VCP Response on HMA Mobile Crisis Need Assessment

August 31, 2022

Introduction

As stakeholders in the Vermont system of mental health care, we share with the State of Vermont the common vision that Vermonters in crisis should have access to high-quality care in the least restrictive environment. In 2021, the State seized the opportunity to draw on an enhanced Medicaid match rate for "mobile crisis," seeing a potential to address concerns from families and other community members about the need for more mobile response.

For decades, VCP network agencies have been engaging in mobile crisis services, supporting Vermonters experiencing a mental health crisis in their homes, schools, and communities; providing crisis de-escalation, referral, and resources; and diverting the need for higher levels of care. Mobile crisis services have been part of a continuum of Emergency Services [ES] care, that includes 24/7 response statewide; community-, home-, school- and office-based screening and assessment for inpatient care; co-response with law enforcement; clinicians embedded in police barracks and Emergency Departments, and more. In turn, ES programs are nested within a continuum of services that include substance use disorder services, intellectual and development disability services, and mental health services across the lifespan from early intervention to disaster response and postvention. According to VCP Repository data, in 2021 network ES programs provided 53,078 services to 10,644 clients, with 74% of those services coded to locations other than "emergency department," "hospital," or "telehealth." The DA continuum of crisis services also includes crisis bed programs, which delivered 101,100 hours of service to 386 clients in 2021.

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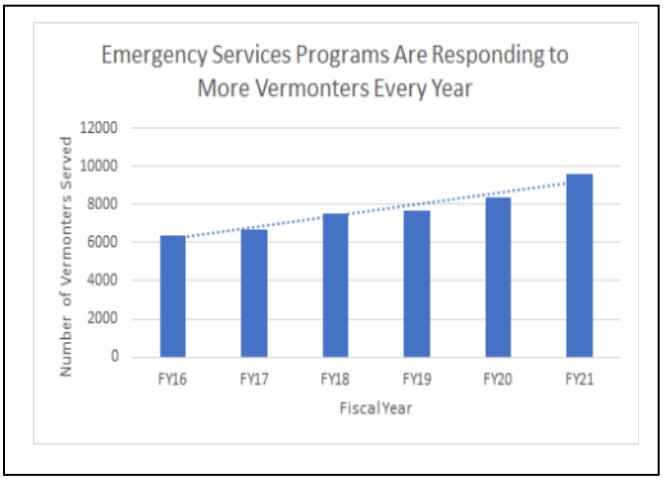

Consistent with national and international trends, use of VCP network agency Emergency Services has increased significantly in the last ten years. One consequence of the increased demand is that ES staff and community providers have directed Vermonters in crisis to Emergency

Departments [EDs]. Given the size of Vermont's catchment areas and the time it could take to travel to individual clients' homes, this norm has allowed for clearer and faster access to mental health screeners. It has also facilitated medical clearance for Vermonters who meet criteria for inpatient care. Unfortunately, the combination of increased demand and use of EDs has, in some communities, reduced the availability of mobile crisis services. That said, **VCP network agencies are providing high quality mobile crisis services** whenever and wherever it is possible, with staffing capacity as the primary barrier. These high-quality services include follow-up: 42% of clients received a follow-up service from the DA within 24 hours, and 64% within seven days. 86% of clients surveyed said they received the services they needed, and 91% said they were treated with respect.

As part of AHS's planning and implementation of enhanced mobile crisis, Health Management Associates [HMA] delivered a Needs Assessment on mobile crisis services in Vermont in July, 2022. HMA engaged with Emergency Services during the period that they were developing this needs assessment, most notably around data collection. Below please find VCP's comments and recommendations in response to the HMA recommendations in bold below (p.72).

