PEDIATRIC BEHAVIORAL HEALTH URGENT CARE

2nd Edition

Including Considerations for Meeting the Needs of Children with Autism Spectrum Disorders and Intellectual and Developmental Disabilities

children's mental health campaign

SUPPORTED BY THE PETER & ELIZABETH TOWER FOUNDATION
AND THE HERMAN AND FRIEDA L. MILLER FOUNDATION

CHILDREN'S MENTAL HEALTH CAMPAIGN

Children's Mental Health Campaign

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

MAMH
Massachusetts Association *for* Mental Health

The Massachusetts Association for Mental Health (MAMH) has worked since its founding in 1913 to forge compassionate understanding of behavioral health conditions and to combat disparities in health services access. MAMH 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. MAMH carries out its work through policy studies, legislative advocacy, and knowledge dissemination to promote fact-based policymaking and service solutions. MAMH is an executive member of the CMHC.

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ACKNOWLEDGMENTS

In early 2015, the Children's Mental Health Campaign (CMHC), with the generous financial support of the C.F. Adams Charitable Trust, launched a multi-year project to gather data to quantify and understand the 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 (ASD) or intellectual and developmental disabilities (IDD), suffer the longest ED boarding rates in Massachusetts hospitals.

In 2017, the CMHC gratefully received financial support from The Miller Innovation Fund to study one proposed solution: behavioral health urgent care for children. As a member of the CMHC leadership team, the Massachusetts Association for Mental Health (MAMH) reported on the needs of the target population and developed a model of pediatric behavioral health urgent care that could be used to design a pilot program.

In 2018, The Peter & Elizabeth Tower Foundation awarded the CMHC funds to study the unique needs and behavioral health urgent care service requirements of children and adolescents who have co-occurring neurodevelopmental conditions, autism spectrum disorders (ASD) and/or intellectual and developmental disabilities (IDD). The goal of the study was to adapt the findings from the first study to create a model of care to best meet the needs of children with co-occurring behavioral health and neurodevelopmental conditions. We are deeply grateful for their support.

In addition, we are grateful for 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.

Delivery of behavioral health care in Massachusetts is a true public-private partnership. Government officials, policymakers, regulators, and payers are leaders in the effort to address ED boarding and provided generous input to this report, including a collaborative review of preliminary findings and proposed solutions. We particularly note the Massachusetts Department of Mental Health's focus on earlier intervention and the Massachusetts Executive Office of Health and Human Services initiative to pursue reform of the ambulatory behavioral health system in the Commonwealth, which specifically recognizes the importance of developing behavioral health urgent care.

The CMHC team extends its sincere thanks to the children, adolescents, and their families 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 list of key informants, sites visited, expert consultations, focus groups, and the Boarding Advisory Committee, all of whom were instrumental to the success of this study.

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Autism Law Enforcement Education Coalition
Autism Speaks
Baylor College of Medicine
Behavioral Health Network
Boston Children's Hospital (including Family Advisory Councils)
Boston Medical Center
Boston Police Department
Bradley Hospital RI
Cambridge Health Alliance
Center for START Services at the University of New Hampshire
Community Healthlink
Connecticut Department of Children & Families
Crisis Response Center of Pima County Arizona
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GLOSSARY

Accountable Care Organization (ACO) - 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.

Applied Behavior Analysis (ABA) - a commonly practiced therapeutic intervention for individuals with autism; through the application of the principles of learning and motivation from behavior analysis, ABA helps individuals improve social interactions, learn new skills, and maintain positive behaviors.

Autism Spectrum Disorder (ASD) - ASD onsets early in development and is characterized by the presence of persistent deficits in social communication and social interaction, with those affected exhibiting "restricted and repetitive patterns of behavior, interests, or activities that cause clinically significant impairment in several areas of functioning, including personal, social, academic, or occupational."

Board-certified Behavior Analyst (BCBA) - A clinician who has specific training in the principles of applied behavior analysis (ABA). A BCBA is often thought of as working with individuals with Autism, but it is not an Autism-specific vocation.

Children's Behavioral Health Initiative (CBHI) - created to implement the remedy in a class action lawsuit filed on behalf of MassHealth-enrolled children under the age of 21 with Serious Emotional Disturbance (SED). CBHI includes a larger interagency effort to develop an integrated system of state-funded behavioral health services for children, youth, and their families. Six services were developed to meet the mission of CBHI and they include: Family Support & Training, In-Home Behavioral Services, In-Home Therapy, Intensive Care Coordination, Therapeutic Mentoring, and Mobile Crisis Intervention.

Community-Based Acute Treatment (CBAT) - a level of care in Massachusetts available to children/adolescents who require a 24/7 staff-secure (unlocked) acute treatment setting.

Community Service Agency (CSA) - a community-based program that ensures coordination of care for youth with a Serious Emotional Disturbance (SED) who are using multiple Children's Behavioral Health Initiative (CBHI) services or are involved with multiple child-serving systems. CSAs carry out the Intensive Care Coordination piece of the CBHI program.

Crisis Stabilization Unit (CSU) - a small treatment facility of less than 16 beds for people in a mental health crisis whose needs cannot be met safely in residential service settings.

Emergency Department (ED) Boarding - ED boarding is defined by the Commonwealth of Massachusetts' Executive Office of Health and Human Services as patients who spent 12 or more hours, from their time of arrival in the ED, awaiting admission to the appropriate level of psychiatric treatment. Psychiatric patients may "board" while waiting for psychiatric treatment in settings other than the ED, such as a hospital's medical floor or their homes.

Emergency Services Program (ESP) - provides behavioral health crisis assessment, intervention, and stabilization services, 24/7/365, 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.

Family - this report uses the term family to describe biological families, adoptive families, foster families, and caregiving in group living environments and residential care settings.

GLOSSARY

Federally-Qualified Health Center (FQHC) - 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 Care Coordination (ICC) - ICC is a component of CBHI that uses the Wraparound care planning process to coordinate multiple services and supports for youth with Serious

Emotional Disturbance (SED).

Intellectual/Developmental Disabilities (IDD) - Intellectual Disabilities refer to those disabilities that result in deficits of intellectual functioning. Developmental Disabilities refer to those disabilities that result in deficits of adaptive functioning. Intellectual and Developmental Disabilities may occur together or may occur separately.

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

MassHealth - Massachusetts' Medicaid program, which boasts the most robust Medicaid behavioral health benefit in the country. For children and adolescents, the MassHealth program uniquely combines the Children's Health Insurance Program and Medicaid funding in order to achieve 99 percent coverage for children and adolescents.

Medication-Assisted Treatment (MAT) - 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 (MCI) - a youth-serving (under the age of 21) component of the ESP provider. MCI provides a short-term service that is a mobile, on-site, and 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 or safety plan.

Massachusetts Child Psychiatry Access Program (MCPAP) - a system of regional children's behavioral health consultation teams designed to help primary care providers promote and manage the behavioral health of their pediatric patients.

Neurodevelopmental Condition - a group of conditions that typically manifest early in development (often prior to a child entering grade school) and are characterized by impairments of personal, social, academic, or occupational functioning.

Partial Hospitalization Program (PHP) - a program that either provides an alternative to full hospitalization for children and adolescents, or serves as a transition from inpatient care to less intensive outpatient care.

Pediatric Behavioral Health Urgent Care - a multifaceted intervention designed to treat timely and stabilize swiftly emerging behavioral health conditions affecting children and adolescents that do not present as an imminent threat of harm to self or others.

GLOSSARY

Primary Care Provider (PCP) - a health care professional who practices general medicine. For children and adolescents, a primary care provider may be a "family practitioner," who cares for patients of all ages; a "pediatrician," who cares for babies, children, and adolescents; an "internist," who cares for adults but also sometimes older adolescents or young adults; or an "adolescent medicine specialist," who has specific training in caring for adolescents. The report uses the term "primary care provider" or PCP throughout to encompass these specific types of primary care providers that care for children and adolescents.

Serious Emotional Disturbance (SED) - a range of specific mental health conditions that have historically been defined by the Substance Abuse and Mental Health Substances Administration.

Urgent Care - 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.

Wraparound Model - wraparound models of care provide comprehensive, holistic, and youth- and family-driven approaches to responding to serious behavioral health concerns. These models put the child and family at the center of the intervention. A combination of professional and natural supports drives the support and intervention that occurs for the child and family.

EXECUTIVE SUMMARY

Pediatric behavioral health urgent care is a multifaceted intervention designed to treat timely and stabilize swiftly emerging behavioral health conditions affecting children and adolescents that do not present as an imminent threat of harm to self or others. A study of pediatric Emergency Department (ED) boarding, conducted in 2016 by the Children's Mental Health Campaign (CMHC), quantified the issue of long waits in EDs for children and adolescents presenting for emergency behavioral health care.[1] ED boarding is defined by the Commonwealth of Massachusetts' Executive Office of Health and Human Services as patients who spent 12 or more hours awaiting treatment, from their time of arrival in the ED to their admission to the appropriate level of psychiatric treatment.[2] In the study, approximately 14 percent of children and adolescents initially assessed to require inpatient or Community-Based Acute Treatment (CBAT) were discharged home after boarding in the ED, indicating that with appropriate crisis intervention and stabilization, ED boarding might have been avoided.[1] In 2017, The Herman and Frieda L. Miller Foundation awarded the CMHC a Miller Innovation Fund grant to study pediatric behavioral health urgent care and to develop a model that would alleviate ED boarding. In 2018, the Peter & Elizabeth Tower Foundation awarded the CMHC an additional grant to study the needs of children and adolescents with neurodevelopmental conditions (autism spectrum disorder (ASD) or an intellectual or developmental disability (IDD)), who have co-occurring behavioral health conditions that may result in a need for urgent or crisis care. This report integrates the results of the mixed-methods studies conducted on behalf of both the Miller Innovation Fund and the Peter & Elizabeth Tower Foundation. The methodological approach to this study incorporated multiple qualitative data sources, including peer-reviewed and grey literature, key informant interviews, focus groups, site visits, and an expert panel.

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. Considering the high prevalence (50 percent) of behavioral issues among children and adolescents with ASD/IDD as well as their overrepresentation among those who board in EDs, an urgent behavioral health response must consider their needs.

The Crisis Response Center in Tucson, AZ, and the Access Center at Bradley Hospital in Providence, RI, are leading models for the provision of comprehensive behavioral health urgent care to children and adolescents and thus were chosen for site visits. Both function similarly to medical urgent care in that they provide walk-in, immediate treatment of behavioral health conditions. The Access Center is physically connected to multiple levels of behavioral health care and subspecialty care for children and adolescents with ASD/IDD. In addition to these models, there are several innovative elements of behavioral health urgent care that occur in a variety of settings that the researchers visited or reviewed, which support the proposed model of pediatric behavioral health urgent care outlined in this report.

The core components of behavioral health urgent care will be the ability to receive timely admissions (within 48 hours); to provide rapid, community-based access to crisis intervention and assessment; and a meaningful connection to follow-up, ongoing care, and treatment. These functions will primarily be carried out at community-based outpatient behavioral health clinics and by Mobile Crisis Intervention (MCI) teams that deliver a mobile, on-site, and face-to-face therapeutic response to children and adolescents experiencing behavioral health crises. Primary care providers should also be able to provide these functions, but their ability to do so depends on the level of behavioral health integration that they have achieved. Expansion of consultation through the existing Massachusetts Child Psychiatry Access Program (MCPAP) would provide community-based outpatient settings and MCI teams access to psychiatric evaluation and prescribing expertise (MCPAP is currently only available to child and adolescent primary care providers). In addition, the purview of MCPAP could be expanded to cover ASD/IDD, and child and adolescent substance use disorders.

Once an assessment and disposition decision has been made in one of these settings, the child or adolescent may be directed to any number of care options, including outpatient therapy, outpatient pharmacology, 23-hour close observation, partial hospitalization programs, MCI follow up, or a Crisis Stabilization Unit. A successful urgent behavioral health intervention will depend on clinicians having the authority to direct children and adolescents and their families to immediate follow-up care (not the ED). Insurers and follow-up care settings must be required to accept the placement decisions of treating clinicians. Currently, children and adolescents are unable to access care settings because of insurer practices that question the treating clinician's recommendation for follow-up care, severely delaying or denying access altogether. Access may be further complicated by treatment settings that are unwilling to accept children and adolescents deemed "too acute" for care or "not the correct fit" for the treatment setting.

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. Information regarding planned changes in service provision and practice transformation resources should be widely disseminated in the community to assure that families and providers are aware of the availability of behavioral health urgent care services.

