Care Response for Behavioral Health Crises in Cuyahoga County:

Recommendations

May 24, 2023

R
STRATEGY
GROUP

Background

Cuyahoga County ADAMHS Board continuously evaluates the community for ways to better meet the community's behavioral health needs

Behavioral health crisis services are being strengthened throughout the United States

Based upon discussion with and in consultation with ADAMHS, R Strategy Group (RSG) evaluated the feasibility of "Care Response" to build upon existing the crisis response services in the county

Research funding was generously provided by

Our charge

Make recommendations that can be used in development of an RFP that will lead to a Care Response pilot project in a specified area or areas of Cuyahoga County that can become the path for further expansion in the county

Our process

Convened workgroup of local stakeholders and outside consultants to advise process

Interviews with local leaders and advocates

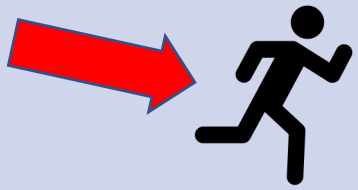
Discussion with Care Response programs in Ohio and nationally

Research of professional literature

Review of media reports

Focus groups and community surveys

Care Response Is Part of the Crisis Care Continuum (SAMSHA, 2020)

	**Someone to talk to**	Essential Characteristics of All Crisis Care Components: • Address recovery needs • Significant role for peers • Trauma-informed care • Safety and security for staff and those in crisis • Law enforcement and emergency medical services collaboration
 CARE RESPONSE	Someone to respond	
	A place to go	

Care Response: What is it?

- Consists of a team of individuals with specific behavioral health and crisis stabilization expertise responding to mental health or addiction crises in the community setting
  - Team members
    - Licensed behavioral health professional and a peer support person with lived experience in the behavioral health system
    - Unarmed
    - Have skill and training to assess specific needs and frequently meet those needs in the community
    - Work with dispatch and other responders (such as police/CIT officers) to assure that the needs of people are met and safety of the person being served and responders is maintained
    - Can frequently avoid police response to behavioral health issues, permitting more focus on other public safety issues

Service Overview
(CMS, 2021)

Help individuals experiencing a crisis event experience relief quickly and resolve the crisis situation when possible

Meets individuals in an environment where they are comfortable and/or at the site where the crisis is occurring

Provides appropriate care/support while avoiding unnecessary law enforcement involvement, ED use and hospitalization

