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HEALTH MANAGEMENT ASSOCIATES

Vermont Mobile Crisis Services Needs Assessment

PREPARED FOR
VERMONT AGENCY OF HUMAN SERVICES

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Executive Summary

The state of Vermont and the Vermont Agency of Human Services (AHS) 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.

Using the federal planning grant, AHS partnered with Health Management Associates (HMA) to conduct a statewide mental health and substance use needs assessment to: identify ways to better coordinate across agencies and systems of care; enhance mobile crisis services; support integration of all mobile crisis teams (MCTs) and Vermont 988, a new national telephone hotline for behavioral health (mental health and substance use) crises that goes live in July 2022; and develop ways to ensure Vermont has equitable, effective and sustainable community-based mobile crisis services for years to come. The findings inform the development and implementation of a comprehensive, community-based statewide mobile crisis intervention Medicaid benefit that meets the needs of Vermonters. The Substance Abuse and Mental Health Services Administration (SAMHSA) describes mobile crisis response as: helping individuals experiencing a crisis event to experience relief quickly and to resolve the crisis when possible; meeting people in an environment where they are comfortable; and providing appropriate care/support while avoiding unnecessary law enforcement involvement, ED use and hospitalization.[1] The Centers for Medicare and Medicaid Services (CMS) has also issued guidance and related requirements for states in order to receive reimbursement for mobile crisis response services through the Medicaid program that aligns with and supports SAMHSA's *National Guidelines for Behavioral Health Crisis Care – A Best Practice Toolkit*.[2]

CMS describes the purpose of community-based mobile crisis services as providing rapid response, individual assessment, and crisis resolution by trained mental health and substance use treatment professionals and paraprofessionals in situations that involve individuals who are presumed to have a mental health condition and/or history of substance use. The service must provide, as appropriate, screening and assessment, stabilization and de-escalation, and coordination with and referrals to health, social and other services and supports, and health services as needed. The mobile response must be available 24/7/365 with services being delivered outside of a hospital or facility setting. CMS also indicates that mobile response must be delivered by a multi-disciplinary team that includes at least one behavioral health care professional qualified to provide an assessment within their authorized scope of practice under state law and could also include other professionals, paraprofessionals, and peers with "expertise in behavioral health or mental health crisis intervention". In addition, the team must be trained in trauma-informed care, de-escalation strategies and harm reduction.

While Vermont has an existing Medicaid benefit for mobile crisis services, the American Rescue Plan Act (ARPA) funding affords Vermont a unique opportunity to enhance and expand existing community mobile crisis services, advance best practices, and positively impact reach and sustainability.

[1] Substance Abuse and Mental Health Services Administration (SAMHSA), "National Guidelines for Behavioral Health Crisis Care – A Best Practice Toolkit Knowledge Informing Transformation," SAMHSA.gov, 2020. Available at: https://www.samhsa.gov/sites/default/files/national-guidelines-for-behavioral-health-crisis-care-02242020.pdf.
[2] IBID.

Vermont's 2018 expenditures across all payers for mental health services represented approximately 13 percent of the overall health care services budget.[3] Between 2018-2019, Medicaid spending increased by $49.1 million, or 2.9 percent to a total of $1.7 billion.[4] Further, half of the 15 hospitals and emergency department (ED) surveyed indicated that 50-75 percent of individuals that present to the ED for a mental health or substance use related crisis could have been evaluated in the community (i.e., did not warrant medical screening). Comprehensive behavioral health crisis systems result in significant cost savings as it can reduce the time individuals in crisis wait in emergency departments (EDs), can reduce unnecessary psychiatric hospitalization by diverting clients to appropriate community-based care, and reduce suicides and other negative outcomes.[5] [6]

The gaps and opportunities identified in this report highlight the strategies necessary to coordinate across systems of care, including a focus on increasing health equity across the population (mental health, substance use, and developmental disabilities; children, youth, families, adults, and elders) and with community-based organizations and law enforcement to ensure an effective, coordinated crisis continuum of care for Vermonters.

Table 1 beginning on Page 4 contains a summary of key Vermont findings from the Needs Assessment as compared to CMS requirements and best practices in mobile crisis response.

[3] Lori L. Perry, "2019 Vermont Health Care Expenditure Analysis," Green Mountain Care Board, May 12th, 2021. Available at: https://gmcboard.vermont.gov/sites/gmcb/files/documents/2019VTHealthCareExpenditureAnalysis_BoardPres_20210512_0.pdf.

[4] IBID.

[5] Shaw, R. (2020). *Financing Mental Health Crisis Services*. Alexandria, VA: National Association of State Mental Health Program Directors.

[6] Substance Abuse and Mental Health Services Administration. Crisis Services: Effectiveness, Cost Effectiveness, and Funding Strategies. HHS Publication No. (SMA)-14-4848. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2014.

Needs Assessment Approach

The needs assessment was based on information gathered through an extensive Vermont stakeholder engagement process, as well as from national crisis literature and initiatives being developed in other states. The approach to the assessment focused on the following:

- Identification of gaps and opportunities to coordinate across systems of care
- Research and analysis of national and state-specific data on evidence-based, best practice mobile crisis response systems
- Review and analysis of crisis workforce and crisis systems capacity to inform a workforce development plan
- Review and analysis of existing trainings available to crisis providers and community-based organizations (CBOs)
- Review and analysis of systems needs for providers and community-based organizations (CBOs)
- Review and analysis of opportunities for interstate collaboration
- Identification of opportunities for multi-payer collaboration
- Review and analysis of current and recommended protocols for coordination
- Review and analysis of current quality metrics and performance measures and oversight capabilities of mobile crisis services

The review of national literature and initiatives included researching information regarding the national landscape in addition to collecting promising models and best practices in mobile crisis services. This included data and information in both the professional and gray literature and looking at the most current information as it is being developed, identifying what other states are planning and/or implementing, reviewing AHS-provided reports and data as well as information about all Vermont local and state pilot projects. The review also included federal and Vermont Medicaid regulations and guidance as they relate to crisis services.

Stakeholder engagement is vital as any effort to transform the crisis care system must reflect the needs and values of relevant stakeholders, including and especially marginalized populations whose needs persistently go unmet. The needs assessment was informed by the following stakeholder engagement activities:

- **Surveys** – a broad-based survey was distributed to a variety of stakeholders to gather insight into Vermonters' experiences, perceived successes and challenges of the existing crisis system and recommendations for improvement. A total of 270 responses were received from various stakeholders including mental health and substance use providers; designated agencies; consumers, family members, and peers; hospitals and emergency departments; law enforcement; emergency medical services (EMS); and schools. Both qualitative and quantitative data gleaned from the survey is used throughout the needs assessment to describe the current state of crisis services within the state as well as to inform options for consideration and recommendations.
- **Key Informant Interviews** – interviews were conducted with key informants from the following organizations/agencies to confirm and gather additional detail on themes that emerged from the survey:
    - Alcohol and Drug Abuse Programs – Clinical Services, Quality
    - Department of Mental Health – Care Management, Quality, Operations, Research and Statistics
    - Department of Disabilities, Aging, and Independent Living – Clinical Services, Quality

  - Department of Public Safety – Mental Health Programs
  - Department of Public Health
  - Intellectual and Developmental Disabilities Services Providers
  - Vermont Care Partners – Team Two
  - Designated Agencies Directors
  - NAMI VT Peer Support
- **Focus Groups** – focus groups were conducted with the following groups of people to further supplement information gathered from the survey and stakeholder interviews:
  - First responders including 911 public-safety answering point (PSAPs), law enforcement and EMS
  - Designated Agencies
  - Mental Health & Substance Use Providers
  - Schools
  - People, and families of people, with a history of receiving crisis services

Best Practices and CMS Requirements vs. VT Current State and Recommendation

Table 1 outlines the CMS requirements and best practices alongside current practices and planning considerations for Vermont as it develops its revamped Mobile Crisis System.

Table 1. Summary of Findings and Recommendations

CMS Requirements/Best Practices	VT Current State	VT Recommendations
Populations Served		
• Services must be provided to individuals who are experiencing a mental health or substance use crisis	• Emergency Service Standards define population served as experiencing a "mental health crisis". Substance use is not explicitly stated	• Mobile Crisis Team (MCT) model must explicitly state individuals experiencing a mental health or substance use crisis are eligible for services • Revise Emergency Service Standards to include substance use in populations served
Crisis System of Care Collaboration		
• States must ensure mobile teams maintain relationships with relevant community partners	• VT has varying levels of partnership with core community partners at the system and service level	• 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
Mobile Team Composition		
• Services must be delivered by a multi-disciplinary team (MDT) team	• In most instances, services are delivered by a single person	• MCT model should expect an MDT

CMS Requirements/Best Practices	VT Current State	VT Recommendations
• Best practices include incorporating trained peers who have lived experience	• Use of peers is not currently required of Emergency Services teams	• MCT staffing should include peers
Mobile Team Training		
• State must establish training standards inclusive of trauma-informed care, de-escalation strategies, and harm reduction	• Not all crisis response team members are fully trained in each of the required areas • Additional training needs have been identified to fully support team members delivering crisis services	• Require harm reduction training • Train providers on the use of standardized and validated screening and assessment tools and assure that teams are skilled in trauma informed care and strategies that allow them to effectively stabilize the person and de-escalate the crisis so that a higher level of care is not needed
Mobile Crisis Team (MCT) Services		
• MCT services available 24/7/365 in the home or any setting where a crisis may be occurring • Services should be outside of an emergency department (ED) • Follow-up services should be provided	• MCT services are not consistently available in the community and 24/7 • Majority of crisis services are delivered in EDs or office-based • Follow-up services are not consistently provided	• MCT service must be available 24/7 in community settings • Follow-up services should be included in MCT model with expectation on timeliness
Technology		
• CMS encourages use and will administratively reimburse for technology	• Vermont has limited use of crisis system and services technology compared to other communities	• Develop a crisis technology plan • Identify sources for funding technology. Vermont should leverage enhanced Federal Funding for IT systems to support telehealth capacity for mobile crisis teams • Promote use of telehealth for initial visit and follow-up care to improve access to rural areas and expand access to underserved populations
Mobile Crisis Network Capacity Planning and Monitoring		
• States and communities are using predictive modeling tools to identify mobile crisis staffing availability capacity	• There is no predictive modeling for mobile crisis availability • The critical data used in predictive modeling is not currently available	• Develop technical capabilities to utilize workforce prediction modeling and tools to determine the volume of mobile crisis staffing needed by the community (internal to state or vendor services)

CMS Requirements/Best Practices	VT Current State	VT Recommendations
		• Develop a short- and long-term approach for using data within a workforce prediction model to determine mobile crisis staffing availability requirements
Contracting		
• States are trying different strategies to achieve the best outcomes for crisis services	• VT utilizes its current contracts with DAs for emergency services	• Consider alternative contracting approach including a vendor for crisis services or to contract crisis services separate from the DA contracts
Quality and Performance Measurement		
• States should develop a systemic process to continuously analyze data for performance evaluation • State must establish timeliness standards	• Current oversight of mobile crisis services does not exist in any meaningful way • Timeliness standards are explicitly stated in the Designated Agency Emergency Service Standards, but there is no data collection and monitoring	• AHS should consider a BH-ASO for quality & administrative oversight of MCT services • Modify MSR data elements collected by MCTs to include time elements, location of service, and disposition
Funding and Provider Payment		
• Multi-payer reimbursement	• Commercial payers do not consistently contract for and reimburse for crisis services	Potential policy and financing options for developing a multi-payer strategy may include: • Adding mobile crisis services to the essential health benefit (EHB) benchmark plan • Enforcing the federal Mental Health Parity and Addiction Equity Act (MHPAEA) that would require mobile crisis services to be included under parity through legislation • Enacting legislation to require fully insured and large groups and state employee health plans to provide mobile crisis services

A. Best Practices Supporting Mobile Crisis Response Systems

This section primarily focuses on the best practices and strategies necessary for developing an effective Mobile Crisis System in partnership with core entities within the Vermont region that will ensure an

effective, coordinated crisis continuum of care for Vermonters. It reviews the national literature, existing practice within the current Vermont Mobile Crisis System, and offers recommendations to develop an enhanced system that will improve outcomes and focus on increasing health equity across Vermont's subpopulations.

1. Mobile Crisis Response Systems & Evidence-Based Best Practices

National Environmental Scan

Data Sources

SAMHSA Guidelines for Crisis Call Centers	CMS Guidance	National Publications
○ Operations, Infrastructure & Staffing ○ Data collection & Technology ○ Integration with 911/Law Enforcement	○ Team composition ○ Training ○ Technology ○ Quality and performance management	○ Substance Use ○ Youth Crisis ○ Telehealth ○ Rural Health

In 2020, the **Substance Abuse and Mental Health Services Administration** (SAMHSA) published the first guidance on crisis services in its *National Guidelines for Behavioral Health Crisis Care – A Best Practice Toolkit*.[7] The toolkit describes three core services of a comprehensive and effective crisis continuum that includes: crisis systems call center hubs, crisis mobile teams, and crisis urgent care/stabilization services. The publication describes the services and associated best practices and highlights the interconnectedness of the different services. The continuum is described in a catchy manner to illustrate the connectedness, yet unique aspects of each service:

- ***Someone to Talk To*** (call center)
- ***Someone to Respond*** (mobile crisis services)
- ***Place to Go*** (crisis walk-in)

The three core components of an effective crisis system are:

- 24/7 clinically staffed crisis call centers;
- 24/7 mobile crisis team (MCT) response in the community to provide assessment and referral;
- Crisis stabilization units that provide short-term (up to 24 hours) stabilization services in a non-hospital setting.[8]

These three pillars are the foundation of the larger Crisis Ecosystem which includes health and social service providers, public safety stakeholders, family members and community partners. All mobile crisis services, within this ecosystem, must be able to refer and link individuals to the full range of services

[7] Substance Abuse and Mental Health Services Administration (SAMHSA), "National Guidelines for Behavioral Health Crisis Care – A Best Practice Toolkit Knowledge Informing Transformation," SAMHSA.gov, 2020.
[8] Jordan Gulley, et al., "Mobile Crisis Teams: A State Planning Guide for Medicaid Financed Crisis Response Services," Technical Assistance Collaborative and California Health Care Foundation, January 2022. Available at: https://www.tacinc.org/wp-content/uploads/2022/01/CHCF-Mobile-Crisis-Services-State-Planning-Guide-2021-01-24_Final.pdf.

and supports during or after the crisis event. The stronger the coordination the more likely a person may avoid future crisis.

Further, the Best Practice Toolkit reinforces that "crisis services are for **anyone, anywhere and anytime**".

SAMSHA outlined the Minimum Expectations to operate Mobile Crisis Team Services as:

- Respond where the person is (home, school, work, park, etc.) and not restrict services to select locations within the region or particular days/times; and
- Connect to facility-based care as needed through warm hand-offs and coordinating transportation when and only if situations warrant transition to other locations.

SAMHSA outlines Best Practices to operate Mobile Crisis Team Services as:
To fully align with best practice guidelines, teams must meet the minimum expectations and:

- Respond without law enforcement accompaniment unless special circumstances warrant inclusion in order to support true justice system diversion;
- Implement real-time GPS technology in partnership with the region's crisis call center hub to support efficient connection to needed resources and tracking of engagement; and
- Schedule outpatient follow-up appointments in a manner synonymous with a warm handoff in order to support connection to ongoing care.

SAMHSA states that the essential functions of mobile crisis services include:

- Triage/screening, including explicit screening for suicidality;
- Assessment;
- De-escalation/resolution;
- Peer support;
- Coordination with medical and behavioral health services; and
- Crisis planning and follow-up.

The Centers for Medicare and Medicaid Services issued **CMS Guidance** that states the purpose of community-based mobile crisis intervention services is to provide rapid response, individual assessment and crisis resolution by trained mental health and substance use treatment professionals and paraprofessionals in situations that involve individuals who are presumed to or known to have a mental health condition and/or use substances.[9] Community-based mobile crisis services must remain available 24 hours a day, every day of the year.

Qualifying community-based crisis intervention services must be:

- Provided to a Medicaid eligible individual **outside of a hospital or facility setting**;
- Respond where the person is (home, work, park, etc.) and not restrict services to select locations within the region or particular days/times; and
- Where appropriate, provides screening and assessment, stabilization and de-escalation, and coordination with and referrals to health, social and other services and supports, as needed, and health services as needed.

[9] Centers for Medicare and Medicaid, "SHO#21-008 RE: Medicaid Guidance on the Scope of and Payments for Qualifying Community-Based Mobile Crisis Intervention Services," Dan Tsai, December 28, 2021. Available at: https://www.medicaid.gov/federal-policy-guidance/downloads/sho21008.pdf.

CMS offered further clarification that a community mental health center (CMHC) is not considered a "facility setting" and therefore crisis services delivered in a CMHC are eligible for enhanced funding.

National Organization Publications

The National Association for State Mental Health Program Directors (NASMHPD) has created a series of publications of crisis services that are posted on their website. Several articles of note that were used to inform the analysis of evidence-based, best practice mobile crisis response systems are:

- *Addressing Substance Abuse in Behavioral Health Crisis Care: A Companion Resource to the SAMHSA Crisis Toolkit* published in 2020. This document outlines very important components of addressing substance use within the crisis continuum including understanding the nature of substance disorders and to seize a crisis opportunity as a moment of potentially reducing the denial regarding the disorder.[10]
- *Cops, Clinicians, or Both? Collaborative Approaches to Respond to Behavioral Health Emergencies* published in 2020. This publication includes the role of mobile crisis teams in being a solution to resolving crisis in the community and diverting from emergency departments and jail.[11]
- *Strategies and Considerations for Providing a More Equitable Crisis Continuum for People of Color in the United States* published in 2021 which describes the role race plays in an individual's social determinants of health, in particular the social determinants of healthcare access and quality, and social and community context.[12] Recommendations include:
    - Build trust with communities of color through transparent data collection and reporting, and meaningful engagement and relationship building with trusted community leaders; and the improved/reduced use of law enforcement in crisis response.
    - Address disparities by allowing providers to incorporate supportive services (e.g., housing and hygiene), and through a more representative and culturally competent workforce.
    - Provide leadership through organizational priorities and contract language modifications that support equity.
- *Strategies for the Delivery of Behavioral Health Crisis Services in Rural and Frontier Areas of the U.S.* published in 2020 explores the challenges and potential strategies and solutions to deliver crisis services to individuals in rural areas.[13]
- *Making The Case for a Comprehensive Children's Crisis Continuum of Care* published in 2018 notes the value of mobile response and stabilization services (MRSS) designed specifically to intercede upstream, before urgent behavioral situations become unmanageable emergencies. These community-based mobile crisis teams are instrumental in averting

[10] Rebecca Boss, Tyler Sadwith, and Brian Daly, "Assessment #4: Addressing Substance Use in Behavioral Health Crisis Care: A Companion Resource to the SAMHSA Crisis Toolkit," National Association of State Mental Health Program Directors (NASMHPD), August 2020. Available at: https://www.nasmhpd.org/sites/default/files/2020paper4.pdf.

[11] Margaret E. Balfour et al., "Assessment 11: Cops, Clinicians, or Both? Collaborative Approaches to Responding to Behavioral Health Emergencies," National Association of State Mental Health Program Directors (NASMPHD), August 2020. Available at: https://www.nasmhpd.org/sites/default/files/2020paper11.pdf.

[12] Kristin A. Neylon, "Strategies and considerations for providing a more equitable crisis continuum for people of color in the United States," Technical Assistance Collaborative Paper No. 5, National Association of State Mental Health Program Directors (NASMHPD), September 2021. Available at: https://www.nasmhpd.org/sites/default/files/5_Disparities_508.pdf.

[13] Kristin A. Neylon, "Assessment #10: Strategies for the Delivery of Behavioral Health Crisis Services in Rural and Frontier Areas of the U.S: National Association of State Mental Health Program Directors (NASMHPD), August 2020, Available at: https://nasmhpd.org/sites/default/files/2020paper10.pdf.

unnecessary ED visits, out-of-home placements and placement disruptions, and in reducing overall system costs.[14]

Addressing Substance Use in Crisis Care

It is essential that "*anyone*, anywhere, anytime" cited in the SAMHSA Best Practice Toolkit, include individuals that use substances. Of great significance in the SAMHSA Crisis Toolkit is the clear inclusion of substance use crisis within the behavioral health definition. It could be interpreted that previous descriptions of crisis care focused solely on mental illness, excluding substance use diagnoses. "There is no doubt now that funding, policies, planning and operationalization of a community-based crisis system needs to incorporate the specific needs of individuals with co-occurring mental health (MH) and SUD as well as individuals with substance use only diagnoses and crisis needs related to substance use itself".[15]

CMS Guidance suggests that community-based mobile crisis intervention teams carry naloxone and have team members trained in its administration to reverse opioid overdoses. CMS also encourages states to equip their mobile crisis units with harm reduction supplies, including fentanyl test strips and suboxone.

Crisis Services for Youth

The primary objective of the MRSS model is to keep youth safe at home, in the community, and in school whenever possible. From a quality and clinical perspective, children, youth, young adults, and families benefit from MRSS because they get to initiate care based on a self-defined crisis. "Crisis" means different things to different families; it is important to use the family's own definition, based on their own needs and strengths.[16] The MRSS model is steeped in the Systems of Care philosophy and the Wraparound process.[17] [18] Wraparound is a planning process that builds on children's strengths, empowers their families, appreciates their cultures, and "wraps" services around their needs. The Wraparound philosophy drives treatment planning and determines activities that can enable children with serious emotional disturbance to grow up at home and, together with their families, achieve positive outcomes.

Many of the tenants of MRSS are included in the CMS definition of community-based mobile crisis services including but not limited to:

- Services are available 24 hours a day, 7 days a week
- Crisis prevention and early intervention
- On site, face-to-face intervention from a mobile team of crisis professionals at the location of the crisis (i.e., the child's home or school or another community setting)
- Multidisciplinary Team model

[14] "A Community-Based Comprehensive Psychiatric Response Service: An Informational and Instructional Monograph," Technical Assistance Collaborative, Inc., 2005, Available at: https://www.tacinc.org/wp-content/uploads/2020/08/Crisis-Manual.pdf.

[15] Rebecca Boss, Tyler Sadwith, and Brian Daly, "Assessment #4: Addressing Substance Use in Behavioral Health Crisis Care: A Companion Resource to the SAMHSA Crisis Toolkit," National Association of State Mental Health Program Directors (NASMHPD), August 2020.

[16] Elizabeth Manley et al., "Making the Case for a Comprehensive Children's Crisis Continuum of Care," National Association of State Mental Health Program Directors (NASMHPD), August 2018. Available at: https://www.nasmhpd.org/sites/default/files/TACPaper8_ChildrensCrisisContinuumofCare_508C.pdf.

[17] "WHAT TO EXPECT IF YOUR FAMILY IS INVOLVED IN WRAPAROUND," ACMH. Accessed June 7th, 2022. Available at: http://www.acmh-mi.org/get-information/childrens-mental-health-101/expect-accessing-mental-health-services-using-public-mental-health-services/at-a-wraparound-meeting/#:~:text=Wraparound%20is%20a%20way%20or,to%20help%20meet%20their%20needs.

