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Assessment #5

A Comprehensive Crisis System:
Ending Unnecessary Emergency Room Admissions and Jail Bookings Associated with Mental Illness

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Alexandria, Virginia

Fifth in a Series of Ten Briefs Addressing: Bold Approaches for Better Mental Health Outcomes across the Continuum of Care

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Executive Summary

We have arrived at a time of great opportunity. A perfect storm in which psychiatric boarding challenges, escalating healthcare costs, public safety concerns around mental health and higher rates of incarceration for individuals experiencing mental health issues have solidified a desire to change how we address acute mental health needs within our communities. We have an opportunity to truly deliver on the commitment to better health outcomes, improved experience for those with acute mental health needs and dramatically lower healthcare costs through the implementation of a recently established set of consensus exceptional crisis care service delivery standards. The National Action Alliance for Suicide Prevention's *Crisis Now*: *Transforming Services is Within Our Reach* report and the corresponding business case resources offer a quantifiable, cost-reducing roadmap to replicate systems that are being implemented, in varying degrees, across the United States. And there is more good news for those looking to implement these practices in their own community. The approaches and the levels of care advanced within the *Crisis Now* model already exist in a vast majority of our communities as physical health and first responder system counterparts; so significant aspects of this design are in many ways familiar to healthcare leaders and community stakeholders. Additionally, tools are now available to calculate the very real impact of developing a comprehensive mental health crisis response system. This data-driven approach that corresponds with the Crisis Now Business Case can be applied to any population through the use of tools on the National Association of State Mental Health Program Directors' (NASMHPD's) website www.crisisnow.com; supporting independent analysis of cost impact that follows design implementation.

This paper represents a call to divert healthcare spending away from the more expensive traditional approaches of emergency department assessment followed by a referral to acute inpatient hospital services to a full continuum that includes less expensive specialized crisis services and accessibility of vital psychiatric inpatient resources. The essential crisis services that will be defined within this paper are (1) regional or statewide crisis call centers coordinating in real time, (2) centrally deployed, 24/7 mobile crisis response teams and (3) short-term, "sub-acute" residential crisis stabilization programs.

Payment reform must occur for optimal comprehensive crisis system implementation; supporting payment of these less expensive and more effective services by all payers of health services. This paper will serve as a roadmap on how to fund and implement a comprehensive crisis system in your community that will lower the overall cost of healthcare and dramatically reduce the time law enforcement spends engaged in addressing mental health crisis while positively impacting public safety and overall health through enhanced access to needed services. Much like the approach we have taken to end suicide, our goal is to get to zero! Zero unnecessary hospital emergency department admissions and zero unnecessary jail bookings through the full adoption and reimbursement of *Crisis Now* practices throughout the United States.

Introduction

Bold goals. Zero unnecessary admits to the hospital emergency department (ED). Zero unnecessary bookings into jail.

Achieving this dream might seem impossible today given the frequency of such events is likely between one and two million per year in the United States if Maricopa County Arizona law enforcement diversion data (23,000 times per year) is viewed as a representation of opportunities within the overall population. Unnecessary ED admits occur for embedded systemic reasons: according to early returns from a Treatment Advocacy Center survey funded by the Bodman Foundation, law enforcement agencies report waiting an average of three hours to connect someone in crisis with a medical facility; a figure that unfavorably compares with 30 minutes to book them into jail on a nuisance crime. And, the average distance is five times longer to reach an access point for care than it is to reach the closest jail. Even where available, community crisis programs may refuse direct admissions; requiring "medical clearance" be completed at the local emergency department and a screening for appropriateness prior to considering admission.

