CRISIS SYSTEM OF CARE STRATEGIC DEVELOPMENT PLAN

February 2017

INTRODUCTION

In April 2016, Southwest Washington took a leap of faith by becoming the first region in Washington to adopt a model of fully integrated managed care for its Medicaid beneficiaries. This decision reflects the community of Southwest Washington's readiness for system change and an acknowledgement that current crisis system practices could be transformed to more effectively meet residents' needs. As the regional Behavioral Health Administrative Services Organization (BH-ASO) Beacon Health Options (Beacon) is charged with the responsibility of improving the experiences of individuals in crisis and the efficiency/efficacy of the crisis system that serves them.

The crisis system today in Southwest Washington largely has been inherited (rather than developed) by many of those who work in it. There is opportunity and appetite for transformation. Recent local efforts have taken inventory of existing resources and identified system gaps. Building on that effort, Beacon wants to focus on possibilities to make rapid gains in enhancing the crisis system by building on the strengths of the existing infrastructure. To that end, Beacon engaged Madenwald Consulting, LLC, to support an analysis of the crisis systems operating within Clark and Skamania counties. Kappy Madenwald is a national expert and leader in community crisis system development. In mid-December 2016, several local stakeholders generously participated in interviews and discussions with Beacon and Madenwald Consulting. These interviews focused on the following questions.

1. Within this new integrated health model, how does a crisis system of care look when it is functioning at its best?

2. From the perspective of those who use crisis services, what kind of access and treatment do they experience, when the crisis system is functioning at its best?

This document has two sections. The first part is a high level summary of a crisis system of care framework and observations on how the crisis system operates today in Clark and Skamania counties. The second part sets forth a strategic plan for priority actions in 2017. We believe these actions reflect local priorities, are achievable within existing resources, and will strengthen the behavioral health crisis system. We offer specific recommendations, but recognize this is starting point for further discussion and feedback. Transformation requires engagement from a cross-section of key stakeholders. Beacon is honored and excited to be part of this dynamic community effort.

Crisis Systems Framework and Key Observations

CRISIS SYSTEMS OF CARE ORGANIZING FRAMEWORK

Behavioral health crises do not fit neatly into a box. Crisis services are not an Essential Health Benefit nor a required service under Medicaid. Thus funding comes from a combination of federal, state, and local dollars.

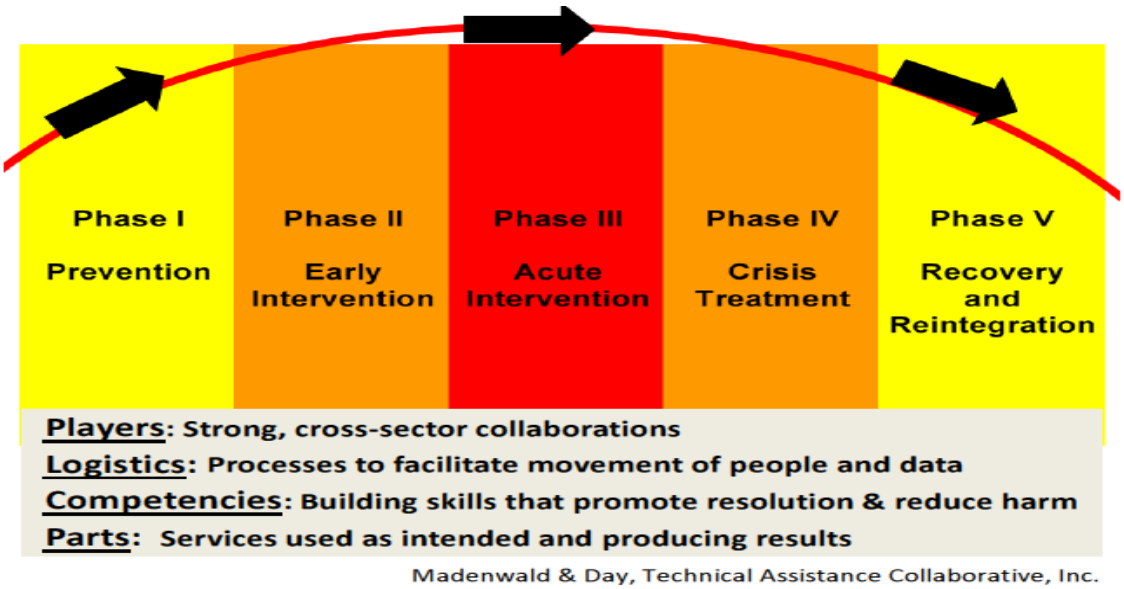
The management and treatment of mental health and substance use related crises is a systems-level and public-health need which requires commensurate response. No single entity or system owns full responsibility for crises, and a single entity or system is not, on its own, sufficiently leveraged to address systems-level complexities necessary for a healthy system. While some individuals do have serious and persistent mental and substance use conditions, often crises are exacerbated by poverty, unstable housing/homelessness, job disruption, school performance, trauma, including exposure to home and community violence, unmet primary health care needs, stressed households, lack of community support, and social isolation.

