Report to
The Vermont Legislature

Mobile Crisis: Outreach Services

In Accordance with Act 185, Section E.314

Submitted to: House Committee on Health Care
Senate Committee on Health and Welfare

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Report Date: January 15, 2023

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Legislative Language

Sec. E.314 DEPARTMENT OF MENTAL HEALTH; MOBILE CRISIS OUTREACH SERVICES

(a) *The Department of Mental Health shall build an urgent care model for mental health by expanding mobile outreach services based on the Department's analysis of statewide mobile crisis services and gaps pursuant to its State Planning Grant from the Centers for Medicare and Medicaid Services. The urgent care model shall address geographic gaps and the regions of the State in which the lack of mobile outreach is most directly driving unnecessary emergency department visits or unnecessary law enforcement responses.*

(b) *The new mobile outreach services shall:*

> (1) *be based on evidence-based and trauma-informed practices, including using peer support staff;*
>
> (2) *be developed in conjunction with the continuum of urgent care response related to the new 9-8-8 suicide prevention line; and*
>
> (3) *comply with federal requirements as needed to qualify for three years of federal financial participation at an enhanced 85 percent federal match rate.*

(c) *The Department, in coordination with the Agency of Human Services Secretary's Office, Department of Vermont Health Access and the Department of Financial Regulation, shall develop a sustainability plan to ensure that the services will continue to be available after expiration of the enhanced federal match rate.*

(d) *On or before January 15, 2023, the Department shall provide a status report on:*

> (1) *the experience of the Rutland pilot project which includes the number of Vermonters served by this pilot though 2022, as well as a description of the evaluation of the operating model of the pilot since it was launched to date;*
>
> (2) *the status of expansion of the urgent care model for mental health by expanding mobile outreach services funded in fiscal year 2023, including grants issued to date, operating status of the programs provided funding, and number of Vermonters served in 2022.*

Executive Summary

Experience of the Rutland Pilot

The Mobile Response and Stabilization Services (MRSS) pilot through Rutland Mental Health Services (RMHS) began with start-up planning and preparations occurring July-September 2021. Service delivery started in October 2021. MRSS was designed to offer in-person, home and community-based services to any Rutland County family requesting immediate stabilization supports. MRSS sought to get families the supports they need, when and where they needed them. The mobile response and stabilization services were designed to reach families before emotional and behavioral challenges escalated to the point of requiring more intensive mental health crisis or hospital services.

From October 2021 through Oct 2022 (13 months), the RMHS MRSS pilot received 108 calls, 75% of which resulted in a mobile response. There were 81 incidents where a family called for support rather than seeking care in the ED or elsewhere and received a mobile response at the time and location of their choosing. Some families who called were not existing clients of the agency, indicating the pilot reached families not otherwise linked with typical mental health services. The pilot is reaching families in need.

When examining the early achievements of the MRSS program, it is noteworthy that workforce recruitment and turnover significantly impacts hours of operation of the MRSS program. The clinical acuity of family needs means each response takes time, most require follow-up stabilization supports (up to 45 days), and with limited MRSS team staffing, this can impact response to the next call for support. This is notable as the requirements needed to fulfill the enhanced levels expected by the Centers for Medicare and Medicaid Services (CMS) includes 2-person multidisciplinary teams and 24/7 availability. A success of the pilot has been the experience of having a family peer support specialist on the team and her ability to connect with and support families. It is important to note that the pilot was planned before CMS issued the option of a new Medicaid benefit for mobile crisis. MRSS could be a component of that benefit and thus would have a sustainability structure. The experience of the Rutland pilot is a valuable indicator of the potential strengths and challenges and steps needed to meet federal minimum requirements. Further information comparing current status and elements needed for CMS qualification is provided in Appendix 2 Comparison Chart.

