Crisis and Transition Services

Data and Evaluation Committee | Alliance to Prevent Suicide

DATE: June 3, 2021 PRESENTED BY: Rebecca Marshall, MD, MPH

Timeline

2014	OHA convenes workgroup to address ED boarding crisis. Workgroup recommends ED Diversion Program
2015	Pilot funding → 4 counties launched pilot programs
2016	Funding → 3 additional sites
2017	OHSU team contracted to help with program development, evaluation and outcomes measurement ("EDD"→"CATS")
2018	Sites begin data collection Funding → 1 additional site
2020	CATS enhancement and expansion funding – 11 sites total

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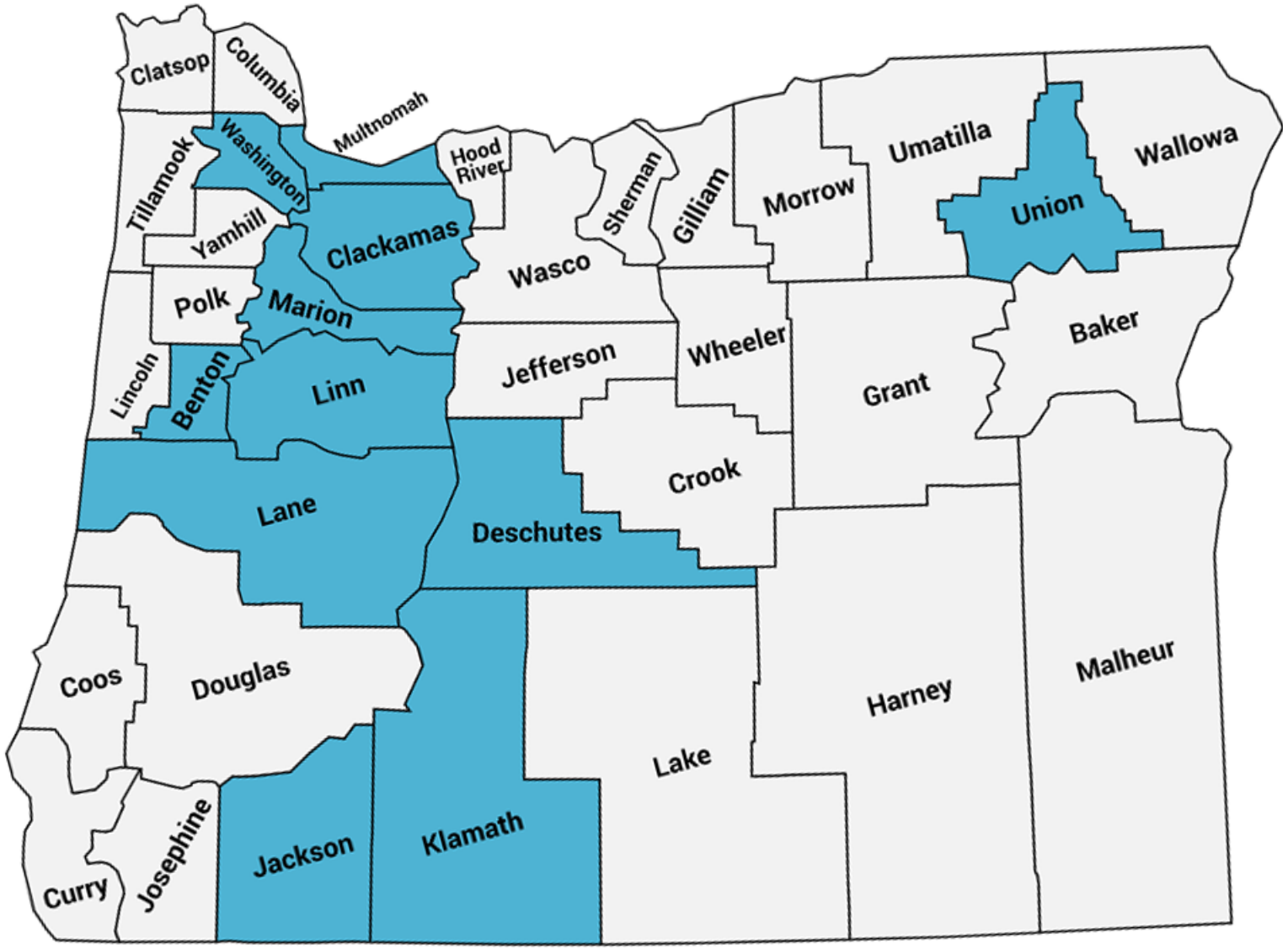
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Washington
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Polk
Marion
Jefferson
Wheeler
Grant
Baker
Lincoln
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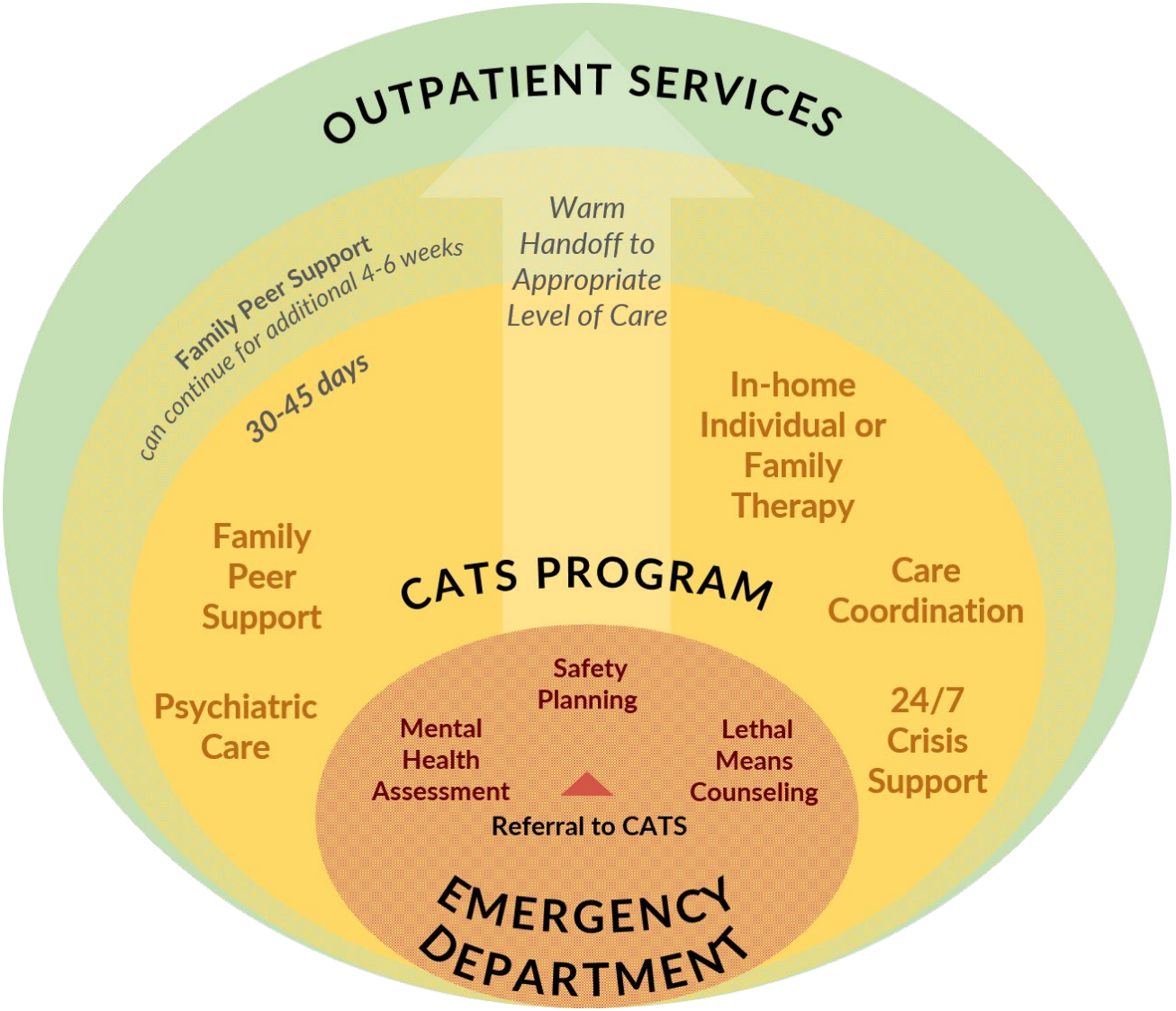
OUTPATIENT SERVICES
Warm Handoff to Appropriate Level of Care
Family Peer Support
can continue for additional 4-6 weeks
30-45 days
In-home Individual or Family Therapy
Family Peer Support
CATS PROGRAM
Care Coordination
Psychiatric Care
Safety Planning
Mental Health Assessment
Lethal Means Counseling
24/7 Crisis Support
Referral to CATS
EMERGENCY DEPARTMENT

