CRISIS NOW
Transforming Crisis Services

Business Case

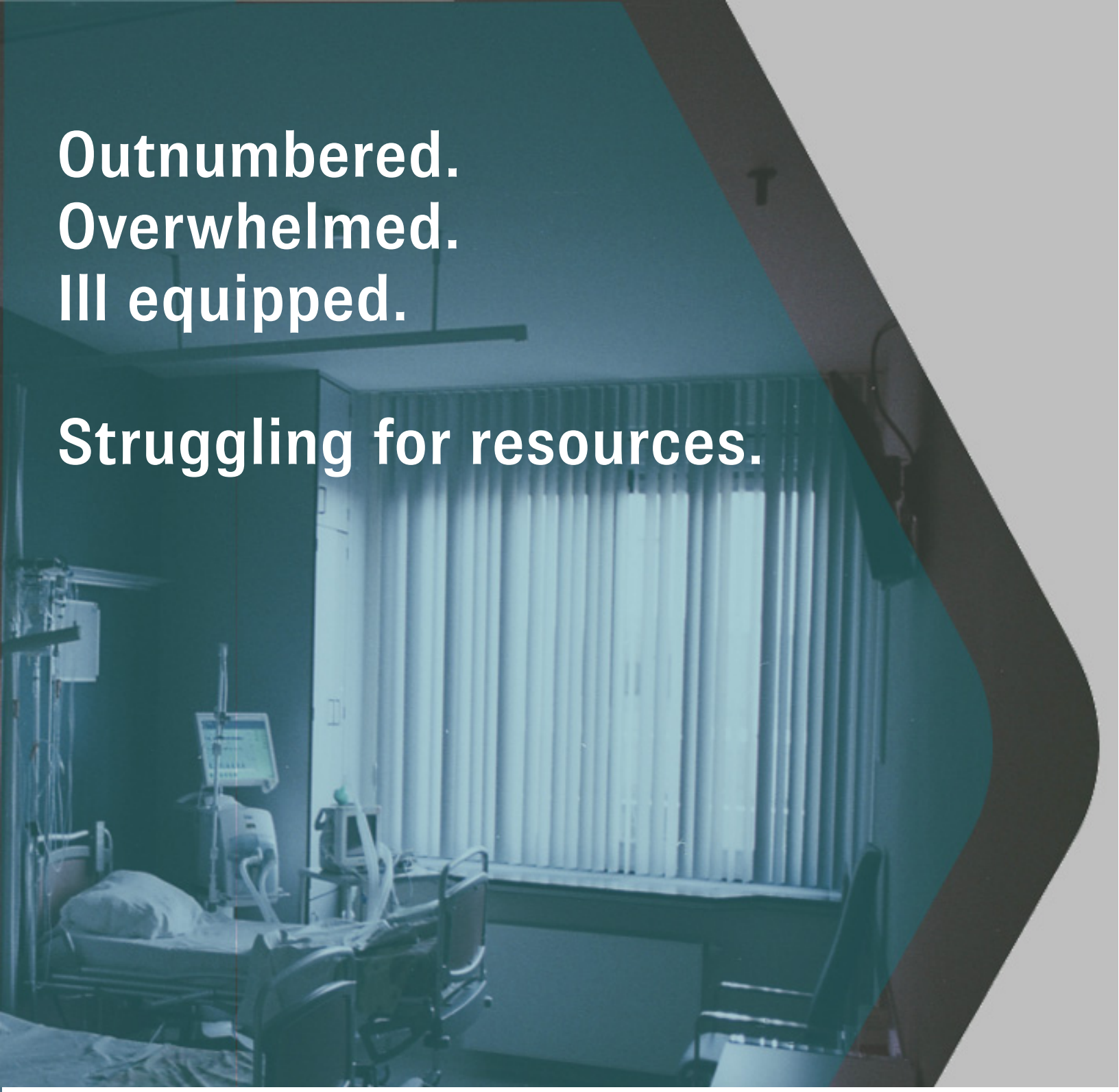
The Crisis Now Model

This business case builds on the foundational model:
Covington D, Hogan, M, et al. Crisis Now: Transforming services is within our reach. National Action Alliance for Suicide Prevention: Crisis services task force; 2016.

Prepared by Crisis Tech 360, a joint venture of RI International and Behavioral Health Link, national leaders in crisis to recovery programs (2018).

