Behavioral Health is Essential To Health

Prevention Works

Treatment is Effective

People Recover
System of Care Expansion Leadership Learning Community: Considerations for SOC Leaders for Implementing Continuum of Crisis Response Services

January 17, 2018
This month’s learning community is hosted by the National TA Network for Children’s Behavioral Health, operated by and coordinated through the University of Maryland.

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Disclaimer: The views, opinions, and content expressed in this presentation do not necessarily reflect the views, opinions, or policies of the Center for Mental Health Services (CMHS), the Substance Abuse and Mental Health Services Administration (SAMHSA), or the U.S. Department of Health and Human Services (HHS).
• Monthly learning community designed to support SOC leaders in all roles
  ▪ SAMHSA grantee directors and coordinators
  ▪ Leaders in content areas
  ▪ Leaders in states, communities, tribes and territories without SAMHSA grants
  ▪ Others with leadership roles in SOC implementation, expansion, and sustainability
• Address topic areas of importance to leaders
• Interactive, use chat box throughout for comments and questions
CONTEXT AND LEADERSHIP CONSIDERATIONS

Dayana Simons & Liz Manley
TA Network
University of Maryland, Baltimore
CMS/SAMHSA Joint Information Bulletin (May 2013)

Intensive Care Coordination: Wraparound Approach
Parent and Youth Peer Support Services
Intensive In-Home Services
Respite
Mobile Crisis Response and Stabilization
Flex Funds

Trauma Informed Systems and Evidence-Based Treatments Addressing Trauma

(Mann and Hyde, 2013)
MRSS Value to Systems of Care

- Quality of Life
- Resource
- Referral source
- Fiscal
The Role of MRSS in the Continuum of Care

• Mobile Response and Stabilization Services (MRSS) is one service within a continuum of care

• Mobile Response and Stabilization Services is an emergent service that can be used early in a crisis situation
Examples of Early Use

- MRSS can be used to divert youth from higher intensity of services such as inpatient care and out of home treatment.
- MRSS can be used at the time that a parent/caregiver identifies that something is different with their child, youth or young adult.
- MRSS connects to community supports and services even when clinical intervention may not be warranted.
- Early engagement with youth and families can prevent the escalation of symptoms and allows for lower cost interventions.
Leadership Challenges

• Setting the Vision
• Documenting the Vision
• Budget Challenges – how do you pay for this services
• Communication Strategies
• Identifying Early Adapters
• Workforce Development – the skills, training and support for the workforce
Leadership Strategies

How to handle uncertainty, ambiguity and rapid change?

– Understand and communicate the vision of where we are going. Recall the vision when things get mucky
– Find your champions and engage new partners
– Be transparent to families, providers, staff and state giving current status and acknowledging challenges
– Share and report progress regularly
– Develop partnerships with family and advocacy and provider groups and organizations
– Be flexible and acknowledge what we don’t know yet
Important Considerations

• Understanding the impact on current system
• Parent and youth culture
• Provider culture
• Advocate culture
• Data use and challenges in integration
• Challenge of quality within transition
• Privacy
NEW JERSEY’S MOBILE CRISIS INTERVENTION SERVICE

Liz Manley
Former Assistant Commissioner
NJ Children’s System of Care
Overuse of Deep-End Services

- Low Intensity Services
  - Out of Home

- Intensive In-Community
  - Wraparound – CMO
  - Behavioral Assistance
  - Intensive In-Community

- Lower Intensity Services
  - Outpatient
  - Partial Care
  - After School Programs
  - Therapeutic Nursery
Language Is Important

Client
Case
Placement
Language Is Important (cont.)

Language of CSOC
- Children, youth, young adult
- Parents, caregivers
- Treatment
- Engagement
- Transition
- Missing
- Family Time

Not the Language of CSOC
- Clients, Case, Consumer
- Mom and Dad
- Placement
- Not Motivated
- Close, Terminate
- Runaway
- Home visits
Key System Components

Contracted System Administrator
- PerformCare is the single portal for access to care available 24/7/365

Care Management Organization
- Utilizes a wraparound model to serve youth and families with complex needs

Mobile Response & Stabilization Services
- Crisis response and planning available 24/7/365

Family Support Organization
- Family-led support and advocacy for parents/caregivers and youth
Key System Components (cont.)

