

TEAM KENTUCKY

CABINET FOR HEALTH
AND FAMILY SERVICES

STATE UNIVERSITY PARTNERSHIP
POLICY BRIEF

Understanding the Behavioral Health Landscape and Feasibility of Mobile Crisis Intervention (MCI) in Kentucky

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What is Known on This Topic?

Comprehensive community crisis response systems that provide those in crisis with someone to talk to, someone to respond, and a place to go are needed to address Kentuckians' behavioral health needs. The introduction of The Kentucky Mobile Crisis Intervention Commonwealth Model provides important policy changes to support the creation or expansion of crisis response systems.

What Did This Project Do?

The purpose of this project was to support State and local efforts to strengthen behavioral health crisis response for adults. This project completed a comprehensive analysis of the Kentucky Medicaid claims and Health Facilities Services Data to examine the prevalence and utilization of all types of care among those with BH conditions, providing a clear picture of healthcare utilization patterns, costs, and needs accounting for demographic and geographic variation. Next, the project convened a Technical Expert Panel that conceptualized and specified a behavioral health-specific avoidable emergency department visit measure. Last the project provided technical assistance in Jefferson, Fayette, Floyd, and Daviess Counties that helped stakeholders assess needs, identify evidence-based practices, and develop strategies designed to address barriers.

What could Medicaid do with these findings?

The project's outcomes offer strategies and metrics for evaluating mobile crisis intervention services across the US, including the creation of a BH-specific avoidable emergency department visit measure. Finally, the innovative implementation strategies used to assist local communities can be disseminated to communities throughout the country to improve implementation and intervention outcomes.

Introduction

Kentucky's adult population is challenged by a range of increasing behavioral health (BH) crisis¹ and have limited access to need services resulting in an overreliance on the criminal legal system and hospitals, resulting in poorer outcomes and increased costs.² To better meet Kentuckians' behavioral health crisis needs, CHFS introduced the Kentucky Mobile Crisis Intervention Commonwealth Model (Commonwealth Model; 907 KAR 15:090) and later the Crisis Continuum of Care (907 KAR 15:100) which provides a community-based model of care that provides comprehensive and integrated services to all Kentucky residents 24/7/365. The Crisis Continuum of Care provides communities with much needed resources; however, the variation in local community population needs, resources, and capacity means there is no one-size-fits-all strategy. To achieve the outcomes associated with comprehensive crisis care, the utilization of best practices in planning, implementing, and evaluating these interventions are required. Implementation focused technical assistance that facilitate local efforts to engage stakeholders, assess local context, and uses data to guide decisions and overcome barriers, can lead to better local outcomes,³ and can inform efforts across the Commonwealth.

Methods

This study uses a mixed-method design. First, the study analyzes Kentucky Health Facilities and Services Data inpatient and outpatient data from 2016-2022 to assess the prevalence of behavioral health conditions in hospital utilization. Behavioral health was defined using ICD-10 F-codes (F01-F99) and select R and T codes. The study conducted descriptive analyses to capture the prevalence of utilization and expenditures where behavioral health diagnoses were primary factors. Primary is defined as a BH condition coded as the first or second diagnoses in the data. A 16-member Technical Expert Panel (TEP) participated in interviews and CMS Measure Lifecycle process to conceptualize and specify a BH-specific avoidable emergency department visit measure. To best support the technical assistance and strengthening of crisis response systems in four unique communities, this study utilizes a robust qualitative protocol to strengthen implementation support in each community. 304 stakeholders across the BH Crisis system in the four communities receiving technical assistance participated in interviews, focus groups, or community engaged visioning activities. Interviews asked stakeholders about crisis interventions, population and organizational needs, and collaborations.

