

Role of Mobile Crisis Management and Crisis Responders in ED Diversion

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Role of the Crisis System

- In examining the role of the crisis system, it is important to note that we have a very dynamic system.
- External demographic and economic changes have increased demand for services.
- Loss of inpatient beds has created a shortage in supply.
- Other changes in the system have resulted in increased demand.

Crisis System

- Philosophy: Services should be delivered in least restrictive setting possible, connected to consumers' home communities whenever possible, and no more intense than needed to meet consumers' needs. "The right service, at the right time, in the right amount at the right cost."
 - Reserve use of state hospitals for those most in need with most challenging conditions in need of longer lengths of stay
 - Increase use of alternatives to hospitalization whenever possible: Mobile Crisis, Facility Based Crisis, Social Setting Detox, Walk-In Clinics, etc.
 - Maximize use of community inpatient beds

Roles of Community Providers

Crisis Response

- Individual, Family, and other Supports
- Local Management Entity (LME) Screening Triage Referral (STR)/Crisis
- First Responders
- Mobile Crisis Teams (MCT) - MH/SA/DD
- Walk In Clinics (WIC) - 75 in 65 counties
- NC START teams- 2 teams in each of 3 regions
- Telepsychiatry
- Facility Based Crisis (FBC) and After-hour Crisis Services
- Emergency Department (ED)

Roles of Community Providers

Crisis Stabilization

- FBC and After-hour Crisis Services
- ED
- NC START and I/DD Respite beds
- Detox Services
- Transition Beds
- Community Inpatient capacity
- State Facilities

LME STR

- STR/Crisis Lines serve as a responder and as a hub – knowing what resources are available and how to link them.

Some important functions:

- Informational resource to LE and Magistrates
- Directing LE to appropriate sites for evaluation
- Linking to Crisis Services (such as MCT, WIC, etc)
- Telephonic crisis response
- Diversion to alternative sites when a primary site is unavailable

NC START

- Goal of NC START is to enhance the existing system of care, provide technical support as well as identify and fill in service gaps where possible.
- Supplements, **does not replace**, the role of Mobile Crisis Management (MCM).
- Each region:
 - Has four respite beds; two planned/two crisis.
 - Covers a large geographic area.
 - Provides both crisis prevention as well as intervention; maintains caseloads.
- Collaboration with MCM is critical to meeting the needs of individuals with I/DD and behavioral health needs.

First Responders

Consistent with 10A NCAC 22P .0302(e), [Critical Access Behavioral Health Agencies] CABHAs shall perform "first responder" crisis response 24 hours a day, 7 days a week, 365 days a year to all consumers accessing CABHA services, as follows:

CABHAs shall serve as first responder when any consumer who has been assessed by the CABHA and is receiving services from the CABHA undergoes a crisis. For purposes of first responder requirements, crisis is defined as: a high level of mental or emotional distress, or an episode, which without immediate intervention will foreseeably result in the person's condition worsening, environmental instability or could result in harm to self or others.

All CABHAs shall be accessible 24/7/365 to respond directly to consumers and to collaborate with and provide guidance to other crisis responders regarding coordination of treatment for CABHA consumers in crisis. The first responder shall use the crisis plan developed with the consumer to coordinate and communicate with all other crisis responders (in accordance with HIPAA and 42 CFR Part 2) to ensure that the crisis plan is implemented.

First Responders CONT'D

Consistent with 10A NCAC 22P .0302(e), CABHAs shall perform "first responder" crisis response 24 hours a day, 7 days a week, 365 days a year to all consumers accessing CABHA services, as follows:

All CABHAs shall have written policies and procedures in place that will be made available to all consumers, and shall include contact information for the consumer to first contact the CABHA rather than other crisis responders, such as hospital emergency departments and mobile crisis management teams. Each CABHA shall provide all consumers with a phone number to contact a live person 24/7/365 for use when crises occur. First response may be telephonic, but face to face intervention shall be attempted prior to referral or if necessary, in conjunction with other crisis responders. If a CABHA refers the consumer to an emergency facility or other crisis responder, the CABHA shall communicate with the crisis responder in order to facilitate coordination of care.