Crisis systems are incredibly complex and idiosyncratic- no two are alike. There are numerous components within any crisis system. Effective crisis systems of care do not naturally exist. They are built. Unless purposely arranged, they do not operate in a coordinated and systematized fashion. An organizing framework gives a community a visual structure in which to map/assess/strengthen what currently exists, and to strategically enhance, strengthen and add new elements.

Using a Crisis Systems of Care Framework can help a community:

1. Identify and address gaps in the safety net
2. Expand knowledge and skillset of laypersons
3. Increase efficient use of resources
4. Reduce handoffs and duplication
5. Provide services that are most meaningful and useful to individuals in crisis and their families
6. Promote development of local solutions
7. Reduce use of coercive interventions
9. Reduce civil and criminal court involvement
10. Reduce need for emergency and inpatient services
11. Reinforce a coordinated, systemic (rather than agency-centric) approach to planning, delivery, policy, and outcome management.

The graphic below provides one organizing and planning framework that offers nine points of opportunity for building depth and breadth into a crisis system. There are five crisis phases for community development and investment: 1) Crisis Prevention, 2) Early Intervention, 3) Acute Crisis, 4) Crisis Treatment, and 5) Recovery/Reintegration. There are four categories of “components” that need to work together effectively: 1) Parts, 3) Players, 4) Logistics 5) Competencies. Within the organizing and planning framework there is some overlap. Some communities invest narrowly in phases III (Acute Intervention) and IV (Crisis Treatment) and miss building resources to prevent or intervene early in crisis and/or there can be the tendency to invest in “parts” without attending to the other three components.



TRANSFORM FROM DETENTION TO PREVENTION

The crisis system in Southwest Washington today is designed around involuntary detention and the role of the Designated Mental Health Professional (DMHP). There is opportunity to move the default crisis response upstream from the involuntary treatment process. Optimally, use of the DMHP assessment becomes an "exception" or when resolution-focused intervention fails to result in sufficient relief/harm reduction, AND the recipient does not or cannot voluntarily consent to a higher level of care.

Stakeholders relayed consistent feedback that the notion of "mobile crisis intervention" today is synonymous with the DMHP assessment process. Calling the crisis team is understood by some service users as activating a legal authority. Potential consequences in this type of model include:

1) People call the crisis team on their own or another's behalf to secure hospitalization, as opposed to asking for crisis intervention that would hopefully diminish the need for higher level of care.
2) People choose not to call the crisis team in an effort to avoid experiencing the loss of control that they believe it will entail, and these individuals are left to self-manage serious crises.
3) People experience crises that do not fall within the narrow scope of practice of the team, and they either don't call because it isn't "bad" enough or are screened out without getting adequate crisis relief.

The predominant goal of each service component of the crisis continuum is resolution rather than disposition. Collective effort is required to develop that capability. All levels of care should have the propensity for and actively strive to be an end service, thereby minimizing successive courses of care and diminishing the likelihood of admission to a restrictive setting. Resolution-focused treatment hones in on the essence of the crisis and identifying idiosyncratic ways to diminish suffering and risk of harm, resolve issues and develop new understandings and strategies. The focus is less on the provider trying to gain an understanding of what is happening and more on creating an environment in which the service user/family gains an understanding of what is happening.

