REPORT ON PEDIATRIC BEHAVIORAL HEALTH URGENT CARE

SUPPORTED BY MILLER INNOVATION FUND
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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.
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**ACCOUNTABLE CARE ORGANIZATION** - An Accountable Care Organization (ACO) is a group of doctors, hospitals, and other health care providers that work together with the goals of delivering better care to members, improving the population’s health, and controlling costs.

**ACUTE TREATMENT SERVICES** - 24-hour, seven-day-per-week, medically-monitored inpatient detoxification treatment that provides evaluation and withdrawal management.

**COMMUNITY-BASED ACUTE TREATMENT** - provided to children/adolescents who require a 24-hour-a-day, seven-day-a-week staff-secure (unlocked) acute treatment setting.

**COMMUNITY SERVICE AGENCY** - a community-based program that facilitates access to and ensures coordination of care for youth with Serious Emotional Disturbance (SED) who require or are utilizing multiple services or multiple child-serving systems.

**CLINICAL STABILIZATION SERVICES** - 24-hour, clinically-managed detoxification services that are provided in a non-medical setting.

**CRISIS STABILIZATION UNIT** - small inpatient facilities of less than 16 beds for people in a mental health crisis whose needs cannot be met safely in residential service settings.

**EMERGENCY SERVICES PROGRAM (ESP)** - provides behavioral health crisis assessment, intervention, and stabilization services, 24 hours per day/7 days per week/365 days per year, through four service components: Mobile Crisis Intervention services for youth, adult mobile services, ESP community-based locations, and community crisis stabilization (CCS) services for ages 18 and over.

**FEDERALLY-QUALIFIED HEALTH CENTER** - a community-based health care provider that receives funds from the Health Resources and Services Administration Health Center Program to provide primary care services in underserved areas.

**INTENSIVE COMMUNITY-BASED ACUTE TREATMENT** - provides the same services as Community-Based Acute Treatment (CBAT) but of higher intensity, including more frequent psychiatric evaluation and medication management and a higher staff-to-patient ratio.

**MEDICATION-ASSISTED TREATMENT** - the use of FDA-approved medications, in combination with counseling and behavioral therapies, to provide a “whole-patient” approach to the treatment of substance use disorders.

**MOBILE CRISIS INTERVENTION** - youth-serving (under the age of 21) component of an emergency service program (ESP) provider. Mobile Crisis Intervention will provide a short-term service that is a mobile, on-site, face-to-face therapeutic response to a youth experiencing a behavioral health crisis for the purpose of identifying, assessing, treating, and stabilizing the situation and reducing immediate risk of danger to the youth or others consistent with the youth’s risk management/safety plan, if any.

**MASSACHUSETTS CHILD PSYCHIATRY ACCESS PROGRAM** - a system of regional children’s behavioral health consultation teams designed to help primary care providers and their practices to promote and manage the behavioral health of their pediatric patients as a fundamental component of overall health and wellness.
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

![Diagram of current fragmented responses]

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. 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. Numerous studies report improvements in clinical and psychosocial outcomes, health services access, and acute services use patterns.
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.

Proposed Model for Pediatric Behavioral Health Urgent Care

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Behavioral Health Urgent Care Report
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.
BACKGROUND AND OVERVIEW

A study of pediatric psychiatric boarding, conducted in 2016 by the Children’s Mental Health Campaign (CMHC), quantified the longstanding issue of long waits in Emergency Departments (EDs) for children and adolescents presenting for emergency behavioral health care. During that period, 1,028 youth who boarded collectively spent approximately seven years in EDs and other non-psychiatric settings. Notably, about 16 percent of children and adolescents initially assessed to require inpatient or Community-Based Acute Treatment were discharged home after boarding in the ED, indicating that with appropriate crisis intervention and stabilization, ED boarding might have been avoided.2

In 2017, The Miller Innovation Fund awarded the CMHC a grant to study pediatric behavioral health urgent care and to develop a model that would impact ED Boarding. This report provides the results of the mixed methods study, including: an overview of the drivers of and landscape within which the need arises for urgent care; the design and execution of the methodology employed in the study; and the findings of the study about the needs for and elements of a child and adolescent behavioral health urgent care response in the Commonwealth.

In this report, “behavioral health” refers to mental health, substance use, and co-occurring conditions.

CHILDREN’S MENTAL HEALTH CAMPAIGN

The CMHC, founded in 2006, is a large statewide network that advocates for policy, systems, and practice solutions and shared responsibility among government and institutions to ensure that all children in Massachusetts have access to resources to prevent, diagnose, and treat mental health issues in a timely, effective, and compassionate way. 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. We are unified in our commitment to integrating mental and emotional health into big-picture approaches to safeguard the health and wellness of all children in Massachusetts.

MASSACHUSETTS ASSOCIATION FOR MENTAL HEALTH

Massachusetts Association for Mental Health has worked since its founding in 1913 to forge an understanding of behavioral health conditions and to combat disparities in health services access. Massachusetts Association for Mental Health envisions a day when all individuals and families across the Commonwealth have the resources and opportunities they need to promote resilience and protect overall health. Massachusetts Association for Mental Health
carries out its work through policy studies, legislative advocacy, and knowledge dissemination to promote fact-based policymaking and service solutions. Massachusetts Association for Mental Health is a member of the executive team of the CMHC and carried out the main study tasks.

HEALTH CARE LANDSCAPE

Despite near universal health insurance coverage and a diverse array of behavioral health services in the Commonwealth, 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.

In order to effectively implement urgent care for children and adolescents with behavioral health conditions in Massachusetts, it was necessary to first consider the Commonwealth’s health care landscape. Massachusetts has the highest rates of health insurance coverage in the nation with its MassHealth program uniquely combining the Children’s Health Insurance Program and Medicaid funding in order to achieve 97 percent coverage. Massachusetts has the most robust Medicaid behavioral health benefit in the country and ranks second in per member per month expenditures for all health care. The Executive Office of Health and Human Services reports that MassHealth investments in Behavioral Health system improvements total $1.17B for the period from FY2016 to FY2022. One focal point of these investments is funding to address ED Boarding and another is to expand Child Behavioral Health Initiative services.

To improve the quality, efficiency, and integration of behavioral health into primary care, MassHealth implemented a new Section 1115 Medicaid waiver, restructuring direct service delivery around patient-centered medical homes in primary care coupled with designated behavioral health community partners. With the advent of this Medicaid Accountable Care Organization Program in 2018, Massachusetts continues to support service and delivery payment reforms aimed at improving access to and cost effectiveness of care. Leaders in the Massachusetts business and insurance community recently announced through Associated Industries of Massachusetts a plan to encourage changes in employee consumption behavior and health care benefits designed to reduce ED utilization by 20 percent over two years, projecting savings of $100M.

Within Massachusetts, we found a diverse array of behavioral health services, including:
- Local community behavioral health organizations;
- Primary care with or without integrated behavioral health and Massachusetts Child Psychiatry Access Program consultation;
- Statewide regional Emergency Services Programs (ESP) with Mobile Crisis Intervention; and
- Intermediate community-based care for children and adolescents with required public insurance benefit and emerging commercial insurance coverage, as per Department of Insurance (DOI) December 2018 Advisory to private/commercial insurance carriers.
However, these services vary considerably in their capacity and quality, from site-to-site as well as regionally. In addition, mobile crisis intervention and intermediate care services are currently only available for children and adolescents enrolled in MassHealth, although it is likely that commercial insurers will begin to cover these services within the next several months, comporting with DMH/DOI guidance issued, as a result of the CMHC’s persistent advocacy.

INEQUITABLE ACCESS AND SERVICES GAPS

In the absence of any service response labeled “pediatric behavioral health urgent care,” children and adolescents with urgent needs attempt either to endure the long waits for outpatient care, to call emergency services, or to go the ED. None of these options provides an appropriate “urgent care” response to needs.

While the impetus for examining the need for pediatric urgent care was “Emergency Department (ED) Boarding,” the practice of holding patients in psychiatric crisis in the ED or in another non-psychiatric setting due to a lack of inpatient psychiatric beds, it quickly became clear that boarding is the result of gaps in the current behavioral health system, including:

1. Long waits are common for new intake to outpatient mental health care. According to two recent studies conducted by the Association for Behavioral Healthcare (ABH) and the Blue Cross Blue Shield of Massachusetts Foundation, waits for outpatient behavioral health care for children and adolescents are considerably longer than for those for adults. For children and adolescents with public insurance, wait times for an outpatient appointment average 2-6 months; for those with commercial insurance, waits are even longer at 4-9 months. Parents across payer types noted that the wait times for their children are unacceptably long. Psychiatry wait times also were particularly egregious, and much longer for children and adolescents compared to adults—for children and adolescents, 43 percent of Association For Behavioral Healthcare member organizations reported wait times of 1-6 months, and an additional 15 percent reported not having a prescriber available at all.

2. Few providers of behavioral health services deliver truly integrated mental health and substance use treatment services. In addition to the problems with weak integration, there are fewer substance use treatment alternatives for children and adolescents than the more robustly developed mental health service delivery system affords those with only psychiatric diagnoses.

3. The design and operation are uneven for regional crisis intervention programs. Access to Emergency Service Programs/Mobile Crisis Intervention is insurance-dependent and there is high variability among regions, leaving many without access, limiting the time spent with an individual child or adolescent and his/her family/caregiver, and forcing many families to EDs.

4. The quality of information provided to consumers about provider networks is poor.
Provider networks are notoriously inaccurate, leading caregivers to make dozens of calls to unavailable providers. All too often, caregivers are unable to find any provider and thus seek care for their child in the ED.\(^{12\, 13}\)

5. Continuity of care is rare between or among acute care providers and primary care or specialty behavioral health care outpatient providers. Outpatient providers are tasked with providing follow-up from acute episodes with little or no communication from acute service providers. This lapse in communication is a particular problem when prescription medications are changed or initiated in crisis or inpatient care and follow-up is needed in outpatient settings.

6. Urgent care centers do not treat behavioral health conditions. Although there has been a proliferation of urgent care centers across the Commonwealth in recent years, these pointedly do not serve individuals with a primary presenting need for behavioral health services. This was confirmed by one of the study authors contacting several urgent care centers, inquiring about their ability to treat behavioral health conditions.

7. There are few options for crisis stabilization unit beds or services for children and adolescents in need of 24 hour or longer stays. While Intensive/Community-Based Acute Treatment services are sometimes used for crisis stabilization unit functions for psychiatric stabilization, insurers reportedly limit stay authorization to a few days. Similarly, Acute Treatment Services (ATS) and Clinical Stabilization Services beds are not sufficiently available to stabilize youth with urgent substance use conditions.

8. Availability of inpatient psychiatric care is insufficient. Over the past fifteen years, the number of inpatient psychiatric beds in the Commonwealth for children and adolescents has decreased due to numerous closures. In fact, as of October 2018, there are only 313 child and adolescent behavioral health inpatient beds throughout the state of Massachusetts; 25 of these beds are for children, 142 are for adolescents, and 146 are non-specific child/adolescent beds. Despite the new Department of Mental Health (DMH) Expedited Admissions policy, ED boarding persists with “lack of bed availability” identified as the primary driver of prolonged boarding. Moreover, restrictive admissions criteria or exclusion criteria further limit access for children and adolescents with certain co-occurring conditions or special needs.

The above outline of child behavioral health system challenges is not exhaustive; however, not all system problems are indicators of the need for Behavioral Health Urgent Care, nor will Behavioral Health Urgent Care solve all system problems.