Expansion of the Urgent Care Model for Mental Health

The state of Vermont and the Vermont Agency of Human Services is one of 20 states that received a federal planning grant to support expanding community-based mobile crisis intervention services for Medicaid beneficiaries. This is an important opportunity to build on the State's crisis services in developing a statewide community-based mobile crisis response system that meets the needs of people experiencing a mental health or substance use crisis. Comprehensive mobile crisis services can help to improve the health and well-being of all Vermonters.

Two key areas, as described in detail in the Recommendations of this report, need to be addressed prior to implementation:

(1) *Identification of providers who were willing and able to deliver enhanced mobile crisis services in the community***.**

(2) *Establishment of a sufficient state oversight model.*

Commented [L(1]: I understand the concept here, but 81 responses in 13 months doesn't sound like there is lots of calls coming on top of each other, so maybe explain differently?

Commented [DN(2R1]: @Sweet, Samantha (She/Her) @Omland, Laurel (She/Her)

Commented [O(3R1]: it's not just the calls, it's the on-going follow-up stabilization to the families who called previously. balancing both with one team is challenging. I tried to succinctly rework it.

Commented [K(4]: @DiStasio, Nicole (they/she) This was taken from HMA. Is that allowable, and will it be confusing if both reports have the same intro?

Contents

Mobile Crisis: Outreach Services 1
Legislative Language 2
Executive Summary 3
Introduction 5
Rutland Mobile Response and Stabilization Services 6
Expansion of the urgent care model for mental health 8
Recommendation 12
Appendix 1: State Staffing Plan 13
Appendix 2: Comparison Chart 14

Introduction

The expansion of the urgent care model for mental health by enhancing mobile outreach services is dependent on the establishment of the new Medicaid coverage option for Community Mobile Crisis Services. Vermont was awarded a Mobile Crisis State Planning Grant for FFY22, held by Department of Vermont Health Access (DVHA) in partnership with the Department of Mental Health and other AHS departments, to conduct a needs assessment, design the new Community Mobile Crisis Services benefit through a State Plan Amendment, and plan for implementation of the new service. DVHA enlisted technical assistance through Health Management Associates (HMA) through a competitive bidding process to conduct the Needs Assessment, engage stakeholders, and support implementation planning and benefit design. The Vermont Mobile Crisis Needs Assessment Report was completed June 2022 and informed the implementation plan. The State Planning grant was approved for a no-cost extension of the Planning Grant through September 2023, as the work necessary to establish the new community mobile crisis Medicaid benefit and initiate service delivery required more detailed action steps and a longer timeline than initially anticipated.

Rutland Mobile Response and Stabilization Services

The Mobile Response and Stabilization Services (MRSS) pilot through Rutland Mental Health Services (RMHS) began with start-up planning and preparations occurring July-September 2021. Service delivery started in October 2021. MRSS was designed to offer in-person, home and community-based services to any Rutland County family requesting immediate stabilization supports. MRSS sought to get families the supports they need, when and where they needed them. The mobile response and stabilization services were designed to reach families before emotional and behavioral challenges escalated to the point of requiring more intensive mental health crisis or hospital services.

Evaluation of the operating model of the pilot since Implementation:
The Department of Mental Health (DMH) and the Department of Vermont Health Access (DVHA) Medicaid Policy representatives met virtually with the RMHS MRSS team leadership at least monthly throughout the pilot project (initially every 2 weeks in the first 6 months) to carry out the implementation plan, check in on MRSS team status and hiring process, review the most recent performance measure reporting, and discuss any issues about the new service and reporting requirements. Two DMH representatives met with the RMHS MRSS team in person in June 2022 to see their space and hear highlights and challenges of the pilot implementation.

Immediately upon the hiring of a clinician who, along with the RMHS Director of Child, Youth & Family Services (CYFS), began outreach activities to inform key community stakeholders about the new service. The MRSS team and CYFS Director conducted outreach to key community stakeholders/groups to discuss the MRSS program and distributed brochures to key sites (schools, pediatrician offices, DCF offices, hospital, FQHC, Sheriff's office). This outreach helped clarify the MRSS program and how it differs from yet relates with their other crisis and longer-term services.