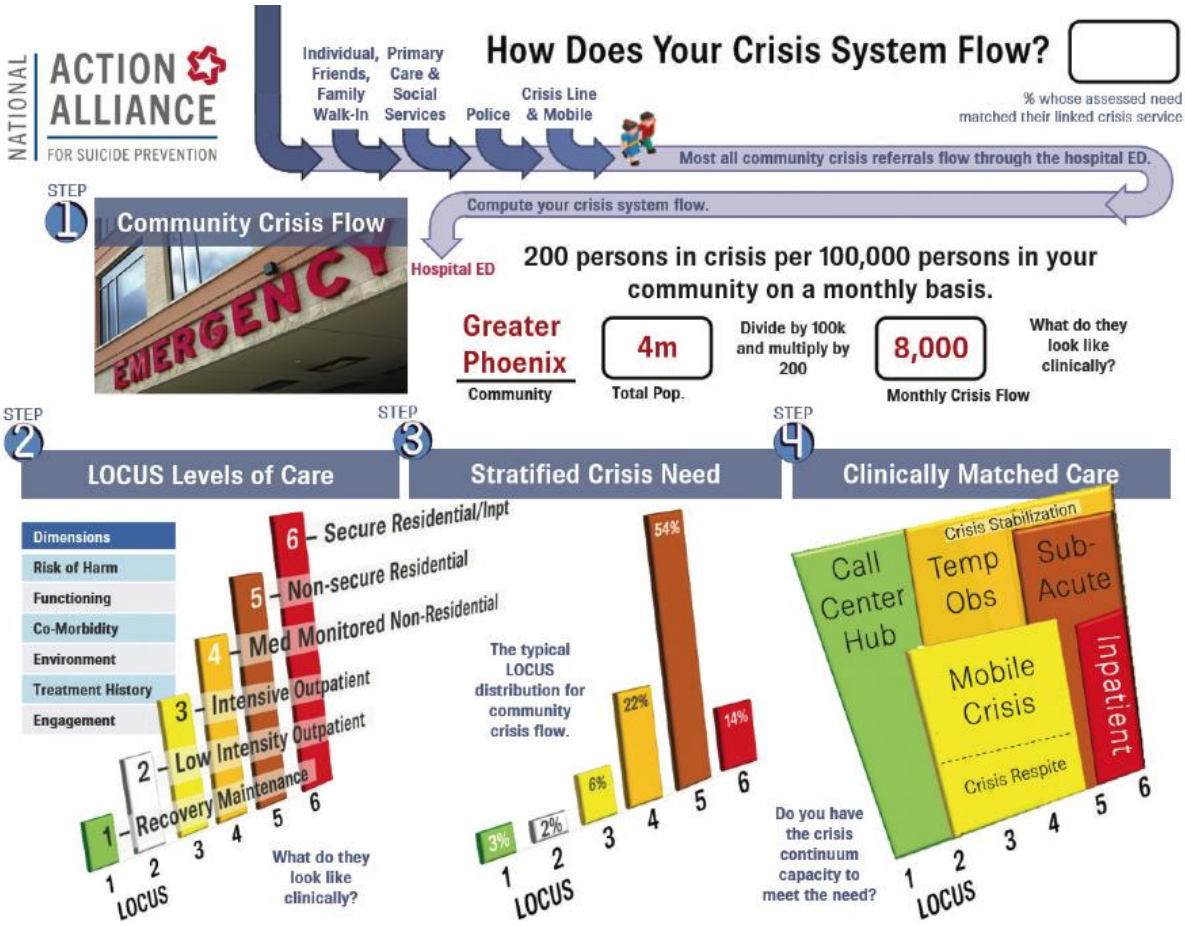
Even a few minutes of contemplating being jailed or spending days in an emergency room due to limited access to mental health crisis care (for ourselves or any of our loved ones) should create a burning platform for change; but real change seems so elusive. The mammoth systems transformation required to alter these intractable practices simply seems beyond our reach.

It is exactly because of the size and scope of this wicked problem that only the boldest goals will break the cycle and trigger change. A similarly devastating challenge is the engagement of individuals who experience a first break of psychosis. In 2002, a small group in the United Kingdom crafted the aspirational Newcastle Declaration: young people experiencing psychosis for the first time and their families should be supported to achieve an ordinary life and quickly move beyond a diagnosis to recovery. While we in the US have also emphasized the value of early treatment, we didn't start with a blue sky declaration. The difference in outcomes is dramatic. The average number of days from onset to service engagement in the United Kingdom has been reduced dramatically according to Kirkbride et al (2017)[i]. In England, services are now mandated to ensure 50% of accepted referrals commence care within 14 days. By contrast, the duration of untreated psychosis in a United States sample has been estimated at 74 weeks[ii].

Despite the recent advancement of consensus exceptional crisis service delivery standards in the National Action Alliance for Suicide Prevention *Crisis Now* report, few communities or populations have substantially implemented these practices that deliver on the promise of better care at a lower cost. The authors of this report aspire to offer a roadmap that leads to a broader adoption of this model throughout the nation. Far too often, crisis services do not represent a systemic approach to addressing community needs but rather a collection of disconnected, overlapping and non-coordinated services offered by well-intended providers; often missing essential pieces needed to align the service delivered with the needs of the individual.