Key informants to the assumptions in this report:

Dr. Michael Hogan, NYS Mental Health Commissioner (2007-2012); Detective Nick Margiotta, Retired Phoenix PD, CIT International Board of Directors; Dr. Michael Allen, Professor Psychiatry and Emergency Medicine; Wendy Farmer, LPC, MBA, CEO, Behavioral Health Link; and RI International crisis facility directors Sarah Blanka, Rivers Carpenter, Purcell Dye, Jodie Leer, Tammy Margeson, Joy Brunson Nsubiga, Arneice Ritchie, and Peggy Wiley.



Outnumbered.
Overwhelmed.
Ill equipped.

Struggling for resources.

Evidence suggests that your community's emergency departments are losing the battle of mental health access and care.

“8 in 10 ED Doctors Say Mental Health System Is Not Working for Patients.”

Survey by the American College of Emergency Physicians (ACEP) of 32,000 physicians, residents, and medical students working in hospital emergency departments.

Is it any different in your community?

Traditional Community Crisis Flow

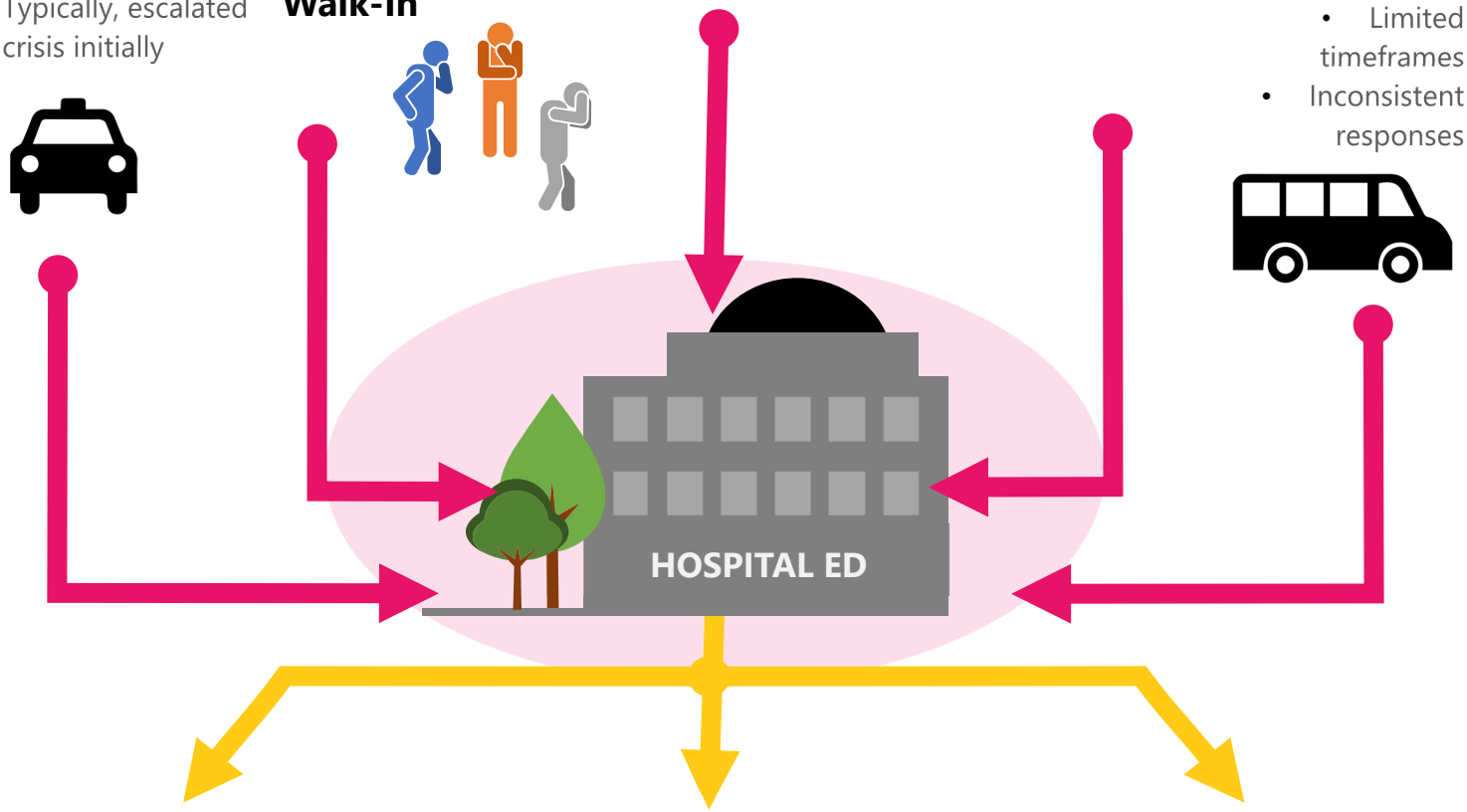
Police
- The untrained MH workforce.
- Typically, escalated crisis initially

