**Recommended Goals and Strategies for the Franklin County Mental Health and Addiction Crisis Center**

Draft recommended by the FCMHACC Governance and Funding Workgroup

Oct. 21, 2020

| Goals | Strategies | *As measured by* | NOTES |
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| **Increase access to mental health and addiction crisis care** | Center is accessible to anyone age 18+ in Franklin County at the time of their crisis (regardless of residency or insurance status) | | |
| | Center is accessible 24/7, 365 days a year | *Hours center is closed from walk-ins and LE/EMS drop=off* | Expectation is zero hours |
| | No exclusions for behavioral acuity | | Note the importance of patient-centered, trauma informed care, not just restraint and medication |
| | Rapid drop-off for first responders (EMS and police) | *Time from arrival to departure of LE/EMS* | Source: EHR event? Possible LE/EMS data to validate? |
| | No refusal for law enforcement, EMS or mobile crisis teams for appropriate transports | *Hours on divert for LE/EMS drop-offs* | Transport protocols being recommended by Consumer Care WG |
| | Center accept both voluntary and involuntary patients (including probates) | *Admissions by status (voluntary vs involuntary [and within this: probate vs other]) and among those presenting involuntarily, percent who convert to voluntary receipt of services* | source: EHR?<br><br>Note that many who start out as voluntary can become involuntary over time, and vice versa. This may impact measurement. |
| | Center treats substance abuse and mental health issues | *Presentations by primary diagnostic grouping (AOD diagnoses only, MH diagnoses only, and dual diagnosis)* | Demographics and trends of substance; source: EHR |

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| **Improve quality of crisis care by offering a spectrum of mental health and addiction services** | System provides enhanced services pre Crisis (e.g. Call Center, Mobile Response) | Call center volume and stats, mobile crisis runs, ROW transports | If multiple operators within the Center, clarify the role of the Advisory Council on strategic oversight of crisis continuum vs. crisis center operator only (recommendation is continuum) |
| | Center facilitates 'warm handoffs' to community-based programs after crisis care is provided | | |
| | | *Percent of individuals who receive a follow-up assessment/community provider service within seven days oh discharge from Center*<br><br>*Percent of individuals accessing services same-day as need is identified (OR Average days to first follow-up service)*<br>*Percent of individuals who are engaged by community provider prior to discharge from Center (the "warm hand-off")* | |
| | Manage readmissions to the center (or other facility) within (30 days/72 hours?) | *Percent of discharges that are followed by a readmission within (30 days/72 hours?)*<br><br>*Netcare mobile crisis data* | Would need coordination between EHRs of different facilities Dependent upon buy-in from MCP payors and the homeless population served<br><br>Is there a threshold/benchmark or any comparison data?<br><br>Possibly different benchmarks per level of care in Center |
| | Center receives and provides patient and aggregate data/feedback loops to the broader continuum of care | | Need for public/community dashboard, scorecard (display some of the metrics in this sheet) |
| | Fewer people with active behavioral health needs are transported to jails | *Percent of mental health-related CPD calls for service that result in a transport to Franklin County Jail* | Source: CPD monthly report of MH calls for service |
| | Fewer people with active behavioral health needs are transported to emergency departments | *Number of people redirected from EDs to Center* | |
| | Medical services provided, reducing need for ED transports | *Number of transfers out of Center for medical services* | Source: EHR |

