Behavioral Health Crisis Services

A COMPONENT OF THE CONTINUUM OF CARE

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INTRODUCTION

Mental health (MH) crisis services are a core component of a behavioral health (BH) system of care. It is important for communities to clearly understand what constitutes a best practices continuum of crisis services and how to measure the effectiveness of individual crisis programs and the overall crisis continuum of care.

This paper summarizes the recent research on the crisis services continuum, with emphasis on the use of crisis service metrics as tools to continuously improve quality, spur discussions that identify strategies for improving service connectivity and coordination within a crisis continuum, and more fully build out various parts of the community system of care.

BEST PRACTICES IN CRISIS SERVICES

Crisis services are critical for individuals with significant behavioral health needs. For many of these individuals, the onset of a crisis may be their first interaction with the MH system. When crisis services are unavailable or ineffective, other services from the community safety net, such as law enforcement and hospital emergency departments (ED), must fill the breach, sometimes in ways that may contribute to further traumatization. Typically, reliance on EDs and law enforcement, which generally must manage a wide array of health and safety matters, is less effective and more expensive than specialized, community-based MH crisis intervention models of care.

Getting crisis services "right" is critical to engaging individuals in MH follow-up services. Crisis services can offer tools and supports that help individuals not only to move through crises but also to engage in their recovery and successful community living. The "right" crisis services include a continuum of services that aim to de-escalate the crisis in a safe setting, relying on a client-centered approach that is respectful and provides the individual with supports to minimize the crisis.

A best practice that should permeate all services along the crisis continuum is the use of trained and certified peer specialists, individuals who are in recovery and have had lived experience with mental illness. Evidence demonstrates that use of peer specialists facilitates engagement of individuals in recovery and services during the crisis and thereafter.

Crisis services alone, however effective in mediating crises, must be part of a larger continuum of care that supports, to the maximum extent possible, individuals in their recovery and efforts to lead successful lives in the community. These services include, but are not limited to, practices that are based on research, such as those listed by the Substance Abuse and Mental Health Services Administration: assertive community treatment teams (including forensic models), consumer-operated services, family support and psychoeducation, illness management, interventions for disruptive behaviors, integrated treatment for co-occurring disorders, MEDTeam (medication, treatment, evaluation, and management), permanent supportive housing, supported education, wraparound services for children and youth, and other evidence-based practices.[1] Without a comprehensive service array that provides social and housing supports to assist individuals with recovery, crisis services will stand alone as an over-utilized set of services that merely temporarily alleviate crises.

The interest and commitment to address acute psychiatric distress in the most appropriate setting has led to a continuum of alternatives, which are briefly described below and also more fully described in Appendix 1. The important values that should guide a crisis continuum of care are discussed below.

Essential Values for Crisis Services

The Substance Abuse and Mental Health Services Administration adopted practice guidelines for responding to mental health crises, including essential values for the crisis continuum.[2] These include the following:

- ***Safety for everyone involved.*** Interventions should avoid harm by considering the risks and benefits of specific interventions. The system should be designed to establish feelings of personal safety and security for the individual in crisis.
- ***Active engagement of the individual in crisis.*** Interventions should be delivered in person-centered ways. Shared responsibility and active partnership should be established between the practitioner and the individual in crisis. The individual's strengths and abilities to assist in the resolution of the emergency must be recognized. The individual should be viewed as a credible source of information.
- ***Holistic treatment.*** The whole person, not just the presenting psychiatric crisis, should be evaluated and considered. Interventions should be trauma-informed, addressing trauma from past experiences and the present crisis experience. Treatment should include a focus on prevention of a future crisis through individualized planning.
- ***Recovery, resilience, and natural supports.*** Interventions should support the individual and contribute to his or her overall goals for recovery. Hope, engagement with natural supports, and the fostering of dignity are key components in any crisis system.

These values can be attained in a system that is designed to be accessible, safe, least-restrictive, clinically effective, and consumer- and family-centered. This system should likewise be developed in partnership with individuals, law enforcement, EDs, and other care providers.[3]

Continuum of Crisis Services

Crisis services ideally include a continuum of services specifically created with the intention to stabilize and improve the individual's symptoms and facilitate engagement in treatment in the least restrictive setting possible. Best practices in crisis services include the following components:[4,5,6]

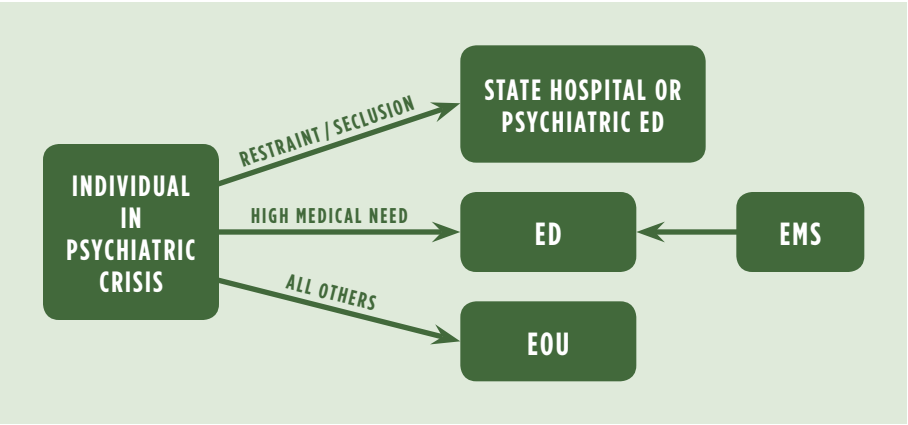
- Psychiatric emergency centers
- Hospital emergency departments
- Inpatient psychiatric hospital care
- 23–48-hour crisis stabilization/observation beds
- Short-term crisis residential and crisis stabilization services (extended observation units)
- Crisis triage/assessment centers and crisis urgent care centers
- Emergency medical services (EMS)
- Mobile crisis services/mobile crisis outreach teams (MCOT)
- Crisis telehealth services
- 24/7 crisis hotlines
- Warm lines
- Psychiatric advanced directives
- Peer crisis services
- Transportation

Appendix 1 (see page 20) provides descriptions of each component of the crisis continuum. Below, the role of the extended observation unit, a critical component of the crisis continuum, is highlighted.

The Role of the Extended Observation Unit

Within the crisis system, the extended observation unit (EOU) plays a significant role in allowing individuals in crisis to be stabilized in the community rather than at an inpatient facility or the hospital emergency department. In addition, the EOU is a secure facility with the capacity to accept involuntary and voluntary individuals in psychiatric crisis. This feature provides law enforcement officers an alternative to taking individuals to jail or a hospital. As depicted in the illustration below, an EOU is not appropriate for individuals with high medical need, in need of restraint or seclusion, or who are actively violent; however, almost all other psychiatric crises can be managed in the EOU in the community. Extended observation and treatment can take place for up to 23 to 48 hours.

FIGURE 1: Crisis System



The goals of the EOU are as follows:

- Prompt and comprehensive assessment of a behavioral health crisis
- Rapid stabilization in a secure, protected, and safe environment
- Crisis resolution
- Linkage to appropriate aftercare services
- Reduction of inpatient and law enforcement interventions.[7]

It is important that local community leaders come together in advance of operating an EOU to clearly identify the role it will serve in the overall community response to psychiatric crises as well as to address inclusion/exclusion criteria and appropriate referrals to the EOU. This strategy helps reduce confusion and conflict for all stakeholders involved in the crisis resolution process and allows for clarity regarding preferred dispositions for individuals in crisis. Key community leaders to be involved in this planning should include, but may not be limited to, local mental health authorities (LMHAs), law enforcement, hospitals (including hospital districts in counties that include one), emergency medical services (EMS), and county leaders, as well as consumers, family members, training programs (including medical schools where available), private behavioral health service providers, funders, and others, depending on the community.

MEASURING THE FUNCTIONING AND IMPROVEMENTS IN THE CRISIS SYSTEM AND CRISIS PROGRAMS

In the context of this paper, *crisis system* refers to all the various components that make up a community crisis system, and *crisis programs* refers to the specific crisis program components. It is important for communities to determine measures of success for the crisis system as a whole and for individual crisis programs. Balfour, Tanner, Jurica, Rhoads, and Carson (2015) recently provided a useful framework to guide the selection and use of crisis system and program measures. They note that measures must be tailored to the crisis system at large and to individual crisis programs. Each measure must be meaningful, feasible, and actionable.[8] Meaningful measures are ones that express the values upon which the services are built. Feasible measures are ones that have accessible data that can be collected with reasonable effort and costs. Actionable measures are those that are within the scope of control of the system or program to act on and change. It is also important to select a reasonable number of measures; collecting more data does not necessarily translate into better analysis or understanding of the system.

