David W. Covington, LPC, MBA
CEO & President, RI International

Beyond Inpatient

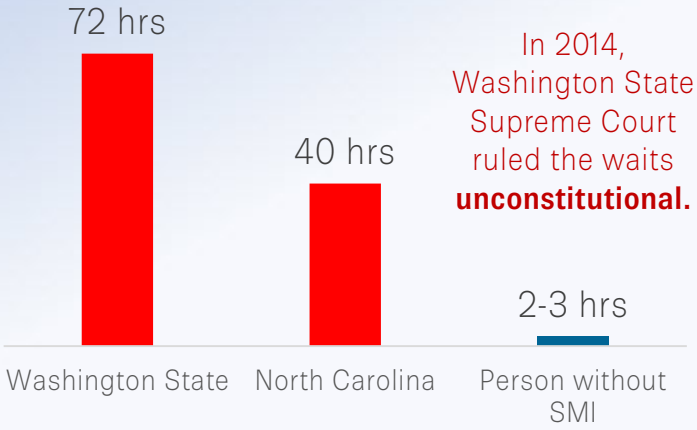
The Crisis Now Continuum System

CRISIS HEALTH RECOVERY CONSULTING


The Need
For Better Crisis Care

Disastrous Access to Care Wastes Resources

Psychiatric Boarding: Long Hospital ED Waits



Law Enforcement: Impact on Public Safety

One study found that **1 in 10 calls** for service involved a person with a serious mental illness

In Madison, Wisconsin, law enforcement found that behavioral health calls for service take **twice as long to resolve** (3 hours versus 1.5 hours on average)

Psychiatric Boarding

Seattle Times (2013): Lack of space forced those involuntarily detained to wait for treatment, on average three days, in chaotic hospital EDs and ill-equipped medical rooms. Frequently parked in hallways or bound to beds, usually given medication but no psychiatric care.

Carolinas Healthcare benchmarked boarding times in their EDs in 2015 but has since reduced wait times 50% from the figure cited.

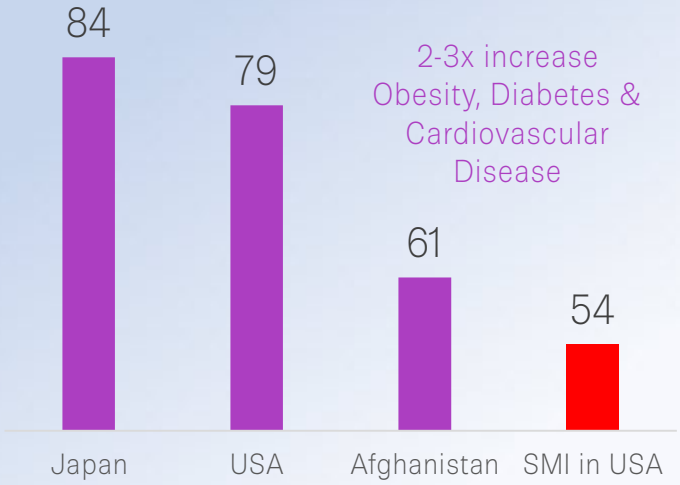
Law Enforcement

Chappell, D (2013) Policing and the Mentally Ill: International Perspectives. Boca Rotan, FL: CRC Press)

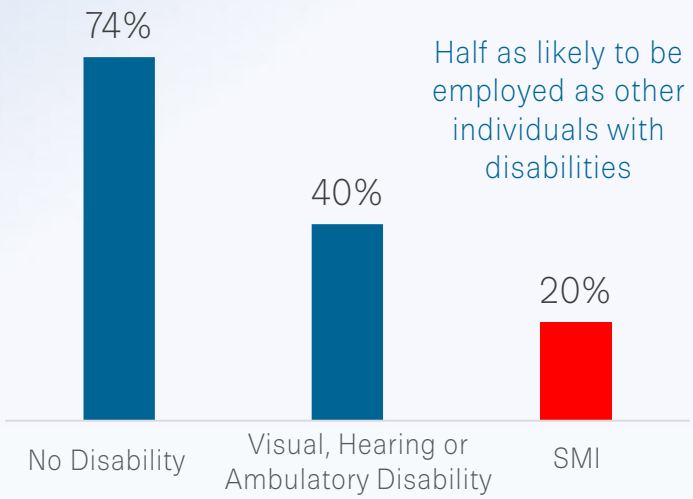
Madison, Wisconsin data cited by Ruby Qazilbash, Associate Deputy Director, Bureau of Justice Assistance, August 31, 2017 ISMICC Federal Committee

What are the Current Real Outcomes?

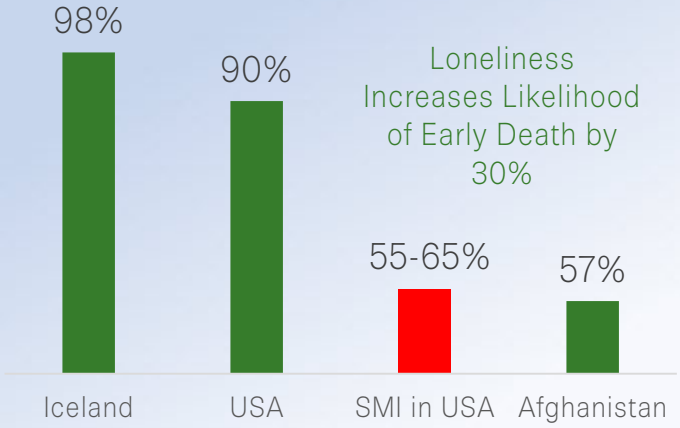
Health: Avg Life Span



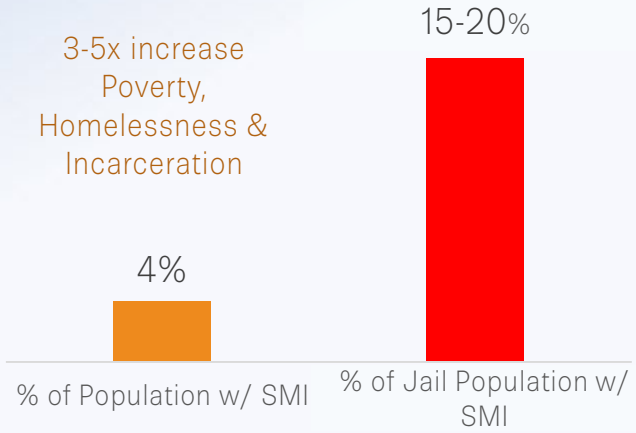
Finance: Employment



Community: Friends & Social Supports



Autonomy: Making Own Life Decisions



Health
Life expectancy data WHO and NASMHPD, and Disease Prevalence from World Psychiatry

Finance
Employment data from American Community Survey and NAMI SMI

Community
Nation data from World Happiness Report ("Someone to rely on in times of trouble"). SMI data from AZ Health Risk Assessments ("Someone to talk to about problems" and "Someone invites me out for dinner/activity.")

Autonomy
"Prevalence of SMI Among Jail Inmates" and "Poverty and Severe Psychiatric Disorder"

Life for the nearly 10 million people with **SMI in the US** has comparable outcomes to *the average person in Afghanistan.*

Thousands Die Alone and In Despair

Suicide Rate: Hazard Ratio vs. General Population

Unspeakable Family Pain: Tragic Outcomes

In 2013, Virginia State Senator Creigh Deeds told CNN he was alive to work for change in mental health. A week earlier, he was stabbed multiple times by his son, who then died of suicide. This happened hours after a mental health evaluation suggested "Gus" needed more intensive services. Tragically, he was released before the appropriate care could be found.

Suicide Risk

According to the American Association of Suicidology, the 2014 suicide rate for males 65+ was 32 per 100,000, but 51 per 100k for those over 85.

In 2010, USA Today reported the US Army suicide rate at 22 per 100,000 but the Fort Hood rate was 47 per 100,000.

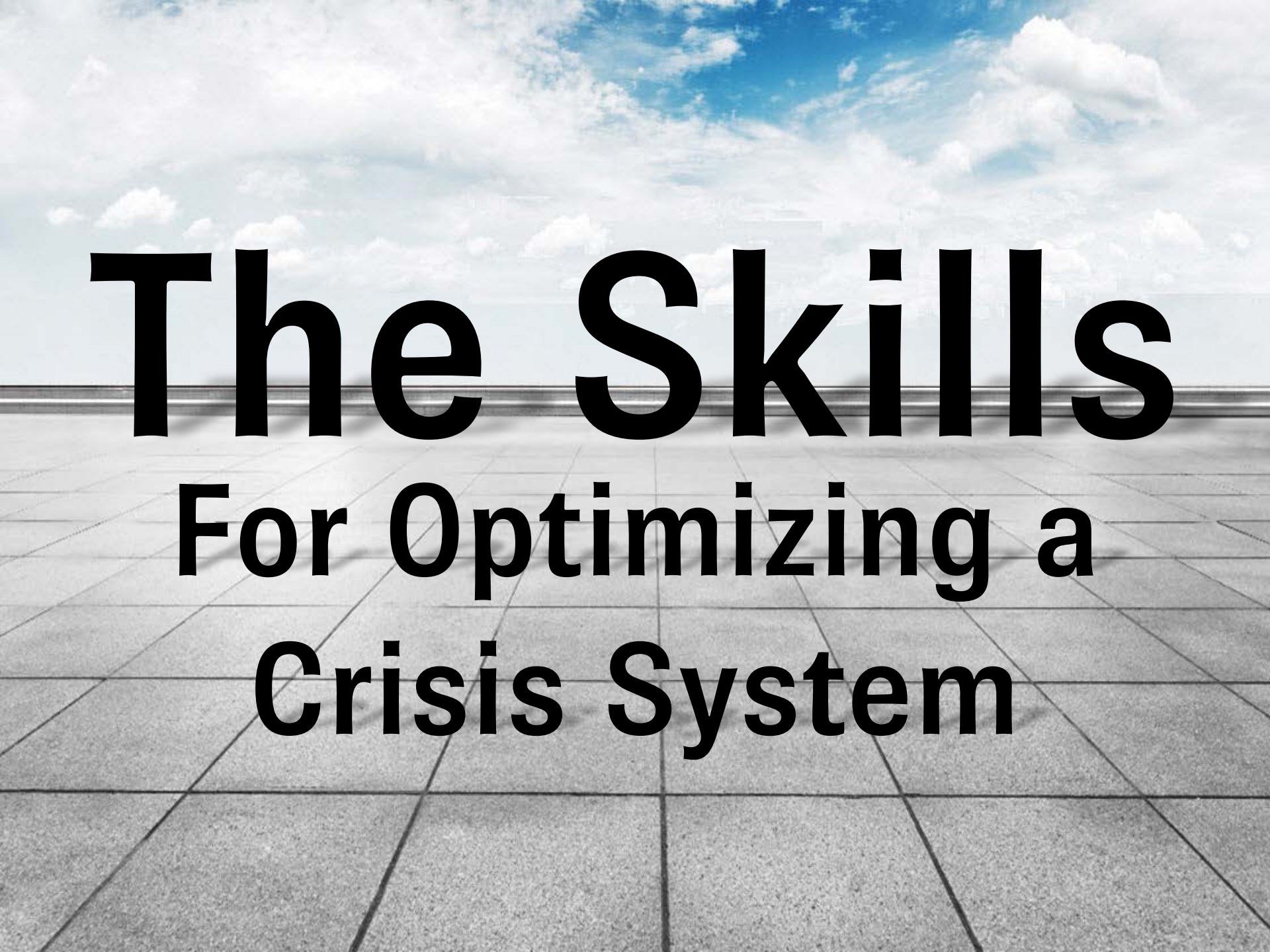
The Suicide Prevention Resource Center (SPRC) reported Alaskan Native/American Indian males ages 15 to 24 had the highest rate at 28 per 100k. In 2010, USA Today reported those AN living in Alaska had a suicide rate of 42 per 100,000.

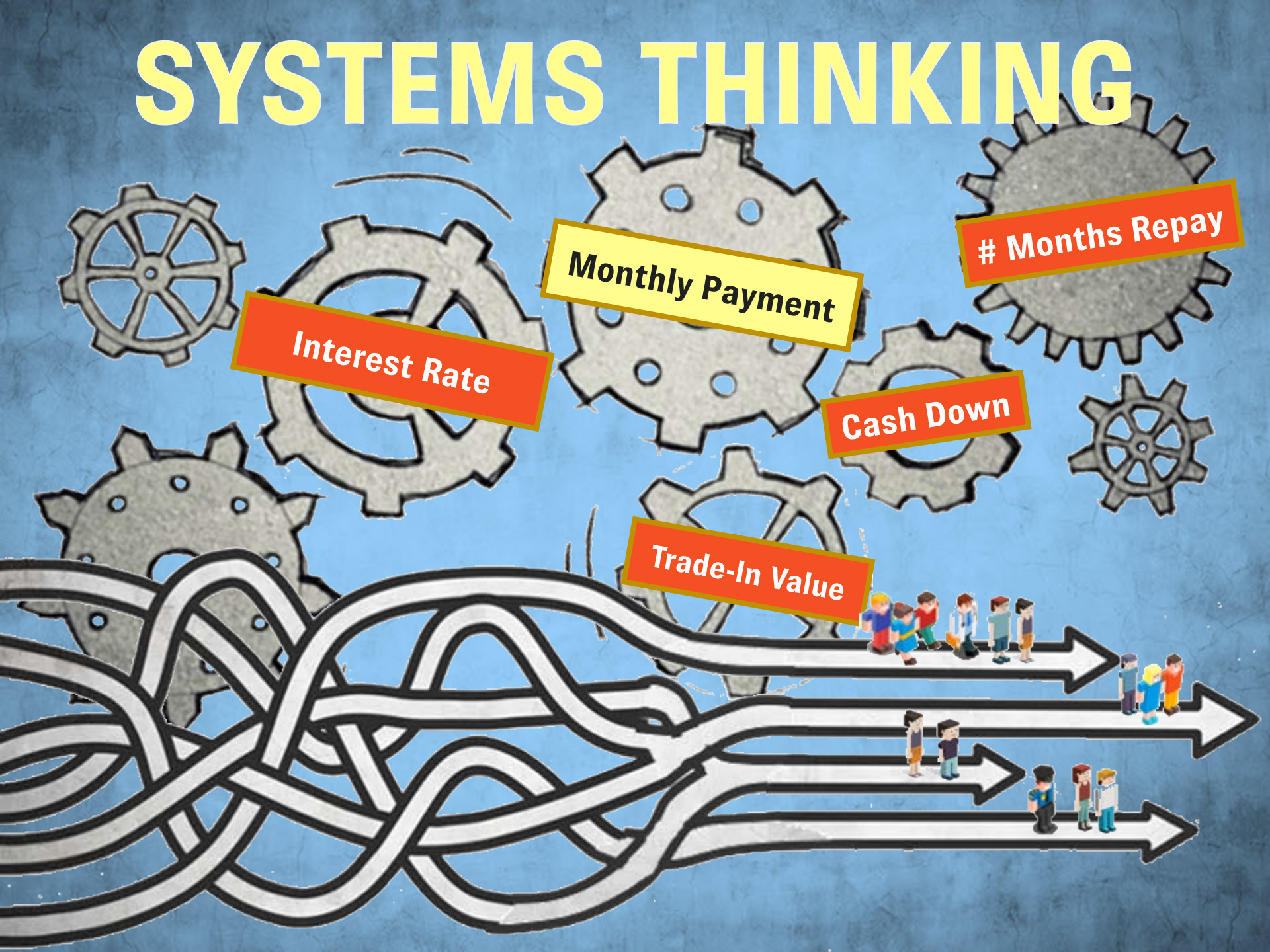
The SPRC says little can said with certainty about death rates for LGBT youth due to limited data collection. Other research suggests two three times the national rate.

In 2008, a UK study by Osborn found the hazard ratio for individuals with SMI, including Schizophrenia, to be nearly 13 times the general population. In 2010, King's Health Partners found the risk to be 12 times greater during the first year following diagnosis of a serious mental illness.

Violence

While rare, incidents of individuals with SMI who were untreated being involved in the tragic deaths of others have garnered the attention of our national dialogue.


The Skills
For Optimizing a
Crisis System


SYSTEMS THINKING
Interest Rate
Monthly Payment
Months Repay
Cash Down
Trade-In Value

SUPPLY CHAIN MANAGEMENT

New Year's Day, you are taking inventory on a key product and you have the following number remaining on the shelf from December. Which is best?

