



Crisis System Reform Update

January 29, 2010

Presented by:
Laura K. Nelson & Justin Chase
ADHS/DBHS

Contributors*

- **Magellan Health Services** (David Covington, Gabriella Guerra, Celeste Lippy, Dan Wendt)
- **Cenpatico** (Randy Ek, Jay Gray, Emily Wetter, Renee Waterstradt)
- **CPSA** (Vanessa Seaney, Howard Shore, Kendra Kilgore)
- **NARBHA** (Raymond Johnson, Bob Rehak, Laura Hartgroves)
- **Behavioral Health Planning Council** (Emily Jenkins)
- **Phoenix Police Department** (Nick Margiotta)
- **Community Bridges** (Frank Scarpati & John Hogeboom)
- **ConnectionsAZ** (Chris Carson & Robert Williamson)
- **Crisis Response Network** (Suzanne Rabideau)
- **Recovery Innovations** (Michelle Bloss)
- **Various 1st Responders** (Phoenix FD, Mesa FD, Mesa PD, Gilbert PD, Tempe FD & Chandler FD)
- **MIHS** (Gene Cavallo)
- **lasis Healthcare** (Gregory Jahn)
- **Southwest Behavioral Health** (Jeff Jorde & SueAnn Atkerson)
- **TERROS** (Larry Villano, Tiara Crouse, Peggy Chase)
- **Valle del Sol** (Luz Samina)
- **JFCS** (Michael Zent & Mary Jo Whitfield)
- **NOVA** (Steve Carter)
- **Native American Connections** (Diana Yazzie-Devine)
- **People of Color Network** (Karen Guetel)
- **CHOICES, Inc.** (Jill Rowland & Ron Smith)
- **Partners in Recovery** (Christy Dye & Stacy Gardner)
- **Southwest Network** (Amy Henning & Anita Barnas)
- **CIA** (Teri Boothby, Annette Church, Nadia Orozco)
- **Crossroads Mission** (Myra Garlit & Gordon Block)
- **SMMHC** (Rob Evans & Deborah McMullen)
- **ACTS** (David Waples, Mike Carr & Bill Cady)
- **The Living Center** (Rick Ploski & Anthony Alberta)



*The contributors provided various sources of information and input which assisted ADHS/DBHS in developing the following report. This list does not imply endorsement.

ADHS/DBHS

Crisis Reform Workgroup*

- Cross-departmental representatives from:
 - Office of the Medical Director
 - Clinical Operations
 - Grants Management
 - Information Systems
 - Office of Human Rights
 - Adult Network Operations
 - Children's System of Care
 - Quality Management/Utilization Management
 - Compliance
 - Finance
 - Office of Program Support



Regional Contractors

Geographic Service Area (GSA)	Counties Served	RBHA/TRBHA
1	Apache, Coconino, Mohave, Navajo and Yavapai Counties	Northern Arizona Behavioral Health Authority (NARBHA)
2	Gila, Pinal, La Paz and Yuma Counties	Cenpatico Behavioral Health of Arizona
3	Cochise, Graham, Greenlee and Santa Cruz Counties	Community Partnership of Southern Arizona (CPSA)
4	Gila and Pinal Counties	Cenpatico Behavioral Health of Arizona
5	Pima County	Community Partnership of Southern Arizona (CPSA)
6	Maricopa County	Magellan Health Services
Tribal RBHAs: <ul style="list-style-type: none"> •Gila River Indian Community, •Pascua Yaqui Tribe and •White Mountain Apache Tribe 		Tribal Contractors: <ul style="list-style-type: none"> •Navajo Nation and •Colorado River Indian Tribes

T/RBHA MAP



Purpose

The purpose of this project is to establish a service package which ensures that a proven comprehensive crisis system is in place that accommodates the entitled services of the Title XIX population; while sustaining necessary crisis services for the Non-Title XIX population based on the current and proposed funding reductions.

Issue Statement

Based on the current and anticipated reduction in state appropriated funds, ADHS/DBHS is working to establish a service package which ensures that a proven comprehensive crisis system is in place that accommodates the entitled services of the Title XIX population; while sustaining necessary crisis services for the Non-Title XIX population.

- The purpose of the behavioral health crisis system is to:
- *engage individuals experiencing a crisis situation early,*
- *stabilize within the community whenever possible,*
- *reduce unnecessary incarceration and burden on law enforcement, and*
- *decrease avoidable emergency room utilization.*

Process

1. Define Crisis Services
2. Articulate the targeted outcome of crisis services
3. Establish a crisis service package for all Non-Title XIX recipients
4. Establish a crisis service package for all Title XIX recipients
5. Establish monitoring mechanisms to measure outcomes and fiscal responsibility
6. Think outside the box!

Primary Issues

- Nearly all of the RBHAs' FY 2010 Non-Title XIX/Non-SMI/Non-Block Grant funds were allocated to crisis services prior to the most recent non-XIX funding cuts.
- Crisis services are among the most costly services provided, yet there is minimal oversight or ability to demonstrate effectiveness.
- An additional round of funding cuts is expected in the near future.

Definition: Crisis

Crisis: *A temporary state of upset and disorganization, characterized by an inability to cope with a particular situation using customary methods of problem solving, and by the potential for a radically positive or negative outcome.*
[Slaikau, 1984]

- Crisis: *An acute response to a critical incident wherein:*
 - *Psychological homeostasis is disrupted.*
 - *One's usual coping mechanisms have failed.*
 - *There is evidence of human distress and/or dysfunction*
 - (Everly, G.S., 2001)

Definition: Crisis Services

- Crisis Services: *immediate and unscheduled behavioral health services provided: (a) In response to an individual's behavioral health issue to prevent imminent harm or to stabilize or resolve an acute behavioral health issue; and (b) At a Level 1 psychiatric acute hospital or a Level 1 sub-acute agency. [AAC R9-20-101(37)]*
- Crisis Services: *A collection of integrated services that are available 24 hours a day, seven days a week to respond to and assist individuals in a mental health emergency. These services are provided to persons who are in an emergency condition or crisis situation. The person's need may be such that they require treatment to reduce the likelihood of death, harm to themselves or someone else, serious injury or deterioration of a physical condition on a major setback in their condition or illness. Examples of these service include but are not limited to:*
 - *Crisis Hotlines*
 - *Crisis residential and respite services*
 - *Crisis mobile outreach*
 - *Short-term crisis counseling*
 - *Crisis walk-in clinics*
 - *Crisis stabilization services*

-(Technical Assistance Collaborative, April 2005)

Definition: Crisis Intervention

- Crisis Intervention (DBHS CSG): Services provided to a person for the purpose of stabilizing or preventing a sudden, unanticipated, or potentially deleterious BH condition, episode or behavior.
- Crisis Intervention (Everly, 2001): *The provision of acute psychological support the goals of which are:*
 - *Stabilization of the symptoms/signs of distress*
 - *Mitigation of the symptoms/signs of distress*
 - *Restoration of functional capabilities*
 - *Referral to follow-up by someone representing some higher level of support/care*
- Crisis Intervention (CARF): CI programs offer services aimed at the assessment and immediate stabilization of acute symptoms of mental illness, alcohol and other drug abuse, and emotional distress or in response to acts of DV or abuse/neglect. CI services consist of mobile response, walk-in centers, or other means of face-to-face assessments and telephone interventions.

Definition: Crisis Stabilization

Crisis Stabilization (CARF): CS programs are organized and staffed to provide the availability of overnight residential services 24/7 for a limited duration to:

- stabilize acute psychiatric or behavioral symptoms,
- evaluate treatment needs, and
- develop plans to meet the needs of the persons served.

Often CS programs are used as a preemptive measure to deter unnecessary inpatient hospitalization

DBHS Covered Services Guide

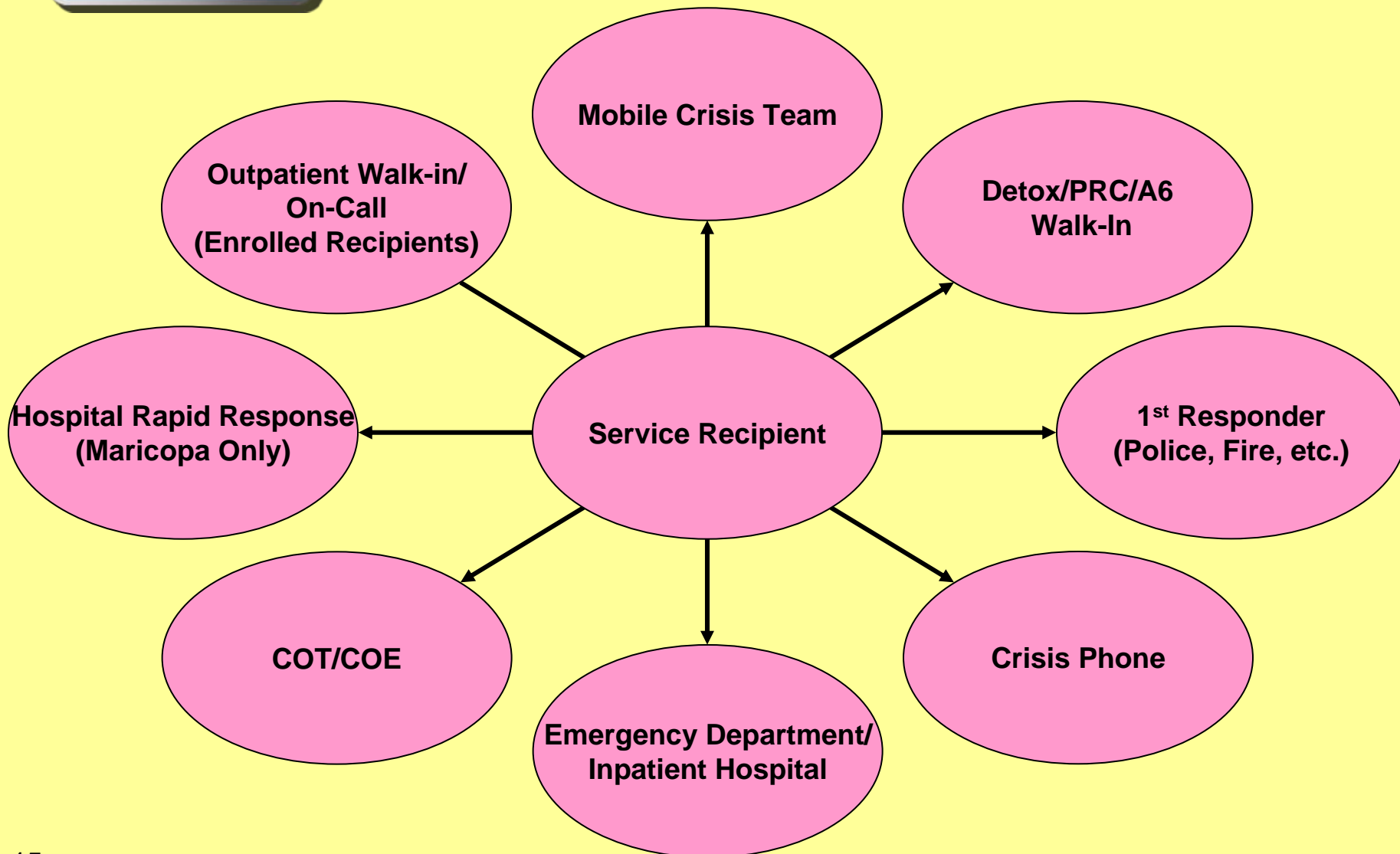
Crisis Services may include*:

- Screening
- Assessment
- Evaluation
- Counseling & therapy
- Medication services
- Medication management
- Case management
- Skills Training
- Self-Help/Peer Services
- Transportation
- Adtl. Support Services
- Psychiatric; room and board
- Detoxification; room and board
- Laboratory Services
- Radiology
- Medical Imaging

*Also see AHCCCS
BH Svcs. Guide

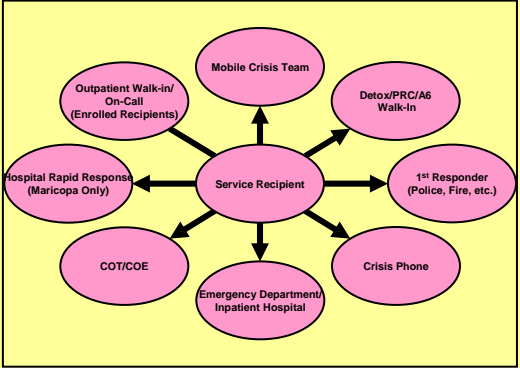
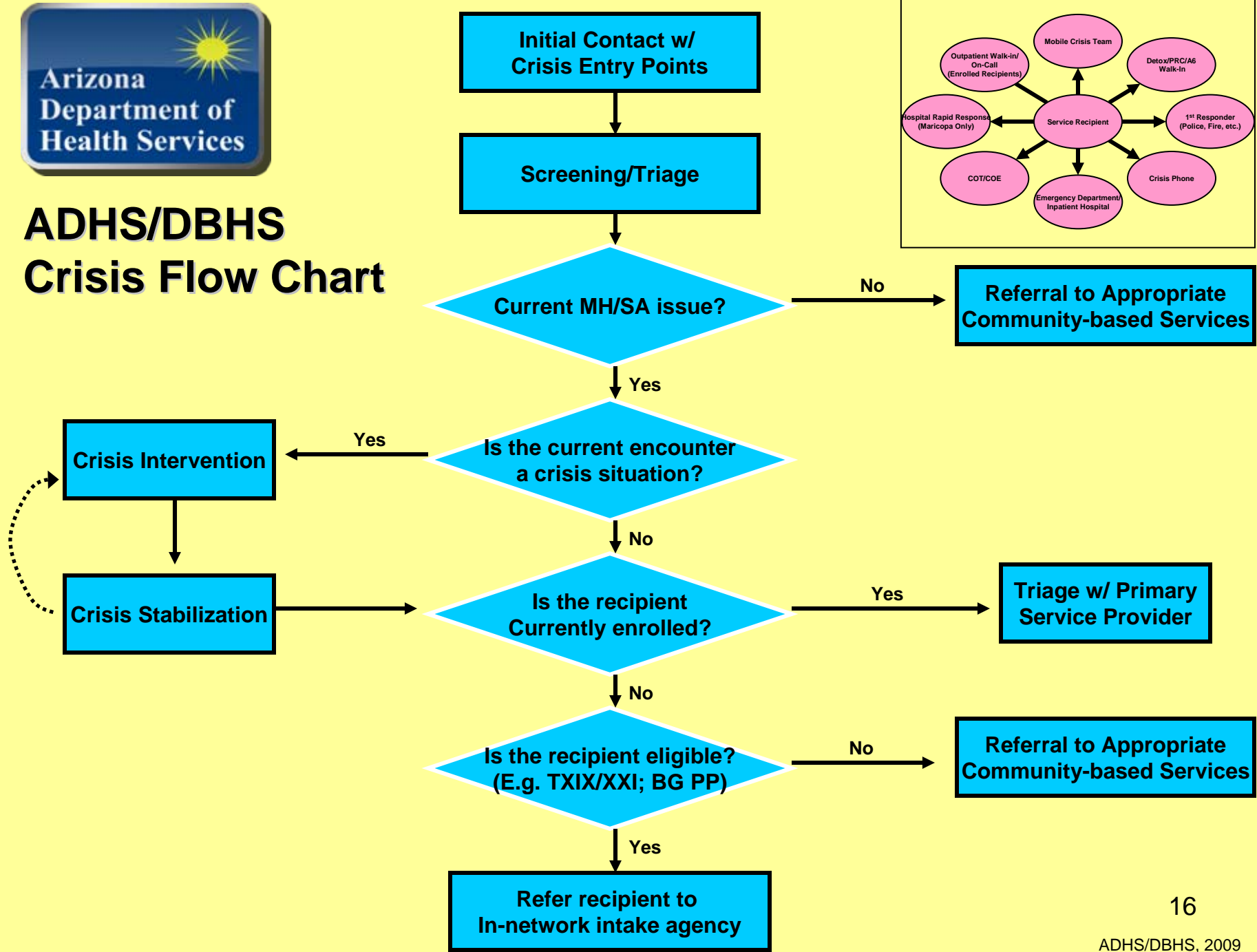


ADHS/DBHS Crisis System Entry Points





ADHS/DBHS Crisis Flow Chart



What is the targeted outcome?

- Decrease suicide/homicide rate among service recipients?
- Reduce hospital ED utilization?
- Reduce wait times in EDs?
- Reduce recidivism rates at EDs and crisis service providers?
- Reduce unnecessary incarceration and detainment?
- Reduce non-acute utilization of Level I beds?
- Reduce COT/COE?
- Improve continuity of care by coordinating with community-based supports and services?
- Return recipient to community as quickly as clinically possible?

How will we address the following?

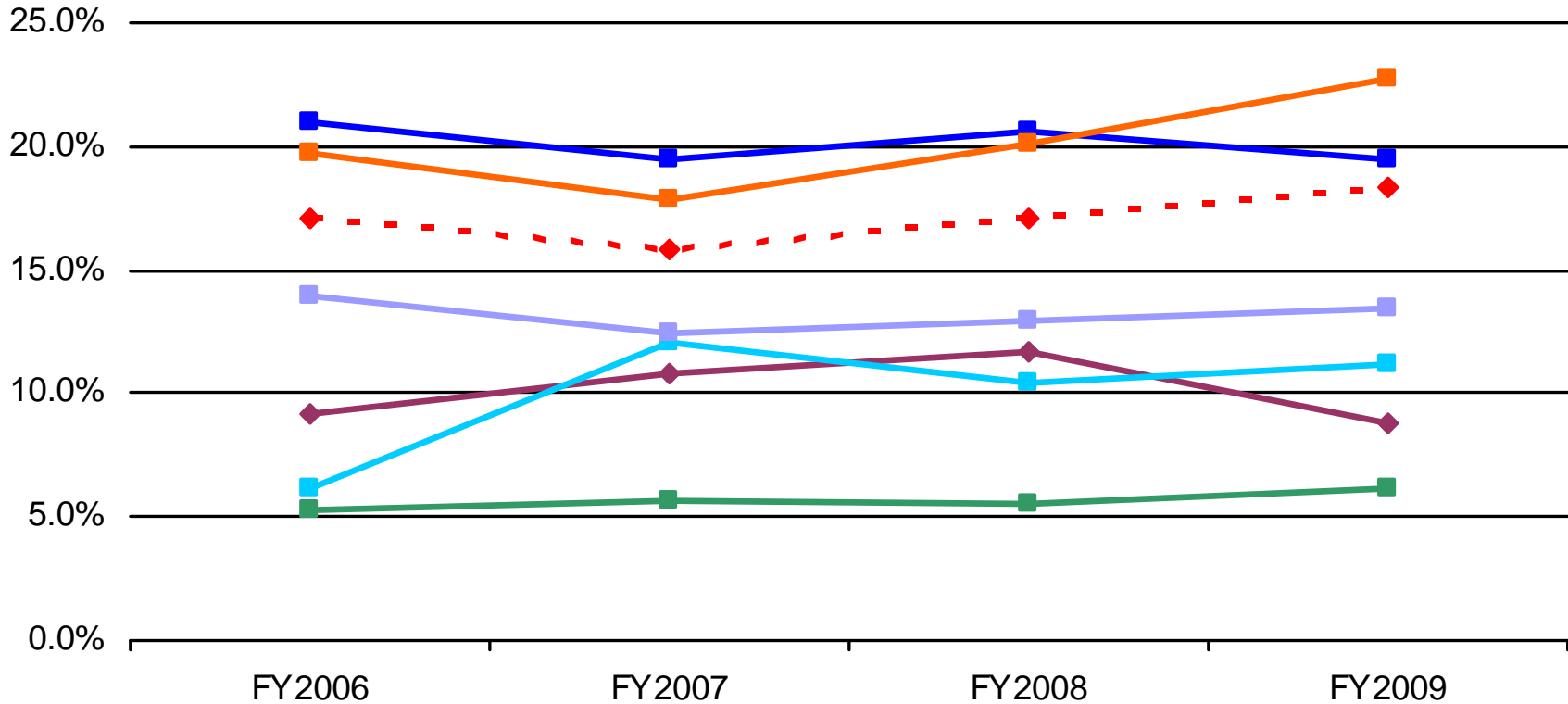
- Walk-Ins/non-enrolled individuals
- Police/Fire Dept./1st Responder referrals
- COT/COE
- DTS/DTO
- Enrolled recipients presenting in crisis
- Repeat users of crisis system
- Medication Services (refills & crisis formulary)



