TCPI Exemplary Practice Performance Summary, January 2019
RI International
Paul Galdys, Deputy CEO
RI International provides exceptional crisis stabilization care by infusing patient and family engagement throughout the organization; leading to successful implementation of initiatives that reduce hospitalization and healthcare costs.

RI International (RI) is not-for-profit service provider that delivers an array of crisis and outpatient recovery-based services in 50 programs across five states and New Zealand. Our services are broken down into four key business units: Crisis, Health, Recovery and Consulting; supporting RI's mission of empowering people to recover, succeed in accomplishing their goals, find meaning and purpose in life, and reconnect with themselves and others. We proudly delivered 54,668 episodes of care in 2018; a number slightly above the number of unique individuals served during the year given some individuals received care in multiple programs. We are often recognized as an international thought leader in behavioral healthcare for the team's lead role in the development of the Zero Suicide initiative, Crisis Now exceptional practice standards, the focus on inclusion of individuals with lived experience (peers) in the workforce starting in the early 2000's and the first living room model of crisis service delivery in 2003.

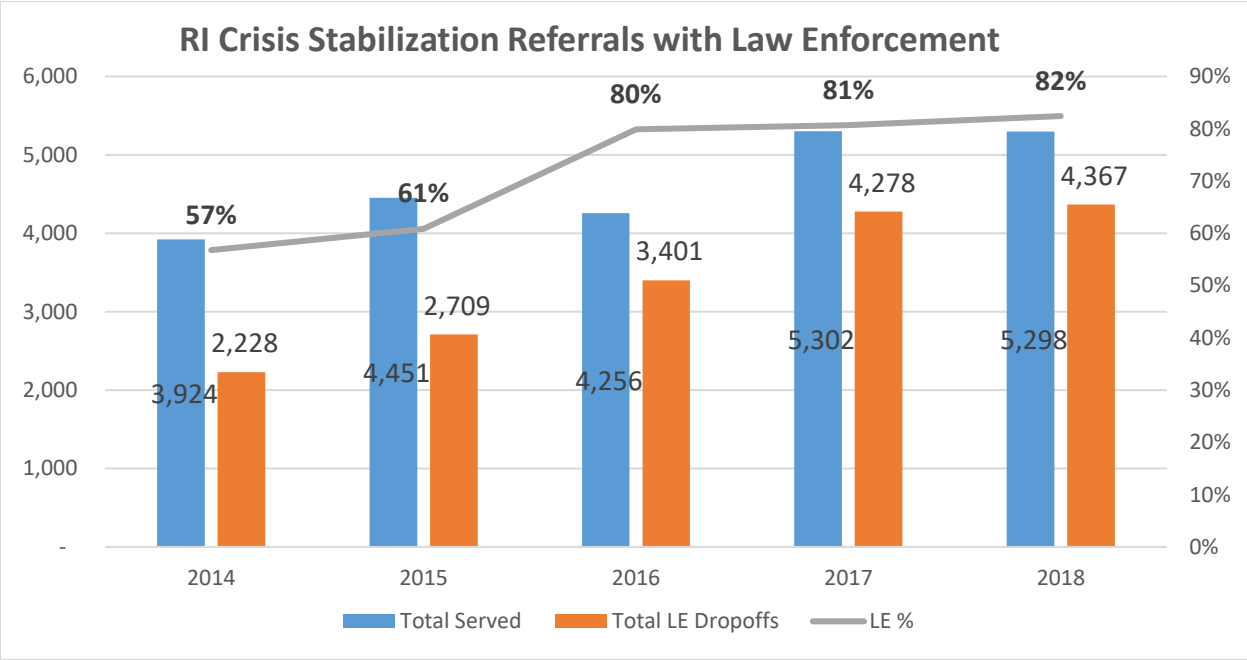
RI International achieved success on TCPi AIMs 3 and 4 by reducing hospitalizations and demonstrating an overall reduction in healthcare costs. We leverage relationship with first responders to eliminate incarceration as an alternative to connecting to accessible quality mental health crisis services. We focus on throughput (the time it takes to get services) when individuals are dropped off at our crisis facilities to ensure we provide timely accessible mental health crisis services and a level of service that encourages law enforcement to connect people to this cost effective level of care in lieu of more expensive emergency department assessments that often lead to inpatient care.

