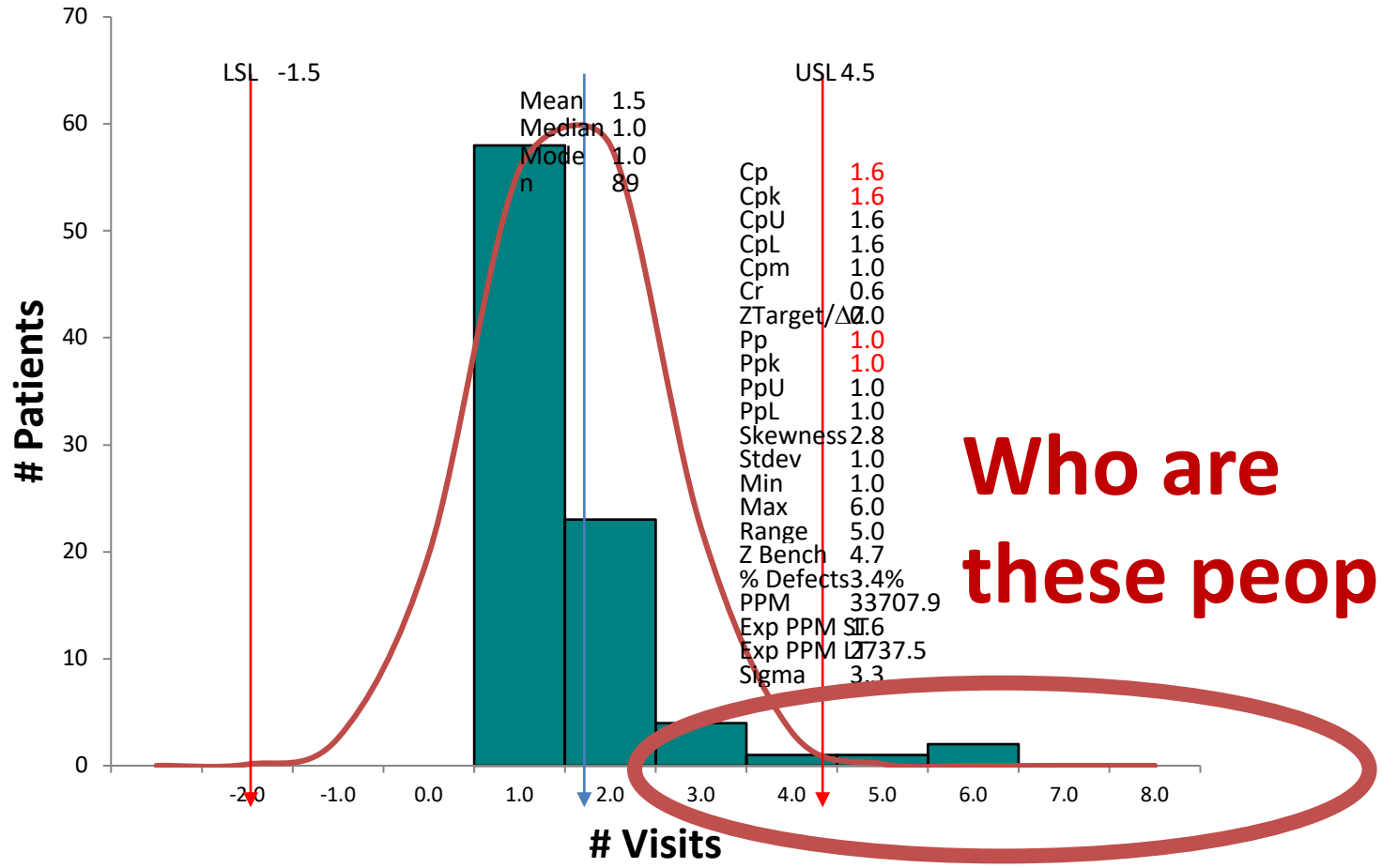
Example: Repeat Revocations to the CRC

(Patients on outpatient civil commitment who have had their outpatient status "revoked" due to non-adherence or clinical decompensation)



Who are these people?

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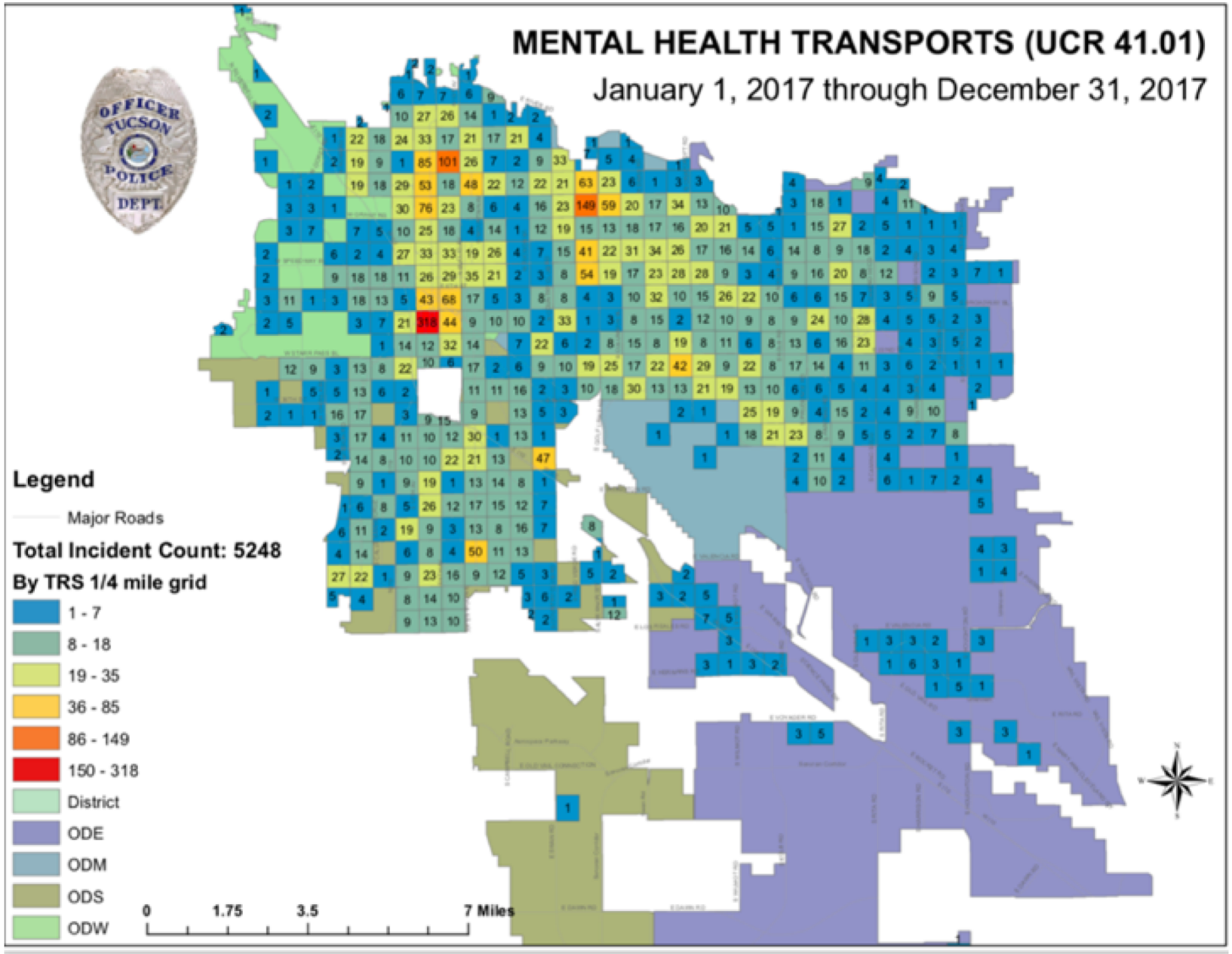
Where are these patients coming from?

