beacon health options

Agenda

Meeting Title:	Clark County Crisis Collaborative
Date/Time:	May 18, 2017, 10:00-11:30 AM
Location:	Children's Center, 13500 SE 7th St, Vancouver, WA 98683 phone 877-668-4493 or 650-479-32089 pc: 79999944

10:00 – 10:10 Introductions

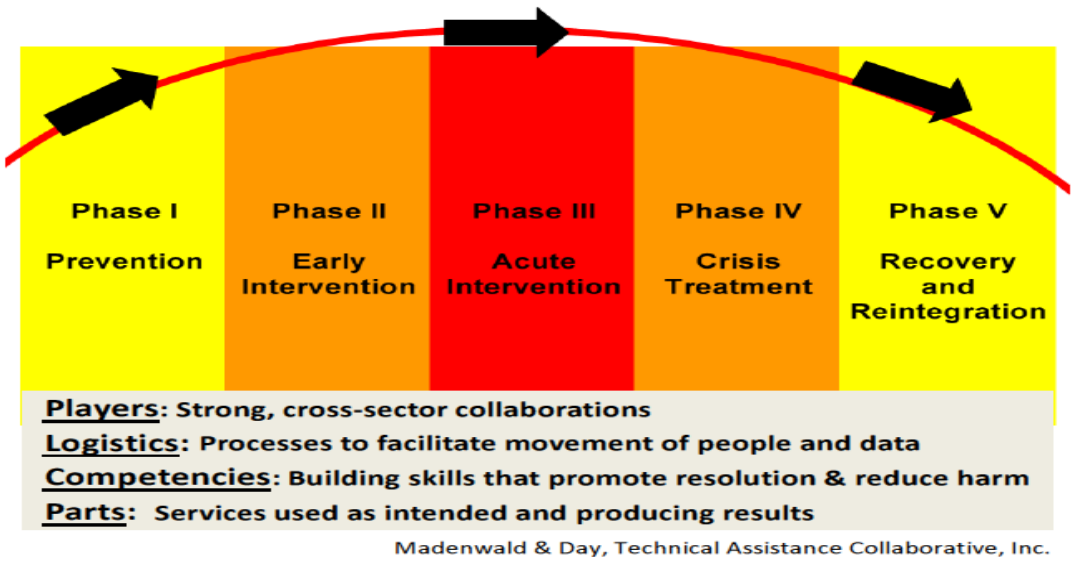
10:10 – 10:20 Announcements and Updates on Recommended Key Action Steps

10:20 – 11:00 Small group work

- Collaborative Charter: Define Goals & Purpose
- Data measures: what are the key measures to collect, v 1.0 items
- Review medical clearance: what is the process and how is this an issue?

11:00 - 11:20 Group report out and large group discussion

11:20 – 11:30 Re-schedule June meeting (date/time/location) and Next Steps



Clark County Crisis Collaborative
Draft Charter

Clark County Crisis Collaborative purpose:

- Cross sector, county specific system collaborative group to focus on system-wide improvements and transformation.
- Identify gaps in the Crisis System continuum of care (reference Crisis system of care organizing framework) in prevention, early intervention, acute intervention, crisis treatment and recovery and integration efforts as well as logistics, players, competencies and parts involved in assisting crisis system users experience adequate relief and resolution.
- Develop written protocols that describe roles and expectations in interactions between the players in the crisis system such as pragmatic, working MOUs between key entities starting with the crisis teams, ProtoCall and lead treatment agencies with specific attention to mutual expectations throughout a crisis episode, filing of crisis plans and alerts, on-call schedules and administrative support, post-crisis follow-up commitments, and lead persons for collaborating on improvements.
- Develop a communications strategy to share written protocols with key community partners so they understand the crisis continuum of care and opportunities for upstream interventions.
- Develop county specific Crisis System of Care (CSOC) protocol handbook for use and dissemination (such as at CIT trainings, Mental Health First Aid, staff orientation, use by other sectors, and NAMI). Describe access, inform about involuntary processes, but have the primary focus be on voluntary alternatives.
- Map out specific responsibilities and expected competencies in performance standards
- Review medical clearance practices
- Decide critical data for the community to track to assess crisis system performance and review the data routinely, such as real-time data sharing, cost analysis and target populations.
- Track data and strategize how to:
    - reduce the use of involuntary interventions in crisis episodes.
    - increase the use of peer or parent peer specialist involvement in crisis episodes.
    - reduce out of area placements.

