

REPORT ON PEDIATRIC BEHAVIORAL HEALTH URGENT CARE

EXECUTIVE SUMMARY

children's mental health campaign



MSPCC - BCH - HCFA - HLA - PPAL - MaMH

SUPPORTED BY MILLER INNOVATION FUND

ACKNOWLEDGMENTS

In early 2015, the Children’s Mental Health Campaign (CMHC), with the financial support of the C.F. Adams Charitable Trust, launched a multi-year project to gather data to define clearly the scope of issues that lead to Emergency Department (ED) boarding and to use that data to inform a set of solutions to the problem. ED boarding is the practice of holding patients in the hospital ED for extended periods of time while evaluating the need for or finding a bed for hospital admission. Children with behavioral health conditions, and those with co-occurring autism spectrum disorders or intellectual and developmental disabilities suffer the longest ED boarding rates in Massachusetts hospitals.

In 2017, The Miller Innovation Fund awarded the Children’s Mental Health Campaign (CMHC) funds to study one solution, behavioral health urgent care for children. The study reported here was developed to examine the needs of the target population and the elements of urgent care required to design a pilot of services. Later in 2017, the Peter and Elizabeth C. Tower Foundation awarded the CMHC funds to study the unique needs and urgent care service requirements of Massachusetts’ children and adolescents in the target population who have co-occurring autism spectrum disorders (ASD) and/or intellectual and developmental disabilities (IDD). We are deeply grateful for their support.

We also want to cite the invaluable collaboration with the Blue Cross Blue Shield of Massachusetts Foundation as it pursued its new, “Expanding Access to Behavioral Health Urgent Care,” initiative to fund planning and implementation of model interventions for adults with behavioral health conditions.

The CMHC team extends its sincere thanks to the children, adolescents, their families and caregivers who serve as inspiration for our research and advocacy. We would also like to thank our fellow advocates and community-based service providers for their collaboration on this study and for their dedication to improving the behavioral health system for children and adolescents. Please see Appendix A for a full alphabetical list of our key informants, site visit sites, consultations, focus groups, and the Boarding Advisory Committee, all of whom were instrumental to the success of this study.

Delivery of behavioral health care in Massachusetts is a true public private partnership. State government leaders, policymakers, regulators, and payers are leaders in the effort to address psychiatric boarding and provided generous input to this report, including a collaborative review of preliminary findings and proposed solutions.

THANK YOU TO THESE SIGNIFICANT PARTNERS AND STAKEHOLDERS

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Community Healthlink
Connecticut Department of Children & Families
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Department of Mental Health
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EXECUTIVE SUMMARY

BACKGROUND AND OVERVIEW OF THE CURRENT STATE OF CHILD AND ADOLESCENT BEHAVIORAL HEALTH CARE

Despite near universal health insurance coverage and a diverse array of behavioral health services in the Commonwealth of Massachusetts, children and adolescents with behavioral health conditions seeking care are faced with delays in access to a fragmented system that is variable in its capacity, quality, and intensity across all service types. There are numerous deficits in the current child and adolescent behavioral health service delivery system that reflect gaps in care and systemic issues in delivery. These include:

- Long waits for access to outpatient care;
- Limited treatment available for youth with co-occurring conditions;
- Limited clinical and management information sharing across provider entities;
- Uneven regional crisis intervention capabilities;
- Poor continuity of care among emergency, inpatient, and outpatient settings;
- No behavioral health capacity at medical urgent care centers;
- Limited crisis stabilization bed availability;
- Too few inpatient beds and hospitals with restrictive admission criteria; and
- Children and adolescents boarding in emergency departments (EDs) due to limited disposition capacity.