Scenario A

1m

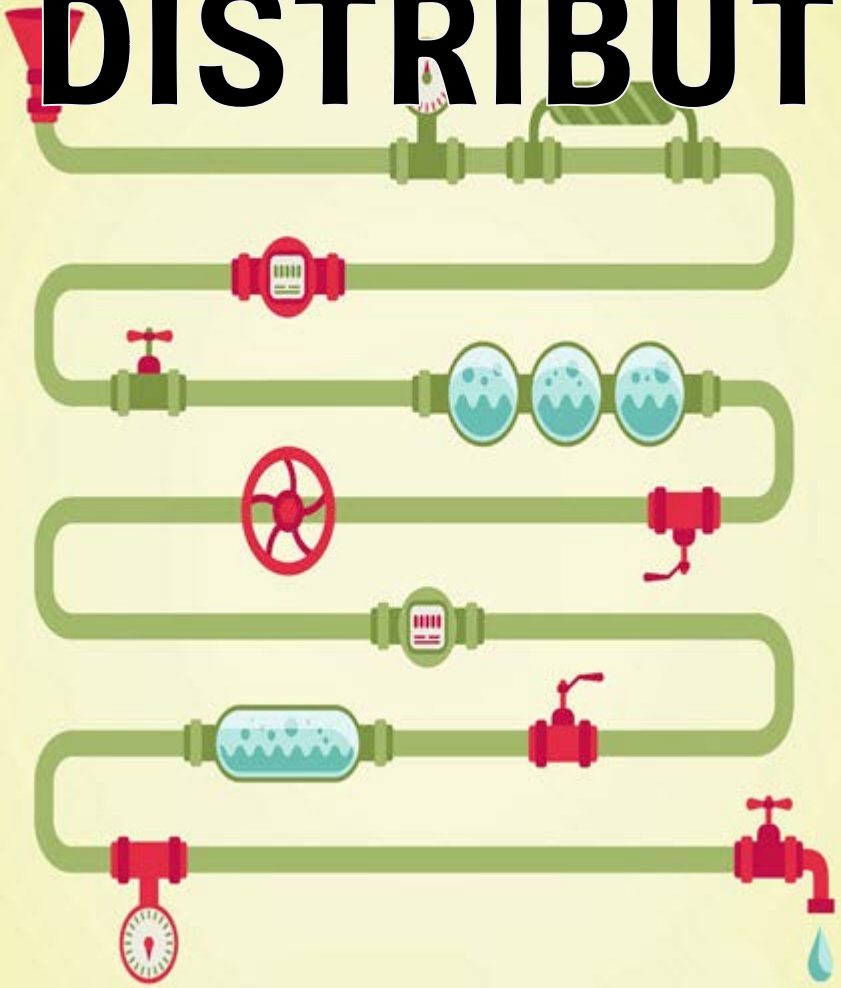
Scenario B

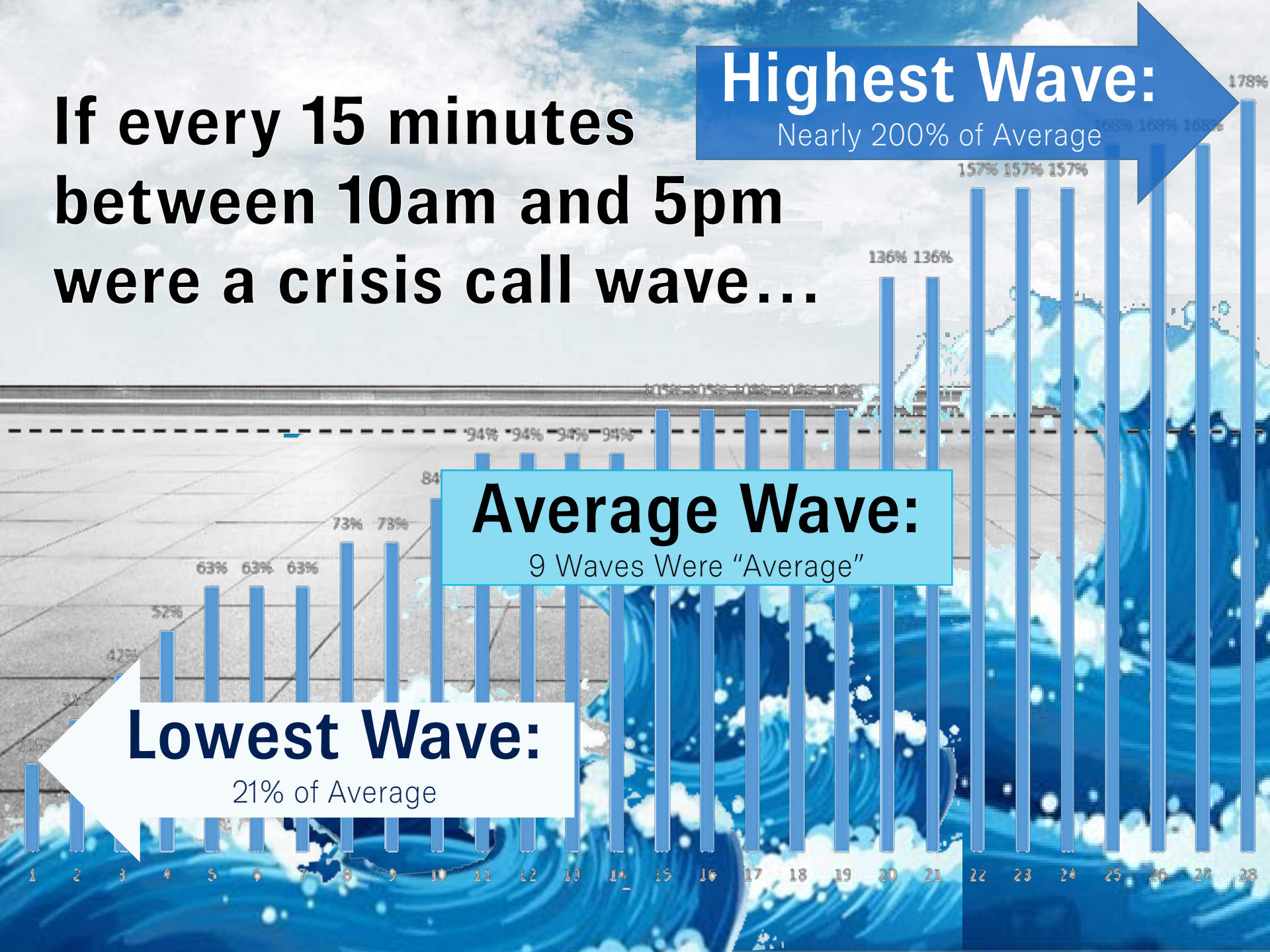
1

Scenario C

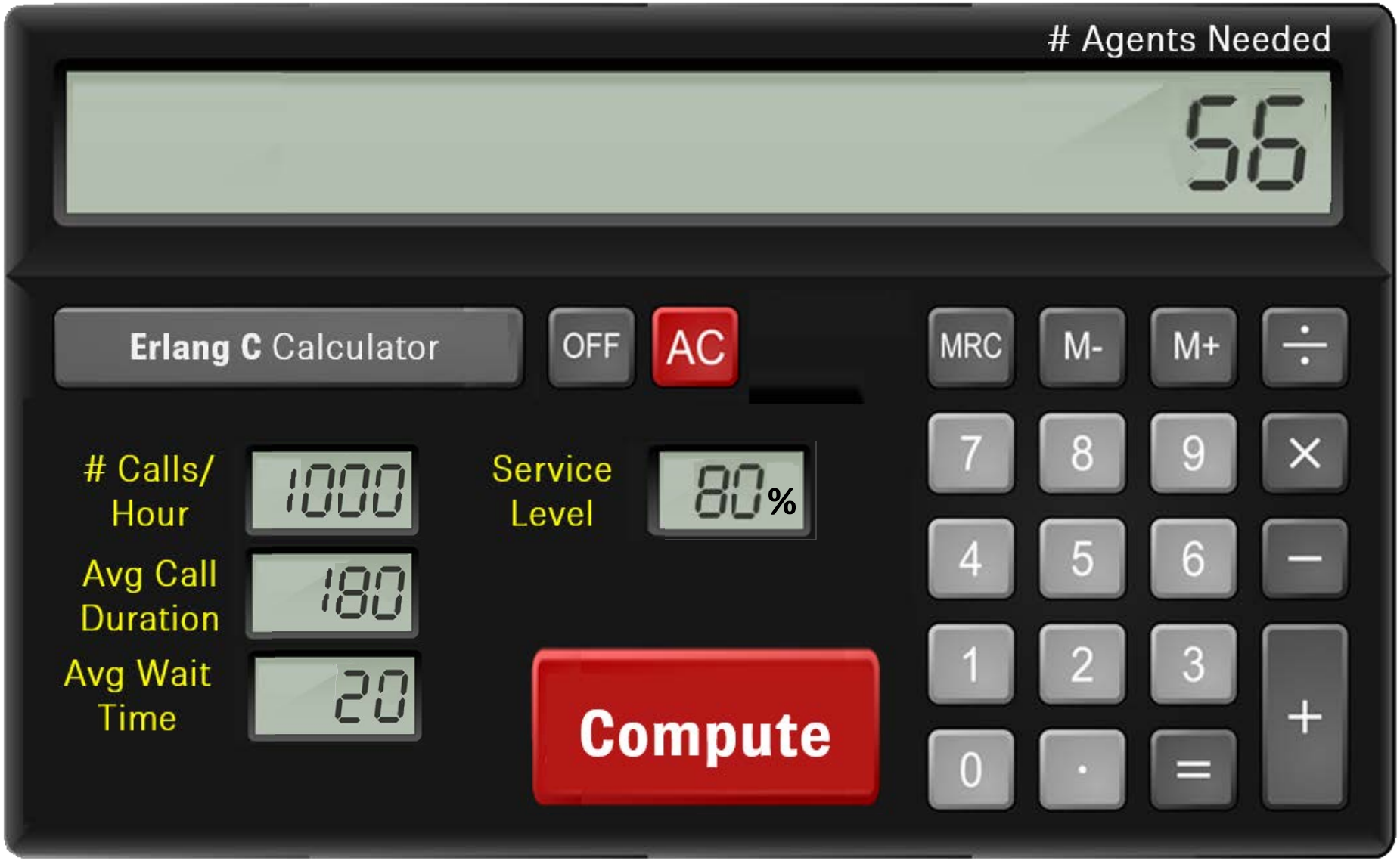
0

WHAT KIND OF DISTRIBUTION?




If every 15 minutes between 10am and 5pm were a crisis call wave…
Highest Wave:
Nearly 200% of Average
Average Wave:
9 Waves Were "Average"
Lowest Wave:
21% of Average
178%
157% 157% 157%
136% 136%
94% 94% 94% 94%
73% 73%
63% 63% 63%
52%
42%
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28

FORECASTING CRISIS NEED


Agents Needed
56
Erlang C Calculator
OFF
AC
MRC
M-
M+
÷
Calls/ Hour
1000
Service Level
80%
7
8
9
×
Avg Call Duration
180
4
5
6
−
Avg Wait Time
20
1
2
3
+
Compute
0
.
=

3 Models

Let's Build

Model #1	Model #2	Model #3
Traditional	Crisis Now	Crisis Now
State Hospital Beds	Continuum	System

CRISIS NOW
Transforming Crisis Services

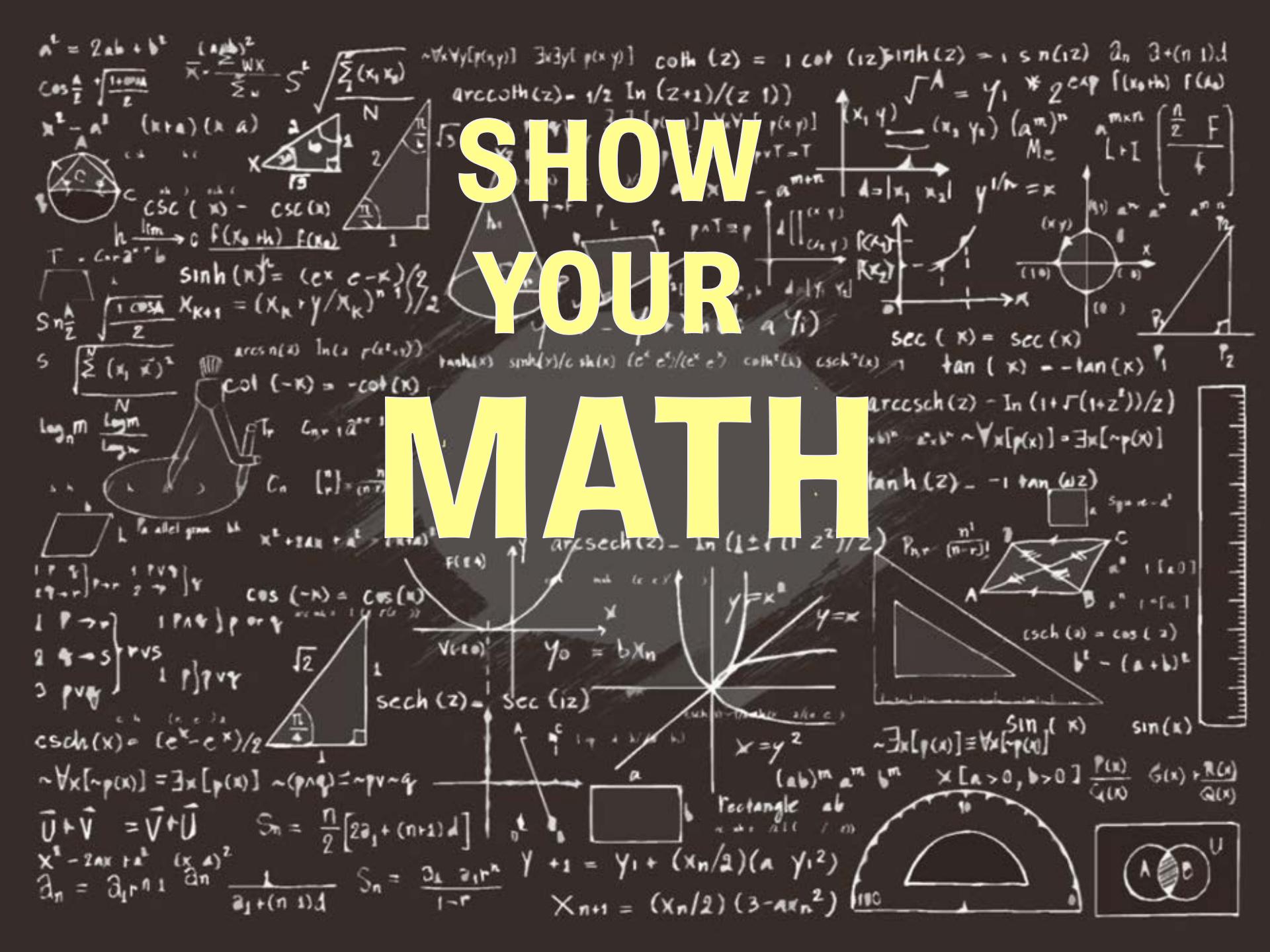
Action Alliance

NSPL Lifeline

NASMHPD

National Council

Arizona AHCCCS


SHOW
YOUR
MATH

Model #1

Traditional

Public Inpatient

In the First Model, implement the 50 public sector psychiatric inpatient beds per 100,000 population necessary to meet community crisis needs.


50
/100,000

50 /100,000

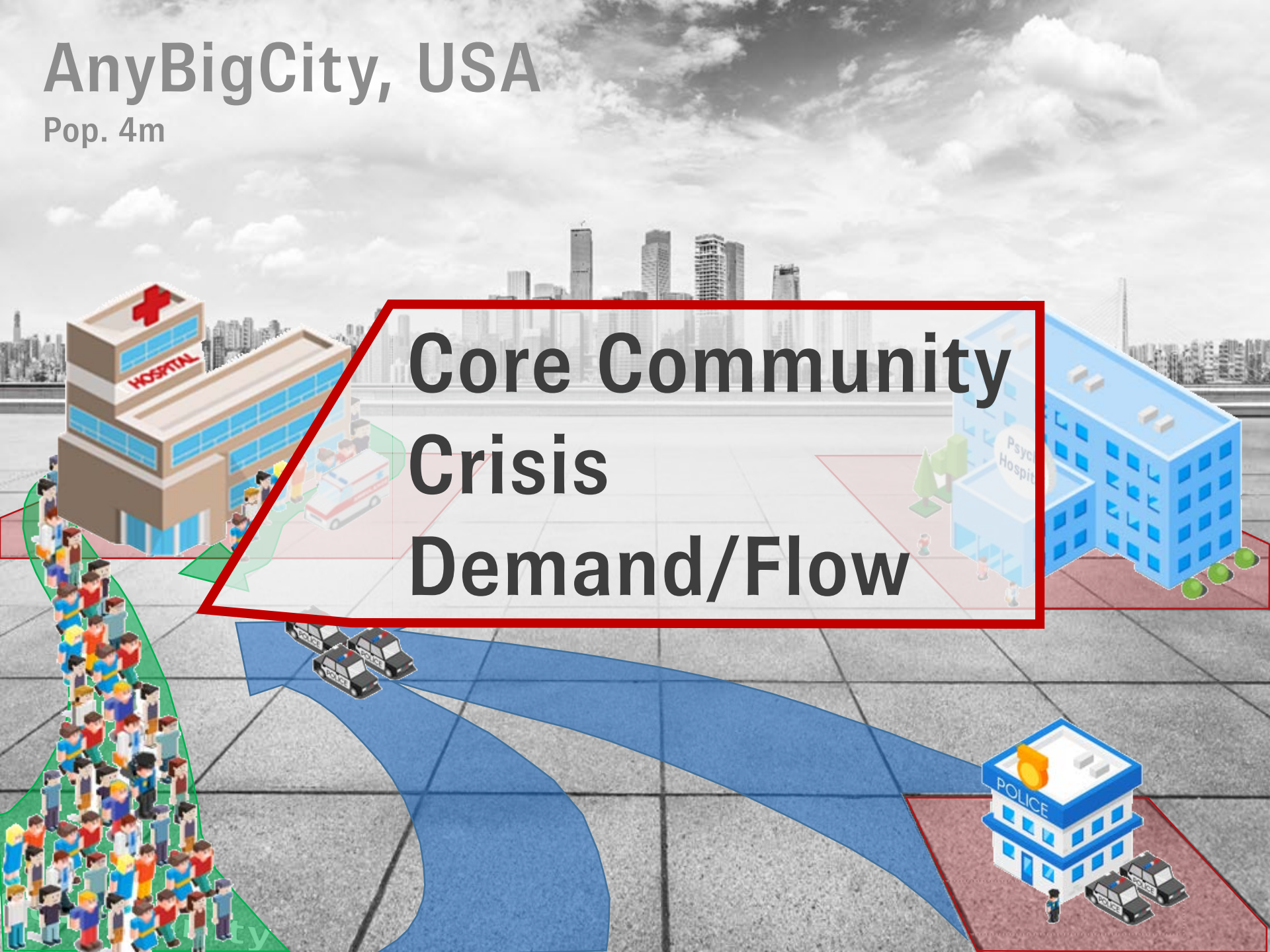
The consensus opinion of an expert panel on psychiatric care estimated the need as around 50 public psychiatric beds per 100,000 population *(Treatment Advocacy Center)*.

AnyBigCity, USA

Pop. 4m

AnyBigCity, USA

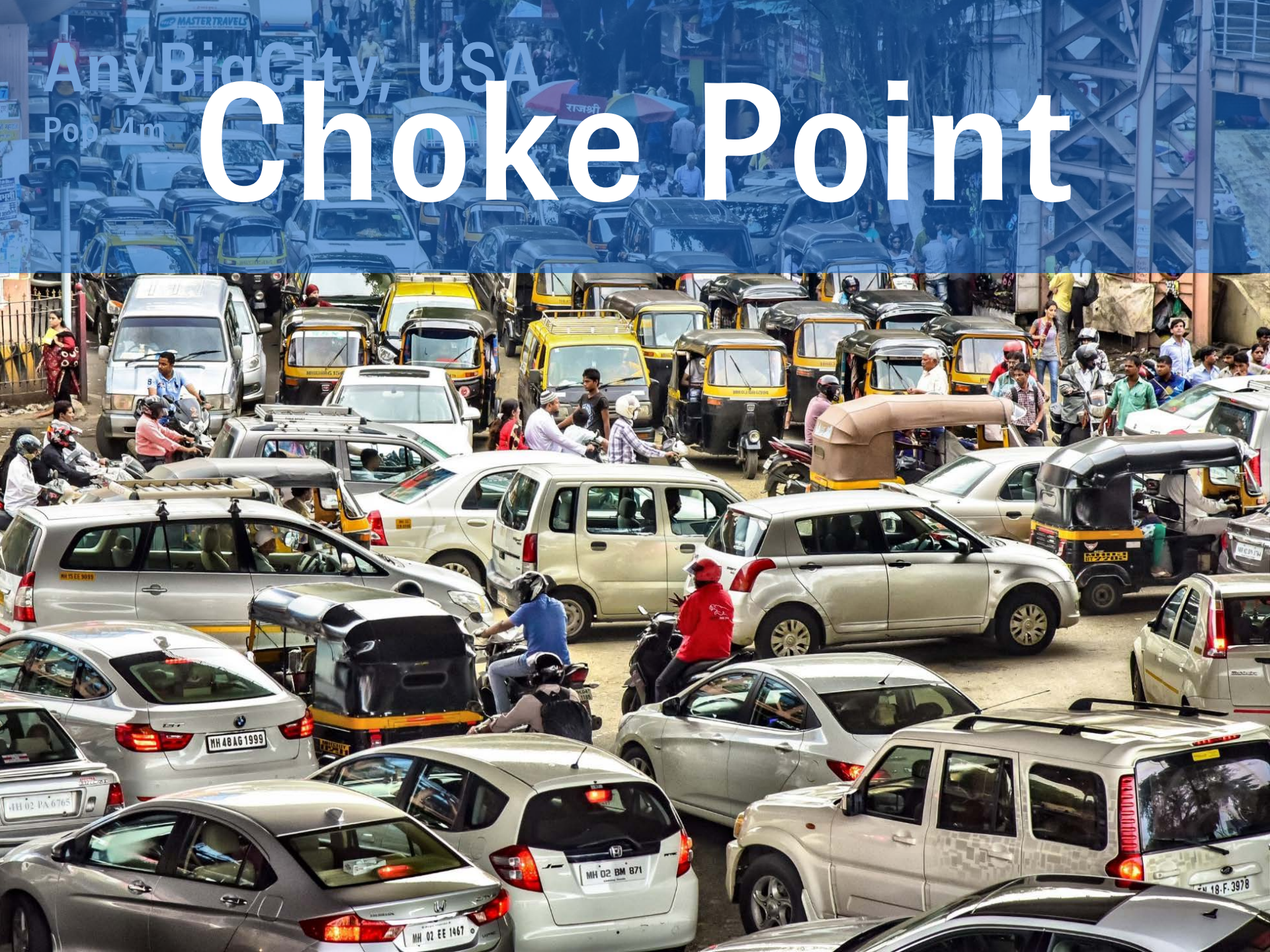
Pop. 4m


AnyBigCity, USA
Pop. 4m
Core Community
Crisis
Demand/Flow
HOSPITAL
POLICE

AnyBigCity, USA

Pop. 4m

Choke Point



AnyBigCity, USA

Pop. 4m

CALIFORNIA HOSPITAL ASSOCIATION

Providing Leadership in Health Policy and Advocacy

April 2015

TO: Whom it May Concern

FROM: Sheree Kruckenberg, Vice President Behavioral Health

SUBJECT: Access to Timely Psychiatric Emergency Services

California, like the nation, is struggling to ensure individuals with a suspected/potential mental illness are able to receive a timely psychiatric evaluation and access to an appropriate level of treatment, if needed.

The California Hospital Association (CHA) represents over 400 hospitals. In 2011, these hospitals received over 1.1 million individuals in their emergency departments (EDs) in need of some level of behavioral health intervention. An analysis of emergency department utilization data between 2006 and 2011 verified that the overall use of EDs for behavioral health visits increased 47% during this 5-year time period and the trend data indicate this continues to increase each year.

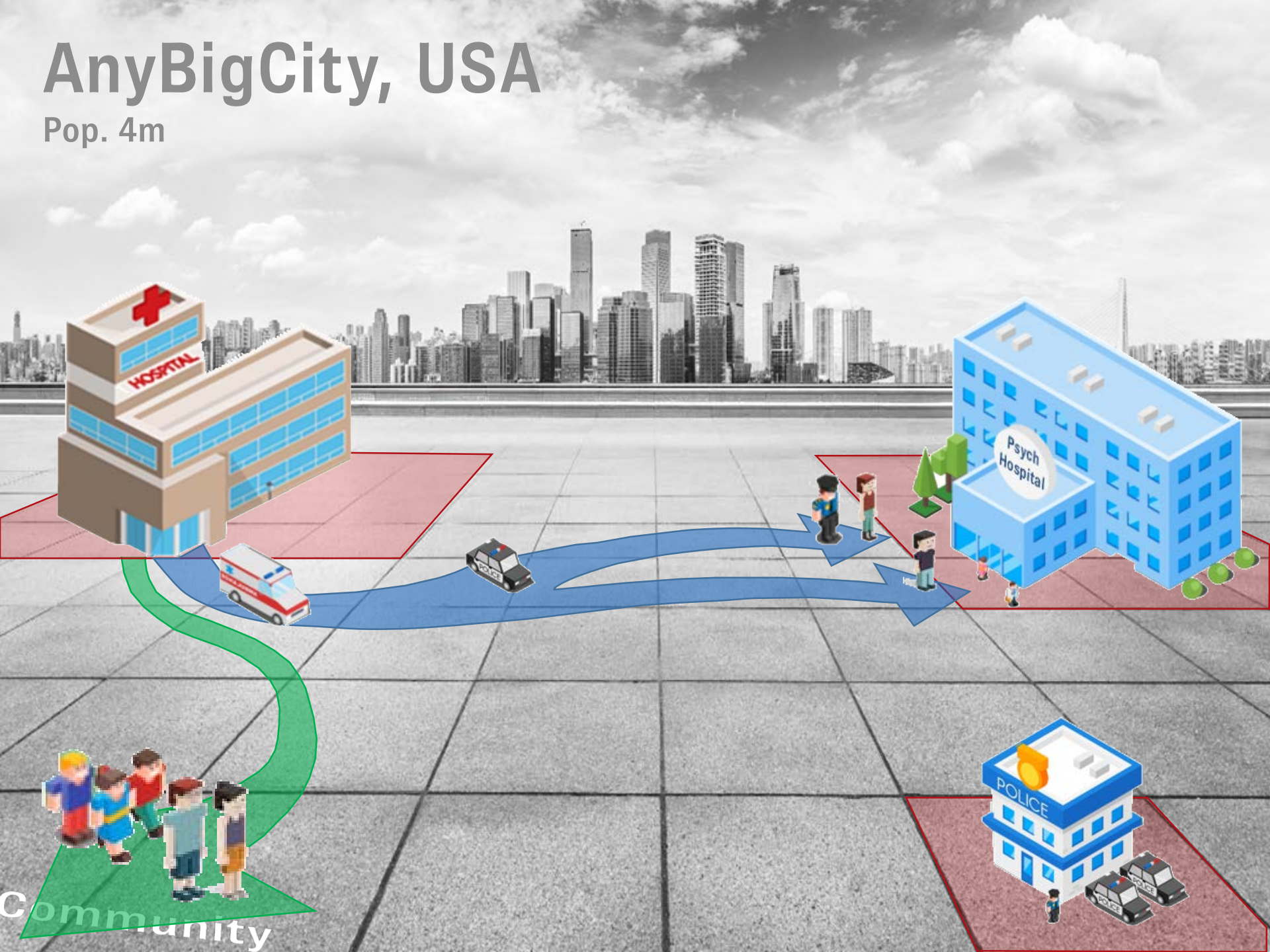
The vast majority of individuals arriving at a community medical/surgical hospital ED with a behavioral health need do not have a physical health condition that requires an emergency level of care intervention. This holds true for psychiatric emergency medical conditions as well. Unfortunately, however, there are often no alternative behavioral treatment settings available on a 24/7 basis. This forces hospital emergency departments, including those without behavioral health clinicians, to become the only available resource in many communities.