Can we target interventions to prevent the need for involuntary law enforcement transports?



Courtesy Sgt. Jason Winsky, Tucson Police Dept.

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The "Group Home Guy"

Multiple partners coming together to solve a complex problem

Multiagency QI Process
to reduce revocations originating in group homes

Group Home

Crisis Line

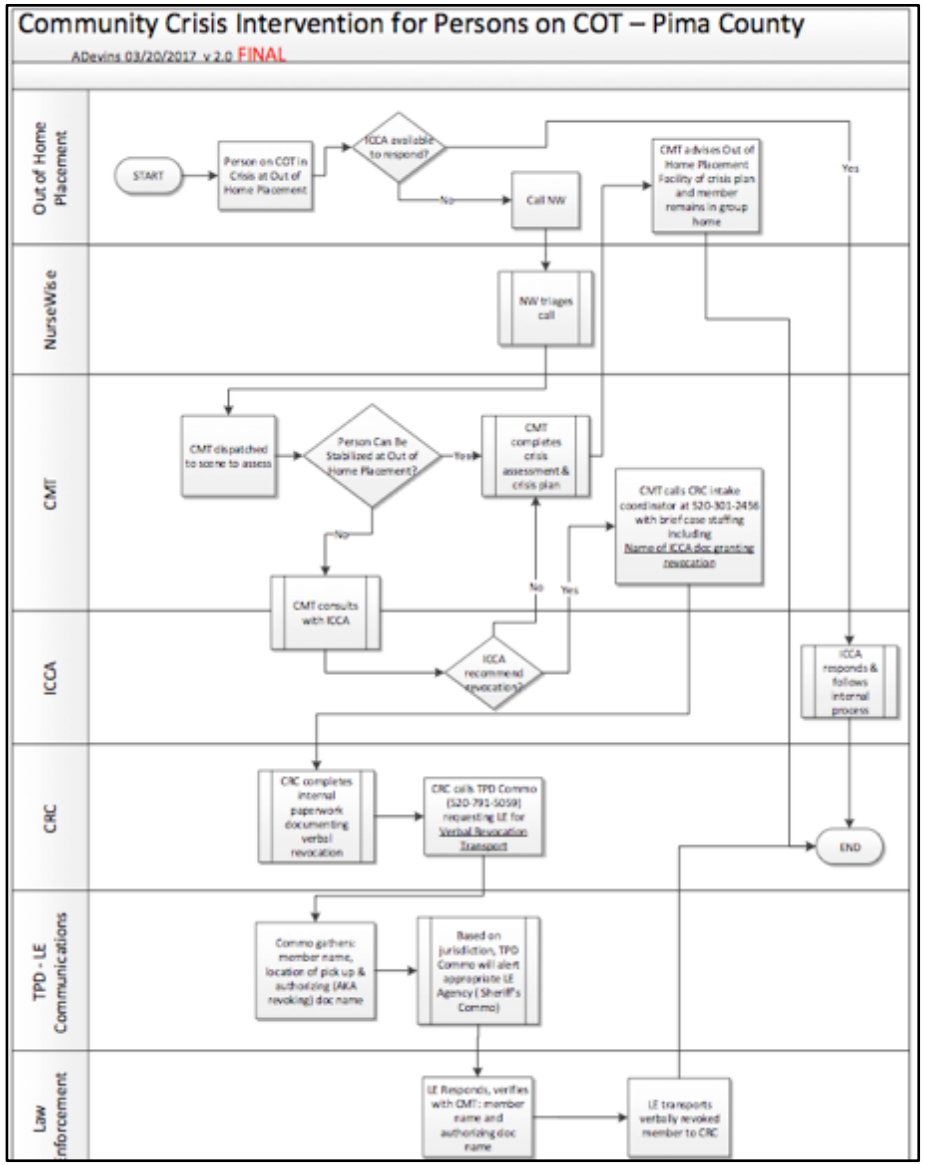
Mobile Crisis Team

Outpatient Clinic

Crisis Response Center

911 Dispatch

Law Enforcement



Courtesy Amy Devins, Cenpatico

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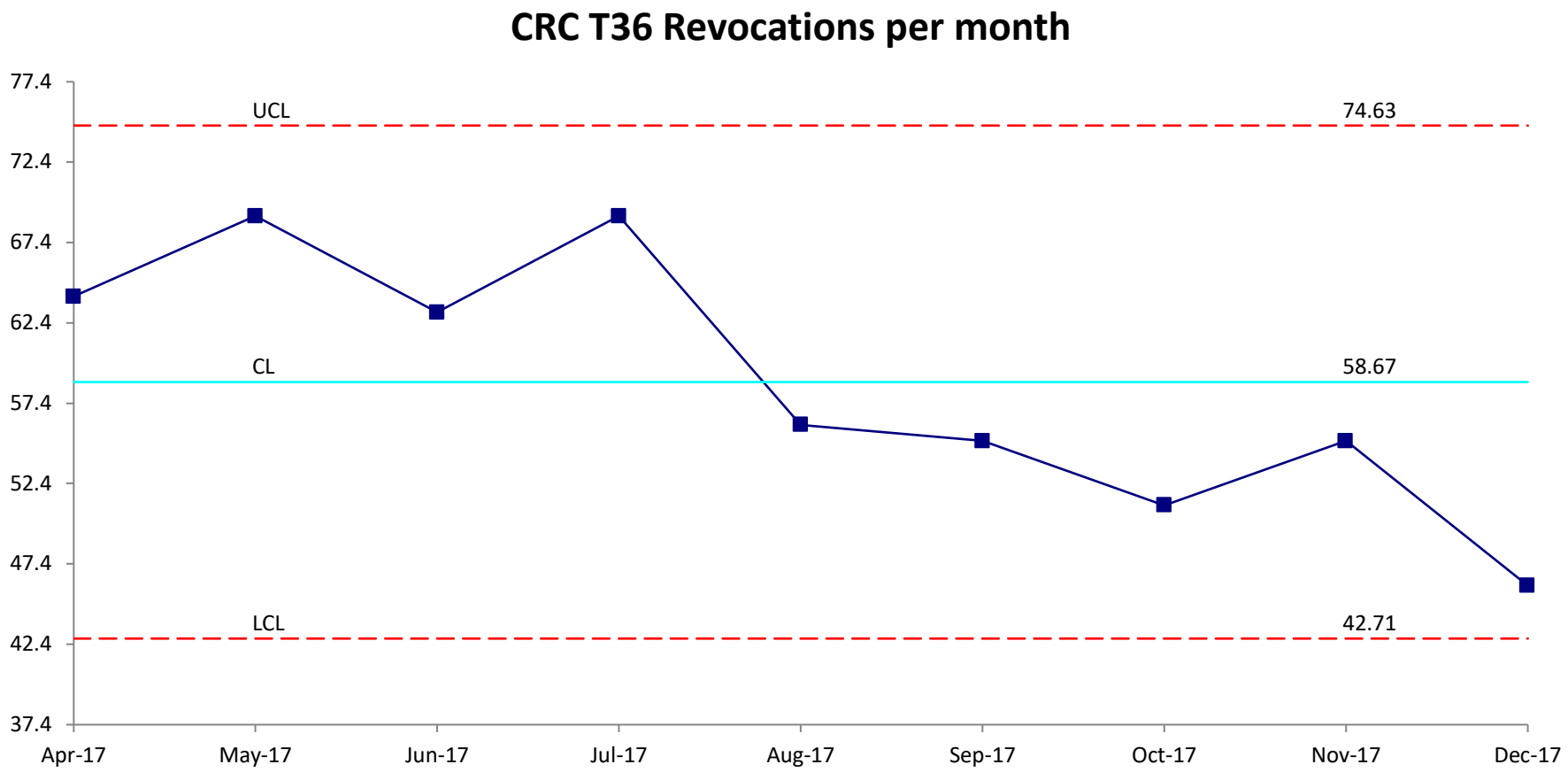
Results: Decrease in civil commitment revocations



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It took a LONG time and LOTS of collaboration to get where we are today.

2000

< City (Tucson) MH Court

2001

CIT Training > program started

2002

Felony > MH Court

< Mobile Crisis Teams

2004

County bond passes > to build crisis facility

2006

Jail Based > Restoration to Competency

2007

Jan 8 2011 shooting > at *Congress On Your Corner*

2010

< Pima County **Office of BH Administrator**

< DTAP Program
Drug Treatment Alternative to Prison

2011

< Peers in the Jail

< Crisis Response Center opens Aug 2011

2012

< Rural MH Courts

Law Enforcement MH Support Teams

< PCSO TPD >

2013

2014

Jail + MH **Data Exchange** < JHIDE Analytics >

2015

MacArthur Grant > awarded to Pima County

2016

< Co-responders (cop + clinician)

< Repeat T36 Utilization (civil commitment/AOT)
Data Sharing Task Force

< 24/7 access to Opiate MAT at CRC

< 100% MHFA training achieved at TPD and PCSO

2017

< MH First Aid
Training for law enforcement begins

< Learning Site
designation by DOJ/BJA

< MHFA Impact Award
National Council for BH

< Repeat Jail Detainees
Task Force

2018

