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Services and support for living well

Crisis 360 Evaluation Final Report

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Special thanks

Thank you to all those who participated in this evaluation. Without your expertise and contributions this would not have been possible.

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Table of Contents

Introduction 4
Executive Summary 6
Method of Approach 7
Literature Review 12
Key Findings 15
- Defining crisis needs and services 17
- Outcomes and pay-for-performance measures 20
- Community stabilization services 21

Recommendations 22
- Incentivized Performance Measures 23
- Contract Adjustments 24
- Service Development 26
- Engaging Individuals not previously connected to services 28
- System Partnerships 29
- Additional Recommendations 31

Conclusion 32
ATTACHMENTS 33
- A: Literature Review References 33
- B: Summary of Online Survey and Kick off Break out Group Responses 37
- C: Workgroup Member Profiles 42

Introduction

As the Regional Behavioral Health Authority (RBHA) in Maricopa County, Mercy Maricopa Integrated Care (Mercy Maricopa) is responsible for the coordination and delivery of behavioral health crisis services to the 4 million individuals living in this County, about 10 percent of whom are actively receiving behavioral health services through the RBHA.

On April 1, 2014, Mercy Maricopa Integrated Care (Mercy Maricopa) implemented their contract with the Arizona Department of Health Services (ADHS) to serve as the Regional Behavioral Health Authority (RBHA) for GSA Six, which encompasses Maricopa County, and parts of Pinal County in Arizona. This represents the largest public behavioral health system in the United States, and celebrates one of the most robust behavioral health crisis systems in the country. A key part of Mercy Maricopa's proposal to ADHS committed to undergoing a 360-degree evaluation of the GSA Six behavioral health crisis system. The goals of this evaluation are to:

1. Enhance the member and family experience
2. Address the needs of the entire community
3. Leverage available state, county, federal, and local resources to meet the community's needs
4. Maximize funding streams
5. Reduce duplicative services
6. Work together to address local issues
7. Increase availability of funding for direct services
8. Take a systematic, data-driven approach to continuously improve the responsiveness and effectiveness of the crisis system
9. Provide all community members access to a full continuum of crisis services
10. Facilitate access to appropriate, community-based services and reduce inappropriate facility-based admissions

Mercy Maricopa utilized a member-centered approach throughout the evaluation process. This model emphasizes the community crisis system as belonging to the *community* by bringing together multiple 'systems' of care and support for members. Our goal for a member-centered crisis system is to support our members in achieving recovery and resiliency through:

1. Prevention & early intervention
2. Community based care
3. Recovery focused interventions
4. Coordination among a continuum of accountable care providers
5. Stabilization in the least restrictive environment
6. Ongoing support

Mercy Maricopa operationalized these goals in the 360 evaluation by:

- Obtaining input from members, families, stakeholders, and providers
- Analyzing available data related to utilization of crisis services and member outcomes
- Collaborating with key community partners such as first responders, and hospitals
- Evaluating available performance data related to the timeliness and accessibility of crisis services as well as outcomes data

Through the evaluation process, Mercy Maricopa gathered information to inform next steps related to enhancing the crisis system for Maricopa County. This report outlines the evaluation process and the recommendations that will shape these efforts moving forward.

Executive Summary

Mercy Maricopa's facilitated a 360-degree evaluation of the community crisis system from April 2014 to August 2014. To ensure our process was as robust as possible, Mercy Maricopa convened over forty (40) stakeholders including members, families, providers and community agencies to discuss the needs of children, youth, adults and their families during a crisis episode. Our team combed through hundreds of pages of collected data including secondary literature, results from our online survey, and comprehensive notes from our facilitated evaluation activities. Based on the review and analysis of the data, key findings and recommendations were identified to better support our members. Recommendations were broken into the following categories:

- Incentivized performance measures
- Contract adjustments
- Service development
- Engaging individuals not previously enrolled in services
- System partnerships
- Additional recommendations

Specific recommendations related to these areas are presented in the following narrative. Mercy Maricopa will use this information to inform its efforts to enhance the crisis system moving forward.

Method of Approach

Mercy Maricopa's emphasis on the crisis system began in 2012 while preparing our bid for the GSA 6 Regional Behavioral Health Authority (RBHA) Request for Proposal (RFP) . During this period of time, we met with numerous crisis service and outpatient providers to identify strengths and opportunities for the crisis system. These include:

- Aurora Behavioral Health
- Banner Hospitals
- CHOICES Network
- Community Bridges
- Comtrans
- Connections Arizona
- Crisis Preparation and Recovery
- Crisis Response Network
- EMPACT-SPC
- Jewish Family and Children's Services
- Maricopa Integrated Health System
- Mountain Health and Wellness
- National Alliance of the Mentally Ill (NAMI), Arizona
- Partners in Recovery
- People of Color Network
- Quality Care Network
- Recovery Empowerment Network (REN)
- Recovery Innovations of Arizona
- St. Joseph's Hospital
- St. Luke's Behavioral Health
- Southwest Behavioral Health
- Southwest Network
- TERROS
- Valley Hospital

These member and family-centric, provider led discussions led to the content of our bid and contributed to a strong foundation of knowledge on how the crisis system functions.

Implementation

Mercy Maricopa's commitment to crafting a member and family-centric crisis system continued throughout our implementation period as we continued to meet with providers to discuss the crisis system. During our implementation period, March 2013 – March 2014; we toured and held discussions with crisis system providers; including:

- Arizona Department of Adult Probation (ADAP)
- Arizona Department of Corrections (ADC)
- Arizona Department of Juvenile Corrections (ADJC)
- Arizona Department of Juvenile Probation (ADJP)

- Arizona Emergency Medical Services Functional Group
- Arizona Veterans Administration
- Aurora Behavioral Health
- Community Bridges
- Comprehensive Medical and Dental Plan (CMDP)
- Connections Arizona
- Department of Child Safety (formerly Child Protective Services)
- Division of Developmental Disabilities (DDD)
- Desert Vista
- Maricopa Integrated Health System
- Phoenix Fire Department
- Phoenix Police Department
- Recovery Innovations
- St Luke's Behavioral Health

Mercy Maricopa used these meetings to discuss things that were going well, opportunities to enhance the provider network, identify specific needs, and listen to their recommendations on how to enhance the crisis system for our members.

Additionally, Mercy Maricopa's Implementation Committee – comprised exclusively of peers, family members, providers and external stakeholders - was facilitated weekly from February 2014 through May 2014 to provide insight and oversight to our implementation. Crisis services and the 360 Evaluation were repeatedly discussed; committee member questions and recommendations were addressed and incorporated throughout the process.

Based on our meetings with members and providers, Mercy Maricopa developed several key policies, protocols and tools related to the crisis system during our implementation period; these include:

- Crisis Services Policy
- Provider Manual Section 3.2 Appointment Standards and Timeliness of Services
- Provider Manual Section 3.18 Pre-petition Screening, Court Ordered Evaluation, and Court Ordered Treatment
- Provider Manual Section 3.25 Behavioral Health Crisis Intervention Services
- Collaborative protocol with First Responders
- Collaborative Protocol with Arizona Department of Adult Probation
- Collaborative Protocol with Maricopa County Juvenile Probation Department
- Collaborative Protocol with Veterans Administration
- Collaborative Protocol with Arizona Department of Corrections
- Collaborative Protocol with Arizona Department of Juvenile Corrections
- Collaborative Protocol with the Division of Developmental Disabilities
- Collaborative Protocol with the Department of Child Safety
- Member services desktop protocol: Handling Crisis Calls
- Provider training curriculum related to crisis services
- Internal crisis services desktops and workflows
- Crisis communications plan

- Internal staffing pattern and job descriptions

Crisis 360 Evaluation

Mercy Maricopa committed to initiate our 360-degree evaluation of the crisis system on 'day 1 ½.' After going live on April 1, 2014, the first internal meeting to discuss our formal approach was held on April 14, 2014.

Literature Review

Mercy Maricopa underwent an extensive review of literature including local, national and international best practices, policies, and empirical research. This review provided opportunity for Mercy Maricopa to discuss and share exemplary models throughout our 360 evaluation. This review also laid a strong foundation of knowledge for our team to build upon and inform discussions. A summary the literature is included under 'key findings' of this report.

Online Survey

Mercy Maricopa implemented an online survey and asked our providers and stakeholders to 'share widely' in an effort to collect as much information and feedback as possible. We disseminated this survey to all individuals that participated in focus groups and encouraged them to send the survey link to other system stakeholders. This online survey asked open-ended questions and did not limit the length of responses, allowing for as much text as participants wanted to provide. Questions included:

1. In your opinion, where does the crisis system begin and end?
2. What are the innovative best practices currently used within the Maricopa County Crisis System?
3. What are the top three strengths of the Maricopa County Crisis System?
4. What are the tope three opportunities for improvement within the Maricopa County Crisis System?
5. What service gaps exist within the Maricopa County Crisis System?
6. Please share any additional thoughts or considerations regarding the Maricopa County Crisis System.

