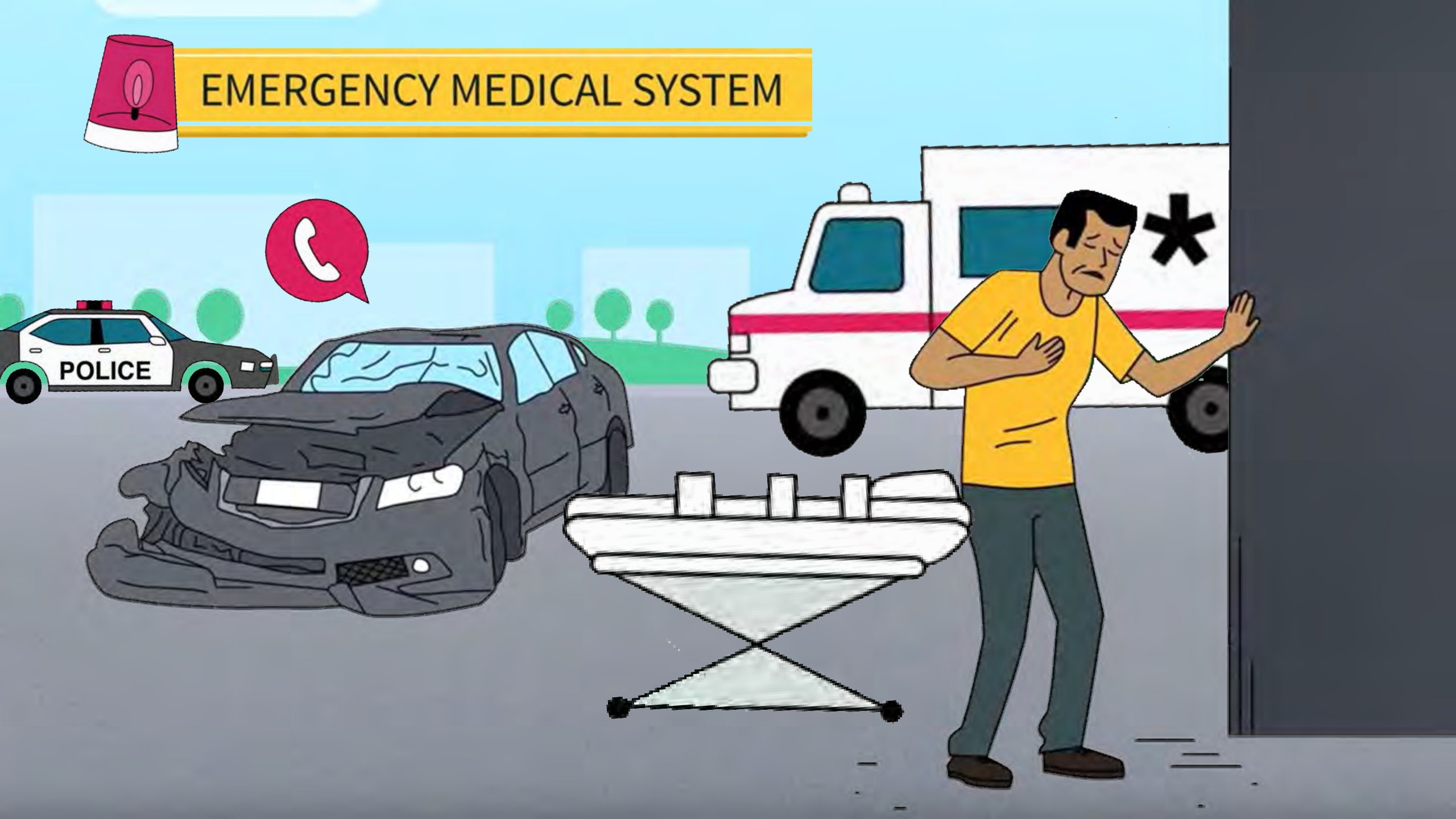
CRISIS NOW

Transforming Crisis Services


COLLAPSE...
DARKNESS


EMERGENCY MEDICAL SYSTEM
POLICE

NATIONAL ACTION ALLIANCE FOR SUICIDE PREVENTION

Crisis Now

Transforming Services is Within Our Reach


Innovations Award Winner:
Georgia Crisis
and Access Line


BusinessWeek
16 Ideas for Improving Government Services
Crisis & Access Line, State of Georgia (June 2009)
HOME INVESTING COMPANIES TECHNOLOGY INNOVATION MANAGING SMALL BIZ B-SCHOOLS ASIA EUROPE LIFESTYLE MAGAZINE


Care
Traffic
Control


THE
FUSION
MODEL

Do not pass go. Do not collect $200.

