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

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

PROPOSAL

Implement Mobile Response and Stabilization Services across Vermont to help children, youth and families in distress in a timely way through infusing resources to adequately meet the current demand.

DESCRIPTION

Mobile Response and Stabilization Services (MRSS) differ from traditional crisis services in that MRSS provides 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 has been shown in other states to be responsive to child, youth and family needs, clinically and cost effective in "averting unnecessary" higher levels of care in settings such as emergency departments, inpatient psychiatric care, residential treatment or other placement disruptions, and is often the first point of contact with families (NASMHPD 2018).

Other states instituted MRSS in response to a major tragedy such as a school shooting or pending legal action under EPSDT. **In Vermont, we would like to take a more proactive approach rather than waiting for a tragedy to drive system change. We know we are not immune to tragedy and we need to have the right resources in place to do all we can to reduce the likelihood of one happening in our state.**

Vermont strives to get upstream as a system, but due to many factors including funding levels, much of our system supports are available only in reaction to an identified problem. We want to shift from being reactive to responsive. When supports and stabilization are offered earlier for families in their chosen setting (home or community), we can shift the trajectory for children and their families, heading off the need for more intensive, expensive and/or longer-term services down the road.

In Vermont we have the following challenges:

- ✓ Increases in children/youth (0-17) who go to Emergency Departments with a mental health crisis and then wait, sometimes for days, for a plan to be put into place (inpatient, crisis alternative program, or community-based).
- ✓ Designated Agencies' emergency services are expected to provide "Mobile outreach capability and crisis stabilization services *as feasible within existing resources* to help prevent need for higher level of care" (emphasis added). There is a gap between the current resourced capacity of the DA emergency services teams and the current demand for these services.
- ✓ The DA emergency services teams manage this gap between resource and demand by determining what constitutes a crisis and prioritizing crisis screening for inpatient admissions.
- ✓ Families and providers see a need for responsive, in-home community supports beyond screening.

Please refer to the Data to Support the Need in the Appendix at the end of this document for more detail.

Our goals to address these challenges include:

- Re-prioritize mobile response in our child and family system to respond to a *family-defined* crisis to help families in distress in a timely way through infusing resources to adequately meet the current demand.

- Interrupt a family-defined crisis and serve as a point of access for responding to the identified needs of the family so the child/youth can remain safe at home, in the community and in school.
- MRSS is resourced for sustainability and effective response to local need.

Core components of MRSS

- Crisis defined by the caller – Just Go!
- Face-to-face mobile response to the child's home, school or location preferred by the family (90% of the calls) within [TBD 30-60]-minutes of call
- On-site/ in-home de-escalation, assessment & 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 under the supervision of a psychiatrist
- Centralized Call Center (strongly recommended)
- Data tracking and performance measurement reporting

Would anyone be better off as a result of MRSS?

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

Successes in Other States who have implemented MRSS

Other states have shown significant positive outcomes for children and families following implementation of mobile response and stabilization services. Some specific examples include the following:

Connecticut	Washington State	Arizona	New Jersey
•showed a 25% reduction in ED visits among children/youth who used MRSS compared to youth who didn't access MRSS. •found the 2014 average cost of an inpatient stay for Medicaid-enrolled children and youth was $13,320 while the cost of MRSS was $1,000, a net savings of $12,320 per youth.	•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's MRSS reportedly "saved 8,800 hours of law enforcement time, the equivalent of four full-time officers".	•MRSS services were provided in a pilot region 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*

Vermont would anticipate similar impacts on the following:

- Reduction of ED visits for mental health needs
- Decrease use and lengths of stay in higher levels of care, including out-of-home placements
- Reduce wait times for services and support
- Increase placement stability for children involved with child welfare
- Identify and offer more upstream services in the home or community resulting in better outcomes for families and lower system cost
- Improve the health and well-being of children, youth and families

TIMELINE

- Release RFI in Winter 2020 to generate interest and input for development of an RFP.
- Release RFP in Spring 2020 for pilot regions. Identification of pilot regions following RFP.
- Implementation is targeted to begin July 1, 2020 (FY21) to pilot MRSS in three regions. Providers will need to hire and train staff prior to starting service provision, which is anticipated to begin October 1, 2020.
- Opportunity to expand statewide (10 regions) beginning FY22 with investment of funds and realized savings from first year of implementation.

UP-FRONT INVESTMENT

Investment in FY 21 of MRSS pilot is outlined below. This could be a collaboration between DMH, DCF and DVHA. The investment for one MRSS team is calculated at nearly $664K. For three pilot teams, the investment is estimated to be $1,991,332, prior to any reimbursement through Medicaid or other sources. We estimate that 80% of the children served through MRSS are Medicaid-enrolled. Therefore, we will be looking at what are the Medicaid-covered components in order to estimate what the State will be able to leverage through Medicaid funding.

	FTE	Annualized Cost	MRSS Team Cost	Credentials
Program Director	1	$ 116,480	$ 116,480	Master Level Licensed as Psychologist (Master or Doctor Level), Licensed Clinical Mental Health Counselor (LCMHC), Social Worker (LICSW)
Clinician	2.78	$ 87,360	$ 242,570	Masters Level might be licensed or license eligible (same categories as above)
Behavioral Specialist	2.78	$ 58,240	$ 161,713	Behavioral Specialist or family peer
Psychiatric Consultation	0.25	$ 266,000	$ 66,500	Psychiatrist or APRN
Overtime (estimated at 10%)			$ 16,171	
Subtotal			$ 603,434	
Admin Cost (10%)			$ 60,343	
MRSS Team Total (DOES NOT TAKE INTO CONSIDERATION MEDICAID REIMBURSEMENT)			**$ 663,777**	
Pilot 3 teams			$ 1,991,332	
Statewide estimate 10 teams (exact # teams TBD)			$ 6,637,774	

PROJECTED GROSS & GENERAL FUND SAVINGS

These projected savings are very preliminary calculations and are based on conservative estimates for Vermont using the experience of other states. Savings would be realized at the level proposed beginning one-year post-implementation, recognizing the potential for some initial savings in FY21. We anticipate MRSS will impact the use of emergency departments, psychiatric inpatient, and residential treatment.