The RMHS MRSS team has office space in the same building as the RMHS Emergency Services team; co-location contributes to effective coordination between the teams. The building also has a large indoor space with varied equipment and items for youth to engage in physical activity to help with emotional/behavioral regulation if that is identified as a need.

The RMHS MRSS team believes a safe response requires a 2-person team, especially in situations where they are responding to a family they have not previously served. The MRSS team has received calls from and provided a mobile response to families who were previously not known to the agency. Many were families with intensive needs that could not be resolved with an initial mobile response, but who needed stabilization services and referral for other supports and services to address their scope of needs (housing, financial, and food insecurity; on-going mental health services for at least one, but often several family members; coordination of care with a multi-disciplinary team; referral for further assessment of early childhood services, developmental services, etc.).

Given the current staffing levels, MRSS is available 8:30AM-4:30PM Mon-Fri with the ability to flex and adjust timing according to families' needs. Several families who called for support requested to schedule the mobile outreach at a later time rather than have the MRSS team respond immediately. This was not anticipated by the State or RMHS, yet it was at the request of the families, not the MRSS team, and thus is an option for families. It is one of the many data points RMHS is tracking and reporting on monthly to DMH.

MRSS was designed to be relatively short-term, with stabilization services offered for up to 45-days. The staffing crisis across the mental health and broader system has made transferring care from the MRSS team to other services and resources (i.e., case management, psychiatric services/med management, therapy, mentors, etc.) difficult. Some families have needed more than one episode of care through the MRSS program.

Staffing

This MRSS pilot is funded for 7.0 Full-Time Equivalent (FTE) positions, including one program manager and three paired teams of a clinician and either a case manager or family peer support worker. RMHS, like most Designated Agencies and other business sectors in Vermont and nationally, has experienced significant workforce challenges in getting the MRSS pilot fully staffed and operational.

<u>RMHS MRSS team staffing as of 12/1/2022</u>

- program director (1.0 FTE), hired January 2022;
- clinician (1.0 FTE), hired September 2021;
- case manager (0.5 FTE), hired full-time March 2022 and reduced to part-time November 2022; and a
- family peer support worker (1.0 FTE), hired August 2022

Total = 3.5 FTE

Of note, two current team members moved to Vermont from out of state to take these positions. Unfortunately, other out-of-state candidates who were under recruitment did not accept their offers, citing difficulties in finding housing. RMHS was able to secure a Master's-level intern to provide clinical supports to the MRSS team 2 days/week; this is a temporary situation.

The family peer support worker can fulfill the non-clinical role on the 2-person MRSS team providing initial mobile response and can provide follow-up stabilization services with or without another MRSS team member. Rutland's family peer support worker completed a 40-hour Peer Support Specialist program through Vermont Technical College. RMHS sees tremendous value in having a peer on the MRSS team, as families have really connected with her and she has been able to engage and make progress with families who have intense challenges and who may otherwise not have worked with RMHS.

The team is also supported by the RMHS Director of Child, Youth & Family Services, who fills in as needed to respond to calls if the MRSS team is already deployed. On the off hours when the MRSS team is not available due to the limited staffing, the RMHS Emergency Services team covers and offers to schedule a time for the MRSS team in-person response, if desired by the family.

Workforce recruitment and turnover significantly impact hours of operation of the MRSS program. The family peer support worker can effectively engage with and support families as a core member of the two-person team and provides follow-up stabilization services (often in absence of 2nd team member), which anecdotally some families have valued. Families access MRSS who sometimes haven't otherwise accessed supports through MRSS, so the pilot is reaching families in need. The clinical acuity of family needs means responses take time and, with limited MRSS team staffing, can impact response to the next call for support. Data reporting was designed to focus on the most important information about the service and people it supported, while trying to minimize administrative burden on the team whose priority is to provide crisis supports when needed.