A quality improvement process is a healthy, nonpunitive approach to openly discussing successes and shortcomings in any project. Defining domains and measures in advance of program implementation allows communities to identify what the program is intended to accomplish and how value is determined. Use of data is critical to separate what people think is happening from what is actually happening. Data should be used for the following objectives:

- To establish baseline performance
- To reduce use of ineffective solutions
- To monitor change to ensure improvement over time.[9]

The specific aim of a crisis service continuum is to stabilize an individual in crisis in order to prevent harm, reduce the use of the emergency department, prevent unnecessary hospitalization, and divert him or her from the criminal justice system for the treatment of mental health conditions. In measuring these aims, it is important to acknowledge that the impact the crisis system has on these types of outcomes is limited. For example, a crisis system that is not linked to a fully functioning outpatient system (that includes housing and research-based practices) may not be able to transition an individual to appropriate care after stabilization.

Given the potential issues in measurement, it is important to select process and outcome measures and track data over time for the crisis system. It is also important to use measures specific to the operations and outcomes of each component, including the EOU. Performance metrics for crisis services have been difficult to clearly identify due to the lack of a standard definition of "crisis services" at the

national or state level. Given that caveat, the crisis measurement framework of Balfour et al. can be used to guide local efforts to better understand and improve the crisis system and crisis programs.[10] These measures were developed using the framework from the Institute of Medicine's "Six Aims of Improvement": Safe, Patient-Centered, Effective, Timely, Efficient, and Equitable.[11] Implementation and application of performance measures requires a planned approach over a period of at least two years, as described below, drawing from Balfour and colleagues' experience with the use of quality scorecards and similar implementation of performance measures. The specific performance measures for the crisis systems and individual programs, specifically the EOU, follow the implementation discussion below.

Implementation of Performance Measures

Implementation of performance measures must include several considerations.

- ***Individual provider performance and crisis system performance.*** Balfour describes an "internal" quality scorecard for use within individual organizations and refers to a dashboard for the overall crisis system of care. This is an important distinction because a "scorecard" may sound too punitive when shared across a system of care, whereas an external "dashboard" points to indicators that may need attention or those that are going smoothly.[12]
- ***Selection of measures.*** It is useful to collaborate with system partners in the identification of the performance measures that would be most useful to the crisis system and its components. Some partners may already collect data and can provide feedback on their experiences. It would be useful as a starting point to create agreement among crisis system partners about the implementation of priority measures that track known quality of care concerns. The feasibility of providers collecting and reporting on every performance measure described in this paper may be limited by the type of services they provide, their resources, and their capacity to collect and manage data. Therefore, targeting a few key measures at the outset would be useful.
- ***Standard definitions.*** The measures must be clearly and uniformly defined in order to collect the same information among multiple providers (and staff within provider organizations). For example, if one program interprets the definition of "unscheduled returns" as "within the time period of seven (7) days," and another program decides to use "within seven (7) days but not counting returns within 24 hours of discharge," the information will not be comparable.
- ***Electronic collection, data quality, and dashboards.*** Once measures are defined and agreed upon, the electronic medical record or other data systems must be able to accurately track and report the data in a standardized format. Since manual data collection processes are error-prone, an electronic dashboard is often used to present the information (however, if the validity of the data on the dashboard is frequently questioned, partners in the crisis system of care will not want to continue reporting the information). A sample dashboard based on the work of Balfour is included below.[13] *(Please note the data in this table are samples only and do not represent specific benchmarks or performance.)*

SAMPLE DASHBOARD

CODE	METRIC NAME	TARGET BENCHMARK	JAN 2016	FEB 2016	MAR 2016
VOLUME FOR EXTENDED OBSERVATION UNIT (EOU) WITH CAPACITY OF 6 BEDS					
A1	Total Encounters/EOU per month	TBD	240	196	178
A2	Total Adult Admissions/EOU (6 beds)	175	162	154	181
A3	Total Patient Days/EOU	186	170	180	185
TIMELINESS					
5	Door to RN Assess	30 min.	30 min.	36 min.	120 min.
6	Door to MD Access	4 hours	3 hours	1.5 hours	4 hours
7	Median Time to Admit	TBD	4 hours	2.7 hours	6 hours
8	Left Without Being Seen	0	2	1	4

- ***Quality improvement focus.*** In the context of quality improvement, the dashboard could be an important tool for assessing process improvements and strategies that enhance outcomes of crisis care. In particular, when looking at crisis measures across a system of care, if the approach emphasizes quality over penalty, partners are more likely to value the data collection and dashboard process because the information can lead to positive changes.
- ***Baseline performance.*** When starting a measurement program, it is important to identify the baseline performance and areas for improvement. This usually takes between one and three years of data collection to provide the time to adopt and define the measures, collect data over a long enough period to establish baselines, and have confidence in the data collection and reporting systems. It may take longer to establish benchmark performance goals.
- ***Dashboard timeliness.*** Another important factor is the timeliness of dashboard reporting. Some measures will need to be tracked monthly, others over longer time frames. For example, utilization should be tracked monthly for a variety of clinical and financial issues. Consumer satisfaction may be measured annually, but the need to track and respond to consumer and family member complaints should occur in real time. If the data are old, they do not have as much value in guiding quality improvements.
- ***Clinical and administrative management training.*** It is essential that clinical and financial managers review and understand the implications of the dashboard; education of these staff is critical to the effective use of the dashboard. A dashboard may report the number of consumers who "left without being seen." This information may be very useful in looking at the flow of consumers entering a program and how they are engaged once on site. Law enforcement drop-off data and time spent at crisis locations data can be very useful in understanding the peak periods and staffing needs of crisis programs.
- ***Multiple benefits of reporting.*** Once the performance measures are fully operational, providers in the crisis system of care can demonstrate their effectiveness, improve quality and efficiency, and use the fully vetted measurement system to contract with funders using value-based purchasing strategies that reward providers for performance.

Performance measures that address extended observation units and crisis systems of care are listed in the tables that follow. Building on the framework of Balfour et al., the information in the tables indicates the domain, the measure, the measure definition, the source of the measure (which indicates if it is from a national source or needs to be created locally), and rationale for why the measure is used and how to use it. In all cases, use of continuous quality improvement tools is recommended, (e.g., PDSA (Plan, Do, Study, Act)). The section immediately below describes the reason to have measures for each domain and how to operationalize them.

Reason for Use of and How to Operationalize Extended Observation Unit Specific Measures

Measures of Timeliness. Timeliness is critical in crisis services in order to engage and satisfy customers, both the individual and the people who are presenting the individual and accepting him or her after services are provided. Operationalizing these measures requires identifying incoming and outgoing referral sources and data that are feasible to collect in order to track the time between critical decision points in the chain of events of the crisis episode. Once benchmarks are determined, tracking of performance and review of results are possible. Where problems are identified, key stakeholders can use continuous quality improvement tools to make desired changes.

Measures of Accessibility. Crisis is often a person's first contact with mental health services, and, therefore, a positive "patient experience"—one that is timely, respectful, and welcoming—is essential for engagement into ongoing services. An EOU must be accessible to community customers. In that an EOU is not held to Emergency Medical Treatment and Labor Act (EMTALA) standards, it must be monitored for overly rigorous exclusion practices. As depicted in Figure 1 of this paper, individuals in need of restraint and seclusion or those with high medical needs may be more appropriate for other settings. Otherwise, the EOU should be able to accommodate their needs. The EOU must develop a system to track the reason for each denial of admission and follow up with record reviews of denied cases to determine what led to the denial. Based on those findings, remedies can be developed to minimize denials for inappropriate reasons. Use of a "mystery caller" assessment can be used to determine the quality of caller response of the program.

Measures of Safety. The safety of individuals receiving services and staff who provide services is a core function of the EOU. Implementation of national standards can provide a legitimate set of metrics to track and improve these measures. Quality improvement activities can incorporate strategies learned from creating trauma-informed treatment environments to impact these measures.