Statewide & GSA Data

% of Total Clients

Statewide & RBHA % of Total Clients Served For Crisis Services
(Title XIX All Adults)
FY 2006, 2007, 2008 & 2009

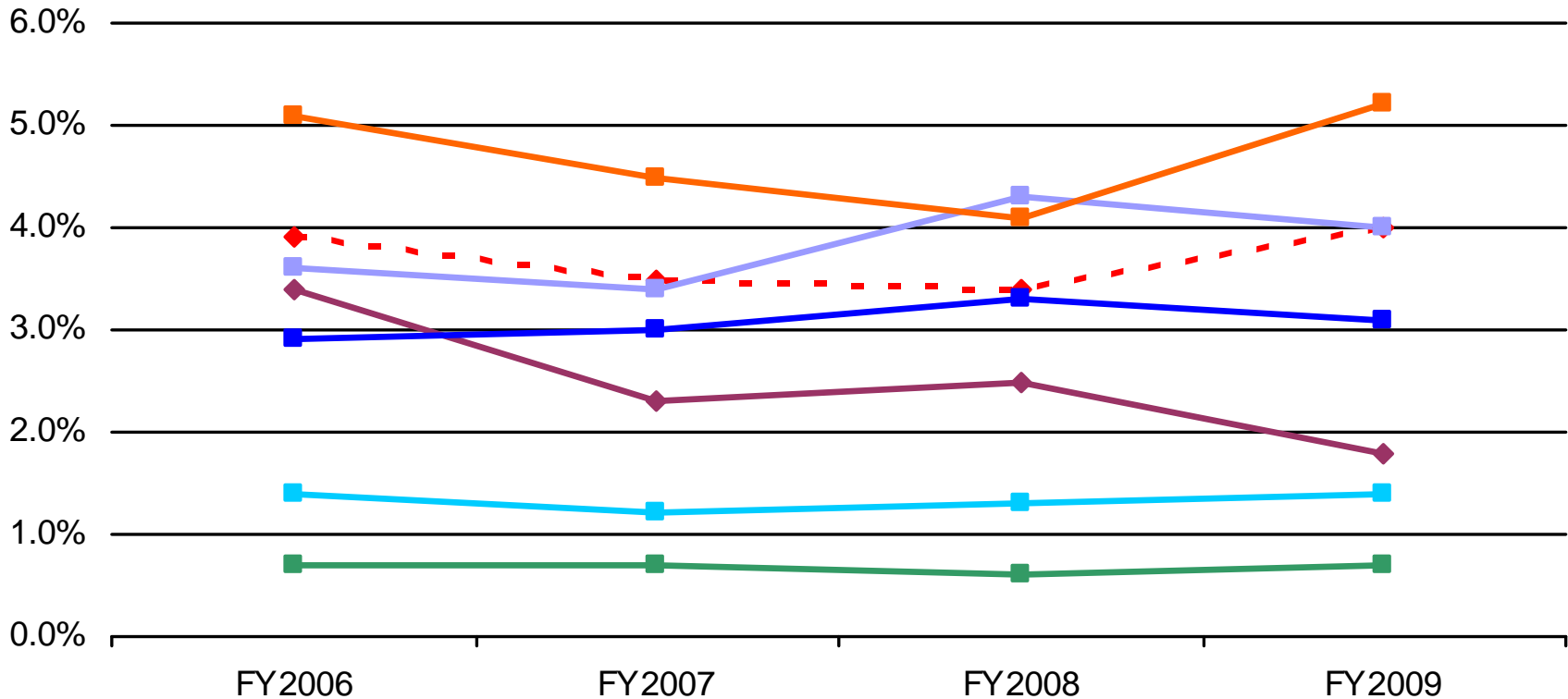


- - ◆ - - **Statewide Crisis Services**
◆ **GSA2 Crisis Services**
■ **GSA4 Crisis Services**
■ **GSA6 Crisis Services**

■ **GSA1 Crisis Services**
■ **GSA3 Crisis Services**
■ **GSA5 Crisis Services**

% of Total Funds

**Statewide & RBHA % of Total Funds Utilized For Crisis Services
(Title XIX All Adults)
FY 2006, 2007, 2008 & 2009**



- - ◆ - - Statewide Crisis Services
- - ◆ - - GSA2 Crisis Services
- - □ - - GSA4 Crisis Services
- - □ - - GSA6 Crisis Services

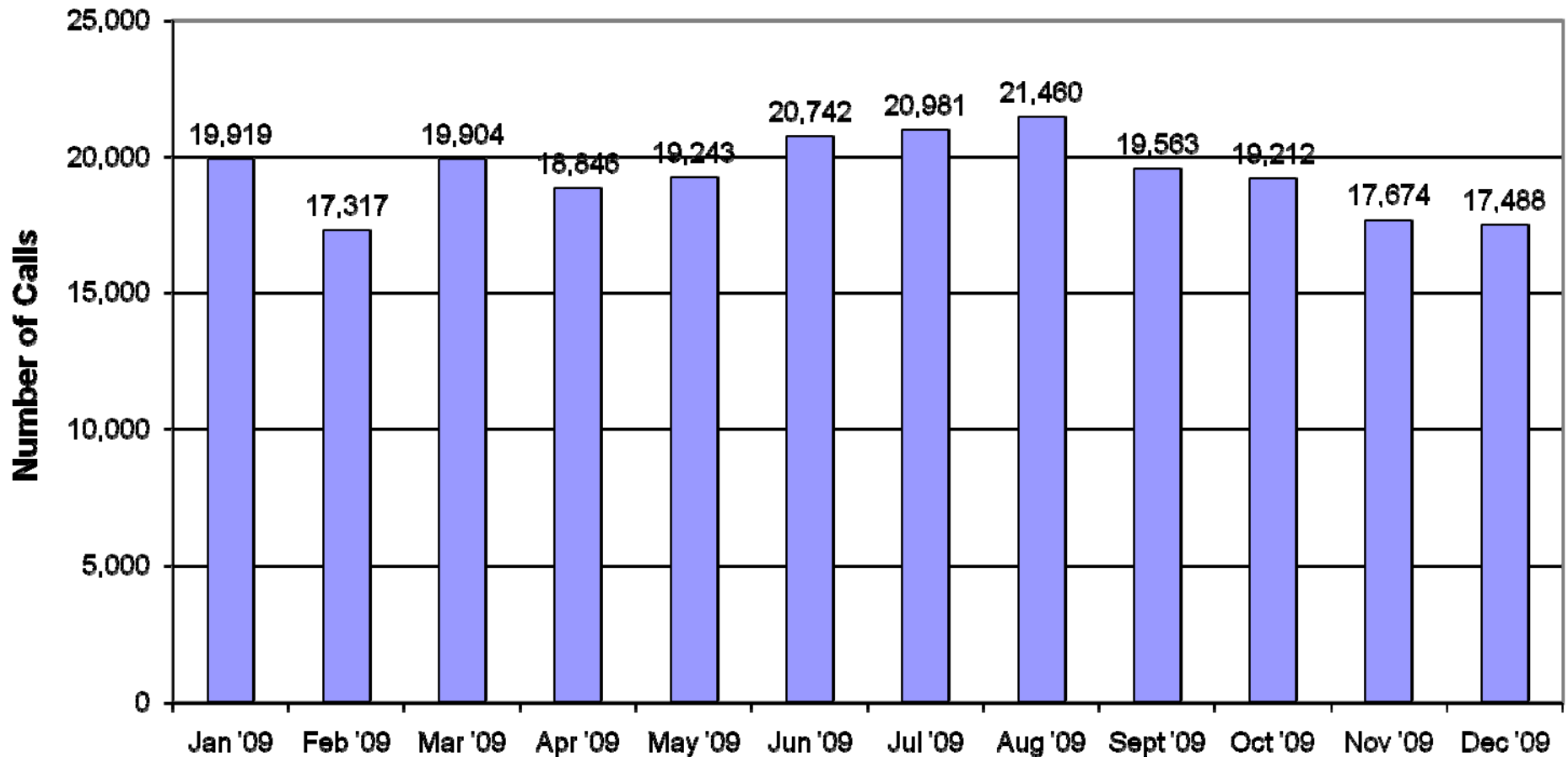
- - □ - - GSA1 Crisis Services
- - □ - - GSA3 Crisis Services
- - □ - - GSA5 Crisis Services