GO DIRECTLY TO ~~JAIL~~
THE HOSPITAL

Seattle Times 2013. **3 Days Average**

ACEP Now
The Official Voice of Emergency Medicine

LATEST NEWS
Medicare-for-All Might Not Cause Surge in Hospital Use
Call for Applications: *JACEP Open*

An official publication of
American College of Emergency Physicians
ADVANCING EMERGENCY CARE

Federal Gov't Declares Emergency Physicians Incapable of Performing Medical Screening Exam for Psychiatric Patients in AnMed Lawsuit

October 17, 2017 by **Robert A. Bitterman, MD, JD, FACEP**

There is no EMTALA issue in emergency medicine more difficult, more confusing, or more risk-prone than managing psychiatric patients in the ED. The AnMed Health case is the quintessential example and should greatly concern emergency physicians.

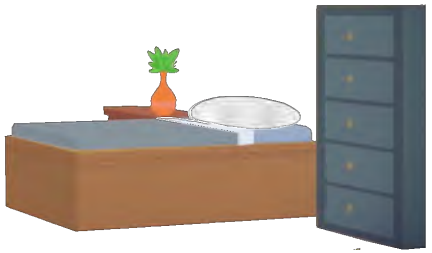
AnMed Health, a hospital system based in Anderson, South Carolina, recently settled with the Office of Inspector General (OIG) for $1.295 million for allegedly failing to appropriately screen and stabilize psychiatric patients presenting to the hospital's ED.

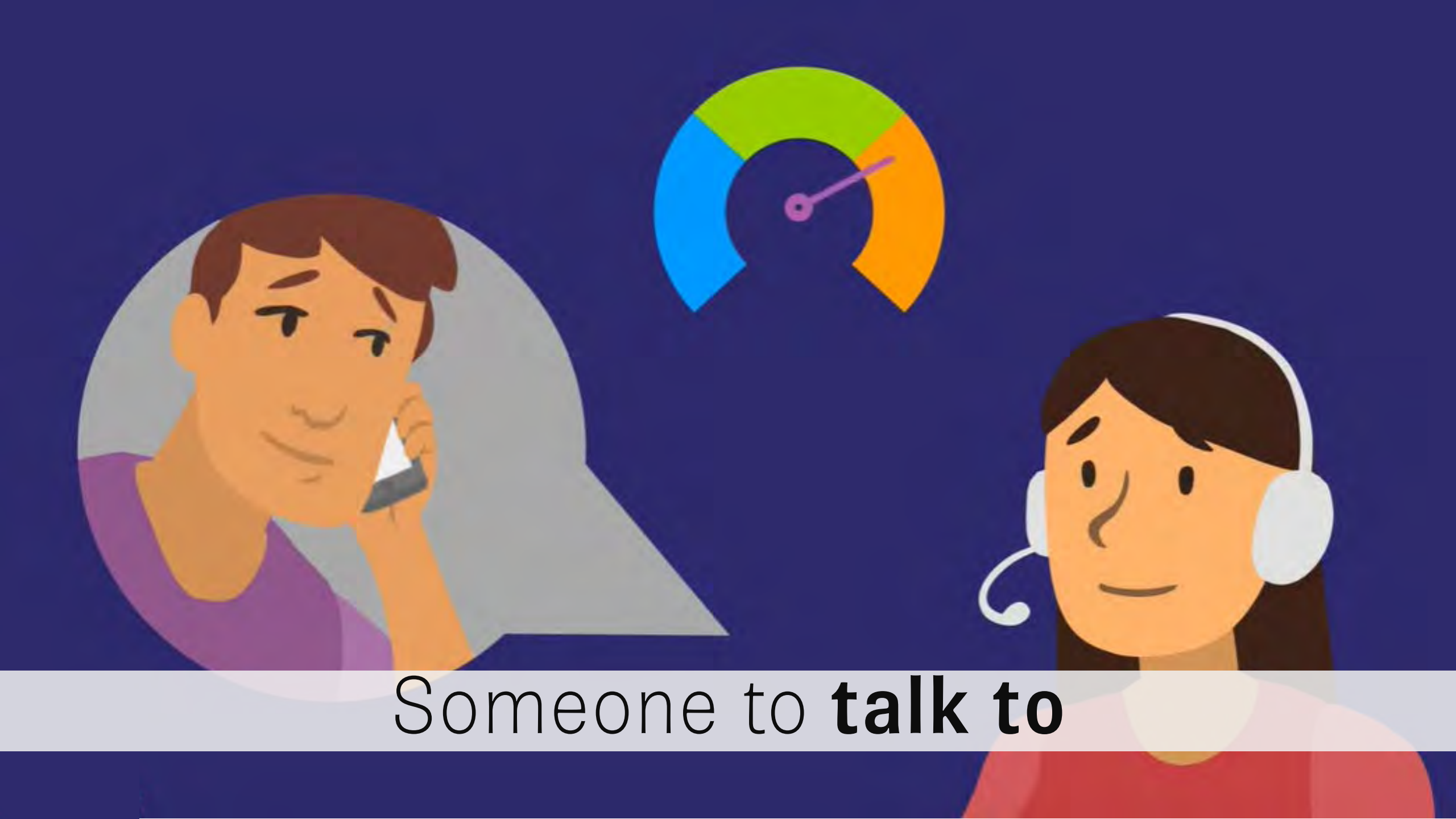
The Centers for Medicare and Medicaid Services (CMS) and the OIG, the agencies within the Department of Health and Human Services (HHS) charged with enforcing EMTALA, claimed that AnMed Health:

1. Should have required its on-call psychiatrist to come to the emergency department to personally examine all patients with psychiatric symptoms and participate in the screening and stabilizing of each patient, irrespective of whether the emergency physician needed or requested the services of the on-call psychiatrist—asserting in effect that emergency physicians are incapable of screening or stabilizing psychiatric patients under EMTALA;
2. Should have admitted involuntary committed (IVC) patients to its inpatient psychiatric unit instead of boarding them in its emergency department for many days until they could be transferred to the nearby state psychiatric hospital, despite the fact that for more than 30 years by written policy and actual practice the hospital only admitted "voluntary" patients to its psychiatric unit; and
3. Emergency physicians inappropriately transferred the patients in an unstable condition when patients were transported in the back of a locked secure police car for approximately 11–12 minutes to the nearby state psychiatric hospital.[1,2]

Three Sequential Steps.

Contact | Support | Rescue




Someone to **talk to**

Someone to **come to you**


Someplace to get care **for a night or 3**

Let's do the math.

Low | Medium | High

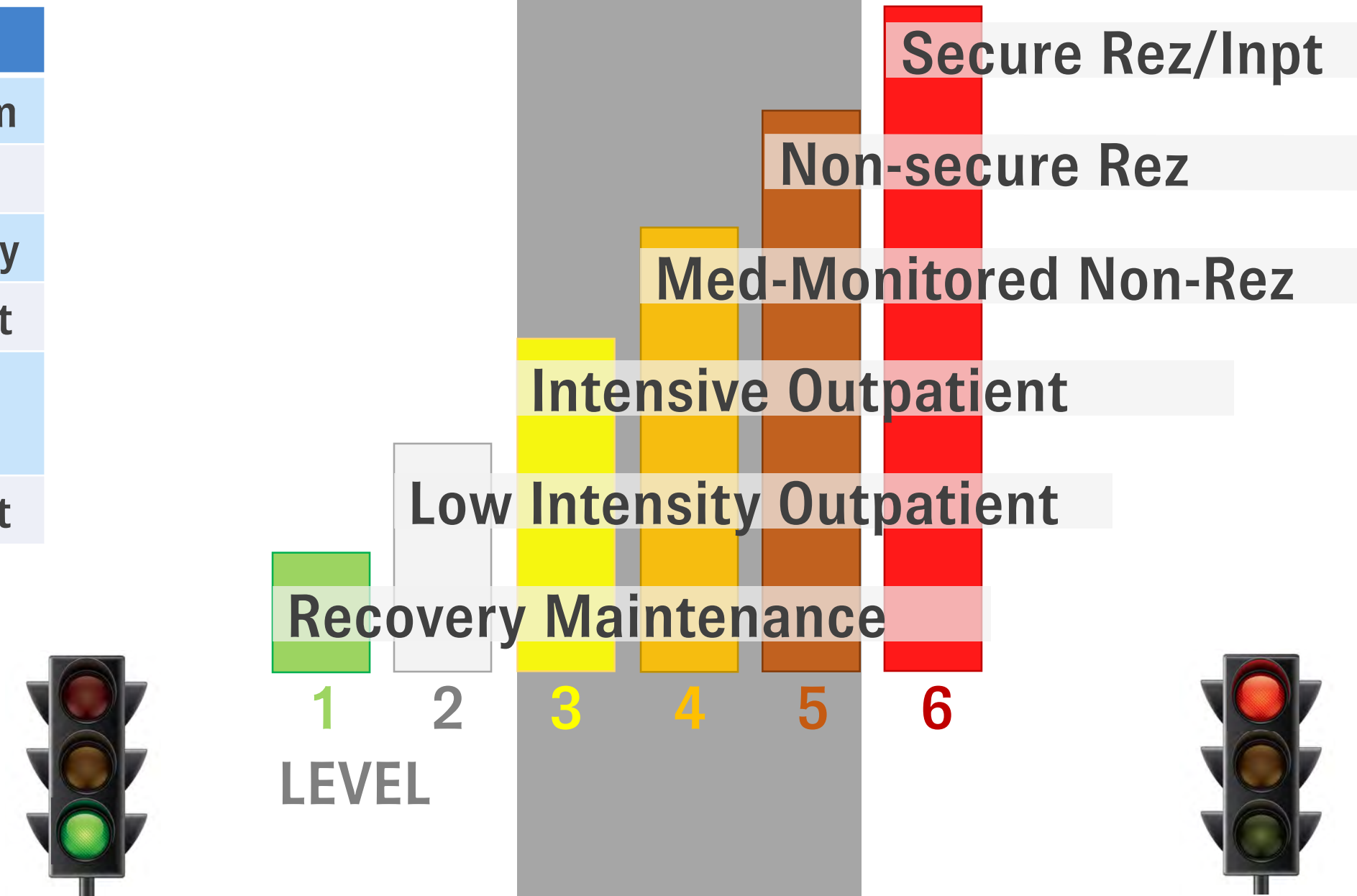
Outpatient & Follow-Up Care

VS.

Psychiatric Acute Care Inpatient

LOCUS (Level of Care Utilization System)

Dimensions
Risk of Harm
Functioning
Co-Morbidity
Environment
Treatment History
Engagement



