

**Children's Mental Health Increased Emergency Department Visits**  
**Crisis Workgroup Recommendations**  
**November 8, 2014**

**OVERVIEW**

A number of hospitals in Oregon are experiencing increasing challenges in serving young people who go to emergency departments for behavioral health challenges. Youth are waiting in emergency departments or pediatric hospital rooms, sometimes for many days, due to a lack of options for safe, therapeutic services. Families, health care providers and insurers are concerned about this growing problem. "Psychiatric boarding," as it is called, is unlikely to be therapeutic, is at times traumatic for young people, their families and hospital staff, and it creates logistic and financial problems for hospitals. This problem is national as well as local.

Services, policy and practice within the children's system of care are all connected, and any element can affect how the system functions as a whole. With this in mind, the Addictions and Mental Health Division (AMH) convened a two-session workgroup to evaluate data and solicit expert opinion on the problem's contributing factors and possible solutions. The workgroup included representatives from emergency departments, psychiatric units, pediatric units, sub-acute psychiatric residential treatment programs, community mental health programs (CMHPs), intensive community-based treatment service providers, child welfare, private insurance, coordinated care organizations (CtOs), family members, and young adults.

The following is a summary of contributing factors identified and recommended solutions made by the workgroup.

## **CONTRIBUTING FACTORS**

### **Capacity and continuum of care**

- The number of children enrolled in Medicaid since 2005 has doubled and has increased by 40,000 since January 2014.
- The number of psychiatric hospital beds has not changed in 20 years.
- The use and availability of residential care has diminished.
- Many areas do not have acute intensive diversion programs.
- When family crises occur, only limited numbers of respite programs are available to support kids while things calm down.
- When youth in foster care have behavioral crises and cannot go back to their current homes, there are limited safe alternatives.
- Members of the system of care at times fail to develop timely discharge resources for youth and families in higher levels of care. This results in youth waiting for placement, creating a cascade of delays in access to all levels of care.
- Access to child psychiatric assessment is poor, due to inadequate numbers of providers in many areas of the state.

### **Coordination and Referral**

- Families do not know what services might be available for acute needs, so they use the emergency department for services that may be available in the community.
- Families use the emergency department because they are frightened and are not certain that they can get the intensive services they need in a timely manner.
- CCOs and private insurance representatives do not have real-time notification of emergency department use by their members.
- Privately insured clients lack care coordination.
- Bed availability data is lacking, which leads to inefficient matching of needs with placements.

### **Payment methods**

- Fiscal incentives or disincentives are not aligned with good care. For example, emergency visits, regardless of whether they are for a medical or mental health crisis, are covered as a

flat rate under a medical code rather than a mental health code.

- Many commercial insurers require that deductibles are collected in full for an emergency department or hospital stay, before a patient can be admitted to sub-acute levels of care. This creates an enormous burden for families and further disrupts discharge planning.
- The system is very difficult to navigate; multiple payers can be involved, and all of them may have different benefit packages.
- CCOs and commercial insurance companies have different review practices and ways of authorizing various levels of care.
- Many commercial insurers do not have contracts with acute diversion programs –the kind of programs that offer intensive outpatient care.
- Funding is from a wide variety of sources, including private payers and local, state and federal programs; this complexity can have a negative impact on the array of services available and what is known to be available.

#### **RECOMMENDED SOLUTIONS:**

##### **Qualities of effective strategies will:**

- 1.) Be systemic, coordinated and collaborative, rather than directed only at single points in the continuum of care.
- 2.) Include all payers in a local community, including CMHPS, private insurance and CCOs.
- 3.) Develop locally –each community has unique strengths and systems in place to address these issues.
- 4.) Be trauma-informed .
- 5.) Be culturally responsive.
- 6.) Involve family and youth input at early stages of development.
- 7.) Include relationships with system navigators (peer or professional) as a core strategy.

##### **Capacity and continuum of care**

- Estimate the capacity needed at acute and sub-acute levels based on analysis of current context for each community. For example, what level of preventive and diversion resources are possible and probable, and how would that influence the numbers of beds needed in the short, medium and long term?

- Increase the use of community-based crisis stabilization approaches, which should include:
  - Crisis diversion teams; and
  - Respite strategies, including facility-based respite for youth in foster care.
- Develop hospital-based acute care mental health treatment and referral services that will support youth and families when they arrive in the emergency department, or co-locate outpatient crisis stabilization teams that can support the family until the youth gets into care.
- Form community resource teams that will actively work toward discharge to lower levels of care for young people who are in higher levels of care.

This is particularly needed for youth who are not enrolled in Wraparound. Teams should represent the Department of Human Services, Oregon Youth Authority, education, mental health providers, peer support specialists, and insurance providers (CCO or commercial). This should be done proactively and as soon as possible.

- Increase access to acute telemedical services in remote community emergency departments, hospital units, and outpatient settings.
- Increase support services for young people, both in school and after school, to engage them in positive, productive, and supportive social activities.

### **Coordination and referral**

- Create a standard method of informing payers when their members go to emergency departments and hospital units.
- Create an electronic database of available acute resources statewide.
- Create effective tools for educating families about the options they have to access routine and acute mental health services, by both insurer and location.
- Make sure that young people and their families who seek care in the emergency department or hospital receive coordinated connection to outpatient care, regardless of the disposition of their case.

### **Payment methods**

- Remove up-front deductible payments that commercial insurers require of members who access acute care services.
- Allow emergency departments to bill for mental health services to young people in such

a way that they will be reimbursed for the care they provide.

- Take a closer look at the "funding silos" that impede implementation of effective diversion strategies.
- Increase use of flexible funding pools to address needs that are not traditional medical services and thus not covered by traditional payers.

**Oregon Health Authority role:**

The Oregon Health Authority (OHA) is responsible for ensuring that children and families everywhere in the state receive the health services they need, and that the crisis services that are available are adequate to meet those needs. The children's mental health system must have capacity to mitigate crisis and to work with the family to plan for ongoing services that will address the underlying issues. Each community's unique strengths and resources will define its strategies and solutions to creating a rapid yet therapeutic response to families faced with a behavioral health crisis. Strategies to improve local options must be developed at both state and local levels.

- 1.) AMH has included this challenge as part of its 2015-2018 Behavioral Health Strategic Plan. One immediate action taken by OHA will be to develop a way to track the length of time that clients stay in emergency departments waiting for resources. This would be one benchmark of the system.
- 2.) OHA will pilot two or three diversion programs to evaluate how well they reduce use of emergency departments for mental health crisis needs.



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