Creating and Sustaining High Quality Crisis Services: A Systemic Approach

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A behavioral health crisis is an emergency.

It requires a **systemic** response with the **same quality and consistency** as the response to heart attack, stroke, fire, and other emergencies.

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911: WHAT'S YOUR EMERGENCY?

"I'm having chest pain."

"I'm suicidal."

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Officer-involved shootings

One quarter

of officer involved shootings were linked to **mental illness**[1]

"Suicide by Cop"

Studies range from 10% - 49% depending on the study sample and methodology used[2-6]

1. Washington Post Police Shooting Database: https://www.washingtonpost.com/graphics/investigations/police-shootings-database/
2. Dewey L, Allwood M, Fava J, Arias E, Pinizzotto A, Schlesinger L. Suicide by cop: clinical risks and subtypes. Arch Suicide Res 2013;17(4):448-61.
3. Hutson HR, Anglin D, Yarbrough J, Hardaway K, Russell M, Strote J, et al. Suicide by cop. Ann Emerg Med 1998;32(6):665-9.
4. Kennedy DB, Homant RJ, Hupp RT. Suicide by Cop. FBI Law Enforce Bull 1998;67(8):21-7.
5. Mohandie K, Meloy JR, Collins PI. Suicide by cop among officer-involved shooting cases. J Forensic Sci 2009;54(2):456-62.
6. Patton CL, Fremouw WJ. Examining "suicide by cop": A critical review of the literature. Aggression and Violent Behavior 2016;27(107-120).

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Prevalence of Mental Illness

	US Adults[5]	Jail
SMI[3] -Men -Women	4%	 **17.1%** **34.3%**
Any mental disorder[4]	18%	**76%**
+ Co-occurring SUD[4]	3.3%[6]	**49%**

What about kids?

The National Center for Mental Health and Juvenile Justice found that **70.4%** of youth in the juvenile justice system have been **diagnosed with at least one mental health disorder.**

High-risk youth are estimated to cost society **$1.2 to 2 million each** in rehabilitation, incarceration, and costs to victims.

1. Steadman HJ et al. (2009) Prevalence of serious mental illness among jail inmates. Psychiatric Services. 60(6):761-5.
2. 44%. Hall LL et al. (2003) TRIAD Report: Shattered Lives: Results of a National Survey of NAMI Members Living with Mental Illnesses and Their Families.
3. Includes PTSD. Excluding PTSD rates are 14.5% for men and 31.0% for women. Steadman HJ, Osher FC, Robbins PC, Case B, Samuels S. (2009). Psychiatric Services. 60(6):761-5.
4. Glaze LE, James DJ. (2006) Mental Health Problems Of Prison And Jail Inmates. Bureau of Justice Statistics.
5. NIMH Statistics https://www.nimh.nih.gov/health/statistics/index.shtml
6. SAMHSA (2015). Behavioral Health Trends in the United States: Results from the 2014 National Survey on Drug Use and Health.

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There are over
2 million jail bookings
of people with serious mental illness each year.[1]

Nearly **half** of people with SMI have been arrested at least once.[2]

5

Impact of incarceration

- Offenders with mental illness are
  - Incarcerated twice as long
  - Three times more likely to be sexually assaulted while incarcerated
  - More likely to be in solitary confinement which exacerbates psychiatric symptoms
- Adverse effects post-release include
  - Interruption in Medicaid and other benefits
  - Difficulty finding employment
  - More likely to become homeless
  - More likely to be rearrested
- At twice the cost to taxpayers.

1. Treatment Advocacy Center & National Sheriffs Association (2014). The Treatment of Persons with Mental Illness in Prisons and Jails: A State Survey
2. Dumont DM et al. (2012). Annu Rev Public Health. 2012 Apr 21; 33: 325–339.
3. Office of National Drug Control Policy

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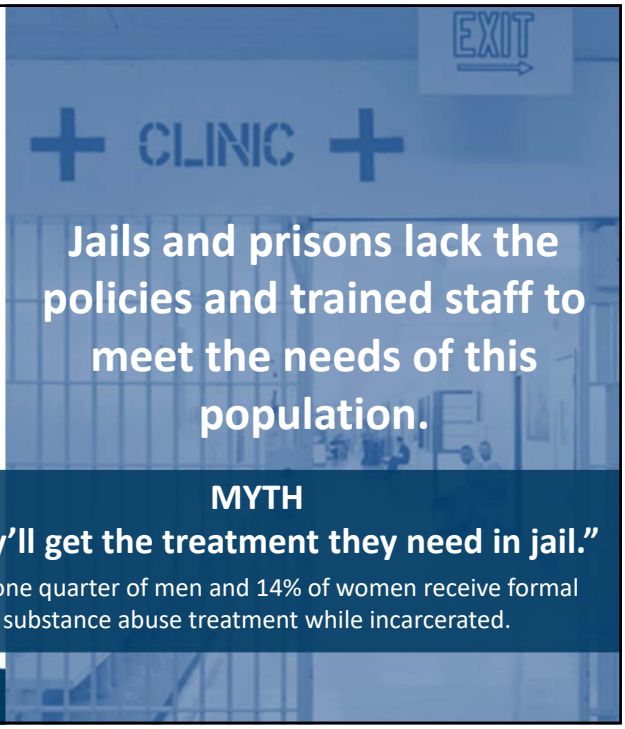

Jails and prisons lack the policies and trained staff to meet the needs of this population.

MYTH
"They'll get the treatment they need in jail."
Only one quarter of men and 14% of women receive formal substance abuse treatment while incarcerated.

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If they do make it to an ED…

- 84% of EDs report boarding of psychiatric patients for hours
- Increased risk
  - Assaults, injuries, self-harm
- Increased cost
  - Sitters, lost revenue ($2300/day)
  - Unnecessary inpatient admits
- Poor patient experience
  - Nontherapeutic environment with untrained staff

Psychiatric boarding = long waits for inpatient psychiatric beds with little/no treatment, for hours or sometimes even days.