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why
we do
what
we do
☺

Jason Winsky added 2 new photos — with **Corey Doggett** and **4 others**.

31 mins ·

I don't often post about my job, but I can't resist sharing this story. Yesterday, my team received a judge's order to transport a 67 year old woman to a local mental health facility. We discovered that the woman was living in her car (which doesn't run) in a church parking lot for the last ten years. Every day, she works in the church garden and is generally self sufficient. When we met with her, my team was somewhat confused as to why this woman needed to be transported to a mental hospital, but with a judge's order, our hands were tied.

When we told the woman she had to go with us, she became very upset. Pointing to her car, she told us "my whole life is in that car." She just wouldn't leave her car, and we didn't blame her. We knew that she would likely stay in the hospital overnight, leaving her car vulnerable. After trying many other options, suddenly I realized: let's just bring her car with her to the hospital. Easier said than done, since the car didn't run and she had no money for a tow.

With a few phone calls, the Tucson community I love so much rallied to support this woman. **Andrew Cooper** and **Shaun McClusky** pointed me to Barnett's towing, who referred me to Gavin Mehrhoff, owner and operator of East Side towing. I talked to Gavin, and he quickly agreed, at NO cost, to tow the woman's car to the hospital, and when she's done there, tow it back to the church.

But the kindness didn't stop there. Working with the always awesome Doctor **Margaret Balfour** and the folks at **ConnectionsAZ** was amazing, not only did their hospital security team agree to watch the woman's car, they even promised to help find a room at the hospital where she could SEE her car.

