Telling the Story: Data, Dashboards, & the Mental Health Crisis Continuum

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Disclaimer

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Agenda

- Welcome and Introductions: Robert Shaw, MA, Senior Research Associate, NRI
- Review of the Technical Assistance Coalition Paper, *Telling the Story: Data, Dashboards, & the Mental Health Crisis Continuum*:
  - Kristin Neylon, MA, Associate Director of Government Programs, NRI
  - Robert Shaw, MA
- Georgia’s Technology Supported Crisis Response System:
  - Dawn Peel, Director, Office of Crisis Coordination, Georgia Department of Behavioral Health and Developmental Disabilities
  - Wendy White Tiegreen, Director, Office of Medicaid Coordination and Health System Innovation, Georgia Department of Behavioral Health and Developmental Disabilities
- Tennessee’s Crisis and Hospitalization Data: A Commissioner’s Perspective
  - Marie Williams, LCSW, Tennessee Department of Mental Health and Substance Abuse Services
- Question and Answer
Review of Technical Assistance Coalition Paper:
Telling the Story: Data, Dashboards, & the Mental Health Crisis Continuum
Behavioral Health Crisis Services are an Increasing Priority Across the U.S.

- 988, the new three-digit code for the National Suicide Prevention Lifeline is set to go live on July 16, 2022; demand for Lifeline services is anticipated to double as a result.

- New and enhanced resources from the federal government for crisis services:
  - 5% Set Aside in the Mental Health Block Grant for Crisis Services
  - American Rescue Plan funds *(Caution: although these funds are available to enhance crisis services, it is possible that few funds are allocated for this purpose. The influx of funds may appear that systems are flush with resources to enhance crisis services systems, when the reality is that many SBHAs are trying to stabilize a fractured service delivery system.)*

- Societal shift to provide more equitable services and reduce reliance on law enforcement as the primary responder to behavioral health crises
2022 TAC Report: *Telling the Story – Data, Dashboards, & the Mental Health Crisis Continuum*

**Purpose:** Understanding how crisis continuums operate is crucial to ensuring high-quality crisis services and that no one “falls through the cracks.” The significant programmatic and funding changes implemented at the federal level make now an opportune time for state behavioral health authorities to implement or enhance their data collection processes for crisis services.

**Goals of the Report:**
1. Identify which data and outcome measures are most important to SBHAs and other stakeholders to ensure the effectiveness and continuity of behavioral health crisis services.
2. Determine which data and outcome measures are feasible and meaningful for all SBHAs to report to SAMHSA.
3. Understand how SBHAs analyze and present crisis data in the forms of dashboards and reports to monitor their systems and share important trends with stakeholders.

**Paper currently being reviewed by SAMHSA; will be posted to [www.nasmhpd.org](http://www.nasmhpd.org) and emailed to all participants upon publication.**
2022 TAC Report - Methodology

- Online literature review to identify best practices in data collection and measures used by similar industries to monitor quality and effectiveness.

- Review of each SBHA’s website for the presence of data dashboards and reports for crisis services. Based on this review, NRI staff identified 12 SBHAs to interview for this report.
Availability of Crisis Services & Data Collection Activities Across the U.S.

SAMHSA’s National Guidelines identify three essential crisis services:

- Someone to Call: Crisis Hotlines
- Someone to Come: Mobile Crisis Response
- Somewhere to Go: Crisis Stabilization Units (and Crisis Residential Facilities)

Data monitoring is critical to understanding how individuals move through the system so that no one falls through the cracks.
Managing Crisis Services

- Managing crisis services is an iterative process that requires the constant collection of data or information that can be used to assess all aspects of a provider’s or a state’s crisis service activities.

- Great efforts are expended to collect data that document the activities of providers, often with the goal of demonstrating that funding has been well spent. Those efforts are valuable, but do not necessarily lead to management decisions or data that are useful for managers.
Nothing is Perfect, but that Shouldn’t Stop Us

- States and their providers do not often operate in an environment where they have all the data they could use and that all the data they collect are accurate and timely.

- Even sub-optimal data are valuable and can provide insight, albeit broad, rather than minute.

- When those are all that a provider or state has, management decisions can still be made, and later unmade if subsequent data indicate that a wrong turn has been taken.