Throughout the current tenure of Executive Administration, the Massachusetts Executive Office of Health and Human Services has undertaken significant, innovative delivery and payment reforms in the MassHealth program. Simultaneously, advocates and system administrators have been working to extend the intensive Children's Behavioral Health Initiative (CBHI) services available to MassHealth enrollees to privately insured children and adolescents. Any change to enhance current services, fill service gaps, or create urgent care behavioral health services must operate within the framework of these and related reforms.

In order to create pediatric behavioral health urgent care, the CMHC recommends the following actions:

- Institute and finance enhancements to comprehensive behavioral health outpatient clinics' capacity to provide standing capacity to treat urgent walk-in cases as well as the ability to monitor cases over a 24-hour period;

- Implement improvements to the MCI program, including the creation of enhanced MCI teams with specialized training and technical support in Autism Spectrum Disorder and other Intellectual/Developmental Disabilities;

- Expand MCPAP or similar tele-consult service to provide remote assistance to pediatric behavioral health urgent care and MCI teams, across clinical settings, with expertise in Autism Spectrum Disorder, Intellectual/Developmental Disabilities, and substance use disorders; and

- Grant clinicians providing pediatric urgent behavioral health interventions the authority to direct children and their families to appropriate follow-up care settings;

Implementing these recommendations must take into consideration both the current pediatric behavioral health system and anticipated ambulatory care redesign plans in Massachusetts. The need for pediatric behavioral health urgent care is well documented. There is broad consensus across patients, providers, and policymakers that providing immediate access to care for children with an urgent behavioral health need has great potential to prevent full emergencies from developing and alleviate some demand on emergency departments, thus mitigating the ED boarding problem. The CMHC strongly advocates for the adoption of these recommendations and stands ready to work with the pediatric population in need, practitioners, providers, policymakers and payors to devise, finance and implement practice transformation to implement pediatric behavioral health urgent care.

BACKGROUND

INTRODUCTION

A study of pediatric ED boarding, conducted in 2016 by the Children's Mental Health Campaign (CMHC), quantified the issue of long waits in EDs for children and adolescents presenting for emergency behavioral health care.[1] ED boarding is defined by the Commonwealth of Massachusetts' Executive Office of Health and Human Services as patients who spent 12 or more hours awaiting treatment, from their time of arrival in the ED to their admission to the appropriate level of psychiatric treatment.[2] Psychiatric patients may "board" while waiting for psychiatric treatment in settings other than the ED, such as a hospital's medical floor or their homes. During that period, 895 youth who boarded collectively spent approximately seven years in EDs and other non-psychiatric settings. Notably, approximately 14 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.[1] In 2017, The Herman and Frieda L. Miller Foundation awarded the CMHC a Miller Innovation Fund grant to study pediatric behavioral health urgent care and to develop a model that would alleviate ED boarding. In 2018, the Peter & Elizabeth Tower Foundation awarded the CMHC an additional grant to study the needs of children and adolescents with neurodevelopmental conditions (autism spectrum disorder or an intellectual or developmental disability) who have co-occurring behavioral health conditions that may result in a need for urgent or crisis care. These findings will be employed to adapt the Pediatric Behavioral Health Urgent Care model developed for the Miller Innovation Fund to meet the needs of those children and adolescents with autism spectrum disorder (ASD) and/or intellectual or developmental disabilities (IDD). This report braids together the results of the mixed-methods studies conducted on behalf of both the Miller Innovation Fund and the Peter & Elizabeth Tower Foundation. The Massachusetts Association for Mental Health (MAMH), a member of the executive team of the CMHC, completed the main study tasks.

TARGET POPULATION

Pediatric Behavioral Health Urgent Care: 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.

Experts consistently cited two core reasons for developing an urgent behavioral health response for children and adolescents:

1. Avoiding the escalation of symptoms and deterioration of role functioning while waiting for care access, particularly for children and adolescents with ASD/IDD.
2. Providing an antidote to ED boarding given the limited capacity of MCI teams to provide crisis intervention and stabilization, and the exceedingly long waits experienced by children and adolescents with co-occurring ASD/IDD.

BEHAVIORAL HEALTH

In this report, "behavioral health" refers to mental health, substance use, and co-occurring mental health and substance use conditions. Child and adolescent behavioral health conditions refer to the way that children and adolescents think, feel, and act.[3]

Approximately one in five children and adolescents meet the diagnostic criteria for a mental health condition before the age of 18, and seven percent of children and adolescents meet the criteria for substance use conditions.[4,5] In addition, 10 percent of children and adolescents meet the criteria for a Serious Emotional Disturbance (SED) with one domain-specific impairment.[6] Historically defined by the Substance Abuse and Mental Health Substances Administration, SEDs encompass several specific mental health conditions.[7] With half of all adult psychiatric conditions occurring before the age of 14 and 75 percent occurring before the age of 24, access to high-quality behavioral health treatment for children and adolescents mitigates the adverse impacts of these conditions and promotes mental health and wellbeing.[8]

Crisis versus Emergency

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." 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, 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.[13]

AUTISM SPECTRUM DISORDER AND INTELLECTUAL/DEVELOPMENTAL DISABILITIES

Children and adolescents diagnosed with intellectual/developmental disabilities (IDD) meet criteria for identified deficits in two areas: intellectual functioning and adaptive functioning. The onset of these challenges must occur early in development, before the 21st birthday. Neurodevelopmental conditions include a group of often co-occurring conditions with onset in the developmental period—usually manifesting before a child enters primary school—and is characterized by deficits in "personal, social, academic, or occupational functioning."[9]

Autism Spectrum Disorder (ASD) is considered a neurodevelopmental disorder and those diagnosed with ASD also meet the criteria for having a developmental disability.[9] The onset and diagnosis of ASD is typically in the early developmental period and is characterized by the presence of persistent deficits in social communication and social interaction, with those affected exhibiting "restricted and repetitive patterns of behavior, interests, or activities that cause clinically significant impairment in several areas of functioning, including personal, social, academic, or occupational."[10]

This report uses "ASD/IDD" to refer to:

- Individuals with ASD without a co-occurring intellectual disability;
- Individuals with ASD with a co-occurring intellectual disability; and

- Individuals with an intellectual or developmental disability other than ASD who experience similar challenges.

Prevalence data for ASD varies but has been generally rising in recent years. According to the DSM-5, the estimated prevalence of ASD is one percent of the population.[9] The Centers for Disease Control report that the prevalence may be as high as one in 59 children, using 2014 data.[11] The general population prevalence of IDD, according to the DSM-5, is approximately one percent, with the prevalence of severe intellectual disability estimated to be less than one one-hundredth of one percent (0.006 percent).[9,12]

FAMILY

Throughout the report, children and adolescents are often discussed in the context of their "families," recognizing the importance of the family environment to the behavioral health and well-being of all children and adolescents. While the term "family" may conjure the image of biological parents and children living together, this report acknowledges the diverse family and caregiving situations in which children and adolescents live. Specifically, this report uses the term "family" to describe biological families, adoptive families, foster families, group living environments, and residential care settings.

HEALTH CARE LANDSCAPE

In order to effectively design and implement a behavioral health urgent care model for children and adolescents with co-occurring behavioral health and ASD/IDD in Massachusetts, it was necessary to first consider the entire health care landscape in the Commonwealth of Massachusetts. Despite near universal health insurance coverage and a diverse array of behavioral health services in the Commonwealth, children and adolescents with behavioral health conditions, including those with co-occurring ASD/IDD, face delays in access to a fragmented system that is variable in its capacity, quality, and intensity across all service types.

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."[14] 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.[15] 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.[16] 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.

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 lead to adverse outcomes.

CHILDREN AND ADOLESCENT BEHAVIORAL HEALTH SYSTEM

Behavioral health urgent care design must consider the existing pediatric behavioral health infrastructure, including:

- Outpatient behavioral health organizations;
- Primary care with integrated behavioral health;
- Tele-behavioral health care, including the Massachusetts Child Psychiatry Access Program consultation;
- Mobile Crisis Intervention (MCI) teams;
- School-based behavioral health care; and
- Home-based behavioral health care.

All of these services vary considerably in their capacity and quality, from site-to-site as well as across Massachusetts' service areas and regions.

MASSACHUSETTS MEDICAID PROGRAM: MASSHEALTH

Massachusetts has the highest rate 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 99 percent coverage for children and adolescents.[17] In addition, 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.[18] The Executive Office of Health and Human Services reports that MassHealth investments in Behavioral Health system improvements will total $1.17B between FY2016 and FY2022, with specific focuses on addressing ED Boarding and expanding the services provided through the Children's Behavioral Health Initiative (CBHI).[19] CBHI was implemented as a result of the Rosie D. court decision and provides community- and home-based behavioral health services to children under age 21 enrolled in MassHealth. For those who qualify, CBHI services include:

- Family support and training;
- In-home behavioral services;
- In-home therapy;
- Intensive care coordination;
- Therapeutic mentoring; and
- Mobile Crisis Intervention (MCI)[20]

These services, while robust in their design, often have long waiting lists and are often implemented in a disparate manner. It should be noted that CBHI does not specifically train its providers in ASD/IDD, which acts as a significant barrier for families seeking these services. CBHI serves as more of a general "check-in" on the family's overall wellbeing rather than the intensive treatment necessary for children and adolescents with ASD/IDD. In order for it to be effective, 24/7 availability is necessary and the treatment would need to more stringently adhere to a high-fidelity wraparound model.

COMMERCIAL INSURANCE

In Massachusetts, approximately 60 percent of children and adolescents are covered by commercial insurance.[15] Until recently, commercial insurers did not cover the robust CBHI services available to children and adolescents enrolled in MassHealth. Now, approximately, 45 percent of children and adolescents enrolled in commercial plans are eligible to receive a similar array of high-intensity home- and community-based behavioral health services. The CMHC played a key role in the advocacy strategy for this policy change.

SELECTED MASSACHUSETTS BEHAVIORAL HEALTH LEGISLATION

The Massachusetts Legislature passed the first mental health parity legislation in 2000, *An Act relative to mental health benefits*, and passed additional legislation in 2008, *An Act relative to mental health parity*, to expand the scope of the original legislation. These laws effectively require all but a handful of self-insured employers in the Commonwealth to cover mental health benefits at parity with physical health benefits.[21,22] Massachusetts passed legislation in 2010, *An Act relative to insurance coverage for autism* (ARICA), which requires most private health insurance plans to cover "medically necessary" diagnostic evaluations, treatments, and care to patients with ASD. This legislation specifically notes that covered treatments include: habilitative or rehabilitative care (and cites Applied Behavior Analysis as a recommended treatment method), pharmacy care, psychiatric care, psychological care, and therapeutic care (speech, occupational, and physical therapy).[23] Although ARICA does not apply to MassHealth plans, MassHealth does cover most of the same treatments outlined in this law.[24]

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, government leaders, clinical service leaders, and health care policymakers from across the Commonwealth. 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.

LITERATURE REVIEW

The peer-reviewed and grey literature scan gathered articles and reports on clinical needs, current systems, and urgent and emergency behavioral health care. Due to the limited literature on pediatric behavioral health urgent care, the authors expanded research criteria to include existing elements of behavioral health urgent care, including:

- Adult behavioral health urgent care;
- Walk-in behavioral health services;
- Intensive outpatient services;
- Crisis assessment and evaluation;
- Neurodevelopmental consult to assessment, evaluation, and care planning;
- Stabilization and respite services;
- Diversion services; and
- Specific interventions for ASD/IDD.

KEY INFORMANT INTERVIEWS AND FOCUS GROUPS

The study was informed by key informant interviews with a range of stakeholders, including families, policy makers, and decision makers in governmental, payer, and provider organizations. The informants were chosen to assure that both the family and the provider voice were prominent in the development of a Pediatric Behavioral Health Urgent Care model (Appendix A). 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 (Appendix B). A modified version of this guide was used for key informants to the ASD/IDD component of the work (Appendix C). The guide was additionally modified for use in focus groups. A complete list of focus groups also can be found in Appendix A.