Collaboration and Coordination Across Systems of Care

- **Integrate 988 within front end crisis response to ensure seamless experiences for individual and promote effective community partnerships.** VCP supports this recommendation. Vermont's in-state 988 call centers are already embedded within two designated agency [DA] Emergency Services [ES] programs who are connected to the broader network of DA ES programs, which will make this integration more seamless.
- **Develop Crisis /EMS Partnerships to promote ED diversion and involvement of law enforcement at time of crisis.** ES programs have long established relationships in communities with local EMS and law enforcement providers. Network agencies are open to exploring this on a formal level**.** It is unfortunate that this Needs Assessment did not name the nationally-recognized Team Two Training, funded and supported by DMH, as one of the cornerstone training elements for crisis services and collaboration in Vermont. Another pressing area of need for our crisis system of care is new challenges around law enforcement partnership and safety for crisis responders, as it relates to Department of Public Safety's new Use of Force policy.
- **Partner with school districts and crisis providers to develop a program supporting education/awareness and to develop a school-based mobile crisis assessment.** VCP network agency ES programs have strong relationships with local schools, and currently provide school-based mobile crisis assessment. ES programs provided 210 crisis services in schools in FY20. Significantly, The HMA Needs Assessment neglects to mention Vermont's robust school-based mental health services offered through contractual partnerships between DAs and schools. VCP network agencies provide numerous home-based crisis responses provided by school-based staff in the VCP network. School-based clinicians, behavior

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intervention and support programs, and therapeutic schools wrap children and youth with school-based mental health services, crisis supports, and home and community-based (mobile) responses. In FY20, 3662 Vermont children were served in schools, in 91% of supervisory unions, receiving an average of 15 care coordination services each. According to DMH's School Mental Health Report for FY2020, the majority of school-based mental clients who were identified at intake with risk of suicide, non-suicidal self-injury, or danger to others had that risk resolved at their next review, typically six months later. In VCP's School Satisfaction Survey Results, which included input from over 360 school leaders and professionals in 2020, 83% of school staff said that the partnership with DA school mental health services provided a service that was not otherwise available to the school. Additionally, VCP facilitates Youth Mental Health First Aid trainings statewide, through a contract with the Agency of Education.

- **Develop a workgroup to examine within and across partner organizations to improve crisis planning and transitions of care.** VCP network agencies are committed to improving crisis planning and transitions of care. This recommendation appears to elevate the work of the AHS Mobile Crisis Planning Grant process while minimizing the role of longstanding existing structures to implement and support mobile crisis in our current system. VCP disagrees with the statement that "there is no unified governmental office or department with ultimate responsibility for oversight of mobile crisis services, which leads to diffusion in the ability to drive change at the program-level [sic] as well as overall cross-sector collaboration." This is the role of the Department of Mental Health. That said, VCP understands the importance of ensuring that all AHS departments are informing the enhancement of mobile crisis, and would endorse a workgroup or organizational structure that would support ongoing cross-agency collaboration.
- **MCT should establish strong and formal partnerships with identified groups to ensure coordination and collaboration across systems of care at both the system and service level (people with lived experience, families, advocates, providers, government, elected officials, law enforcement, criminal justice officials, EMS, EDs, schools, etc.)** VCP network agencies have solid partnerships with EDs, law enforcement, primary care, community health teams, DCF, schools, municipalities, and more. Many of these collaborations extend beyond ES services to other DA programs. For example, the presence of multiple Community Outreach Teams expands the MCT net and, in many cases in addition to working in partnership with MCTs, are in a position to intervene to minimize full MCT engagement. Those partnerships allow agencies to facilitate the continuity of services, transition of care and supports that happen by virtue of our comprehensive systems and connections in the community. A significant risk of contracting with an outside entity for mobile crisis would be the need for new entities to establish parallel partnerships, when they already exist with DA ES programs.
- **MCT model should explicitly state coordination with and referrals to health, social and other services and supports.** VCP has no concerns with this recommendation. It reflects the work that is already being done by DA ES programs every day.
- **Explore interstate collaborations agreements with neighboring states such as Massachusetts, New Hampshire, and Maine.** This may be a concept worth exploring but there is no evidence that barriers to care currently exist due to a lack of formal interstate collaboration agreements.