- It is the duty of states and providers to attempt to provide services as best as can be given whatever environment they operate in.
Most Important Metrics for Behavioral Health Crisis Hotlines Identified by SBHAs

Top three measures identified as most important for behavioral health crisis hotlines:

1. Average Handle Time
2. Caller Disposition
3. Calls Resulting in Emergency/Mobile Dispatch and Active Rescue

Note on demographic data:

- Demographic data were identified during calls as important data in that they allow states and providers to tailor services for their communities. However, they are extremely difficult to collect, especially during crisis situations. Only successful in collecting this information about half the time.
Most Important Metrics for Mobile Crisis Response Identified by SBHAs

Top measures identified as most important for mobile crisis response include:

1. Disposition of Mobile Dispatch
2. Response Time
3. Number of Assessments Completed

Bar chart showing:
- Disposition of Mobile Dispatch: 89%
- Response Time: 56%
- Assessments Completed: 33%
- Availability of Services: 25%
- Case Review Completion: 25%
- Diversion Rates: 22%
- Follow-Up Service Connections: 11%
- Satisfaction Survey: 11%
Metrics for Crisis Stabilization Units & Crisis Residential Facilities

Top three measures identified as most important for crisis stabilization and residential services include:

1. Readmission Rates
2. Disposition at Discharge
3. Diversion Rates
Many measures are available to help monitor the quality of individual services. To tell the story of how the crisis continuum is working as a whole, SBHAs collect measures that monitor service transitions and diversion to ensure no one “falls through the cracks.”
Year One of 988

Based on projections from SAMHSA and Vibrant, DBHDD projects demand for behavioral health crisis services will DOUBLE in the first year of 9-8-8.

With limited funds to expand capacity, 9-8-8 is anticipated to significantly impact the current crisis system.

IMPACT

Someone to Call

564,608 calls, texts, and chats projected, including calls to 9-8-8 and GCAL

Georgia will receive approximately 793 additional calls, texts, and chats DAILY

Someone to Respond

56,460 mobile crisis dispatches estimated to be needed

Approximately 100 additional mobile crisis dispatches DAILY

A Safe Place to Go for Crisis Care

67,137 admissions estimated across CSUs, BHCCs, SCBs, and detoxification facilities

An estimated additional 94 individuals will require admission to crisis facilities DAILY

Projections based on SAMHSA and Vibrant projections provided in April 2021
Background

• In 2006, DBHDD identified the need to have a uniform point of entry for the state-funded crisis system in order to improve efficiency, maximize resources, and provide metrics which are used to inform system improvement.

• Over a period of sixteen (16) years, DBHDD and Behavioral Health Link have partnered to design an electronic system that serves a call center, dispatches mobile crisis teams, and provides real-time information about state-funded crisis bed access.

• The system has been designed to provide real-time data for certain parts of the crisis system. The system also allows historical information to be extracted to monitor a wide variety of metrics.

• DBHDD opened its first Crisis Stabilization Units and initiated its first Mobile Crisis contracts regionally in the 1990s.
Call Center Data Points

9-8-8 Data

Georgia Crisis and Access Line Data

Georgia Crisis and Access Line Demographics
Why we use data

- Monitor System Performance and Capacity:
  - Track trends in volume (days, hours)
  - Track system capacity
- Clinical Presentations (calls resulting in Mobile dispatch, types of call, etc.)
- Measure compliance with Key Performance Indicators for contract and grant management
- Use for strategic planning
- Outcomes
Increases in Call Volume from NSPL

**Year Over Year Growth**

- **Annual NSPL Calls Offered**
  - FY '20: 35,000
  - FY '21: 45,000
  - FY '22: 55,000

**Month Over Month Growth**

- **4th Quarter NSPL Calls Offered**
  - FY '22: 5,000
  - FY '21: 4,000
Keeping Up With Demand

![Graph showing Speed to Answer and Abandonment Rate over FY2021, FY2022, and June. The graph shows a decrease in Speed to Answer and a steady decrease in Abandonment Rate. The Y-axis represents Seconds, ranging from 0 to 250, and the X-axis represents Abandonment Rate, ranging from 0 to 35. The graph indicates improvements in both metrics over the specified periods.]
Dashboard Sampling

