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

Ohio Crisis Academy

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TA NETWORK

DEPARTMENT OF HEALTH & HUMAN SERVICES. USA

SAMHSA
Substance Abuse and Mental Health Services Administration

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Children's Crisis Continuum of Care

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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.*
- Key services to *shift from overuse of high-end services and supports to home- and community-based services*
- Paper published by NASMHPD "makes the case" for a comprehensive children's crisis continuum of care

Manley, E., Schober, M., Simons, D. & Zabel. M. (2018). Making The Case for a Comprehensive Children's Crisis Continuum of Care. National Association of State Mental Health Program Directors. https://www.nasmhpd.org/sites/default/files/TACPaper8_ChildrensCrisisContinuumofCare_508C.pdf

Goals of Comprehensive Crisis Continuum

Diverting unnecessary Emergency Department visits

Instituting evidence-based HCBS to provide meaningful alternatives to inpatient and residential treatment

Supporting parents and caregivers sense of urgency

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

Pires, S. (2010). *Building systems of care: A primer, 2nd Edition.* Washington, D.C.: Human Service Collaborative for Georgetown University National Technical Assistance Center for Children's Mental Health.

Use of Emergency Departments (EDs)

- 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.
- EDs:
  - Lack specialized expertise to respond to pediatric psychiatric emergencies leads to "boarding"
  - Expensive for payers
  - Time consuming and traumatic for parents and children

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

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.

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

Federal Guidance

2013 CMCS/SAMHSA Joint Informational Bulletin:

- Describes 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*

Center for Medicaid and CHIP [CMCS] and Substance Abuse and Mental Health Services Administration [SAMHSA] (2013). Joint Informational Bulletin. Coverage of Behavioral Health Services for Children, Youth, and Young Adults with Significant Mental Health Conditions. https://www.medicaid.gov/federal-policy-guidance/downloads/cib-05-07-2013.pdf

Federal Guidance (cont.)

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

Interdepartmental Serious Mental Illness Coordinating Committee[ISMICC] (2017). The Way Forward: Federal Action for a System That Works for All People Living With SMI and SED and Their Families and Caregivers (Washington, DC). https://www.samhsa.gov/sites/default/files/programs_campaigns/ismicc_2017_report_to_congress.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

The Value of MRSS within a Crisis Continuum

- Can effectively deescalate, stabilize, and improve treatment outcomes
- 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.

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

- 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.

Manley, E., Schober, M., Simons, D. & Zabel. M. (2018). Making The Case for a Comprehensive Children's Crisis Continuum of Care. National Association of State Mental Health Program Directors. https://www.nasmhpd.org/sites/default/files/TACPaper8_ChildrensCrisisContinuumofCare_508C.pdf

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
- 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.

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Crisis Continuum Infrastructure, Components, and Functions

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

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

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

System Coordination and Community Collaboration (cont.)

- Primary and Psychiatric Care Providers
- Child Welfare
- Law Enforcement
- Schools/Education
- EDs
- 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
  - Federal grants

  Often used in combination

- Strategies to build a continuum include:
  - Braided or 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.

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.

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.
- 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.

NJ MRSS Mission and Goal

- Mobile Response and Stabilization Services help youth and their families that are experiencing an emotional or behavioral stressor by interrupting the family-defined crisis and ensuring youth and their families are safe and supported.
- MRSS provides on-site assessment, intervention support and skill-building necessary to stabilize a youth's behavior towards improved functioning, living situation stability, and community involvement.
- MRSS collaborates across youth-serving systems to support youth and family engagement and to coordinate supports that help youth and families become safe, healthy.and connected.

NJ MRSS Program Structure

MRSS Eligibility

Youth and Young Adults under 21 experiencing

Family Defined Crisis

MRSS Access

- 24/7 Single Point of Access: CSOC *Contracted System Administrator (CSA)*
- Clinical Triage and Criteria
- Parent/Caregiver Verbal Consent
- Warm Line Connection with local MRSS
- Crisis Intervention Response

NJ MRSS Program Structure

- 24/7 Community Response – MRSS serves families where they are, anywhere in NJ, within 60-minute timeframe
- 72 Hour Initial Intervention
- Up to 8 Week Stabilization Period
- Crisis Assessment Tool (CAT)
- Individualized Crisis Planning

NJ MRSS Structure

- Local Organization within System of Care Structure
- Provider Network
- Connection with Family Support Organization and Youth Partnership
- Staffing Model
- Training, Certification, and Supervision
- State and Local System Collaboration