Intensive In-Community

• Flexible, multi-purpose, in-home/community clinical support for parents/caregivers and youth with behavioral and emotional disturbances who are receiving care management, MRSS, or out-of-home services

Out of Home

• Full continuum of treatment services based on clinical need

DD-IIH and Family Support Services

• Supports, services, resources, and other assistance designed to maintain and enhance the quality of life of a young person with intellectual/developmental disability and his or her family, including respite services and assistive technology

Substance Use Treatment Services

• Outpatient, out of home, detox treatment services (limited), co-occurring services

Traditional Services

• Partial Care, Partial Hospitalization, Inpatient, and Outpatient services
Mobile Response and Stabilization Services help children/youth and their families who are experiencing an emotional or behavioral stressor by interrupting immediate crisis and ensuring youth and their families are safe.

MRSS provides the support and skills necessary to return youth and families to typical functioning.
What is a Crisis

A crisis occurs when:

- One’s sense of balance is disrupted
- Coping and problem solving skills that worked in the past are not working
- Life functioning is disrupted
- Crisis is defined by the person/family experiencing it!
NJ MRSS Program Elements

- NJ youth and young adults under 18
- NJ young adults involved with DCF under 21
- Parent/caregiver consent
- Escalating emotional or behavioral needs
- Family defined crisis
NJ MRSS Program Elements (cont.)

Program Eligibility:

- Clinical Criteria
- Special Populations and System Merge (Family Crisis Intervention Units)
- Open for all NJ Families
NJ MRSS Program Elements (cont.)

Program Access:

- Single Point of Access – 24/7 CSOC Contracted Systems Administrator (CSA)
- Clinical Triage
- Verbal Consent
- Warm Line with Local MRSS
- Crisis Intervention Response
NJ MRSS Program Elements (cont.)

Program Structure:

✓ 24/7 Community Response – Where you are, anywhere in NJ
✓ 72 Hour Intervention
✓ Up to 8 Week Stabilization Period
✓ Provider Network
✓ County Based Organization within the System of Care
  • Family Support Organization
  • Care Management Organization
  • Children’s Interagency Coordinating Councils
Lessons Learned

• Set, document and communicate the vision
• Create a feedback loop with communities
• Use the data to make changes and use it to tell the story
• Communicate early and often
• Identifying early adapters
• The crisis is defined by the youth and family
• MRSS can work with all populations
• Use community partners to assist in making connections to community supports. Not all youth benefit for treatment
• Invest in a single point of access and assessment tool
For More Information

NJ’s Children’s System of Care
www.state.nj.us/dcf

PerformCare
www.performcarenj.org
CONNECTICUT’S MOBILE CRISIS INTERVENTION SERVICE

Tim Marshall, L.C.S.W.
Clinical Manager
CT Department of Children and Families
Background

• Why mobile crisis in Connecticut?
  • High rates of ED use for behavioral health
  • High utilization of inpatient and residential treatment
  • Late 1990’s shift toward system of care, community-based treatment

• Mobile Crisis Implementation (mid 1990s to mid 2000s)
  • Increasing dissatisfaction with Mobile Crisis service delivery into the mid-2000’s
  • 50% mobility rates, limited mobile hours
  • Variability in quality across funded sites
  • Continued high rates of ED use, Mobile Crisis use remained flat
  • Consumer and referrer complaints

• Model Re-Design and Re-Procurement (2008-2009)
  • Model re-design based on national best practices
  • Re-procurement of provider network
  • New goals and benchmarks, accountability
  • Political challenges
What is Mobile Crisis?

- Mobile Crisis Intervention Services (formerly known as “Emergency Mobile Psychiatric Services”)
- A team of trained mental health professionals who can respond immediately on-site, or by phone, when a child is experiencing a mental health need or is in crisis
- Teams consist of: Site Director; MA-level licensed/eligible clinicians; psychiatric consult time; family partners
- Funded by state grants (DCF) with third party reimbursement from Medicaid and commercial insurers

**Who can receive Mobile Crisis?**

- Anyone can call on behalf of a youth who is in crisis or has a mental health need
- **A “crisis” is defined by the family**
- Any child 18 or younger in Connecticut (19 year olds, if in school)
- Available regardless of system involvement, insurance, ability to pay
- **Exclusions:** Youth in Residential Treatment Centers, Sub-Acute Units, Inpatient Hospitals
The Mobile Crisis Service System