Due to the lack of a crisis system, individuals in crisis often interface with the justice system, first responders, hospital emergency departments (EDs) and correctional facilities. These resources are essential to supporting a healthy community but are not designed to

meet the unique needs of individuals experiencing a mental health crisis. The diagram below represents potential paths of flow for individuals experiencing a mental health crisis. We estimate that for every 100,000 members of a representative population, 200 of those population members will experience a crisis that requires something more than a typical outpatient or phone intervention. Research has offered data that can be used to stratify the service level needs of those individuals and that data can be applied to most efficiently design a cost-effective service delivery system.



Assessing Crisis Service Intensity Needs

Timely access to vital acute psychiatric inpatient (hospital) care is frequently unavailable for individuals experiencing the most significant mental health crises. A decade of LOCUS assessment data gathered in Georgia by mobile crisis teams, emergency departments and crisis facilities indicates that 14% of individuals experiencing a crisis who have reached these higher levels of care have a clinical need that aligns with inpatient care (LOCUS level 6). A majority (54%) of these individuals experiencing a mental health crisis have needs that align better with services delivered within a crisis facility and 32% have lower level needs that would benefit from assessment by a mobile team (LOCUS levels 1-4). It is important to note that this LOCUS data set (*below*) does not include an assessment of individuals contacting the crisis line alone so it is used to only stratify the clinical needs of

those engaged by higher levels of care and is not being used to predict crisis line resource needs.

Georgia LOCUS Distribution			
LOCUS from Mobile Team, ED and Crisis Facility Assessments			
Locus Level	**Percentage**		**Intervention**
1	3%		
2	2%		
3	6%		
4	22%	32%	*To Mobile Team*
5	54%	54%	*To Crisis Observation*
6	14%	14%	*To Acute Inpatient*

Represents data gathered by Georgia Crisis Access Line.

Essentials of a Crisis System

Before going further, it is important to understand what the key elements of a comprehensive mental health crisis system are and what is expected within those services; keeping in mind that cost savings are realized when an individual's needs are effectively met by a service that results in a lower per episode cost of care than what is currently being provided.

1. **Regional or Statewide Crisis Call Centers**. This represents the incorporation of a readily accessible crisis call center that is equipped to efficiently connect individuals in a mental health crisis to needed care. These programs use technology for real-time coordination across a system of care and leverage big data for performance improvement and accountability across systems every minute of every day. At the same time, they provide high-touch support to individuals and families in crisis that adheres to National Suicide Prevention Lifeline (NSPL) standards.

2. **Centrally Deployed Mobile Crisis on a 24/7 Basis**. Mobile crisis services are typically comprised of a two-person (licensed clinician and peer partnerships are common) crisis response team that offers outreach and support where people in crisis are; either in the person's home or a location in the community (not a healthcare facility). Recently, programs have shown greater success by using GPS-enabled technology dispatched from the crisis call center to efficiently connect individuals in crisis with the nearest available mobile team. Programs should include contractually required response times and medical backup.

3. **Residential Crisis Stabilization Programs**. These facility-based programs offer short-term mental health crisis care for individuals who need support and observation. Design of these facility-based programs may vary but ideally will include a medically staffed flexible observation/stabilization area (often limited to 24 hours of care) that implements a no referral refused process in which walk-ins, law enforcement and other first responder referrals are immediately accepted without requiring any form of screening prior to acceptance. These observation /

stabilization programs are often paired with some form of subacute short-term (2-5 day) facility-based crisis program (could be inpatient, respite or residential) to offer more than 24 hours of care without escalating to more costly acute inpatient options that would result in longer lengths of stay and higher per diem costs than programs with specific mental health crisis resolution expertise.

Crisis Resource Need Calculator

The *Crisis Resource Need Calculator*[iii] offers an estimate of optimal crisis system resource allocations to meet the needs of a community as well as the impact on healthcare costs associated with incorporation of those resources. The calculator analyzes a multitude of factors that includes population size, average length of stay in various system beds, escalation rates into higher levels of care, readmission rates, bed occupancy rates and local costs for those resources. In communities in which these resources do not currently exist, figures from like communities can be used to support planning purposes.

The calculations are based on data gathered from several states and the *Crisis Now* Business Case video that explains the rationale behind the model can be seen on NASMHPD's www.crisisnow.com website. Quality and availability of outpatient services also influences demand on a crisis system so the *Crisis Resource Need Calculator* should be viewed as a guide in the design process. True assessment of system adequacy must include a look at overall functioning of the existing system. Signs of insufficient resources will include, but are not limited to, psychiatric boarding in emergency departments and incarceration for misdemeanor offenses when connection to urgent care is the preferred intervention.

