Better outcomes in both cost and quality of care are achievable through community-based initiatives that redefine the meaning of "crisis" and address and stabilize behaviors prior to escalation to the level of requiring inpatient care.

~SAMHSA

The Need for Mobile Response and Stabilization Services (MRSS) in Vermont: From Reactive to Responsive

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What I'll cover today

- Why Mobile Response & Stabilization Services (MRSS) for Vermont families?
- What is Mobile Response?
- Who can use it?
- How does it differ from other crisis services?
- Review of the pilot proposal and funding
- Outcomes to be measured

One Family's Story

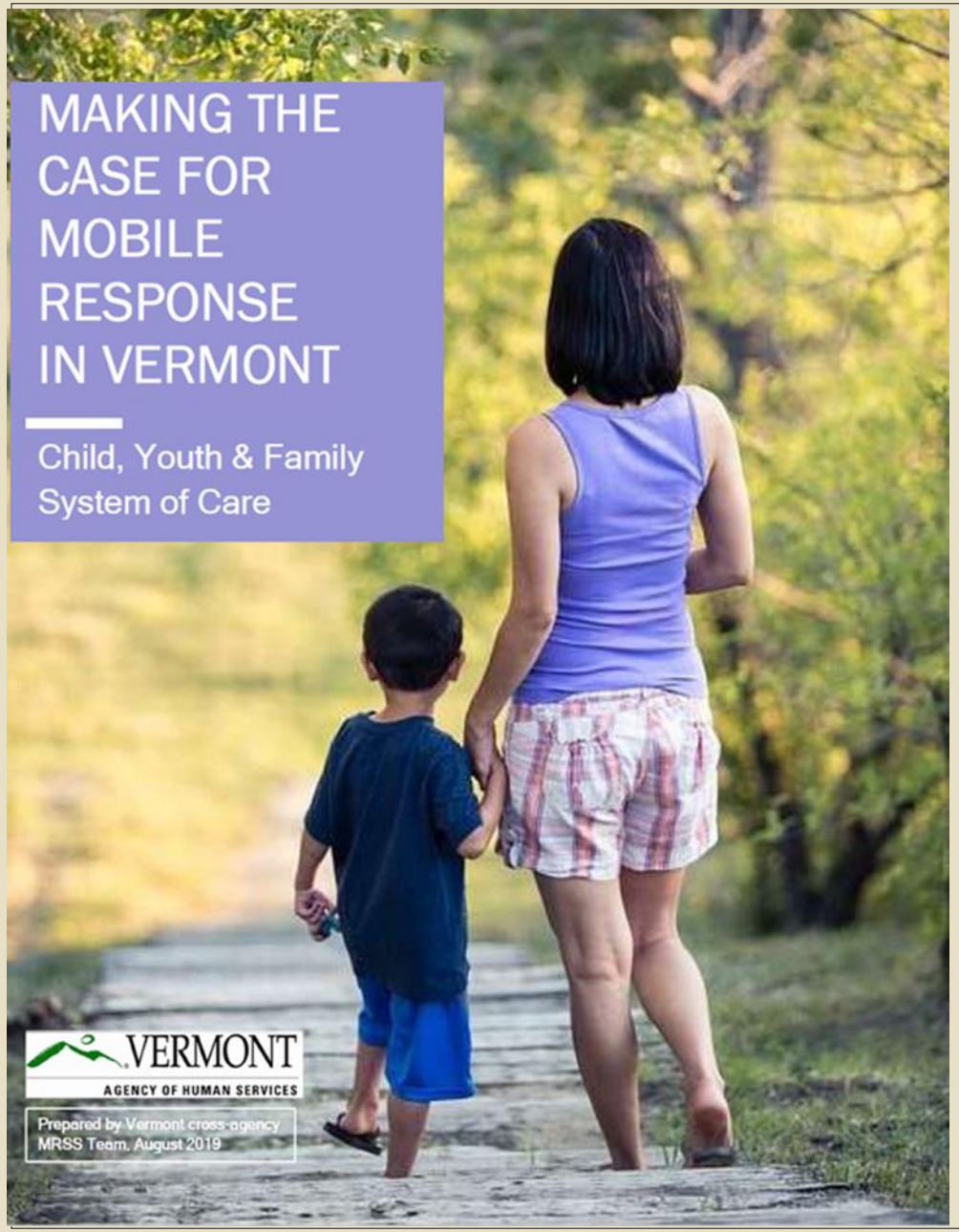
I am an adoptive mom for a young man who is 14 years old chronologically, and developmentally age 5. While he has a complex learning and medical profile, it was not until his early teen years that both his physical size and mental health needs increased.

Earlier this year we were sent to the emergency department (ED) because he became so dysregulated while at a routine med check with his psychiatrist that he was not safe coming home. He remained in the ED (without services) for 6 days, while being refused five assessment bed placements in three states because of his complicated co-occurring mental health and developmental service needs. On day six, we were discharged home without having the level of services we needed in place. Not surprisingly, we returned to the ED just three days later for another six day stay…searching for an assessment bed where my son could receive support and be safe. This time we were fortunate enough to be accepted by the VCIN (VT crisis intervention network) and then supported by a specialized development disability services agency.