This online survey collected thirty-two (32) responses from anonymous sources. Results were analyzed by our facilitators and shared with the workgroup to guide the discussions that followed.

Kick-off

On May 14, 2014 a group of forty (40) peers, family members, community stakeholders, contracted providers and representatives from ADHS convened for a half-day of facilitated discussion to formally kick off the 360 evaluation process.

Participants were provided an overview of the evaluation process and were broken in to groups, each with a facilitator to guide them through the questions. Each group was asked to answer the following questions:

- Have you had a personal experience with the crisis system? What was that experience like?
- What are the ideal outcomes of an effective crisis system?
- What innovative models of crisis services have you seen nationally and internationally?
- What are the critical components of an effective crisis system
- What are the top three things the Maricopa County crisis system has done exceptionally well?
- What are the top three opportunities for the Maricopa County crisis system to improve?
- Who are the key partners and their roles in developing and managing an effective crisis system?

Groups were then brought back together to report their responses to the questions and participate in a facilitated dialogue with the collective group of attendees. During the report out, several key themes began to emerge; the facilitators used this opportunity to further explore these themes via active feedback and probing to inform activities moving forward.

The kick-off was documented by the team of facilitators taking minutes and break out group notes captured on flip chart paper and comment cards made available to each attendee. Preliminary analysis of this data was aggregated and analyzed using empirically validated, qualitative research methods. This preliminary data was routinely revisited throughout the remainder of the evaluation in the workgroup setting.

Workgroup

Mercy Maricopa identified a cohort of peers, and subject matter experts to guide us through five (5) targeted discussions related to the crisis system. This workgroup and their affiliations included:

- Matthew Kennedy, Recovery Empowerment Network
- Nick Margiotta, Phoenix Police Department
- Christy Dye, Partners in Recovery
- Larry Vilano/Justin Chase, Crisis Response Network
- Laura Larson-Huffaker, La Frontera EMPACT-Suicide Prevention Center
- Brenda Benage, Connections Arizona
- Mike Boylan, Crisis Preparation and Recovery
- John Hogeboom, Community Bridges
- MaryJo Whitfield, Jewish Family and Children's Services

The following representatives from Mercy Maricopa staffed the workgroup:

- Don Fowls, Chief Medical Officer
- Tad Gary, Chief Clinical Officer
- Gabriella Guerra, Head of Crisis and Cultural Services
- Patti Ritchie-Williams, Crisis Manager
- Teresa Pena, Cultural Competency Administrator
- Karrie Steving, Children's System of Care Administrator

Inter-Growth consultants facilitated the workgroups:

- Sondra Stauffacher, Senior Vice President of Performance Optimization
- Robert Hess III, Senior Consultant

The workgroup convened each week for up to three hours to work through facilitated activities and discussions. The workgroup was routinely directed back to the information gathered through previous discussions. Further, they reviewed national and international models, provided constructive feedback and made recommendations to enhance the entire system. Workgroup topics included:

- Outcomes of the ideal crisis system
- Defining the crisis needs and services
- Court ordered treatment process
    - Additionally present for this session: Dr. Carol Olson (MIHS), Gene Cavallo (MIHS), Shelley Curran (Mercy Maricopa Court Liaison Administrator)

- Outcomes and pay-for-performance measures
- Community stabilization services

Wrap-up

Upon completion of the workgroups, Mercy Maricopa's team conducted review of the data collected and drafted preliminary recommendations. The workgroup was convened one final time to review the preliminary recommendations and provide feedback. This preliminary review proved critical to the successful operationalization of our recommendations.

On August 12, 2014, Mercy Maricopa invited our initial kick-off group back to review the workgroup's recommendations. Participants were provided the opportunity to seek clarification and provide feedback or offer additional considerations.

Children's System Focus Group

Throughout the evaluation process, a need for a focus group to address the specific needs of children and families was identified. Therefore, a group of providers convened on September 5, 2014 to discuss children's crisis services. This discussion highlighted the successes of the current DCS Rapid Response program and efforts to engage school staff when crisis mobile teams are dispatched to a school. Participants reinforced the need for training on complex trauma in children, implementing family supports, coordination of care between adult and children's providers when both the child and caregivers are receiving services. Participants also identified opportunities to increase coordination of care, implement respite as a preventative measure to crisis episodes, outpatient providers could offer more in-home services and to strengthen partnerships within the school system to use them as anchors for children and families in care. Recommendations from this group are included within this report.

Literature Review

Our literature review included examining service delivery models from international and national sources including: SAMHSA, American Psychological Association, the National LifeLine, and review of state models from Arizona, California, Colorado, Georgia, Hawaii, Louisiana, Minnesota, New Mexico, Oklahoma, Pennsylvania, Texas and Washington, and Wisconsin. Key findings include:

Crisis Episodes and Services

- National strategy for suicide prevention emphasizes that suicide prevention should be: (a) in the community where the person interacts with family members, friends, physicians, and others, (b) proactive screening should be happening via the primary care provider (U.S. Department of Health and Human Services, Office of the Surgeon General, National Action Alliance for Suicide Prevention, 2012).
- Individuals in crisis need accesses to appropriate medications, including emergency medications (American Psychological Association, 2002).
- In 2010, 2.2 million hospitalizations and 5.3 million emergency department visits involved a diagnosis related to a mental health condition (Agency for Healthcare Research and Quality, 2010).
- Factors that increase the risk of crisis include: poverty, unstable housing, coexisting substance use, and other physical health problems associated with mental illness (SAMHSA, 2009).
- Crisis Intervention Training for first responders, including Police officers is the impetus for reducing unnecessary incarceration (Saint Elizabeth, unknown)
- All crisis services must incorporate the recovery model; defined as: an ongoing personal process of empowerment by which an individual overcomes the negative impact of psychiatric disability (and other co-occurring disabilities), regains hope, self-esteem, self-worth, pride, dignity and meaning by acquiring increasing ability to maintain stabilization or remission of the disorder. Functioning is maximized with appropriate supports despite the possible ongoing constraints of the disorder during period of relapse/crisis (State of Hawaii, 2003).
- Organized efforts will have the greatest impact in (a) structuring funding so it is person-centered, (b) addressing stigma among service providers that limit respect for peer support specialists, (c) shift from politically focused funding to a funding model that doesn't separate mental health from other health services (Milwaukee County Mental Health Redesign and Implementation Task Force, 2014).
- Ten essential values of mental health crisis: (1) avoiding harm, (2) intervening in person-centered ways, (3) shared responsibility, (4) addressing trauma, (5) establishing feelings of personal safety, (6) based on strengths, (7) the whole person, (8) the person as a credible source, (9) recovery, resiliency, and natural supports, (10) prevention (SAMHSA, 2009).
- Infrastructure for effective crisis intervention: (a) staff that is appropriately trained and that has demonstrated competence, (b) staff and leadership that understand, accept, and promote the concepts of recovery and resiliency, (c) staff that has timely access to critical information, (d) staff that is afforded the flexibility and the resources, (e) staff that is empowered to work in partnership with individual being served, (f) an organized culture that does not isolate its programs or its staff (g) coordination and collaboration with outside entities, (h) rigorous performance-improvement programs (SAMHSA, 2009).
- The net benefit for mental health crisis stabilization services is approximately $2.16 for every dollar invested (Wilder Research, 2013). Acute treatment episode costs in residential crisis settings are 44% lower than in general hospitals (Fenton, et al, 2002). Crisis mobile teams cost 23% less per intervention than police interventions (Scott, 2000).

- Federal Agencies providing funding for mental health crisis include: Department of Veterans Affairs (VA), Department of Defense (DoD), Substance Abuse Mental Health Services Administration (SAMHSA), Health Resources and Services Administration (HRSA), and Centers for Medicare and Medicaid (CMS) (National Association of State Mental Health Program Directors Research Institute, Inc., 2012)

Call Center

- Call center staff training includes: applied suicide intervention skills training (ASIST), lethality assessments, basics of Dialectical Behavior Therapy (DBT), basic counseling skills, community resources, call protocols, data entry and clinical documentation, mandated reporting protocols, mental health issues, substance abuse, child abuse, sexual abuse, domestic violence, LGBTQ issues and cultural diversity. Training should also include shadowing experienced crisis specialists on crisis calls and independently answering calls under supervision of trained specialists/supervisors (California Department of Mental Health, 2011).
- Call center policies for helping callers at imminent risk of suicide must include: active engagement, using the least invasive intervention, active rescue – initiating rescue without callers consent-, initiate life-saving services for suicide attempts that are in progress, leveraging third party callers, supervisory consultations must be available and accessible, caller ID, confirming receipt of emergency services when dispatched, procedure for following-up when emergency contact is unsuccessful, collaboration with emergency services and first responders (SAMHSA, 2010).
- Warmline callers saw a reduction in both the use of crisis services and feelings of isolation. They also found that keeping the warmline open after 5:00pm was especially helpful (Dalgin, Maline and Driscoll, 2011).