The table on the next page shows the very real cost savings that can be realized by implementing mobile crisis and facility-based crisis services in your community. In this table, the population of the community is set at 2,000,000 and if this community was working to address the acute mental health needs of individuals experiencing a crisis solely through inpatient care, data indicates that those with LOCUS levels 5 and 6 (68%) would be referred to inpatient care. This would require 999 beds if the average length of stay was around 9 days; which aligns with the Treatment Advocacy Center's published consensus estimate of needing 50 beds for every 100,000 members of the population. The table that follows (*next page*) includes a per diem inpatient rate of $700 which would result in an inpatient cost of $255,357,435. After applying an ED cost of $2,264 per person to 35% of those who are initially referred to an inpatient bed (medical clearance and assessment), total estimated cost rises to $281,211,661. For the 32% of individuals with LOCUS levels 1-4, no cost or service is included in the calculations although it seems unlikely no actual cost would be incurred. When mobile team and facility-based crisis services are included in optimal ratios (*last column of table that follows*), total cost drops by 50% in these projections despite engaging all of these individuals. This means that 32% more individuals are served with programs that align better to the unique level of clinical need while lowering cost by 50%. Additionally, alignment of clinical level need to the service delivered improves from 14% to as high as 100% in a *Crisis Now* system.

Crisis System Needs Analysis - Population of 2,000,000		
	Baseline	**Evolved**
# of Crisis Episodes Annually *(200/100,000 Monthly)*	**48,000**	**48,000**
"Needed" Acute Beds for Population	*999*	*296*
Number of Acute Hospital Bed Days Needed Per Year	*364,796*	*107,949*
ALOS	*9*	*9*
Acute Inpatient Readmission Rate	*15%*	*15%*
Acute Bed Occupancy Rate	90%	90%
% Initially Served by Acute Inpatient	68%	14%
Number Initially Served by Acute Inpatient	32,628	6,590
Number Referred to Acute Inpatient From Crisis Facility	-	3,065
Number of Acute Inpatient Beds Needed	**999**	**296**
Cost Per Acute Inpatient Bed Per Day	$ 700	$ 700
Total Cost of Acute Inpatient Beds	**$ 255,357,435**	**$ 75,564,555**
Total Number of Episodes in Acute Inpatient	32,628	9,655
Diversion Rate of Crisis Facility (From Acute)	75%	75%
ALOS of Crisis Subacute Bed	2.5	2.5
Crisis Facility Readmission Rate	*15%*	*15%*
% Initially Served by Crisis Subacute Bed	0%	0%
Number Initially Served by Crisis Subacute Bed	-	-
Number Referred to Crisis Subacute Bed by Obs Chair	-	12,260
Crisis Subacute Bed Occupancy Rate	90%	90%
Number of Crisis Subacute Beds Needed	**-**	**93**
Avg. Cost Per Crisis Subacute Bed Per Day	$ 700	$ 700
Total Cost of Crisis Facility Beds / Chairs	**$ -**	**$ 23,838,305**
Rate of Escalation to Subacute Bed	40%	40%
ALOS in Observation Chair	0.8	0.8
% Initially Served by Crisis Obs Facility	0%	54%
Number Initially Served by Crisis Facility	-	26,038
Number Referred to Crisis Facility by Mobile Team	-	4,612
Crisis Bed Occupancy Rate	70%	70%
Number of Crisis Observation Chairs Needed	**-**	**96**
Avg. Cost Per Crisis Bed / Chair Per Day	$ 800	$ 800
Total Cost of Crisis Facility Beds / Chairs	**$ -**	**$ 28,022,171**
Total Number of Episodes in Crisis Facility	-	30,649
Diversion Rate of Mobile Team (From Crisis Facility)	70%	70%
% Served by Mobile Team	0%	32%
Number Served Per Mobile Team Daily	4	4
Number of Mobile Teams Needed	**-**	**15**
Cost Per Mobile Team	$ 400,000	$ 400,000
Total Cost of Mobile Teams	**$ -**	**$ 5,896,207**
Total Number of Episodes with Mobile Team	-	15,372
TOTAL Unique Number of Individuals Served	**32,628**	**48,000**
TOTAL Unique Number of MT / Crisis / Acute Episodes	**32,628**	**55,677**
TOTAL Inpatient and Crisis Cost	**$ 255,357,435**	**$ 133,321,237**
Change in Cost	**0%**	**-48%**
ED Costs (35% of Initial Acute & 4% in Crisis Facility wit	**$ 25,854,227**	**$ 7,580,016**
TOTAL Cost	**$ 281,211,661**	**$ 140,901,254**
TOTAL Change in Cost	**$ (140,310,408)**	**-50%**

