DECEMBER 2023

JACSR Presentation

Connections Health Solutions Overview

connections

Most communities in America…

911: WHAT'S YOUR EMERGENCY?

"I'm having chest pain."

"I'm suicidal."

SAMHSA's Vision

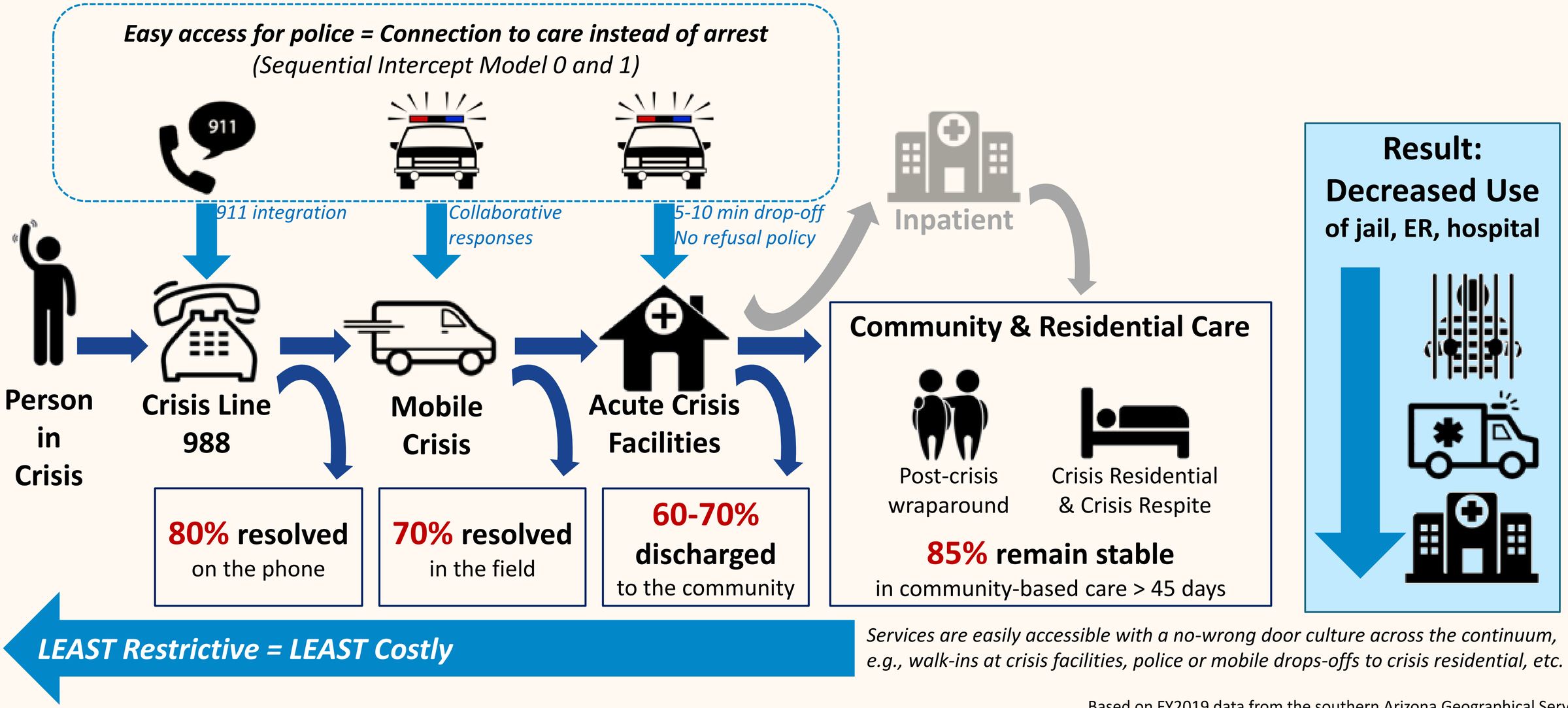
"Someone to contact"

988 SUICIDE & CRISIS LIFELINE

"Someone to respond"
(mobile crisis)

"A safe place for help"
(specialized facilities & stabilization services)

A Coordinated Crisis System



Services are easily accessible with a no-wrong door culture across the continuum, e.g., walk-ins at crisis facilities, police or mobile drops-offs to crisis residential, etc.