In the county where I live, mobile services are not available to persons in crisis. Instead families can call the crisis phone line, and someone can call you back, but mostly only to provide phone consultation. Not all DA's have mobile services currently in Vermont. This can and would have made a significant difference for our family, had we received those proactive services and supports much earlier in his development.

In-person crisis support, in the moment, provides support to both the child and the adults providing their care. Can you imagine telling someone over the phone how to perform a surgery with intricacies and evolving factors? Why do we think social emotional supports for mental health are any less worthy of directed and skilled care in the exact moment that they are needed?

~Kathleen



CHALLENGES

- More children (0-17) going to Emergency Departments in crisis and some experiencing further traumatization while there
- Current gap between the resourced capacity of DA emergency services teams and the demand for these services
- Challenges with flow through the children's system of care
- Providers see a need for responsive, in-home community supports beyond this screening
- Families are asking for more immediate in-home supports

GOAL

We want to:

- help families in distress in a timely way
- provide support to prevent higher levels of care
- prevent out of home placements
- provide services in the home or community whenever possible
- provide services to ensure stability and safety
- improve the health and well-being of children, youth & families

Mobile Response Proposal for Vermont, White paper (August 2019)

What is Mobile Response?

- Mobile Response and Stabilization Services provide more **upstream services**
- A mobile face-to-face response is provided to a **family-defined crisis** to provide support and intervention for a child/youth and their family, **before** emotional and behavioral difficulties escalate
- MRSS is showing positive outcomes in other states

Core Components of Mobile Response

- Crisis is **defined by the caller**, not the provider – a "Just Go!" approach
- **Face-to-face** mobile response to location preferred by the family
- In-home **assessment, de-escalation, crisis planning, resource referral**
- Brief **follow up stabilization services**, case management
- **MRSS Team** consists of:
  - Team coordinator/ clinical director
  - Licensed or license-eligible clinician
  - Behavioral Specialist or Family Peer Services Worker
  - Access to a psychiatrist or APRN
- Robust **staff training** plan
- Centralized **Call Center** (strongly recommended)
- **Data tracking** and performance measurement reporting
- Close coordination with the DA Emergency Services and Child, Youth and Family Services programs

Who is eligible for Mobile Response?

- Any child or youth Vermont resident who is:
  - in the community (Rutland County for pilot)
  - under the age of 18 (or under age 22 if still in school)
  - experiencing escalating emotional symptoms, behaviors, or traumatic circumstances (e.g. placement in foster care) which impact the youth's ability to function at their baseline at home, school or in the community
- The presenting need may be related to a psychiatric disorder, developmental disability, substance use, or combined or unknown factors at the time of initial MRSS contact
- Without Mobile Response, the child/youth may be at risk of waiting at an emergency department, psychiatric hospitalization, out of home treatment, legal charges, or loss of their living arrangement
- Child/youth's caregiver gives consent for MRSS
- Goal: provide timely mobile response to a family-defined crisis regardless of insurance type (Medicaid, commercial, uninsured)

Successes in other States with MRSS

Connecticut:

- showed a 25% reduction in ED visits among children who used MRSS compared to children who didn't access MRSS
- found the 2014 average cost of an inpatient stay for Medicaid-enrolled children was $13,320 while the cost of MRSS was $1,000, a net savings of $12,320 per youth

Washington State:

- Seattle, WA MRSS reported diverting 91-94% of hospital admissions and "estimated that it saved $3.8 to $7.5 million in hospital costs and $2.8M in out-of-home placement costs"

Arizona:

- "saved 8,800 hours of law enforcement time, the equivalent of four full-time officers"

New Jersey:

- MRSS services provided to children entering foster care to support them and try to reduce the trauma experienced at that moment. Data showed that 46/46 children who entered foster care and who had a mobile response were able to remain in their first placement.

Sources: *Child Health and Development Institute and NASMHPD, 2018*

Mobile Response & Stabilization Services Team Proposal

- VT MRSS pilot will be modeled after other states with lower population regions to have staffing during peak hours on weekdays (6AM-10PM) and weekends (1PM-10PM), rather than having mobile response 24/7.
- Paired Team of clinician and behavioral specialist or family peer provide mobile response
- $600,000 general fund is estimate to cover new staff for Mobile Response team
- Key strategy to scale this up is to understand proportion of Medicaid-eligible, commercial, uninsured
- Want to provide the service regardless of payer type

MRSS Estimated Costs

	FTE	Annualized Cost	MRSS Team Cost	Credentials/ Notes
MRSS Program Director	1	$ 116,480	$ 116,480	Licensed as Psychologist (Master or Doctor), Clinical Mental Health Counselor (LCMHC), or Social Worker (LICSW)
Clinician	2.78	$ 87,360	$ 242,570	Masters Level, licensed or license-eligible
Behavioral Specialist or Family peer	2.78	$ 58,240	$ 161,713	BA-level or trained family peer
Psychiatric Consultation	0.25	$ 266,000	$ 66,500	Psychiatrist or APRN
Overtime (estimated at 10%)			$ 16,171	*Estimates do not account for the potential to leverage Medicaid reimbursement, or costs associated with workforce development and evaluation*
Subtotal			$ 603,434	
Admin Cost (10%)			$ 60,343	
MRSS Team Total Estimated Cost			$ 663,777	