In Massachusetts, advocates, policymakers, and philanthropists are working together to understand the challenges in the care system, assess solutions that are rooted in evidence, and implement changes that align and integrate with system advantages. These entities recognize that inadequate crisis care and lack of capacity to treat urgent situations before a crisis occurs put children and adolescents and their families at risk, drive up costs due to hospital use, engage law enforcement in health care matters, and sometimes lead to human tragedies.
METHODOLOGY

The methodological approach to this study incorporated multiple qualitative data sources, including a review of peer-reviewed and grey literature, key informant interviews, focus groups, and an expert panel. Key informants included families/caregivers, government leaders, clinical service leaders, and healthcare policymakers from across the Commonwealth of Massachusetts. The expert panel included clinical program and public policy thought leaders from across the United States. The literature review was systematic, employing defined search criteria. The interview, focus group, panel, and site visit data were derived using structured guides.

COMPREHENSIVE ENVIRONMENTAL SCAN

The study design employed mixed methods. While no primary quantitative data were analyzed, the study team examined primary and secondary data sources. Qualitative data were collected from multiple sources and analyzed in an environmental scan format. Sources are detailed below.

SCAN OF PEER-REVIEWED AND GREY LITERATURE

The authors conducted a defined scan of the peer-reviewed and “grey” literature, gathering articles and reports on clinical needs, current systems, and urgent and emergency care. Because there is limited literature on pediatric Behavioral Health Urgent Care, the authors studied research results for existing elements of urgent care, including:

- Adult Behavioral Health Urgent Care
- Walk-in services
- Intensive outpatient services
- Crisis assessment and evaluation
- Stabilization and respite services
- Diversion services

KEY INFORMANT INTERVIEWS AND FOCUS GROUPS

We conducted key informant interviews with a range of stakeholders including caregivers, policy makers, and decision makers in governmental, payer, and provider organizations. The informants were chosen with intent to assure that the family, caregiver, and provider voice were prominent, and the full list is found in Appendix A of this report. In order to secure the targeted information required for the study, the study team drafted, tested, and finalized a Key Informant Interview Guide for use with all key informants. The Key Informant Interview Guide is found in Appendix B. The Guide was modified for use in focus groups, ensuring that standard data elements were explored and collected from each source. A complete list of focus groups also can be found in Appendix A.
The study team conducted visits to several sites providing some or all of the elements of a pediatric Behavioral Health Urgent Care. Given the absence of consistent Behavioral Health Urgent Care within the behavioral health care system in the Commonwealth, we identified and visited four sites in Massachusetts, each of which developed a unique model and provide some aspect of urgent care. We identified several innovative sites providing pediatric Behavioral Health Urgent Care in other parts of the country. The team selected and visited the Crisis Response Center in Tucson, AZ because the program has the most comprehensive array of services and provided outcome data demonstrating its efficacy. A sample Site Visit Guide can be found in Appendix B, and a complete list of sites visited can be found in Appendix A.

In addition to the five site visits, the co-author Mauch participated in a two-day Expert Panel, “Comprehensive Community Crisis Services: Structure & Standards,” convened by the Substance Abuse and Mental Health Services Administration on emergency and urgent care reforms. Dr. Mauch also served as an organizer and participant in a two-day expert meeting, “The Nantucket Children’s Mental Health Summit,” which brought together chairs of psychiatry and vice chairs and directors of child and adolescent psychiatry from each of the schools of medicine in Massachusetts and Texas to deliberate on system reforms to improve service delivery and clinical outcomes for children and adolescents with behavioral health conditions. The Summit was convened by the Hackett Family Foundation, The Meadows Mental Health Policy Institute, and Massachusetts Association for Mental Health.
FINDINGS ON THE NEEDS FOR URGENT CARE

Findings are drawn from all data sources, as outlined in the preceding Methodology Section. In the topics covered below, findings from the literature reviewed, from key informant groups and individuals, and from site visits are integrated and accordingly cited. The review of findings begins with a look at the needs of users—the children, adolescents, and families and caregivers who find conditions emerging that are urgent, moving toward a crisis, but short of a life-threatening or dangerous-to-self-or-others situation. This is followed by an outline of findings on approaches to meet those needs, including service delivery responses that may be identified as urgent care or as elements of intensive outpatient or emergency services. In the last part of this Section, gaps in urgent care are identified and analyzed for their applicability to an informed-design model for urgent care.

USER NEEDS

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. Please note that 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.

Near universally, key informants reported three primary groups of children and adolescents in need of Behavioral Health Urgent Care: those who were experiencing sub-acute changes in behavior or thinking, those failing to perform social role functions, and those with suicidal ideation. These observations aligned with literature that consistently reported these presentations among youth using crisis intervention services.15 16 17 18 19 20

CHILD NEEDS

"Getting on top of the clinical presentation of the child is essential to avoid an emergency situation."

-Lisa Fortuna, MD, MPH, Boston Medical Center

Clinical experts and families/caregivers alike stressed the importance of providing an urgent care response to children exhibiting significant behavioral dysregulation, thought disorder, suicidal ideation, and/or role dysfunction, while considering the developmental and environmental factors affecting the child and his/her family/caregiver.

In order to fully consider the needs of children and adolescents, the ecological context of the child must be considered. An environmental stimulus may initiate an acute reaction by the child. The needs of children and adolescents presenting to Behavioral Health Urgent Care will vary significantly depending on:

1. Underlying behavioral health or neurodevelopmental vulnerabilities;
2. Exposure to adverse social determinants of health (e.g. homelessness, food insecurity, etc.); and
3. Presence of a life transition or relationship stress (e.g. child welfare system involvement, juvenile justice involvement, a move, school change, parental divorce, peer conflict, etc.).

The presence of one or more of these factors as well as the characteristics of the child or adolescent and his/her family/caregiver will determine the needs and inform the plan for resolution. In some cases, children stabilize within several hours simply by being moved to a different setting. In other situations, changing settings exacerbates the intensity of the crisis, necessitating home-based interventions. In all cases, a crisis system must understand that the experience of the crisis itself can be traumatizing for a child. Thus, the response should seek to be calming and comforting for children and adolescents and their families/caregivers.

Further, as advised by clinical experts serving as key informants to this study, the capacity for crisis response is predicated on thorough clinical assessment and treatment plan formulation. For example, the crisis is not per se that a child threatens or attempts to assault another. That behavior may be indicative of the presence of an underlying need. The treatment team, along with the family/caregiver, must work to ascertain the underlying need and to help the child or adolescent together with his/her family/caregiver access appropriate treatment resources.

**ADOLESCENT NEEDS**

For adolescents, key informants and program site staff alike noted the importance of considering their degree of social role dysfunction – in relation to peers, families/caregivers, communities, and institutions, such as schools – and the environmental context in which they live and are educated.

Adolescents have many of the same needs and considerations as children, including the consideration of the environment in which the adolescent is developing, behavioral health/neurodevelopmental vulnerabilities, social determinants of health, life transitions, peer conflict, and individual/family characteristics. For adolescents, though, there are particular developmental factors that impact treatment access that must be considered. Adolescents develop increasing autonomy and independence from their families or caregivers while peer relationships become of primary importance. The use of young adult peers is a very effective method to increase adolescents’ engagement with care. In addition, informants advised that whenever possible an adolescent urgent response should be collaborative with the adolescent and the adolescent’s family/caregiver.

While young children frequently present with behavioral dysregulation, adolescents are far more likely to present with depression, suicidal ideation, and/or substance use. Symptoms

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“*It is essential to restore and maintain well-being in the environment where the child or adolescent needs to function.*”

- Lisa Fortuna, MD, MPH, Boston Medical Center
presenting in adolescence may represent the onset of adult behavioral health disorders. Adolescents may have a history of depression or suicidal ideation that has been exacerbated by an issue at school or at home or they may be presenting with suicidal ideation for the first time. A response to this presentation will depend on the particular adolescent, his/her history, and the capacity of the family to safely manage the suicidal ideation. It is essential that Behavioral Health Urgent Care for adolescents has the capacity to respond to this complexity.

FAMILY NEEDS

Families of children and adolescents in crisis are not a homogeneous group; a child or adolescent from any family may experience a behavioral health crisis at some point in the course of his/her development. The family’s response to the crisis will depend largely on the current state of key family members, their historical experience with care systems, as well as on the family’s access to resources at that point in time. Because all children and adolescents and, therefore, families will have different needs, it is essential for an effective urgent behavioral health response to be flexible (a “no wrong door” approach). Family stakeholders serving as key informants indicated that providers are more effective when they demonstrate respect for and welcome family members as allies. Families should be viewed as assets to the child’s/adolescent’s care plan, even if, in the moment, they are experiencing stress, guilt, stigma, and shame. It will be up to the care team, inclusive of Family Partners, to empower families, as experts in their child, so that they are able to collaboratively develop a care plan. For children and adolescents, a crisis response cannot be solely child-focused; it must also reflect a family-based approach.

In order for pediatric Behavioral Health Urgent Care to be successful, families need to know when it is appropriate to bring a child or adolescent to urgent care in lieu of the ED. It is critical that there be multiple, community-based points of access to pediatric Behavioral Health Urgent Care. Throughout the crisis, providers should anticipate that the family will be highly stressed, which is a normative and expected response. By acknowledging the impact of the crisis on the entire family, providers can empower caregivers as part of their child’s or adolescent’s care team.

CRISIS VERSUS EMERGENCY

Goldstein and Findling argue that an “emergency” differs from a “crisis” because an emergency is “a relatively abrupt, sudden situation in which there is an imminent risk of harm: (1) risk of suicide; (2) risk of physical harm to others; (3) states of seriously impaired judgment in which the individual is endangered; or (4) situations of risk to a defenseless victim.” On the other hand, a crisis is a “loss of psychological equilibrium” and tends to last longer than an emergency but has a decreased risk of danger to the self or to others. In a pediatric emergency psychiatric assessment, Goldstein and Findling assert that a detailed clinical interview must be conducted in order to determine if the presenting problem is truly an emergency or if it is a longer-standing crisis.21

“Outpatient therapy is not adequate. The services happening are not meeting the needs of the child anymore.”

-Lisa Lambert, PPAL

Behavioral Health Urgent Care Report
Behavioral Health Urgent Care Report

URGENT CARE SERVICES RESPONSE: ELEMENTS OF CURRENT-STATE URGENT CARE

Findings from the peer-reviewed literature, published policy reports, and materials provided during site visits paint a picture of a recently emerging urgent care landscape in the physical health world, paralleled by a barely visible adoption of Behavioral Health Urgent Care. Several experts interviewed struggled to define “Urgent Care” in behavioral health, primarily because there are so few examples of Behavioral Health Urgent Care.

URGENT CARE

Although the authors found little in the literature defining pediatric Behavioral Health Urgent Care, most clinical experts interviewed defined the characteristics of the pediatric population in need of service in remarkably similar terms, and mainly in contrast to a psychiatric emergency. 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, revealed by changes in behavior or thinking, role dysfunction, emerging intent of self-injury, or threats to others.

Within physical health, “urgent care” is defined as health care that is provided on a “walk-in basis for the treatment of acute illness or injury that is not life or limb threatening.” It is distinguished from emergency care because emergency care includes the treatment of patients with life-threatening conditions as well as non-urgent conditions for which patients believe they have no alternative point of care. It is worth noting that from 2008 to 2015, there was a substantial increase in the utilization of urgent care centers and a decrease in the use of the ED to treat most medical conditions. In 2012, urgent care centers surpassed the ED as the acute care site at which low-acuity physical conditions are most commonly treated.

BEHAVIORAL HEALTH “URGENT CARE:” URGENT OR EMERGENCY?