Mobile Team Composition

- **Require a multidisciplinary team for mobile crisis staffing requirements in alignment with best practices and CMS guidance.** It is unclear as to whether this is recommending changes to current regulations around qualifications for crisis staff. It appears to us that Vermont's current requirements for ES staff align with CMS regulations.
- **"…Ongoing workforce development challenges may impede ramp up of efforts of MCTs to provider 24/7 community-based mobile crisis services."** This is the crux of the issue, as was reflected in survey responses that noted "staffing as the biggest challenge," "a consistent theme from focus groups was the lack of available crisis staff and lack of timely response," and "focus group feedback also noted the challenges with workforce development and retention." This is the reality across the healthcare care system. Expectations around all aspects of mobile crisis, including mobile team composition, response time, and ability to reach people in community-settings, need to be based on realistic and reasonable expectations of staffing. VCP recommends that the State makes significant and sustained investments in staffing capacity in ES programs, at parity with 24/7 clinical providers in health care, in order to enhance mobile crisis capacity.

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- **Peers should be explicitly stated as required staffing for MCTs. Further, peer supports for family members/caregivers should be included in crisis services for youth.** VCP strongly supports the inclusion of peer supports in crisis services. There are already programs in the State where peers are currently working in ES programs and adjacent to crisis services, including in EDs. We have some concerns about implementation timing in the context of peer supports not currently being a Vermont Medicaid service. This requirement should have an agreed-upon phase-in period, and will require adequate funding, planning for workforce development, staffing capacity, and alignment with DMH's current peer certification implementation process.

Training

- **Promote the use of national tools; implement trainings that may be adopted and adapted across specialized populations; develop robust trainings for BA-level mobile response team staff; enhance peer support training; require harm reduction training; strengthen family and collateral engagement training; coordinate and leverage existing platforms to provide training to mobile crisis providers; maintain the use of multiple training modalities and formats; train providers on core clinical competences to serve special populations.** The Needs Assessment identifies a lack of standardization across DA programs for trainings as identified in the list above. It should be noted that DA ES staff are currently trained in a variety of best practices, including trauma-informed care, CAMS, CALM, and use of the C-SSRS. VCP supports recommendations for investment in training for ES staff. It is unfortunate that this assessment did not name the nationally-recognized Team Two Training, funded and supported by DMH, as one of the cornerstone training elements for crisis services and collaboration in Vermont. It should also be noted that by virtue of the fact that DAs are the State's primary provider of ID/DS

services, training and consultation on working with individuals with ID/DS is available to DA ES staff on an ongoing basis.

- **Train providers on the use of standardized and validated screening and assessment tools.** VCP supports this recommendation. The Needs Assessment referenced VCPI, but failed to make note that designated agencies, with the support of the State, have been working on a multi-year quality improvement effort with the Vermont Suicide Prevention Center [VTSPC] through the Center for Health and Learning to implement the Zero Suicide framework at agencies, including with ES teams. VTSPC has provided consistent and ongoing trainings and ongoing technical support for agency use of the Columbia Suicide Severity Rating Scale, as well as many other elements of the Zero Suicide framework, including CAMS, CALM, and best practices for care coordination, follow-up care, safety planning. Some agencies have been working with VTSPC for over six years to implement Zero Suicide at their agency and within the broader community. In addition, VCP and DMH have supported the standardization of the C-SSRS by ensuring that this tool is embedded in standardized screening forms.