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RMHS is offering an incentive bonus in their recruitment efforts, yet they are still challenged in filling vacant roles on the MRSS team. In addition to not filling positions, they reported that their case manager shifted from full-time to half-time in November 2022 to pursue a graduate degree. While this is unfortunate for the MRSS pilot, RMHS sees it as an investment in this staff person in the long-term as she is committed to the work and intends to return to full-time status with RMHS upon completion of her degree program. Yet, this reduction of FTE puts more on the MRSS program director and other staff.

Performance Measures

From October 2021 through Oct 2022 (13 months), the RMHS MRSS pilot received 108 calls, 81 (75%) of which resulted in a mobile response. The calls that did not result in a mobile response were due to: the issue was resolved by phone (11%); the family declined a mobile response and there was no need to contact Emergency Services (6%); or a direct referral was made to Emergency Services due to imminent safety concerns (4%). Nearly 60% of families who contacted RMHS MRSS for an initial mobile response requested to schedule the mobile response at a later time, rather than an immediate response, to accommodate their family's needs (e.g. family called in the morning but requested the MRSS team to come to the home in the late afternoon when the parent(s) was home from work).

Of the calls that resulted in an immediate mobile response, 90% were on site in less than 45 minutes. Location of response is in Table 1. Most initial mobile responses (80%) needed additional follow-up support and stabilization services to address the assessed need; 9 (11%) were able to be resolved at the initial on-site response; 1 was unable to be safely resolved and required Emergency Services.

Table 1.

Location of Initial Mobile Response	% of all Initial Mobile Responses
Youth/family's home or residence	67%
Youth's school	12%
Youth's/family's Primary Care Practice	0%
Emergency Department	0%
Youth's/family's workplace	0%
Other community setting (including RMHS' MRSS office at request of family)	21%

The pilot experience has allowed the state team and RMHS leaders to discuss the data reporting template to best capture and track information related to the MRSS activities. Updates to the reporting include adding data elements regarding peer support services and stabilization services, to more fully capture the work of the MRSS team.

Expansion of the urgent care model for mental health

The expansion of the urgent care model for mental health by enhancing statewide mobile outreach services is dependent on the establishment of the new Medicaid coverage option for Community Mobile Crisis Services. Vermont was awarded a Mobile Crisis State Planning Grant for FFY22, held by Department of Vermont Health Access (DVHA) in partnership with DMH and other AHS departments, to conduct a needs assessment, design the new Community Mobile Crisis Services benefit through a State Plan Amendment, and plan for implementation of the new service. DVHA enlisted technical assistance through Health Management Associates (HMA) through a competitive bidding process to conduct the Needs Assessment, engage stakeholders, and support implementation planning and benefit design. The Vermont Mobile Crisis Needs Assessment Report was completed June 2022 and informed the implementation plan.

The State Planning grant was originally intended to end September 2022; however, the work necessary to establish the new community mobile crisis Medicaid benefit and initiate service delivery required more detailed action steps and a longer timeline than initially anticipated. Therefore, DVHA sought and was approved for a no-cost extension of the Planning Grant through September 2023. The need for a no-cost extension of the Planning grant was driven

by findings in the Mobile Crisis Needs Assessment. Two key areas needed to be addressed prior to implementation:

(1) *Identification of providers who were willing and able to deliver enhanced mobile crisis services in the community:*
The Needs Assessment identified that, while crisis services are available to Vermonters statewide through Designated Agencies, the extent to which *mobile* crisis services are delivered where people were at in the community is not as clear due to data limitations. Further, the mobile crisis outreach that Designated Agencies have been providing is not at the enhanced level expected by the Centers for Medicare and Medicaid Services (CMS). This includes 2-person multidisciplinary teams and 24/7 availability. Emergency Services Directors at DAs expressed concern as to the ability to meet these expectations. To ensure that the new Community Mobile Crisis Services benefit would be delivered at the level necessary to take advantage of the enhanced federal match rate, the State found it necessary to enter a procurement process to secure necessary commitments from potential mobile crisis providers.

