Measuring the Effectiveness and Outcomes of Crisis Bed Registries

Transformation Transfer Initiative 2019
The Importance of Crisis Bed Registry Metrics

NRI’s 2018 Case Study of Existing Bed Registries found that creating and making public reports on the operation of bed registries is a useful approach to improve registry effectiveness and document successes.

- Establishing and working towards common goals among partners
- Creating a feedback loop to continuously improve access and quality
- Holding partners accountable for improving the delivery of behavioral health services
- Building public support by demonstrating the impact of a registry and crisis services on public health
Caveats

• We measure what we value.
  • Data collection during the development of bed registries naturally focus on operations, timeliness of updates, and efficiency of client movement.
  • As tools to improve the delivery of care to people in crisis, bed registry metrics should include its broader systemic impact on public health and public safety.
• Engage partners early and often about measures.
Today’s Presenters

Mihran Kazandjian
Research Associate
NRI

Krista Ragan
Program Manager
North Carolina Behavioral Health Crisis Referral System

Elizabeth Romero
Delaware

Debbie Atkins
Director
Georgia Office of Crisis Coordination
What are TTI states reporting? (or planning to report?)

In June, NRI sent out a short survey to all 23 TTI states as well as other states with existing crisis bed registries.

Survey asked about what information states are putting into reports, who sees reports, and other information about measures states are using.

- 17 TTI states responded
- 2 non-TTI states responded
Public or Private Reports

NRI found that in many states, the decision to build reports on the operation of crisis bed registries were not made until after the registry was operating.

• Some of these States then experienced resistance from providers to making reports public (or fearing adverse reactions) decided to not make reports public

• A lesson learned from states with existing systems was to discuss with all stakeholders what should be measured and what will be made public while designing and implementing the system.
Polling Question #1

What role do stakeholders such as crisis counselors and hospitals have in reviewing data? (check all that apply)

• They approve measures
• They suggest measures
• They are consulted on measures before the state selects them
• They are consulted on measures before they are implemented
• They are consulted on measures after they are implemented
• They are instructed on how to collect and report measures
• They have full access to data
• They have limited access to data
• They receive narratives of reports from the state
• They do not receive reports
Administration/Operations Measures

<table>
<thead>
<tr>
<th>Measure</th>
<th>Number of States</th>
</tr>
</thead>
<tbody>
<tr>
<td>Time that elapses between updates</td>
<td>16</td>
</tr>
<tr>
<td>Number of beds currently available</td>
<td>16</td>
</tr>
<tr>
<td>How compliant are facilities at updating their registry</td>
<td>15</td>
</tr>
<tr>
<td>Types of beds currently available</td>
<td>15</td>
</tr>
<tr>
<td>Reasons for referral denials</td>
<td>7</td>
</tr>
<tr>
<td>Referral denials by facility</td>
<td>6</td>
</tr>
</tbody>
</table>
Date and time of referrals: 5
Number of referrals denied admission over a period of time: 5
Average wait time for clients in crisis wait for approved placement: 5
Demographic characteristics of patients needing referrals: 5
Average wait time for clients in crisis wait to be referred: 4
Average wait time for clients in crisis wait to be physically admitted: 4
Other Administrative/Operations Measures

- A separate, secure portion of the registry tracks individuals boarding for inpatient and Community-Based Acute Treatment levels of care for 24 hours or longer. This allows us to track data regarding boarders and barriers to placement. We also track individuals who are on inpatient psychiatric units, ready for discharge/transfer, and waiting for placements. (MA)

- If referrals are canceled (NC)
- How placement are transported (NC)
- If there are no shows or not admitted (NC)
What types of outcome measures does (or will) your registry collect to document improvements to care/outcomes?