Nicks BA and Manthey DM. (2012) The impact of psychiatric patient boarding in emergency departments. Emerg Med Int. 2012
American College of Emergency Physicians (2014) http://newsroom.acep.org/download/ACEP+Polling+Survey+Report.pdf
Zeller et al (2014) https://dx.doi.org/10.5811%2Fwestjem.2013.6.17848

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What we need:

- **A SYSTEMIC response to behavioral health crisis**
- that delivers EVIDENCE-BASED care to people who need it
- with MEASURABLE OUTCOMES
- in the LEAST-RESTRICTIVE setting that can safely meet the person's needs
- (and by the way, the least-restrictive settings also tend to be the LEAST-COSTLY)

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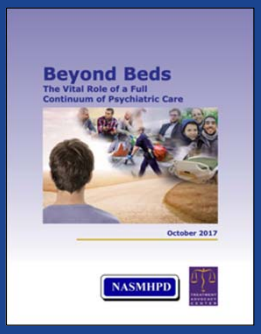
Why isn't there a national standard for crisis services?

- No standard nomenclature
  - For example: a "crisis stabilization unit" can be many things
- Crisis services fly under the federal radar
  - Primarily financed by Medicaid, which is regulated at the state level
- Stigma?

"If you've seen one state mental health system, you've seen ONE state mental health system."

Progress towards national definitions and standards



Simply building more inpatient beds won't solve the problem of access to MH care. **Systemic approaches** are needed, including crisis care.

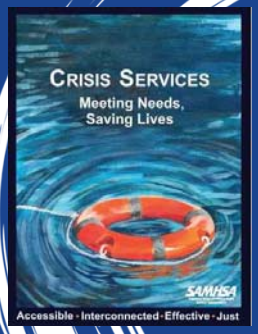
https://www.nasmhpd.org/sites/default/files/TAC.Paper_.1Beyond_Beds.pdf

Defines crisis system **essential services**: crisis line with "air traffic control" capability, mobile crisis teams, crisis stabilization, crisis best practices (e.g. recovery-focused and trauma informed)

https://theactionalliance.org/sites/default/files/crisisnow.pdf

Review of national best practices in crisis services with a focus on improving crisis systems through the **standardization of outcome measures**.

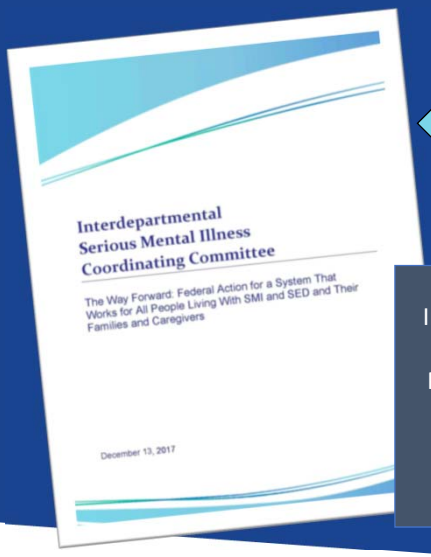
https://www.texasstateofmind.org/wp-content/uploads/2017/01/MMHPI_CrisisReport_FINAL_032217.pdf



[illegible]-depth toolkit [illegible] SAMHSA to assist in th[illegible]mentation of crisis [illegible]

https://store.samhsa.gov/product/crisis-services-meeting-needs-saving-lives/PEP20-08-01-001

A National Standard for Crisis Systems?



- **Interdepartmental SMI Coordinating Committee (ISMICC)**
- Created by 21st Century Cures Act
- 45 recommendations in 5 focus areas
- *2.1 Define and implement a national standard for crisis care*

In response, the Group for the Advancement of Psychiatry is developing a comprehensive report defining elements of the ideal crisis system

Measurable Performance Standards
in the following areas

- Governance & Finance
- Crisis Continuum: Essential Services & Program Capabilities
- Clinical Best Practices & Competencies

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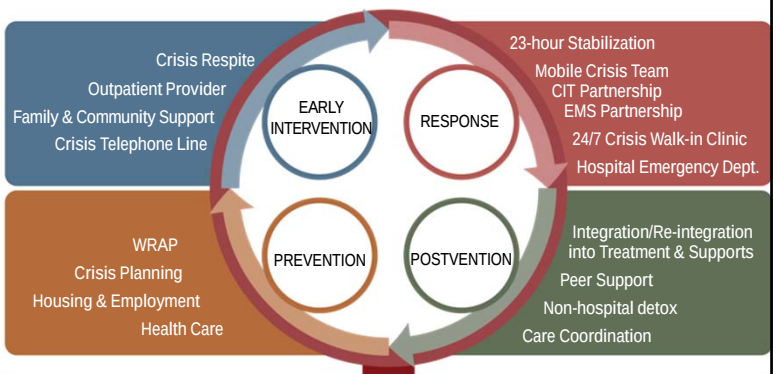
SYSTEM
vs. Services

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

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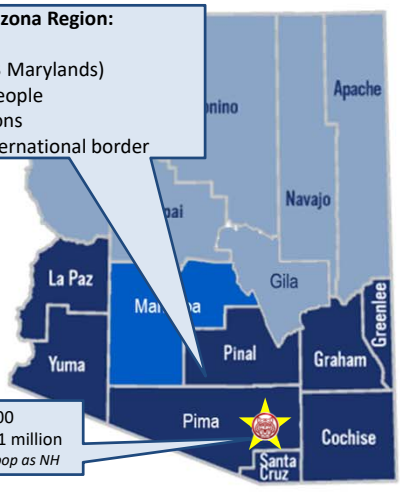
Arizona Crisis System Structure

Southern Arizona Region:
8 counties
38,542 mi² (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 Authority (RBHA)
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Counties

Contracted Crisis Providers

The **financing & governance** structure supports **organization, accountability, & oversight** of the 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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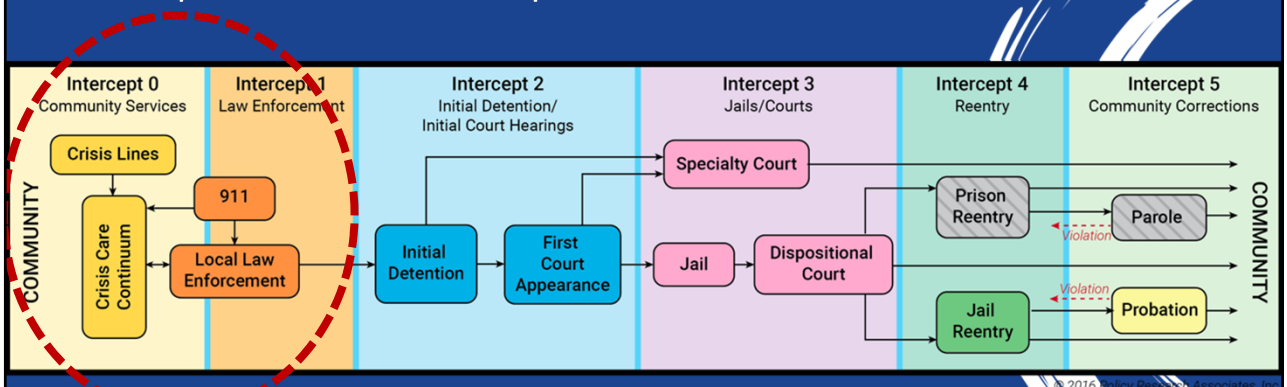
Sequential Intercept Model



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What is the Sequential Intercept Model?