SITE VISITS AND EXPERT PANEL MEETINGS

The study team conducted visits to several sites, which were selected because they provide some or all of the elements of a pediatric behavioral health urgent care intervention. Given

the absence of consistent behavioral health urgent care within the behavioral health care system in the Commonwealth, the team identified and visited five sites in Massachusetts that had developed a unique model to provide some aspect of behavioral health urgent care. After conducting a scan on innovative sites providing pediatric behavioral health urgent care outside of Massachusetts, the team selected two out-of-state sites for visitation. The Crisis Response Center in Tucson, AZ was chosen because it provides the most comprehensive array of services and its efficacy is supported by data outcomes.[25] The team also visited Bradley Hospital in Rhode Island because of its expertise in providing specialized care to children and adolescents with co-occurring behavioral health and ASD/IDD. 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 seven site visits, Dr. Mauch participated in a two-day expert panel on emergency and urgent care reforms, which informed this report. The panel was titled "Comprehensive Community Crisis Services: Structure & Standards" and was convened by the Substance Abuse and Mental Health Services Administration (SAMHSA). She also presented the Pediatric Behavioral Health Urgent Care Report Volume 1 at the Crisis Now Summit, a gathering of government leaders and program experts from a dozen countries working together to adopt an international declaration and universal redesign for behavioral health urgent and crisis care. One result of this work, and the impact of the CMHC's pediatric behavioral health urgent care study, is the 2020 release of SAMHSA's "National Guidelines for Behavioral Health Crisis Care – A Best Practice Toolkit."[26]

Dr. Mauch also twice served as an organizer and participant in a two-day expert meeting, "The Nantucket Children's Mental Health Summit," convened in 2018 and 2019 by the Hackett Family Foundation, The Meadows Mental Health Policy Institute, and Massachusetts Association for Mental Health. In 2019, the Summit focused on urgent care solutions to pediatric behavioral health access issues and the initial Miller Innovation Fund findings were presented to the Summit participants. The Summit brought leaders in child and adolescent psychiatry, including experts in neurodevelopmental conditions, 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.

FINDINGS

CHARACTERISTICS OF TARGET POPULATION

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 children and adolescents using crisis intervention services.[27-33]

CHILDREN AND ADOLESCENTS

In order to be a responsive and effective intervention, a pediatric behavioral health urgent care model must consider the environmental and developmental needs of children and adolescents. 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 trauma and adverse childhood experiences;
3. Exposure to adverse social determinants of health (e.g. homelessness, food insecurity, etc.); and
4. 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.).

In the proposed model, the presence of one or more of these factors as well as the characteristics of the child or adolescent and their family will determine the needs and then 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, an effective crisis system must understand that the experience of the crisis itself can be traumatizing. Thus, the response should seek to be calming and comforting for children and their families.

> ***"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 advised that an effective behavioral health urgent care intervention should have the capacity for thorough clinical assessment and clinical/diagnostic formulation. The child's behavior indicates the presence of an underlying and unmet need. The treatment team must work to ascertain the underlying need in order to connect the family to appropriate ongoing treatment.

While adolescents have many of the same needs and considerations as children, most of them

develop increasing autonomy and independence from their families, as peer relationships become of primary importance. At times, engaging adolescents with their behavioral health care poses a challenge. The inclusion of a near-peer or young adult peer on the adolescent's care team and allowing the adolescent to be involved in care planning are two effective methods for increasing adolescents' engagement with care. Involving the adolescent should not necessarily be done at the expense of engaging the adolescent's family in care planning.

Although young children frequently present with behavioral dysregulation, adolescents are far more likely to present with depression, suicidal ideation, and/or substance use. Symptoms presenting in adolescence may represent the onset of adult behavioral health conditions. Adolescents presenting to behavioral health urgent care 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. An effective urgent response to this presentation will depend on the particular adolescent, their history, and the capacity of the family to safely manage the suicidal ideation. It is essential that behavioral health urgent care has the capacity to respond to the increasing complexity of adolescents.

"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

FAMILIES

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 their 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, and on the family's access to resources at that point in time. 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 or adolescent's care plan, even if, in the moment, they are experiencing stress, guilt, stigma, and shame. 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, inclusive of Family Partners can empower families as experts on their children, so that they are able to develop a care plan collaboratively. For children and adolescents, a crisis response cannot be solely child-focused; it must use a family-based approach.

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

-Lisa Lambert, Parent/ Professional Advocacy League

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. 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. It is critical that there be multiple, community-based points of access

to pediatric behavioral health urgent care (a "no wrong door" approach).

CHILDREN AND ADOLESCENTS WITH ASD/IDD

The prevalence of behavioral issues among children and adolescents with ASD/IDD is approximately 50 percent. For some, the level and range of challenging behavior drives urgent and emergency care needs.[34] For this group, co-occurring psychiatric diagnoses are very common, with estimated rates varying between 70 percent and 92 percent. Common co-occurring psychiatric diagnoses include Attention Deficit Hyperactivity Disorder, Oppositional Defiant Disorder, anxiety disorders, and mood disorders.[35-40] Emerging literature suggests higher-than-average suicide rates as well as exposure to trauma among children and adolescents diagnosed with ASD compared to children and adolescents without ASD.[41-45] Despite this high prevalence, identifying psychiatric conditions and exposure to trauma in children and adolescents with ASD can be difficult because many assessments are based on interviewing and eliciting thoughts, a particularly challenging task for children with ASD/IDD who have limited verbal communicative abilities.[28] For a child or adolescent with ASD/IDD who is a experiencing a behavioral crisis, it is first necessary to interpret the presenting behavior, which is often accomplished by communicating with the child's family.[46,47] Making diagnostic distinctions between ASD and other psychiatric diagnoses is challenging and requires expert clinical acumen.[27]

> ***"There is a subset of children who have a pretty significant anxiety disorder co-morbid with ASD."***
>
> ***-Chase Samsel, MD***

Children and adolescents with ASD are more likely than their neurotypical peers to come into contact with emergency responders and visit the ED for psychiatric concerns.[48-50] In fact, several studies have noted that psychiatric issues are the leading cause of ED visits for children and adolescents with ASD.[50-53] Once in the ED, children with ASD are more likely to:

- Board in the ED;[54]
- Board for longer in the ED;[1]
- Be subjected to seclusion and restraint;[55] and
- Be directed to psychiatric hospitalization.[37,38,50-60]

The higher prevalence of inpatient psychiatric hospitalizations and emergency psychiatric care among children and adolescents with ASD/IDD is linked to the presence of co-occurring mental health conditions. However, these trends are also driven by the lack of community-based care for children and adolescents with ASD/IDD.[46]

Children and adolescents with ASD/IDD must have access to crisis intervention, both mobile and in-home, as well as to inpatient care. To maintain role functioning over the long-term children and adolescents with ASD/IDD often require ongoing support and care. In 2018, recognizing the need to have inpatient psychiatric care for youth with ASD/IDD, Massachusetts policymakers developed specifications for a specialized unit. These units will receive enhanced rates through MassHealth to accommodate the number and expertise of staff necessary to support the unit. Policymakers expect that commercial insurance carriers

will add this service to their networks. In March 2019, a private psychiatric facility opened a specialized inpatient psychiatric unit for children and adolescents with ASD/IDD. Prior to the creation of this unit, children and adolescents with co-occurring behavioral health and developmental needs were routinely being sent outside of Massachusetts for inpatient care. There must be a sufficient number of specialized psychiatric beds available to serve this population because children and adolescents with ASD often do not thrive in traditional mental health inpatient units, if they are even admitted. They are often turned away because they present with externalizing behaviors that are difficult to manage.[61,62] Demand for emergency psychiatric care is consistent throughout the calendar year for children and adolescents with ASD/IDD, unlike among neurotypical peers whose demand routinely decreases in summer months. Thus, it should be possible to establish the appropriate inpatient bed capacity for children and adolescents with ASD/IDD in the Commonwealth.[1]

> ***"There is no one guide that says, 'if your child has mental health needs and ASD, here is what you should do"***
>
> ***-Parent***

FAMILIES OF CHILDREN WITH ASD/IDD

Despite the robust legislative requirements for insurance coverage of ASD/IDD services in the Commonwealth, the continuum of care for children and adolescents is limited by the nascent provider networks and a lack of behavioral health clinicians trained in ASD/IDD. For children and adolescents with ASD/IDD, it is important for families to have access to high-quality, consistent, community-based care, which often prevents the need for higher acuity emergency and crisis services.[63]

Even with improved access to community-based services, there will be a cohort of children and adolescents who will need to access urgent behavioral health services. These behavioral crises can be a consequence of changing physical conditions, increased psychological stress, inadequate accommodations in place at school, or insufficient home-based behavioral support. In these situations, families of children with ASD/IDD currently have no place to turn. The Mobile Crisis Intervention teams are not trained in ASD/IDD, so are at best inconsistent in their ability to intervene in crises. Additionally, families are frequently unwilling to take their children to the ED, knowing that the chaotic and high sensory environment will likely exacerbate the situation.[41] A trip to the ED is particularly harmful not only due to the disruptive nature of the ED but also because children and adolescents with ASD/IDD are less likely to receive inpatient care, even if they require it. This leads to longer periods of ED boarding. For some families, lack of safe transportation acted as a barrier to seeking care anywhere other than emergency care in the ED. Therefore, many families in crisis are left managing their children at home, up until the point when the family is physically not capable of keeping the child and other family members safe, usually when the child becomes physically larger and stronger than the adults in the home. Many parents did not identify

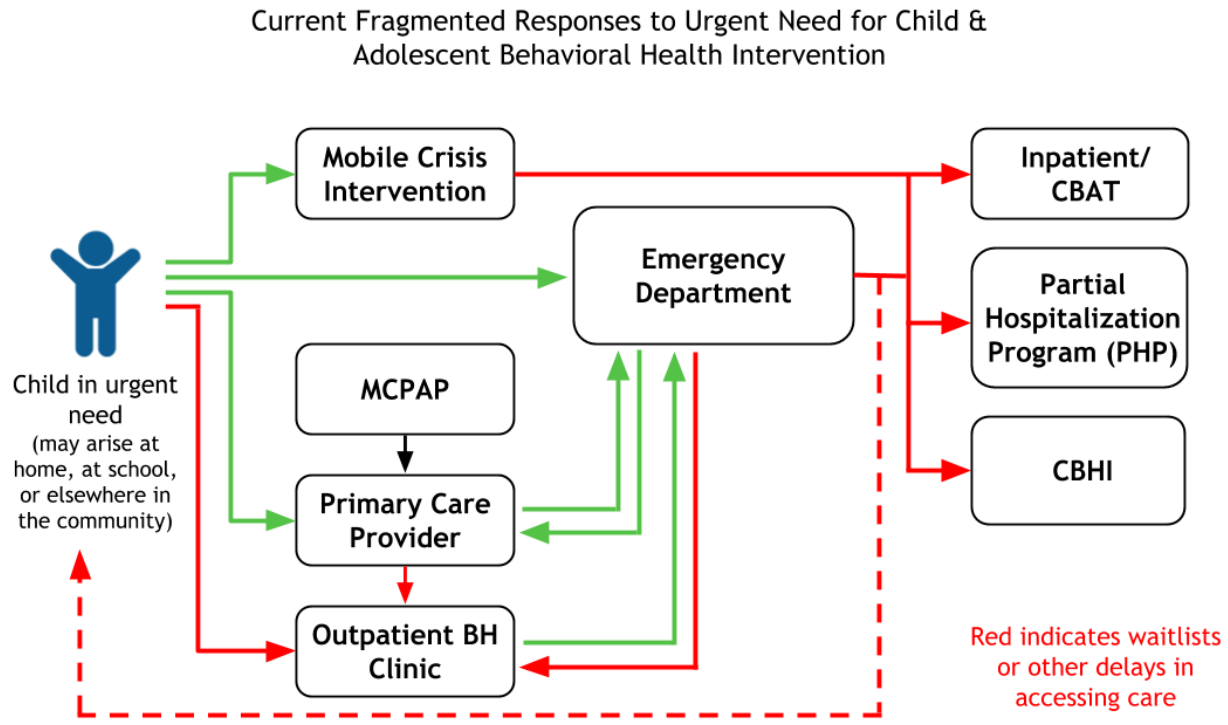
> ***"A lot of the time, families don't realize how abnormal their lives have become. A 'crisis' may be evolving over time."***
>
> ***Liz Martineau, Nashoba Learning Center***

situations as emergencies until they were at the point of being unable to physically restrain their children, though behavioral events had long been occurring. Experts in ASD/IDD noted that families of children with ASD have a high tolerance for behavioral dysregulation in the home because they have been unable to access timely and responsive behavioral services.

In behavioral health urgent care across all care settings, families need treatment environments that are sensory informed and staffed by providers and personnel trained in ASD/IDD.[27,36,64] For example, waiting and treatment areas should be quiet with low or lamp lighting, since fluorescent lighting can be irritating to children and adolescents with ASD/IDD. These areas should also contain sensory modifications, including rocking chairs, weighted blankets, bean bag chairs, and soft objects (e.g., cotton balls, blankets, etc.).[36]

CURRENT MASSACHUSETTS SYSTEM

Illustration 1. Current State System Response to Urgent Care Needs



Illustrated above 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 may present to one of several parts of the care system, as Massachusetts has no defined "behavioral health urgent care" capacity. 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.