When the woman saw what we had done, the relief in her face was obvious and she agreed to go with us to the hospital. I want to thank my team, especially **Darrell Hussman** and Todd for being so patient and compassionate, **Margaret Balfour** who runs the best crisis center in the country, and Gavin at East Side towing for making a small but critical difference in this woman's life. I love my job!

connections HEALTH SOLUTIONS

Lessons Learned

- The solution is **not** always more inpatient beds!
- Stabilize crisis in the **least-restrictive** setting possible (which also tends to be the **least-costly**)
- **Governance and payment structures** to incentivize these programs and services
- **Data-driven** decision-making and continuous quality improvement
- Stakeholder **collaboration** across silos
- **Culture of:**
  - **NO WRONG DOOR**
  - **"Figure out how to say YES instead of looking for reasons to say no."**

Integrated Crisis Systems: Funding For Positive Outcomes

The Southern Arizona Model

Jay Gray, PhD

Chief Officer of Integrated Care

Arizona Complete Health: A Centene Health Plan

Expert Panel on Comprehensive Community Crisis Services: Structure and Standards

Substance Use and Mental Health Services Administration

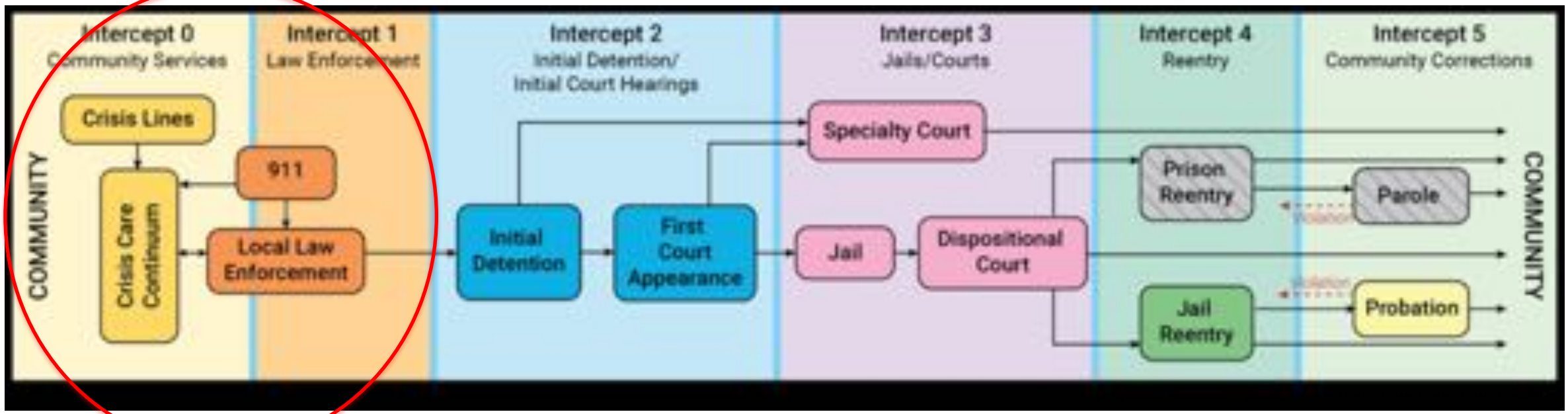
Rockville, MD – July 9th & 10th

SAMHSA

Substance Abuse and Mental Health Services Administration

Sequential Intercept Model

- Linking systems through the crisis system to improve the health of our communities
- Focused on creating multiple points of intervention in order to prevent escalation in the system



SAMHSA's Gains Center. (2013) Developing a comprehensive plan for behavioral health and Criminal Justice collaboration: The Sequential Intercept Model Delmar NY: Policy Research Associates Inc.

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Desired Outcomes

Decrease

- ED, Hospital, police and fire utilization for members in behavioral health crisis
- Justice involvement
  - Arrests, incarceration, legal proceedings

Increase

- Real time access to behavioral health services
- Stabilization in the least restrictive setting
- Engagement
- Coordination of Care

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Crisis System: A Collaborative Approach

Crisis Hotline
- Direct line for Law Enforcement
- Telephonic Triage of Calls
- Information, Care Coordination
- Outpatient Scheduling

911 Communication Center
- Working on co-location of Behavioral Health Professionals
- Direct Access to Mental Health Support Team

Mental Health Support Teams (MHST)
- Unique Team Specializing in Civil Commitment, Challenging Behaviors, and Follow-up
- Officers/Deputies & Detectives

Mobile Crisis Teams
- BH Professionals and Techs
- On-site crisis intervention in less than 60 minutes
- 30-min Response Time for LE

Individual / Family Crisis

Co-Responder Teams
- MHST Detective
- Mobile Team Clinician

Crisis Residential Facilities
- Available 24/7
- Direct Community Referrals
- 5-10 day stays

24/7 Community Observation Units
- Serve Adults and Youth
- <10 minute LE drop-off time
- Law enforcement never turned away
- Detox/Crisis for Voluntary/Involuntary members
- Coordinate with EDs, Court, Inpatient psych
- Clinic, 23 hour OBS, and triage