In a Massachusetts Health Policy Commission (HPC) study examining five years of insurance data, the HPC found that the share of ED visits among those with behavioral health conditions who spent greater than twelve hours “boarding” in the ED increased from 17 percent of visits to 23 percent of all visits. Of patients who presented to the ED with a behavioral health diagnosis, adolescents aged 12 to 17 were more likely than any other age group to board.¹

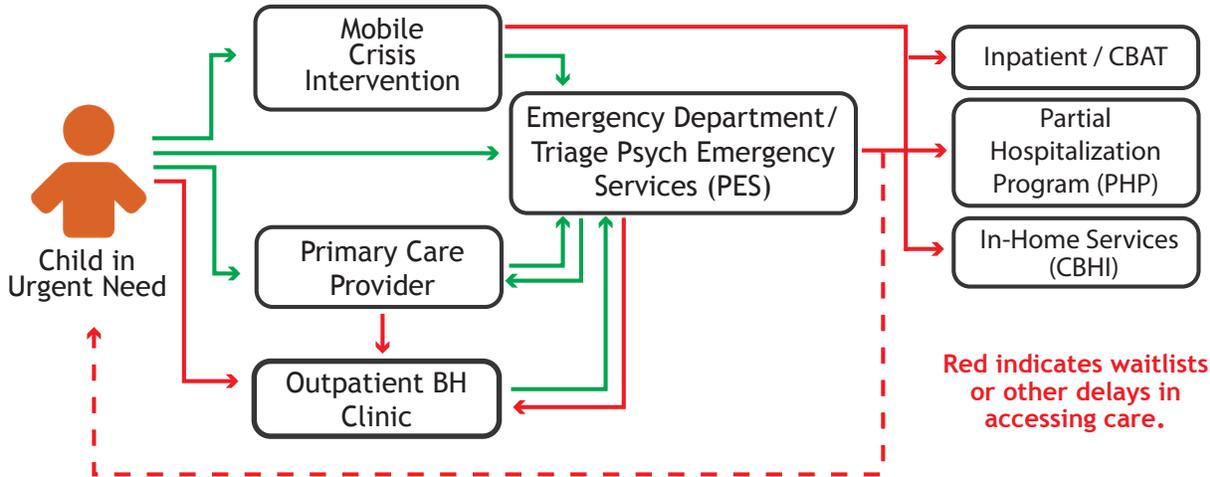
The Children’s Mental Health Campaign (CMHC) studied ED boarding in ten Massachusetts hospitals during one week per month throughout 2016. During that period, 1,028 youth who boarded collectively spent about seven years of bedded days awaiting placement.²

In the absence of any service response labeled “pediatric behavioral health urgent care,” children and adolescents with urgent but not crisis level needs either endure the long waits for outpatient care, call emergency services, or go to the ED. None of these options provides an appropriate “urgent care” response to needs.

Illustrated below is the current state of the child and adolescent behavioral health care system as it responds to “urgent care” needs. At present, a child or adolescent in urgent need with behavioral dysregulation, role dysfunction, thought disorder, or suicidal ideation falling short of imminent threat of harm to self or others may present to one of several parts of the care system, as Massachusetts has no defined “Behavioral Health Urgent Care” capacity. Should a child or adolescent appear at their primary care clinic or at an outpatient behavioral health clinic, they might well find themselves on a waitlist until a specialty appointment is

available, due to the lack of any walk-in or on-demand capacity. Others might first try the emergency services program/mobile crisis intervention team or the ED of their local hospital. In the case of the hospital, the child/adolescent and his/her family/caregiver may end up boarding for long periods of time. For those reaching out to the emergency services program/mobile crisis intervention, there may be some intervention at a family home, program site, or school that would avoid the ED, but these interventions are often brief and disrupted by the team’s need to respond to the next crisis in the queue.

Current Fragmented Responses to Urgent Need for Child & Adolescent Behavioral Health Intervention



FINDINGS ON THE NEEDS FOR BEHAVIORAL HEALTH URGENT CARE

Even for those who attempt to be seen at an outpatient clinic, the long stay on the waitlist may lead to further deterioration, driving the individual to a crisis and then to ED-based care. Primary Care Practices (PCPs) with embedded behavioral health clinicians may find that the range of services needed for a sufficient urgent care response, which may include rapid assessment, treatment planning, and behavioral health treatment initiation (including individual, family, group, intensive outpatient, medication or Medication-Assisted Treatment), cannot be delivered by or directed from the PCP setting. Thus, individuals may be sent to a specialty clinic or to the ED. Effectively, the ED is at the core of most responses to what might, in better-equipped systems, be organized as an Urgent Care response.

