CHILD AND YOUTH WAIT TIMES AND ACCESS TO TREATMENT

KEY INITIATIVES AND UPDATES

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THE DATA SHOW AN INCREASE IN OVERALL NEED – WITH AN INCREASE RIGHT NOW

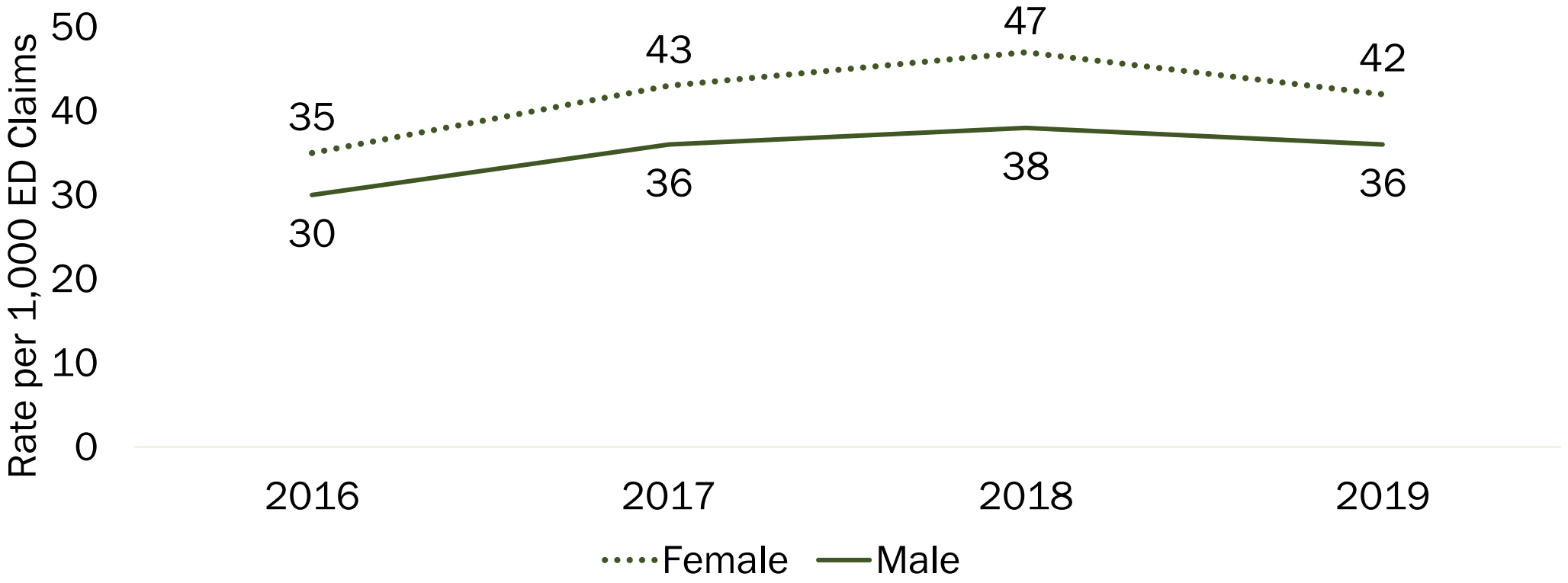
RECENT YEAR TRENDS

- Number of children and youth receiving services has risen over time
- Number of voluntary child and adolescent patients waiting for care in emergency departments rising from 2018 to 2020
  - Pre-COVID: 17.7% increase in ED visits among children/youth primarily for a mental health concern from 2016 to 2019. This increase occurred despite there being slightly fewer children in Vermont in 2019 compared to 2016 (Kasehagen, VHCURES, 2020)