In behavioral health, emergency care versus urgent care is not as well defined as in physical health, as there is no consistent definition of a psychiatric emergency. According to the American Psychiatric Association (APA), emergency psychiatric services should be able to address the full range of behavioral health and psychiatric emergencies immediately, including involuntary treatment. Whereas, urgent services only need to provide short-term care and stabilization with the goal of avoiding a potential emergency. The American Academy of Child and Adolescent Psychiatry (AACAP) provides guidance that a “psychiatric emergency is a dangerous or life-threatening situation in which a child needs immediate attention” for risk of harm to self, risk of harm to others, or acute changes in behavior or thinking.

“In psychiatry, urgent can be considered similarly to medicine: things that need attention right away but are not emergencies. In psychiatry, we have not had a treatment component to urgent interventions like there is in the medical world. What the system needs more than anything else is urgent access to TREATMENT.”

- Beth Wharff, PhD, MSW, LICSW, Boston Children’s Hospital
In contrast to a psychiatric emergency, 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 of harm to self or others. Urgent care needs are revealed by changes in behavior or thinking, role dysfunction, emerging intent of self-injury, or threats to others.

**NUANCES OF PEDIATRIC URGENT CARE**

With at least one in five children and adolescents being diagnosed with a mental health disorder before the age of 18, it is imperative that models of Behavioral Health Urgent Care be adapted to best meet the needs of children and adolescents. Janssens and colleagues defined a pediatric psychiatric emergency as “involving a danger of harm to the patient or to others, which is primarily determined by the patient’s context, or it involves a context in which there is a threat to child’s life and development.” Further, it is imperative to consider age-related and developmental factors for children, which can drastically affect whether a behavior or thought should be characterized as “emergent” or “urgent.” Halamandaris and Anderson note the specific importance of adult figures, stating, “a child’s behavior or thoughts are brought to psychiatric attention when an adult figure interprets them as inappropriate or unmanageable in the current environment.” In fact, child-specific crises are distinct from adult crises because they are often determined by the timing of the child’s behaviors with respect to the resources available to adults. Because children’s crises are almost always interpreted through the lens of an adult caregiver, what a particular caregiver defines as a crisis can vary considerably depending on a family’s social capital and access to resources. In sum, a child’s crisis cannot be separated from the context in which it occurred—whether that is within a family context, school, or an out-of-home placement. In order to resolve the crisis, the child’s entire systems of support must be engaged. We note that for some children and adolescents, their symptoms may reflect the emergence of biologic psychiatric illness. However, the entire biopsychosocial context must be considered in formulating treatment plans.

**URGENT CARE SERVICES RESPONSE**

All data sources are in agreement that for children and adolescents presenting in urgent need, a more cohesive response is needed that mitigates the fragmentation of the current state of care; builds capacity in existing service delivery settings; and provides a timely response with continuity across care elements to stabilize the crisis and set a course for resolution.

Experts interviewed underscored the need for Behavioral Health Urgent Care. They cited two core reasons:

1. Avoiding escalation of symptoms and deterioration of role functioning while waiting
for care access, and

2. Providing 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 avoided further fragmentation of the behavioral health care delivery system and aligned with recently implemented practice and payment reforms.

ELEMENTS OF CURRENT BEHAVIORAL HEALTH URGENT CARE

When a child or adolescent is in need of urgent behavioral health care, where they ultimately receive services depends on the available resources in a given geographic area, family choice, cultural and linguistic factors, and insurance status/carrier. There are certain settings that offer expedient access to behavioral health care, though not all of the settings described exist for youth in the Commonwealth. Based on our review of the literature, site visits, and key informant interviews, the following interventions, elements, and settings may function as part of Behavioral Health Urgent Care.

Highlighted Practice: Connections Health Solutions operates the Crisis Response Center (CRC) in Tucson, Arizona, serving approximately 2,200 children and adolescents per year in Maricopa County. The comprehensive urgent care program is situated in a building that is adjacent to a hospital emergency department and inpatient services.

Within the CRC, Connections Health Solutions delivers an array of services available on a 24/7 basis that begins with intake, having the capacity to receive and rapidly accept (within minutes) a child or adolescent transported by police, ambulance, parents, schools, or others. Assessment is rapid, initiated within 45 minutes of intake, and triage to a range of services occurs soon thereafter. The site has the capacity to administer and analyze lab tests and to medically clear youth for admission to treatment. The CRC operates a 10-bed crisis stabilization unit (CSU) providing close observation for up to 23 hours. In addition, outpatient, intensive outpatient, medication and medication-assisted treatment induction and step-down support services are initiated or arranged by the team of master’s level social workers, psychiatric nurses, and psychiatrists that work on site. Because there is “no wrong door” for police, who universally receive Crisis Intervention Training (40 hours), fewer youth are taken to either an emergency room, a hospital, or to juvenile court. The CRC’s medical director collaborates closely with medical directors of other community facilities and the CRC sets daily time slots for Child & Family Team Meetings to facilitate outpatient clinic staff participation in care planning. Schools engage in Mental Health First Aid training and along with police work as partners with the CRC. The CRC has the benefit of “block funding”

“In physical health, the patient is triaged appropriately; a patient does not need to fail at the lowest level of care in order to access a higher level of care. In the behavioral health system, you need to fail numerous times in order to access needed higher levels of care, such as out of home, residential placement, or DMH support.”

- John Sargent, MD, Tufts University School of Medicine
as it is viewed as a service that requires standing funding “like the fire department.” While the program bills insurance, it does not depend on reimbursement to fund core operations. Both walk-in clinic and close observation beds are under a single roof and are licensed as an integrated outpatient clinic. The program reported a low (1.1 percent) readmission rate and a high (85 percent) patient satisfaction rate in FY2017.

**ED-BASED INTERVENTIONS**

*The only things an ESP team can do are give you an outpatient appointment, send the MCI team, or get you to an ED; why is an ‘urgent appointment’ not an option? [We] need to work at the systems level on streamlining linkages to various levels of care.*  
- Kappy Madenwald, MSW, TAC

All too often, a lack of behavioral health care in the community leads families to seek out behavioral health care in the ED. In response to this trend, some hospitals have implemented ED-based behavioral health interventions. Though the focus of this report is on Behavioral Health Urgent Care outside of the ED, interventions created for the ED may be applicable to Behavioral Health Urgent Care that is provided in outpatient clinic settings. Within the ED, a specialized team of behavioral health clinicians provides brief treatment (typically family-based) to target presenting symptoms and to stabilize youth prior to treatment planning. Similar to medical models of intervention in the ED, the goal of these interventions is to provide immediate treatment to decrease presenting symptoms, thereby precluding the need for inpatient care and discharging the child or adolescent to care in the community. Several models have successfully reduced the incidence of inpatient stays and increased engagement with outpatient behavioral health providers.  

37 38

Highlighted Practice: Boston Children’s Hospital operates an ED-based model, designed specifically for the treatment of suicidal adolescents. The program is “family-based crisis intervention,” designed to provide an alternative to ED boarding, during which little treatment is provided, despite efforts to offer evaluation and disposition services. As an alternative to long waits in the ED, Children’s Hospital Social Work employs five modules—psycho-education, cognitive behavioral skill-building, therapeutic readiness, safety planning, and unified crisis narrative—to stabilize the adolescent’s symptoms in order to avoid an inpatient psychiatric hospitalization.  

47 The program is designed to stabilize the adolescent during the ED visit, so that they may return safely to the family home. In a study of the program’s efficacy, clinicians provided follow-up contact and assessment at the one-day, one-week, two-week, one-month and three-month marks after discharge from the ED. The intervention has demonstrated success, with patients receiving family-based crisis intervention being admitted to the hospital significantly less frequently (only 7 of 67 in the initial cohort reported an inpatient hospitalization at the three-month follow-up after the initial ED visit) than those receiving usual treatment.  

48

The American Academy of Pediatrics (2006) recognizes the importance of ED-level interventions for youth in crisis; some youth require inpatient hospitalization, however,
many youths who seek behavioral health care in the ED do not require this level of care, as demonstrated by the CMHC’s boarding project.\textsuperscript{49} In fact, 1 in 7 youth who presented to the ED in crisis and were initially assessed to require inpatient care were eventually discharged home in that study.\textsuperscript{50} Although sometimes necessary, EDs are not the ideal setting in which to treat all behavioral health crises.\textsuperscript{51 52 53 54 55 56 57}

**PSYCHIATRIC EMERGENCY SERVICES**

Psychiatric Emergency Services, sometimes referred to as psychiatric EDs, are designed to provide accessible, professional, cost-effective services to individuals in psychiatric and/or substance use emergency. Psychiatric Emergency Services strives to stabilize patients on-site in order to avoid an inpatient hospitalization, similar to an ED-based intervention, and provides emergency, urgent walk-in, and police-initiated evaluation and crisis services 24 hours per day, 7 days per week to all who present, regardless of acuity or insurance status. Because they are considered a psychiatric ED, Psychiatric Emergency Services do not have exclusionary criteria or “no-admit” lists, which are in place at other levels of care to prevent certain patients from entering the facility.\textsuperscript{58} Ideally, children and adolescents receive Psychiatric Emergency Services care in a dedicated and separate space from adult patients.\textsuperscript{59}

\begin{quote}
"You need to have good clinicians providing the care and making sound clinical decisions and good disposition decisions."

- Henry White, MD, The Brookline Center
\end{quote}

Highlighted Practice: In 2011, Bellevue Hospital in New York opened the Children’s Comprehensive Psychiatric Emergency Program for children ages 0-18, which functions similarly to a Psychiatric Emergency Services. The program is staffed 24/7 by child psychiatrists, child psychiatric nurses, social workers, psychologists, and caseworkers. Referrals typically come from schools, outpatient providers, family members, emergency services, or the police.

Each child who presents to the Children’s Comprehensive Psychiatric Emergency Program and their family receives a comprehensive evaluation by a child and adolescent psychiatrist. After the evaluation, children are admitted to the 6-bed brief-stabilization unit within the Children’s Comprehensive Psychiatric Emergency Program, are admitted to an inpatient unit, or are discharged home with a connection to outpatient care. In one study, following evaluation, 59 percent of children were sent home, 13 percent were briefly stabilized at the Children’s Comprehensive Psychiatric Emergency Program, and 28 percent were admitted to a psychiatric inpatient unit. Visits by most (55 percent) of the children were classified as emergent (immediate danger to self or to others), while 31 percent were classified as urgent (significant exacerbation of symptoms over the past five days), and 14 percent were non-emergent/non-urgent (e.g. medication refills). Although 86 percent of children presented in either urgent or emergent crisis, 59 percent could be discharged after evaluation, intervention, and access to immediate outpatient care.\textsuperscript{61}

**OUTPATIENT BEHAVIORAL HEALTH WALK-IN CARE**

Unlike an ED or a Psychiatric Emergency Services, psychiatric urgent care is designed to
address urgent needs, not emergency needs. Where psychiatric urgent care exists, it often
does not have 24/7 availability and instead typically has more standard hours (M-F, 9-5) with
limited availability on nights and weekends. Psychiatric urgent care settings are typically
located on a hospital campus or in the community. Similar to medical urgent care, psychiatric
urgent care has walk-in capacity or availability within a day (versus waiting weeks to months
to see an outpatient clinician). Clinicians with expertise in evidence-based practices deliver
urgent, walk-in psychiatric care for children and adolescents.62 63 64 66 67 68

**Highlighted Practice:** In Ontario, Canada, there are three clinics that each dedicate one
8-hour day per week for walk-in appointments, offering the community access to a single
session of therapy for when they are most in need. For this particular set of clinics, solutions-
focused, brief, and narrative therapies are used with the goal of a single session of therapy. In
the end, 45-50 percent of families do not require a referral. At each site, 3-5 clinicians (a mix
of Master’s- and Bachelor’s-level social workers with a few crisis-trained paraprofessionals)
staff the walk-in clinic each week. The receptionist plays a vital role to the walk-in
component of these clinics by welcoming and assuring families that they have come to the
right place.69

**Highlighted Practice:** Martha’s Vineyard Community Services (MVCS) operates an “Enhanced
Urgent Care Program” for children and adolescents, serving an island community in
Massachusetts. The Enhanced Urgent Care Program is based in a walk-in clinic, adjacent to
Island Counseling Services, and proximate to the Emergency Services Mobile crisis intervention
team location. The site is also located across the street from the Island’s high school, where
staff are reportedly in daily communication regarding the needs of shared children and
adolescents.