Walk In Clinic

Functions include

- Immediate care for adult, family, or adolescent in crisis
 - assessment and diagnosis for mental illness, substance abuse, and developmental disability issues
 - planning and referral for future treatment
- Medication management, outpatient treatment, and short-term follow-up care.
- Psychiatric aftercare with bridging treatment

Telepsychiatry

Some Uses:

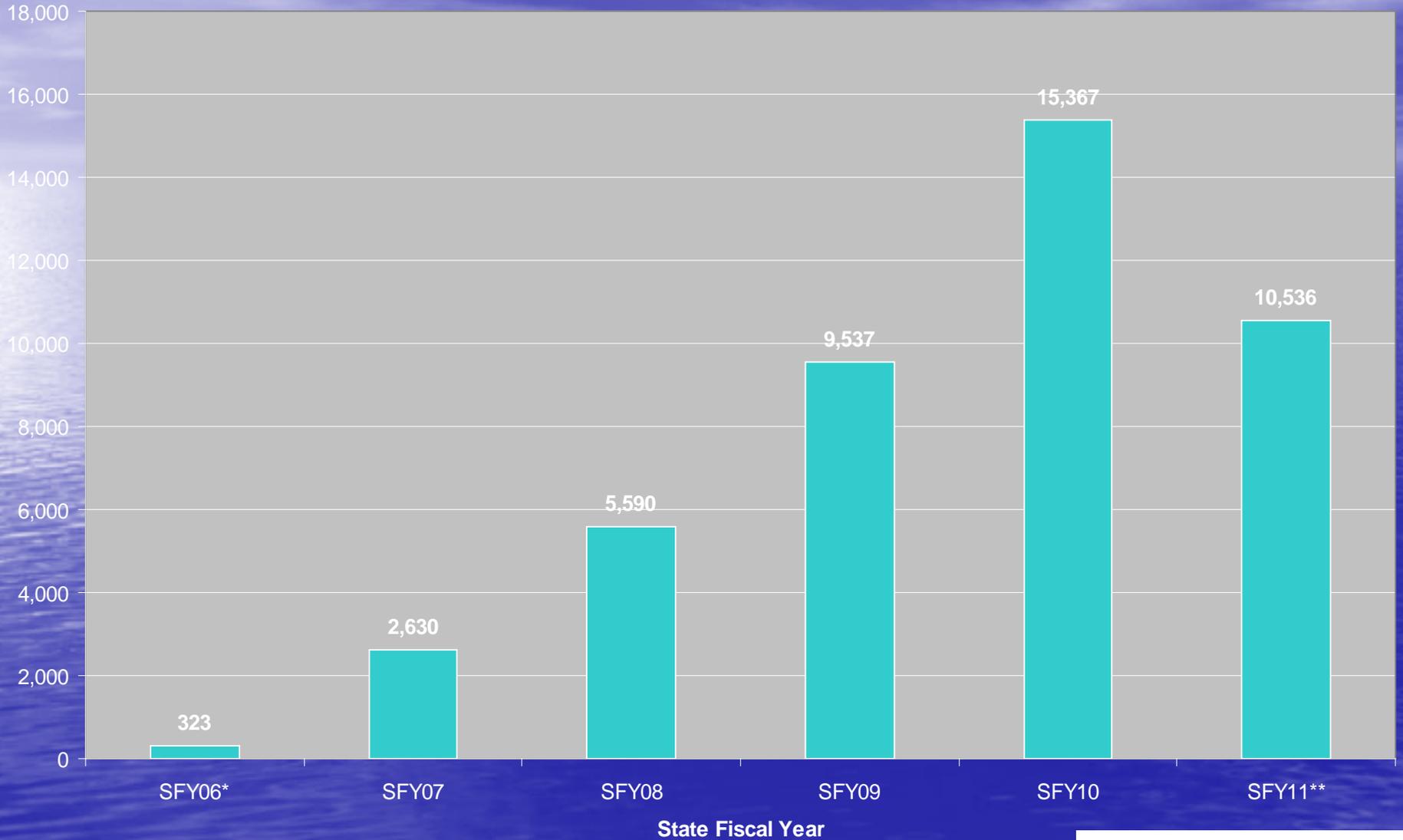
- Psychiatric evaluation and care to youth at a detention center and to inmates in the county jail.
- Psychiatric services from hub site to hospital emergency room, including mental health and substance abuse diagnostic, screening, triage capabilities
- Psychiatric services from hub site to a pediatric practice, or other provider clinics; emergency psychiatric services from psychiatrist's home to after hours clinic
- Coordination of discharge planning, linkage to aftercare from a hub site to remote sites at State Hospital