<table>
<thead>
<tr>
<th>Measure</th>
<th>Number of States</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of placements over a specific period of time by each reporting facility</td>
<td>10</td>
</tr>
<tr>
<td>Number of clients with approved placements during a specific time period (e.g. number of bed placements per month)</td>
<td>8</td>
</tr>
<tr>
<td>Number of referrals through the bed registry</td>
<td>8</td>
</tr>
<tr>
<td>Demographic characteristics of patients needing referrals</td>
<td>7</td>
</tr>
<tr>
<td>Average wait time from referral to acceptance (all clients)</td>
<td>7</td>
</tr>
<tr>
<td>Average wait time from referral to denial (all clients)</td>
<td>7</td>
</tr>
</tbody>
</table>
Outcome Measures (cont’d)

1. Average wait times for admission (in general) to each reporting facility (all clients)
2. Geographic differences in referrals, admissions, and denials to assess needs across the state
3. Number of clients diverted from an inpatient hospital bed to less intensive settings, but still referred to treatment
4. Number of crisis line calls over a specific period of time
5. Number of emergency department visits over a specific period of time

Number of States
Other Outcome Measures

• Detailed information is tracked via a secure component of MABHA for those who are boarding 24, 48, and 96 hours or longer

• De-identified data collected/analyzed to determine what factors alone or in combination may result in longer stays

• More difficult placements

• Identification of services not available at all in our state

• Calculate occupancy rates in order to measure outcomes as defined by the Department of Mental Health
The Administrative/Operations Measures
States Find to Be Most Useful

• "Useful measures include: a) length of stay b) appropriate level of care c) info on where individuals are being referred from d) length of time in the referral process, etc. Basically, any data that will help drive the system programmatically and for strategic planning purposes has been found to be useful"

• Number of Beds available and Provider System Usage

• Rate of completion of the count/age/gender of available beds

• (Number of beds currently available, Demographic characteristics of patients needing referrals, Number of referrals denied admission over a period of time, and Reasons for referral denials).

• bed/referral capacity, contact information, and total capacity per unit/facility,

• monitor members who have been awaiting placement (either step-down or step-up) for over 24 hours

• children’s outpatient services submit referral and waitlist data on a monthly basis per the requirements of a lawsuit

• information related to updating status, compliance, facility types with accepting status. Future goal: wait times, reasons for denials, referral response times

• Short term care facility bed occupancy rate; patient placement delays in screening/ED’s being reduced (traded through existing data collection).
The Measures States Find to Be Most Useful to Monitor the Success of the Registry

- **8 states**: Average wait time between referral and acceptance/Approved placements
- **4 states**: Up-to-date bed availability; Increase in the number of participating levels of care/usage of system; Service utilization/Turnover/Number of placements made by system
- **2 states**: Location of services/Reduction in distance traveled to services; Denial rates; Volume of inpatient/ED services; Reduction in the number of boarders in the ED
- **1 state**: Number of individuals diverted from ED; Number of ED visits over time; Evaluation of acceptance and rejection rates based on demographics; Operational integrity of system; Qualitative feedback from stakeholders
Who can Access the Registry?

- Emergency Department Staff
- Crisis/Respite Staff Members
- Private Psychiatric Hospital Staff
- State Psychiatric Hospital Staff
- General Hospital Staff
- Community Behavioral Health Providers
- Other types of Behavioral Health Professionals
- Residential Treatment Center Staff
- Department of Corrections/ Criminal Justice Agents
- Public
- Other
What Groups See Reports from Crisis Bed Registry?

- Crisis Providers: 12
- Psychiatric Hospitals: 6
- Emergency Departments: 7
- Legislature: 10
- Community MH Providers: 7
- Families and Consumers (and Their Organizations): 8
- Other: 2
Discussion and Questions
Krista Ragan
Program Manager
North Carolina Behavioral Health Crisis Referral System
NC BH-CRSys: Design

• Secure, HIPAA-compliant, web-based system
  • Only eligible facilities have access (voluntary*, approx. 250 eligible)
  • Memorandum of Understanding and Business Associate Agreement with each facility

• Emphasize that the primary role of BH-CRSys isn’t as a registry or for data collection, it’s a tool to aid in the timely and appropriate placement of those experiencing behavioral health crises