Based on FY2019 data from the southern Arizona Geographical Service Area

Balfour ME, Hahn Stephenson A, Delaney-Brumsey A, Winsky J, & Goldman ML. Cops, Clinicians, or Both? Collaborative Approaches to Responding to Behavioral Health Emergencies. *Psychiatric Services*. 2022 Jun;73(6):658-669. https://doi.org/10.1176/appi.ps.202000721

“Crisis Stabilization Units” & Facility-Based Crisis Services – An Imperfect Guide

Each person should be matched to the program that can safely & effectively meet their needs. Mismatches between acuity & intensity lead to poor outcomes.

People

HIGH ACUITY
Danger to self/other, acute agitation
Significant intoxication/withdrawal

MODERATE ACUITY

LOW ACUITY
Needs engagement &
help with social stressors

Program

HIGH INTENSITY
LOCUS 6 “Medically managed”
ASAM WM 3.7 or 4
High medical/nursing involvement
Hospital-level safety standards

MODERATE INTENSITY
LOCUS 5 “Medically monitored”
ASAM WM 3.7 or 3.2
Variable levels of med/nursing

LOW INTENSITY
Staffed primarily by peers
Minimal or no med/nursing

zone of high variability

- Crisis Respite
- Living Rooms
- Inpatient-like/Subacute
- Crisis Residential/Subacute
- Peer Respite
- Medically supervised detox ASAM WM 3.7
- Sobering / “social detox” ASAM 3.2
- 23-hr obs
- Crisis Receiving Centers
- PES
- EmPATH
- CPEP

Hospital / ED Affiliated

Programs may be accessed directly, via first-responders, and/or as step-down from a more intensive level of care.

Lots of local variation in:

- Licensing
- Nomenclature
- Reimbursement
- Involuntary process
- Locked vs unlocked
- Police drop-offs
- Length of stay

But ALL should provide

- Crisis intervention/treatment *(vs holding to await transfer to another level of care)*
- Safe and therapeutic milieu
- Peer support & engagement
- Care coordination and help with social determinants of health
- Trauma-informed approaches
- Capability of addressing co-occurring MH and SUD needs

For review see: Balfour ME, Hahn Stephenson A, Delaney-Brumsey A, Winsky J, & Goldman ML. Cops, Clinicians, or Both? Collaborative Approaches to Responding to Behavioral Health Emergencies. *Psychiatric Services*. 2022 Jun;73(6):658-669. https://doi.org/10.1176/appi.ps.202000721

Crisis Centers Serve as the Backbone to Crisis Response

For physical health emergencies communities know to go to the ER to get immediate, critical care. In the same way, crisis centers serve as the unequivocal front door for behavioral health emergencies 24/7/365.

Key Elements of a Connections Crisis Center:

Accept 100% of individuals in behavioral health crisis

We treat even the highest acuity individuals safely. This includes co-occurring SUD, involuntary and voluntary patients, aggressive, psychotic, violent. **We never refuse law enforcement.**

Co-located levels of care to treat all acuities in crisis

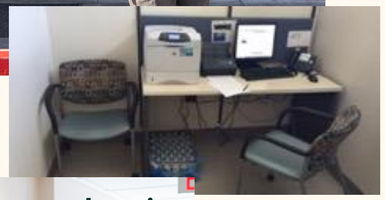
We co-locate urgent care, 23-hour Observation, and crisis stabilization units to ensure that regardless of the need we can handle the entire crisis journey.

Multi-disciplinary treatment teams

We use multidisciplinary treatment teams including MDs, NPs, PAs, nurses, case managers, behavioral health specialists, peer support specialists to provide comprehensive care.

Emphasis on least restrictive care

We start with the assumption that the crisis will be resolved. We provide intensive treatment so that 65-70% of those in our care return to the community within 24 hours.



