
HMA

HEALTH MANAGEMENT ASSOCIATES

*Behavioral Health Crisis Services –
Models and Issues*

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Executive Summary

There is general agreement that far too many persons with behavioral health (mental illness and/or substance use disorder [SUD]) issues are arriving in hospital emergency departments (EDs) and not being well served in that setting. The underlying issues interfering with the appropriate treatment of persons in a behavioral health crisis are complex and many. There are many large service systems that can be involved: physical health, emergency services, law enforcement, and certain community social services, in addition to behavioral health. These service systems have their own points of entry (in many cases multiple doors for the individual system) with great variation in the skills, training, and experience of the person at the initial point of contact. There are obvious challenges around which agency should take initial responsibility and how services are coordinated. Each situation requires a judgment about who does what and when, as well as communication and coordination across systems and professionals.

Given the breadth of the behavioral health emergency response environment, there have been multiple service configurations designed to improve the system. Since much of this capacity is still emerging, evidence for the best approach to these services is very limited. Further, the different environments (especially urban versus rural) and community resources may result in best practices that vary.

Standalone Behavioral Health Crisis Centers

Crisis centers function like a behavioral health ED. They stabilize and assess persons in crisis in an environment conducive to their needs, resulting in better outcomes. Fewer individuals require inpatient psychiatric treatment, and referrals are made to more appropriate settings. Crisis centers are often paired with crisis residential units that provide longer term services but short of psychiatric hospitalization. There are a limited number of crisis centers in Michigan, two are operational and two others are in the planning stage. Some point to the law which requires ambulances to transport emergencies to hospital emergency departments (EDs) as a major impediment. While this is an issue, there are many other obstacles to developing and sustaining crisis centers.

Mobile Crisis Teams

Mobile crisis teams go out into the community to begin the process of assessment and definitive treatment outside of a hospital or health care facility. These teams include a psychiatrist available by telephone or for in-person assessment as needed and clinically indicated. Mobile crisis services can be a valuable part of a crisis service system, but they are not a singular solution.

Co-located, Dedicated Behavioral Health Crisis Emergency Services Unit

This service configuration has hospitals creating a dedicated psychiatric emergency services unit. This is a standalone ED specifically for psychiatric patients. The advantages of such a unit is that staffing can be tailored to the needs of this population, and the physical environment can be controlled to help alleviate stressors. This approach to the behavioral health ED problem may have limited application because some urban areas have many hospitals, and rural areas have the obvious volume and resource issues.

Behavioral Health Staffing in Hospital EDs

Increasing behavioral health staff resources in EDs is a variation on the dedicated unit approach and can take many forms. It can consist of in-house hospital personnel of various professional credentials, collaborative arrangements with behavioral health staff or teams from community agencies, use of paraprofessionals as staff enhancement, and/or psychiatric or lower level professional telehealth.

While there are numerous substantive issues that must be addressed to move the service delivery system forward, the dominant theme from our research was that the behavioral health care service continuum was critical to success in responding to behavioral health crisis situations. Breakdowns at any point in the service array lead to dysfunction throughout the system. While the most prominent example is a shortage of inpatient psychiatric beds, the need for outpatient behavioral health services in the community gets equal billing. This follows the general health care principle that it is better to engage services in the least intensive yet appropriate manner and setting for better outcomes and lower cost.

Beyond the care continuum, there are many other complex, challenging issues that must be addressed in building an effective service delivery system for behavioral health crises. These include: well-designed triage and direction into the service system; interagency coordination; financial issues, especially public and private health insurance coverage of non-traditional crisis services; and a wide range of legal issues covering law enforcement, Emergency Medical Services and ambulance licensing, scope of practice laws, and consumer protections for behavioral health patients.

Introduction/Background

There appears to be general agreement that far too many persons with behavioral health (mental illness and/or substance use disorder [SUD]) issues are arriving in hospital emergency departments (EDs) and not being well served in that setting. Holding behavioral health patients in EDs has been termed “psychiatric boarding” and is a growing problem with 90 percent of ED physicians reporting this reality.¹ Long waits in noisy EDs may exacerbate symptoms; and often the EDs do not have the professional staff best suited to provide services. The flip side of this is ED “streeting” where behavioral health patients are discharged prematurely and/or without supports. In either case, “boarding” or “streeting” is damaging to these patients. From a cost standpoint, ineffective treatment of behavioral health patients in EDs is a poor use of resources. The ED itself is an expensive setting and can result in unnecessary and costly admissions for public and private insurers. In short, it is the wrong place at the wrong time for many patients for lots of reasons.

Behavioral health crisis centers are one alternative and an additional approach advocated as a solution to the problems with behavioral health patients who do not need ED services and yet are waiting for the next level of behavioral health care while in the ED. The crisis centers in operation function like specialized behavioral health EDs. They stabilize and assess persons in crisis in an environment conducive to their needs, resulting in better outcomes. Fewer individuals require inpatient psychiatric treatment, and referrals are more appropriate.