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OHSU Evaluation and Technical Assistance Team

- Developed RedCAP database
- TA to sites to collect and report data
- 2-month follow up with CATS families
- Quarterly data reports for partners and OHA
- Data-driven technical assistance to sites and OHA regarding CATS model / evolution

Outcomes Data

Collected from:

- Clinical providers
- Family support specialists
- Youth
- Families

When collected:

- At intake
- During program
- At closure
- 2-mo follow up (with families)

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What data do we collect?

1. Demographic, clinical history, and presenting referral info
2. CATS clinical and peer service info
3. Transition plan info
4. Feedback, program satisfaction, clinical and functional outcomes

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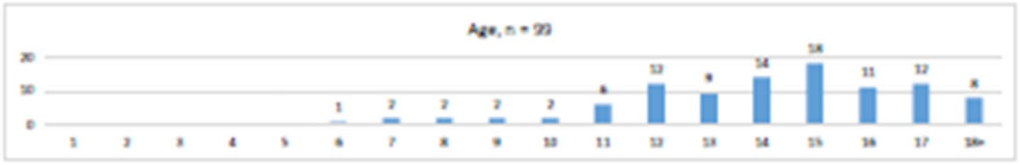
CRISIS AND TRANSITION SERVICES | OHSU STATEWIDE REPORT

STATEWIDE CATS DATA

October 1, 2020 - December 31, 2020

Youth and Families Served	Families Referred to Family Peer Support	Families Engaged with Family Peer Support
99	51	41

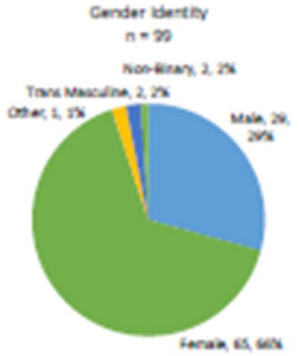
DEMOGRAPHIC INFORMATION

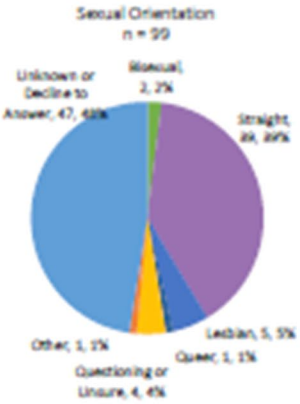


Race		
American Indian or Alaska Native	3	3%
Asian	5	5%
Black or African American	6	6%
Native Hawaiian or Other Pacific Islander	0	0%
White	75	76%
Unknown or Decline to Answer	18	18%

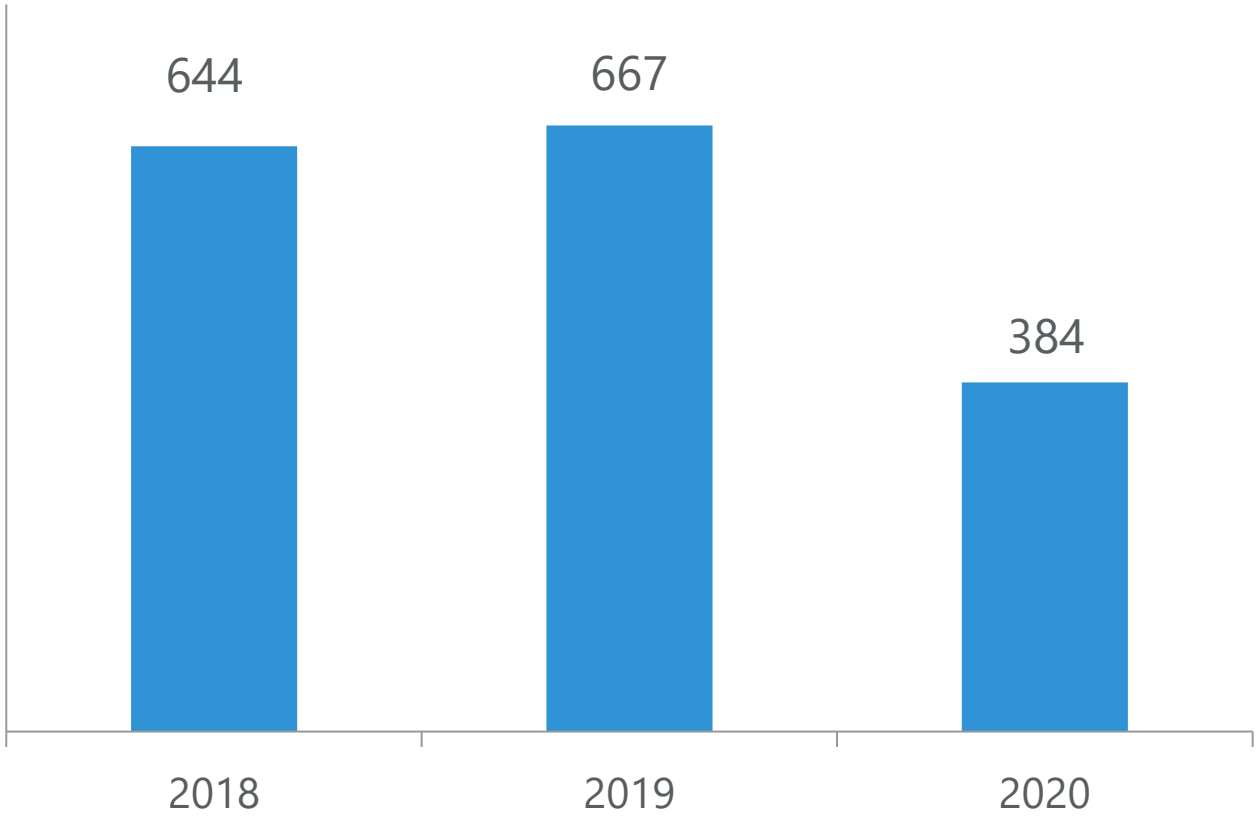
Ethnicity		
Hispanic, Latino, or Spanish Origin	17	17%
Not Hispanic, Latino, or Spanish Origin	65	66%
Unknown or Decline	17	17%

Social and Environmental		
Previously or currently in foster care	8	8%
Previously or currently involved with juvenile justice	6	6%
History of trauma	68	69%
Parent requires interpreter	5	5%
Family is experiencing significant financial difficulties	9	9%
Youth missed > half of school in past two weeks	21	21%
Previous mental health ED visit(s)	22	22%
Previous inpatient admission(s)	7	7%
Previous suicide attempt(s)	27	27%
Youth has been in CATS before	2	2%