NJ MRSS System Collaboration

- Psychiatric Screening Centers:
  - Ability to connect with CSOC current providers through CSA
  - Request MRSS if youth are not hospitalized
  - Nurtured Heart Approach® training
  - System Review Committees
- Collaborative Initiatives with Division of Child Protection and Permanency:
  - MRSS for every youth placed in a resource or kinship home
  - Functional Family Therapy-Foster Care (FFT-FC)
  - Attachment, Regulation, Competency (ARC) GROW
- Partnering to respond to victims of Human Trafficking
- Juvenile Justice System Collaboration
  - MRSS-Family Crisis Intervention Unit
  - Station House adjustments

NJ MRSS Funding

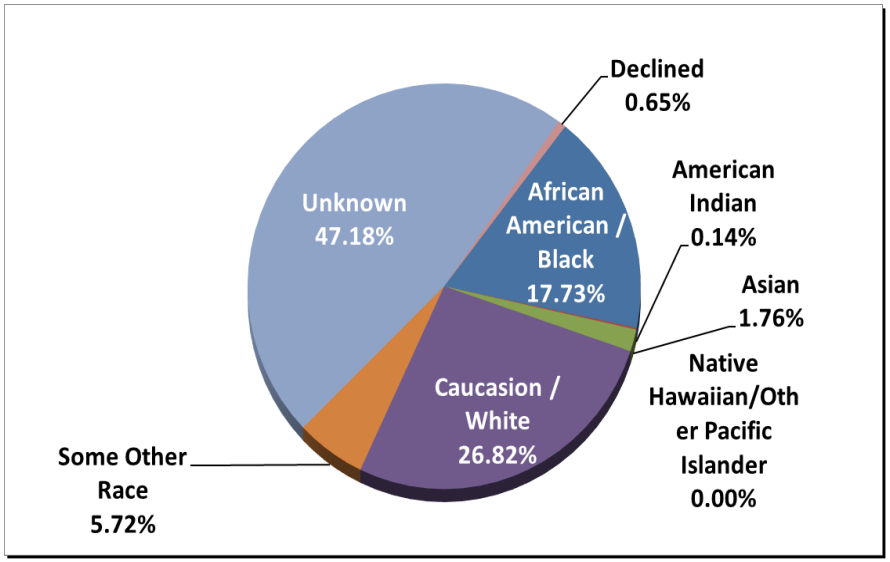
- Presumptive Eligibility
- Medicaid State Plan Amendment Rehabilitation Option – Early and Periodic Screening, Diagnostic and Treatment (EPSDT)
- State Funding for Youth Not NJ Family Care Eligible
- Wrap/Flex Funds to Support Non-Medicaid Reimbursable Services
- Third Party Liability Insurance Coordination (TPL)

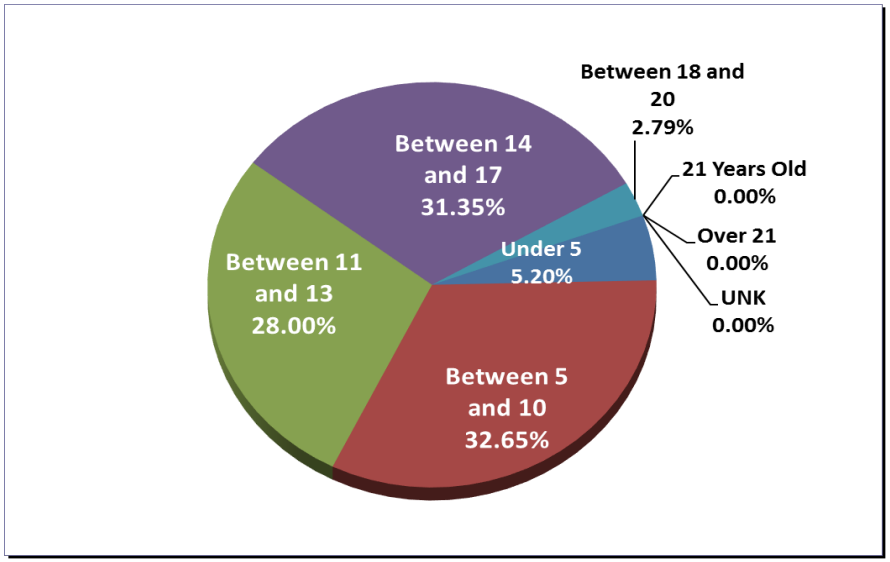
MRSS directly bills Medicaid's Fiscal Agent, per member per dispatch rate and per 15-minute unit.