So why aren’t there more behavioral health crisis centers? Many point to the laws governing ambulance transport as the root of the problem and a barrier to developing more appropriate settings and service systems. Michigan law and regulation requires that any emergency transport have a licensed hospital as its destination. This is the action that precedes a person in a behavioral health crisis arriving at a hospital ED, precluding immediate diversion to a crisis center. While this is the reality and a significant problem itself, it is hardly the entire story or even the most important element in the range of issues that are at the root of this harmful situation.

The underlying issues interfering with the appropriate treatment of persons in a behavioral health crisis are complex and many. For instance, there are many large service systems that may be involved. They include physical health, emergency services, law enforcement, and certain community social services in addition to behavioral health. These service systems have their own points of entry (in many cases multiple doors for the individual system) with great variation in the skills, training, and experience of the person at the initial point of contact. The behavioral health system has its own complexities and issues with service coverage and coordination across both private and public spheres. There are significant legal issues including professional scope of practice laws, facility and service licensing (including ambulance emergency destination restrictions), and protections for patients including medical clearance and “certifications for involuntary admissions.” Financing has its own set of challenges since insurers (public and private) have their own systems of rules that only reimburse certain services rather than the funding capacity to serve anyone in crisis, regardless of coverage status.

The various service systems potentially involved in response to emergent or urgent situations are intended to cover the diversity of difficulties that individuals can present and consequently have

enormous collective functional span. While each system has its own specialization and ability to effectively address problems that fit within its orbit, urgent and emergent situations can involve multiple issues that overlap systems. A person having a psychotic episode may have physically injured themselves or others. That would require not only behavioral health services but physical health care and law enforcement as well. A homeless person with uncontrolled diabetes and severe depression also requires response from multiple systems: community social services for housing and other social determinants of health, medical professionals to address the diabetes and any other physical health issues, and behavioral health professionals to focus on the depression. These are just a couple of what are likely an almost infinite range of problems that can be encountered. There are obvious challenges in which agency takes initial responsibility and how services are coordinated. Each situation requires a judgment about who does what and when, as well as communication and coordination across systems and professionals.

Behavioral Health Crisis Response Models

Given the breadth of the behavioral health emergency response environment, there have been multiple service configurations designed to improve the system. These include mobile crisis teams; behavioral health staffing in EDs; a co-located, dedicated behavioral health emergency services unit (alongside traditional EDs); and standalone behavioral health crisis centers. Much of this capacity is still emerging so evidence for the best approach to these services is very limited. Further, the different environments (especially urban versus rural) and community resources may result in best practices that vary.

Standalone Behavioral Health Crisis Centers

The shorthand definition of standalone behavioral health crisis centers is that they are functionally behavioral health dedicated EDs. A 2014 SAMHSA report has offered a richer definition: “23-hour crisis observation or stabilization is a direct service that provides individuals in severe distress with up to 23 consecutive hours of supervised care to assist with deescalating the severity of their crisis and/or need for urgent care. The primary objectives of this level of care are prompt assessments, stabilization, and/or a determination of the appropriate level of care. The main outcome of 23-hour observation beds is the avoidance of unnecessary hospitalizations for persons whose crisis may resolve with time and observation.”²

It is interesting that crisis center services as described above are almost always paired with crisis residential units (or crisis stabilization facilities) which provide capacity for short-term stays as an alternative to inpatient psychiatric hospitalization. Again, we have a useful SAMHSA definition: “a direct service that assists with deescalating the severity of a person’s level of distress and/or need for urgent care associated with a substance use or mental health disorder. Crisis stabilization services are designed to prevent or ameliorate a behavioral health crisis and/or reduce acute symptoms of mental illness by providing continuous 24-hour observation and supervision for persons who do not require inpatient services.”³

While SAMHSA has provided definitions, it seems fair to observe that there appears to be a lack of standardization in the use of terms and the actual organization of services. Crisis stabilization programs

can refer to both short and longer-term settings. Some crisis services can be for up to 48 hours but still not be considered a residential or inpatient unit. Unless otherwise indicated, we will use the SAMHSA definitions and treat crisis centers as 23 hours or less and residential units as short stays that avoid an actual inpatient admission.