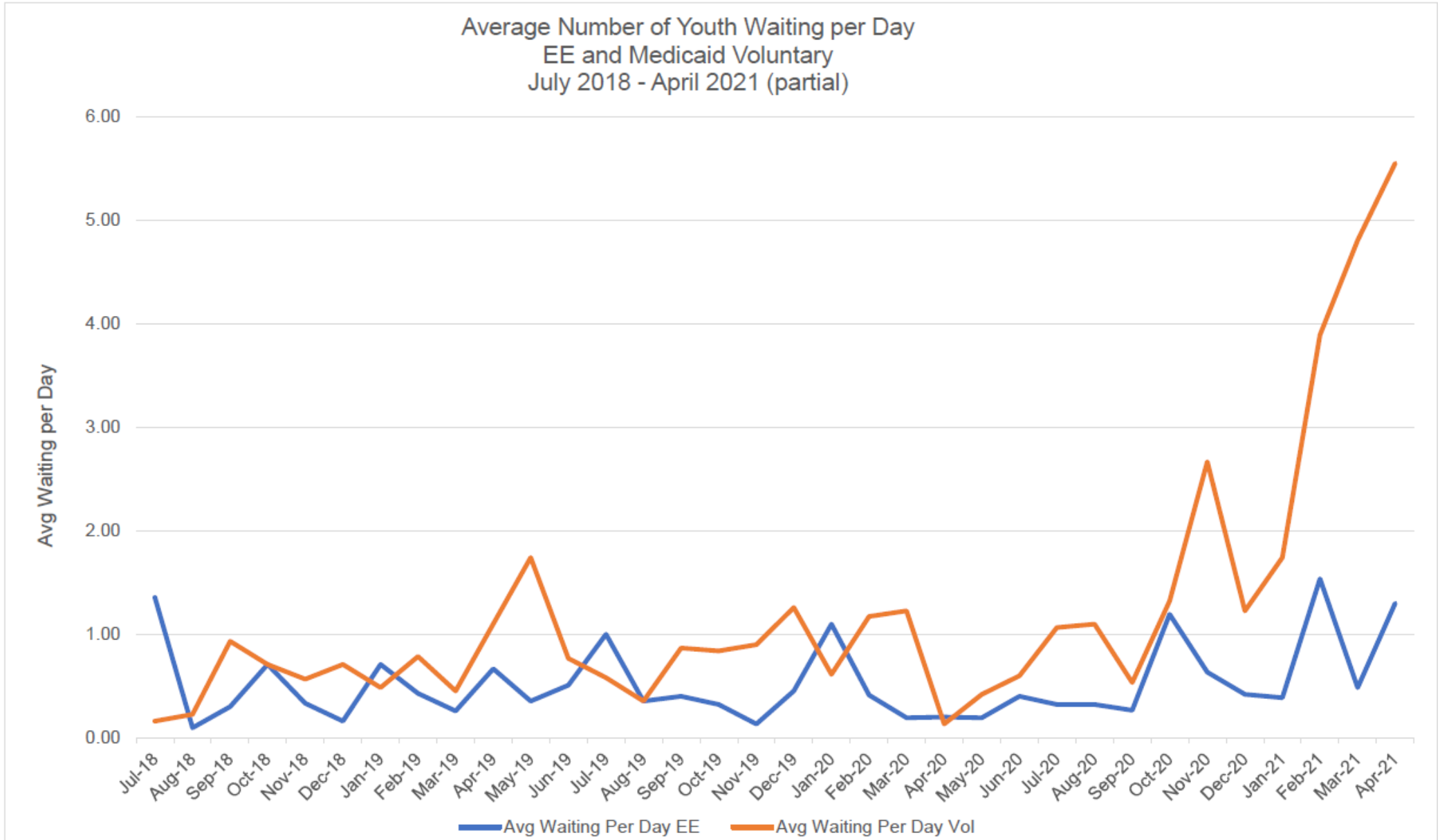
CURRENT SETTING AND OBSERVATIONS

- Inpatient, residential and crisis bed capacity is reduced due to COVID (workforce and distancing/prevention measures)
- Even during a pandemic when overall ED visits declined, children & youth are going to the ED for MH concerns and at higher numbers than before.
- Emergency department wait times for children and youth