• Functions:
  • Up-to-date profile information on Facilities – Search & Filter
  • Accepting Status of Receiving Facilities – Updated at least twice daily
  • In-system referrals
  • All of the above result in data for the facilities and de-identified data for regional and statewide analysis for data-informed decision making (as allowable under HIPAA)
NC BH-CRSys: Data types

• Operational data – easy to collect, important at the beginning and for ongoing monitoring – tells you that you have a system
  • Participating facilities
  • Updating information
  • Users

• Data for deeper analysis
  • The information that allows us to really drill down
  • Data that allows us to look at demographics, referral information, regions, statewide analysis, etc.
  • Not just identifying gaps in services. Able to look at more complex analysis of factors that may be involved in longer waits, examine the impact of different processes and policies, and more
First Step: Purpose of registry

• Identifying the purpose and base design of your registry/system
  • Is it strictly a registry?
  • A data collection tool?
  • A multifunctional tool?
  • Who are the potential users?
  • What information may be in it?
Example Metrics

• Referrals sent to facilities that cannot accept them (i.e. outside of catchment area; geriatric referral sent to facility that doesn’t accept anyone over 55, etc.) *(Education/Training needs or changes to system design)*

• Number of psychiatric holds overnight in the Emergency Department *(Analysis of average % of ED beds at facilities that are occupied by behavioral health holds)*

• Average length of stay by presenting problem and other factors *(compared to services available and location)*

• Involuntary (Civil) Commitments
Identifying the role/purpose of data in your system

• What is the purpose of the information you will be collecting?
• What do you want to collect?
• What do you need to collect?
• What are you able to collect?
• How will it be collected?
• How will you get data out of it?
Additional considerations for data planning

• Addressing Anecdotal Information
  • There is a lot of anecdotal information out there, which is important and can be very useful in design and in telling the story, but data is needed to back it up

• Addressing the “Need More Beds” Statement
  • Misconception that behavioral health crises beds are “one-size fits all”
  • Outside of those working in the field or with lived experience, there may be a lack of understanding how crisis placement works may be a challenge

• Distinct populations, regions, availability of services, processes, policies and statutes
  • There are considerations for who is served, what is available in different regions, policies and procedures that may result in major differences – need to understand potential factors that could tie into the data analysis
BH-CRSys lessons learned: We are a work in progress....

• Start at version 1.0
  • It’s the beginning, expect challenges, plan for upgrades

• Observe how things work – at multiple points
  • Watching how others operate may tell you what information is available, and what is important, when feedback can’t

• Ask what is needed, but utilize active listening
  • A lot of data elements/needs came up in passing conversations or after through conversations about functions or features
Elizabeth Romero
Delaware
RESHAPING DELAWARE'S BEHAVIORAL HEALTH TREATMENT SYSTEM

Elizabeth Romero, MS
Director
elizabeth.romero@delaware.gov (302) 255-9398
DELWARE STATISTICS
## Delaware Overdose Deaths

<table>
<thead>
<tr>
<th>Year</th>
<th>Number of Deaths</th>
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<tr>
<td>2012</td>
<td>172</td>
</tr>
<tr>
<td>2013</td>
<td>188</td>
</tr>
<tr>
<td>2014</td>
<td>223</td>
</tr>
<tr>
<td>2015</td>
<td>229</td>
</tr>
<tr>
<td>2016</td>
<td>308</td>
</tr>
<tr>
<td>2017</td>
<td>345</td>
</tr>
<tr>
<td>2018</td>
<td>400</td>
</tr>
</tbody>
</table>
DELAWARE RANKED FIRST IN THE NATION FOR HIGH-DOSE OPIOID PRESCRIPTIONS

ANNUAL HIGH-DOSE (≥90MME/DAY) PRESCRIBING RATES PER 100 PERSONS

Delaware United States

2008 11.9
2009 11.5
2010 11.4
2011 8.8
2012 8.3
2013 7.6
2014 7.1
2015 6.7
2016 6.1
2017 5.0

DELAWARE RURAL HEALTH CONFERENCE 6/3/2019 Slide 32
CURRENT TREATMENT AND ENGAGEMENT: BUILDING ON OUR EXISTING PERFORMANCE