TRANSFORM THE CRISIS USER EXPERIENCE

Crisis services as they are delivered currently are largely being done to people rather than with people. For many people a crisis episode is their first experience with a mental health or substance use intervention. That first experience will influence what they choose to do next- for better or for worse. We have substantial opportunity to better understand what happens to each individual and family in the aftermath of these crisis events through a collective, comprehensive data set that is shared with the community.

It is imperative that we invite service users and family members to actively participate in the shaping and delivery of the Southwest Washington crisis system. Those who have experienced crises and their family bring expertise — rich in nuance, culture, gut instinct, preferences, and historic know-how. Collaboration and shared decision-making follows, leading to well-informed health care decisions and idiosyncratically effective results.

Important questions to service users that a crisis system should address:

- Were these services best for me/my partner/my child?
- Did I have a choice?
- Did I/my partner/my child experience relief?
- How long did it take?
- Am I more hopeful and feeling better as a result of the treatment?
- Am I (is my child/loved one) now active in treatment and/or recovery strategies that are productive and in sync with personal goals, values and choices?

INCREASE CRISIS SYSTEMS LEVEL COORDINATION & TRANSPARENCY

A weakness of the current system is that no one can see the full picture of what is happening crisis-wise at any given time across the counties. Although there is interface, it appears that the crisis system components largely operate as distinct parts, with each somewhat insularly performing its function, rather than as one part of a coordinated system of care. There is significant need for and value in systems-level collaboration in the mental health/substance use crisis arena. There is also great need for better data collection and sharing to promote transparency and track progress toward identified goals.

Specific Recommendations & Next Steps

Building effective Crisis Systems of Care is a continuous process of adding depth and breadth and applying new knowledge. There are many ways to start and the work is never complete. An effective crisis system requires continuous evolution, as the communities and components themselves constantly change. With that caveat, we recommend the following priority areas for initial focus. We have chosen these because we believe progress is achievable in a relatively short timeframe, improvements have potential for paying significant dividends and through the recent community engagement process, the following priorities emerged. Their numbers do not reflect their relative importance.

1. DEVELOP A CRISIS SYSTEMS OF CARE COLLABORATIVE FOR EACH COUNTY

Experience has shown that with little investment—other than time—communities can dramatically improve Crisis Systems of Care by focusing on player partnerships, logistics, and competencies. We recommend the formation of cross-sector and county-specific crisis system collaborative groups to be the entities to focus on these system-wide improvements. As the regional BH-ASO, Beacon sees our role as the organizer, the entity responsible to ensure work is completed between meetings to make forward progress, ensure people feel invested in the forum and that their time is well spent.

We are cognizant of competing demands for people's time and the various other regional convening bodies that have developed to inform system development, including the Behavioral Health Advisory Board (BHAB) of the Regional Health Alliance and the Behavioral Health Planning Council. We are impartial to whether the crisis collaboratives are sub-groups of an existing entity or stand alone. It is essential to have participation of people with lived experience. It may make sense for a separate youth crisis system collaborative or to roll the function into an existing youth venue.

We recommend that Skamania County have its own crisis system collaborative outside of Clark County to focus specifically on identifying opportunities and to tackle challenges unique to Skamania's rural geography. We believe there is unexplored opportunity to maximize Skamania County's potential by mapping a Crisis System of Care specific to the county, cultivating resources, aligning partners within the county, home-growing new resources, etc. In other rural/frontier communities this has included developing local peer specialists, using the talents and any downtime of local EMTs in different ways, and educating a diverse representation of residents in skills like Mental Health First Aid. There are efforts to get a FQHC and that is well worth supporting. Finding an alternate to Sheriff department-based evaluations should be high on the agenda.

The following activities are examples of focus areas for each collaborative:

1. 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.
2. Track data and strategize how to reduce the use of involuntary interventions in crisis episodes.
3. Track data and strategize how to increase the use of peer or parent peer specialist involvement in crisis episodes.
4. Track data and strategize how to reduce out of area placements.
5. Develop written protocols that describe roles and expectations in interactions between the players in the crisis system.
6. 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.

2. DEVELOP A SPECIALIZED MOBILE CRISIS TEAM FOR YOUTH AND FAMILIES

We recommend that there be a separate and specialized mobile crisis service team for children and youth. Crisis intervention for children and youth must be robust, resolution-focused and family-centered. Effective crisis intervention for children and youth requires additional attention to the experience of parents or other caregivers who are often exhausted, overwhelmed and concerned.