Measures of Least Restrictive Settings. Providing services in the most naturalistic environment and

involving the individual's natural supports such as family and friends are conducive to rapid and sustainable stabilization of the crisis. In line with this, keeping the locus of control with the individual, as opposed to imposing external controls, empowers the individual to take responsibility and ownership of his or her recovery. Tracking the type of community disposition, and the success at converting from involuntary to voluntary treatment, measures the EOU's effectiveness at promoting services in the least restrictive setting. Tracking these data points, determining a benchmark, and identifying opportunities for improvement are essential for evaluating effectiveness and progress. Follow-up interviews and focus groups can be used to identify factors contributing to increases and reductions in these measures.

Measures of Effectiveness. These measures of effectiveness help the EOU in identifying individuals returning to the EOU who were not ready for discharge, did not have a smooth transition, or could not get their needs met in the community; cases that may represent an opportunity for improvement at the EOU or indicate problems in the continuum of care in the community; and cases in which individuals returned or were admitted to an inpatient facility, indicating inadequate outpatient services or errors in decision making at the EOU. Focused studies of selected case records can supply the data to determine whether internal factors or external factors caused the problem. Internal and/or external stakeholders can then use quality improvement tools to plan, implement, and evaluate program changes.

Measures of Consumer and Family Centeredness. The patient and family experience of care impacts the likelihood of engagement in treatment and adherence to treatment recommendations. Family involvement in care can increase the support provided to the individual receiving treatment and improve outcomes. Surveys and focus groups are ways to gather input required to make program improvements and enhance the patient and family experience as well as the level of positive family involvement.

Measures of Partnership. Partnerships with those who are transferring individuals to the EOU and receiving them from the EOU represent integral players in the recovery journey of the person being treated. Measures of the indicators of success in these partnerships provide opportunities for improvement. Diversion from law enforcement requires a user-friendly process for officers; transfer from law enforcement to the mental health system should occur as quickly as possible. When the EOU is on diversion, individuals in psychiatric crisis are often taken into the criminal justice system. Transfer from the ED to the EOU should occur as quickly as possible to prevent psychiatric boarding at the ED. Smooth care transitions are critical to reducing cycling in and out of the crisis system. Each partnership has unique aspects and therefore should be measured distinctly as the opportunities for improvement are likely to vary.

Extended Observation Unit Specific Measures[14]

DOMAIN: TIMELINESS[15]

MEASURE	DEFINITION	SOURCE
Door to Diagnostic Evaluation	Median time (in minutes) from EOU arrival to provider contact	NQF-0498 (CMS OP-20) Modified for EOU rather than ED
WHY MEASURE IS IMPORTANT / HOW IT CAN BE USED: This is a measure of the wait time from point of entry to seeing a clinician, which can impact the patient experience of seeking care. Set goals aimed at enhancing the patient experience and reducing wait times to see practitioners and incidents of leaving without being seen.		
Left Without Being Seen	Number of patients who leave the EOU without being evaluated by qualified personnel divided by the total number of EOU visits	NQF-0499 (CMS OP-22) Modified for EOU rather than ED
WHY MEASURE IS IMPORTANT / HOW IT CAN BE USED: This is a measure of lost opportunity to help patients who come to the crisis site but leave before seeing a helping professional. Set goals aimed at reducing or eliminating the incidence of lost opportunities.		
Median Time from EOU Arrival to EOU Departure for Admitted EOU Patients	Time (in minutes) from EOU arrival to EOU departure for patients admitted to the facility from the EOU	NQF-0496 (CMS ED-1) Modified for EOU rather than ED
WHY MEASURE IS IMPORTANT / HOW IT CAN BE USED: This is a measure of total time at the entry point of the crisis setting, which impacts the experience of those patients who come in for service and then stay at the crisis center. Set goals for minimal time spent at the entry point before a decision is made to admit the person for other facility-based crisis services.		

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DOMAIN: TIMELINESS [CONT'D]

MEASURE	DEFINITION	SOURCE
Median Time from EOU Arrival to EOU Departure for Discharged EOU Patients	Median time (in minutes) from EOU arrival to EOU departure for patients discharged from the EOU	NQF-0496 (CMS OP-18)[16] Modified for EOU rather than ED
WHY MEASURE IS IMPORTANT / HOW IT CAN BE USED: This is a measure of total time at the entry point of the crisis setting, which impacts the experience of those patients who come in for service and are discharged. This is an indicator of internal process efficiency in assessing, serving, and discharging the patient. Set goals for minimal time spent at the entry point before a decision is made to discharge.		
Median Time from EOU Arrival to EOU Departure for Transferred EOU Patients	Median time (in minutes) from EOU arrival to EOU departure for patients transferred to an outside facility from the EOU	NQF-0496 (CMS OP-18) Modified for EOU rather than ED
WHY MEASURE IS IMPORTANT / HOW IT CAN BE USED: This is a measure of total time at the entry point of the crisis setting, which impacts the patient experience of those who come in for service and are transferred to an outside facility. This is an indicator of availability of outside facility services and the process time to make the transfer. Set goals for minimal time spent at the entry point before a decision is made to transfer.		
Admit Decision Time to EOU Departure Time for Admitted Patients	Median time (in minutes) from admit decision time to time of departure from the EOU for patients admitted to the facility from the EOU	NQF-0497 (CMS ED-2) Modified for EOU rather than ED
WHY MEASURE IS IMPORTANT / HOW IT CAN BE USED: This is a measure of time at the entry point of the crisis setting, which impacts the experience of those patients who come in for service and are determined to be in need of admission to the crisis facility. This is an indicator of capacity to identify an available slot for services and the process time to do the admission. Set goals for minimal time spent at the entry point once a decision is made to admit for further services.		
Admit Decision Time to EOU Departure Time for Transferred Patients	Median time (in minutes) from admit decision time to time of departure from the EOU for patients transferred to an outside facility from the EOU	NQF-0497 (CMS ED-2) Modified for EOU rather than ED
WHY MEASURE IS IMPORTANT / HOW IT CAN BE USED: This is a measure of time at the entry point of the crisis setting, which impacts the experience of those patients who come in for service and are determined to be in need of admission to an outside facility. This is an indicator of the availability of outside facility services and the process time to initiate the transfer. Set goals for minimal time spent at the entry point once a decision is made to transfer for further services.		

DOMAIN: ACCESSIBILITY

MEASURE	DEFINITION	SOURCE
Denied Referrals Rate	Percent of referrals denied admission to the crisis program for any reason other than overcapacity	No standard specifications, define locally
WHY MEASURE IS IMPORTANT / HOW IT CAN BE USED: This is a measure that helps determine the extent to which exclusionary practices are being used by the crisis program. By tracking the cases diverted for any reason other than overcapacity, the crisis program can determine the use of exclusionary practices and modifiy them as appropriate.		
Call Quality	Composite score on "mystery caller" assessment tool	No standard specifications, define locally
WHY MEASURE IS IMPORTANT / HOW IT CAN BE USED: This measure determines the quality of responses to callers to the crisis program, which impacts patient experience. Using mystery callers and standard assessment tools to identify problems with call quality and correct with training for responders and technology solutions (in cases where the calls are left in queue too long or misdirected).		

DOMAIN: SAFETY

MEASURE	DEFINITION	SOURCE
Rate of Self-Directed Violence (SDV) with Moderate or Severe Injury	Number of incidents of SDV with moderate or severe injury per 1,000 visits	Use CDC methodology
WHY MEASURE IS IMPORTANT / HOW IT CAN BE USED: This measure tracks the rate of SDV where moderate to severe injury occurs. Use this measure to evaluate the effectiveness of safety measures and make adjustments to reduce the number and severity of incidents. Staff training in identification of suicidal ideation, prevention and intervention skills, and physical plant modifications are essential.		

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DOMAIN: SAFETY [CONT'D]

MEASURE	DEFINITION	SOURCE
Rate Other-Directed Violence with Moderate or Severe Injury	Number of incidents of violence to other persons receiving care with moderate or severe injury per 1,000 visits	Use CDC methodology
WHY MEASURE IS IMPORTANT / HOW IT CAN BE USED: This measure tracks the rate of Other-Directed Violence with moderate to severe injury. Use this measure to evaluate the effectiveness of safety measures and make adjustments to reduce the number and severity of incidents. Staff training in verbal de-escalation and management of aggressive behavior is an approach to employ.		
Incidence of Workplace Violence with Injury	Total number of incidents of workplace violence to staff resulting in injury, divided by the total number of hours worked	Use OSHA methodology
WHY MEASURE IS IMPORTANT / HOW IT CAN BE USED: This measure tracks the number of incidents of workplace violence to staff which result in injury per hours worked. Use this measure to evaluate the effectiveness of safety measures and make adjustments to reduce the incidence and severity of injuries. Staff training in verbal de-escalation and management of aggressive behavior is an approach to employ.		