Initiation of Alcohol & Other Drug Dependence Treatment: Age 18 & Older

**DELAWARE**

38%

**UNITED STATES**

36%

Source: CMS Adult Core Set for Medicaid, 2016
CURRENT TREATMENT AND ENGAGEMENT: BUILDING ON OUR EXISTING PERFORMANCE

Engagement of Alcohol & Other Drug Dependence Treatment: Age 18 & Older (Engagement Rate)

**DELAWARE**
16%

*Source: CMS Adult Core Set for Medicaid, 2016*

**UNITED STATES**
14%
STARTING SOONER
BEHAVIORAL HEALTH & CHRONIC DISEASE

<table>
<thead>
<tr>
<th>Chronic Medical Condition</th>
<th>% With Depression / Anxiety</th>
<th>% Treated For Depression / Anxiety</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arthritis</td>
<td>32.3%</td>
<td>7.1%</td>
</tr>
<tr>
<td>Hypertension</td>
<td>30.5%</td>
<td>5.5%</td>
</tr>
<tr>
<td>Chronic Pain</td>
<td>61.2%</td>
<td>5.9%</td>
</tr>
<tr>
<td>Diabetes Mellitus</td>
<td>30.8%</td>
<td>5.2%</td>
</tr>
<tr>
<td>Asthma</td>
<td>60.5%</td>
<td>6.8%</td>
</tr>
<tr>
<td>Coronary Artery Disease</td>
<td>48.2%</td>
<td>5.7%</td>
</tr>
<tr>
<td>Cancer</td>
<td>39.8%</td>
<td>5.7%</td>
</tr>
</tbody>
</table>

**SOURCE:** National Council for Behavioral Health and The American Hospital Association (2019).
DELAWARE’S TREATMENT SYSTEM

SUBSTANCE USE TREATMENT AND RECOVERY TRANSFORMATION (START) INITIATIVE

DELAWARE TREATMENT AND REFERRAL NETWORK (DTRN)
THE INDIVIDUAL IS CONSIDERED ABOVE ALL — TREATMENT IS PERSON-CENTERED
INSTANTLY CONNECTING PEOPLE IN CRISIS WITH THE CARE THEY NEED

- A transparent, efficient, and effective flow between primary and emergent care and behavioral health specialty care
- Matches a patient with services and resources
- Improves transitions of care
- Improves and enhances patient and care provider experience
- Gives patients a better chance to live the best life possible
DTRN AT A GLANCE

- There are over 800 users from 42 organizations within the state.
  - 21 new organizations are in the queue to be onboarded
  - All Health System EDs are participating and Peninsula Regional in Maryland will be joining
  - 7 primary care groups will be participating by August
  - Pediatric providers will be participating by end of summer (Nemours, Kids Dept, etc.)
- Since Go live September 2018, there were 13,147 referrals and current averaging weekly referrals is 450.
- Most referrals (66%) were responded to within 30 minutes.
- Through June 2019 there were a total of 1,155 declines to referrals.
UTILIZATION: TOTAL REFERRALS

September 2018 through June 2019

Referrals Received:
- Connec: 1943
- Dover: 1514
- Rockfor: 1404
- Meado: 1286
- Receve: 1207
- SUN: 651

Referrals Sent:
- Ri: 1490
- Bajh: 1317
- Con: 864
- Treb: 750
- Beb: 648
- Dep: 584
Initially, most referrals were for Psych Inpatient (90% in September) now PI encompasses 50% of the total referrals in June. Providers are referring to more outpatient services.
September 2018 – June 2019
Overall 9% of the referrals were declined with majority due to Patient Acuity (38%) and Bed Availability (30%).

Most Patient Acuity declines were the result of clients “not admitted due to preexisting medical conditions”.

The most common decline within bed availability was due to the facility being at capacity or a lack of beds based on age (adolescents and geriatric) and the sex of the patient (mostly female).

