A SYSTEM LEVEL VIEW: PUBLIC HEALTH'S CRITICAL ROLE IN IMPROVING PUBLIC SAFETY

POPULATION POLICE SEE…

- Usually high system utilizers
  - EMS
  - Behavioral Health
  - Detox
  - Hospitals
  - Jails
  - Etc.
- In Theory – Public Health is our Community's "Safety Net"
- Ideally it is a viewed as a "System" with Coordination and Integration of various partners including Medicaid and Local Entities (city, county state, other government')
  - Rarely the case…usually quite fractured & inefficient

EFFECTIVE CRISIS RESPONSE KEY TO LAW-ENFORCEMENT'S PARTNERSHIP IN PUBLIC HEALTH DIVERSION

- From the Law Enforcement Perspective
- Goal – Diversion from CJ to BH System when appropriate
- Early Intercepts are key to healthy communities, improved health outcomes, reducing suicide, reducing use jail, ER, crime, etc.
- Not just "Quality" Services but key Concept "Accessibility"

ANYTIME THE POLICE ARE DIVERTING TO BEHAVIORAL HEALTH SYSTEM - POSITIVE SIGN

- Common concerns/questions
  - ✓Time BH wants us to stay - “gotta go”
  - ✓Getting the “hot-potato”
- Law-Enforcement’s Perception of Behavioral Health’s Role in the Interaction
  - ✓You’re the helping people/experts

EFFECTIVE CRISIS RESPONSE
REMOVE THE BARRIERS!

- **3 Main Elements** — Services & Accessibility based on "Customer Service" as defined by the Needs of the Cops

  1. **No Wrong Door Philosophy** (they can enter anywhere, and BH can move amongst their system)
  2. **Expedient** – Quick Turn Around
  3. **If Mobile Response** – Quick & Certain Responses (not "triage")

EFFECTIVE CRISIS RESPONSE

- **Needs to be faster & easier than jail**
- **Long-Term positive or implications**
  - ✓ **Police are not "required" to do this**
  - ✓ **You have the power to reinforce or undo – "No UM" Please ☺**
  - ✓ **2001 Experience**
  - ✓ **Path of least resistance – sidewalks, etc.**
- **Different "barriers" in Rural than Urban due to density, etc., but the same "culture" should apply regardless of demographics, etc.**
  - ✓ **Blended Funding**
  - ✓ **Achieving Trip Aim Outcomes**
  - ✓ **Patient Experience, Improved Outcomes. Cost Savings**

PUBLIC HEALTH SYSTEMS….

- Many Public Health Systems are fragmented
- Not only Physical and Behavioral but also by payer source
- Crisis frequently not integrated or coordinated with the long-term treatment/outpatient side
  - Acerbated with lack of coordination of Physical Health Care.
- Directly ties into Public Safety Concerns

EMERGENCY DEPARTMENT COSTS

- Average ER visit cost $2,000
- Average ER visits by chronically homeless SMI 7/year
- Roughly 4,000 chronically homeless SMI recipients in Greater Phoenix Area
- $56,000,000/year in ER costs alone

- If each of the 38 emergency departments in the Greater Phoenix area saw 1 chronically homeless SMI recipient per day
  - Annual cost: $27,740,000

NAMI, 2005

TREATMENT VS. INCARCERATION COSTS

- Annual cost per inmate
  - $22,794/year

- The average cost for drug treatment per year is:
  - $1,800 for outpatient care
  - $2,500 for intensive outpatient treatment
  - $3,900 for opiate replacement therapy
  - $4,400 for short-term residential care
  - $6,800 for long-term residential care

MACRO SYSTEMS

- THINK BIG!!!
- To Work effectively requires integration and accountability at the Payer Source(s) Level
- SAMHSA White-paper
- Example

WHAT DOES A CRISIS CONTINUUM LOOK LIKE?