Mobile Teams

- Emergent mobile response must be available around the clock and accessible within 1 to 2 hours (American Psychological Association, 2002).
- Urgent responses must be distinguished from emergency services and may be provided within 24+ hours (American Psychological Association, 2002).
- Mobile teams can reduce psychiatric hospitalization by 55% (Scott, 2000)
- Individuals using a hospital-based intervention vs. a mobile team-based intervention were found to be 51% more likely to return to the hospital within 30 days after a crisis (Guo et al, 2001).

Crisis Respite

- Evidence suggests that crisis respite programs are at least as effective and much less expensive than hospital care (American Psychological Association, 2002).
- Crisis respite can help prevent out-of-home placements and abuse and neglect situations, preserves the family unit, and supports family stability (Hardin, 1994).
- Crisis residential services [crisis respite] is an alternative to inpatient hospitalization and offers: psychiatric/medical assessment, crisis stabilization and intervention, medication management and monitoring, individual group and/or family counseling, daily living skills training (State of Hawaii, 2003).

Stabilization

- 23-hour observation along can potentially divert inappropriate admissions due to misdiagnosis and limit the need for brief inpatient admissions (American Psychological Association, 2002).

- 8% of patients who receive 72-hour crisis care end up getting admitted within 2-weeks (American Psychological Association, 2002).
- Stabilization services are provided up to 23 hours, 59 minutes to evaluate the need for inpatient psychiatric hospitalization, medication and symptom management, intoxication monitoring or time-limited detoxification services, and consumer education (State of Hawaii, 2003).
- The main outcome of 23-hour observation beds is the avoidance of unnecessary hospitalizations for persons whose crisis may resolve with time and observation (SAMHSA, 2012).

Key Findings

The workgroup was asked to identify outcomes of the ideal crisis system both for the members and families we serve and process measures for the system as a whole. The workgroup quickly made it evident that it is necessary to approach children, youth and families differently than how we approach adults. A re-occurring statement reified the position that we *"cannot shrink the adult system to meet the needs of children' this needs to be designed from the ground up, specifically to meet the needs of kids and families."* Recognizing the importance of this approach, we identified domains for (a) adults, and(b) children and youth, as demonstrated in Table 1.

Member and family outcome domains for adults emphasized self-determination, improved functioning and coordination of care. Domains identified for children, youth and their families emphasized stability, security and increasing the capacity of the system to better meet these individual's needs. For all populations, there was an emphasis on preventing members from going into crisis and intervening as quickly as possible – citing the average 9-1-1 dispatch takes ten minutes to respond on scene – reinforcing the need for a similarly timely response during a crisis.

Table 1. Member and Family Outcome Domains

Adults	Children and Youth
Reduce reliance on crisis system	Provide the right service, right time, right dosage
Increase engagement in services	Support and therapeutic intervention
Accessibility (on demand responsiveness)	Reduce out of home placements
Keep members safe and alive	Culturally competent and responsive to the needs of the family
Create positive member experiences/heightened satisfaction	Educate foster care providers (early identification and intervention of crisis symptoms)
Increase in voluntary access	Reduce number of days in EDs
Crisis prevention	Create awareness & accessibility
Cultural competency in care	Reduce disruptions
Improved health (physical and mental)	
Intervene in the least restrictive environment	
Awareness of mental health crisis and how to access services	

When discussing system level outcome domains, the workgroup focused on the needs of individuals in the context of the entire community – beyond the scope of Mercy Maricopa's contracted crisis system. From this macro lens, we identified domains that were rooted in the "members' and families' shoes." Table 2 outlines the domains identified during this session.

Table 2. System Outcome Domains

Keeping crisis utilization under defined benchmarks	Decreased bed days & length of stay
Connecting individuals to services that are using the crisis system for the first time	Decreased Court Ordered Evaluation and Court Ordered Treatment
Decreased hospital admission & readmission	Reduce suicide rates
Reduce/no hospital holds	Increased capacity to serve individuals with co-morbid physical conditions

Decrease ED utilization for individuals w/ psych axis 1 diagnosis	Decreased Court-Ordered Evaluations & Court Ordered Treatment
	Reduce incarceration

Mercy Maricopa and the facilitators captured 'other considerations' (see Table 3.) during the discussion that speak to opportunities and barriers to achieving the ideal outcomes. These considerations were then incorporated and addressed in subsequent discussions.

Table 3. Other Considerations

Services should go to members and families	Payment models need to support the delivery model and outcomes
Increase 'clinical ownership' of members; outpatient providers should see themselves as responsible for their member's outcomes	Consider GSA six population increase and its impact on crisis utilization
Report utilization (and re-utilization) of crisis services across the continuum (start to finish) including booking in jail, emergency departments etc.	Individuals should be supported in the community to prevent crisis situations
Incorporate incentives that align with system goals – crisis & contracted providers	Need to define utilization benchmarks and recidivism rates
Offer intermediate levels of care	Need to support children in the foster care system and the families that care for them
Identify ways to reduce the number of "hand-offs" that members and families experience	Coordination of care, assessment, and treatment planning across system partners is critical to improve continuity of care
Services and systems should focus on quality vs. compliance	Behavioral health system should be able to meet the needs of children and adults with complex needs (developmental disabilities, dementia)

Defining crisis needs and services

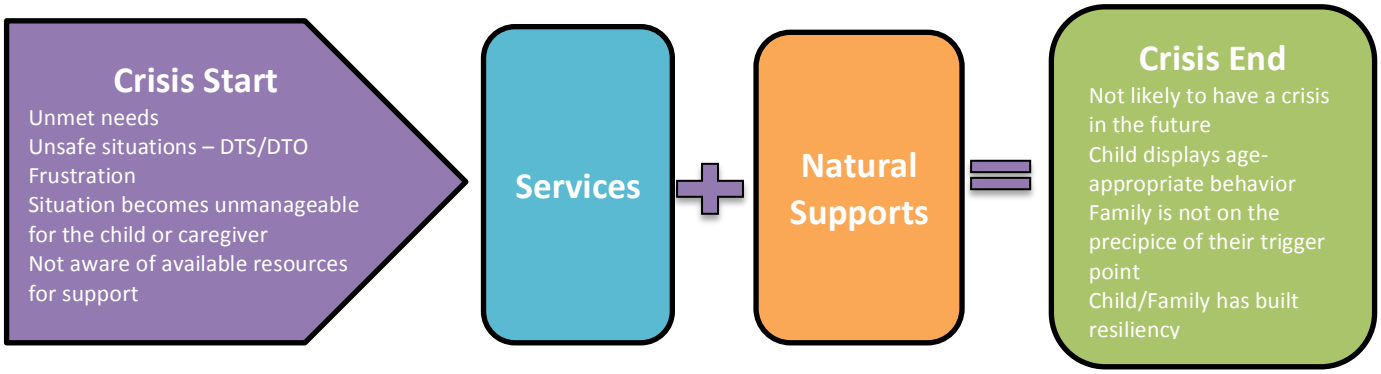
Mercy Maricopa is committed to supporting members and families in a way that is culturally responsive, builds upon their strengths, and addresses their needs. Recognizing that crisis is an individually defined state, we asked evaluation participants to identify common contributing factors and precipitating events that may lead to a crisis episode. The responses were rooted in unmet needs that, when supported by clinical interventions and natural supports lead to the stabilization of members and families.

Mercy Maricopa recognizes that a behavioral health crisis does not end with the disposition of the clinical intervention. Yet, as a safety net, the crisis system is not designed to provide ongoing care. Thus, connection to outpatient providers, community and natural supports are the true catalysts in member and family stabilization.

We developed a model that identifies the needs of children, adults and families along with precipitating factors that may lead to a crisis episode. We delineated interceptor points where members and families may seek support in their communities. These interceptor points serve as opportunities for strategic partnership as well as bolstering their capacity to serve members through mechanisms such as Mental Health First Aide™ and greater awareness of available resources.