LOCUS

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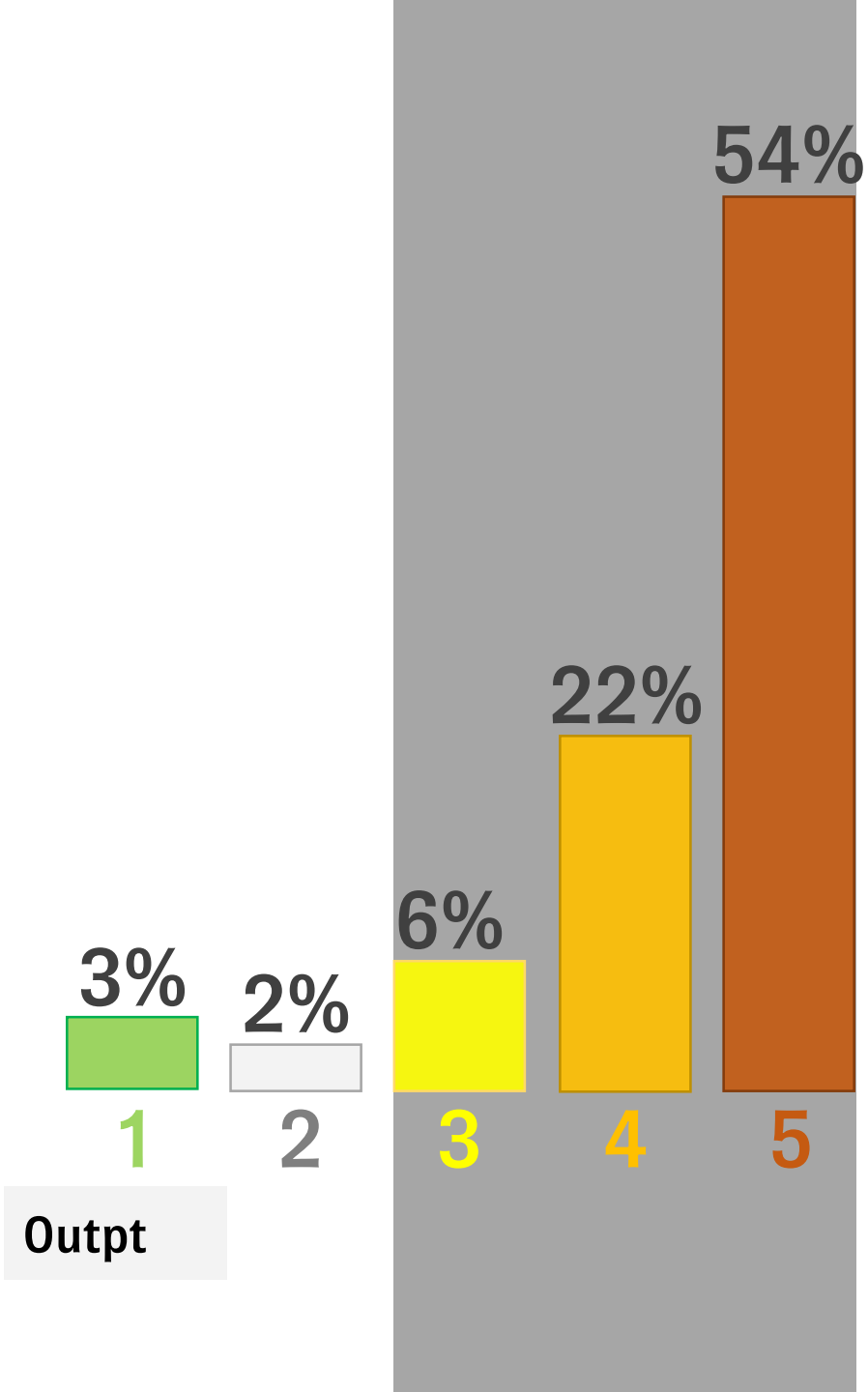