Episodes
BY AGE GROUP

- 0 - 18: 375 (54.5%)
- 18 - 65: 48 (6.98%)
- 65 and older: (35.61%)
- Unknown: (2.91%)

Episode
BY ACUITY

- Blank: 1 (0.15%)
- Emergent: 150 (21.8%)
- Inappropriate Call: (11.92%)
- Info Only: (6.98%)
- Referral Only (Non ...): (5 (...)
- Routine: 239 (34.74%)
- Urgent: (16.28%)
- Warm Call – Support...: (16.28%)
Crisis Connections (FY22)

- **A Safe Place for Help**: 42% required short-term observation or inpatient services.
- **Someone to Talk To**: 31% needed someone to talk to or a connection to resources or an outpatient appointment.
- **Someone to Respond**: 27% required a mobile crisis response or active rescue.

*Based on reporting by episode*
Mobile Crisis Response Services Dashboards
Call Center to MCT Deployment

Georgia Crisis & Access Line

Mobile Crisis Response Service

2 Vendors

Behavioral Health Link

Benchmark

Behavioral Health Link

Behavioral Health Link

Benchmark
Dispatch Technology
Mobile Crisis Data Functionality

<table>
<thead>
<tr>
<th>Average Dispatch Time</th>
<th>Average Response Time</th>
<th>Average Assessment Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of Dispatches</td>
<td>Completed Calls</td>
<td>Dispatches by Location</td>
</tr>
<tr>
<td>Dispatches by Triage Level</td>
<td>Dispatches Involving Law Enforcement</td>
<td>Dispatches by Outcome/Linkage</td>
</tr>
</tbody>
</table>

- **Drill-up/Drill-down data:** Can be viewed statewide or by region
- **Data can be measured daily, month to date, or monthly:**
  - Monthly data also includes:
    - Percentage of referrals to medical facilities
    - Percentage of referrals to Crisis Stabilization Units
    - Percentage of referrals to State Hospital/State-Contracted Beds
Behavioral Health Crisis Center (BHCC) Data
Behavioral Health Crisis Center (BHCC)

Crisis Service Center 24/7 → Temporary Observation → Crisis Stabilization Unit

Outpatient

Crisis Service Center
“walk-in”
Emergency Receiving & Evaluation

Temporary Observation (Recliners)

CSU Admission for Stabilization

Referral to more appropriate service (hospital or community)

Residential

Not all sites are this full model – some are CSU only
Electronic Management of State-Funded Crisis Beds

- GCAL manages telephonic and electronic referrals for individuals who need a state-funded crisis bed.
- Referrals can be tracked via the referral status board. Referrals have triage information that is updated daily to reflect updates and changes in referral status.
- Crisis Stabilization Unit and Temporary Observation Unit utilization can be accessed in real time to include specific individuals served or certain data metrics.

NOTE: GCAL system also contains known Medicaid Psychiatric Facilities to promote referral and use of “plan” services for Medicaid beneficiaries.
Active Bed Board Referral Data

• Includes:
  • Demographic Information necessary for referral
  • Location of individual
  • Screening and Triage Information
  • Insurance coverage
  • Time awaiting match for a necessary admission

• Benefits
  • Allows real-time communication between referral and crisis treatment facility
  • Expedites referral process
  • Ensures referrals are appropriately triaged
BHCC Data

Crisis Service Center/ Temporary Observation Data Points:

<table>
<thead>
<tr>
<th>Number of Walk In Referrals</th>
<th>Crisis Service Center Diversion</th>
<th>Temporary Observation Beds Available</th>
</tr>
</thead>
<tbody>
<tr>
<td>Temporary Observation Chair Occupation</td>
<td>Temporary Observation Length of Care</td>
<td>Temporary Observation Diversion</td>
</tr>
</tbody>
</table>

Crisis Stabilization Unit Data Points:

<table>
<thead>
<tr>
<th>Bed Status (Available, Occupied, Out of Service)</th>
<th>Number of New Referrals</th>
<th>Number of Individuals Accepted for Admission</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disability Type/ Primary Presentation</td>
<td>Occupancy Rate</td>
<td>Length of Stay</td>
</tr>
</tbody>
</table>

DEVELOPMENTAL GOAL: These data are largely reliant on timely and accurate provider self-report across a broad network of crisis system providers. Opportunities for quality improvement will present as data begins to be reviewed.
Marie Williams, LCSW

- Commissioner
- Tennessee Department of Mental Health & Substance Abuse Services

Marie.Williams@tn.gov
TN Crisis Services History

Crisis response teams were established in 1991

Contract with 13 providers across the state to deliver mobile crisis services 24/7/365

Statewide hotline number routes caller to nearest provider based on area code and defaults to one provider if does not route due to unknown area code.

