Emergency/Crisis Services Analysis and Recommendations
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March 4, 2014

The following presentation of data and information was analyzed to determine the need for expanded behavioral health emergency/crisis services and the effectiveness of the current model of practice. Based on the analysis these conclusions were drawn:

- The need for behavioral healthcare emergency/crisis services has increased.
- The current emergency/crisis services model and staffing pattern is insufficient to meet these increased needs.
- A different model of emergency/crisis services is recommended to better meet client and community need and allow for financial sustainability.

Evidence of Need and Analysis

Local Economic Conditions: Licking and Knox Counties have both experienced increases in poverty and significant fluctuations in unemployment during the past five years. For the 2007-2011 period, 13.0% of individuals in Knox County were below the poverty line, up from 10.1% in 2000. Although poverty is slightly lower in Licking County, the upward trend there has been similar; for the same period, 11.6% of Licking County individuals were below the poverty line, up from 7.5% in 2000 (U.S. Census Bureau: 2000 Census and 2010 Quick Facts). The proportion of students who are considered "economically disadvantaged" has risen sharply in all school districts in both counties from 2005 to 2012. By the 2012-13 school year, the two largest districts in the two-county area—Newark City Schools and Mount Vernon City Schools—were experiencing rates of 59.7% and 48.65%, respectively (Ohio Department of Education District Profile Report, 2012). The unemployment rate in both counties has largely tracked the statewide rate, and peaked at 9.6% in 2009 (Knox). In August 2013, the unemployment rate had decreased in both counties, to 6.5% in Knox County and 6.6% in Licking County (ODJFS, Ohio Labor Market Information, Civilian Labor Force Estimates; August 2013 rate is not seasonally adjusted). These statistics indicate an improving economy in both counties, but also indicate a significant number of working poor families.

Geographic Area	Percentage of Persons Below Poverty Line 2008 – 2012
Licking	12.4%
Knox	14.6%
State	15.4%
US	14.9%

Source: United States Census Bureau Census and Quick Facts (2011 & 2013)

The number of individuals eligible for Medicaid has risen in tandem with these trends. From 2003 to 2010, there was a 60% increase in the number of individuals receiving Medicaid in Licking County in the Covered Families with Children (CFC) category. The increase was 56% for the same time period in Knox County for the CFC program. The Aged Blind and Disabled category has also seen increases from 2003 to 2010 (33% in Licking, 23% in Knox).

Social and demographic factors: Population growth is an important factor in both Licking and Knox Counties. The total population of each county grew by 11.3% in Knox County and 15.1% in Licking County from 2000 to 2012 (U.S. Census Bureau: 2000 Census and 2010 Quick Facts). As mentioned above, the increase in the number of adults and children living in poverty and receiving Medicaid is also an important demographic factor.

Geographic Area	2000	2010	Change	Percentage Change 2000-2010	2012	Percentage Change 2000-2012	2013 Estimate
Licking	145,491	166,492	21,001	14.43%	166,483	15.1%	167,537
Knox	54,000	60,921	6,421	11.78%	60,930	11.3%	60,705
State	11,353,140	11,536,504	183,364	1.62%	11,553,031	1.8%	11,570,808
US	281,421906	308,745,538	27,323,632	9.7%	313,873,685	10.5%	316,128,839

Source: United States Census Bureau Census and Quick Facts (2011 & 2013)

Impact on Service Delivery: These factors present a variety of challenges to MHR, particularly the increase in the size of the population in general, the increase in economically disadvantaged children, and the increase in the Medicaid-eligible population. Based on the application of prevalence data rates from SAMHSA (8.8%), we estimate that 12,325 (Licking) and 4,489 (Knox) residents ages 12+ are substance dependent and in need of substance abuse treatment services. Based on prevalence rates for serious mental illness, we estimate that 7,088 (Licking) and 2,773 (Knox) adult residents are in need of mental health treatment services. The current MHR system of care roughly provides treatment to 1 out of 5 people who are substance dependent and approximately half (46%) of adults with serious mental illnesses. In addition, Knox County residents reported experiencing on average 3 mentally unhealthy days during the past 30 days with Licking County residents reporting 3.6 (*2013 Ohio County Health Ranking and Road Maps*). **Evidence of this increased need for crisis services leading to greater access to care for underserved people is evident in the following trends:**

- **Increased demand for services**: Calls to providers for adult services have increased by 41% in comparing fiscal years 2012 and 2013 to fiscal years 2010 and 2011. Calls for services for youth have increased 42% between the same comparable years. (MHR Performance Target Reports SFY 2010 – 2013)

- **Increased suicide-related calls**: The crisis hotline provided by MHR provider agency Pathways has seen a 42% increase in calls from individuals threatening or attempting suicide. This increase is directly related to a suicide prevention and follow-up grant received by Pathways but underscores the need for crisis services for significant numbers of individuals in the MHR service area.