LOCUS

Dimensions
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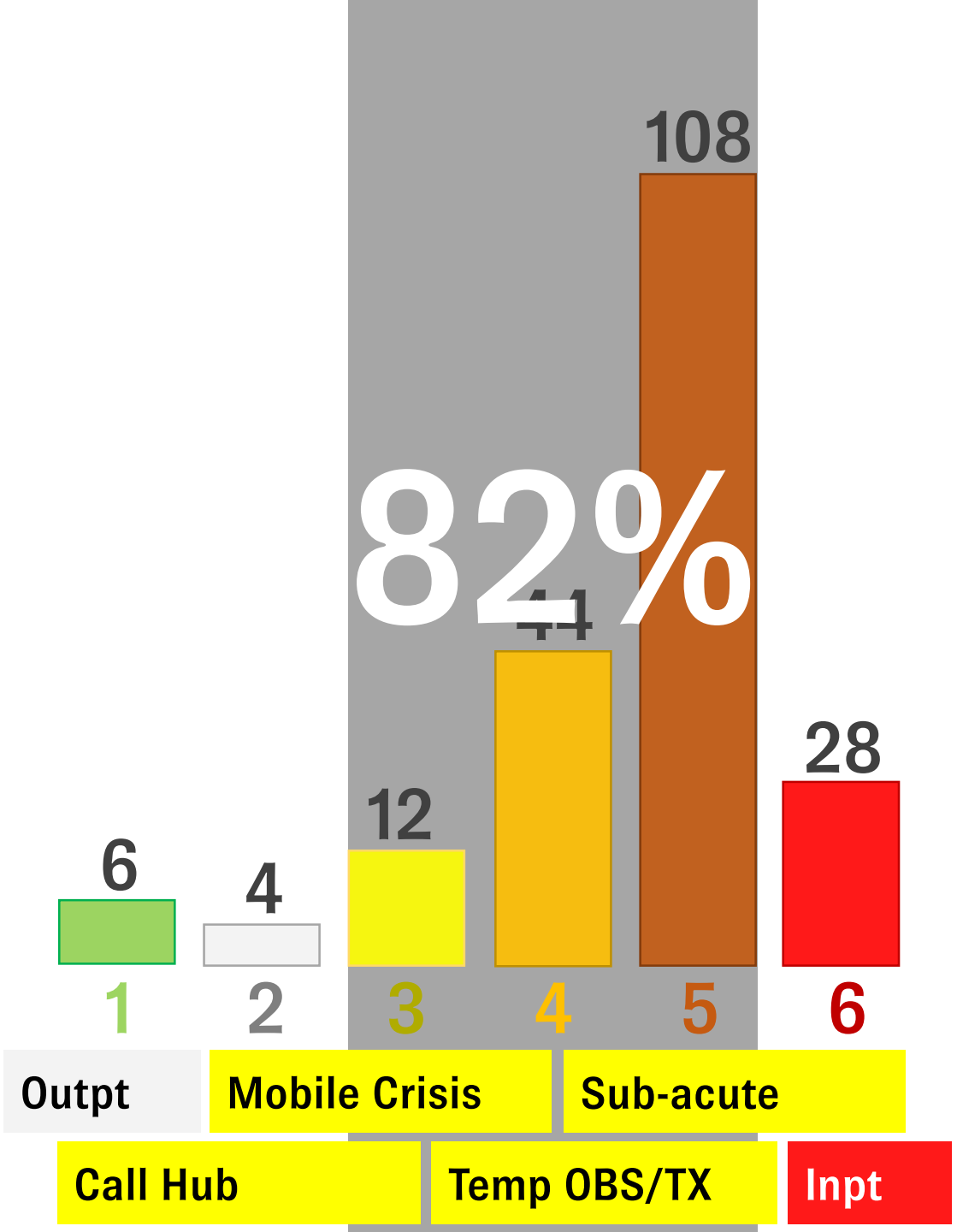
