Co-Responder High Utilizer teams and AOT – a model for costs savings and efficacy

Dr. Jason Miller Crisis Response Medical Director

Executive Summary

- Goal: reduce 911 calls, ED utilization, and avoidable hospitalizations among high utilizers with serious mental illness (SMI).
- Strategy: combine court-ordered Assisted Outpatient Treatment (AOT) with a Co-Responder field team.
  - Triage in the field, rapid linkage to care, and court-backed adherence for the highest-risk cohort.
- Expected results (based on literature & field experience):
  - Fewer psychiatric hospitalizations and bed-days; lower arrests and homelessness.
  - Shifts spend from inpatient/ER to planned outpatient and medications.
  - Net savings likely in high-utilizer subgroup even after program costs.

PICC- Program for Intensive Care Coordination

Initiated in 2019, a collaborative with Southwest Texas Regional Advisory Council (STRAC), SA Police Department, SA Fire Department and CHCS. Funded by STRAC Consortium.

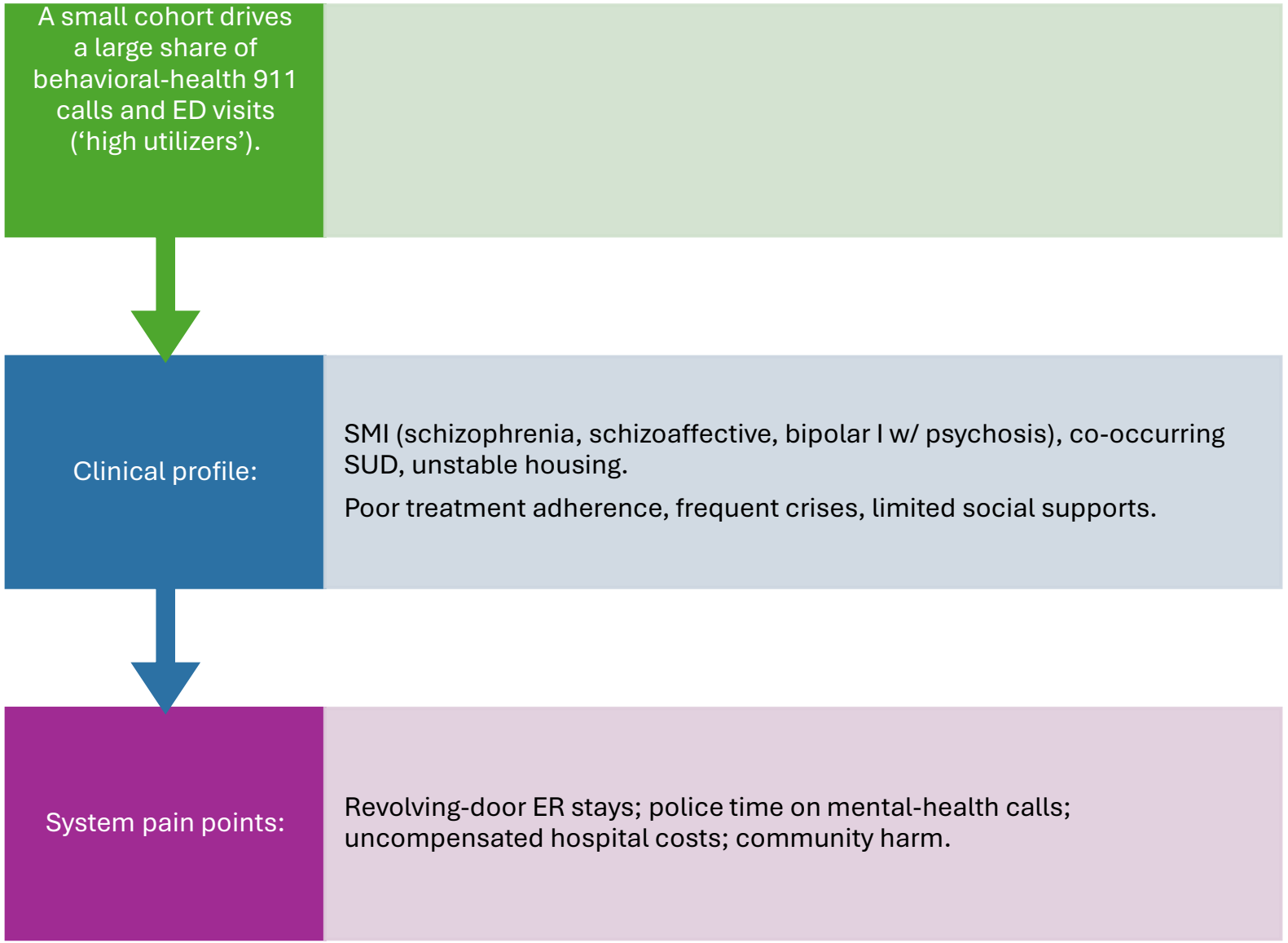
PICC is staffed with 4 QMHP's, 0.5 Psychiatrist and 0.5 LVN. Mostly field based with SAPD - Mental Health Officers and SA Fire Department Mobile Integrated Health Unit