INDIVIDUALS 11-17 YEARS COMPRISE APPROXIMATELY 40% OF THE CHILD POPULATION IN VERMONT, YET ACCOUNT FOR ABOUT 80% OF THE EMERGENCY DEPARTMENT UTILIZATION FOR MENTAL HEALTH RELATED CONDITIONS. (PRE-COVID)



Note: Claims restricted to Vermont children under the age of 18 that visited an emergency department in Vermont or New Hampshire.
Source: VHCURES All Payer Claims data. Analysis by Kasehagen, L. (2020)



Analysis conducted by DMH Research and Statistic unit.
Analysis based on data maintained by the VPCH admissions department from paperwork submitted by crisis, designated agency, an d hospital screeners.

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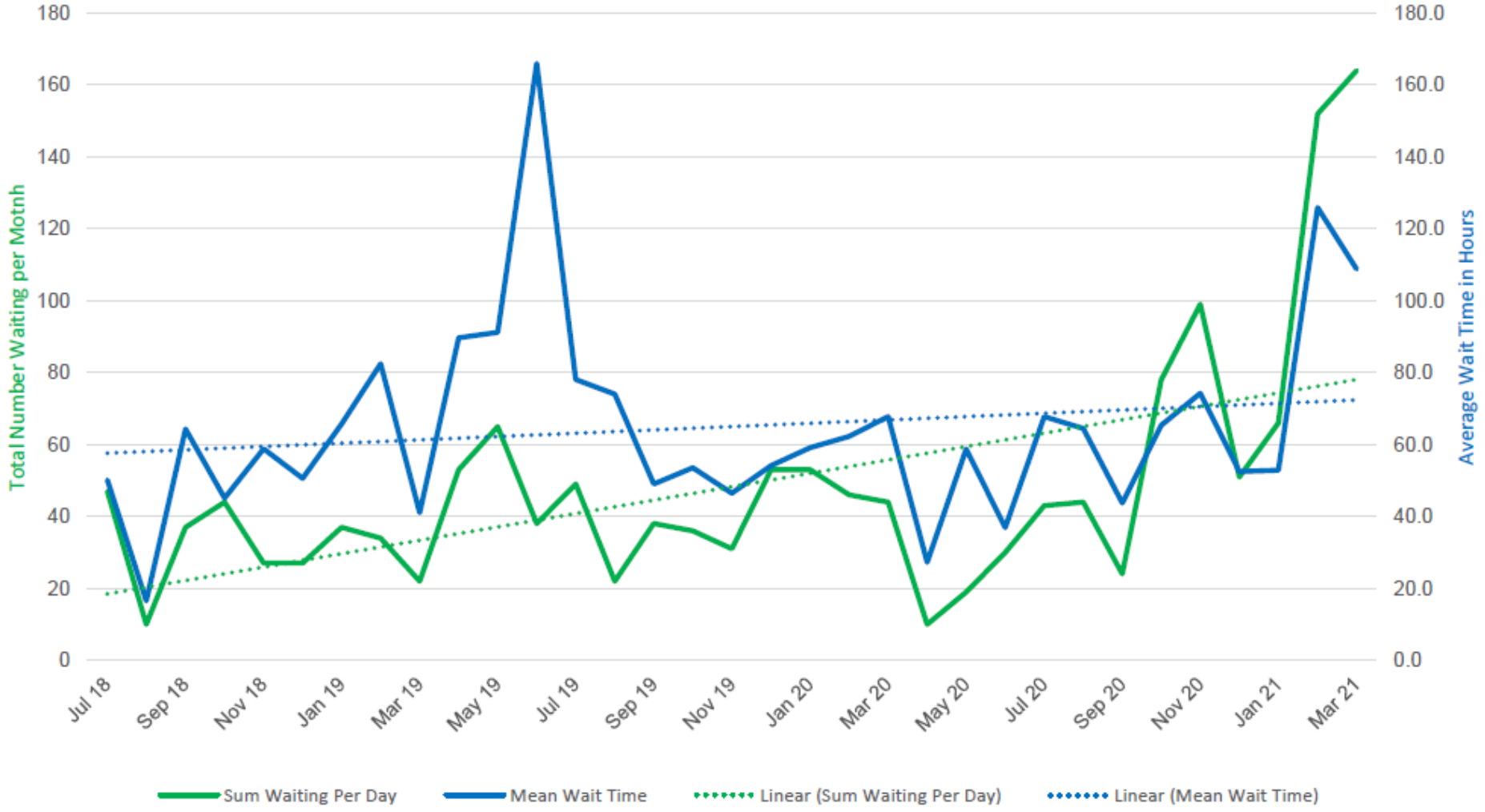
Comparison of Average Wait Time to Total Numbers of Youth Waiting Inpatient Placement for Youth Emergency Exams and Medicaid Voluntary Jul 2018 - Mar 2021