EMERGENCY DEPARTMENT

When any children and adolescents in behavioral health crisis arrive at the ED, they are met with a system ill-equipped to meet either their behavioral health needs or their specific needs as children and adolescents. EDs are particularly disruptive to children and adolescents with ASD/IDD due to the chaotic and sensory rich environment.[42]

From the ED, there are significant delays in access to higher levels of care (e.g., CBAT, inpatient, partial hospitalization programs, CBHI) as well as delays for community-based follow up care in outpatient behavioral health clinics. The child or adolescent and their family may end up boarding for long periods of time while awaiting appropriate care at a high financial cost, as EDs are exceptionally expensive treatment settings. In summary, EDs are burdened with too many cases admitted that might otherwise be effectively treated in outpatient or urgent care settings. For those children and adolescents with behavioral health and those with co-occurring ASD/IDD conditions, EDs are ill equipped to timely and effectively treat and stabilize them. Consequently, high numbers of children and adolescents wait and are not admitted. Those with behavioral health and co-occurring ASD/IDD conditions are among the children and adolescents who wait the longest in EDs for inpatient admission.

SCHOOLS

Because schools are expected to be a major referral source to pediatric behavioral health urgent care, providers must also partner with schools in order to divert from calls to police or emergency services as well as to assure that schools are versed in mental health first aid and trauma-informed care. School-based partnerships will be informed by the Children's Mental Health Campaign school-based behavioral health project. For children and adolescents with ASD/IDD, there are often existing services in place at school, per Individualized Education Plans, so coordination with schools is especially important.

MOBILE CRISIS INTERVENTION

"The only things an ESP team can do is 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, Technical Assistance Collaborative

In Massachusetts, the Mobile Crisis Intervention program for children and adolescents comes closest to providing children, adolescents, and their families with an "urgent" behavioral health intervention. The MCI program is one of the services provided through the Children's Behavioral Health Initiative (CBHI) and is, therefore, only available to children enrolled in MassHealth and select commercial insurance plans. The MCI team 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."[65] In addition to the immediate intervention, this program

provides up to seven days of follow-up crisis intervention and stabilization services. However, in practice, MCI teams primarily function to assess a child for "level of care" due to the following systemic issues:

- Clinicians do not necessarily provide a thorough crisis assessment and/or crisis intervention because MassHealth quality metrics incentivize MCI to provide rapid response for each call for assistance, pulling clinicians away from incomplete interventions to respond to new crises.
- The placement decisions of MCI teams are often disputed by health plans or recommended care settings (e.g., inpatient unit, community-based acute treatment, etc.).
- MCI clinicians are not competitively compensated; consequently, leading teams are often comprised of new and inexperienced clinicians, who do not always receive adequate supervision and training from senior clinicians.
    - This lack of training is particularly problematic given the acuity and complexity of the children, adolescents, and their families with whom MCI teams work.
    - Without adequate training and ongoing supervision, clinicians may be under-prepared to intervene and often they leave due to stress and burnout.
- Families of children with ASD report a reluctance to call MCI in crisis situations because MCI clinicians lack specific training for children with behavioral health conditions and co-occurring ASD/IDD.
    - Of those families who do call, some cited slow response times and several reported that MCI teams explicitly stated that they were unable to assist with behavioral dysregulation in children with ASD/IDD.

> ***"If he was too escalated, MCI wouldn't come out. For example, if the MCI team could hear him yelling in the background, they would just say, 'go straight to the ED.' So, you either go straight to the ED or have the police come to help out with transport. It's hard to admit you can't handle your family situation and then to have MCI be a dead end is very discouraging. A stronger crisis team would be helpful."***
>
> ***- Parent***

At times, law enforcement is called to assist a family with extreme and unsafe behaviors. In these situations, it is key to also have the MCI team present because they heavily affect the final disposition of the child/adolescent.

OUTPATIENT CARE

Outpatient behavioral health care provides ambulatory (not overnight) care for the treatment of behavioral health conditions. Outpatient care may be delivered at a freestanding specialty behavioral health clinic, a behavioral health clinic affiliated with a larger health or hospital system, or a primary care provider. Outpatient care includes appointments that do not generally exceed three hours in duration and appointments typically occur only one or two days per week.[66] Outpatient care may include several different psychological treatment modalities (e.g., Cognitive Behavioral Therapy, Dialectical Behavioral Therapy, Interpersonal

Therapy, etc.) and also encompasses psychopharmacological prescribing and medication maintenance.

Should a child or adolescent present to an outpatient behavioral health clinic, they will likely be added to a long waitlist until a specialty appointment becomes available; outpatient behavioral health clinics almost never offer walk-in or on-demand availability. 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.[67,68] For children and adolescents with public insurance, wait times for an outpatient appointment average two to six months; for those with commercial insurance, waits are even longer at four to nine months. Parents across payer types noted that the wait times for their children are unacceptably long.[60] Psychiatry wait times also were particularly egregious, and much longer for children and adolescents compared to adults. For children and adolescents, 43 percent of ABH member organizations reported wait times of one to six months, and an additional 15 percent reported not having a prescriber available at all.[59] 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.

For children and adolescents with ASD, there are extreme waits for receiving a diagnosis of ASD, which is necessary for receiving services, and for accessing services.[69] Although children with ASD can be diagnosed as early as age two, the average age of diagnosis is after age four.[70-72] This two-year gap is problematic, as there is evidence that the early initiation of specialized interventions (as early as 18 months) results in better long-term outcomes.[73-75] In Massachusetts, wait times for diagnostic evaluations for ASD can be as long as three to six months. Once a diagnosis of ASD has been established, wait times for specialized interventions such as Applied Behavior Analysis (ABA) are one year or longer.

In addition to the long waits for ABA, several families reported the nearly impossible struggle of finding an outpatient therapist with expertise in treating children and adolescents with co-occurring behavioral health and ASD needs. Families referenced the difficulty of parsing out whether aggressive behavior is primarily driven by ASD or an underlying behavioral health condition. In the absence of skilled clinicians to treat and address the underlying causes of aggressive behavior, families are left to manage ongoing aggressive behavior without support, often until a crisis arises.

PRIMARY CARE PROVIDERS

For families not already engaged with the behavioral health system, the primary care provider (PCP) is often the first step in accessing behavioral health care. A PCP may help the family identify the need for specialized behavioral health care. However, behavioral health expertise varies among PCPs; furthermore, behavioral health is not universally integrated with primary care in Massachusetts. Even for primary care practices with an embedded behavioral health clinician, the current integrated model does not necessarily allow for a comprehensive urgent behavioral health response, one that includes crisis intervention, treatment planning, and connection to ongoing treatment.

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.[76] To remedy the lack of behavioral health training in pediatrics and the lack of child and adolescent psychiatrists, the Massachusetts Child Psychiatry Access Program (MCPAP) was implemented statewide in 2004, providing near real-time consultation by a child psychiatrist to pediatricians across the Commonwealth. Since that time, MCPAP has expanded to include three regional teams, staffed by two full-time child and adolescent psychiatrists, independently licensed master's-level clinicians, resource and referral specialists, and program coordinators. These regional teams provide both education and consultation to pediatricians in order to improve their competency with behavioral health identification and treatment. MCPAP also helps the primary care provider's office coordinate care for patients who require specialist community-based care.[77] Since its inception in Massachusetts, Massachusetts Child Psychiatry Access Program has been adopted by 30 states.

ISSUES AND GAPS IN THE CURRENT MASSACHUSETTS SYSTEM

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 their family members or caregivers, presenting with urgent needs.

LACK OF CRISIS STABILIZATION UNITS

There are few options for crisis stabilization unit beds or short-term services for children and adolescents in need of 24 hour or longer stays. While Intensive/Community-Based Acute Treatment services sometimes function as crisis stabilization, insurers reportedly limit stay authorization to a few days. Similarly, Acute Treatment Services and Clinical Stabilization Services beds, which are available to treat adults with urgent substance use conditions, do not exist for children and adolescents with urgent substance use conditions.

NAVIGATING THE BEHAVIORAL HEALTH SYSTEM AND CARE MANAGEMENT

Massachusetts utilizes multiple 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, which creates fragmentation and a difficult-to-navigate system. In physical health, chronic illness management is a routine part of care. For example, a patient with diabetes works with their care team to learn to manage the condition, including ongoing treatment as well as crisis planning. Similar management, if it is even available, is underutilized for behavioral health conditions.

In addition, communication is limited among behavioral health treatment entities, despite the necessity of working 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. Despite little to no communication with acute service providers, outpatient providers are tasked with providing follow-up care from acute episodes. When prescription medications

are changed or initiated in crisis or inpatient care and follow up is needed in outpatient settings, a lapse in communication can lead to serious medical consequences. 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, supported by electronic communication and record processes.[78]

> ***"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***

For children and adolescents enrolled in MassHealth, CBHI includes Intensive Care Coordination (ICC), which is intended to help coordinate behavioral health care. However, because ICC is a part of the CBHI system, it often does not coordinate with the acute care system or with the child's primary care provider, missing an opportunity for coordination and leading to further fragmentation.

LACK OF ASD/IDD INTEGRATION WITH BEHAVIORAL HEALTH CARE

In Massachusetts, the state agencies responsible for mental health and developmental disabilities are separate from one another, so these sets of services are not well integrated. Accessing care for children and adolescents with a behavioral health condition and co-occurring ASD/IDD is often challenging and confusing for families. The absence of clear protocols for managing co-occurring behavioral health and ASD/IDD conditions exacerbates the already poorly integrated eligibility and coverage determinations across the two state agencies.[10] Further complicating the service landscape are the differential requirements that schools and health insurers impose on the provision of ASD/IDD services. Because of the robust requirements for health insurers to reimburse for ASD/IDD services, several essential ASD/IDD services have been shifted from the educational system to the health care system. As a result, many children are not receiving sufficient services in school and may even be missing time at school to receive needed care. The gaps between the health care and educational systems must be filled, policies must be aligned, and service provision must be coordinated in order to assure that children and adolescents with ASD/IDD are receiving optimal care and attending school.

LACK OF INTEGRATION BETWEEN MENTAL HEALTH AND SUBSTANCE USE TREATMENT SYSTEMS

Though this report uses the term "behavioral health" to describe both mental health and substance use conditions, few providers deliver truly integrated mental health and substance use treatment services in Massachusetts. Across the entire care system, for both adults and children, mental health and substance use treatment services are poorly integrated with one another.

REVERSE TRIAGE

Triage is a process specifically designed to ensure that the patients with the most acute needs are cared for first. In behavioral health, the most acute patients also tend to be those at highest risk for ED boarding.[1] Inpatient and residential treatment settings reportedly decline to admit children and adolescents waiting in EDs, describing them as "too acute" for treatment. This "reverse triage" phenomenon results in easier access to acute care for less acute patients. The reverse triage effect is especially problematic for children and adolescents with ASD/IDD. In the CMHC's 2016 study examining pediatric psychiatric boarding, 13 percent of the overall sample of children and adolescents who presented to the ED in psychiatric crisis had ASD/IDD. Of those, 87 percent boarded, compared with 82 percent of the entire sample. Children and adolescents with ASD/IDD boarded for longer; 38 percent of those who presented to the ED spent more than three days awaiting care, compared with 22 percent of the entire sample.[1]

> ***"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 Universitv School of Medicine***

WORKFORCE ISSUES

Behavioral health providers in Massachusetts 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.[19] According to the latest Milliman report on parity, Massachusetts ranks sixth in the nation on disparate payments between primary care providers and behavioral health providers; primary care providers are reimbursed at a 60 percent higher rate than behavioral health providers.[79] In addition, there is often a more significant administrative burden on behavioral health providers compared with physical health providers, 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 practices, etc.), many providers do not accept insurance or leave the profession entirely, creating highly disparate and selective access to a well-trained workforce.[80]

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. Workforce shortages are especially pronounced among those who specialize in treating children with ASD/IDD, which is further complicated by the need for increased staffing to address the additional needs of these children and adolescents, such as activities of daily living, communication, and other issues that arise as a result of a younger developmental status. Families of children and adolescents with behavioral health conditions who have struggled to access services within the present care continuum noted the importance of considering workforce implications.

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, an issue that factors into clinicians leaving insurance networks, and expanding current services in order to reduce the need for additional administrative roles.[60]

> ***"We are frustrating our workforce instead of supporting them. We are not using the people that we have in a way that is efficient."***
>
> ***- Jacob Venter, MD, Cambridge Health Alliance***

MODELS OF 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. Nationwide, there are settings that offer low threshold and immediate access to behavioral health care but unfortunately the widespread availability of such care does not exist for children and adolescents in the Commonwealth. The following programs are leading models for the provision of behavioral health urgent care to children and adolescents. Both function similarly to medical urgent care in that they provide walk-in, immediate treatment of behavioral health conditions.