Attending to these normal, but impactful parental crisis states can maximize parents and caregivers' ability to problem-solve, make tough decisions and support their children.

Mobile crisis intervention for youth and their families should be delivered in the community (home, school, etc.) as a rule. Use of emergency department or 911 should be limited to exceptional circumstances related to medical conditions or high acuity. The team should be capable of providing extended crisis support, if necessary. We also recommend pairing clinicians with family peer specialists.

A specialized mobile crisis team for children, youth and families will be developed in 2017. We also recommend identifying one to two voluntary inpatient beds or respite beds for brief (24 to 48 hour) out-of-home stabilization for children and youth. The crisis team could be assigned to manage the entry and exit back into the home and community. A key outcome of a children, youth and family crisis system collaborative would be their input about necessary hours of operation and describing expectations for interactions/partnerships between children, youth and families, crisis services and schools, juvenile court, child welfare, and existing children's system providers, etc.

3. ENHANCE THE ROLE OF THE CRISIS SYSTEM ENTRY POINT

The entry point into the crisis system plays a critical role. The long-term goal is to develop "air traffic control" capabilities for real-time tracking of access to intensive services like mobile crisis, bed availability in crisis stabilization units and dashboard tracking of the system's performance. In the interim, we will focus on opportunities for efficiencies to promote our goal of being more mobile and to free-up precious clinical time. This will include enhancing resolution-focused telephonic engagement that diminishes the need for face-to-face evaluations; developing agreed-upon criteria and processes for dispatching mobile teams; conducting follow-up calls to ensure patients followed through on plans, and maximizing shared use of a front-entry point database so all involved parties involved can follow the course of care.

4. DIVERSIFY FUNCTIONS OF MOBILE CRISIS TEAMS

As noted earlier, mobile crisis and the DMHP assessment process currently are too often synonymous. Below are specific recommended action steps to enhance the mobile crisis team's ability to shift to "mobile as a rule" mentality and away from dispatching a mobile intervention on the basis of meeting ITA assessment criteria.

- **Shift to a "mobile as a rule" mentality.** Identify where and how to broaden practices (telephonic and in-person) that have an overly narrow scope of screening for involuntary services. Future recruitment efforts should prioritize staff with previous in-home work experience and geographically/culturally diverse team members. Staff should be equipped with tools that minimize the need to return to the office to complete paperwork (i.e. laptops, server access, cell phones, etc.).

- **Develop separate team job descriptions for mobile crisis responder and DMHP.** The role of mobile crisis and the DMHP are two distinct roles and should be filled as such. Roughly 20% of individuals seen in person are detained. For the other 80%, the emphasis should be on providing community-based and resolution-focused crisis intervention that may

include up to 7-day follow up services to ensure an individual is linked to more permanent care. Recruit staff with experience in brief treatment and training in trauma response, Solution Focused Therapy, Dialectical Behavior Therapy, Motivational Interviewing, Cognitive Behavioral Therapy, or similar modalities who can deliver a single treatment intervention with distinct beginning, middle and end.

- **Make it the norm that a peer is part of any two-person response.** The Clark County crisis team has increasingly been using a peer specialist, which is a great direction to be headed. Future efforts should focus on further expansion of peer supports in the crisis workforce. Particularly as the focus shifts to community-based and resolution-focused treatment, this bi-disciplinary approach is very effective. Joint training of peer specialists and clinicians is important.

5. DEVELOP A CRISIS SYSTEM OUTCOME TRACKING DASHBOARD

Stakeholders invested in developing the crisis system need to be able to view process and outcome performance data. This data is important to inform areas for investment of time and resources and to demonstrate the value of those investments across sectors. The appendix includes a draft dashboard of crisis system measures to track and review with crisis system collaborators. It is broken down into what data is already easily available to track and data that may be useful but will require more effort to consolidate and track.

The goal will be to make the data publicly available on the Beacon website. Key questions we seek input on from stakeholders are: 1) Are these the right data elements to track i.e. is anything missing or shouldn't be included? 2) What is the right frequency for updating it? 3) How can the data be used strategically to improve system performance?

Longer-term goals would be to develop a dashboard with real-time data along with real-time bed and treatment capacity trackers for the region.