- Every person follows a path through the justice system: Arrest, detention, arraignment, pre-trial, etc.
- At every point along this path, there is an opportunity for the behavioral health system to "intercept" the person and either
  - Stop them from progressing further (diversion)
  - Mitigate the effects of justice involvement
- Crisis services are focused on Intercept 1:
  - Interactions with law enforcement to <u>prevent unnecessary arrest</u>

Munetz MR and Griffin PA. (2006) "Use of the Sequential Intercept Model as an Approach to Decriminalization of People With Serious Mental Illness." Psychiatric Services 57:4.

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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 with its subcontracted providers to create 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

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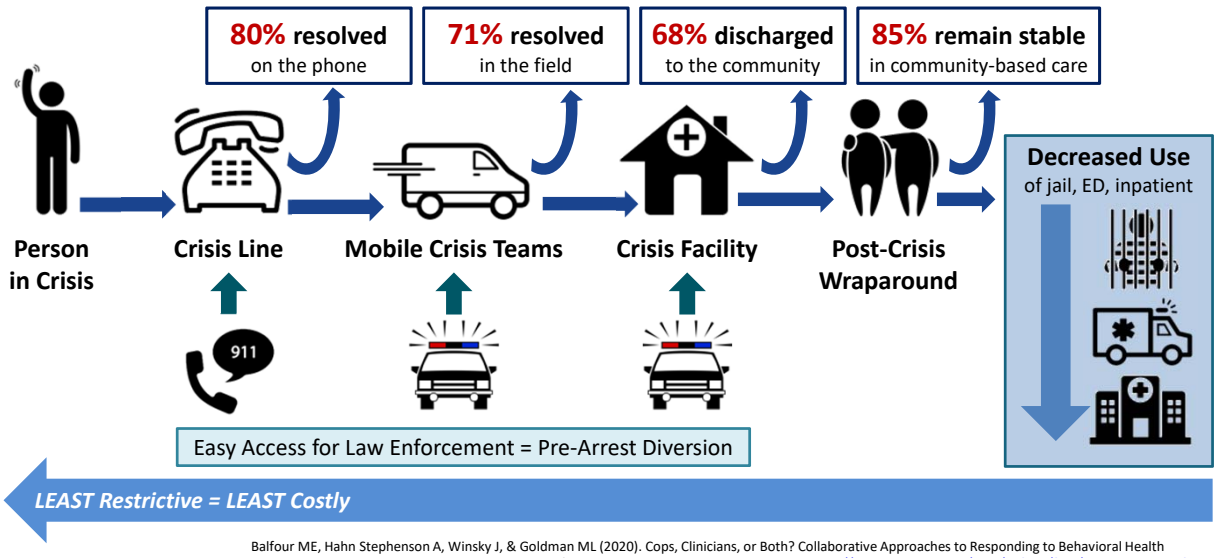
The Crisis Continuum



Balfour ME, Hahn Stephenson A, Winsky J, & Goldman ML (2020). Cops, Clinicians, or Both? Collaborative Approaches to Responding to Behavioral Health Emergencies. Alexandria, VA: National Association of State Mental Health Program Directors. https://www.nasmhpd.org/sites/default/files/2020paper11.pdf

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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

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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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

arizona complete health

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

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The Crisis Response Center

- Built with Pima County bond funds in 2011
  - Alternative to jail, ED, hospitals
  - Serving 12,000 adults + 2,400 youth per year
  - Managed by Connections since 2014
- **Law enforcement receiving center with NO WRONG DOOR**
  (no exclusions for acuity, agitation, intoxication, payer, etc.)
- Services include
  - 24/7 urgent care clinic (adult length of stay 2 hours, youth 3 hours)
  - 23-hour observation (adult capacity 34, youth 10),
  - Short-term subacute inpatient (adults only, 15 beds, 3-5 days)
- Space for co-located community programs
  - peer-run post-crisis wraparound program, pet therapy, etc.
- Adjacent to
  - Crisis Call Center
  - Banner University Medical Center Emergency Department
  - 66-bed Inpatient psych hospital
  - Mental health court

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

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Connections Model

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

- "No wrong door"
- We take *everyone*:
  - No such thing as "too agitated" or "too violent"
  - Can be highly intoxicated
  - Can be involuntary or voluntary
- Fewer medical exclusionary criteria than many inpatient psych hospitals
- Law enforcement is never ever turned away
- Studies show this model:
  - Critical for pre-arrest diversion[2]
  - Reduces ED boarding[3,4]
  - Reduces hospitalization[3,4]

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.

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

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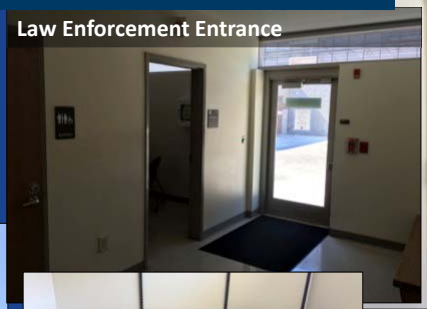
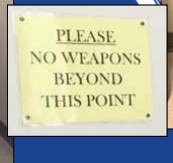
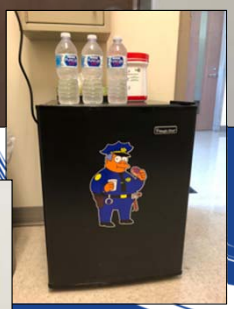
Easy Access for Law Enforcement so we are the preferred alternative to drop off at jail or ED

Gated Sally Port
Crisis Response Center - Tucson AZ



Law Enforcement Entrance





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The locked 23h obs unit provides a safe, secure, and therapeutic environment:

- Continuous observation
- Lack of means to hurt oneself or others
- Therapeutic milieu: Open area for therapeutic interactions with others
- As welcoming as possible

Crisis Response Center, Tucson AZ

Urgent Psychiatric
Phoenix, AZ

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23-Hour Observation

- ***Culture shift: Assumption that the crisis <u>can be</u> resolved***
- Interdisciplinary Teamwork
  - 24/7 psychiatric provider coverage (MD, NP, PAs)
  - Peers with lived experience, nurses, techs, case managers, therapists, unit coordinators
- Early Intervention
  - Median door to doc time is ~90 min
  - Interventions include medication, detox/MAT, groups, peer support, safety planning, crisis counseling, mindfulness
- Proactive discharge planning
  - Collaboration and coordination with community & family partners

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 (recovery support specialist) members!"