THE CRISIS RESPONSE CENTER AT CONNECTIONS HEALTH SOLUTIONS

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 behavioral health urgent care program is situated in a building that is adjacent to a hospital ED and inpatient services.[23]

Within the CRC, Connections Health Solutions delivers an array of services available on a 24/7 basis that begins with intake; the CRC has the capacity to receive and immediately 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 children and adolescents for admission to treatment. The CRC operates a 10-bed crisis stabilization unit, 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 who work on site. Because there is "no wrong door" for police, who universally receive 40 hours of Crisis Intervention Training, fewer children and adolescents are taken to EDs, hospitals, or juvenile courts. The CRC's medical director collaborates closely with medical directors of other community behavioral health organizations and the CRC sets daily time slots for Child & Family Team Meetings to develop care plans with the involvement of outpatient clinic staff. Schools engage in Mental Health First Aid training and along with police work as partners with the CRC. The CRC is funded through block grants, as it is considered a service that requires standing funding akin to funding provided to first responders. While the program bills insurance, it does not depend on reimbursement to fund core operations. Both walk-in clinic and 23-hour close observation

beds are located within a single entity and are licensed together 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.[23]

THE ACCESS CENTER AT BRADLEY HOSPITAL

The Access Center at Bradley Hospital provides families in Rhode Island with a single point of access to an array of behavioral health services, receiving hundreds of calls to their Kids' Link crisis line from families each week. Trained clinicians staff the Access Center and perform evaluations in order to determine the appropriate level of care for the child or adolescent, diverting many who would otherwise seek care in the ED. In 2018, the Center received approximately 6,000 calls, of which only four percent necessitated an ED visit. In addition to the Access Center, Bradley Hospital also has an outpatient crisis clinic that addresses urgent behavioral health needs, which are classified as "not necessarily requiring hospitalization but necessitating an intervention within 48 hours."[81] Children and adolescents who visit this clinic receive an evaluation within 48 hours and often require treatment beyond what can be provided in a traditional outpatient behavioral health setting.

Both the Access Center and crisis clinic at Bradley Hospital are connected to multiple levels of behavioral health care and subspecialty care for children and adolescents with ASD/IDD. In addition to traditional outpatient behavioral health care, Bradley Hospital offers in-home evaluations, a comprehensive Partial Hospitalization Program (PHP), school-based consultation, family training, and inpatient care. The PHP at Bradley has distinctive programming that is organized both by age and by developmental ability. Developmental considerations such as board-certified behavior analyst (BCBA) expertise, a structured and low stimulation environment, and medication management are central to the partial hospitalization program and essential for providing high-quality care to children and adolescents with ASD/IDD. In addition to the PHP-based BCBA support, Bradley's BCBAs, psychologists, and Bachelor's-level staff (under psychologist supervision) also travel to the school, home, or other providers in order to integrate behavioral support for children and adolescents with ASD/IDD into these settings. Bradley's close collaboration with schools and families ensure that children and adolescents receive care in the most natural setting possible (e.g. home and school), avoiding higher levels of care and minimizing ED visits.

ELEMENTS OF BEHAVIORAL HEALTH URGENT CARE

Findings from the peer-reviewed literature, published policy reports, and materials provided during site visits paint a picture of an emerging urgent care landscape in the physical health world, paralleled by a barely visible adoption of behavioral health urgent care. The following interventions and programs may function as pieces of a behavioral health urgent care model.

ED-BASED INTERVENTIONS

A lack of community-based behavioral health care often leads families to seek care in the ED. In response to this trend, some hospitals have implemented ED-based behavioral health interventions. The American Academy of Pediatrics recognizes the importance of ED-level interventions for children and adolescents in crisis because a small percentage of children and adolescents do require inpatient hospitalization. However, most children and adolescents

experiencing a behavioral health crisis do not require inpatient care, as demonstrated by the CMHC's boarding project. 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 provided in outpatient clinic settings. Within the ED, a specialized team of behavioral health clinicians provides brief, typically family-based treatment to target presenting symptoms and to stabilize children and adolescents 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.[31,82-90]

Highlighted Practice: Boston Children's Hospital uses an ED-based model, family-based crisis intervention, designed specifically for the treatment of suicidal adolescents and to provide an alternative to ED boarding. This intervention 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.[71] 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 than those receiving usual treatment.[72]

OUTPATIENT BEHAVIORAL HEALTH WALK-IN CARE

Unlike an ED, walk-in outpatient behavioral health care is designed to address urgent (and not emergency) needs. Where psychiatric urgent care exists, it often does not have 24/7 availability and instead typically has more standard hours (Monday-Friday, 9-5) with limited availability on nights and weekends. Psychiatric urgent care settings are 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. Clinicians with expertise in evidence-based practices deliver urgent, walk-in psychiatric care for children and adolescents.[26,76,91-95]

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 (the behavioral health outpatient clinic), and proximate to the Emergency Services MCI team location. The staff deliver collaborative care not only in conjunction with other MVCS clinical operations, but also with the schools, primary care providers, hospital, community programs, families, and first responders/public safety officers that refer or provide continuous care to program participants. The site is located across the street from the island's high school, where staff are 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 walk-in accessibility in that location.

The MVCS Enhanced Urgent Care Program is staffed by a trained clinical team, who have the authority to direct children and families to adjacent outpatient and day program care, either to resume or initiate treatment. Within 15 minutes of arrival, the urgent care team provides the child or adolescent with an assessment of mental health and substance use needs, using evidence-based screening tools. The assessment informs safety planning and initiation/linkage to ongoing treatment, which sometimes occurs on site, depending on the nature of the treatment. The urgent care team also manages care transitions and arranges safe transportation of children and adolescents in need of emergency, inpatient, or substance use treatment.

The program has standing funding from the Department of Mental Health (DMH), ensuring it is staffed and operated regardless of the amount of revenue collected through insurance reimbursement. The funding structure is essential to MVCS' ability to implement and sustain the urgent care program. 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 the first full year (calendar year 2018) of the Enhanced Urgent Care Program's operation over the performance of the Emergency Services Program in 2017. In 2018, there was a 21 percent decrease in the number of Emergency Services Program evaluations from 2017 utilization, due to the capacity of the Enhanced Urgent Care Program. From 2017 to 2018, there was a 43 percent decrease in inpatient psychiatric admission episodes for children and adolescents, birth to age 20. For adults, aged 21 and older, the related decrease in inpatient psychiatric admissions was 34 percent for 2018. Finally, for children and adolescents, there were 52 percent fewer overnight stays in the hospital ED in 2018. These first-year performance results underscore the efficacy of urgent behavioral health care in reducing the use of higher cost emergency and hospital care.

Highlighted Practice: The Stanley Street Treatment and Resources (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 traditional outpatient behavioral health clinic, which typically had an eight-week wait for an appointment, a 45 percent no-show rate, and steep financial losses, to a walk-in behavioral health clinic. 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, after which they may be scheduled for same-day individual or group treatment; groups operate also on a walk-in basis once a client has been through intake. This flexibility enables clients to determine the type and timing of their own treatment. Those referred to and/or electing multiple group sessions per week are considered to be in intensive outpatient treatment. While the core focus of the program is on treating people with substance use conditions, there are many individuals who receive individuals who receive individual and group treatment for co-occurring mental health and substance use conditions. SSTAR has the capacity to provide medication-assisted treatment, and individuals meeting medical criteria may initiate medication-assisted treatment one day after intake.

MOBILE INTERVENTIONS

Mobile Crisis Intervention is a key element of urgent behavioral health care.[96-103] 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.[102]

Highlighted Practice: Behavioral Health Network (BHN) operates the MCI team for children and adolescents in Springfield, Massachusetts. Of the 1,200 crisis assessments performed each month, approximately 400 are for children and adolescents. Of those children evaluated by the MCI team, only 10 to 15 percent are deemed to require inpatient hospitalization, compared to 25 percent who present to the ED in behavioral health crisis. The BHN MCI team diverts the remaining children and adolescents from inpatient hospitalization; a small percentage enter a community-based acute treatment program. The majority are rerouted to the 24/7 walk-in capacity offered at BHN's Emergency/Mobile Crisis Intervention site. BHN's MCI site closely collaborates with the Springfield schools and police, helping to divert children and adolescents in crisis at school from the use of ambulance transport to the ED. BHN stressed the need for creating safe transportation alternatives to ambulances in order to divert more children and adolescents from the ED. Currently, ambulances are only authorized to transport patients to the ED.

Highlighted Practice: START is a research-based model of community-based crisis intervention for individuals with co-occurring IDD (including ASD) and behavioral health needs. The Center for START Services at the University of New Hampshire's Institute on Disability/University Center for Excellence in Disability provides technical assistance in the implementation of the START model to communities nationwide. In order to become trained in the START model, clinicians must complete a one-year training program that addresses the mental health aspects of ASD/IDD. The START model primarily serves children who live with their families; START coaches work alongside the family in the home to develop solutions to behavioral crises, improving overall family functioning. The START team remains engaged with the child after the crisis has resolved, providing ongoing behavioral health care as well as developing a care plan in both the school and home settings.

The START model has been implemented for children and adults. The children's model, unlike the adult model, does not include inpatient or crisis beds. Even without the "bedded component," ED use among children and adults engaged in a START program is the same. Though primarily implemented in the home, the START model is designed to meet children "where they are at," so if the child is at a Crisis Stabilization Unit (CSU), the START coach will meet the child at the CSU and help to co-evaluate the child.

The researchers cite the University of New Hampshire's Institute on Disability/University Center for Excellence in Disability's START model as essential to designing enhancements for Massachusetts' MCI teams.

Highlighted Practice: The Autism and Law Enforcement Education Coalition is a program developed in Massachusetts which has gained national attention to train first responders (police officers, firefighters, and emergency and courtroom personnel) in recognizing ASD among children, adolescents, and adults. Trainings are tailored to various sub-groups of first responders (firefighter, police officer, court room personnel, emergency department

personnel/EMTs) and are run by a peer first responder (e.g., police officers conduct police officer training) who have family experience with ASD.

TELEHEALTH INTERVENTIONS

Due to the unpredictable nature of behavioral health crises, telehealth is frequently a component of urgent behavioral health interventions.[89,91] Families, especially those living in non-metropolitan areas, those who are non-English speaking, and those living in poverty lack access to specialized behavioral health and psychiatric treatment, this lack of access is more pronounced for ASD/IDD services.[104] Telehealth interventions, including those provided for the diagnosis and treatment of ASD/IDD, offer an opportunity to provide subspecialty pediatric care in otherwise hard-to-reach settings.[95,105] 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.[91,95]

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 24/7 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.[106] 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.[91] A current model being implemented at Boston Children's Hospital uses telepsychiatry consultation at pediatric primary care to provide quicker access for patients in geographically dispersed primary care settings.[107]

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 behavioral health 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.[27] 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, staffed by mental health nurses and psychiatrists, is available 24/7/365, and provides information services, clinical services (including triage and assessment), and other activities all using telehealth technology.[108]

Highlighted Practice: Clinical leaders at UMass Department of Psychiatry devised an alternative strategy for children and adolescents with ASD/IDD presenting with urgent psychiatric care or crisis intervention needs in the UMass Medical Center ED. Designed to avoid ED boarding, the ED clinicians assess incoming cases for acute safety risk to determine if they can be cared for at home, with safety risks, clinical needs and family support managed by daily Youth MCI team staff services, provided in consultation with MCPAP psychiatrists. Youth MCI works to rapidly engage outpatient psychiatrists or developmental specialists

already treating the child to promote continuity of care. For those cases determined to be in need of a specialty inpatient unit, the child is initially retained at the ED for 96 hours to preserve priority on the waitlist, then discharged with above described supports to await admission. For those cases that resolve while receiving home support, appointments are set with the Bridging Clinic/Can Do Clinic (a Neurodevelopmental Clinic) for more intensive intervention pending return to community psychiatric or developmental specialist outpatient services.

UMass has within its Pediatric Emergency MH Unit, one bed used as mini inpatient unit to assess, change medications, or stabilize a child for up to 5 or 6 days, before returning home with supports. This bed is reserved for children who cannot wait at home and cannot be admitted timely to an inpatient bed. Subsequent inpatient stays are often brief. UMass reports that reimbursement for this bed is only for the daily ED encounter. Children with private insurance are not eligible for this service, as the model is only covered by MassHealth.

PROPOSED MODEL OF URGENT CARE

TARGET POPULATION OF CHILDREN AND ADOLESCENTS

The description of the clinical presentation of the children and adolescents 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 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 crises are more likely to include suicidal ideation, substance use, role dysfunction, or the onset of a severe mental health condition.