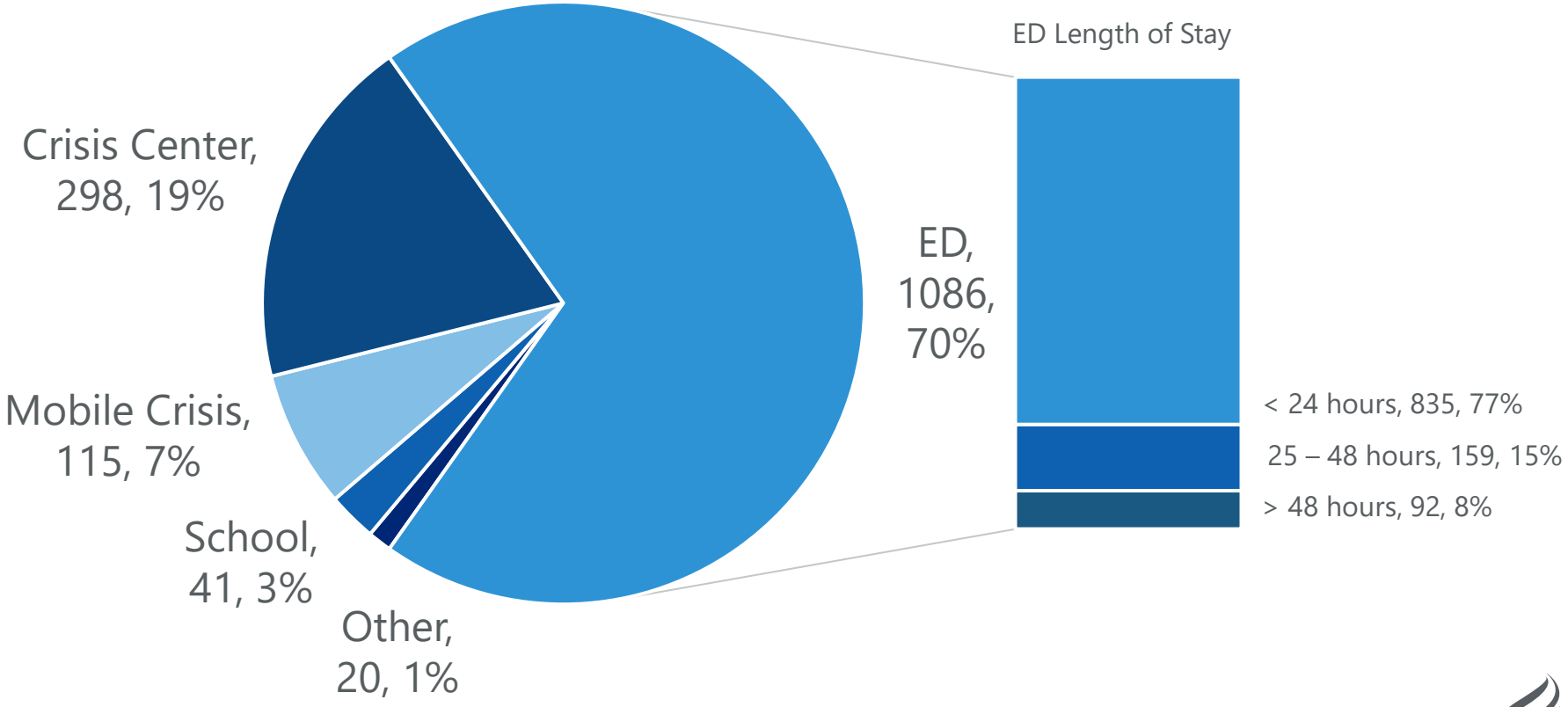




Youth served
2018 – 2020, n = 1695



Referral source
2018 – 2020, combined, n = 1560



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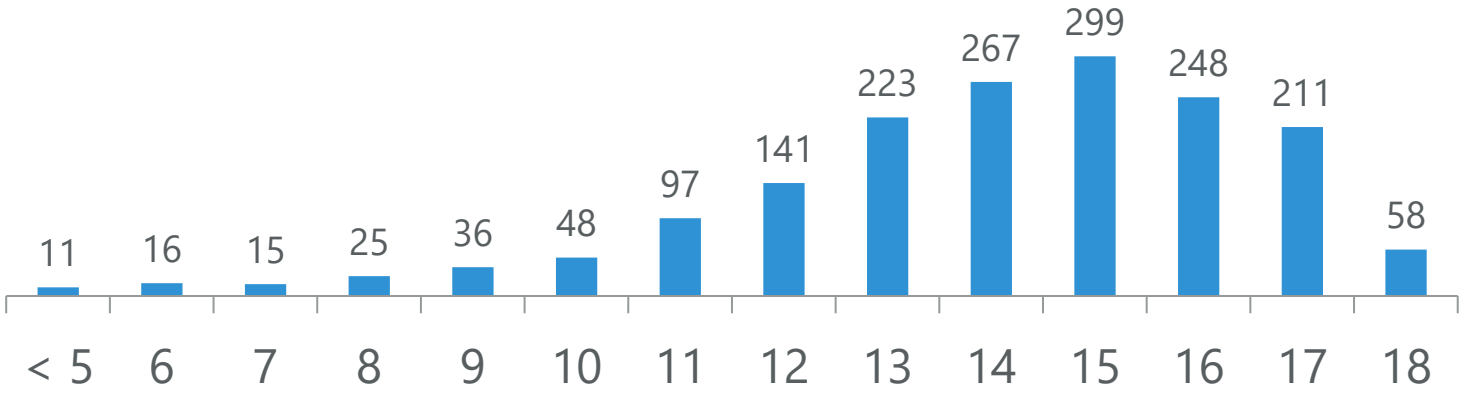
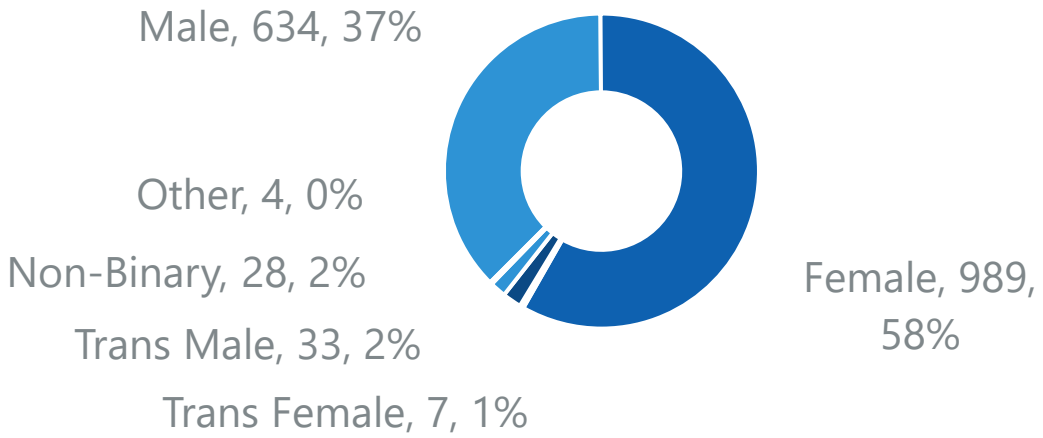
Youth demographics
age & gender identity, 2018 – 2020, combined, n = 1695