(2) *Establishment of a sufficient state oversight model:*
The Needs Assessment also identified a need for the State to provide enhanced oversight of this model to ensure that it is being delivered at the enhanced federal standards, which requires the State to meet quarterly service-level expectations to be able to continue to claim the enhanced federal match. The State is exploring options for how to ensure this can be achieved. This legislative session, DMH will be seeking approval for four new permanent state positions for the following functions: provider contracting, network management, training (either directly or via oversight of service provider's own training), data collection and reporting, and review of provider billing/reimbursement. (See Staffing Plan in Appendix 1)

DMH was identified as the lead AHS Department for community mobile crisis services, with the recognition that the benefit covers individuals who may have needs that fall under the purview of other AHS Departments (e.g., VDH-DSU, DAIL, DCF, DOC). The DMH budget for FY23 included funds for partial expansion of mobile crisis supports ($5,946,997, a combination of General Fund and Medicaid) which will support continuation of the RMHS MRSS pilot and ramping up activities for the new statewide mobile crisis benefit leveraging the enhanced Mobile Crisis benefit under Medicaid. The Department proposed an additional program budget request for FY24 for statewide implementation ($2,943,843 additional General Funds and Medicaid).
The State developed a Request for Proposals to solicit qualified vendors to provide community-based mobile crisis services in all state-defined service areas to achieve a statewide, equitable, mobile crisis response system of care that is community-based rather than relying on emergency departments and meets the needs of individuals of all ages experiencing a mental health and/or substance use related crisis. The specific services include rapid community crisis response, screening and assessment, stabilization and de-escalation services, coordination with and referrals to health, social, other services and supports, and follow-up services as needed. Further requirements are detailed in the RFP. RFP 96 - Community Mobile Crisis Services was posted by DMH on 11/1/2022 and closes 12/30/2022. The identified review team is currently reviewing and scoring proposals and hopes to begin contract negotiations with successful bidder(s) in early 2023. Service delivery is anticipated to begin September 1, 2023.

DMH is offering limited funding to support the vendors' planning and implementation of the Community Mobile Crisis Services, using HCBS Enhanced FMAP funding and the FY23 legislatively appropriated urgent care funding, depending upon the scope of the need. These funds will be available during the first six months of program start-up to rapidly assist providers in meeting the programmatic goal of providing community mobile crisis response, screening and assessment, stabilization, de-escalation, and follow-up services. Potential categories of vital start-up funding needs may include:

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This legislative session, DMH will be seeking approval for additional quality oversight staff for the following functions: provider contracting, network management, training (either directly or via oversight of service provider's own training), data collection and reporting, and review of provider billing/reimbursement. An alternative to expanding quality oversight at DMH would be to procure for an administrative service organization (ASO) to administratively manage community-based mobile crisis services.

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Commented [T(8R7]: The FY 23 budget request was also using the enhanced FMAP at 85%. I think at that time, we were not aware of the full requirements to pull down that funding, which is why we were not able to implement as originally planned in FY 23.

- Staff recruitment or related costs (e.g., advertising or sign-on bonuses)
- Training, training supports, or training materials
- Software or technology enhancements (e.g., to support telehealth or information sharing)
- Other

In addition to identifying and engaging the Community Mobile Crisis Services provider network, the implementation plan addresses the following:

- Federal Approval Process
- Medicaid Management Information System (MMIS) Changes
- Provider Operations/ Enrollment/ Readiness
- Program/ Contract Oversight and System Partnerships
- Benefit Administration and Compliance
- Policy and Program Alignment
- Training/ Education
- Technology Planning/ Needs
- Workforce Qualifications
- Marketing & Outreach
- Sustainability/ Multi-Payer Strategy