24/7 Crisis Living Rooms
- Direct inpatient admissions from the community

Inpatient Facilities
- Direct inpatient admission from the community

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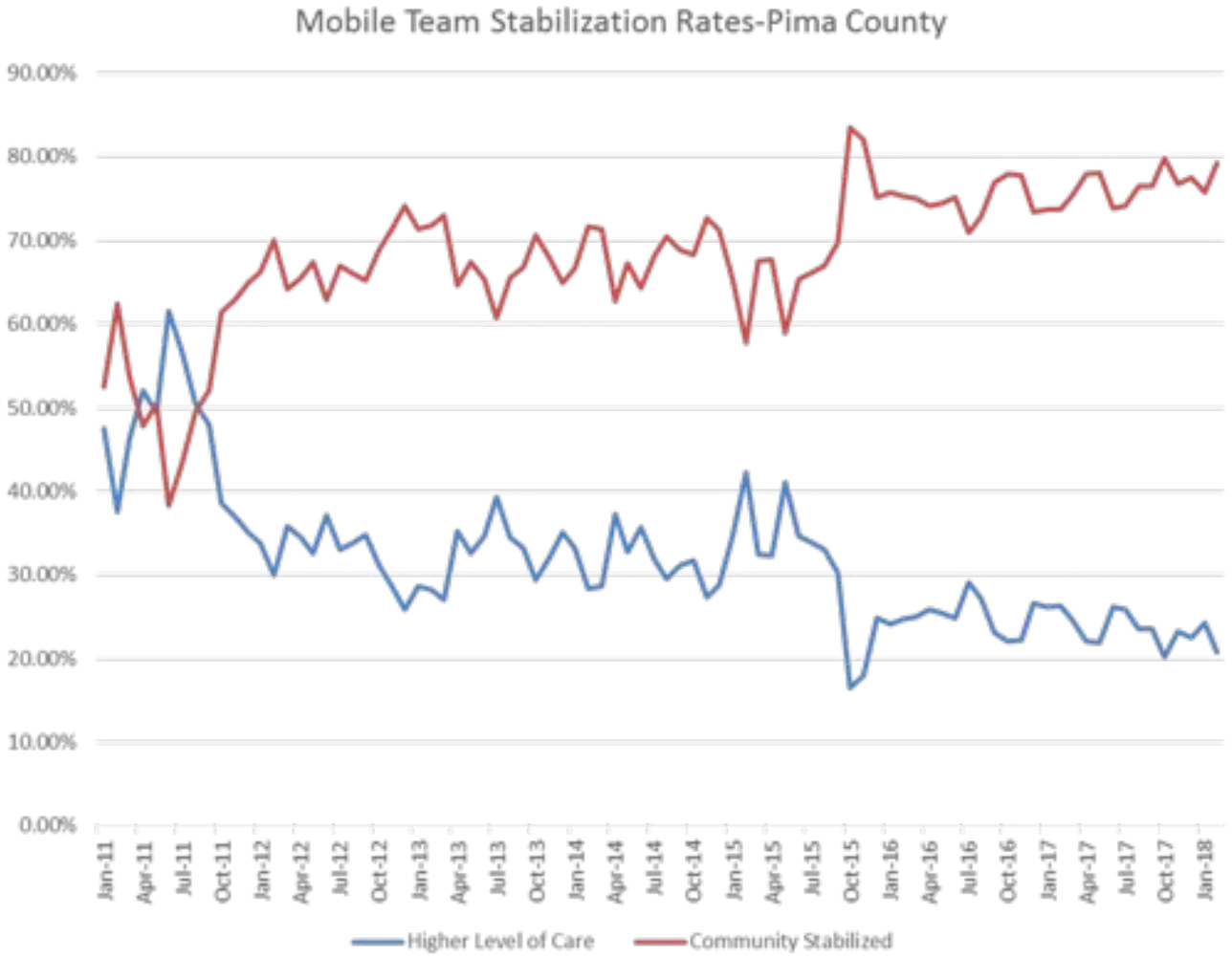
System in Practice – Crisis Line and Mobile Teams



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Crisis Line

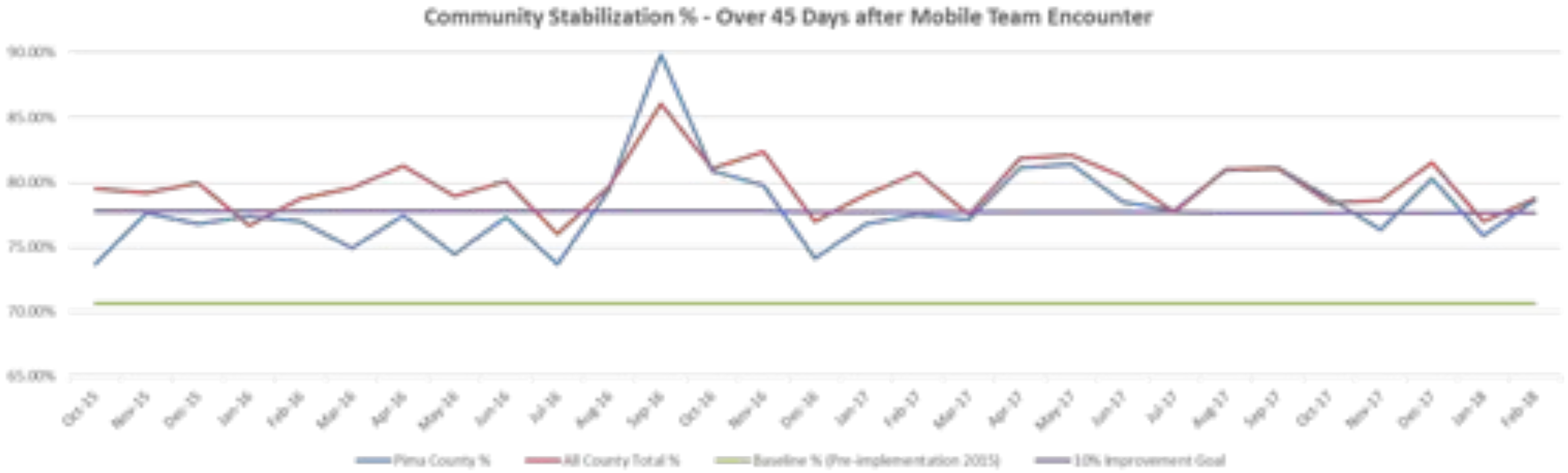
- 10,450 Calls Per Month in 2017
- Over 80% of calls are resolved via phone
  - Coordinate services with outpatient providers
  - Schedule follow up services (average of 555 per month)
  - Allow members to speak with BHP's and Nurses

Mobile Crisis Teams

- Of crisis line contacts an average of 17% are activated
- This is 1,779 activations per month
- Of these 72% of mobile team response are resolved on scene
- Average response time of 34 minutes

Mobile Team Effectiveness

With dramatic improvement in stabilization rates, we want to ensure members who are community stabilized are not re-engaging the system