Connect individuals with facility-based care, if needed

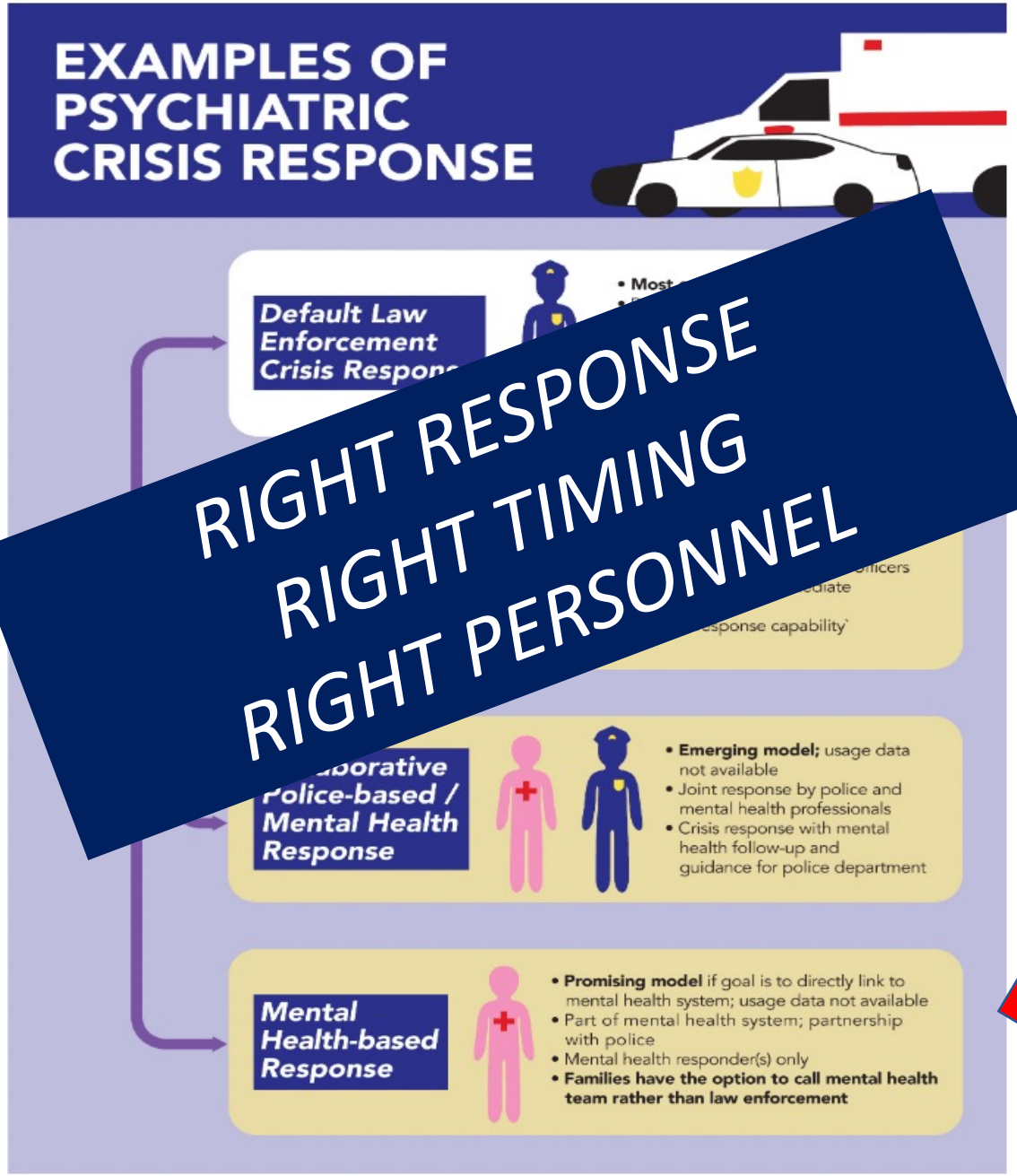
Warm Hand-offs

Coordinate transportation

24/7 availability

Rapid response

Examples of Community Crisis Response: Someone to Respond (Pinals, 2020)



Why Care Response?

- Reduced need for police involvement
- More situations resolved in community (less hospitalizations)
- Improved safety
- Less crime in areas covered by Care Response
- Increased involvement in treatment after crisis
- Well-received
- Preferred by community
- Cost effective

Recommendations on Care Response

Based upon existing research, experience of communities across the nation, and preferences of individuals surveyed in Cuyahoga County, **we recommend that Cuyahoga County implement a community-based, unarmed Care Response program that will be rapidly available and staffed by behavioral health professionals and peers.**

Specific Recommendations

- Care Response services should commence with a *pilot program* in one or more geographic regions of the county, with plan to expand based upon the learnings of the pilot program.
- Entity or entities implementing Care Response should be selected through a competitive process by responding to a Request for Proposals (RFP) to find the vendor(s) with the greatest likelihood of success in addressing the complexities of Care Response.
- The specific pilot region(s) chosen to better meet needs of underserved

Suggestions for Pilot Area

- Demographics reflect significant population of underserved individuals by virtue of:
  - Race
  - Ethnicity
  - Socioeconomic status
  - Sexual orientation
- Area of high need
  - High volume of calls relating to MH/SUD issues
  - Disproportionately low calls and service utilization in view of demographics
- Area with more adverse outcomes in interactions between served individuals and current responders
- Interest and support of proposed pilot community

Suggestions for Pilot Area (continued)

- Support of partner agencies:
  - Social service agencies
  - Behavioral health agencies
  - Behavioral health crisis facilities
  - Hospitals
  - Law enforcement
  - Dispatch services
  - Other community behavioral health crisis responders, if present (e.g., co-response programs)
- Uncomplicated dispatch landscape (single 911)
- Sufficient population size to generate meaningful number of encounters to assess program effectiveness and inform future expansion