Duration: Perpetual until otherwise designated
Members:

- Clark County Crisis
- MCO's
- Law Enforcement
- Hospitals
- Providers
- Consumers/lived experience
- Housing
- Regional Crisis Line- Protocall

Role:
As the BH-ASO, Beacon will be the organizer and entity responsible to ensure that work is completed between meetings to make forward progress, ensure people feel invested in the forum and the time is well spent.

Other minimum roles and responsibilities:

- Attend meetings monthly
- Provide input to issues, strategies and direction
- Support the overall work of the crisis system
- Assist in recruiting additional stakeholders from targeted sectors
- Members shall receive no compensation for participation
- Follow through on agreed upon assignments

1. REVIEW MEDICAL CLEARANCE PRACTICES

Many communities have grappled with this issue of requiring medical clearance prior to psychiatric hospitalization. This is the case in Southwest Washington. However, the practice is time-consuming, costly, and generally is not patient-centric. From a patient-first lens, it is important to balance the potential health benefit that comes from the medical clearance with what potential harms it may introduce. This includes costs that the patient must bear, risk of unnecessary testing, discomfort, testing under coercive circumstances, delay in treatment of the crisis condition, and additional transportation. We recommend that the community review the necessity of this practice and seriously consider transitioning to a practice where medical clearance is the exception and not the rule. This practice is already in place at the detox facility operated by Lifeline Connections.

What is the current medical clearance process? How is this an issue?

DASHBOARD 1.0 (GREY FILL = NOT READILY AVAILABLE AT THIS TIME)

Clark County Crisis System Metrics v 1.0
Crisis Front Entry Point- Regional Crisis Line
Total calls to Crisis Line
Total clinical calls to Crisis Line
Percent diverted from ER and/or ITA commitments
Percent referred to Mobile Outreach for follow up
Percent conferenced to 911 due to immediate danger
Total number of calls reporting concerns of suicide
Number of proactive Crisis Alerts created
Mobile Crisis Indicators
Number referred for service
Percent of encounters in person (vs phone)
Average Response Time
Percent of encounters using peers
Average service time (Initial dispatch)
Location of Intervention
Community-based
Emergency Room/Hospital
Other
Resolution
Evaluation for ITA
Discharged with referral to Provider
Higher Level of Care
Resolved, no further steps
Unable to contact/refused services
Referral to Crisis Case Management
Adverse Incidents
Average Service Time (Dispatch to Resolution)
Emergency Department Usage
Behavioral Health ED Visits Total
Behavioral Health ED Visits Admitted (at IP facility)
Behavioral Health ED Visits Diverted
Behavioral Health ED Median Length of Stay in hours (for those admitted at LSC-ED)
Behavioral Health ED Median Length of Stay in hours (for those discharged at LSC-ED)
ITA Evaluations

Number of initial MH ITA Evaluations
Number of Involuntary Admissions
Number of Voluntary Admissions
Number of 14 Day Commitments
Number of 90 Day Commitments
Number of 180 Day Commitments
Number of SUD ITA Referrals
Number of Involuntary SUD Admissions
Number of Voluntary SUD Admissions
Number of Waiting for SUD Placement
Unavailable Bed Reports Completed
Single Bed Certifications Completed
Number of LRA/CR's in place
Number of LRA/CR's Revoked
Number of LRA Extensions
Initial Out of County Placements
E&T Admission Percentage Rate (Percent)
Number Open in Case Management
Western State Hospital
Monthly Census Number (Average) Allocation: 45
Diversion Placements
WSH Discharges
Monthly Waitlist Number (Average)

PHASE TWO PERFORMANCE MEASURES

The following measures currently are not readily available but would be useful data points on the effectiveness of the crisis system.

- Average cost per person per episode
- Number of crisis users successfully seen by a provider within 7 days of the crisis episode
- Law enforcement involvement in any portion of the intervention
- 30-day hospital readmission rates
- Number of times law enforcement is involved (wellness checks; detaining, etc.), disposition, collaboration
- Repeat crisis episodes in 7/30/90 day increments
- Juvenile detention
- Jail data

Types of Measures[1]

Structure Measures- refer to the environment in which care is delivered, a facility's organization and resources

- What do you HAVE?
  - Is there a psychiatrist co-located in a clinic?
  - Staff to patient ratios

Process Measures- refer to the techniques and processes used to treat patients.