Figures 2 & 3 demonstrate how when unmet needs are supported through clinical services, community and natural supports, members and families become stabilized in their communities.

Figure 1. Child, Youth and Family Needs



Children's Needs

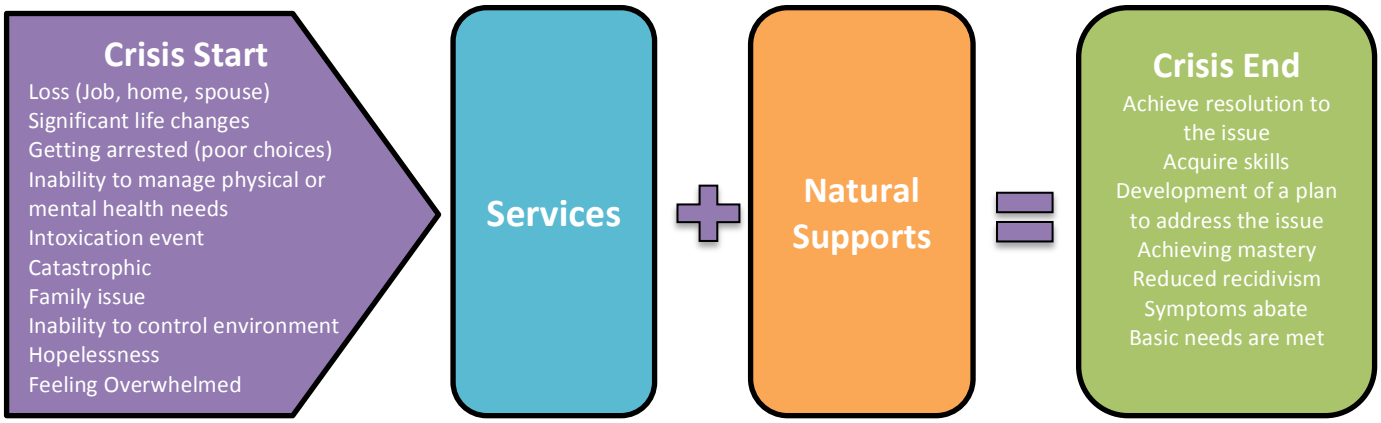
Opportunity to fail in safe environment	Opportunity to explore and push limits
Nurturing	Education
Be active, engaged in activities	Someone who understands them
Structure	Consistency
Self-regulation	Engagement
Parenting	Strong sense of self
Safety	Caring Living Environment

Family Needs

Tools for managing illness and reaction to symptoms	Understanding of social structure/ priorities
Communication in their own language	Access to resources (financial)
Respect for beliefs	Tools for self-advocacy
Acknowledgement	Clear expectations
A break	Validation
Holistic view of family	An ally/advocate
Accountability	Support

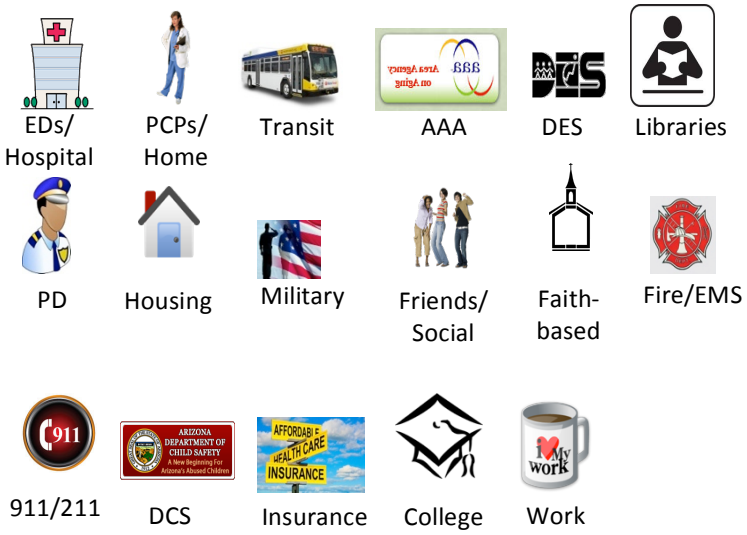
Interceptor Points

Figure 2. Adult Member and Family Needs



Adult Member Needs	
Basic human needs – food, shelter, clothing	Follow through on previous episodes
Safety	Access to PH services
Companionship	Sense of belonging
Care for pets	Meaningful activities
Meaning	Relationships
Purpose	Health literacy
Mastery	Lack of Impairment
Employment	Freedom from violence
Coping w/ significant life changes	Coping w/ loss (job, home, spouse)
Coping w/ catastrophic events	Coping w/ legal interaction (getting arrested)
Hope	Sobriety support
Managing physical and mental health needs	Ability to control environment
Connectedness	Stress management

Interceptor Points



Outcomes and pay-for-performance measures

The workgroup revisited outcome measures and their linkage to pay for performance measures. This discussion further focused the utility of member, family and system outcomes as mechanisms to incentivize the entire provider network to support members and families when they are experiencing a crisis. A summary of the key points include:

- Members need to get connected within 24 hours of discharge – outpatient providers need availability. Consider bridge appointments, open access and extended hours of availability. Some providers have demonstrated success with these models; they can be used as models and provide technical assistance to providers who haven't adapted this model yet.
- We want to incentivize the system to respond quickly and appropriately to meet the needs of members and families, averting crisis situations. Enrolled members should not have a crisis because their needs should be met based on the level of support that we provide. We need to drive towards a 'crisis-free' philosophy for enrolled members.
- All providers must serve members and families in a way that respects their unique culture, needs, and preferences.
- Outcomes should address provider involvement during crisis situations for those members assigned to them.
    a. Involve SMI clinics/outpatient providers during crisis episodes
    b. Analyze member utilization of crisis services, work with providers to better support those with high crisis utilization
    c. Work with outpatient clinics to reduce preventable emergency department admissions for psychiatric reasons

The workgroup also explored pay for performance incentives for providers who meet established performance benchmarks. Participants noted the value of monetary and non-monetary incentives including better aligning Quality Management audit tools to match desired outcomes, and specialized certifications/designations for individual clinicians as well as provider agencies.

Community stabilization services

Mercy Maricopa is committed to providing services to members and families in the community. Community and in-home settings provide a therapeutic environment that reinforces member's connection to community and natural supports. Crisis community stabilization services include: crisis hotline, warmline, mobile teams, and rapid response services; including hospital rapid response.

The workgroup identified several critical practices for delivering effective services to members and families, supporting community stabilization, including:

- Centralized dispatch for all mobile teams, rapid response teams, and bed management
- Connecting members to psychiatric intervention (regardless of where they are located)
- Make Psychiatrists available to offer Doc to Doc with PCPs, ED doctors etc.
- Using licensed clinicians to overcome credentialing requirement at hospitals
- Developing clinical decision tools and pathways to support multiple system stakeholders in determining appropriate crisis response
- Providing ongoing training and technical assistance to providers
- Connecting members to appropriate levels of support to support recovery and promote resiliency
- Making Court Ordered Evaluations mobile and accessible at multiple locations, from multiple providers
- Developing child-specific teams with specialized clinical and developmental expertise to support children and families in the community

The importance of care coordination and connecting members back to their assigned providers was discussed on several occasions. The workgroup offered that *'the most significant challenge to care coordination is coordinating with outpatient providers when the member is in crisis.'* Currently, emails and phone calls are sent within 24 hours, often after the member has returned home. To address this, the workgroup identified an array of tools for facilitating communication, including making near real-time information available through a health information network/exchange; using peer navigators to provide support to members and families after hours and on the weekends and to connect them to an outpatient provider; and requiring outpatient providers to have mechanisms in place to support members during and after a crisis.

Recommendations

Throughout the 360-degree evaluation, data was captured and progressively analyzed using qualitative research techniques such as coding and recursive abstraction. Our expert facilitators utilized several techniques to ensure the validity of our findings; including: interviewer corroboration, peer debriefing, prolonged engagement and respondent validation. Based on the analysis and recommendations provided by all participant's; recommendations were grouped into key areas:

- Incentivized performance measures
- Contract adjustments
- Service development
- Engaging individuals not previously enrolled in services
- System partnerships
- Additional recommendations

Mercy Maricopa recognizes that system change requires time and resources. Consequently, we identified strategies to be implemented progressively, over-time to allow the system opportunity to embrace and implement the proposed approaches.

Workgroup members reviewed preliminary recommendations and provided significant insight into their operational and clinical significance. The workgroup's feedback was incorporate into the recommendations. The initial kick-off group was then re-convened to review the recommendations, seek clarification and provide feedback.