The National Action Alliance for Suicide Prevention: Crisis Services Task Force in their document, *Crisis Now: Transforming Services is Within Our Reach*,⁴ further described crisis residential units as “usually small (e.g., 6-16 beds), and often more home-like than institutional. They are staffed with a mix of professionals and paraprofessionals. They may operate as part of a community mental health center or in affiliation with a hospital. The Task Force recommends crisis stabilization facility function is maximized when the facilities:

- ❖ Function as an integral part of a regional crisis system serving a whole population rather than as an offering of a single provider
- ❖ Operate in a home-like environment
- ❖ Utilize peers as integral staff members
- ❖ Have 24/7 access to psychiatrists or Master’s-level mental health clinicians”

Crisis centers can be designated as mental health or mental health/SUD. There are different local circumstances that lead to this distinction in breadth of service. It should be noted that the perspective of some experts is that it is very difficult to operate with this distinction and that an effective crisis response requires the capacity to address both mental health and SUD issues. The result is usually a function of both resources and organizational considerations.

In a similar vein, experts in the field stress the importance of a care continuum that can meet the range of needs for individuals who present for services. This includes an effective prevention and outpatient service capacity as well as sufficient and effective inpatient psychiatric hospital capacity. Crisis centers and crisis residential units can play a critical role in this care continuum.

Nationally, there appears to be considerable crisis center capacity although it is difficult to dissect how much of this is through crisis centers as described at the beginning of this section, crisis residential units, or crisis stabilization programs generically with a range of service types. The 2014 SAMHSA report covering eight states shows substantial crisis services resources in all states with most descriptions giving the impression that they include crisis centers.⁵ Whether there is comprehensive coverage across the entire state is unclear in many instances.

Among the best-known organizations, RI Crisis is one of RI International’s (formerly Recovery Innovations) business units operating in five states: Arizona, California, Delaware, Texas, and Washington State. They include crisis stabilization as a core part of their overall program. The Restoration Center in San Antonio, Texas, is a locally developed crisis service center that includes a crisis walk-in center and a 48-hour observation unit (with average lengths of stay about 20 hours). A final national example is in Idaho; crisis centers operate in three of the state’s largest cities, primarily responding to walk-ins and law enforcement referrals.

Michigan has at least two crisis centers in operation and two that are in the planning stages. The center with the broadest capacity is Common Ground in Oakland County. It is a private non-profit that started as a telephone hotline 47 years ago. It picked up the pre-admission screening function in 1995 for Oakland County and, inspired by Recovery Innovations, in 2011 broadened its crisis services to include a screening, assessment, and observation center; a residential unit; and a detoxification (detox) unit. It also has capacity to link with a wide range of community social services on site. CEI, the community mental health authority (and community mental health services program [CMHSP]) for Clinton, Eaton, and Ingham counties, has operated a crisis center for decades but seems to be more under the radar. They have a crisis center with six beds, with plans to expand to 10. CEI's other crisis services are in different geographic locations and with plans to consolidate to the main campus. Both Network 180 (Kent County CMH) and Washtenaw County are actively planning for crisis centers.

Mobile Crisis Teams

The 2014 SAMHSA report starts its definition of mobile crisis teams in this way: “The American Psychiatric Association (APA) Task Force defines mobile crisis services as having the ‘capacity to go out into the community to begin the process of assessment and definitive treatment outside of a hospital or health care facility,’ along with a staff including ‘a psychiatrist available by phone or for in-person assessment as needed and clinically indicated’. Mobile crisis teams provide acute mental health crisis stabilization and psychiatric assessment services to individuals within their own homes and in other sites outside of a traditional clinical setting.”⁶

The SAMHSA report continues with this additional information (with acknowledgements to other sources as well): “Although most mobile crisis teams are a link between the community and the emergency department (ED), some are co-located in facilities that have both outpatient and ED services, fewer are co-located in inpatient services and outpatient services, and some operate in more than one of these domains. The main outcome objective of mobile crisis teams is to reduce psychiatric hospitalizations, including hospitalizations that follow psychiatric ED admission. Some mobile teams are focused on reducing arrests of mentally ill offenders. Diversion is also a main goal of police-based teams, which may be staffed by mental health consultants or exclusively by police officers with mental health training.”⁷

SAMHSA's 2014 Crisis Services report showed all eight states with mobile crisis team services in place, although it is again unclear how much coverage there is in each state. Most references include mobile crisis teams as a part of the overall system, not as the primary method of responding to behavioral health crises. It is noteworthy that these services are not necessarily in the home and that teams can be considered mobile even when housed with outpatient and hospital ED services. Some in the field believe there should be limits on these teams due to both safety and financial concerns.