[18] "Guiding Principles of Systems of Care," Child Welfare Information Gateway, Accessed June 9th, 2022. Available at: https://www.childwelfare.gov/topics/management/reform/soc/history/principles/.

- Peer and natural supports
- Use of a standardized screening and assessment tool
- Crisis stabilization services subsequent to the initial acute intervention. These services may include in-home supports and short-term care coordination and may be provided over the span of a few days or over several (up to eight) weeks, depending on the needs of the family.
- Connect families to follow-up services and supports
- System Coordination and Community Collaboration

The National Council for Well-Being published the *Roadmap to the Ideal Crisis System* in 2021.[19] This guide provides concepts and approaches communities can use to continuously improve their crisis system to move closer to an ideal system. It also describes mobile crisis within a continuum of other services and is more expansive than SAMHSA's Toolkit because it includes information such as continuing crisis care post crisis, residential crisis care, and crisis transportation. Moreover, the document describes clinical best practices within crisis care that includes:

- A framework and response that is: welcoming, hopeful, safe, trauma-informed and culturally affirming
- Engagement of family members and other natural support
- Use of crisis plans and advanced directives
- Core competencies of crisis responders that include:
    - Engagement
    - Assessment in the crisis setting that supports informed decision making
    - Intervention
    - Addressing acute agitation

The Well-Being Trust has published a *Consensus Approach and Recommendations for the Creation of a Comprehensive Crisis Response System* in November of 2021.[20] This is the first publication that has emphasized and provided a crisis care continuum that articulates the upstream and downstream aspects of crisis intervention. Figure 1 below, *Crisis Response Continuum of Care,* the need for services beyond the three core services within the continuum of crisis care includes addressing outreach and engagement to people at risk of crisis and providing post-crisis intervention.

[19] National Council for Mental Wellbeing, Committee on Psychiatry and the Community for the Group for the Advancement of Psychiatry, "ROADMAP TO THE IDEAL CRISIS SYSTEM: Essential Elements, Measurable Standards and Best Practices for Behavioral Health Crisis Response," March 2021. Available at: https://www.thenationalcouncil.org/wp-content/uploads/2022/02/042721_GAP_CrisisReport.pdf.

[20] "Consensus Approach and Recommendations for the Creation of a Comprehensive Crisis Response System," 988 Crisis Hotline, Well-Being Trust, November 2021. Available at: https://wellbeingtrust.org/wp-content/uploads/2021/11/988-Crisis-Response-Report-November-FINAL.pdf.

Figure 1. Crisis Response Continuum of Care [21]

Follow-up Care

SAMHSA notes that essential functions of mobile crisis services include crisis planning and follow-up. *When indicated, mobile crisis service providers should also follow up with individuals served to determine if the services to which they were referred were provided in a timely manner and are meeting their needs. This activity is typically completed through telephonic outreach but there may be times when further face-to-face engagement may be warranted or even necessary when the individual cannot be reached by phone*. [22]

Enhanced federal funding is available for follow-up services provided by mobile crisis teams. Further, CMS is requiring some form of follow-up care within 48 hours to connect individuals to necessary behavioral health services. CMS guidance notes that effective crisis models provide follow-up access to mental health care within 48 hours via telehealth or in-person. The period between when an individual accesses crisis services and receives ongoing treatment is a critical gap and ongoing support is vital to maintain stabilization for some individuals.

Telehealth

As described further in the Technology section, CMS Guidance authorizes Medicaid reimbursement for mobile crisis assessment and screening via telehealth, potentially expanding access to clinicians who can provide screening and assessment to communities that are traditionally underserved or that have been served only by a law enforcement response. Further, CMS permits state Medicaid agencies to fund information technology (IT) systems that includes providing cell phones or iPads to state staffed mobile crisis teams to facilitate telehealth services with a clinician at another location during a crisis intervention.

[21] IBID.

[22] Substance Abuse and Mental Health Services Administration (SAMHSA), "National Guidelines for Behavioral Health Crisis Care – A Best Practice Toolkit Knowledge Informing Transformation," SAMHSA.gov, 2020.

Crisis Services in Rural Areas

SAMHSA notes the following challenges related to crisis service delivery in rural areas:

- Workforce
- Distance to travel and transportation
- Sustainability
- The use of technology
- Broadband access

While the use of technology, particularly telehealth, offers opportunities to deliver crisis services to individuals in rural areas, inconsistent broadband connectivity can be a barrier. Below are approaches that SAMHSA recommends:[23]

- Learn how other area first responder services, such as law enforcement, fire, and emergency medical services, operate.
- Leverage existing first responder transportation systems to promote access to care in a way that aligns with area emergency medical services.
- Incorporate technology, such as telehealth, to improve access to limited licensed professional resources.
- Develop crisis response teams whose members serve multiple roles in communities with limited demand for crisis care to advance round-the clock support when called upon.
- Establish rural reimbursement rates for services that support the development of adequate crisis care. Create crisis service response time expectations that consider the region's geography while still supporting timely access to care.

Vermont Findings

In Vermont, crisis services are delivered through 10 Designated Agencies (DAs) across the state with one DA in each region. Emergency Care and Assessment Services (Emergency Services, ES) are defined as time-limited, intensive support intended to resolve or stabilize the immediate crisis through direct treatment, support services to significant others, or arrangement of other more appropriate resources, according to the 2021 Mental Health Provider Manual.[24] In addition to these 10 DAs, DMH works with two Specialized Service Agencies (SSAs), Pathways Vermont, which serves adults, and the Northeastern Family Institute (NFI), which serves children and families. These SSAs may operate in more than one geographic area and are not defined as DAs.

The Mental Health Provider Manual states that a DA shall provide mental health crisis screening and crisis assessment services to residents of any age in their catchment area who are in acute mental or emotional distress and need crisis support or stabilization.[25] The current contract language in the emergency service standards describing a crisis as a "mental health crisis", excludes persons with primary substance use.[26] Use of "behavioral health" instead of "mental health" is considered to be more inclusive as behavioral health looks at how behaviors impact an individual's overall health — physical and mental.

[23] IBID.
[24] "Vermont Mental Health Provider Manual," Vermont Department of Mental Health, January 2021. Available at: https://mentalhealth.vermont.gov/sites/mhnew/files/documents/Manuals/MH_Provider_Manual_1-14-21.pdf.
[25] IBID.
[26] "Designated Agency Emergency Services Standards," Vermont Department of Mental Health, 2017. Available at: https://mentalhealth.vermont.gov/sites/mhnew/files/documents/Manuals/Emergency_Services_Standards_2017-12.pdf.

While nationally the term behavioral health is often used interchangeably with mental health and substance use, Vermont does not use the term behavioral health in this manner as it believes that it can perpetuate stigma. Vermont believes that people with mental health diagnoses may feel it is a hurtful misuse of the term that might imply the cause of a mental health condition is behavior or a choice. Therefore, through this document, the phrase "mental health and substance use", or "MH/SU" is used when that is what is being described and "behavioral health" is used when referenced in national documents.

The Designated Agency Emergency Services Standards (2017), describes the Description of Services which includes: [27]

- Crisis Response
- Inpatient Screening
- Court Screening
- Community Emergencies/Disaster response
- Reassessment
- **Mobile Outreach**

There are limitations with the current data collected with regard to the location of mobile crisis services. As such, the overall utilization of mobile crisis services as well as the extent to which crisis services are delivered in the community is not fully known.

The Designated Agency Emergency Services Standards (2017) states that DAs must have the capacity to provide "**Follow-up**, where possible and if appropriate, to emergency contacts to ensure that linkages were appropriate, and referrals were made if needed". [28] While a survey of the DA's revealed that all mobile crisis teams provide follow-up care, there are limitations with the current data collected with regard to the follow up services. As such, the extent to which follow up care is delivered is not fully known.

A broad-based statewide survey was distributed to collect stakeholder feedback on the current crisis system of care. The results revealed the following:

- 70 percent of the 270 survey respondents indicated that **community-based crisis services** (in the home, work, school, etc.) are currently missing or needs to be improved upon.
- 50 percent of the 270 survey respondents indicated that **crisis call line services** are working well.
- 90 percent of 244 respondents noted that there were post-crisis gaps in follow-up services
    - **Timely access to mental health services** was noted by 83 percent of respondents
    - **On-going mobile crisis follow-up services** until established in treatment services was noted by 71 percent of respondents
    - **Timely access to other supports and services**, including navigation, housing, childcare, nutrition and transportation was noted by 69 percent of respondents
- In response to the biggest challenges to effective community-based mobile crisis services in Vermont (in the home, workplace, school, other), of the 235 respondents, 68 percent noted **timely access to treatment services** once the person is stabilized and 64 percent noted **program funding.**
- Consumers and/or families reported that **speaking with someone over the phone** and **kind and helpful staff** were the most helpful crisis services.

[27] IBID.
[28] IBID.

- 54 percent of consumers reported that **not knowing where or who to call** has been the hardest thing about getting crisis services.
- Consumers and families reported poor access to crisis services during the evening, night and weekend hours.
- Consumers and families that have accessed crisis services reported receiving services in hospital emergency departments most of the time (67 percent) although 65 percent of consumers and families indicated they would like to receive crisis care in the community.
- Half of the 15 hospital/ED respondents indicated that 50-75 percent of individuals that present to the ED for a mental health or substance use related crisis could have been evaluated in the community (i.e., did not warrant medical screening). **This presents significant savings potential for Vermont Medicaid and other payers.**
- In response to particular groups that are not well served by the current mobile crisis system, the top responses (in rank order) were homeless individuals, Individuals with intellectual or developmental disabilities, individuals with substance use disorder and children and youth.

Qualitative Response Analysis

Pockets of Excellence

- The survey asked respondents to select "pockets of excellence" or areas that work well in Vermont's mental health and/or substance use related crisis system. In total, 71 respondents selected the "other" option and entered their own narrative. The majority of these 71 respondents (55 percent) indicated that either nothing is working well or that they are uncertain of what is working well. Other common responses included that the crisis services were generally strained and depleted and that they need more (7 percent), that community-based crisis services are working well (7 percent) and that recovery coaching is working well (6 percent).

Gaps

- In terms of what services are currently missing or can be improved upon, a total of 53 respondents provided answers in the "other" category. Responses varied but a few common themes included peer services, having more beds and residential options (including ED alternatives), and wraparound or follow up services.
- When asked about the challenges to effective community-based mobile crisis services, a total of 50 respondents selected "other." Of these 50 respondents, 44 percent indicated staffing as the biggest challenge.
- Other gaps included poor access in rural areas, difficulty identifying people who need services, issues with law enforcement involvement, stigma, trust, lack of funding, lack of peer support and lack of population representation among the providers/staff. Some themes were more prevalent for certain populations. For instance, representation, lack of trained staff, and cultural competence were listed more often in the BIPOC, tribal and LGBTQIA2+ populations. Respondents also acknowledged unique challenges for specific populations such as homeless people not having access to housing or ways to communicate, and immigrants and refugees needing access to interpretation services.
- It was noted by mental health and substance use providers as well as designated agencies that refugees and immigrants are underserved as these individuals do not traditionally seek out crisis care. Translation issues was noted as a challenge.

A consistent theme from focus groups was that lack of available crisis staff and lack of timely response was a primary challenge to the current crisis system. Focus group feedback also noted the challenges with workforce development and retention.

While there is not a required standardized risk assessment for crisis teams, a survey of the emergency service providers noted that most (77 percent) MCTs use the Columbia Suicide Severity rating scale (C-SSRS).

Crisis Services for youth

While emergency service providers serve individuals of all ages, a Mobile Response and Stabilization Services (MRSS) pilot was recently launched. Since late 2017, DMH has been working with other AHS departments, including Vermont Health Access (DVHA), Child and Families (DCF) Family Services Division, and the Aging and Independent Living (DAIL) Developmental Disabilities Services Division to explore MRSS for the child, youth and family system of care. Vermont state-level system of care leaders identified the following challenges:[29]

- Increase in children/youth (0-17) who go to Emergency Departments with a mental health crisis and then have to wait for days for a crisis plan to be put into place (inpatient, crisis alternative program, or community-based plan)
- Current gap between the resourced capacity of DA emergency services teams and the demand for these services
- Challenges with flow through the children's system of care
- Providers see a need for responsive, in-home community supports beyond this screening
- Families are asking for more immediate in-home supports

Rutland Mental Health Services launched a grant funded pilot in October 2021 to provide MRSS. Ramp up of this service has been slow due to hiring and retention challenges. MRSS received 64 calls between October 2021 – May 2022 and 18 families are currently receiving stabilization services. While utilization of the MRSS is slowly increasing, it is too early to know how the program is performing.

Future State Recommendations

Based on the information gathered and synthesized by HMA, we offer the following recommendations:

- Vermont may elect to reprocure the emergency services network which would offer a unique opportunity to make necessary operational and programmatic changes to ensure 24/7 access to community-based crisis care that aligns with best practices.
- MCT contract requirements should explicitly state services must be available 24/7 in community settings.
- Revise Emergency Service Standards and Mental Health Provider Manual to include substance use in populations served.
- Incorporate the unique needs of youth and families into the model building from the successes of the MRSS and the wraparound process.
- Use of standardized assessment tool should be required.
- Promote the use of telehealth to improve access to rural areas and expand access to underserved populations. Vermont should leverage enhanced Federal Funding for IT systems to support telehealth capacity for mobile crisis teams.
- Thoughtful consideration is needed regarding improving access and culturally competent care to underserved populations including refugees, immigrants, homeless individuals and individuals with intellectual or developmental disabilities.

[29] Laurel Omland, "The Need for Mobile Response and Stabilization Services (MRSS) in Vermont: From Reactive to Responsive," Vermont Department of Mental Health, February 2020. Available at: https://legislature.vermont.gov/Documents/2020/WorkGroups/House%20Health%20Care/Mental%20Health/W~Laurel%20Omland~The%20Need%20for%20Mobile%20Response%20and%20Stabilization%20Services%20(MRSS)%20in%20Vermont%20-%20From%20Reactive%20to%20Responsive~2-12-2020.pdf.

- 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 three days for adults and up to seven days for youth). Vermont should leverage enhanced Federal Funding for follow-up services provided by mobile crisis teams.
- Ensuring all Vermonters know who to call for a behavioral health crisis will be critical. Vermont should consider a marketing campaign of the new model of emergency services.

2. Collaboration and Coordination with Key Mobile Crisis Response System Partners

National Environmental Scan

Best practice mobile crisis systems are guided by two types of partnership – Crisis Care Collaboration and Crisis Care Coordination. Both involve engaging with cross system partners to ensure the necessary services and supports are in place to address a mental health crisis. However, they are distinct activities, each playing a vital role in addressing needs – one occurs at the system level, while the other occurs at the service level, engaging individuals, and families. Cross System Collaboration occurs at the macro system level where partnerships are formed to plan, implement, and monitor a crisis system of care and coordination. Crisis Care Coordination occurs at the micro level, to address case-specific intervention, operational sharing, communicating, and planning in the day-to-day operations of delivering crisis services. Both are critical activities to effectively deliver the necessary system oversight, delivery of services, and quality improvement activities and outcomes.

The following are descriptions of core stakeholder groups and their role and stake in the system for both crisis collaboration and coordination. It is particularly important to provide a platform for people most impacted by crisis, those who experience crisis, and their support system and/or families.

Core Stakeholders Groups: Opportunities for Collaboration and Coordination

People with Lived Experience, Families (broadly defined), and Advocates

It is critical to include the participation of people with lived experience and engage networks or families of individuals with a history of mental illness, substance use, homelessness, justice involvement, psychiatric hospitalization, and incarceration. Advocates provide on the ground experience and information, as well as potentially champion the implementation of any recommendations. Mental health crisis systems have been found to produce avoidable adverse outcomes for racially marginalized, historically disenfranchised (LGBTQAI2+ and disabled), rural, and under-resourced communities. Authentic community engagement can reduce and avoid tokenism and encourage equity across provider networks.

Community-Based Medical, Mental Health and Social Services Providers

Organizations offering medical services and health care, mental health and substance use services, and those that meet the need for housing, employment, transportation, food, and other social determinants of health, play a critical role in the safety net. Community members in need often struggle to maintain stability in the community and to access routine medical care, leading to chronic conditions that drive reliance on avoidable acute care and emergency service encounters. When possible, providing individuals with an assessment by a community-based mobile crisis clinician offers an alternative to an emergency department (ED) and other hospital encounter. Through this alternative, a mental health professional can determine whether an individual needs immediate stabilization services, including those for psychiatric crisis stabilization and substance use withdrawal, and can triage and stabilize minor medical conditions. Models can include the option for law enforcement officers and Emergency Medical

Services (EMS) technicians to divert from EDs and inpatient care to an appropriate lower level of care by accessing assessment and stabilization. Hospitals can save resources needed to meet community needs for acute care that can only be provided in a hospital and individuals receive focused services designed to stabilize and initiate recovery.

Governmental Administrators and Elected Officials

City, county, state governments, and elected officials, are stewards of dollars for critical infrastructure and safety net services, with a responsibility to implement policy that meets the needs of constituents and preserves the public trust. Public officials and leaders have an opportunity to invest in a crisis services model that transcends the traditional silos of safety net services and delivers improved outcomes and reduced costs. Policy makers and funders can play a strong role in driving and supporting alignment across the many agencies and entities that must work together to provide a coordinated response. State agencies are recognizing the importance of developing a shared understanding for the direction of crisis services to collectively support collaboration at the local level that will not inadvertently provide conflicting information or direction to local communities.

Law Enforcement

The primary role of law enforcement is public safety; yet they are also called upon too frequently to address the needs of people experiencing a mental health crisis or in need of treatment and support. Sixty percent of the law enforcement that responded to the Vermont survey said they receive at least 1-2 mental health-related calls in a single shift. Examples include responding to 911 mental health calls, addressing opioid overdose, and managing and/or co-managing homelessness. Crisis Intervention Teams (CIT) offers an alternative to this approach by using a collaborative and coordinated response whereby law enforcement, mental health professionals, and mental health advocates, problem-solve and take responsibility for improving the mental health crisis response system—so that police and jails are not the default responders and locations.[30]

Other First Responders

EMS is frequently on the "front line" with mental health crisis. Like police officers and sheriff's deputies, EMS has a responsibility to support public safety with the specific charge to provide urgent and emergent health care response throughout the community. EMS uses algorithms and protocols based on prevailing medical standards to identify and respond to all health conditions. Mental health and substance use conditions often co-occur with medical conditions – acute or chronic – while at the same time mental health and substance use conditions themselves can be co-occurring. The complexity of this presentation combined with the primary role of EMS to perform acute health care triage and transportation has historically resulted in transport of all such cases to an ED, even when the EMS technician suspects that the primary presenting concern is due to mental illness or substance use. Partnerships between EMS and mental health agencies, whereby a community-based mobile clinician accompanies EMS to assess for appropriate triage at the point of crisis, greatly reduces the potential for unnecessary ED boarding and ensures the most appropriate intervention is provided at the earliest possible juncture.

[30] Laura Usher et al., "Crisis Intervention Team (CIT) Programs: A Best Practice Guide for Transforming Community Responses to Mental Health Crises," CIT International, August 2019. Available at: https://www.citinternational.org/resources/Best%20Practice%20Guide/CIT%20guide%20desktop%20printing%202019_08_16%20(1).pdf.

Hospitals (Emergency Departments)

Emergency departments (ED) often become the default recipients of individuals experiencing acute mental health crises. Individuals can end up "boarding" in EDs, contributing to ED over-crowding, return visits or ED bounce-backs, and an unsafe or unhealthy environment for mental health and medical patients and staff. There are barriers within state agencies, payer organizations, and hospitals that perpetuate ED patient boarding for mental health patients. In response to the VT statewide survey, 40 percent of EDs have seen current mental health patients return "often" in the last month (3-5 times), while 60 percent say the current data sharing between EDs and mobile crisis teams is insufficient to support care coordination.

Schools

Most school-aged youth spend more of their waking hours in a school setting than they do at home. Nationally, schools have historically used the ED and law enforcement as crisis intervention for children demonstrating concerning behavior.[31] Understanding and addressing disparate treatment is important as youth of color exhibiting "concerning behaviors" are more often referred to law enforcement nationally. Collecting and understanding disaggregated data and developing tools for identifying underlying trauma and mental health needs and implementing equitable and appropriate (non-criminal) responses are important. In Vermont, 37.5 percent of school survey respondents indicated that their school is frequently told to bring the student to a local hospital when attempting to connect students with crisis services. Schools are natural partners in designing a crisis continuum and in supporting the development of a comprehensive crisis treatment plan. School social workers and counselors can work together with youth and young adults, families, community mental health providers, and law enforcement to ensure the least restrictive, and most comprehensive crisis and treatment plan is in place to support ongoing recovery both in the community and school setting.

Criminal Justice and Judicial System

Individuals with a history of mental health crisis often also have legal involvement with the criminal justice and judicial system. They may have multiple unresolved citations or charges resulting in outstanding warrants, repeat detentions or incarcerations, or other legal involvement that results from – and contributes to – their instability in the community while also creating a burden on the law enforcement system. Specialty Courts, District Attorneys, and Public Defenders partner with law enforcement, providers, and other system stakeholders to develop support and treatment alternatives for individuals in a mental health crisis that address their core mental illness and/or substance use in lieu of criminal justice actions. Diversion programs are a key tool to reduce recidivism and improve outcomes for both the individual and the community.

Engaging stakeholders throughout the program development process promotes buy-in and creates a standing venue for bi-directional communication with those who will ultimately implement the mental health crisis response system recommendations.

Models of Cross Sector Collaboration

As previously stated, crisis collaboration occurs at the macro or system level. Collaboration involves many stakeholders with unique perspectives and roles engaged in the delivery of services that are responsive to individuals experiencing a mental health crisis. The roles, culture, and agenda of each stakeholder group must be respected to assure full and effective participation across the crisis

[31] Elizabeth Manley et al., "Making the Case for a Comprehensive Children's Crisis Continuum of Care," National Association of State Mental Health Program Directors (NASMHPD), August 2018. Available at: https://www.nasmhpd.org/sites/default/files/TACPaper8_ChildrensCrisisContinuumofCare_508C.pdf.

ecosystem. Each stakeholder is essential to every part of the crisis response process, from the initial needs assessment to the ongoing evaluation. Strong partnerships are critical to generating enthusiasm for designing, funding, and implementing crisis systems and for ensuring that these systems function effectively on an ongoing basis.[32] To help people gain recovery and stability most effectively in the community, stakeholders must collectively develop a common mission and culture of collaboration that supersedes individual roles and agendas to inform comprehensive efforts. The common vision builds upon community assets to improve the health and wellbeing of individuals with mental health and other challenges, with the result being better outcomes and cost reductions for communities. Joint Memorandums of Understanding, policies, data agreements, and standard operating procedures underpin crisis system partnership and mandate policy on a federal, state, or local level and demonstrate highly developed crisis-system collaboration and coordination.