The increasing dependence on medical/surgical hospital EDs to provide behavioral evaluation and treatment is not appropriate, not safe, and not an efficient use of dwindling community emergency resources. This includes not only hospitals, but emergency transportation providers and law enforcement. More importantly, it impacts the patient, the patient's family, other patients and their families, and of course the hospital staff.

The increasing dependence on medical/surgical hospital EDs to provide behavioral evaluation and treatment is not appropriate, not safe, and not an efficient use of dwindling community emergency resources. This includes not only hospitals, but emergency transportation providers and law enforcement. More importantly, it impacts the patient, the patient's family, other patients and their families, and of course the hospital staff.


AnyBigCity, USA
Pop. 4m
Dimensions
Risk of Harm
Functioning
Co-Morbidity
Environment
Treatment History
Engagement
6 – Secure Residential/Inpt
5 – Non-secure Residential
4 – Med Monitored Non-Residential
3 – Intensive Outpatient
2 – Low Intensity Outpatient
1 – Recovery Maintenance
1
2
3
4
5
6
LOCUS
Psych Hospital
POLICE
Community


AnyBigCity, USA
Pop. 4m
HOSPITAL
Psych Hospital
54%
22%
14%
6%
3%
2%
1
2
3
4
5
6
LOCUS
Community
LOCUS data based on eleven years of data for the statewide Georgia Crisis & Access Line, encompassing more than **1.2 million episodes** of care for crisis and focused on emergency department contacts.


AnyBigCity, USA
Pop. 4m
HOSPITAL
Psych Hospital
POLICE
POLICE
POLICE
POLICE
Community

Emergency Medicine International

Indexed in Web of Science

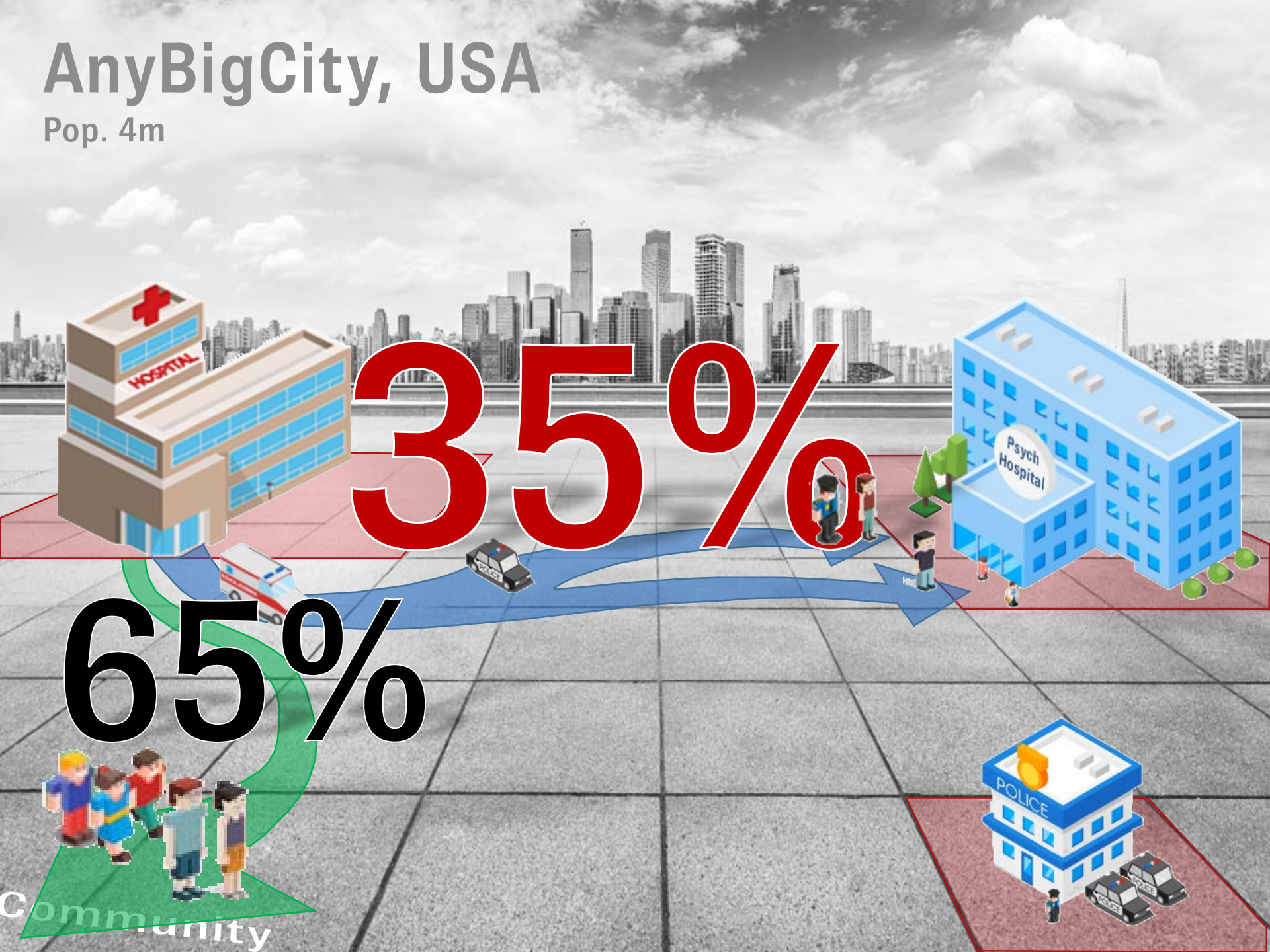
The Impact of Psychiatric Patient Boarding in Emergency Departments

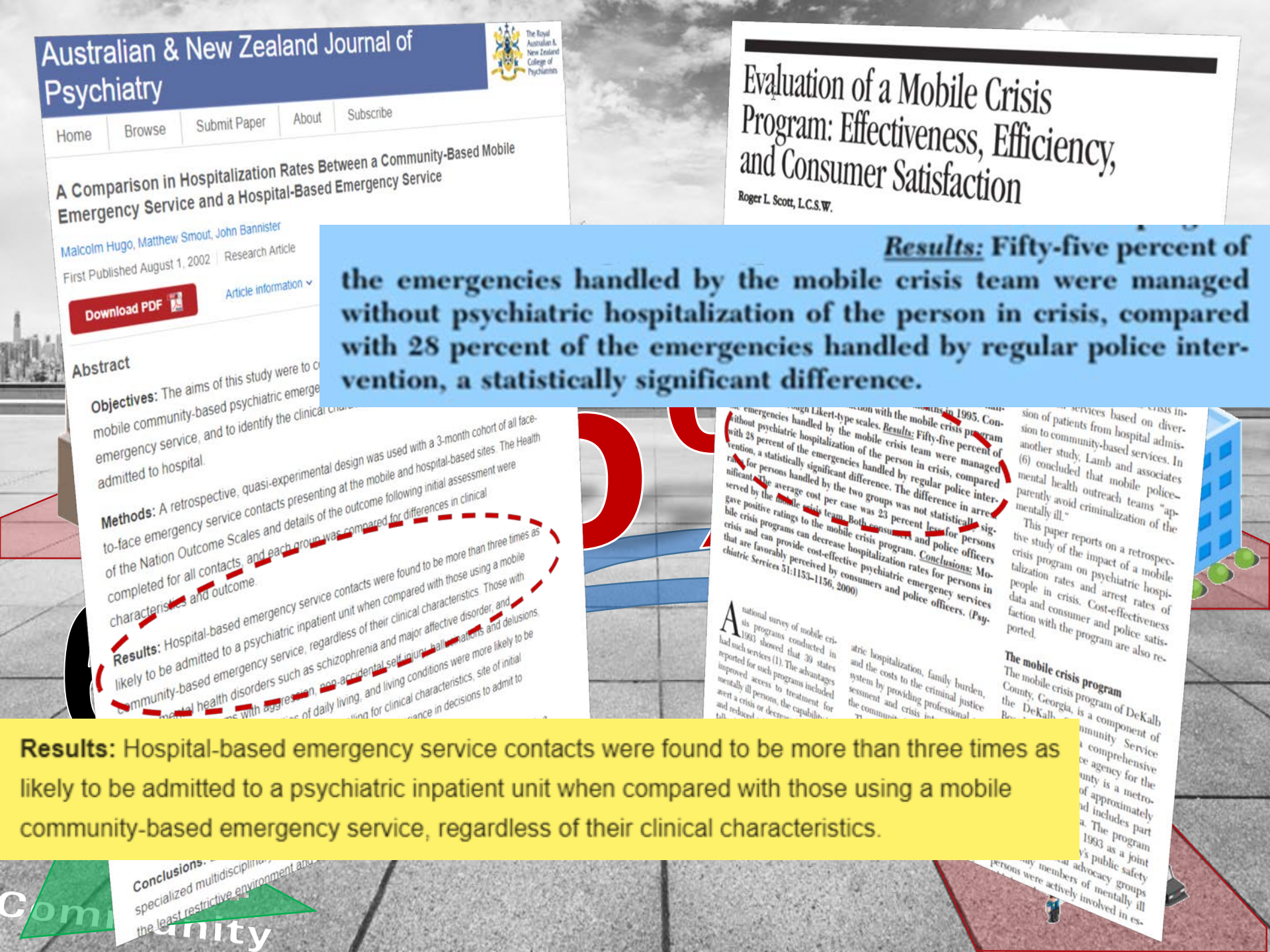
B. A. Nicks * and D. M. Manthey

Abstract

Studies have demonstrated the adverse effects of emergency department (ED) boarding. ... of resource utilization, throughput, and financial impact for psychiatric ... The authors retrospectively studied all psychiatric and ... (≥68,000 adult visits) from ... reimbursement.

January 2007-2008. The main outcomes were ED length of stay (LOS) and associated reimbursement. *Results*. 1,438 patients were consulted to psychiatry with 505 (35.1%) requiring inpatient psychiatric care management. The mean psychiatric patient age was 42.5 years (SD 13.1 years), with 2.7 times more women than men. ED LOS was significantly longer for psychiatric admissions (1089 min, CI (1039–1140) versus 340 min, CI (304–375); $P < 0.001$) when compared to non-psychiatric admissions. The financial impact of psychiatric boarding accounted for a direct loss of ($1,198) compared to non-psychiatric admissions. Factoring the loss of bed turnover for waiting patients and opportunity cost due to loss of those patients, psychiatric patient boarding cost the department $2,264 per patient.


AnyBigCity, USA
Pop. 4m
HOSPITAL
35%
Psych Hospital
65%
POLICE
Community


Australian & New Zealand Journal of Psychiatry
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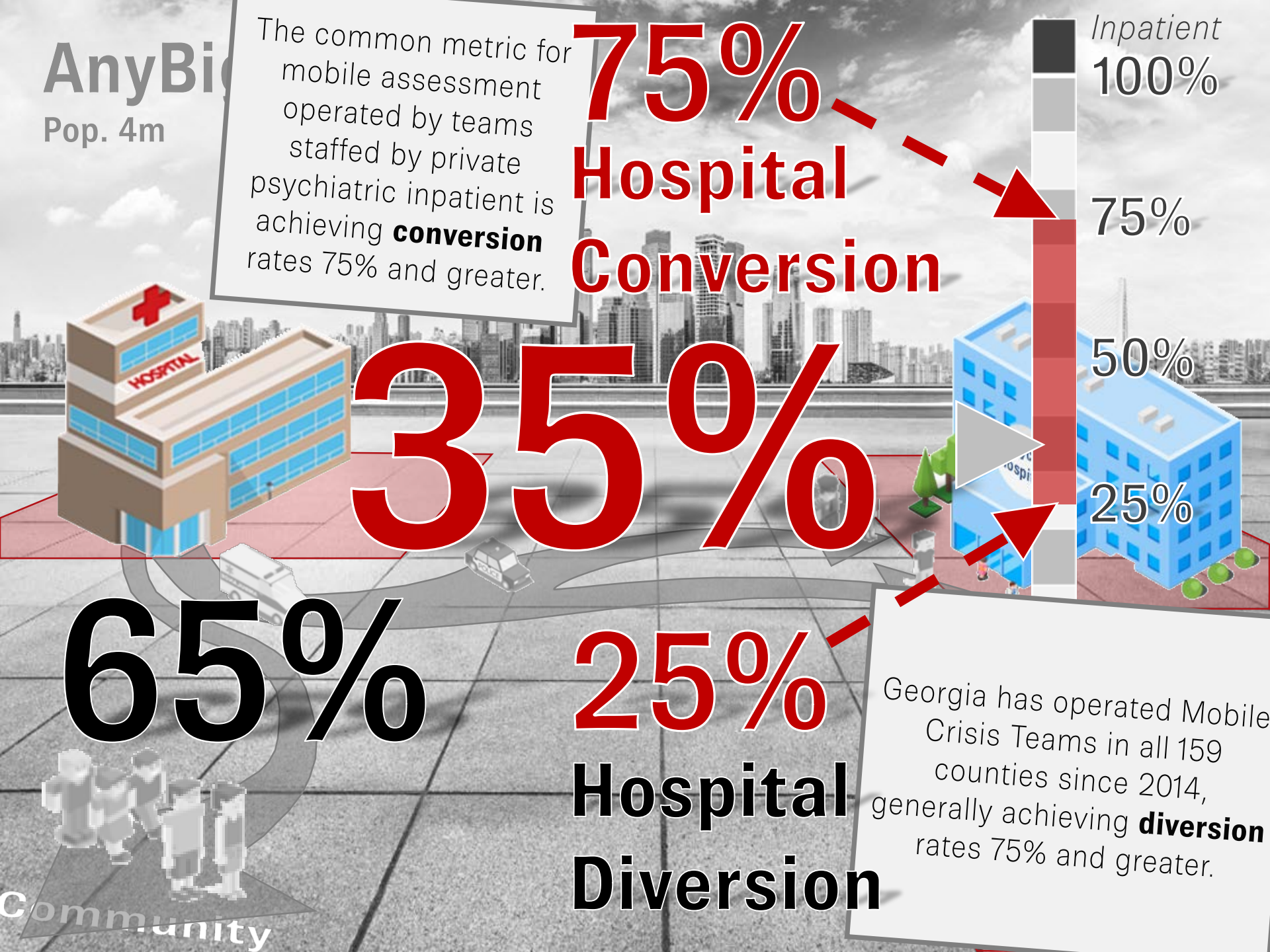
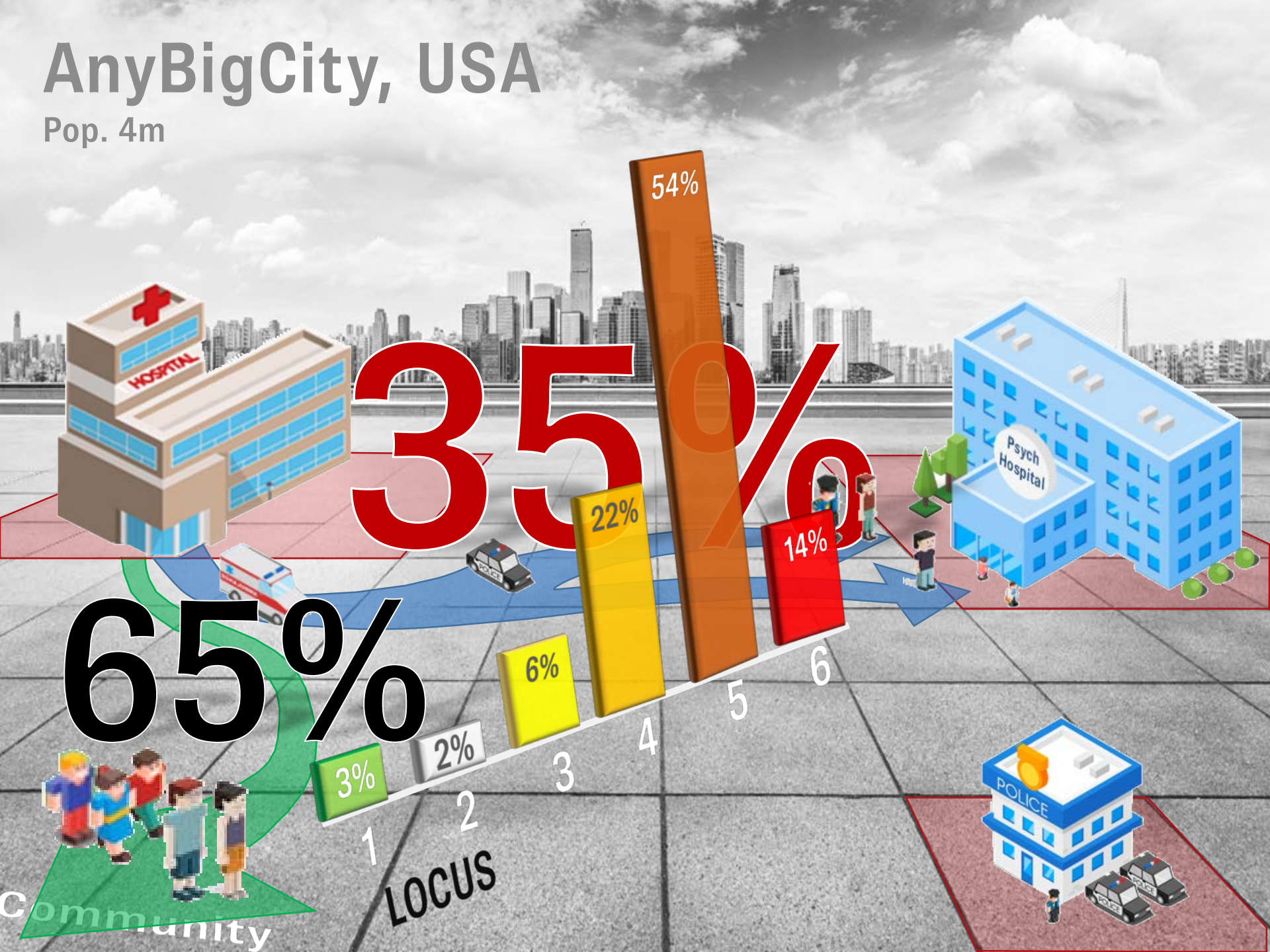
A Comparison in Hospitalization Rates Between a Community-Based Mobile Emergency Service and a Hospital-Based Emergency Service
Malcolm Hugo, Matthew Smout, John Bannister
First Published August 1, 2002 | Research Article
Download PDF
Article information
Abstract
Objectives: The aims of this study were to c
mobile community-based psychiatric emerge
emergency service, and to identify the clinical
admitted to hospital.
Methods: A retrospective, quasi-experimental design was used with a 3-month cohort of all face-to-face emergency service contacts presenting at the mobile and hospital-based sites. The Health of the Nation Outcome Scales and details of the outcome following initial assessment were completed for all contacts, and each group was compared for differences in clinical characteristics and outcome.
Results: Hospital-based emergency service contacts were found to be more than three times as likely to be admitted to a psychiatric inpatient unit when compared with those using a mobile community-based emergency service, regardless of their clinical characteristics. Those with
Conclusions:
specialized multidisciplin
the least restrictive environment and
Evaluation of a Mobile Crisis Program: Effectiveness, Efficiency, and Consumer Satisfaction
Roger L. Scott, L.C.S.W.
Results: Fifty-five percent of the emergencies handled by the mobile crisis team were managed without psychiatric hospitalization of the person in crisis, compared with 28 percent of the emergencies handled by regular police intervention, a statistically significant difference.
emergencies handled by the mobile crisis team were managed without psychiatric hospitalization of the person in crisis, compared with 25 percent of the emergencies handled by regular police intervention, a statistically significant difference. The difference in arrest rates for persons handled by the two groups was not statistically significant. The average cost per case was 23 percent less for persons served by the mobile crisis team. Both consumers and police officers gave positive ratings to the mobile crisis program. Conclusions: Mobile crisis programs can decrease hospitalization rates for persons in crisis and can provide cost-effective psychiatric emergency services that are favorably perceived by consumers and police officers. (Psychiatric Services 51:1153–1156, 2000)
A national survey of mobile crisis programs conducted in 1993 showed that 39 states had such services (1). The advantages reported for such programs included improved access to treatment for mentally ill persons, the capability to avert a crisis or decrease
atric hospitalization, family burden, and the costs to the criminal justice system by providing professional assessment and crisis
The mobile crisis program
The mobile crisis program of DeKalb County, Georgia, is a component of the DeKalb
Results: Hospital-based emergency service contacts were found to be more than three times as likely to be admitted to a psychiatric inpatient unit when compared with those using a mobile community-based emergency service, regardless of their clinical characteristics.