ED visits among "High Utilizer" Children/Youth by Health Service Area

Member HSA	# Members	# ED MH Visits	Avg ED Visits/Member
Burlington	1056	631	0.60
Barre	644	481	0.75
St Albans	577	230	0.40
Rutland	505	626	1.24
Bennington	470	411	0.87
White River Jct	447	252	0.56
Brattleboro	290	292	1.01
St Johnsbury	277	152	0.55
Springfield	269	243	0.90
Newport	268	126	0.47
Morrisville	264	80	0.30
Randolph	200	80	0.40
Middlebury	124	77	0.62
Grand Total	**5391**	**3681**	**0.68**

Rutland is the only HSA with more ED visits than # members of high utilizers; means multiple ED visits among some high utilizer members

Project of Depts of Vermont Health Access (DVHA), Mental Health (DMH), and Onpoint Health Data consultant

Children Waiting in Vermont Emergency Departments

Patient Type	Total # Discharges	Total # Bed Days	Length of Stay in Days (Mean)	Length of Stay in Days (Median)
Children (voluntary)	1589	1180	0.7	0
Children (involuntary)	71	225	3.2	2
Total	1660	1405	0.8	2

Source: *Act 200 Report, 2019*

Increased rates of children who go to an ED with a mental health crisis and then wait, sometimes for days, for a plan to put into place compared to 5 years ago

Children's ED visits comprise **16%** of the total # of ED discharges and total ED bed days (VAHHS)

Children waiting **involuntarily** in EDs wait **3.2 days** on average

Children waiting **voluntarily** have shorter waits

ED settings can be frightening for children and youth in a mental health crisis

Statewide top 5 MH reasons child at ED:

1. Mood disorders
2. Anxiety disorders
3. Attention deficit, conduct and disruptive behavior disorders
4. Suicide and intentional self-inflicted injury
5. Adjustment disorders