For example, Mobile Crisis is required by CMS to conduct follow-up services with the express goal of making referrals and linkages to continuing services. Key elements and strategies in successful linkage include: [33]

- Data sharing agreements to promote the responsible sharing of information
- Formalized memorandums of understanding (MOUs) to codify working relationships which:
    - Define shared definitions and understandings
    - Outline roles and responsibilities
    - Codify the oversight body to review performance, outcomes and recommend quality improvement measures
    - Data sharing agreements and processes to promote the timely exchange of client and/or other relevant information (within the confines of privacy and confidentiality rules)
    - Shared protocols tailored to the partner (e.g., law enforcement vs. social service provider)
    - Web-based platforms with real-time tracking of service availability with scheduling capability
    - Shared care coordination platforms monitoring referrals and linkages (e.g., Aunt Bertha, Unite Us)
    - Psychiatric Advance Directives
- Electronic information systems with compatibility to allow information sharing (e.g., past treatment information, current event information or to confirm engagement with linked service has occurred)
- Full continuum of key crisis services (call center, mobile crisis and stabilization services)
- Ensuring all data sharing adhere to all confidentiality rules
- Surveillance of the system performance

The *Crisis Intervention Training (CIT) Programs: A Best Practice Guide for Transforming Community Responses to Mental Health Crisis* developed by CIT International, a law enforcement developed organization, outlines effective practices to address the needs of individuals who interface with law

[32] Margaret E. Balfour et al., "Cops, Clinicians, or Both? Collaborative Approaches to Responding to Behavioral Health Emergencies," *Psychiatric Services*, 73:6 (2021): 658-669, https://doi.org/10.1176/appi.ps.202000721.
[33] SAMHSA, "National Guidelines for Behavioral Health Crisis Care – A Best Practice Toolkit Knowledge Informing Transformation," SAMHSA.gov, 2020.

enforcement. [34] ***Throughout the document, relationships and collaborations are the cornerstone of the work***, not training for law enforcement. It should be noted, however, that training for law enforcement is one of the best practices identified.

Yet, developing and sustaining these collaborations is not easy. The *CDC Foundation* developed a Toolkit to assist jurisdictions to support strong public safety-public health collaborations which would address the opioid crisis. They note, "Although many jurisdictions are already engaged in multi-sector partnerships to address the overdose crisis, overcoming siloed strategies is challenging. Bridging philosophical and practical gaps between public health and public safety can be particularly difficult, given their different roles, duties, and training." [35]

The SAMHSA *National Guidelines for Behavioral Health Crisis Care – A Best Practice Toolkit* [36] which describes effective crisis services, should not be viewed as stand-alone resources operating independent of the local community mental health and hospital systems, but rather an integrated part of a coordinated continuum of care. Service needs and preferences of the individual served must be assessed to inform the interventions of the crisis provider and the connections to care that follow the crisis episode. This is not easily achieved given the complex dynamics that are in play in many communities throughout the country that have complex health ecosystems influencing the care delivery system. Pieces of a continuum of care will not typically align and partner fully without a purposeful intent, regular communication between crisis services, local hospital and outpatient service leaderships must be coordinated in a thoughtful manner that focuses on the needs of the community served. [37]

Arizona, King County and Massachusetts provide some examples of cross sector collaboration.
The Arizona Medicaid agency, Arizona Health Care Cost Containment System (AHCCCS), has written contract requirements to foster cross-system crisis system partnerships. The following are excerpts from the health plan contracts that encourage them to work with system partners and develop protocols: [38]

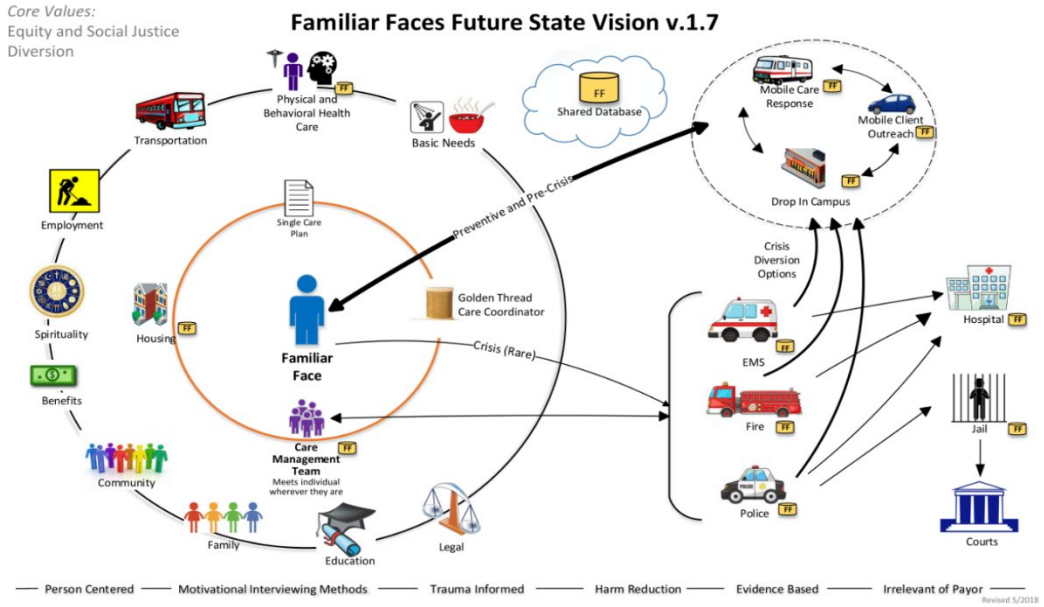
- AHCCCS supports a coordinated system of entry into crisis services that are community-based, recovery-oriented, person-focused, help stabilize the individual as quickly as possible to assist them in returning to their baseline level of function. ***Collaboration, the improvement of data collection standards, and communication are integral in enhancing quality of care leading to better health care outcomes, while containing cost***. Expanding provider networks capable of providing a full array of crisis services geared towards the individual is expected to maintain a person's health and enhance quality of life. ***The collection, analysis, and use of crisis service data for crisis service delivery and coordination of care is critical to the effectiveness of the overall crisis delivery system.***
- The Contractor shall work in partnership … **to meet, agree upon and reduce to writing joint collaborative protocols** with local law enforcement and first responders, which, at a minimum, shall address:

[34] Laura Usher et al., "Crisis Intervention Team (CIT) Programs: A Best Practice Guide for Transforming Community Responses to Mental Health Crises," CIT International, August 2019. Available at: https://www.citinternational.org/resources/Best%20Practice%20Guide/CIT%20guide%20desktop%20printing%202019_08_16%20(1).pdf.
[35] CDC Foundation, "Public Health and Safety Team (PHAST) Toolkit", March 2020. Available at: https://www.cdcfoundation.org/sites/default/files/files/PHAST_Web_Toolkit_Pilot_Version_2.0_For_Dissemination.pdf.
[36] Substance Abuse and Mental Health Services Administration (SAMHSA), "National Guidelines for Behavioral Health Crisis Care – A Best Practice Toolkit Knowledge Informing Transformation,"SAMHSA.gov, 2020.
[37] Substance Abuse and Mental Health Services Administration (SAMHSA), "National Guidelines for Behavioral Health Crisis Care – A Best Practice Toolkit Knowledge Informing Transformation,"SAMHSA.gov, 2020.
[38] "AHCCCS Contract Amendments," Arizona Health Care Cost Containment System, Accessed June 9th, 2022. Available at: https://www.azahcccs.gov/Resources/OversightOfHealthPlans/SolicitationsAndContracts/contracts.html.

- Jail diversion and safety
- Strengthening relationships between first responders and providers when support or assistance is needed in working with or engaging members
- Procedures to identify and address joint training needs

King County, Washington, provides another example of cross system collaboration with many projects underway to promote these partnerships. The *Familiar Faces Initiative* is a partnership between law enforcement and mental health system.[39] The goal of this initiative is to have better outcomes for individuals with physical and mental health issues who frequently become incarcerated. The chosen name for the program, Familiar Faces, reflects the acknowledgment that the individuals for whom this program was designed are familiar to both law enforcement and mental health agencies who have historically worked in silos. The partners now have a shared vision to share data and work collaboratively to address the needs of this population. Figure 2 *below* is from the Familiar Faces webpage.[40] And highlights the future state vision for meeting the needs of individuals with crisis mental health and/or substance use needs.

Figure 2. Familiar Faces Future State Vision



Another example from King County is the **Law Enforcement Assisted Diversion (LEAD)** program.[41] In 2011, the King County Sheriff's Office and other local law enforcement municipalities pioneered LEAD, an innovative harm reduction approach designed to address low-level substance possession and sales as well as prostitution. LEAD provides law enforcement with a ***credible alternative*** to booking people into jail for criminal activity that often stems from unmet mental health needs or poverty. LEAD diverts individuals away from the criminal legal system—bypassing prosecution and jail time—and connects them with intensive case managers who can provide crisis response, immediate psychosocial

[39] "Familiar Faces Initiative," King County, WA 2022, Accessed June 6th, 2022. Available at: https://kingcounty.gov/elected/executive/health-human-services-transformation/familiar-faces.aspx.
[40] IBID.
[41] "Law Enforcement Assisted Diversion," King County, Last updated June 15, 2020. Available at: https://kingcounty.gov/depts/community-human-services/mental-health-substance-abuse/diversion-reentry-services/lead.aspx.

assessment, and long-term wraparound services including substance use treatment and housing. The establishment of this real response took many hours of cross-system collaboration to make this work. The following video conveys information about what their process was like to set up this program. The video can be viewed here: https://kingcounty.gov/depts/community-human-services/mental-health-substance-abuse/diversion-reentry-services/lead.aspx.

Massachusetts includes the following language regarding *Service, Community, and Collateral Linkages* in the contract with Emergency Service Providers (ESPs):[42]

- The ESP communicates, consults, collaborates, refers to, and ensures continuity of care with many other resources involved with utilizers of ESP services including, but not limited to, the following:
    - Primary care services and hospitals
    - State agencies
    - Schools
    - Residential programs
    - Law enforcement entities
- The ESP develops and maintains relationships with the hospitals in its catchment areas characterized by ongoing and consistent communication, problem solving, and planning. The ESP works with the ED to evaluate ED and inpatient service utilization patterns, identify strategies to reduce unnecessary hospitalization, and plan how to divert utilization from the ED setting to the ESP's alternative community-based services.
- With Member consent, the ESP collaborates with the Member's Primary Care Clinician.
- The ESP develops and maintains close working relationships with recovery-oriented and consumer-operated resources in its local community, including but not limited to Recovery Learning Communities (RLCs), Clubhouses, and AA/NA. The ESP develops specific linkages with the RLCs relative to warmline services, if offered by their local RLC.

Models of Crisis Care Coordination

Cross System Coordination differs from Cross System Collaboration as collaboration reflects higher level, partnerships planning of a system, or "macro level", while coordination exists at a "micro level" and includes case specific and operational sharing, communicating, and planning in the day-to-day operations of delivering crisis services. Both are critical to effectively delivering the necessary system oversight, delivery of services and quality improvement activities and outcomes.

System Coordination is particularly important as ARPA-qualifying community-based mobile crisis intervention services require coordination with, and referrals to, other needed services and supports, and maintaining relationships with relevant community partners including medical and mental health providers, community health centers, crisis respite centers, managed care organizations, and others.[43]

Once the key macro, or system-level elements to ensuring collaboration are in place, it is important to foster these relationships daily to promote the most effective daily clinical outcomes for individuals in

[42] "Emergency Services Program Mobile Crisis Intervention," Massachusetts Behavioral Health Partnership, Accessed June 6th, 2022, https://www.masspartnership.com/provider/ESP.aspx.
[43] Jordan Gulley, et al., "Mobile Crisis Teams: A State Planning Guide for Medicaid Financed Crisis Response Services," Technical Assistance Collaborative and California Health Care Foundation, January 2022. Available at: https://www.tacinc.org/wp-content/uploads/2022/01/CHCF-Mobile-Crisis-Services-State-Planning-Guide-2021-01-24_Final.pdf.

crisis. The *National Guidelines for Behavioral Health Crisis Care – A Best Practice Toolkit* describes three core pillars for a well-coordinated and collaborative crisis continuum: [44]

- Crisis systems call center hubs
- Crisis mobile team staffing model (and sufficient staff – staffed 24/7/365)
- Crisis urgent care/stabilization service model

In describing call center hubs, the Toolkit includes the following recommendations (*Note: Bold text highlights items that connect with mobile crisis*):

- Call-takers that use high-touch support about mental health and substance use in a similar way a 911 call-taker would respond to a community call. To effectively address the crisis response needs, crisis call hubs at a minimum need to:
  - Operate 24/7/365
  - Be staffed with clinicians overseeing the clinical triage and team members
  - Answer every call and coordinate resources to address needs
  - Connect with crisis mobile teams and crisis urgent care in the region
  - Provide warm handoffs and follow-up to ensure care linkages are effective

- Use technology for real-time coordination across a system of care. Examples of technology tools include:
  - Recording outcome status disposition for every call, especially to understand the resolution for a call with high acuity
  - 24/7 scheduling for community-based services to ensure that there are next steps in place after a crisis call has concluded
  - Bed tracking technology to know in real-time the availability for urgent care/ crisis stabilization services
  - High-tech, GPS-enabled mobile dispatch in which a call center hub and community mobile service providers electronically communicate, while enabling the call center to see a visual representation of the availability and location of mobile teams in the community
  - Use of real-time and static dashboards to know the current performance of the crisis system
  - Use of caller ID functioning to identify the place where a person is at imminent risk of harm
  - Connectivity with local 911 systems

A video on the National Association of Mental Health Programs Directors (NASMHPD) Crisis Now website demonstrates the collaboration that is active in Arizona and contains stakeholders, including law enforcement, from around the state conveying what is working for them regarding crisis collaboration and coordination. The video can be viewed here: https://www.youtube.com/watch?v=ORq1MkODzQU. [45]

Vermont Findings

Current State Strengths

Most states have "pockets of excellence" in crisis collaboration and coordination within certain regions or jurisdictions. Our stakeholder engagement in Vermont found that law enforcement-mobile crisis partnerships are a "pocket of excellence" in the state, with 70 percent of law enforcement departments

[44] Substance Abuse and Mental Health Services Administration (SAMHSA), "National Guidelines for Behavioral Health Crisis Care – A Best Practice Toolkit Knowledge Informing Transformation," SAMHSA.gov, 2020.
[45] "Crisis Now: Transforming Crisis Services in Arizona," *YouTube* video, 7:40. February 24th, 2017. Available at: https://www.youtube.com/watch?v=ORq1MkODzQU.

sharing substance use and mental health-related information with crisis partners. Other strengths include:

- Broad governmental representation in and commitment to the mobile crisis grant planning process (Department of Vermont Health Access, Vermont Agency of Human Services, Vermont Department of Mental Health, Vermont Department of Health, Vermont Department of Children and Families, Vermont Department of Disabilities, Aging, and Independent Living, Howard Center, Washington County Mental Health Services).
- Leveraging the existing monthly Designated Agency Emergency Services meeting to coordinate efforts and update on progress.
- Improved coordination through the Embedded Mental Health Crisis Specialist Program, January 2021 Memo to the State Legislature in response to ACT 154, specifically regarding:
    - "The Department of Public Safety shall collaborate with the Department of Mental Health to develop a master memorandum of understanding that supports a unified statewide program that incorporates trauma-informed responses and is developed with the ongoing engagement of stakeholders, including individuals with lived experience of a mental health condition or psychiatric disability, those whose identities cause them to experience additional marginalization, and those with direct experience with families in crisis and domestic violence."[46]

Current State Gaps

Even with strong law enforcement partnerships, there is still a prevailing sentiment among survey respondents that partnerships can be expanded. Notably, most school respondents reported they have called for a mobile crisis team to address a student in crisis and: 1) lacked a timely response, 2) were told there were no staff available, or 3) were frequently told to send the student to the ED. Moreover, 88 percent of Vermont schools identified a need for improved information sharing between schools and mobile crisis services.

The hospital/ED question on the Vermont stakeholder survey about how to improve collaboration between crisis teams and EDs, returned 11 respondents requesting a system of communication to improve Crisis System operations. Another common response was having consistent, qualified mobile crisis team members.

We also found our attempts to engage and garner input from people with lived experience in the crisis system was less successful than other stakeholder groups. This is not inconsistent with multi-stakeholder engagements. The survey conducted yielded 270 responses, yet only 8, or 3 percent, of the total number of respondents fall into the category of people with lived experience. This represents the fourth least represented group in the survey, [EMS (1 percent), Courts System (1 percent), Healthcare Providers (3 percent)]. Also like many other states, Peers and Recovery coaches are not currently required to support crisis response and are not Medicaid billable.

Another interesting finding, also not inconsistent with other jurisdictions, was the low participation of EMS. While there is significant focus on law enforcement's role in the crisis service delivery system, EMS is often an afterthought, despite a ground swell of innovation in EMS and crisis (e.g., ET3, CAHOOTS (Crisis Assistance Helping Out On The Streets), and other ways EMS is evolving to better respond to mental health crisis.

[46] Vermont Commissioner of Public Safety to State Legislature, January 2021, Memo: Embedded Mental Health Crisis Specialist Program to the State Legislature.

There are also opportunities to leverage additional gains within law enforcement and mobile crisis teams. As Table 2 shows, law enforcement respondents to the statewide survey encourage increased coordination and collaboration in the following areas:

- 80 percent said "increasing opportunities for mobile crisis to jointly respond and manage health and other related calls," and "having mobile crisis accept police 'handoffs or transfers' of people in need of their support in the community" can strengthen the partnership.
- 60 percent said "increasing the number of crisis stabilization centers where police can 'drop-off' people in need" can strengthen the partnership.

Table 2. What can be done to strengthen the partnership between mobile crisis – law enforcement? (n=10)

Answer	%	Count
Increase opportunities for mobile crisis to jointly respond and manage health and other related calls.	80%	8
Have mobile crisis accept police "handoffs or transfers" of people in need of their support in the community.	80%	8
Joint training with mobile crisis teams.	30%	3
More training on responding to mental health crises and how to coordinate with mobile crisis teams.	10%	1
Increase the number of crisis stabilization centers where police can "drop-off" people in need	60%	6
Reduce wait times at emergency departments	30%	3
Reduce wait times for community-based mobile crisis services	40%	4
Convene regular meetings with Law Enforcement and Crisis Teams	30%	3
Improve information sharing across systems	50%	5
Other (please describe)	10%	1

Additional gaps or barriers identified include:

- No unified governmental office or department with ultimate responsibility for oversight of the mobile crisis services, which leads to diffusion in the ability to drive change at the program-level as well as overall cross-sector collaboration.
- Limited coordination in DA oversight, leading to a lack of standardization across crisis program sites.
- No established system metrics and dashboard to measure outcomes within programs and across program sites. This makes it difficult to identify best practices within programs that might be standardized or replicated or used to inform policy at a state level.

Requirements of DAs regarding coordination as defined in the **DA provider agreement*** include:

- "The covered services will include all services that are required by the State to be available to children, youth, and families, in accordance with the State Medicaid Plan and Global Commitment to Health waiver, including…Service Planning and Coordination…"
- There is also a requirement for the DA to work with the Local Interagency Team (LIT) and the AHS Field Director in coordination of services.
- Requirement of DA to adhere to coordination services and protocols as described in the Mental Health Provider Manual, sections 3.8 Service Planning and Coordination, and 4.8 Collaboration and Integration with Other Providers.

**Example above is from the Howard Center Provider Agreement*

Requirements of DAs regarding coordination as defined in the **Mental Health Provider Manual** include:[47]

- Section 4.8, "Clear coordination between residential or inpatient staff and community providers, as well as with schools, health care providers, case workers, out of home providers, individuals and family members is essential for comprehensive care and is expected whenever releases allow."
- Section 4.8 - Other elements: lead service coordinator, release of information, joint comprehensive treatment plans, identification of or connection to a PCP, and coordination with varying levels of care, including transition support.

Future State Recommendations

Based on the information gathered and synthesized by HMA, we offer the following recommendations:

- <u>Integrate 988 within front end crisis response to ensure seamless experiences for individuals and promote effective community partnerships</u>

  On July 16, 2022, 988 will become the new three-digit telephone and text/chat number for the National Suicide Prevention Lifeline (NSPL) (1-800-273-TALK), increasing accessibility to mental health crisis services for more than 332 million Americans. This is an attempt to create a more centralized process for individuals experiencing mental health emergencies, and it has the potential to enhance access to more effective emergency response workers. It will be critical for all mobile crisis teams to have processes and protocols for coordination. VT's two 988 vendors will be Northwestern Counseling and Support Services (NCSS) and Northeast Kingdom Human Services (NKSHS).

- <u>Develop Crisis/EMS Partnerships to promote ED diversion and involvement of law enforcement at time of crisis</u>

  As mentioned above, there are several effective partnership models which couple EMS and mental health clinicians. The CAHOOTS model out of Eugene, OR pairs a crisis intervention worker who is skilled in counseling and de-escalation techniques, with a medic who is either an EMT or nurse. The team is trained to address both the emotional and physical needs of the patient while reducing the need for police and EMS involvement. Once the individual is assessed, CAHOOTS can transport patients to facilities such as the emergency department, crisis

[47] "Mental Health Provider Manual" Vermont Department of Mental Health, January 2019. Available at: https://mentalhealth.vermont.gov/sites/dmh/files/documents/Manuals/Mental_Health_Provider_Manual_v5.11.pdf.

center, detox center, or a shelter, free of charge. As of January 2021, the CAHOOTS team was responding to an average of 65 calls per day.[48]

- Partner with school districts and crisis providers to develop a program supporting education/awareness and to develop a school-based mobile crisis assessment

  The survey found that the most common barrier in connecting students with mobile crisis services is lack of parent/guardian permission. Parental education and engagement around emotional health and wellness is a complicated issue and can oftentimes include a complex interplay with linguistic and cultural factors. In addition, the mental health of children is often connected to their parents' mental health. Studies have found that 1 in 14 children has a caregiver with poor mental health.[49] Parental engagement strategies between schools, school districts, and crisis providers are needed at both the macro- and micro-level to both destigmatize mental health and substance use issues at a community level, and to engage parents in crisis and ongoing treatment planning.

- Develop a workgroup to examine within and across partner organizations to improve crisis planning and transitions of care

  Vermont currently benefits from broad governmental representation in and commitment to the mobile crisis grant planning process (Department of Vermont Health Access, Vermont Agency of Human Services, Vermont Department of Mental Health, Vermont Department of Health, Vermont Department of Children and Families, Vermont Department of Disabilities, Aging, and Independent Living, Howard Center, Washington County Mental Health Services). However, it seems 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 as well as overall cross-sector collaboration.

2.1 Featured Partnership: Interstate Collaboration:

National Environmental Scan

In rural areas, such as within much of Vermont, crisis system catchment areas often include multiple counties, depending on geography and population. Catchment areas often do not directly equate to specific counties or geographic areas and in communities that border on other states, people frequently "migrate" to those states. Vermont covers 9,250 square miles, with a 2020 estimated population of 643,077 people.[50] With a sizeable rural population including 417,515 people living in rural Vermont (USDA-ER), roughly 64% of the population residing in rural areas, there is significant health care "migration" of Vermonters who live near the borders of New York, Massachusetts, and New Hampshire. It is essential that the state, hospitals, crisis providers, and other human services providers work

[48] Ben Adam Climer and Brenton Gicker, "CAHOOTS: A Model for Prehospital Mental Health Crisis Intervention," Psychiatric Times, 38:1 (January 2021), https://www.psychiatrictimes.com/view/cahoots-model-prehospital-mental-health-crisis-intervention.