Recommendations have been reviewed and approved by Mercy Maricopa leadership and will be implemented incrementally over the next three years. Moving forward, Mercy Maricopa will continue to work with members, families, community stakeholders, and system partners to develop and implement a thoughtful plan for addressing each of the recommendations proposed through this process. Through this collaborative and systematic approach, Mercy Maricopa will continue to enhance service delivery to members and families, supporting them in achieving recovery and promoting resiliency.

Incentivized Performance Measures

A key component to enhancing the crisis system is aligning payment and incentives to achieve identified system outcomes. The workgroup identified the measures outlined in Table 4 below as important indicators of a successful crisis system; and as such, should be tied to financial incentives.

Table 4. Incentivized performance measures

FY 2015 Outcome	FY 2016 Outcome	FY 2017 Outcome	Applicable Providers
Improve the experience in care for members and families	Improve the experience in care for members and families	Improve the experience in care for members and families	SMI clinics, Sub-acute, outpatient providers, access and transition points, crisis phones
XX[1]% decrease in hospital hold	XX% decrease in hospital hold from Year 1	XX% decrease in hospital hold from Year 2	SMI clinics, Sub-acute, outpatient providers, inpatient providers, access and transition points, crisis phones
XX% decrease in ED utilization for BH needs for connected members*	XX% decrease in ED utilization for BH needs for connected members* from Year 1	XX% decrease in ED utilization for BH needs for connected members* from Year 2	SMI clinics, outpatient providers
Contact with OP provider within 24 hours of crisis episode	Real time OP notification of crisis episode. OP involved in treatment and coordinates discharge.	Real time OP notification of crisis episode. OP involved in treatment and coordinates discharge.	SMI clinics, Outpatient providers, crisis phone, sub-acute facilities, access and transition points
XX% decrease in avoidable inpatient admissions, XX% decrease in readmission rate for connected members	XX% decrease in avoidable inpatient admissions, XX% decrease in readmission rate for connected members from Year 1	XX% decrease in avoidable inpatient admissions, XX% decrease in readmission rate for connected members from Year 2	SMI clinics, Outpatient providers, crisis phones, sub-acute facilities, inpatient facilities, access and transition points

* *Connected members* have an open episode of care.

Mercy Maricopa is working to develop baseline data for each of the established performance measures outlined in the table above. This data will be used to develop benchmarks and goals for performance incentives.

[1] The workgroup recommended Mercy Maricopa to identify baseline data then determine an appropriate percent of change.

Contract Adjustments

The workgroup identified multiple opportunities to modify existing service provider contracts to support members and families in achieving recovery and promote resiliency. The goal is to assist members and families in averting crisis situations whenever possible, resolve crisis situations quickly, and connect them to the appropriate services and supports they need. The workgroups recommendations for contract adjustments are outlined in Table 5.

Table 5. Adjustments to existing contracts

Provider Type	Recommended Change
SMI Clinic	• Expand office hours to include evenings and weekends • Encourage open access clinics – prohibit turning away members who are late for appointments; especially members on COT • Support members in crisis during business hours • Make contact with members in sub-acute and inpatient facilities • Active participation in discharge planning • Afford crisis providers access to targeted information (e.g., medications, last appointment, treatment plan) • Engage members and families in ongoing care to avert crisis situations • Decrease the number of amendments for court-ordered treatment due to missed appointments
Outpatient Providers	• Expand availability of on-call services • Encourage open-access clinics • Afford crisis providers and on-call staff access to targeted information (e.g., medications, last appointment, treatment plan) • Participation in discharge planning • Engage members and families in ongoing care to avert crisis situations
Hospital Rapid Response (HRR)	• Licensed clinicians only • Require credentialing with hospitals • Access to psychiatric support • Decrease inpatient admissions
Connect to Care	• Serves as a warm hand off for individuals assessed by HRR • Responsible for follow up care, connecting individuals to appointments within 72 hours of discharge, contacting the OP clinic, transporting the individual home
Transition Support	• Extend benefit to 30 days for those who will be eligible and are completing AHCCCS applications; or those undergoing an SMI evaluation (to allow for lag time until they get into Mercy Maricopa's system, and provide follow-up from intake)
Parent Assistance Center	• Expand availability and awareness of parent assistance line. • Provide post-crisis support to parents

COT/COE	• Increase participation in crisis system discussions, activities, enhancements • Enhance discharge-planning processes and increase awareness of discharge placement options • Expand weekend and evening discharges • Expand use of mobile COE team; expand to support COT amendments • Engage members and families to avoid the COE process
Mobile Teams	• Require 60 minute response time; incentivize 30 minute response time • Reduce response time for Police calls from 33 minutes to 20 minutes over time • Explore the need for additional capacity/targeted teams

Service Development

The workgroup also recognized the need to develop additional services to meet the needs of members and families. While some of these services are available in some form in the current service delivery system, workgroup participants identified the need for expansion or modification of existing models. Recommendations for service development are outlined in Table 6, as well as proposed timelines for implementation.

Table 6. Developing services to support members and families in the community

Timeline	Service	Description
FY 2015	Community Stabilization	• Provide time-limited pre and post crisis, individual and family stabilization services (7 days for connected members, 30 days for non-connected members who will qualify) • Serve as short term support for the individual after a crisis situation: ○ Transport the individual and/or family home from ED visits ○ Assist the individual in getting their medication ○ Provide in-home wraparound supports ○ Conduct in-home and telephonic follow up ○ Contact the individual's assigned provider or newly assigned provider to connect them to ongoing care within 24 hours after crisis ○ Transport the individual to their follow-up appointment ○ "Warm" transfer is critical
FY 2015	Crisis Respite	• Short-term (ALOS=7 days), recovery-focused, facility-based service for individuals when their symptoms exacerbate • Incorporated as an approach in the individual's Crisis Plan • Diversion from inpatient admission • Individual engages in daily activities
FY 2015	Home Care Training to Home Care Client (HCTC)	• Expand the network to provide HCTC services for children and families
FY 2015	Secure Transportation	• Develop alternative forms of secure transportation in lieu of ambulances
FY 2015	Mental Health First Aid & Crisis System Awareness	• Expand the availability of Mental Health First Aid, offered at no cost to community stakeholders (i.e. schools, EDs, VA, Tribes, faith-based organizations, after-school programs [YMCA, boys and girls club]
FY 2015	Crisis Management Services	▪ Provides bed management services to facilitate member access to appropriate levels of care
FY 2016	Short Term Stabilization Housing	• Provide immediate access to housing for members in crisis situations • 15-30 day transitional housing
FY 2016	Short-term stabilization for	• Step up/step down facility used to stabilize the individual and

	specialty populations (DD, Dementia, Autism Spectrum D/O)	support their return to a community setting • Diversion from inpatient • Collaborate with DD to fund/develop specialty programs to meet the unique needs of members enrolled in the DDD and their families
FY 2016	Psychiatry Consult Line	• Telemed, and/or phone based access to adult and child psychiatrist(s) to provide crisis consults & doc to doc services for EDs, and crisis providers
FY 2016/ 2017	Medication Access Clinic	• Engage walk-in clinics in areas with high utilization of crisis services to provide medication refills and services • Connect to Psychiatry Access Line/telemed provider and H.I.E. for decision support and care coordination

Engaging Individuals not previously connected to services

While much of the workgroup discussions centered on supporting members and families that were already connected to a behavioral health provider, participants recognized that crisis services are available to all community members, many of whom have not had previous contact with the behavioral health system. These individuals and families often need assistance in navigating the system, understanding what to expect, and connecting to ongoing services. Additionally, it was discussed that individuals and families need access to information about the availability of behavioral health services prior to a crisis. To address these needs, the workgroup made the following recommendations.

Table 7. Connecting individuals and families to behavioral health services

Develop clinical pathways specific for members experiencing first episode of psychosis
Provide Mental Health First Aid training throughout the community (e.g., neighbor to neighbor programs, community centers, schools)
Provide members and families with a roadmap for navigating the service delivery system – what they can expect, and how they can access support
Consider new members that have accessed crisis services as priority for intake appointments – requiring intakes within emergent timeframes
Warm transfer individuals to ongoing supports (e.g., Crisis Navigator, community stabilization) until they are fully engaged in services
Partner with Community Information and Referral organizations to educate and inform the community on the availability of behavioral health services
Connect members and families to community resources to meet their basic needs for housing, employment, food, and transportation
Increase knowledge of services so front line staff understand what services are provided, by whom, and how to access them
Provide specific training for crisis providers on child development recognizing that the needs of children and youth are different than the needs of adults

System Partnerships

As the crisis system is designed to meet the diverse needs of all individuals and families in Maricopa County, many of whom are involve in other systems, system partnerships are critical to the success of the crisis system. Services must be coordinate with all systems in which individuals and families participate to effectively and efficiently meet their needs. While the current service delivery system has developed positive relationships with system partners, the workgroup identified opportunities to expand those partnerships as outlined in Table 8.