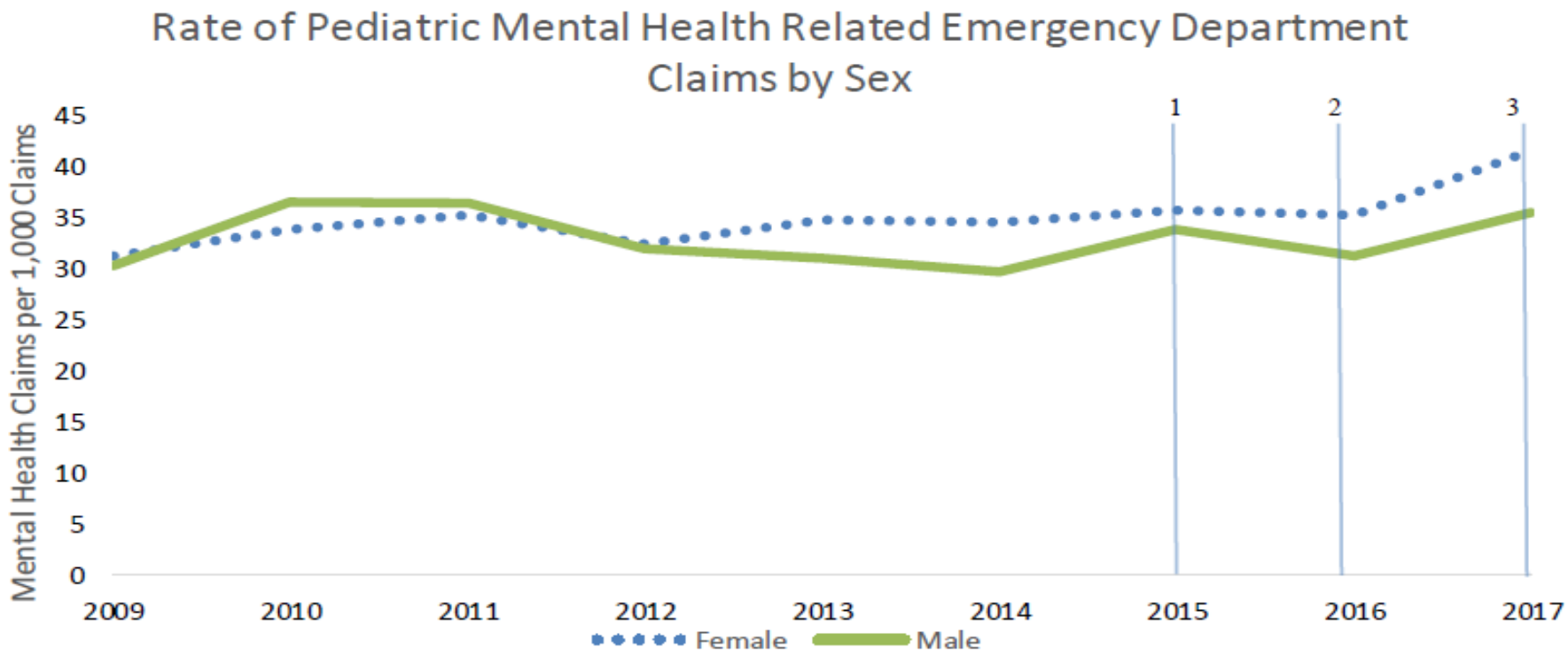
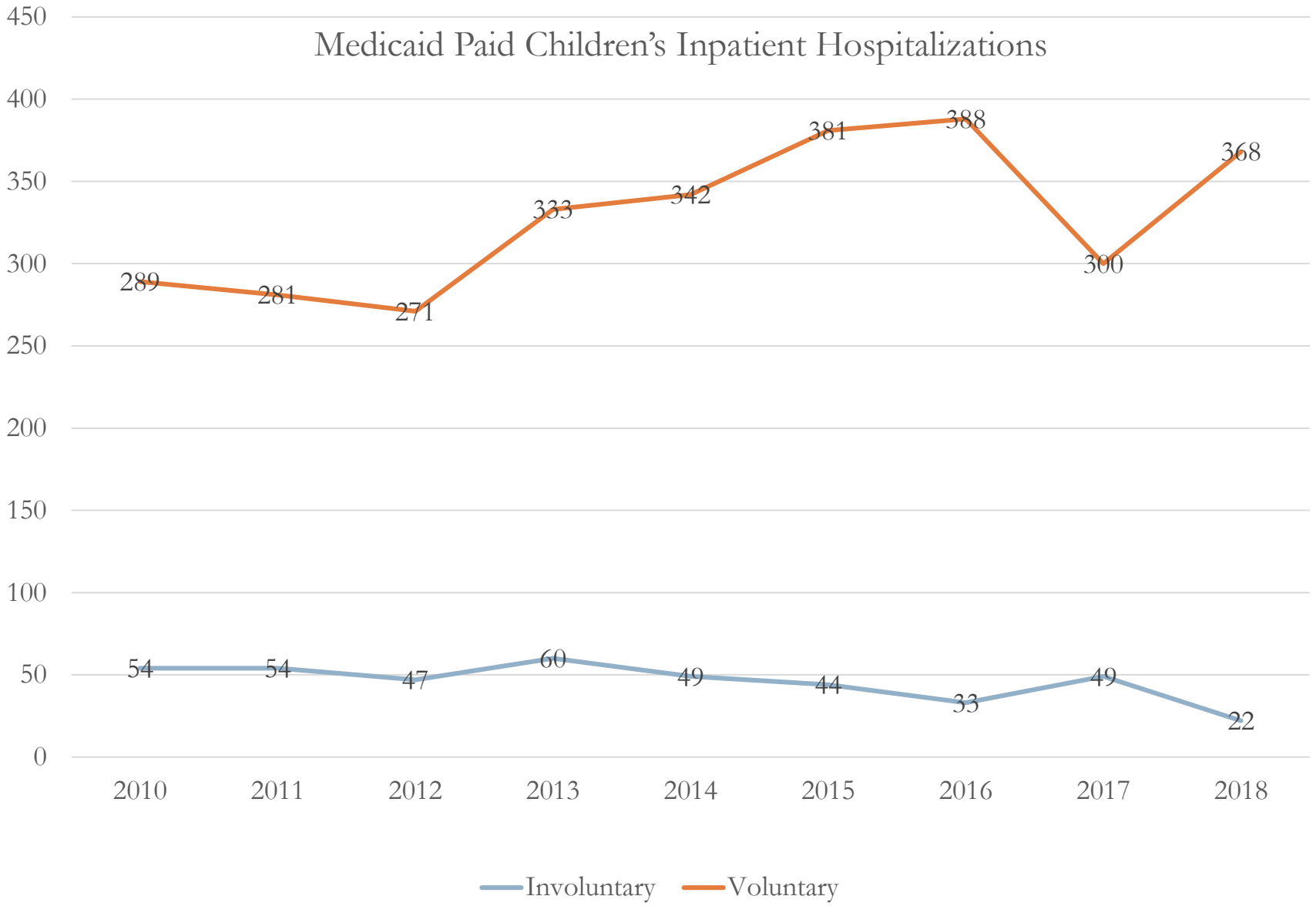


Figure 4: Rate of mental health related claims per 1,000 emergency department claims by sex. Diagnosis fields 1-6 were searched for a mental health related diagnosis code. Claims restricted to Vermont children under the age of 18 that visited an emergency department in Vermont or New Hampshire.