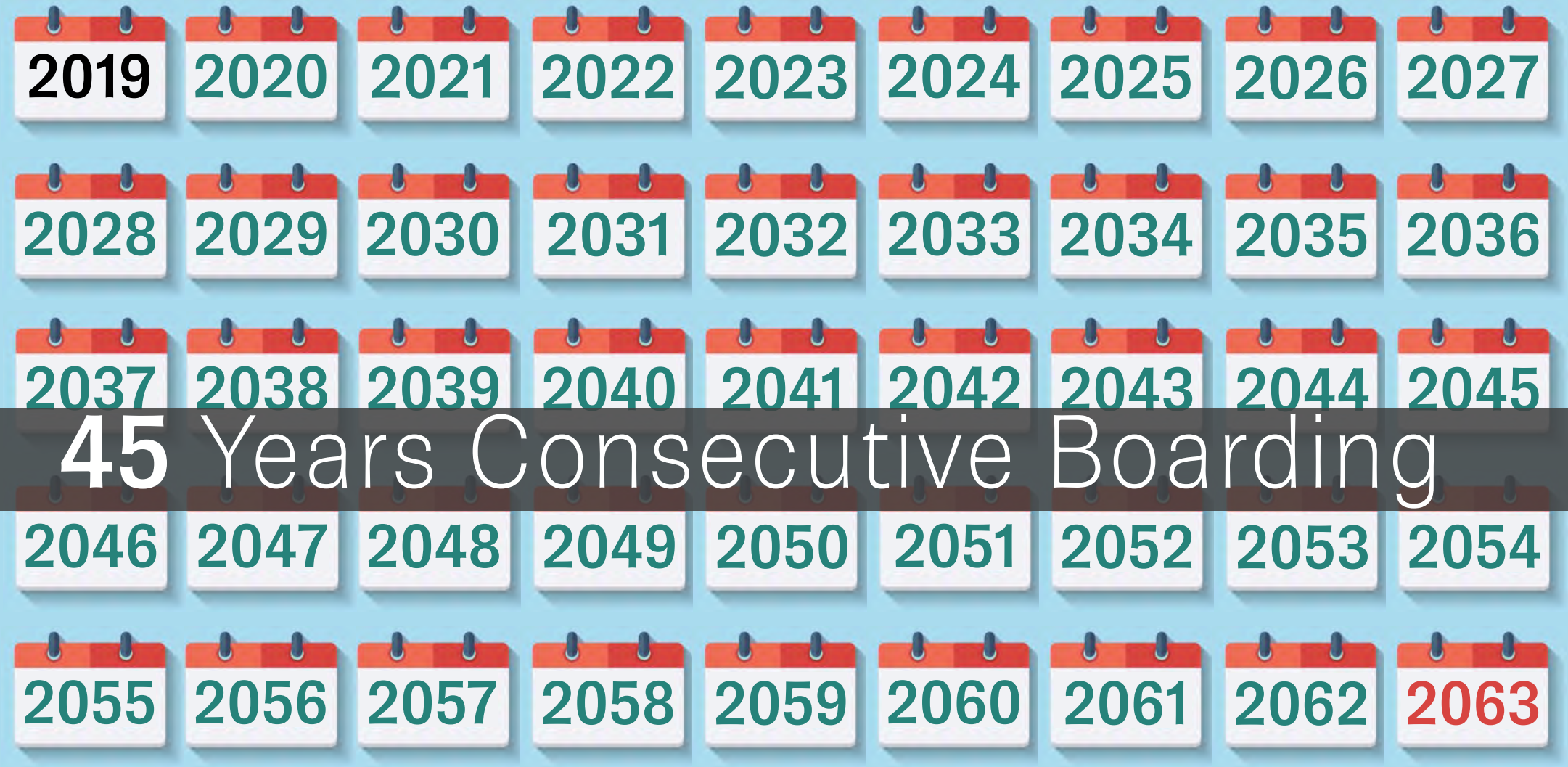
200 persons
per 100,000 population per month