While mobile crisis services have been covered by Michigan's Medicaid program for 20 years, only recently (effective October 1, 2017) has it required the public behavioral health system to provide for a mobile intensive crisis stabilization team for children in each geographic jurisdiction. The priority is to “avert a psychiatric admission or other out of home placement or to maintain a child or youth in their home or present living arrangement...”⁸ Several CMHSPs had mobile crisis capacity prior to this

requirement. Common Ground had partial county coverage 12 hours per day. Until late 2017, Genesee County was the only reported 24/7 operation with full county coverage. Northern Lakes Community Mental Health (NLCMH), a CMHSP serving six northern Michigan counties (Crawford, Grand Traverse, Leelanau, Missaukee, Roscommon, and Wexford), implemented its mobile intensive crisis stabilization program during the fall of 2017 with the support of a grant from the Michigan Health Endowment Fund. Called Family Assessment & Safety Team, or FAST, services are provided on a 24/7 basis throughout NLCMH's service area for families with children in behavioral health crisis.⁹

Co-located, Dedicated Behavioral Health Emergency Services Unit

In December 2015, The Joint Commission issued a short paper that addressed the problems of behavioral health patients in hospital EDs along with a range of potential solutions. The range of solutions included hospitals creating “a dedicated psychiatric emergency services unit (a standalone ED specifically for psychiatric patients).”¹⁰ The advantages of such a unit is that staffing can be tailored to the needs of this population and the physical environment can be controlled to help alleviate stressors.

In late 2017, Gwinnett Medical Center in Lawrenceville, Georgia, a suburb of Atlanta, opened a new 5,000 square foot specialized behavioral health unit that can hold up to eight patients at a time. This unit was created adjacent to the existing hospital ED, at a cost of nearly \$3 million. The hospital reports that they will contract with a full-time staff of behavioral health care professionals to work with some of the system's ED nurses who will be assigned to provide for the medical care needs of the patients.¹¹

This approach to the behavioral health ED problem may have limited application. A very large medical center like Gwinnett's, which dominates a geographic area, is the most likely location for such a unit in a hospital alongside an existing ED. Urban areas with many hospitals, where the behavioral health ED patients are more dispersed, face a resource concentration issue. Rural areas have obvious volume and resource issues as obstacles. Also, there are questions about the quality of medical services for physical health issues in these behavioral health units.

Behavioral Health Staffing in Hospital EDs

Increasing behavioral health staff resources in EDs is a variation on the dedicated unit approach and can take many forms. It can consist of in-house hospital personnel of various professional credentials, collaborative arrangements with behavioral health staff or teams from community agencies, use of paraprofessionals as staff enhancement, and/or psychiatric or lower level professional telehealth.

It is likely that these types of arrangements are prevalent in various forms throughout the nation. For example, in Ingham County, there are different service configurations with each of the two local hospitals. In one, the hospital itself has an in-house behavioral health team that initially provides services in the ED. In the other hospital, the local public CMHSP embeds a team in the ED from 2 pm to 2 am each day.

The Michigan Health Endowment Fund is itself funding projects that aspire to increase behavioral health capacity in hospital EDs. One approach is with Pine Rest Christian Mental Health Services, which has proposed to educate staff and provide telephonic consultation and case management services to

hospital EDs across west Michigan. Their focus is on children presenting with behavioral health issues. The Michigan Department of Health and Human Services has just begun a project to explore partnership relationships between hospitals and public community behavioral health agencies to provide Community Living Support services in EDs and inpatient psychiatric units. This would enable the deployment of trained paraprofessional staff in these hospital settings for appropriate support to patients and relief to other hospital staff.

There are, no doubt, almost endless examples of variations on this approach across the country. This solution concedes that the hospital ED is not an ideal environment for behavioral health patients but seeks to provide higher quality and more timely services in that context.

Moving Forward – Diving into the Issues and Possible Strategies

The notion that developing behavioral health crisis center capacity will somehow solve the problem of behavioral health patients in hospital EDs seems simplistic even if the transportation of those patients to crisis centers could be arranged. This is a tremendously complex problem. Hopefully, this paper has effectively described some of that complexity ranging from the variety of needs of the presenting individuals themselves to the many service systems and local variability of resources. This section has the modest aim of discussing the many challenges and offering potential strategies for forward movement. Overriding themes are the need for a care continuum and coordination across service systems.

Effective Triage and Direction into the Service System

As observed earlier, there are numerous possible initial methods of contact in behavioral health emergencies. Behavioral health agencies have their own contact points, and public systems typically have a legal mandate for a crisis hotline or call center. Emergency response systems have 911 call centers. There are now also 211 call centers for referral to community resources. Law enforcement is sometimes the first point of contact whether in response to a call from the community or involvement in an actual situation. Finally, individuals can be referred by other professionals or simply find their way to services on their own.

Each of these contact methods involves personnel with different training, knowledge, and skills. Some may be volunteers. Others are trained but in the context of their position and role. A 911 operator has very specific training and priorities around emergency situations: they are likely to call on Emergency Medical Systems (EMS) or law enforcement, or both, to respond. Law enforcement officers will generally start from a criminal justice orientation, but those trained in behavioral health issues will have a broader perspective. EMS will have different capacity based on the level of personnel, with paramedics having more training than Emergency Medical Technicians (EMTs). A crisis hotline staff person is likely to handle a call very differently and isn't predisposed to take any action other than to empathize and talk. Hopefully this representative but hardly exhaustive list of possible initial points of contact provides some sense of the range of perspectives that exist as individuals enter "the system".