Source: *Vermont Health Care Uniform Reporting and Evaluation System (VHCURES)*



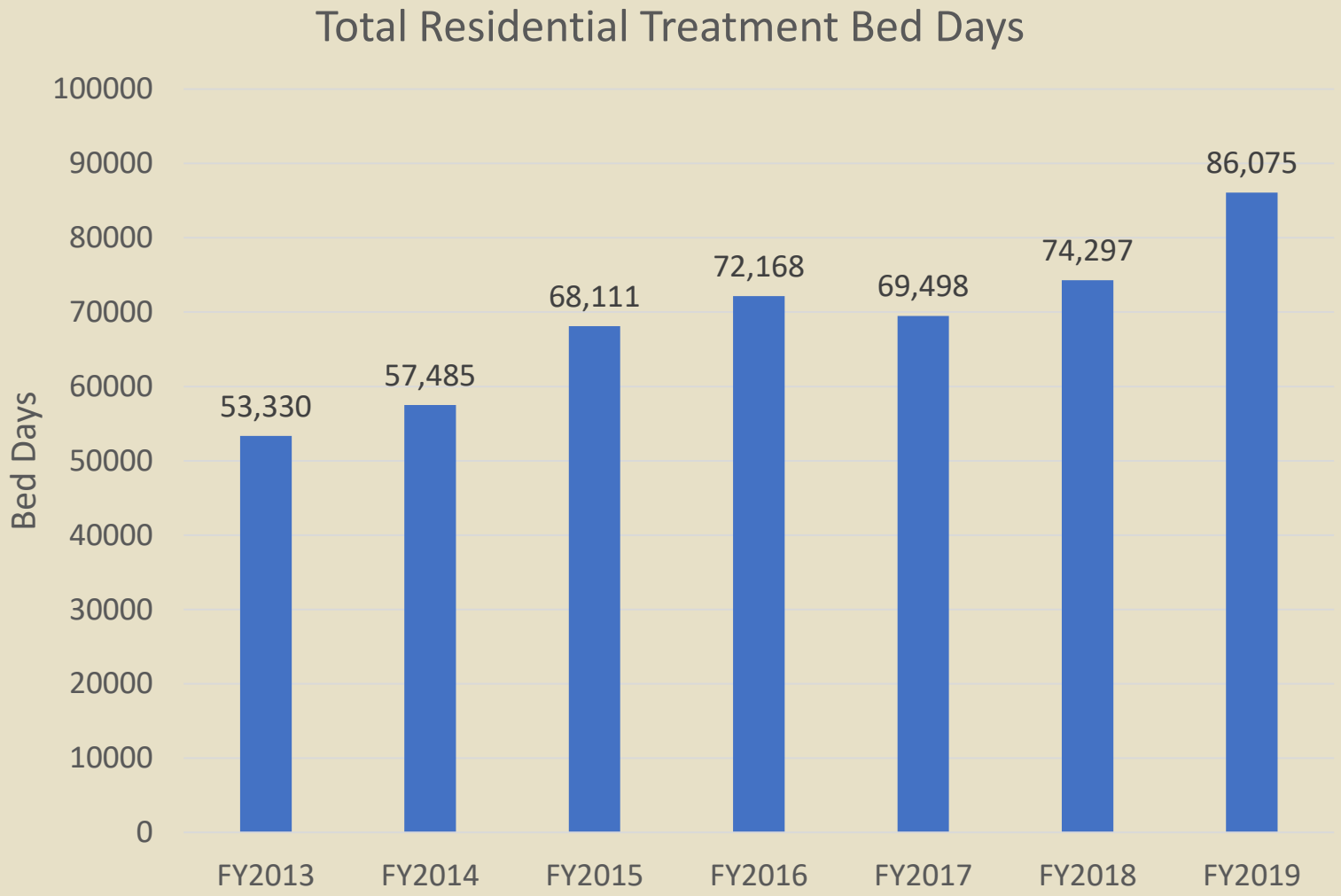
Medicaid Paid Children's Inpatient Hospitalizations

Involuntary admissions have declined slightly

Voluntary admissions have increased

MRSS could help divert voluntary inpatient admissions

Out-of-Home Treatment Trend for AHS



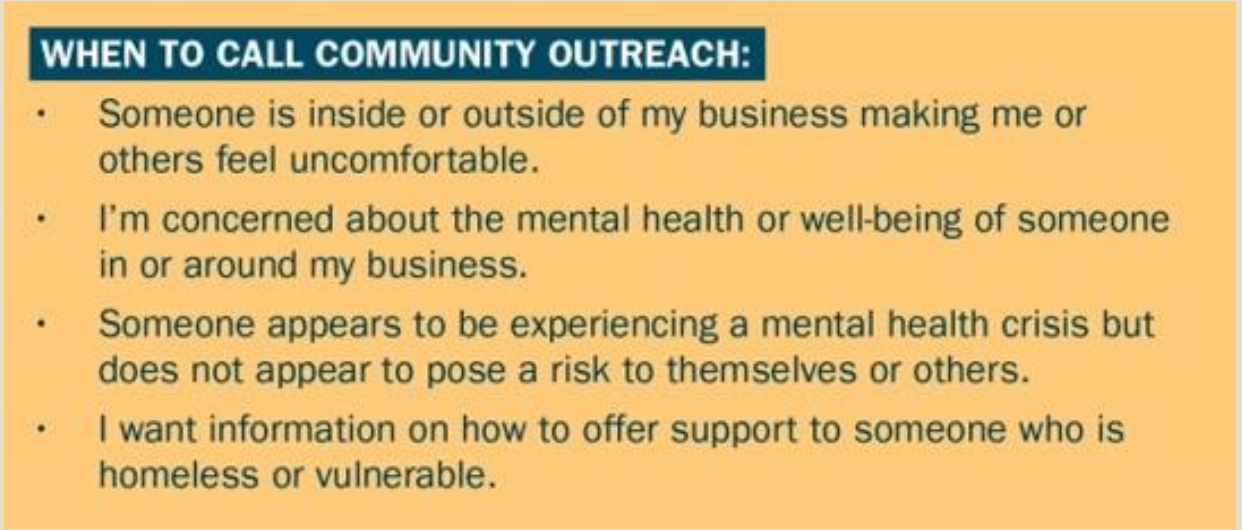
Total Bed Days = total number of days a child/youth stays overnight in a residential treatment program

Children and youth are referred to out-of-home residential treatment through DCF-FSD, DMH, or DAIL-DDSD under the Act 264 Coordination of Services Process

How does MRSS differ from Community Outreach Teams?