Only 7% of the declines did not provide a reason.
THE INDIVIDUAL IS CONSIDERED ABOVE ALL — TREATMENT IS PERSON-CENTERED
Polling Question #2

What data do you wish your bed registry program could collect and report that would improve access and quality of care?
Debbie Atkins
Director
Georgia Office of Crisis Coordination
Overview of Current Reports

• CSU Length of Stay Report for one of our regions.
Current Reports

• CSU Admissions for a region
## County of Origin Data

### DBHDD - County of Origin - FY 2019

<table>
<thead>
<tr>
<th>Region 1</th>
<th>Avita</th>
<th>Cobb-Douglas</th>
<th>Highland Rivers</th>
<th>Total CSU Admits</th>
<th>% of total population</th>
<th>Total CSU &amp; SCB Admits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Catoosa</td>
<td>0</td>
<td>0</td>
<td>80</td>
<td>80</td>
<td>3.5%</td>
<td>108</td>
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<tr>
<td>Chattooga</td>
<td>1</td>
<td>1</td>
<td>74</td>
<td>75</td>
<td>1.4%</td>
<td>173</td>
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<tr>
<td>Dade</td>
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<td>0</td>
<td>29</td>
<td>29</td>
<td>0.5%</td>
<td>43</td>
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<tr>
<td>Decatur</td>
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<td>0</td>
<td>297</td>
<td>297</td>
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<td>310</td>
<td>312</td>
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<td>Haralson</td>
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<td>18</td>
<td>44</td>
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<td>111</td>
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<tr>
<td>Highland Rivers</td>
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<td>6</td>
<td>38</td>
<td>44</td>
<td>0.8%</td>
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<tr>
<td>Bartow</td>
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<td>296</td>
<td>536</td>
<td>536</td>
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<td>102</td>
<td>102</td>
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<td>Pickens</td>
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<td>50</td>
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<td>75</td>
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<tr>
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<td>234</td>
<td>258</td>
<td>258</td>
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<td>52</td>
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<td>1.4%</td>
<td>113</td>
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<tr>
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<td>184</td>
<td>393</td>
<td>393</td>
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<td>19</td>
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<tr>
<td>Rabun</td>
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<td>Stephens</td>
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<td>30</td>
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<td>56</td>
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<tr>
<td>Towns</td>
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<td>31</td>
<td>31</td>
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<td>50</td>
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<tr>
<td>Union</td>
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<td>13</td>
<td>26</td>
<td>26</td>
<td>0.4%</td>
<td>49</td>
</tr>
<tr>
<td>Whitfield</td>
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<td>5</td>
<td>14</td>
<td>14</td>
<td>0.2%</td>
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<td>1053</td>
<td>22.87%</td>
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<tr>
<td>Cobb</td>
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<td>700</td>
<td>718</td>
<td>718</td>
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<td>2205</td>
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<td>Douglas</td>
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<td>126</td>
<td>2.6%</td>
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<tr>
<td>Cobb-Douglas</td>
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<td>805</td>
<td>898</td>
<td>898</td>
<td>29.52%</td>
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<tr>
<td>Total Admits</td>
<td>774</td>
<td>1629</td>
<td>3675</td>
<td>3675</td>
<td>100.00%</td>
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<tr>
<td>Catchment Admits</td>
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<td>1646</td>
<td>2055</td>
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<td>100.00%</td>
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<tr>
<td>Total CSU &amp; SCB Admits</td>
<td>2050</td>
<td>2541</td>
<td>3042</td>
<td>3042</td>
<td>100.00%</td>
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</table>

### Georgia Department of Behavioral Health and Developmental Disabilities

**Region 1 Crisis Stabilization Unit Comparison:**

- Total Unit Admissions, Total Catchment Admissions, and Combined CSU & SCB Admissions
- **July 2018-June 2019: FY 2019**

[Graph showing data comparison]
Private Contract Bed Data
Contract Bed Performance Measures