- Minimum SAMHSA Model:
  1. Crisis Hotline/Warmline
  2. Mobile Crisis Services
  3. 23-hour Stabilization/ Observation Beds
  4. Short-Term Crisis Residential/Stabilization
  5. Advanced Directives
  6. Peer Crisis Services

- Ideally even more community based options.
- All need to operate with “No-Wrong Door” Philosophy!
- Done correctly drives “stakeholders” to most appropriate and least costly level of care.
- No “single” funder can provide all, Integrated dollars key to sustainability

ACCOUNTABILITY

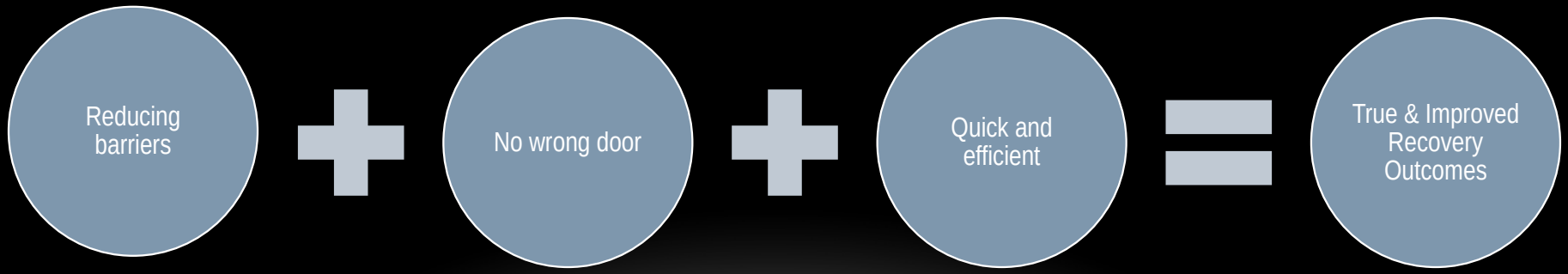
- Integrated funding whether by design or by collaboration
- Equally Important – Provider/System Accountability…
- Bridging Silos…

CRISIS SERVICE PACKAGE

- 24/7 Crisis Line (20,000 calls per month)
- 24/7 Mobile Crisis Teams (1,600 dispatches per month)
- Two Psychiatric Urgent Care Centers (24/7)
- Two Substance Abuse/Detox Centers (24/7)
- Inpatient Psychiatric Hospital Services
- Hospital-Based Rapid Response (Mobile Teams)
- Peer-Operated Warm Line (4,000 calls per month)
- Two Behavioral Health Access Facilities (24/7)
- Two Behavioral Health Transition Facilities (24/7)

JAIL DIVERSION & IMPROVED MEMBER OUTCOMES – WHILE SAVING PUBLIC SYSTEM MONEY!!!