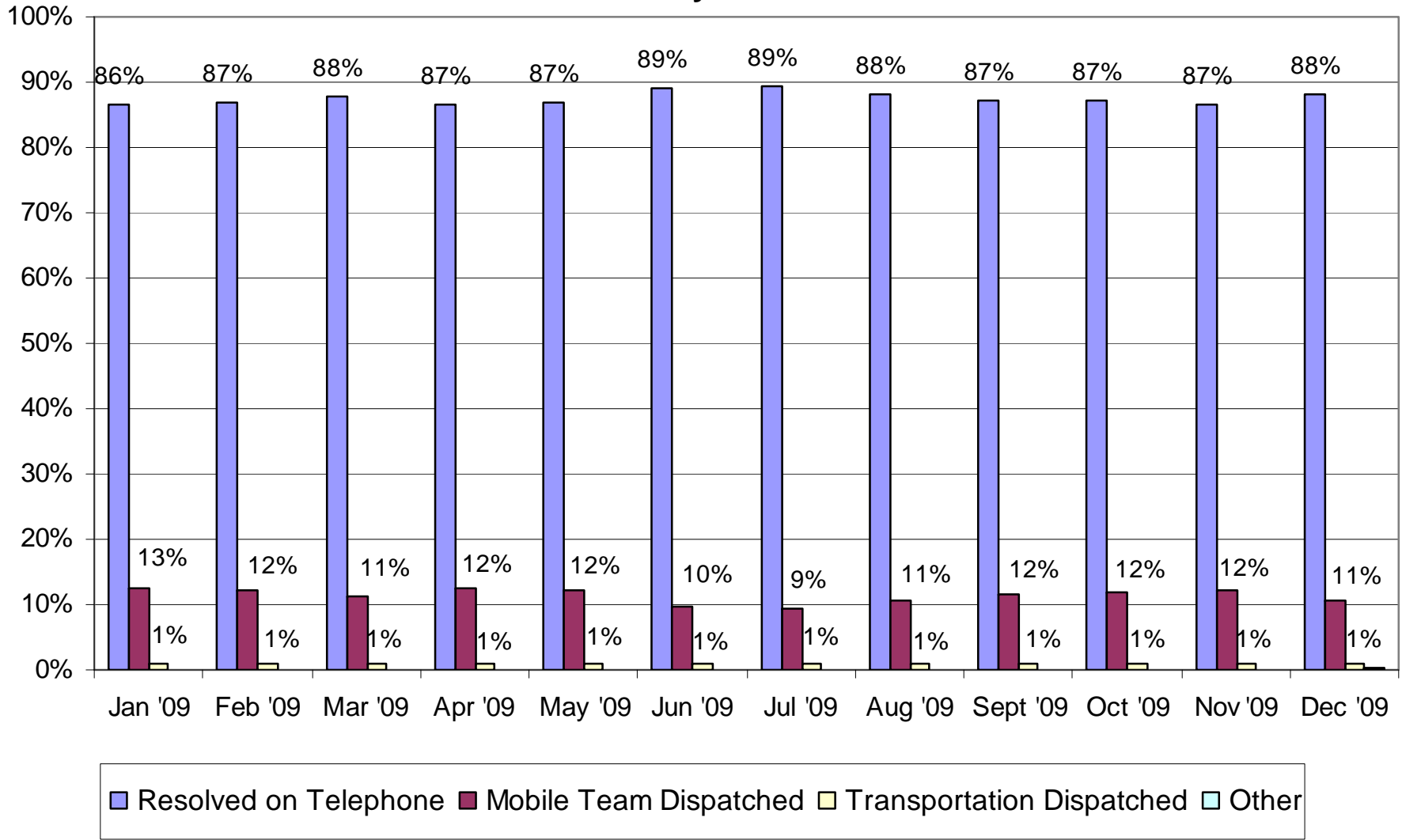
Maricopa County Crisis Data

Crisis Calls by Month January 2009 - December 2009

Telephonic Crisis Services – Telephonic crisis intervention services providing: crisis triage, behavioral health/suicidal risk assessments, crisis planning to stabilize and resolve crisis situations and prevent sudden deleterious behavioral health