[49] Wolicki SB, Bitsko RH, Cree RA, et al. "Associations of mental health among parents and other primary caregivers with child health indicators: Analysis of caregivers, by sex—National Survey of Children's Health, 2016–2018," *Adversity and Resilience Science: Journal of Research and Practice*. Published online April 19, 2021, https://doi.org/10.1007/s42844-021-00037-7.

[50] "Vermont" Rural Health Information Hub, last modified March 23rd, 2021, Available at: https://www.ruralhealthinfo.org/states/vermont.

together to develop a comprehensive system of care that meets the needs of individuals who may travel across state lines to visit or seek care.

The American Rescue Plan (ARP) enacted on March 11, 2021, establishes a state option for mobile crisis, with specific training for mobile crisis in trauma-informed care, de-escalation strategies and harm-reduction.[51] The training requirements and other provisions offer an opportunity for states to collaborate that will maximize resources, co-develop materials and coordinate care for individuals when they cross state lines to ensure continuity of mobile crisis services.

One option for states includes collaborating around training and capacity building for MCTs include the use of interstate compacts. This provides a flexible, state structure for collaboration and process for consensus building among multiple states. Compacts are defined by the Council of State Governments as: *formal agreements between two or more states that bind them to the compacts' provisions, just as a contract binds two or more parties in a business deal. As such, compacts are subject to the principles of contract law and are protected by the constitution's prohibition against laws that impair contractual obligations. Compacts have the force and effect of statutory law and take precedence over conflicting state laws regardless of when those laws are enacted.*[52]

Developing interstate compacts is typically a state-driven process that is often developed by legislation. There are over 200 interstate compacts currently in place among states that are organized independently within a member-state agency. The National Center for Interstate Compacts (NCIC) has participated in the creation of many compacts that include all 50 states as members including:

- Interstate Compact for Adult Offender Supervision
- Interstate Compact for Juveniles
- Interstate Compact for the Placement of Children
- Emergency Management Assistance Compact
- Military Children's Interstate Compact

Interstate compacts allow states to collaborate when addressing problems that often span boundaries between states. These offer an opportunity for states to jointly problem solve, coordinate, and share in training and technical assistance. For example, the Interstate Commission for Juveniles offers an array of training and technical assistance to states that include webinars focused on legal issues, crossing state lines for juveniles and adolescents, on demand modules, training, and technical assistance.[53] There is also an interstate directory of contacts in each state for coordination and outreach.

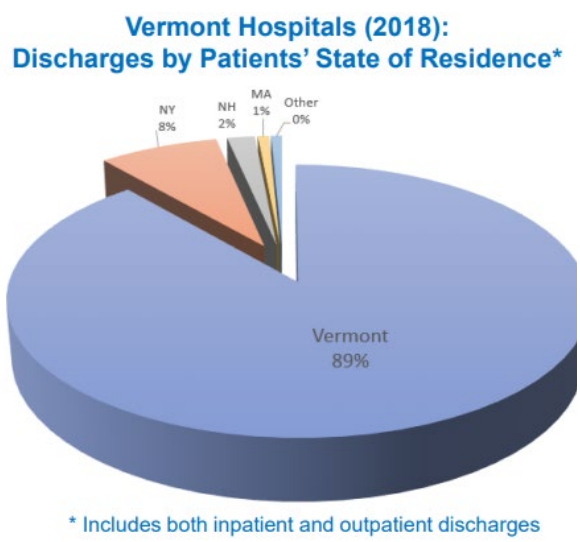
The Interstate Compact Coordinators Organization is an affiliate of the Legal Division of the National Association of State Mental Health Program Directors (NASMHPD). An additional opportunity for states includes SAMHSA's efforts in conducting regional convenings of states centered around mobile crisis resources, collaborations, and planning. If formalized, these interstate networks provide an opportunity for states to formalize collaborations and agreements to bolster MCT across states.

[51] Congress.gov. "H.R. 1319 – 117th Congress (2021-2022): American Rescue Plan Act of 2021." March 11th, 2021. https://www.congress.gov/bill/117th-congress/house-bill/1319/text#toc%20H155EAEF98A524898BC6F93FE5BB8CB2A.

[52] "Multistate Problem Solving with Interstate Compacts," National Center for Interstate Compacts: Council of State Governments, November 2021. Available at: https://compacts.csg.org/wp-content/uploads/2020/11/Compact-Resource-Guide-1-1.pdf.

[53] "Interstate Commission for Juveniles," Interstate Commission for Juveniles, accessed on June 14th, 2022. Available at: https://www.juvenilecompact.org/.

Figure 3



Vermont Findings

As discussed further below, Vermont reduces barriers to out-of-state care by designating certain border hospitals as Vermont Medicaid providers and paying these hospitals the same rates as in-state hospitals. In 2020, the Vermont Legislature reported that the University of Vermont Medical Center (VT) and Dartmouth Hitchcock (NH) account for a major part of in/out migration. A considerable number of Vermonters seek medical services through Dartmouth-Hitchcock Medical Center with estimates that the Medical Center served 40 percent of patients residing in Vermont (2020).[54] Dartmouth-Hitchcock has a long-standing partnership with Fletcher Allen Health Care at the University of Vermont that led to the formation OneCare Vermont.[55]

OneCare Vermont serves more than 250,000 beneficiaries covered by Medicare, Medicaid, or commercial insurance.[56] The University of Vermont Medical Center (VT) and Dartmouth Hitchcock (NH) account for a major part of in/out migration. In 2015, approximately 20 percent of UVMMC's business come from New York residents, and a considerable number of Vermonters seek medical services through Dartmouth-Hitchcock.[57]

Future State Recommendations

Based on the information gathered and synthesized by HMA we offer the following recommendations:

The cross-state health system migration underscores the need to coordinate care for people experiencing a mental health crisis. This includes exploring the development of **interstate compacts** to maximize coordination of training, resources and care for people experiencing a crisis who cross state lines. Interstate compacts are defined as agreements between two or more states that facilitate the ability for health care providers to practice in multiple states. This includes expediting the licensing process or credentialing to allow providers to practice under a single multistate license. Amidst COVID-19, many states adopted telehealth flexibilities allowing certain eligible providers the ability to practice if they were not licensed in the state. Vermont adopted rules allowing physicians (MD), physician assistants, and podiatrists the ability to practice during the emergency, "deemed" and "emergency".[58]

[54] "Dartmouth Hitchcock Medical Center and Clinics Facts and Figures," Dartmouth Health, Accessed on June 6th, 2022. Available at: https://www.dartmouth-hitchcock.org/about/facts-figures.
[55] "OneCare Vermont ACO Case Study: Community Care Coordination Program" Centers for Medicare and Medicaid, October 2020. Available at: https://www.onecarevt.org/wp-content/uploads/2021/01/ACO-CaseStudy-OneCareVermont_1_4_21.pdf.
[56] "OneCare Vermont ACO Case Study: Community Care Coordination Program" Centers for Medicare and Medicaid, October 2020.
[57] Nolan Langweil, "Vermont's Health Care System Overview: Payers and Players," Vermont Legislative Joint Fiscal Office, January 2021, Available at: https://ljfo.vermont.gov/assets/Publications/Presentations/c59334febc/GENERAL-352717-v1-Vermonts_Health_Care_System_-_2021_udpate.pdf.
[58] " U.S. States and Territories Modifying Requirements for Telehealth in Response to COVID-19," Federation for State Medical Boards, May 31, 2022. Available at: https://www.fsmb.org/siteassets/advocacy/pdf/states-waiving-licensure-requirements-for-telehealth-in-response-to-covid-19.pdf.

Developing these types of interstate compacts among neighboring states can offer the opportunity to ensure that people experiencing a mental health crisis receive the appropriate services and follow up care. Vermont may consider developing an interstate compact with neighboring states and designated staff. The State can review neighboring states' existing crisis systems strategic plans and delivery systems to examine potential collaborations. With Vermont's significant rural geography, DAs often provide mobile crisis services to clients living in geographic areas several hours away from care team members. The ability to use telehealth and other technologies to support the provision of services will be a critical component for Vermont.

Vermont may look to partner with states that have robust mobile crisis training. For example, Massachusetts' Executive Office of Health and Human Services (EOHHS) issued a Request for Response (RFR) in February 2022 for a training and technical assistance provider with expertise in mobile crises. This RFR seeks a qualified bidder who must provide targeted training for mobile crisis intervention clinicians to increase knowledge and enhance skills in high-quality evidence-based crisis intervention. This training will enhance the skills for crisis teams in evidence-based practices to support the rollout of Community Behavioral Health Center's crisis capacity. MA is examining opportunities to work with other neighboring states. Vermont may consider working in partnership with MA to explore agreements in which they could contribute funding to the vendor that would allow Vermont's MCTs to participate in training and other resource sharing. An additional option includes partnering with states that are developing Mobile Crisis Team certification process and training such as Alabama. This interstate collaboration could include developing MOUs for sharing of resources, training, and other agreements to maximize funding and best practices.

3. Mobile Crisis Team Composition

National Environmental Scan

Nationally, there is more demand for behavioral health (mental health and substance use) treatment than workforce capacity to deliver services. The United States' behavioral healthcare system is facing a workforce crisis. A survey of mental health and substance use provider organizations and healthcare management entities showed that 68 percent reported experiencing workforce shortages due to the pandemic, and 97 percent reported difficulty recruiting employees.[59]

CMS requirements – States must ensure that services are delivered by a **multi-disciplinary team** that:

- Includes at least **one behavioral healthcare professional (BHP)** who is qualified to provide an assessment within their authorized scope of practice under state law and should also include **other professionals or paraprofessionals** with expertise in behavioral health or mental health crisis intervention.
- CMS further noted that "the licensed behavioral health professional may be linked via telehealth to other team members onsite".
- States have latitude to determine the composition of their multi-disciplinary teams.
    - Multidisciplinary teams can be built with psychiatrists, nurses, medical doctors, social workers, behavioral health technicians, and peer support specialists. Additionally, states

[59] National Council for Mental Wellbeing, "Impact of COVID-19 on Behavioral Health Workforce," thenationalcouncil.org, September 2021. Available at: https://www.thenationalcouncil.org/wp-content/uploads/2022/04/NCMW-Member-Survey-Analysis-September-2021_update.pdf.

should establish mechanisms to ensure language accessibility to provide culturally appropriate care.

Currently, states vary in the way in which they define behavioral healthcare professionals. Some states require independent licensure whereas others allow license eligible individuals to conduct the assessment under the supervision of an independently license practitioner.

Significant role for peer and family support services

SAMHSA deems incorporation of peers within the mobile crisis team as a best practice.
CMS also recognizes the value of peer integration, noting that best practices include incorporating trained peers who have lived experience in recovery from mental illness and/or substance use and formal training within the mobile crisis team. The peer's role is to strengthen the engagement with the person experiencing the crisis by sharing his or her experiences and building rapport. The peer may also engage with family members or others who are important to the person experiencing the crisis. Many states include peer roles as part of their multidisciplinary mobile crisis teams to provide 24/7 rapid response to persons in crisis, including screening and assessment, stabilization and de-escalation, and coordination and referrals. [60] Qualified behavioral health professionals (which are defined by State Standards) play a vital role in screening and assessment. Given mental and physical health provider shortages, many states have revisited their state standards and/or implemented strategies to use peer support specialists alongside other professionals and telehealth to meet the needs of individuals in crisis. For example, Colorado allows a peer specialist and a bachelor's-level clinician to work together on site to address a crisis, with a licensed professional accessible via telehealth. [61]

SAMHSA released *National Guidelines for Behavioral Health Crisis Care – A Best Practice Toolkit*, which further describes the minimum expectations to operate mobile crisis team services and outlined the Minimum Expectations to Operate a Mobile Crisis Team Services as including a licensed and/or credentialed clinician capable to assessing the needs of individuals within the region of operation. [62]

Peer support specialists are also integral team members. Peer support specialists are individuals with lived experience of mental illness and/or substance use who receive professional training to "assist others in their recovery journeys." [63] Peer support specialists help to "model recovery, teach skills, and offer supports to help people experiencing mental health challenges lead meaningful lives in the community." [64] The core of the peer service philosophy and practice is that people with psychiatric difficulties can and do recover and live meaningful lives, and peers can help one another with the recovery process in ways that professionals cannot. [65] SAMHSA Guidelines further notes that, "for community-based mobile crisis programs, incorporating peers can add complementary qualifications to the team so that individuals in crisis are more likely to see someone they can relate to while they are receiving services. Peers should not reduplicate the role of BHPs but instead should establish rapport,

[60] Substance Abuse and Mental Health Services Administration (SAMHSA), "National Guidelines for Behavioral Health Crisis Care – A Best Practice Toolkit Knowledge Informing Transformation," SAMHSA.gov, 2020.
[61] "ASPE Issue Brief, Crisis Services and the Behavioral Health Workforce," HHS Office of the Assistant Secretary for Planning and Evaluation, March 2021. Available at: https://aspe.hhs.gov/sites/default/files/private/aspe-files/265416/bhcrisisservib.pdf.
[62] Substance Abuse and Mental Health Services Administration (SAMHSA), "National Guidelines for Behavioral Health Crisis Care – A Best Practice Toolkit Knowledge Informing Transformation," SAMHSA.gov, 2020.
[63] "Evidence for Peer Support," Mental Health America, May 2019. Available at: https://www.mhanational.org/sites/default/files/Evidence%20for%20Peer%20Support%20May%202019.pdf.
[64] IBID.
[65] "Core Competencies for Peer Workers in Behavioral Health Services," *BRSS-TACS*, Substance Use and Mental Health Services Administration, Last Updated December 7th, 2015. Available at: https://www.samhsa.gov/sites/default/files/programs_campaigns/brss_tacs/core-competencies_508_12_13_18.pdf.

share experiences, and strengthen engagement with the individual experiencing crisis. They may also engage with the family members of (or other persons significant to) those in crisis to educate them about self-care and ways to provide support."[66]

SAMHSA also notes other benefits of peers as critical team members:

- Increased assurance of trauma-informed environment, and recovery approaches
- Demonstrated evidence that people with disabilities can recover from crises and hope for their future
- Better outcomes including:
    a. Reduction in hospitalization
    b. Reduction in emergency department usage for mental health/substance use
    c. Lower recidivism rate (3.3 percent in Crisis Residential as compared to 15 percent hospital recidivism)[67]

Vermont Findings

AHS defines **Qualified Mental Health Professionals** (QMHP's) as a "person with professional training, experience and demonstrated competence in the treatment of mental illness, who shall be a physician, psychologist, social worker, mental health counselor, nurse or other qualified person designated by the commissioner."[68]

Qualifications for a QMHP are:[69]

1. **Master's degree in human services field (licensure preferred) and**:
    a. Clinical exposure to populations with major mental illness, and
    b. One to two years of experience in providing services for people with at least two of the following: mental illness, substance abuse, or serious emotional disorders; and
    c. Appropriate experience and training in crisis evaluation and intervention as determined by the DA Emergency Services Director or designee, or DOC designee.

OR

2. **Bachelor's degree in related human services field and**:
    a. Clinical exposure to populations with major mental illness, and
    b. Two to three years of experience providing services for people with at least two of the following: mental illness, substance abuse, or serious emotional disorders, and
    c. Appropriate experience and training in crisis evaluation and intervention as determined by the DA Emergency Services Director or designee, or DOC designee.

OR

3. **Bachelor's degree in a field unrelated to human services and**:
    a. Clinical exposure to populations with major mental illness, and
    b. Three to five years of experience providing services for people with at least two of the following: mental illness, substance abuse, or serious emotional disorders, and

[66] Substance Abuse and Mental Health Services Administration (SAMHSA), "National Guidelines for Behavioral Health Crisis Care – A Best Practice Toolkit Knowledge Informing Transformation,"SAMHSA.gov, 2020.
[67] Jim Hajny et al., "Peers as Crisis Service Providers," National Coalition for Mental Health Recovery, June 2015. Available at: https://www.nasmhpd.org/sites/default/files/Peers%20as%20Crisis%20Service%20Providers_SAMSHA_6.10.15.pdf.
[68] Vermont Agency of Human Services Department of Mental Health, " Qualified Mental Health Professional Manual and Standards," mentalhealth.vermont.gov, 2017. Available at: https://mentalhealth.vermont.gov/sites/mhnew/files/documents/Manuals/QMHP_Standards2017_FINAL_041717.pdf.
[69] IBID.

c. Appropriate experience and training in crisis evaluation and intervention as determined by the DA Emergency Services Director or designee, or DOC designee.

OR

4. **Alternative qualification**: If an applicant does not meet the qualifications but meets other criteria and has experience in providing crisis services to severely mentally ill individuals, an application may be submitted for designation consideration. The application should include information that explains the reason(s) for the exception.

A survey of the designated agencies revealed that emergency services teams employ twice as many master's-level (licensed and unlicensed) staff than bachelor's-level staff. Further, **difficulty identifying, hiring and retaining qualified and experienced staff** emerged as a top response to current gaps or challenges reported by DAs.

Peer Support

In Vermont, the use of peers is not currently required of emergency services teams, however some DAs have recently included peers as team members for crisis services. The Mobile Response and Stabilization Services (MRSS) pilot at Rutland Mental Health Services includes a Family Peer Services Worker as core staff. There was consistent feedback from focus groups on the vision for enhanced community-based mobile crisis services including the use of peers for crisis services.

Pending legislation (H. 740) describes future peer workforce requirements for mobile crisis teams. "*The Department of Mental Health shall build an urgent care model for mental health by expanding mobile outreach services. … The new mobile outreach service shall be based on evidence-based and trauma-informed practices, including using peer support staff".* [70]

Several stakeholders, including individuals with lived experience, were interviewed regarding collaboration with persons with lived experience and the use of peer services within Vermont. Findings from those interviews revealed the following:

- The current use of peer support services is limited to a small amount of grant funding and needs to be expanded.
- The use of peers for mobile crisis response can help ensure empathetic responses to those experiencing a crisis while also addressing the workforce shortage that all communities are experiencing.
- If the Vermont peer certification does not move forward in legislation, the state should ensure that peers are used within mobile crisis services and set the criteria for peers to participate.

Finally, qualitative responses to the statewide survey were analyzed and a common theme to the question about what services are currently missing from the crisis continuum included peer services.

Future State Recommendations

Based on the information gathered and synthesized by HMA, we offer the following recommendations:

- A multidisciplinary team should be expected for mobile crisis team staffing in alignment with best practices and CMS guidance. The use of telehealth should be promoted to assist with staffing and capacity issues.

[70] H.740 Senate Proposal of Amendment to Bill– Fiscal Year 2023 Appropriations Act, 2022. Available at: https://ljfo.vermont.gov/assets/Uploads/f077ba6916/GENERAL-362428-v1-H_740_-_2022_-_Senate_proposal_of_amendment_-_making_appropriations_for_the_support_of_government.pdf.

- While Vermont's definition of behavioral health professional includes both master's-level and bachelor's-level staff which allows for a larger pool of eligible staff, ongoing workforce development challenges may impede ramp up efforts of MCTs to provide 24/7 community-based mobile crisis services. Development of robust trainings for bachelor's level staff can be a vehicle for VT to promote this BA level crisis workforce.
- Peer supports should be required staffing for MCTs. Further, peer supports for family members/caregivers should be included in crisis services for youth. Vermont's recent legislation requiring peers be included in mobile crisis team staffing will advance the efforts to improve workforce development that is necessary for 24/7, two-person response teams.

4. Mobile Crisis Team Training

National Environmental Scan

SAMHSA Guidance

While members of the crisis services delivery team may be licensed mental health and substance use professionals operating within the scope of their license and must be compliant with training requirements of state licensing boards, SAMHSA guidance recommends that these practitioners strengthen their skills and knowledge through ongoing CEU and CME professional advancement opportunities focused on improving team members' ability to deliver crisis care.[71]

Verification of skills and knowledge of non-professional staff is essential to maintaining service delivery standards within a crisis program, always including the incorporation of ongoing supervision with licensed professionals available on site. Supervision and the verification of skills and knowledge shall include, but is not limited to, active engagement strategies, trauma-informed care, addressing recovery needs, suicide-safer care, community resources, psychiatric advance directives, and role-specific tasks.[72]

Training crisis team members must include training on the *National Guidelines for Behavioral Health Care Best Practice Toolkit*, with a strong emphasis on the essential structural elements of a crisis system and crisis care principles and practices such as: addressing recovery needs, the role of peers, trauma-informed care, suicide safer care, safety/security for staff and consumers, and crisis response partnerships with law enforcement.[73]

CMS Requirements

All MCT member training must include de-escalation, trauma-informed care, and harm reduction techniques. To further support harm reduction techniques, CMS advises that MCT teams be equipped with, and trained in, the use of naloxone and harm reduction supplies such as fentanyl strips and suboxone.

The recent CMS Guidance on the Scope of and Payments for Qualifying Community-Based Mobile Crisis Intervention Services includes criteria for licensed behavioral health practitioners and unlicensed individuals with training and experience in behavioral health care who are under the supervision of licensed practitioners. The guidance also specifies formal training within the mobile crisis team that includes responding without law enforcement accompaniment to support justice system diversion;

[71] Substance Abuse and Mental Health Services Administration (SAMHSA), "National Guidelines for Behavioral Health Crisis Care – A Best Practice Toolkit Knowledge Informing Transformation," SAMHSA.gov, 2020.
[72] IBID.
[73] IBID.

implementing technologies to track teams; and scheduling outpatient follow-up appointments and services. CMS is also requiring states to establish and ensure training and timeliness standards.

National Council Guidance

The National Council states that mobile crisis teams should have training in basic engagement, assessment, and intervention.[74] If staff have extensive clinical experience delivering care in other settings, they may need additional training to adapt their skills for crisis services.[75]

Crisis teams must be prepared to address the unique challenges of the five phases of crisis intervention continuum that spans across: (1) prevention (pre crisis); (2) early intervention (early crisis); (3) acute intervention; (4) crisis treatment; and (5) recovery and reintegration. Since crisis teams are composed of interdisciplinary team members there will be some foundational training and then specialized training for members with specific licensing/credentialing. The team would include behavioral health providers, peers, community health workers, crisis clinicians and other staff such as psychiatric care providers (NPs), MDs or physician assistants (PAs) ensuring all staff are trained in foundational competencies that may include confidentiality, laws, consent, effective outreach and engagement, collateral contacts, revisiting denials, safety planning/ ensuring safe transition plans, utilizing strengths-based approaches, family and social supports/ eco mapping, person-centered treatment planning.[76]

The National Council recommends providing trauma-informed care training into each team member's new employee orientation with refreshers delivered as needed. This includes utilizing standardized assessment tools that evaluate the level of trauma experienced by the individuals served by the crisis program to create action steps based on those assessments.