Individuals, Friends, Family Walk-In

Primary Care & Social Services

Crisis Call Lines

Mobile Outreach
- Few locations
- Limited timeframes
- Inconsistent responses

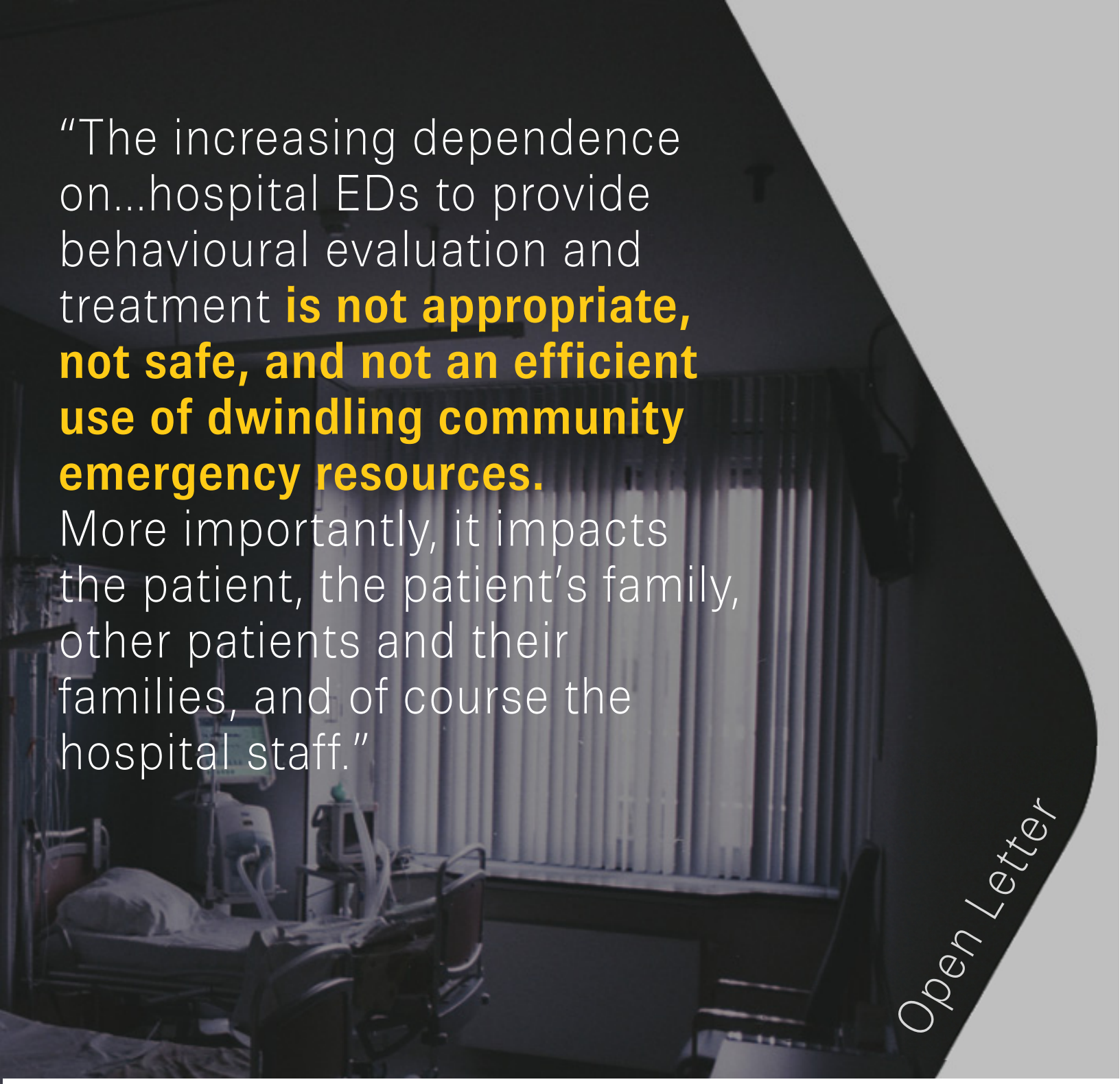


ACUTE SERVICES
- Extreme cases only where capacity exists
- Interminable waits common

REFERRED ELSEWHERE
- Outpatient Mental Health
- Community Resources
- Detoxification/Substance Abuse Services

SERVICES DECLINED
- Referred back to community/ natural supports
- No therapeutic support
- Incarceration/Relocation

Where's the Choke Point in the Usual Approach?