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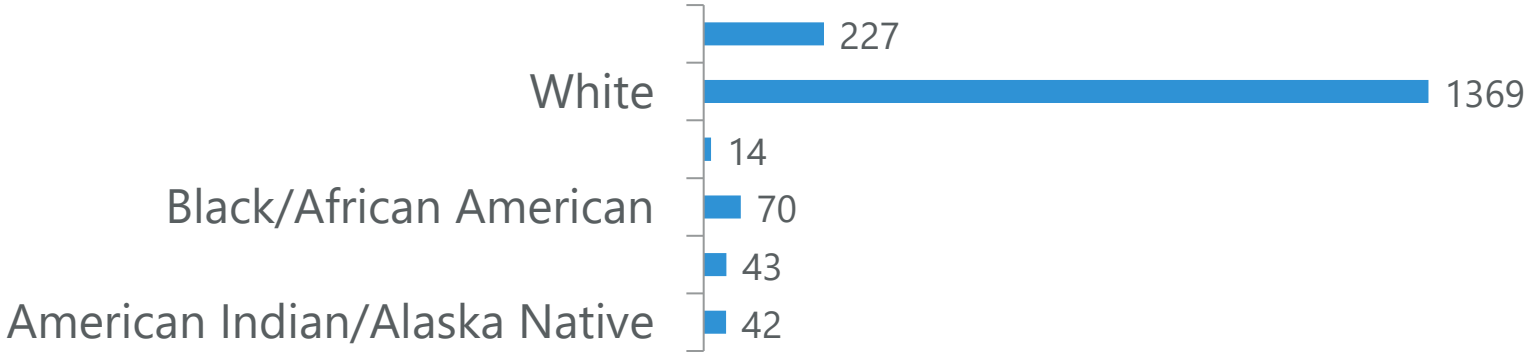
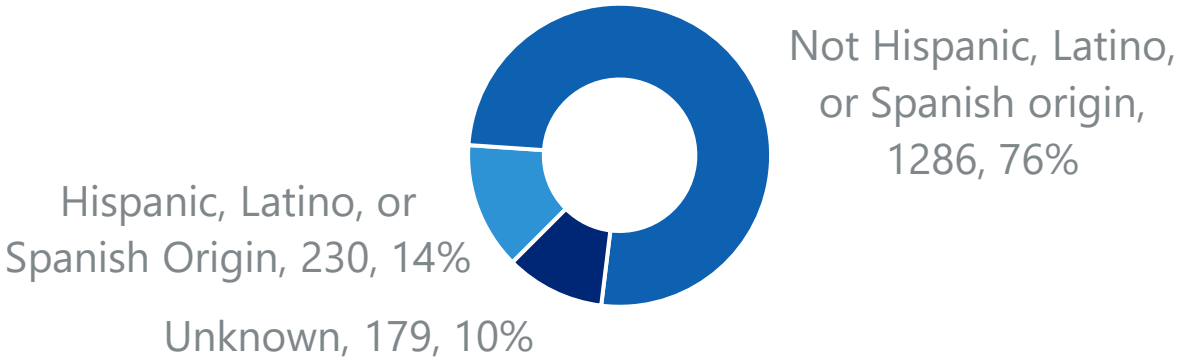
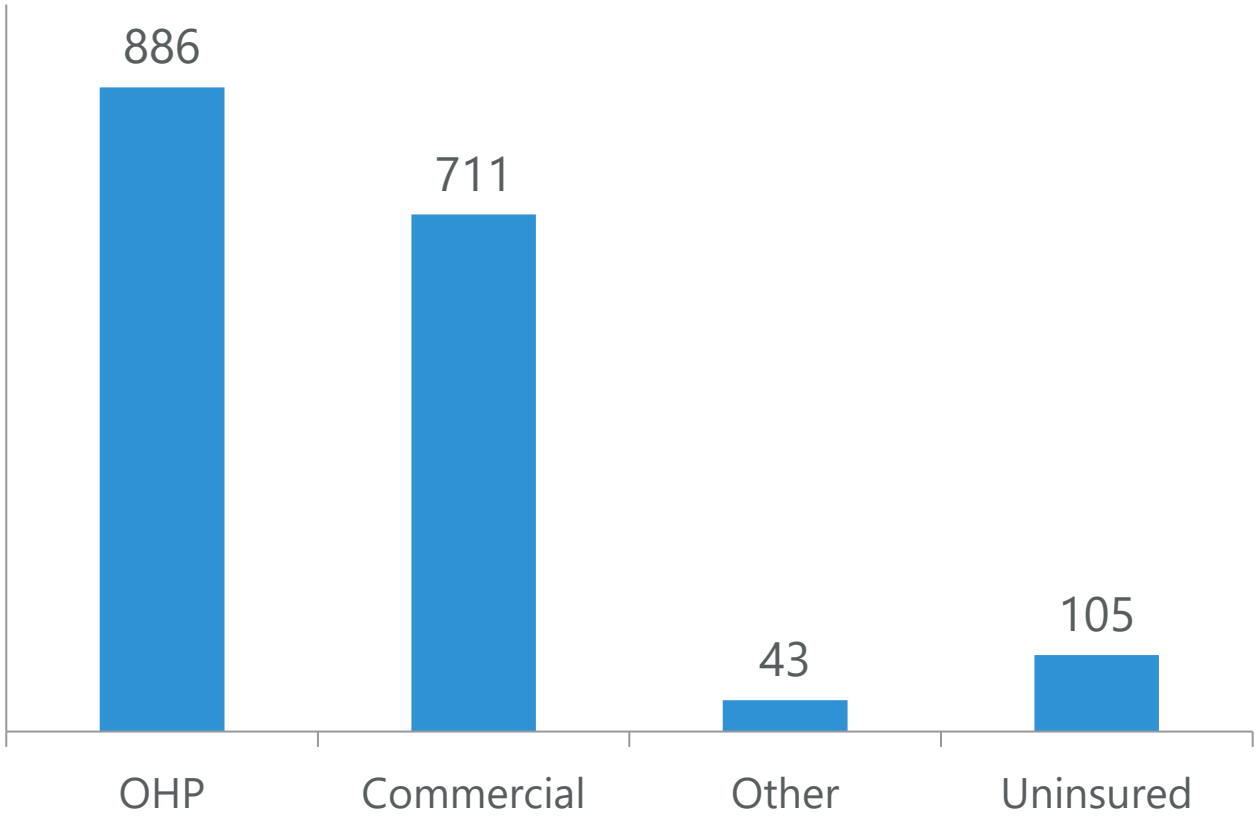
Youth demographics
race & ethnicity, 2018-2020 combined, n = 1695





Youth demographics insurance, 2018 – 2020, n = 1695



Youth history
2018 – 2020 combined, n = 1695

9%	currently or previously in foster care
8%	currently or previously involved with juvenile justice system
62%	have a trauma history
28%	have had a previous suicide attempt
28%	have had a previous MH ED visit
11%	have had a previous inpatient admission