211 Hotline Activity	2011			2012			2013		
	LC	KC	Total	LC	KC	Total	LC	KC	Total
BHP Answering Service Calls – Emergency Services	2140	361	2501	1282	298	1580	1537	241	1778
Additional Calls Involving Suicide Threats	268	60	328	2415	569	2984	2976	813	3789
Additional Calls Involving Suicide Attempts	31	5	36	399	112	511	595	93	688
Additional Calls Related to Mental Health Issues				376	68	444	570	45	715

Source: SFY2011-2013 Pathways Hotline Report

- **Increased presentation of behavioral health emergencies in local hospital emergency rooms:** There is an increasing trend (2011 -2013) in both counties of more people presenting with behavioral health crises in hospital emergency rooms than may have been seen by BHP Crisis Services. This suggests that the program lacks capacity and availability to provide adequate crisis services to the community due to the current staffing pattern.

Year	Licking – Licking Memorial Hospital					Knox – Knox Community Hospital		
	Total Patients Presenting in ER	# With Behavioral Health Emergencies Seen in ER			Total # Behavioral Health Emergencies Seen by BHP Regardless of Setting	Total Patients Seen in ER	# With Behavioral Health Emergencies Presenting in ER	Total # Behavioral Health Emergencies Seen by BHP Regardless of Setting
		AOD	MH	Total				
2011	58,516	635	1503	2138	2075	30,542	809	714
2012	58,401	686	1561	2247	1467	27,218	872	788
2013	54,830	612	1574	2186	1190	25,684	834	648

Source: 2011 – 2013 data provided by Licking Memorial Hospital, Knox Community Hospital, and MHR Performance Target Reports (SFY 2010 – SFY 2013)

- **Identified need for better engagement of people in services following a crisis especially those new to the system:** Immediate engagement in services following a crisis is a critical part of safety planning by providing access to care lessening the possibility of further crises and increasing health, wellness, and public safety. Increased crisis staffing would allow for a crisis worker time to provide next day follow-up services as a bridge between the initial crisis encounter and the first clinical appointment.

Year:	Total # of Persons Seen by BHP in Crisis Services	# Of New Clients Seen in Crisis (Not Open in System)	% Of New Clients Seen in Crisis (Not Open in System)	# Of New Clients Seen in Crisis Enrolled in Services Following Crisis	% Of New Clients Seen in Crisis Enrolled in Services Following Crisis	# Of New Clients Seen in Crisis Who Did Not Receive Additional	% Of New Clients Seen in Crisis Who Did Not Receive

						Services Following the Crisis	Additional Services Following the Crisis
2013	1758	558	32%	103	18.5%	455	81.50%

Source: BHP Report (2014)

Limits of Current Practice Model

- The staffing pattern cannot meet increased community needs. Current staff is overstretched in their responsibilities to meet the expectations of the community.
- It is difficult to recruit and retain this workforce. Burn out is a critical problem.
- Staff does not have time to adequately provide crucial follow-up services to ensure people engage in treatment after a crisis.
- Many related health officer tasks, such as the preparation of probate affidavits, have no funding source but are required as part of the job. With the passage of pending Civil Commitment legislation, there may be increased probate activity with potentially new outpatient commitments.
- Limited ability to provide services in the community including partnering with CIT officers in crises and addressing problems in schools. There are also safety issues related to community visitation when it may not be safe for one health officer to address a crisis outside of the office.
- Other community relationships and partnerships are strained due to limited availability of health officers. This includes hospitals; the criminal justice system and law enforcement; and families and individuals.
- Transportation of clients to hospitals is often a problem. Staff relies on off duty police officers in the event a person has no means to pay for an ambulance. This often results in very long stays in emergency rooms.
- The current funding model does not allow for the flexibility needed to appropriately provide crisis service delivery.

Emergency/Crisis Services Practice Models Addressing Identified Needs

The following are two models of emergency service/crisis intervention practice that have proven effective in addressing needs identified in this analysis.