"The increasing dependence on...hospital EDs to provide behavioural evaluation and treatment **is not appropriate, not safe, and not an efficient use of dwindling community emergency resources.** More importantly, it impacts the patient, the patient's family, other patients and their families, and of course the hospital staff."

Open Letter

Sheree (Kruckenberg) Lowe, VP of Behavioral Health for the California Hospital Association, representing 400 hospitals and health systems

Seattle Times 2013.
Lack of space forced those involuntarily detained in EDs to wait on average 3 days.

Every time such an inhumane psychiatric boarding occurs, the hospital experiences a cost/loss of $2,264

Radically transforming mental health

Good crisis care prevents suicide and provides help for those in distress. It cuts the cost of care, reduces the need for psychiatric acute care, hospital ED visits and police overuse.

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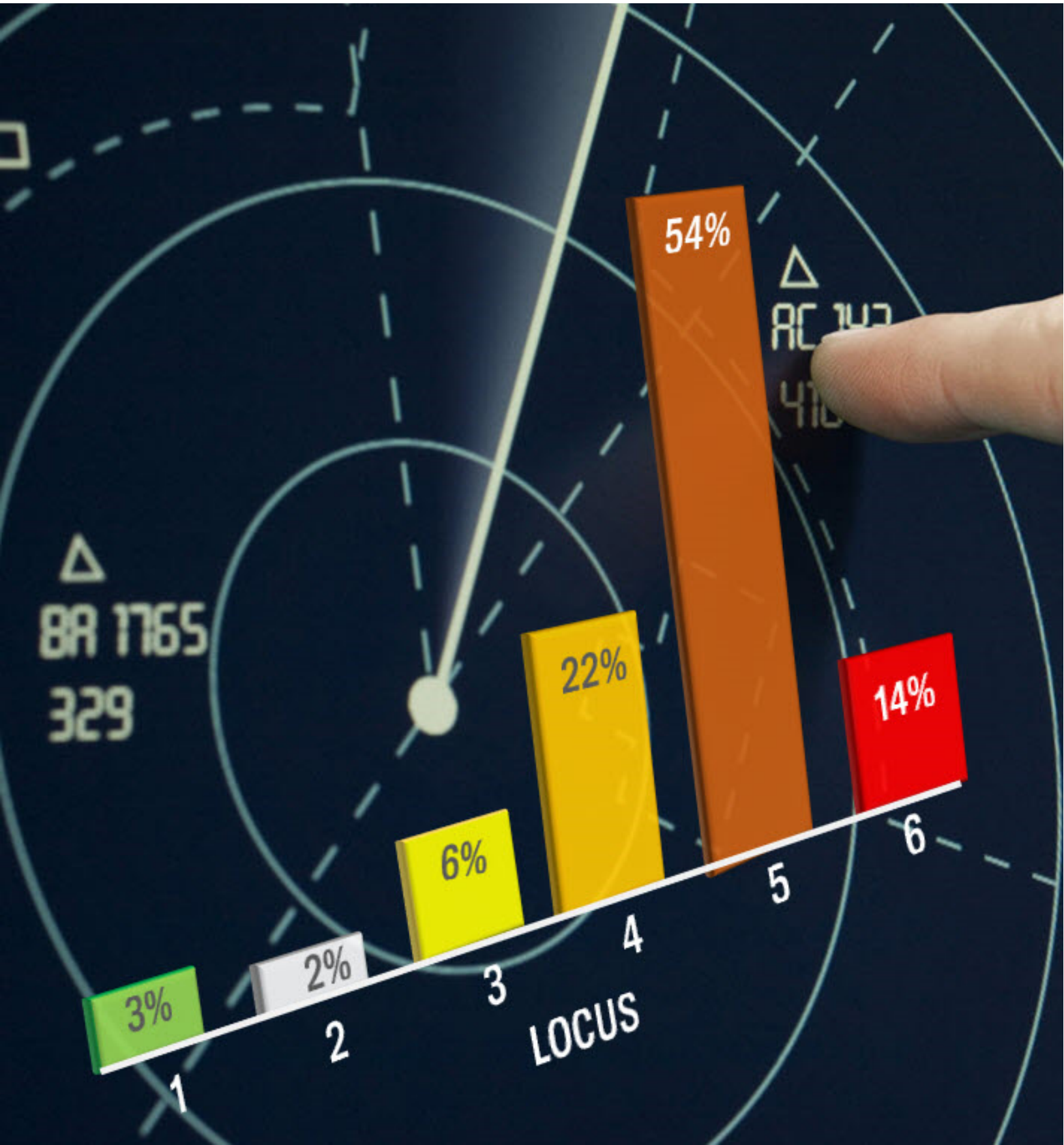
We utilized more than a decade of statewide crisis data to produce the analysis in this report.