Workplan[1]

Action Item	Start Date	End Date
Release Notice of Intent to Procure for mobile crisis services in VT	8/1/2022	
Letters of Intent received from prospective bidders		8/31/2022
Revise mobile crisis RFP as needed based on bidder interest	9/15/2022	9/15/2022
Mobile crisis RFP released	11/1/2022	
Finalize oversight model, including identification of quality metrics and data collection/reporting needs.	11/1/2023	6/1/2023
Mobile crisis RFP responses due		12/30/2022
Hold requirements meetings for updates to state information systems; complete system work	1/1/2023	8/31/2023
Mobile crisis RFP and start-up funding awarded	2/10/2023	
Provider contracting process	2/1/2023	5/1/2023
Provider readiness assessments	5/1/2023	8/31/2023
State Plan Amendment submitted to CMS	5/1/2023	5/1/2023
Public notice posting	6/1/2023	6/30/2023
Response to public comment	7/1/2023	8/15/2023
Go-Live	9/1/2023	

Commented [O(9]: consider adding line re:
- Peer Certification

Commented [DN(10R9]: Added a footnote.

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[1] The current workplan does not include the concurrent work to pursue peer supports as a Medicaid reimbursable service, nor Peer Supports Credentialing Program; however, both of those plans are in development to align with the “Go Live” date for Mobile Crisis Response.

Recommendation

The state of Vermont and the Vermont Agency of Human Services is one of 20 states that received a federal planning grant to support expanding community-based mobile crisis intervention services for Medicaid beneficiaries. This is an important opportunity to build on the State's crisis services in developing a statewide community-based mobile crisis response system that meets the needs of people experiencing a mental health or substance use crisis. Comprehensive mobile crisis services can help to improve the health and well-being of all Vermonters.

Two key areas need to be addressed prior to implementation:

(1) *Identification of providers who were willing and able to deliver enhanced mobile crisis services in the community*: The Needs Assessment facilitated by Health Management Associates (HMA) identified that, while crisis services are available to Vermonters statewide through Designated Agencies, the extent to which *mobile* crisis services are delivered where people were at in the community is not as clear due to data limitations. Further, the mobile crisis outreach that Designated Agencies have been providing is not at the enhanced level expected by the Centers for Medicare and Medicaid Services (CMS). This includes 2-person multidisciplinary teams and 24/7 availability. Emergency Services Directors at DAs expressed concern as to the ability to meet these expectations. To ensure that the new Community Mobile Crisis Services benefit would be delivered at the level necessary to take advantage of the enhanced federal match rate, the State found it necessary to enter a procurement process to secure necessary commitments from potential mobile crisis providers (See Comparison Chart in Appendix 2).

(2) *Establishment of a sufficient state oversight model:* The Needs Assessment also identified a need for the State to provide enhanced oversight of this model to ensure that it is being delivered at the enhanced federal standards, which requires the State to meet quarterly service-level expectations to be able to continue to claim the enhanced federal match. The State is exploring options for how to ensure this can be achieved. This legislative session, DMH will be seeking approval for four new permanent state positions for the following functions: provider contracting, network management, training (either directly or via oversight of service provider's own training), data collection and reporting, and review of provider billing/reimbursement. (See Staffing Plan in Appendix 1)

Commented [K(12]: include recommendation regarding oversight and next steps (from inventory report)

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Appendix 1: State Staffing Plan

