UNIVERSITY of MARYLAND
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THE INSTITUTE FOR INNOVATION & IMPLEMENTATION

Making the Case for a Comprehensive Children's Crisis Continuum of Care

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Why A Crisis Continuum of Care for Children?

- When children, youth and young adults experience a behavioral health crisis, parents and caregivers may not know what to do, or who is available to help meet the family's needs.

Why A Crisis Continuum of Care for Children?

- A crisis continuum of care – designed specifically to meet the needs of children, youth and young adults, and their parents/caregivers – is necessary *to deescalate and ameliorate a crisis before more restrictive and costly interventions become necessary, and to ensure connection to necessary services and supports.*

Comprehensive Crisis Continuum Components

- A comprehensive crisis continuum includes:
  - screening and assessment, ideally using a validated screening tool
  - mobile crisis response
  - crisis stabilization services and residential crisis, where necessary
  - psychiatric consultation
  - referrals and warm hand-offs to home- and community-based services ongoing care coordination

Mobile Response and Stabilization Services (MRSS) Within a Crisis Continuum

- Can effectively *deescalate, stabilize*, and *improve treatment outcomes*.
- Are specifically designed to *intercede before urgent behavioral situations become unmanageable emergencies* and *are instrumental in averting unnecessary emergency department visits, out-of-home placements and placement disruptions, and in reducing overall system costs*.

Technical Assistance Collaborative. (2005).
A Community-Based Comprehensive Psychiatric Response Service: An Informational and instructional monograph.
Retrieved from http://tacinc.org/media/13106/Crisis%20Manual.pdf

Why Include MRSS In a Crisis Continuum?

- Children, youth, young adults and families can initiate care based on a self-defined crisis
- Engaging families in a culturally and linguistically competent crisis response is essential not just for reducing risk in the current crisis and preventing future crises but also for developing trust

Massachusetts Parent/Professional Advocacy League. (2011). Crisis Planning Tools for Families: A Companion Guide for Providers. Retrieved from https://www.masspartnership.com/pdf/Crisis-Planning-Tools_Guide_for_ProvidersFinal.pdf

Emergency Department (ED) Data

- Pediatric psychiatric ED visits nationwide increased from an estimated 491,000 in 2001 to 619,000 in 2010.
- ED usage rates for publicly insured children and children without any health insurance are *four-fold* above those who are privately insured.

Pittsenbarger, Z.E., Mannix, R. (2014). Trends in Pediatric Visits to the Emergency Department for Psychiatric Illnesses. Academic Emergency Medicine (21)1, 25-30. Retrieved from https://onlinelibrary.wiley.com/doi/epdf/10.1111/acem.12282

The Historical Response to Crisis

- Emergency Departments (ED):
  - Lack specialized expertise to respond to pediatric psychiatric emergencies leads to “boarding”
  - Expensive for payers
  - Time consuming and traumatic for parents and children

Better outcomes in both cost and quality of care are achievable through community-based initiatives that redefine the meaning of ‘crisis’ and address and stabilize behaviors prior to escalation to the level of requiring inpatient care.

Goals of Comprehensive Crisis Continuum

1. Diverting unnecessary ED admissions
2. Instituting evidence-based home- and community-based services that provide meaningful alternatives to inpatient treatment

Shannahan, R., & Fields, S. (2015). Services in Support of Community Living for Youth with Serious Behavioral Health Challenges: Mobile Crisis Response and Stabilization Services. The National Technical Assistance Network for Children's Behavioral Health

Federal Guidance

- **2013 CMCS/SAMHSA Joint Informational Bulletin** Medicaid reimbursable home and community-based services for children and youth with complex behavioral health needs.
  - Named several services critical to developing a high-quality crisis continuum, including *mobile crisis response and stabilization* and *residential crisis stabilization*

Federal Guidance

- **Interdepartmental Serious Mental Illness Coordinating Committee Charter (ISMICC) first report to Congress** (2107) recommended:
  - Defining and implementing a national standard for crisis care
  - Developing an integrated crisis response system to divert people with SMI and SED from the justice system
  - Crisis intervention team training for those in criminal justice

The Value of MRSS within a Crisis Continuum

- Designed to intercede upstream, before urgent behavioral situations become unmanageable emergencies
- Instrumental in averting unnecessary ED visits, out-of-home placements and placement disruptions, and in reducing overall system costs.*
- Keep a child, youth or young adult safe at home, in the community, and in school whenever possible.
- Viable alternative to acute care and residential treatment because they consistently demonstrate cost savings while simultaneously improving outcomes and achieving higher family satisfaction.