Enhancing the skills of the personnel involved and more effective cross-training across service systems have potential benefit in more appropriate direction to services. A paramedic with enhanced training and telehealth support could evaluate an emergency situation and rule out physical health involvement and direct the patient to a crisis center where their needs would be more effectively addressed. A 911 operator potentially could be trained to direct an emergency response to a behavioral health mobile crisis team. None of this is easy and there are legal and licensing aspects to these situations (to be addressed in more detail later). But better triage and initial direction is an important piece to building an effective response to behavioral health issues, as well as the broad range of other issues that individuals bring from the community. It is encouraging that Crisis Intervention Teams are receiving this training in pilot sites across the country.

It is noteworthy that in fiscal year 2017, Common Ground, Oakland County's Crisis Center (www.commongroundhelps.org), had only 486 transports to their facility by ambulance (from the hospital ED) out of a total of 6,587 persons presenting for service. More were transported by law enforcement (611), but the vast majority (5,490) directed themselves to the crisis center and "walked in". Idaho's three crisis centers were characterized as entirely law enforcement diversion or walk-in.

This speaks to another important aspect of the front-end system, good communication with the community on the availability of different services. You can't find the right place if you don't know about it. A public information campaign that gets the word out to community agencies, public and private, as well as the general public is a must for a well-functioning service entry process.

Legal Challenges

There are multiple legal issues that must be addressed for the service system to be effective. These include a number of EMS and ambulance requirements, medical clearance, legal ability to hold or restrain (including secure facilities), certifications for involuntary psychiatric admissions, and scope of practice laws for various professionals involved in services. The point of this section will be to describe the impact that these legal constraints have on the system of care rather than provide precise accounts of the legal content.

Legal requirements for EMS personnel and ambulance operations are extensive. That makes sense given the nature of the situations that the system confronts, emergencies where life and death are often the stakes. EMS is directed at the county level by Medical Control Authorities. They have protocols including those to assess a patient as a non-emergency behavioral health patient. In that case, the patient can be transported to a crisis center or other destinations, but most insurers won't reimburse that transport, so this rarely happens. (Medicare only pays for emergency transports to hospitals and virtually all insurers follow the Medicare standard.) As noted above, there are different levels of personnel that staff emergency response services including paramedics and EMTs. Presently, the EMS system is focused on obtaining health insurance reimbursement for paramedic services, actually delivering services at the point of contact rather than transporting to the hospital ED, and identifying strategies to reduce the number of nuisance calls.

The ambulance destination requirement is a major concern from some interested in developing crisis center service capacity. (Michigan’s Public Health Code regulation R 325.22112 states “An ambulance operation, both ground and rotary, shall transport an emergency patient only to an organized emergency department located in and operated by 1 of the following: (a) a hospital licensed under part 215 of the code, (b) a freestanding surgical outpatient facility licensed under part 208 of the code that operates a service for treating emergency patients 24 hours a day, 7 days a week and complies with medical control authority protocols, (c) an off-campus emergency department of a hospital licensed under part 215 of the code if the off-campus emergency department is available for treating emergency patients 24 hours a day, 7 days a week, complies with medical control authority protocols, and has obtained provider-based status...”¹²) Our research did not confirm the degree of concern in other states or even with the two operational crisis centers in Michigan. Certainly, it would be preferable if patients only in need of behavioral health services could be directly transported to a crisis center. But there are major concerns regarding the possible medical issues that might be in play, including those that can be the underlying cause of behavioral health symptoms. Perhaps with proper training, a paramedic could perform the medical evaluation or do it with the support of an emergency physician using telehealth. That option should be explored and, if affirmed by appropriate professionals, the law requiring hospital EDs as the ambulance destination could be changed.

Medical clearance is another issue that is an impediment to moving patients through the hospital ED and into appropriate care. There is considerable activity on this front, including in Michigan. Working with their hospital partners, the Detroit Wayne County Mental Health Authority has reduced the average authorization approval time from 21 hours to 3 hours.¹³ The American College of Emergency Physicians has issued a review of literature, *Care of the Psychiatric Patient in the Emergency Department*.¹⁴ Summary recommendations include the elimination of routine laboratory testing except in limited circumstances. It is clear that medical clearance is an important step in the care process and can be expedited with some focus and effort.

The legal ability to hold individuals for assessment/evaluation to determine need for treatment is another issue to consider in the decision about how to route patients. Hospitals or jails have clear authority to hold patients in a secure environment. Other settings, such as crisis centers, may have this authority conferred based on delegated legal responsibilities such as preadmission screening. The hospital brings into play the process of “certification”, another legal step. It enables hospitals to hold patients in the first 24 hours and then a subsequent level of certification enables involuntary admissions to inpatient psychiatric hospitals.