According to the National Institute for Health (NIH) Center for Studying Health System Change, hospitals and health plans nationwide are studying and implementing Urgent Care in response to consumer demand and strains in ED capacity and cost.³ The clinical implications of urgent care for people with behavioral health conditions include: addressing gaps in continuity of acute and ambulatory care; and reducing avoidable ED and inpatient utilization.⁴ Numerous studies report improvements in clinical and psychosocial outcomes, health services access, and acute services use patterns.⁵

Urgent behavioral health care—inclusive of mental health, substance use, and/or co-occurring conditions—responds to needs that fall short of posing an immediate risk. Consistent with findings in the peer-reviewed clinical and program policy literature, key informants identified three groups of children and adolescents in need of pediatric Behavioral Health Urgent Care. Behavioral Health Urgent Care in this study refers to those services that treat youth with sub-acute mental health, substance use, and/or co-occurring disorders, including those exhibiting acute changes in behavior and thinking, suicidal ideation, and social role dysfunction.

Experts interviewed underscored the need for Behavioral Health Urgent Care. They understand the importance of urgent intervention to avoid clinical or behavioral escalation, prevent functional deterioration, and provide an antidote to ED boarding given the limited capacity of psychiatric emergency services to provide crisis intervention and stabilization. All stressed the importance of a solution that avoids further fragmentation of the behavioral health care delivery system and aligns with recent and soon-to-be implemented practice and payment reforms. An effective change strategy will build on and improve upon current service delivery infrastructure, while selectively implementing new service elements essential to providing urgent care for children and adolescents with behavioral health conditions.

The authors note that in keeping with the notion of building on current system infrastructure, one might conclude that developing urgent care within EDs is advisable, or that hospitals are best equipped to provide an alternative to urgent care. Given the higher cost of delivering care inside EDs and even in hospital-based ambulatory care clinics, experts interviewed emphasized investments in community behavioral health clinics and integrated primary care practices. Medical urgent care centers, for example, are most often set in freestanding ambulatory clinics; few are set as walk-in clinics in hospital ambulatory care centers.

Although pediatric behavioral health urgent care is proposed as a solution to ED boarding, one might also conclude that more beds are the solution, thus relieving the delays in placement to hospital level of care. We also note that public policymakers have already planned regulatory and financing solutions to the dilemmas of the limited range of special competencies in current psychiatric units, poor geographic distribution of inpatient beds, and structural deficits in reimbursement for special staffing and administratively necessary days (AND).

Pediatric behavioral health urgent care is also an important response to a more fundamental matter of the quality and appropriateness of care. That is, in the current system, a delayed response to urgent needs through failures to offer timely access to outpatient assessment, care planning, and rapid treatment drives deterioration in clinical status and behavioral functioning - placing children, their families, and their communities at unnecessary risk. The solution to this dilemma is not found in more inpatient beds but rather in strengthening the capacity to intervene at an earlier point in the cycle of need.