Table 8. Expanding system partnerships to coordinate service delivery

Organization	Partnership Opportunities
Health Plans	▪ AHCCCS & Third Party Insurance – provide technical assistance for crisis providers to leverage third party payer resources for crisis services ▪ Develop protocols with health plans to provide after-care and support to individuals and families after a crisis ▪ Train health plan PCPs and specialist on mental health first aid, signs and symptoms of crisis – offer access to Psychiatric Access Line/telemed for consults of shared members ▪ Provide support and education to inform maternity care programs, chronic care and disease management programs about the availability of BH supports
ALTCS	▪ Collaborative protocol that delineates clinical pathways for older adults in crisis and those with dementia etc.… ▪ Leverage ALTCS expertise to educate providers on the special needs of the aging and disabled populations ▪ Partner with ALTCS Program Contractors to jointly develop placement options /alternatives to inpatient for members with special needs, including medically complex needs
DES – DCS	▪ Provide marketing and educational materials on BH services for use at DES sites ▪ Conduct periodic on-site brief screening/educational programs ▪ Create more opportunities for co-location of services
Schools	▪ Engage Project Aware grantees (if Arizona is awarded) ▪ Collaborate with Child Find, Special Education Department, Guidance Counselor's Association, School Psychologist Association, Student Resource Officer's Association, Charter School Association to provide school-based crisis toolkits (how to access services, stabilize children and families in crisis, develop school-wide mental health crisis protocols etc.) ▪ Mental Health First Aid training ▪ Providers to identify the schools in their area that serve the highest number of children, provide education, and consider providing school-based services ▪ Work with NAMI and schools to offer programs such as Family to Family ▪ Offer *Love and Logic* parent training in schools
Workforce Connection	▪ Provide marketing and educational materials on BH services for use at employment sites ▪ Conduct periodic on-site brief screening/educational programs
Hospital Association	▪ Convene hospital stakeholders to coordinate system-wide strategies ▪ Develop collaborative protocols to detail coordination activities

DDD	• Consider specialized behavioral health DD step-up/step-down facility (or how we can re-configure an existing provider to meet this need)
Police Department(s)	• Continue to facilitate Crisis Intervention Training • Further collaborate on mutually beneficial system goals
Indian Health Services	▪ Explore information sharing opportunities to provide notification to I.H.S./638 agencies of members accessing the crisis system
Housing Providers	▪ Bridge Housing – educate inpatient providers about availability of housing and bridge housing as an alternative to residential treatment
COE Courts	▪ Explore opportunities to expanded availability and accessibility to court to process COT recommendations
Veterans Administration	▪ Provide T.A. to providers on how to leverage VA funds to provide crisis services. ▪ Explore information sharing opportunities to provide notification of Veterans accessing the crisis system and coordinating follow-up care with VA ▪ Re-visit petition processes for Veterans (add coordination steps to ensure Veterans who say they will voluntarily access services through the VA; actually do). ▪ Educate providers on the VA Hotline and how to connect veterans to those services ▪ Provide specialized education to providers on addressing the needs of veterans ▪ Formalize agreement with the VA to provide BH services that are not available through their network, including crisis services ▪ Create Veteran's Navigator position
Universities	▪ Mental Health Awareness training ▪ Education on crisis services
Public Health	▪ Statewide anti-stigma campaign ▪ Research joint grant opportunities ▪ Public education campaign on crisis services
Community Prevention Coalitions	▪ Incorporate crisis education into prevention strategies
Fire Department	▪ Continue work with the Fire Department to support community members in crisis situations ▪ Provide regular training and support related to identifying individuals with behavioral health needs and how to contact the crisis line
Department of Juvenile Corrections	▪ Develop processes for seamless community re-integration for children being released from detention, including timely eligibility reinstatement, and immediate connections to services ▪ Connect families of children in detention to supports

Additional Recommendations

The workgroup identified some additional recommendations for enhancing the service delivery system. These recommendations represent opportunities to maximize funding and resources, increase the accessibility of services, and improve the member and family experience in care, as outlined in Table 9.

Table 9. Recommendations to maximize funding, increase accessibility, and improve member and family experience

Assess system capacity to determine the need for additional sub-acute/crisis facilities	Increase monitoring and auditing of members on court ordered treatment, and amendments
Create process to expedite admission to residential care for members in crisis/inpatient care	Develop member and family experience in care standards for all observation and inpatient providers
Advocate to Centers for Medicare and Medicaid, Arizona Governor's Office, AHCCCS/ADHS to expand information sharing across multiple systems (Indian Health Services, Veterans Administration, Arizona Department of Education, Division for Child Safety, DES-Department of Developmental Disabilities)	Enhance clinical practice • Use national standards of care • Incorporate crisis services into At Risk Crisis Plans – should build upon each other • Improve the use of psychiatric evaluations prior to inpatient admission
Teach providers how to pursue Third Party Liability (TPL) and other funding streams	Through relationships with commercial and other insurers, increase funding for crisis services
Develop formal agreement with the VA to provide BH and crisis services to their members	Educate schools on the availability of school-based funding for Medicaid services
Focus on workforce development to reduce employee attrition and disruption in care	Provide proactive care for children living with their families and younger children to prevent crisis situations

Conclusion

Mercy Maricopa started its 360-degree evaluation of the community crisis system as a primary priority after our go-live as the RBHA in GSA 6. The intent was to identify: current best practices and programs that effectively serve members and families experiencing a crisis; opportunities to expand those services; areas for service/program development to address gaps in care; and to expand the reach of the behavioral health system through key partnerships with community organizations and system partners.

Through a robust process of facilitating interviews, focus groups, provider meetings, review of secondary literature, collecting an online survey and facilitating our workgroup of subject matter experts, recommendations were made to further enhance the delivery of crisis services. Additionally, this process further highlighted the importance of a proactive service delivery system that provides ongoing community support to members and families and connects them to the services they need when they need them, averting crisis situations. Therefore, many of the recommendations for system change address the full continuum of care.

The recommendations presented in this report have been reviewed and approved by Mercy Maricopa leadership and will be implemented incrementally over the next three years. Moving forward, Mercy Maricopa will continue to work with members, families, community stakeholders, and system partners to develop and implement a thoughtful plan for addressing each of the recommendations proposed through this process. Through this collaborative and systematic approach, Mercy Maricopa will continue to enhance service delivery to members and families, supporting them in achieving recovery and promoting resiliency.

ATTACHMENTS

A: Literature Review References

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B: Summary of Online Survey and Kick off Break out Group Responses

Have you had personal experience with the crisis system? What was that experience like?	
The system is different for adults vs. kids.	Sometimes recommended services are not right for patient but providers don't have skills to treat them so they refer to the crisis system
Need to raise awareness of resources available in crisis system	It was easier to give up then try to navigate the system
Extensive wait time for mobile teams 2 1/2 hours+	Crisis is often de-escalated by the time the mobile team arrives
Need to know the right words to say to access care	Persons in crisis need immediate response, 60 min is too long
Having to bounce around from provider to provider re-agitates	

What are the ideal outcomes of an effective crisis system?	
Link to outpatient provider	Parents and family members need support when child is in crisis
Information sharing (H.I.E.)	Meet Me Where I Am
Reduced need for crisis services	Mobile clinic - (i.e. trailer)
Common language and tools among providers	Close the loops between inpatient and outpatient care
Fast response to the crisis	Members feel cared for, respected, safe, listened too
Bridge between levels of care	Reduce mental health stigma and skill build w/ PCPs so they can treat
Jail diversion	Community education on crisis services
Continuity to on-going supports	Response timeliness is key
Education on how to access services	

In your opinion, where does the crisis system begin and end?	
Member	Connected to Support
Phones	Crisis fills Gaps in Care (serves GMH/SA NTXIX)
Follow-up	Mobile Teams
Communication	Emergency Departments
Outpatient Providers	In the Community
General population	Walk-in Services
Marketing/Education re: Crisis	Detox
Safety	Inpatient
First Responders/911	Schools

What innovative models of crisis services have you seen nationally and internationally?	
Text messaging, chat	Case rate funding
Have nurses on mobile teams	Avatars
Community re-entry for jail population	Behavioral health units in the EDs
Discharge planning teams	use of peers as service providers
Trevor project - LGBT crisis line	H.I.E.
closing gaps through care coordination	Mobile clinics (i.e. trailers)
telemedicine	Narcondose to prevent overdose
Funding for flexible intervention	EMT as a BHP
Community-wide approach led by municipal government (Bend, OR)	Defined crisis respite to reduce paperwork to access care
Use of outpatient provider as crisis provider	