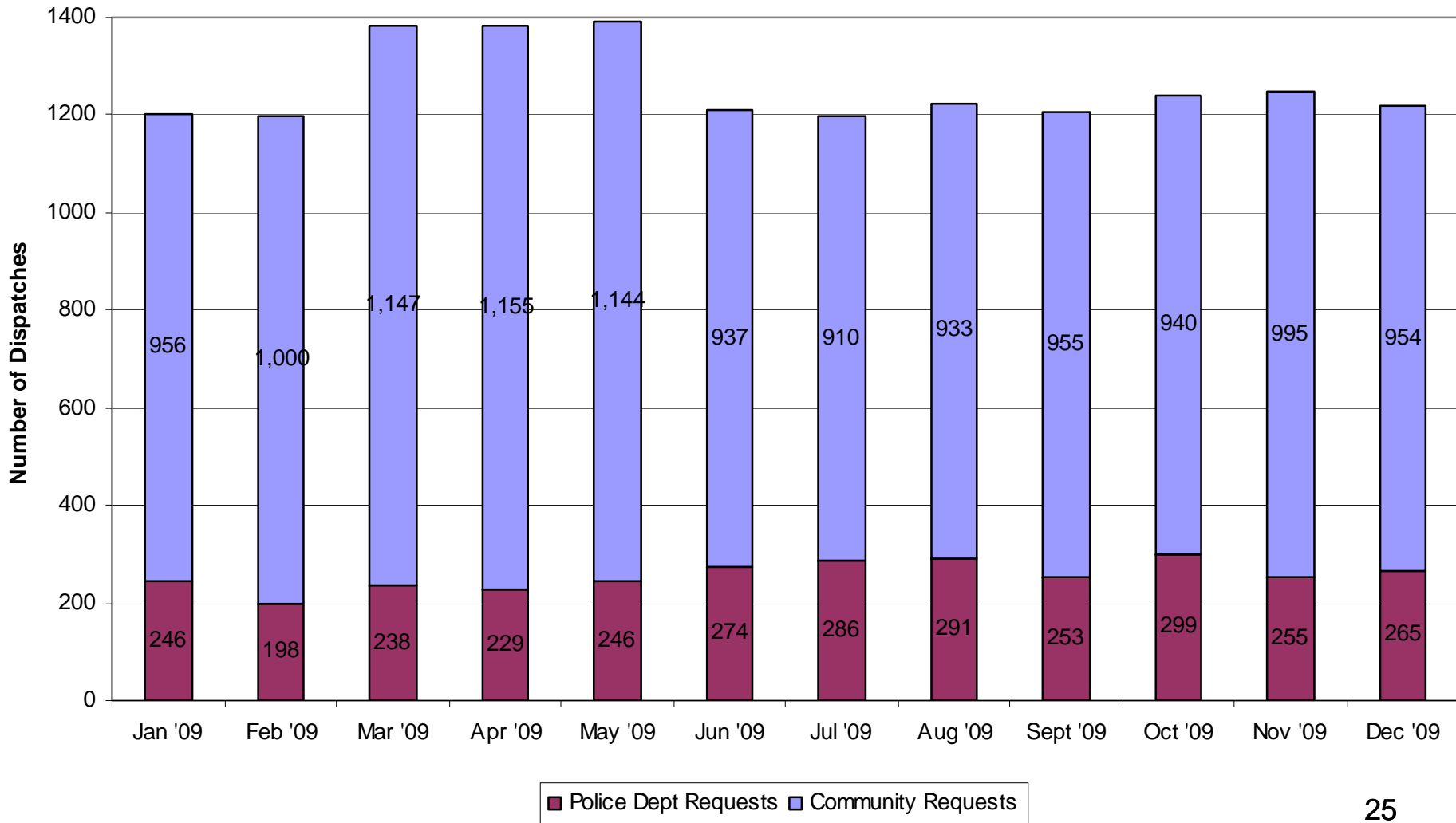


Crisis Call Dispositions January - December 2009

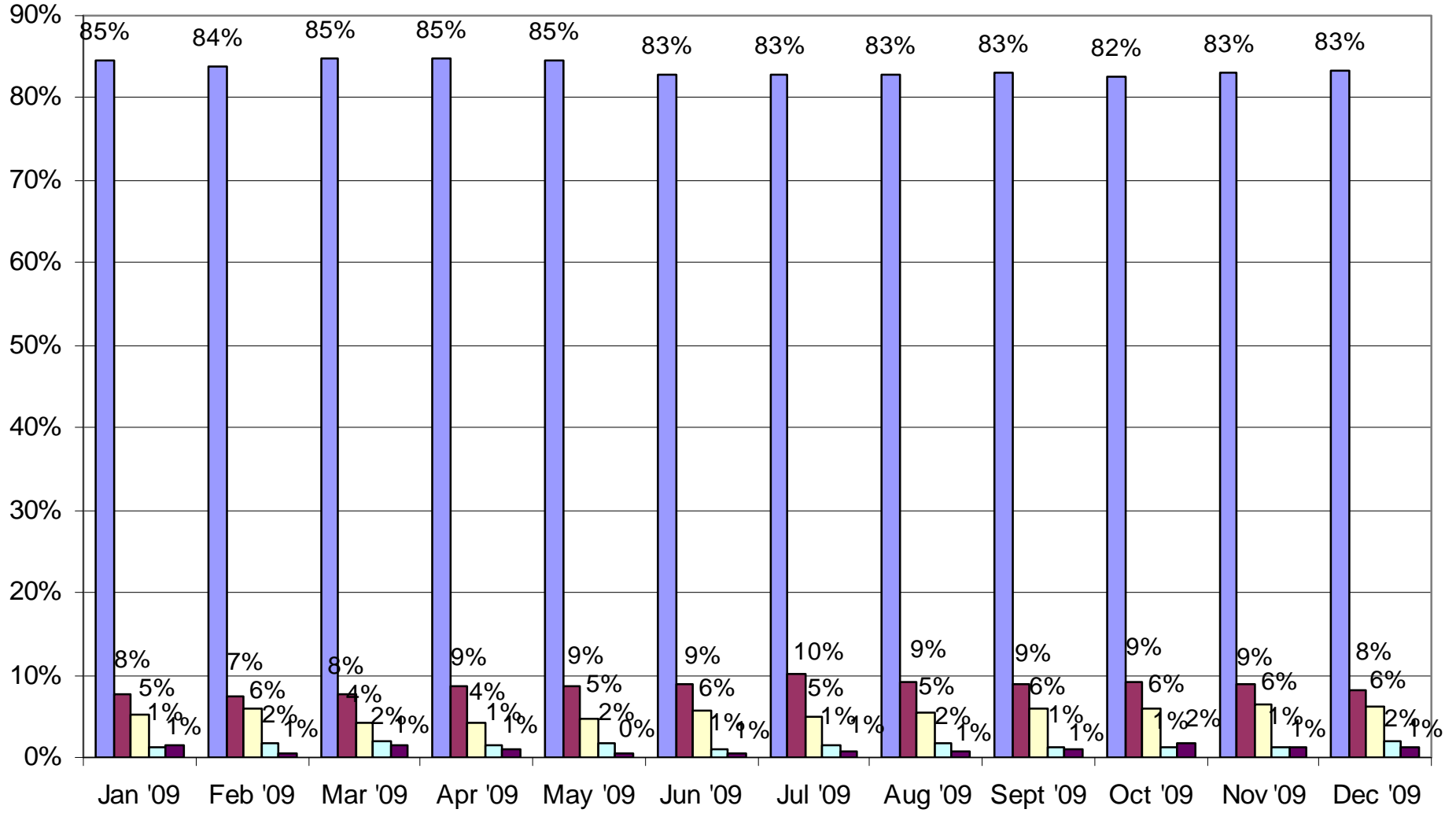


Mobile Team Dispatches January - December 2009

A two person counseling team that travels to meet the individual in crisis where they are within the community and provides crisis risk assessment/analysis and de-escalation, crisis counseling, critical incident debriefing and consultation, resource linkage and when clinically necessary, transitions to an appropriate level of behavioral health and psychiatric services.



Mobile Team Dispositions January 2009 - December 2009

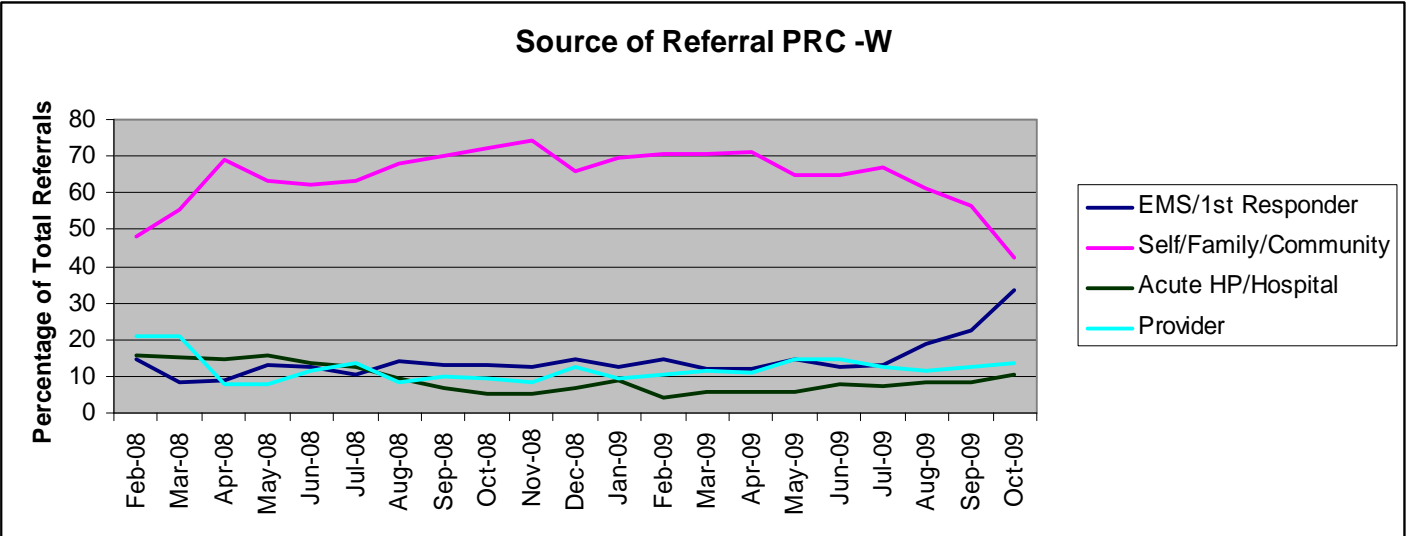
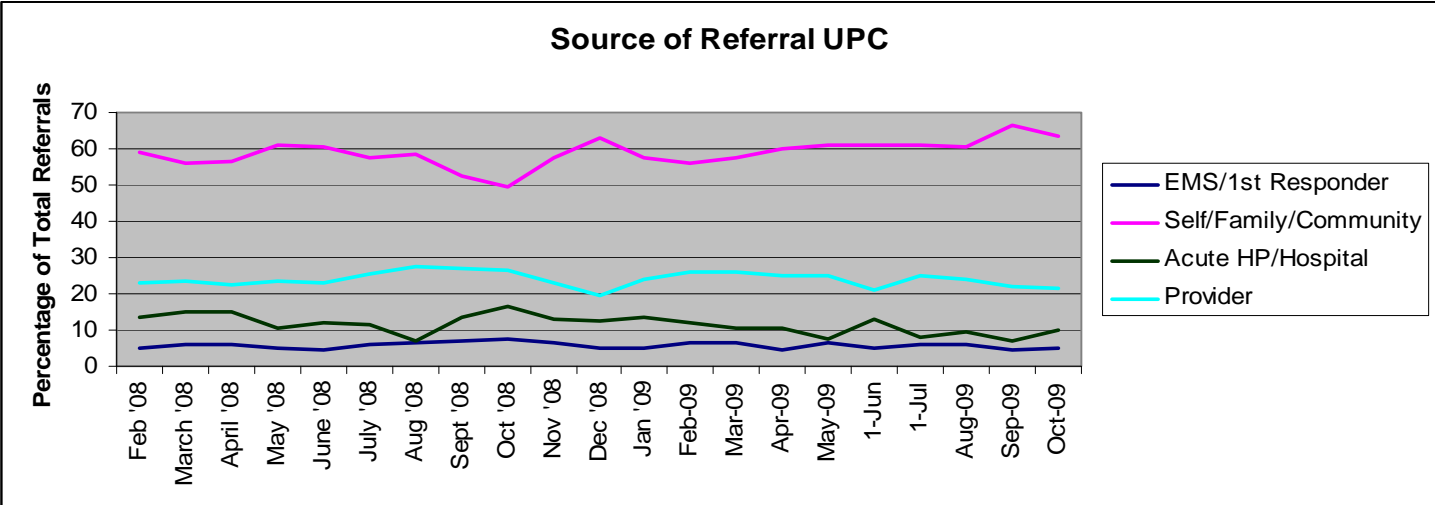


■ Community Stabilized
 ■ Connections AZ/RIAZ
 ■ Petition
 ■ Detox
 ■ Hospital

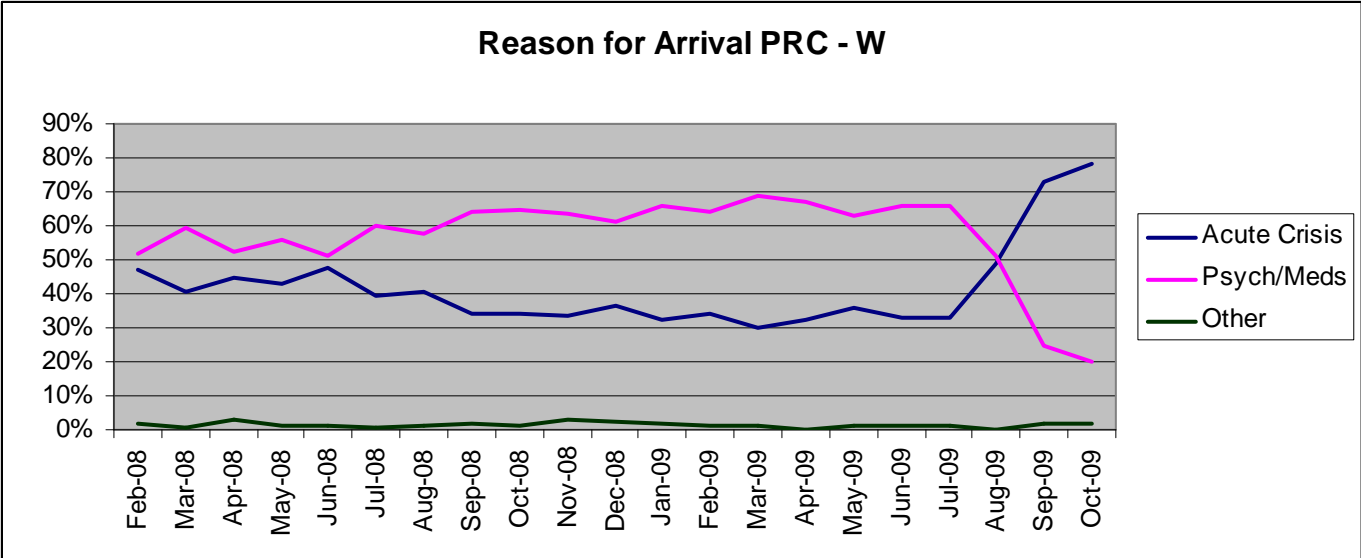
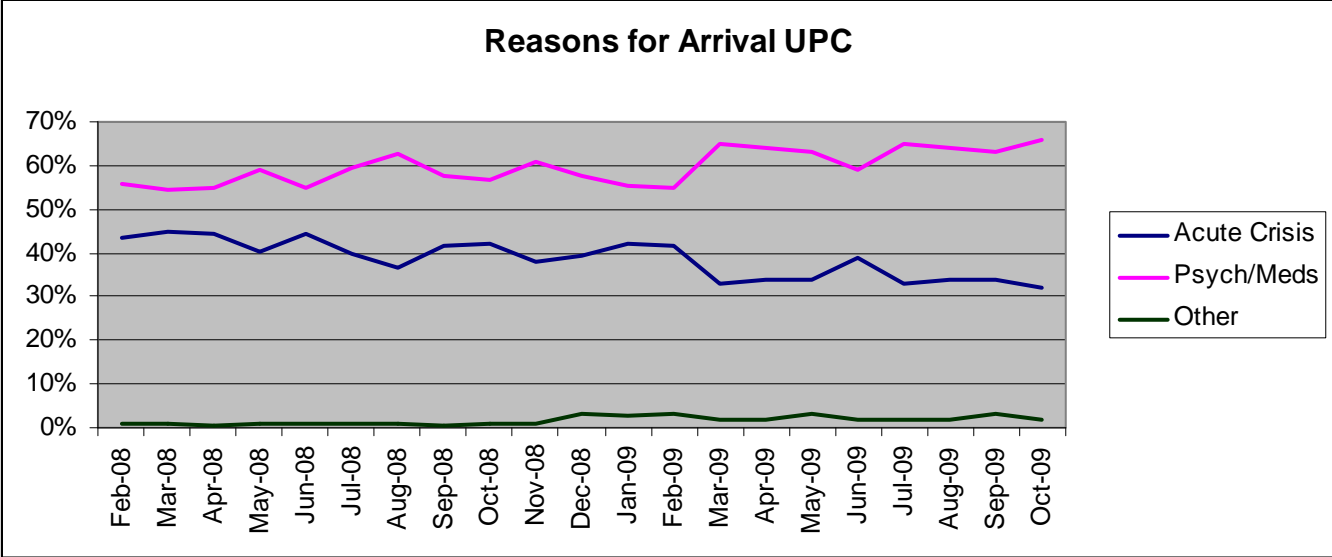