Mobile Crisis Response Systems and Evidence-Based Practices

- **MCT contract requirements should explicitly state service must be available 24/7 in community settings** It is one thing to require MCT services be available 24/7 in the community; it is another to fund and staff these services at a level that would enable this to be fulfilled. For years, agencies have been egregiously underfunded compared to counterparts in healthcare and State government, and for years, staffing in ES has been at crisis levels. Regarding making services available 24/7 in the community: ES programs make case-by-case triage decisions on how to support people who reach out in crisis, based on clinical presentation, staffing capacity, staff safety, awareness of the client or family, and many more factors. How will compliance with a 24/7 requirement be monitored? How will staffing capacity be taken into consideration? Will the State increase funding for designated agencies to increase staffing, recruitment, and retention and ensure that this funding is sustained? VCP recommends that the State makes significant and sustained investments in staffing capacity in ES programs, at parity with 24/7 clinical providers in health care, in order to enhance mobile crisis capacity.
- **Revise Emergency Service Standards and Mental Health Provider Manual to include substance use in populations served** VCP network agencies currently serve Vermonters in crisis, whether they are experiencing a mental health or substance use crisis. ES programs also serve Vermonters with intellectual and developmental disabilities. In Vermont, meeting eligibility criteria has not been a barrier to access to ES services. We have no concern about revising regulatory language (note: there is no longer an "Emergency Service Standards" – this content is embedded in the Mental Health Provider Manual).
- **Incorporate the unique needs of youth and families into the model building off the of the successes of the MRSS and the wraparound process** DA ES Programs and clinical programs at large have long practiced within the tenants that HMA defined as being "successes of the MRSS and wraparound process," including:
    - the child or family defines the crisis;
    - the use of system of care philosophy,
    - a strengths-based approach that empowers families,

- appreciate cultures, and
- "wraps services around their needs."

Additionally, the Act 264 Coordinated Services Planning structure in Vermont requires service systems to coordinate with each other to support child, youth, and family needs and to engage in proactive crisis planning. ES programs are structured differently in different DAs – for example, some agencies serve all ages in their ES programs, and some have crisis services for children, youth and families separated – but all embrace this philosophy.

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- **Use of standardized assessment tool should be required. I**n 2018 and 2019, VCP network agencies engaged in a collaborative peer process to develop standardized fields for crisis assessments. This approach aligned with new EMR systems that organize information gathering to align with the rest of the EMR system and to promote data collection and analysis. It is unknown whether HMA and/or the AHS workgroup reviewed this standardized assessment. HMA did not specify which assessment tool should be used. VCP would need to review the recommended tool before forming a position.
- **Incorporate technology, such as telehealth, to improve access to rural areas. Vermont should leverage enhanced Federal Funding for IT systems to support telehealth capacity for MCTs.** As the Needs Assessment notes, a significant barrier to effective use of telehealth is access to broadband in rural communities. Nevertheless, agencies have already dramatically increased use of telehealth as a result of the pandemic.
- **Follow-up services should be included in MCT model with expectations and protocols for follow up care provided to youth and adults after a crisis encounter inclusive of time elements (up to 3 days for adults and up to 7 days for youth). Vermont should leverage enhanced Federal Funding for follow-up services provided by mobile crisis teams.** The HMA report states that it is "not known" whether follow up care is occurring. This is data that is readily available through MSR, and data that VCP reports on annually in our outcomes reports. In FY21, 42% of ES clients received a follow-up service from the DA within 24 hours (up from 40% in FY20), and 64% within seven days (up from 60% in FY20). Data is available for further analysis (for example, agency-specific, location-specific or service-specific follow up care) across community and hospital settings to better understand the ways in which current ES services engage clients post-crisis and prevent hospitalization. It should be noted that often agencies refer follow-up care to a different program within the DA – for example, a client's CRT or school-based treatment team, who engage with the client at the location of the client's choosing. Given that the client already has a relationship with these providers, this is a best practice approach. Expectation for follow up services should include all DA services, not limited to ES or MCT staff.
- **Ensuring all Vermonters know who to call for a mental health crisis will be critical. Vermont should consider a marketing campaign of the new model of emergency services.** VCP supports improving public information on access to emergency services, although not the characterization of this work as a "new model of emergency services." This would require an investment of resources.

Technology

- **In alignment with other state technology planning, the State should develop a crisis system services technology plan and identify sources for funding technology.** VCP supports the recommendations regarding technology. It should be noted that information sharing, and service coordination is much easier when the MCT program is embedded in the same EMR/platform as the rest of the community mental health system. Any fragmentation of provider services would likely negatively impact the smooth transition of clinical care to clients as well as create a significant added administrative burden for all parties, with significant additional expense.
- **Promote use of telehealth to improve access to rural areas and expand access to underserved populations.** VCP agrees that telehealth is an important tool in providing and expanding access, especially with limited staffing resources. During the pandemic, we observed that the use of telehealth with clients, families, and community partners was very individualized, and based on multiple factors such as broadband access and speed, timeliness, safety (in hospital EDs), and individual preference. It will be important for DMH or any other entity overseeing mobile crisis to clarify expectations about when telehealth is an acceptable substitute for community-based care and when it is not.