Mobile crisis teams are the first line staff working with people experiencing mental health crises to provide immediate care, alleviate pressure on the health care system and to potentially divert people from the criminal justice system and emergency departments to more appropriate care. While crisis services have evolved over the past several decades to provide more person-centered, culturally appropriate care for individuals, it is essential to implement trainings that meet the needs of people with complex medical, mental health and social needs. This includes ensuring there is access to specialty assistance as outlined by the National Council Roadmap to the Ideal Crisis System including the following populations of people with unique needs:[77]

- Children and adolescents
- Older adults
- Individuals with Developmental Disabilities (IDD) and Brain Injury (BI)
- Cultural and linguistic minorities, immigrants/refugees
- Individuals receiving or in need of Medication Assisted Treatment (MAT) for opioid use disorder (OUD)
- Individuals with eating disorders
- The forensic population

[74] Committee on Psychiatry and the Community for the Group for the Advancement of Psychiatry, "ROADMAP TO THE IDEAL CRISIS SYSTEM: Essential Elements, Measurable Standards and Best Practices for Behavioral Health Crisis Response," National Council for Mental Wellbeing, March 2021. Available at: https://www.thenationalcouncil.org/wp-content/uploads/2022/02/042721_GAP_CrisisReport.pdf.
[75] IBID.
[76] IBID.
[77] IBID.

Vermont Findings

Harm Reduction Training

To support harm reduction techniques, CMS advises that mobile crisis teams be equipped with naloxone and harm reduction supplies such as fentanyl strips and suboxone. According to the Designated Agency (DA) responses to the stakeholder survey, only one of the six respondent DAs indicated that all staff responding to crisis calls are trained to administer Naloxone/Narcan. Three of the six respondent DAs indicated that some of the staff responding to crisis calls are trained. One respondent DA indicated no staff are trained and one respondent DA indicated all organizational staff are trained to administer Naloxone/Narcan.

Furthermore, only one of five respondent DAs indicated that all staff responding to crisis calls are equipped with Naloxone/Narcan. Two of the DA respondents indicated some of the staff responding to crisis calls are equipped Naloxone/Narcan.

Clinical Training & Training Needs to Fully Support Crisis Response Staff

In accordance with Vermont's Emergency Services Standards, DAs are required to provide all staff with clinical training on an annual basis, and clinical staff must have specific expertise in developmental disabilities and child/adolescent services.[78] DAs also provide a range of training for mobile teams that vary across agencies.

Below is a summary of the types of crisis-related trainings currently being provided by the Designated Agencies according to the statewide survey responses.

Table 3. Survey Results (Current Crisis Related Trainings Being Provided to DA staff)

Current crisis related trainings being provided to DA staff (9 Designated Agencies (DA) Responded)		
Training Topics	**Percent of DAs**	**Number of DAs**
Engagement strategies	67%	6
Use of crisis plans and advanced directives	67%	6
Screening & Assessment	100%	9
Suicide Prevention	89%	8
Intervention	78%	7
Stabilization & De-escalation	67%	6
Harm Reduction	78%	7
Evidence-based practices	89%	8
Trauma-informed care	100%	9
Coordination & Referral	56%	5
Family dynamics, parenting support and behavior management	33%	3
Language accessibility & Cultural competency	78%	7
Training related to serving special populations	56%	5
Use of technology to support mobile teams	67%	6
Worker safety and self-care	100%	9

[78] "Designated Agency Emergency Services Standards," Vermont Department of Mental Health, 2017. Available at: https://mentalhealth.vermont.gov/sites/mhnew/files/documents/Manuals/Emergency_Services_Standards_2017-12.pdf.

Other	11%	1

Of the four DAs that provided additional information on the trainings related to special populations:

- Four are providing training related to children and adolescents, and
- Three are providing training related to individuals with developmental disabilities and brain injury.

The table below indicates areas of training, as identified by eight DAs, to fully support staff who are delivering crisis services.

Table 4. Survey Results (Types of Trainings Needed to Fully Support Staff who are Delivering Crisis Services)

Types of trainings needed to fully support DA staff who are delivering crisis services (8 DAs Responded)		
Training Topic(s)	**Percent of DAs**	**Number Of DAs**
Engagement strategies	63%	5
Use of crisis plans and advanced directives	50%	4
Screening & Assessment	63%	5
Suicide Prevention	38%	3
Intervention	75%	6
Stabilization & De-escalation	75%	6
Harm Reduction	50%	4
Evidence-based practices	75%	6
Trauma-informed care	63%	5
Coordination & Referral	38%	3
Family dynamics, parenting support and behavior management	63%	5
Language accessibility & Cultural competency	75%	6
Training related to serving special populations	63%	5
Use of technology to support mobile teams	50%	4
Worker Safety and Self Care	63%	5
Substance Use Disorder	75%	6
Other	25%	2

Of the four DAs that provided additional information on the trainings needed related to special populations:

- All four indicated the need for trainings related to serving: children and adolescents; older adults; individuals with developmental disabilities and brain injury; and LGBTQAI2+ individuals, and
- Four indicated the need for trainings related to serving: cultural and linguistic minorities, immigrants/refugees; individuals who are receiving Medication Assisted Treatment (MAT) for opioid use disorder (OUD); people with eating disorders; and the forensic population.

It was also noted in the stakeholder survey that representation, lack of trained staff, and cultural competence were listed more often in the BIPOC, tribal and LGBTQAI2+ populations as a gap or barrier to care.

Practitioner types most in need of additional training to deliver crisis services

According to stakeholder survey responses, the DAs have identified bachelor's-level practitioners and peer support specialists as the practitioner types most in need of additional training to deliver crisis services.

Barriers to training

The DAs most often cited the cost of training as well as the cost associated with replacing staff time as the challenges in accessing training. The highest cited barrier to being able to participate in training was that the time was not convenient. Other challenges and barriers noted included staffing shortages, cost, and the lack of capacity for supervisors with expertise to develop trainings given they are being called upon to fill gaps in direct service provision.

Preferred Training Modalities

Of the nine DAs who responded to the stakeholder survey questions related to how they are providing trainings, all indicated that they provide training through a combination of face-to-face, virtual or otherwise use a hybrid model. For future trainings, most are interested in face-to-face trainings and hybrid models. All nine indicated that they use internal staff along with local or other Vermont organizations to provide training. Five indicated they also use National training providers and one indicated that they also use other states.

Current Training Platforms

Vermont Health Learn

Vermont Health Learn delivers education and virtual events using a statewide e-learning platform. Access is available at any time through Firefox, Chrome, Safari or Edge. Courses using this platform are developed by OneCare Vermont, Vermont Department of Health, Vermont AHS, and Blueprint for Health.

D2L/Brightspace is the parent company and hosts the platform. D2L/Brightspace built the platform, however State administrators can modify the platform as needed. Uploading materials and handling the accounts are all done at the state level as well as all modifications to the site. The State can populate all the content and make it visible when ready to share a particular training. OneCare, Department of Health and DVHA each has a person who can get technical support related to the platform through the current contract.

Currently, trainees must set up an account to access courses. Accounts are approved by the state (Blueprint & ADAP). In the future, accounts could be open to the public and made available based on specific training needs, requirements, or topic. In addition, there is the ability to perform bulk enrollment of groups of individuals. The current contract is limited to 500 accounts but could be expanding to meet additional need.

The platform has the capacity to do live training, but all trainings are currently pre-recorded and offered on-demand. The platform can link to other platforms, existing trainings and resources that are available publicly, such as YouTube videos, live links, and other materials/formats. It is also very user-friendly for administrators to add new units, modules, or content.

The platform can guide people to their appropriate modules and through the various trainings they are required to complete in the correct sequence. The data hub within the platform tracks information such as awards/CEUs, content progress by person, and enrollments/withdrawals from courses among other measures.

State administrators have indicated that the platform is very easy to use and has the capacity to house significant amounts of content and data. In addition, post-training webinar surveys have indicated that users have had no issues with the platform. The only challenge identified by the state administrators is related to the current CEU process. Given the platform was originally designed for the education system, not the healthcare system, the state has had to develop a workaround to assure that the CEU process works as it should for healthcare practitioners. The system does not currently allow the state to select who the CEU is offered to. If CEUs are not needed for a course, the system does not require a modification or workaround to issue a certificate of completion.

Vermont Cooperative for Practice Improvement & Innovation

The Vermont Cooperative for Practice Improvement & Innovation (VCPI) is a statewide membership cooperative, representing mental health and substance abuse providers, state agencies, hospitals, professional associations, peers, families and more working to support practice improvement and workforce development in the Vermont system of care. VCPI plans, coordinates, and hosts a variety of training events: workshops, seminars, conferences, and other unique learning activities (online and in-person). In addition, VCPI also facilitates the sharing of resources, expertise, materials, and workforce development activities across the members, both online and in person.

VCPI uses Northern Vermont University's (NVU) learning management system, Canvas, to create and deliver course content. Canvas is the web-based learning management system utilized by institutions within the Vermont State Colleges System. Canvas enables students to access their courses anywhere there is an internet connection. To effectively utilize the platform, users need a computer that meets at least NVU's online minimum technical requirements.

DMH has an existing agreement with VCPI to provide trainings and to host a learning collaborative. In addition, VCPI assists with identifying subject matter experts to build training material content. Zoom technology is currently being used to host webinars and stakeholder meetings. The platform can provide CEUs, issue certificates, track attendance and completion of trainings, and evaluate events.

The technology can support both public access to trainings and related materials as well as secure access through its learning management system. Through the learning management system, private sections can be created with specific training materials relevant to specific entities and/or provider types. Some of the Designated Agencies currently have a membership in VCPI. There are also individuals who are members. State officials have indicated that entities are familiar with VCPI and have had positive experiences with using the cooperative for training.

Future State Recommendations

Based on the information gathered and synthesized by HMA, we offer the following recommendations:

- Promote the use of national tools
  - SAMHSA offers free online training materials for practitioners that are relevant to the core competencies for crisis teams.[79] For instance, SAMHSA's Disaster Technical Assistance Center offers Creating Safe Scenes, an online course that "helps first responders assist

[79] "Practitioner Training," SAMHSA, Accessed June 7th, 2022. Available at: https://www.samhsa.gov/practitioner-training.

individuals in crisis with mental illness or substance use using safe, positive approaches. It helps first responders understand more about mental health, mental illness, and substance use so they can better assess risks and apply the safest strategies for taking care of themselves and the individuals they are called to serve."[80]

- The National Council for Mental Wellbeing provides a toolkit for behavioral health provider organizations to develop and implement a trauma-informed, resilience-oriented staff training plan for screening and assessments.[81]
- The Crisis Prevention Institute offers programs for certification on nonviolent crisis intervention and verbal intervention including training on disengagement safety techniques, trauma-informed care, de-escalation, and risk assessment.[82]
- The National Center for START Services Mental Health Aspects of Intellectual/Developmental Disabilities (MHIDD) also offers training courses for mobile crisis responders to provide effective crisis supports to individuals with I/DD and MH needs. The organization is based in New Hampshire and partners with several state agencies to provide technical support and training, including the neighboring state Maine.[83]
- The Massachusetts Behavioral Health Partnership (MBHP) Emergency Services Program/Mobile Crisis Intervention (ESP/MCI) also offers free trainings for emergency services providers as it relates to clinical quality.[84]

- Implement trainings that may be adopted and adapted across specialized populations to improve access and facilitate culturally competent care to underserved populations
  - Develop standardized training and clinical supervision to ensure that those providing crisis services meet core clinical competencies in serving special populations such as those with intellectual and developmental disabilities, culturally and linguistically diverse populations, refugees, immigrants, older adults, veterans, homeless individuals and LGBTQIA2+ identifying individuals.
  - Trainings that may be adopted and adapted across specialized populations could include utilizing biopsychosocial assessments, adopting evidence-based screening tools to assess age specific needs, health and co-occurring needs, cultural/religious considerations, literacy and communication abilities and preferences. In addition, training focused on adverse childhood experiences (ACEs), trauma-informed care, structural and systemic racism, and ways to address cultural differences that includes addressing and mitigating issues of stigma, religion, coping styles and mistrust of the health care system, and family dynamics. Focusing on trainings that address issues LGBTQIA2+ identifying individuals face including legal issues, the "coming out" process as it relates to mental health, how to make a provider organization more LGBTQIA2+-welcoming and specific clinical guidance for addressing the needs of each of the LGBTQIA2+ population.

[80] "Creating Safe Scenes Training Course," SAMHSA, Last Modified April 26th, 2022. Available at: https://www.samhsa.gov/dtac/creating-safe-scenes-training-course.
[81] "Trauma-Informed Care Screening and Assessment," National Council for Mental Wellbeing, Accessed on June 7th, 2022. Available at: https://www.thenationalcouncil.org/program/trauma-informed-care-screening-and-assessment/.
[82] "CPI Training Programs," Crisis Prevention Institute, Accessed on June 7th, 2022. Available at: https://www.crisisprevention.com/Our-Programs.
[83] "Course for Mobile Crisis Responders," Mental Health Aspects of Intellectual/Developmental Disabilities Professional Development Series, National Center for START Services, Accessed on June 7th, 2022. Available at: https://centerforstartservices.org/MHIDD-Mobile-Crisis-Response-Course.
[84] "Emergency Services Program Mobile Crisis Intervention," Massachusetts Behavioral Health Partnership, Accessed June 7th, 2022. Available at: https://www.masspartnership.com/provider/ESP.aspx.

- With a growing number of children in Vermont needing psychiatric emergency care, crisis teams should have staff members onboard who have expertise in caring for younger children and adolescents. This includes having the knowledge and experience working with youth-serving community organizations, engaging families, and available funding to care for the financial, clinical, and social needs of clients. Crisis teams should also develop robust partnerships with community partners, schools, and community-based organizations.
- Mobile teams may want to also consider specialty trainings to ensure competencies for individuals who identify as lesbian, gay, bisexual, transgender, queer, asexual, intersex, and non-binary individuals (LGBTQIA2+).
- Vermont also has a significant aging population with 20 percent of population over the age of 65.[85] Older adults often have more complex mental health and physical health needs and increased rates of substance use requiring care coordination with multiple providers and specialists. This would require additional training focused on: identifying co-morbidities and substance abuse/misuse, medication adherence, warning signs of abuse and neglect, among others. As crisis teams build their network, they should ensure they have formal referral agreements with Area Agencies on Aging (AAAs) and other providers with special expertise. Leveraging the AAAs and their network of training and resources will assist the mobile teams with ensuring holistic care for this population. Additional sources include the AARP caregiving resources called Home Alone Alliance that includes training, videos, and other support resources.[86]
- In addition, teams should be trained on how to connect individuals to services and supports who have co-occurring needs such as mental health/substance use, behavioral health/intellectual and developmental disabilities (BH/IDD), behavioral health/physical health (BH/PH) and complex unmet social needs. The MCT members should be proficient in connecting individuals to the appropriate level of care across the continuum of care. For individuals that use substances, the team should be trained in how to connect people to sobering or stabilization centers or withdrawal management (detox) programs and longer-term treatment options across the substance use continuum such as Intensive Outpatient (IOP) or outpatient services.

- Develop robust trainings for mobile response team staff with bachelor's degree level training
  - Development of robust trainings for bachelor's level staff can be a strategy to improve and expand workforce capacity.
- Enhance Peer Support Training
  - In addition to many of the core competencies described in this section, additional trainings for peers may include: the roles and responsibilities of the peer on the mobile crisis team, scope and supervision requirements, and compassion fatigue and self-care trainings.
- Require harm reduction training
  - As indicated above in the Vermont findings related to harm reduction, there is a lack of consistency across DAs in training crisis response staff to administer Naloxone/Narcan as well as requiring emergency services staff to be equipped with Naloxone/Narcan when responding to crisis call. The ability to administer Naloxone/Narcan should be a core competency of all staff responding to crisis situations.

[85] U.S. Census Bureau, Vermont QuickFacts, July 2021, Available at: https://www.census.gov/quickfacts/VT.
[86] "Home Alone Alliance," AARP Public Policy Institute/Initiatives, Accessed June 7th, 2022. Available at: https://www.aarp.org/ppi/initiatives/home-alone-alliance/.

- Train providers on the use of standardized and validated screening and assessment tools
  - Each MCT must have at least one behavioral health care professional qualified under state law to provide assessment within their authorized scope of practice. Trainings for these professionals should ensure that assessments are provided in accordance with applicable federal and state rules and regulations.
  - Only six of the 10 DAs indicated in the stakeholder survey that they use a standardized assessment tool. MCT members should be trained on standardized and validated screening tools, identification of needs, how to recognize signs, symptoms and warning signs for individuals who may experience a crisis. This also includes screening and assessing for specific ethnic, cultural and linguistic needs in alignment with CLAS (culturally and linguistically appropriate services) standards, individuals with disabilities, people who use American Sign Language (ASL), among others. Additional skills include a focus on trauma-informed care, triage screening, risk assessments and interventions using standards such as the National Suicide Prevention Lifeline guidelines/ Suicide Safer Care Plan.[87] This may also include standardizing assessments, signs and symptoms of decompensation, and screening for unmet social needs.
  - MCTs should also be trained on the use of validated co-occurring assessments such as the American Society of Addiction Medicine (ASAM) criteria to help determine and match the individual to the appropriate level of care, and services that meet their needs.
  - The MCT should be trained in skills that allow them to effectively stabilize the person and de-escalate the crisis so that a higher level of care is not needed. The team should be trained in supportive counseling, emergent interventions and interventions to avoid the need for a higher level of care. When serving children and youth, teams should be trained on de-escalation strategies and interventions that are developmentally appropriate and build resiliency.
  - Community-based mobile crisis intervention team members may need to initiate safety planning interventions, make follow-up referrals and engage in other coordination activities relating to the crisis both on scene and shortly following the crisis intervention with other community providers, including recovery centers as described above. In addition, mobile crisis teams may follow up with people to determine if services for which referrals were made were provided in a timely way and were meeting their needs. The team should be trained and skilled in crisis resolution planning, creation of crisis plans or a Wellness Recovery Action Plan (WRAP), the use of crisis safety planning tools, relationship building with community providers, and knowledge of community resources and how to access them. Team members should receive training that gives them the skills and ability to connect people to existing resources such as community mental health centers, federally qualified health centers (FQHCs), primary care, mental health providers, assertive community teams (ACT), school-based supports, other home-based services and supports.

- Strengthen family and collateral engagement training
  During focus group discussions, one of themes was the need for mobile crisis workers to be better trained in how to engage and work with families. Mobile crisis staff should receive training and be proficient in engagement strategies, inclusive of trauma-informed care, recovery principals, communication strategies such as active listening, motivational interviewing and

[87] "National Suicide Prevention Lifeline (NSPL) Suicide Risk Assessment Standards," Link2Health Solutions, Inc., Revised as of April 17th, 2007. Available at: https://suicidepreventionlifeline.org/wp-content/uploads/2016/08/Suicide-Risk-Assessment-Standards-1.pdf.

other strategies that support trust-building with the person experiencing the crisis. The team should also be able to effectively share information and engage family members and significant others. Training may include a focus on the importance of family and collateral involvement and how to share information and the necessary permissions needed when communicating with people other than the person experiencing the crisis. Additionally, given the distrust that may exist among subpopulations, training on engagement specific to historically underserved populations, including refugees, immigrants, and communities of color is also critical.

- Coordinate and leverage existing platforms to provide training to mobile crisis providers
  Vermont currently has existing training platforms that providers are accessing in varying and somewhat limited ways. Various state entities already have established relationships as administrators or partners with the vendors who have developed the platforms. In addition, content is developed in conjunction with these state entities. The platforms are easily configurable to include a variety of training content, including videos to be accessed on-demand, live training capabilities, as well as linkage to other platforms, resources, and materials in a variety of formats. This approach also allows the State to easily take advantage of trainings that are already available nationally.

- Maintain the use of multiple training modalities & formats
  Based on stakeholder survey results and the potential for leveraging the State's current training platforms, it is recommended that Vermont continue to provide training in multiple formats using a combination of modalities to meet the needs of providers. This approach complements the recommendations to coordinate and leverage existing training platforms and promoting the use of national tools.

B. Infrastructure Supporting Crisis System Sustainability

This section describes the core components and best practices for maintaining a Mobile Crisis System in collaboration and coordination with key system partners with a continuing focus on increasing health equity across the population.

1. Mobile Crisis Network Capacity Planning and Monitoring

National Environmental Scan

As states are enhancing crisis response services and expanding mobile crisis in response to the availability of enhanced Federal Medical Assistance Percentage (FMAP), states are looking to identify more sophisticated approaches to determine how to estimate the capacity needs for mobile crisis response and to ensure the predicted capacity for available mobile response meets the performance thresholds such as response times. As such, some are looking to **Workforce Management Tools** for determining call center staffing. One example of a tool used for call centers is a product called NICE which supports call centers in ensuring that the optimal number of call takers and with the right set of skills, are staffed at the right time.[88] Numbers that are used to calculate the correct number of staff needed at

> ***Workforce Management Tools***
>
> *Used for many years in numerous industries to predict staffing needs and support development of schedules to ensure meeting performance measures.*

[88] "What is Workforce Management for Call Centers?" Nice.com, Accessed June 6th, 2022. Available at: https://www.nice.com/guide/wfo/workforce-management-for-call-centers.

any time include performance requirements (how fast the call must be answered) and other call processing metrics such as average call volume by half hour increments, average length of call, amount of time for breaks and other activities such as training and coaching. From these numbers and use of scientific calculations, the predicted number of staff is calculated. The call center helper website is a good example of a free basic calculator to determine staffing levels. [89]

Some crisis service providers are beginning to use these similar workforce management tools to predict mobile crisis team availability that meets predetermined metrics such as one- and two-hour response times. In Arizona and Georgia, crisis providers have been using these approaches and tools for over 15 years to determine the scheduling of mobile crisis to ensure the availability of mobile crisis response is provided within designated timeframes.

In both examples, the organizations utilized staff with data processes and analytics capabilities to develop the initial projections and continuously use the modeling capabilities to determine if changes were needed in predicting the number of mobile crisis response staffing needed. In Arizona, the community used the data to begin the prediction process and identified additional data points to be collected to have a robust predicting model. The community used some basic best guesses (as is done in budgeting processes) on some data points as they started out using other publicly available data such as population size and average travel time within a community. They then transitioned to use of actual mobile crisis service data (mobile crisis volume, response times, intervention time). This process took three to six months to have the additional data needed.

Additionally, within the Arizona communities, the mobile crisis network capacity prediction resulted in notably differing configurations for urban, rural and frontier communities. For example, communities with a very low and remote population (e.g., frontier) were only required to have an *on-call* team available 24/7. Urban communities always had at least two mobile crisis teams active with additional teams being added over the course of the day to account for increasing demand in the afternoon and evening hours.

Some states are exploring these strategies to determine what would constitute a sufficient network of mobile crisis response that is responsive to needs and within timeframes. These states are exploring what they will include in their contracts to ensure there is a sufficient network of mobile crisis to be responsive to different community needs (e.g., geography).

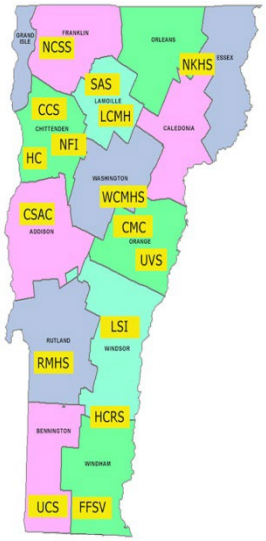
[89] "Erlang Calculator – for Call Centre Staffing (Online Version 5.0," Call Centre Helper, Accessed June 6th, 2022. Available at https://www.callcentrehelper.com/tools/erlang-calculator/.

