Crisis Now: Analyzing Outcomes & Business Case for Bypassing the Hospital ED

Transformation Transfer Initiative 2019
Webinar 5: August 15, 2019
Welcome & Introductions

David W. Covington, LPC, MBA
CEO and President
RI International
www.crisisnow.com
Change Is Underway

The Core Elements of Crisis Now are changing the way we treat mental health crises

LEARN MORE

CrisisNow.com

David W. Covington, LPC, MBA
#CrisisTalk

A PLATFORM FOR CRISIS CONVERSATIONS

check out our latest article

See It Now!

#CrisisTalk

Stephanie Hepburn, J.D.
CRISIS: 4.2 Develop an integrated crisis response system to divert people with SMI and SED from the justice system (also 2.1 Define and implement national standard for crisis care and 2.2 Develop a continuum of care that includes adequate psychiatric bed capacity and community-based alternatives to hospitalization)

ZERO SUICIDE: 3.7 Advance the national adoption of effective suicide prevention strategies. All federal departments, including VA and DoD, should adopt Zero Suicide as a model for suicide reduction, and agree to develop and implement strategic plans with achievable and transparent targets for progress. Consider ways to widely disseminate and universally apply these strategies in the public health system.

PEER SUPPORTS: 2.8 Maximize capacity of BH workforce: Include coverage of peer and family support specialists in federal health benefit programs (also 3.1 Comprehensive continuum of care, with team-based models that are interdisciplinary and incorporate peer and family support specialists, 4.2 Crisis response system should include warm lines staffed by certified peer specialists and 5.2 Adequately fund the full range of services, including family and peer support services
Polling Question #1

Crisis “NOT TOP TEN” list…

*What is the number one problem in your state’s psychiatric crisis system?*
#10 – Shotgun Referrals

- Individuals who need more intensive residential care are referred by fax to multiple facilities all at the same time, because the crisis center/ER knows that most agencies will deny and/or not respond in a timely fashion
#9 – Who’s on First?

• The first facility giving acceptance is where the individual goes without regard to the person’s preference, how far away the facility is from family supports, etc.

CRISIS
NOT TOP TEN LIST
#8 – I’m stuck!

There’s no way to really know if someone is stuck in an Emergency Department unless the staff make noise (squeakiest gets grease)
#7 – Cherries for Everyone

Receiving facility staff may sift through all referrals, and pick out the ones that will be easier in their milieu
#6 – Through the Cracks

No one knows how many are being sent home without care and/or walk out of the ED against medical advice
#5 – Calling & Waiting

Communication depends on numerous phone calls, faxes. ED staff and crisis facility staff make and field numerous phone calls about each case. If nurses at either facility are busy, the other must wait for call backs. No time frames are set for receiving facilities to give referral decisions.

CRISIS

NOT TOP TEN LIST
#4 – Just Following Protocol

Costly, invasive and time consuming medical tests are often required unnecessarily.
#3 – Crisis First Stop

Almost all individuals are sent to the Emergency Department for medical clearance, even if not indicated.
#2 – Bed Available?

There is no transparency around the census for inpatient.
#1 – Psych Boarding

No accountability for using the ED as a holding cell.
"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."

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

Psychiatric boarding in hospital EDs may not be preferred, but it’s an unfortunate reality and completely legal.
Federal Government Declares Emergency Physicians Incapable of Performing Medical Screening Exam for Psychiatric Patients in AnMed Lawsuit

By Robert A. Bitterman, MD, ID, FACEP | on October 17, 2017 | 2 Comments

There is no EMTALA Issue in emergency medicine more difficult, more confusing, or more risk-prone than managing psychiatric patients in the emergency department. The AnMed Health case is the quintessential example and should greatly concern emergency physicians.

AnMed Health, a hospital system based in Anderson, South Carolina, recently settled with the Office of Inspector General (OIG) for $1.295 million for allegedly failing to appropriately screen and stabilize psychiatric patients presenting to the hospital’s emergency department.