1. **State Crisis Program Director** (PG 28): responsibilities may include:
    a. program design, integration, oversight/collaboration of all State Crisis activities, such as Mobile Crisis, 988, and Designated Agency Emergency Services, Alternatives to EDs, work with community-level law enforcement divergence strategies (CAHOOTS, embedded social workers).
    b. legislative reports, testimony, and stakeholder engagement.
2. **Mobile Crisis Program Operations Manager** (PG 27): responsibilities may include:
    a. contract/grant management with mobile crisis provider(s),
    b. federal program compliance,
    c. writing/maintaining the Mobile Crisis Provider Manual.
    d. Facilitate inter-agency steering committee for mobile crisis (as this crosses DAIL, VDH-DSU, DCF also).
    e. Participate in Medicaid rate setting activities, including collaborating with commercial and other payers.
3. **Mental Health Mobile Crisis Program Mental Health Analyst III** (PG25): responsibilities may include:
    a. design and implementation of the data and reporting items for federal, state, and other reporting requirements.
    b. Participation in the rate model development, revisions, ongoing rate setting activities.
    c. Responds to leadership, legislative, media requests for data analytics.
    d. Mange MMIS/IT system changes, including acting as a liaison to Gainwell, DVHA, and providers through the MMIS/IT build (for example, bundled rates, pay-for-performance, zero-paid encounter claims, etc.)
4. **Training and Curriculum Development Supervisor** (PG 26) Responsibilities may include:
    a. designing and developing training curriculum and materials for state crisis programs such as Mobile Crisis, 988, and Designated Agency Emergency Services, Alternatives to EDs, work with community-level law enforcement divergence strategies (e.g., CAHOOTS, embedded social workers)
    b. Integration of state/federal compliance, general business operations into a comprehensive training program.
    c. Capable of training delivery in a variety of medium (webinar, in person, etc.).
    d. Strategic planning for program improvement activities through training and technical assistance to providers.
    e. Accessible material development for leadership, legislative updates, and media response

Appendix 2: Comparison Chart

	Street Outreach	Embedded Clinicians with State Police	Designated Agency Emergency Services	New! Mobile Crisis
Which geographic locations are served by this program?	Chittenden County: • Burlington Church Street area • Colchester • Essex • Hinesburg • Milton • Richmond • Shelburne • South Burlington • Williston • Winooski	Clinicians are embedded in all 10 State Police Barracks across the State which covers the whole State.	All 10 Designated Agencies respond to their catchment areas. All catchment areas in Vermont are covered by a Designated Agencies.	Statewide
Who is Calling?	• Self-referred • Current service providers • Law Enforcement • Merchants • Concerned community members • Family/friends	• Anyone needing police services (dispatched with law enforcement to calls related to mental health, substance use, and other social service needs)	• Current clients served by Designated Agency • Anyone that knows about the Community Mental Health Agency in their county • Emergency Department/court house personnel	• Any individual, family, or community member calling about a mental health or substance use crisis

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What service is being provided?	• Outreach services to adults, young adults, and families
	• Outreach to businesses, and law enforcement to coordinate support for individuals who have mental health, substance use, housing or other social service needs
		• Provide crisis support
		• Provide referral to resources that offer support and treatment
			• Crisis call lines by region
			• Mobile crisis outreach in community as resources are available (varies by region)
			• Emergency screenings for safety (suicidal and/or homicidal) and reassessments
			• Emergency screenings for inpatient hospitalizations
			• Court house screening for inpatient level of care
			• Postvention and community emergency disaster response
			•
				• Crisis call line
				• Community-based rapid response mobile crisis services
				  ○ Mental health and substance use screening and assessment;
				  ○ Stabilization and de-escalation; and
				  ○ Coordination with and referrals to health, social and other services and supports, as needed
				• Follow up stabilization services up to 3 days for adults and 7 days for children/youth

What are the hours of operation?	• Varied per county • Mostly daytime hours/5-7 days a week	• Up to 40 hours a week • Typically, weekdays/daytime hours	• Crisis call lines available 24/7; however, teams are not mobile in the community 24/7.	• Mobile 24 hours a day/ 7 days a week/ 365 days a year