What are the innovative best practices currently used within the Maricopa County Crisis System?	
CIT Training	Firehouse model
Centralized dispatch	Crisis Navigators
Specialty Mobile Teams	Cross system collaboration (PD, EDs, Inpatient)
Access Points	Mobile team telephone access to nurses
Sub-acute units	Staffing transports w/ EMT (CBI)
Recovery focus	RBHA on-call availability

What are the top three strengths of the Maricopa County Crisis System?	
Crisis line	Having a funded crisis system
Thorough assessments	Many types and levels of care
Crisis provider collaboration	Providers who are willing to get better
Robust crisis system	Pioneer the concepts of recovery and resiliency
First responder collaboration	Availability of detox services
Peers as service providers	Self-defined crisis
24 hour availability & accessibility	Connect to care program
Access to Nurse Practitioners or Psychiatrist	Crisis fills gaps of on-going care
Array of services across levels of care	CIT training

What are the top three opportunities for improvement within the Maricopa County Crisis System?	
Effective bed management	Streamline ability of UPC & RRC to find appropriate placements (consider 3r Party Payers and appropriate levels of care)
Increase access to State Hospital and Desert Vista	Enhanced coordination between PPSAs and Crisis providers
Increased follow-up and post-vention	Crisis line should focus on the person not just 'pass

	the call on'
More children's crisis expertise	Decrease hold times in EDs
Response timeliness	The system needs a 'system'
More medical staff presence on mobile teams, at UPC,	The RBHA should provide oversight, not CRN. We need RBHA leadership to organize the pieces.
Increase # of psychiatrists	Increase access to services for special populations (i.e. tribal members)
Increase # of beds available	Collaboration with foster families
Have ACT teams actually respond 24/7	More GMH/SA resources (consider co-location at crisis facilities)
Move people out of Desert Vista faster and in the evenings & on weekends	Connect H.I.E. to DES, DCFSF and Medical Providers
Provider notification when crisis happens	Medically complex psychiatric patients
Connect schools to crisis providers	Special populations (DD, American Indians, Medically complex, LGBT)
More children's beds	NTXIX, GMH/SA COT services
Access points in east valley and n/e valley	Children's sub-acute and walk-in
Crisis prevention	Shared risk modeling
Telepsychiatry to EDs	standardized language and shared assessments
More crisis navigators resources	T.A. on evidence based models for crisis
Technical assistance on T36, COE and COT laws	Jail re-entry as part of the crisis system
Too many crisis plans read "call the crisis line" - QM monitoring for effective crisis planning	More physicians and psychiatrists
Collaborative protocol with education system	Make mental health first aide available to the general population

What service gaps exist within the Maricopa County Crisis System?	
Communication between providers	More Crisis Navigators - this should be a warm transfer not just referral
Residential placements	Appointment availability standards for GMH/SA - currently six weeks
Children's urgent psych	Family stabilization for children in crisis
Respite for adults	DD supports and targeted interventions
Agencies on the far southwest and far north sides of Maricopa County	Training across the board on working with acute psych patients
Outreach for non-med compliant members before it becomes a crisis	Where are outpatient providers during and after the crisis?
After hours contact with outpatient providers	COT services for GMH/SA, NTXIX
Crisis prevention	Voluntary individuals w/ good insurance get priority
Need more psychiatrists	Cultural competency when serving American Indians

What are the critical components of an effective crisis system?	
Real time data (H.I.E.)	A system that is not solely based on SMI status
Robust, well-funded substance abuse programs	Outcome data - clinical information that recommends levels of care
CPS collaboration	Family navigators
Centralized dispatch	Kids sub-acute/walk=in
Bed management	Bridge housing
Standardized tools	Crisis should be a portal to stability
Fire house model	Basketball court system
Predictive scheduling	Understanding of childhood development and trauma informed care
Multiple points of access	Connect H.I.E. to HINAZ to access medical info
Saturate public with awareness and education (tobacco, tumor causing teeth staining smelly puking habit)	Standardize crisis worker training
Medication education	Child-specific services - 'children are not mini-adults'
Follow up care	

Who are the Key partners and their roles in the crisis system?		
Schools	Refugees	AHCCCS Acute Health Plans
Fire Departments	Arizona Department of Veterans Affairs (state-level)	Third Party Payors
Police Departments	APS/ALTCS	Media - to education and de-stigmatize
911	County Attorney's Office	Legislature - policy changes that support crisis intervention
Arizona Department of Corrections	Diversion Court	Providers - availability during crisis
Hospitals	Cradle to Crayons	Municipal, County and Tribal leadership
National Guard	Faith based organizations	Hospital Association
DCFSF (CPS)	Mercy Maricopa - to provide significant leadership in bringing the pieces together	Funding Sources MUST be at the table
Juvenile Corrections	Peers and Family members	Immigration
Jails	DDD	Tribes
Probation	Veterans Administration	Parole

Additional Thoughts	
Standardized ROIs	Competition among providers is good, but has created fragmented system
There continues to be a misunderstanding of T36, COE and COT laws among providers	Need a flow chart of the crisis system from start to end w/ varying routes members can go
Outpatient teams need to held accountable for their members in the crisis system	Leadership from the RBHA is needed to stop providers from seeking solutions on their own
Need to incentivize crisis prevention	Focus on preventing crisis
Staff need better training	A really health CFT should eliminate a crisis episode
Parent support and family stabilization post-vention	True coordination is not an exercise in compliance
Crisis Navigators are underutilized	It would be interesting to learn various system's work around to address crisis (i.e. law enforcement, schools, behavioral health providers).
EDs need training on working with behavioral health crisis	

C: Workgroup Member Profiles

Workgroup Members:

- ***Matthew Kennedy, Recovery Empowerment Network*** – Matthew has worked within the behavioral health system in Maricopa County since 2004, and has served in a variety of roles including: resource specialist, Information Technology Manager, Data Research and Reporting Analyst, Sr. Analytics and Outcomes Specialist and currently works as the IT Manager for Recovery Empowerment Network.

- ***Nick Margiotta, Phoenix Police Department*** - Nick Margiotta has over 18 years' experience working in improving public safety and the quality of life in communities by the effective integration and utilization of the Public Health System. Utilizing a "System Engineer" perspective, he has extensive experience in the area of Crisis Services, Homelessness and Crisis Intervention Team (CIT) Programs. He has pioneered various initiatives and national-best practices in each of these arenas. Working closely with Community Behavioral Health, Law-Enforcement and various community stakeholders, he has developed and helped to connect silos of care and services – improving quality of care, efficiency and fiscal accountability.

- ***Christy Dye, Partners in Recovery*** - Ms. Dye has been the President/CEO of Partners in Recovery in 2009. Prior to this position, she served as President/CEO of Recovery Innovations of Arizona, a founding partner in the PIR. She also served as the Arizona Department of Health Services/Division of Behavioral Health Division Chief for Clinical and Recovery Services from 2005 – 2007. From 1997 to 2005, she served as Arizona's State Director for Substance Abuse Treatment/Prevention at ADHS/DBHS. She has been the recipient of numerous awards during her career, including the 2006 Arizona Behavioral Health Leadership in Services Award from the Center for Applied Behavioral Health Policy, ADHS/DBHS Employee of the Year 2005, Ebony House Leadership Award 2005, the 2002 and 2008 National Association of State Alcohol/Drug Abuse Directors Leadership Award, two Arizona Governor's Office Awards for Excellence, the Department of Economic Security Human Services Award 2002, and Harvard Medical School's Visiting Scientist Award 1998. She received a Master of Public Health degree from the University of Arizona/College of Medicine and a Bachelor of Arts degree from University of Illinois.

- ***Larry Villano, TERROS -*** Larry Villano, LPC, LISAC is Senior Vice President at TERROS. He has 17 years of experience of delivering, managing and developing telephonic and mobile based crisis services as well as crisis prevention services. He has a certificate in Nonprofit Management from Arizona State University and masters degrees from University of Phoenix and Indiana University.

- ***Justin Chase, Crisis Response Network*** - Justin Chase has served as a behavioral health administrator, executive, network/program developer, direct practitioner and project manager within the State of Arizona public behavioral health and child welfare system for 10 years. Justin possesses expertise in developing, implementing, managing and monitoring cross-population service management and development modalities based on evidence-based and emerging practices. Justin is a Licensed Master Social Worker in the State of Arizona, a Certified Professional in Healthcare Quality and a Certified Six Sigma Green Belt. Justin is a member in good standing with the National Association of Social Workers and Crisis Intervention Team, Intl.