The Centers for Medicare and Medicaid Services (CMS) and the OIG, the agencies within the Department of Health and Human Services (HHS) charged with enforcing EMTALA, claimed that AnMed Health:

1. Should have required its on-call psychiatrist to come to the emergency department to personally examine all patients with psychiatric symptoms and participate in the screening and stabilizing of each patient, irrespective of whether the emergency physician needed or requested the services of the on-call psychiatrist—asserting in effect that emergency physicians are incapable of screening or stabilizing psychiatric patients under EMTALA;

2. Should have admitted involuntary committed (IVC) patients to its inpatient psychiatric unit instead of boarding them in its emergency department for many days until they could be transferred to the nearby state psychiatric hospital, despite the fact that for more than 30 years by written policy and actual practice the hospital only admitted “voluntary” patients to its psychiatric unit; and

3. Emergency physicians inappropriately transferred the patients in an unstable condition when patients were transported in the back of a locked secure police car for approximately 11–12 minutes to the nearby state psychiatric hospital, instead of transferring the patients via the usual hospital door.
Lack of space forced those involuntarily detained in EDs to wait on average 3 days.

Every time a psychiatric boarding occurs, the hospital experiences a cost/loss of $2,264.
True/False

Individuals in a suicidal crisis or dangerous to themselves or others in a mental health addiction crisis must go to a hospital ED for first medical clearance.
Arizona
Phoenix (Peoria) (1996)
Respite (2015)
Living Room 2 (2019)*
Washington State
Fife (2009)
Lakewood E&T (2014)
Olympia E&T (2019)*
Spanaway (2020)*
North Carolina
Henderson (2009)
Durham (2015)
Jacksonville (2019)
Fayetteville (2020)*
Delaware
Ellendale (2012)
Newark (2016)
California
Riverside (2015)
Palm Springs (2016)
RI Recovery Response Center Arizona
Total Crisis Admissions & Law Enforcement %

- Law Enforcement Drop-Offs
- All Admissions

<table>
<thead>
<tr>
<th>Year</th>
<th>Law Enforcement</th>
<th>All Admissions</th>
<th>Law Enforcement %</th>
<th>All Admissions %</th>
</tr>
</thead>
<tbody>
<tr>
<td>2014</td>
<td>2,228</td>
<td>3,924</td>
<td>57%</td>
<td></td>
</tr>
<tr>
<td>2015</td>
<td>2,709</td>
<td>4,451</td>
<td>61%</td>
<td></td>
</tr>
<tr>
<td>2016</td>
<td>3,401</td>
<td>4,256</td>
<td>80%</td>
<td></td>
</tr>
<tr>
<td>2017</td>
<td>4,278</td>
<td>5,302</td>
<td>81%</td>
<td></td>
</tr>
<tr>
<td>2018</td>
<td>4,367</td>
<td>5,298</td>
<td>82%</td>
<td></td>
</tr>
<tr>
<td>2019</td>
<td>4,724</td>
<td>5,698</td>
<td>83%</td>
<td></td>
</tr>
</tbody>
</table>
Zero Rejections
Zero Hospital Visits First
3 to 5 Minute Turn Around
20,000 Consecutive Guests
**Core 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

**Homelessness**
**Social Isolation**

**Unemployment**
**Suicide**

**Increased Mental Trauma**
What are the four most important elements in the crisis facility equation?
SYSTEMS THINKING

- Interest Rate
- Monthly Payment
- Cash Down
- Trade-In Value
- # Months Repay
New Year’s Day, you are taking inventory on a key product and you have the following number remaining on the shelf from December. Which is best?

Scenario A: 1m
Scenario B: 1
Scenario C: 0
WHAT KIND OF DISTRIBUTION?
If every 15 minutes between 10am and 5pm were a crisis call wave...

**Average Wave:**
9 Waves Were “Average”

**Highest Wave:**
Nearly 200% of Average

**Lowest Wave:**
21% of Average
FORECASTING CRISIS NEED

\[ P_w = \sum_{i=0}^{N-1} \left( \frac{A^i}{i!} \right) + \left( \frac{A^N}{N!} \right) \left( \frac{N}{N-A} \right) \]
What is the Crisis Now model?