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Most are discharged to the community the following day
Avoiding preventable inpatient admission, even though they met medical necessity criteria when they first presented

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Law Enforcement Approach: Tucson Model

Research shows[1,2] that CIT is *most effective* when the training is VOLUNTARY and the Tucson Model strongly supports this philosophy. The Tucson Model mandates basic training for everyone, while more advanced training is voluntary. High rates of training are achieved through culture change and by creating incentives to make the training desirable.

LEADERSHIP enacts organization-wide policies, procedures, training, culture

- Community Policing
- Guardian vs. Warrior
- Use of Force Continuum
- De-escalation Required
- Implicit Bias Training
- Officer Wellness

ALL officers receive Basic Training (Mental Health First Aid – 8 hours)

- Mental health basics and community resources
- De-escalation and crisis intervention tools

SOME officers receive Intermediate Training (CIT – 40 hours)

- ***Voluntary*** participation
- ***Aptitude*** for the population

SPECIALIZED Units receive CIT + Advanced Training

- ***Collaboration*** with behavioral health systems, social services, and other community partners
- Dedicated Mental Health Teams
- Co-Responder Teams
- Substance Use Deflection Teams
- Outreach Teams (e.g. Homeless)
- Case Management Teams
- SWAT & Hostage Negotiators

100% of the force is **MHFA trained**

70% of first responders & 911 call-takers are **CIT trained**

Specialty units are **100% CIT trained** & receive ongoing **Advanced CIT refreshers**

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Balfour ME, Hahn Stephenson A, Winsky J, & Goldman ML (2020). Cops, Clinicians, or Both? Collaborative Approaches to Responding to Behavioral Health Emergencies. Alexandria, VA: National Association of State Mental Health Program Directors. https://www.nasmhpd.org/sites/default/files/2020paper11.pdf

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Tucson MHST Model: A Preventative Approach

Dedicated Mental Health Support Team

MHST **officers** focus on **service & transport**.

- Locate over 95% of patients with civil commitment pickup orders
- Hundreds of patients transported to treatment without uses of force
- Develop relationships and recognize patterns
- Helps with CIT calls when needed

MHST officers wear plainclothes because it decreases the anxiety of the person receiving services and also has an effect on the officer's attitude.

MHST **detectives** focus on **prevention & safety.**

- Investigate calls that otherwise wouldn't be looked at (e.g. "I'm concerned about my neighbor")
- Prevent people from falling through the cracks
- Connect people treatment instead
- Focus on public safety but avoid criminal justice involvement whenever possible

The "weird stuff" detectives

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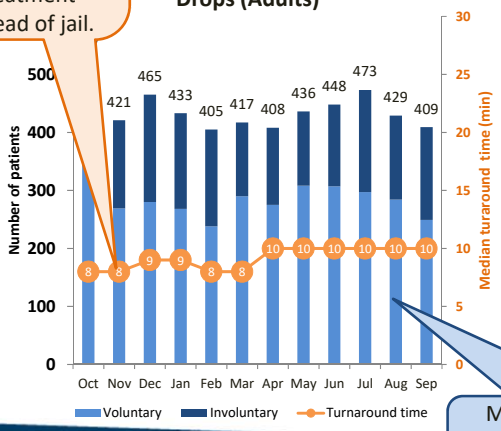
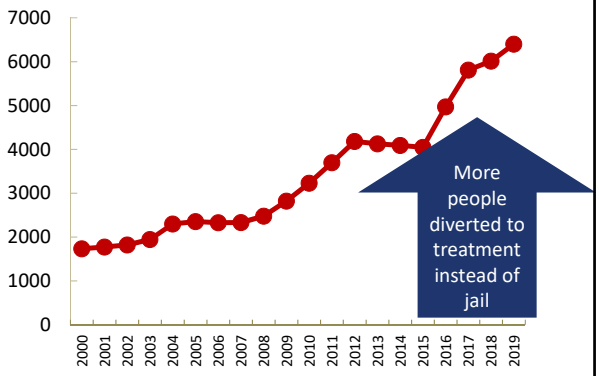
MORE People Taken to Treatment…

Cops like quick turnaround time (10 min) so that it's easier to bring people to treatment instead of jail.

CRC Law Enforcement Drops (Adults)



Tucson Police MH Transports



Most drops are voluntary (light bars), meaning the officers are engaging people into treatment.

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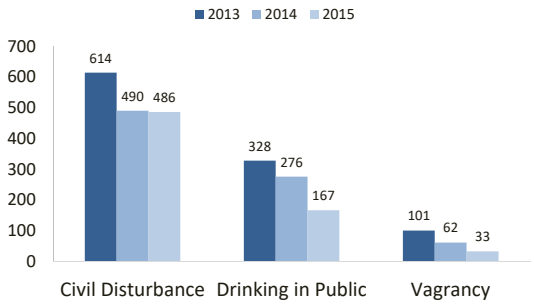
… and LESS Justice Involvement

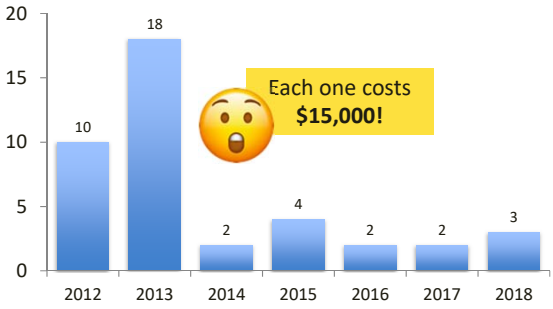
Fewer calls for low-level crimes that tend to land our people in jail.

TPD "Nuisance Calls" Per Year



Culture change in how law enforcement responds to mental health crisis.