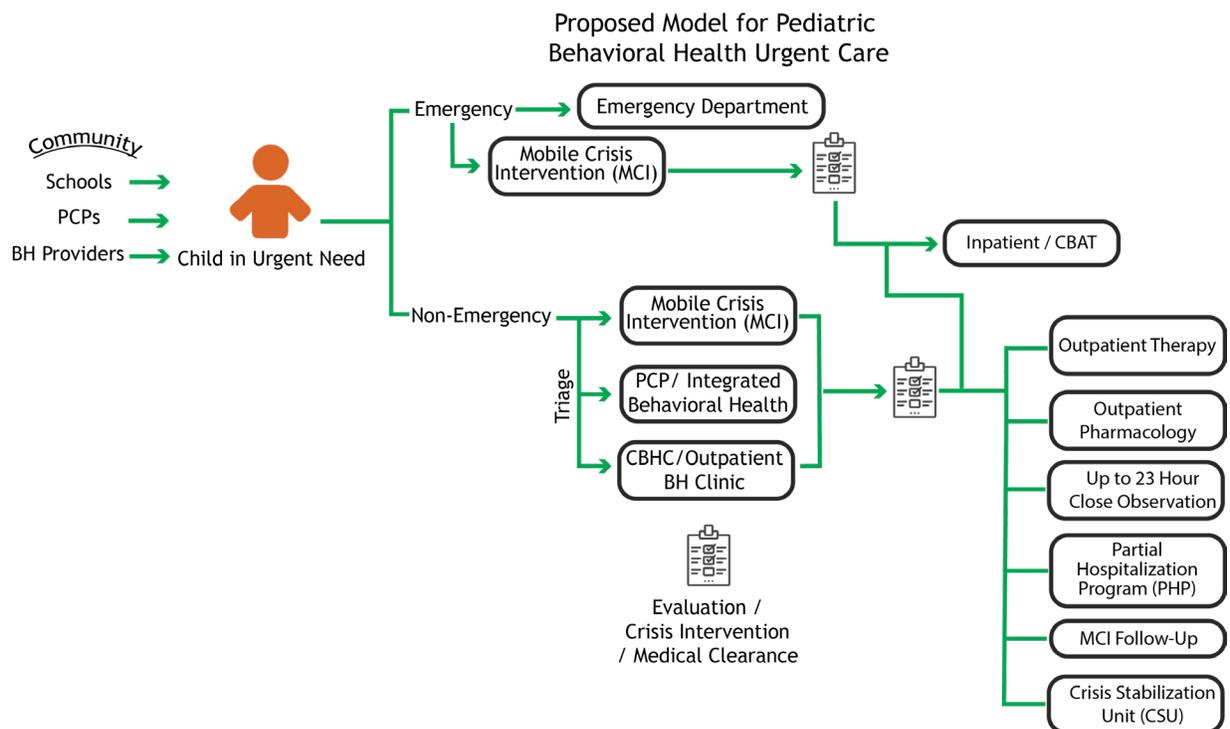
PROPOSED MODEL OF PEDIATRIC BEHAVIORAL HEALTH URGENT CARE

Given numerous service delivery and payment reforms in the Commonwealth, an urgent care solution can be crafted to meet the needs of children and adolescents with behavioral health conditions by employing a three-pronged strategy. The strategy includes: enhancing core

services available; filling selective service gaps; and implementing legal, regulatory, financing, and practice transformation support to facilitate uptake and broad scale adoption.

In order to implement pediatric Behavioral Health Urgent Care as a solution to the fragmented system that too frequently revolves around the ED in the current system, several steps will need to be taken in the Commonwealth’s health care system. These include:

- Enhanced functionality at Community Behavioral Health Clinics to provide walk-in or same day service, expanded night and weekend hours, rapid assessment and treatment initiation, integrated mental health and substance use interventions, medical clearance, close observation for up to 23 hours, care planning, and case management;
- Improved response at Emergency Services Programs/Mobile Crisis Intervention to achieve ED diversion, provide stabilization services, and manage transitions in care across settings;
- Defined Triage function, possibly based in a Call Center staffed by a trained team, that links to and backs up Mobile Crisis Intervention (MCI), Primary Care Practices (PCPs) with integrated Behavioral Health (BH), and/or Community Behavioral Health Center (CBHC) Outpatient Clinics to deliver Urgent Care;
- Specified functional role in bridging outpatient and crisis services and supporting transitions between inpatient and community care settings;
- Added child and adolescent and family/caregiver support and stabilization services, including crisis stabilization unit or similar beds with 24-hour observation and treatment capacity; and
- Integrated behavioral health and primary care practices that incorporate treatment for co-occurring conditions and have the authority to direct care to a broader array of behavioral health interventions.