Vermont Findings

Current VT Mobile Crisis Providers

In 2003, Vermont established its Designated Agencies (DAs) through legislation to assure that people in local communities receive services and supports, consistent with available funding, the state System of Care Plans, the local System of Care Plans, outcome requirements, regulations promulgated by DDMHS.[90]

Figure 4. Map of Designated Agencies



Currently, there are 10 DAs operating in various geographic regions of Vermont as outlined in Figure 4. Map of Designated Agencies. Currently, the Department of Mental Health contracts with DAs to provide crisis mobile services under the Emergency Services Program. The contract and provider manual currently do not contain requirements for the availability of mobile crisis nor response times that drive what is needed for a mobile crisis network.

At present, the types of data used within workforce management prediction capacity models are not currently available for the mobile crisis reporting (e.g., volume of community-based mobile responses, mobile response/travel times, face to face intervention time). However, publicly available data concerning population demographics and geographic data such as square miles/community could be used in Vermont to support workforce predictions and help target workforce capacity. Currently, there is wide variability between the total population by each DA's assigned service area with a range of 26,485 to 163,774.

The statewide survey asked questions to uncover approximate data that could be used in workforce support and potential mobile crisis availability modeling. Following are highlights:

- Of the seven DAs who responded, 100 percent indicated that the average travel time to respond to a community-based setting in their catchment is 1 hour.
- The survey conveys that the further travel times are generally one hour with some being one-three hours. When asked the travel time for the furthest or most remote location that the ES staff is required to travel to deliver community-based crisis services, of the 8 DAs who responded, 62 percent indicated that it is 1 hour, and 38 percent indicated 1-3 hours.
- Based on respondent answers, the average duration of a mobile crisis intervention is generally an hour with some being one to two hours, as depicted in Table 5.

[90] "Administrative Rules on Agency Designation," Department of Developmental and Mental Health Services, June 1st, 2003 Available at: https://dail.vermont.gov/sites/dail/files//documents/administrative-rules-on-agency-designation.pdf.

Table 5. Survey Response - Average Duration of Mobile Crisis Intervention

Indicate the average time or duration for each encounter or service, by location (this does not include travel time) *DAs with varied responses excluded										
	< 1 Hour		1 Hour		1-2 Hours		2-3 Hours		3+ Hours	
Answer	**%**	**Count**	**%**	**Count**	**%**	**Count**	**%**	**Count**	**%**	**Count**
Office Based (n=6)	-	-	83%	5	17%	1	-	-	-	-
Community (n=7)	-	-	57%	4	43%	3	-	-	-	-
Hospital/ED (n=6)	-	-	33%	2	67%	4	-	-	-	-

- The DAs conveyed that there is some 24/7 availability of a licensed staff to provide consultation to mobile crisis response, as needed, as depicted in Table 6.

Table 6. Survey Response - Availability of Emergency Staff

Please indicate the availability of emergency staff by discipline for telephonic consultation: (n=6) *excluding DAs with varied responses								
	24/7/365		Monday – Friday (9 AM – PM)		Monday – Friday (5 PM – 11 PM)		Not at all	
Question	**%**	**Count**	**%**	**Count**	**%**	**Count**	**%**	**Count**
Licensed behavioral health clinician (n=6)	83%	5	17%	1	-	0	-	0
Unlicensed Master level behavioral health clinician (n=8)	88%	7	-	0	12%	1	-	0
Nurse (n=6)	17%	1	33%	2	-	0	50%	3
Psychiatrist (n=5)	100%	5	-	0	-	0	-	0
Bachelor level staff (n=6)	50%	3	33%	2	%	0	17%	1
A Peer or Recovery Support Specialist (n=7)	43%	3	14%	1	%	0	43%	3

- However, consumers indicated that access to mobile crisis services is not always available 24/7, as indicated in the table below.

Table 7. Consumer Access to Mobile Crisis Services

Do you know what crisis services are available, when they are available, and where you can get them?								
	Monday – Friday (9 AM – 5 PM)		Monday – Friday (5 PM – 12 AM)		Monday – Friday (12 AM – 9 AM)		Weekends	
Answer	**%**	**Count**	**%**	**Count**	**%**	**Count**	**%**	**Count**
Almost no access	0%	0	25%	6	28%	7	28%	7
Some access	76.92%	20	41.66%	10	36%	9	40%	10
No access	0%	0	4.16%	1	4%	1	0%	0
Not Sure	23.08%	6	29.16%	7	32%	8	32%	8

Future State Recommendations

Based on the information gathered and synthesized by HMA, we offer the following recommendations:

- The state must develop the technical capabilities to utilize workforce prediction modeling and tools to determine the volume of mobile crisis staffing needed by community to ensure that there is a sufficient mobile crisis response available per the CMS' staffing guidance and within the timeframes that Vermont establishes. The state should consider if the capabilities are within a state agency or through vendor services.
- The state should develop a short- and long-term approach for using data within a workforce prediction model to determine mobile crisis staffing availability requirements. Short-term approach should use the best available and publicly available data to establish initial mobile crisis staffing availability requirements. A longer-term strategy must include collection of critical data points to use moving forward with adjusting the mobile crisis staffing availability requirements per need.

2. Mobile Crisis Contracting

National Environmental Scan

States vary in how they contract for mobile crisis services. Most states contract for mobile crisis services within a broader composite of services such as with an integrated health plan or with a behavioral health carve-out health plan. However, some states are using contract approaches that separate out the crisis service component from other services. Below are a few examples of different state approaches to contracting for crisis services.

The State of **Arizona** contracts for a specialty integrated health plan (one plan is awarded a contract per each of the three geographic regions). The specialty plan has about four distinct components, one of

which is to administer the crisis services that are available for anyone in the state using Medicaid and non-Medicaid funding sources. The requirements from the latest RFP convey the Contractor is responsible for the provision of a full continuum of crisis services, which include but are not limited to: [91]

- Crisis telephone response,
- Mobile crisis teams,
- Facility-based stabilization (including observation and detox), and
- All other associated covered services are delivered within the first 24 hours of a crisis episode.

There are extensive requirements outlined for the Contractor which include but are not limited to:

- Use of crisis services best practices (including many that align with the CMS Guidance),
- Education with the community about the availability of crisis services and how to access services,
- Timely notification to another health plan who has primary responsibility for the individual, encounter submissions, and
- Crisis system utilization assessment and reporting.

The State of **Louisiana** has recently implemented crisis services as part of the Medicaid benefit. As part of bringing up the crisis services, the state has some short and long-term strategies it is using to develop the crisis services continuum and engage highly motivated providers with a crisis services-orientated understanding. One of the strategies that the state used was to have providers interested in delivering crisis services apply to participate in a training program developed and administered by the Louisiana State University (LSU) Center for Evidence to Practice. To participle, a provider had to apply to take the training. Providers who completed the training could negotiate contracts with the Medicaid-managed care plans. Some providers were already existing providers within the LA Medicaid system and some providers were new providers to the Medicaid program. The Louisiana Department of Health has a webpage that outlines the services available and the status of bringing up the services across the state regions. [92]

The State of **Massachusetts** contracts with 20 Emergency Services Programs (ESP) which includes 24/7 mobile crisis services to provide crisis services to all cities and town throughout the state. There is one locally based mobile crisis team for each of the 20 catchment areas. MA funds its crisis services through state funds and its state plan for Medicaid. MCOs are contractually obligated to utilize ESP services. ESPs deploy their MCTs and each ESP has a 247-toll free number. There is also a statewide automated number that, although it is not staffed, provides a centralized number for individuals to call regardless of where they are located and redirects callers to their nearest ESP based on ZIP code. The state has a public facing statewide bed registry to allow for real-time connection to stabilization services. ESPs report on quality metrics including response time, the percentage of assessments that occur in a community setting and rates of diversion to community-based care. Massachusetts has taken measures to increase community engagements by MCTs, including increasing rates for assessments conducted within the community as well as implementing client and provider education strategies around hospital diversion and stabilization services.

In addition to the state examples provided above, other national publications outline essential components of contracts for crisis service administration. The National Council for Mental Wellbeing's

[91] Arizona Health Care Cost Containment System (AHCCCS), competitive Contract Expansion, Solicitation # YH20-0002, https://www.azahcccs.gov/PlansProviders/HealthPlans/YH20-0002.html.
[92] Louisiana Department of Health, Behavioral Health, LA Crisis Response System webpage. Retrieved at: https://ldh.la.gov/page/4190 Retrieved at: https://ldh.la.gov/page/4190.

publication, *Roadmap to the Ideal Crisis System,* conveys ideas about how states can contract for crisis services that move the state closer to an ideal crisis system.[93] The publication provides additional examples of how states have contracted such as South Dakota and Michigan. Following are some highlights from the publication specific to the topic of contracting:

- The need for an "accountable" entity that has some core responsibilities including the creation of the global budget for the ideal crisis system and that the contracting reflects this,
- Require crisis staff who are accountable for the crisis programs and outcomes,
- Require technology that can support crisis system and services flow monitoring, and
- Include requirements for consultation and training for system partners.

Vermont Findings

The Vermont Agency of Human Services (AHS)/ Department of Vermont Health Access (DVHA) delegates to the AHS/Department of Mental Health (DMH) contracting and oversight of the Designated Agencies (DAs) who are currently responsible for the delivery of emergency services including mobile crisis. The Mental Health Provider Manual, DMH DA Provider Agreement, and the DMH Designated Agency Emergency Services Standards each describe program and performance expectations for emergency services (ES) delivered by DAs. The Designated Agency Emergency Services Standards (2017) describes the responsibilities for DAs in delivering mental health emergency services which includes:

- Population Served
  - The Emergency Service Standards state that Emergency Services shall be provided to any persons living in or presenting in a Designated Agency's catchment area that are experiencing an acute *mental health* crisis
- Description of Services
  1. Crisis Response
  2. Inpatient Screening
  3. Court Screening
  4. Community Emergencies/Disaster response
  5. Reassessment
  6. **Mobile Outreach**
- Methods for Response
- Capacity
  - Consultation and coordination for mental health crisis until the immediate crisis is resolved, all available and appropriate resources have been utilized, or responsibility is transferred to another agency or appropriate person;
  - Follow-up, where possible and if appropriate, to emergency contacts to ensure that linkages were appropriate and referrals were made if needed;
  - Documentation of all contacts and their disposition;
  - Emergency screening on a face-to-face basis in accordance with a Designated Agency's policies and procedures; and
  - 24/7 face-to-face Qualified Mental Health Professional (QMHP) and psychiatric assessment for involuntary inpatient admissions.
- Transport

[93] National Council for Mental Wellbeing, Committee on Psychiatry and the Community for the Group for the Advancement of Psychiatry, "ROADMAP TO THE IDEAL CRISIS SYSTEM: Essential Elements, Measurable Standards and Best Practices for Behavioral Health Crisis Response," March 2021. Available at: https://www.thenationalcouncil.org/wp-content/uploads/2022/02/042721_GAP_CrisisReport.pdf.

In addition to these 10 DAs, DMH works with two Specialized Service Agencies (SSAs), Pathways Vermont, which serves adults, and the Northeastern Family Institute (NFI), which serves children and families. These SSAs may operate in more than one geographic area and are not DAs.

Future State Recommendations

Given that crisis response is a specialty service within the continuum of mental health and the oversight of crisis services requires particular skills, the state should consider alternative contracting approaches to ensure providers who are highly motivated to provide crisis services and have the required skillsets are selected in addition to proper oversight. Options for the state include:

- Consider procuring mobile crisis services directly apart from DA contracts. This option would require the state to build internal infrastructure to procure and monitor the contracts.
- Contracts should include all the CMS requirements and crisis care and operational best practices such as use of technology for recording of crisis care interventions, electronic dispatch, data collection, analytics, and information sharing, and dashboards supporting transparency with the community. The contracts should also include reporting requirements and meeting performance metrics.

3. Technology Strategies

National Environmental Scan

Federal Endorsement for the Use of Technology

The CMS guidance for mobile crisis restates some of the crisis services best practices published in SAMHSA's *National Guidelines for Behavioral Health Crisis Care – A Best Practice Toolkit* including "implementing real-time GPS technology in partnership with the region's crisis call center hub to support efficient connections to needed resources and tracking of engagement; and scheduling outpatient follow-up appointments and services to connect to ongoing care and home and community-based services and supports." [94] [95]

Further, CMS guidance authorizes Medicaid administrative claiming for technology noting "State Medicaid agency costs that may be eligible for this enhanced administrative match include, but are not limited to, the following examples:[96]

- Systems in support of establishing and/or improving crisis call centers that can enable Medicaid beneficiaries to access mobile crisis teams,
- Systems integration activities in support of the 988 activities,
- Providing cell phones or iPads to state staffed mobile crisis teams to facilitate telehealth services with a clinician at another location during a crisis intervention,
- Developing and implementing software applications to facilitate communication between crisis call centers and mobile crisis providers and supervisory clinicians with mobile crisis team staff,
- Implementing text and chat technologies that many beneficiaries, including youth, may be more comfortable using as part of the services offered by crisis call centers, and

[94] Centers for Medicare and Medicaid, "SHO#21-008 RE: Medicaid Guidance on the Scope of and Payments for Qualifying Community-Based Mobile Crisis Intervention Services," Dan Tsai, December 28, 2021. Available at: https://www.medicaid.gov/federal-policy-guidance/downloads/sho21008.pdf.

[95] SAMHSA, "National Guidelines for Behavioral Health Crisis Care – A Best Practice Toolkit Knowledge Informing Transformation," SAMHSA.gov, 2020.

[96] Centers for Medicare and Medicaid, "SHO#21-008 RE: Medicaid Guidance on the Scope of and Payments for Qualifying Community-Based Mobile Crisis Intervention Services," Dan Tsai, December 28, 2021. Available at: https://www.medicaid.gov/federal-policy-guidance/downloads/sho21008.pdf.

- Implementing accessible technologies for individuals with disabilities.

Lastly, the CMS letter allows states to include highly trained and specialized practitioners to be part of the team that can be connected virtually via telehealth to members of the mobile team in the community. CMS outlines that telehealth may also be used at either the outset of the crisis as part of screening, assessment and stabilization, or in near term follow-up to the crisis with the beneficiary regarding coordination and referrals. These activities may also be considered items or services for which medical assistance is available under the state plan or a waiver of such plan as community-based mobile crisis intervention services.

Technology Use - National Landscape Review

Based on a review of the national technology landscape for crisis services, technology is playing an increasingly important role in the crisis service sector. Technology is being used within the practice of delivering crisis care and for administrative processes to support effective deployment of crisis care workers as well as monitoring for effectiveness and outcomes.

Examples of technology tools that are being used in places across the nation for real-time crisis care coordination include:

- Use of real-time and static dashboards to enable rapid insight into the current state and performance of the crisis system overall (calls, mobile teams, crisis walk-in)
- Use of caller ID functioning to identify the place where a person is at imminent risk of harm
- Use of health records created to document crisis events which can include decision support tools guided by risk scoring
- GPS-enabled mobile dispatch in which a call center hub and community mobile service providers electronically communicate, while enabling the call center to see a visual representation of the availability and location of mobile teams in the community
- 24/7 scheduling for community-based services to ensure that there are next steps in place after a crisis call has concluded
- Bed tracking technology to enable real-time bed capacity and availability for urgent care/crisis stabilization services
- Connect with local 911 systems, as needed
- Use of text and chat technology
- Documenting outcome status disposition for every crisis event, especially to understand the resolution for a call with high acuity

Below are other state-level examples of crisis systems leveraging technology.

The state of **Georgia** Crisis and Access Line (GCAL) operated by Behavioral Health Link, has built a technology system that has the following capabilities:[97]

- State of the art call management telephone system
- Electronic health record that includes a service referral and tracking system
- GPS-enable mobile crisis dispatch
- Urgent and routine outpatient scheduling interface
- Electronic crisis facility real-time bed availability registry
- Use of voice analysis technology to provide real-time feedback on the caller's emotional state to help improve care delivery

[97]"Software -Behavioral Health Link," Accessed June 6th, 2022. Available at: https://behavioralhealthlink.com/saas/.

- Deployment of existing intensive service resources (such as an Assertive Community Treatment team) that are already engaged with the individual

The state of **Arizona** currently has several crisis call centers that are leveraging and maximizing the use of technology including: [98]

- Electronic health records that are customized for crisis calls
- Electronic dispatch of mobile teams that include sharing of clinical information and automatic collection of time stamp of activity with the press of a button
- GPS technology to see where mobile teams are in the community
- Mobile teams have electronic tools (e.g., tablets) to receive dispatch, quickly press features to record time stamps and receive and send information regarding the crisis need and intervention
- Call centers can support mobile teams in electronically setting up appointments with community-based providers

Other states have implemented technology strategies to overcome barriers related to rural geographies or to address workforce shortages. Examples of this technology innovations include the use of telehealth, as "capacity extenders" to enable staffing efficiency and improve access. Many states, including **South Carolina** [99], **South Dakota** [100], and **Oklahoma** [101] [102] have expanded behavioral health assessment capacity by supplying computer tablets to first responders (law enforcement or EMS), allowing them to connect directly with behavioral health clinicians. These efforts support rural communities in accessing behavioral health support and reduce unnecessary hospital transport for individuals who could be stabilized in the community. Throughout the U.S., 33 states have created or are in the process of creating a live bed registry. [103]

In addition to having technology to support crisis care coordination, communities have implemented technology solutions that support monitoring the effectiveness of the overall crisis care system including real-time activity and availability of call center, mobile, and crisis stabilization services and to determine responsiveness to system partners such as first responders. To this end, performance dashboards that support air traffic control-type functioning in the crisis system play an important role in solidifying crisis care. [104] Both the Arizona and Georgia examples above demonstrate the use of these dashboards.

Some crisis systems across the nation are using technology to supports sharing of data across entities to support care coordination and operational needs such as bed availability. There are a few places that have worked with a community's Health Information Exchange (HIE) to develop ways to transmit crisis services. Arizona has been working on this, however challenges with 42 CFR restrictions with sharing

[98] Crisis Now Successes in Arizona video retrieved at: https://www.youtube.com/watch?v=ORq1MkODzQU.
[99] Eric Wicklund, "Avera to Use Telehealth to Connect Police, Mental Health Professionals," mHealth Intelligence, July 31, 2020. Available at: https://mhealthintelligence.com/news/avera-to-use-telehealth-to-connect-police-mental-health-professionals.
[100] "Emergency and Assessment," Charleston Dorchester Mental Health Center. Accessed on June 6th, 2022. Available at: https://www.charlestondorchestermhc.org/services/emergency/.
[101] Shelby Montgomery, "Oklahoma County Sheriff's Office changes how deputies respond to mental health calls," *Koco News*, February 10, 2022. Available at: https://www.koco.com/article/oklahoma-county-sheriff-mental-health-ipad/39040325.
[102] Stephanie Hepburn, "In Oklahoma, People in Need and First Responders Get iPads for Rapid Face-to-Face Mental Health Response," CrisisNow and CrisisTalk, July 6, 2021. Available at: https://talk.crisisnow.com/in-oklahoma-people-in-need-and-first-responders-get-ipads-for-rapid-face-to-face-mental-health-response/.
[103] Tami Mark et al., "Inpatient Bed Tracking: State Responses to Need for Inpatient Care," U.S. Department of Health and Human Services Assistant Secretary for Planning and Evaluation Office of Disability, Aging and Long-Term Care Policy, August 2019. Available at https://bit.ly/3oBPUH4.
[104] Substance Abuse and Mental Health Services Administration (SAMHSA), "National Guidelines for Behavioral Health Crisis Care – A Best Practice Toolkit Knowledge Informing Transformation," SAMHSA.gov, 2020.

substance use or treatment information has slowed the process down. In order to share data across entities, there must be data sharing agreements most often known as Business Associates Agreements. These agreements are needed between crisis provider organizations as well as with other entities such as hospitals or EMS.

Some crisis system communities across the nation are sharing data to identify individuals with the highest needs who are utilizing the most services across system partners. For example, 911, EMS and crisis call centers are beginning to work together to identify individuals with high service utilization to support them in developing effective support resources outside of crisis management. One example of this is in **Colorado Springs** which has a Community Assistance Referral & Education Services (CARES)[105] program which endeavors to assists frequent users of the 9-1-1 and emergency departments (6 visits to the ED or 6 9-1-1 calls within a 6-month period) in Colorado Springs with their physical, medical and behavioral health needs through outreach, assessment, connection to community resources and care navigation. Referred patients are offered the opportunity to participate in a voluntary intervention designed to find resources and address barriers to healthcare access; this intervention can last for up to 12 months. Commonly identified barriers include lack of adequate housing, food, transportation options, primary care physicians (PCPs), medical specialists, insurance, and behavioral health treatment. The CARES team consists of intake providers, medical navigators, and behavioral health clinicians. The navigation teams are designed to provide integrated intensive interventions to members who consent to treatment. This allows community resource providers to keep vulnerable populations healthy rather than only providing reactive emergency services.

Technology is also being used or explored to support the use of electronic capabilities to access *accurate, up to date* resources that are needed by individuals and families experiencing crisis such as food, transportation and hygiene resources. In preparation of implementing 988, SAMSHA provided planning grants through Vibrant, a national 988 convening organization vendor. Each state had to prepare a 988 Implementation Plan and one component was to address having an electronic resource directory that is maintained with current community resources. Vibrant is in the process of developing and offering technology called the "Uniform Platform" to 988 centers throughout the nation. Part of their technology including a referral database. [106]

Vermont Findings

Within the Vermont mental health and crisis services system, the use of technology is essentially limited to the use of electronic health records (EHRs). There are some tools being used in Vermont such as telehealth that can be expanded in its application to crisis services. There is extensive opportunity to expand the use of technology to enhance the delivery of crisis services and to monitor crisis care including for the use of mobile crisis services. This section will summarize the current use of technology for providing delivery care with a focus on crisis care within Vermont.

Current and Reported Use of Technology in Vermont

The surveys that were distributed to the DAs (who currently provide crisis mobile services) contained questions related to their use of technology within the delivery of services. As depicted in Table 8, DAs conveyed that telehealth is utilized but there is minimal use of technology.

[105] https://coloradosprings.gov/fire-department/page/community-and-public-health-cares.

[106] "Vibrant Emotional Health, The Need for a Uniform Platform for the 988 Network," Vibrant Emotional Health, Accessed June 14, 2022. Available, Retrieved at: https://www.hca.wa.gov/assets/program/unified-platform-public-final-press-release.pdf.

Table 8. Survey Response - Organization's Use of Technology for Mobile Crisis Services

Describe your organization's use of technology to support your mobile crisis services (8 Designated Agencies (DA) Responded)		
Answer	**Percent of DAs**	**Number of DAs**
None	-	0
GPS-enabled mobile dispatch connecting the call center and community mobile service providers electronically communicate	13%	1
Telehealth	100%	8
Web-based bed registries and appointment scheduling	13%	1
System dashboards	13%	1
Other:	37%	3

The three respondents that selected "other" stated that the following technology is used:

- *Response 1 - Laptops, pagers, building access at agency sites around catchment,*
- *Response 2 - Pagers, cell phones, laptop computers, electronic medical record system, and*
- *Response 3 - iPads and laptops to take on mobile response in the community, though rarely used.*

Further, there is significant variance among DAs with regard to the frequency of telehealth from "almost never" to "the majority of crisis responses". One DA that maximizes the use of telehealth has provided tablets to their community partners (Law Enforcement, EMS and emergency departments) which has improved access and response time for crisis assessments. Of the 8 DAs who responded, 100% indicated that they have a data and information management platform sufficient to meet state reporting requirements.