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Results

Findings from the descriptive analyses of Kentucky Medicaid Claims and HFSD inpatient and outpatient data, shows that the number of behavioral health diagnoses among adult Kentucky Medicaid population and all adult hospital utilizers, increased during the study period. Furthermore, the findings indicate that behavioral health diagnosis are present in 4.3% to 14.6% of all hospitalizations when examining primary diagnoses, demonstrating that behavioral health is a major driver for hospital utilization and expenditures. The findings also show that mental and behavioral health disorders due to psychoactive substance use, account for the highest adult utilization, and opioid related disorders, other anxiety disorders, major depressive disorders, and reaction to severe stress are specific behavioral health conditions responsible for highest utilization levels.

The Technical Expert Panel process conceptualized a measure titled *potentially avoidable behavioral health emergency department visits* that is expressed as a rate where the numerator is potentially avoidable BH ED visits containing a primary behavioral health ICD-10 diagnosis. The denominator is the volume of all ED visits that did not result in an admission. The specified measure has not completed the CMS measure lifecycle and is therefore not ready to be used. Analysis of interviews with TEP members and other stakeholders found a strong need to increase behavioral health care resources to divert behavioral health ED utilization to more appropriate, effective, and less expensive options. As such, the intended purpose of the measure is to capture access to primary care and other non-ambulatory care for acute, scheduled behavioral health care needs. Stakeholders emphasized the potential for unintended consequences for developing such a measure and that the measure should not be used as a triage tool or a mechanism for categorizing or evaluating the appropriateness of ED visits for reimbursement purposes.

Results from the qualitative findings indicate four major themes that were consistent across the communities. First, stakeholders expressed universal excitement towards the State's efforts to expand and strengthen BH crisis resources to address a wide array of challenges. Second, stakeholders were uncertain how to maximize the evolving policy landscape around BH crisis response, with uncertainty around where they should start first. Third, stakeholders indicated that misunderstandings and stigmas towards people in BH crisis create barriers to improving crisis response systems, noting that developing a shared language and understanding is needed to solve problems. Routine coordination and collaboration among key crisis system stakeholders is viewed as vital to addressing barriers to effective crisis response, particularly as it relates to workforce challenges and improving services.

Policy Implications

The findings from the comprehensive analyses of the BH challenges experienced by Medicaid beneficiaries

and adult Kentuckians utilizing hospitals, provides CHFS with a baseline to understand the impact of The Commonwealth Model (907 KAR 15:090) and Crisis Continuum of Care (907 KAR 15:100) on behavioral health services and outcomes. The conceptualization of the potentially avoidable behavioral health emergency department visit measure in this project, has the potential to assist local, state, and federal stakeholders in understanding population needs, serve as an indicator of access to behavioral health care, and be used to evaluate the effectiveness and costs related to mobile crisis intervention services. However, the measure is not ready to use, as it requires further development to complete the Measure Lifecycle process. These analyses can also be used by local communities to be understanding population needs while strengthening crisis response systems. Interviews with stakeholders point to the complex challenges associated with the implementation of cross-system interventions. Local communities have existing crisis response systems often through 911, and transitions to 988-centered crisis response will require sustained implementation focused technical assistance that creates evaluation structures intended to address barriers through ongoing stakeholder engagement.

Conclusion

The findings reinforce the breadth of BH challenges Kentuckians face and understanding these challenges are necessary for designing interventions to address these needs, as well as evaluating outcomes. The Crisis Continuum of Care is an important step in improving crisis response systems, and its long-term effectiveness hinges on local communities' ability to adapt and adopt effective interventions that meets their communities needs and unique contexts.

References

- ¹ U.S. Census Bureau, Household Pulse Survey, 2023.
- ² SAMHSA (2020). *National Guidelines for Behavioral Health Crisis Care: Best Practice Toolkit*. Washington, DC.
- ³ Proctor, E. K., Landsverk, J., Aarons, G., Chambers, D., Glisson, C., & Mittman, B. (2009). Implementation research in mental health services: an emerging science with conceptual, methodological, and training challenges. *Administration and Policy in Mental Health and Mental Health Services Research*, 36, 24-34.