Specific Recommendations

- The Care Response program should meet the basic criteria for mobile crisis
- The pilot period
  - Six months of “lead-in”
  - Twelve months of service provision/program assessment
- Engage the pilot community as a full partner in the development, implementation, and assessment of the pilot
- Staffing of the Care Response team should reflect the characteristics of the community
- Staff safety and wellness must be a priority

Specific Recommendations

- A training curriculum should be developed from currently available resources adapted to meet Cuyahoga County and pilot area needs, with input from:
  - Local experts
  - Pilot area residents
  - Consumers of services
  - Family members.
  - Consider outside vendor to assist
- Staff will utilize standardized tools for assessment and assistance in determining disposition of clients
- Dispatch processes should be agreed upon before implementing to services
- Clarity should be provided about most appropriate location of care for clients who require facility-based crisis interventions (“A place to go”)

Specific Recommendations

- The Care Response pilot should be data-driven.
  - An outside vendor may be considered for data expertise and management
- A data dashboard which is available to anyone should be created and posted online.
- Quality measures should be selected to determine compliance in executing the pilot and success of pilot.

Specific Recommendations

- Care Response sponsor(s) should seek multiple funding streams to support the pilot project and promote long-term viability.
- Applicants proposed budget should meet promising practice standards and include a plan for billing for services as a source of revenue beyond grant funding.
- The funder(s) should consider budgeting as much as $1.65M for an 18-month pilot program.
- The system should begin planning for expansion of services early in the pilot period based upon knowledge gained from the pilot.

Budget Assumptions for 2 Teams

Expense type	Amount		Notes
	6-month lead-in	12-month implementation	
Clinical Director/lead trainer (1)	$87,500	$175,000	Licensed Independent Practitioner—supervises and trains staff, liaisons with partners and community
Licensed BH professional (2)	$57,500 (3 months)	$230,000	Provides direct service 40 hrs/week
Peer support Specialist (2)	$50,000 (3 mo)	$200,000	Provides direct service 40 hrs/week
Advisory panel (8)	$9,600 2meetings/mo	$9600 1 meeting/month	$25/hour
Community research assistants (2)	$20,000	$80,000	$30/hour 20 hours/week
Community Training	$4000	$4000	Mental Health First Aid training for 100 community members each year
Travel	$20,000	$5,000	To existing MCT programs for observation and training
Vehicles (2)	$100,000	0	
Equipment	$50,000	$25,000	Radios, phones, computers
Fuel and vehicle maintenance	$2500	$10,000	
Supplies	$10,000 (initial procurement)	$20,000	Naloxone, Harm reduction kits, medical supplies, bus passes, housing vouchers, food, water, clothing
Development of training plan	$100,000 (includes payment to community trainers)	$30,000	May be separate RFP to different vendor. Includes development of plan for 911/988 interface and dispatch
Data plan and analysis	$100,000	$100,000	May be separate RFP. To different vendor
Communications and outreach	$30,000	$20,000	
Sign-on bonus	$10,000	$4,000	$2000/employee hired
Retention bonus	$6,000	$20,000	$1000 at 3 and 6 months of employment $2000 at 12 months
Contingency	$70,000	$100,000	
TOTAL	$727,100	$932,600	