Mobile Crisis Team

- Funded by state funds and Medicaid fee for service
- Critical component in crisis service array
- Available 24/7/365
- Meet the individual where they are – as close to a persons home as possible
- Goal is to avoid Emergency Room or Inpatient admission, link to services provided in the most appropriate setting of care
- Currently 41 Teams covering all counties

Mobile Crisis Management

Growth in People Served: Medicaid & IPRS Combined



*SFY06 includes just Q4
**SFY11 includes just the first 6 months

Services Provided

- Billing numbers do not tell the whole story
 - MCM visits/re-assessments beyond a 24 hr period
 - Follow up when a discharged client is a no-show
 - Transport and other Services

Mobile Crisis Funding

- Recurring state allocations
 - \$5.7 million
 - Medicaid fee for service
 - \$3.1 million
 - IPRS
 - \$3.6 million
 - Non-UCR funds
 - \$3.8 million
- Cost per episode of care approximately \$552

Mobile Crisis Staffing

- Psychiatrist availability
- Substance Abuse staff (CCS,CSAC,CCAS)
- QP who is a Nurse, CSW, or Psychologist
- QP or AP with experience in Developmental Disabilities
- Other team members may be non-licensed qualified professionals and paraprofessionals

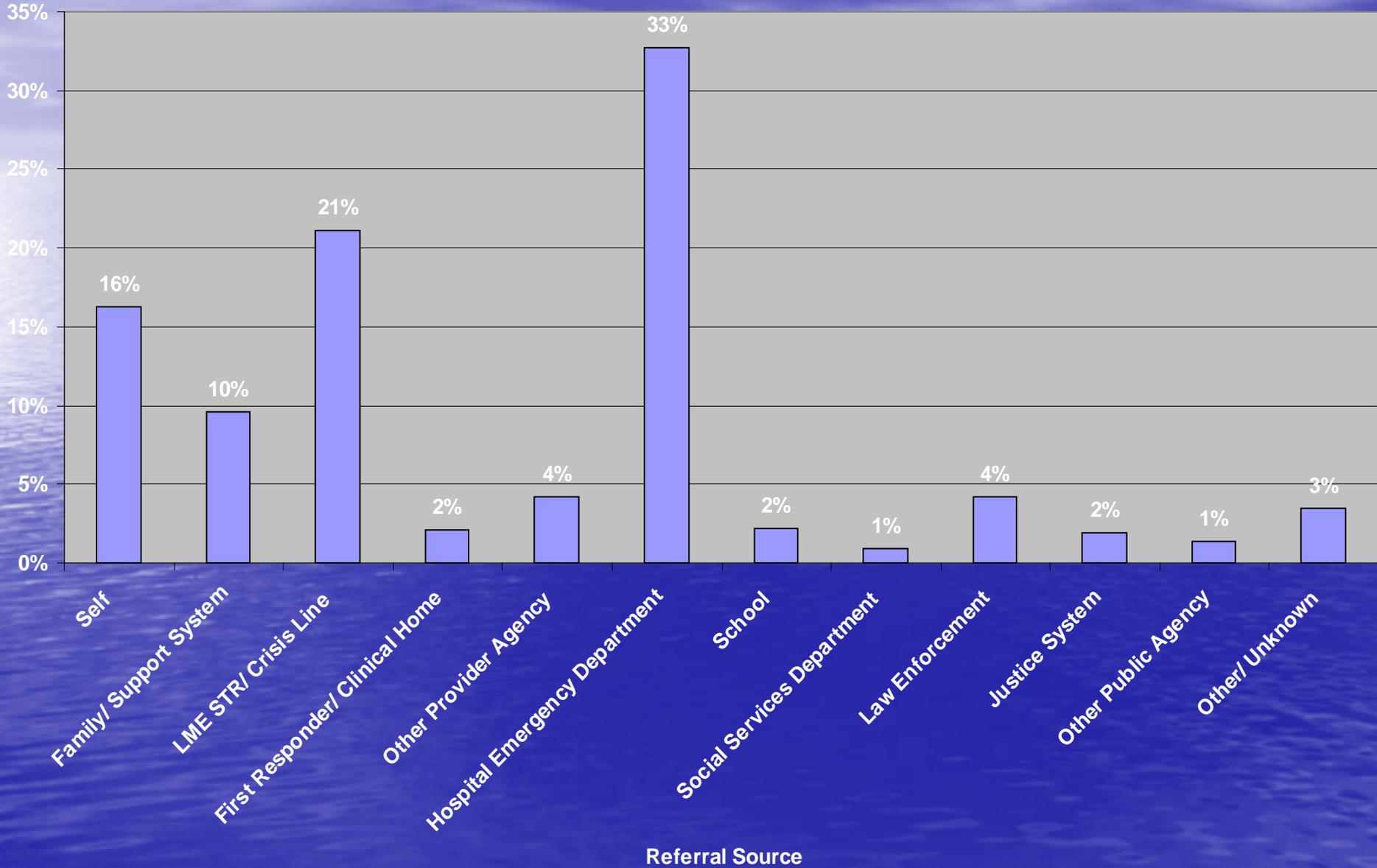
Staffing Dilemmas

- Does the use of licensed staff to do initial crisis assessments affect ED volume, lengths of stay, or outcomes?
- How does use of the MCT psychiatrist affect ED volume, lengths of stay, and outcomes?
- Is it important to have a first commitment evaluator available within MCM and WIC?

Accessing Mobile Crisis

- Crisis Call to LME STR
- Direct Call From
 - Law Enforcement
 - Magistrates
 - Non-behavioral health providers
 - Emergency Room

Mobile Crisis: 15,184 Total Referrals
from January to June 2010



Source of Referrals to ED

- Aggregated Summary: 114 Clients seen by MCM in ED

Referral Source:

Self – 32%

LEO – 29%

Family/Support – 17%

EMS – 6%

Clinical Home – 3.5%

MCM – 3%

Group Home – 1%

PCP – 1%

School – 1%

DSS – 1%

LME – 1%

- Self/Family/Support - 49% of admissions to the ED
- LEO – 29% of admissions to the ED

Response Location

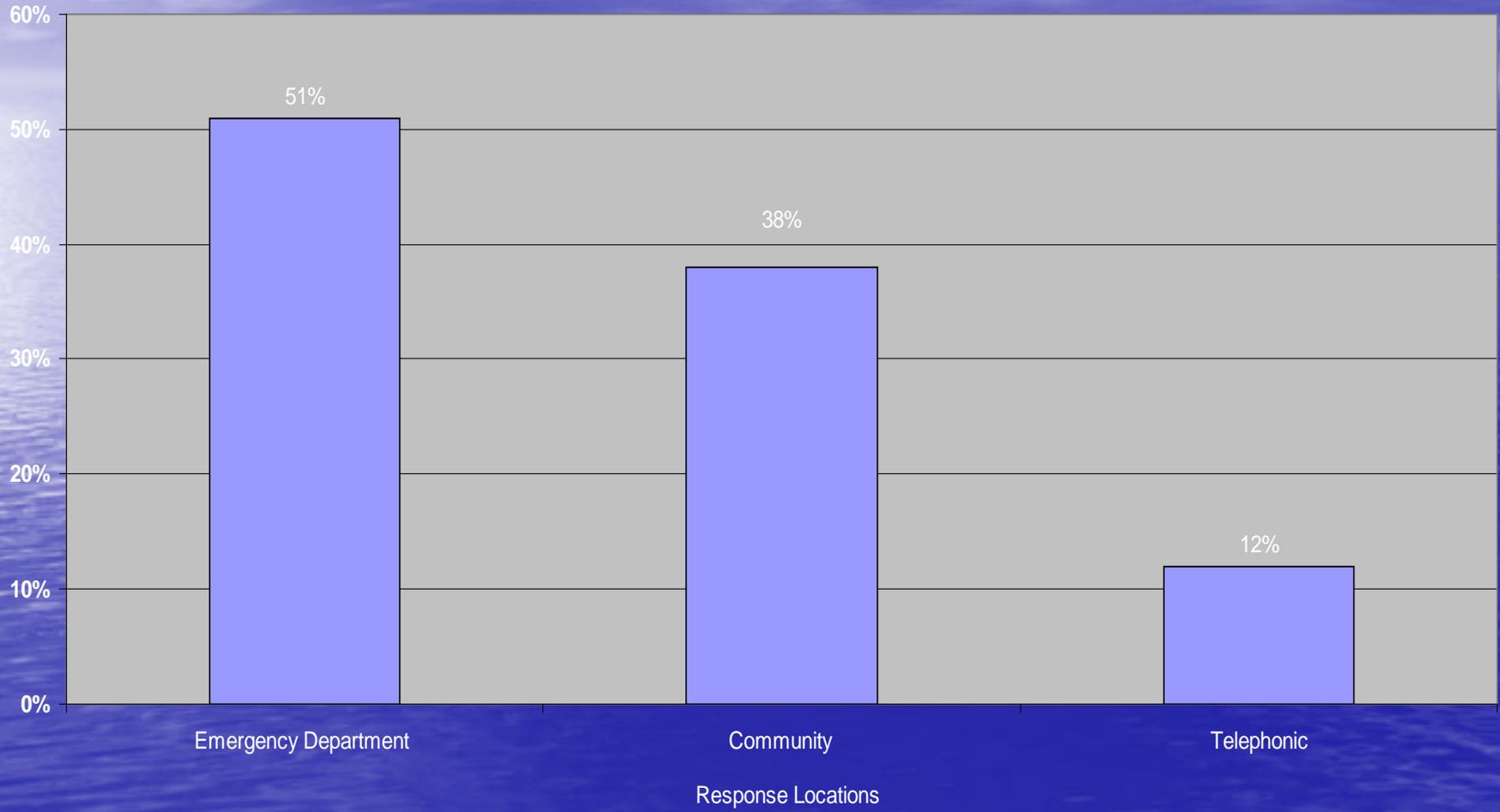
- Individual's home
- Schools
- Magistrate's offices
- Urgent care centers