Maricopa County's Urgent Psychiatric Care Facilities

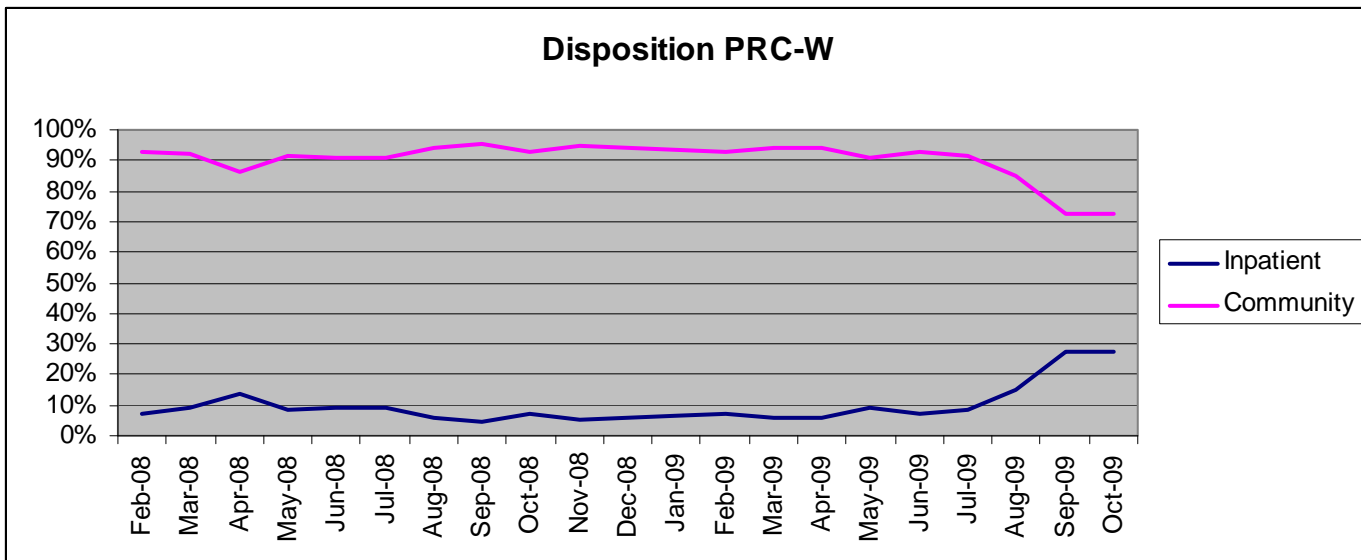
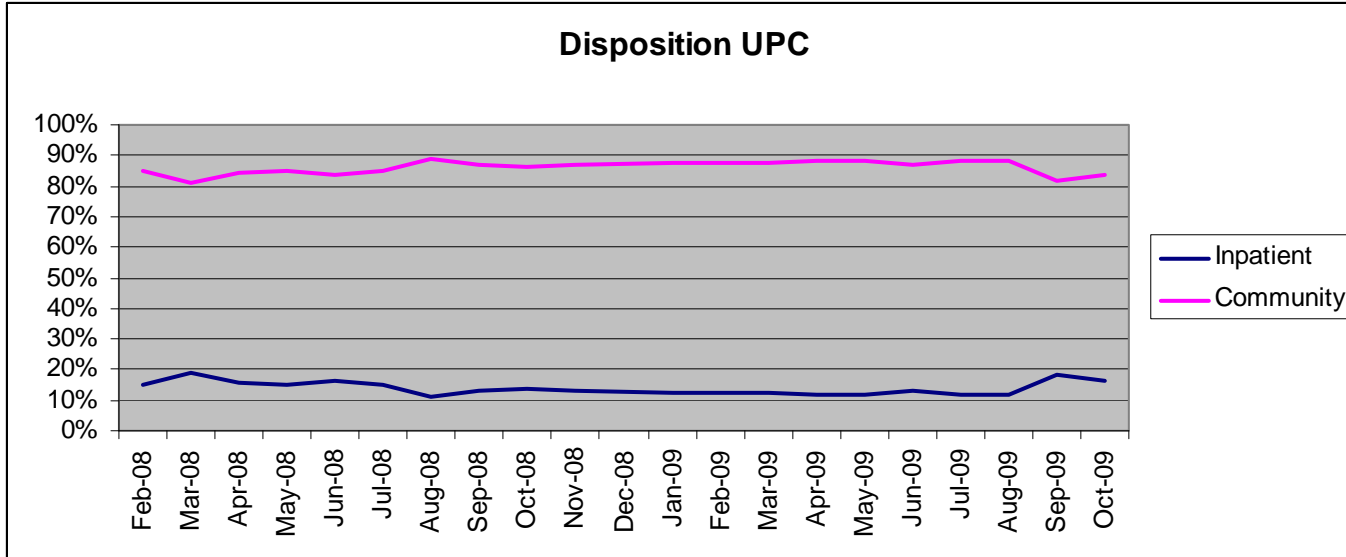
UPC/PRC-W Source of Referral