DOMAIN: LEAST RESTRICTIVE SETTINGS

MEASURE	DEFINITION	SOURCE
Community Dispositions	Percentage of visits resulting in discharge or transfer to community-based setting	No standard specifications, define locally
WHY MEASURE IS IMPORTANT / HOW IT CAN BE USED: This measure tracks the percent of releases to community-based settings versus more restrictive environments. Use this measure to evaluate the effectiveness of the program to resolve crises and move participants to community settings. This measure should be used in conjunction with the access measure on Denied Referrals Rate to ensure people are not excluded from participation unnecessarily and those that are accepted are successfully transitioned to community-based services.		
Conversion to Voluntary Status	Percentage of involuntary arrivals requiring admission/transfer to inpatient care that are admitted/transferred under voluntary status	No standard specifications, define locally
WHY MEASURE IS IMPORTANT / HOW IT CAN BE USED: This measure tracks the percentage of involuntary arrivals that were converted to voluntary status. This measure should be used to evaluate the success of the program to engage people in treatment under their own volition without force or coercion.		

DOMAIN: EFFECTIVENESS

MEASURE	DEFINITION	SOURCE
Unscheduled Return Visits—Total	Percentage of discharges that resulted in an unscheduled return visit	No standard specifications, define locally
WHY MEASURE IS IMPORTANT / HOW IT CAN BE USED: This measure tracks the percentage of discharged individuals that return on an unscheduled basis whether or not they were re-admitted or transferred to an inpatient facility. Use this measure in combination with the measures below that track the percent admitted/transferred or not admitted/transferred.		
Unscheduled Return Visits—Not Admitted	Percentage of discharges that resulted in an unscheduled return visit in which the return visit did not result in admission or transfer to an inpatient psychiatric facility	No standard specifications, define locally
WHY MEASURE IS IMPORTANT / HOW IT CAN BE USED: This measures the percentage of people discharged that returned on an unscheduled basis and were not admitted or transferred to an inpatient setting. Use this measure to evaluate the program's effectiveness at connecting people to community-based services.		
Unscheduled Return Visits—Admitted	Percentage of discharges that resulted in an unscheduled return visit in which the return visit resulted in admission or transfer to an inpatient psychiatric facility	No standard specifications, define locally
WHY MEASURE IS IMPORTANT / HOW IT CAN BE USED: This measures the percentage of people discharged that returned on an unscheduled basis and were admitted or transferred to an inpatient setting. Use this measure to evaluate the program's effectiveness at stabilizing symptoms, sufficiently resolving crises, and connecting individuals to community-based services.		

DOMAIN: CONSUMER AND FAMILY CENTEREDNESS

MEASURE	DEFINITION	SOURCE
Consumer Satisfaction	Likelihood to recommend	IHI Experience of Care
WHY MEASURE IS IMPORTANT / HOW IT CAN BE USED: This measure is a common metric used to gauge consumer satisfaction. Use this measure to track overall consumer satisfaction and experience of care with the program. Use this information to increase satisfactory aspects of care and to decrease unsatisfactory aspects.		
Family Involvement	Percentage of individuals for whom there is either a documented attempt to contact family or other supports, or documentation that the individual was asked and declined consent to contact family/other supports	No standard specifications, define locally
WHY MEASURE IS IMPORTANT / HOW IT CAN BE USED: This measure tracks the percentage of cases in which the program attempts to contact and engage family and others to provide support to the individual in crisis. Family involvement can help wrap emotional and other psychosocial supports around the individual and facilitate crisis resolution and stabilization. Psychoeducational programs to prepare family members to support the individual with a psychiatric disorder are an evidenced-based approach to improve outcomes.		

DOMAIN: PARTNERSHIP

MEASURE	DEFINITION	SOURCE
Law Enforcement Drop-off Interval	Time (in minutes) from law enforcement arrival to law enforcement departure	EMS Offload Interval
WHY MEASURE IS IMPORTANT / HOW IT CAN BE USED: This measure tracks the time it takes law enforcement to transfer detained individuals into the treatment setting. This is a critical element in the interface of law enforcement with the mental health system. Rapid transfer is considered "police-friendly" by allowing officers to respond to a person in psychiatric crisis, divert the individual from incarceration in the criminal justice system, and get officers back on the streets rather than have them waiting for long periods in treatment settings. Use this measure to evaluate program effectiveness at managing rapid handoffs from law enforcement. Strategies to employ include staffing the program with medical personnel who can handle minor medical emergencies and do medical clearance.		
Hours on Divert	Percentage of hours the crisis center was unable to accept transfers from medical EDs or admits from law enforcement due to overcapacity	No standard specifications, define locally
WHY MEASURE IS IMPORTANT / HOW IT CAN BE USED: This measure tracks the percentage of time in hours that the program was unable to accept transfers from medical EDs or admits from law enforcement due to overcapcity. This measure should be used in conjunction with measures of access. As a measure of partnership, this metric should be used to minimize the time the program cannot accept individuals from medical EDs or law enforcement. Development of protocols for medical clearance, admits, and transfers are essential strategies to successfully manage relationships with law enforcement and EDs.		
Median Time from ED Referral to Acceptance for Transfer to the EOU	Time (in minutes) from initial contact from the referring ED to notification that the patient has been accepted for transfer to the EOU	No standard specifications, define locally
WHY MEASURE IS IMPORTANT / HOW IT CAN BE USED: This measure tracks the time in minutes from referral to notification of acceptance to ED partners. Rapid notification of acceptance allows ED partners to know they can transfer individuals with psychiatric disorders and free up space in the ED for physical health emergencies that they are better equipped to deal with. Development of protocols for staff to use in receiving referrals and responding is an essential strategy to employ.		
Post-Discharge Continuing Care Plan Transmitted to Next Level of Care Provider Upon Discharge	Percentage of discharges in which the continuing care plan was transmitted to the next level of care provider	NQF-0558 (HBIPS-7)
WHY MEASURE IS IMPORTANT / HOW IT CAN BE USED: This measure tracks the transmission of critical information on continuing care to the receiving care provider. Use this measure to evaluate the effectiveness of transmitting this critical information, which will enhance successful transitions from the program to other care providers.		

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DOMAIN: PARTNERSHIP [CONT'D]		
MEASURE	**DEFINITION**	**SOURCE**
Provisional: Post-Discharge Continuing Care Plan Transmitted to the Primary Care Provider Upon Discharge	Percentage of discharges in which the continuing care plan was transmitted to the primary care provider	NQF-0558 (HBIPS-7)
WHY MEASURE IS IMPORTANT / HOW IT CAN BE USED: This measure tracks the transmission of critical information on continuing care to the receiving primary care provider. Use this measure to evaluate the effectiveness of transmitting this critical information, which will enhance successful transitions from the program to primary care providers. This measure can potentially enhance the willingness of primary care providers to accept and treat individuals with psychiatric disorders.		

Crisis System Measures

The measures in the table below draw from the work of Balfour[17] in collaboration with community partners interested in assessing the effectiveness of the crisis system. The measures are preliminary but represent a starting point of value-based measures that any community collaborative could use to begin the quality improvement process for its crisis system. The reasons for use and operationalization of these measures are similar for extended observation unit measures in the table above. Similarly, the measures below provide the data necessary for using continuous quality improvement tools.

DOMAIN: TIMELINESS		
MEASURE	**DEFINITION**	**SOURCE**
Call Center Abandonment Rate	Percent of calls switched to the queue of callers who listen to the message and/or menu and hang up	HHSC-MCO contract
WHY MEASURE IS IMPORTANT / HOW IT CAN BE USED: This measure tracks the percent of calls that individuals abandon after listening to the announcement without waiting for the call to be answered. This measure can be used to determine the need for additional resources to answer calls and respond directly to callers.		
Call Center Time to Answer	Percent of calls answered by toll-free line staff within 30 seconds, measured from the time the call is placed in queue after selecting an option	HHSC-MCO contract
WHY MEASURE IS IMPORTANT / HOW IT CAN BE USED: This measure tracks the percent of calls answered within 30 seconds after going into the queue. This measure can be used to determine the need for additional resources to answer calls and respond to callers.		
Mobile Team Dispatch to Arrival	Median time (in minutes) from mobile team dispatch to arrival on scene	DSHS-LMHA contract
WHY MEASURE IS IMPORTANT / HOW IT CAN BE USED: This measure tracks the median time it takes a mobile crisis team to arrive on the scene once it is dispatched. The benchmark for this metric will vary by geography of the service delivery area. By tracking response time and benchmarking comparable sites, the program can set goals to improve performance.		
Door to Qualified Behavioral Health (BH) Professional	Crisis facilities' median time (in minutes) from patient arrival at the door to meeting with a qualified BH professional	DSHS-LMHA contract
WHY MEASURE IS IMPORTANT / HOW IT CAN BE USED: This is a measure of the wait time from point of entry to seeing a BH practitioner, which can impact the patient experience of seeking care. Set goals aimed at enhancing the patient experience and reducing incidents of leaving without being seen.		