We use a data-driven, peer and family-informed approach to increase the value of services to individuals and communities through a culture of continuous quality improvement. We infuse patient and family engagement into every aspect of the organization. We have been a pioneer in the advancement of a peer workforce, design of what is now seen as standards of crisis care and physical environment advancements within the living room and retreat models. Our commitment to peer involvement includes ongoing dialog and survey feedback from individuals served. Additionally, we employ nearly 1,100 team members in the programs and over half identify themselves as having lived experience; working in a multitude of roles that include dedicated peer positions, management, and organizational leadership roles. We take pride in ensuring that the patient and family voice is rippled throughout the agency.

Using technology such as electronic bed boards, we have an efficient work flow process from the time a member enters the door; allowing us to serve more members which avoid unnecessary E.D. visits, hospitalizations and incarcerations. These efficiencies reduce overall system costs, reduce hospitalization, increase conversion rates (when a member moves from involuntary status to voluntary for treatment) and improve overall patient satisfaction.

Recovery Innovation Crisis Program

Our crisis program in Peoria, AZ, is a Recovery Response Center (Crisis Stabilization Program). The program served 5,298 individuals in 2018 with 82% arriving in the back of a police car. Through a culture of person and family engagement, we "never say no" to first responder referrals. We have accepted over 14,000 consecutive referrals from law enforcement where individuals are brought into care instead of being dropped off at an emergency department (ED) where individuals wait for care and incur ED related health care expenses that are typically avoidable (over 96% of individuals served did not require a referral to an ED after arrival last year). Through our "never say no" campaign we have eliminated unnecessary hospitalization and delays in accessing needed care. The graph below shows the increase in our total admissions and law enforcement drop offs over a four-year period that held steady last year.



By increasing the number of drop-offs at our facility, we effectively reduce ED drop offs and AIM #3 in reducing hospitalizations. Additionally, our efforts positively impact AIM #4 of reduce health care costs, by infusing patient and family voice throughout the organization and through the use of technology, which prompted the following outcomes:

- We have a partnerships with law enforcement to accept all referrals which increased the number of drop offs at the facility by 96% from 2014 to 2018;
- Using electronic bed boards we have immediate access to bed status and have a process to ensure increased throughput which increased capacity and reduced the need for ED visits and inpatient hospitalizations which allowed the program to serve 35% more individuals with the existing resources;
- We are able to serve an increased number of individuals in mental health crisis served in the facility by 35% from 2014 to 2018; *and*
- Our Joint Commission safety and quality review performance is exceptional with only one finding during the last one site review.

In May 2018, we reviewed the previous year's data and averaged a 70% conversion rate from involuntary to voluntary and 159 conversions per month which resulted in a total of 1,910 conversions during the last 12 months (May 2017 through April 2018). During the year, our average length of stay was closer to two days and RI experienced a lower rate of escalation to the subacute facility. This roughly translates into a $47,750,000 avoided cost if all individuals experienced a typical inpatient length of stay (estimated at 25 days and assuming a $1,000 daily total); a figure that is 4 times the annual funding for RI's crisis stabilization and subacute facility. A lack of crisis facilities in a community does push individuals to EDs which come with their own costs which the National Association of State Mental Health Program Directors (NASMHPD) cites (*from Wake Forrest Study*) at $2,264 cost to the ED per episode for an individual with a mental health challenge. In 2013, the National Institute of Health cited an average emergency department cost of $1,233 which is avoided for 96% of individuals we serve in our crisis stabilization program. In 2018, this would translate into an emergency department savings of $6,271,137 when compared to models in which all individuals are first medically cleared via an emergency department assessment. The ability to take direct law enforcement drop-offs eliminates these ED costs as well as the corresponding delay to accessing care.