For this calculation we focused on the reduction in total expenditure for DMH-funded residential treatment. This reduction could be attained through reducing lengths of stay and/or diverting admissions due to families feeling more supported and stable with MRSS. Following implementation of MRSS, New Jersey saw a 15% reduction in residential and average LOS decreased by 25% over the course of three years. Below represents a cost savings of approximately 10% of DMH children's residential expenditures beginning in year 2 (FY 22).

Annual gross savings: $674K, General Fund equivalent - $396K
Cumulative gross estimated savings for FY 22 – FY 25: $2.7M, General Fund equivalent - $1.58M

MRSS may also have impacts on residential treatment for children in DCF custody.

Although psychiatric inpatient care or emergency department episodes for children are not part of DMH's budget, these are high Medicaid expenses for AHS. We are not including savings from these expenditures at this time; however, we know other states have seen an impact. For example, updated information from Connecticut's MRSS return on investment determination showed the following:

ROI = (Alternative Outcome cost per episode – MRSS cost per episode) X episodes of Alternative Outcome diversion

CT Inpatient average cost per episode of care $12,150
CT MRSS cost per episode of care $978
Averted cost per episode (inpatient cost per episode – MRSS cost per episode) $11,172
483 inpatient diversions with MRSS
averted cost per episode X inpatient diversions = **$5,396,076 averted costs**

Vermont would use a similar approach once there is actual data following MRSS implementation to evaluate impact of the pilot. Future ROI evaluation could include using inpatient and emergency department information.

ASSESSMENT OF RISK

Workforce challenges may delay full implementation. Savings are projected and may not be fully realized or on the timeline offered. Designated Agencies will be continuing to provide current services while implementing a new initiative before anticipated outcomes can be achieved.

APPENDIX: DATA TO SUPPORT THE NEED

Children's Emergency Department Claims for Mental Health Codes

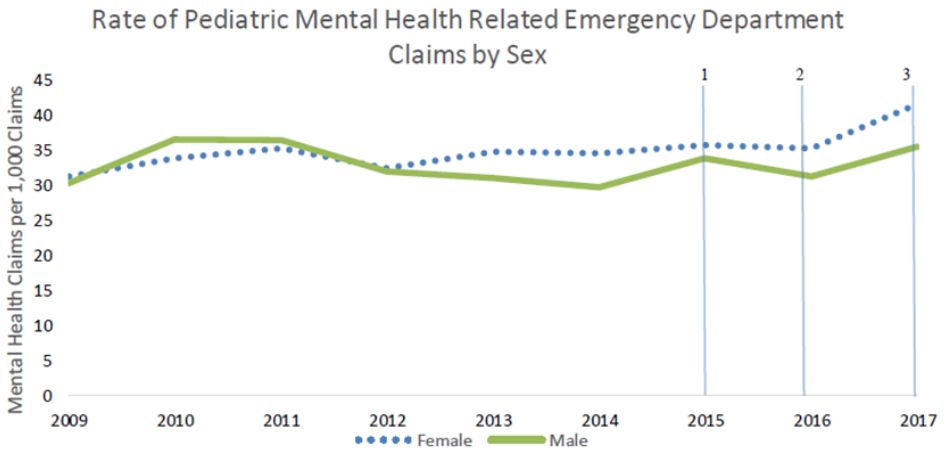


Figure 4: Rate of mental health related claims per 1,000 emergency department claims by sex. Diagnosis fields 1-6 were searched for a mental health related diagnosis code. Claims restricted to Vermont children under the age of 18 that visited an emergency department in Vermont or New Hampshire.

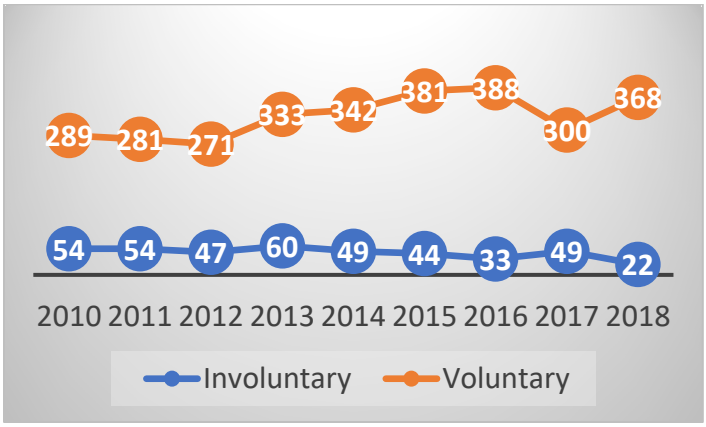
Source: *Wade et. all (2019); data from Vermont Health Care Uniform Reporting and Evaluation System (VHCURES)*

Children waiting in 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*

Medicaid Paid Children's Inpatient Hospitalizations



Source: *DMH Research and Statistics*