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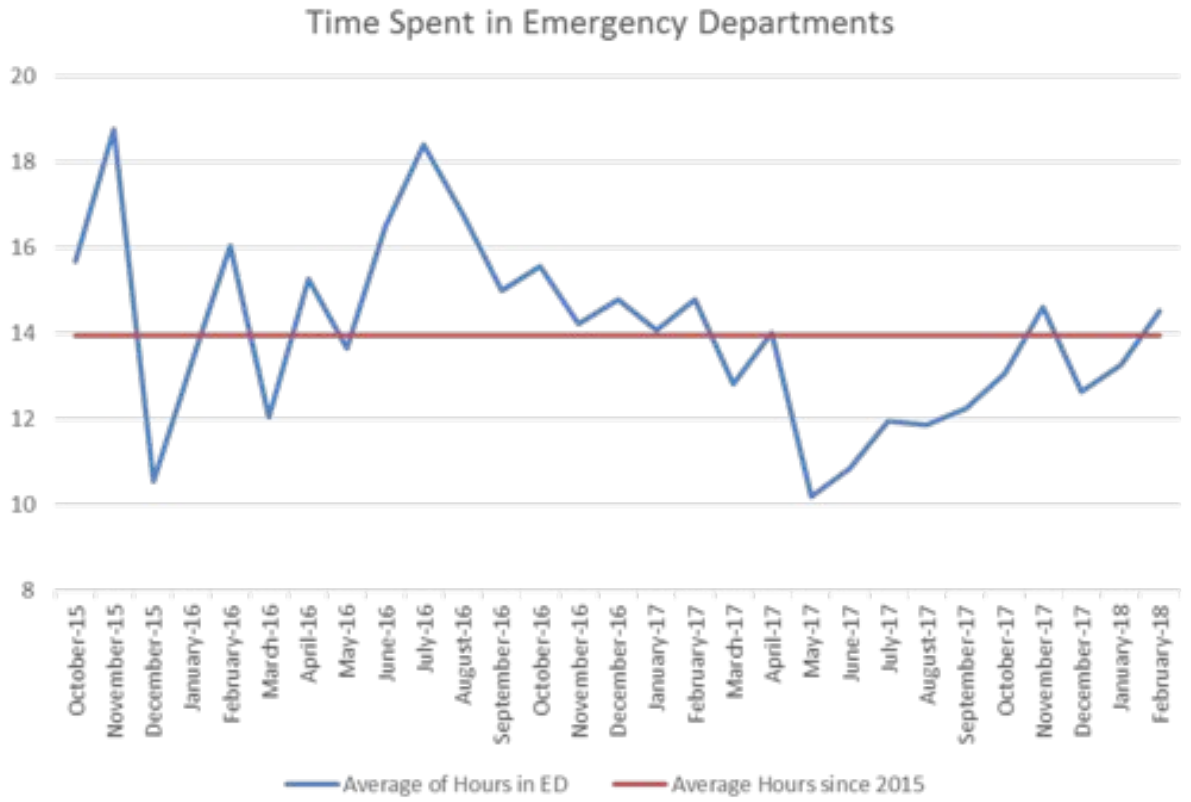
Time Members Spend in Emergency Departments

For members admitted to Emergency Departments

- In rural communities Mobile Teams provide assessments for treatment
- Mobile Teams provide disposition information to the Crisis Line
- The Crisis Line alerts Cenpatico to members waiting for placement over 16 hours
- Cenpatico/Crisis line/Hospitals and Mobile Teams work together to coordinate placement to a higher level of care.



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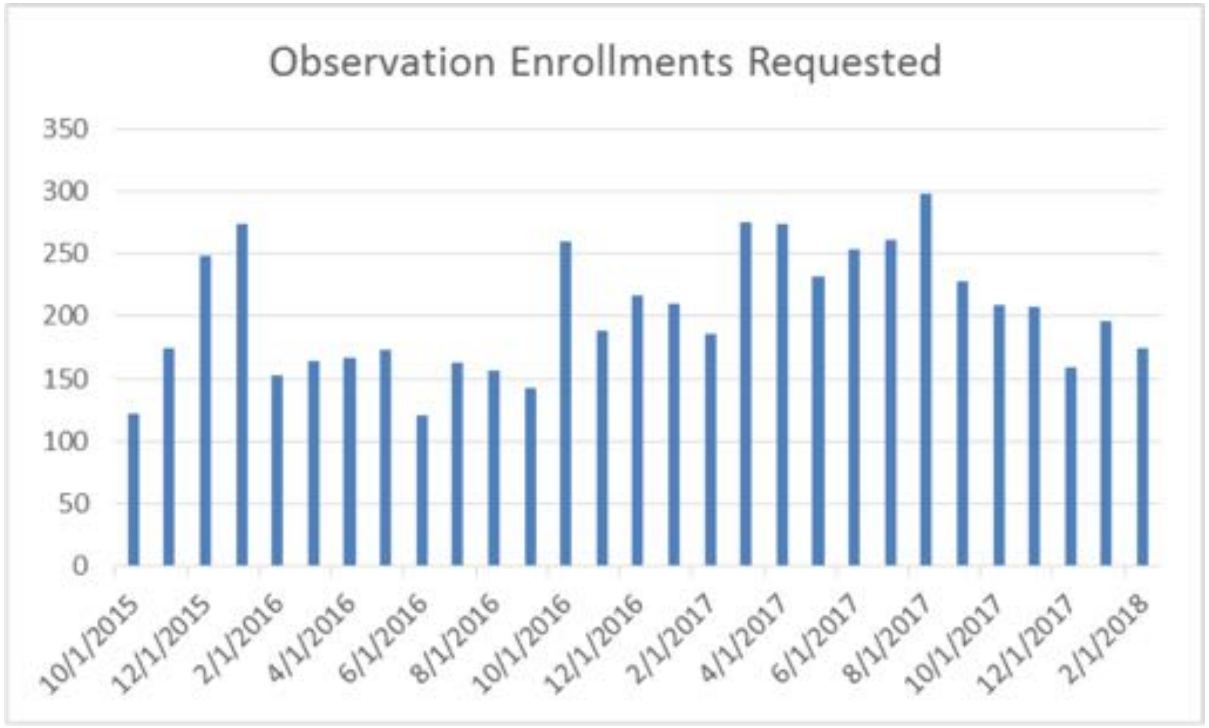
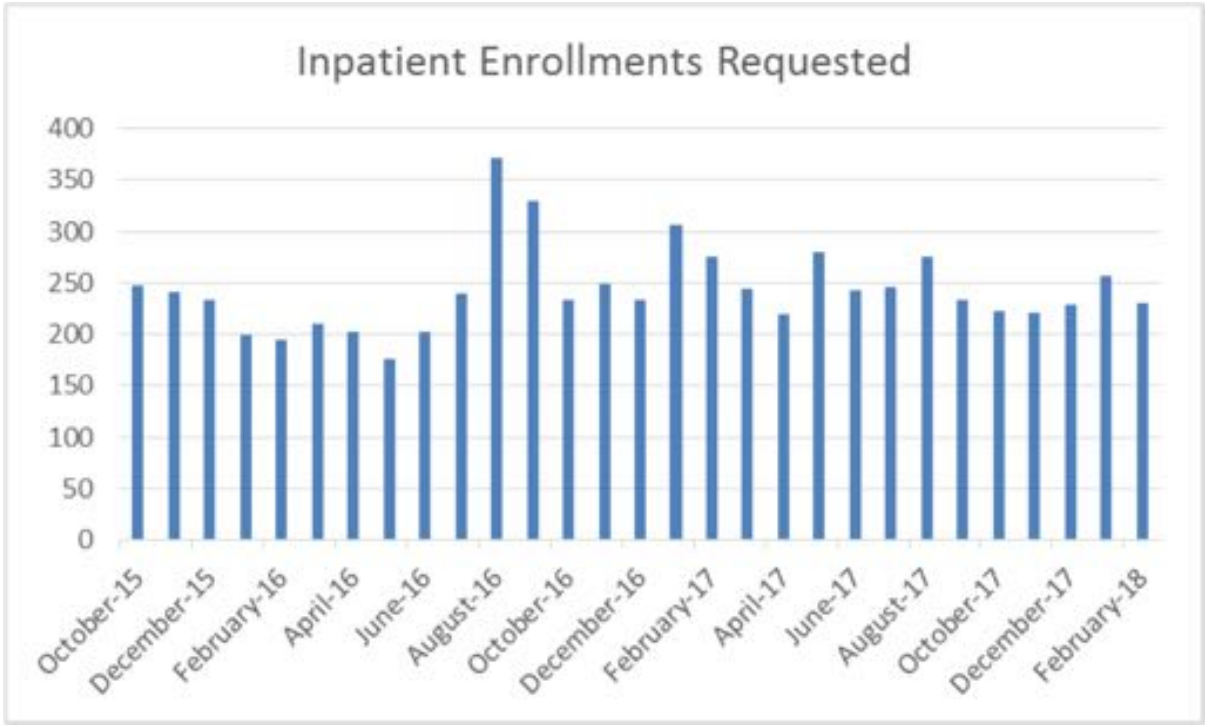
Urgent Engagements