Transforming Clinical Practice Initiative

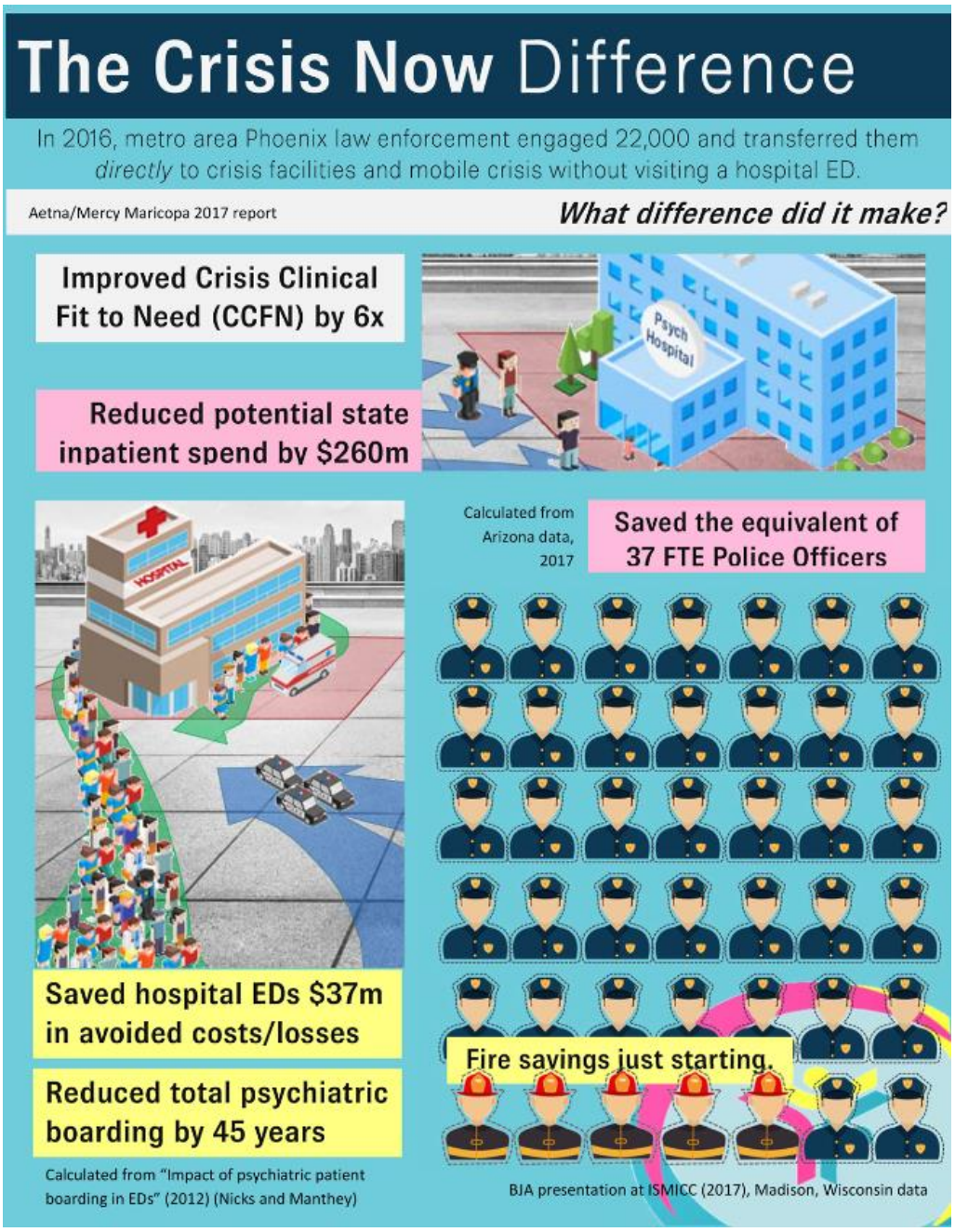
Working in partnership with the Practice Innovation Institute, we have quickly progressed through all 5 phases of transformation and graduated TCPI on January 11, 2019. By embedding patient and family engagement that promote health outcomes, we demonstrate notable reduction in costs and unnecessary hospitalizations. Additionally, we are is actively engaged in a value-based contract focused on coordination of care, follow up with the behavioral health provider within 7 days of intervention and we are proud to report a score of a 100% in 2018.