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 the need for behavioral health 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 a behavioral health assessment as a condition of back-to-school clearance.

For children and adolescents, an effective urgent behavioral health response will:

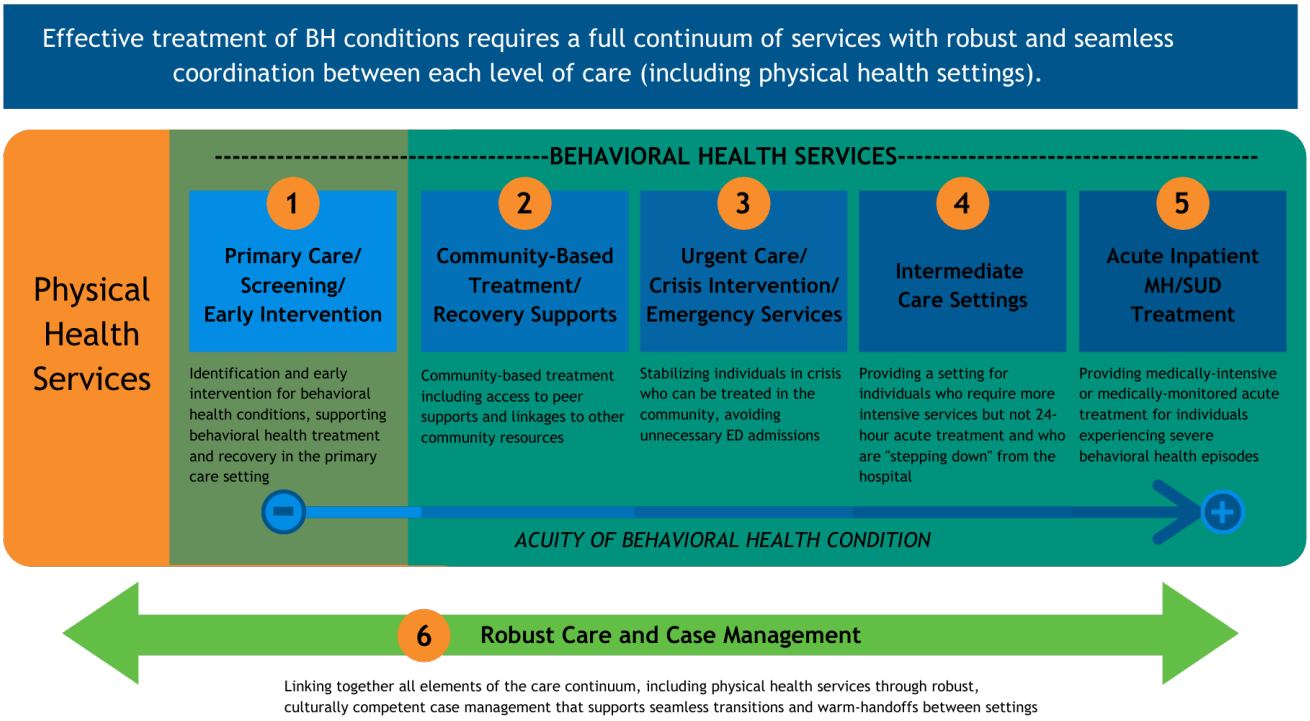
- Avoid further fragmentation of the current state of care while simultaneously aligning with practice and payment reforms.
- Build capacity in existing service delivery settings
- Integrate care elements and provider expertise for those with co-occurring behavioral health and/or ASD/IDD; and
- Provide a timely response with continuity across care elements to stabilize the crisis and set a course for resolution.

CREATING PEDIATRIC BEHAVIORAL HEALTH URGENT CARE

Developed by Manatt Health for the Blue Cross Blue Shield of Massachusetts Foundation, the schematic found below illustrates a continuum of behavioral health care designed to meet the range of behavioral health needs of individuals in the Commonwealth. As noted in the schematic, an urgent behavioral health intervention falls between community-based treatment and intermediate or acute care settings.[73]

Illustration 2. Courtesy of the Blue Cross Blue Shield of Massachusetts Foundation and Manatt Health.

OVERVIEW OF A MODEL BEHAVIORAL HEALTH CARE SYSTEM



An effective urgent care response includes rapid assessment, treatment planning, behavioral health treatment initiation (individual, family, group, intensive outpatient, habilitative options, behavioral supports, medication, or medication-assisted treatment), integrated ASD/IDD care planning, and the ability to connect children and adolescents to higher levels of care, if needed. The chart, *Illustration 3*, illustrates the need for designated urgent behavioral health interventions, as outpatient behavioral health clinics, pediatric primary care practices, and EDs do not have access to all of the care elements necessary for an urgent behavioral health response.

Illustration 3. Functional Comparison of ED, Behavioral Health Clinic, PCP, and Urgent Care Site.

FEATURE	EMERGENCY DEPARTMENT	BEHAVIORAL HEALTH CLINIC	PEDIATRIC PCP CLINIC	URGENT CARE SITE
Evening/Weekend	++	-	+	++
Walk In Access	++	-	+	++
Rapid Intake	+	-	+	++
Assessment	++	-	+	++
Lab Services	++	-	++	++
Medical Clearance	++	-	-	++
Triage	+	+	+	++
Close Observation (up to 23 hours)	++	-	+	++

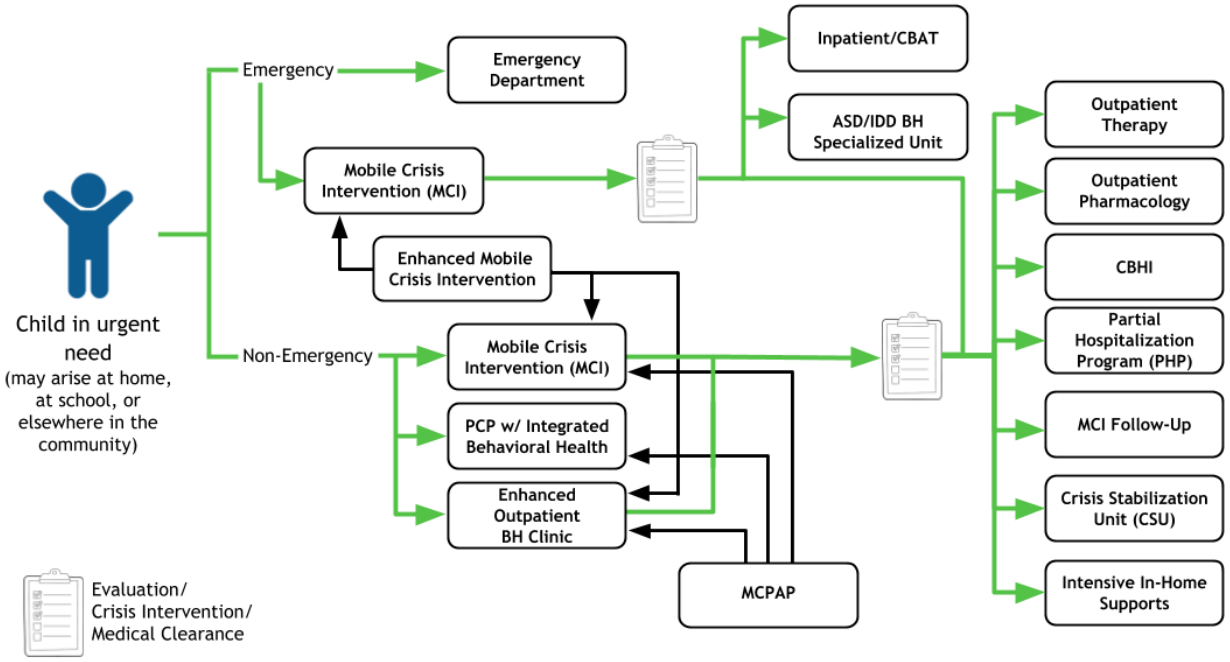
SYMBOL LEGEND: (++) Always Available; (+) Sometimes Available; (-) Rarely Available

PROPOSED MODEL OF PEDIATRIC BEHAVIORAL HEALTH URGENT CARE

Despite the array of behavioral health services and widespread insurance coverage in Massachusetts, gaps in the current behavioral health system continue to impede timely access to behavioral health care when an urgent need arises.

In the proposed model for pediatric behavioral health urgent care, families, primary care practitioners, specialty settings, or schools might refer children to behavioral health urgent care. While some children in urgent need may continue to seek care in the ED, optimally, children in urgent need will be triaged to one of several settings equipped to provide pediatric behavioral health urgent care. These settings include Mobile Crisis Intervention, integrated primary care providers, or comprehensive community behavioral health clinics. In each of these settings, the child and family in need would receive a standardized evaluation, care planning, and expedited access to an array of ambulatory interventions, pharmacological treatment, and crisis stabilization services within hours of arriving. For children and adolescents with co-occurring ASD/IDD, evaluation and intervention protocols must incorporate neurodevelopmental considerations and evidence-based behavioral supports.

Proposed Model for Pediatric Behavioral Health Urgent Care



CREATING WALK-IN AVAILABILITY

The core capability of behavioral health urgent care will be the ability to receive timely, community-based (within 48 hours) access to crisis intervention and assessment and a meaningful connection to follow-up, ongoing care and treatment. These functions will primarily be accomplished at community-based outpatient behavioral health clinics and by MCI teams. Primary care providers should also be able to provide these functions, but their ability to do so depends on the level of behavioral health integration that they have achieved.

> ***"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***

ENHANCED OUTPATIENT BEHAVIORAL HEALTH

Community-based outpatient behavioral health settings will primarily be responsible for delivering a "place-based" behavioral health urgent care intervention, rather than creating a "new place to go" in the care delivery system. In order to achieve this new function, outpatient behavioral health settings must provide care for extended hours (such as until 8pm on weekday evenings) and for additional days (such as availability for at least parts

of Saturdays and Sundays) to accommodate the schedules of children and their families. Community-based outpatient behavioral health settings will be required to offer walk-in capacity each day to initiate comprehensive assessment and treatment. Instead of every single clinician being booked for every hour of the workday, appointment slots will be kept intentionally open to accommodate walk-in patients. For children and adolescents with behavioral health conditions and co-occurring ASD/IDD, outpatient behavioral health clinics will employ ASD/IDD expertise through enhanced MCI teams described below in "Mobile Crisis Intervention" or through tele-consultation with ASD/IDD experts described below in "Massachusetts Child Psychiatry Access Program." This arrangement will be funded through a combination of "standing funding" and enhanced reimbursement rates, both of which will be discussed in the "Financial Models" section.

Enhanced outpatient behavioral health should have the capacity to provide care and observation for up to 24 hours. Currently, outpatient behavioral health clinics are licensed to provide care for up to 24 hours, though they rarely do so. A key component of behavioral health urgent care will be the capacity to allow children and adolescents to stabilize for up to 24 hours in an outpatient behavioral health clinic. The provision of this type of care will require an enhanced reimbursement structure to incentivize and adequately finance the provision of this prolonged care within outpatient settings.

ENHANCED MOBILE CRISIS INTERVENTION

In order for the Mobile Crisis Intervention (MCI) program to effectively provide behavioral health urgent care, the quality of MCI teams must be improved by training frontline crisis clinicians in evidence-based crisis intervention, altering quality metrics, changing payment incentives, and developing a statewide approach to ensure that the MCI program is robust, effective, and responsive. In addition, certain enhanced MCI teams must have the ability to address crises and provide behavioral management for children and adolescents with co-occurring behavioral health and ASD/IDD diagnoses. These enhanced teams will be differentially staffed and financed, both of which will be further addressed during implementation planning, following the EOHHS release of MassHealth Behavioral Health Ambulatory Care Reform. This will be discussed further in the "Payment Mechanisms" section of "Implementation Considerations."

> ***"The existing mental health system does not work for kids on the Autism Spectrum. For example, it is impossible to do a med check for a child on the Autism Spectrum in 15 minutes. It takes at least 30 minutes if everything is going well, but could take up to three hours."***
>
> ***-Jean Frazier, MD***

PRIMARY CARE PROVIDERS

Child and adolescent primary care settings should have the ability to provide behavioral health assessment and triage, which is done by an integrated behavioral health clinician. Ideally, the number of pediatric primary care practices with integrated capacity will continue to increase, thereby increasing the number of practices capable of providing an urgent behavioral health intervention to children and adolescents. Inclusive of Federally Qualified Health Centers, primary care settings that provide onsite behavioral health specialty services

should be incentivized, through differential reimbursement rates, to accommodate rapid assessment, treatment initiation, and referral to continuing treatment, team, unit or home-based services designed for crisis stabilization. A key function of primary care settings will be to identify when a child or adolescent needs more intensive behavioral health care. At that point, primary care providers must be aware of behavioral health urgent care in order to refer children and adolescents appropriately.