DOMAIN: ACCESSIBILITY

MEASURE	DEFINITION	SOURCE
Language Accessibility	Crisis providers communicate in the preferred language of consumers	No standard specifications, define locally
WHY MEASURE IS IMPORTANT / HOW IT CAN BE USED: This measure tracks the incidence of matching consumers with providers who are able to communicate in the preferred language of the consumer. Where there are descrepancies, the program can seek staff who can match the language preferences of the consumer population served.		

DOMAIN: LEAST RESTRICTIVE SETTINGS

MEASURE	DEFINITION	SOURCE
Community Dispositions	Percent of mobile team visits resulting in community disposition Percent of EOU resulting in community disposition Average number of follow-up contacts by MCOT or designee after initial crisis encounter	No standard specifications, define locally
WHY MEASURE IS IMPORTANT / HOW IT CAN BE USED: These measures track the success of the crisis programs in being able to resolve crises and stabilize the person in the community setting without resorting to inpatient settings. The tracking of the number of follow-up contacts by MCOT and other providers allows the crisis programs to plan for and allocate the resources to successfully stabilize the crisis.		
Conversion to Voluntary Status	Percentage of involuntary arrivals requiring admission/transfer to inpatient care that are admitted/transferred under voluntary status	No standard specifications, define locally
WHY MEASURE IS IMPORTANT / HOW IT CAN BE USED: This measure tracks the percentage of involuntary arrivals that converted to voluntary status. This measure should be used to evaluate the success of the program to engage people in treatment under their own volition without force or coercion.		
Crisis in the Outpatient Setting	Number of crisis encounters in the outpatient setting	No standard specifications, define locally
WHY MEASURE IS IMPORTANT / HOW IT CAN BE USED: This measure tracks the number of crisis encounters in the outpatient setting, which can be compared to the number that have to go to a more restrictive crisis setting.		
Special Weapons and Tactics (SWAT) Calls	Percent of SWAT calls that are mental health related	No standard specifications, define locally
WHY MEASURE IS IMPORTANT / HOW IT CAN BE USED: This measure tracks the percent of calls in which a SWAT team is deployed for mental health related reasons versus CIT or other law enforcement officers. This can be used as an indicator of the real or perceived dangerousness of mental health calls.		
Emergency Room (ER) Utilization	Number of mental health or substance abuse ER presentations	No standard specifications, define locally
WHY MEASURE IS IMPORTANT / HOW IT CAN BE USED: This measure tracks the utilization of ERs by people presenting with BH disorders. The community crisis system can use this measure to plan for the array of crisis services needed to divert these individuals to specialized BH services.		
ED and/or Psychiatric ED Admissions to the Hospital	Percent of psychiatric crisis encounters in the ED or Psychiatric Emergency Department that result in an admission to an inpatient facility	No standard specifications, define locally
WHY MEASURE IS IMPORTANT / HOW IT CAN BE USED: This measure tracks the percent of cases that are seen in the medical ED or psychiatric ED that end up being admitted into an inpatient facility. The community system can use this metric to examine the sufficiency of community-based services as well as the capability of the EDs to resolve crises and stabilize individuals without using inpatient services.		

DOMAIN: COMMUNITY SAFETY

MEASURE	DEFINITION	SOURCE
Reduction in Suicide Rate	Reduction in death caused by self-directed injurious behavior with an intent to die as a result	Center for Disease Control, National Center for Injury Prevention and Control, Self-Directed Violence Surveillance
WHY MEASURE IS IMPORTANT / HOW IT CAN BE USED: This measure tracks the rate of suicide in the community. Use of this metric allows the community to examine the impact of suicide prevention initiatives.		
Transports and Use of Force	Percent of law enforcement transports for mental health crisis resulting in use of force	No standard specifications, define locally
WHY MEASURE IS IMPORTANT / HOW IT CAN BE USED: This measure provides a metric that can be impacted by trauma-informed care training for first responders.		
Law Enforcement Fatalities	Percent of law enforcement fatalities with mental health nexus	No standard specifications, define locally
WHY MEASURE IS IMPORTANT / HOW IT CAN BE USED: This metric tracks incidents in which lethal force occurs. The community can use this metric to determine the training needs of law enforcement as well as the use of clinicians teamed up with first responders.		
Law Enforcement Calls for Suspected Mental Health Conditions	Percent of law enforcement calls for welfare check or suicide-related reports	No standard specifications, define locally
WHY MEASURE IS IMPORTANT / HOW IT CAN BE USED: This measure tracks the percent of calls in which law enforcement is deployed to address the mental health needs in the community. This metric allows the community to develop strategies to provide the BH care that is needed for these types of cases.		

DOMAIN: DIVERSION FROM JUSTICE SYSTEM

MEASURE	DEFINITION	SOURCE
Jail Bookings	Percent of jail bookings with identified mental illness	No standard specifications, define locally
WHY MEASURE IS IMPORTANT / HOW IT CAN BE USED: This measure tracks the percent of cases in which MH services are required for individuals booked into jail. The community can use this metric to determine the BH treatment resources needed for inmates and the extent to which pre-booking jail diversion is needed.		
Jail Days	Number of jail days for mental health population and percent of total jail days	No standard specifications, define locally
WHY MEASURE IS IMPORTANT / HOW IT CAN BE USED: This measure tracks the days incarcerated individuals with mental illness serve relative to other non-mentally ill individuals. This metric can be impacted by jail diversion strategies to get qualified people into treatment settings outside of jails.		

DOMAIN: MINIMIZE EMERGENCY DEPARTMENT BOARDING

MEASURE	DEFINITION	SOURCE
Admit Decision to ED Departure	Median time (in minutes) from admit decision to ED departure for behavioral health admits	No standard specifications, define locally
WHY MEASURE IS IMPORTANT / HOW IT CAN BE USED: This measure tracks the time individuals with BH problems stay in EDs due to inability to transfer to BH settings. This metric can indicate the adequacy of BH capacity to accept transfers and the processes and protocols used to expedite transfers.		
Psychiatric Boarding	Total hours of psychiatric boarding in medical EDs	AHRQ Quality Indicators
WHY MEASURE IS IMPORTANT / HOW IT CAN BE USED: This measure tracks the time individuals with BH problems stay in EDs due to inability to transfer to BH settings. This metric can indicate the adequacy of BH capacity to accept transfers and the processes and protocols used to expedite transfers.		
Crisis Facilities on Diversion	Percentage of hours the EOU was unable to accept transfers from medical EDs due to overcapacity	No standard specifications, define locally
WHY MEASURE IS IMPORTANT / HOW IT CAN BE USED: This is a measure that indicates the capacity of the EOU to accept transfers. It also can be used to indicate problems with the flow of patients through the EOU. Tracking the hours on diversion due to overcapacity sets the stage for quality improvement activities.		

DOMAIN: GET PEOPLE CONNECTED

MEASURE	DEFINITION	SOURCE
Follow-Up After Crisis Encounter	Percent of crisis encounters followed up with a phone call within 72 hours	No standard specifications, define locally
WHY MEASURE IS IMPORTANT / HOW IT CAN BE USED: This measure tracks follow-up calls that support transition of care and potentially prevent readmissions.		
Follow-Up After Crisis Encounter	Percent of crisis encounters followed up with a face-to-face encounter within seven (7) days	HEDIS FUH/NQF-0576 with potential modification related to license status of staff and EOU
WHY MEASURE IS IMPORTANT / HOW IT CAN BE USED: This measure tracks face-to-face follow-up after a crisis encounter. This metric can be used to evaluate the process of follow-up. Combined with a look at readmission for the same cases, quality improvement strategies can be employed to avoid preventable admissions.		
Continued Treatment in the Community	Number of people served in the crisis system that do not have a hospital admission within 30 days of crisis encounter	No standard specifications, define locally
WHY MEASURE IS IMPORTANT / HOW IT CAN BE USED: This measure tracks hospital admissions for those who receive a crisis encounter. This metric can be used to identify cases in which further investigation is required to determine the reason for admission and improve the impact of crisis services to avoid admissions.		
Community Tenure	Days spent in the community between admissions or instead of hospitalization	No standard specifications, define locally
WHY MEASURE IS IMPORTANT / HOW IT CAN BE USED: This measure tracks the community tenure of individuals who were hospitalized. This metric can be an indicator of the adequacy of inpatient treatment, the quality of discharge planning, and/or the adequacy of community services to engage and support the individual.		