What is the Crisis Now model?

Three core services in a crisis continuum deployed as full partners with law enforcement, hospitals and first responders.

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Law Enforcement By-passes the Emergency Room and Proceeds Directly to Crisis

Mobile Crisis

Crisis Facilities

5 to 7 Minute Turn-Around Police Drop Off. No Call. No Referral. No Rejection. Simple.

Crisis Facilities

“Air Traffic Control” Crisis Call Center Hub Connects and Ensures Timely Access and Data

What difference does Crisis Now make?

In the 4-million-person community of Maricopa County (Phoenix, Arizona) the continuum of crisis services has had the following outcomes compared with a community without them.

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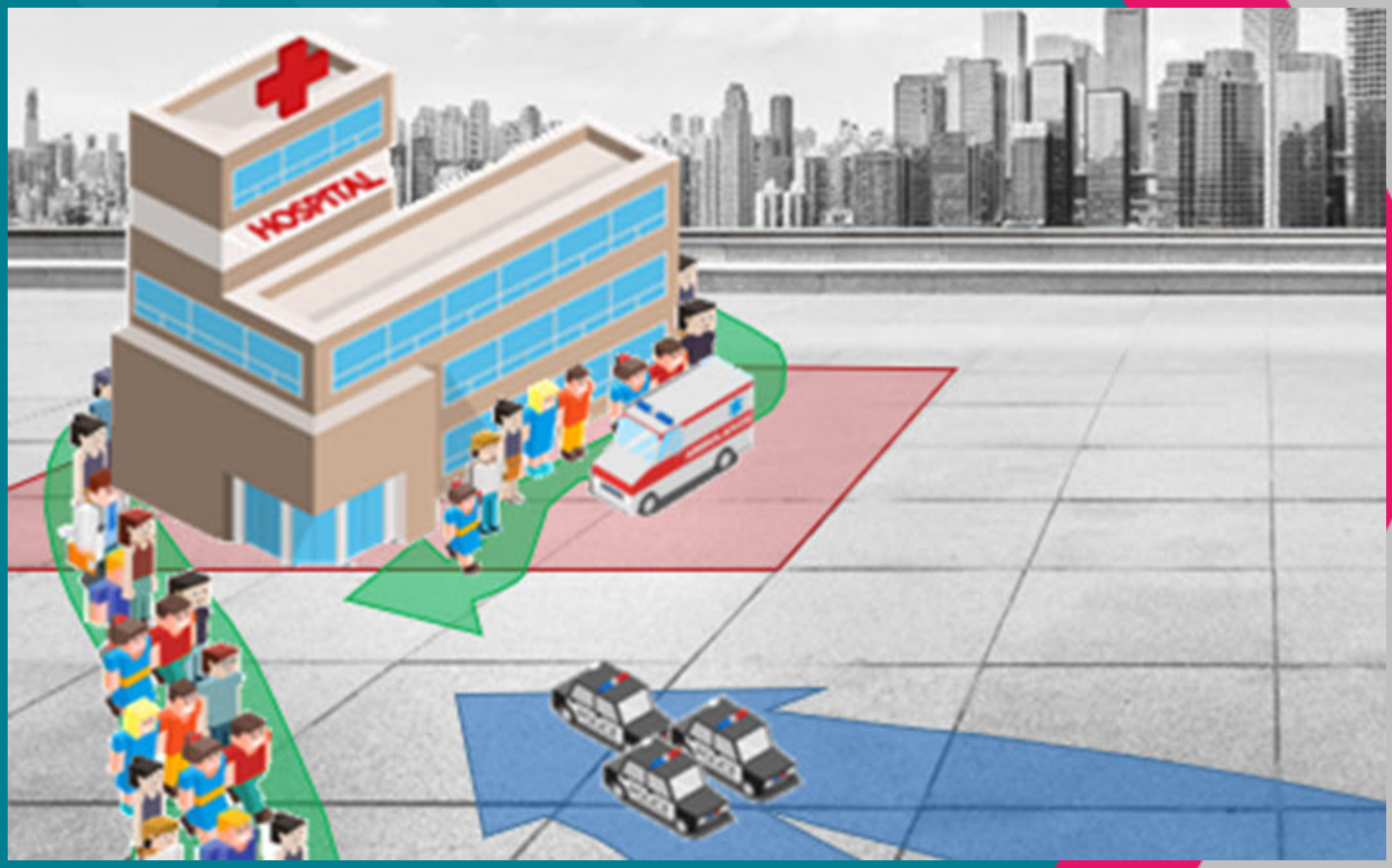
37 FTE Police Officers Engaged in Public Safety Instead of Mental Health Transportation/Security