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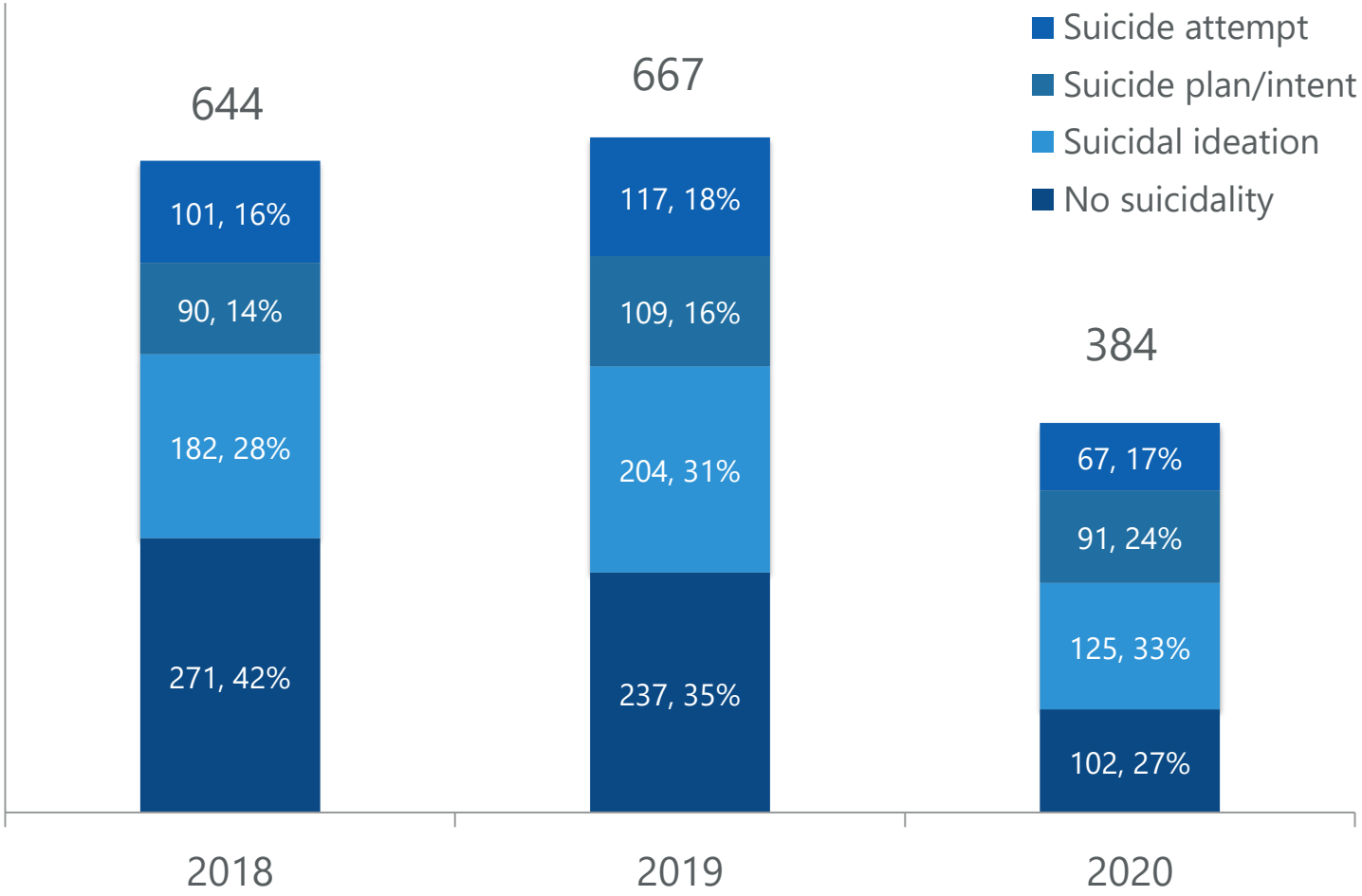
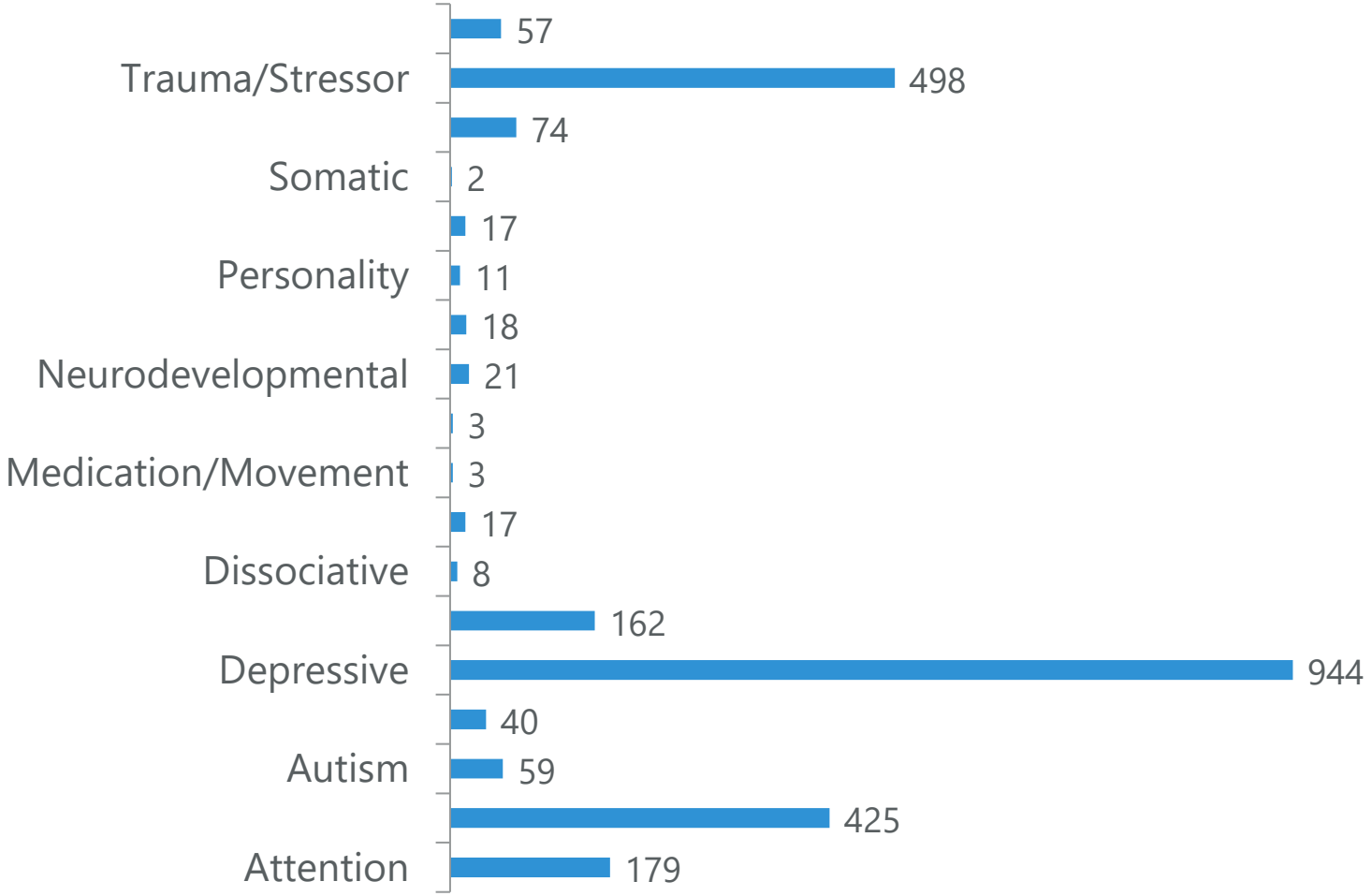
Presenting referral information suicidality, 2018-2020, n = 1695



Presenting referral information diagnosis, 2018 – 2020 combined, n = 1695



CATS services
2018 – 2020, n = 1695

73% received individual therapy

48% received family therapy

47% had a home visit with a CATS team member

26% engaged with a family support specialist

61% accessed phone crisis support

38% accessed in-person crisis support

CATS outcomes
2018 – 2020, n = 1695

6% had a suicide attempt during CATS (n = 446)

11% had an ED visit and/or admission during CATS (n = 1560)

86% completed the CATS program

78% obtained the clinically appropriate level of care at closure (n = 377)

Top 3 Barriers to Obtaining Clinically Appropriate Care

1. Family chose not to access recommended level of care (14%)
2. Youth unwilling to engage in further treatment (10%)
3. Limited access to an in-network provider, geographical barriers, or waitlist barriers (8%)