Primary role is to provide aggressive referral, linkage and transition to next level of care

Target population are individuals who have had more than 6 Emergency Detentions or frequent users of our Psychiatric Emergency Services (PES) System within the last 12 months.

Goal: Reduce EDO's therefore reducing the utilization of ER's and PES beds.

The Problem & Target Population



The Economic Burden

A typical PICC client has had 10 ED visits in the last year. They have had an average of 6 hospitalizations with average length of stay of 8 days.

An average ER visit costs $2,453 for labs, diagnostic fees, facility fee. This of course is a range from $1,000.00-4,000.00.

An average cost for an 8 day hospitalization (again this can vary tremendously) is $12,000.00

The Economic Burden

- Therefore, the minimum cost of a PICC patient just for their ER and inpatient admissions is $91,624.00. This does not take into account housing costs, the burden to police, EMS. An example is that one estimate is that the overall cost for officers to do an emergency detention is $432.00. The cost for an ambulance is approximately $1800.00 per trip for a mental health emergency.

What is Assisted Outpatient Treatment (AOT)?

Civil court order for outpatient treatment for individuals with SMI and a history of non-adherence and deterioration.

Time-limited (e.g., 6–12 months) with due-process protections; least-restrictive alternative to inpatient commitment.

Enables rapid re-engagement and care plan modification if non-adherence recurs.

Historical Roots of AOT – Early Influences

Early outpatient commitment in Europe and US tied to ‘moral treatment’ ethos.