MASSACHUSETTS CHILD PSYCHIATRY ACCESS PROGRAM

The Massachusetts Child Psychiatry Access Program (MCPAP) presents an opportunity to optimize the limited access to child and adolescent psychiatry. Building on the existing infrastructure of MCPAP, consultation need not be limited to primary care providers. With expanded capacity, consultation could occur across clinical and community settings (e.g., MCI, community behavioral health organizations, and schools). An expanded MCPAP model would create additional access to medication management for both MCI teams and outpatient behavioral health providers, an instrumental component of providing community-based behavioral health urgent care.

POST-CRISIS INTERVENTION PLACEMENT

Once an assessment and placement decision has been made in any one of these settings (primary care, outpatient behavioral health, or wherever the MCI evaluation occurs), the child or adolescent may be directed to any number of care options, including outpatient therapy, outpatient pharmacology, 23-hour close observation, Partial Hospitalization Programs (PHP), MCI follow up, or a Crisis Stabilization Unit (CSU). Currently, the child and adolescent behavioral health system includes outpatient therapy, pharmacology, PHPs, and MCI follow up, though access to all of these services can be difficult. In addition to improving access to these services, the CMHC recommends the creation of 23-hour observation in outpatient behavioral health clinics and child and adolescent CSUs. A successful urgent behavioral health intervention will be contingent on those leading the clinical team of behavioral health urgent care having the authority to immediately direct children and adolescents to the appropriate follow-up care. Insurers and follow-up care settings must be required to accept the disposition decisions of treating providers. Without the cooperation of the follow-up care settings and insurers, this system cannot function.

CREATION OF CHILD & ADOLESCENT CRISIS STABILIZATION UNIT

Though a behavioral health urgent care intervention may not include a CSU, a CSU would allow children and adolescents in need of short-term care option over 24 hours a setting in which to stabilize.

IMPLEMENTATION CONSIDERATIONS

There are numerous considerations when implementing any new service or service improvement. Throughout the current Executive Administration, the Massachusetts Executive Office of Health and Human Services (EOHHS) has undertaken significant service delivery and payment reforms in the MassHealth program. Simultaneously, advocates and system administrators have been working through the regulatory agencies governing health insurance

to expand the availability of CBHI services to children enrolled in commercial insurance and correct longstanding parity issues. Any change to enhance current services, fill service gaps, or create urgent care services must operate within the framework of these and related reforms. The following are key considerations that will inform an effective implementation.

> ***"You can't have urgent care if you do not have care."***
>
> ***-Henry Sachs, MD, Bradley Hospital***

INPATIENT AVAILABILITY

Pediatric behavioral health urgent care is one proposed and partial solution to ED boarding. Another proposed and partial solution is creating additional inpatient child and adolescent psychiatric beds. However, the gap in care for which pediatric behavioral health urgent care is designed would not be alleviated by the creation of additional inpatient psychiatric beds. Urgent behavioral health care is specifically targeting children and adolescents who require expedient access to behavioral health care but with appropriate crisis intervention and connection to treatment could be maintained in community-based settings, thereby reducing the demand for ED care.

Though additional inpatient psychiatric beds are not a component of the proposed pediatric behavioral health urgent care, the Campaign recognizes the need for additional inpatient psychiatric treatment settings for children and adolescents, especially in certain regions of the state and for children and adolescents with behavioral health conditions and co-occurring ASD/IDD. 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 March 2020, there were only 323 child and adolescent behavioral health inpatient beds throughout the state of Massachusetts. In addition, as of March 2020, the Commonwealth is facing additional closure threats.

Specifically, few acute psychiatric services are designed to serve children and adolescents with co-occurring ASD/IDD, so these children historically have been sent out of state for inpatient psychiatric care. In recognition of the need for increased inpatient capacity for this population, the Department of Mental Health issued a Request for Information to support the development of licensing requirements, models, and rates for specialized acute services. Since then, a new unit has been developed to meet the needs of children with co-occurring behavioral health conditions and ASD/IDD. The long-term sustainability of this program is dependent on a rate structure that supports the staffing (with respect to both expertise and number of staff) necessary for such a unit.

In recognition of the persistent issue of ED boarding, the Department of Mental Health's Expedited Psychiatric Inpatient Admissions protocol requires hospital EDs to work closely with health plans and psychiatric inpatient units in order to alleviate ED boarding and quickly place individuals in inpatient psychiatric care. Despite this new protocol (implemented in 2018), ED boarding persists and the first year of data illustrate a significant over-representation of children and adolescents under 18 among those who have waited more than 96 hours in EDs for inpatient care. According to this data collection process, "lack of bed availability" is most often identified as the primary driver of ED boarding among children and adolescents.[110]

STAFFING

A pediatric behavioral health urgent care intervention requires a robust staffing model, equipped with a multi-disciplinary team of behavioral health clinicians, including

- Master's level clinicians trained in evidence-based urgent care assessment, management and crisis intervention techniques;
- Care Coordinators/case managers to assist the family with care planning;
- Family Partners to provide support from the family perspective to families as they navigate care planning;
- Registered Nurses to provide medical clearance for all children and adolescents as well as to manage children and adolescents with co-occurring medical conditions; and
- Child/adolescent psychiatrists or advanced practice registered nurses to initiate and modify medication (this function may be accomplished through MCPAP).

In situations where the child presenting to behavioral health urgent care has co-occurring behavioral health and ASD/IDD conditions, the urgent team should be augmented by the following specialists, either in-person or via telemedicine:

- Board Certified Behavior Analysts to provide expertise in understanding and de-escalating behavior for children with co-occurring behavioral health and ASD/IDD;
- Physicians and/or nurse practitioners to provide medical clearance in situations where behavioral etiology is difficult to ascertain due to limitations in verbal communication among children and adolescents with co-occurring behavioral health and ASD/IDD;
- Developmental Pediatricians to provide consultation on complex cases where questions about behavioral etiology persist; and
- Family Partners, similarly for children and adolescents with behavioral health conditions, Family Partners are instrumental for families who have children with co-occurring behavioral health and ASD/IDD.

> ***"You need to have good clinicians providing the care and making sound clinical decisions and good disposition decisions."***
>
> ***- Henry White, MD, The Brookline Center***

An effective staffing model will be successful only with a payment structure that supports the provision of thorough and complete assessments, interventions, and care plans, which have been impeded by the rigid fee-for-service payment structure heretofore employed by payers.

SUSTAINABLE PRACTICE TRANSFORMATION AND TECHNICAL ASSISTANCE

In order to support the development of pediatric behavioral health urgent care, it will be necessary for outpatient behavioral health settings to transform their operations and practices. To support fidelity to the model, a learning community should be established that would provide technical assistance for practice transformation as well as training for frontline staff. Clinicians should be incentivized to complete trainings in evidence-based crisis intervention including those designed for children and adolescents with co-occurring

behavioral health and ASD/IDD. Several parents interviewed as key informants to this study noted the lack of community-based providers specializing in more complex behavioral health conditions as a barrier to accessing timely care, which directly led to the escalation of behavioral health symptoms to a crisis level (e.g., eating disorders, self-harm). Therefore, the proposed learning community should also provide trainings in managing and treating urgent presentations in the community to avoid the development of crises.

Creating the learning community is particularly necessary as a support to recruitment and retention of a larger ASD/IDD-trained workforce. Currently, much of the frontline workforce has been only informally prepared through personal family experience. There is currently not a specified training for crisis intervention available to BCBAs and an informal apprenticeship model has developed in its place; however, this model is not adequately meeting workforce shortages and limitations. Assuring that frontline ASD/IDD staff are dually trained to manage both behavioral health and ASD/IDD needs is essential. Moreover, a formal training for BCBAs on crisis intervention should be developed and offered through this learning community.

In addition to training current staff, it will be necessary to create a workforce pipeline. To develop this pipeline, policymakers should create incentives for master's-level social work and counseling interns to have internships within the behavioral health urgent care system. In addition, it is important to create incentives for Advanced Practice Registered Nurses to specialize in child and adolescent psychiatry. Staff burnout, particularly among staff working with children and adolescents with ASD/IDD, is an issue across all levels of care and must be addressed by building in necessary staff supports. To address burnout and increase the longevity of staff, it is necessary to implement and support ongoing reflective supervision practices.

SPECIALIZED RESPONSES

Within pediatric behavioral health urgent care, it will be necessary to develop specialized responses and interventions for complex and "hard to place" populations, including children and adolescents presenting with aggressive or sexualized behaviors, children and adolescents with co-occurring medical conditions, and children and adolescents presenting with substance use disorders. By addressing regulatory barriers to integration, true integration of treatment for mental health and substance use disorder must occur across behavioral health clinics, primary care practices, and MCI teams. In all of these settings, staff must be trained to manage and treat children and adolescents exhibiting this presentation. Responses to these specific situations may be augmented by MCPAP or other consultive telemedicine programs.

PAYMENT MECHANISMS

For pediatric behavioral health urgent care to be successful, it must be financed for long-term 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 many of the services proposed are billable to MassHealth (and in the long-term, commercial insurers as well). Services uncovered by MassHealth or other insurers will need other sources of funding, likely a combination of philanthropic investment (to demonstrate the efficacy of a pilot model) and long-term state appropriation. Given the current climate of investment in behavioral health within the Commonwealth's Medicaid 1115 Waiver, the

model is well-suited to be piloted within an Accountable Care Organization that could use its Delivery System Reform Incentive Payments 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 utilization.

A key element of the proposed model is the ability to access payer-blind, walk-in care, which will necessitate the use of funding for "standing capacity." The financing strategy should consider funding for "standing capacity" as the main source of revenue, supplemented by fee-for-service reimbursement, with the eventual participation of all payers. A payment structure should be able to support hours-long, or even days-long, interventions. EOHHS MassHealth Behavioral Health Ambulatory Care Reform is forecast to address standing capacity.

It is important to consider the financial implications for the creation of ASD/IDD capacity across the continuum of the behavioral health care system. At every level of care, the additional staffing levels and staffing expertise necessary for effective treatment requires an enhanced rate structure. In addition, treatment costs across care levels must account for the length of treatment and the longer duration of high-intensity treatment for children and adolescents with ASD/IDD.

"Outpatient therapy [for children and adolescents with co-occurring ASD/IDD] could not occur in a 50-minute time slot. It would need to be longer because of the communication barriers."

- Parent

REGULATORY

In addition to financing changes, there are several regulatory modifications that will need to occur to support the adoption of pediatric behavioral health urgent care. For example, it will be necessary to 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. In addition, behavioral health urgent care sites must be able to provide the medical clearance required for patient transport, inpatient admission, or treatment initiation.

To ensure effective implementation, it is crucial to address the significant administrative burdens due to misalignment between various agencies' protocols and requirements. For example, the standards for clinic licensure at the Department of Mental Health (DMH) and the Department of Public Health are not currently aligned. Alignment would enable a unified rapid response protocol and support true integration of mental health and substance use treatment. Similarly, DMH and the Department of Developmental Services do not coordinate with one another but provide overlapping services to children and adolescents with co-occurring behavioral health and ASD needs. In order to address this issue, the two departments must establish linkages for assessment consultation and care planning protocols in order to integrate the treatment of behavioral health and neurodevelopmental conditions.

NAVIGATION AND CARE TRANSITIONS

As illustrated in the proposed model of care, pediatric behavioral health urgent care must

function within the behavioral health care continuum in order to be effective. Current gaps in communication and clinical information sharing between crisis and outpatient care must be mitigated and addressed. Urgent behavioral health care must be able to interface between both higher and lower intensity behavioral health care settings. To do so, a specified functional role in bridging outpatient and crisis services and supporting transitions between inpatient and community care settings should be created. Structure resources and clinical administrative authority to incentivize management of care transitions across settings, inclusive of school settings, especially for children and adolescents with co-occurring mental health and ASD/IDD.

> ***"In providing an urgent care response, we need to promote continuity in treatment relationships between pediatric primary care, specialty providers and the child and family. Practice transformation and reimbursement incentives are needed."***
>
> ***- Michael Yogman, MD***
>
> ***Chair, American Academy of Pediatrics, Child Mental Health Task Force***

DESIGN OF PHYSICAL SPACE

Delivering pediatric behavioral health urgent care by enhancing the services already provided at outpatient behavioral health clinics will necessitate a reconfiguration of the physical space of clinics to meet the needs of children and families. For urgent outpatient appointments, spaces must be able to accommodate multiple elements of care provision, including dedicated spaces for reception and intake, individual and group clinical consultations, and family meetings. All of these spaces should consider the sensory aspects of space (e.g., lighting, noise levels, etc.), particularly for children and adolescents with ASD/IDD. The physical space should be designed to treat and accommodate the needs of both the families and the children and adolescents. The space also should be able to accommodate hours-long interventions and may be co-located with crisis stabilization or MCI programs.