- What do you DO?
  - % patients screened for depression
  - Turnaround time for evaluation

Outcome Measures- refer to the consequences of the patient's interaction with the healthcare system

- Does it WORK?
  - Mortality
  - Patient satisfaction
  - Improvement in rating scales
  - Readmissions

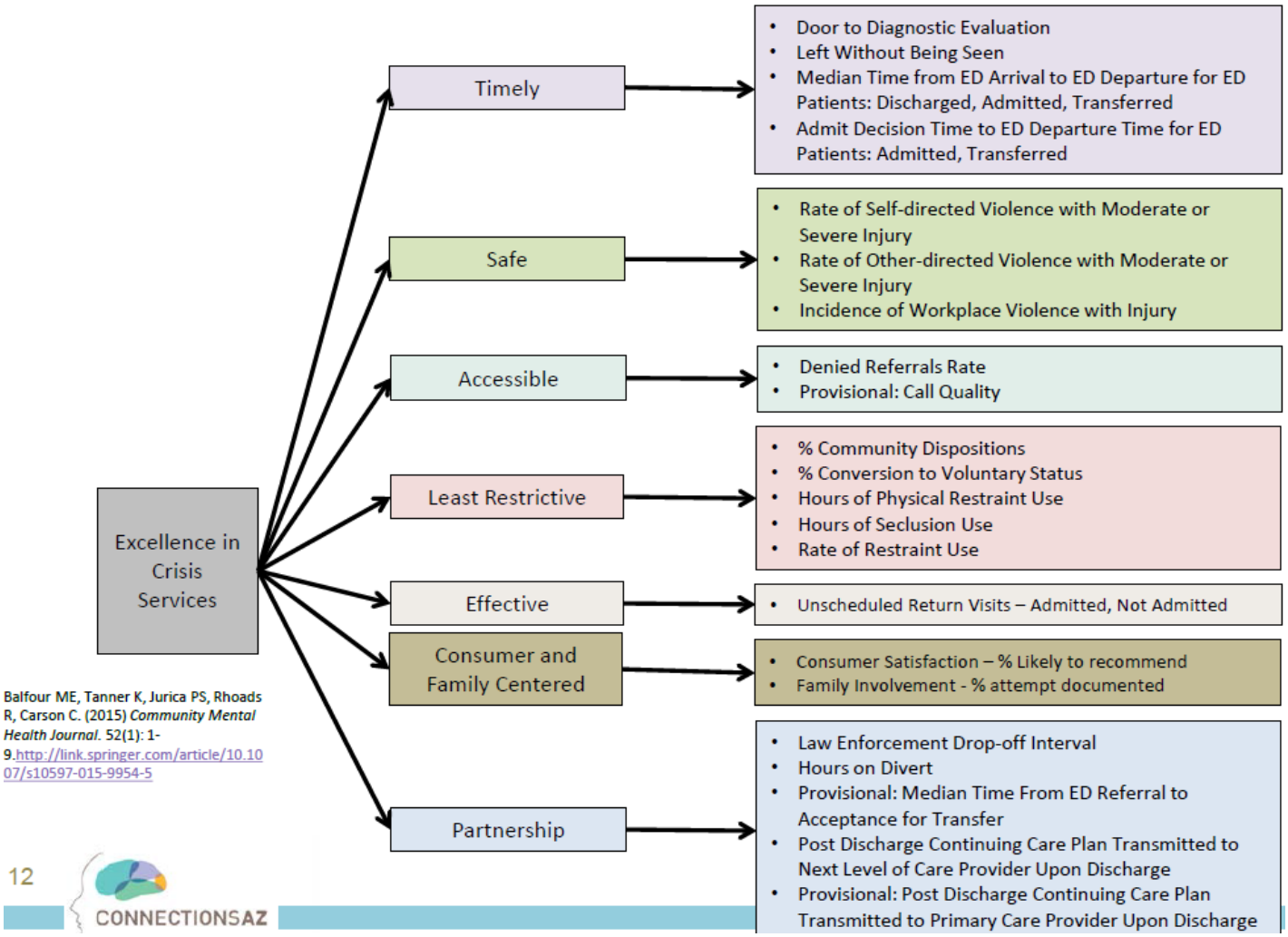
Measure Selection

1) Is it meaningful? Does it reflect a process that is clinically important and is there evidence supporting the measure?
2) Is it feasible? Is it possible to collect the data and can it be done accurately, quickly and easily?
3) Is it actionable? Do the measures provide direction for quality improvement activities?

[1] Margaret Balfour, slide deck: "Measuring Success: Development and Implementation of Values-Based Performance Measures for Behavioral Health Crisis Services"

CRISES- Crisis Reliability Indicators Supporting Emergency Services[2]

Sample of Value Based Performance Metrics (for facility-based psychiatric emergency services and 23-hour observation)



[2] Balfour, Margaret E., et al. "Crisis Reliability Indicators Supporting Emergency Services (CRISES): A Framework for Developing Performance Measures for Behavioral Health Crisis and Psychiatry Emergency Programs." Community Mental Health J (2016) 52:1-9