Example of a table produced by the Crisis Resource Need Calculator

Building the Business Case

Communities that lack a crisis service continuum pay the price in terms of public safety, the cost of law enforcement engaged in addressing mental health crisis, the expense of incarceration, the impact on quality of life for individuals in the community and elevated healthcare spend on mental health crisis care. Those unable to access needed services in a timely manner pay the price of psychiatric boarding (waiting in an ED for hours or days for mental health care) and consequences of their actions that are influenced by mental health challenges; including incarceration. For payers of healthcare, a lack of resources translates into paying for inefficiencies such as unnecessary ED bills that are estimated to typically cost between $1,200 and $2,264 when 96% of individuals directly referred to a crisis provider do not require an ED visit. Acute psychiatric inpatient care often comes with a higher per diem rate and longer average lengths of stay than crisis facility counterparts. And when the ED is not connected to a psychiatric hospital, an additional ambulance transport expense is often realized. The escalated expenses increase healthcare costs associated with mental health crisis episodes by an estimated 100% (double) of the costs realized within a comprehensive crisis system.

The desired model is to connect individuals to a crisis provider as quickly as possible using a systemic approach that is similar to that of the physical healthcare system. The table below offers a look at some analogies to how desired *Crisis Now* service elements align with physical health counterparts; offering a prototype that can also be used to model reimbursement for these similar services in a manner consistent with parity expectations.

Responding to a Health Crisis			
	Physical Health	**Mental Health (Most)**	**Mental Health (Crisis Now)**
Call	911	Crisis Line	Crisis Line
Community Service	Ambulance / Fire	Police	Mobile Team
Facility Option	Emergency Dept.	Emergency Dept.	Crisis Obs and Stab Facility
Facility Response	Always Yes	Wait for Assessment	Always Yes
Escalation Option	Specialty Unit (PRN)	Inpatient if Accepted	Crisis Facility or Acute (PRN)

Table demonstrating health crisis response approach similarities

Crisis Now Transforming Crisis Services: Business Case[iv] suggests that a comprehensive crisis system is affordable and within our reach. The cost of crisis services is covered by the decreased spend on the more expensive traditional hospital based services. The savings can fund a comprehensive crisis system and radically transform behavioral health delivery. "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".[v]

The *Crisis Now Business Case*[vi] profiles Maricopa County, Arizona, which includes the greater Phoenix area. There, the associated savings of a crisis system containing all three core aspects of a crisis system have included:

- 37 full-time equivalent (FTE) police officers engaged in public safety instead of mental health transportation/security;
- Reduction in psychiatric boarding of 45 years annually; *and*

- Decrease in inpatient spend by $260 million.

Getting to Zero

Bold goals. Zero unnecessary admits to the hospital emergency department. Zero unnecessary bookings into jail. Getting to zero requires a true commitment by mental health crisis providers to accept all referrals from first responders. In order to execute on that commitment, facility-based crisis providers need to offer sufficient observation / stabilization chair capacity and be adequately connected to additional facility and community-based resources to support adequate flow out of these chair resources. Although there are communities who strive to meet the need for mental health crisis services through some level of respite, residential, subacute or acute bed capacity, IMD restrictions and the hard capacity limitations that are associated with these resources often fall short of meeting the need on their own. The more flexible 23 hour observation /stabilization chairs that offer some ability to expand in numbers (depending on licensing and credentialing limitation of the space) to address the needs of a larger number of individuals than their bed counterparts is an essential part of the crisis system design. Mercy Care funded programs in Maricopa County have demonstrated the efficacy of this design by accepting thousands of first responder referrals without a refusal over the past several years. Of course, the impact of these programmatic design efforts cannot be realized until local law enforcement are engaged with a commitment to utilizing these resources.

Currently, some of the organizations treating the largest number of individuals with behavioral health conditions are jails and prisons. "With close to 11 million people being processed through jails each year, compared with approximately 625,000 being admitted into the nation's prisons, jails house the majority of the inmate population with SMI".[vii] However, communities that have committed to offering pre-booking jail diversion in the form of Crisis Intervention Team (CIT) training with law enforcement and a comprehensive crisis system that accepts all law enforcement referrals in a timely manner are able to reduce these numbers.