82%

What's the difference?

More effective, humane & inexpensive



45 Years Consecutive Boarding

Calculated from “Impact of psychiatric patient boarding in EDs” (2012) (Nicks and Manthey)


37 Full-Time Equivalent Police

Did the Shoe Fit?

“Crisis Clinical Fit to Need” 6x Greater

Crisis Now Crisis System Calculator (Basic)

	No Crisis Care	Crisis Now
# of Crisis Episodes Annually *(200/100,000 Monthly)*	14,880	14,880
# Initially Served by Acute Inpatient	10,118	2,083
# Referred to Acute Inpatient From Crisis Facility	-	828
Total # of Episodes in Acute Inpatient	10,118	2,911
# of Acute Inpatient Beds Needed	310	89
Total Cost of Acute Inpatient Beds	$ 92,290,601	$ 26,553,906
# Referred to Crisis Bed From Stabilization Chair	-	3,312
# of Crisis Beds Needed	-	25
Total Cost of Crisis Facility Beds / Chairs	$ -	$ 7,507,853
# Initially Served by Crisis Stabilization Facility	-	8,035
# Referred to Crisis Facility by Mobile Team	-	1,428
Total # of Episodes in Crisis Facility	-	9,464
# of Crisis Observation Chairs Needed		
Total Cost of Crisis Observation Chairs	$	$
# Served Per Mobile Team Daily	4	4
# of Mobile Teams Needed	-	5
Total # of Episodes with Mobile Team	-	4,762
Total Cost of Mobile Teams	$ -	$ 1,826,367
# of Unique Individuals Served	10,118	14,880
TOTAL Inpatient and Crisis Cost	$ 92,290,601	$ 46,920,073
ED Costs ($1,233 Per Acute Admit)	$ 12,475,987	$ 3,589,598
TOTAL Cost	$ 104,766,588	$ 50,509,671
TOTAL Change in Cost	$ (54,256,917)	-52%

Please edit these 3 variables to estimate optimal allocations

Avg. Cost of Acute Bed/Day	ALOS of Acute Inpatient	Population Census
$ 816	10	620,000