Process available for all members who are not open under a current episode of care with an outpatient provider



- 203 Urgent Enrollments per month
- For patients in 23-hour observation facilities
- 1 hour response time



- 203 Urgent Enrollments per month
- For patients in admitted to inpatient psychiatric facilites
- 24 hour response time

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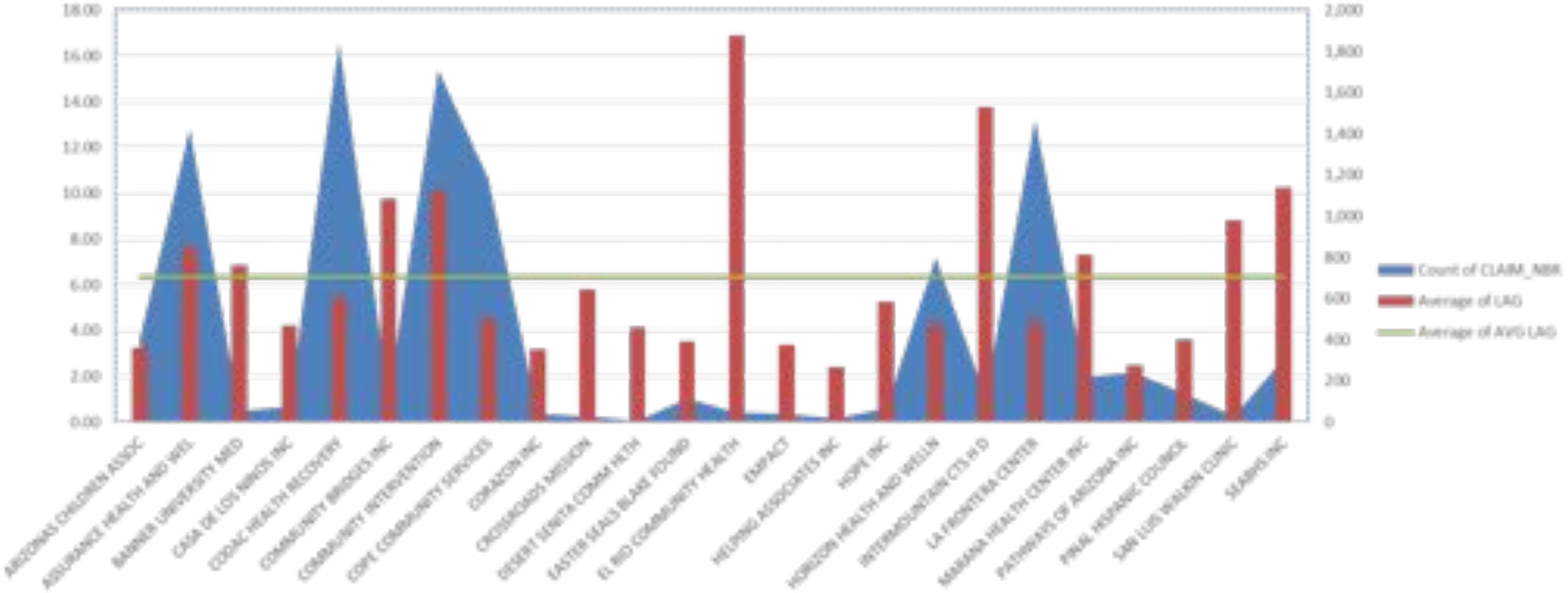
Outpatient Services: Process Improvement



- The above reflects lag receiving crisis services and a billed significant service by the outpatient provider.
- Average lag between services was 6.6 days from October 2015 to December 2017.