Covered Services and a Consistent Code Set

Mental health crisis services need to be covered by all payers of healthcare services. And these payers should strive to find ways to cover these services, much like they do with their physical health counterparts, in support of parity and as a means to lower their overall spend on mental health crisis episodes. The Mental Health Parity and Addiction Equity Act requirements would suggest a mandate exists to include these services, much like they do their covered physical health analogies, as a covered benefit. The law's provisions prohibit group health plans and health insurance issuers that provide mental health or substance use disorder coverage from applying greater benefit limitations on those health issues than on medical/surgical benefits.

To effectively broaden the mix of payers, the mental health community must evolve a common vernacular that supports crisis systems in all communities. The writers of this paper recommend that a group of healthcare billing subject matter experts convene to take on this task as soon as possible.

Policy and Licensure

Often, policy makers, state officials and payers of healthcare services say that they can't afford to fund crisis services. As we have seen in the business case section of this paper, it is hard to envision how communities and payers of healthcare can continue to pay the price of not establishing a comprehensive crisis system.

In 2017, the *Interdepartmental Serious Mental Illness Coordinating Committee (ISMICC)* released a report called *The Way Forward: Federal Action for a System That Works for All People Living with SMI and SED and Their Families and Caregivers*.[viii] This report contains five areas of focus:

1. Strengthen federal coordination;
2. Access and engagement -- make it easier to get good care;
3. Treatment and recovery -- Close the gap between what works and what is offered;
4. Increase opportunities for diversion and improve care for people with SMI and SED involved in the criminal and juvenile justice systems; *and*
5. Develop finance strategies to increase availability and affordability of care.

The focus areas identified by ISMICC are broad, but achievable over time and will improve the overall delivery system. This will require a commitment from the community; including public-private partnerships.

We are seeing some fundamental traction with the passage of the National Suicide Hotline Improvement Act; a bill that could spur the development of a three-digit code (like 411 or 611) to act as a national mental health crisis and suicide prevention hotline. However, this is only a start and without the changes described in this paper, even such a strong development across states would only speed the access into the chokehold with law enforcement and hospital emergency departments.

There are more effective ways to meet the needs of individuals experiencing a behavioral health crisis other than ED visits and jail bookings. Individuals experiencing a medical emergency should absolutely go to an ED. Individuals who commit serious crimes should be taken to jail. A comprehensive crisis system meets the needs of individuals in crisis who don't meet the two conditions above.

> ***Now is the time to establish comprehensive crisis are a foundational, transformative, life-saving core element of behavioral health care and of suicide prevention.***[ix]

ISMICC Focus 1: Strengthen Federal Coordination to Improve Care, 1.4., Harmonize improved policies to support federal coordination.[x] The premise of this goal is to address definitions, barriers across federal departments and age-related barriers and alignment of benefit eligibility. This is a tall order and will require coordination and collaboration between federal and state statutes and policy.

A number of states have adjusted licensure standards to reflect modern provider types, locations and services to align with crisis services. There is an opportunity for more states to remove barriers to crisis center services and mobile crisis. Depending on how the state is structured, this could require statutory, administrative rule and policy changes. States should work with providers and other stakeholders to address these barriers so a crisis system can be developed while striving to align with the evolving vernacular to support universal opportunities to implement these needed services throughout the country.

Practices also exist that are not based on policy, but rather on a misunderstanding or misinterpretation of policy. These practices push individuals in crisis to EDs for treatment and/or clearance before accessing a crisis facility. Addressing these issues can contribute to reduction in unnecessary hospital ED visits along with associated transportation by law enforcement, ambulance or other means.

Conclusion

The escalating costs communities pay for not investing in a comprehensive crisis system are unsustainable; manifesting as demands on law enforcement, other first responders, justice systems, emergency departments and healthcare payers that push beyond the capacity of these local resources and result in adverse outcomes for those in need of care. And the impact to vulnerable members of our communities can be devastating. A comprehensive crisis system that includes the three core components is essential to all communities across the nation. This all sounds daunting, but Rome was not built in a day. Keep in mind that small steps in the right direction add up and over time will become the crisis system that we all want and need. And it is within our reach. Bold goals. Zero unnecessary admits to the hospital emergency department (ED). Zero unnecessary bookings into jail. These are attainable goals through implementation of the *Crisis Now* model and will actually cost less than maintaining the status quo. If we, as a nation, are ready to deliver on the promise of better health, better healthcare experiences and lower cost of care, then we must take action to advance these exceptional practice standards now.

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