In the proposed model for pediatric behavioral health urgent care, outlined above, families, primary care practitioners (PCPs), specialty settings or schools might refer children to urgent care. While some children in urgent need may continue to seek care access through the ED, optimally, children in urgent need will be triaged to an established pediatric behavioral health urgent care program. These established programs might operate in any one of several settings, including mobile crisis intervention services, integrated primary care (PCP) settings, or community behavioral health clinics. In each of these settings, the child and family in need would receive within hours a standardized evaluation, care planning, and expedited access to a needed array of ambulatory interventions, pharmacological treatment, and crisis stabilization services.

SYSTEM IMPLEMENTATION AND UTILIZATION OPTIMIZATION CONSIDERATIONS

Formation of a learning community will support practice transformation, delivering the communications, training, and technical assistance activities required for effective implementation of a new model of pediatric Behavioral Health Urgent Care. A host of legal, regulatory, and financing structures will need modification to support adoption of pediatric behavioral health urgent care to address unified licensure, practice standards, care direction, and care financing.

In discussions with Massachusetts State Government officials, there are several significant considerations for the selection and implementation of the pediatric Behavioral Health Urgent Care pilot. These include tackling the source of the greatest number of ED boarding cases, controlling costs, and providing care that is more responsive to MassHealth members.

In Year 2 of the Miller Innovation Fund Grant, the CMHC will employ a 10-part process to guide selection and optimize utilization of the pediatric Behavioral Health Urgent Care pilot.

1. Define the target service area: Analyze the target geographic service area to determine where the selected Accountable Care Organization and Community Service Agency population lives and where they access routine and emergency behavioral health care. Note: The CMHC will review statewide ED Boarding data to identify areas generating the highest per capita and longest stay ED Boarding cases.
2. Outline existing resources: Survey the resources available within the targeted Accountable Care Organization service area to its members, including existing hospitals, crisis care facilities, integrated pediatric practices, and specialty Behavioral Health outpatient clinics, residential treatment, respite programs, and case and care management services. Note: Geo-mapped profiles of behavioral health services available throughout the Commonwealth will be available in May of 2019 through the implementation of Network of Care Massachusetts.
3. Profile the target client population: The pediatric Behavioral Health Urgent Care pilot will need a profile of clinical, demographic, and socioeconomic factors within the target patient population and service area. Note: The CMHC investigated the process and will file a request with EOHHS/MassHealth to develop a profile of the target patient population and service area.
4. Analyze cost patterns and potential cost offsets: As noted earlier in the report,

while we may not have access to MassHealth claims files or proprietary data on facility reimbursement rates, cost estimates can be developed to guide implementation and outcomes evaluation for the pilot area. Note: The CMHC will undertake, in collaboration with MassHealth and an identified Accountable Care Organization and Community Service Agency, the modeling of cost patterns and potential cost offsets.

5. Identify target service delivery sites for engagement and diversion: Accounting for both health conditions and demographic variations and needs, the pediatric Behavioral Health Urgent Care pilot will need to identify how it could best engage patients with emerging conditions to divert them from either delayed access to outpatient care or emergency access to EDs and inpatient care. Engagement with pediatric PCPs, Community Behavioral Health Organizations, and ESPs, for example, may be initial places to begin transitioning members from ED care to urgent care. Note: The CMHC will engage with MassHealth to identify and then approach a target service area and its Accountable Care Organization and Community Service Agency.

6. Develop measurable outcomes: Beyond the immediate costs associated with an episode of urgent care, the pediatric Behavioral Health Urgent Care pilot will need to measure and report the cost impact of shifting from ED care to urgent care, including continuing care in specialty clinics, and integrated pediatric primary care, residential, or other intensive care. Note: The CMHC will determine with its funders the best options for measurement and best sources for rapid evaluation of the pilot.