TPD SWAT Calls for Suicidal Barricade



Balfour ME, Winsky JM and Isely JM; The Tucson Mental Health Investigative Support Team (MHIST) Model: A prevention focused approach to crisis and public safety. *Psychiatric Services*. 2017;68(2):211-212; https://dx.doi.org/10.1176/appi.ps.68203

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More LE-MH Collaborations = better community stabilization

Co-Responder Teams

- Mobile crisis clinician assigned to MHST detectives
- Investigations & follow-up for high-risk individuals

Percent of calls resulting in **involuntary hospitalization decreased from 60% to 20%**

Deflection Program

- Peer co-responders focused on SUD and overdoses
- Option not to arrest for possession of small amounts

In the first 18 months, **1,500 people were connected to treatment instead of arrest.**

Homeless Outreach

- Identify and engage people needing services instead of arresting them
- Lots of collaboration with community stakeholders

200 people housed in the first year of the program

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Next… Using Data to Improve Care

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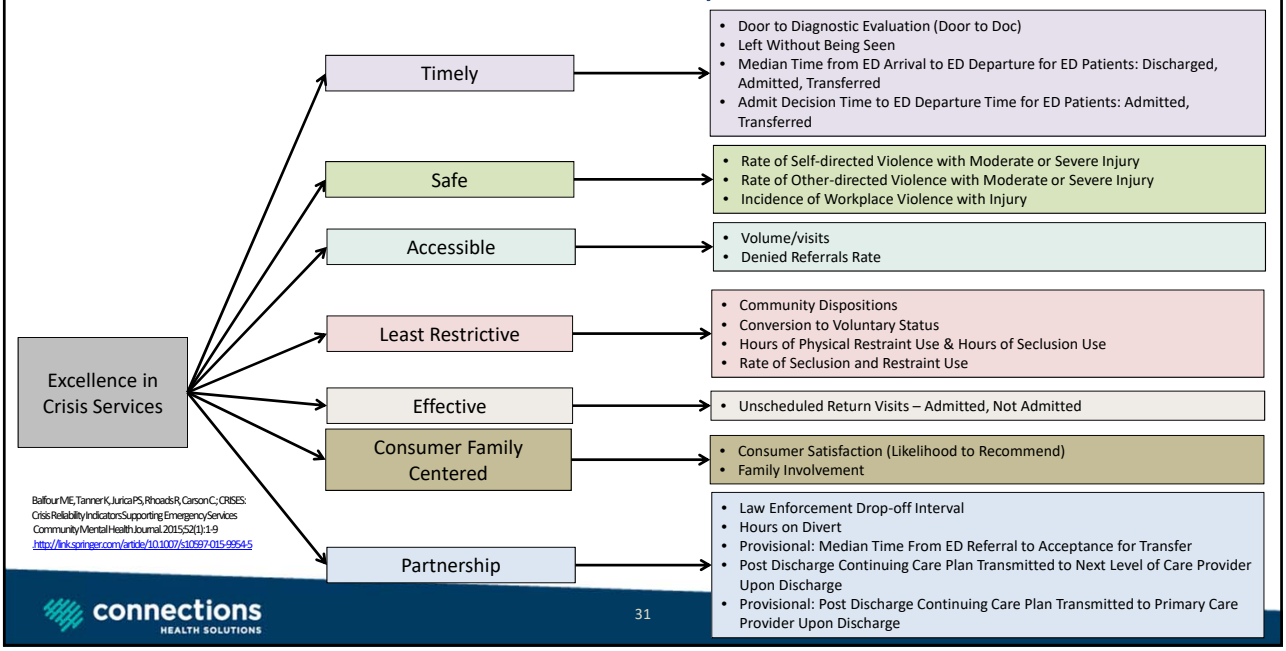
Outcome metrics for facility-based crisis services



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

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Standard Crisis Scorecard Across the Southern Arizona Region

The **Regional Behavioral Health Authority** requires the other 23h crisis facilities to use this framework.

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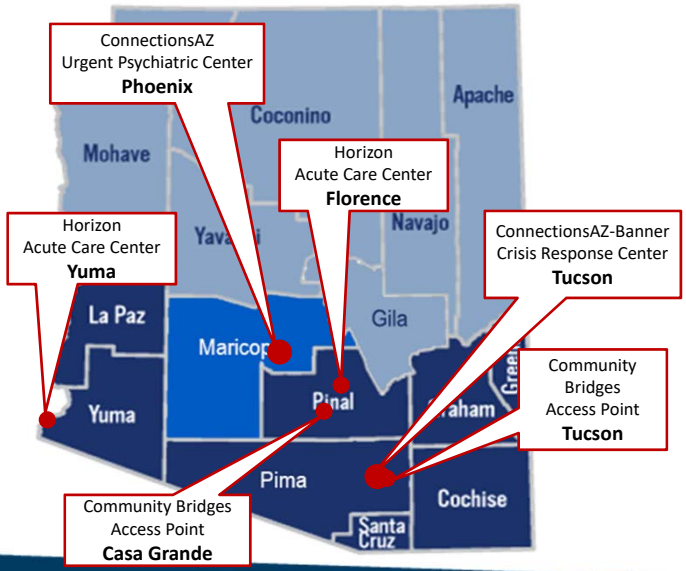
- Consistent outcome measurement across the Southern AZ network
- Monthly data reviews to monitor system performance across the region
  - Insight into volume trends
  - Bed capacity and throughput
  - Community acuity and engagement
  - Ensure accountability and proper discharge planning



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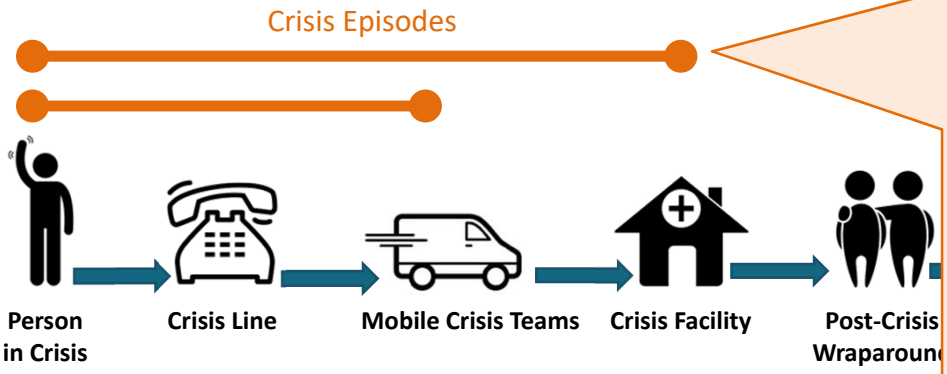
Measuring a crisis episode with multiple providers



How long did it take for the person to move through the various components of the system?

