Behavioral Health Urgent Care and Crisis Stabilization Unit Workgroup: Short-Term Solutions to Behavioral Health ED Volume Workgroup Recommendations

The Short-Term Solutions to Behavioral Health ED Volume Workgroup was formed to quickly respond to the rising concerns regarding the number of children visiting emergency departments (EDs) for behavioral health needs, and the delay in their discharge into appropriate levels of care. The workgroup identified multiple recommendations that could be implemented quickly to address the following needs: (1) preventing youth from unnecessarily going to the ED for behavioral health needs; (2) facilitating timely discharge from the ED to community-based care; (3) facilitating timely inpatient admissions; (4) facilitating timely discharge from inpatient to community-based care; and (5) changing policies and processes. Solutions were subsequently prioritized in consideration of their potential feasibility, timeliness, and impact. Note that many of the recommendations rely on one or more of the other proposed solutions to fully realize their potential impact and can and should be supported by other intermediate and long term solutions.(e.g., expansion of intermediate levels of care is reliant upon addressing workforce shortages, which is reliant upon increasing reimbursement rates).

I. Preventing/Diverting Youth from Unnecessary ED Visits

Youth with mild to moderate behavioral health needs that do not require inpatient admission do not require ED evaluation. Preventing these youth from visiting the ED can improve care for youth by providing them timely, less-restrictive, and more appropriate community-based services. Diversion would also alleviate strain on ED staff allowing them to focus on those with emergency medical needs. The following three recommendations were identified to prevent unnecessary ED visits:

1. *82% ranked as number one or two out of five:* Expand the use of Mobile Crisis to triage youth to serve as an alternative to the EDs; (educate, incentivize, and create accountability structures for schools and police to expand their use of Mobile Crisis).
2. Expedite implementation of one or more behavioral health urgent care center programs (or something similar) and collect pilot data.
3. Engage SDE and schools to ensure federal funding for SEL/student mental health are being used as intended to meet student mental health needs. Provide mental health technical assistance, oversight, review, and transparency of school district plans with respect to addressing social-emotional learning and mental health services.

II. Facilitating Timely Discharges from the ED to Community-Based Care

Ensuring timely discharge for those youth who *do visit* the ED with mild to moderate acuity improves the experience of the child and family and also throughput across the system. Discharging children into appropriate community-based levels of care requires both efficiencies in hospital policies and practices, and also sufficient availability of ambulatory and intermediate levels of care. The following three recommendations were identified to facilitate timely discharge from the ED for youth with mild to moderate levels of need:

1. *56% ranked as number one or two out of five:* Increase reimbursement rates for the intensive home-based services that are currently underfunded.
2. Increase reimbursement rates to acute and intermediate levels of care.
3. Expand utilization of Mobile Crisis to bridge youth in EDs and inpatient beds to appropriate community-based levels of care.

III. Facilitating Timely Inpatient Admissions

For those youth who enter the ED with high acuity requiring inpatient care, it is critical that there be timely access to an inpatient bed and that bed availability be readily accessible by EDs and other crisis intervention service providers. The following three recommendations were identified to facilitate timely inpatient admission:

1. *45% ranked this as number one or two out of seven:* Explore the use of technology for real time service and bed capacity availability (e.g., Behavioral Health Link, Open Bed, Unite Us etc.). The platform would track youth needing placement (including relevant information for special populations) as well as availability of care (inpatient and PRTF beds as well as intermediate levels of care).
2. Dramatically increase reimbursement rates for inpatient and PRTF and actively recruit sites who might have unused additional bed capacity.
3. Increase respite bed capacity.

IV. Facilitating Timely Discharges from Inpatient to Community-Based Care

Congestion in the system can be further aggravated when there are discharge delays for youth ready to step down from inpatient to intermediate or ambulatory levels of care. A primary reason for this challenge is lack of availability (e.g., wait lists) of the appropriate service for the child's needs following inpatient discharge. The following three recommendations were identified to facilitate timely discharge from inpatient services:

1. *63% ranked as number one or two out of four:* Increase reimbursement rates to community-based intermediate levels of care.
2. Increase reimbursement rates for the intensive home-based services that are currently underfunded.
3. Utilize Mobile Crisis as a bridge to next level of care.

V. Related Policy and Process Changes

The challenges above can be exacerbated by policies and/or processes that create unintended inefficiencies or present barriers to implementing solutions, including those proposed above. The following three policy and process recommendations were identified as most important for facilitating the success of short-term solutions addressing behavioral health ED volume:

1. *29% ranked as number one or two out of seven:* Develop specialized capacity at acute and intermediate levels of care to meet the needs of children with serious intellectual and developmental disabilities.
2. Consider changes to existing provider licenses to allow other clinical services to provide services outside the clinic setting, including sufficient reimbursement for in-home services.
3. Consider any possible process improvements within the ED to expedite discharges (e.g., reconsider policy for having a psychiatric evaluation for every child, ensure policies allow for Mobile Crisis to be onsite.