DOMAIN: CONSUMER AND FAMILY CENTEREDNESS		
MEASURE	**DEFINITION**	**SOURCE**
Patient and Family Satisfaction	Likelihood to recommend	IHI Experience of Care
WHY MEASURE IS IMPORTANT / HOW IT CAN BE USED: This measure is a common metric used to gauge consumer satisfaction. Use this measure to track overall consumer satisfaction and experience of care with the program. Use this information to increase satisfactory aspects of care and to decrease unsatisfactory aspects.		

DOMAIN: MEET NEEDS OF COMPLEX PATIENTS		
MEASURE	**DEFINITION**	**SOURCE**
Super Utilizer Patients	Number of "super utilizer" patients and percent of total patient population served in the crisis system	No standard specifications, define locally
WHY MEASURE IS IMPORTANT / HOW IT CAN BE USED: This measure tracks the utilization of individuals served in crisis settings and identifies those who are outliers in terms of very high utilization relative to others. This metric can be used to determine which individuals are experiencing complex problems that are not being adequately addressed.		

DOMAIN: EFFECTIVENESS		
MEASURE	**DEFINITION**	**SOURCE**
Mental Health Inpatient Readmission Rates	Percentage of discharges resulting in readmission within 7, 30, and 90 days of discharge	No standard specifications, define locally
WHY MEASURE IS IMPORTANT / HOW IT CAN BE USED: This measure tracks readmission rates at three intervals and allows for identification of unexpected rates of readmissions. Use of this metric can point to areas of inadequate treatment within inpatient settings or with outpatient services and supports.		

Overlooked Components of the Crisis Continuum

Highlighting system gaps can provide the foundation for identifying overlooked service system components that should be included in the crisis continuum. Many communities rely on a crisis hotline, limited mobile crisis outreach teams (MCOT), EDs, and law enforcement to manage crises. Mobile outreach is a key service that can help with on-site assessment, rapid medication when a psychiatric prescriber is available by telephone or telemedicine (using mobile devices), and the transportation of people who are agreeable to go to a crisis respite program, crisis residence, or a peer-operated crisis program.

In most communities in Texas (and across the nation), crisis outreach services are either not sufficiently available after business hours or are hindered by inadequate geographic coverage (e.g., there may be one crisis team located at a single site in a large metropolitan or geographic area). Other communities may have multiple outreach programs that are not connected to each other, resulting in limited coordination. An effective system of care will have multiple crisis sites, including mobile outreach and communication protocols among crisis teams that allow coordination and critical information sharing. This helps promote efficiency, care coordination, and sharing of after-hour coverage.

Role of Emergency Departments. Another gap in crisis services systems can be found in the use of emergency departments, which frequently become an overutilized, expensive component of the crisis continuum. While some hospital EDs have a separate space for individuals experiencing a psychiatric crisis, most do not, often creating challenges in providing a quiet area or the staffing to help with de-escalating crises, possibly resulting in the potentially traumatizing use of restraints to manage the overall safety of individuals brought to the ED. Emergency departments are also too often used as a holding place for law enforcement and/or to provide medical clearance for psychiatric hospital admission. When law enforcement accompanies an individual to the ED, there is likely no space

for the officer or the individual in crisis to wait. Waiting times can also be very lengthy, removing the officer from other public safety functions. This situation can result in law enforcement officers taking the individual in crisis to jail to avoid a long delay at the ED. Providing access to crisis drop-off programs that are user-friendly and allow law enforcement to rapidly hand off individuals in crisis would be effective in preventing the misuse of officer time, promoting jail diversion, and providing a more appropriate setting for individuals in crisis.

Requirements for medical clearance, specifically determining the medical stability of individuals experiencing a psychiatric crisis prior to admission to a psychiatric hospital, are often variable.[18] Protocols can vary by ED and by psychiatric facility depending on the capability of the psychiatric facility or program to address medical issues. It is important to develop uniform protocols across the crisis system and agreement among facilities and programs about acceptable medical clearance practices. For example, routine laboratory screening may not be necessary for all individuals.[19] It is also essential to communicate the medical clearance requirements throughout the emergency system of care. Emerging practices include conducting medical screens in primary care settings operated by Local Mental Health Authorities (LMHAs) and Federally Qualified Health Centers (FQHCs) when feasible to prevent the need for an ED visit when an alternative setting has the capability of providing medical clearance.

Peer-Provided Crisis Services. Peer-provided crisis services are frequently overlooked as an effective crisis intervention approach. Peer services can exist at each point in the continuum of all crisis care by adding certified peer specialists to staffing for the purposes of engaging and supporting individuals during crises and assisting with follow-up care. Incorporation of peer-support specialists and peer navigators throughout the crisis system is an approach that is expanding across the country. There is increasing recognition that people with lived experience of behavioral health conditions are able to improve the "patient experience" of individuals in psychiatric crisis by engaging and supporting them through the crisis and to assist them in their recovery by helping them connect to services and supports, post-crisis.

Peer-operated crisis respite programs are unique crisis intervention programs that are generally home-like environments operated by people with lived experience of serious mental illness. The environments provide a calm setting for people in psychiatric crisis to receive support and encouragement as they re-regulate their systems and stabilize their crises. While these programs are intended to provide services for 24 or fewer hours, sometimes a stay will extend to several days.[20] One such program is described below.

In addition to the standard components in the continuum of crisis services, there is a service model known as "The Living Room," initially piloted in Maricopa County, Arizona[21] which is described as a "community crisis respite center" and provides a mix of crisis stabilization and peer-provided crisis services. The Living Room model was created to provide a safe place for individuals to work through psychiatric crises. This model offers space for guests to talk with peers and professionals away from the chaos of a hospital emergency department, an environment that could exacerbate an individual's crisis. Most guests come to The Living Room to avoid having to go to the ED and are able to achieve this goal by accessing community-based services. A study of a model of The Living Room implemented in Illinois found that in the first year of operations, 93% of those individuals served in The Living Room were deflected from using a hospital emergency department.[22]

In the Illinois program, the service is provided in an outpatient mental health agency in a setting that has been designed to be warm, comfortable, and private. It likewise includes minimal stimuli and plenty of space for rest and relaxation.[23] It is staffed with one counselor, one psychiatric registered nurse, and three peer counselors. Guests are assessed upon arrival, and if at any time throughout the visit the guest is determined to pose a threat to self or others, procedures are in the place to transport the individual to a more appropriate setting.

Crisis Respite, Crisis Residential Programs, and Extended Observation Units. These services (more fully described in Appendix 1) offer opportunities to provide a safe environment to de-escalate crises and assist individuals with engagement in services. Depending on the needs of the individual, the acuity of the crisis, and the resources of the program, many individuals can use these services as an alternative to inpatient care.

Permanent Supportive Housing. Supportive housing is another critical piece of the community continuum of care that allows individuals with mental illness to stabilize and stop cycling through crisis services. The lack of safe and affordable housing can create significant barriers to achieving psychiatric stability, engaging in services, and obtaining the goal of recovery. In fiscal year (FY) 2015, 10% of all clients utilizing Austin Travis County Integral Care (ATCIC) crisis services were homeless or had

unstable housing. That percentage is considerably higher for individuals accessing ATCIC community crisis beds, with 36% of individuals being homeless or in unstable housing situations.[24]

Supportive housing makes accommodations for affordable housing through housing development and rental assistance, and provides wraparound mental health services to support individuals' success with recovery and integration into the community. These services may include case management, counseling, advocacy, and employment assistance. The availability of permanent housing, including supportive housing models that provide individuals with in-home supports, is a critical component in a behavioral health continuum of care. Having a home and support to maintain good relations with the landlord and other tenants, manage finances, shop for and prepare meals, and maintain an acceptable appearance are important to successful living in the community. Having support to build and maintain friends and family relationships adds to stable community living. Having a home to return to if there is need for a psychiatric hospitalization also provides stability for individuals and their recovery.