Mobile Crisis Network Capacity Planning and Monitoring

- **The State must develop the technical capabilities to utilize workforce prediction modeling and tools to determine the volume of mobile crisis staffing; the State should develop a short- and long-term approach within a workforce prediction model to determine mobile crisis staffing availability requirements.** While the report provided survey responses on availability of ES staff and consumer perception of access to mobile crisis at certain times of the week, it did not sufficiently justify that the problem was a lack of workforce prediction modeling software. While this resource would be nice to have, new funding would be optimized if it were directed to strengthen staffing capacity.

Mobile Crisis Contracting

- **"…The State should consider alternative contracting approaches to ensure providers who are highly motivated to provide crisis services with the required skill sets are selected and that there is proper oversight."** VCP takes exception to the phrasing here that suggests that current ES programs providing mobile outreach are not "highly motivated to provide crisis services" and/or may not have the required skill set. With VCP network agencies, the State currently has vendors in 10 catchment areas for Emergency Services, similar to the Massachusetts model held up by HMA. ES components of the contract and corresponding manual include expectations for best practice, responsiveness, and quality measures, including the Act 79 measures of collaboration with law enforcement and use of peers. Current network agencies provide transparency into services through MSR and MMIS reporting, and AHS can make data requests to the VCP Data Repository.

Procuring mobile crisis services apart from DA contracts would, HMA noted, "require the state to build internal infrastructure." From the VCP perspective, adding an additional layer of administration is the wrong direction to invest funds and resources when there is so much need for direct services. Contracting outside of the community mental health system would further bifurcate or fragment the existing comprehensive services, where agencies support ES clients and their family members to access additional supports and services that address social contributors to health. We do not support pulling the state oversight of mobile crisis services out of DMH. It's important that the entity overseeing mobile crisis is the same entity overseeing the mental health crisis continuum. Finally, such a decision could potentially contradict 18 V.S.A. § 8912 on "contracts with nondesignated agencies" which specifies that DMH can contract with specialized providers for services that are "not available from designated agencies."

Quality Performance Measure Tracking

- **Develop provider and system level metrics that are designed to monitor effectiveness and ensure quality.** There are currently provider and system level metrics in place. VCP recognizes that there may be additional areas where AHS would like to focus. It will be essential for the State to streamline provider level metrics across all ES services, rather than just mobile crisis, given the fluidity with which clients engage in all ES services. New system level metrics should be developed in collaboration with the VCP network, given that VCP network agencies have worked to standardize data elements around time, location, and disposition. Adding new data elements – for example, disposition definitions – that are not currently captured end up taking considerable administrative burden for direct service staff (i.e. opening extra spreadsheets and entering separate data sets) -- taking away capacity for direct service. VCP would be happy to work with the State on this effort. Examples of VCP data and outcomes are available in the annual VCP Outcomes Report.
- **AHS should determine targets.** VCP recognizes that targets for mobile crisis services should be informed by all AHS departments, perhaps through a cross-agency workgroup. DMH oversees the overall continuum of mental health care and crisis response, and in that role establishes and monitors provider and system level metrics for ES services inclusive of but not limited to mobile crisis, and should have a significant if not primary role in determining new targets.
- **Vermont should consider establishing an expectation for the percentage of crisis services that are delivered outside of an institution setting as well as outside of an office-based setting.** VCP understands the logic of this recommendation, and yet a simplistic assumption behind it that ES programs are making this choice out of lack of will on the part of the agency. As noted above, location of service should be determined by factors including client choice, timely access, availability of staff, safety of staff, preference of community partner (school, hospital, health care provider) and more. Any "expectation setting" should be a collaborative process that takes all of these realities into account.
- **Modify MSR data elements collected by MCTs to include time elements, location of service, disposition, and follow up care by MCTs.** As noted above, VCP has engaged in work to standardize data elements around time, location, and disposition, and would be happy to work with the State on this effort. Follow up care reporting should encompass follow up by any DA staff, not limited to MCT staff.