The law enforcement aspect of holding patients often becomes a subjective judgment on the part of the police officer. They can transport the potential criminal to a behavioral health crisis center if they believe that the behavior (action) was a function of a behavioral health condition. They do operate under some limitations in more serious criminal actions, but well-trained officers can make a marked difference in an effective service system. There are diversion pilots in Michigan that are making progress in this area.

Finally, scope of practice is again in play across the range of care settings. Currently, only physicians can provide medical clearance. If nurses or paramedics could legally provide a broader set of services independently, more care and decisions could possibly be made in a crisis center. This is a consideration, not an endorsement. It is important to make prudent decisions about what can be done where and by whom while not compromising medical needs of behavioral health patients. The current rules were created for reasons and, while it could be that times and training and perspective should change those rules, there shouldn't be a rush to judgment. The nature of these rules in other states should be considered. This is an area with potential to improve the system but with deliberation.

Financial Challenges

Payment for behavioral health crisis services (BHCS) is a challenge across many fronts. Many of the discrete services are themselves not routinely covered by health insurance, public or private. Further, related services, such as transportation, are not covered to BHCS settings. And to cap it off, many of the individuals who need these services are uninsured, straining the very limited public funding provided for this population.

Health insurance, both public and private, is traditionally disposed to cover and reimburse for specific individual services. Crisis center services are reasonably described as a behavioral health ED but without the institutional connection to a hospital. That makes some aspects of covering the cost of care problematic, especially anything related to room and board. The observation aspect of these services becomes an issue because there isn't a service intervention that is identifiable. Mobile behavioral health crisis team services have the same problem but magnified. Co-located behavioral health EDs or EDs with enhanced staffing have the advantage of being within a hospital institution and a preferable reimbursement relationship with payers. The payment terms may not be ideal but the fundamental reimbursement problems have been mitigated for these hospital-located services.

Public payers, especially Medicaid, typically are much more accommodating of more progressive methods of service organization and delivery than Medicare or private health insurance. To that extent, the public system has recognized and reimbursed more fully behavioral health services in various forms as long as there was agreement on the legitimacy and projected effectiveness. Crisis center services in Michigan are being reimbursed by the public behavioral health systems in the two localities where they operate currently, and it is expected that the same will hold true in the planned regions. It is important to engage Medicaid and the public system in supporting policy, organizational, and reimbursement changes.

Medicare and private health insurance are a different matter and greatly influenced by the forms they take in various markets. Specifically, a managed care oriented, capitated reimbursement environment provides flexibility that is much more conducive to paying for the complete set of services and costs in crisis centers. That extends to mobile crisis teams and crisis residential services for short term stays. It is a typical pattern that health insurers are reluctant to cover progressive forms of services until their cost effectiveness is firmly established. In this case, it is encouraging that Michigan's Common Ground has worked out a bundled reimbursement financial relationship with a couple of managed care

organizations for their Medicare Advantage and commercial businesses. Planners must be mindful of the health insurance environment in their market area.

Transportation services are another challenging element in the financial equation. We already have addressed the ambulance destination issue in terms of legal constraints. Health insurance reimbursement rules are an additional barrier. Payers, including Medicare and Medicaid, only reimburse for emergency transport to licensed hospital EDs. While it may be possible to get some relief from this obstacle, it will be a difficult and lengthy process in the best case. Medicaid could be more accommodating because it is administered at the state level and is much better positioned to coordinate with the licensing function. Also, there could be flexibility to classify some patient transports as non-emergency and create paths for their coverage.

There is the reality that some persons presenting in a behavioral health crisis do not have health insurance coverage at all. The Medicaid expansion, called Healthy Michigan here, was a huge benefit to addressing this problem for crisis services. Many more “childless adults” now have coverage through Medicaid while others have gained subsidized health coverage through the Marketplace. The volatility of the political disposition toward this health coverage expansion at both the federal and state levels does create an uncertain future in planning for crisis services.

A final observation is that the development of crisis centers and other forms of crisis services requires both building new capacity and funding. While savings in other service spheres – in this case law enforcement and hospital EDs – is legitimate and demonstrable, the reallocation of funding is another matter. If you provide relief for jails and law enforcement officers, you make their workload more manageable, improve services in other spheres, and reduce pressure on resources including infrastructure (i.e., physical facilities). But that doesn’t necessarily reduce the number of police officers required or save much in the way of jail costs. You may prevent the need to build additional facilities or slightly reduce staffing for jail coverage or even patrols. Those are costs on the margin. A similar analogy holds for hospital EDs.