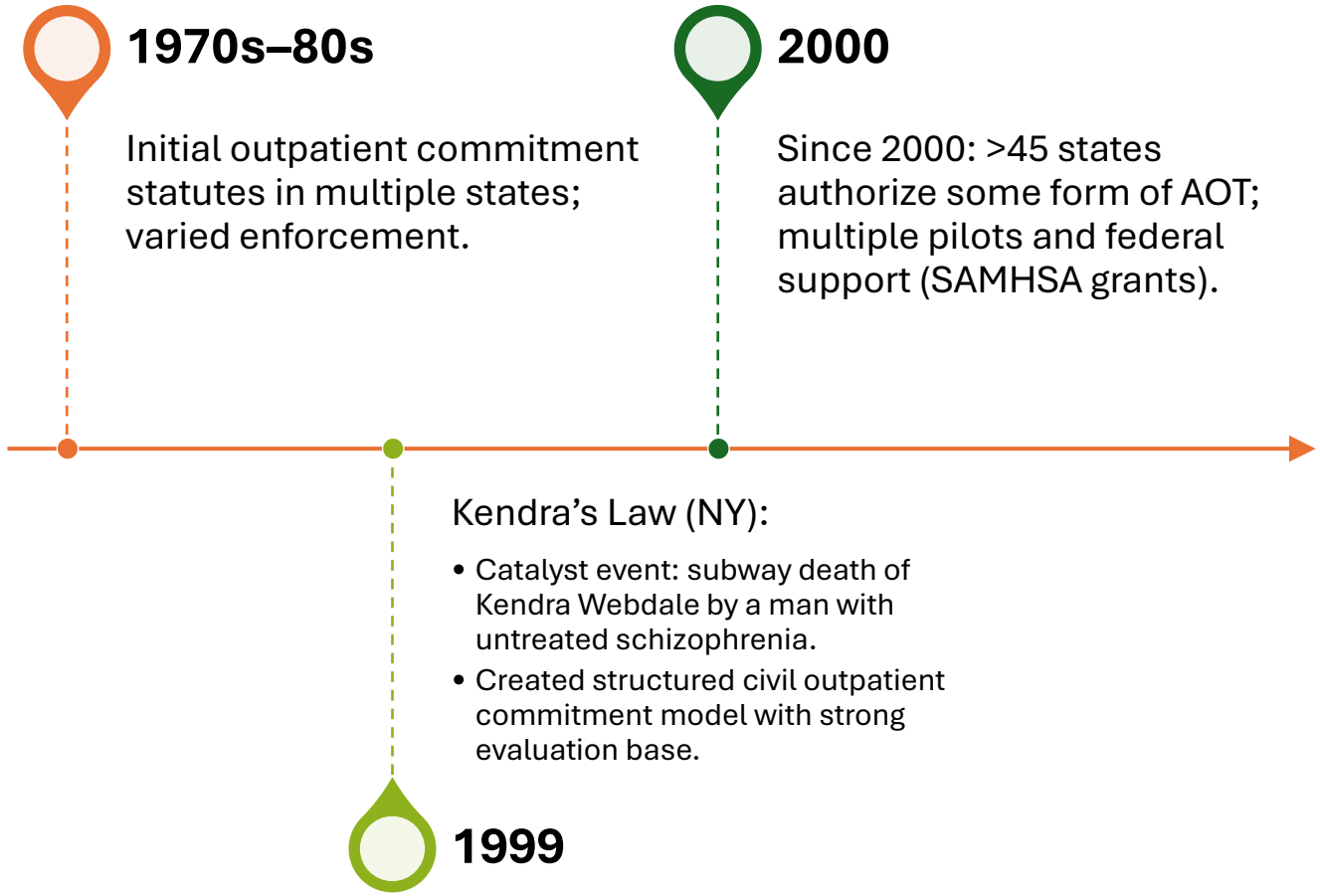
19th century

20th century

Mid-20th century deinstitutionalization:

- Large closures of state hospitals shifted treatment burden to community.
- Emergence of revolving-door hospitalizations and high utilizers of ER/police.

Historical Roots of AOT – Modern Policies



Historical Roots of AOT – Evidence Development

2000s–2010s: Peer-reviewed studies showed reductions in hospitalizations, arrests, homelessness during AOT orders.

Economic evaluations (Swanson et al.) found net savings for high utilizers when combined with case management.

Modern practice increasingly embeds AOT within integrated community and crisis systems.

Co-Responder Team (Police–Paramedic–MH)

Field team co-dispatched for mental-health calls: sworn officer, paramedic, and licensed mental-health clinician.

Functions:

- On-scene de-escalation and medical clearance.
- Brief assessment and safety planning.
- Warm handoff to ICM/ACT and, when indicated, initiation or re-activation of AOT petition.

Integrated Workflow (High-Level)

1) Identify high utilizers

- Data match: 911 CAD, EMS, ED, inpatient, and CMH registry.

2) Co-Responder field response

- Stabilize; start brief plan; transport only when necessary.

3) Rapid linkage

- Same-/next-day psychiatry; med initiation/LAI; benefits & housing work. Establish benefits when needed.

4) AOT as needed

- Petition for individuals with repeated deterioration/non-adherence. Especially helpful when considering the need for guardianship.

5) Review & adjust

- Monthly MDT + court check-ins for AOT clients; data-driven changes.

Evidence Snapshot – AOT

New York (Kendra's Law):

- Large reductions reported in hospitalizations (e.g., ~70%+ in some cohorts), homelessness, and arrests.
- Peer-reviewed analyses show substantial net cost reductions over 1–2 years as inpatient/ED use falls.