Quality Oversight

- **Identify a single entity to be accountable for oversight of performance of the crisis system and ensure services are delivered in alignment with best practice.** DMH effectively serves as the single entity responsible for mobile crisis services. The HMA Needs Assessment recommends additional structures in provider contracting, network management, training, technology, and provider payments. VCP believes that to address most or all of them, AHS would need to boost DMH staffing and resources. It would be unfortunate, however, to invest in significant quality oversight infrastructure without significant investment in the rates and the staff to do the work. Regarding overall quality oversight and quality improvement, the HMA Needs Assessment failed to mention both the considerable efforts of the VTSPC and the VCP Centers of Excellence Certification Process.
- **AHS should consider contractions with a BH ASO to administratively manage community-based mobile crisis services.** As noted above, bifurcating oversight of one aspect of ES from the overall role and responsibility of DMH would fragment oversight and add unnecessary administrative expenses. We believe that both the system and clients would be poorly served. The VCP network would be loathe to see funding that was intended to enhance mobile crisis funneled to an administrative entity, rather than a direct service provider.

Funding and Multi-Payer Reimbursement Strategies

- **…Options may include adding mobile crisis services to the essential health benefit benchmark plan; enforcing MHPAEA that would require mobile crisis services to be included under parity through legislation; and enacting legislation to require fully insured and large groups and state employee health plans to provide mobile crisis services.** VCP supports these recommendations to ensure parity and support capacity for Vermonters to receive this service.

CCBHC Consideration

- The State of Vermont is in the process of vetting Certified Community Behavioral Health Centers (CCBHC), a national safety net model for mental health and substance use disorder treatment. If Vermont establishes CCBHC as a provider type within the state Medicaid program, 24-hour crisis response will be required including mobile crisis teams, intervention services, and crisis stabilization. Certain allowable mobile crisis costs could be funded through federal dollars with a significant enhanced match. As such, if Vermont is going to take advantage of all of the upcoming federal resources, having a system that reflects the CCBHC model will be key.

Summary of VCP Recommendations

1. VCP recommends that AHS make significant and sustained investments in staffing capacity in ES programs, at parity with 24/7 clinical providers in health care, in order to enhance mobile crisis capacity.
2. VCP recommends that Mobile Crisis Services be procured through the Provider Agreement process with DMH, with adjustments to metrics, expectations, training, and data collection as determined collaboratively. Adding an additional layer of administration, either at AHS or via a BH-ASO, is the wrong direction to add expense and invest funds and resources when there is so much need for direct services. Contracting outside of the community mental health system would further bifurcate or fragment the existing comprehensive services. DMH has oversight over the mental health crisis continuum of care and should continue to have oversight of the mobile crisis component.
3. VCP supports the HMA recommendation to Integrate 988 within front end crisis response to ensure seamless experiences for individual and promote effective community partnerships.
4. VCP supports the HMA recommendation for Vermont to leverage enhanced Federal Funding for IT systems to support telehealth capacity for MCTs.
5. VCP supports the inclusion of peer supports in crisis services with an agreed-upon phase-in period. Peer services will require adequate funding, planning for workforce development, staffing capacity, and alignment with DMH's current peer certification implementation process.
6. VCP supports the HMA recommendation that we should ensure that all Vermonters know who to call for a mental health crisis will be critical. Vermont should consider a marketing campaign ~~of the new model~~ of emergency services.
7. VCP supports the HMA recommendation that for alignment with other state technology planning, the State should develop a crisis system services technology plan and identify sources for funding technology.
8. VCP supports the HMA recommendation on promoting use of telehealth to improve access to rural areas and expand access to underserved populations. Additionally, VCP believes it will be important for DMH or any other entity overseeing mobile crisis to clarify expectations about when telehealth is an acceptable substitute for community-based care and when it is not.
9. VCP supports the HMA recommendation for AHS to explore funding and multi-payer reimbursement strategies.

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