AnyBi
Pop. 4m
The common metric for mobile assessment operated by teams staffed by private psychiatric inpatient is achieving **conversion** rates 75% and greater.
75%
Hospital
Conversion
35%
65%
25%
Hospital
Diversion
Georgia has operated Mobile Crisis Teams in all 159 counties since 2014, generally achieving **diversion** rates 75% and greater.
Inpatient
100%
75%
50%
25%
HOSPITAL
Community


AnyBigCity, USA
Pop. 4m
HOSPITAL
35%
65%
54%
22%
14%
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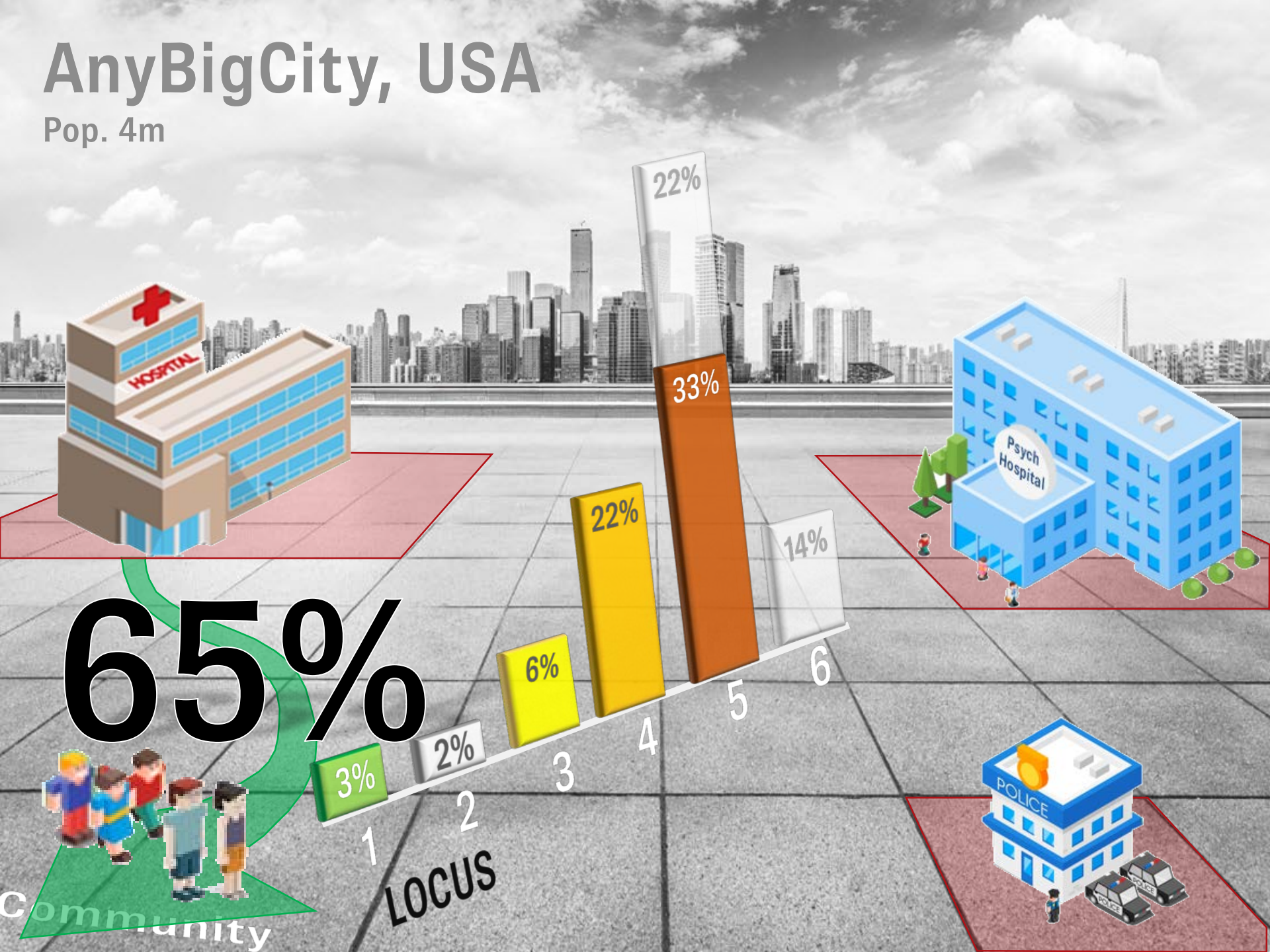
LOCUS
Psych Hospital
POLICE
Community


AnyBigCity, USA
Pop. 4m
HOSPITAL
Psych Hospital
POLICE
65%
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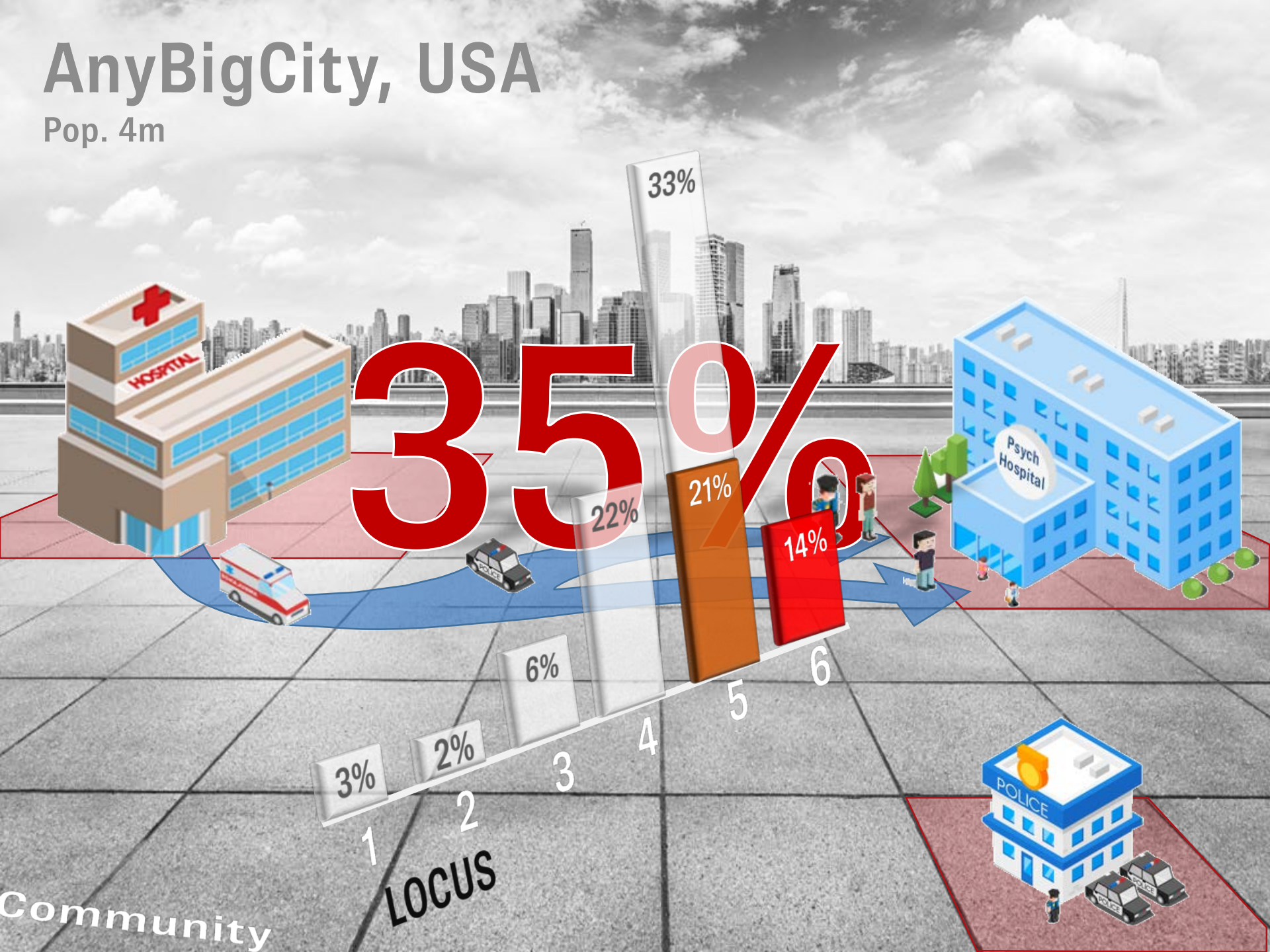
6
LOCUS
Community


AnyBigCity, USA
Pop. 4m
HOSPITAL
35%
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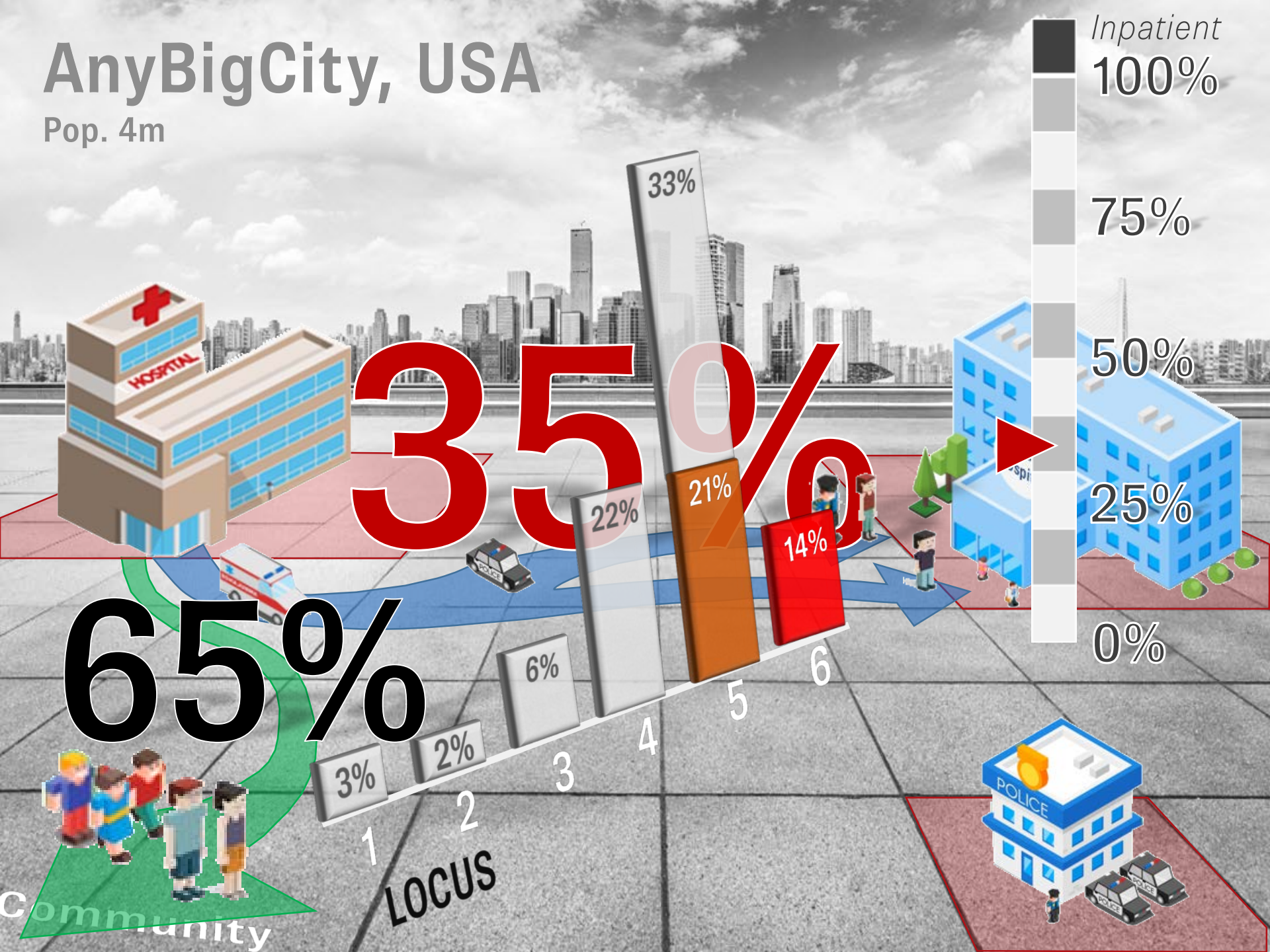
6
LOCUS
Psych Hospital
POLICE
Community


AnyBigCity, USA
Pop. 4m
Inpatient
100%
75%
50%
25%
0%
35%
65%
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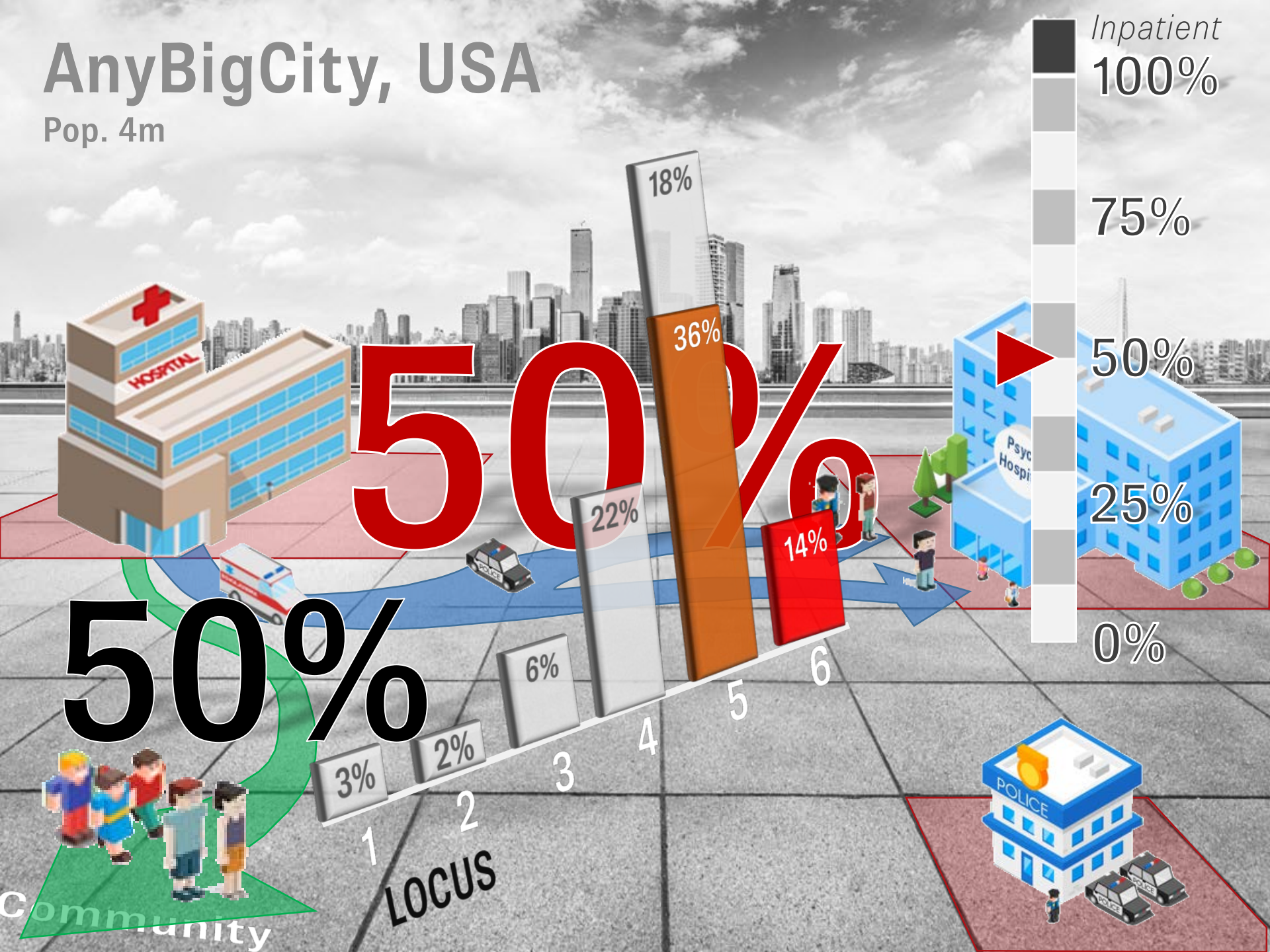
6
LOCUS
HOSPITAL
POLICE
Community


AnyBigCity, USA
Pop. 4m
Inpatient
100%
75%
50%
25%
0%
50%
50%
18%
36%
22%
14%
6%
3%
2%
1
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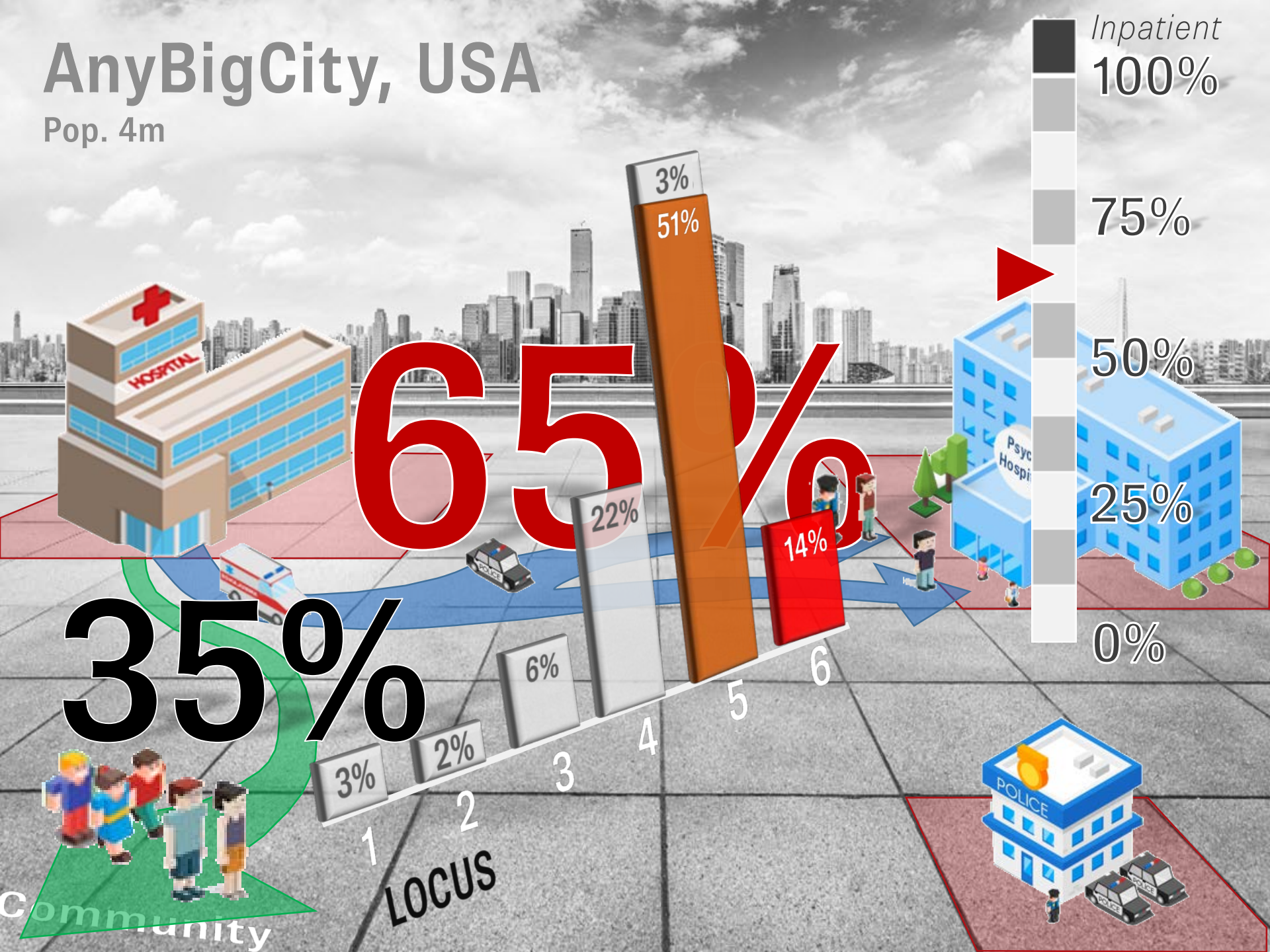
4
5
6
LOCUS
HOSPITAL
POLICE
Psyc
Hospi
Community


AnyBigCity, USA
Pop. 4m
Inpatient
100%
75%
50%
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65%
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51%
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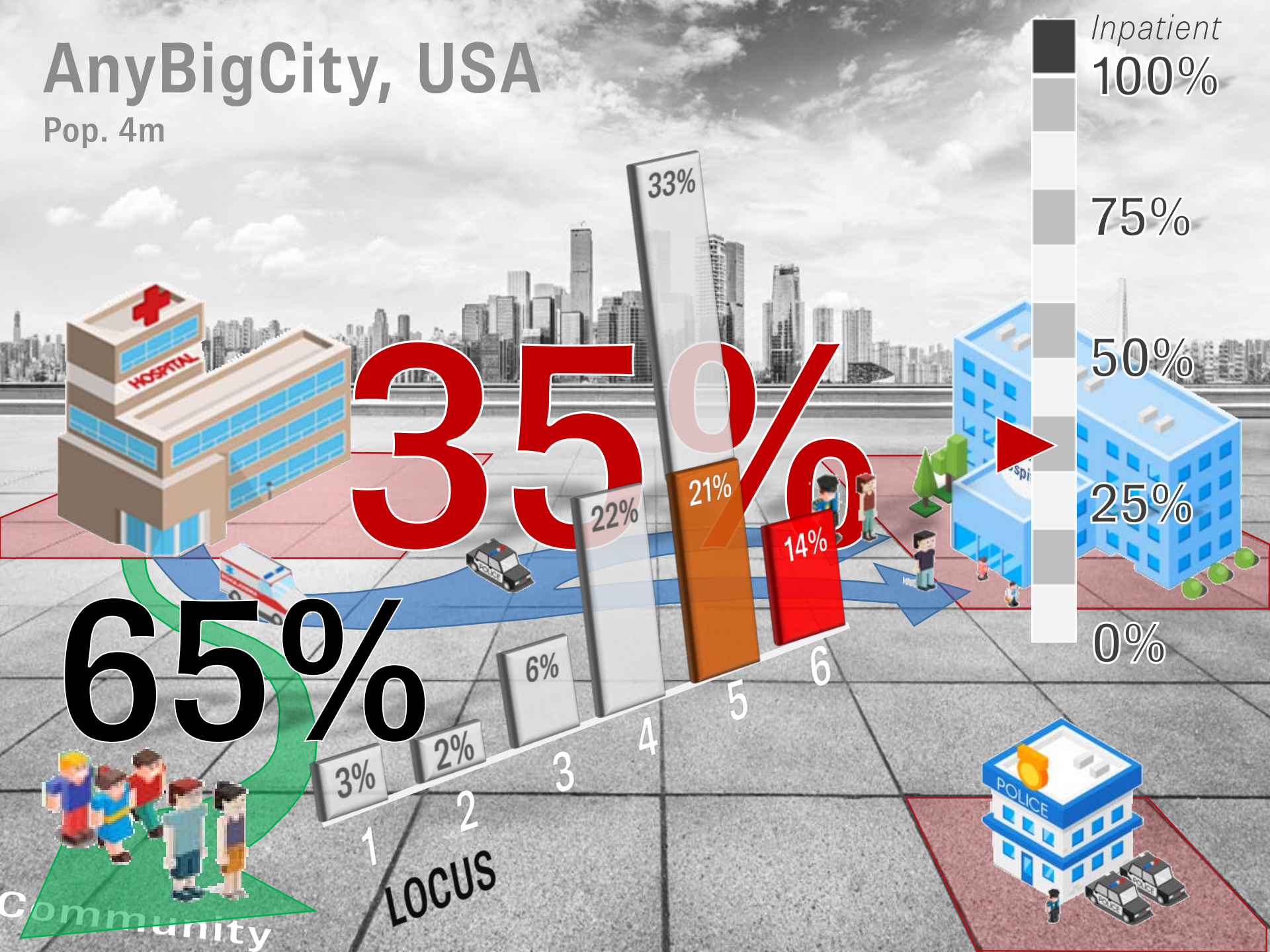
LOCUS
HOSPITAL
POLICE
Community