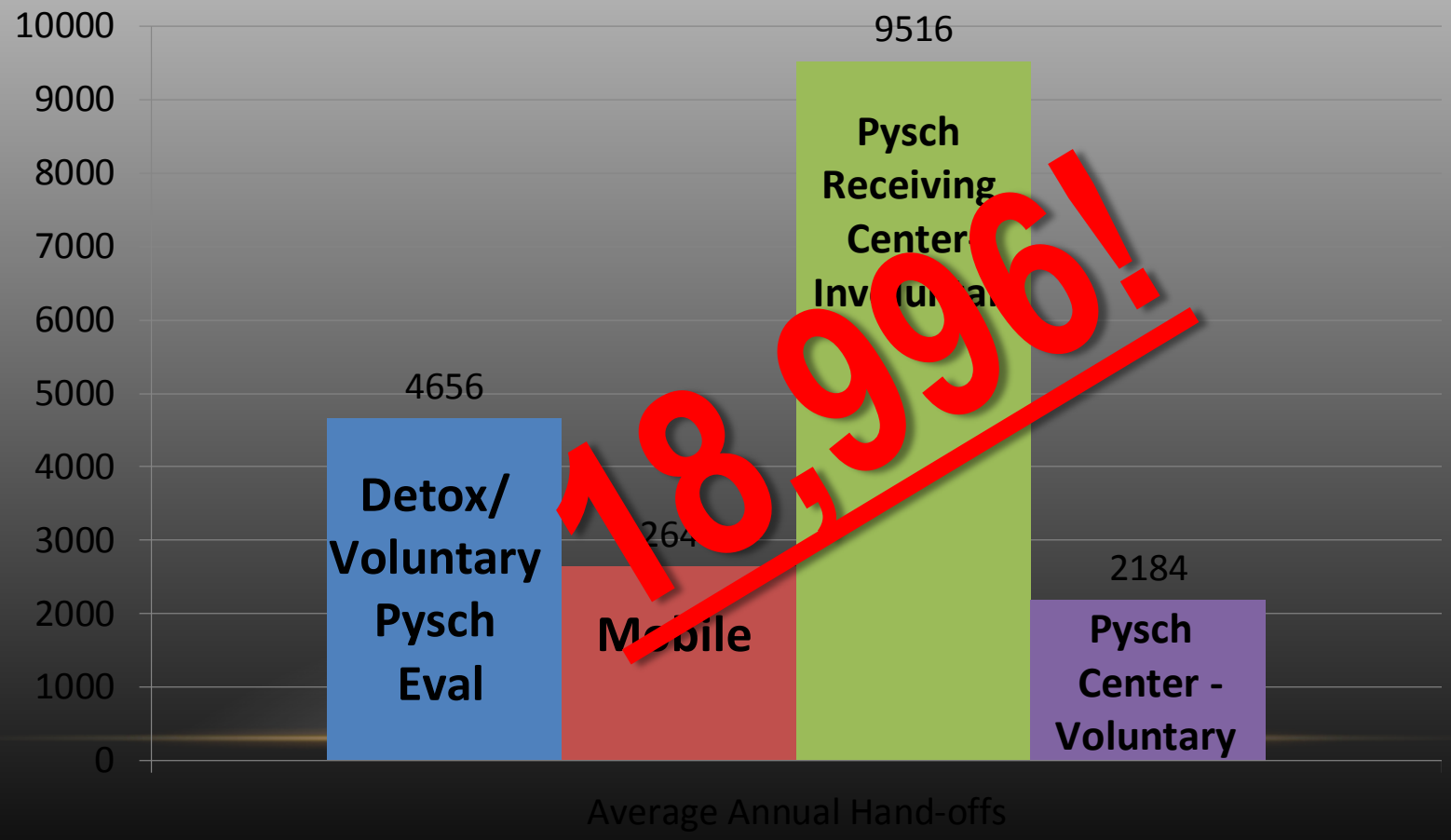
- This new access and utilization can result in countless reductions in incarceration, ED Utilization, linkages to critical long-term treatment opportunities and criminal justice and Public Health cost savings.



"BIG PICTURE/LASTING EFFECTS"