The greatest potential to reallocate funding from the more cost-effective delivery of crisis services is in inpatient psychiatric hospital savings. This gets the attention of health insurers of all stripes because there is a direct and immediate cost savings. The evidence for these savings is compelling. Data from Common Ground shows a \$12.3 million savings in their most recent year. Since 2011, when the new crisis intervention model was initially implemented, their inpatient psychiatric admission rate has declined from over 35 percent to an average below 25 percent. A final telling statistic is that, in state fiscal year 2017, 63 percent of people that arrived on a petition and/or clinical certification were “de-certified”. CEI had a similar outcome where they reversed 55 percent of clinical certifications from one of Lansing’s hospitals. Common Ground was able to work out a very innovative reimbursement methodology with one Michigan health plan where they are paid a lower bundled rate for an unsuccessful inpatient psychiatric diversion and a higher amount for a successful one. Given this data and observable progress, there is exciting potential to develop new and better funding models that can provide a stable financial foundation for crisis services.

There are many challenges in financing crisis centers, mobile crisis teams, and other creative forms of crisis services. Progressive public policies and reimbursement methodologies are helpful in overcoming the various barriers that traditionally arise. There is evolving evidence that can be cited in moving the system forward, but much work remains.

Interagency Coordination

The number and size of the different human services organizations involved in emergency situations make coordination very challenging. Simply organizing and coordinating within these systems can be challenging. The reality that individuals present with characteristics that call for services from multiple organizations at any one time requires that there be effective coordination, difficulty notwithstanding.

One approach to this endeavor is to examine the behavioral health system alongside the criminal justice continuum via the Sequential Intercept Model that has been used by states and communities “to assess available resources, determine gaps in services, and plan for community change.”¹⁵ Washtenaw County used this model to create a comprehensive picture of how people with mental illness and co-occurring disorders flow through the criminal justice system along the model’s five distinct intercept points, with the first being Law Enforcement and Emergency Services. It identified “gaps, resources, and opportunities at each intercept for individuals in the target population.”¹⁶ The outcome of this process was to create a map that enables these two systems to thoughtfully plan how to more effectively combine and coordinate their resources. Expected impacts include successful diversion of appropriate individuals from the criminal justice system to behavioral health treatment and improved behavioral health services in county jails.

A more specific example of how interagency planning can yield improvement is in Ingham County where the Sequential Intercept Model also was used. It identified midnight releases from jail as a cause for increasing crisis situations. Changes in jail operations and processes have resulted in a reduction in crises occurring subsequent to these previously ill-timed releases.

Both examples involve coordination between the behavioral health and criminal justice systems. The very heavy crossover between physical and behavioral health should be obvious from the previous discussion around the complex interactions and requirements of hospital EDs and behavioral health crisis services. This extends to ambulatory and inpatient care settings since an effective and coordinated system of care can prevent exacerbations and, hence, crises. These same principles extend to emergency response systems and other community human service agencies. In all cases, it is important for the community agencies to get their signals straight.

State level policy can be a very positive influence on interagency coordination. It can further current efforts to incentivize cross system coordination by increasing the rewards and penalties and adopting minimum standards in contracts. A more intensive focus on the Duals Demonstration in Michigan (called MI Health Link) for persons eligible for both Medicare and Medicaid would be of value as many of these enrollees have behavioral health conditions and other issues that would benefit greatly from improved interagency coordination. The Duals Demonstration provides the financial flexibility for the contracted

managed care organizations to develop more creative coverage and reimbursement arrangements than have been possible traditionally.

While State level policy can be helpful, this is ultimately a local issue. Different localities have varying needs and characteristics as well as resources. The best model for Detroit is going to be different from the Upper Peninsula's. Working through the collaboration process is an enormous undertaking because of the immense size and complexity of the systems involved. It requires good will as well as hard work and intelligent analysis. It is encouraging that some Michigan communities are engaged and making good progress since this is necessary to achieve effective coordination across systems.

Care Continuum

If there was one dominant theme in our research into this issue, it was that the behavioral health care continuum is critical to success in responding to behavioral health crisis situations. Breakdowns at any point in the service array lead to dysfunction throughout the system. The most prominent example is a shortage of inpatient psychiatric beds.

There is substantial literature on deinstitutionalization and the resulting shortage of inpatient psychiatric beds. But in their paper, *Beyond Beds*, Dr. Debra Pinals and Doris Fuller conclude that “the rush to ‘more beds’ needs to be tempered with illumination and clarity about patient need, the kinds of beds best suited to meet those needs, and the recognition that bed capacity is a function of more than sheets on a mattress. Only a complete continuum of psychiatric care can reduce the human and economic costs associated with mental illness.”¹⁷ This is not to minimize the need for sufficient psychiatric beds. They are essential for a well-functioning system and when unavailable can cause back-ups in crisis centers and EDs.