AnyBigCity, USA
Pop. 4m
Inpatient
100%
75%
50%
25%
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14%
6%
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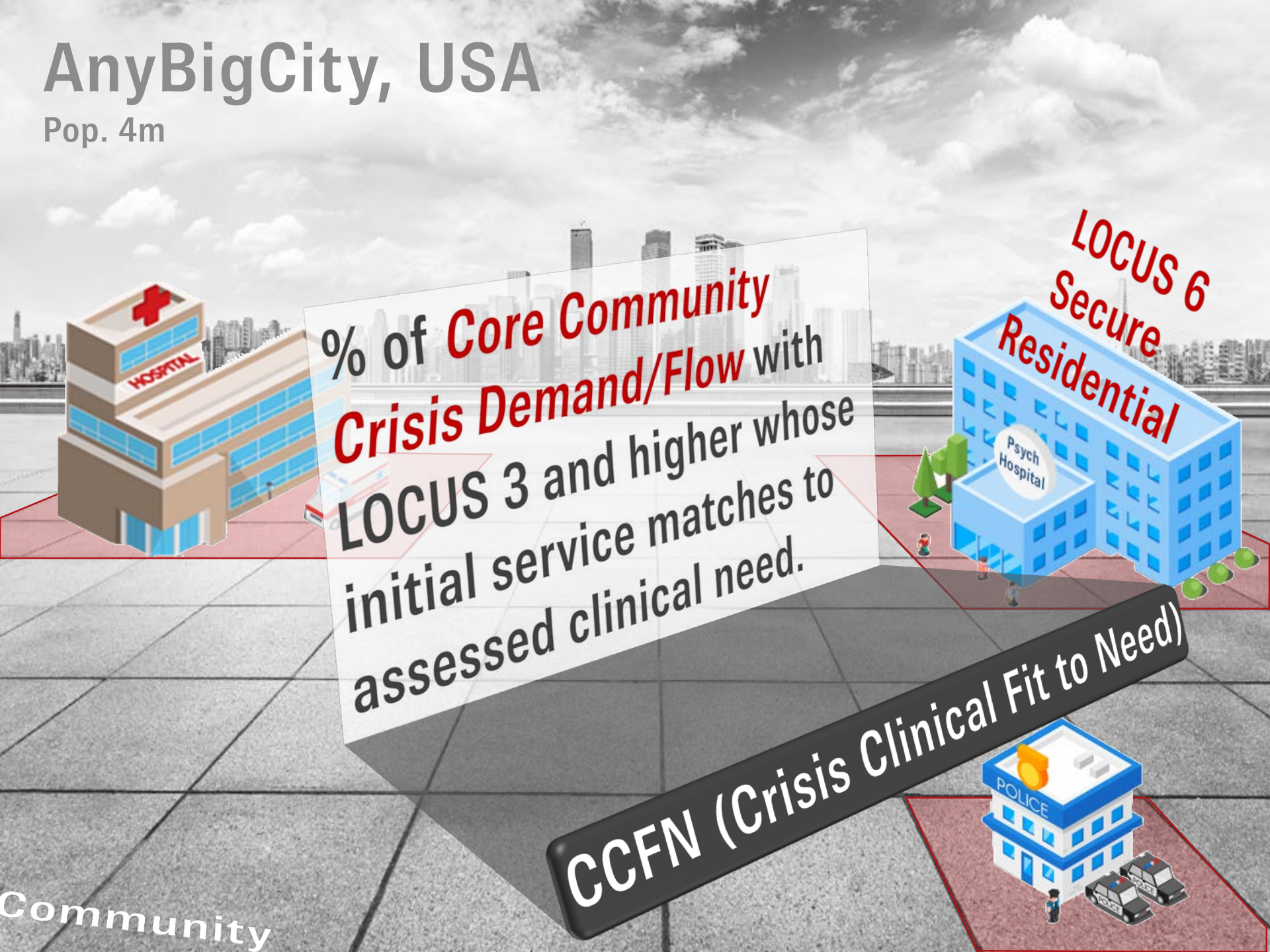
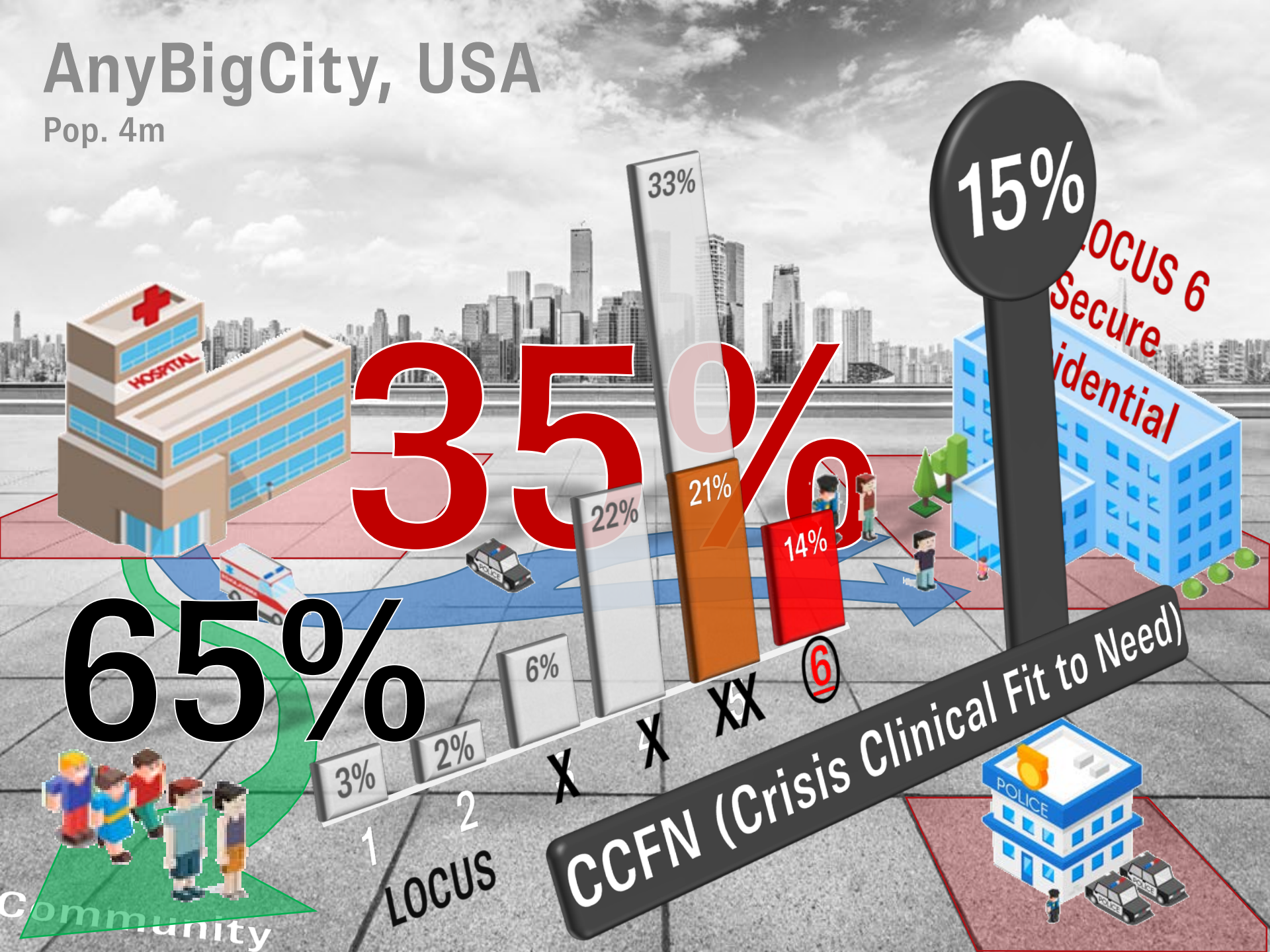
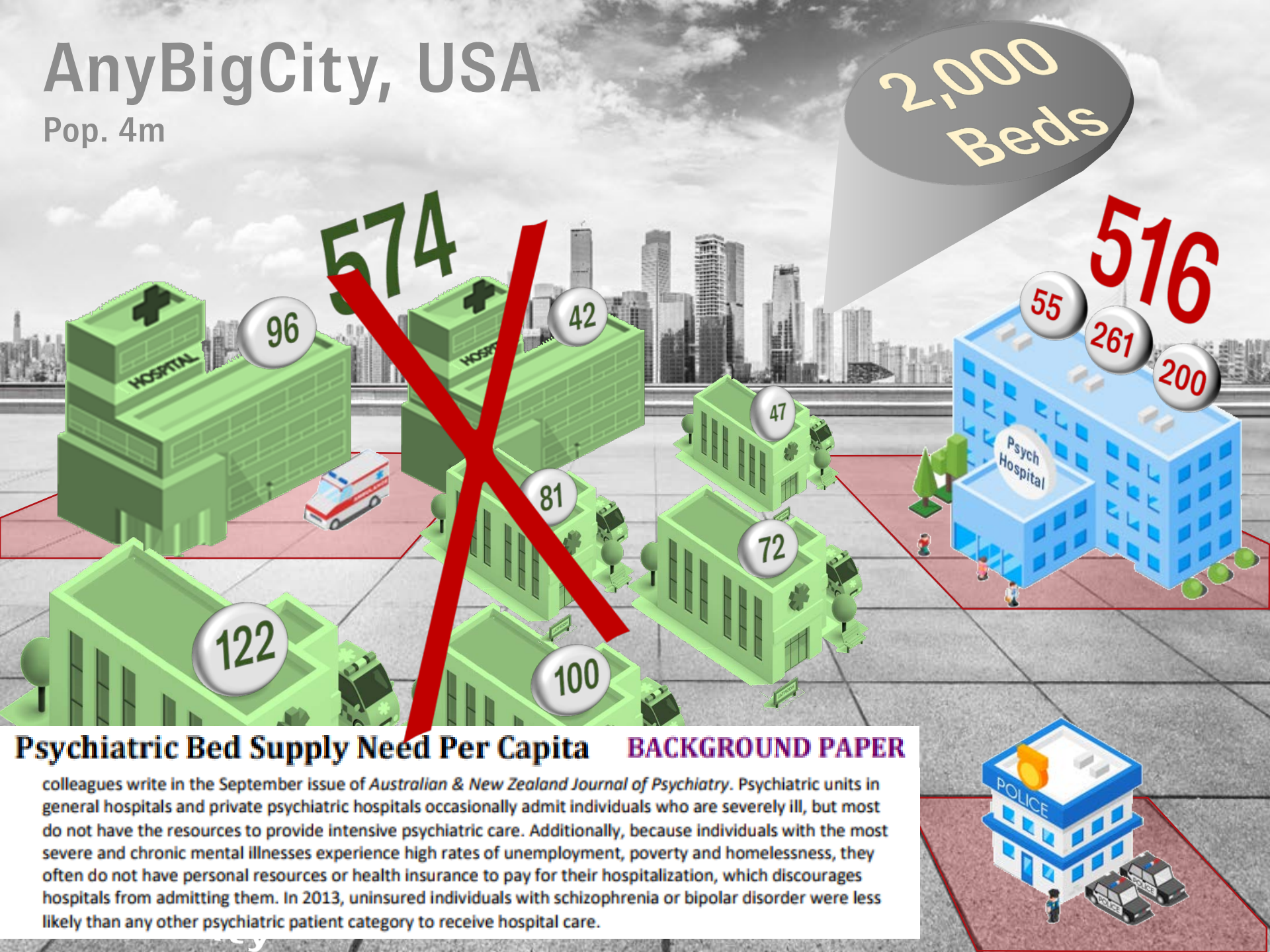
LOCUS
HOSPITAL
POLICE
Community


AnyBigCity, USA
Pop. 4m
% of Core Community Crisis Demand/Flow with LOCUS 3 and higher whose initial service matches to assessed clinical need.
LOCUS 6 Secure Residential
Psych Hospital
HOSPITAL
POLICE
CCFN (Crisis Clinical Fit to Need)
Community


AnyBigCity, USA
Pop. 4m
HOSPITAL
35%
65%
3%
2%
6%
22%
33%
21%
14%
1
2
LOCUS
X
X
XX
6
15%
LOCUS 6
Secure
idential
CCFN (Crisis Clinical Fit to Need)
POLICE
POLICE
Community


Bed Days Per Month
57792
Unique Persons Served Per Month
2601
Crisis Now Calculator
OFF
AC
MRC
M-
M+
÷
7
8
9
×
4
5
6
−
1
2
3
+
0
.
=
Bed Capacity
2000
Readmission Rate
10%
ALOS
20
Occupancy %
95%
Compute



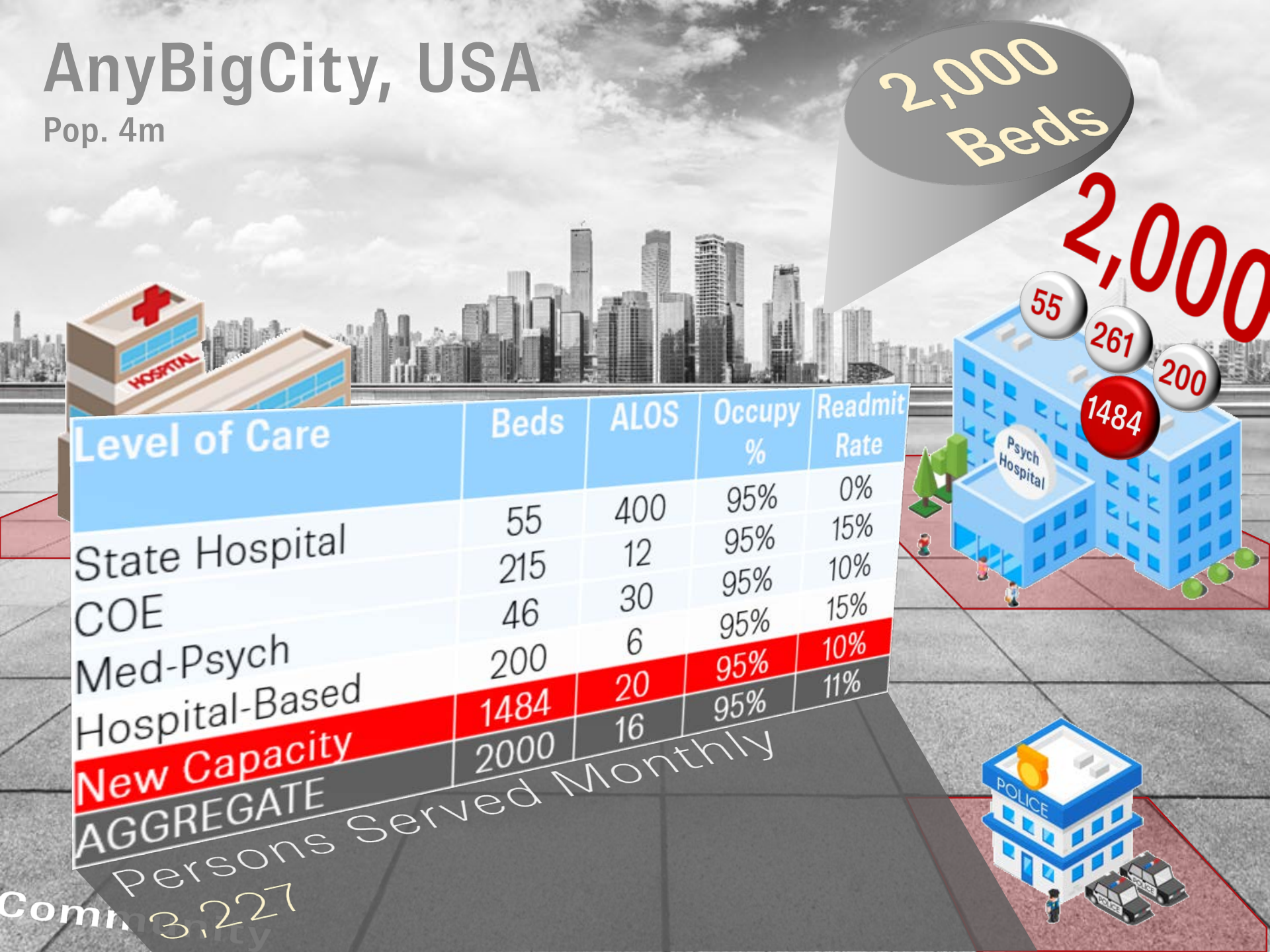
Psychiatric Bed Supply Need Per Capita

BACKGROUND PAPER

colleagues write in the September issue of *Australian & New Zealand Journal of Psychiatry*. Psychiatric units in general hospitals and private psychiatric hospitals occasionally admit individuals who are severely ill, but most do not have the resources to provide intensive psychiatric care. Additionally, because individuals with the most severe and chronic mental illnesses experience high rates of unemployment, poverty and homelessness, they often do not have personal resources or health insurance to pay for their hospitalization, which discourages hospitals from admitting them. In 2013, uninsured individuals with schizophrenia or bipolar disorder were less likely than any other psychiatric patient category to receive hospital care.

AnyBigCity, USA

Pop. 4m



Level of Care	Beds	ALOS	Occupy %	Readmit Rate
State Hospital	55	400	95%	0%
COE	215	12	95%	15%
Med-Psych	46	30	95%	10%
Hospital-Based	200	6	95%	15%
New Capacity	1484	20	95%	10%
AGGREGATE	2000	16	95%	11%

Persons Served Monthly

3,227

Comm

AnyBigCity, USA

Pop. 4m

What does it cost per year?

Model #2

Crisis Now Continuum

In the Second Model, add the principle services of the Crisis Now Continuum: a Crisis Call Center, Mobile Crisis and Crisis Facility Services