Additional recommendations were made, but not seen as priorities of focus. The full list is included in Appendix A. Recommendations from family members are forthcoming as are intermediate and longer-term solutions.

Appendix A: Full List of Recommendations Identified by Workgroup Members

I. Preventing/Diverting Youth from Unnecessary ED Visits

- Expand the use of Mobile Crisis to triage youth to serve as an alternative to the EDs; (educate, incentivize, and create accountability structures for schools and police to expand their use of Mobile Crisis).
- Expedite implementation of one or more behavioral health urgent care center programs (or something similar) and collect pilot data.
- Engage SDE and schools to ensure federal funding for SEL/student mental health are being used as intended to meet student mental health needs. Provide mental health technical assistance, oversight, review, and transparency of school district plans with respect to addressing social-emotional learning and mental health services.
- Use HRSA or other available resources to expand ACCESS Mental Health; consider having ACCESS Mental Health clinicians use a caseload carrying model.
- Pilot a paramedicine model including use of an ambulance-type service that allows transport of children to a home or community site.

II. Facilitating Timely Discharges from the ED to Community-Based Care

- Increase reimbursement rates for the intensive home-based services that are currently underfunded.
- Increase reimbursement rates to acute and intermediate levels of care.
- Expand utilization of Mobile Crisis to bridge youth in EDs and inpatient beds to appropriate community-based levels of care.
- Deploy Mobile Crisis clinicians to EDs to conduct evaluations of incoming BH ED youth visits (i.e., the Mobile Crisis ED facility liaison position).
- Expedite the newly developed DSS RFP for the Intensive Transition Care Managers program.
- Incentivize agencies that have appropriate space to create an overflow unit that can be used for any age group or specialized psych need that may be experiencing a surge (this would require licensing an appropriate space for multiple purposes and coordination by a central entity).

III. Facilitating Timely Inpatient Admissions

- Explore the use of technology for real time service and bed capacity availability, e.g. Behavioral Health Link, Open Bed, Unite Us etc. The platform would track youth needing placement (including relevant information for special populations) as well as availability of care (inpatient and PRTF beds as well as intermediate levels of care).
- Dramatically increase reimbursement rates for inpatient and PRTF and actively recruit sites who might have unused additional bed capacity.
- Increase respite bed capacity.
- Allow community-based providers to provide emergency assessments on inpatient campuses.
- Establish a process utilizing daily emails to immediately stand up a centralized system for tracking acute bed availability, referral and dispositions information.
- Streamline referral and admission process and paperwork to PRTF and inpatient settings.
- Strengthen congregate care model as a resource for therapeutic residential services.
- Increase Solnit residential services, and develop residential resources for children 12 and under, to avert long stays on acute inpatient psychiatric units.
- Reassess the Therapeutic Group Home models to be used as stabilization and transition treatment options.
- Incentivize local hospitals without children's psychiatric beds to add them.

IV. Facilitating Timely Discharges from Inpatient to Community-Based Care

- Increase reimbursement rates to community-based intermediate levels of care.
- Increase reimbursement rates for the intensive home-based services that are currently underfunded.
- Utilize Mobile Crisis as a bridge to next level of care.
- Develop a clinic service for bridging medication management and therapy.

V. Related Policy and Process Changes

- Develop specialized capacity at acute and intermediate levels of care to meet the needs of children with serious intellectual and developmental disabilities.
- Consider changes to existing provider licenses to allow other clinical services to provide services outside the clinic setting, including sufficient reimbursement for in-home services.
- Consider any possible process improvements within the ED to expedite discharges (e.g., reconsider policy for having a psychiatric evaluation for every child, ensure policies allow for Mobile Crisis to be onsite.
- The CT Hospital Association and member hospitals, utilize their Incident Command System for children's behavioral health crisis and seasonal increases as needed.
- Add workforce capacity by expediting licensing process including availability of licensing exams and extension of the Governor's Executive Order regarding licensing.
- Offer comprehensive training and workforce development opportunities to all staff *working in acute and intermediate levels of care for handling treating children with mild* to moderate intellectual and developmental disabilities.
- Propose legislation requiring schools to utilize Mobile Crisis as an alternative to the ED.
- Improve coverage of the full continuum of behavioral health services by commercial insurers.