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| **Establish a financially sustainable business model to assure immediate and ongoing/future success** | Negotiate viable contracts with all applicable payers including, but not limited to, Medicaid, Medicare, and commercial insurance. | *Percentage of gross charges by payer* | Ex:<br><br>Commercial 5%<br>Medicaid (includes FFS and MCO) 65%<br>Medicare (includes Medi-Medi) 15%<br>Uninsured (includes covered by ADAMH) 15% |
| | Implement strategies to maximize cost containment | *Average hourly rate for each occupation category is within accepted percentile range compared to industry benchmarks* | Salaries and benefits are indexed to industry benchmarks; need access to BH workforce benchmarking resources |
| | Ensure appropriate bidding of contracted services | *Variance from target baseline for contracted services* | We can model a target baseline from data solicited from partners regarding their services. |
| | Maximize cost savings from diversions from ED presentations/inpatient admissions | *Estimated cost savings from utilization of Center and preventing ED presentations/inpatient admissions* | Source: Estimate of cost differential and magnitude of change in ED presentations/IP admissions? |
| | Develop strategies to minimize subsidies for ongoing operations of the Center | | |
| | Maximize Medicaid coverage of patients treated at the Center, including ability to grant presumptive eligibility | *Percent of individuals who are Medicaid enrolled and percent of individuals presenting who are converted to Medicaid enrollment* | Source: EHR? |
| | Monitor and manage provider productivity | *Average paid hours per visit*<br><br>*Productive time per work hours* | This is an area that would benefit from a consultant providing a validation of an operators staffing model.<br><br>We could apply a general assumption that each provider needs to generate a certain percent to be financially sustainable and we could benefit from a consultant company that does management engineering and process improvement to provide guidance. |
| | Maximizing service claims that are accepted and paid by payers | *Percent of claims that are denied* | |
| | Develop strategies on patient throughput, allowing for the efficient flow of patients through the Crisis Center | *Percent of patients from the Center with indicated need accepted by inpatient providers* | "Hospital holds" -CXNS |

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| **Establish a workplace culture that attracts, retains, and develops a workforce/talent to provide optimal care for patients.** | Develop strategies that improve employee wellness and reduce employee burnout | *Staff retention and turnover rates are inline with industry benchmarks* | |
| | | *Percent of employees who vacate positions within first year of employment*<br>*Leave usage rates (or other method of measuring burnout)* | |
| | Center provides ongoing teaching and training opportunities that promote employee development, success and career advancement<br>Center provides benefits that promote a positive work/life balance<br>Patient satisfaction and associate engagement<br>Center incorporates diversity and inclusion strategies that ensure its workforce is reflective of the community it serves, including gender, race and ethnicity, sexual orientation/gender identity. Recruitment of staff that is reflective of community demographics | | |

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| **Commit to and measure health outcomes that improve the overall health of the broader community.** | Center develops and publishes a dashboard showing broader community mental health indicators along with comparative benchmarks (i.e. Healthy People goals) | *Number of overdose deaths and age-adjusted rate of overdose deaths within community* | Source: ODH Vital Stats (Public Health Information Warehouse) |
| | | *Number of suicide deaths and age-adjusted rate of suicide deaths within community* | Source: ODH Vital Stats (Public Health Information Warehouse) |
| | | *Number of CPD calls for domestic violence and child and elder abuse* | |
| | | *Percent of population experiencing a major depressive episode* | Source: National Survey on Drug Use and Health, substate estimates |
| | Center incorporates recognized best practices for opitmal health outcomes for its patients | *Percent of patients successfully connected to primary care* | |
| | | *Social determinants of health metrics (% of patients with insurance, % of patients with stable housing, % of patients with food insecurity, % of patients employed)* | Stable housing requires a more specific definition |

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| **Adhere to best safety practices, including those required through licensure, certification, and accreditation.** | Develop strategies that promote optimal patient safety and reduce preventable patient harm | *Number of major unusual incidents (restraints/seclusion) and percent of patients who are restrained/secluded* | Some HEDIS/HBIPS measures that align<br><br>Source: EHR |
| | | *Number of elopements* | |
| | | *Use of involuntary medications* | |
| | Develop strategies that promote optimal employee safety and reduce preventable employee harm | *Incidence of workplace injuires* | |
| | | *Incidence of workplace violence* | |
| | Provide staff training opportunities on updated interventions around patient and employee safety (e.g., Trauma Informed Care, SMART tool for medical clearance [to monitor invasiveness of testing], Zero Suicide) | *Percent of staff who undergo training in identified best practices/promising practices/evidence-based models* | |
| | Incorporate intelligent design of physical plant to promote patient and employee safety | | |