SCB Population with LOS of 15 Days or More
Report Period: FYTD 19

<table>
<thead>
<tr>
<th>Region</th>
<th>LOS 15 Days or More</th>
<th>% of total population</th>
<th>Total Provider Admits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Region 1</td>
<td>284</td>
<td>11.4%</td>
<td>2492</td>
</tr>
<tr>
<td>Region 4</td>
<td>19</td>
<td>14.1%</td>
<td>135</td>
</tr>
<tr>
<td>Region 6</td>
<td>96</td>
<td>12.3%</td>
<td>781</td>
</tr>
</tbody>
</table>

Total Admits with 15 or more LOS 399 11.7% 3408

LOS Day Ranges/Region

<table>
<thead>
<tr>
<th>LOS Day Ranges/Region</th>
<th>LOS 15-30</th>
<th>LOS 31-40</th>
<th>LOS 41-50</th>
<th>LOS 51-60</th>
<th>LOS 60+</th>
<th>Total LOS Days</th>
<th>% of Total Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Region 1</td>
<td>273</td>
<td>6</td>
<td>3</td>
<td>0</td>
<td>2</td>
<td>379</td>
<td>95.0%</td>
</tr>
<tr>
<td>Region 4</td>
<td>18</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>4</td>
<td>2.8%</td>
</tr>
<tr>
<td>Region 6</td>
<td>88</td>
<td>5</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>96</td>
<td>1.0%</td>
</tr>
</tbody>
</table>

Total LOS Days 379 11 4 1 4 399

% of Total Population 95.0% 2.8% 1.0% 0.3% 1.0% 100.0%
## CSU Recidivism Rates - Region 2


<table>
<thead>
<tr>
<th>Number of Discharges</th>
<th>Total Number of Individuals</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Discharge</td>
<td>1497</td>
</tr>
<tr>
<td>2 Discharges</td>
<td>196</td>
</tr>
<tr>
<td>3 Discharges</td>
<td>56</td>
</tr>
<tr>
<td>4 Discharges</td>
<td>17</td>
</tr>
<tr>
<td>5 Discharges</td>
<td>7</td>
</tr>
<tr>
<td>6 Discharges</td>
<td>4</td>
</tr>
<tr>
<td>7 Discharges</td>
<td>3</td>
</tr>
<tr>
<td>8 Discharges</td>
<td>1</td>
</tr>
</tbody>
</table>
### Daily Report

**3 Adult CSUs**

<table>
<thead>
<tr>
<th>City Name</th>
<th>Total Beds</th>
<th>CSU Beds Occupied</th>
<th>Transition Beds Occupied</th>
<th>Beds On Hold</th>
<th>Total Occupied</th>
<th>Available Beds</th>
<th>Occupancy Pct</th>
<th>Beds Out Of Service</th>
<th>Admissions</th>
<th>Discharges</th>
<th>Swap Temp Obs To CU</th>
<th>Turnover Rate Pct</th>
<th>Average LOTS Days</th>
<th>Length LOTS Days</th>
</tr>
</thead>
<tbody>
<tr>
<td>B Regional</td>
<td>30</td>
<td>29</td>
<td>0</td>
<td>0</td>
<td>29</td>
<td>1</td>
<td>100.00%</td>
<td>0</td>
<td>4</td>
<td>5</td>
<td>1</td>
<td>33.33%</td>
<td>3.72</td>
<td>10</td>
</tr>
<tr>
<td>CSU</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>dty CSU</td>
<td>24</td>
<td>24</td>
<td>0</td>
<td>0</td>
<td>24</td>
<td>0</td>
<td>100.00%</td>
<td>1</td>
<td>7</td>
<td>6</td>
<td>6</td>
<td>79.17%</td>
<td>3.42</td>
<td>11</td>
</tr>
<tr>
<td>Kent Adult</td>
<td>23</td>
<td>20</td>
<td>0</td>
<td>0</td>
<td>20</td>
<td>3</td>
<td>86.96%</td>
<td>0</td>
<td>2</td>
<td>5</td>
<td>1</td>
<td>34.78%</td>
<td>5.75</td>
<td>27</td>
</tr>
<tr>
<td>CSU</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Up Total</td>
<td>77</td>
<td>73</td>
<td>0</td>
<td>0</td>
<td>73</td>
<td>4</td>
<td>94.81%</td>
<td>1</td>
<td>13</td>
<td>16</td>
<td>8</td>
<td>48.05%</td>
<td>3.89</td>
<td>27</td>
</tr>
</tbody>
</table>