WE'RE ENCOURAGING PHILOSOPHY SHIFT & FAR REACHING CONSEQUENCES

ANNUAL PHOENIX METRO PD HANDOFFS TO THE CRISIS SYSTEM



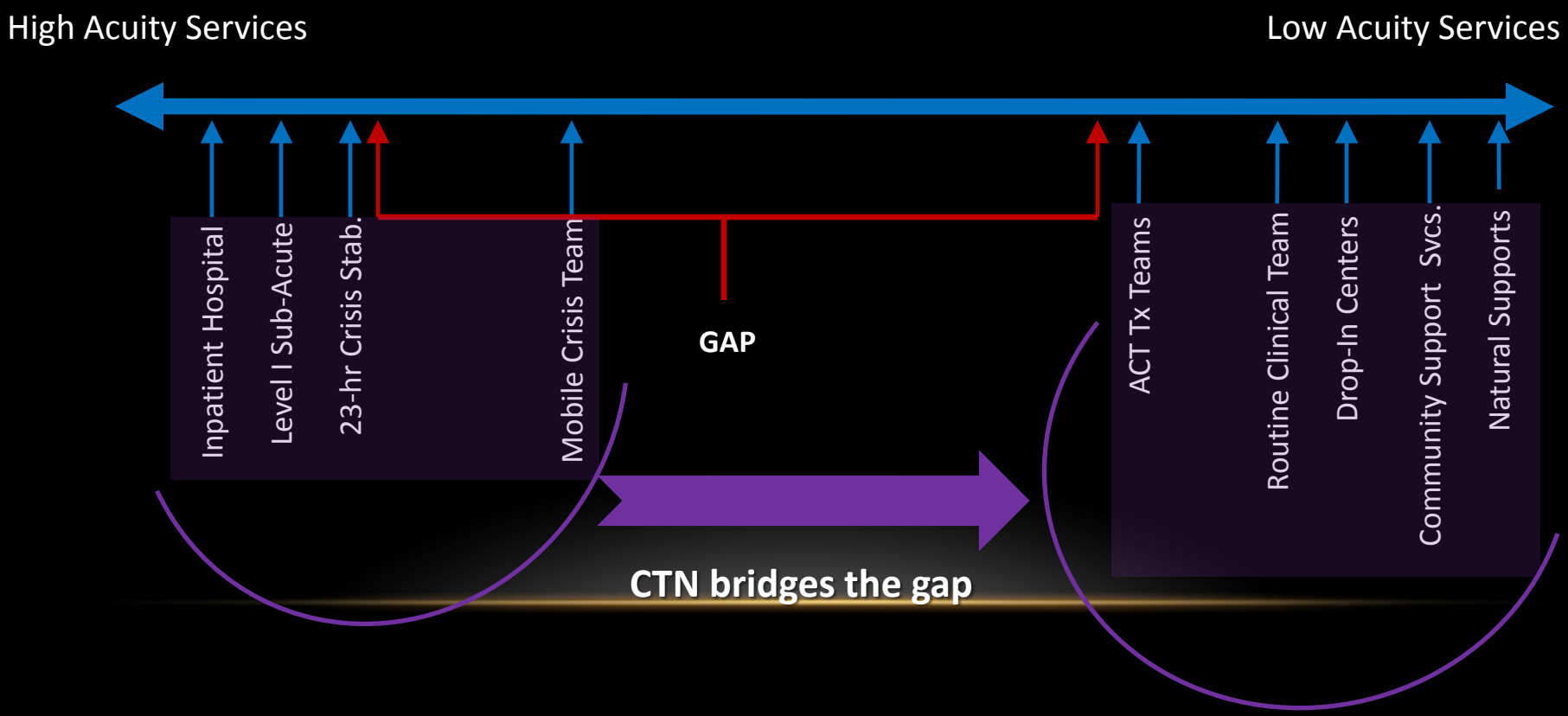
APPENDIX

CRISIS MOBILE TEAM

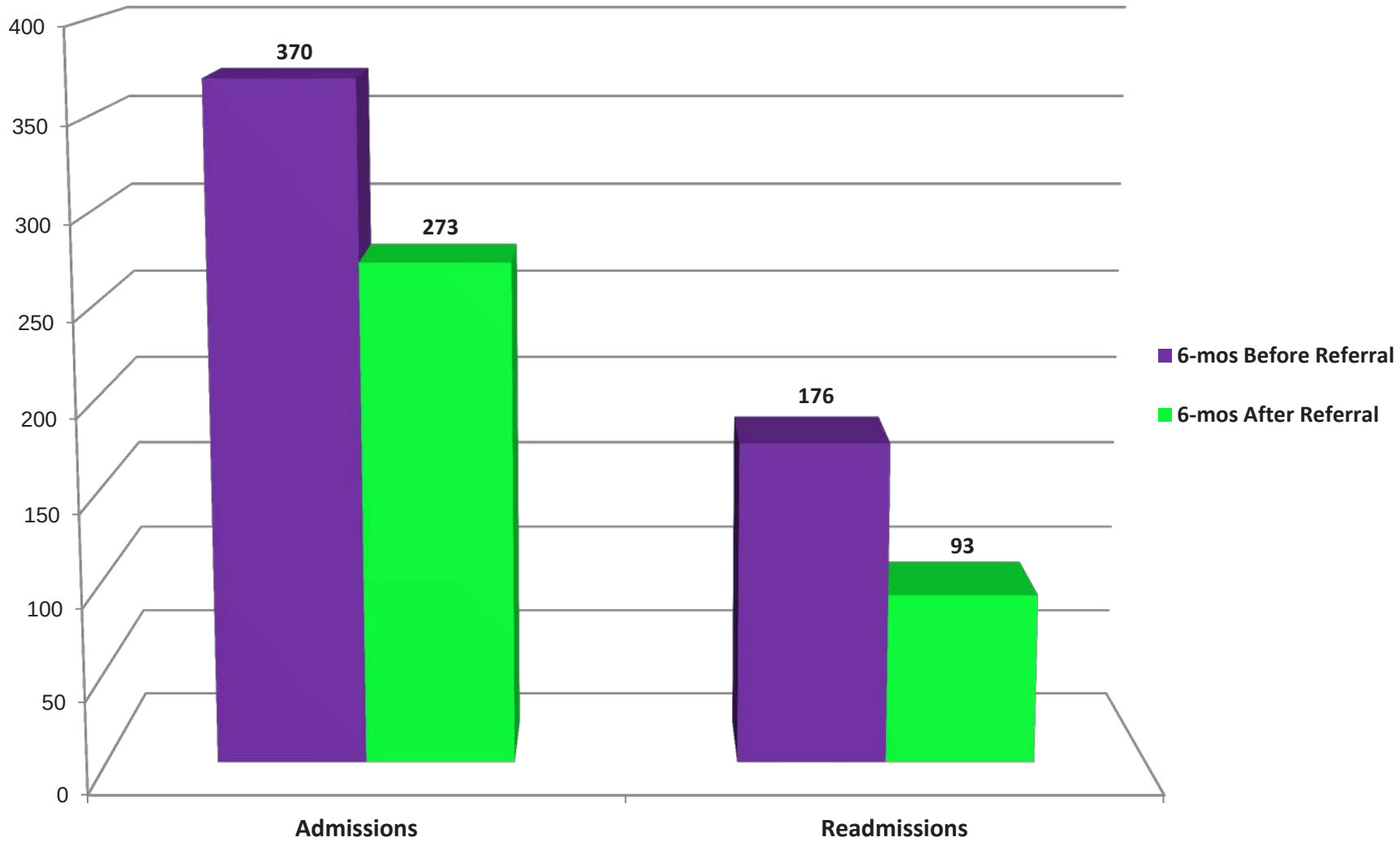
- Roughly 80% Of all Mobile Team Responses Stabilize individuals in their “Community”
  - I.E. 18,000 Times a Year (Less than 1,800 required a Police Response)
- Law-Enforcement Requested Mobile Teams
  - I.E 3,000 Times a Year
  - Approximately 70% Individuals Stabilized in their Community
  - Approximately 27% Transported to Psychiatric/Substance Community Based Receiving Center
  - Less than 3% Transported to Med/Surge E.D.