As depicted in Table 9, only one DA indicated that they had these systems and six responded they did not have these types of system.

Table 9. Survey Response - Information Sharing Systems

Do you have information sharing systems, connecting crisis providers and community providers through a health information exchange? (n=7) *excluding DAs with diff survey responses (analyzed at DA level)		
Yes	14%	1
No	86%	6

The survey also inquired about the use of data sharing agreements. Table 10 conveys that there are very few data sharing agreements currently utilized. The respondents that stated their organization had data sharing agreements in place indicated that the agreements were with the "Department of Mental Health, local FQHC, State hospital, or local hospital".

Table 10. Survey Results - Data Sharing Agreements

Does your organization have any data sharing agreements with other crisis system stakeholders e.g., state agencies, providers, child welfare/juvenile justice, law enforcement, etc.? (n=8) *analyzed at DA level		
Answer	**Percent of DAs**	**Number of DAs**
Yes (if so, please describe)	38%	3
No	63%	5

As depicted in Table 11 , the largest barrier to expanding or implementing technology was funding. Interestingly, two respondents stated that there are no barriers to expanding or implementing technology.

Table 11. Survey Results - Barriers to Using Technology

What are the barriers to expanding or implementing technology? (n=11) *analyzed at individual level		
Answer	**Percent of Respondents**	**Number of Respondents**
None	18%	2
Funding	55%	6
Lack of supplies (i.e., tablets or videoconferencing)	9%	1
Staff training	0%	0
Lack of web access	9%	1
Other (please describe):	9%	1

Although barriers were expressed, the survey completed by law enforcement representatives, conveyed some optimism to leverage technology in the future as depicted in Table 12.

Table 12. Survey Response - Opportunities to Leverage Technology

Do you believe there are any opportunities to leverage technology? (n=8)		
Answer	**Percent of Respondents**	**Number of Respondents**
Yes	62%	5
No	38%	3

According to the Vermont 988 Implementation Plan, Vermont developed and implemented an Electronic Bed Board system in 2011. The system is currently managed by the Department of Mental Health (https://bedboard.vermont.gov/) and provides real-time availability across the system of care, including inpatient, crisis, intensive residential, and residential. The system is open to the public to search for bed availability and can be utilized by Lifeline call centers to determine initial availability.[107] The system does not facilitate referrals, nor should Lifeline Centers refer individuals directly to these resources as placement is done through the Emergency Room or local Designated Agencies.

Several organizations within Vermont have electronic databases that catalog available community resources.

- Vermont 211 provides information and referrals to resources that are provided telephonically (by calling 211) or on the internet. [108] Vermont 211 maintains a database that contains information about community resources for callers throughout Vermont, including detailed data on health and human service programs. The Vermont 211 database currently contains over 750 agencies, with more than 2,290 programs and 6,350 services.
- Help Me Grow VT (HMG VT), a program of the United Ways of Vermont, provides professional information & referral services in accordance with AIRS (Alliance of Information & Referral Systems) National Standards. [109] The HMG VT resource center, in partnership with Vermont 211, assists expectant parents and families with young children through age eight, handling calls related to the health, development, behavior and learning of children.

Vermont Initiatives to Expand Technology

Vermont's 988 Implementation Plan touches on several technology topics that are associated with mobile crisis services technology discussion. The plan conveys the following:

- **Text and Chat:** Currently, the Lifeline call centers that will be answering 988 calls, do not provide text and chat services. Vermont is exploring text and chat capabilities for the Vermont 988 call centers. There is currently an ongoing conversation with both Lifeline call centers to discuss how to staff this service. Vermont is working toward implementation of PureConnect to meet this need. PureConnect provides text and chat platforms.
- **Mobile Dispatch:** Between July 2022 and June 2023, the state will explore crisis call centers to dispatch mobile crisis outreach teams including capabilities for real-time coordination of mobile response.
- **Technology Needs:** Continued assessment of technology needs of the Lifeline call centers.

The plan states that there has been use of *some* federal funding (5 percent crisis set aside requirement of the federal block grants) for the Lifeline call centers for a variety of things such as staffing however did not specify if funding was used for technology. [110]

[107] "VT DMH Bed Board," Vermont Department of Mental Health, Accessed June 7th, 2022. Available at: https://bedboard.vermont.gov/.
[108] "211 Vermont," Vermont 2-1-1, Accessed June 6th, 2022. Available at: https://www.navigateresources.net/211vermont/.
[109] "Help Me Grow Vermont," Health Me Grow Vermont, Accessed June 6th, 2022. Available at https://www.helpmegrowvt.org/.
[110] Mark Hurst et al., "Using the 5% MHBG Set-Aside to Support Programming for First Episode Psychosis: Activities and Lessons Learned from the State of Ohio," Webinar, National Association of State Mental Health Program Directors (NASHMPD), June 29th, 2015, Available at: https://www.nasmhpd.org/content/using-5-mhbg-set-aside-support-programming-first-episode-psychosis-activities-and-lessons.

Of significance, the 988 Implementation Plan conveys the challenges presented by the limited high-speed internet in Vermont rural areas and the technology implications for providing 988 response services.

Beyond the scope of crisis service technology, yet critical to include in the Vermont technology planning landscape, Vermont has other initiatives underway to expand technology. Within Vermont's "Proposal to Enhance, Expand, and Strengthen HCBS under the Medicaid Program", the state plans to fund the purchase of technology infrastructure, provide financial support to HCBS providers to support encounter data submission requirements pertaining to value-based payment reform, purchase equipment to allow staff to enter data at the point of care, and create an electronic patient engagement platform. [111] Assessing the current software systems in use and identifying ways to coordinate with the Technology and Cross-system Data Integration Efforts of the strategic roadmap is outlined in the HCBS spending plan to ensure SDOH data of clients is captured in the Vermont Health Information Exchange (VHIE) and claims data. This will further support the development of standards, consent policies and data sharing agreements to facilitate aggregation and exchange of SDOH data. Coordination with the design and support implementation of VT's data governance council will assist with coordination around the use of SDOH data similar to how the Green Mountain Care Board data governance council was established.

Current Technology Requirements with Vermont Contract requirements

According to the *Department of Developmental and Mental Health Services' Administrative Rules on Agency Designation*, Designated Agencies must "have a technological infrastructure that enables cost effective information collection, analysis, and telecommunication functions along a list of elements ranging from information and reporting to DDMHS, conduct financial analysis and budget management, conduct business with external partners while protecting consumer confidentiality." The document does not speak to the requirements and capabilities of DAs to manage crisis referrals or how the EHR will promote the provision of crisis services. Additionally, the document requires "working agreements" with all service providers or persons who self-manage the provision of services on behalf of the DA. Confidentiality is an important safeguard required of all DAs and stated in section 4.14 of the Administrative Rules.

The Department of Mental Health DA Provider Agreements state that "DA shall ensure that any contracts involving information systems that may include Health Information Exchange ("HIE") must include an overall approach that is consistent with the State of Vermont's evolving standards for interconnecting Health Information Technology ("HIT") systems. For instance, information systems such as Electronic Health Record ("EHR") or Electronic Medical Record ("EMR") systems shall be in accordance with the technology approach outlined in the most recent Vermont Health Information Technology Plan."

The Vermont Mental Health Provider Manual states that all "DA/SSA and/or any subcontractor must be able to produce specific encounter data from the EHR using MSR coding if requested by the State. All electronic records must be HIPAA compliant and retained for 10 years from the date of service."

[111] "Vermont's Proposal to Enhance, Expand, and Strengthen HCBS under the Medicaid Program," Vermont Agency of Human Services, June 14, 2021. Available at: https://humanservices.vermont.gov/sites/ahsnew/files/documents/MedicaidPolicy/GCRProposedPolicies/21-039-Vermont-HCBS-FMAP-Proposal.pdf.

Future State Recommendations

Based on the information gathered and synthesized by HMA, we offer the following recommendations:

In alignment with other state technology planning, the state should develop a crisis system services technology plan that:

- Aligns and integrates with other Vermont technology initiatives
- Identifies sources for funding technology
- Develops an implementation plan with a specific implementation date
- Utilizes crisis system technology best practices that support integration across crisis services including:
    - Electronic health records that are customized for crisis calls (document crisis events and has decision support tools that are guided by risk scoring), have an electronic dispatch of mobile teams that include sharing of clinical information and auto collects time stamp of activity with the press of a button
    - GPS-enabled mobile dispatch in which a call center hub and community mobile service providers electronically communicate, while enabling the call center to see a visual representation of the availability and location of mobile teams in the community
    - Electronic devices for mobile teams (e.g., tablets) to receive dispatch, allowing for access to critical information about the individual or family they are deployed to go see (e.g., features that allow for easy recording of time stamps and receiving and sending information regarding the crisis need and intervention)
    - Technology tools to support mobile teams in electronically setting up appointments with community-based providers
    - Integrates with the Vermont bed-registry already operating
    - Real-time and static dashboards to know the current state and performance of the crisis system overall (calls, mobile teams, crisis walk-in)
    - Text and chat technology
- Utilize the use of the CMS enhanced administrative claiming maximizing all that is allowable for implementing crisis technology including call centers' capabilities that interact with mobile crisis.
- Promote use of telehealth to improve access to rural areas and expand access to underserved populations.

4. Quality/Performance Measure Tracking

National Environmental Scan

SAMHSA's national crisis care guidelines address the importance of monitoring system and provider performance. [112] These guidelines stress that in addition to monitoring fidelity to best practice, states should develop a systemic process to continuously analyze data for performance evaluation. Active contract monitoring of key performance indicators should provide for a transparent process, which will support quality improvement efforts. The National Council for Mental Wellbeing's publication, *Roadmap to the Ideal Crisis System* suggests the use of performance incentives including the use of incentives and penalties, for example, an important quality metric might be: 85 percent of mobile crisis requests are

[112] Substance Abuse and Mental Health Services Administration (SAMHSA), "National Guidelines for Behavioral Health Crisis Care – A Best Practice Toolkit Knowledge Informing Transformation," SAMHSA.gov, 2020.

responded to in less than 1 hour, the contract might be designed to include a 5 percent performance bonus for exceeding 90 percent and a 10 percent penalty for under 75 percent.[113]

Currently, there are no national standardized quality measures for the delivery of mobile crisis services. CMS requires states to establish and ensure timeliness standards. CMS further encourages states to consider additional travel time that may be needed for mobile crisis teams to respond in rural and remote areas when developing timeliness standards.

Implementing the new mobile crisis initiative provides state policymakers the opportunity to identity key measures and collect data. This limited set of measures might include:[114]

- Average response time for mobile crisis intervention
- Percentage of individuals who receive follow-up care within 24 or 48 hours
- Disposition of the case (i.e., number of individuals taken to a psychiatric hospital voluntarily and the number taken involuntarily; individuals connected to CSUs; individuals connected to respite)
- The number and percentage of crisis calls when the MCT engages/requests police response
- The number and percentage of individuals who receive mental health and/or community-based substance use services within a defined period following a mobile crisis team intervention
- The number and percentage of individuals who receive follow-up contact by the MCT within a defined period
- The number and percentage of encounters that included a peer support specialist as part of the MCT
- Measure of individuals' and families' satisfaction with services (e.g., how likely are they to recommend this service)
- Demographics of service recipients (race, gender, ethnicity, LGBTQAI2+) for the purposes of evaluation of trends and underserved populations
- It is highly recommended that systems connect data in a manner that offer real-time views of agreed-upon system and provider-level dashboards that can also be used to support alternative payment reimbursement approaches focused on value.[115]

The Table below notes the suggested or required quality measures by agency/organization.

Table 13. Suggested and/or Required Quality Measures by Source.

Organization/Resource	Quality Metric
CMS (Guidance SHO #21-008)	CMS is requiring states to establish and ensure timeliness standards. Preferred response times by the mobile crisis team under one hour. Mobile crisis teams should have the capability to make **referrals to outpatient care and to follow up** to ensure that the individual's crisis is resolved, or they have successfully been connected to ongoing services.

[113] National Council for Mental Wellbeing, Committee on Psychiatry and the Community for the Group for the Advancement of Psychiatry, "ROADMAP TO THE IDEAL CRISIS SYSTEM: Essential Elements, Measurable Standards and Best Practices for Behavioral Health Crisis Response," March 2021. Available at: https://www.thenationalcouncil.org/wp-content/uploads/2022/02/042721_GAP_CrisisReport.pdf.

[114] John O'Brien et al., "Federal Policy Recommendations to Support State Implementation of Medicaid-Funded Mobile Crisis Programs," Technical Assistance Collaborative, January 2022. Available at: https://www.tacinc.org/wp-content/uploads/2022/01/Federal-Policy-Recommendations-Final-Draft-1.133.pdf.

[115] Substance Abuse and Mental Health Services Administration (SAMHSA), "National Guidelines for Behavioral Health Crisis Care – A Best Practice Toolkit Knowledge Informing Transformation," SAMHSA.gov, 2020.

	Effective models also provide follow-up access to mental health providers **within 48 hours** either via telehealth or in-person services.
SAMHSA	• Number served per 8-hour shift • Average response time • Percentage of calls responded to within 1 hour… 2 hours • Longest response time • Percentage of mobile crisis responses resolved in the community.
Vermont DMH (AHS DMH Designated Agency Emergency Services Standards)	Telephone Emergency Services shall include 24-hour, seven-days-a-week (24/7) direct personal telephone response which shall: • respond to all calls within an average of **five minutes** of the initial telephone contact with a Designated Agency; • triage calls and provide information, referral, or immediate access to services to assist the caller in resolving the crisis; and • document all telephone contacts and their disposition. Face-to-Face Emergency services shall include the capacity for 24/7, face-to-face evaluation and treatment. Face-to-face services shall: • Provide on-site services by a qualified screener, within an average of **30 minutes** from the identified need or request for emergency examination screening. • Be closely and routinely coordinated with all necessary community emergency resources, including medical and law enforcement support. • Have 24/7 access to psychiatrist or an advanced practice registered nurse (APRN) for consultation or face-to-face psychiatric assessment. If a psychiatrist is not available, a warrant can be used. • Travel time to services shall not exceed what is usual and customary in the geographic region. • Coordinate urgent care appointments **within 48 hours** of initial crisis intervention. Reassessment: Individuals under the custody of the Commissioner of Mental Health who are on Involuntary Status awaiting an inpatient hospital bed need to be reassessed twice daily (approximately **12 hours apart**) to determine ongoing level of care needs.
Vermont DMH (DA Provider Agreement)	Percentage of crisis services occurring within the community. Monitoring Activity: • Number of crises where ES worked with police • Number of peer specialists
Vermont DMH (Mental Health Provider Manual)	Access to Care. Emergency Services Access Standards: • Emergency Services shall be available 24 hours a day, 7 days a week, with telephone availability within an average of **five minutes**. Face-to-face Emergency Services must be available within an average of **thirty minutes** of identified need.

	• Emergency Services shall be closely and routinely coordinated with all necessary community emergency resources, including medical and law enforcement support. Mobile outreach shall demonstrate and track effective diversion of **avoidable emergency room utilization**.

Vermont Findings

Currently, standardized data reports detailing each Designated Agency are not generated or shared with DAs. DMH produces an annual fiscal year report that includes data on the four types of emergency services by DA including:

- Total clients served
- Clients receiving an ES service
- Percent of total clients receiving an ES service
- Number of emergency services per client

The Department of Mental Health DA Provider Agreements require DAs to report monthly crisis data to AHS using the MSR reports. However, there are limitations with the current data collected for mobile crisis services including lack of consistent use of codes by DAs for crisis assessments and follow-up services.

MSR data could allow for robust reporting on process, performance measures and SDOH measures. Vital information that is not currently collected through the MSR data submission is time elements. As such, response time is not monitored. In order to track response time, time elements will need to be added to the data collection (i.e., time of request for service, service start time).

A broad-based statewide survey was distributed to collect stakeholder feedback on the current crisis system of care which reinforced the need for determining and monitoring performance measures. The results revealed the following from 235 respondents:

- 68 percent noted **timely access to treatment services** once the person is stabilized.
- 64 percent noted **program funding** as the biggest challenges to effective community-based mobile crisis services in Vermont (in the home, workplace, school, other).
- 40 percent of consumers and families reported **poor access to crisis services during the evening, night and weekend hours**.
- 67 percent of consumers and families that have accessed crisis services **reported receiving services in hospital emergency departments most of the time**, whereas 65 percent of consumers and families indicated they would like to receive crisis care in the community.

Further, many of the respondents from schools noted their school is frequently told to bring the student to a local hospital when attempting to connect students with crisis services. While CMS considers a community mental health center (CMHC) a community-based location, it is suggested that AHS track and monitor the percentage of crisis encounters that occur outside of a CMHC to ensure services are delivered in homes and schools.

Further, in response to the statewide survey, 222 respondents indicated **which outcome or performance measures are important** to understand mobile crisis program services**.**

Table 14. Survey Responses - Indicate which of these outcomes or performance measures are important to understand mobile crisis program services.

Answer Choice	Percent of Respondents	Number of Respondents
Average response time	62%	137
Percentage of individuals who receive follow-up care within 24 or 48 hours	73%	163
Final outcome of crisis intervention (i.e., number of individuals taken to a psychiatric hospital voluntarily or involuntarily; individuals connected to mental health or substance use treatment; number of individuals whose crisis was resolved and did not require further support)	72%	160
Frequency of peers being used to respond to crisis as part of the mobile crisis team	40%	89
Frequency of mobile crisis team engaging/requesting police assistance and vice versa	54%	119
Community satisfaction with services	56%	124
Frequency of individuals who receive mental health and/or community-based substance use treatment services following a mobile crisis team intervention	54%	120
Demographics of service recipients (race, gender, ethnicity, LGBTQ+) for the purposes of evaluation of trends and underserved populations	46%	102
Other (please describe)	11%	25

Future State Recommendations

Based on the information gathered and synthesized by HMA, we offer the following recommendations:

Without real time monitoring of performance, Vermont's efforts to implement a statewide mobile crisis benefit will risk failure. Well defined program standards and requirements established through contracts and clear, consistent provider monitoring and oversight functions will improve accountability, quality, accessibility, and effectiveness of mobile crisis response services. The following are needed to support continuous quality improvement:

- Develop provider and system level metrics designed to monitor effectiveness and ensure quality. These quality assurance strategies, when implemented together, will also strengthen relationships across the crisis continuum to better serve those in need and assist with long-term quality improvement efforts**.**
- AHS should determine targets for performance on each of the quality metrics**. At minimum, quality metrics for the mobile crisis teams should include:**

Quality Measure	Suggested Target
Average response time	One hour with exceptions for rural locations that include travel time in excess of 45 minutes
Disposition of the case	70% Diversion from 24-hour levels of care

Location of intervention (community mental health center, home/work, ED, etc.)	75% community-based
Percentage of individuals who receive follow-up care within 48 hours	50% of adults receive follow-up care within 48 hours 75% of youth receive follow-up care within 48 hours

- 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 a community mental health center/"office-based" setting.
- Modify MSR data elements collected by MCTs to include time elements, location of service, disposition and follow-up care by MCTs (inclusive of modality – in-person or telehealth).
- Vermont should ensure consistent codes and modifiers in data collection for community-based mobile crisis services to allow for monitoring and quality improvement efforts related to mobile crisis services. Necessary modifications to the MSR data elements collected by MCTs include time elements, location of service, disposition and follow-up service delivered by the MCT (inclusive of modality – in-person or telehealth).

5. Quality Oversight

National Environmental Scan

System administrators and crisis service providers should continuously evaluate performance using shared data systems. System transparency and regular monitoring of key performance indicators supports continuous quality improvement efforts.[116] It is highly recommended that systems connect data in a manner that offers real-time views of agreed-upon system and provider-level dashboards that can also be used to support alternative payment reimbursement approaches focused on value.[117] As noted earlier in this report, The National Council for Mental Wellbeing's publication, *Roadmap to the Ideal Crisis System* notes the need for an "accountable" entity that has some core responsibilities including the creation of the global budget for the ideal crisis system and that the contracting reflects this.[118]

Monitoring a comprehensive statewide delivery system for community-based mobile crisis services will require dedicated resources. Real-time monitoring of performance by data collection and analysis as well as provider support through individual and statewide provider meetings are tools that will allow Vermont to establish and maintain network and performance management of emergency services. It is suggested that ES network and performance management be a function of a single entity and not shared among different departments or divisions. Many states outsource performance and network management to an Administrative Services Organization (ASO) which is responsible for administrating the services as opposed to delivery of crisis services.

[116] IBID.

[117] IBID.

[118] National Council for Mental Wellbeing, Committee on Psychiatry and the Community for the Group for the Advancement of Psychiatry, "ROADMAP TO THE IDEAL CRISIS SYSTEM: Essential Elements, Measurable Standards and Best Practices for Behavioral Health Crisis Response," March 2021. Available at: https://www.thenationalcouncil.org/wp-content/uploads/2022/02/042721_GAP_CrisisReport.pdf.

State Examples of Oversight Structures

- **Washington:** Washington Health Care Authority contracts with Behavioral Health Administrative Service Organizations (BH-ASO) to oversee crisis services. There is one BH-ASO in each region. Seven out of ten regions opted to become county-governed BH-ASOs; Beacon Health Options, a national managed behavioral health care organization, was selected as the BH-ASO for the other three regions.[119] BH-ASOs contract with providers and are responsible for provider oversight.
- **Massachusetts**: MassHealth (the Medicaid program) contracts with the Massachusetts Behavioral Health Partnership (part of Beacon Health Options) to oversee the statewide Emergency Services Program (ESP). There is one ESP in each of the 20 defined areas in MA. Each ESP submits monthly reports on Mobile Crisis Team metrics to MBHP. MBHP provides monthly reports to providers on performance metrics.
- **Arizona**: Arizona Health Care Cost Containment System (AHCCCS) contracts with 3 Regional Behavioral Health Authorities (RBHAs), which contract with providers. AHCCCS provides specific regulations to RBHAs. RBHAs are responsible for oversight of providers. Quarterly reports on metrics.
- **Georgia:** The Georgia Department of Behavioral Health and Developmental Disabilities (DBHDD) provides direct oversight of providers. DBHDD contracts directly with two Mobile Crisis providers for services in six regions encompassing all 159 counties in the state.

Vermont Findings

Current oversight of mobile crisis services does not exist in any meaningful way. Oversight of the DA emergency services is primarily the responsibility of DMH, however DMH is not sufficiently resourced to allow for robust quality oversight. The Mental Health Provider Manual, DMH DA Provider Agreement and the DMH Designated Agency Emergency Services Standards each describe program and performance expectations for emergency services (ES) delivered by DAs. The mechanisms for oversight include the Agency Review and DA Designation which are conducted every four years.