MRSS Quality and Outcomes

- Individual Level
  - Debriefing
  - Individual Outcome Reports
- Provider Level
  - Data Dashboards
  - Routine Meetings
- Systems Level
  - Creative Practice/Success Stories/Recognitions
  - System Review

Demographics of Youth Served by MRSS





Identified gender of youth served as of 4/1/19- 55% male, 45% female

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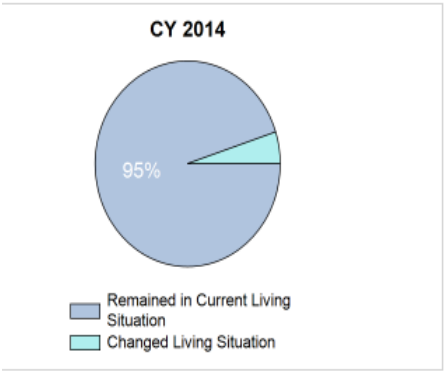
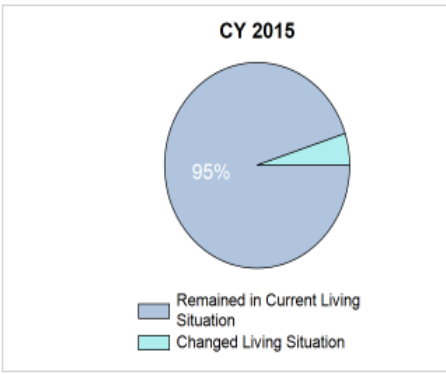
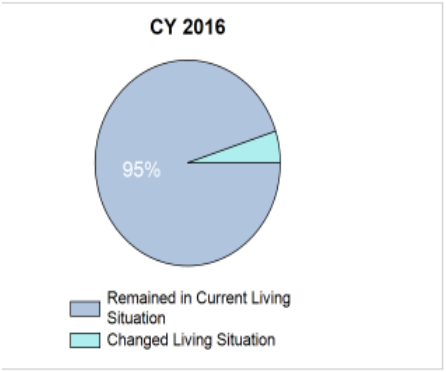
MRSS Living Situation



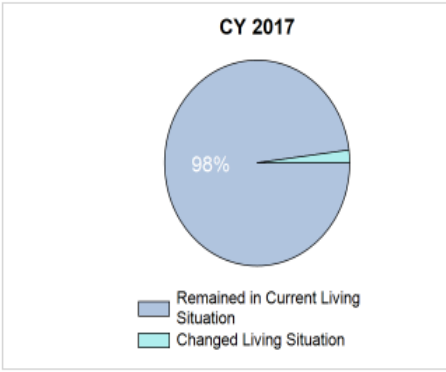
Total Assessments	Remained Count
34,530	32,806



Total Assessments	Remained Count
37,593	35,756



Total Assessments	Remained Count
38,693	36,863



Total Assessments	Remained Count
47,264	46,467

Since its inception in 2004, MRSS has consistently **maintained 94% of children in their current living situation, at the time of service, including children who are involved with the child welfare system.**

Families have reported high satisfaction with services, with a 250% increase in families accessing MRSS.