6. 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.

Appendix: Draft Crisis System Dashboard Metrics

The following metrics are all currently available. They would be tracked by month, county, and child vs adults, where applicable.

CRISIS FRONT ENTRY POINT		
Total Number of Calls		
Number of Calls dispatched Mobile Crisis		
% of calls reporting concerns of suicide		
% of Calls Diverted from HLOC		
Number of Proactive Crisis Alerts Created		
MOBILE CRISIS INDICATORS	**Clark County**	**Skamania County**
Mobile Crisis encounters		
Number referred for service		
% 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		
Outpatient/Diversionary Referral to provider		
Referral to Crisis Case Management		
Evaluation for ITA		
Higher Level of Care		
Resolved, no further steps		
Unable to contact/refused services		
Adverse Incidents		
Average Service Time (Dispatch to Resolution)		
EMERGENCY DEPARTMENT USAGE		
Behavioral Health ED Visits Total		
Behavioral Health ED Visits Admitted (@ Inpatient facility somewhere)		
Behavioral Health ED Visits Diverted		
Behavioral Health ED Median Length of Stay (For those admitted)		
Behavioral Health ED Median Length of Stay (For those discharged)		

ITA evaluations	Clark County	Skamania County
Number of initial MH ITA evaluations		
Number of Involuntary admissions		
Number of Voluntary admissions		
Number of 14 day hearings		
Number of 90 day hearings		
Number of SUD ITA evaluations		
Number of Involuntary SUD admissions		
Number of Voluntary SUD admissions		
Number waiting for a SUD placement		
Unavailable Bed Reports completed		
Single Bed Certifications completed		
Number of LRA/CR's in place		
Out of county placements		
E&T admission rate		
Number open in Case Management		
Washington State Hospital	**Clark County**	**Skamania County**
Census		
Placements		
Discharges		
Waitlist		

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 calls to law enforcement (regional dispatch)
- Number of times law enforcement is involved (wellness checks; detaining, etc.)
- Repeat crisis episodes in 7/30/90 day increments

About the Authors

Beacon Overview

Beacon Health Options is a health improvement company that serves 48 million individuals across all 50 states and the United Kingdom. On behalf of employers, health plans and government agencies, we manage innovative programs and solutions that directly address the challenges our behavioral health care system faces today. Beacon is a national leader in the fields of mental and emotional wellbeing, addiction, recovery and resilience, employee assistance, and wellness. We support people in making difficult life changes needed to be healthier and more productive. Partnering with a network of providers nationwide, we help individuals live their lives to their fullest potential. In Washington State, Beacon serves a number of large employers, and is managing crisis services to SWWA.

On April 1, 2016, Beacon Health Options began providing services to residents of Clark and Skamania counties. As the Behavioral Health Administrative Services Organization (BH-ASO) for Southwest Washington, Beacon is responsible for behavioral health crisis services for all individuals in these two counties regardless of their insurance status or income level. Beacon is also responsible for additional non-crisis services for low-income individuals who lack insurance coverage. The BH-ASO structure is part of the Washington Health Care Authority's Fully Integrated Managed Care (FIMC) model, which seeks to bring whole-person, integrated care to Washington's Medicaid population.

About Madenwald Consulting

Kappy Madenwald, LISW, has more than 20 years of clinical and administrative experience and an additional 10 years of consultative experience in behavioral health. Previously the Director of Clinical Services at Netcare Corporation, the primary provider of mental health, alcohol and other drug crisis and assessment services in Columbus, OH. Kappy has extensive experience in mobile, community-based and hospital-based delivery and management of crisis intervention services. She specializes in the design, implementation and evaluation of person-centered service delivery systems - including comprehensive state or community crisis systems - that are integrated at a systems and direct care level, are delivered in a fashion that promotes self-direction and recovery, are least restrictive/least intensive in nature and are designed to assure timely and purposeful movement through care. Kappy has worked directly on state level service planning and implementation initiatives in Massachusetts, Maryland, Iowa, North Carolina and Georgia and at a regional/local level in Oregon, New York, New Mexico, Arizona, Texas, Pennsylvania and California. She has also provided direct technical assistance to numerous county, regional or local authorities or nonprofit organizations throughout the U.S.