What was the outcome?

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The Arizona Crisis Line: Linking the System Together across multiple health plans

Crisis Line Linkages

- Reporting tools that provide data for coordination of care
- Communicating directly with insurance plans, system partners and outpatient providers

Trigger Triage

- Automated PDF summaries of crisis contact
- Housed on an SFTP site
- Updated in real time
- Accessible by each individual health plan

24hr Summary Report

- Automated Excel overview of crisis contact in the last 24hrs
- Updated every morning via SFTP or secure email
- Sorted by health plan to ensure no crossover

Courtesy Johnnie Gaspar, AZ Complete Health

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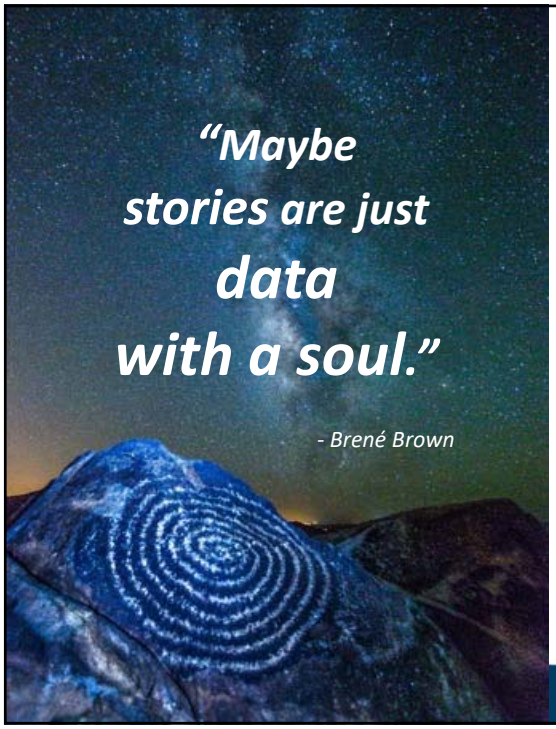

Systems Approach: How can crisis data help improve the whole behavioral health system?

Every crisis visit is a **story** about how someone **couldn't get their needs met** in the community.

If we **turn the stories into data**, it can **reveal trends** about things that need improving in the overall behavioral health system.

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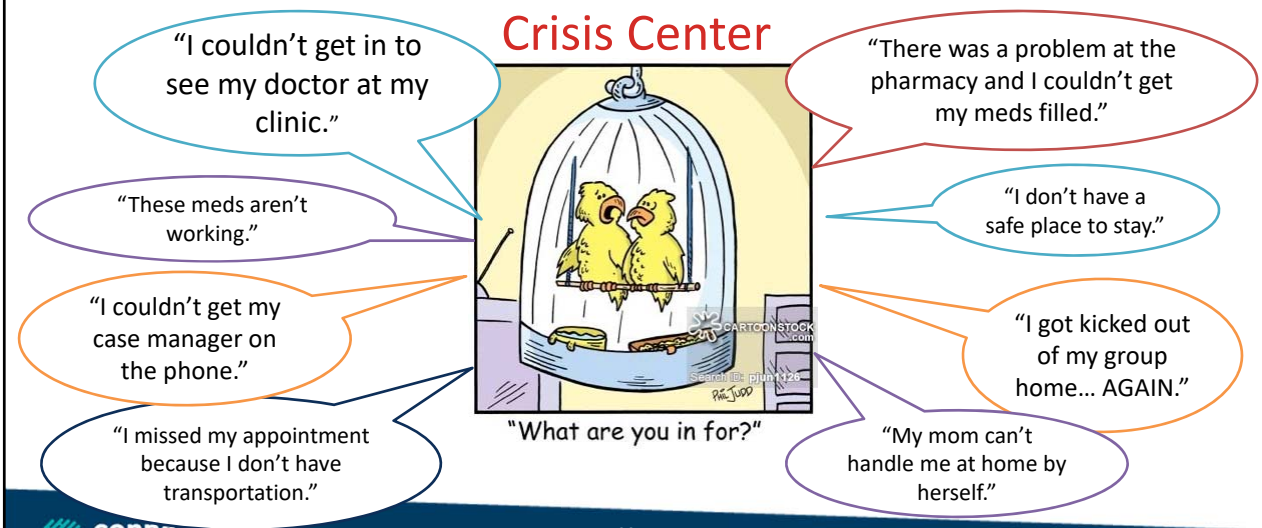
The Canary in the Coal Mine for what's NOT working in the community



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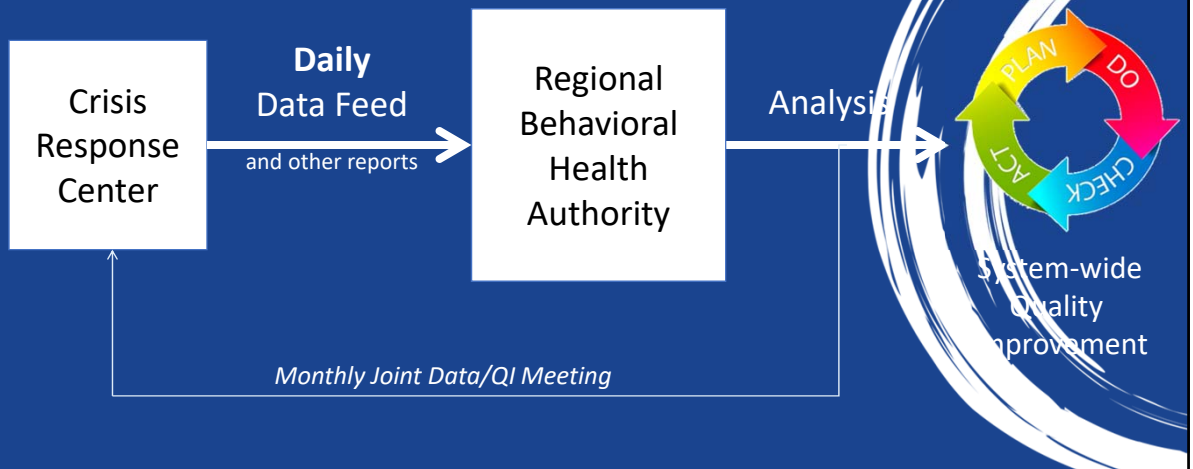
CRC-Payer Data/QI Partnership