**4 Adult CSUs**

<table>
<thead>
<tr>
<th>City Name</th>
<th>Total Beds</th>
<th>CSU Beds Occupied</th>
<th>Transition Beds Occupied</th>
<th>Beds On Hold</th>
<th>Total Occupied</th>
<th>Available Beds</th>
<th>Occupancy Pct</th>
<th>Beds Out Of Service</th>
<th>Admissions</th>
<th>Discharges</th>
<th>Swap Temp Obs To CU</th>
<th>Turnover Rate Pct</th>
<th>Average LOTS Days</th>
<th>Length LOTS Days</th>
</tr>
</thead>
<tbody>
<tr>
<td>Areea CSU</td>
<td>30</td>
<td>24</td>
<td>0</td>
<td>0</td>
<td>24</td>
<td>6</td>
<td>80.00%</td>
<td>13</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>20.00%</td>
<td>5.33</td>
<td>23</td>
</tr>
<tr>
<td>osta CSU</td>
<td>24</td>
<td>16</td>
<td>0</td>
<td>0</td>
<td>16</td>
<td>8</td>
<td>66.67%</td>
<td>0</td>
<td>2</td>
<td>10</td>
<td>0</td>
<td>50.00%</td>
<td>3.31</td>
<td>15</td>
</tr>
<tr>
<td>ovilla CSU</td>
<td>24</td>
<td>23</td>
<td>0</td>
<td>0</td>
<td>23</td>
<td>1</td>
<td>95.83%</td>
<td>0</td>
<td>4</td>
<td>4</td>
<td>1</td>
<td>37.50%</td>
<td>3.30</td>
<td>13</td>
</tr>
<tr>
<td>Up Total</td>
<td>78</td>
<td>63</td>
<td>0</td>
<td>0</td>
<td>63</td>
<td>15</td>
<td>80.77%</td>
<td>13</td>
<td>9</td>
<td>17</td>
<td>1</td>
<td>34.62%</td>
<td>4.37</td>
<td>23</td>
</tr>
</tbody>
</table>

**5 Adult CSUs**

<table>
<thead>
<tr>
<th>City Name</th>
<th>Total Beds</th>
<th>CSU Beds Occupied</th>
<th>Transition Beds Occupied</th>
<th>Beds On Hold</th>
<th>Total Occupied</th>
<th>Available Beds</th>
<th>Occupancy Pct</th>
<th>Beds Out Of Service</th>
<th>Admissions</th>
<th>Discharges</th>
<th>Swap Temp Obs To CU</th>
<th>Turnover Rate Pct</th>
<th>Average LOTS Days</th>
<th>Length LOTS Days</th>
</tr>
</thead>
<tbody>
<tr>
<td>Savannah</td>
<td>16</td>
<td>10</td>
<td>0</td>
<td>1</td>
<td>11</td>
<td>5</td>
<td>68.75%</td>
<td>3</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0.00%</td>
<td>5.10</td>
<td>8</td>
</tr>
<tr>
<td>s Price CSU</td>
<td>16</td>
<td>14</td>
<td>0</td>
<td>0</td>
<td>14</td>
<td>2</td>
<td>87.50%</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>25.00%</td>
<td>3.21</td>
<td>7</td>
</tr>
<tr>
<td>way CSU</td>
<td>24</td>
<td>24</td>
<td>0</td>
<td>0</td>
<td>24</td>
<td>0</td>
<td>100.00%</td>
<td>0</td>
<td>1</td>
<td>1</td>
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<td>8.33%</td>
<td>3.08</td>
<td>6</td>
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<tr>
<td>Place CSU</td>
<td>12</td>
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<td>0</td>
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<td>0</td>
<td>100.00%</td>
<td>0</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>33.33%</td>
<td>4.42</td>
<td>15</td>
</tr>
<tr>
<td>lla CSU</td>
<td>16</td>
<td>15</td>
<td>0</td>
<td>1</td>
<td>16</td>
<td>0</td>
<td>100.00%</td>
<td>0</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>37.50%</td>
<td>4.73</td>
<td>21</td>
</tr>
<tr>
<td>Up Total</td>
<td>84</td>
<td>75</td>
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<td>2</td>
<td>77</td>
<td>7</td>
<td>91.07%</td>
<td>4</td>
<td>8</td>
<td>8</td>
<td>8</td>
<td>15.95%</td>
<td>4.25</td>
<td>21</td>
</tr>
</tbody>
</table>