Crisis Call Center

Mobile Crisis

Crisis Facilities

Outpatient

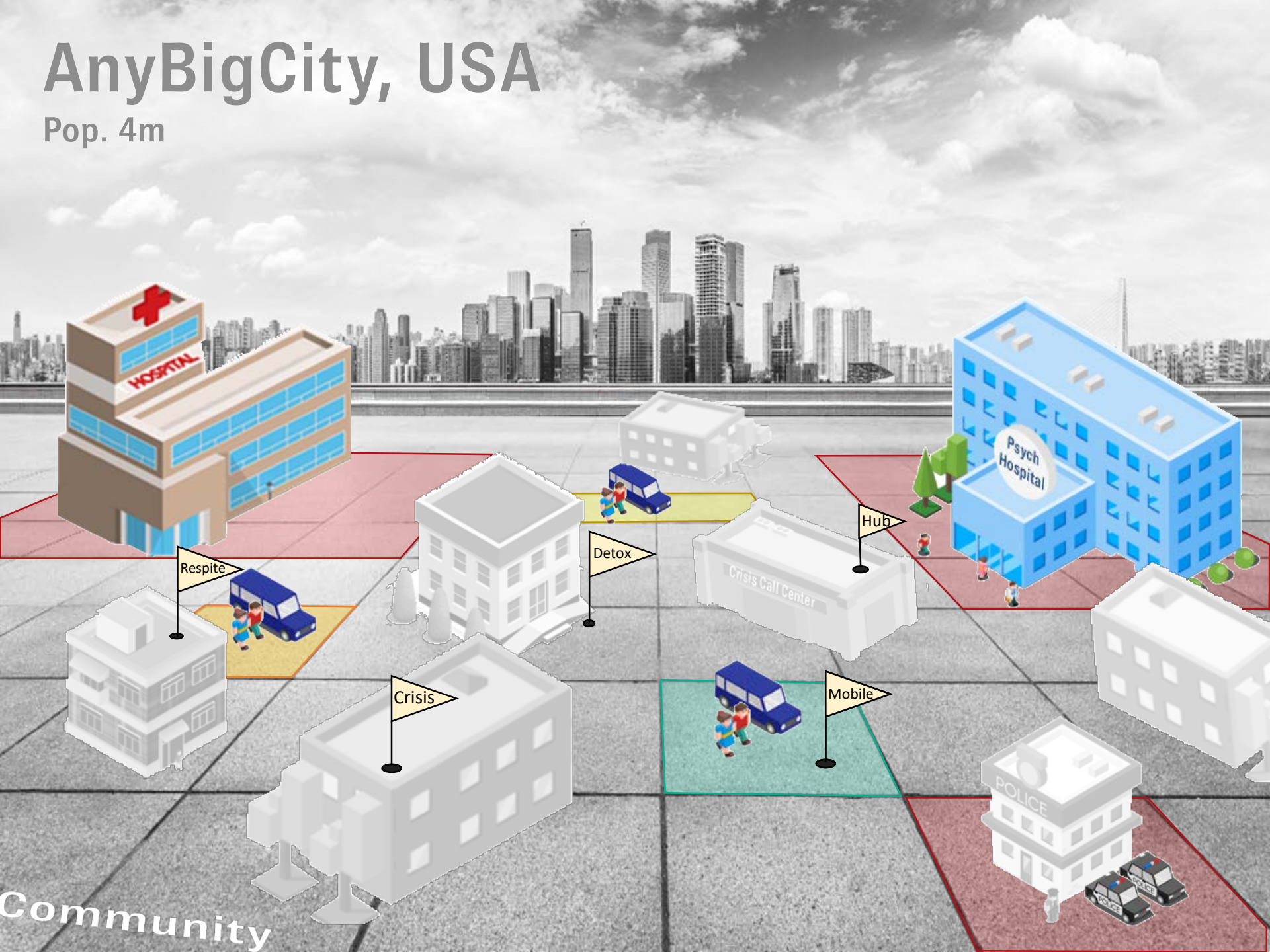
Inpatient

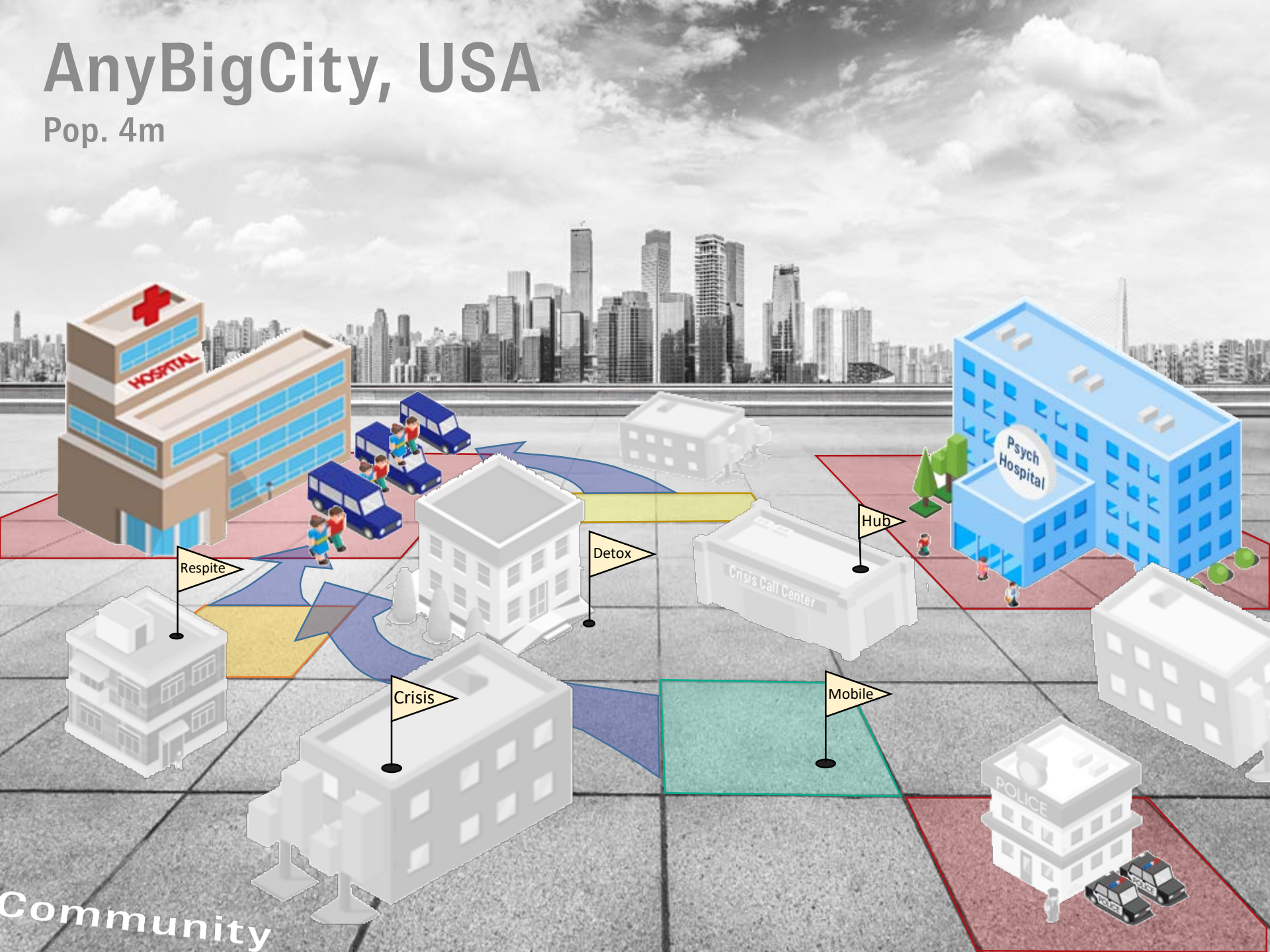
The Crisis Now Continuum


AnyBigCity, USA
Pop. 4m
HOSPITAL
Psych Hospital
Respite
Detox
Hub
Crisis Call Center
Crisis
Mobile
POLICE
Community

AnyBigCity, USA

Pop. 4m

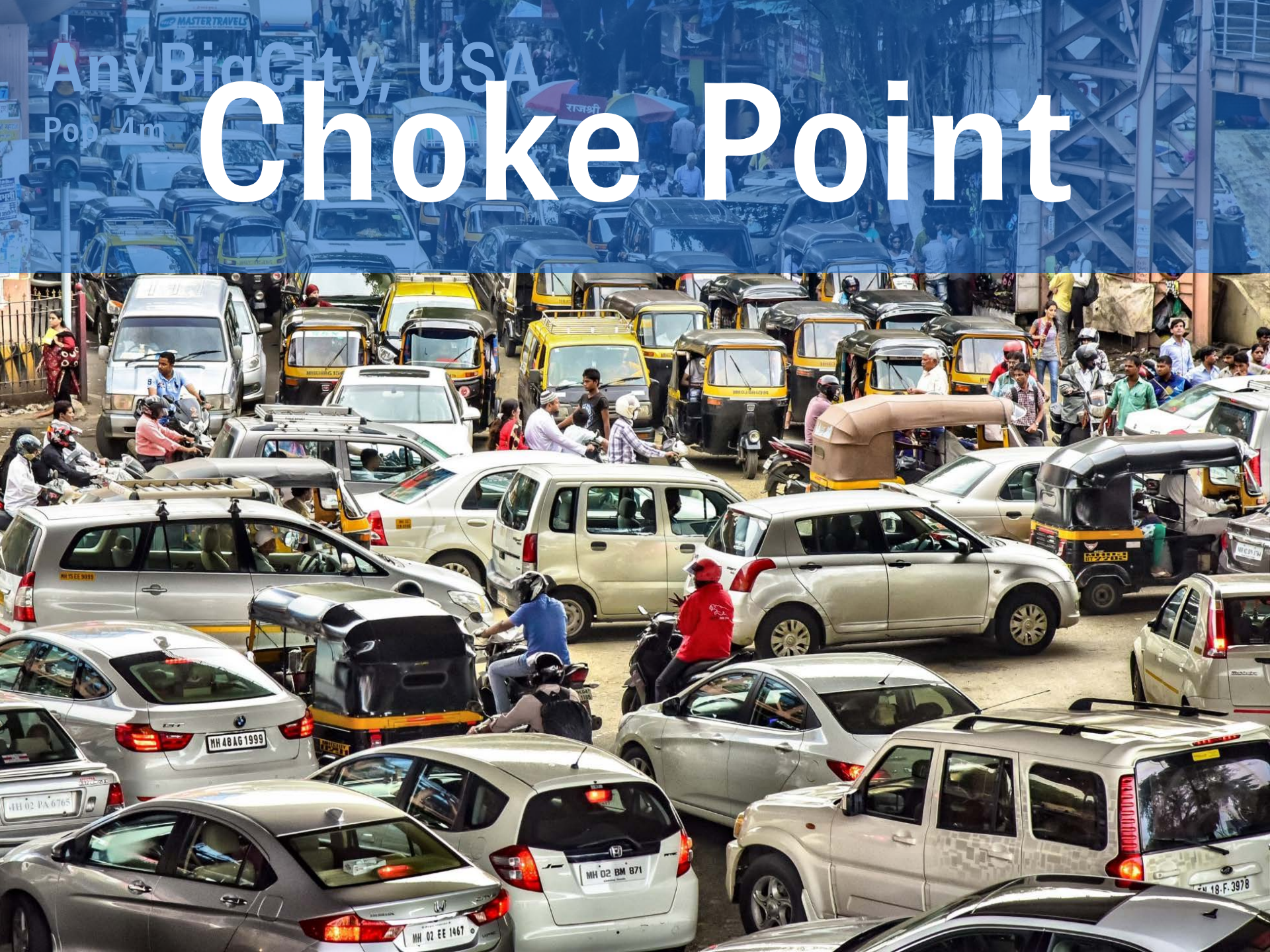

AnyBigCity, USA
Pop. 4m
HOSPITAL
Respite
Detox
Crisis Call Center
Hub
Psych Hospital
Crisis
Mobile
POLICE
Community


AnyBigCity, USA
Pop. 4m
HOSPITAL
Respite
Detox
Crisis
Hub
Mobile
Psych Hospital
Crisis Call Center
POLICE
Community

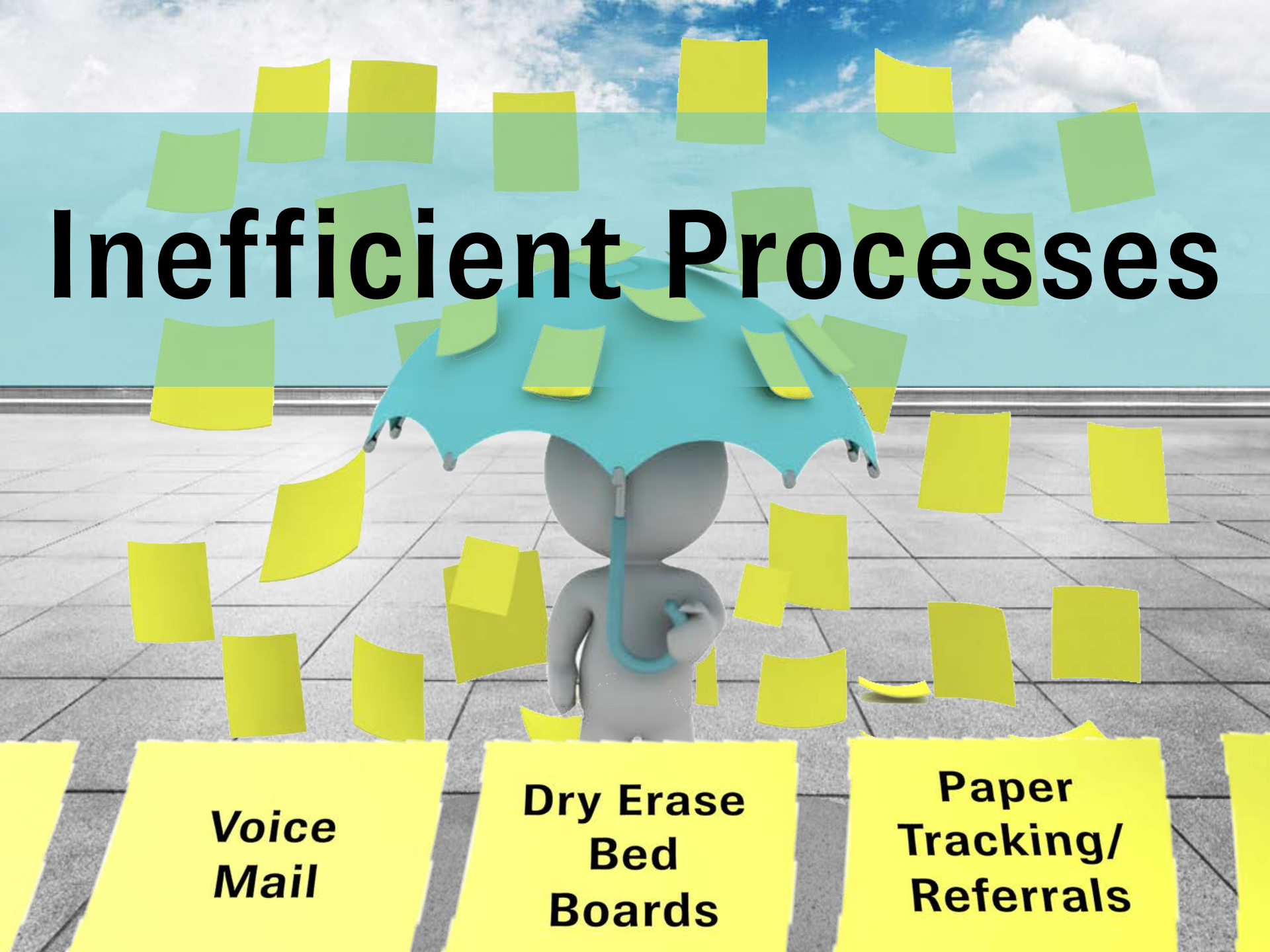
AnyBigCity, USA

Pop. 4m

Choke Point



Inefficient Processes



Model #3

Crisis Now System

In the Third Model, fully deploy the principle practices of the Crisis Now System and add Crisis Navigator and a 24/7 Outpatient Clinic

Real Time Data Exchange

Meet at Their Location

Immediate Police Drop Off

Outpatient

Inpatient

The Crisis Now System


AnyBigCity, USA
Pop. 4m
HOSPITAL
Psych Hospital
Crisis Call Center
POLICE
Respite
Detox
Hub
Crisis
Mobile
Community

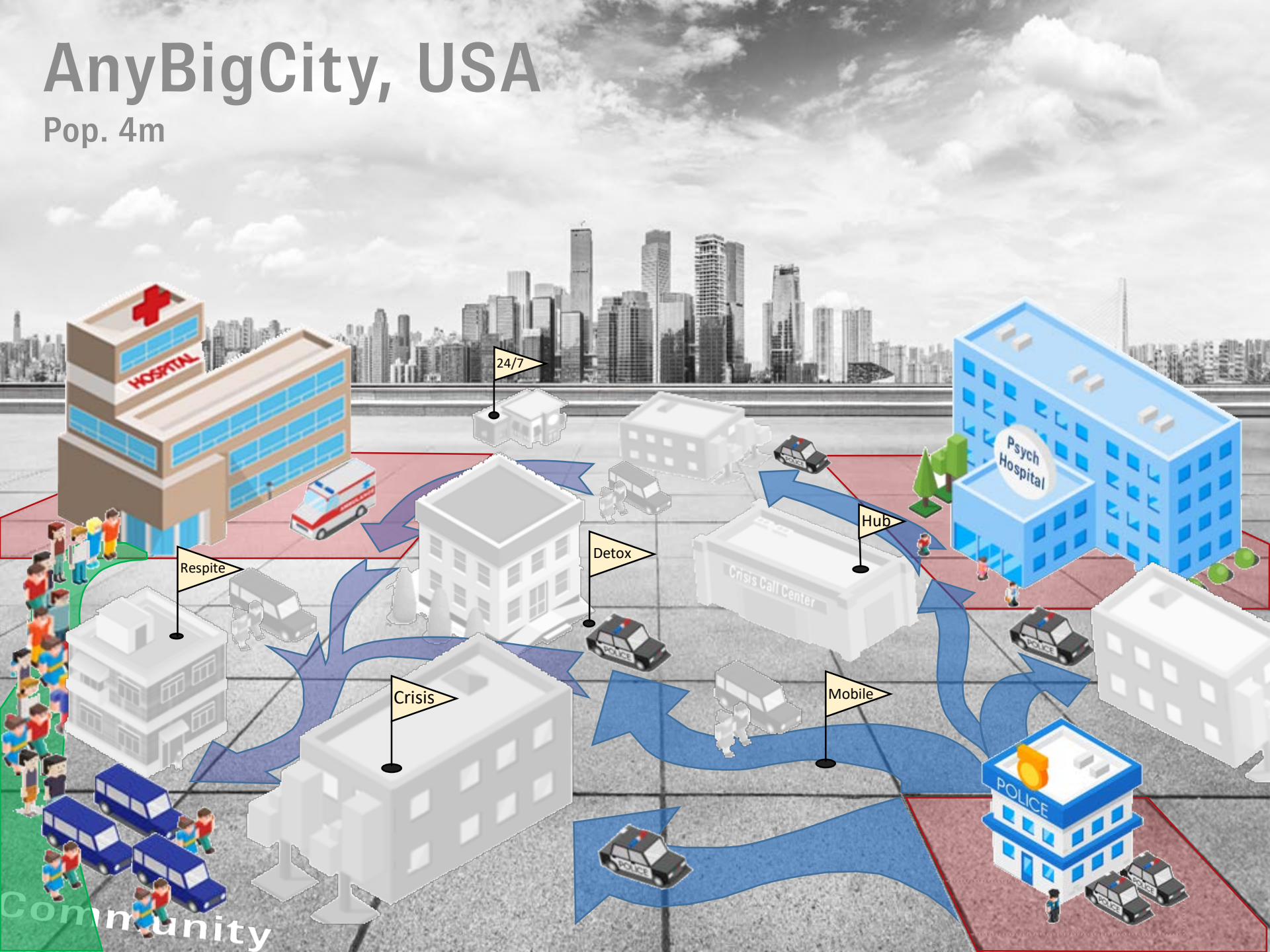

AnyBigCity, USA
Pop. 4m
HOSPITAL
24/7
Navigator
Respite
Detox
Hub
Psych Hospital
Crisis Call Center
Crisis
Mobile
POLICE
Community