TDMHSAS is also proud to participate in the National Suicide Prevention Lifeline with 6 TN providers assisting in answering the calls across the nation

Respite services were established in 1992 to allow a community-based option that offers a temporary reprieve from an environmental stressor

Crisis Stabilization Units and Walk-in Centers were added in 2008

Contract with 7 providers to provide 8 CSUs and Walk-in Centers to operate 24/7/365

Grateful to serve with dedicated and dynamic team: Deputy Commissioner Matt Yancey, Assistant Commissioner Rob Cotterman, Director of Crisis Services and Suicide Prevention Jennifer Armstrong
Statewide Mobile Crisis Coverage

Mobile Crisis Teams

- Alliance Health Services
- Professional Care Services
- Pathways Behavioral Health Services
- Quinco Mental Health
- Carey Counseling Center
- Centerstone
- Mental Health Cooperative
- McNabb Center
- Ridgeview Behavioral Health Services
- Volunteer Behavioral Health
- Frontier Health
8 Crisis Stabilization Units, Adding 3 More

Current CSU Locations

Proposed CSU Locations
Statewide Mobile Crisis for C&Y

Children and Youth Mobile Crisis Teams

- **Youth Villages**
- **Mental Health Cooperative**
- **McNabb Center**
- **Frontier Health**
Tennessee’s Mental Health Crisis Services Continuum
Connecting people to the right treatment, in the right place, at the right time.

- ≈128,000 Calls for help annually
- 58% Resolved on the phone
- 41% Referred to mobile crisis
- 1% Directed to ED for medical concerns
- 72,000+ crisis assessments completed
- 63% Diverted from hospitalization

Person in Crisis → Statewide Crisis Line → Face to Face Assessments → Community-Based Resources

For individuals not meeting commitment criteria

Less Restrictive Environment: Better Option for Patient and Lower Cost Intervention

Less-Restrictive Alternatives:
- Crisis Respite Services
- Crisis Walk-In Services
- Crisis Stabilization Units
- Outpatient Community-Based Programs and Services

Decreased Usage:
- Inpatient Hospitalization, Jail, and Emergency Room

Department of Mental Health & Substance Abuse Services
Data from state fiscal year 2021
Pre-Arrest Diversion Infrastructure Program
Data Collected Sept 2017-June 2019

More than 13,000 people diverted from jail to treatment FY18-20

- Shelby
- Madison
- Davidson
- Putnam
- Hamilton
- Knox
- Hamblen

$9,845,920
Estimated cost savings to local criminal justice system

4,591
Law enforcement officers trained in mental health topics

785
Behavioral health professionals trained on criminal justice topics

For More Info:
### Shared Funding Model

<table>
<thead>
<tr>
<th>Service</th>
<th>FY22 TDMHSAS Funding</th>
<th>FY20 TennCare Funding *</th>
</tr>
</thead>
<tbody>
<tr>
<td>State Wide Crisis Hotline</td>
<td>$50,000</td>
<td>$0</td>
</tr>
<tr>
<td>Mobile Crisis - Blended funding with Medicaid and state dollars. Rates based on a PMPM (per member per month) model as determined by TennCare with state dollars contributing approx. 20% of total. Funded to ensure firehouse model.</td>
<td>$5,397,695</td>
<td>$20,304,565</td>
</tr>
<tr>
<td>Respite – State pays at cost not to exceed 1/12 of total maximum liability per month while TennCare (Tennessee Medicaid Waiver) pays a fee for service.</td>
<td>$527,547</td>
<td>$132,367</td>
</tr>
<tr>
<td>Crisis Stabilization Unit/Walk-in Center – State pays at cost not to exceed 1/12 of total maximum liability per month while TennCare pays a fee for service.</td>
<td>$15,089,192</td>
<td>$4,534,470</td>
</tr>
<tr>
<td>Total Crisis Investment</td>
<td>$21,064,434</td>
<td>$24,971,402</td>
</tr>
</tbody>
</table>

In FY23, TDMHSAS received **$34,919,716** in federal American Rescue Plan funds to create three (3) new CSU/Walk-in Centers.