Call Center Hub

Mobile Crisis

Crisis Facilities

“Air Traffic Control” Crisis Call Center Hub Connects and Ensures Timely Access and Data
5 to 7 Minute Turn-Around

Law Enforcement By-passes the Emergency Room and Proceeds Directly to Crisis
Core Community Crisis Flow defined: Only those individuals who require law enforcement, hospital ED and/or mobile crisis intervention

What percentage of the group above fall in between needing acute psychiatric inpatient and routine outpatient?
We utilized more than a decade of statewide crisis data to produce the analysis in this report.

A Fully Informed Model

Our team compared the outcomes of a traditional inpatient beds model alone versus a Crisis Now continuum model in a metropolitan population of 4 million.
How Does Your Crisis System Flow?

Most all community crisis referrals flow through the hospital ED.

Community Crisis Flow

200 persons in crisis per 100,000 persons in your community on a monthly basis.

Greater Phoenix

4m Community Total Pop.

Divide by 100k and multiply by 200

8,000 Monthly Crisis Flow

What do they look like clinically?

The typical LOCUS distribution for community crisis flow.

LOCUS Levels of Care

Strengthened Crisis Need

Clinically Matched Care

Dimensions
- Risk of Harm
- Functioning
- Co-Morbidity
- Environment
- Treatment History
- Engagement

What do they look like clinically?

Do you have the crisis continuum capacity to meet the need?

% whose assessed need matched their linked crisis service
Throughput
<table>
<thead>
<tr>
<th></th>
<th>No Crisis Care</th>
<th>Crisis Now</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong># of Crisis Episodes Annually (200/100,000 Monthly)</strong></td>
<td>14,880</td>
<td>14,880</td>
</tr>
<tr>
<td><strong># Initially Served by Acute Inpatient</strong></td>
<td>10,118</td>
<td>2,083</td>
</tr>
<tr>
<td><strong># Referred to Acute Inpatient From Crisis Facility</strong></td>
<td>-</td>
<td>828</td>
</tr>
<tr>
<td><strong>Total # of Episodes in Acute Inpatient</strong></td>
<td>10,118</td>
<td>2,911</td>
</tr>
<tr>
<td><strong># of Acute Inpatient Beds Needed</strong></td>
<td>310</td>
<td>89</td>
</tr>
<tr>
<td><strong>Total Cost of Acute Inpatient Beds</strong></td>
<td>$92,290,601</td>
<td>$26,553,906</td>
</tr>
<tr>
<td><strong># Referred to Crisis Bed From Stabilization Chair</strong></td>
<td>-</td>
<td>3,312</td>
</tr>
<tr>
<td><strong># of Crisis Beds Needed</strong></td>
<td>-</td>
<td>25</td>
</tr>
<tr>
<td><strong>Total Cost of Crisis Facility Beds / Chairs</strong></td>
<td>$ -</td>
<td>$7,507,853</td>
</tr>
<tr>
<td><strong># Initially Served by Crisis Stabilization Facility</strong></td>
<td>-</td>
<td>8,035</td>
</tr>
<tr>
<td><strong># Referred to Crisis Facility by Mobile Team</strong></td>
<td>-</td>
<td>1,428</td>
</tr>
<tr>
<td><strong>Total # of Episodes in Crisis Facility</strong></td>
<td>-</td>
<td>9,464</td>
</tr>
<tr>
<td><strong># of Crisis Observation Chairs Needed</strong></td>
<td>-</td>
<td>30</td>
</tr>
<tr>
<td><strong>Total Cost of Crisis Facility Beds / Chairs</strong></td>
<td>$ -</td>
<td>$11,031,947</td>
</tr>
<tr>
<td><strong># Served Per Mobile Team Daily</strong></td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td><strong># of Mobile Teams Needed</strong></td>
<td>-</td>
<td>5</td>
</tr>
<tr>
<td><strong>Total # of Episodes with Mobile Team</strong></td>
<td>-</td>
<td>4,762</td>
</tr>
<tr>
<td><strong>Total Cost of Mobile Teams</strong></td>
<td>$ -</td>
<td>$1,826,367</td>
</tr>
<tr>
<td><strong># of Unique Individuals Served</strong></td>
<td>10,118</td>
<td>14,880</td>
</tr>
<tr>
<td><strong>TOTAL Inpatient and Crisis Cost</strong></td>
<td>$92,290,601</td>
<td>$46,920,073</td>
</tr>
<tr>
<td><strong>ED Costs ($1,233 Per Acute Admit)</strong></td>
<td>$12,475,987</td>
<td>$3,589,598</td>
</tr>
<tr>
<td><strong>TOTAL Cost</strong></td>
<td>$104,766,588</td>
<td>$50,509,671</td>
</tr>
<tr>
<td><strong>TOTAL Change in Cost</strong></td>
<td>$(54,256,917)</td>
<td>-52%</td>
</tr>
</tbody>
</table>
How Does Your Crisis System Rate?