Community Outreach Teams

- Generated by needs of a community for situations that needed a response other than law enforcement
- Outreach Specialist in partnership with local and regional law enforcement
- May respond with law enforcement or not, through police dispatch
- Serves primarily adults (86%), some youth (14%)
- Respond to individuals with unmet social service needs, often due to mental health or substance use issues



Currently in Chittenden County, considering expansion into Washington County

How does MRSS differ from Community Outreach Teams?

Mobile Response & Stabilization Services

- Family requests support, is key focus of intervention
- Mental health clinician paired with behavioral specialist or family peer with specialized training to work with children, youth & families
- Timely in-home or community response for child/youth with emotional & behavioral escalation *before* becomes crisis
- Children & youth have different developmental needs and require different interventions than adults
- Child, youth & family *System of Care* values and partners (Schools, child welfare, juvenile justice, pediatricians)
- Prevent crises from happening, not triaged, Just Go!

You should call if you feel that your child is in a crisis situation that is too difficult for you to handle. You may be concerned about your child's anger, tantrums, peer conflicts, depression or anxiety, suicidal thoughts or behavior, school problems, parent/child conflicts.

Would anyone be better off as a result of MRSS?

Anticipated impacts include:

- Avoid potential traumatization of children/youth and their families from waiting in EDs
- Prevent placement disruption
- Children remain connected to home and community
- Children have continuity of their school
- Reduce the stigma of hospitalization
- Families feel more immediately heard and supported
- Families who feel supported may be ready earlier for their child to return home from an inpatient, crisis program or residential treatment

Outcome Measures

Measure	Desired Direction
ED visits for mental health needs (Utilization (#), lengths of stay (LOS), spending ($))	↓
Higher levels of care: inpatient, hospital diversion (#, LOS, $)	↓
Out-of-home treatment (#, LOS, $)	↓
Placement stability for children involved with child welfare	↑
Health and well-being of children, youth and families	↑
Access to MH services	↑
Use of law enforcement to respond to family crises	↓
Timely response of MRSS (mobility rate)	↑
Consumer (child, youth, family) & Stakeholder satisfaction	↑

Next Steps

- Identify funding plan
- Implementation plan with RMHS
  - MRSS model
  - Workforce
  - Financing
  - Evaluation of pilot
  - Contract development
- Public Messaging
- Monitor and adjust
- Report to AHS and legislature on pilot outcome (Jan 2022)

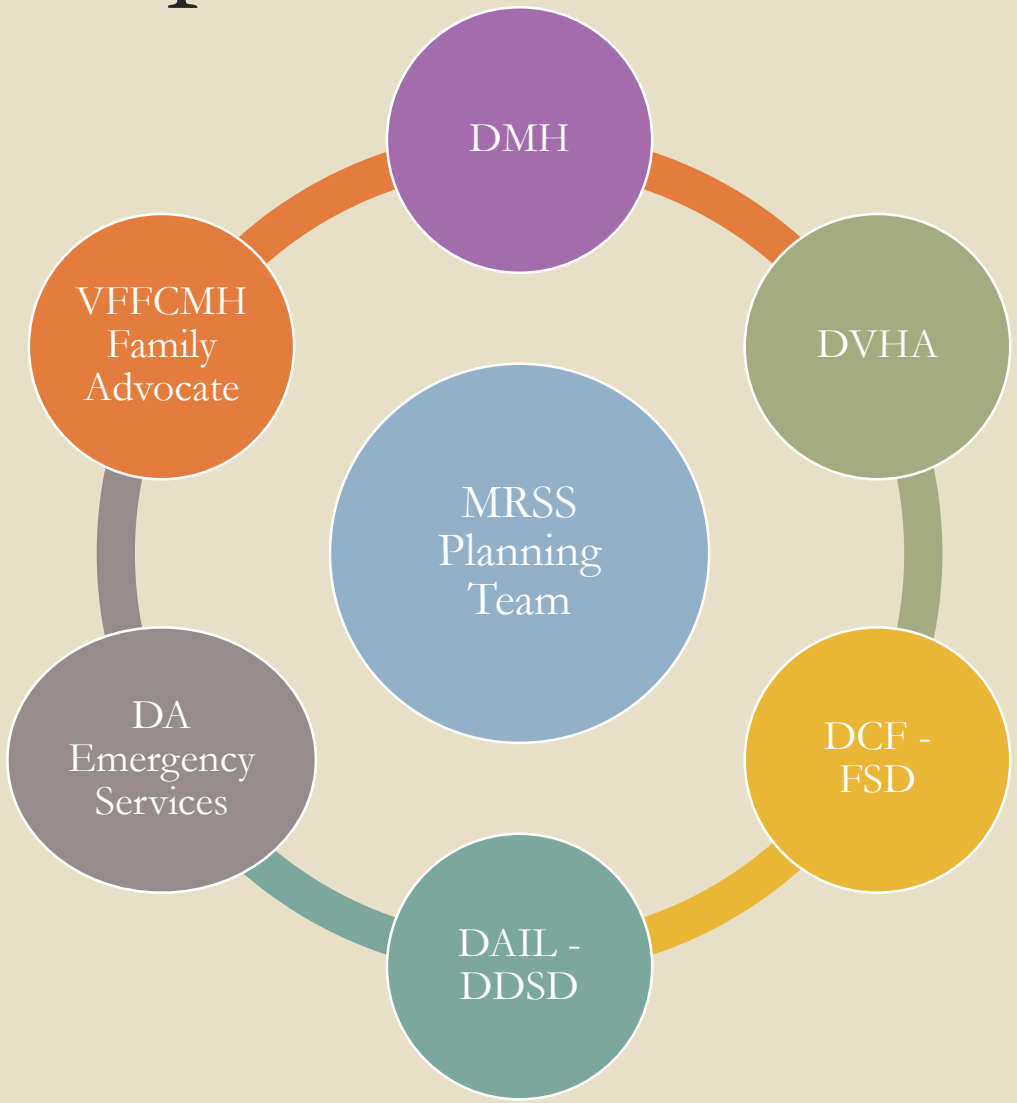
YOU DON'T HAVE TO SEE THE WHOLE STAIRCASE,
JUST TAKE THE FIRST STEP.