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

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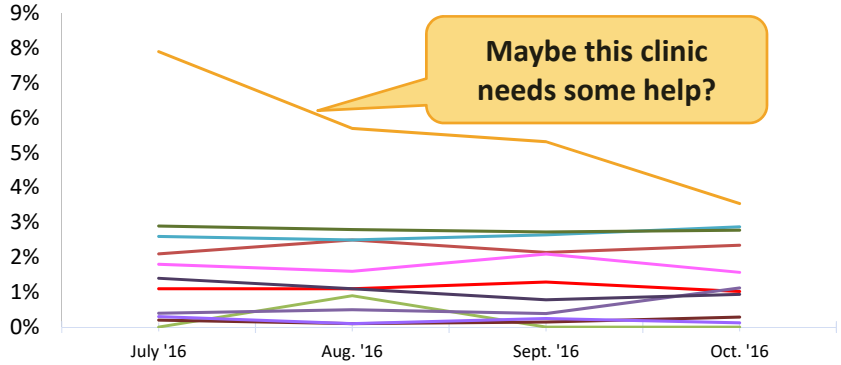
The Power of Crisis-Payer Collaboration

Percent of each clinic's adult population that had a CRC visit



CRC has the NUMERATOR

RBHA has the DENOMINATOR

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"Familiar Faces" QI Plan

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

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, RBHA, 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.

Warnings

Event Date: 1/9/2017
DO NOT DISCHARGE before ART with HOPE DRC, Jerry D[redacted], 990-[redacted], per consultation with Cenpatico MORE

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

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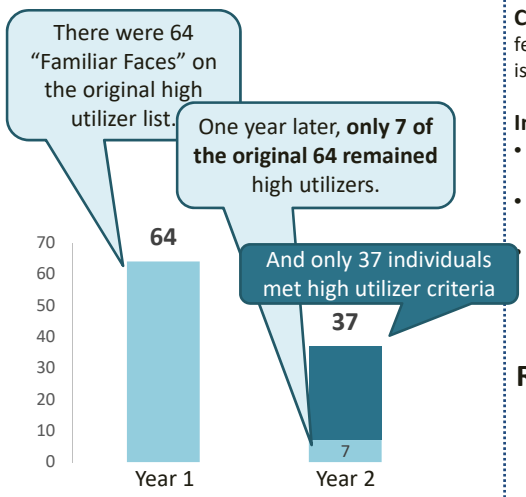
Results: Fewer "Familiar Faces"



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 proactively do welfare checks on nights and weekends to help plan for 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 clinic 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 Q1 2016 to **1** in Q1 2017.

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

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Clinical Approach: "Be a detective, not a bouncer."

- Don't end at "They don't need to be here"
- Figure out what they ACTUALLY need
- Explore reasons for using the crisis center to meet their needs
  - What do they need?
  - Why haven't they been able to get it?
  - What is reinforcing their repeat visits?
  - What do we want to reinforce instead? (Replacing the behavior)
- Partner with patient and "the system" to get their actual needs met

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Familiar Faces: An Evolution

Date of Notificatic	ACC Plan	Funding Category	BH Category	Eligibility Group	Primary Reason for Call	Secondary Reason for Call	Plan Disposition
11/1/2018	ACC - UnitedHealthcare Community Plan	TXIX	Child	ACUTE	Notification of Admission to 23 hour COU	Harm to Self	Notification of Admission to CRC Tucson COU
11/1/2018	ACC - UnitedHealthcare Community Plan	TXIX	Child	ACUTE	Notification of Admission to 23 hour COU	Harm to Self	Notification of Admission to CRC Tucson COU
11/1/2018	No AHCCCS Complete Care Plan	TXIX	GMH	NONE	Notification of Admission to 23 hour COU	Disturbance in Thought	Notification of Admission to CRC Tucson COU
11/1/2018	ACC - Arizona Complete Health	TXIX	SMI	DISABL	Notification of Admission to 23 hour COU	Suicidal Thoughts	Notification of Admission to CRC Tucson COU
11/1/2018	ACC - Arizona Complete Health	TXIX	SMI	DISABL	Notification of Admission to 23 hour COU	Suicidal Thoughts	Notification of Admission to CRC Tucson COU
11/1/2018	ACC - UnitedHealthcare Community Plan	TXIX	GMH	ACUTE	Notification of Admission to 23 hour COU	Suicidal Thoughts	Notification of Admission to CRC Tucson COU

- Prior to 10/1/2018 the RHBA met directly with the CRC and other 24/7 crisis centers with outpatient providers to staff and more effectively plan coordination of care
- 24hr Crisis facilities now alert the crisis line to create both a trigger triage, and daily notification of a member presentation
- This allows each ACC plan to coordinate on familiar faces on a weekly if not daily bases
- It allows the plan more insight into a members presentation and thus can help with care management assignment and admission

Courtesy Johnnie Gaspar, AZ Complete Health

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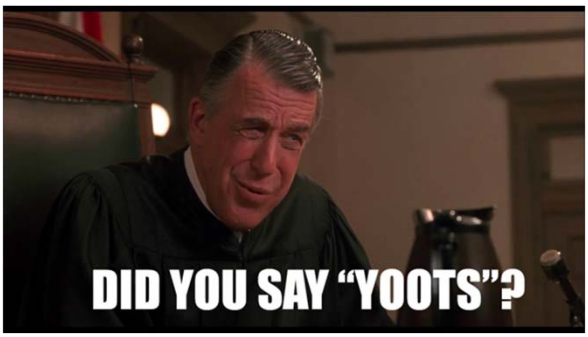
Youth Services
Trends & Interventions