Analysis conducted by DMH Research and Statistic unit.
Analysis based on data maintained by the VPCH admissions department from paperwork submitted by crisis, designated agency, and hospital screeners. Voluntary patients are only Medicaid patients and may not include all such patients. FY2021 is partial through March 2021. All patients waiting are included, regardless of eventual disposition.

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Why the upward trend?

Increased mental health stress (COVID) +

Seasonal demands +

Reduced mental health treatment capacity (COVID) =

Children and youth waiting in Emergency Departments

Will the current increase last beyond the effects of the pandemic?

Current Children's Crisis and Inpatient Capacity

As of 4/21/2021

	Maximum Capacity (# beds)	Closed (# beds)	Current Capacity (%)
Brattleboro Retreat Inpatient for Children (Osgood 1)	12	7	42%
Brattleboro Retreat Inpatient for Adolescents (Tyler 3)	18	4	78%
NFI Hospital Diversion Program - North	6	2	67%
NFI Hospital Diversion Program - South	6	2	67%
Howard Crisis Stabilization Program	6	0	100%
TOTAL	**48**	**15**	**69%**

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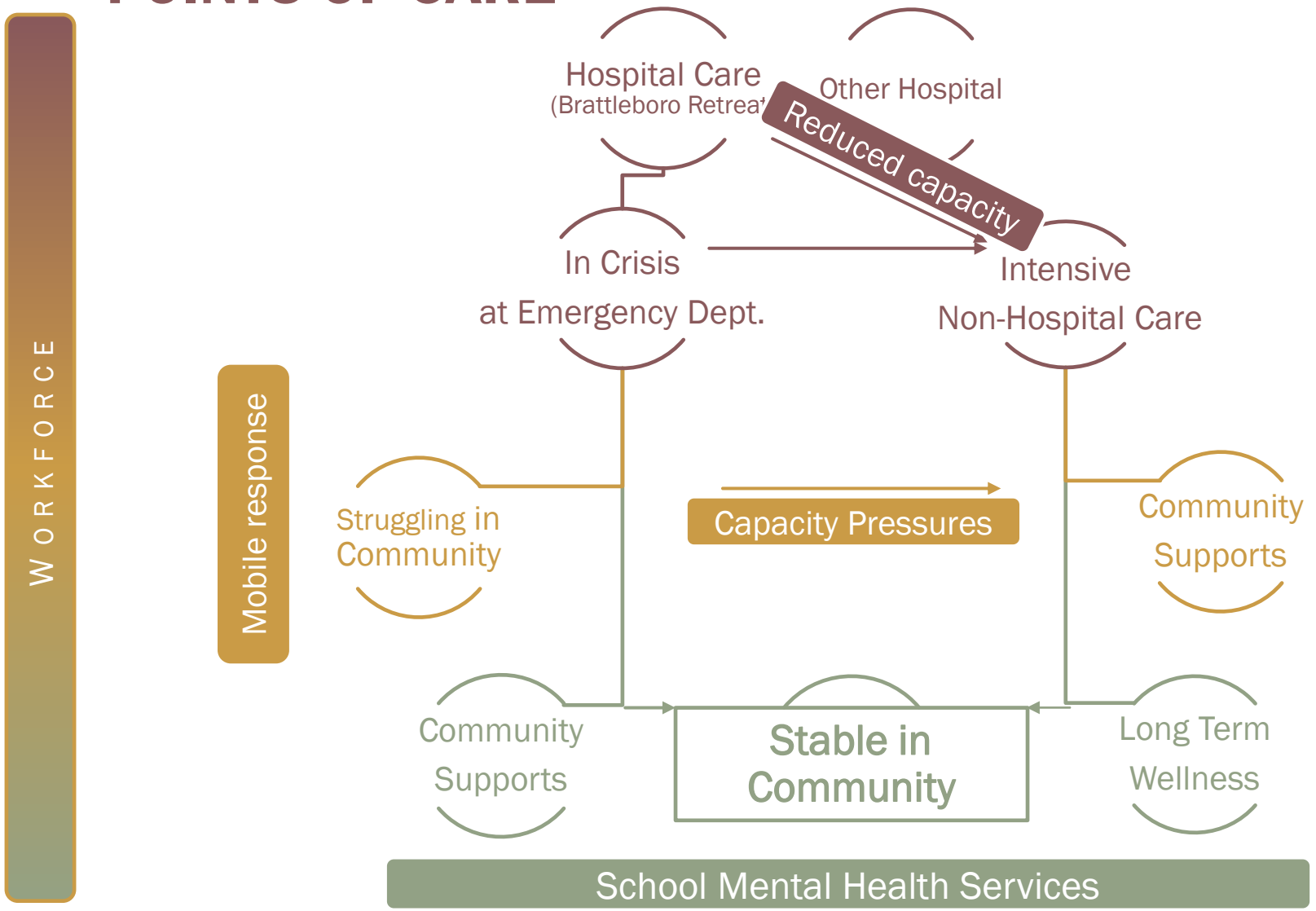
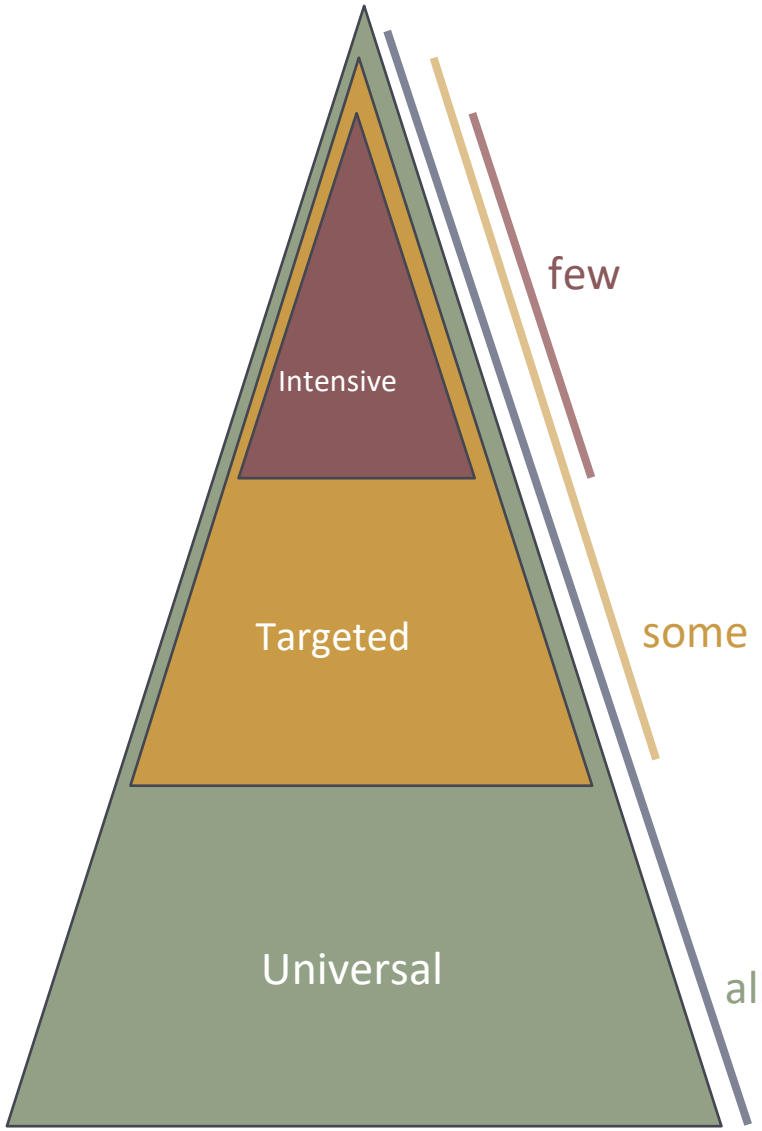
Source: DMH Research & Statistics team using Bed Board data