- **Mobile Crisis Provider Network**
  - Six primary contractors
  - Fourteen total sites (subcontracts, satellites, statewide coverage)
  - 170+ full time and part time/per diem employees

- **Statewide Call Center**
  - Call triage; warm transfer to Mobile Crisis provider
  - Clinical coverage during non-mobile hours, Mobile Crisis follow-up during next available mobile hours

- **Performance Improvement Center (Mobile Crisis-PIC)**
  - Web-based Data Collection and Entry
  - Data Analysis, Reporting and Quality Improvement
  - Standardized Training Curriculum
  - Standardized Practice Development
  - Evaluation Research and Ad Hoc Data Requests

(Vanderploeg, J., Lu, J., Marshall, T., & Stevens, K., 2016)
Accessing Mobile Crisis

• **Mobile Crisis Mobile Hours**
  - 6am to 10pm, Mon-Fri
  - 1pm to 10pm, Sat/Sun/Holidays
  - Crisis clinician response during non-mobile hours, with Mobile Crisis mobile follow-up offered at next mobile hours
  - Capacity to handle multiple calls simultaneously

• **Key Provider Performance Benchmarks**
  – **High volume**: Reach your community
  – **Be mobile**: 90% or higher mobility
  – **Respond quickly**: 45 minutes (or less) for at least 80% of all mobile responses
  – All measured and reported transparently by the Mobile Crisis PIC
Accessing Mobile Crisis (cont.)

• Why provide a mobile response vs. telephone?
  – Crisis situation and mobile response might be first system introduction
  – Making a face-to-face connection, assessing strengths and needs in person
  – Addresses access barriers that impact disadvantaged populations
  – Mobile response facilitates being a resource not just to the family, but to the community
Mobile Crisis Providers
Available Services

- **Mobile response** to homes, schools, EDs, community locations
- **Crisis stabilization**
- **Diversion from the ED, collaboration** with ED, inpatient hospitals, law enforcement intervention, schools
- **Clinical assessment** using standardized instruments
- **Follow-up services** for up to 45 days (and unlimited episodes of care)
- **Access to psychiatric evaluation** and medication management
- **Collaboration** with families, schools, hospitals, other providers
- **Referral and linkage** to ongoing care as needed
Standardized Training

Core Modules – 1 (4x/year)
1. Crisis Assessment, Planning and Intervention
2. Traumatic Stress and Trauma Informed Care
3. Emergency Certificate Training
4. Assessing Violence Risk in Children and Adolescents

- Parents are paid co-trainers and members of agency Quality Improvement teams
- Parents are also welcomed to take part in the in-house trainings

Core Modules – 2 (3x/year)
1. 21st Century Culturally Responsive Mental Health Care
2. Disaster Behavioral Health Response Network (DBHRN)
3. An Overview of Intellectual Disabilities and Positive Behavioral Supports
4. Question, Persuade and Refer (QPR) (in-house training)
5. Strengths-Based Crisis Planning
6. Columbia Suicide Severity Rating Scale (C-SSRS) (Online training)
7. Adolescent Screening, Brief Intervention and Referral to Treatment (A-SBIRT)(in-house training)
Mobile Crisis Episodes of Care

- **Phone Only**
  - 22% of all episodes

- **Face to Face**
  - 44% of all episodes
  - 1 to 5 days
  - Streamlined assessment and intake process

- **Stabilization and Follow-Up**
  - 34% of all episodes
  - Comprehensive standardized intake process
  - Assessment and outcome measures at intake and discharge
  - No limit on repeat episodes of care
Staffing

- 170+ full time and part time/per diem clinicians statewide
- Most Mobile Crisis teams housed within large community-based mental health clinics with full service array
- Clinicians are typically Master’s Level (MSW, LPC, or LMFT), licensed or license-eligible clinicians
- .50 to 1.0 FTE Directors at each site (MA or Doctoral level)
- Each contract includes capacity for psychiatric consultation and medication management
- Family partners used on some teams, primarily for parent engagement and follow-up
- Team responses are preferred, but less likely to occur as volume has increased over time
- Total Funding to Mobile Crisis Intervention Services
Age

- 0.4%
- 4.1%
- 11.9%
- 23.4%
- 26.8%
- 33.3%

(N = 9,839)
Racial Background

- 61.4% American Indian/Alaska Native
- 23.0% Asian
- 12.8% Black/African American
- 0.6% Native Hawaiian Pacific Islander
- 1.8% White
- 0.3% Other