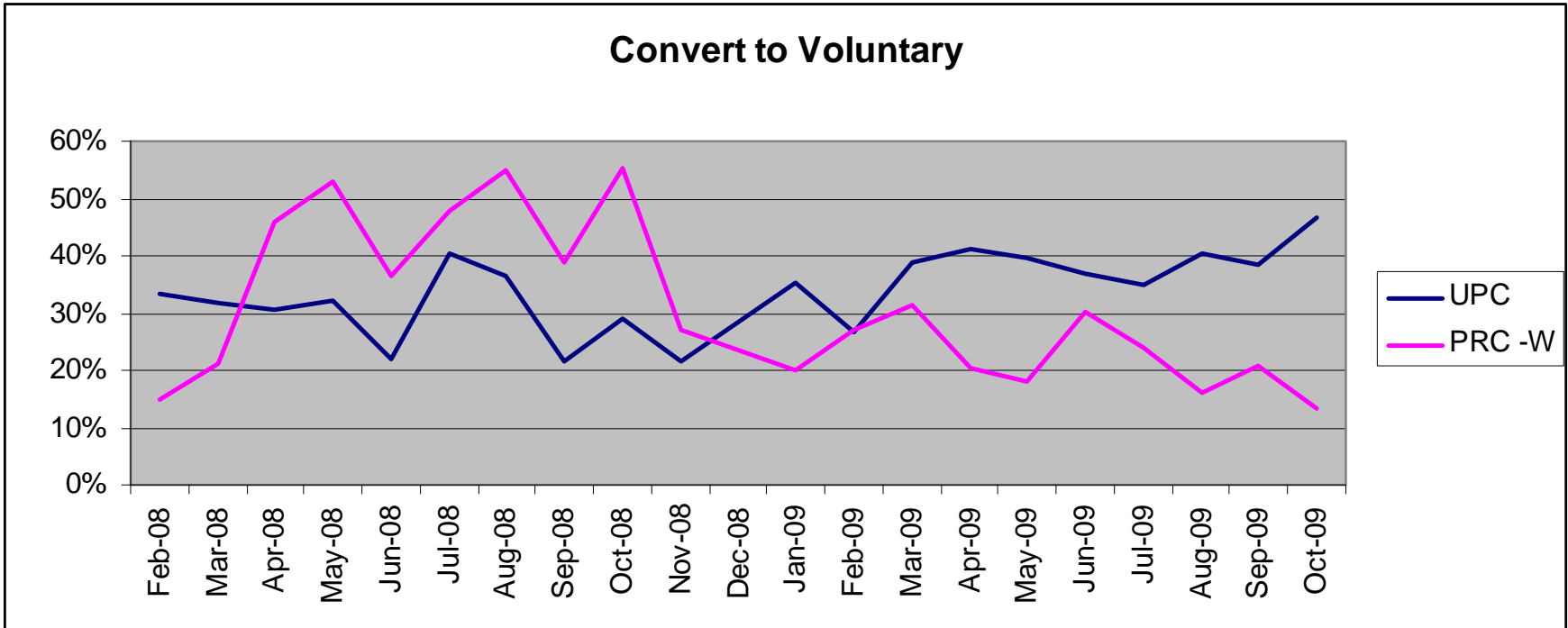
UPC/PRC-W Reason for Arrival



UPC/PRC-W Disposition

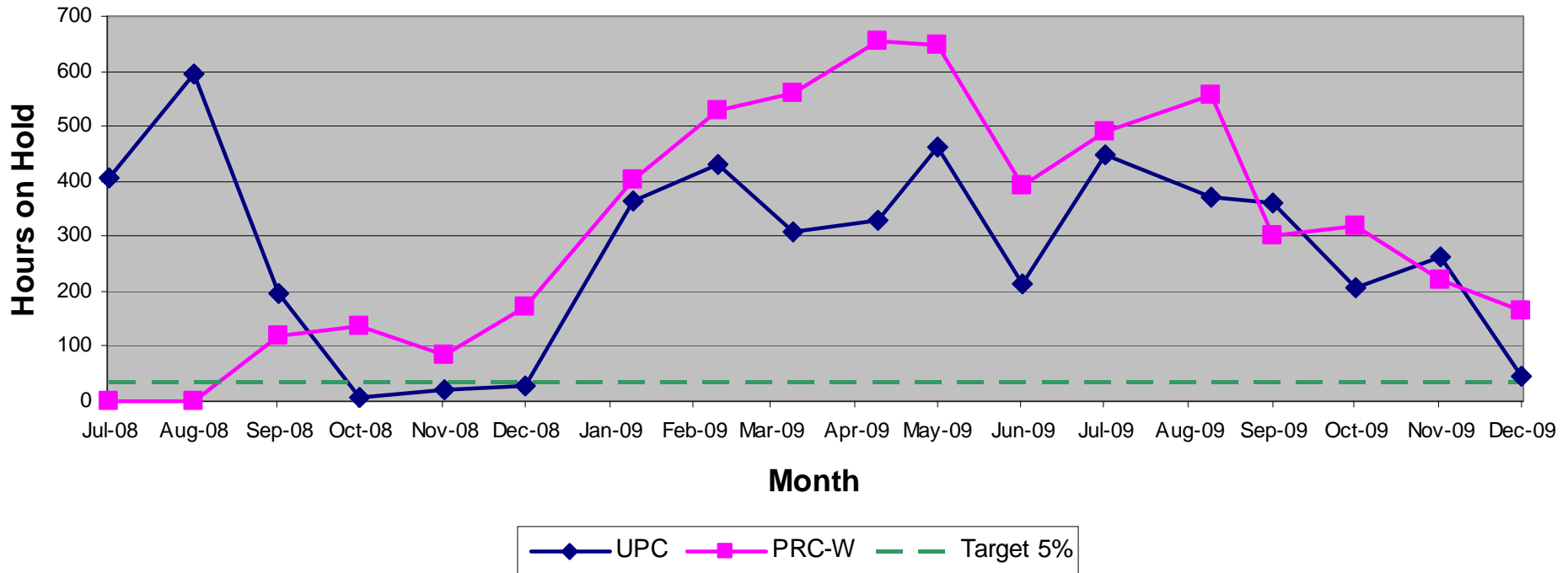


UPC/PRC-W Convert to Voluntary



UPC and PRC-W Hospital Hold

Magellan Hospital Hold July-08 - December-09





Maricopa County's Primary Detoxification Sub-Acute Facilities

Community Bridges

Average Lengths of Stay

- Central City Addiction Recovery Center
 - Crisis Services ALOS – 9.71 hours
 - Detoxification Services ALOS – 4.2 days
- East Valley Addiction Recovery Center
 - Crisis Services ALOS – 10.21 hours
 - Detoxification Services ALOS – 4.1 days

Community Bridges – CCARC

- 13,405 – Crisis Admissions (FY 2009)
 - 6% Hospital referrals
 - 37% police and fire department referrals
 - 13% police department transports
 - 18% CRT transports
- 1,654 – Detoxification Admissions (FY 2009)
 - 53.87% alcohol admissions
 - 43.23% opiate admissions
 - 2.90% benzodiazepine admissions

Community Bridges – EVARC

- 5,748 – Crisis Admissions (FY 2009)
 - 8% Hospital referrals
 - 10% police and fire department referrals
 - 8% police department transports
- 1,582 – Detoxification Admissions (FY 2009)
 - 43.87% alcohol admissions
 - 53.79% opiate admissions
 - 2.34% benzodiazepine admissions



Rural Substance Abuse Transitional Centers (A6)

Rural Substance Abuse

Transitional Center - Payson

- 478 – Admissions (FY 2009)
 - ALOS – 3.43 days
 - 6% referred from Payson Regional Hospital
 - 8.63% diverted in lieu of Payson Regional Hospital
 - 15% referred from police and fire departments
 - 13% transported by police department
- Peer Support Outreach
 - 181 individuals were engaged and/or transported by peer support specialists within the community

Rural Substance Abuse Transitional Center - Globe

- 288 – Admissions (FY 2009)
 - ALOS – 3.68 days
 - 5% referred from Cobre Valley Hospital
 - 7.29% diverted in lieu of Cobre Valley Hospital
 - 14% referred from police and fire departments
 - 13% transported by police department
- Peer Support Outreach
 - 112 individuals were engaged and/or transported by peer support specialists within the community

Rural Substance Abuse

Transitional Center - Winslow

- 491 – Admissions (FY 2009)
 - ALOS – 1.06 days
 - 5% referred from Little Colorado Medical Center
 - 1.43% diverted in lieu of Little Colorado Med. Ctr.
 - 15% referred from police and fire departments
 - 9% transported by police department
- Peer Support Outreach
 - 83 individuals were engaged and/or transported by peer support specialists within the community

Rural Substance Abuse

Transitional Center - Holbrook

- 288 – Admissions (FY 2009)
 - ALOS – 3.68 days
 - 5% referred from Little Colorado Medical Center
 - 2.78% diverted in lieu of Little Colorado Med. Ctr.
 - 14% referred from police and fire departments
 - 13% transported by police department
- Peer Support Outreach
 - 58 individuals were engaged and/or transported by peer support specialists within the community



Crisis Services & 1st Responders

What benefit does the current crisis system provide?

- 'No Wrong Door'
 - Maricopa County Crisis Providers have fully embraced this philosophy
- Timeliness of Response
 - Mobile Team Response Times
 - 23-hour stabilization facility wait times
 - UPC, PRC-W, Central City & EVAC

What areas could use improvement?

- Better collaboration between ACT/IRT Teams and the crisis system
- Enhance collaboration between crisis providers and community-based and faith-based groups

What impact would a restricted crisis system have?

- If the quality and responsiveness of the crisis system does not change, then the close collaboration with 1st responders will continue as well.
- If the above cannot be maintained, there would be a complete breakdown in 1st responders' willingness to refer for crisis intervention.

An Example of Impact

- In 2006 the Maricopa County RBHA eliminated 2 mobile crisis teams from their network.
- Over the next 6 months the following occurred:
 - The Mobile Team denial rate (refuse to respond) went from 5% to 22%
 - A 50% increase in crisis line referrals to 911 dispatch

What impact would the elimination of a crisis system have?

- Jail or emergency departments will be the primary disposition.
 - When police request a mobile team the police officer feels that the individual is at risk and must be either professionally stabilized or removed from the community. A removal of mobile crisis services and stabilization facilities will force police officers to take individuals to jail or an emergency department
- There will be an increase in 1st responders relocating individuals in a crisis episode to another jurisdiction to avoid further involvement.
- There will be a rapid increase in 1st responder initiated petitions

An Example of Impact

- Maricopa County has a daily average of 8,000-9,000 incarcerated individuals.
 - 66% (or 5,280) have an identified substance use disorder
 - 20% (or 1,600) are receiving psychotropic medications
- Police refer roughly 3,000/year to mobile teams
 - Based on 50% of individuals referred by police would otherwise be incarcerated, there would be an increase of 1,500 individuals in Maricopa County alone.

What are the most important crisis services, in order, for 1st responders?

1. Front Door Access – Crisis Stabilization

- If there is no alternative to EDs and jail, the 1st responders will not bother utilizing crisis phone or mobile teams.

2. Crisis Phones

- A majority of the 10,000/month crisis calls would likely go to 911 dispatch; which would cripple the 911 emergency system.

