Mobile Response Talking Points

WHAT:

Vermont has an opportunity to strengthen and improve access to mental health care for children, youth and their families by implementing Mobile Response. This proposal is to implement a Mobile Response team in Rutland County through the designated community mental health agency, Rutland Mental Health Services.

The implementation of Mobile response would build upon and strengthen the existing capacity of RMHS Emergency Services Program. The core components of Mobile Response include:

- Face-to face mobile response to the child or youth's home, school or other location
- On-site/in-home de-escalation
- Assessment, planning and resource referral
- Follow-up stabilization services and case management
- Data tracking and performance measure of pilot outcomes

A MRSS team consists of a clinical director overseeing the team, typically a paired team of licensed or license-eligible clinician and behavioral interventionist (or family peer worker) who provide the mobile response, and access to a psychiatrist or APRN for consultation as needed. A DA may need more than one paired team of responders on during peak times.

Mobile Response and Stabilization Services 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.

When supports and stabilization are offered before difficulties escalate and in the family's chosen setting in the community, we can shift the trajectory for children and their families, heading off the need for more intensive or longer-term services down the road.

WHY? Mobile Response represents a critical targeted investment in our community mental health system of care that is based on data:

1) We have seen a significant increase over the past three years in children under 9 who are accessing crisis services through our community mental health agencies
2) Higher rates of children/youth (0-17) who go to an Emergency Department with a mental health crisis and then wait, sometimes for days for a plan to put into place years ago.
    a. Leaders in emergency departments, Designated mental health Agencies (DA), and inpatient pediatric psychiatric programs, as well as families have expressed frustration to the Agency of Human Services about the impact on families and the system when children/youth are waiting in EDs during mental health crises
3) In 2019 we had 35 children place in residential settings who were 5-10 years old. That is 35 children too many.
4) There is a gap between the current resource capacity of the Designated Agencies Emergency Services Teams and the current demand for services. DA's manage this gap by triaging to the highest level of need and prioritizing crisis screening for inpatient admission
5) Families and providers see a need for responsive, in-home community supports
6) Rutland is an ideal region for the pilot as Rutland has the highest average ED's visits for children and youth with mental health needs across the state (see chart below) as well as the highest proportion of crisis response happening in ED's for children 0-18

National Model & Outcomes

Mobile Response is national model with measurable outcomes that in other states has been shown 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).

MRSS in other states has been shown to:

- Reduce **ED visits**, recurring visits, and lengths of stay, thus reducing ED-related costs
- Reduce **inpatient admissions** and/or lengths of stay, thus reducing inpatient-related costs and improving system flow
- Reduce **residential admissions** and/or lengths of stay, thus reducing residential-related costs
- Increase **placement stability** of children in state's custody in foster care, thus reducing associated costs of placement disruption
- Reduced **law enforcement** response when intervene upstream before difficulties escalate into more intensive crisis
- The reductions in utilization of higher levels of care, staff time savings and fiscal savings are one part of the story. Importantly, **families report feeling more supported** and **children remain connected to their community**. MRSS may be the point of entry for additional supports and services.

To cite a few examples from other states (NASMHPD, 2018):

- CT: A study of the Connecticut MRSS showed a 25% reduction in ED visits among youth who used MRSS compared to youth who didn't access MRSS. Evaluation of CT's MRSS program 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..
- WA: The Seattle 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".
- AZ: Arizona's MRSS reportedly "saved 8,800 hours of law enforcement time, the equivalent of four full-time officers".

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**

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