Resource savings for fire fighters also exist but not yet quantified.

A Staggering Reduction of 45 Cumulative Years of Psychiatric Boarding (aka Waiting in the ED)



Creating a savings to hospitals of **$37 million** in avoided costs/losses

Reduced Potential State Acute Care Inpatient Expense by $260 million

The cost avoidance represents the net savings of a $100 million investment in a full, integrated crisis continuum

Key references to the mathematics in this report:

"The Impact of Psychiatric Patient Boarding in Emergency Departments" (2012) (Nicks and Manthey):

- 35% of those consulted to psychiatry required inpatient care
- The average hospital ED length of stay was 1,089 minutes)
- The hospital psychiatric patient boarding cost was $2,264 per person

"Amazing Results of Team Work: 2016 Diversions" (2017) (Mercy Maricopa Integrated Care RBHA, Arizona):

- In 2016, 21,943 individuals with mental health and addiction challenges were handed off from Phoenix area police departments directly to crisis
- Reportedly, approximately 1,000 individuals received a direct connection through fire fighters, but these relationships are newer and the full potential is yet unknown.

"Psychiatric Bed Supply Per Capita" (2016) Treatment Advocacy Center:

- The consensus opinion of an expert panel on psychiatric care estimated the need as around 50 public psychiatric beds per 100,000 population

"Georgia Crisis & Access Line LOCUS" (2006-2017) Behavioral Health Link

- 1.2 million caller episodes of care were evaluated for higher intensity cases in which emergency department, law enforcement or mobile crisis were involved
- 54% were LOCUS Level 5, which warrants non-secure sub-acute crisis levels of care

"Crisis Now Business Case" (2017) David Covington presentation at the National Dialogues on Behavioral Health Conference (New Orleans)

- Crisis Now model improves "Crisis Clinical Fit to Need (CCFN)" by 6x (meaning that the LOCUS assessment matches the connected service description)
- Psychiatric inpatient expense reduced from a potential $485 million to $125 million (savings of $260 million after adding the $100 million investment in crisis continuum)
- Seattle Times reported avg. psychiatric boarding time in Washington State 3 days (2013)
- Carolinas Healthcare reported baseline psychiatric boarding 40 hours on average (Dr. John Santopietro presentation at the National Council for Behavioral Health)
- Average hospital ED waiting time for person without SMI 2 to 3 hours

"The Impact of Psychiatric Patient Boarding in Emergency Departments" (2012) (Nicks and Manthey):

- 35% of those consulted to psychiatry required inpatient care
- The average hospital ED length of stay was 1,089 minutes (just over 18 hours)

"Law Enforcement and Mental Health" (2017) Ruby Qazilbash Bureau Justice Assistance to Interdepartmental Serious Mental Illness Coordinating Committee (ISMICC)

- In Madison, WI, law enforcement BH calls 3 hours versus 1.5-hour average contact
- By contrast, in the Arizona model BH calls 45 minutes to 1 hour (direct transport to sub-acute crisis urgent care with 5 to 7-minute turnaround, per Nick Margiotta)

Leave the dry erase markers to the brainstorming sessions

Is your crisis bed board electronic?

CrisisTech 360

crisisnow.com

The time is now to transform our approach to crisis mental health care. Together, we can, and must, do this.

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