CRISIS TRANSITION NAVIGATOR PROGRAM
SYSTEMIC GAP

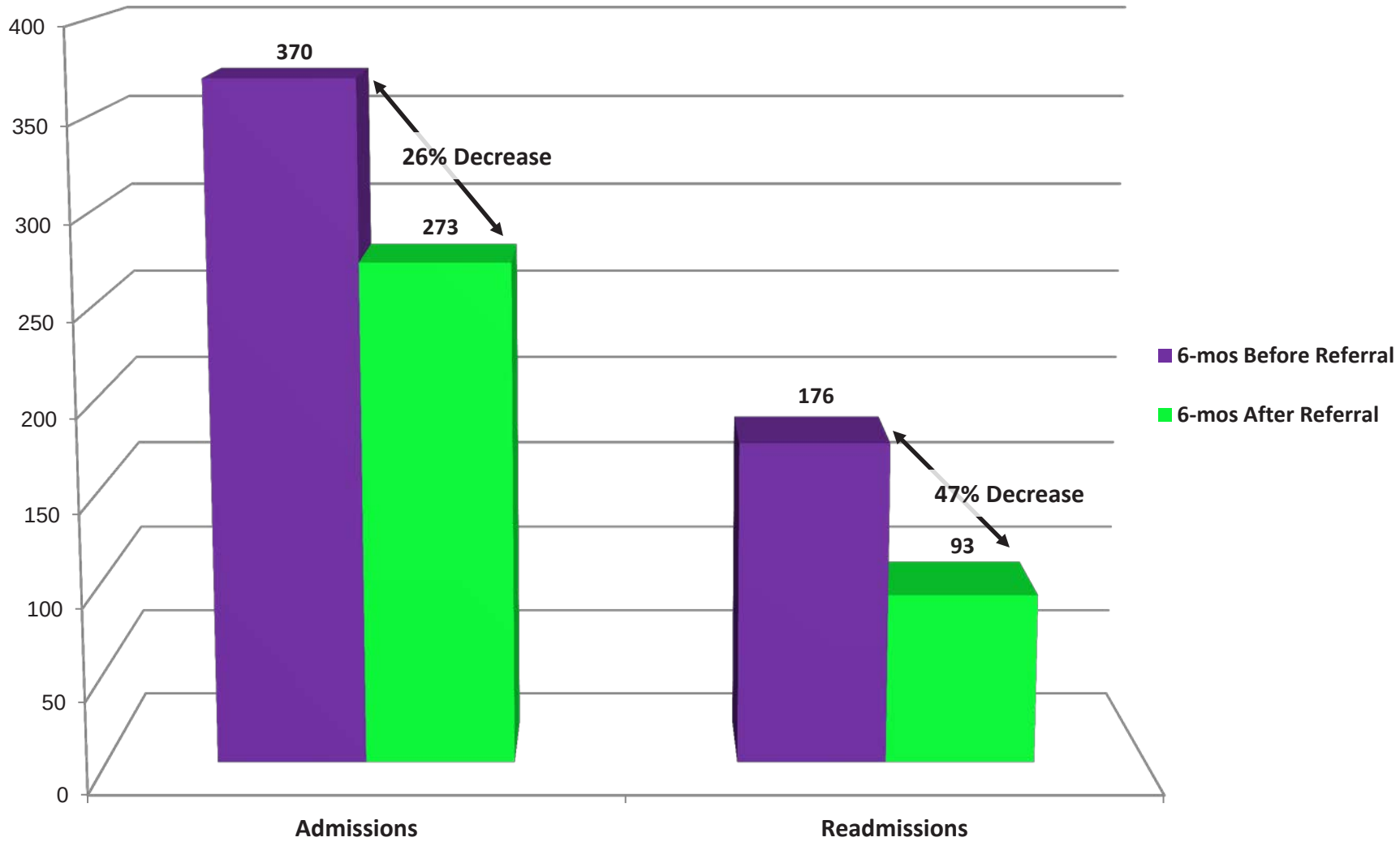
- There is a systemic gap between routine care, inpatient and crisis services