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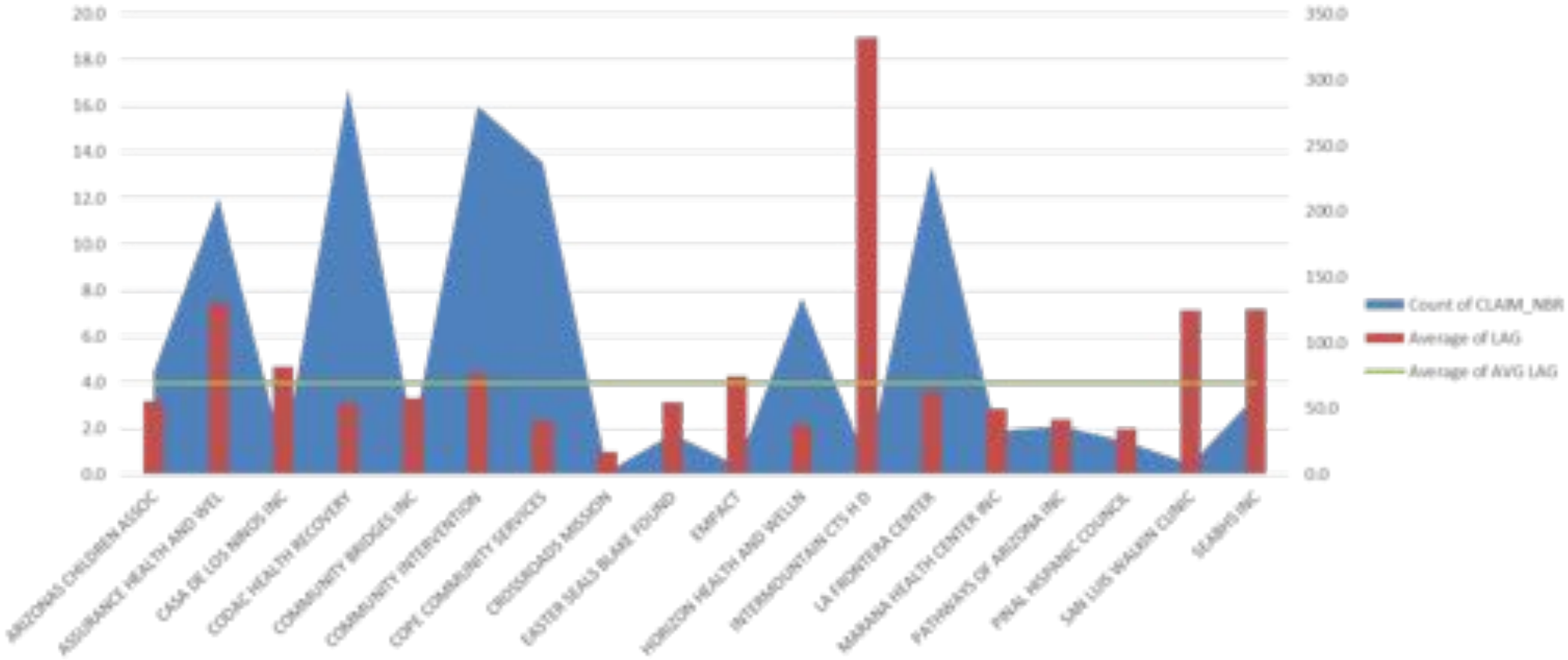
Outpatient Services: Process Improvement



- We have begun working with providers to improve responsiveness after a crisis
- Quarter 1 of 2018 has shown improvement
- Average lag is now under 4 days.

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Funding Crisis Services: Mix of Funds

Source	Serving
Medicaid	Medicaid members
State Appropriated Crisis Funds	Uninsured/Underinsured
State Appropriated SMI Funds	Non-Medicaid Adults with SMI
Substance Abuse Block Grant	Uninsured/Underinsured with SUDs
Mental Health Block Grant	Uninsured/Underinsured Youth with SED Adults with Mental Illness
Pima County Funds	Uninsured/Underinsured Residents of Pima County Civil Commitment Pre-petition Screenings in Pima County

Re-calibrated During the Year Based on Utilization By Population Served

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Crisis System Funding: Dollars Follow the Members

FY'18 Projected	Medicaid	Block Grant	State Only	County	Total	Payment Method
Crisis Mobile Teams	$ 8,106,300	$ 314,000	$ 1,982,600	$ -	$ 10,402,900	Block, FFS
Crisis Living Room	$ 686,400	$ -	$ 152,700	$ -	$ 839,100	Block
Crisis Stabilization	$ 25,586,500	$ 200,000	$ 2,505,500	$ 1,257,900	$ 29,550,300	Block, FFS
Crisis Phones	$ 9,555,500	$ -	$ 1,120,900	$ 14,500	$ 11,590,900	Block
Peer Crisis Warm Lines	$ 228,000	$ -	$ -	$ -	$ 228,000	Block
Rapid/Urgent Enrollment	$ 976,400	$ -	$ 336,200	$ -	$ 1,342,600	Block
Brief Crisis Residential	$ 1,320,000	$ 264,000	$ 176,600	$ -	$ 1,760,000	Block, FFS
Second Responder	$ 2,500,000	$ -	$ -	$ -	$ 2,500,000	Block, FFS
Pre-Petition Screening	$ -	$ -	$ -	$ 250,000	$ 250,000	Block
Totals	**$ 48,959,500**	**$ 778,000**	**$ 6,303,900**	**$ 2,422,400**	**$ 58,463,800**	

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Crisis Services: Rates

Crisis Mobile Teams	
1 Person	$102.00 per unit of H2011
2 Person	$122.40 per unit of H2011

Stabilization Beds/Chairs	
S9484 *< 6 hours*	$60.19 - $161.71
S9485 *6-24 hours*	$339.14 - $951.66
Varies based upon purchasing of availability, capacity, and rural considerations	

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Considerations

Cross System/Cross Departmental Collaborative Buy-in at State and Local Levels

- Shared vision, share budget information
- Recognition that the various state and local government and health care systems serve many of the same people
- Recognition of the role of SDOH on total cost of community health and proactive measures to address SDOH
- Alignment of goals and financial incentives
- Measures of the total cost of community health
  - Law Enforcement, EMT/Fire, Legal/Justice, Medical and Behavioral Health, Jails/Detention
  - And the interplay between the systems

Challenges: Member Engagement

- Crisis events are an opportunity to engage residents into care at a time when they are most open to engaging into care
- Hand offs/transitions from crisis providers to ongoing treatment providers is a challenge
  - Second responder services
  - Rapid engagement into services
  - Funding outreach for unengaged residents following crisis events
- Improved strategies to engage residents with SUDs, repeat utilizers of crisis, ED, EMT/Fire, law enforcement and justice services
  - About 70% of adults in jail have a SUD
  - About 69% of adults in jail screen positive for potential brain injury.

Questions?

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