The site offers both “Enhanced Urgent Care” and “Emergency Services” in a suite of offices
with examination, consultation and treatment rooms, and a private reception area with its
own entrance. The program operates on a walk-in basis from 8 AM to 8 PM (last walk-in at 6
PM), backed up by Emergency Services at later hours. The program also embeds the urgent
care staff in the school for several hours per week to provide accessibility in that location.

The program is staffed by a trained clinical team dedicated to the program, with authority to
direct children and families to adjacent outpatient and day program care, either to resume
or initiate treatment. The urgent care team receives the client and family and provided the
presenting youth with a care response within 15 minutes of arrival. Assessment is provided
using evidence-based screening tools and forms the basis of safety planning and wrap around
services, and on-site treatment initiation. The program administers an assessment of mental
health and or substance use needs, followed by brief intervention and linkage to treatment.
The urgent care team will manage care transitions and arrange safe transportation of
individuals in need of emergency, inpatient or substance use treatment.

The staff deliver collaborative care not only in conjunction with other MVCS clinical
operations, but also with the schools, pediatricians, hospital, community programs,
families/caregivers, and first responders/public safety officers that refer and or will provide
continuous care to program participants.
The funding structure is essential to MVCS’ ability to implement and sustain the urgent care program. The program has “standing funding” from the Department of Mental Health, ensuring it is staffed and operated regardless of the amount of dollars collected through insurance reimbursement. The combination of DMH standing funding, paid out on a cost reimbursement basis, and public and private insurance reimbursement, is supplemented by foundation funding and local fundraising support, the sum of which is dedicated to staff training and practice transformation efforts.

MVCS tracked results of the first full year of the operation of the Enhanced Urgent Care Program in 2018 over performance of the Emergency Services Program in 2017. In 2018, there was a 21 percent decrease from 2017 utilization in the number of Emergency Services Program evaluations, due to the capacity of the Enhanced Urgent Care Program. There was a 43 percent decrease for 2018 over 2017 in Inpatient Psychiatric Admission Episodes for children and adolescents, aged 0 to 20. For adults, aged 21 and older, the related decrease in Inpatient Psychiatric Admissions was 34 percent for 2018. Finally, for the children and adolescents, aged 0 to 20, there were 52 percent fewer overnight stays in the hospital ED in 2018. These first year performance results underscore the efficacy of Urgent Care in reducing the use of higher cost emergency and hospital care.

**Highlighted Practice:** The SSTAR Program in Fall River, Massachusetts, operates a walk-in behavioral health clinic for persons aged 18 to 80, and the majority of those served are transition aged youth (aged 18-25). SSTAR transformed its outpatient clinic, which typically had an 8-week wait for an appointment, a 45 percent no show rate, and steep financial losses. The walk-in behavioral health clinic operates with “open access” from 7:30 AM to 8 PM. A walk-in client is rapidly seen for intake and brief assessment, following which they may be scheduled for a same-day individual or group treatment; groups operate also on a walk-in basis once a client has been through intake. This enables clients to determine the type and timing of their own treatment. While the core focus of the program is on treating people with substance use conditions, there is an active track of individual and group treatment for co-occurring mental health and substance use conditions. Individuals meeting medical criteria may initiate medication assisted treatment a day after intake. Those referred to and/or electing multiple group sessions per week are in intensive outpatient treatment.

**MOBILE CRISIS INTERVENTION**

Mobile crisis intervention is a key element of urgent behavioral health care. According to the National Action Alliance for Suicide Prevention, the essential functions of community-based mobile crisis services are triage/screening, assessment, de-escalation/resolution, peer support, coordination with medical and behavioral health care, and crisis planning and follow-up.

In Massachusetts, there is a mobile crisis intervention program for children and adolescents enrolled in MassHealth that provides “mobile, on-site, face-to-face therapeutic response to a youth experiencing a behavioral health crisis for the purpose of identifying, assessing, treating, and stabilizing the situation and reducing immediate risk of danger to the youth or others.” Mobile crisis intervention can provide up to 7 days of crisis intervention and
stabilization services. More detail on the Massachusetts mobile crisis intervention program can be found on page 31.

Highlighted Practice: Behavioral Health Network (BHN) operates emergency services and mobile crisis intervention services in Springfield, Massachusetts. Of 1200 crisis assessments performed each month, approximately 400 are for children and adolescents. While an estimated 25 percent of children presenting in the local ED end up in inpatient care, only 10 - 15 percent of those seen by BHN are assessed to require hospitalization. Some enter a community-based acute treatment program as an alternative to hospitalization. Others are diverted through work of the mobile crisis intervention team and the 24/7 walk-in capacity offered at BHN’s Emergency/mobile crisis intervention site. Close collaboration with Springfield schools and police serves to divert youth to 24/7 walk-in services, rather than calling 911, which would result in an ambulance ride to the ED. BHN also notes the need for safe transportation to avoid use of 911/ambulances only authorized to an ED. Staff indicates that a crisis stabilization unit would enable greater levels of diversion from EDs and inpatient beds.

Highlighted Practice: In Milwaukee, Wisconsin, the “Mobile Urgent Treatment Team” is a community-based team that is specifically designed for children and adolescents and available 24/7, which devises a treatment plan, including links to community-based supports in the child’s home to stabilize the child and the family in order to avoid an out-of-home placement. The aim of the intervention is to reduce the incidence of future crises and manage the behavioral health condition in the community. Over the short-term, there is case management and follow-up provided by the Mobile Urgent Treatment Team. The Milwaukee Public Schools have a dedicated mobile crisis services team to address crises that arise within the schools, staffed by Master’s level behavioral health clinicians (primarily social workers), psychologists, a psychiatric nurse, and a consulting psychiatrist. The Mobile Urgent Treatment Team is part of a larger system in place in Wisconsin, where all counties are required to have emergency mental health services that have a mobile crisis team available for at least eight hours per day, 7 days per week that are required to be specifically adapted for children and adolescents.

TELEHEALTH INTERVENTIONS

Within the scope of behavioral health, telehealth interventions include: telepsychiatry (an appointment with a psychiatrist via phone or video), telephonic triage, and remote behavioral health consultation for non-behavioral health clinical staff. Due to the unpredictable nature of behavioral health crises, telehealth is frequently a component of urgent behavioral health interventions.

TELEPSYCHIATRY

Several emergency psychiatric programs specifically use telehealth technology to increase access to psychiatry. In Norway, there is an on-call system for psychiatric emergencies; psychiatrists are accessible via telephone and videoconferencing 24 hours per day for consultations with patients and nurses located at three regional psychiatric centers in order
to ensure decentralization of high-quality psychiatric services for emergency care. In one pediatric ED, the implementation of telepsychiatry was successfully used to shorten length of stay in the ED, which significantly reduced cost and did not have a negative impact on patient safety. In a rural community in Australia, a telepsychiatry clinic was set up for patients to communicate with a psychiatrist who was based at a hospital in a metropolitan area. Prior to the appointment, patients were screened and assessed by the clinical staff at the mental health center. In advance of the appointment, patient information was sent to the psychiatrist. This model, while not specific to children or adolescents or to crises, could be adapted and incorporated for an urgent, pediatric behavioral health response. A current model being implemented at Boston Children’s Hospital uses telepsychiatry consultation to pediatric primary care to provide quicker access for patients in geographically-dispersed primary care settings.

**TELEPHONIC-TRIAGE**

One hospital, located in an urban area of Australia, used a 24-hour telephone line to triage patients calling its emergency psychiatry program in order to provide a single point of access to a range of services. Only about one-third of calls required a clinician to perform a psychiatric assessment; the other two-thirds of calls were transferred to a different clinical department or to a community agency. By using tele-triage, two-thirds of callers were directed to the appropriate resources without ever presenting to the ED. The Mental Health Emergency Care Access Program in a rural area of Australia uses a similar triage model; they have created an emergency telephone triage and video assessment as a “no wrong door” approach to services. The team is staffed by mental health nurses and psychiatrists, is available 24/7/365, and can provide information services, clinical services (including triage and assessment), and other program activities all, using telehealth technology.

**CONSULTATION**

Telehealth is also employed to improve the capacity of direct service providers through consultation with specialists. In one urban community, mental health professionals responding to child and adolescent emergencies, consulted with child and adolescent psychiatrists. This telepsychiatry intervention was only one component of a larger, multisystemic approach to respond to the psychiatric emergencies of children.

In response to the shortage of child and adolescent psychiatry, Massachusetts developed and implemented a statewide consultative solution—the Massachusetts Child Psychiatry Access Program. These regional teams consult with and educate primary care providers on management and treatment of behavioral health conditions. Though Massachusetts Child Psychiatry Access Program addresses a significant need in the Commonwealth, it is specifically noted that, “Massachusetts Child Psychiatry Access Program is not meant to replace necessary emergency services.” More detail on Massachusetts Child Psychiatry Access Program can be found at page 31 under Current State Service Delivery Responses.
SCHOOL-BASED INTERVENTIONS

It is crucial to consider the role of school-based interventions in any model designed for children and adolescents. School-based health centers are a well-established model for providing primary care and behavioral health services within schools and strive to keep children healthy and in class.\(^9\) School-based health centers are particularly successful with serving hard-to-reach populations, especially minorities and males, and they reportedly do a better job than other care settings at providing crucial services such as mental health care and behavior screens.\(^9\) It has been demonstrated that adolescents are 10-21 times more likely to prefer visiting a school-based health centers for mental health care over a community health center.\(^9\) Further, students who reported depression and past suicide attempts were significantly more willing to use a school-based health centers for counseling services compared with other care settings.\(^9\) Unlike outpatient clinics, school-based health centers have virtually no attrition and no no-show rates because of the ease of access to students during the school day.\(^9\) School-based health centers have also been demonstrated to decrease the need for emergency services.\(^9\) In fact, access to school-based health centers for children enrolled in Medicaid with mental health conditions was correlated with lower hospitalization and emergency room expenses compared with Medicaid-enrolled children without access to a school-based health centers.\(^9\) In one school-based model, mental health clinicians assessed the need for emergency psychiatric hospitalization and were often able to avoid such a referral by developing safety and therapeutic plans.\(^9\) Of course, school-based mental health services must collaborate with community-based providers in order to assure that youth have access to the full continuum of behavioral health services, especially during times when schools are closed—such as vacations, evenings, weekends, and holidays.\(^9\)

**Highlighted Practice:** At Blackstone Valley Regional Vocational Technical High School in Upton, Massachusetts, the school-based health centers, school nurse, and guidance department screen all 9th graders for depression using the Brief Screen for Adolescent Depression (BSAD). For those youth identified as urgently “at risk,” a plan is developed to link the student to a counselor at a community-based mental health provider.\(^9\) Within the Boston Public Schools, a clinician from a community-based agency can provide consultation to school personnel during an urgent situation. If the school is aware that the child receives mental health treatment outside of the school, the outside clinician may be contacted in an emergency, if parents cannot be reached.\(^9\) Ensuring coordination of community- and school-based care is essential for handling crises that arise in school.