*Technical Assistance Collaborative. (2005). A Community-Based Comprehensive Psychiatric Response Service: An Informational and instructional monograph. Retrieved from http://tacinc.org/media/13106/Crisis%20Manual.pdf

Examples of Cost Savings and Avoiding Unnecessary Care

- Connecticut
  - Evaluation of the state's Emergency Mobile Psychiatric Services (EMPS) found the 2014 average cost of an inpatient stay for Medicaid-enrolled children and youth was $13,320 while the cost of MRSS was $1,000, a net savings of $12,320 per youth.
  - In FY2013, EDs referred to EMPS 1,121 times and 553 referrals were coded as "inpatient diversions." Of the 553 referrals, approximately 60% (or 332) were Medicaid-enrolled for a cost savings of over $4 million.

Examples of Cost Savings and Avoiding Unnecessary Care

- King County, WA
  - Since October 2011, the Children's Crisis Outreach Response System (CCORS) has served 4,445 unique youth with a total of 5,438 service records. Out of the 5,438 total service records, only 15 (<1%) indicated that the CCORS encounter ended with a foster care placement.
  - Between 2013 and 2015, CCORS was successfully able to divert 91-94% of hospital admissions.
  - An evaluation of CCORS estimated that it saved $3.8-7.5 million in hospital costs and $2.8M in out-of-home placement costs.

Examples of Cost Savings and Avoiding Unnecessary Care (cont.)

- Pima County, AZ
  - CRC opened in 2011 and provides 24/7 services, including MRSS, family and youth peer support, and a crisis hotline.
  - Pima County Sheriff's Office & Tucson Police Dept. receive crisis intervention training, including how to contact the Mobile Acute Crisis (MAC) teams.
  - In FY14, 4,433 adult and juvenile law enforcement transfers saved 8,800 hours of law enforcement time, the equivalent of four full-time officers.
  - In FY15, 1,101 adults and children were transferred from the ED to the CRC after initial stabilization to receive additional crisis services, rather than being admitted, saving $456,138

Examples of Cost Savings and Avoiding Unnecessary Care (cont.)

- Texas
  - 2007 MRSS initiative resulted in declining hospitalization which translated into direct and measurable cost savings of $1.16 to $4.51 return on every dollar invested.

Crisis Continuum: Infrastructure, Components, and Functions

- Single Point of Access
- No Wrong Door
- Crisis Hotline
- Electronic Health Record
- Triage
- Mobile Response and StabilizationAssessment
- Crisis Intervention and Initial Identification
- Crisis Stabilization
- Residential Crisis Stabilization
- Recovery and Reintegration

Crisis Continuum: Infrastructure, Components, and Functions

MRSS Common Elements:

- Crisis is defined by the caller
- Services are available 24 hours a day, seven days a week
- Able to serve children and families in their natural environments, for example, at home or in school
- Include specialized child and adolescent trained staff and do not rely on predominantly adult-oriented crisis response workers
- Build on natural support structures and reduce reliance (and therefore costs) on hospitals and formal crisis response systems.
- Connect families to follow-up services and supports, including transition to needed treatment services

Crisis Continuum: System Coordination and Community Collaboration

- Strategies for encouraging coordination and collaboration include:
  - co-location and locating in community
  - use of crisis text lines, warm lines, and suicide hotlines;
  - use of paraprofessionals

Crisis Continuum: System Coordination and Community Collaboration (cont.)

- Primary and Psychiatric Care Providers
- Child Welfare
- Law Enforcement
- Schools/Education
- Emergency Departments
- Juvenile Justice and Family Courts
- Community Organizations

Crisis Continuum: System Coordination and Community Collaboration (cont.)