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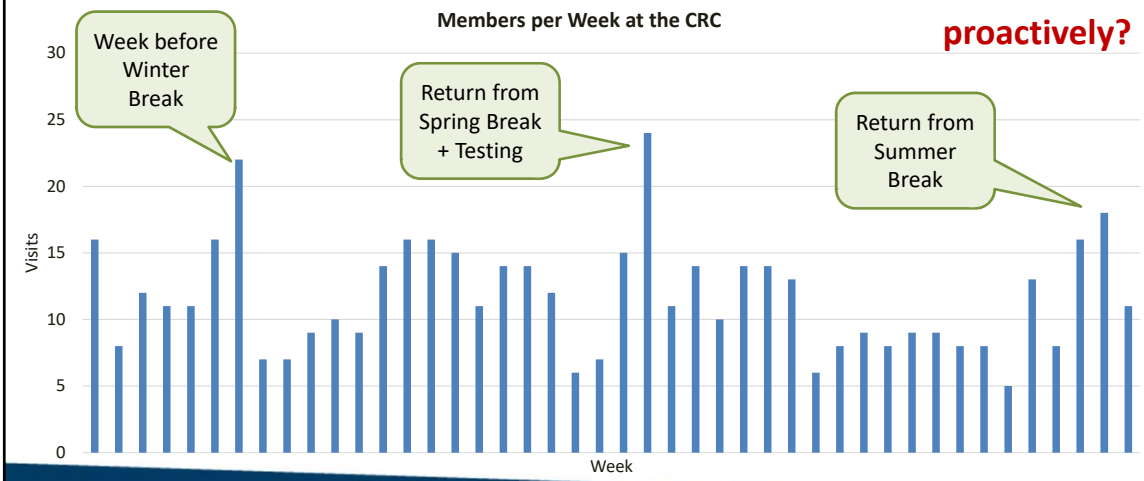
Youth Trends

How can we address proactively?



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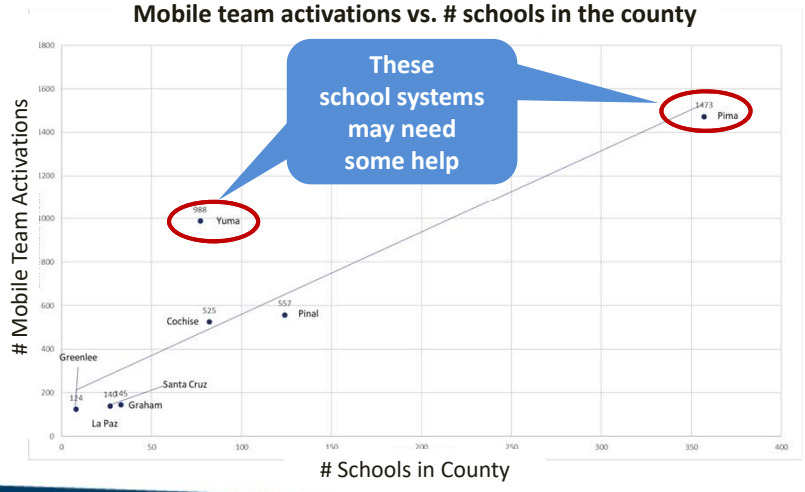
Which schools need the most help?



- The RBHA took a deeper dive to target communities for a pilot program
- Compared mobile team response by county in relation to number of schools
- This allowed us to find **outliers** to target for a pilot program

Courtesy Johnnie Gaspar, Arizona Complete Health

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New School Based Programs

Goal is to identify & enroll members in need of ongoing support

Behavioral Health Co-Location	Medicaid Funding for School Service Provision	Youth Engagement Specialist Program Y.E.S.
• Outpatient Behavioral Health and School partnership • Block Funded Responsibilities • Rotates between five schools 1 day per week • Provides outreach and engagement • Conducts eligibility screening • Coordinates enrollment	• Direct funding for the school based provision of Behavioral Health Services • Fee for Service Responsibilities • Rotates between the same five schools 1 day per week (off day) • Provide direct service provision • Therapy, Case Management, School based behavioral support	• School Resource Officer and Counselor Partnership • Block Funded Responsibilities • On call 8-5 to respond as a Subject Matter Expert at the request of school staff • Attend Individual Education Plan meetings (IEP) • Train on Mental Health First Aid

Courtesy Johnnie Gaspar, Arizona Complete Health

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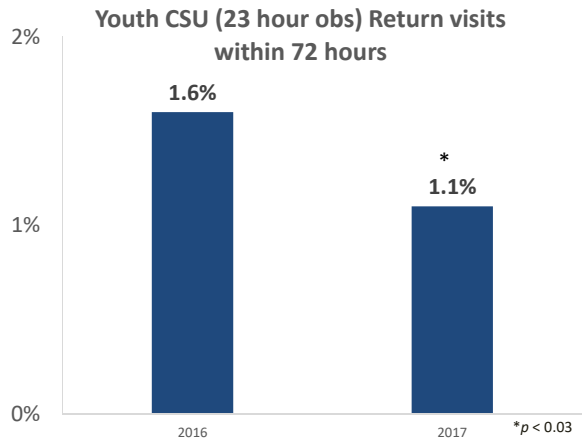
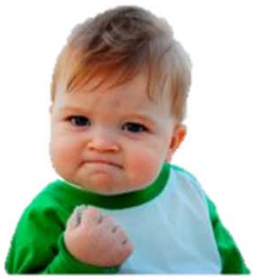
Reduced Readmissions on Youth Unit





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

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Lessons Learned & Key Ingredients

- 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 and values-based** 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."**

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Questions?

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Associate Professor of Psychiatry, University of Arizona
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BJA Bureau of Justice Assistance U.S. Department of Justice
CSG Justice Center THE COUNCIL OF STATE GOVERNMENTS

Tucson is one of the DOJ's Learning Sites for Mental Health Law Enforcement Collaboration. Funding for a visit may be available.

https://csgjusticecenter.org/law-enforcement/projects/mental-health-learning-sites/

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Models of Crisis Stabilization

Nomenclature varies by state, but as a general guide:

Model	Description	Level of Care	Acuity	Locked	Police drops	Use of peers
23 hr. obs	Short-term (< 24 hrs.) assessment and stabilization with hospital level staffing and safety protocols	LOCUS 6 "Medically Managed" with 24/7 nursing and medical coverage	Can take both low and high acuity/violent patients	Yes	Yes	Yes
Living Rooms	Short-term (< 24 hrs.) stabilization in a home-like environment with mostly peer staffing	LOCUS 5 "Medically Monitored" with medical/nursing staff available but not on-site 24/7	Lower acuity patients not at imminent risk of harm to self/other, not agitated or violent	No	Sometimes	Yes
Sobering Centers & "Social Detox"	Short-term (< 24 hrs.) stabilization for patients with substance use needs, typically not using meds			No	Sometimes	Yes
Crisis Residential	Intermediate term (days to a couple weeks) crisis stabilization in a residential setting			No	Usually not	Yes

Programs may also have niche specializations depending on other affiliated community services. For example: San Antonio's program is located on a housing campus and focuses heavily homelessness recovery. Tucson's center is attached to an emergency room and collaborates closely with the ED to reduce ED boarding.

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