**Highlighted Practice:** The McLean School Nurse Liaison Project (MSNLP) is a grant funded service that is part of the Massachusetts Child Psychiatry Access Project (MCPAP). MSNLP serves school districts in Southeastern Massachusetts, providing education, consultation and informational resources to middle and high schools. Services are delivered by advance practice nurses with strong pediatric psychiatry experience. These professionals are on call during school hours to respond to inquiries for information and consultation on a range of mental health issues and to provide professional development training events. MSNLP assists school nurses and other school personnel to address child and family social, emotional and behavioral issues. Staff also provide schools access to educational materials, resource
referral databases, and skill building opportunities. MSNLP routinely receives requests from other regions of the state and is working to raise funds to extend its services. Some of the topics covered in educational forums and materials are: the stigma of mental illness; developing coping skills; psychiatric medications in school settings; understanding depression, ADHD, anxiety, somatic symptoms, and effects of trauma; substance abuse; self-harm; and motivational interviewing. The program goals are to educate to improve mental health throughout the community and provide early intervention to assist and support school staff facing unfamiliar situations.

It should be noted that the fee-for-service embedded clinician model does not adequately address the mental health needs of nearly enough students in schools. This is particularly because their time is accounted for by a set of students who are part of their ongoing caseload based on needs identified on Individualized Educational Plans (IEPs), leaving little bandwidth for urgent intervention or crisis response. A care coordination/referral model would be much more effective in terms of serving the volume of students presenting with behavioral health needs. There is typically not enough internal capacity at school, even with embedded clinicians. However, external capacity is also often insufficient, so some schools are hesitant to identify children who may need services because they are unable to provide a timely referral.

The School-Based Diversion Initiative in Connecticut specifically aims to reduce juvenile justice involvement for youth with mental health needs. The program works with middle and high schools to help school staff identify children with behavioral health needs, build connections between the schools and community-based mental health services, and revise schools’ policies to increase their capacity for responding to mental health needs of students. The program has successfully decreased court referrals by 45 percent and simultaneously increased the use of Emergency Mobile Psychiatric Services by 94 percent during the first year of participation.108

**SUMMARY OF SERVICE AND SYSTEMS ISSUES**

While the relationship and opportunities that exist between urgent care facilities and ED is important, the overall utilization of urgent care should be strategically considered across all care delivery models.

As reported at page five in more detail, 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;
- No 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 between ED, inpatient, and outpatient settings;
- No behavioral health capacity at medical urgent care centers;
- Limited crisis stabilization bed availability; and
- Too few inpatient beds and others with restrictive admission criteria.
CURRENT STATE SERVICE DELIVERY SYSTEM RESPONSES TO THE NEED FOR BEHAVIORAL HEALTH URGENT CARE

Illustrated below is the current state of the child and adolescent behavioral health care system as it responds to “urgent” needs. At present, a child or adolescent in urgent need - as earlier defined 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 present to their primary care clinic or at an outpatient behavioral health clinic, they might well find themselves on a waitlist until a specialty appointment becomes available due to the lack of any walk-in or on-demand capacity. Others might first try the emergency services program (ESP)/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 while awaiting appropriate inpatient care. 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 may be disrupted by the team’s need to respond to the next crisis in the queue.

Illustration 1. Current State System Response to Urgent Care Needs

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 child or adolescent 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 a Behavioral Health 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. 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. Numerous studies report improvements in clinical and psychosocial outcomes, health services access, and acute services use patterns.

MOBILE CRISIS INTERVENTION PROGRAM

Currently, the mobile crisis intervention teams in Massachusetts come closest to providing children, adolescents, and their families/caregivers with an “urgent” intervention. However, the mobile crisis intervention team clinicians’ primary function is to assess a child for “level of care.” Clinicians do not necessarily provide a thorough crisis assessment and/or crisis intervention due to myriad systemic issues that dis-incentivize the provision of such services. Quality metrics for this service require rapid response, which may not allow clinicians adequate latitude to spend more time intervening. Mobile crisis intervention staff do not have the authority to direct admission to timely, clinic-based treatment interventions, nor do they have the option of referring to walk-in clinics or observation beds to stabilize an urgent situation. In addition, because these positions are not competitively compensated, teams are often composed of new, inexperienced clinicians, who are not receiving adequate supervision and training given the clinical acuity and complexity of the children, adolescents, and families/caregivers with whom they work. Without adequate training, clinicians may be under-prepared to intervene and often they leave due to stress and burnout.

MASSACHUSETTS CHILD PSYCHIATRY ACCESS PROGRAM

The longstanding and persistent lack of child and adolescent psychiatrists results in most children being treated for behavioral health conditions by their primary care pediatrician. As a remedy for the lack of behavioral health training in pediatrics, Massachusetts Child Psychiatry Access Program was implemented statewide in 2004, providing near real-time consultation by a child psychiatrist to pediatricians across the Commonwealth. Since that time, Massachusetts Child Psychiatry Access Program has expanded to include regional teams, staffed by two full-time child and adolescent psychiatrists, independently licensed master’s level clinicians, resource and referral specialists, and program coordinators, and provides both education and consultation to pediatricians in order to improve their competency with behavioral health identification and treatment. Massachusetts Child Psychiatry Access Program can also help the pediatrician’s office coordinate care for patients who require specialist community-based care. Since its inception in Massachusetts, Massachusetts Child Psychiatry Access Program has been adopted by 30 states and is being incorporated into the federal budget in 2019.
SYSTEMIC AND STRUCTURAL ISSUES

In addition to the fragmented elements of care that appear in Illustration 1, there are systemic and structural challenges in the current system that limit a timely and rational care response to a child or adolescent, and his/her family members or caregivers, presenting urgent care needs.

ACCESS BARRIERS

For children and adolescents under 21 in the Commonwealth, access to community-based intermediate-level behavioral health care is insurance-dependent and greatly limited for those who are commercially insured. Due to the implementation of the Children’s Behavioral Health Initiative, developed as a result of the Rosie D. court decision, children and adolescents enrolled in MassHealth who have serious emotional disturbance have access to a wide continuum of home-based services and supports. The robust array of services covered by MassHealth has led families with commercial insurance to enroll in a secondary MassHealth plan, so that their children can access these intermediate level services, despite often incurring a substantial monthly premium for coverage. Commercial insurers were recently directed by the Department of Insurance (DOI) and Department of Mental Health (DMH) to cover several of those intermediate services starting in 2019, as a result of the persistent advocacy of the Children’s Mental Health Campaign.

NAVIGATION/CARE MANAGEMENT

In Massachusetts, there is a multitude of best practice, evidence-based programs; however, all too often, these programs exist in isolation from one another or only serve a small subset of the population, resulting in a fragmented and difficult-to-navigate system. In physical health, the management of chronic illness is a routine part of care. For example, a patient with diabetes works with his/her care team to learn to manage the condition, including ongoing treatment as well as crisis planning; however, the analogous service, if it is even available, is underutilized for behavioral health conditions. Again, only for those youth with MassHealth, the Child Behavioral Health Initiative system includes Intensive Care Coordination, intended to help coordinate care and serve as a navigator throughout the system of care. Because they are part of the Child Behavioral Health Initiative system, ICCs often do not coordinate with the acute care system or with the child’s pediatrician, leading to further fragmentation.

Communication is limited among behavioral health treatment entities, despite the necessity to work collaboratively to develop a comprehensive and coordinated care plan. This lack of communication is particularly disruptive during crises—there may be little-to-no communication between the outpatient mental health provider and the ED, for example. Improving communication among systems, streamlining linkages to various care settings, placing the child and family at the center of care, collaborating with the family on care planning, and, with the assistance of care navigators, assisting families with behavioral health system navigation would all contribute to an effective and efficient behavioral health urgent care response. Model practices call for shared coordination and care management protocols.
REVERSE TRIAGE

Triage is a process specifically designed to ensure that the sickest patients get taken care of before those who are less acutely ill. In behavioral health, often the most acute patients are at higher risk for ED boarding, waiting hours or days in inappropriate non-psychiatric settings. Inpatient, intensive, and subacute residential treatment settings reportedly decline to admit children and adolescents waiting in EDs, describing them as “too acute” to treat. This “reverse triage” system results in less acute patients having priority access to the most intensive level of psychiatric care.

WORKFORCE ISSUES

Behavioral health providers in Massachusetts, like elsewhere in the country, receive lower reimbursement rates from insurers compared with physical health providers. In a recent study, the Association for Behavioral Healthcare found that behavioral health providers were on average paid 22 percent less than practitioners in other primary and specialty care practices. In addition, the administrative burden on behavioral health providers is often significant and not in alignment with the physical health system, directly violating both state and federal parity requirements. Due to these and other systemic barriers (e.g. different credentialing processes for each insurance plan, lack of incentive to train in evidence-based practice, etc.), many providers do not accept insurance or leave the profession entirely, creating highly restrictive access to a well-trained workforce. More detail on workforce issues can be found on page 42 under System Implementation Considerations.

URGENT CARE SOLUTION

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 employing a three-pronged strategy. The strategy involves: enhancing core services capabilities; filling selective services gaps; and implementing legal, regulatory, financing, and practice transformation supports to facilitate uptake and broad scale adoption.

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 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 free standing
ambulatory clinics, while some 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 note also that experts did not recommend more inpatient beds, as 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.

Illustration 2, detailed below, compares the functional capabilities of an Emergency Department, a Community Behavioral Health Clinic, and a Primary Care Practice Clinic to a designated Urgent Care Program. A reader will note that few of the functions needed for an urgent care response operate routinely or on demand at the clinics, pediatric practices, or EDs currently available in the Commonwealth’s care system. The service gaps and system issues outlined in the preceding section are apparent in the illustration.

In order to implement pediatric Behavioral Health Urgent Care as a solution to the fragmented system that revolves around the ED in the current state 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, medical clearance, close observation for up to 23 hours, care planning, and case management;
- Improved response by 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

“Right now, there is a real disconnect between the information that the outpatient mental health center has and what information the ED has. The ED almost has to start from scratch when a child presents in crisis, and the outpatient mental health center may have all of the pertinent information.”

- Henry White, MD, The Brookline Center
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 short-term 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.

Other needed functions, including the capacity for laboratory services and medical clearance, are outlined in Illustration 2.