Who is responding?	• Typically, a single (one) associate or bachelor level staff	• Typically, a single (one) associates or bachelor level staff accompanied with law enforcement	• Typically, a single (one) non-licensed staff (at times partnering with law enforcement)	• Services must be delivered by a 2-person multi-disciplinary team that includes at least one mental health or substance use health care professional (at a minimum bachelor's level) and other professionals or paraprofessionals with expertise in mental health or substance use crisis intervention (can be a trained peer) • One member of the two-person team can be present through telehealth • Training requirements must be met; must include trauma-informed care, de-escalation strategies, and harm reduction
Are peers included?	• No	• No	• Not typically	• Yes
How is the program funded	• Medicaid (54% FMAP) • Mental Health Block Grant	• Vermont State Police General Fund	• Medicaid (54% FMAP) •	• Enhanced-match Medicaid (85% FMAP) through 3/2027. • States can get federal matching funds for activities related to delivery of community-based mobile crisis,

Commented [O[15]: Is this only Medicaid? I thought there was also GC Investment funding here.

Commented [SS(16]: Should we say for how long we have the 85% match?

Commented [SS(17R16]: Until March 31, 2027

Commented [DN(18R16]: Yes. Added.

				call centers, other crisis stabilization services, and 988 system integration
Where is the service being delivered?	• In the community • Service is only available in two counties (Chittenden & Washington)	• Through all 10 State Police barracks responding to their community's needs	• In the community • In office • Over the phone • In emergency departments • Court house • All 10 Designated Agencies covering the State.	• In the community • In office • Services must be provided outside of a hospital or facility setting • Statewide
Emergency Department as the site?	• No, but could refer clients to the Emergency Department	• No, but could refer clients to the Emergency Department	• Currently between 12.1-14.9% from FY2019-2021, with an annual average of 13.5% are in EDs.	Explicitly not allowable.
How is coordination of care handled?	• If a current client, DA has access to Electronic Health Record which includes treatment plan. If it is not a current client, there is no centralized database.	• If a current client, DA has access to Electronic Health Record which includes treatment plan. If it is not a current client, there is no centralized database. • Clinical information obtained through the electronic medical record is not shared with	• If a current client, DA has access to Electronic Health Record which includes treatment plan. If it is not a current client, there is no centralized database. •	• It is part of the follow up services to coordinate the care. • At this time, there is no centralized database.

		law enforcement (HIPAA)		

What are the reporting requirements?	• Total # of contacts
	• % of current clients
	• Primary presenting concern
	• Referrals made
	• Law enforcement involved
	• Proactive Community outreach Supports
	• Outcome (#) is the emergency Department
	• If Emergency needed, means of transport
	• Level of distress
		• Date & time
		• Age & gender
		• Town of residence
		• Type of contact
		• Risk factors & presenting problem
		• Reason for mental health service
		• Amount of travel time to scene
		• Location of contact
		• Referrals
		• Time spent collaborating with law enforcement
		• Time active on scene
		• Number of contacts made on scene
		• Outcome
		• Substance related
			• Location of assessment
			• Length of service
			• Diagnosis
			• Required to document:
			  ○ Identified issue
			  ○ Issue addressed
			  ○ Collateral contact info
			  ○ Clinician's assessment
			  ○ Disposition or plan
			• # crises where ES responded with law enforcement
			• # peer specialists in ES
			•
				• Draft minimum elements include:
				  ○ Average Response time
				  ○ Response time % within 60 minutes
				  ○ Location of service
				  ○ MCT provider types who responded to the crisis
				  ○ Disposition of crisis
				  ○ Percentage of individuals who are not admitted to 24-hour level of care, who receive follow up services by the MCT within 48 hours
				  ○ Client demographics
				• The remaining reporting requirements are under development

How is the oversight managed by the State?	• Annual report • Contract administrator oversight	• Annual report • Department of Public Safety oversight	• DMH Care Management team contacts with Emergency services and review of all	• Department of Mental Health staff will have oversight • More information tbd

			involuntary clients waiting in Emergency Rooms • Qualified Mental Health Professional (QMHP) training every two years • Designation Reviews	