The availability of housing stock and access to housing is a community issue that must be addressed through county and city agencies, developers, and others. Typically, housing is not under the control of LMHAs; however, LMHAs play an essential role in advocating for the housing needs of people with psychiatric disabilities and providing critical supports to ensure housing stability.

The focus on a Housing First approach, which separates having access to housing from requirements to participate in treatment, is increasingly seen as a best practice in reducing crisis and supporting recovery. In this approach, individuals hold the lease and receive support to maintain their housing. Outreach, especially by peer-support specialists, is effective in this model and assists with treatment engagement once stable housing is obtained.

Housing serves to prevent involvement with law enforcement by getting individuals off the streets where they are perceived as public nuisances and exposed to opportunities for trespassing, loitering, and other infractions of the law that can easily result in arrest and incarceration. In order to be successful for frequent crisis users, housing supports must be linked to adequately intensive community-based services such as Assertive Community Treatment.

Assertive Community Treatment. Assertive Community Treatment (ACT) and its forensic variation, Forensic Assertive Community Treatment (FACT), are essential system components for helping medically and behaviorally complex patients—who also frequently use inpatient, jail, and ED services—maintain housing and reduce the frequency of crises. ACT has been shown to reduce system-wide costs for high utilizers of crisis services.[25] When ACT and FACT are provided with high fidelity to their critical program components, the results include reductions in use of inpatient hospitalization, use of crisis units, and the number of jail bookings.[26, 27] Every community in Texas (and most across the nation) have too little available capacity for intensive, ongoing care such as ACT/FACT to manage medically complex patients at high risk for frequent crises. On average, Texas communities have less than 10% of the capacity they need for such care.[28, 29]

CRISIS SERVICES POLICY ISSUES

Emergency Care Psychiatric Clinical Framework

For many years, there was a lack of national standards for psychiatric care in emergency departments. In 2010, professional bodies adopted the Emergency Care Psychiatric Clinical Framework, which established guidelines for improving clinical services in hospital emergency departments for people with mental illness and substance use disorders.[30] Even with an improved clinical framework, EDs are not appropriate clinical settings for most individuals in psychiatric crisis, and boarding in emergency departments because of a lack of community crisis and outpatient services should be deemed unacceptable.

A critical issue that is often a source of frustration for law enforcement is transporting individuals in crisis to an EOU only to find that they require medical clearance to be admitted. While it is vital for patient safety to assess and treat medical conditions (which are not always apparent to non-medical staff) this practice often results in law enforcement waiting for long periods of time at emergency departments for the individual to become

"medically cleared" before transport to the designated program can occur. The establishment of training and clear protocols, and ensuring that all stakeholders understand and follow them, is an important part of a successful extended observation unit.[31] The protocol could involve having the physician at the designated facility (that will admit the individual) provide medical clearance or having a community-based primary care physician conduct an exam to provide medical clearance. This latter approach has been utilized in some locations where either the community mental health center or LMHA has established a primary care clinic or has an arrangement with a Federally Qualified Health Center to offer medical clearance in emergency situations.

Care Transitions

Crisis services provide an opportunity to bridge care transition issues that often exist between inpatient and outpatient clinical services. If alternative placement or outpatient treatment exists in a community, crisis services have the ability to link the individual to the appropriate community-based treatment. For example, if a link is needed to a crisis stabilization or crisis residential placement, the link may be from mobile crisis outreach teams (MCOT) to crisis stabilization and then from crisis stabilization to ongoing outpatient treatment.

In every community, there is a strong need for collaboration among the community mental health system, hospital emergency departments, and all stakeholders involved in crisis management, including law enforcement. The goal is to ensure that individuals are connected to appropriate services through care transitions once their immediate crisis is stabilized or an action plan is made to transfer them to an appropriate setting. Emergency department "boarding" is not a reasonable treatment option for an individual in psychiatric crisis. Establishing collaboration among community mental health services, public and private hospitals, law enforcement, the court system, and public officials is necessary. These stakeholders will need to have the commitment and accept responsibility for creating a system of care, including a crisis continuum, for providing treatment to individuals at the right place and the right time.[32]

Use of Telemedicine

In the vast majority of communities, providing telemedicine services in extended observation units is critical to allowing ready access to psychiatry on a 24-hour, 7-day-a-week basis, especially in rural areas. With modern technology and equipment, telemedicine is an appropriate way to deliver these critical services. Communities should be actively engaged with policy makers on the importance and appropriateness of using telemedicine. In the past, there have been efforts to curtail or unnecessarily restrict the use of telemedicine.

Regulated Versus Licensed Crisis Services

In Texas, the continuum of crisis services was authorized by the legislature and placed under the responsibility of the Texas Department of State Services (DSHS). DSHS created a process through a contract amendment, known as Information Item V, Crisis Service Standards, to regulate local mental health authorities' crisis services, including extended observation units and crisis stabilization beds.[33] This contract amendment clearly presents the requirements for crisis services and includes on-site visits and ongoing oversight and monitoring. However, DSHS regulation does not mean it issues a "license" or "certification" for these services. Yet, managed care organizations (MCOs) contracting with the state expect a license or certification number for these types of services. With proper education, MCOs will be better able to understand the regulatory process and move forward with contracting for these services. However, this approach has not proven to be effective with some MCOs.

Continuum of Services

Building a robust crisis continuum without the foundation of an equally robust community-based service array will only shift repeated use of hospital services to repeated use of crisis services. Although community-based crisis services are usually more appropriate than a hospitalization or jail placement, they are still not the most appropriate services for ongoing treatment of mental health conditions. Ensuring appropriate treatment options through a robust community-based service array can help stop a revolving door of crisis service use and support individuals' efforts toward recovery and effective chronic disease management.

CRISIS SERVICES FINANCIAL ISSUES

Safety Net Services

Conceptually, crisis services for mental health can be compared to safety net services delivered by the fire department in a local community. The fire station is there, fully staffed, and takes care of all calls—every hour and every day of the year. There may be days when the fire station staff idly waits for a call, but when the call comes, they respond.[34] Crisis mental health services provide the same safety net function for a different purpose: to be able to respond quickly to a psychiatric emergency. This safety net requires a financial commitment of local and state governments to help establish the capacity and ongoing support, while other funding such as Medicaid and private insurance pay for services delivered to individuals who have coverage.

There are financial issues related to appropriate reimbursement for mental health crisis services. Adults accessing mental health crisis services in Texas are typically uninsured or have Medicaid coverage. As mentioned earlier, getting MCOs to contract and use mental health crisis services is critical since the majority of Medicaid-eligible individuals in Texas are enrolled in a Medicaid MCO. At the same time, state and local funding for crisis services is limited, which results in LMHAs and other local systems not having sufficient capacity to meet the needs for crisis services. Consequently, people in crisis with mental health and substance use disorders end up in general acute care hospital EDs and jails.

Use of public funds is essential to maintaining the static capacity of crisis services in a community. Without public funds to ensure that capacity for psychiatric crisis care exists when needed, people in crisis will have to go to less appropriate settings. If psychiatric crisis services were considered analogous to other emergency services such as fire, police, and emergency medical services (EMS), they would be more widely dispersed throughout the community to allow timely access and response when needed.

Cross-Systems Collaboration and Funding

As noted throughout this document, mental health crises impact multiple systems, most notably the public mental health system, hospital emergency departments, emergency services (police/EMS/fire department), and the funders of services such as state and local governments (including Medicaid and MCOs). In that psychiatric crises can and do occur in a variety of locations across the community, and any one of these systems can be requested to respond, it is important that collaboration among systems is in place to ensure that the best coordinated response is available. This approach offers the potential to result in better outcomes and lower costs.

A problem in many community systems is that the expense for serving community members in crisis is not well integrated such that the costs and savings are linked in a way that incentivizes system improvements and supports sustainability. For example, Delivery System Reform Incentive Payment (DSRIP) funding has allowed the creation of innovative crisis alternatives in communities across the state. However, the benefits of reduced costs to hospital emergency departments, the criminal justice system, and Medicaid MCOs accrue to those systems and not to the entity receiving and expending the DSRIP funds. Without explicit sustainability strategies in place that include continued financing by all the systems that benefit from the innovative crisis programs, once the DSRIP dollars are no longer available, the programs are no longer feasible.