Illustration 2. Functional Comparison of ED, Urgent Care, Behavioral Health Clinic, and PCP Clinic

<table>
<thead>
<tr>
<th>FEATURE</th>
<th>EMERGENCY DEPARTMENT</th>
<th>BEHAVIORAL HEALTH CLINIC</th>
<th>PEDIATRIC PCP CLINIC</th>
<th>URGENT CARE SITE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Evening/Weekend</td>
<td>++</td>
<td>-</td>
<td>+</td>
<td>++</td>
</tr>
<tr>
<td>Walk In Access</td>
<td>++</td>
<td>-</td>
<td>+</td>
<td>++</td>
</tr>
<tr>
<td>Rapid Intake</td>
<td>+</td>
<td>-</td>
<td>+</td>
<td>++</td>
</tr>
<tr>
<td>Assessment</td>
<td>++</td>
<td>-</td>
<td>+</td>
<td>++</td>
</tr>
<tr>
<td>Lab Services</td>
<td>++</td>
<td>-</td>
<td>++</td>
<td>++</td>
</tr>
<tr>
<td>Medical Clearance</td>
<td>++</td>
<td>-</td>
<td>-</td>
<td>++</td>
</tr>
<tr>
<td>Triage</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>++</td>
</tr>
<tr>
<td>Close Observation (up to 23 hours)</td>
<td>++</td>
<td>-</td>
<td>+</td>
<td>++</td>
</tr>
<tr>
<td>Treatment Initiation (individual, group, IOP, Meds, Medication-Assisted Treatment)</td>
<td>+</td>
<td>+</td>
<td>++</td>
<td>++</td>
</tr>
<tr>
<td>Respite Care Access</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>++</td>
</tr>
<tr>
<td>Crisis Stabilization</td>
<td>+</td>
<td>-</td>
<td>-</td>
<td>++</td>
</tr>
<tr>
<td>Multifaceted Care Plan</td>
<td>-</td>
<td>+</td>
<td>+</td>
<td>++</td>
</tr>
<tr>
<td>Intensive Outpatient Treatment Access</td>
<td>-</td>
<td>+</td>
<td>-</td>
<td>++</td>
</tr>
<tr>
<td>Crisis Stabilization Unit Access</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>++</td>
</tr>
<tr>
<td>Inpatient Access</td>
<td>+</td>
<td>-</td>
<td>-</td>
<td>+</td>
</tr>
</tbody>
</table>

SYMBOL LEGEND: (++) Always Available; (+) Sometimes Available; (-) Rarely Available
RECOMMENDATIONS

As noted throughout this report, in the absence of a clearly defined pediatric Behavioral Health Urgent Care model in Massachusetts, this study sought to gather information on effective elements of care for providing a response to urgent behavioral health needs. Moreover, the study team determined that several service elements were needed that would be insurance or payer agnostic and would be configured to align with, strengthen, and integrate with existing care systems for children and adolescents and their families/caregivers in the Commonwealth.

In the schematic below, we illustrate these service elements and their fit to a continuum of care designed to meet the range of behavioral health needs of people in the Commonwealth. This schematic is provided courtesy of the Blue Cross Blue Shield of Massachusetts Foundation and was developed by Manatt Health. The schematic was developed as part of a Blue Cross Blue Shield Of Massachusetts Foundation study to examine the reforms needed in Massachusetts’ Behavioral Healthcare System. The report is embargoed until its release on January 31, 2019.

Illustration 3. Proposed Continuum of Behavioral Health Care

OVERVIEW OF A MODEL BEHAVIORAL HEALTH CARE SYSTEM

Effective treatment of BH conditions requires a full continuum of services with robust and seamless coordination between each level of care (including physical health settings).

Illustration Courtesy of the Blue Cross Blue Shield of Massachusetts Foundation and Manatt Health.
PROPOSED MODEL OF URGENT CARE

Despite the array of behavioral health services and widespread insurance coverage in Massachusetts, gaps discovered in the current behavioral health system continue to impede timely access to behavioral health care when an urgent need arises. The persistence of ED boarding among children and adolescents, despite the DMH expedited admissions policy, and the significant over-representation of youth under 18 in the DMH data who have waited more than 96 hours indicate that the availability of timely behavioral health services is particularly lacking for youth. Although there has been a proliferation of urgent care centers across the Commonwealth in recent years, including some with pediatrics, these pointedly exclude individuals with a primary presenting need for behavioral health care. In the absence of a service called “Behavioral Health Urgent Care,” children and adolescents with urgent needs either endure long waits for outpatient care (during which their urgent need may escalate to an emergency) or call or go to EDs. Neither of these alternatives is right-sized or provides the right care for the needs of the child or adolescent and his/her family/caregiver.

Illustration 4. Proposed Model of Urgent Care

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.

TARGET POPULATION OF CHILDREN AND ADOLESCENTS

The description of the clinical presentation of youth who would benefit from and likely use behavioral health urgent care was consistent across the literature, key stakeholder interviews, focus groups, and site visits:

_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, revealed by changes in behavior or thinking, role dysfunction, emerging intent of self-injury, or threats to others. In younger children this most often manifests as behavioral dysregulation and role dysfunction, while in adolescents, urgent behavioral health crisis may more likely include suicidal ideation, substance use, or onset of severe mental illness, also with role dysfunction._

All sources emphasized that children and adolescents should not be treated in Behavioral Health Urgent Care if they pose an immediate risk of harm to themselves or to others, have an unstable medical condition, or have severe or new onset psychotic symptoms.

Many stakeholders also pointed to a target pool of young people for urgent care created by the implementation of “zero tolerance” policies at many schools, which has become a driver of increased demand for immediate child and adolescent behavioral health services. The “urgent” nature of the crisis is a school policy requiring back-to-school “clearance.”

RECOMMENDATIONS TO ENHANCE SERVICES AND FILL GAPS TO PILOT A MODEL OF URGENT CARE

Our recommendations for a model of Behavioral Health Urgent Care are organized into three sections (below):

1. **Enhancements to the Current System Elements:** Although, currently, children and adolescents cannot access appropriate care during a crisis, the Massachusetts behavioral health system has some of the necessary infrastructure to provide this care, though certain program elements are in need of improvement:
   1.1 Strengthen the capacity of both specialty behavioral health care and integrated pediatric primary care systems to deliver urgent care rather than creating a “new place to go” in the care delivery system. This recommendation includes expanded hours and days in order to accommodate working families.
   1.2 Improve access to child and adolescent psychiatry, substance use disorder treatment, and co-occurring conditions treatment across clinical and community
settings (i.e. Mobile crisis intervention, community behavioral health organizations, schools and school mental health clinics, etc.) by expanding Massachusetts Child Psychiatry Access Program and other telepsychiatry consultation.

1.3 Improve the quality of the Mobile Crisis Intervention program by training crisis clinicians, altering quality metrics, changing payment incentives, and developing a statewide approach to make it a robust and effective system for resolving urgent behavioral health situations in the community.

1.4 Structure resources and clinical administrative authority to incentivize management of care transitions across settings.

1.5 Ensure true integration of treatment for mental health and substance use conditions, in both primary care practice and behavioral health specialty clinic settings, as well as with ESPs and first responders.

2. New Program Components: In addition to enhancing current services, the children's behavioral health system will need additional program elements in order for the proposed urgent care model to be implemented successfully:

2.1 Increase access to outpatient pediatric behavioral health appointments through the creation of walk-in capacity at strengthened Community Behavioral Health Clinics and other outpatient clinics that would be differentially reimbursed to accommodate rapid assessment, treatment initiation, and referral to continuing treatment, team, or home-based services designed for crisis stabilization.

2.2 Provide for a safe and welcoming place for children and adolescents and their families/caregivers to access rapid assessment, crisis intervention, and stabilization, enabling close observation and stays of up to 23 hours, and integrated with other needed home- and community-based services.

2.3 Increase access to outpatient pediatric behavioral health appointments at Federally Qualified Health Centers that provide onsite behavioral health specialty services; ensure differential reimbursement rates to accommodate rapid assessment, treatment initiation, and referral to continuing treatment, team, unit or home-based services designed for crisis stabilization.

2.4 Provide for a safe and welcoming place for children and adolescents and their families/caregivers to access rapid assessment, crisis intervention, and stabilization, enabling close observation and stays of up to 23 hours, and integrated with other needed home- and community-based services.

2.5 Develop specialized responses and interventions for complex and “hard to place” populations, including:

   2.5.1 Youth with ASD [This work is specifically being funded by The Peter and Elizabeth C. Tower Foundation] and/or intellectual and developmental disabilities;
   2.5.2 Youth presenting with aggressive or sexualized behavior; and
   2.5.3 Youth with a co-occurring medical condition.

2.6 Assure that urgent outpatient appointments and mobile crisis intervention services are available to children and adolescents and their families/caregivers regardless of their insurance carrier or status.

3. Model Design Considerations: Lastly, we outline key considerations for implementation of the proposed model of urgent care, including enhancements to and expansion of core elements of the children’s behavioral health system in the Commonwealth:
3.1 Provide authority to those leading the clinical team at Behavioral Health Urgent Care clinics or reception centers or in mobile crisis intervention programs to direct children and adolescents and their families/caregivers to immediate care (not the ED) required to resolve or stabilize the presenting problems.

3.2 Implement an effective model of Pediatric Behavioral Health Urgent Care, which requires a robust staffing model, equipped with a multi-disciplinary team of behavioral health clinicians:

   3.2.1 Master’s level clinicians trained in evidence-based urgent care assessment, management and crisis intervention techniques;
   3.2.2 Child Psychiatrists and/or nurse practitioners to initiate and modify medication;
   3.2.3 RNs to examine and treat youth (particularly among youth with co-occurring medical diagnoses);
   3.2.4 Care Coordinators/case managers to assist the family with care planning; and
   3.2.5 Family Partners to provide support from the family perspective to parents/caregivers as they navigate care planning.

4. Learning Community to Support Practice Transformation: Communications, training, and technical assistance are needed to support effective implementation of a new model of urgent care to ensure consistent training of staff, adoption of the model with fidelity to standards, and thoughtful practice transformation.

   4.1.1 Create a training and technical assistance hub for clinicians and other team members to learn evidence-based best practices for crisis evaluation and intervention;
   4.1.2 Create incentives for Advanced Practice Registered Nurses to specialize in child and adolescent psychiatry;
   4.1.3 Create incentives for master’s level social work and counseling interns to have internships within the Behavioral Health Urgent Care system, in order to create a workforce pipeline; and
   4.1.4 Consider supporting reflective supervision to increase the longevity of staff.

5. Legal, Regulatory, and Financing Considerations: A host of legal, regulatory and financing structures will need modification to support adoption of Pediatric Behavioral Health Urgent Care. Examples include but are not limited to:

   5.1.1 Create payment mechanisms for tele-mental health in order to optimize limited resources such as child psychiatry and to enable flexible crisis intervention and stabilization strategies;
   5.1.2 Enable Urgent Care sites to provide medical clearance required for patient transport, inpatient admission, or treatment initiation;
   5.1.3 Align standards at DMH and DPH governing clinic licensure to enable a unified rapid assessment protocol and to support true integration of mental health and substance use condition treatment; and
   5.1.4 Fund “standing” capacity at Pediatric BH UC that makes available on-demand or walk-in assessment and treatment services and addresses costs associated with providing close observation up to 23 hours and serving all payers and uninsured or undocumented families.
SYSTEM IMPLEMENTATION
CONSIDERATIONS

There are numerous considerations when implementing any new service or service improvement. For example, physical space for a walk-in urgent care outpatient setting must accommodate multiple elements of care provision. An effective staffing model will be successful only with a payment structure that supports the provision of thorough and complete interventions and care plans, work that has been impeded by the rigid fee-for-service payment structure heretofore employed by payers. Planned change in service provision will be disseminated in the community to assure that families/caregivers and providers are aware of the model. The following are key considerations that will inform an effective implementation:

1. CONSIDER THE CONTEXT: ORGANIZATION OF CARE AND REFORMALIGNMENT

During the last two years, the Massachusetts Executive Office of Health and Human Services (EOHHS) has undertaken service delivery and payment reforms in the MassHealth program. At the same time, advocates and system administrators have been working through the regulatory agencies governing health insurance to extend the intensive Child Behavioral Health Initiative services available to MassHealth enrollees to privately insured children and adolescents. Any change to enhance current services, fill service gaps, or create dedicated urgent care services must operate within the framework of these and related reforms.

2. HAVE FORM FOLLOW FUNCTION: DESIGN INFORMED BY USER NEEDS AND TESTED SOLUTIONS

In recommending enhancements to existing Outpatient Behavioral Health Clinics as the site for delivery of Pediatric Behavioral Health Urgent Care, attention must be paid to reconfiguring or organizing spaces that fit the services functions and patient needs.