7. Engage stakeholders as champions of change: As noted above in this report, Massachusetts employers and payers want to improve care access and minimize care costs. Hospital providers want relief for EDs, and all behavioral healthcare providers want adequate reimbursement for current and new services. Patients and their families want a more responsive, less traumatizing, and effective alternative to boarding in EDs or waiting for months for access to outpatient care. Each of these stakeholders can be champions for change. Note: The CMHC has identified and will engage these stakeholders in the early months of Year 2.

8. Educate patients and families: The selected Accountable Care Organization and Community Service Agency will need to craft a plan to contact and educate target members about the pediatric Behavioral Health Urgent Care pilot as new options for their care. As this is a new concept in behavioral health care, patient education will be essential to optimizing utilization. Note: The CMHC will work with the selected Accountable Care Organization and Community Service Agency on a marketing plan.

9. Rapid Evaluation for Continuous Quality Improvement: Operating processes will need to be implemented by the pediatric Behavioral Health Urgent Care pilot to gather clinical, utilization, and cost data. The data must be shared across the Accountable Care Organization system to support a process of continual improvement. Note: The CMHC will determine with its funders the best options for measurement and best sources for rapid evaluation of the pilot.

10. Monitor results to support broad scale adoption: In addition to reporting the above noted clinical, utilization, and cost data for tracking of outcomes, the pediatric Behavioral Health Urgent Care pilot and Evaluators will need to solicit feedback from patients, families, providers, and payers to ensure accountability and to derive input to guide

adaptations to the urgent care model to ensure responsive design in any move to broad scale adoption of the model. Note: The CMHC will seek support for Year 3 funding to solicit stakeholder feedback and conduct qualitative analysis of the input from those sources.

The goals of the pilot demonstration are two: to test and modify accordingly the proposed model of pediatric behavioral health urgent care; and to develop and define a clear plan for the investments required to soundly implement and reliably sustain pediatric behavioral health urgent care in the Commonwealth.

The full report outlines in detail the implementation considerations, pilot demonstration, and utilization optimization.

For the full copy of this report, please visit childrensmentalhealthcampaign.org.

REFERENCES

Reference Material

Appendix A: List of Key Informants

Appendix B: Key Informant Interview Guide & Sample Site Visit Guide

1 Massachusetts Health Policy Commission. “Behavioral Health-Related Emergency Room Boarding in Massachusetts.” November 2017.

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4 Coster, J.E., Turner, J.K., Bradbury, D. et al. (2017) Why Do People Choose Emergency and Urgent Care Services? A Rapid Review Utilizing a Systematic Literature Search and Narrative Synthesis. Academic Emergency Medicine. ISSN 1069-6563

5 Sunderji, N., Tan de Bibiana, J. & Stergiopoulos, V. (2015). Urgent Psychiatric Services: A Scoping Review. Canadian Journal of Psychiatry September 2015

The Children's Mental Health Campaign (CMHC) is a large statewide network that advocates for policy, systems and practice solutions to ensure all children in Massachusetts have access to resources to prevent, diagnose, and treat mental health issues in a timely, effective, and compassionate way. This will only happen through a shared responsibility among government and health care institutions working together to improve mental health care and access for children and youth.

The CMHC Executive Committee consists of six highly reputable partner organizations: The Massachusetts Society for the Prevention of Cruelty to Children (MSPCC), Boston Children's Hospital, the Parent/Professional Advocacy League, Health Care for All, Health Law Advocates, and the Massachusetts Association for Mental Health. The CMHC network includes more than 160 organizations across Massachusetts.

We are unified in our commitment to safeguard the mental and emotional health and wellness of all children in Massachusetts.

As a society, we cannot afford ignorance and inaction when it comes to the mental health of children. Compassion calls us to ease the suffering of any child who may be in emotional pain because of things happening to them or around them as well as those who suffer from biological or genetic conditions. Common sense requires us to assess and intervene long before a child's behavior becomes harmful to themselves or others. And determination drives us to help children and their families by fighting for access to supportive resources, proven interventions and treatments that will allow them to grow into healthy adults - ideally with an understanding of how they can manage their own mental health to avert crises and chronic distress.