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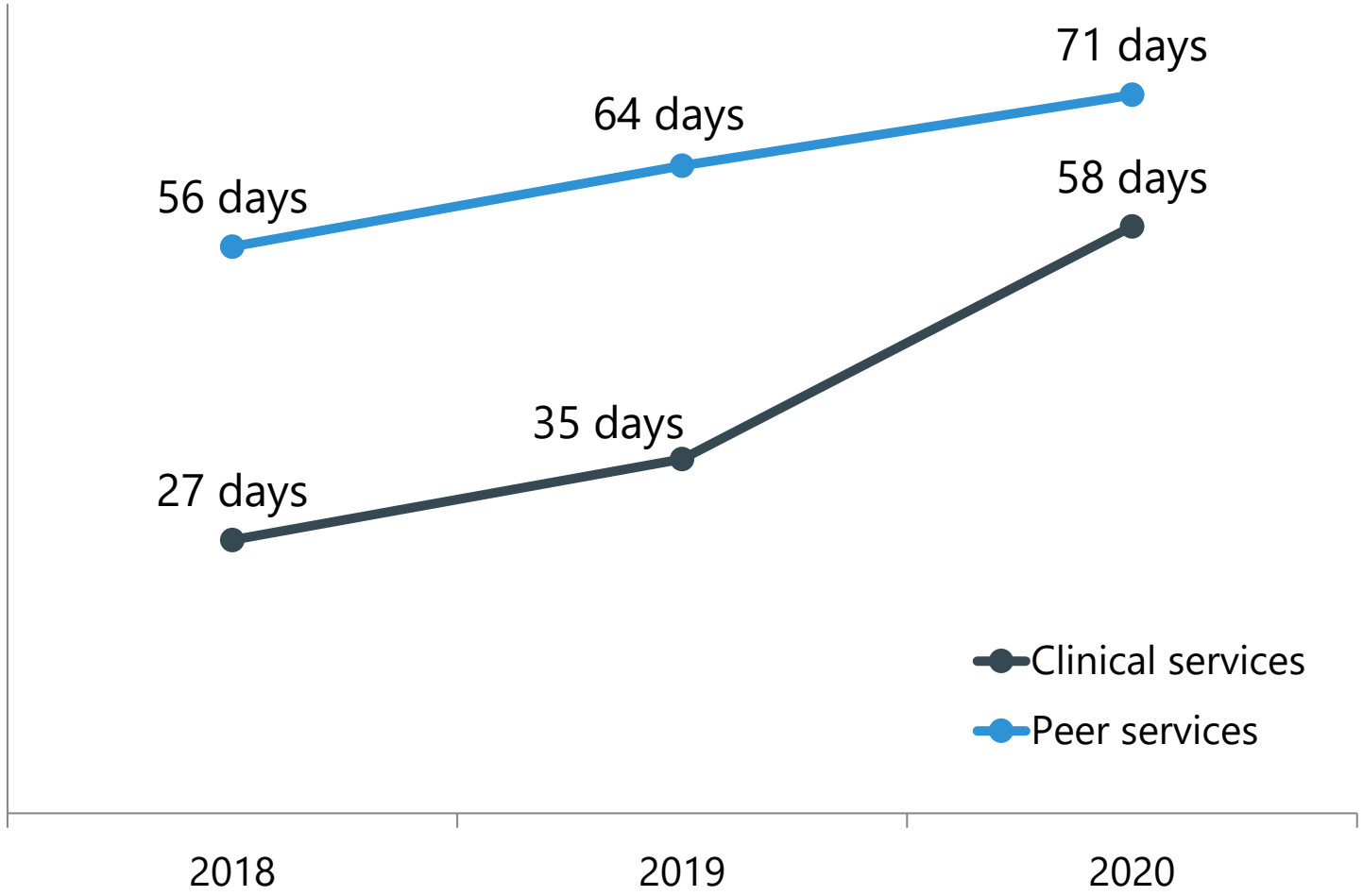
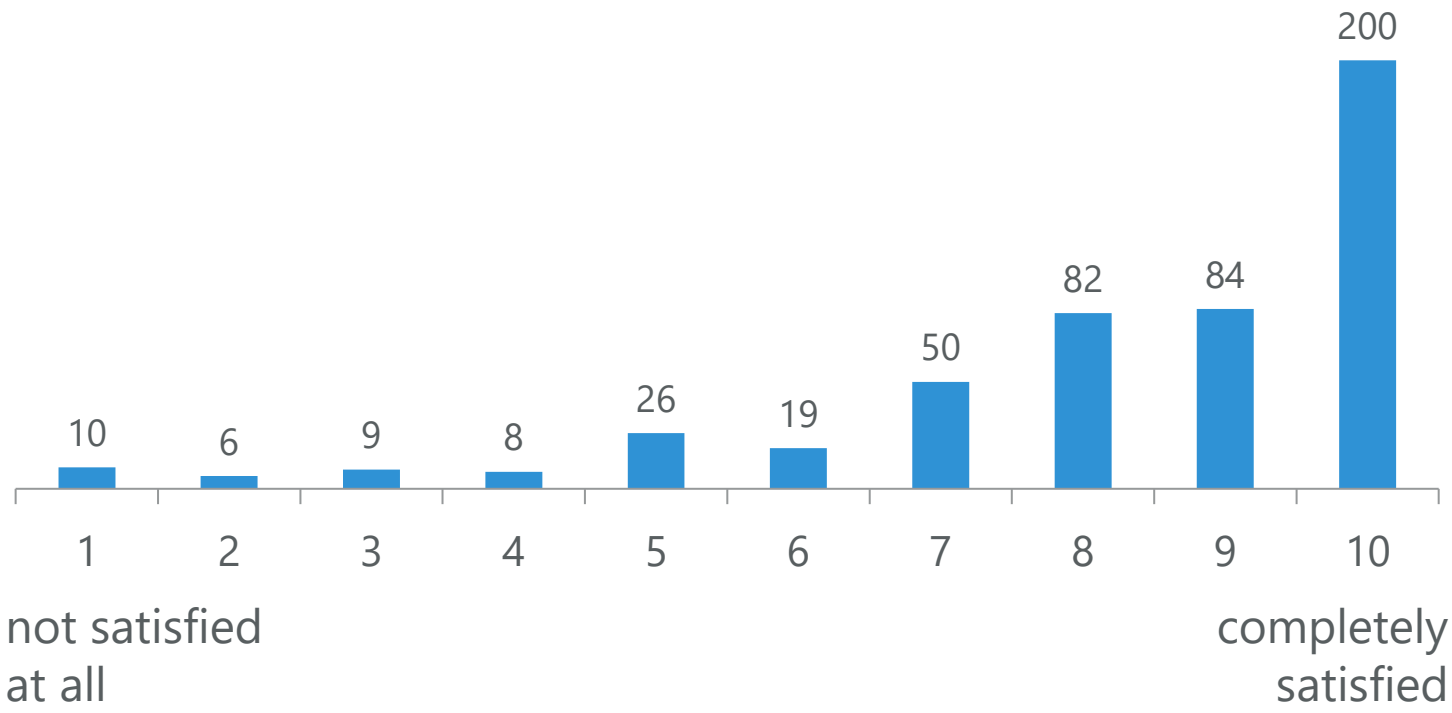
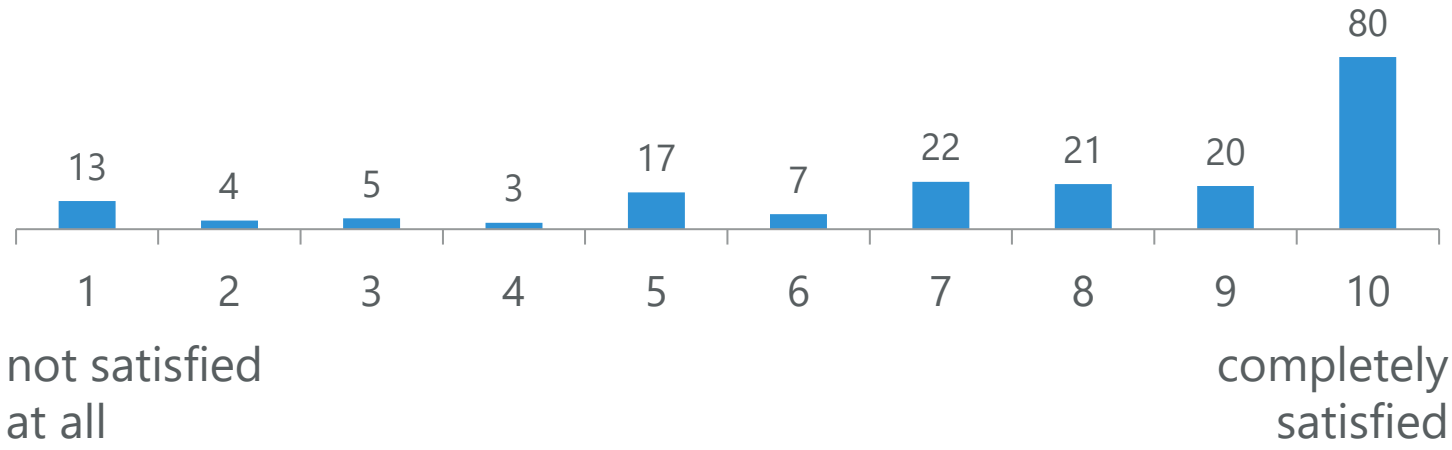
CATS services
average length of care, 2018 – 2020, n = 1695