Cross-systems collaboration to develop agreements on expected outcomes and sustainable financing is best done early in the planning and implementation phase of a crisis services project. This effort provides an incentive to be clear about the program design, the development of metrics to ensure program success and sustainability, and, most importantly, the rapid-cycle quality improvement needed to keep the program on track to meet expectations.

Texas Medicaid

The Texas Medicaid program currently pays for discrete mental health services such as psychiatry, counseling, rehabilitation, and targeted case management during crisis situations. However, Texas does not take full advantage of the State Plan benefits available through the Center for Medicaid and Medicare Services (CMS) for the mental health services crisis continuum. Instead, the state funds much of the crisis continuum through 100% general revenue funding. For example, a mobile crisis team approach is used as a way to appropriately divert individuals from hospitals and law enforcement, but there is no Medicaid payment for a daily rate (per diem) to cover the costs of team-based services available on a 24-hour basis.

Other states are using Medicaid State Plan services to fund 23-hour crisis stabilization/observation beds, short-term crisis residential services, mobile crisis services, and peer crisis services.[35] The addition of these services to the State Plan would allow for a per diem rate to cover the full range of staff costs needed to meet the requirements of the service. The Medicaid payment for the crisis continuum is exclusive to costs related to the delivery of treatment and prohibits any payment of room and board. Therefore, this is not a complete coverage of the costs but does increase the amount of Medicaid funding available for crisis services.

Currently, there are no rates for a range of crisis services, including mobile crisis services, which are more costly to provide than regular clinic-based services.

Texas Medicaid Managed Care

The majority of Texas Medicaid beneficiaries and services are now in a capitated managed care system. The goals of managed care are to improve access, reduce overall Medicaid costs, and improve beneficiary satisfaction. Medicaid MCOs receive a per-member, per-month payment from the Texas Health and Human Services Commission (HHSC). This payment allows flexibility in meeting members' needs. There is no requirement to contract only for Medicaid State Plan services or at Medicaid fee-for-service rates. When alternative services provide cost- and clinically-effective care, the MCO has the ability to pay for those services.

There are a few MCOs that are currently contracting for 23-hour crisis stabilization, EOU, and short-term crisis residential services. These services can be provided to members in lieu of more expensive services such as inpatient hospital stays and ED visits. If a Medicaid MCO chooses not to contract for extended observation units or crisis residential services, the member would then be sent to an inpatient facility within the MCO network.

By contract, MCOs are required by the HHSC to operate behavioral health crisis hotlines 24 hours a day/7 days a week for their members, in addition to the state's requirement for LMHAs to operate crisis hotlines for anyone in their community, regardless of insurance coverage. HHSC allows, but does not require, MCOs to arrange emergency services and crisis behavioral health services through mobile crisis teams. At this time, MCOs are paying for discrete services provided by mobile crisis outreach teams, such as psychiatric evaluation, counseling, case management, and rehabilitation services, but at the same rate as non-crisis services that would be delivered in an office or at the person's home by one person and during regular business hours. These rates are inadequate because teams must travel to other sites and need transportation and other equipment to ensure their safety and the safety of the individuals they serve.

CONCLUSION

Development of a comprehensive crisis system that is timely, safe, accessible, consumer- and family-centered, and effective is essential to the creation of a safe and healthy community. This system should be the least restrictive system possible and involve critical community partnerships. Crisis services are a critical component of a comprehensive community behavioral health system. To create high-quality crisis systems and crisis programs, the development of metrics to measure performance and to make quality improvements is an important endeavor.

The work to develop national standards and definitions for crisis services has lagged behind other areas of health care practice. However, substantial progress has been made in recent years to allow effective measurement of crisis systems and crisis programs. It is timely to build on this work as federal and state systems are moving to pay-for-performance models that require the use of metrics in determining the performance and value of health care services.

This paper has outlined the best practices in crisis services, identified metrics for making quality improvements, and described some of the current policy issues impacting the deployment and development of these services. Our intention for this paper is that it will stimulate earnest discussion at the community level in support of the development of local crisis systems and programs.

APPENDIX 1: DESCRIPTION OF THE CRISIS SERVICE ARRAY

CRISIS SERVICE	BRIEF DESCRIPTION	SERVICES
Psychiatric Emergency Centers	The essential functions of a psychiatric emergency center include immediate access to assessment, treatment, and stabilization for individuals with the most severe and emergent psychiatric symptoms.	Assessment, treatment, and stabilization services; immediate access to emergency medical care.
Hospital Emergency Departments	Similar to a psychiatric emergency center, includes immediate access to assessment, treatment, stabilization, and admission/referral to inpatient care for individuals with the most severe and emergent psychiatric symptoms.	Assessment, treatment, and stabilization services; immediate access to emergency medical care, referral and/or admission to inpatient psychiatric care.
Inpatient Psychiatric Hospital Care	Inpatient treatment for individuals who are a danger to themselves or others due to mental illness or who have a psychosis or compromised ability to cope in the community and cannot be safely treated in another level of care.	Inpatient treatment, assessments, medication administration and management; meetings with extended family and others; development of a transition plan and referrals to appropriate community services.
23–48-Hour Crisis Stabilization / Observation Beds	Intensive treatment in a safe environment for individuals who have significant thoughts of suicide or significantly compromised ability to cope in the community.	Prompt assessments, medication administration, meetings with extended family and other supports; referrals to appropriate services.
Short-Term Crisis Residential and Crisis Stabilization Services (Extended Observation Units)	Urgent care treatment in a safe environment for individuals who have acute crisis symptoms.	24-hour supervision, prompt assessments, medication administration, individual/group treatment, meetings with family and other supports; referrals to community treatment.
Crisis Triage / Assessment Centers and Crisis Urgent Care Centers	Walk-in locations in which crisis assessments and the determination of priority needs are made by medical staff (including prescribers). Crisis urgent care centers provide immediate walk-in crisis services. They may or may not be based in a hospital.	Crisis assessment, medication administration, and support services.
Emergency Medical Services (EMS)	Ambulance or paramedic services, rapid response to emergency calls providing out-of-hospital acute medical care, transport to emergency departments and other services.	Acute response, assessment, and stabilization in the community; may include peace officer and mental health specialists accompanying the EMS.
Mobile Crisis Services/ Mobile Crisis Outreach Teams (MCOT)	Rapid response to crisis calls in the community by mental health specialists providing outreach, de-escalation of crises, and determination of needed treatment.	Acute mental health stabilization and psychiatric assessment in the community; psychiatrist available by phone or in-person assessment; may include peace officer and peer support specialists accompanying team.
Crisis Telehealth Services	Access to emergency psychiatry services at crisis facilities and other settings that allow highly trained staff to provide interventions without the cost of being on site continuously or when services would otherwise be unavailable.	Assessment, crisis de-escalation, and prescribing services.
24/7 Crisis Hotlines	Direct service delivered through a free telephone line that is answered 24 hours a day/7 days a week by licensed and trained staff.	Immediate support, appropriate referrals; link to mobile crisis team or emergency medical services response if appropriate.
Warm Lines	Peers provide telephonic support during hours of operation.	Peer support and compassion, message of hope; link to crisis hotline if appropriate.

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APPENDIX 1: DESCRIPTION OF THE CRISIS SERVICE ARRAY [CONT'D]

CRISIS SERVICE	BRIEF DESCRIPTION	SERVICES
Psychiatric Advanced Directives	A documented plan to determine a person's future course of treatment during a psychiatric crisis.	Individuals with psychiatric illness clearly articulate their wishes in advance of a psychiatric emergency situation.
Peer Crisis Services	Calming, home-like environment during a crisis, operated by individuals with lived experience of mental illness. Intended to last less than 24 hours but can last several days.	Peer-led interventions and support.
Transportation	Transportation in a safe and timely manner when crisis services are needed.	Depending on the circumstance, this service is provided by mobile crisis teams, EMS, or local law enforcement.

END NOTES

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[14] This table of specific measures draws in part from the referenced article, Balfour, M.E. (2016, May), pages 5-6; the Institute of Medicine's "Six Aims for Improvement"; and from other sources known to the authors.

[15] These timeliness metrics are based on CMS measures designed for emergency departments with some modifications. Balfour et al. indicates that these are directly applicable to facility-based crisis programs.

[16] The CMS measures included in the timeliness domain were written for Emergency Departments (ED) and are directly applicable to EOUs. The language has been adapted to replace "ED" with "EOU."

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