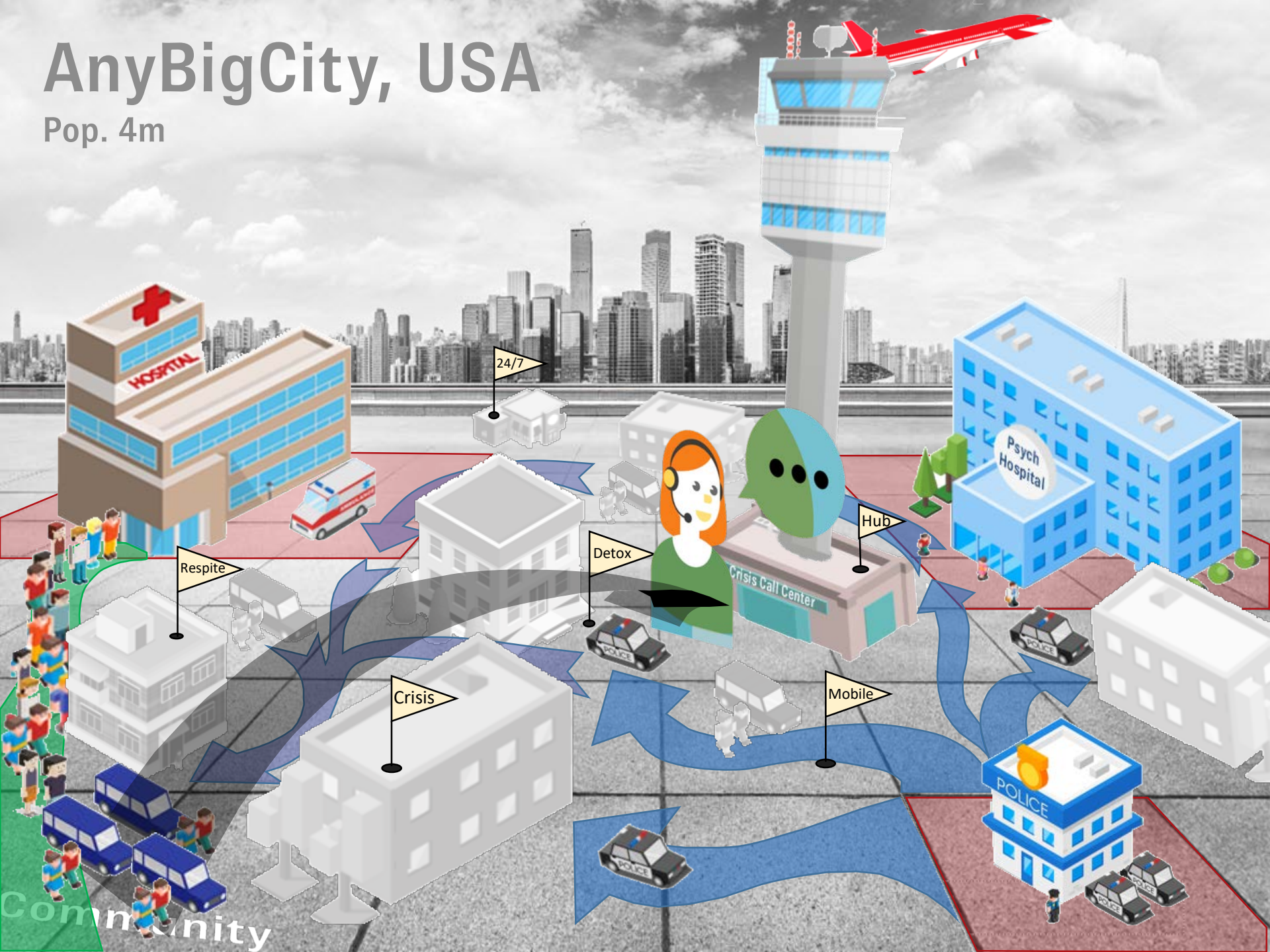
AnyBigCity, USA

Pop. 4m

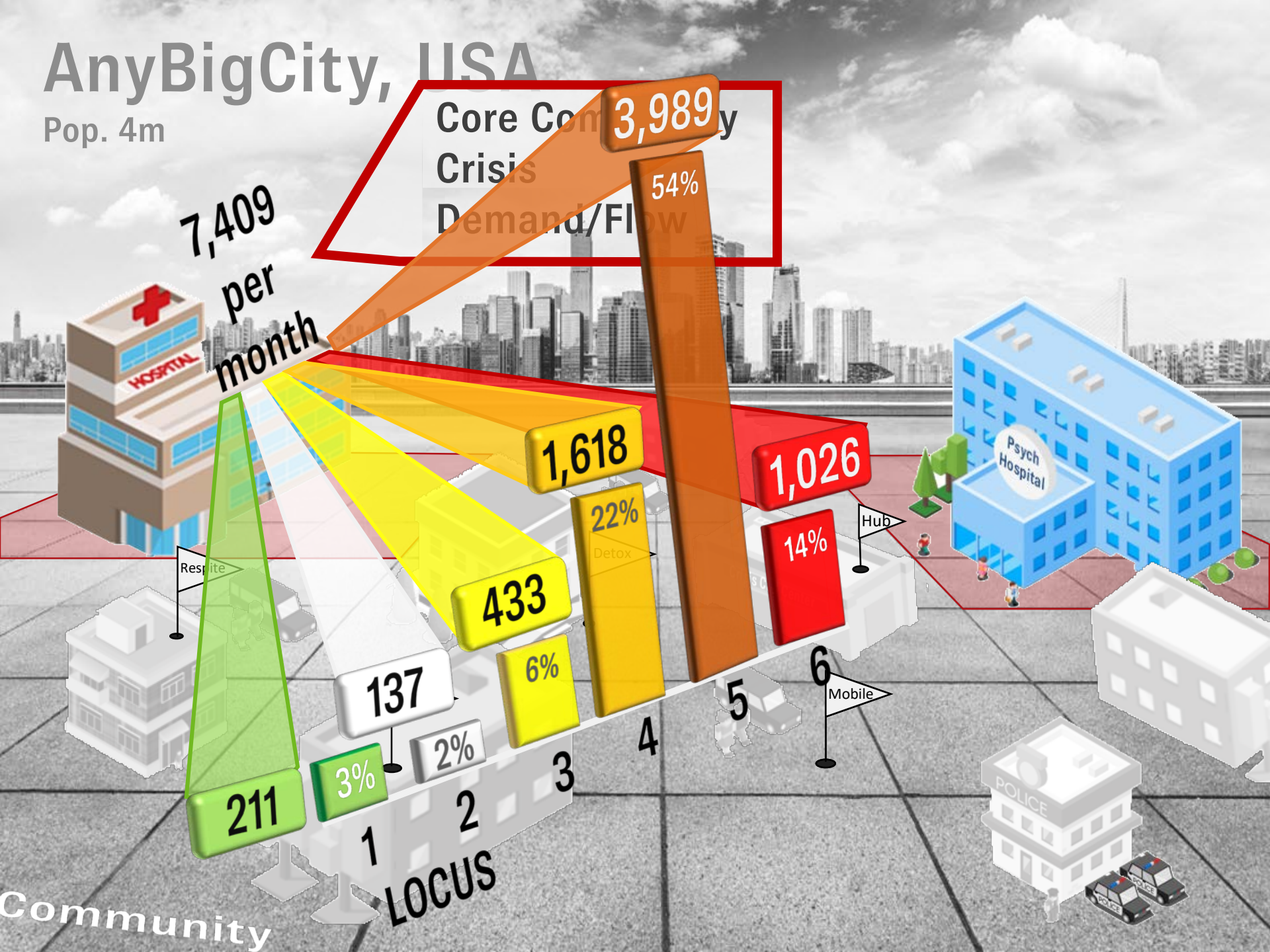
AnyBigCity, USA

Pop. 4m

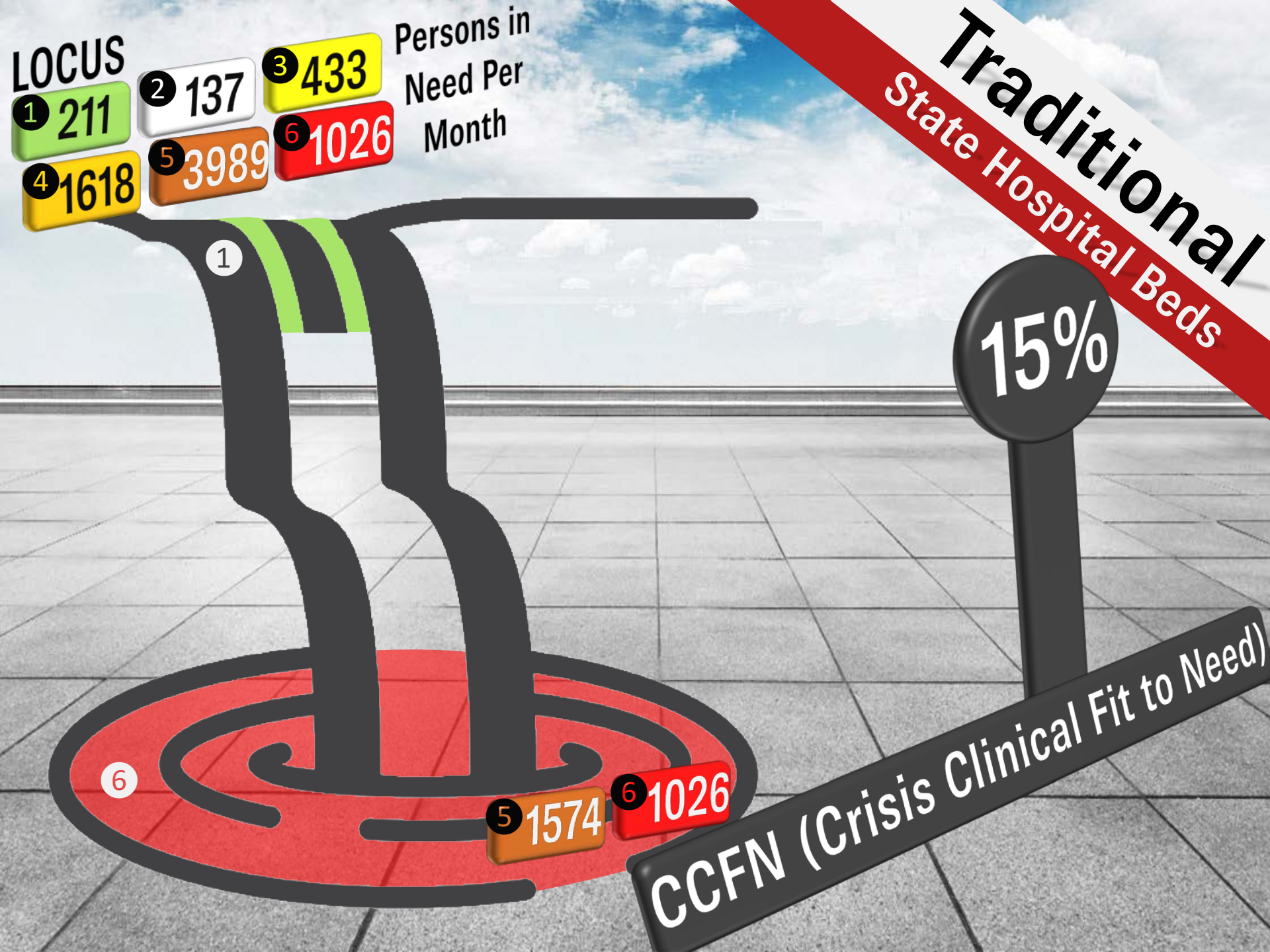


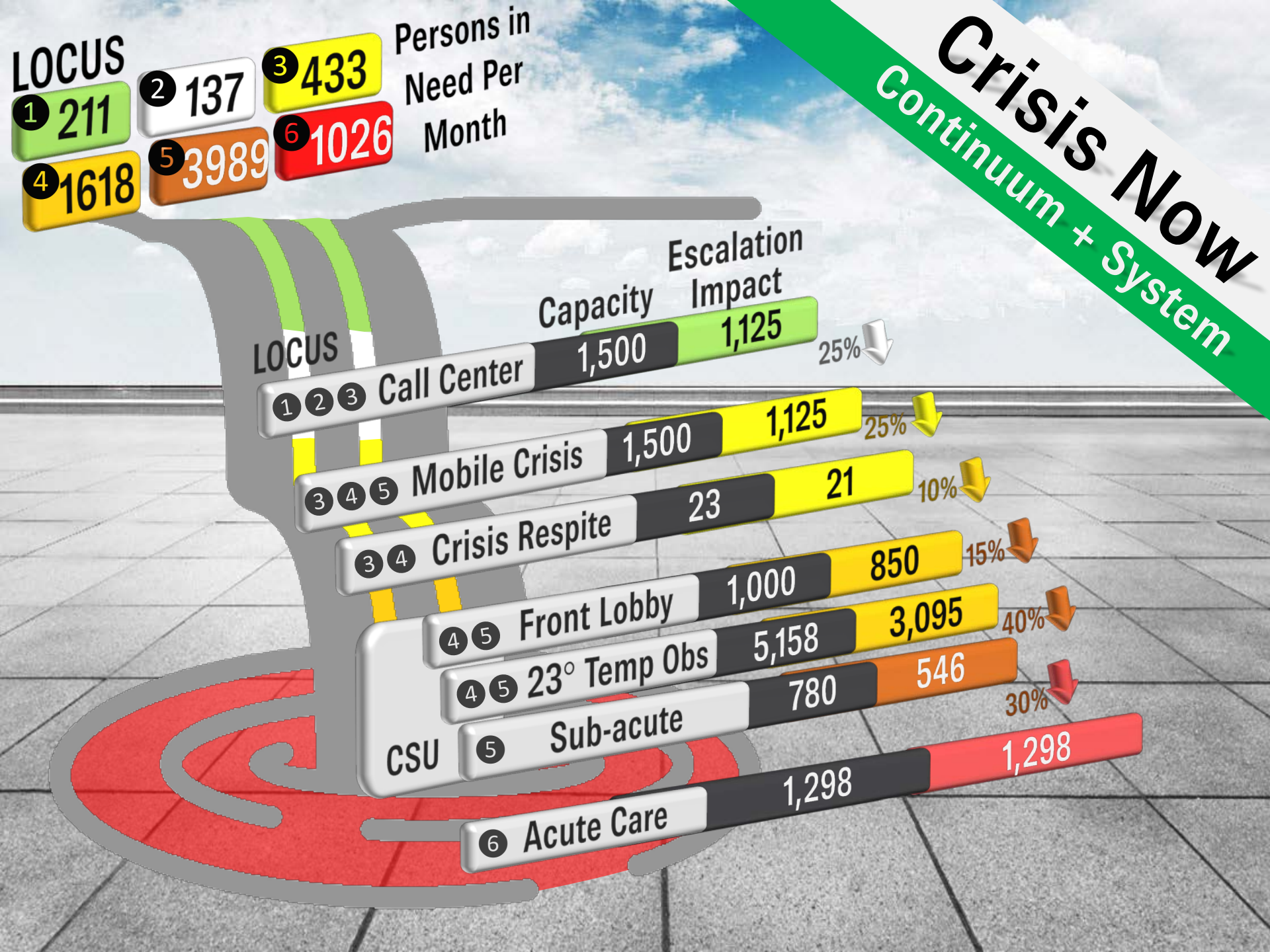

AnyBigCity, USA
Pop. 4m
HOSPITAL
24/7
Psych Hospital
Hub
Detox
Respite
Crisis Call Center
Crisis
Mobile
POLICE
Community

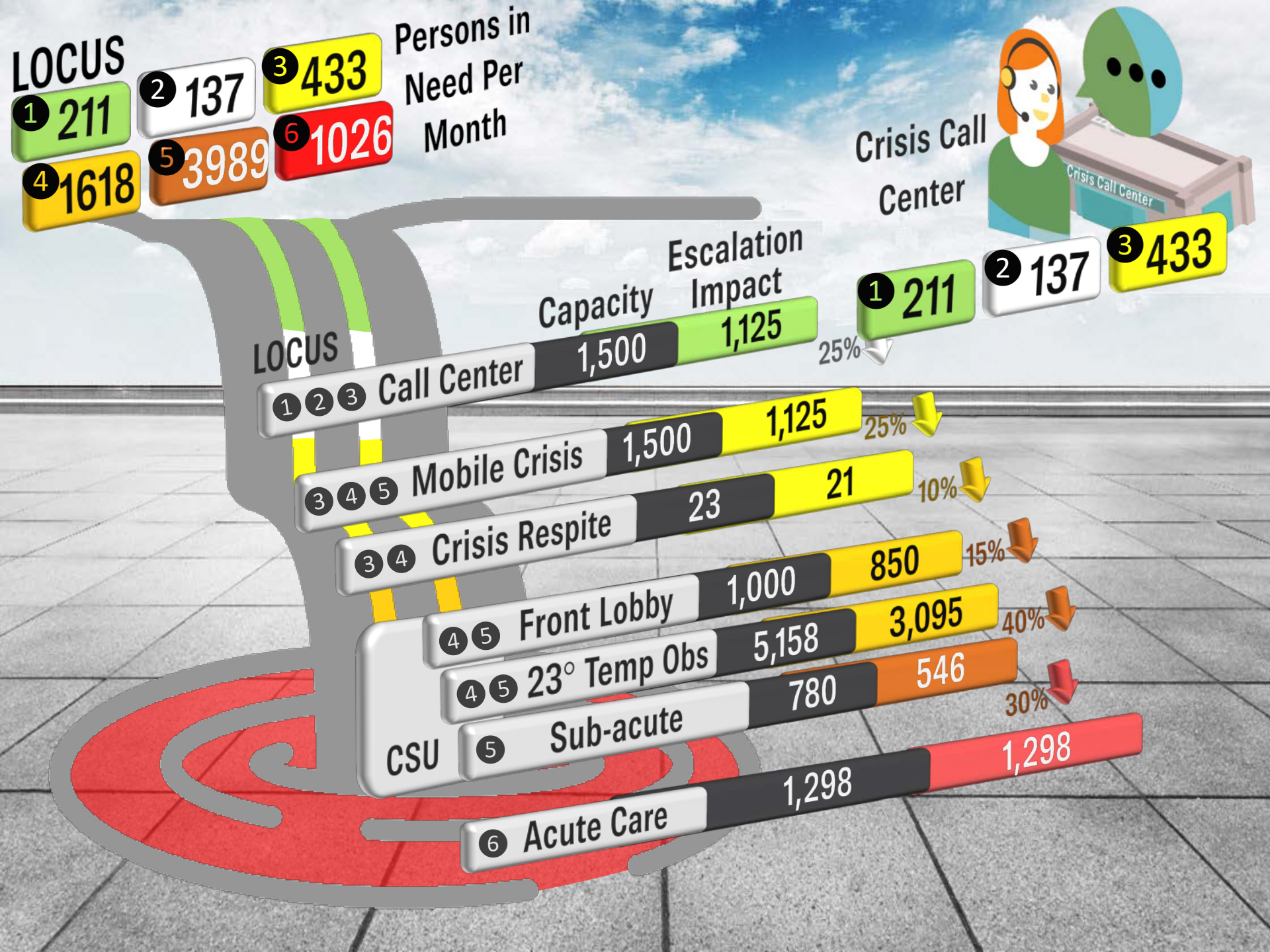

AnyBigCity, USA
Pop. 4m
Throughput

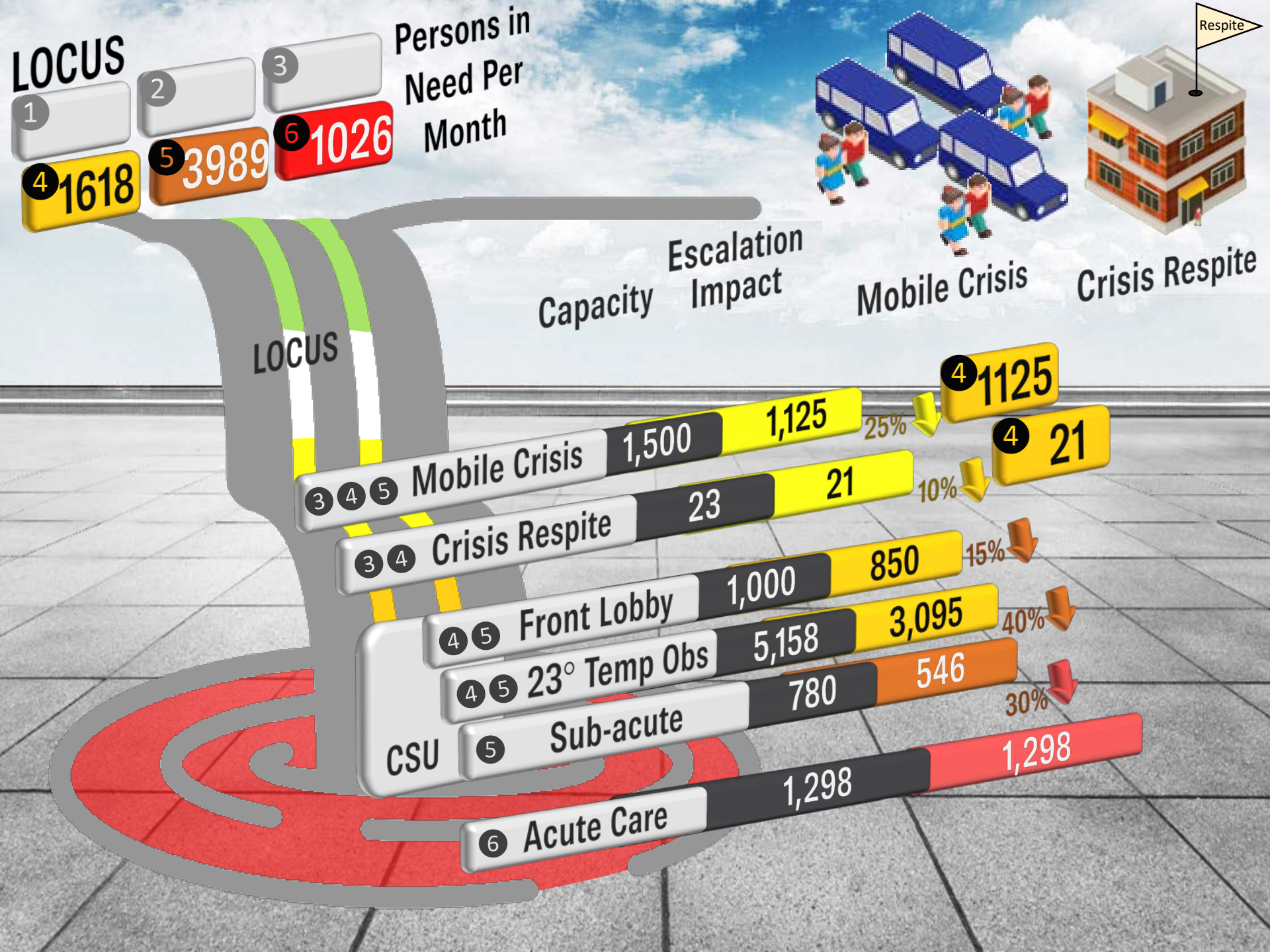

AnyBigCity, USA
Pop. 4m
Core Co y
Crisis
Demand/Fl w
7,409
per
month
3,989
54%
1,618
22%
Detox
1,026
14%
433
6%
137
2%
211
3%
1
2
3
4
5
6
LOCUS
Community
Respite
Hub
Mobile
HOSPITAL
Psych
Hospital
POLICE

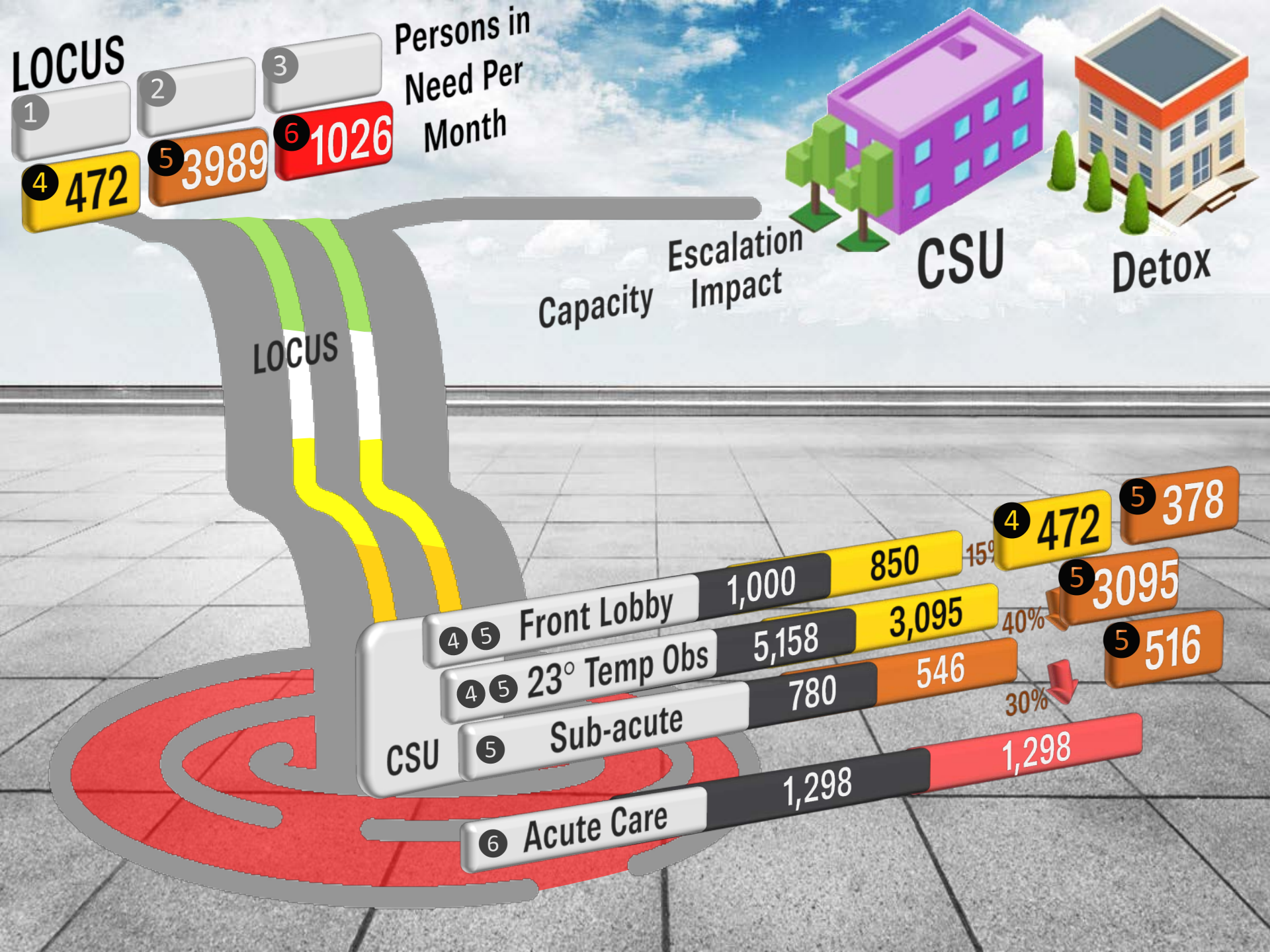

LOCUS
1 211
2 137
3 433
4 1618
5 3989
6 1026
Persons in Need Per Month
1
2
3
4
5
6