For urgent outpatient appointments, it will be necessary to have a dedicated space for reception and intake, individual and group clinical consultations, and family meetings. All of these spaces should incorporate consideration of the sensory aspects of space (i.e. lighting, noise levels, etc.), particularly for youth with ASD. The physical space should also be devised to treat/accommodate the needs of families/caregivers as well as the child/adolescent, i.e. the use of family-centered design. The space also should be able to accommodate hours-long interventions, and may be co-located with crisis stabilization or emergency services programs.

3. SECURE HUMAN CAPITAL: PROVIDER CAPABILITIES AND WORKFORCE ISSUES

In Massachusetts, a new or expanded care response for urgent behavioral health needs cannot be created without considering the limited child and adolescent behavioral health workforce. In order to optimize the existing workforce, an urgent response could be developed by expanding current services in order to reduce the need for additional administrative roles. Families/caregivers of children/adolescents with behavioral health conditions who have...
struggled to access services within the present care continuum noted the importance of considering workforce implications. They wonder if the Commonwealth could accommodate the creation of a new level of behavioral health care for children and adolescents, citing the cost effectiveness of instead expanding the existing system. To improve access across the Commonwealth, key informants suggested we place a higher value on the behavioral health workforce and correct systemic parity violations. Other suggestions included streamlining insurance processes to minimize the unpaid time that providers dedicate to paperwork, a longstanding issue identified in the 2018 Blue Cross Blue Shield of Massachusetts Foundation report as a factor contributing to clinicians leaving insurance networks.

Lastly, providers should be incentivized to complete trainings and certificate programs in evidence-based practice in order to increase the competency of the community-based workforce to evaluate and intervene with complex children/adolescents and their families/caregivers. Several parents noted the lack of community-based providers specializing in more complex behavioral health conditions as a barrier to accessing care at the right time, which directly leads to the escalation of behavioral health symptoms to a crisis level (e.g. eating disorders, self-harm). In order to deliver equitable, high-quality care to all children and adolescents, the workforce must be supported and valued.

4. GENERATE SUPPORT AND IDENTIFY CHAMPIONS: STAKEHOLDER INTERESTS AND POLICYMAKER CONSENSUS

In order to garner support needed for program changes and practice transformation, planners need to develop a Community Engagement and Education strategy. The strategy should include:

4.1 Partnerships with families and caregivers as allies in their child’s care;
4.2 Partnerships with police, EMTs, and other first responders to engage and redirect to urgent care;
4.3 Partnerships with schools to divert from calls to police or emergency services; and
4.4 Outreach to primary care practices, so that pediatricians and families/caregivers are aware of the availability and parameters of pediatric Behavioral Health Urgent Care.

5. FINANCE FOR SUSTAINABILITY: STRATEGIES IN PLAY IN THE COMMONWEALTH

While the first logical step in recommending implementation of pediatric Behavioral Health Urgent Care in the Commonwealth is to initiate a demonstration that tests and refines the model prior to broad adoption. Financing strategies for the demonstration must be designed with an eye to sustainability and scalability. Because there are limitations placed by the Centers for Medicare and Medicaid on MassHealth funding “demonstrations,’’ it will be critical to consider that the array of services proposed is billable to MassHealth. Any exceptions to billable services elements will need other sources of funding, perhaps some combination of state appropriations and philanthropic investment. Given the current climate of investment in behavioral health within the Commonwealth’s Medicaid 1115 Waiver, the model could be piloted with an Accountable Care Organization partner that could use novel payment strategies to incorporate otherwise non-billable services. The goals of pediatric Behavioral Health Urgent Care are well-aligned with the Accountable Care Organizations’ strategy to
increase quality and decrease cost by avoiding unnecessary ED utilizations.

Additionally, it is clear that “standing funding” is needed to operate walk-in/on-demand capacity that is blind to insurance coverage. A key step in demonstration planning is to secure commitments to combine philanthropic, Delivery System Reform Incentive Payment, and MassHealth funds. The financing strategy may consider “standing” funding as the main source of revenue, supplemented by fee-for-service reimbursement, with participation of all payers. A payment structure should be able to support hours-long, or even days-long, interventions. Use of “standing” funding as the main source of revenue would be supplemented by fee-for-service reimbursement, with participation of all payers. A successful pediatric Behavioral Health Urgent Care pilot would demonstrate cost savings through decreased unnecessary utilization of the ED and inpatient care, the highest cost services in the Behavioral Health system.

6. REMOVE BARRIERS TO ADOPTION: LEGAL AND REGULATORY MATTERS

Multiple sources contributing to the study stressed the importance of addressing “administrative burden” in the planning for a demonstration and execution of broad scale adoption. This entails tackling, across DMH, Department of Mental Health, and MassHealth, lack of alignment in clinic licensure, Emergency Medical Treatment and Active Labor Act implementation, provider credentialing, remote/tele-prescribing, medical clearance, and other matters.
PILOT DEMONSTRATION AND UTILIZATION OPTIMIZATION

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 rising costs, and providing more responsive care 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 patient population lives and where they are accessing routine and emergency behavioral health care. Note: The CMHC will review 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: Geomapped 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, putative 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 and Community Service Agency 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.

In Year 3, the CMHC proposes to launch implementation of a pilot demonstration of pediatric behavioral health urgent care. 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.
In summary, the need for pediatric Behavioral Health Urgent Care is well documented. There is broad consensus across patient, provider, and policy stakeholders and leaders that providing immediate access to care for children with an urgent behavioral health need has great potential to alleviate some of the longstanding systemic failures in behavioral health care. These include: the ongoing crisis of pediatric psychiatric boarding, over-utilization of police intervention, the harmful impact of the need to “fail up” into high intensity services, and the costly and damaging cycle of avoidable repeat hospitalizations.

Urgent behavioral health care is a solution whose time has come and the CMHC urges thoughtful and expeditious implementation.
REFERENCES

Reference Material
Appendix A: List of Key Informants
Appendix B: Key Informant Interview Guide & Sample Site Visit Guide

In N. Allen-Scannell (Chair), Kids in Crisis: Unpacking the problem of pediatric psychiatric “boarding” and developing policy solutions. Symposium conducted at the 30th Annual Children’s Mental Health Research and Policy Conference, Tampa, FL.
15 Lee, J., & Korczak, D. (2010). Emergency physician referrals to the pediatric crisis clinic:


50 American College of Emergency Physicians, & Pediatric Emergency Medicine Committee.
Adolescent Psychiatry, 56(10), S123.
80 Center for Health Care Strategies, Inc. (2011). The role of mobile response and stabilization services to support CMEs.
86 Ermer, D. J. (1999). Experience with a rural telepsychiatry clinic for children and
91 Massachusetts Department of Public Health (2010). Here for the kids: The school-based health center model at work in Massachusetts.
106 Massachusetts Department of Public Health (2010). Here for the kids: The school-based health center model at work in Massachusetts.
APPENDICES

Appendix A: List of Interviewees, Focus Groups, Telephonic Consultations, and Site Visits Interviewees

Interviewees

1. Shelley Baer, MS
   Vice President, Massachusetts Behavioral Health Partnership
2. Stephanie Jordan Brown, MA, MA
   Director, Office of Behavioral Health, MassHealth
3. Maria Cheevers, MA
   Director, Office of Research & Development, Boston Police Department
4. Shella Dennery, PhD, LICSW
   Director, Boston Children’s Neighborhood Partnerships Program
   Instructor in Psychiatry, Harvard Medical School
5. Vic DiGravio, MPA
   President & CEO, Association for Behavioral Health
6. Lisa Fortuna, MD, MPH
   Medical Director for Child & Adolescent Services, Boston Medical Center
7. Lisa Lambert
   Executive Director, Parent/Professional Advocacy League
8. Michael Lee, MD, MBA
   Executive & Medical Director, Children’s Hospital Integrated Care Organization
9. Kappy Madenwald, MSW
   Affiliate, Technical Assistance Collaborative Founder, Madenwald Consulting, LLC
10. Joan Mikula, MA
    Commissioner, Massachusetts Department of Mental Health
11. John Sargent, MD
    Chief, Child & Adolescent Psychiatry; Vice Chair, Child & Adolescent Psychiatry;
    Floating Hospital for Children at Tufts Medical Center Professor, Tufts University
    School of Medicine
12. Mark Schechter, MD
    Chair of Psychiatry, North Shore Medical Center
13. Emily Sherwood, MPA  
   Deputy Commissioner for Children, Youth, & Family Services, Department of Mental Health
14. Marylou Sudders, MSW, ACSW  
   Secretary, Executive Office of Health & Human Services
15. Scott Taberner  
   Chief of Behavioral Health, MassHealth
16. Jacob Venter, MD, MPA, CPE, FAPA  
   Division Chief, Child & Adolescent Psychiatry, Cambridge Health Alliance
17. Amy Weinstock, MA  
   Director, Autism Insurance Resource Center
18. Beth Wharff, PhD, MSW, LICSW  
   Chief of Social Work, Department of Psychiatry; Director, Social Work Training Program; Boston Children’s Hospital
19. Henry White, MD  
   Clinical Director, The Brookline Center for Community Mental Health
20. Jacob White, MD  
   Child & Adolescent Psychiatry Fellow, Boston Children’s Hospital
21. Michael Yogman, MD  
   Chair, American Academy of Pediatrics, Child Mental Health Task Force  
   Assistant Clinical Professor, Harvard Medical School
22. Charlene Zuffante, MSW  
   Director of Child & Adolescent Services, DMH Metro Boston

**Focus Groups**
1. Master’s-level Emergency Services Program (Emergency Services Program/Mobile Crisis Intervention) providers
2. Children’s Behavioral Health Advisory Council
3. Boston Children’s Hospital’s Behavioral Health Family Advisory Council
4. Parent/Professional Advocacy League Families
5. Pediatricians from the western region of Massachusetts

**Telephonic Consultation/Substance Abuse and Mental Health Services Administration Summit/ Nantucket Children’s Summit**
1. David Covington, MBA  
   CEO & President, RI International
2. Michael Hogan, PhD  
   Principal, Hogan Health Solutions
3. Lisa Hovermale, MD  
   Adjunct Assistant Professor of Psychiatry, University of Maryland School of Medicine
4. Andrew Keller, PhD  
   CEO, The Meadows Mental Health Policy Institute
5. Tim Marshall, MSW  
   Director of Community Mental Health, Connecticut Department of Children & Families
6. Maureen Hackett  
   Hackett Family Foundation
7. Debra Pinals, MD  
   Clinical Professor of Psychiatry, Michigan Medicine
8. Katherine Sternbach, MS, MBA  
   Partner, TriWest Group
9. Paul Summergrad, MD  
   Chairman, Tufts University School of Medicine

Site Visits
1. Margaret Balfour, MD, PhD, Vice President, Connections Arizona, Crisis Response Center, Tucson, AZ
2. Juliette Fay, President & CEO, Martha’s Vineyard Community Services, Vineyard Haven, MA
3. Nicole Gagne, President & CEO, Community Healthlink, Worcester, MA
4. Nancy Paull, MS, CEO, SSTAR, Fall River, MA
5. Katherine Wilson, President & CEO, Behavioral Health Network, Springfield, MA