Response Location CONT'D

- Group homes
- Consumer's Home
- Medical/primary care offices
- Emergency departments
- Police stations, jails, and other community sites

Mobile Crisis Mamangement
July 2010 to December 2010

Total Responsess = 16451



BH ED Volume as a Function of MCM

LME	ED visits as Percent of all causes	MCT volume per 10,000	MCT Volume	MCT - ED
A Mixed	3.4%	4.8	127	2%
B Rural (Sat)	4.8%	17.2	1,007	3%
C Urban	2.8%	2.1	53	0%
D Urban	3.7%	17.4	761	30%
E Rural	2.1%	25.7	696	75%
F Urban	4.7%	5.5	177	10%
G Urban	2.6%	4.4	119	5%
H Rural	3.0%	17.2	1,007	3%
I Mixed	1.5%	24.3	716	96%
J Rural	1.9%	44.2	1,034	73%
K Urban	3.4%	3.1	146	1%
L Urban (Sat)	2.6%	1.4	150	0%
M Urban	2.4%	8.5	761	1%
N Mixed	3.8%	27.0	667	55%
O Mixed	2.3%	1.7	40	60%
P Mixed	3.7%	20.5	474	49%
Q Mixed	3.5%	10.6	409	56%
R Mixed	3.3%	26.4	1,950	57%
S Mixed	3.5%	13.7	749	56%
T Rural	3.5%	70.4	3,680	48%
U Mixed	3.8%	12.4	441	13%
V Mixed	2.7%	20.6	529	28%
W Urban	1.6%	1.4	150	0%
X Rural/Mixed	5.9%	8.4	424	10%