Calculate your own community

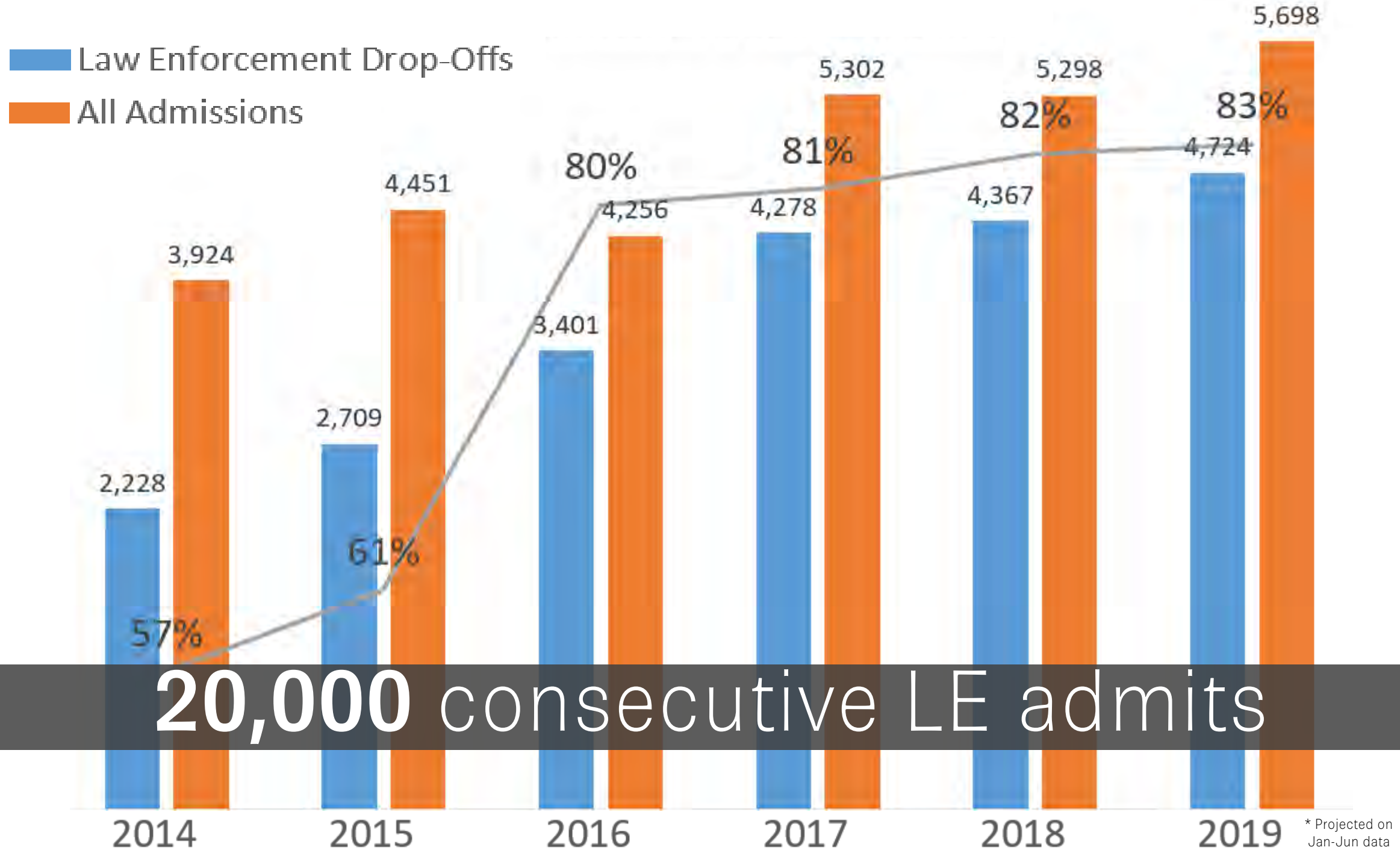

If we can do this, you can too!


EXIT


Zero Rejections
Zero Hospital Visits First
3 to 5 Minute Turn Around


PEORIA
POLICE


POLICE
ENTRANCE



20,000 consecutive LE admits

Pre-2014
One Payor

mercy care

Steward
Health Care Network

HEALTH | CHOICE
ARIZONA

CARE 1ST
HEALTH PLAN ARIZONA
A WellCare Company

Magellan
COMPLETE CARE®

arizona
complete health™

Commercial
Payors

Tribal
RBHAs

Arizona Landscape?

Medicare
Advantage Plans

UnitedHealthcare®
Community Plan

AHCCCS
Arizona Health Care Cost Containment System

American Indian Health
Program (AIHP)

Banner
University Health Plans


CRISIS NOW
Transforming Crisis Services
NASMHPD
RI
INTERNATIONAL
NHS Clinical Commissioners
Taking the Lead:
Investing in Community Crisis Response/Continuum
IIMHL
2nd Crisis Now Global Summit
(Urgent & Emergency Mental Health Care)
September 9 & 10, 2019 in Washington DC

IIMHL 2019

CrisisNow.com

Read it now!

Stephanie Hepburn

#CrisisTalk


BHL
Behavioral Health Link


RI
INTERNATIONAL