GENERATE SUPPORT AND CONSENSUS

In order to garner support needed for practice transformation, pilot sites and early model adopters will need to develop a community engagement and education strategy. These planned changes in service provision must be disseminated in the community to assure that families and providers are aware of the pediatric behavioral health urgent care model. It will first be essential for providers to reach out to families and primary care providers to assure that families are aware of this new level of care. Both primary care providers and families must be aware of the availability and parameters of pediatric behavioral health urgent care in order for it to be adopted successfully. Providers also will need to form partnerships with first responders (police, fire, EMTs) to engage and redirect to behavioral health urgent care. In addition, first responders should be trained in both mental health first aid and crisis intervention, a training which exists for ASD/IDD (see the Autism and Law Enforcement Education Coalition "Highlighted Practice" on page 31).

PILOT DEMONSTRATION AND UTILIZATION OPTIMIZATION

In discussions with Massachusetts 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 Tower Foundation grant and Miller Innovation Fund grant, the CMHC is employed a 10-part process to guide selection and optimize utilization of the pediatric Behavioral Health Urgent Care pilot. In Year 3, as we await release of EOHHS' Ambulatory Care Redesign, the CMHC is poised to act on those considerations.

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 reviewed 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, specialty neurodevelopmental experts, residential treatment, respite programs, and case and care management services. Profiles incorporate consideration of the distinct characteristics and needs of children and adolescents with urgent behavioral health conditions, including those with co-occurring neurodevelopmental conditions of ASD/IDD. Note: The geo-mapped profiles of behavioral health services available throughout the Commonwealth have been developed by the Massachusetts Association for Mental Health 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.

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 are in development to guide implementation and outcomes evaluation for the pilot area. Note: The CMHC has undertaken, 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 is engaged 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 of change. Note: The CMHC has identified and is actively engaged with these stakeholders throughout Year 2 and into the start of Year 3.

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.

CONCLUSION

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 in which children and adolescents with ASD/IDD are at highest risk of longest waits, 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.

APPENDICES

APPENDIX A: LIST OF INTERVIEWEES, FOCUS GROUPS, TELEPHONIC CONSULTATIONS, AND SITE VISITS INTERVIEWEES

Interviewees

1. Ellen Attaliades, MA
   President and CEO, Association of Developmental Disability Providers (ADDP)
2. Shelley Baer, MS
   Vice President, Massachusetts Behavioral Health Partnership
3. Joan Beasley, PhD
   Director, Center for START Services at the University of New Hampshire Institute on Disability
4. Carolyn Bridgemohan, MD
   Associate Physician, Developmental Medicine; Co-Director, Autism Spectrum Center, Boston Children's Hospital
5. Stephanie Jordan Brown, MA, MA
   Director, Office of Behavioral Health, MassHealth
6. Bill Cannata
   Program Director, Autism and Law Enforcement Education Coalition
7. Maria Cheevers, MA
   Director, Office of Research & Development, Boston Police Department
8. Shella Dennery, PhD, LICSW
   Director, Boston Children's Neighborhood Partnerships Program
9. Vic DiGravio, MPA
   President & CEO, Association for Behavioral Healthcare
10. Lisa Fortuna, MD, MPH
    Medical Director for Child & Adolescent Services, Boston Medical Center
11. Jean Frazier, MD
    Executive Director, Eunice Kennedy Shriver Center, University of Massachusetts Medical School
12. Janet George, EdD
    Assistant Commissioner for Policy, Planning, and Children's Services, Department of Developmental Services
13. Dania Jekel, MSW
    Executive Director, Asperger/Autism Network
14. Jennifer Jencks, LICSW, PhD
    Director, Access Center, Bradley Hospital; Assistant Director of Lifespan Pediatric Behavioral Health Emergency Services

15. Lisa Lambert
    Executive Director, Parent/Professional Advocacy League
16. Michael Lee, MD, MBA
    Executive & Medical Director, Children's Hospital Integrated Care Organization
17. Julie Love, MSN, APRN, PMHNP-BC
    Clinical Director, McLean School Nurse Liaison Project
18. Kappy Madenwald, MSW
    Affiliate, Technical Assistance Collaborative Founder, Madenwald Consulting, LLC
19. Elizabeth Martineau, MBA
    CEO, Board Chair, President and Clinical Director, Nashoba Learning Group
20. Joan Mikula, MA
    Commissioner, Massachusetts Department of Mental Health
21. Elizabeth Morse
    Deputy Commissioner, Department of Developmental Services
22. Margaret R. Paccione-Dyszlewski, PhD
    Director, Clinical Innovation, Bradley Hospital
23. Jane Ryder, MPA, MPA
    Commissioner, Department of Developmental Services
24. Chase Samsel, MD
    Attending Psychiatrist, Department of Psychiatry; Associate Training Director, Child and Adolescent Psychiatry Fellowship, Boston Children's Hospital
25. 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
26. Mark Schechter, MD
    Chair of Psychiatry, North Shore Medical Center
27. Emily Sherwood, MPA
    Deputy Commissioner for Children, Youth, & Family Services, Department of Mental Health
28. Brian Skehan, MD, PhD
    Assistant Professor, University of Massachusetts Medical School
29. Sarah Spence, MD, PhD
    Assistant, Department of Neurology; Co-Director, Autism Spectrum Center, Boston
30. Eric Storch, PhD
    Vice Chair & Head of Psychology, Menninger Department of Psychiatry and Behavioral Sciences, Baylor College of Medicine
31. Marylou Sudders, MSW, ACSW
    Secretary, Executive Office of Health & Human Services
32. Scott Taberner
    Chief of Behavioral Health, MassHealth
33. Judith Ursitti, CPA
    Director, State Government Affairs, Autism Speaks

34. Jacob Venter, MD, MPA, CPE, FAPA
    Division Chief, Child & Adolescent Psychiatry, Cambridge Health Alliance
35. Amy Weinstock, MA
    Director, Autism Insurance Resource Center
36. Beth Wharff, PhD, MSW, LICSW
    Chief of Social Work, Department of Psychiatry; Director, Social Work Training Program; Boston Children's Hospital
37. Henry White, MD
    Clinical Director, The Brookline Center for Community Mental Health
38. Jacob White, MD
    Child & Adolescent Psychiatry Fellow, Boston Children's Hospital
39. Michael Yogman, MD
    Chair, American Academy of Pediatrics, Child Mental Health Task Force Assistant Clinical Professor, Harvard Medical School
40. Charlene Zuffante, MSW
    Director of Child & Adolescent Services, DMH Metro Boston

Focus Groups

1. Advocacy for Autism in Massachusetts
2. Autism Commission – Health Care Subcommittee
3. Master's-level Emergency Services Program (Emergency Services Program/Mobile Crisis Intervention) providers
4. Children's Behavioral Health Advisory Council
5. Boston Children's Hospital's Behavioral Health Family Advisory Council
6. Parent/Professional Advocacy League Families
7. 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. Rita Gardner, MPH, LABA, BCBA
   President and CEO, Melmark, Andover, MA
5. Nancy Paull, MS
   CEO, SSTAR, Fall River, MA
6. Henry Sachs III, MD
   Interim President & Chief Medical Officer, Bradley Hospital, Providence, RI
7. Katherine Wilson
   President & CEO, Behavioral Health Network, Springfield, MA

CMHC Boarding Project Advisory Group

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, MA
    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

APPENDIX B: KEY INFORMANT INTERVIEW GUIDE & SITE VISIT GUIDE

Key Informant Interview Guide
Background Statement on Miller Innovation Fund and Tower Foundation Urgent 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.

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?

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?

Policy Questions:

1. Given the service delivery and payment reforms underway in Massachusetts, what do you recommend as a payment model or reimbursement methodfor 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?

APPENDIX C: KEY INFORMANT INTERVIEW GUIDE FOR ASD/IDD STAKEHOLDERS

Key Informant Interview Guide
Background Statement on Miller Innovation Fund and Tower Foundation Urgent Care Study

The CMHC received two grants –one from the Miller Foundation and one from the Peter & Elizabeth Tower Foundation—to research an effective model of urgent care for children and adolescents experiencing a mental 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 (ASD) and/or an intellectual/developmental disability (IDD). The CMHC reached out to MAMH and asked us to join their leadership team and as part of our membership, we are responsible for conducting this research project.

Right now, MAMH is conducting a scan of the literature and interviewing key stakeholders—both in MA and nationally—to inform the model. This work is carried out with Amy Weinstock of the Autism Insurance Resource Center (AIRC), who is engaged as a consultant to the CMHC.

Using the literature scan and qualitative data, we will be publishing a report addressing the implementation of children's mental 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 urgent care within the existing and emerging children's mental health infrastructure.

Stakeholder Interview and Focus Group Questions and Discussion Topics

1. How would you characterize an urgent mental health need for a child with ASD/IDD?
    a. How can such a need be distinguished from a mental health emergency, requiring immediate attention to prevent harm to oneself or to others?

2. How would you characterize an urgent mental health need for an adolescent with ASD / IDD?
    a. How can such a need be distinguished from a mental health emergency, requiring immediate attention to prevent harm to oneself or to others?

3. What are the characteristics of the population of children with ASD/IDD who would benefit from mental health urgent care?
    a. How are these characteristics different for adolescents with ASD /IDD?

4. What specific needs do younger children with ASD /IDD have when they are experiencing a mental health crisis?
    a. What EBP or behavioral techniques work well to meet these needs?

5. What specific needs do adolescents with ASD/IDD have when they are experiencing a mental health crisis?
    a. What EBP or behavioral techniques work well to address these needs?

6. In what setting(s) do you envision an urgent response being delivered to children with ASD /IDD?
    a. Would the setting be different for adolescents with ASD /IDD?

7. In which settings would referrals to urgent care most likely arise (Family? Schools? Residential? Foster care?)

8. Short of a separate and dedicated care space for children and adolescents with ASD /IDD what adaptations could be made to existing clinical spaces to best meet the needs of children and adolescents with ASD /IDD?
    a. How do these vary according to age, ASD vs. IDD, gender, etc.?

9. What are the essential care elements for best serving children and adolescents with ASD/ IDD?
    a. How are these elements best organized to deliver effective mental health urgent care services to children and adolescents with ASD/IDD?
    b. How are these elements different for youth with ASD/IDD?

10. Of the various models (MCI, PES, primary care integration, urgent appointments in BH clinics, and co-location with urgent care), which one(s) would be optimally beneficial for children and adolescents with ASD/IDD?

a. Would a certain model be particularly suited for a particular demographic (age, gender, geographic location, diagnosis, etc.)

11. What would be the best way to integrate treatment of SUD into an urgent level of care?

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

13. What might ASD/IDD provider(s) concerns be about the urgent care model you propose?

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

15. 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 geared specifically to children with ASD/IDD?

a. Are there standing reimbursement structures that support the model of care you r recommend?
b. Are there any innovative payment models that could be leveraged, particularly in the ACO landscape?

2. What legal or regulatory changes will be necessary to implement operationally the mental health urgent care model and assure its financial viability?

a. Operationally viable?
b. Financially viable?

3. How would reimbursement rates need to be altered to meet the level of care required to treat children and adolescents with ASD/IDD (increased time, staff, etc.)?

4. What are the particular treatment access barriers that you observe for children and adolescents with ASD/IDD?

a. How can these barriers be addressed?

5. Is there a role for MCPAP for ASD/IDD? Does a consultation model adequately address needs or does it risk becoming a permanent bandage for a larger problem?

Service Delivery by Setting Questions:

MCI

1. How would the existing MCI program in MA need to be modified/expanded in order to

adequately meet the urgent BH needs of ALL children and adolescents with ASD/IDD?

a. Is there current specialized capacity within the MCI program for children with ASD/IDD?

2. What are the existing barriers with the MCI model (not permitted in schools, held out of certain hospital EDs, only covered by Medicaid, etc.)?

Primary Care Integration

1. Would it be possible for children and adolescents with ASD experiencing an urgent BH need to be treated in a primary care office?

a. If so, what accommodations will be necessary in order to make this model successful? For embedded urgent appointments in primary care, how what payment structure makes this program optimally sustainable?

a. Is there a way to collaborate with ACOs for this model?

Urgent Appointments in BH Clinics

1. Would it be possible for children and adolescents with ASD experiencing an urgent BH need to be treated in an OP mental health clinic?

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.

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?

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?

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?

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

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

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

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

CHILDREN'S MENTAL HEALTH CAMPAIGN