- ***Laura Larson-Huffaker***, ***La Frontera EMPACT-Suicide Prevention Center*** – Laura has been the Executive Director of EMPACT-SPC since 2006. She holds a Masters in Counseling from Arizona State University and a

Certificate of Professional Development and Organizational Leadership from the University of Pennsylvania.

- ***Brenda Benage, Connections Arizona*** – Brenda Benage has served as the Chief Operations Officer at Connections AZ since September 2011. Prior to this position, she was held executive leadership roles with Magellan Health Services from 2007 – 2010; including Chief of Network Operations. Brenda also worked with Value Options from 1999 – 2007, as the National Director of Utilization Management, then the Chief of Programs and Provider Management. Brenda holds a Masters in Counseling from Indiana University Bloomington.

- ***Mike Boylan, Crisis Preparation and Recovery*** – Mr. Boylan has a Master's Degree in Social Work from Arizona State University and has his certification with the Arizona Board of Behavioral Health Examiners. Michael has been providing crisis intervention services in a multitude of capacities for the past 16 years. He started his career as a crisis counselor serving a diverse population in New York City in a public elementary school. He moved to Arizona in 1994 and began providing services in the County-wide Mental Health Crisis System and later served as Director of Crisis and Referral Services under ValueOptions in 1998 until 2001. He began his work with Crisis Preparation and Recovery in 2001 as a crisis counselor and currently provides operational direction and program development to CPR

- ***John Hogeboom, Community Bridges*** - Mr. Hogeboom is the Vice President/Chief Operating Officer of Community Bridges, Inc. (CBI) which is the largest provider of substance abuse and crisis services within the State of Arizona. Mr. Hogeboom has over 18 years of clinical and administrative experience at CBI and working within the behavioral health field. Since joining CBI, he and Dr. Frank Scarpati, CBI's President/Chief Executive Officer, have developed several of their key programs across Arizona, including the highly recognized Peer Support Model and Rural Stabilization and Recovery Units operated and Ambulatory Detoxification Models. Mr. Hogeboom also served on the Arizona Board of Behavioral Health Examiners from 2005– 2011, where he was chair of the Substance Abuse Credentialing Committee. Most recently, he is working with his Operations Team in enhancing CBI Systems of Care Network to increase service capacity within the Crisis System by developing community-based models of support.

- ***MaryJo Whitfield, Jewish Family and Children's Services*** - Mary Jo Whitfield was named Vice President of Behavioral Health in July 2006. She has more than 30 years' experience working in the field of Behavioral Health and is highly skilled in developing, implementing and managing programs that serve Medicaid eligible children, families and adults with general mental health and substance abuse disorders, persons with serious mental illness and youth ages 16 – 21. She has also worked extensively in minority communities to increase the provision of services to those populations that are underserved. Prior to joining JFCS, Ms. Whitfield held the position of Chief Clinical Officer for Value Options, the Regional Behavioral Health Authority for Maricopa County at that time, where she ran the operations of the adult clinics serving persons with serious mental illness and directed the areas of Clinical Administration, Children's Services, Program Development, Program Management and Crisis Services. Currently, Ms. Whitfield is collaborating on a project to develop and implement integrated health care in Maricopa County. She also is taking part in the start-up phase of a Maricopa County based program focusing on children ages 0 – 5 who are part of the foster care system. Ms. Whitfield holds a Master of Social Work degree from the University of Arizona and a Bachelor of Social Work degree from the University of Nevada, Las Vegas. She is a member of the Maricopa County Education Service Agency Youth Transition Advisory

Council (MYTAC), Maricopa Health Centers Governing Council, and sits on the Partners in Recovery Governing Team board.

Mercy Maricopa Key Staff:

- ***Don Fowls, Chief Medical Officer –*** Don Fowls, MD has been a leader in the behavioral health and psychiatric community for over 20 years. After several years as a practicing physician, Dr. Fowls launched a successful consulting firm that equipped healthcare providers with expertise and technical assistance that led to demonstrated improvements in member outcomes. Dr. Fowls joined Mercy Maricopa as Chief Medical Officer upon its implementation as the Regional Behavioral Health Authority in April 2014.

- ***Tad Gary, Chief Clinical Officer*** - Tad Gary serves as Chief Clinical Officer (CCO) of Mercy Maricopa. He is responsible for clinical program development and oversight of multiple large service delivery systems, including the Adult and Children's Systems of Care, the Maricopa County Behavioral Health Crisis System, and Individual and Family Affairs. Tad has worked in public behavioral health for over 15 years and has held multiple leadership roles, as well as directly providing counseling and psychosocial rehabilitation services. Tad has significant experience in program development and evaluation, performance improvement, and managed care. Tad currently serves as Past-President of the Arizona Counselors Association, and is on the Board of Directors of the National Alliance for Mental Illness (NAMI) - Valley of the Sun Chapter. Tad earned his bachelor's degree in Psychology, a master's degree in Special Education and a master's degree in Counseling. Tad is a licensed professional counselor (LPC) in the State of Arizona and a nationally certified rehabilitation counselor.

- ***Gabriella Guerra, Head of Crisis and Cultural Services*** - With more than 21 years of clinical and administrative experience in the non-profit, government and public behavioral health arenas, Gabriella Guerra has extensive experience working in the provider community, implementing system initiatives and developing and evaluating programs using evidence-based guidelines. Ms. Guerra oversees crisis and cultural services including the crisis system, court liaisons, tribal liaison, cultural competency and prevention system. She joined Mercy Maricopa after serving as the Chief Clinical Officer for Lifewell Behavioral Health and being in senior leadership at Magellan of Arizona. She holds an MSW in with an emphasis in planning and administration and has spent more than fifteen years in Arizona, where she has gained an in-depth knowledge of public health systems.

- ***Patti Ritchie-Williams, Crisis Manager*** – Patti joined Mercy Maricopa as the Crisis System Manager after seven years working at the Crisis Response Network, most recently as the Director of Innovation for Crisis Services and Collaboration. Prior to this position, Patti was the Director of Community Based Services at Florence Crittenton Services of Arizona, a Clinician for Southwest Behavioral Health and has held numerous volunteer roles including interning with Project Care at the City of Phoenix, and a Unit Assistance with Child Protective Services. Patti holds a Bachelor's Degree in Social Work from Arizona State University.

- ***Teresa Pena, Cultural Diversity Administrator*** – Teresa is a community-oriented leader with extensive experience working with children, youth and families in both the United States and Mexico. She joined Mercy Maricopa after serving as the Cultural Competency Administrator for Magellan Health Services of Arizona from 2008 – 2014. Prior to working for Magellan, Teresa served as the Youth Services Director at the Friendly House, Inc. has worked as a bilingual counselor in southern Arizona and spent three years working with Lutheran Social Ministries of the Southwest in Public Relations and Education/Outreach. Teresa is a Certified Healthcare Interpreter for English and Spanish. She holds a Master's Degree in Education and Human Resources as well as a Masters of Education from Northern Arizona University, and a Bachelor's Degree in Educational Psychology from the Universidad de Sonora.

Facilitators:

- ***Sondra Stauffacher, Senior Vice President of Performance Optimization, Inter-Growth –*** Sondra Stauffacher has over 20 years of leadership experience in quality management, performance improvement, systems analysis and development, business planning, project management, and group facilitation. As Senior Vice President of Performance Optimization for Inter-Growth, she provides expertise in quality improvement systems, contract negotiations and implementations, program and systems evaluations, strategic planning, and performance improvement systems and processes. Previously, Sondra served as the Arizona Department of Health Services Division Chief of Quality Management Operations. She implemented statewide quality management, utilization and medical management systems in compliance with Medicaid requirements, utilized continuous quality improvement (CQI) processes and PDSA models to make systems enhancements, and designed and implemented statewide performance improvement projects in accordance with Medicaid specifications.

- ***Robert Hess III, Senior Consultant, Inter-growth*** - Robert has been a Senior Consultant with Inter-Growth since 2013. Robert's career has spanned the system of care working in child welfare, education, faith-based, behavioral health and primary care. Robert has implemented billion dollar healthcare systems, managed acquisitions, secured multi-millions in funding, developed nationally recognized best practices, conducted evaluations and needs assessments, spearheaded performance improvement projects, and instituted business intelligence strategy. Robert's work has been recognized and solicited nationally as well as internationally as a consultant, author, researcher and conference presenter after successfully executing initiatives in Mexico, India, Costa Rica and most recently working in conjunction with the United Nations and World Health Organization in the Philippines.