RI operates as a national leader in areas of Zero Suicide and *Crisis Now* consensus exceptional practice standards as co-leads of these National Action Alliance for Suicide Prevention initiatives. The RI-developed data table (interactive model) below represents the data currently being used to guide crisis system design on the National Association of State Mental Health Program Director's (NASMHPD's) *Crisis Now*.com website. The model includes real Maricopa County healthcare cost and capacity impact to inform the national model that is now in place. Evolved data are defined to mean that the program has moved from the baseline in which a system meets mental health crisis needs solely through emergency departments and acute inpatient beds to one in which is evolved: incorporating a full continuum of crisis services that include mobile teams, crisis stabilization chairs, subacute beds and acute inpatient in ratios that align with the typical levels of clinical need of individuals who experience a crisis (please see graphic above, RI Peoria Crisis Center, for breakdown of over a decade of statewide Level of Care Utilization (LOCUS) data for individuals engaged by mobile teams, crisis facilities or in EDs). RI has done this research, analyzed the data in collaboration with Medicaid and other state agencies and then made the models and tools publicly accessible to all with the NASMHPD website to advance these cost saving quality improvement efforts throughout the nation.

Crisis Now Crisis System Calculator (Basic)		
	No Crisis Care	**Crisis Now**
# of Crisis Episodes Annually *(200/100,000 Monthly)*	103,200	103,200
# Initially Served by Acute Inpatient	70,176	14,448
# Referred to Acute Inpatient From Crisis Facility	-	5,743
Total # of Episodes in Acute Inpatient	70,176	20,191
# of Acute Inpatient Beds Needed	**2,149**	**618**
Total Cost of Acute Inpatient Beds	**$ 627,529,387**	**$ 180,553,124**
# Referred to Crisis Bed From Stabilization Chair	-	22,972
# of Crisis Beds Needed	**-**	**175**
Total Cost of Crisis Facility Beds / Chairs	**$ -**	**$ 51,049,600**
# Initially Served by Crisis Stabilization Facility	-	55,728
# Referred to Crisis Facility by Mobile Team	-	9,907
Total # of Episodes in Crisis Facility	-	65,635
# of Crisis Observation Chairs Needed	**-**	**206**
Total Cost of Crisis Facility Beds / Chairs	**$ -**	**$ 75,011,657**
# Served Per Mobile Team Daily	4	4
# of Mobile Teams Needed	**-**	**32**
Total # of Episodes with Mobile Team	-	33,024
Total Cost of Mobile Teams	**$ -**	**$ 12,666,740**
# of Unique Individuals Served	**70,176**	**103,200**
TOTAL Inpatient and Crisis Cost	**$ 627,529,387**	**$ 319,281,121**
ED Costs ($1,233 Per Acute Admit)	**$ 86,527,008**	**$ 24,895,602**
TOTAL Cost	**$ 714,056,395**	**$ 344,176,723**
TOTAL Change in Cost	**$ (369,879,672)**	**-52%**

Model for Maricopa County Arizona (population 4.3 million).

As can be seen from the Calculator, the *Crisis Now* program can drastically reduce the number of inpatient beds needed and move more services to lower intensity settings, such as crisis beds, crisis observation chairs, and mobile teams. If the results shown were achieved, it would result in more individuals served (103,200 vs. 70,176) while reducing costs by 52%. Although this calculator is focused on projections for communities, the graphic that follows on the next page represents assessed impact of crisis service implementation in Maricopa County where RI International is one of three crisis stabilization service providers.



RI International is an active participant of the Practice Innovation Institute (Pii), Arizona's Practice Transformation Network.

As of January 2019, RI International has completed the 5 Phases of Transformation.

Practice Innovation Institute
Engage. Transform. Reward.