**6 Adult CSUs**

<table>
<thead>
<tr>
<th>City Name</th>
<th>Total Beds</th>
<th>CSU Beds Occupied</th>
<th>Transition Beds Occupied</th>
<th>Beds On Hold</th>
<th>Total Occupied</th>
<th>Available Beds</th>
<th>Occupancy Pct</th>
<th>Beds Out Of Service</th>
<th>Admissions</th>
<th>Discharges</th>
<th>Swap Temp Obs To CU</th>
<th>Turnover Rate Pct</th>
<th>Average LOTS Days</th>
<th>Length LOTS Days</th>
</tr>
</thead>
<tbody>
<tr>
<td>goa CSU</td>
<td>24</td>
<td>23</td>
<td>0</td>
<td>0</td>
<td>23</td>
<td>1</td>
<td>95.83%</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>16.67%</td>
<td>6.17</td>
<td>38</td>
</tr>
</tbody>
</table>

Since 1987

Analytics Improving Behavioral Health™

52
New Reporting

- **Dashboards for all Key Performance Indicators.** (LOS, Diversion, Utilization, Denials)
- **Additional reporting items to measure the system** (all can be sorted by presentation of IDD, MH, SUD, or ASD)
  - Referral Location (specific Jail, ED, Provider or Mobile Crisis Team)
  - Wait times for placement from all referral sources and review times
  - Denial reports to include frequency, reason, and referral source
  - Volume of reviews that timed out without a disposition.
  - Volume of individuals accessing the system and through which level (urgent care voluntarily or involuntary holds from secure places)
  - Volume by payor source
  - Re-admit rates by crisis provider and by outpatient provider
  - Volume of admissions and discharges on nights and weekends
  - Volume of admissions that were enrolled with an outpatient provider
  - Placement outcomes post crisis
  - Volume sent out to Medical Facility
  - Tracking for SUD admissions by substance
  - Utilization volume of transition beds
  - Diagnosis
  - Acuity on units and beds days that were on 1:1
  - Volume and length of time a bed is on hold or out of service and the reason why
  - Volume of referrals initiated, number accepted, and number discharged home from an ED without disposition.
Discussion and Questions
Polling Question #3

In what areas would you be interested in expanding the range of measures that you are collecting or developing? (check all that apply)

- Behavioral health services costs
- Behavioral health services outcomes
- Behavioral health services utilization
- Police responses and time taken to address mental health calls
- EMT responses and time taken to address mental health calls
- Emergency room boarding
- Please list other__________________________
The Crisis Now Difference

In 2016, according to Aetna/Mercy Maricopa, metropolitan area Phoenix law enforcement engaged 22,000 individuals that they transferred directly to crisis facilities and mobile crisis without visiting a hospital emergency department. What difference did it make?

- Improved Crisis Clinical Fit to Need (CCFN) by 6x
- Reduced potential state inpatient spend by $260m
  Calculated from Arizona data, 2017
- Saved equivalent of 37 FTE police officers
- Saved hospital EDs $37m in avoided costs/losses
  Calculated from “Impact of psychiatric patient boarding in EDs” (2012) (Nicks and Manthey)
- Reduced total psychiatric boarding by 45 years
  Firefighter savings not yet realized / quantified.
Next Webinar

Join Us: **August 15 at 2:00pm to 3:30pm Eastern** for a presentation by David Covington on the Crisis Now approach to a crisis response system that links law enforcement directly with crisis facilities.