CRISIS CONNECT
Bridging the Gap after a Behavioral Health Crisis

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Project Description

I wanted to address the problem of repeat utilization of high cost behavioral health crisis services that result in poor outcomes for clients. I believed I could do this by starting Crisis Connect; a telephonic post crisis follow up program.

Problem Statement:

In Alameda County current rates of follow up to outpatient treatment after a behavioral health crisis are significantly lower than the MediCal average; 25% and 37% at 7 and 30 days respectively. The time after discharge from a psychiatric emergency setting is a high-risk time for patients. The are at increased risk for re-hospitalization and suicide.

Discovery:

Crisis Provider Input

- Interviews and ride-alongs with crisis providers
- Case studies to evaluate consumer experiences
- Multidisciplinary team case conferencing following our highest utilizers of crisis services.

These exercises illustrated the misalignment of the county services with real world consumer experiences.

Consumer Engagement

- Focus groups with consumers
- Iterative process whereby consumer experts and Behavioral Health front line staff co-developed patient-facing resources and call scripts

These exercises illustrated the need to meet the consumers where they are.

Goal:

Decrease the repeat utilization of high cost services and poor outcomes for patients using the behavioral health crisis system.

Outcome-oriented Objectives:

Within 12 months:

- Increase current 7 and 30 day follow up rates by 10%
- Decrease Recidivism into the PES from > 50% to < 45%
- Decrease the number of repeat 5150's of High-Risk Patients by 5%
- Increase Care Connect Metric - Follow-Up After Emergency Department Visit for Mental Illness (FUM) by 10%
- Increase number of referrals to appropriate outpatient services

Results

Crisis Connect
Telephonic Post-Crisis Follow Up Program

The Crisis Connect program launches in *Fall 2019* to provide telephonic follow-up and linkage by licensed clinicians and peers to identified patients within 24 - 48 hours of a behavioral health crisis contact. Individuals not reachable by phone will be referred to outreach programs.

At Crisis Stabilization

Health literate information and resources

At Crisis Stabilization:
Behavioral Health Crisis Providers will provide psychoeducation about the importance of outpatient follow up after a behavioral health crisis, introduce the Crisis Connect Program, and supply health literate information and resources.

After the Crisis

Telephonic Follow UP

Peer Informed Scripting

Community Health Record

After the Crisis:
Clinicians will use a multi-touch approach to connect with patients. With access to our county's new Community Health Record (CHR), staff will see client's utilization across physical and behavioral health enabling more integrated and individualized connection to services based on the client needs.

Lessons Learned

- The system of care does not have a standard practice of hearing from consumers and documenting their preferences in an actionable way.
- Follow up care needs to be better coordinated after a mental health crisis and reflect the consumer's preferences.
- Adapting medical-model follow up scripting Project Re-Engineered Discharge (RED) didn't resonate with consumers or Behavioral Health providers. Post-crisis follow scripting for our target population requires a unique, multi-touch (multiple call) approach – one that puts the patient's immediate needs and wants at the forefront.

Next Steps:

Measure Outcomes

Outpatient Follow Up Rates
Number of Repeat 5150 holds
Recidivism
Follow Up After Emergency Room Visit Rates
Outpatient Referrals

Mission Model Canvas

Key Partners

- Alameda County Care Connect
- Alameda County Behavioral Health Care
- Alameda Health System
- Bay Are Community Services
- Emergency Medical Services

Key Activities

- Solidify funding
- Establish billing
- Hire Staff & Provide training
- Create Enrollment Criteria & Protocols
- Establish a quality/ oversight review process

Key Resources

- Funding from Care Connect of $ 825K PY1 and $300K PY2 and access to Care Connect consultants.

Value Propositions

- Increase current 7 and 30 day rates by 10%.
- Decrease Recidivism within the crisis system and in particular the PES by 5% within the first year. Currently, this rate is over 50%.
- Decrease the number of repeat 5150's by 5%.
- Increase Care Connect Metric - Follow-Up After Emergency Department Visit for Mental Illness (FUM) by 10%.
- Increase number of referrals to appropriate outpatient services.

Buy-in & Support

- Crisis Service Providers
- Board of Supervisors
- Alameda County Behavioral Health

Deployment

- Licensed clinicians and peers will provide Crisis Follow-Up Interventions 7 days a week, 8 hours a day.

Beneficiaries

- **Patients:** Post crisis follow-up has the potential to reduce hospital readmissions and additional Emergency Department visits, and connect individuals to the most appropriate follow up care at the right time given their individual needs.
- **Alameda County**: A reduction in the use of high cost crisis services will free up dollars to provide greater access to all consumers and may assist in developing new service lines.

Mission Budget/Cost

- For $825,000 IN from Alameda County Care Connect, Care Connect can pull down $1,850,000 from the State IF we can reduce ED/PES utilization.

Mission Achievement/Impact Factors

- Currently ACBHCS does not have a defined program or process for follow up for its members who have experienced a behavioral health crisis. With the addition of this program, a decrease in recidivism and an increase in outpatient follow up rates would indicate success.