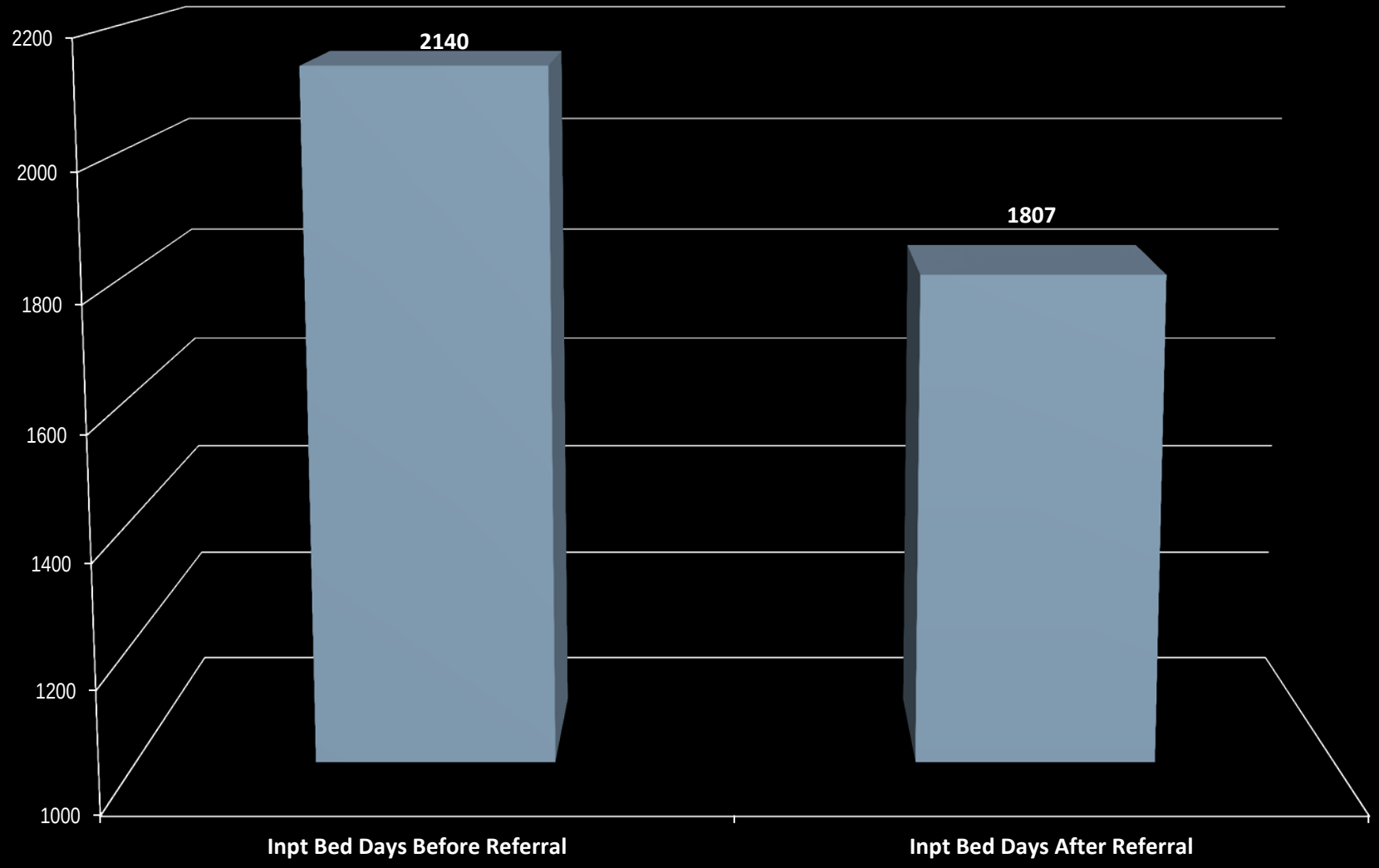
Inpatient Admissions and Readmissions



Inpatient Admissions and Readmissions



TOTAL INPATIENT BED DAYS



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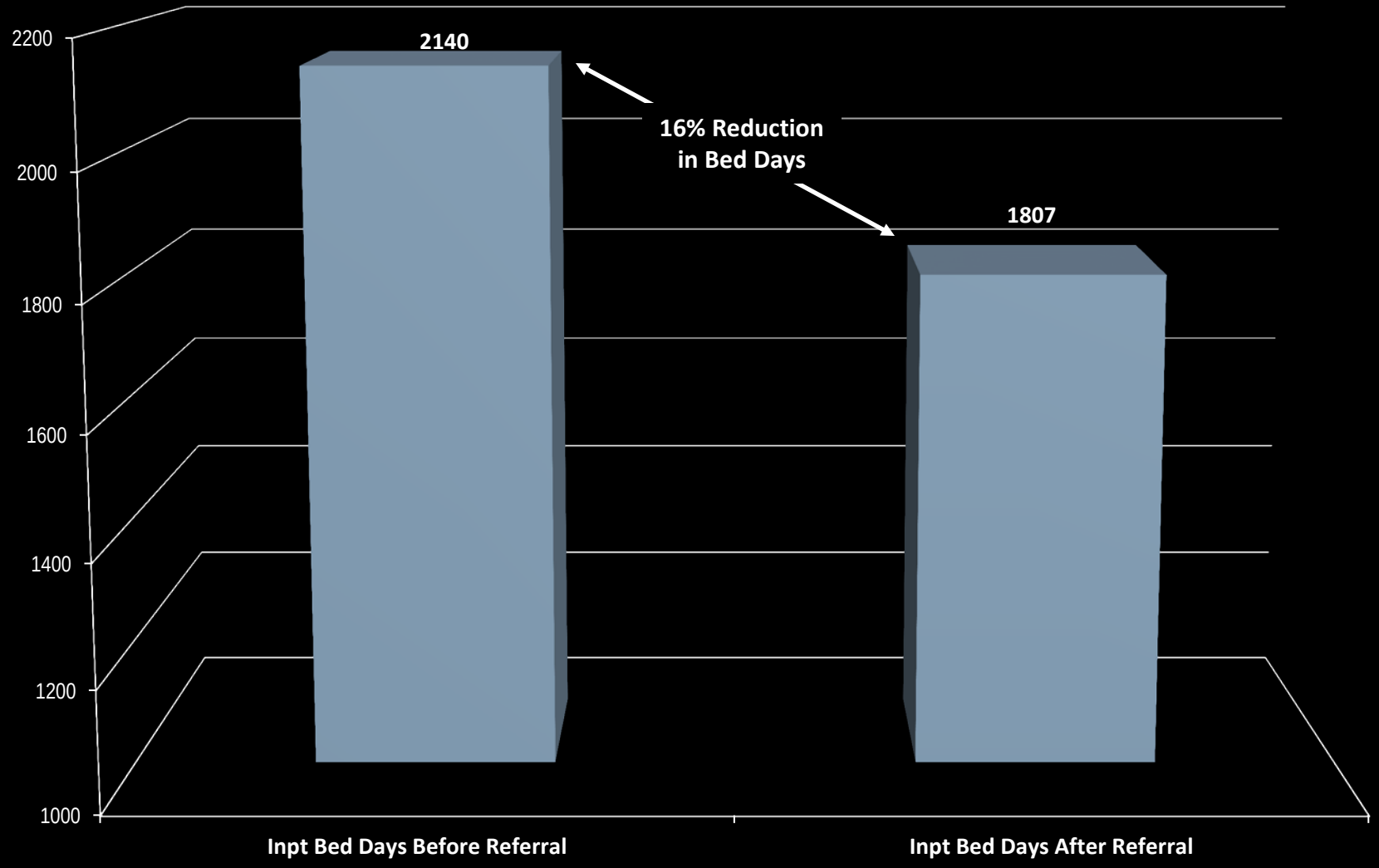

PROJECT H3 “UNOFFICIAL OUTCOMES”

- ✓ 300 Formerly Chronically Homeless Individuals House
  - ✓ Most where homeless for nearly 10 years
  - ✓ Nearly all have a behavioral health and/or medical need
- ✓ After one year after housing Reduction in Recidivism of nearly 80%!*
- ✓ Nearly 70% Reduction in ER Utilization

*Sampling is based on available data of 18 H3 Participants who have been housed 12+ months. Total cohort data is an extrapolated rate from sample group across the entire cohort. Data extrapolated to include “anticipated” arrests over an annualized period.