(N = 9,354)

Note: Clients may self-identify more than one Race.
Ethnic Background

- Non-Hispanic Origin: 67.2%
- Mexican, Mexican American, Chican: 17.3%
- Puerto Rican: 13.3%
- Cuban: 0.7%
- South or Central American: 0.1%
- Hispanic/Latino Origin: 0.1%

(N = 9,283)
Insurance Status

- Husky A: 61.9%
- Private: 30.0%
- No Health Insurance: 2.2%
- Husky B: 1.6%
- Other: 3.4%
- Medicaid (non-HUSKY): 0.2%
- Military Health Care: 0.7%
- Medicare: 0.0%
Presenting Problems

- Harm/Risk of Harm to Self
- Disruptive Behavior
- Depression
- Family Conflict
- Anxiety
- Harm/Risk of Harm to Others

Central: Harm/Risk of Harm to Self 30%, Disruptive Behavior 24%, Depression 27%, Anxiety 29%, Family Conflict 23%, Harm/Risk of Harm to Others 26%

Eastern: Harm/Risk of Harm to Self 43%, Disruptive Behavior 14%, Depression 15%, Anxiety 27%, Family Conflict 18%, Harm/Risk of Harm to Others 14%

Hartford: Harm/Risk of Harm to Self 26%, Disruptive Behavior 16%, Depression 13%, Anxiety 26%, Family Conflict 23%, Harm/Risk of Harm to Others 24%

New Haven: Harm/Risk of Harm to Self 29%, Disruptive Behavior 11%, Depression 7%, Anxiety 18%, Family Conflict 24%, Harm/Risk of Harm to Others 26%

Southwestern: Harm/Risk of Harm to Self 17%, Disruptive Behavior 12%, Depression 7%, Anxiety 14%, Family Conflict 24%, Harm/Risk of Harm to Others 26%

Western: Harm/Risk of Harm to Self 13%, Disruptive Behavior 7%, Depression 8%, Anxiety 9%, Family Conflict 14%, Harm/Risk of Harm to Others 29%

Statewide: Harm/Risk of Harm to Self 13%, Disruptive Behavior 7%, Depression 7%, Anxiety 6%, Family Conflict 14%, Harm/Risk of Harm to Others 26%
Trauma Exposure

<table>
<thead>
<tr>
<th>Region</th>
<th>Percentage</th>
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<tbody>
<tr>
<td>Central</td>
<td>57%</td>
</tr>
<tr>
<td>Eastern</td>
<td>69%</td>
</tr>
<tr>
<td>Hartford</td>
<td>57%</td>
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<tr>
<td>New Haven</td>
<td>70%</td>
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<tr>
<td>Southwestern</td>
<td>55%</td>
</tr>
<tr>
<td>Western</td>
<td>64%</td>
</tr>
<tr>
<td>Statewide</td>
<td>61%</td>
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Statewide Call and Episode Volume (Mobile Crisis FY2011 – FY2017)

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>211 Only</th>
<th>Mobile Crisis Episode</th>
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<tbody>
<tr>
<td>FY 2011</td>
<td>2,808</td>
<td>9,457</td>
</tr>
<tr>
<td>FY 2012</td>
<td>3,330</td>
<td>10,459</td>
</tr>
<tr>
<td>FY 2013</td>
<td>4,469</td>
<td>11,105</td>
</tr>
<tr>
<td>FY 2014</td>
<td>5,626</td>
<td>12,376</td>
</tr>
<tr>
<td>FY 2015</td>
<td>4,166</td>
<td>12,478</td>
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<tr>
<td>FY 2016</td>
<td>4,370</td>
<td>12,419</td>
</tr>
<tr>
<td>FY 2017</td>
<td>4,533</td>
<td>13,488</td>
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Statewide Mobility Rates

Goal = 90%

Baseline: 50.0%
FY 2011: 90.3%
FY 2012: 92.5%
FY 2013: 91.9%
FY 2014: 91.7%
FY 2015: 92.4%
FY 2016: 92.5%
FY 2017: 93.0%
Service Area Mobility Rates (FY2017)

- Central: 90.9%
- Eastern: 93.4%
- Hartford: 91.9%
- New Haven: 93.7%
- Southwestern: 93.8%
- Western: 95.4%
- Statewide: 93.0%

Goal = 90%
Statewide Response Times Under 45 Minutes (Mobile Crisis Episodes FY2010 – FY2017)