Dedicated police entrance with workspace

Warm welcoming walk-in entrance

Connections Crisis Center Outcomes

Connections' care model has been lauded in peer-reviewed publications for both adults and adolescents[1-4] and is effective to stabilize crises and connect to community care.

65-70%
Community disposition rate

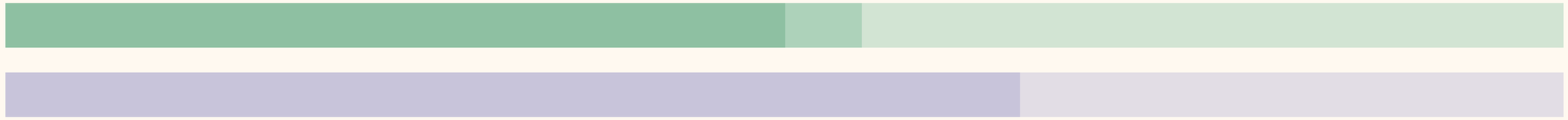
60-70%
Conversion to voluntary rate

>90%
7-day outpatient BH follow-up

<5%
Re-admission rate to Connections

<10
Minute law enforcement drop-off time

Patient Demographics



50-55% Law Enforcement Drop-off

65% Substance use Disorder

Sources: 1. National Council for Behavioral Health. Roadmap to the Ideal Crisis System: Essential Elements, Measurable Standards and Best Practices for Behavioral Health Crisis Response, pages 105 – 106. 2. Substance Abuse and Mental Health Services Administration. (2020). National Guidelines for Behavioral Health Crisis Care: Best Practice Toolkit, pages 54 - 56. 3. Balfour ME, Zinn T, Cason K, Fox J, Morales M, Berdeja C, Gray J. (2018). Provider-Payer Partnerships as an Engine for Continuous Quality Improvement. Psychiatric Services, 69(6), 623-625. 4. Pediatric Behavioral Health Urgent Care 2nd Edition, Children's Mental Health Campaign, pages 27 -28. 5. Number excludes patients seen in non-core service lines.

Roadmap to the Ideal Crisis System

National Council for Mental Wellbeing report to help communities develop crisis systems + companion report on crisis system metrics.

Roadmap Report

CrisisRoadmap.com

Crisis Metrics Report

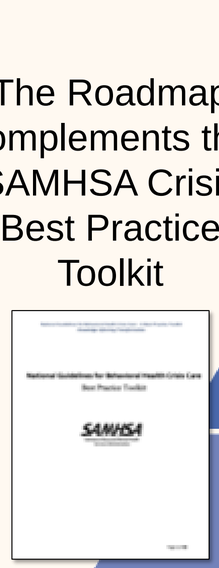
http://bit.ly/MDICrisisMeasures

Crisis Roadmap Vision

A BH Crisis System is an **essential community service** just like police, fire, & EMS.

A crisis **system** is more than a single crisis program.

The Roadmap complements the SAMHSA Crisis Best Practice Toolkit



Oregon Can be a Leader in Behavioral Health Crisis Care

We recognize, and applaud, the recent passage of HB2757 and the many changes underway to create rule requirements for crisis stabilization centers. We have included some additional questions to consider below:

- Do defined license types exist for discrete behavioral health crisis services (i.e. 23-hour observation, walk-in/urgent care, crisis stabilization unit, mobile crisis response, etc.)?
- Do specific crisis reimbursement codes exist that can sustain 24/7/365 crisis services?
- What legislative impediments are there to a care model that accepts 100% of individuals, 24/7/365, regardless of clinical acuity or circumstance? E.g., are involuntary commitment laws in alignment?
- If legislative impediments are not clear, are there ongoing analyses to identify where barriers may exist?

THANK YOU
Core to Connections' values is system collaboration, we would welcome any follow-up questions or feedback.

Margie Balfour, MD, PhD
Chief Clinical Quality Officer
margie.balfour@connectionshs.com

Morgan Matthews
VP, Partnerships
morgan.matthews@connectionshs.com