- Schools/Education
- Emergency Departments
- Juvenile Justice and Family Courts
- Community Organizations

Workforce Strategies

- Telehealth
- Co-location
- Satellite Locations
- Broad-based Teaming

Financing a Crisis Continuum of Care

- Potential sources include:
  - Medicaid,
  - commercial insurance,
  - local and state educational funds,
  - child welfare,
  - mental health state general funds,
  - and/or federal grants.

Often used in combination

Financing a Crisis Continuum of Care

- Strategies to build a continuum include:
  - braided
  - blended funding
  - re-prioritizing where funds are used.

- States and localities may elect to blend or braid to address the needs of children, youth, and young adults.

Financing a Crisis Continuum of Care: Blended (or Pooled) Funding

- Precludes the ability to report which funding stream incurred a specific expense.
- Funders must accept reports on services provided across the population served, rather than services provided to specific children, youth, and young adults using their stream of dollars.
- Federal and state statutes prohibit the blending of some funds.

Financing a Crisis Continuum of Care: Braided Funding

- Brings funding streams together under a coordinated agency or single entity.
- Streamlines service provision by eliminating the need for an individual to enter separate programs to obtain each component identified in a single plan of care. Although a single entity oversees all expenditures, each stream is maintained to allow for the careful accounting of how every dollar from each stream is spent.

Financing a Crisis Continuum of Care: Braided Funding (cont.)

- Most federal funding streams require careful tracking of staff time, with requirements for allocation of personnel hours and other revenue-specific accounting and allocation requirements. Consequently, when multiple funding streams are paying for a single program or system, the system needs to be carefully designed and monitored to ensure compliance with all applicable federal and state statutes and regulations.

Rutgers UBHC Training and Technical Assistance –Trains All System Partners, Families

Department of Children and Families
Division of Children's System of Care (CSOC)

Trauma Informed SOC, Utilizes an Integrated Approach to Care Embedded in System of Care Approach (values and principles)

Policy Authority, Funding Agency
Approves and manages the Provider Network
(BH carve out; Providers bill on fee for service basis)

Statewide Youth Ambassador

Children's Interagency Coordinating Council (CIACC)-One per county (21)-local planning bodies

PARTNERSHIP

- **Dept. of Human Services Division of Mental Health and Addiction Services**
- **Dept. of Human Services Division of Medical Assistance and Health Services (Medicaid)**
- **Dept. of Human Services Division of Developmental Disabilities**

Contracted System Administrator (ASO+)

Single Point of Entry and Access to Care 24/7
Triage, Utilization Management
Care Coordination
Authorizes Services
Non risk based
Hosts CSOC's MIS (EHR and Data)

Family Support Organizations
Family-led peer support and advocacy for parents/caregivers and youth group

Populations Served are youth (and their families) with one or more of the following:
- Behavioral health challenges
- Substance use challenges
- Intellectual/developmental disabilities
- Autism

Youth with **multisystem involvement:
child welfare and/or **juvenile justice**

Youth and Family Voice

Other Authorized Services includes but is not limited to:
- Biopsychosocial Assessments
- In home Clinical/Therapeutic
- Out of Home Care (OOH)
- Partial Hospitalization/Partial Care
- Substance Use Services
- In home Behavioral for I/DD youth
- Family Support Services for I/DD Youth
- Non Medical Transportation
- Interpreter Services
- Outpatient
- Assistive Technology

Mobile Response & Stabilization Services
Crisis response and planning; 24/7/365 within 1 hour

Care Management Organization
Utilizes ***Wraparound*** model to serve youth and families with moderate and complex needs; designated health home entity

Physical Health Integration

Child Family Teams

Client Case Placement

CANS ASSESSMENT TOOL Utilized in Triage, for Treatment Planning and Outcomes Tracking

NURTURED HEART APPROACH®

- 1115 Waiver-Children's Supports Waiver, I/DD and SED
- State Plan Amendments
  - Targeted Case Management-CMO
  - Psych under 21 Benefit-OOH Programs
  - Rehabilitative Option-MRSS, IIC/BA, Out of Home
- State Option to Provide Health Homes
- Flex Funds

State and Federal Appropriations

Title XIX and Title XXI

Questions & Discussion

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