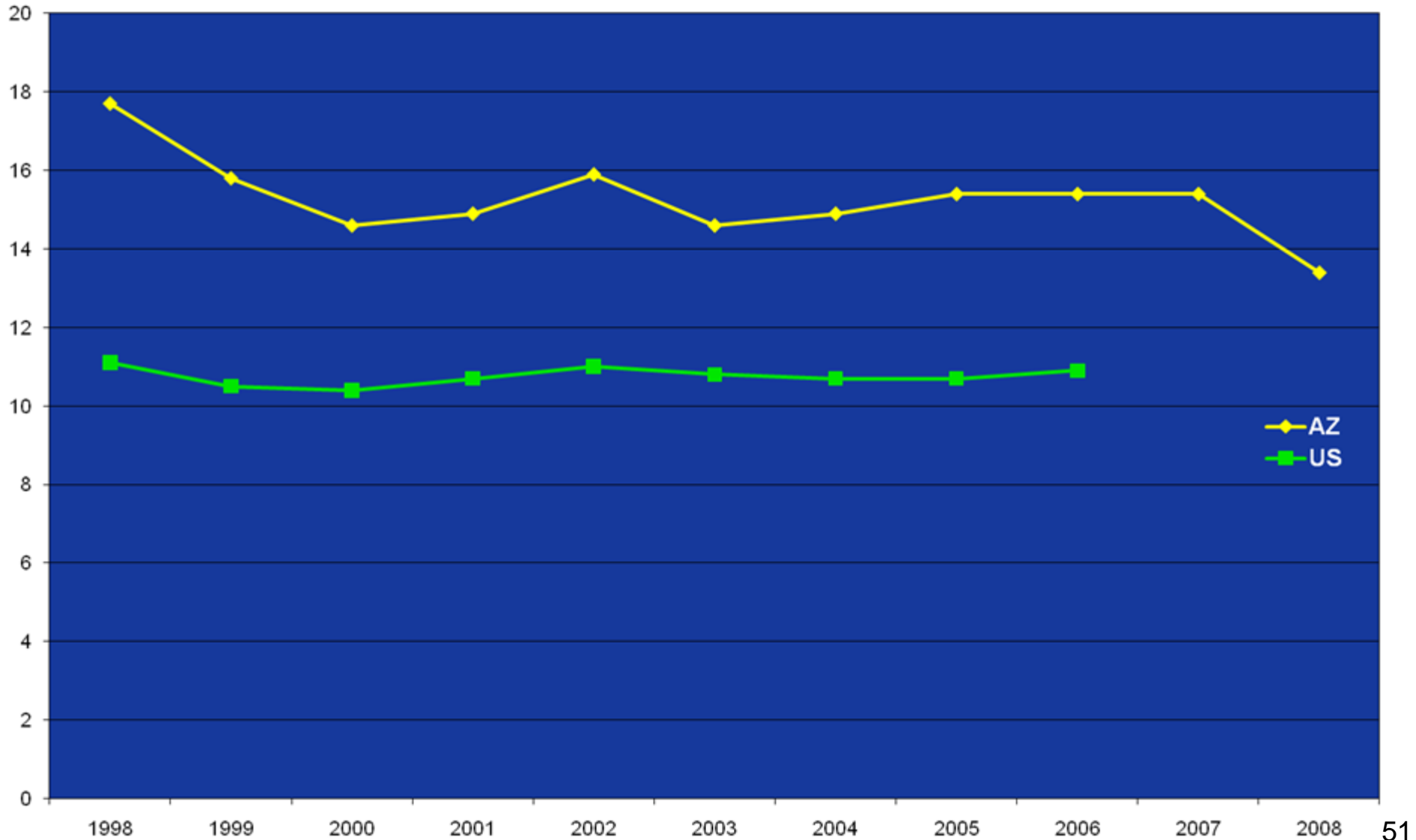
3. Crisis Mobile Teams

- Regardless of best practices, if it is easier or quicker for a 1st responder to take an individual to an ED or to jail, they will stop utilizing crisis services.



Arizona Suicide Trends

Suicide Mortality Rates for Arizona & United States 1998-2008



Suicide Prevention Strategic Plan

FY 2010 - 2015

- Goal: Reduce the rate of completed suicide to 10 per 100,000, by 2015.
 - Objective A: Increase gatekeeper comfort with intervention & referrals by 5%
 - Objective B: Increase life satisfaction to 10% among ADHS program participants as measured by the end of FY 2010
 - Objective C: Increase parent child bonding among DBHS prevention program participants by 5% by the end of FY 2010

Garrett Lee Smith Grant

- Youth Suicide Prevention and Early Intervention
- 3-Year Grant, ending September 29, 2012
- \$1.5 million award (\$500,000/year)
- The purpose of Arizona's Suicide Prevention Project is to reduce the rate of completed suicide among Arizona youth, ages 15-24.
- Activities Include:
 - developing the capacity of Lesbian, Gay, Bisexual, Transgender, and Questioning (LGBTQ) organizations to incorporate evidence based strategies into their programs.
 - provide training in gatekeeping and climate improvement for education, behavioral health and juvenile corrections.



ADHS/DBHS Budgetary Preparations

Current FY 2011 Budget Proposal

	Appropriated				Non-Appropriated	Total
	General Fund	Tobacco Tax	Substance Abuse Fund	Sub-Total	IGA Funding*	
Crisis Services	\$14,141,100		\$2,250,000	\$16,391,100	\$15,000,000	\$31,391,100
Supported Housing	\$5,324,800			\$5,324,800	\$3,001,300	\$8,326,100
Seriously Mentally Ill (Medication)	\$6,928,400	\$30,638,000		\$37,566,400		\$37,566,400
Total Funding	\$26,394,300	\$30,638,000		\$59,282,300	\$18,001,300	\$77,283,600

*Expected to be continued but not guaranteed. Maricopa County portion based on estimate available for this use.

ADHS/DBHS Crisis Service Package Proposal



Tiered Approach

1. Crisis Phone

- Which includes BHP and BHT crisis intervention & peer-based warm lines

2. Mobile Crisis

- CPS Rapid Response and Hospital Rapid Response are not considered part of the crisis continuum.

3. 23-hour Stabilization

- Level I Sub-Acute; Rural SA Centers & Crisis Respite

4. Short-term Crisis Stabilization <72 hours

- Level I Sub-Acute, Level I Hospitalization, Rural Substance Abuse Transitional Centers & crisis respite

ADHS/DBHS Crisis Funding Proposal

	GSA 1	GSA 2	GSA 3	GSA 4	GSA 5	GSA 6	Total	% of Total
Crisis Phones	\$58,756	\$202,600	\$2,430	\$280,000	\$363,970	\$1,329,772	\$2,237,528	13.60%
Mobile Crisis Services	\$773,186	\$509,033	\$95,808	\$597,517	\$425,794	\$1,217,954	\$3,619,292	22.10%
Facility-based Crisis Services*	\$2,610,189	\$730,784	\$98,455	\$1,466,410	\$1,586,946	\$4,041,496	\$10,534,280	64.30%
Other								
Total	\$3,442,131	\$1,442,417	\$196,693	\$2,343,927	\$2,376,710	\$6,589,222	\$16,391,100	100.00%
Percentage	21.00%	8.80%	1.20%	14.30%	14.50%	40.20%	100.00%	

*Facility-based Crisis Services Include: (1) 23-hour stabilization, (2) detoxification, (3) Rural Substance Abuse Transitional Centers, and

(4) Level I sub-acute/hospitalization (solely for the purpose of continued crisis stabilization)

ADHS/DBHS Funding Proposal Rationale

- Utilizing the 9/23/2009 Crisis Services Survey, this scenario preserves the full allocation of Crisis Phone and Mobile Crisis Services, and uses the same distribution percentages to separate out the remainder of funds for Facility-Based Crisis Services.
- By combining 23-hour, Rural SA Transitional Centers and Inpatient Stabilization into 1 category, each RBHA can use their discretion as to how best allocate these remaining dollars based on geographic, population and resource needs.



Out of the Box Thinking & Possible Solutions

How do we start?

- Intensive Community Education
- Community-based Resource Development
- Policy clarifications
- Contract revisions
- Billing/Claims Restriction Enforcement
- Funding adjustments
- Block Grant reallocation

NOTE

The following are strategies that ADHS/DBHS is exploring. No formal decisions have been made, and further research is necessary.

Policy Clarifications

- Covered Services Guide
 - Crisis Intervention Services (Mobile) [pg. 128]
 - *Wherever possible, the two-person crisis team should consist of a behavioral health professional and a behavioral health technician. In some situations (e.g., the safety of staff and control of the environment are not primary concerns, such as in hospitals, schools, residential settings) it may only be necessary to send a single individual out to intervene. Depending on the acuity of the person, the crisis intervention services may be provided by either a qualified behavioral health professional or behavioral health technician.*
 - Define these two phrases
 - By clearly permitting BHTs to provide mobile crisis services on 1- and 2-person teams would be a huge cost-saving measure. (RBHAs are currently interpreting this differently)

Billing Restrictions/Limitations

- Mobile Crisis Services
 - Exploration into possibly converting the 15-minute unit into a per-episode billing unit.
- Potentially cap the benefit for consecutive days in a facility-based crisis facility.
 - (E.g. no payment beyond 4-days)

Establish Admission Criteria

- Admission Criteria (ALL must be met)
 1. The individual is determined to be in crisis per [*insert crisis criteria*]
 2. The individual has an identified issue or goal that cannot be resolved at this point in time with a less restrictive intervention.

Brief Crisis Intervention

- Brief Crisis Intervention Process:
 - Intervene Immediately
 - Stabilize
 - Facilitate Understanding
 - Focus on Problem-Solving
 - Encourage Self-Reliance
- Key Feature:
 - No Follow-Up

Establish Discharge Criteria

- Discharge Criteria (ANY can be met)
 1. Identified crisis is resolved
 2. Recipient is referred to a higher level of care
 3. Recipient is referred to community resources outside the T/RBHA network

Timeliness of Service

- Potentially implement the 3 tiered response timeframes for adult population.
 - Immediate (within 2 hours)
 - For use with Crisis Stabilization and Mobile Crisis Services
 - Urgent (within 24 hours)
 - For individuals who appear in need of intervention to prevent a crisis situation (E.g. medication, etc.)
 - Routine (within 7 days or 23 days)
 - What role should ACT teams and outpatient clinics have in crisis response?

CPS Rapid Response

- Explore the possibility of transitioning this program to an office or community-based service provided within 72-hours from the point of referral
 - Similar timeframe to the Families FIRST program



Questions or Comments?