Martin Luther King, Jr.

ADDITIONAL INFORMATION

The Focus on Mobile Response

- MRSS Planning Team of AHS departments and community partners was formed (2018)
- Think Tank to discuss the need for MRSS in Vermont (June 2018)
- State-to-state peer learning and technical assistance to learn from the experience of other states who have implemented MRSS (December 2018, ongoing)



Anticipated Challenges for MRSS implementation

Initiative fatigue

Workforce recruitment & retention

Funding

Data system

Competing priorities

Implementation needs to occur while still providing current system of supports

Strengths for MRSS Proposal

Families are asking for immediate in-person support

Cross departmental involvement

Interest across stakeholders

Technical support from NASMHPD and other states

Data supports the need for MRSS

Past experience in Vermont with mobile response

Example from Connecticut MRSS

(Emergency Mobile Psychiatric Services EMPS)

We Can Help Now!

DIAL 2-1-1

For EMPS Mobile Crisis Intervention Services

Is your child in crisis?

Do you need immediate help with:

- *A child who is angry and out of control?*
- *A child who is destroying property, breaking the law, or doing things that are life threatening?*
- *A child who is threatening to hurt him/herself or others?*
- *Any behavioral/emotional crisis involving a youth?*

DIAL 2-1-1 to get help NOW!

When your child is in crisis, 2-1-1 is your lifeline.

It's not easy to get through to a child who is out of control. The good news is that help is only a phone call away. By dialing 2-1-1, you are reaching out to trained counselors who can immediately help resolve the crisis.

How do I know if I should dial 2-1-1?

You should call if you feel that your child, under the age of 18, is in a crisis situation that is too difficult for you to handle. Examples of these situations are:

- A child who is putting him/herself or others in danger.
- A teen who is acting violently.
- An angry child who is behaving dangerously.

What is 2-1-1?

2-1-1 is a toll-free, confidential service connecting people to the health and human services they need.

"Hello, You've dialed 2-1-1 how can we help?"

What happens when I call 2-1-1?

When you call 2-1-1 for help with a youth in crisis, you will be connected with EMPS-Mobile Crisis Intervention Services.

Mobile Crisis is an intervention service for children and youth in crisis. Crisis Clinicians are available immediately, 24 hours a day, 365 days a year, in person or by phone.

Just let me help!

What does Mobile Crisis do?

Mobile Crisis helps resolve behavioral or emotional crisis, at home, in school, wherever help is needed.

Crisis Clinicians respond immediately to the crisis, and work with the child and family to develop a crisis plan to bring the situation under control as soon as possible.

What happens next?

Support is provided to the child and family for up to 6 weeks. Follow-up care involves the child, family members, and community based supports.

I have more questions, who should I ask?

You can dial 2-1-1 with any questions you may have about 2-1-1 or **Mobile Crisis** services.

DIAL 2-1-1

Mobile Crisis is a program funded by the State of Connecticut in partnership with United Way of Connecticut 2-1-1.
www.empsct.org

Connecticut 2-1-1 Get Connected. Get Answers.

United Way

Utilization & Total Cost of Care for Vermont Children & Youth with Mental Health Needs

Project Purpose

- Can we identify the utilization & costs of higher intensive services for children & youth with mental health needs in Vermont?
- Do those costs & utilization change following implementation of MRSS?
- Where is the biggest impact?
  - For whom
  - What level of care
  - What payer type
  - Health Service Area
  - Other demographics

Project Background

- Depts of Vermont Health Access (DVHA), Mental Health (DMH), and Onpoint Health Data consultant
- Informed by other states' analyses of Return on Investment
- All payer data (commercial, Medicaid, Medicare)

Costs of Care & Utilization for Vermont children with intensive needs

High Utilizer Operational Definition

Any child 1-21 with a mental health/substance abuse diagnosis in 2018 and:

- 1 or more hospitalizations with a mental health diagnosis OR
- 1 or more hospital diversion program claims OR
- 1 or more outpatient ED visits with a mental health diagnosis OR
- Any residential (PNMI) treatment OR
- 4 or more HCBS OR
- 4 or more Case Management services.

The **non-high utilizer groups** comprises all children with at least one mental health diagnosis that in 2018 that was not identified by the above logic as a high utilizer.