Helping Ohio's Children and Youth in Crisis Grant – Licking/Knox County Kids' Mobile Outreach/Crisis Team

- Developed after the Mobile Urgent Treatment Team (MUTT) this model is a recognized best emergency services treatment practice.
- MUTT provides 'portable' services that are conducted any place in the community. This includes schools, homes, and jail. It is not office based.
- MUTT is intended to serve high-risk kids (ages 8 – 24) and their families that are either not receiving services or underserved in the community. The team remains with a kid and their family until they have fully engaged in treatment and other services.
- The team is comprised of a variety of partners depending upon the crisis and the needs of the kid and family. Primary partners include BHP health officers, kid and adult CPST workers, CIT officers, and Board of DD workers when needed.
- The program is 'block granted.' This allows for greater flexibility in service delivery and pays for necessary services needed to resolve crises and maintain safety that are not allowed under current Medicaid billing rules. It pays for, when necessary, two or more BHP workers to actively engage with a kid and family at the same time during a crisis and in planning. It pays for on call and case planning between professionals.
- The project is concerned with outcomes of service. This includes:
  1. The number served in both counties
  2. The percentage of kids provided with a plan of action necessary to return to a safe and/or improved level of functioning
  3. The percentage of kids engaged with ongoing service coordination and/or treatment services at 30 days and 6 months.
- The project has exceeded its outcomes. As of the end of January 2014, 87 kids and families had been served the majority remaining in treatment. Most of these kids were new to the system. The project had projected to serve 100 kids and families for the entire 12-month grant period.

Geauga County Emergency Services Model

- The Geauga County Board of Mental Health and Recovery Services contracts with Ravenwood Mental Health Center to provide 24/7 emergency services.
- Ravenwood is a comprehensive behavioral healthcare organization providing both mental health and substance abuse prevention and treatment services. They are the Board's designated hospital pre-screening agency. BHP is the designated hospital pre-screening agency for MHR.
- Hospital pre-screening agencies provide mental health evaluation and hospital pre-screening leading to emergency hospital evaluation (pink slipping) and probate activities in addition to crisis intervention. Pre-screening agencies also employ crisis workers who are approved as health officers by Boards.
- Ravenwood provides portable services in addition to office services. This includes a mobile team.
- The Geauga board decided 20 years ago to change how emergency services was funded. This was due to on going problems with unit rates and lack of earned income with resulting loss.
- Unlike ongoing treatment services where appointments are scheduled, emergency services has no ability to plan or schedule a crisis. In treatment, we pay for specific service. In crisis we pay for availability.
- The program was block granted. No income is earned from the Board. This pays for the availability of services. This is known as the 'Firehouse' model. The block grant pays for the salaries and fringe of all health officers; office space and utilities, phones, office supplies; on call and overtime; transportation of clients if there is no other payer source; and administrative overhead related to the program.
- It also pays for necessary tasks that have no other payer source. This includes the development of probate affidavits and other activities with the probate court, the ability for more than one health officer to engage in a crisis, and allows the flexibility to provide services in the community often in conjunction with CIT officers.
- The cost of the block grant for SFY14 was $295,333. Budgeting was based on the number of FTEs; the Geauga program employs six FTEs. Emergency/crisis services are intended to serve all populations. The current Geauga County population is 92,000 and per capita cost estimated at $3.50.
- The Geauga board allows Ravenwood to bill Medicaid or third party insurance for services in addition to receiving block grant funding.
- At the end of the fiscal year, the board working with the provider evaluates the amount of earned Medicaid income and may make adjustments in the next fiscal year block grant.

Recommendations:

Based upon analysis of the effectiveness of the current method of emergency service delivery, other more effective practices, and community needs, the following recommendations have been made:

- Develop a new model of emergency/crisis intervention services to more effectively and efficiently meet client and community need. This would include:
  1. Increased staffing pattern
  2. Flexible service delivery
  3. Improved engage of people in treatment services following a crisis and increase access to care
  4. Retention of the workforce
  5. Provision of necessary transportation
  6. Portable services
  7. Improve other first responder partnerships including CIT
  8. Improve availability to community partners and families and individuals
  9. Increase community visibility

- Provide block grant funding to the program to allow for greater flexibility of service delivery and financial sustainability.
  1. Improve community safety
  2. Improve access to care outcomes
  3. Lessening of financial burden to deliver the service