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<tbody>
<tr>
<td></td>
<td>62%</td>
<td>86%</td>
<td>85%</td>
<td>88%</td>
<td>87%</td>
<td>89%</td>
<td>89%</td>
<td>88%</td>
</tr>
</tbody>
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Goal = 80%
Service Area Response Times
Under 45 Minutes (FY2017)

<table>
<thead>
<tr>
<th>Area</th>
<th>Goal</th>
<th>2017 Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>Central (1049)</td>
<td>90%</td>
<td>90%</td>
</tr>
<tr>
<td>Eastern (991)</td>
<td>93%</td>
<td>93%</td>
</tr>
<tr>
<td>Hartford (1845)</td>
<td>85%</td>
<td>85%</td>
</tr>
<tr>
<td>New Haven (1058)</td>
<td>92%</td>
<td>92%</td>
</tr>
<tr>
<td>Southwestern (1089)</td>
<td>93%</td>
<td>93%</td>
</tr>
<tr>
<td>Western (1228)</td>
<td>81%</td>
<td>81%</td>
</tr>
<tr>
<td>Statewide (7260)</td>
<td>88%</td>
<td>88%</td>
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Goal = 80%
Clinical Outcomes (FY2017)

- Mobile Crisis is a brief intervention (average length of stay is under 20 days)
- Getting parent-completed discharge measures has proven increasingly challenging
- All changes are statistically significant
- SAMHSA Service to Science outcome measure development

| Table 1. Statewide Ohio Scale Scores (based on paired intake and discharge scores) |
|---------------------------------|-----|--------|--------|-------|---------|------------------|
|                                 | N   | Mean (intake) | Mean (discharge) | t-score | Sig.    | % Clinically Meaningful Change |
| Parent Functioning Score        | 236 | 39.53     | 40.92           | 1.91    | P<0.1   | 11.4%             |
| Worker Functioning Score        | 3025| 43.84     | 45.66           | 11.46   | P<0.01  | 8.4%              |
| Parent Problem Severity Score   | 235 | 24.58     | 20.15           | -7.21   | P<0.01  | 18.7%             |
| Worker Problem Severity Score   | 3005| 27.90     | 25.27           | -16.87  | P<0.01  | 10.2%             |
Cost vs. Cost Savings

• Costs for developing important component of a comprehensive system of care
• There have been only a few studies of the cost offsets associated with mobile crisis--possible cost savings exist in the following areas:
  – Diversion from hospital-based emergency services
    • Emergency department (ED)
    • Inpatient hospitalization
  – Diversion from Highest Levels of Care in BH System
    • Psychiatric residential, group homes
  – Diversion from arrest/incarceration
  – Depending on eligibility, savings to public system (Medicaid) as well as commercial insurance providers
Average Cost of Episodes of Care: Inpatient vs. Mobile Crisis

Inpatient: $11,439
Mobile Crisis: $793
Estimated Medicaid Cost Savings

EMERGENCY DEPARTMENT (ED) USAGE OF Mobile Crisis FOR INPATIENT DIVERSION

• EDs referred to Mobile Crisis **1,167 times** in FY 2017

• ED staff coded 449 referrals as “inpatient diversions”

• Approximately 62% (278) of those were for youth enrolled in Medicaid

• 278 inpatient diversions × $10,646 (avg. cost savings between inpatient and Mobile Crisis episode) = $2,959,588

• Other possible savings: ED diversion; arrest/incarceration diversion; higher level of care diversion; savings to commercial insurance
Lessons Learned

• Develop contracts with key model specifications and performance expectations
• Institute culture of “crisis defined by caller”
• Institute culture of “JUST GO!”
• Single statewide call center: Easier for families; enhances access
• Standardized practice model for all sites
• Promote access, quality and outcomes using performance data analysis and reporting, workforce development, data transparency
• Mobile crisis creates an important linkage to EDs
  – Divert from ED (by responding to schools, homes)
  – Help connect youth and families in ED back to the community
• Programs are kept fiscally viable by combining grant funds and third party reimbursement
• Adapt/leverage the model to link and integrate with other services/systems (e.g., SBDI)
For More Information

www.empsct.org

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Questions?
Next SOC Expansion Leadership Learning Community

Current Issues for Working with Family and Youth Organizations in SOCs

February 21, 2018
2:30-4:00 ET

Register by clicking here