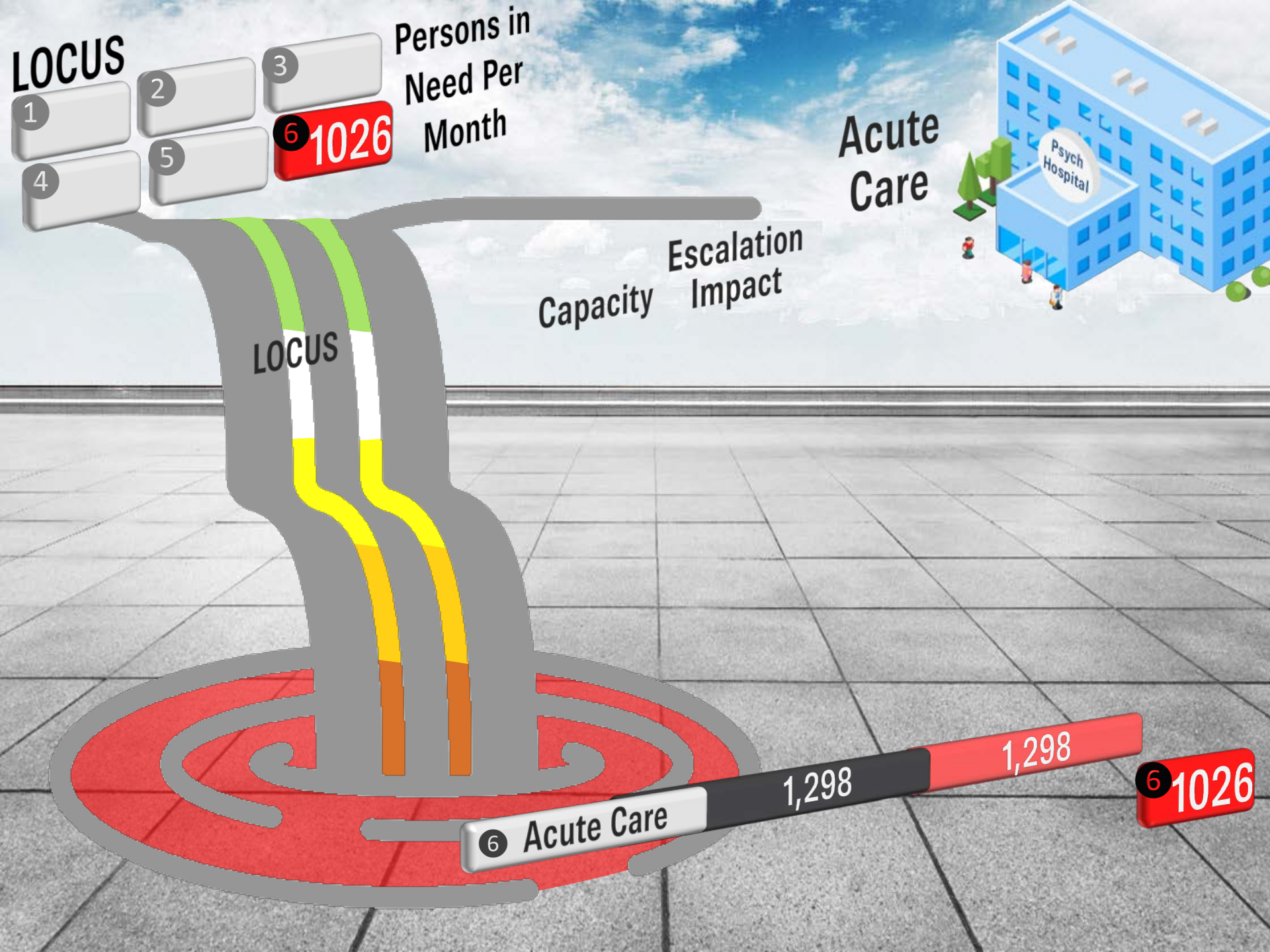

LOCUS
1 211
2 137
3 433
4 1618
5 3989
6 1026
Persons in Need Per Month
Traditional
State Hospital Beds
15%
CCFN (Crisis Clinical Fit to Need)
1
6
5 1574
6 1026

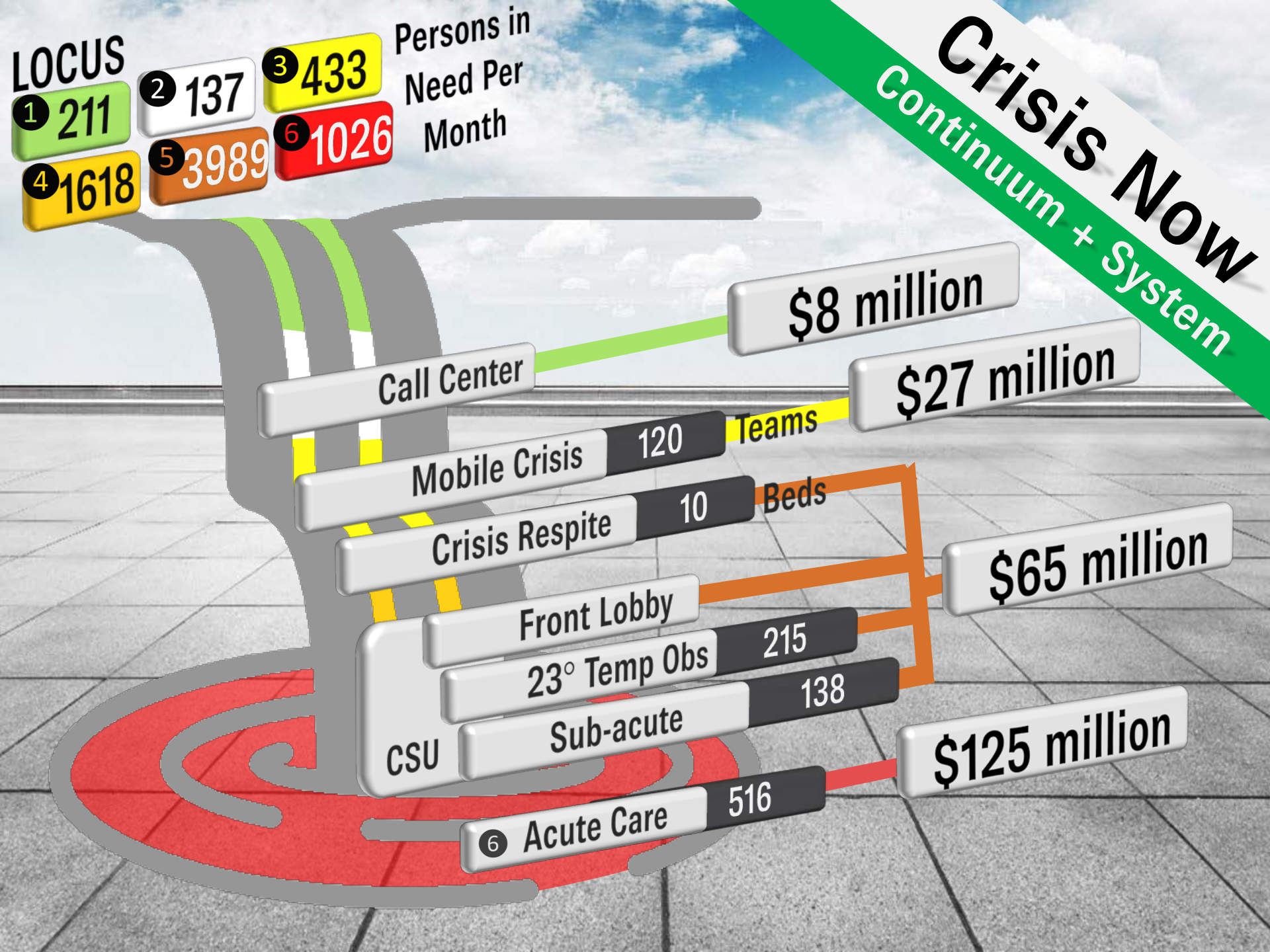

LOCUS
1 211
2 137
3 433
4 1618
5 3989
6 1026
Persons in Need Per Month
Crisis Now
Continuum + System
LOCUS
Capacity
Escalation Impact
1 2 3 Call Center
1,500
1,125
25%
3 4 5 Mobile Crisis
1,500
1,125
25%
3 4 Crisis Respite
23
21
10%
4 5 Front Lobby
1,000
850
15%
4 5 23° Temp Obs
5,158
3,095
40%
CSU
5 Sub-acute
780
546
30%
6 Acute Care
1,298
1,298

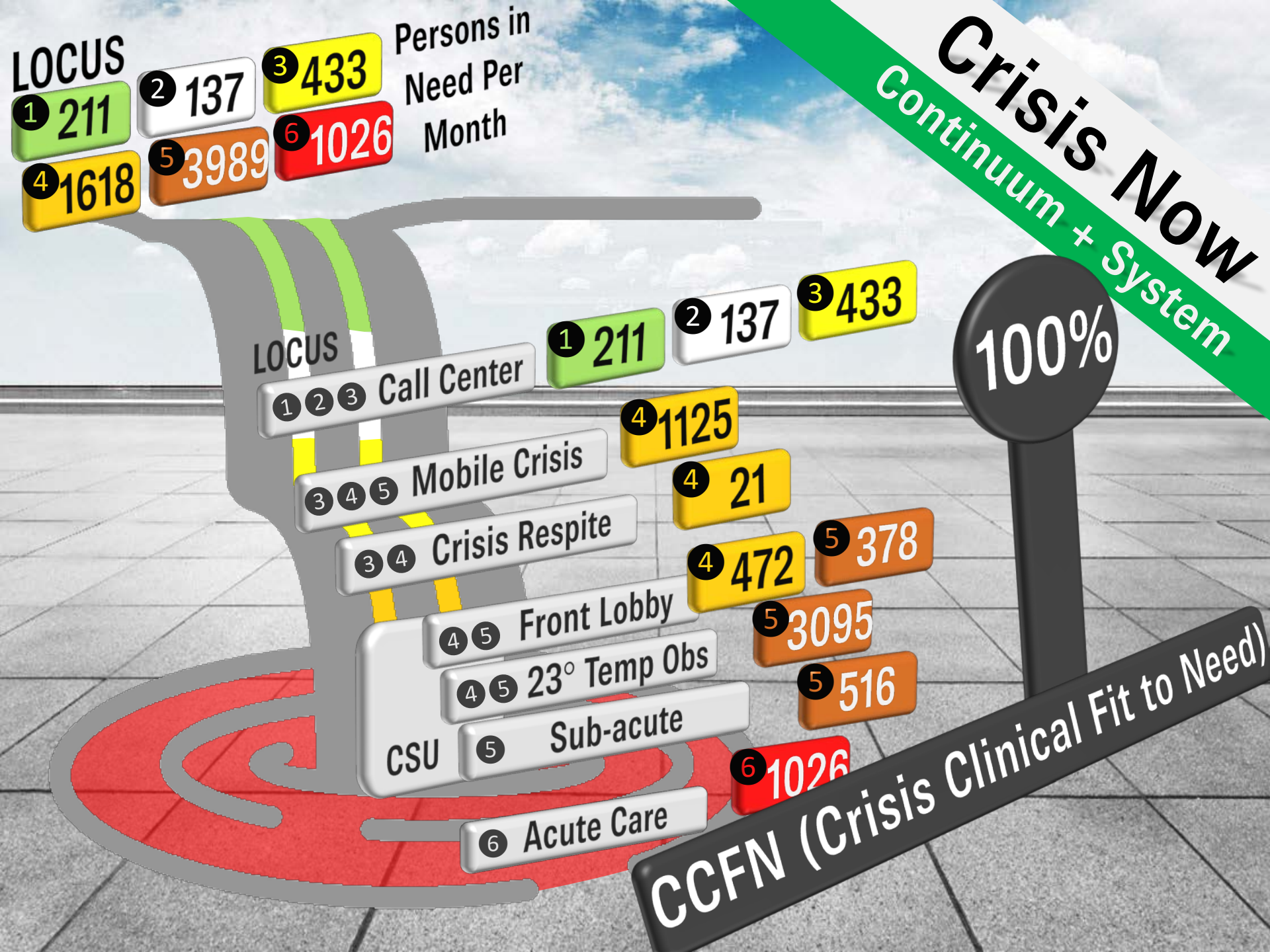

LOCUS
1 211
2 137
3 433
4 1618
5 3989
6 1026
Persons in Need Per Month
Crisis Call Center
Crisis Call Center
1 211
2 137
3 433
LOCUS
Capacity
Escalation Impact
1 2 3 Call Center
1,500
1,125
25%
3 4 5 Mobile Crisis
1,500
1,125
25%
3 4 Crisis Respite
23
21
10%
4 5 Front Lobby
1,000
850
15%
4 5 23° Temp Obs
5,158
3,095
40%
CSU
5 Sub-acute
780
546
30%
6 Acute Care
1,298
1,298

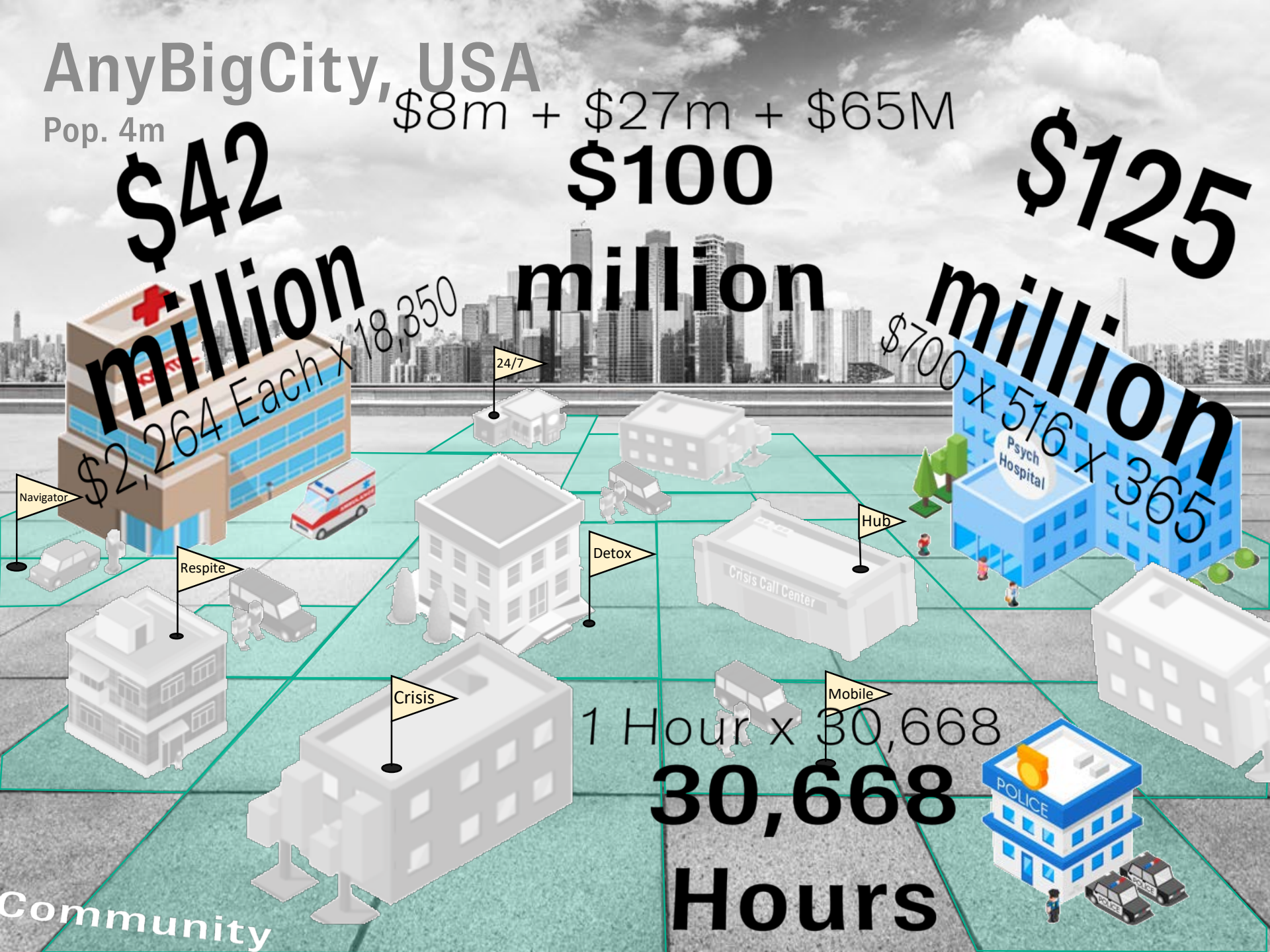

LOCUS
1
2
3
4 1618
5 3989
6 1026
Persons in Need Per Month
Capacity
Escalation Impact
Mobile Crisis
Crisis Respite
Respite
LOCUS
3 4 5 Mobile Crisis
1,500
1,125
25%
4 1125
3 4 Crisis Respite
23
21
10%
4 21
4 5 Front Lobby
1,000
850
15%
4 5 23° Temp Obs
5,158
3,095
40%
CSU
5 Sub-acute
780
546
30%
6 Acute Care
1,298
1,298


LOCUS
1
2
3
4 472
5 3989
6 1026
Persons in Need Per Month
Capacity
Escalation Impact
CSU
Detox
LOCUS
CSU
4 5 Front Lobby
1,000
850
15%
4 472
5 378
4 5 23° Temp Obs
5,158
3,095
40%
5 3095
5 Sub-acute
780
546
30%
5 516
6 Acute Care
1,298
1,298


LOCUS
1
2
3
4
5
6 1026
Persons in Need Per Month
Acute Care
Psych Hospital
Capacity
Escalation Impact
LOCUS
6 Acute Care
1,298
1,298
6 1026


LOCUS
1 211
2 137
3 433
4 1618
5 3989
6 1026
Persons in Need Per Month
Crisis Now
Continuum + System
$8 million
Call Center
$27 million
Mobile Crisis
120
Teams
Crisis Respite
10
Beds
$65 million
Front Lobby
23° Temp Obs
215
CSU
Sub-acute
138
$125 million
6 Acute Care
516


LOCUS
1 211
2 137
3 433
4 1618
5 3989
6 1026
Persons in Need Per Month
Crisis Now
Continuum + System
LOCUS
1 2 3 Call Center
1 211
2 137
3 433
3 4 5 Mobile Crisis
4 1125
3 4 Crisis Respite
4 21
4 5 Front Lobby
4 472
5 378
4 5 23° Temp Obs
5 3095
CSU
5 Sub-acute
5 516
6 Acute Care
6 1026
100%
CCFN (Crisis Clinical Fit to Need)


AnyBigCity, USA
Pop. 4m
$8m + $27m + $65M
$42 million
$2,264 Each x 18,350
$100 million
$125 million
$700 x 516 x 365
24/7
Navigator
Respite
Detox
Hub
Crisis
Mobile
Psych Hospital
Crisis Call Center
POLICE
1 Hour x 30,668
30,668 Hours
Community


Outcomes
Of Better Crisis Care

AnyBigCity, USA

Model #1	Model #2	Model #3
Traditional	Crisis Now	Crisis Now
Public Sector	Continuum	System
Inpatient Beds		

AnyBigCity, USA

Pop. 4m

Model #1

Traditional

Public Sector

Inpatient Beds

VS.

Model #3

Crisis Now

System

CCFN (Crisis Clinical Fit to Need) ↑ 567%

Everyone receives the right service.

Law Enforcement Hours ↓ 72%

Over 37 FTE Officers Freed Up

Total Costs (Hospital + BH) ↓ 53%

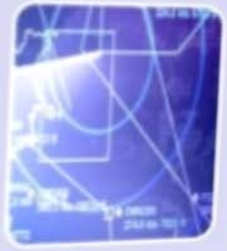
Nearly $300 Million Savings


DISABILITY RIGHTS
ARE CIVIL RIGHTS
Olmstead

How Does Your Crisis System Rate?

A Framework for State/Regional Self-Assessment

For more info see http://crisisnow.com





What makes Level 5 different?	① Call Center Hub	② Mobile Outreach	③ Sub-acute Stabilization	Crisis Now System	Level 5 System Also Conforms to 4 Modern Principles
Level 5: FULLY INTEGRATED	Real Time Access Valve Mgmt	Meets Person at Home/Apt/Street	Direct LE Drop Off <10 Min	Equal Partners 1st Responders	① Priority Focus on Safety/Security
Level 4: CLOSE	Air Traffic Control Connectivity	Adequate Access Statewide	Adequate Access Statewide	Adequate Access Statewide Plus →	② **Suicide Care Best Practices**, e.g. Systematic Screening, Safety Planning and Follow-up
Level 3: PROGRESSING	Data Sharing (Not 24/7 or Real Time)	Statewide Access but Reliant on ED	Statewide Access but Reliant on ED	Integrated System w/ Diversion Power	③ Trauma-Informed, Recovery Model
Level 2: BASIC	Formal Partnerships	Adequate Access <1 Hr Response	Adequate Access >50% Bed Available	Adequate Access Major Payers Included	④ Significant Role for Peers
Level 1: MINIMAL	Shared MOU/ Protocols	Some Availability Limited to Urban	Some Availability Limited to Urban	Limited State/ County Support	
	Agency Relationships	None or Very Limited Availability	None or Very Limited Availability	Fragmented Status Quo	

Self-assessment (View)

slideshare


CRISIS NOW
Transforming Crisis Services
CRISIS NOW
Successes in Arizona
This is Real (Watch Here)
YouTube


Eval & Tx
Occupancy Percentage
92.9
Living Room
Occupancy Percentage
82.1
& Tx
of Stay
35.3
Living Room
Length of Stay
2.95
Respite
Length of Stay
l & Tx
ble Beds
Living Room
Available Beds
CrisisTech
360
This is Real (Watch Here)
YouTube

David W. Covington, LPC, MBA
CEO & President, RI International

RI INTERNATIONAL

Q&A

Crisis Now: Transforming Services

CRISIS HEALTH RECOVERY CONSULTING