Budget Assumptions for 1 team

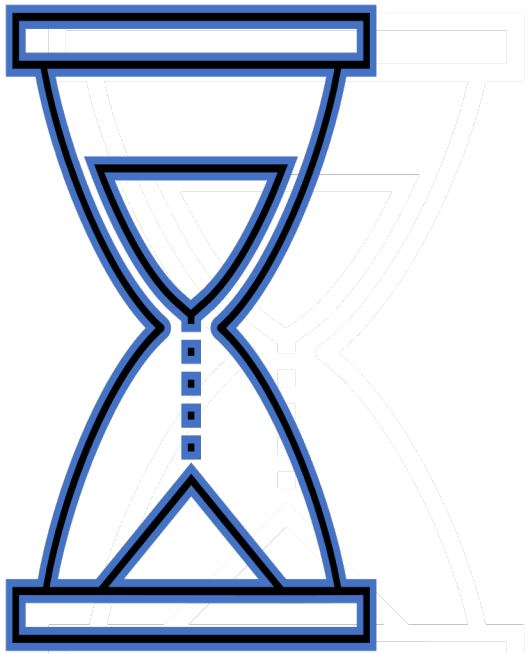
Expense type	Amount		Notes
	6-month lead-in	12-month implementation	
Clinical Director/lead trainer (1)	$87,500	$175,000	Licensed Independent Practitioner—supervises and trains staff, liaisons with partners and community
Licensed BH professional (1)	$28,750 (3 months)	$115,000	Provides direct service 40 hrs/week
Peer support Specialist (1)	$25,000 (3 mo)	$100,000	Provides direct service 40 hrs/week
Advisory panel (8)	$9,600 2meetings/mo	$9600 1 meeting/month	$25/hour
Community research assistants (2)	$20,000	$80,000	$30/hour 20 hours/week
Community Training	$4000	$4000	Mental Health First Aid training for 100 community members each year
Travel	$15,000	$3,500	To existing MCT programs for observation and training
Vehicles (1)	$50,000	0	
Equipment	$50,000	$15,000	Radios, phones, computers
Fuel and vehicle maintenance	$2500	$5,000	
Supplies	$10,000 (initial procurement)	$20,000	Naloxone, Harm reduction kits, medical supplies, bus passes, housing vouchers, food, water, clothing
Development of training plan	$100,000 (includes payment to community trainers)	$30,000	May be separate RFP to different vendor. Includes development of plan for 911/988 interface and dispatch
Data plan and analysis	$100,000	$100,000	May be separate RFP. To different vendor
Communications and outreach	$30,000	$20,000	
Sign-on bonus	$6,000	$2,000	$2000/employee hired
Retention bonus	$6,000	$8,000	$1000 at 3 and 6 months of employment $2000 at 12 months
Contingency	$50,000	$70,000	
TOTAL	$544,350	$748,100	

Care Response—Potential Cost Offset

Crisis Now Crisis System Calculator (Basic)		
	No Crisis Care	**Crisis Now**
# of Crisis Episodes Annually *(200/100,000 Monthly)*	30,000	30,000
# Initially Served by Acute Inpatient	20,400	4,200
# Referred to Acute Inpatient From Crisis Facility	-	1,670
Total # of Episodes in Acute Inpatient	20,400	5,870
# of Acute Inpatient Beds Needed	**497**	**143**
Total Cost of Acute Inpatient Beds	**$ 145,066,667**	**$ 41,738,667**
# Referred to Crisis Bed From Stabilization Chair	-	6,678
# of Crisis Beds Needed	**-**	**51**
Total Cost of Crisis Facility Beds / Chairs	**$ -**	**$ 14,840,000**
# Initially Served by Crisis Stabilization Facility	-	16,200
# Referred to Crisis Facility by Mobile Team	-	2,880
Total # of Episodes in Crisis Facility	-	19,080
# of Crisis Observation Chairs Needed	**-**	**60**
Total Cost of Crisis Facility Beds / Chairs	**$ -**	**$ 21,805,714**
# Served Per Mobile Team Daily	4	4
# of Mobile Teams Needed	**-**	**9**
Total # of Episodes with Mobile Team	-	9,600
Total Cost of Mobile Teams	**$ -**	**$ 3,682,192**
# of Unique Individuals Served	**20,400**	**30,000**
TOTAL Inpatient and Crisis Cost	**$ 145,066,667**	**$ 82,066,573**
ED Costs ($1,233 Per Acute Admit)	**$ 25,153,200**	**$ 7,237,094**
TOTAL Cost	**$ 170,219,867**	**$ 89,303,666**
TOTAL Change in Cost	**$ (80,916,200)**	**-48%**

Population Census	**1,250,000**
ALOS of Acute Inpatient	**8**
Avg. Cost of Acute Bed/Day	**$ 800**

Not-so final word



- Much to be done—whole process is years long, not months long
- Great information locally, in Ohio, and nationally—don't need to re-invent the wheel
- Starting a pilot is good way to move down the path
- Community engagement is essential, valued and responded to
- Diverse viewpoints bring strength

This can be accomplished!