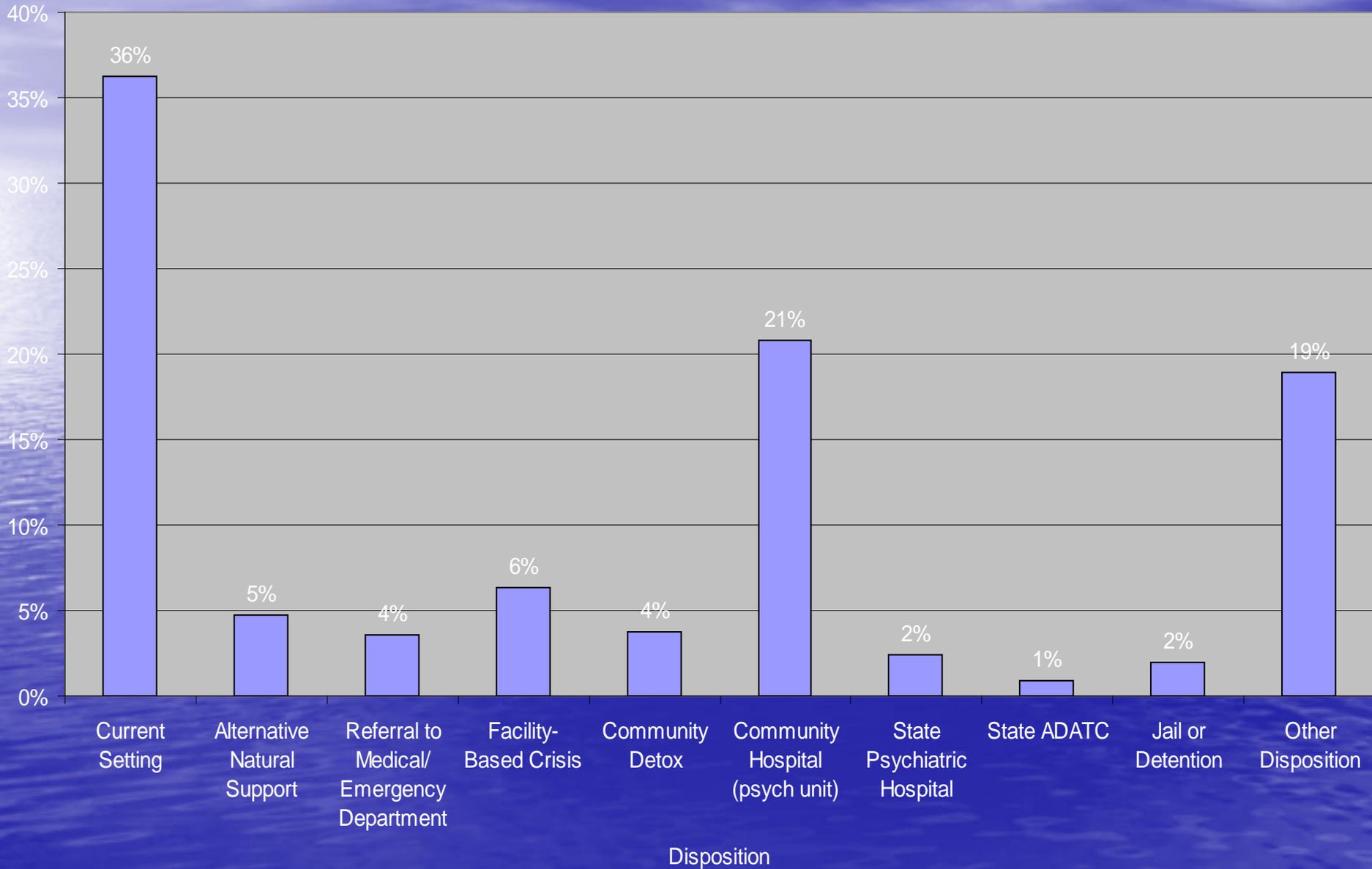
Patients on Delay and Delay Time as a Function of MCM

LME	ED visits as Percent of all causes	MCT volume per 10,000	MCT Volume	MCT - ED	Pts on Delay/ 1000 ED vol	Ave.hrs per pt on delay
A Mixed	3.4%	4.8	127	2%	3.0	50.2
B Rural (Sat)	4.8%	17.2	1,007	3%	1.3	47.9
C Urban	2.8%	2.1	53	0%	4.3	42.3
D Urban	3.7%	17.4	761	30%	5.6	51.8
E Rural	2.1%	25.7	696	75%	2.2	67.5
F Urban	4.7%	5.5	177	10%	3.8	49.5
G Urban	2.6%	4.4	119	5%	7.4	52.8
H Rural	3.0%	17.2	1,007	3%	1.3	47.9
I Mixed	1.5%	24.3	716	96%	2.4	26.7
J Rural	1.9%	44.2	1,034	73%	3.0	38.2
K Urban	3.4%	3.1	146	1%	1.0	55.7
L Urban (Sat)	2.6%	1.4	150	0%	2.4	48.6
M Urban	2.4%	8.5	761	1%	0.9	49.6
N Mixed	3.8%	27.0	667	55%	0.9	84.6
O Mixed	2.3%	1.7	40	60%	1.2	27.6
P Mixed	3.7%	20.5	474	49%	7.7	55.7
Q Mixed	3.5%	10.6	409	56%	0.1	30.4
R Mixed	3.3%	26.4	1,950	57%	1.1	70.8
S Mixed	3.5%	13.7	749	56%	4.2	74.8
T Rural	3.5%	70.4	3,680	48%	1.1	69.0
U Mixed	3.8%	12.4	441	13%	5.0	36.7
V Mixed	2.7%	20.6	529	28%	3.2	49.0
W Urban	1.6%	1.4	150	0%	6.9	44.7
X Rural/Mixed	5.9%	8.4	424	10%	3.0	60.7

Conclusions

- Model of care is different in the rural setting vs the urban setting
- Rural LMEs use more MCM services than Urban LMEs.
- Rural LMEs provide more of their MCM services in the ED setting.
- Both rural and urban LMEs demonstrate success in having lower volume of BH clients and delays in the ED compared to peers.