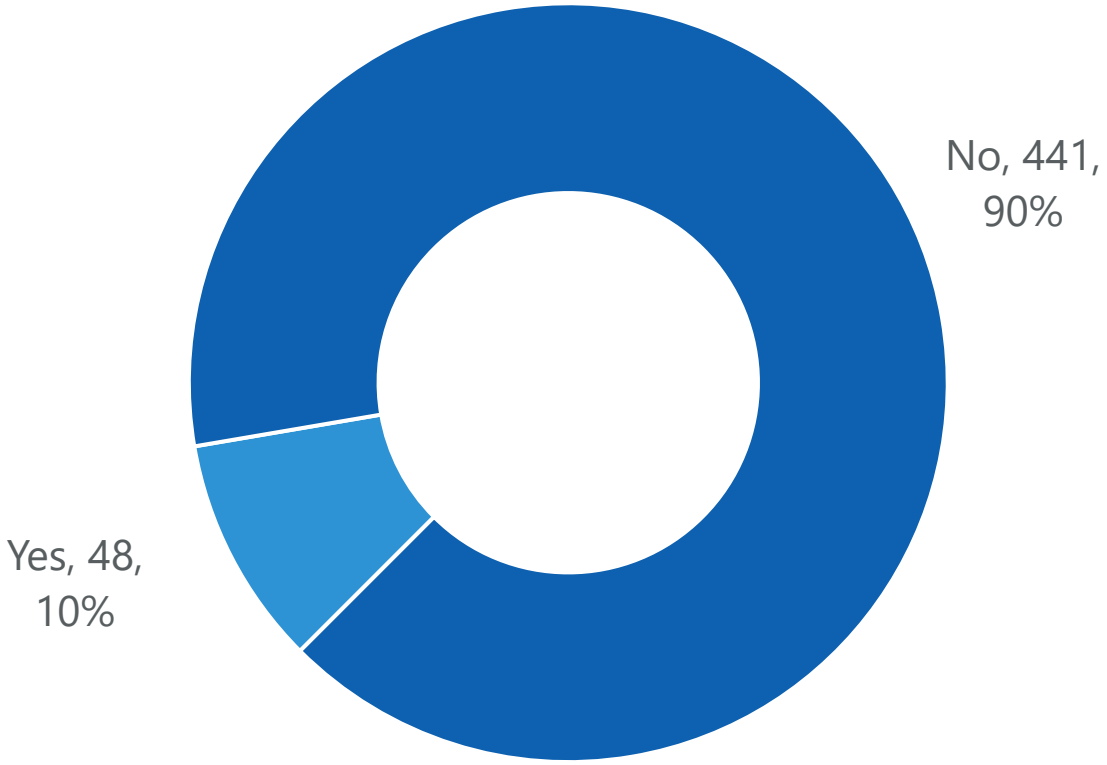
Two months after CATS
caregiver rating of clinical services, 2018 – 2020, n = 494



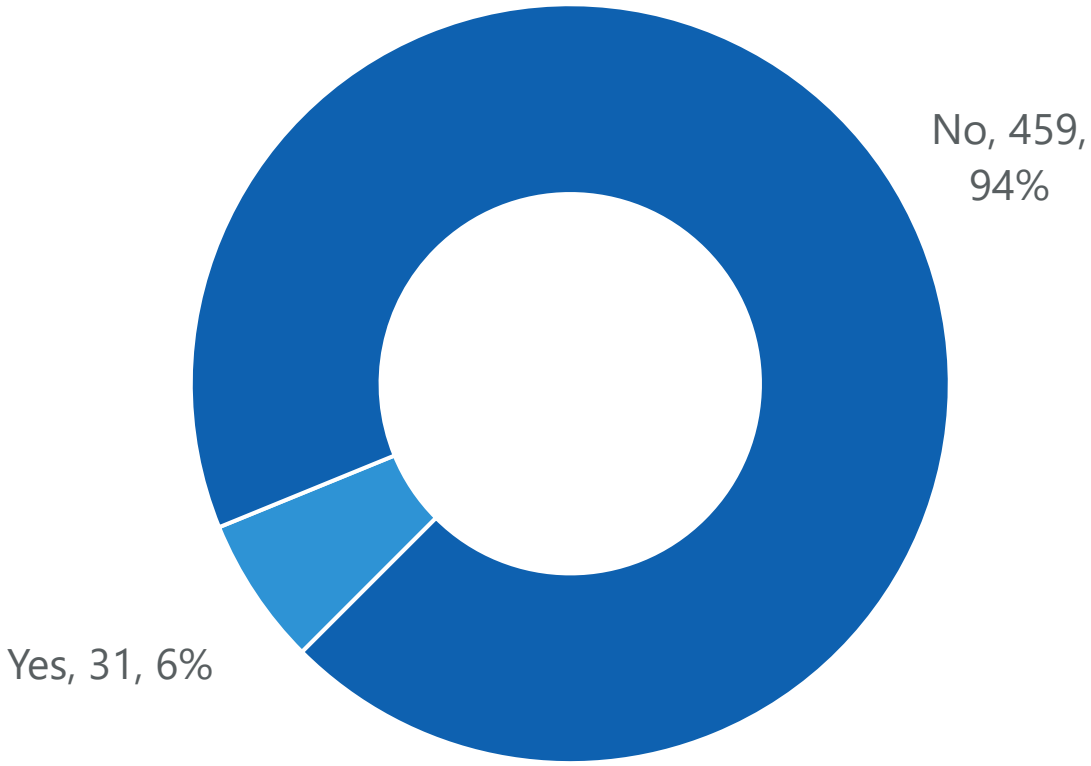
Two months after CATS
caregiver rating of peer services, 2018 – 2020, n = 192