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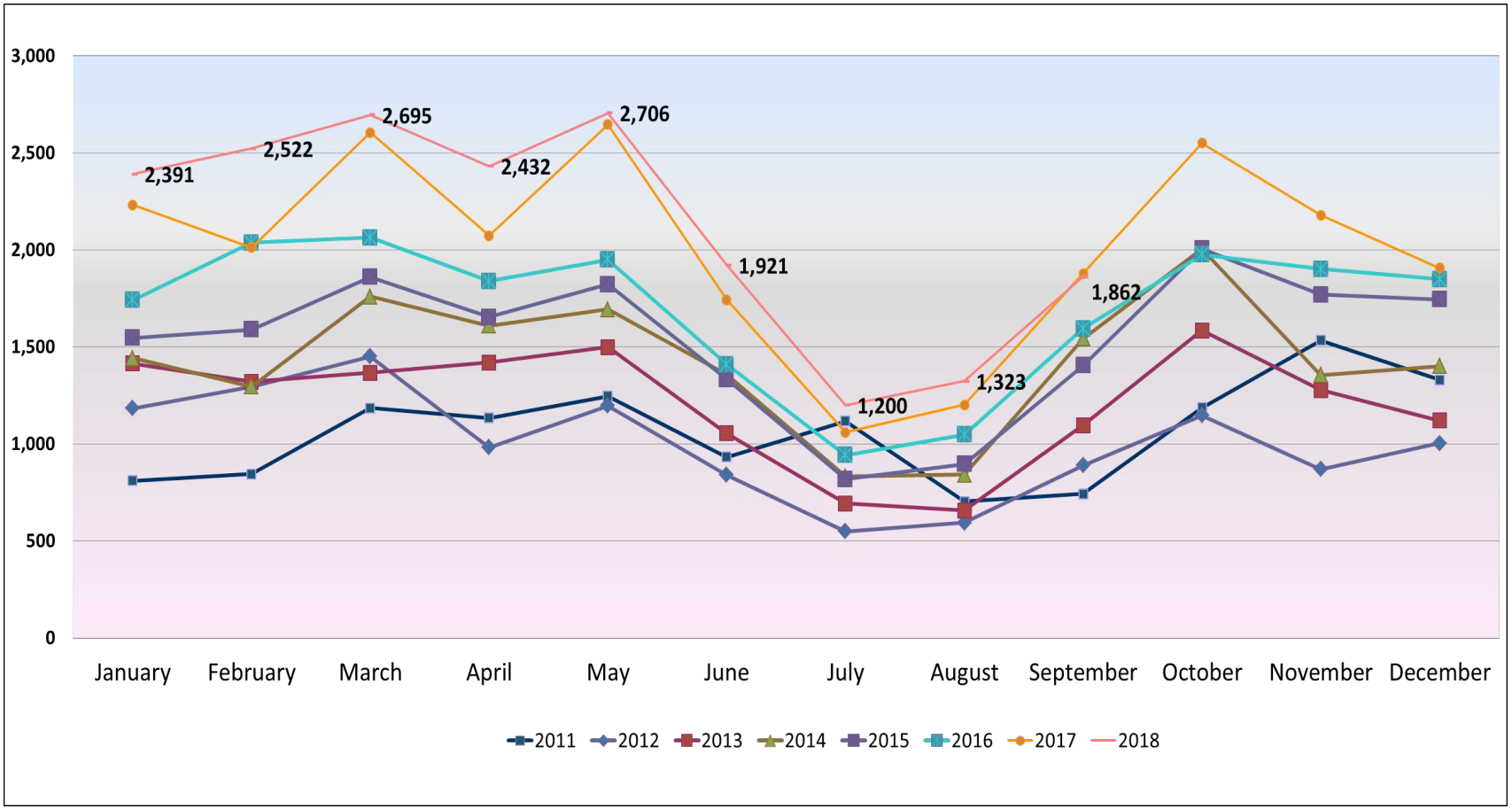
MRSS Readmission

- 30-day readmission rate for youth who transitioned from MRSS between January 1, 2019 and March 31, 2019 was 47%.

- Of youth transitioned from MRSS in 2017, an average of 14% re-enrolled within 12 months.

MRSS Trend



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Youth in Behavioral Health Out of Home Treatment

How Does NJ'S CSOC Model Impact the Youth We Serve?

- ✓ Fewer children in out of home treatment programs, with a decreased length of stay
- ✓ Fewer children accessing inpatient treatment
- ✓ Closure of state child psychiatric hospital and state operated institutional residential treatment centers
- ✓ Reduction from over 350+ youth in out-of-state facilities to currently one youth in behavioral health out-of-home setting
- ✓ Ensures youth receive the right intensity of services for the right duration
- ✓ Fewer youth in detention centers
- ✓ Wraparound model works!!

Nationally recognized model of a

System of Care

- https://www.nasmhpd.org/content/ta-coalition-assessment-working-paper-making-case-comprehensive-children's-crisis
- NJ Family Guide: http://www.performcarenj.org/pdf/provider/youth-family-guide-eng.pdf
- NJ Children's Interagency Coordinating Council Data Dashboard; https://www.nj.go/dcf/childdata/interagency/index.html
- NJ MRSS Service Planning Guide; http://www.performcarenj.org/pdf/provider/service-planning-guides/mrss.pdf
- https://www.state.nj.us/dcf/documents/home/childdata/behavioral/DCBHS10yrReview.pdf
- https://www.nj.gov/dcf/about/divisions/dcsc/CSOC_15.Year.Conference.Presentation.pdf
- Joint CMCS and SAMHSA Informational Bulletin: Coverage of Behavioral Health Services
- for Children, Youth, and Young Adults with Significant Mental Health Conditions

SAMHSA's mission is to reduce the impact of substance abuse and mental illness on America's communities.

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