**Call Center Hub**
- Real Time Access Valve Mgmt

**Mobile Outreach**
- Meets Person at Home/Apt/Street

**Sub-acute Stabilization**
- Direct LE Drop Off <10 Min

**Crisis Now System**
- Equal Partners 1st Responders

**What makes Level 5 different?**
- Air Traffic Control Connectivity

**Level 5: FULLY INTEGRATED**
- Adequate Access Statewide

**Level 4: CLOSE**
- Statewide Access but Reliant on ED

**Level 3: PROGRESSING**
- Adequate Access <1 Hr Response

**Level 2: BASIC**
- Some Availability Limited to Urban

**Level 1: MINIMAL**
- None or Very Limited Availability

**Level 5 System Also Conforms to 4 Modern Principles**

1. Priority Focus on Safety/Security
2. Suicide Care Best Practices, e.g. Systematic Screening, Safety Planning and Follow-up
3. Trauma-Informed, Recovery Model
4. Significant Role for Peers

For more info see [http://crisisnow.com](http://crisisnow.com)
States Self-Assessment

Level 1: 14%
Level 2: 29%
Level 3: 38%
Level 4: 12%
Level 5: 0%
SWAG the math for Crisis Now Phoenix

• How much psychiatric boarding is avoided?
• How many officers are freed up for public safety?
• How much better is Crisis Clinical Fit to Need?
• How much money is saved?
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

Saved hospital EDs $37m in avoided costs/losses

Reduced potential state inpatient spend by $260m

Calculated from Arizona data, 2017

Reduced total psychiatric boarding by 45 years

Saved equivalent of 37 FTE police officers

Calculated from “Impact of psychiatric patient boarding in EDs” (2012) (Nicks and Manthey)

Firefighter savings not yet realized / quantified.
Key references to the mathematics in this report:

- 35% of those consulted to psychiatry required inpatient care
- The average hospital ED length of stay was 1,089 minutes (18 hours)
- 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, approx. 1,000 person directly connected 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

- 1.2m caller episodes of care 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

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

“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 the LOCUS assessment matches the connected service description)
- Psych inpatient expense reduced from potential $485m to $125m (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 BH)
- Average hospital ED waiting time for person without SMI 2 to 3 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)
CrisisNow.com
TTI Webinar 6: EMTALA

• Invited a speaker from CMS to discuss the Emergency Medical Treatment and Labor Act (EMTALA) and the potential impact it may have on hospital participation in bed registry programs.

• Tentatively scheduled for Thursday, September 26, 2019 at 1:00 Eastern
EMTALA (Emergency Medical Treatment and Labor Act) requires Medicare-participating hospitals that offer emergency services to provide a medical screening examination (MSE) when a request is made for treatment for an emergency medical condition (EMC). Hospitals are then required to provide stabilizing treatment for patients with EMCs. *Are you aware of EMTALA?*
Polling Question #3

Do you think EMTALA affects, or could affect, hospital participation generally in bed registries?
Other EMTALA Questions

To help us better plan for September’s webinar, please type any additional questions you may have related to EMTALA for our CMS expert presenting next month in the chat box. You’ll also have an opportunity to submit questions through a brief survey at the end of this webinar.
Thank you!

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