In addition, TDMHSAS received **$17,995,000** in recuring state funds for provider rate increases. These funds will support additional investments in the crisis system.

*Most recent year available data

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**TENNESSEE STATEWIDE CRISIS LINE**

There is hope.

855-CRISIS-1 (855-274-7471)

Do you feel like you are experiencing a mental health crisis?

Our Statewide Crisis Line is here to help individuals struggling with a mental health emergency.

This phone line is free and operated by caring, trained mental health professionals, 24 hours a day, 7 days a week.

Confidential help from anywhere in Tennessee is only a phone call away.

Why are Crisis Data Important?

- Make informed decisions about programmatic changes
- Find solutions to problems
- Identify barriers to accessing needed patient care
- Determine return on investment
- Develop efficiencies for care providers

*Improving Patient Care Starts with Data*
Why Track Crisis Data?

- What problem(s) did the crisis management system solve:
  - Eliminated manual entry in multiple spreadsheets
  - Provided access to client-level information to allow tracking across systems
  - Provided information related to what is working vs. what is not working
  - Provided metrics for monitoring program effectiveness
What Are We Able to Track Now?

The collection of client-level data allows for enhanced data analysis that didn’t previously exist. The data can now be cross-walked against the Behavioral Health Safety Net, state hospital admissions, and suicide death data.

Examples of current metrics captured:
- Crisis Response Times
- Volume of Crisis Calls, Mobile Crisis Assessments, 23-Hour Observation Admissions, Respite Admissions, and CSU Admissions
- Length-of-Stay Data
- Primary Presenting Problem
- Hospitalization Rates
- Alternatives Attempted Before Inpatient Referral
- Follow-Up Efforts
Mobile Crisis Assessment Data
Data includes call and face-to-face assessment volume data, presenting problems, dispositions of assessments, and follow-up efforts.

Crisis Response Time
Mobile Crisis required response time is 2 hours or less. Reports allow providers to see details of longer response times for quality assurance.

Crisis Services Data
CSU, 23 Hour Observation, and Respite data includes admissions and length of stay (in days or hours, depending on the service).

Multiple reports (samples above) can be displayed by month or provider for trends analysis. Detailed reports allow providers QA assistance in detecting outliers and data entry errors.
Collecting Meaningful Data
Provider Interface – Phone Assessments
Collecting Meaningful Data
Provider Interface – Face to Face Assessments
Crisis Management System – How Easy Was it to Create?

Took lots of time, collaboration, patience, and grace! Testing, testing, and more testing before official roll out!

Liaison between leadership, TennCare, IT, and Crisis Providers

- Frequent demos/conversations with both leadership and crisis providers to ensure payer source and provider needs are met to the extent possible.

IT Develops a Platform

- Our internal IT team did all coding and developed all needed reports.
How Easy is it to Use the Crisis Management System?

Providers can manually enter or upload assessment or services data into the system. Technical support is provided by TDMHSAS to ensure data accuracy.

Providers add all crisis call and assessment data weekly, while services data are added monthly.

Creates a Centralized Data Collection Process

Although the data validation and training process could feel cumbersome, providers are able to access their reported data real-time for internal QA and analytics.
The Role of Data

Data informs the “Gameplan” of service delivery.

When you have data, you tell the story of the impact of proposed investments.

We used data to advocate for 3 new CSU’s
\[ \text{Used data to show where inpatient hospitalization rates higher} \]

Data is key in planning and preparing for 988.
All About Accountability and Outcomes

Have to show return on investment

Governor, State Legislature, Citizens

Working with Community Providers
Never doubt that a small group of thoughtful, committed citizens can change the world; indeed, it's the only thing that ever has.

-Marie Williams, LCSW
Marie.Williams@tn.gov
615-532-6500

-Margaret Mead
Thank You!