CMHC Boarding Project Advisory Board Members and Attendees
1. Shelley Baer, MS  
   Director, Emergency Services Program, Massachusetts Behavioral Health Partnership
2. Deborah Brown, MBA, MS/MIS  
   Legislative & Budget Director, Office of Senator Cindy F. Friedman
3. Stephanie Jordan Brown, MA  
   Director, Office of Behavioral Health, MassHealth
4. Rui Carreiro, M.Ed.
   Division Director Developmental Disabilities/Acquired Brain Injury, Eliot Community Human Services
5. Suzanne Curry
   Associate Director, Policy and Government Relations, Health Care For All
6. Leslie Darcy, JD
   Chief of Staff, Executive Office of Health & Human Services
7. Marcia Fowler, MA, JD
   CEO, Bournewood Health Systems
8. Cindy Friedman, M.Ed.
   Senator, 4th Middlesex District
   Chair, Mental Health, Substance Use, & Recovery Committee
9. Kate Ginnis, MSW, MPH
   Director, Behavioral Health Advocacy & Policy, Boston Children’s Hospital
10. Joshua Greenberg, JD
    Vice President, Office of Government Relations, Boston Children’s Hospital
11. Donna Kausek, LMHC
    Program Manager, Youth Mobile Crisis Intervention, Eliot Community Human Services
12. Elizabeth Kelley, MBA, MPH
    Director of Bureau of Health Care Safety and Quality, Department of Public Health
13. Carol Kress, LICSW
    Vice President of Client Partnerships and Chief Executive, Massachusetts Behavioral Health Partnership
14. Lisa Lambert
    Executive Director, Parent/Professional Advocacy League
15. Danna Mauch, PhD
    President & CEO, Massachusetts Association for Mental Health
16. Mary McGeown
    Executive Director, Massachusetts Society for the Prevention of Cruelty to Children
17. Joan Mikula
    Commissioner, Massachusetts Department of Mental Health
18. Maria Mossaides, JD  
Child Advocate, Office of the Child Advocate

19. Janice Peters, MPH  
Manager, Healthcare Policy at Massachusetts Hospital Association

20. Edith Rathbone, JD  
Director of Policy and Legal Counsel, Office of the Child Advocate

21. Elise A. Ressa, MSW  
Behavioral Health Policy Analyst, Massachusetts Association for Mental Health

22. Amy Rosenthal, MPH, MPA  
Executive Director, Health Care For All

23. Nancy Allen Scannell  
Director of External Affairs, Massachusetts Society for the Prevention of Cruelty to Children

24. Matthew Selig, JD  
Executive Director, Health Law Advocates

25. Emily Sherwood, MPA  
Deputy Commissioner of Children, Youth, & Family Services, Department of Mental Health

26. David Swanson, JD  
Chief of Staff and General Counsel, Office of Senator Cindy F. Friedman

27. Scott Taberner  
Chief of Behavioral Health, MassHealth

28. Robert Turillo  
Assistant Commissioner of Program Services, Department of Youth Services

29. Meri Viano  
Associate Director, Parent/Professional Advocacy League

30. Amy Weinstock, MA  
Director, Autism Insurance Resource Center

31. Wells Wilkinson, JD  
Senior Staff Attorney, Health Law Advocates

32. Leigh Simons Youmans, MPH  
Senior Manager, Behavioral Health & Healthcare Policy, Massachusetts Hospital Association
Organizations to Acknowledge

1. Association for Behavioral Healthcare
2. Autism Insurance Resource Council at the University of Massachusetts
3. Behavioral Health Network
4. Boston Children’s Hospital
5. Boston Medical Center
6. Boston Police Department
7. Cambridge Health Alliance
8. Community Healthlink
9. Crisis Response Center of Pima County Arizona
10. Department of Mental Health
11. Executive Office of Health & Human Services
12. Martha’s Vineyard Community Services
13. MassHealth
14. North Shore Medical Center
15. Parent/Professional Advocacy League
16. SSTAR
17. Technical Assistance Collaborative
18. The Brookline Center for Community Mental Health
19. Tufts Medical Center

Additional Acknowledgements

1. Associated Industries of Massachusetts
2. Connecticut Department of Children & Families
3. Hackett Family Foundation
4. Hogan Health Solutions
5. Meadows Mental Health Policy Institute
6. University of Michigan School of Medicine
7. RI International
8. State of Delaware Behavioral Health Services
9. University of Maryland School of Medicine
Appendix B: Key Informant Interview Guide & Site Visit Guide

Key Informant Interview Guide

Background Statement on Miller Innovation Fund and Tower Foundation

Emergent Care Study

The CMHC received two grants—one from the Miller Foundation and one from the Tower Foundation—to research an effective model of urgent care for children and adolescents experiencing a behavioral health crisis. The Tower portion of the grant will allow us to specifically address necessary changes and nuances to a proposed model to meet the needs of youth with autism spectrum disorder. The CMHC reached out to Massachusetts Association for Mental Health and asked us to join their leadership team and as part of our membership, we are responsible for conducting this research project.

Right now, we are conducting a scan of the literature and interviewing key stakeholders—both in MA and nationally—to inform the model. Using the literature scan and qualitative data, we will be publishing a white paper addressing the implementation of children’s behavioral health urgent care in the Commonwealth. With the support of the Campaign, we will advocate for its adoption by the Commonwealth.

Because this level of care has not been fully developed or widely implemented, it is imperative that we speak to experts in Massachusetts who will be able to offer ideas about how to implement such a level of care within the existing and emerging children’s behavioral health infrastructure.

Stakeholder Interview and Focus Group Questions and Discussion Topics

1. What are the characteristics of the population of children and adolescents who would benefit from behavioral health urgent care and crisis stabilization?
   a. What is the clinical presentation of youth who would benefit from Behavioral Health urgent care and crisis stabilization?
   b. What are the demographic or geographic factors that should inform the model of care?

2. Given the characteristics and clinical presentation factors you’ve identified, what are the essential elements, including ideal care settings of behavioral health urgent care targeted to children and adolescents?
   a. How are these elements best organized to deliver effective behavioral health urgent care services to children and adolescents?
   b. How are these elements best targeted to meet the needs of children and adolescents with behavioral health conditions?
   c. How are these elements different for youth with ASD/IDD?
   d. What would be the ideal care setting for youth with ASD/IDD who have a behavioral health emergency?
3. Which evidence-based crisis intervention models should be incorporated into the behavioral health urgent care model?
   a. How would these vary by age group?
   b. How would these vary for children and adolescents with ASD/IDD?

4. Of the various models (Mobile Crisis Intervention, Psychiatric Emergency Services, primary care integration, urgent appointments in Behavioral Health clinics, and co-location with urgent care), which one(s) would be optimally beneficial for children?
   a. Would a certain model be particularly suited for a particular demographic (age, gender, geographic location, diagnosis, ASD/IDD, etcetera)
   b. What would be the best way to integrate treatment of SUD into an urgent level of care?

5. What is the best way to work within the existing workforce to create these additional services, particularly the ASD/IDD workforce?

6. What might provider(s) concerns be about the urgent care model you propose?

7. What might insurer(s) and health plan concerns be about the urgent care model you propose?

8. Do you know of any recent literature that may aid us in our understanding of this topic?

Policy Questions

1. Given the service delivery and payment reforms underway in Massachusetts, what do you recommend as a payment model or reimbursement method for urgent care services?
   a. Are there standing reimbursement structures that support the model of care you recommend?
   b. Are there any innovative payment models that could be leveraged, particularly in the Accountable Care Organization landscape?

2. What legal or regulatory changes will be necessary to implement operationally the behavioral health urgent care model and assure its financial viability?
   a. Operationally viable?
   b. Financially viable?

Service Delivery by Setting Questions

Mobile Crisis Intervention

1. How would the existing Mobile Crisis Intervention program in MA need to be modified/expanded in order to adequately meet the urgent Behavioral Health needs of ALL children and families, including those with ASD/IDD, or those dually diagnosed with a SUD?
   a. Is there current specialized capacity within the Mobile Crisis Intervention program for children with ASD/IDD?

2. What are the existing barriers with the Mobile Crisis Intervention model (not permitted in schools, held out of certain hospital EDs, only covered by Medicaid, etcetera)
Psychiatric Emergency Services
1. For the Psychiatric Emergency Services model, are there any models that presently exist for children, specifically? What about for children with ASD/IDD? What about for youth with a co-occurring SUD?
2. If these services are available regardless of insurance status, how is this program financially sustainable?
3. How are urgent care appointments typically reimbursed at freestanding outpatient clinics?
4. Where would a Psychiatric Emergency Services be located?
5. What workforce would be necessary to staff such a level of care?

Primary Care Integration
1. For embedded urgent appointments in primary care, what payment structure makes this program optimally sustainable?
   a. Is there a way to collaborate with Accountable Care Organizations for this model?
   b. Is there a way to collaborate with Pediatric Primary Care groups, including Federally Qualified Health Centers for this model?
   c. SUD treatment?

Urgent Appointments in Behavioral Health Clinics
1. How are urgent appointments reimbursed in community-based clinics?
   a. Community Behavioral Health Organization clinics?
   b. Federally Qualified Health Center clinics?

Co-location with Pediatric Urgent Care
1. Where are there existing pediatric urgent care centers in MA?
2. Would they have capacity for co-located Behavioral Health services?

Site Visit Guide

Site Visits for Evidence-Based, Evidence-Informed, and Best Practices in Urgent Care and Crisis Intervention Services for Youth Experiencing a Behavioral Health Crisis
Date:

Name of Service Provider:

Point of Contact:
The CMHC received two grants—one from the Miller Foundation and one from the Tower Foundation—to research an effective model of urgent care for children and adolescents experiencing a behavioral health crisis. The Tower portion of the grant will allow us to specifically address necessary changes and nuances to a proposed model to meet the needs of youth with autism spectrum disorder. The CMHC reached out to Massachusetts Association for Mental Health and asked us to join their leadership team and as part of our membership, we are responsible for conducting this research project.

Right now, we are conducting a scan of the literature, interviewing key stakeholders, and conducting site visits—both in MA and nationally—to inform the model. Using the literature scan and qualitative data, we will be publishing a white paper addressing the implementation of children’s behavioral health urgent care in the Commonwealth. With the support of the Campaign, we will advocate for its adoption by the Commonwealth.

I. Overview of Services at Your Site:
   1. Can you give us a brief description of the range of services offered to children and adolescents at your organization?
   2. Do you have any specific programs that serve youth with ASD?
   3. Can you tell us about the use of peers at your organization?

II. Urgent Care & Crisis Intervention Services:
   1. What are the characteristics of the population of children and adolescents that your organization serves who currently receive or who would benefit from behavioral health urgent care and crisis stabilization?
      a. What is the clinical presentation of youth who would benefit from Behavioral Health urgent care and crisis stabilization?
      b. What are the demographic or geographic factors that should inform the model of care?
   2. Given the characteristics and clinical presentation factors you’ve identified, how does your organization respond to urgent / crisis needs for children and adolescents?
      a. What barriers presently exist that limits your provision of these services?
      b. How are these elements best targeted to meet the needs of children and adolescents with behavioral health conditions?
      c. How are these elements different for youth with ASD/IDD?
      d. What would be the ideal care setting for youth with ASD/IDD who have a behavioral health emergency?
   3. Which evidence-based crisis intervention models does your organization employ for the treatment of urgent/crisis presentations?
      a. How do they vary by age group?
      b. Do they differ for children and adolescents with ASD/IDD? If so, how?
   4. Given your program and the staffing limitations that exist in the
Commonwealth, how you’re you found it optimally beneficial to employ a sufficient staff?
5. What might provider(s) concerns be about expanding such a model of care?
6. Have you had any issues with insurers and health plans related to care provision?
7. Do you know of any recent literature that may aid us in our understanding of this topic?

III. Policy Questions
3. Given the service delivery and payment reforms underway in Massachusetts, what do you recommend as a payment model or reimbursement method for urgent care services?
   a. Are there standing reimbursement structures that support the model of care you recommend?
   b. Are there any innovative payment models that could be leveraged, particularly in the Accountable Care Organization landscape?
4. What legal or regulatory changes will be necessary to implement operationally the behavioral health urgent care model and assure its financial viability?
   a. Operationally viable?
   b. Financially viable?
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.