Pinals and Fuller go on to observe that “(c)hanges in practice at any point on the continuum of care connected to the ED can impact boarding dramatically.”¹⁸ They cite a case study where an outpatient crisis stabilization unit was closed and the number of inpatient psychiatric beds cut in half. The result was that the number of ED visits requiring psychiatric consultation at the city's university hospital tripled and the average time to be seen by a psychiatric clinician in the ED increased from 14 hours to 22 hours. This point is reinforced by the Joint Commission. The Commission emphasizes the importance of “outpatient mental health services in the community” in the spirit that crises can be prevented. This follows the general principle that it is better to engage services in the least intensive appropriate form for better health and less cost.

One potential part of the care continuum that requires specific mention is SUD treatment. Common Ground and some other crisis service programs include detox and SUD treatment capacity. Washtenaw County is including the SUD service system as an integral part of their crisis center planning process. The opioid crisis highlights the need to incorporate detox and SUD treatment in the service system. It makes little sense to provide emergency lifesaving treatment and then discharge to the street where the individual is likely to seek another “hit” as they struggle with their addiction. While there are different perspectives on how to incorporate these services into the care continuum, it does seem essential that they be included in an intentional way.

It also should be noted that other populations with unique needs, including individuals with intellectual and/or developmental disabilities and children as two prominent examples, require special planning and specialized services. This adds to the challenge of building an effective care continuum but is also important in appropriately meeting the needs of all persons with need across the behavioral health spectrum.

A well-functioning behavioral health care continuum will reduce the need for crisis services and keep any particular part of the crisis system from being overwhelmed. The current focus on psychiatric boarding in hospital EDs is a visible and disturbing sign of system dysfunction. While the components of the care continuum do not have to be identical, there does need to be a well-developed service system that responds to needs with appropriate treatment interventions. Crisis centers can be an important part of the care continuum along with crisis residential services. Mobile crisis teams that focus on behavioral health emergencies are a nice complement to the crisis services system.

Conclusion

Crisis centers offer an important form of service for the behavioral health care continuum. While they might not be the answer in all communities, they play a key role where they have been implemented. There are definitely challenges in developing this service as discussed above. Building an effective crisis service system is a more encompassing proposition. It is essential that the entire care continuum be in place with all the linkages for the different pieces.

End Notes

- ¹ Pinals, D.A., Fuller, D.A. (October 2017). *Beyond Beds, The Vital Role of a Full Continuum of Psychiatric Care* (page 15). National Association of State Mental Health Program Directors. <https://www.nasmhpd.org/content/ta-coalition-assessment-working-papers-beyond-beds-vital-role-full-continuum-psychiatric>
- ² Substance Abuse and Mental Health Services Administration (2014). *Crisis Services: Effectiveness, Cost-Effectiveness, and Funding Strategies* (page 9). HHS Publication No. (SMA)-14-4848.
- ³ Ibid.
- ⁴ National Action Alliance for Suicide Prevention: Crisis Services Task Force (2016). *Crisis now: Transforming services is within our reach* (page 23). Washington, DC: Education Development Center, Inc., <http://www.actionallianceforsuicideprevention.org/sites/...org/.../CrisisNow.pdf>
- ⁵ Substance Abuse and Mental Health Services Administration (2014). *Crisis Services: Effectiveness, Cost-Effectiveness, and Funding Strategies* (page 18). HHS Publication No. (SMA)-14-4848.
- ⁶ Ibid. Page 10.
- ⁷ Ibid. Page 10.
- ⁸ Michigan Department of Health and Human Services (2017) *MSA 17-25 MSA Bulletin: Intensive Crisis Stabilization Services for Children*. http://www.michigan.gov/mdhhs/0,5885,7-339-71551_2945_42542_42543_42546_42553-87513--,00.html
- ⁹ Northern Lakes Community Mental Health, FAST program, <http://www.northernlakescmh.org/fast>
- ¹⁰ The Joint Commission. *Alleviating ED boarding of psychiatric patients*. Issue Nineteen, December 2015. <https://www.jointcommission.org/issues/article.aspx?Article=Sd2hoStuhEyYulMXvlsMLZN3enJ9vqbB0Ku1h%2bXEHHI%3d>
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- ¹⁴ American College of Emergency Physicians – ACEP Emergency Medicine Practice Committee (October 2014). *Care of the Psychiatric Patient in the Emergency Department – A Review of the Literature*. <https://www.acep.org>.
- ¹⁵ Abreu, D., Pinals, D. Policy Research Associates (March 2017). *Sequential Intercept Model Mapping Report for Washtenaw County, MI*.
- ¹⁶ Ibid.
- ¹⁷ Pinals, D.A., Fuller, D. A., *Beyond Beds*.
- ¹⁸ Ibid.