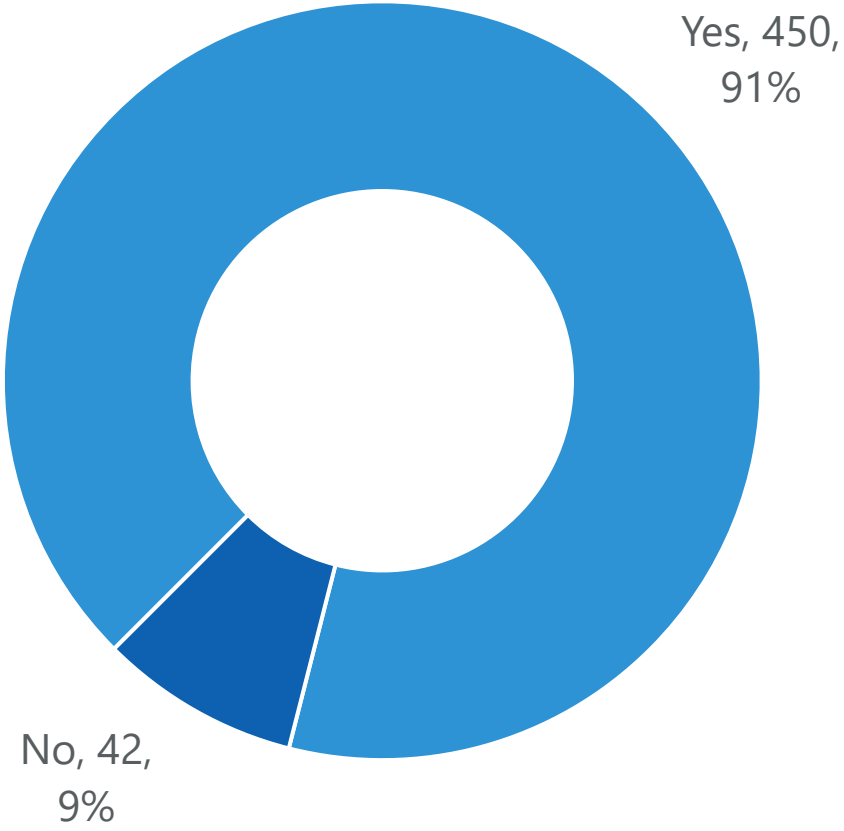
Two months after CATS
ED recidivism, n = 489



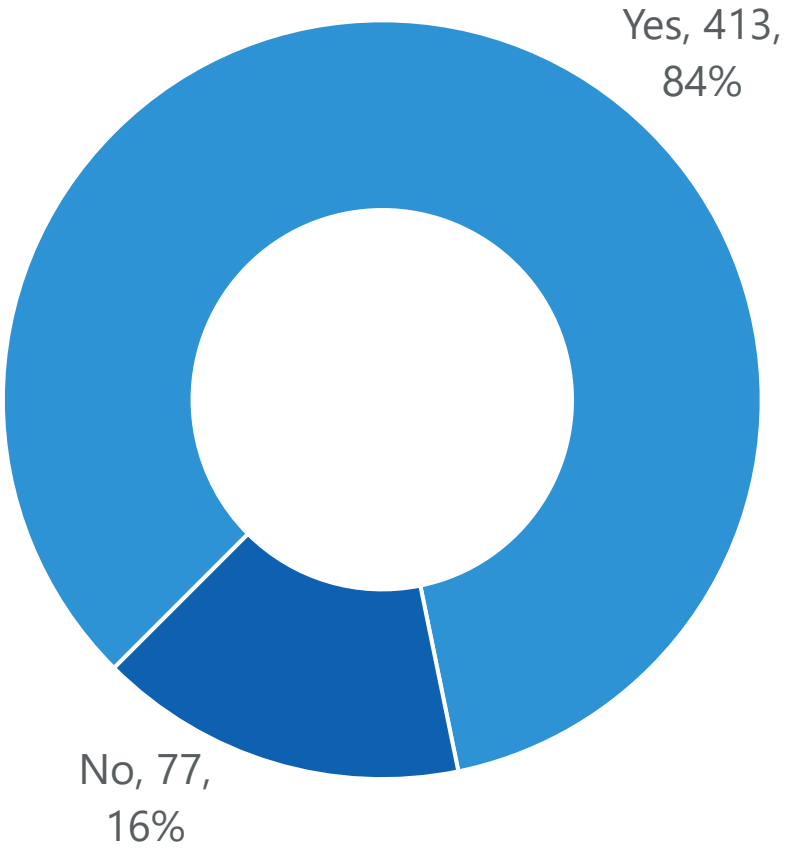
Two months after CATS suicide attempt, n = 490



Two months after CATS
caregiver is confident about what to do in a crisis, n = 492



Two months after CATS youth's care is meeting their needs, n = 490



Future Work

- Integrate APAC data to better assess recidivism, outcomes using comparative data
- Evaluation / TA for IIBHT, Wraparound
- Align data collection with other MH programs / systems such as IIBHT, Wraparound, possibly MRSS?

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Questions?

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Learn more

www.ohsu.edu/CATS

Ribbers, A., Sheridan, D., Jetmalani, A., Magers, J., Laurie Lin, A., Marshall, R. (2020). The Crisis and Transition Services (CATS) Model: A program to divert youths in mental health crisis from the emergency department. Psychiatric Services, 71(11), 1203-1206.

Magers, J., Ribbers, A., Nguyen, S., Marshall, R. (2020). Youth crisis and transition services (CATS): Incorporating family peer support specialists to assist families during crisis. Journal of Family Strengths, 20(2), 1-14.

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Contact us

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JenJennifer Fraga

From: JenJennifer Fraga
Sent: Wednesday, May 26, 2021 4:00 PM
To: JenJennifer Fraga
Subject: FW: REQUEST: Statewide Metric on Suicide Rates

From: Cheryl Cohen <Cheryl.Cohen@pacificsource.com>

Subject: REQUEST: Statewide Metric on Suicide Rates

Hello Partners in Suicide Prevention,

Happy Mental Health Awareness Month! I hope you are well and thriving. ☺

I'm reaching out on behalf of PacificSource and the Gorge Wellness Alliance (GWA), our regional Columbia Gorge mental health promotion and suicide prevention coalition. If there is someone who I neglected to include in this email, please feel free to forward this email. Collaborators are welcome!

Within the Coordinated Care Organization (CCO) model, I'm working on developing two improvement plans, the Comprehensive Behavioral Health Plan and the Community Health Improvement Plan (CHIP), where one focus area will be mental health promotion and suicide prevention across the lifespan. As part of those aligned plans, we need to define measureable outcomes or what "better" will look like. That's why I'm reaching out!

We are a new coalition with many partners, however we do not have a dedicated person or entity who "owns" mental health promotion/ suicide prevention in our region. We would love your input or feedback on what we should be measuring, especially if we can align with statewide metrics or outcomes. So far, we are planning to measure the following as outcomes within our CHIP and Comprehensive BH Plan, which are three year plans:

- The Columbia Gorge region has a sustainably funded, full-time & with benefits staff person to coordinate mental health promotion and suicide prevention efforts across the lifespan, as well as across sectors and counties (we have two counties in Washington that are part of the GWA).
- The GWA tracks the number of suicide prevention trainers, trainings offered, and community members/ healthcare providers who completed an evidence-based suicide prevention training, in both English and Spanish
- Increase in 'traffic' on the GWA website by 25% in the next three years
- Decrease rates of death by suicide by __ % across the Columbia Gorge five-county region as measured by data from the Oregon Violent Death Data Dashboard, Washington Violent Death Reporting System and/ or Washington Department of Health

That last one is the biggest metric that we could use some help with. In 2018, the rate of death by suicide in Wasco and Hood River County was 8 and 3 respectively, as measured by data from the Oregon Violent Death Data Dashboard. In 2019 the death by suicide rate listed for the Southwest Washington Regional Health Alliance (includes Klickitat, Skamania and Clark Counties) was 95, as measured by the Washington Department of Health.

Here are a few of our questions:

1. With the pandemic and increase in mental health struggles and substance use within communities, are we still aiming for a decrease in rates of death by suicide? We believe suicide is preventable and even one death by suicide is too much.

2. If we are still aiming for a decrease in deaths by suicide, is there a best-practice percentage we want to decrease by?
3. Are there other important outcome measures or metrics the GWA should include within our improvement plans, like the Oregon Healthy Teens Survey? If so, what language do you suggest? Are there important things we are missing?

Thank you so much in advance for any input or feedback.

Best,
Cheryl

Cheryl Cohen, LPC, CADC I, PWS
Behavioral Health Strategist, Columbia Gorge Region
Pronouns: She/ Her/ Hers
PacificSource.com