

HOSPITAL DIVERSION PROGRAMMING
KEEPING HIGH RISK ADOLESCENTS SAFE IN THE COMMUNITY
Presented by Bridget Bennett-Lewis, LICSW

CHILDREN’S INTENSIVE SERVICES

The creation of a hospital without walls, a hospital diversion program, to maintain high risk adolescents in their community was created in response to an initiative to reduce the number of psychiatric bed days for children by Rhode Island’s Division of Children, Youth and Family Services. The initiative began approximately 6 years ago. As found elsewhere across the nation, Rhode Island found that too many financial resources were going to support too few children in the hospital at too high a price. They requested that the eight community mental health centers that cover the state work with the state to put together programming to address the problem. The program that was developed was Children’s Intensive Services (“CIS”). The CIS program, however, is one of many programs that comprise the continuum of services for children’s mental health services offered in Rhode Island. The other services, ranging from highest to lowest intensity of service, are: inpatient hospitalization, children’s residential services, outpatient mental health services, project early start, comprehensive emergency services and head start. The new CIS program level of acuity was below hospitalization but above the other community programs.

ELIGIBILITY

The CIS program was funded by dividing up the aggregate costs of hospitalizations of a recent number of years among the 8 community health center as a capitated per person daily rate for each child enrolled in the program. Additional Medicaid services also can be used and billed as regulations allowed. The eligibility as defined by the state is based on the following priorities: first priority is the Medicaid and uninsured children at risk of hospitalization, the second priority is Medicaid or uninsured children at risk of placement and the third priority is insured children at risk of placement. The population for whom the state was attempting to contain costs was clearly the Medicaid children and their families who are at risk of hospitalization and out-of-home placement. Children can range from age 3 up to age 21.

COMPONENTS OF CIS

The six (6) month hospital diversion program offers the full range of clinical services, including psychiatric treatment, nursing services, clinical services including individual and family therapy, case management, in-home respite, therapeutic recreation, hospital and community agency liaison, crisis intervention, weekend outreach and case coordination. There is a minimum of three times a week contact and that contact can be in combination with the child, with the family and/or with collaterals. All staff are masters level clinicians who provide the clinical work and the case management. Caseloads are ideally around eight. Case management is seen as clinical services to these children. There are also individual rehabilitation workers who take the children out on a one to one basis to work on improving their social skills and teaching them how to get along in the community. These children frequently have been excluded from community programming because of behaviors; with the staff support they are able to access these activities. There also is a vocational specialist who helps the children look for jobs. During the summer, the program runs a therapeutic program for 6 weeks that offers different programs for children ages 3 to 13. At age 14 CSI begins working on job placements. All the services and work happen in the home, the school and the community. There are no office-based services. The services are available 24 hours a day, 7 days a week, with emergency services that offer 24-hour coverage. Weekend contacts are done with the children. It is a very intensive service and it works.

MAKES THE PROGRAM SUCCESSFUL

First, it is important to get people to believe that the children do not have to go into the hospital just because they are in crisis. Second, the program has to learn to partner with the hospitals and to use them effectively. The CIS program until recently had gate keeping responsibility for which children on Medicaid go into the hospital. The program determined admission, monitored the duration and linked between the hospital and the community to develop discharge plans. Under CIS, hospital bed days have gone down, length of stay has gone from 30 days to 14 days to 2 days. When gate keeping rests with physician, in contrast, notification about the hospitalization to the mental health center is not as smooth and consistent and children remain in the hospital longer. At present, Rhode Island's Medicaid managed care company has gate keeping responsibility, however, there is work going on to give that

responsibility back to the mental health centers. Hospitals also are in a position to sell the family on the community based services and their effectiveness. Third, the staff of the CIS program must be people who can work in the field and understand the nature of the work. They must have been able to make the switch from office-based treatment to community-based treatment. Staff training is vital and staff need to be able to function as a team. The team needs to include the psychiatric component.

SUMMER THERAPEUTIC PROGRAM

The children in the program need structure during the summer. For the young children, CIS runs a camp. The CIS staff provides transportation and there is 3 or 4 staff to 7 children. With the older children, there is some attaching of the older children to the younger children for some of the recreational activities. For the children ages 14 and up there is summer employment money that is used to hire 15 children and put them in a supported work environment. The children are mentors and offer job coaching. They get paid a small stipend. The program has been very successful. During the summer there has not been one psychiatric hospitalization of any of the children that have been in the program. CIS also has taken staff and placed them in community camps to support CIS children's attendance in those camps.

FAMILY THERAPY

Many of the families that are in the program are burned out with being in the system, burned out with the revolving door to the hospital. They initially balk at people coming into their homes because it is a fairly intrusive. The program works with the family to accept that level of intervention, however, if a family refuses therapy would be offered in the office and then work toward home based work. Such refusals are rare, however. Respite also is a service that is offered in the home and provides support and role modeling for the parent.

MULTI-AGENCY FUNDING

To be able to offer the intensity and the variety of services to fill the gaps and service need for an effective diversion program, funding from multiple sources is a requirement. No state is able to shoulder the entire amount of money that will be required. One way to access additional funds is to develop multi-agency initiatives. In Rhode Island, the CAST dollars were

used to create a multi-agency planning team to figure out how to fill the gaps in community based care. A grant of more than 15 million dollars over 5 years was obtained and divided among the community mental health center regions. Some of those monies pay for the camp, together with monies from the school department and the housing authority. Respite also is paid for with those monies. Public housing authorities are a funding resource and the state's Medicaid authority should be brought to the table to develop funding options. Creativity and pooled funding is needed for exemplary program development.