National/State reports:

- Multiple jurisdictions show improved adherence and functioning during orders (>=6 months).

Evidence Snapshot – Co-Responder Teams

Growing adoption; outcomes vary by design and local context.

Many sites report reduced use-of-force, faster diversion, and manageable costs (e.g., Denver scale-up).

Operational Design Highlights

Staffing:

- MH specialist caseloads 1:10–1:20; psychiatric provider 0.3–0.5 FTE/100 clients; 2 officers, 2 paramedics

Hours & coverage:

- CRT 10 hour shifts depending on call volumes.

Data & QA:

- Cross-agency data-use agreements; court review for AOT.

KPIs & Learning Agenda

Utilization:	911 calls, EMS transports, ED visits, inpatient bed-days, jail days.
Clinical:	Medication adherence (incl. LAI), appointment adherence, symptom/functioning scales.
Housing & social:	Stable housing days, benefits acquisition, vocational engagement.
Equity & safety:	Use-of-force incidents, involuntary holds, demographic parity checks.
Cost:	Per-member per-year spend; program cost per outcome; ROI at 6, 12, 24 months.

Legal & Ethical Guardrails

Use	• Use AOT only for narrowly defined clinical risk and repeated deterioration.
Emphasize	• Emphasize least-restrictive care; maximize voluntary engagement first.
Establish	• Establish clear information-sharing MOUs/BAAs; document minimum-necessary use.
Include	• Include independent advocacy; transparent grievance and review pathways.

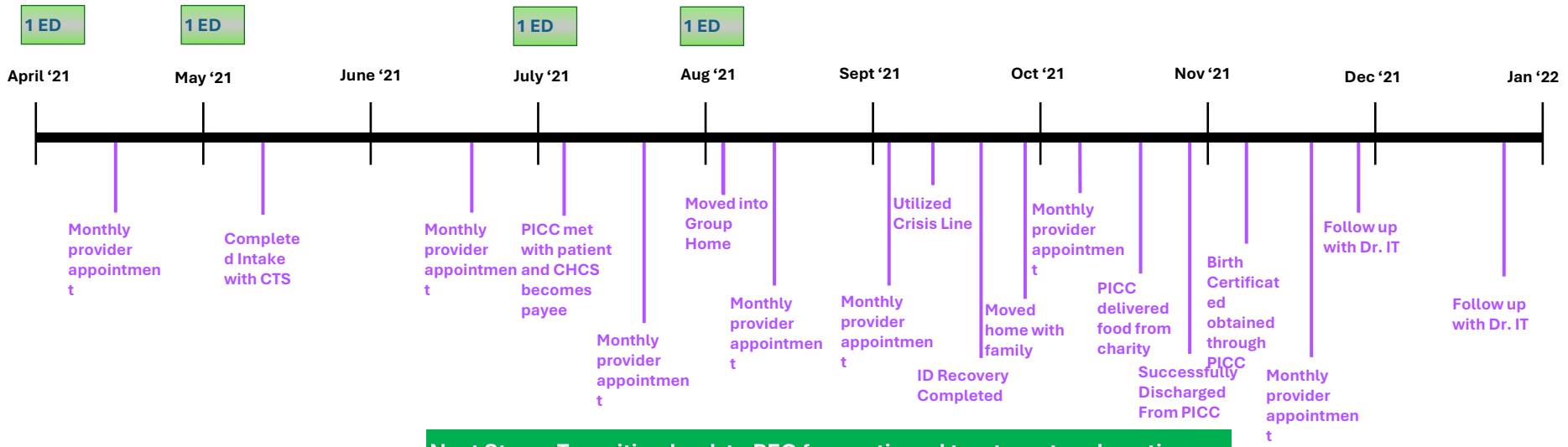
Added to PICC
February 2021

Patient Profile:
- 50-Year-old male
- Schizoaffective, Bipolar Type
- Type 2 Diabetes

Patient Utilization: January '20- December '21:
- PD Contacts – 289
- Emergency Detentions – 9
- EMS: PICC and EMS Runs – 73

STCC Program Utilization
- Law Enforcement Navigation

PICC Contacts 12/1/20-12/1/21:
Phone with Patient – 25
In Person with Patient – 81
Phone with Other – 6
In Person with Other – 7
Doctor Appointment with Patient – 8
Total PICC Contacts: 127



Next Steps: Transition back to PEC for continued treatment and continue to maintain stable housing.