- All insurers: Medicaid, Medicare, Commercial

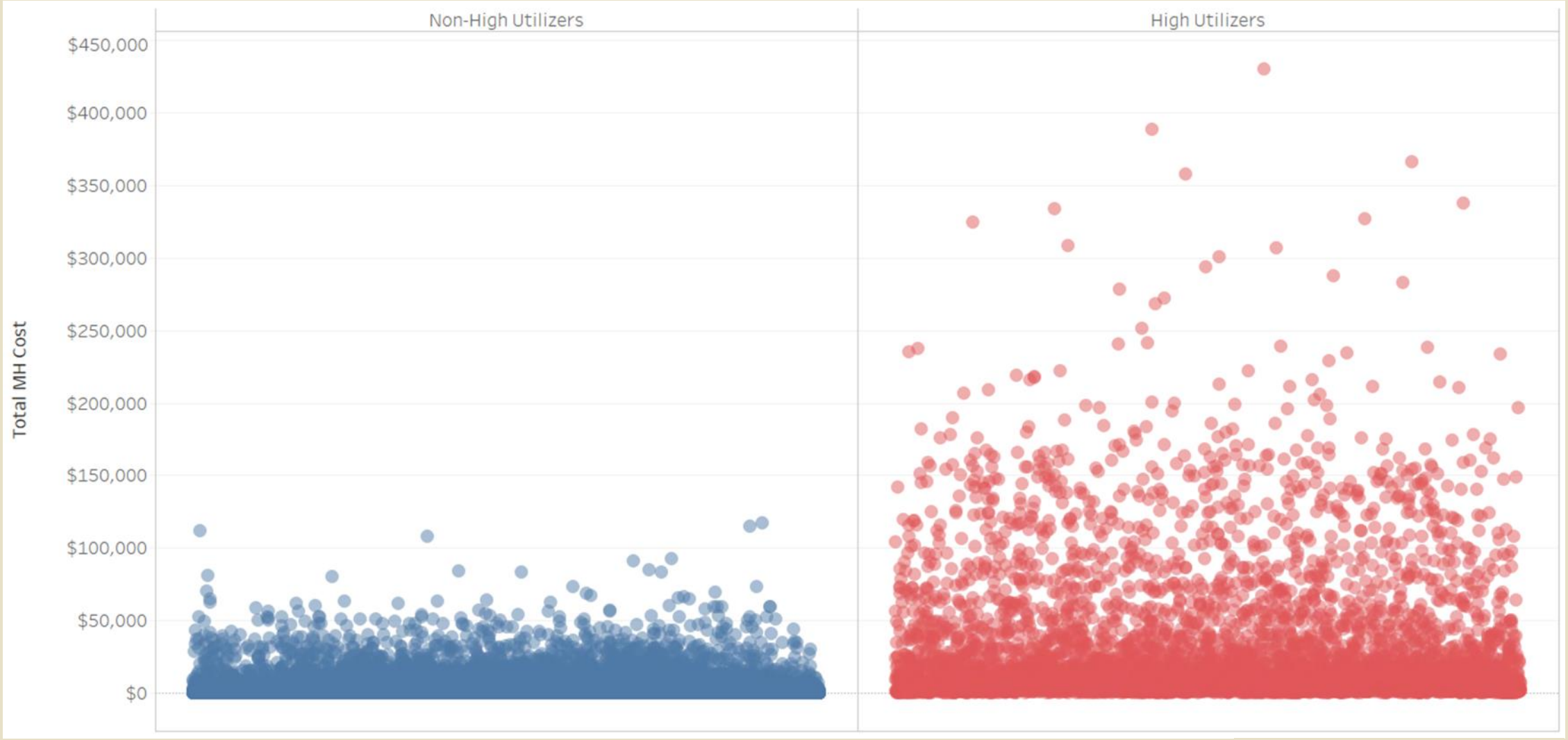
Project of Depts of Vermont Health Access (DVHA), Mental Health (DMH), and Onpoint Health Data consultant

Utilization and Costs

	Non-High Utilizers	High Utilizers	All Members
# Members	29,246	5,391	34,637
# Members with an Inpatient MH Discharge	0	960	960
# Members with an MH ED visit	0	1,813	1,813
# Members with 4+ HCBS days	0	585	585
# Members with 4+ Case Management services	0	3,438	3,438
# Members with any residential (PNMI) treatment	0	323	323
# Members with any hospital diversion claims	0	298	298
Total MH Cost	$ 83,209,302	$ 155,219,182	$ 238,428,483
Avg MH Cost/member	$ 2,845	$ 28,792	$ 6,884
Median Total MH Cost	$ 1,055	$ 10,418	$ 1,477

Project of Depts of Vermont Health Access (DVHA), Mental Health (DMH), and Onpoint Health Data consultant

Cost comparison Non-High Utilizers to High Utilizers



Onpoint Health Data

By Payer

	% Members w/in Group		% Members btwn Groups	
Product Type	**Non-High Utilizers**	**High Utilizers**	**Non-High Utilizers**	**High Utilizers**
Commercial	25.5%	11.3%	92.4%	7.6%
Medicaid	74.4%	★ 87.4%	82.2%	★ 17.8%
Medicare	0.1%	1.2%	37.7%	62.3%

	Avg MH Cost/member		
Product Type	**Non-High Utilizers**	**High Utilizers**	**All Members**
Commercial	$ 1,478	$ 21,070	$ 2,963
Medicaid	$ 3,311	$ 29,558	$ 7,985
Medicare	$ 3,739	$ 45,627	$ 29,820

Project of Depts of Vermont Health Access (DVHA), Mental Health (DMH), and Onpoint Health Data consultant