Mobile Crisis: 15,110 Total Disposition
from January to June 2010



Disposition Dilemmas

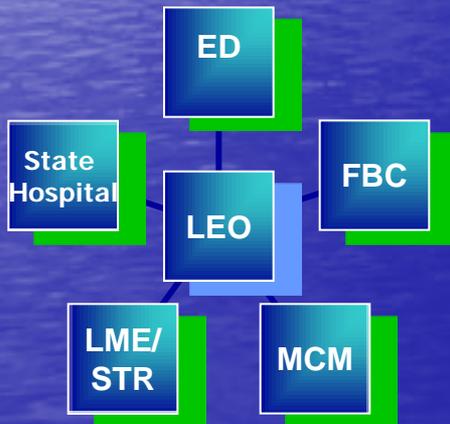
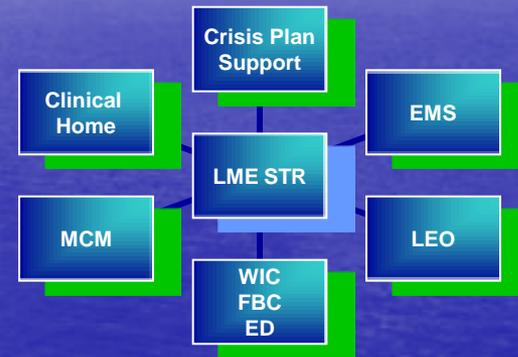
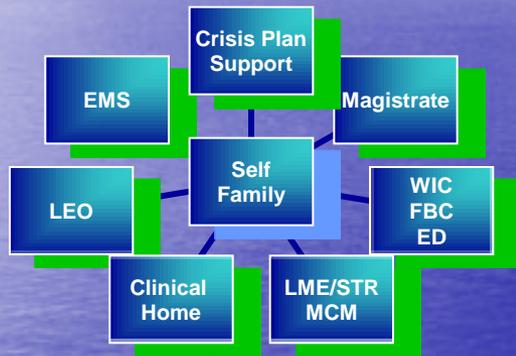
- Linkage to an on-going provider is an important function provided by MCM. Are EDs that do not use MCM linking to services effectively?
- Individuals evaluated in the "field" by MCM and determined to require hospitalization must be housed while awaiting admission. Are there alternative settings for patients waiting for admission?
- If medical clearance is needed for admission to a hospital, the individual may need to go to the ED (even if behavioral health services are effectively provided in the FBC). Are there alternatives? Can Primary Care serve this function?

Putting the Pieces Together

Key is for each community to work together with the components they have to design a working system and identify gaps.

- Some examples and promising practices:
 - IVC orders:
 - Law enforcement notify LME STR when custody order received. LME notify Mobile Crisis to respond to scene.
 - Mobile Crisis clinicians be certified as 1st commitment examiners under pilot project – could break commitment at the scene. LE transport to location determined by MCM.
 - Magistrates trained to offer evaluation by the MCT prior to petition/custody order
 - Mobile Crisis Teams/EDs/LME work together to identify functions that Mobile Crisis can perform in the ED (and that LME can afford to pay for!)
 - Hospitals credential Mobile Crisis Team clinicians to deliver services in ED
 - MCTs embedded within CABHA (integrated with FBC, WIC, Outpatient)
 - Case Management utilizing applications that track the consumer from crisis through resolution

Key Points in Triage



Mobile Crisis Services

- Provide support to decrease crisis and allow individual to remain in their home
- Crisis Assessment (including assessment of appropriate setting for continued care of patient based on risk factors for danger to self or others)
- Recommendations for behavioral management of disruptive behavior
- Coordinate with police Crisis Intervention Teams
- Help locating an inpatient psychiatric bed if needed

Mobile Crisis Services CONT'D

- Coordinate services required to discharge an individual from an Emergency Room to community based service
- Facilitate referrals to crisis stabilization resources, or other community intervention services or supports
- Brief Treatment/Intervention
- Development of a Crisis Plan