STRAC
Southwest Texas Regional Advisory Council

Case 1 Combined approach

50 year old female

Diagnoses: Schizoaffective Disorder, Bipolar II Disorder, Generalized Anxiety Disorder, Panic Disorder and Substance-Related and Addictive Disorder

Choice of substance: Heroin, Fentanyl, Cocaine, Methamphetamine, Amphetamines

Consumer engaged with PICC from 3/6/2023 – 6/30/2025.

Total of 13 ED visits between 4/5/2023 – 8/10/2024.

Connected to AOT on 10/24/2024

ED utilization significantly reduced post-AOT; only 1 ED visit on 1/15/2025.

Resided at Crosspoint; maintained sobriety from methamphetamine.

Collaboration with AOT provided increased accountability, support, and resources, teams effectively shared care responsibilities.

Consumer alternated between contacting PICC and AOT for support, rather than consistently using one team.

Economic impact

Cost savings of 29,436.00 JUST IN ER VISITS!

Case 2 Combined approach

- **45 year old female**
- Diagnoses: Schizoaffective Disorder; Substance-Related and Addictive Disorder.
- Choice of substance: Methamphetamine
- Consumer engaged with PICC from 9/1/2020 – 3/31/2025.
- Total of 24 ED visits between 10/8/2020 – 12/21/2024.
- Connected to AOT on 2/18/2025.
- ED utilization reduced to zero following AOT connection.
- Resided in San Antonio Housing through Haven for Hope.
- Reconnected with daughter, who began providing support (e.g., cooking, cleaning)
- Maintained sobriety from methamphetamine after AOT connection.
- Currently working toward GED; plans to relocate closer to daughter.
- Collaboration with AOT has been beneficial, particularly with medication management and linkage to outside resources (e.g., GED support).

Economic impact

Cost savings of $14.718.00 just in ER visits.

In 2021 PICC, after accounting for its' own costs saved the medical system over 3 million dollars.

Risks & Mitigations

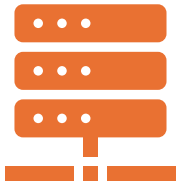
Civil liberties concerns	• Narrow eligibility; robust due process; independent advocacy; frequent reviews.
Net cost neutrality	• Prioritize highest utilizers; rigorous fidelity; use LAIs; close hospital/housing partnerships.
Workforce capacity	• Competitive pay; peer pipeline; tele-psychiatry; cross-training and supervision.
Interagency friction	• MOU playbook; regular joint debriefs; command-level champions; shared metrics dashboard.

Considerations

Individuals who fail a combined AOT/PICC initiative may require guardianship given their level of impairment.

In Bexar county the Judge who runs AOT also does guardianships.

Implementation Roadmap (0–12 Months)



0–90 days:

Data match & cohort sizing; MOUs; staffing plans; define court processes; procure EHR/mobile tech.

90–180 days:

Hire/train; pilot CRT shifts; stand up Co-responder tream; begin voluntary engagement; file first AOT petitions.

6–12 months:

Expand to 24/7 as indicated; continuous QA; interim ROI read-out; refine eligibility and workflows.

Funding & Sustainability

BLEND: MEDICAID (CLINIC, ACT, LAIS), LOCAL MH LEVY, ARPA/STATE GRANTS, HOSPITAL PARTNERSHIP DOLLARS.

COST-SHARE WITH HOSPITALS/EMS FOR HIGH-UTILIZER REDUCTIONS; EXPLORE VALUE-BASED CONTRACTS TIED TO ED/INPATIENT DECLINES.

SEEK PHILANTHROPY FOR START-UP; PLAN FOR BRAIDED FUNDING AND BILLING OPTIMIZATION BY MONTH 6.

Selected References

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