POINTS OF CARE





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Mobile Response and Stabilization Services (MRSS): Rutland Pilot

- Upstream response defined more broadly than traditional crisis intervention service
  - Crisis is defined by the caller, not the provider – a "Just Go!" approach
  - Face-to-face mobile response to location preferred by the family
  - On-site/in-home assessment, de-escalation, crisis planning, resource referral
  - Brief follow up stabilization services, case management
- Children & youth have different developmental needs and require different interventions than adults
- Reduce reliance on hospitals and emergency response systems
- MRSS Staffing:
  - Team coordinator/ clinical director
  - Paired Response team:
    - Licensed or license-eligible clinician
    - Behavioral Specialist or Family Peer Services Worker
  - Access to a psychiatrist or APRN under the supervision of a psychiatrist

Anticipated Outcome impacts with MRSS

1. Reduce ED visits for mental health needs (#, LOS, $)
2. Decrease use and lengths of stay in higher levels of care such as inpatient, hospital diversion (#, LOS, $)
3. Prevent and/or reduce lengths of out-of-home treatment (#, LOS, $)
4. Increase placement stability for children involved with child welfare
5. Improve the health and well-being of children, youth and families
6. Improve access to MH services
7. Reduce use of law enforcement to respond to family crises
8. Timely response of MRSS
9. Consumer (child, youth, family) & stakeholder satisfaction

The COVID-19 pandemic has significantly effected children, youth and families such that mental health concerns and the need for support continues to be on the rise.

While we may never see reductions in utilization or spending compared to prior years with the implementation of MRSS, we would **bend the curve** of the alternative trajectory and avert unnecessary out-of-home intervention and higher levels of care for children and families who are struggling now.

Successes in other States who implemented MRSS

Connecticut:

- 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.

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:

- Arizona's MRSS reportedly "saved 8,800 hours of law enforcement time, the equivalent of four full-time officers".

New Jersey:

- 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*

Short-term responses

- Problem solving with hospital Emergency Department directors
- Problem solving with community health agencies
- Supporting programs to eliminate COVID-related barriers and working with the Department of Health to provide updated guidance
- Collaborating with CVPH in NY to accept Vermont children and youth
- AHS interagency coordination and collaboration
  - Provide daily consultation around community-based supports and placement options
  - Weekly meetings with Brattleboro Retreat to address barriers to patients who are already in inpatient settings moving through the system

Medium-term responses

- School Recovery Planning
  - Continue to work with Agency of Education on Recovery Planning and strengthening school mental health (Success Beyond Six)
  - Integration of service delivery where children, youth & families are (PCP, early care settings, school)
  - Summer programming
- Mobile response & stabilization services
  - Rutland pilot in Big Bill
- Ensuring that federal funding directed to DMH for community mental health services is implemented in a targeted and strategic manner
- Support for workforce recruitment efforts, partnerships with higher ed, licensure reciprocity
  - Taskforce for a 5-year strategy to strengthen workforce