The **Agency Review** is the mechanism used by the Department of Mental Health to evaluate aspects of the performance of mental health programs offered by Vermont's designated agencies and specialized services agencies. These reviews take place before the official designation process and are meant to provide agencies with information that will help them meet the upcoming designation review. The Agency Review Report includes the following components of ES that is reviewed:

- Program Description
- Performance in relation to four quality domains (access, practice patterns, outcomes, and structure)
- Evaluation of current statistical data
- Evaluation of survey responses
- Summary of Findings and Recommendations

DMH Statistical Reports and Data from the Monthly Service Reports (MSR) are considered in the Agency Review Process. ADAP does not conduct "agency reviews". Rather, ADAP does "site visit reports" as a certification process and only for the DAs that are "Preferred Providers". ES services are assessed under "crisis management" with the expectation that DAs refer and transition clients to lower and higher levels of care with community partners, as appropriate.

[119] Logan Kelly, "Case Study: Washington State's Transition to Integrated Physical and Behavioral Health Care," Center for Health Care Strategies, September 2020. Available at https://www.chcs.org/media/WA-BH-Integration-Case-Study_091620.pdf.

Future State Recommendations

Based on the information gathered and synthesized by HMA, we offer the following recommendations:

Robust quality oversight is necessary to ensure the successful delivery of statewide community-based mobile crisis services.

- 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. Quality oversight functions include but are not limited to:
  - Provider Contracting
  - Network Management
  - Training (either directly or oversight of service provider's own staff training)
  - Leverage technology infrastructure for data collection and reporting of quality measures
  - Provider Payments

- AHS should consider contracting with a behavioral health administrative service organization (BH ASO) to administratively manage community-based mobile crisis services. The contract should also include all CMS requirements and requirements to facilitate crisis care collaboration with system partners, and other activities to advance crisis care intervention and continuously improve outcomes for individuals and families accessing or in need of crisis care. If DMH remains the state department tasked with managing mobile crisis services, substantial additional staffing resources will be required.

6. Funding and Multi-Payor Reimbursement Strategies

National Environmental Scan

There are persistent gaps in access to mental health care, including the ability for people to receive mobile crisis services. In 2018, an estimated 50 percent of adult Medicaid members with serious mental illness did not receive necessary treatment and a 68 percent of Medicaid members with an opioid use disorder did not receive substance use treatment.[120] Recent reports found a majority of states had gaps in Medicaid mental health coverage, with the most significant coverage gaps for supported employment (covered by 25 states), residential services (covered by 28 states), and crisis residential services (covered by 29 states).[121] Although the Mental Health Parity and Equity Act (MHPAEA) requires both self-insured group health plans and state-regulated insurance plans provide behavioral health benefits to cover mental health and substance use services that is no more restrictive than the coverage generally available for medical and surgical benefits, it does not require that payers cover behavioral health services. Many payers outside of Medicaid, including commercial insurers, Medicare, TRICARE, and large group plans, do not generally cover or pay for mobile crisis services.[122]

[120] "Access to Mental Health Services for Adults Covered by Medicaid", MACPAC Report to Congress, June 2021. Available at: https://www.macpac.gov/wp-content/uploads/2021/06/Chapter-2-Access-to-Mental-Health-Services-for-Adults-Covered-by-Medicaid.pdf.

[121] "Implementation of the Mental Health Parity and Addiction Equity Act in Medicaid and CHIP," MACPAC Issue Brief, July 2021. Available at: https://www.macpac.gov/wp-content/uploads/2021/07/Implementation-of-the-Mental-Health-Parity-and-Addiction-Equity-Act-in-Medicaid-and-CHIP.pdf.

[122] "A Hybrid Funding and Coverage Model to Ensure Universal Access to Mobile Crisis Services," Manatt, November 2nd, 2021. Available at: https://www.manatt.com/insights/newsletters/health-highlights/a-hybrid-funding-and-coverage-model-to-ensure-univ.

These gaps in coverage of mental health care (including mobile crisis services) and the potential for increases in the use of MCTs, illustrate a growing need for states to adopt a broad, universal strategy for building a sustainable infrastructure and funding of mobile crisis services, regardless of insurance. This includes developing a coordinated mobile crisis benefit across payors. States will need to devise a multi-faceted strategy that includes the following elements:

- A policy mechanism for insurance coverage and funding for infrastructure, support, and services
- A delivery system for provision of services
- Comprehensive benefit design
- A mechanism to monitor network adequacy, access, and parity

An increasing number of states are enacting legislation to cover infrastructure and other costs associated with MCT. Virginia was the first state to pass legislation establishing funding for 988 through a wireless E-911 surcharge and increases to the prepaid wireless E-911 charge.[123] Following a Department of Justice Olmstead settlement agreement, the State of Georgia was required to integrate 9,000 people with serious mental illness into the community and required mobile crisis teams and assertive community treatment.[124] Georgia enacted transformative changes that include bolstering the behavioral health crisis system with robust mobile crisis teams with GPS dispatch, statewide crisis hotlines, crisis stabilization centers, and a real time psychiatric bed registry that includes 72-hour crisis residential programs and detoxification beds. In FY19, costs for the State's crisis continuum were supported by Medicaid ($12.8 million) and State General Funds ($45.4 million). Georgia will spend approximately $3.8 million on 988 Lifeline implementation and $996,000 for other crisis-related services over the next four years using MHBG, MHBG-COVID and MHBG-ARP funds.

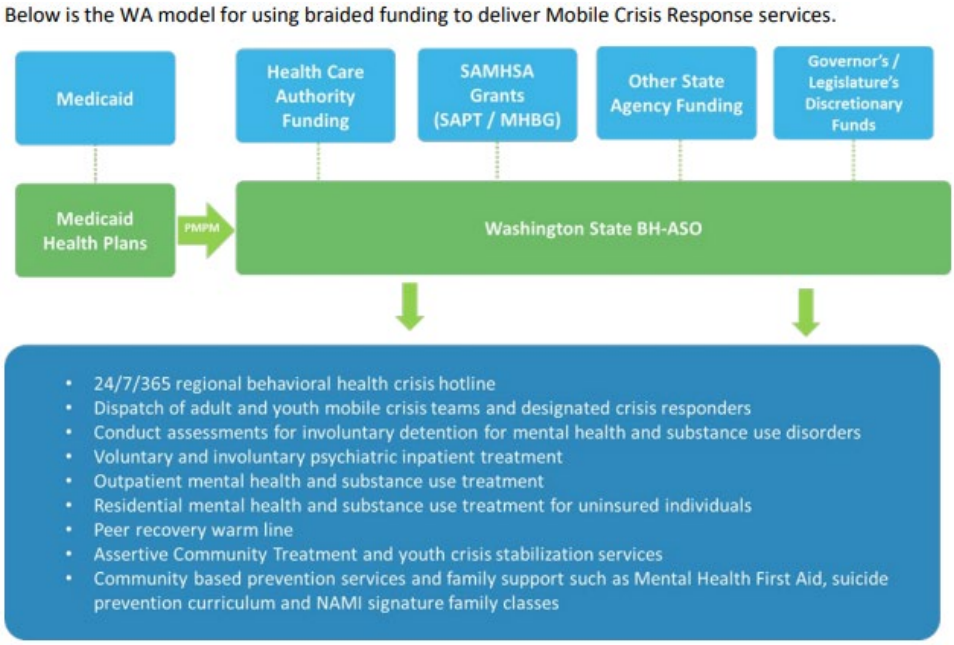
Although states have significant variation in the use of Medicaid for MCTs, they face similar challenges as it relates to coverage by other insurance plans. Washington State developed a braided funding approach across its Medicaid agency, Health Care Authority, SAMHSA grants, other dedicated state funding and Governor's discretionary funds as illustrated in Figure 4 below.[125] Washington's Behavioral Health – Administrative Service Organization (BH-ASO) covers mental health and substance use crisis services, as well as services (with available funding) for Washington state residents who are not eligible for Medicaid benefits. The BH-ASO's hold the State only and federal block grant contracts to provide services that are not covered by Medicaid for low-income individuals and Medicaid members.

[123] Virginia General Assembly, "SB 1302 – 2021 Session: Crisis Call Center Fund; created consistency with federal guidelines," January 13, 2021. Available at: https://lis.virginia.gov/cgi-bin/legp604.exe?211+ful+SB1302.

[124] Arlene H. Stephenson, "States' Options and Choices in Financing 988 and Crisis Systems," National Association of State Mental Health Program Directors (NASMHPD), April 2022. Available at: https://www.nasmhpd.org/sites/default/files/States_Options_And_Choices_In_Financing_988_And_Crisis_Services_Systems.pdf.

[125] "Washington Uniform Application FY 2022/2023 – State Behavioral Health Assessment and Plan: Substance Abuse Prevention and Treatment and Community Mental Health Services Block Grant," Washington State Health Care Authority, Accessed April 1st, 2022. Available at: https://www.hca.wa.gov/assets/program/fy-22-23-block-grant-combined-narrative-final-draft.pdf.

Figure 5. Washington state Model for using Braided Funding to deliver Mobile Crisis Response Services



In 2022, Washington furthered its efforts to ensure parity of coverage for MCT through passage of the Behavioral Health Emergency Services legislation E2SHB 16881 (Chap. 263, Laws of 2022) to protect consumers from charges for out-of-network health care services by addressing coverage of emergency services, including behavioral health emergencies and mobile crisis services.[126] A key provision of the law requires fully insured and group health plans (excluding self-funded plans consistent with ERISA) cover emergency services provided in a hospital up to the point of stabilization without prior authorization regardless of the network status of the hospital or provider. The State law defines the following as behavioral health emergency services:

- A crisis stabilization unit
- An evaluation and treatment facility that can provide directly, or by direct arrangement with other public or private agencies, emergency evaluation and treatment, outpatient care, and timely and appropriate inpatient care to persons suffering from a mental disorder, and which is licensed or certified as such by the Department of Health
- An agency certified by the Department of Health to provide outpatient crisis services
- A triage facility
- An agency certified by the Department of Health to provide medically managed or medically monitored withdrawal management services
- A mobile rapid response crisis team as defined that is contracted with a behavioral health administrative services organization to provide crisis response services in the behavioral health administrative services organization's service area

[126] "E2SHB 1688 (as passed Legislature) – Aligning the No Surprises Act & the Balance Billing Protection Act," Washington State Office of the Insurance Commissioner, March 7th, 2022. Available at: https://www.insurance.wa.gov/sites/default/files/documents/e2shb-1688-as-passed-legislature-summary-table-3-8-22_1.pdf.

Arizona uses braided state and county revenue and capitated per member per month Medicaid (1115 waiver) funding that is based on service utilization. [127] The state then uses this funding to pay its Regional Behavioral Health Authorities to provide and oversee crisis response services, regardless of insurance type. [128] This diverse funding structure allows Arizona to provide crisis services to Medicaid members for a minimum of 24 hours and 72 hours for individuals not receiving Medicaid benefits. Those services not covered by Medicaid (infrastructure costs, services to uninsured individuals, etc.) are covered by other non-Medicaid state and county funding.

California is leveraging state and federal grant funding to develop the Behavioral Health Continuum Infrastructure Program (BHCIP) which includes crisis services. BHCIP includes $2.2 billion to be awarded through competitive grants to qualified entities to construct, acquire, or rehabilitate real estate assets, or to invest in mobile crisis infrastructure to expand the community continuum of behavioral health treatment resources. [129] California's crisis services are covered by a specialty mental health benefit service under Medicaid as a carveout service of comprehensive managed care and are provided by some counties, with varying capacities and coverage. [130]

Massachusetts funds its Emergency Services Programs (ESPs), including Mobile Crisis Teams, through state funds and its state plan for Medicaid. Massachusetts MCOs are contractually obligated to utilize ESP services. The state funds its youth MCT program through the Medicaid state plan, as a rehabilitative service under the EPSDT program.

Vermont Findings

Vermont's 2018 expenditures across all payers for mental health services represented approximately 13 percent of the overall health care services budget. [131] Between 2018-2019, Medicaid spending increased by $49.1 million, or 2.9 percent to a total of $1.7 billion. [132] Among all services, mental health including Mental Health Clinics, and Home & Community-Based Services were ranked the third highest expenditure category. Across all Vermont residents, 84 percent of spending is paid for by commercial health care insurers and the two largest public insurance programs (Medicare and Medicaid), 13 percent is paid for by residents out of their own pocket, and 3 percent is paid for by other government programs (e.g., the Veterans Administration). In 2021, half of Vermonters (49 percent) are primarily covered by private health insurance (approximately 304,600 persons) while 24 percent are enrolled in Medicaid and 21 percent Medicare. Among those with private insurance, approximately 63 percent are enrolled in self-insured plans as illustrated in Figure 7. [133]

[127] Jordan Gulley, et al., "Mobile Crisis Teams: A State Planning Guide for Medicaid Financed Crisis Response Services," Technical Assistance Collaborative and California Health Care Foundation, January 2022.
[128] IBID.
[129] Marlies Perez and Corrin Buchanan, "Behavioral Health Continuum Infrastructure Program and Community Care Expansion Listening Session,"
California Department of Health Care Services, PowerPoint Presentation, October 2021, Available at: https://www.dhcs.ca.gov/Documents/CSD_YV/BHCIP/BHCIP-Listening-Session-9-30-21.pdf.
[130] IBID.
[131] Lori L. Perry, "2019 Vermont Health Care Expenditure Analysis," Green Mountain Care Board, May 12th, 2021. Available at: https://gmcboard.vermont.gov/sites/gmcb/files/documents/2019VTHealthCareExpenditureAnalysis_BoardPres_20210512_0.pdf.
[132] IBID.
[133] Paul Fronstin, "Trends in Self-Insured Health Plans Since the ACA," Employee Benefit Research Institute, No. 540, September 30, 2021. Available at: https://www.ebri.org/docs/default-source/ebri-issue-brief/ebri_ib_540_selfinsurance-30sep21.pdf?sfvrsn=d35f3b2f_4.

Figure 6. Vermont Resident Health Care Spending for 2019

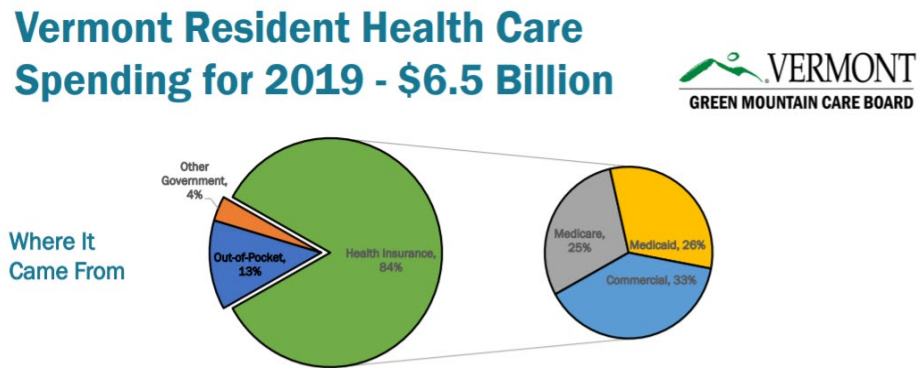
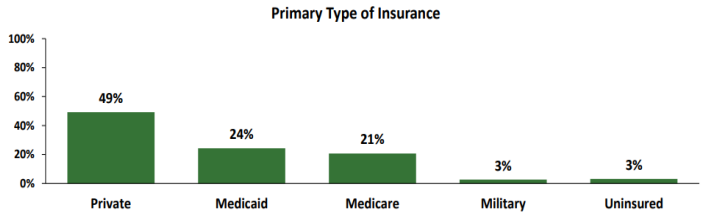


Figure 7. 2021 Vermont Household Health Insurance Survey Vermont Department of Health March 2022



Insurance Type	Estimated Population
Private	304,600
Medicaid	150,000
Medicare	128,200
Military	16,600
Uninsured	19,400

Vermont has been at the forefront of multi-payer reimbursement and delivery system models through the state's CMS approved all payer model and the Vermont Blueprint for Health (Blueprint). The Blueprint is Vermont's state-led initiative charged with implementing sustainable health care delivery reform. The Blueprint was originally codified in Vermont statute in 2006, then modified further in 2007, 2008, and finally in 2010.[134] The Blueprint is an established framework that illustrates how to oversee and manage multi-payer reimbursement for provision of high-quality primary care and other services (i.e., Community Health Teams) that affect health and wellbeing across populations delivered outside of the medical setting. The Blueprint's thirteen health service areas (HSAs) have significant overlap with State of Vermont human services districts and the regions served by the designated mental health and home health agencies. The Blueprint's multi-payer participation of Medicaid, Medicare and commercial insurance includes an enhanced per person per month payment based on the number of patients that are attributed to the practice by each insurer. The attribution methodology used by all insurers is intended to determine the practice's active caseload and managed by the providers.

Finally, according to a recent survey of the DAs, there are a few contracts with commercial plans for mobile crisis service:

- Only four of the nine DAs (44 percent) that responded to the survey report having contracts with commercial payers for Emergency Services

[134] Vermont General Assembly, "18 V.S.A. § 702: Blueprint for Health; strategic plan," The Vermont Statutes online, Accessed on June 14th, 2021. Available at: https://legislature.vermont.gov/statutes/section/18/013/00702.

- Seven of ten DAs (70 percent) report consistently billing commercial payers for Emergency Services
- Four of eight DAs (50 percent) report commercial payers consistently paying Emergency Services claims

Future State Recommendations

Based on the information gathered and synthesized by HMA, we offer the following recommendations:

The importance of developing a multi-payer strategy to ensure universal access to mobile crisis services is underscored by the high percentage of Vermonters who are uninsured and those who are insured by commercial plans that do not cover these services. The State may use a variety of sources to fund mobile crisis teams through braiding of Medicaid, local funding, and grants such as SAMHSA Substance Abuse Prevention and Treatment or Mental Health Block Grants, and the other general funding dedicated for mobile crisis services. Vermont may also consider options such as requiring fully insured large group plans to cover emergency behavioral health services – including MCT benefits. With the roll-out of 988 and community efforts to redirect responses to the behavioral health system, states should prepare for an increase in demand for MCT. Policy and financing options for developing a multi-payer strategy may include:

- Adding mobile crisis services to the essential health benefit (EHB) benchmark plan
- Enforcing the federal Mental Health Parity and Addiction Equity Act (MHPAEA) that would require mobile crisis services to be included under parity through legislation
- Enacting legislation to require fully insured and large groups and state employee health plans to provide mobile crisis services

Vermont has taken fundamental steps through the HCBS Spending Plan Projection and HSBS Spending Narrative in Response to Section 9817 of the American Rescue Plan Act of 2021 calls to use funding from this opportunity to secure contractor support to define service requirements that may include statewide mobile response and stabilization services, peer support, and permanent supportive housing.[135] This plan along with House Bill 740 which requires the Department of Mental Health to build an urgent care model for mobile outreach and crisis services including compliance with federal requirements to receive the enhanced 85 percent federal match rate, align to build a multi-payer approach.[136] The legislation calls for coordination by DMH, AHS and DVHA to develop a sustainability plan to ensure that services continue to be available after expiration of the enhanced FMAP with a report due on January 15, 2023.

Vermont may consider adopting a similar approach and amend the law to mandate all large and small group health plans (and the option for self-funded) to provide coverage of mobile crisis services. The services could also potentially include other emergency behavioral health services in the continuum such as crisis stabilization centers, inpatient or outpatient hospitals or behavioral health emergency services providers licensed by the state. If Vermont were to consider this as an option, it would be important to conduct a fiscal analysis as the law could increase claims costs for public employees, and school employee health plans administered by the state, such as the fully insured plans, due to

[135] "Vermont's Proposal to Enhance, Expand, and Strengthen HCBS under the Medicaid Program," Vermont Agency of Human Services, June 14, 2021. Available at: https://humanservices.vermont.gov/sites/ahsnew/files/documents/MedicaidPolicy/GCRProposedPolicies/21-039-Vermont-HCBS-FMAP-Proposal.pdf.

[136] "Vermont House Bill 740 (2021-2022): An act related to making appropriations for the support of government," State of Vermont General Assembly, June 3rd, 2022. Available at: https://legiscan.com/VT/text/H0740/2021.

expanded services and provider types covered under balance billing protections. This analysis would be important as approximately 63 percent of Vermonters are in self-insured plans. The fiscal review would also include examining increased administrative costs for the plans due to contracting and credentialing of new behavioral health emergency providers. There may also be higher rates that could impact the state medical benefit contribution and employee premiums for health benefits.

For constructing the Medicaid rate for mobile crisis teams, the state may consider a per diem rate based on fee for service (FFS) in the first year to allow the collection data (as described in Section B.4 above) with cost components that include, but are not limited to, the following:

- Wages by discrete labor category (may be annual salary, hourly rates, or per shift rates)
- Fringe benefits (if staff are full-time, then paid time off, health insurance, etc.; if contracted labor or not full-time, some other incentives may be considered to expand the workforce)
- Training as per national guidance and as required under Section 9813 under ARPA (assumption is that all training required by the state and ARPA will be mandatory and fully funded in the payment model)
- Allocation of costs for time spent for team members to receive training (meaning coverage required by other staff members during this time)
- Factor in staff turnover rates and associated incremental costs for training and other costs due to turnover
- Ancillary costs associated with mobile teams (e.g., naloxone, harm reduction supplies)
- Administrative costs

The mobile crisis encounter data for year one as described in the above section, will allow the establishment of rates, and eventually transitioning to a capitated Per Member Per Month (PMPM) fee or a bundled payment for the provision of services. This may also include transitioning to more alternative payment models with quality components and the potential for earning incentive funding for meeting specific metrics, including the potential for upside risk if meeting specific performance metrics and option of taking downside risk.

Conclusion

HMA offers the recommendations below across the 10 mobile crisis service elements. These recommendations are based on our in-depth analysis of each element.

Recommendations Summary Table

Table 15. Summary of Recommendations

Mobile Crisis Services Elements	Recommendations
Collaboration and Coordination Across Systems of Care	• Integrate 988 within front end crisis response to ensure seamless experiences for individuals and promote effective community partnerships • Develop Crisis/EMS Partnerships to promote ED diversion and involvement of law enforcement at time of crisis • Partner with school districts and crisis providers to develop a program supporting education/awareness and to develop a school-based mobile crisis assessment

Mobile Crisis Services Elements	Recommendations
	• Develop a workgroup to examine within and across partner organizations to improve crisis planning and transitions of care • 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.) • MCT model should explicitly state coordination with and referrals to health, social and other services and supports • Explore interstate collaboration agreements with neighboring states such as Massachusetts, New Hampshire and Maine
Mobile Team Composition	• Require a multidisciplinary team for mobile crisis team staffing requirements in alignment with best practices and CMS guidance • While Vermont's definition of behavioral health professional that includes both master's level and bachelor's level staff allow a larger pool of eligible staff, ongoing workforce development challenges may impede ramp up efforts of MCTs to provide 24/7 community-based mobile crisis services. Development of robust trainings for bachelor's level staff can be a vehicle for VT to promote this BA level crisis workforce • 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. Vermont's recent legislation requiring peers be included in mobile crisis team staffing will advance the efforts to improve workforce development that is necessary for 24/7 two-person response teams
Training	• Promote the use of national tools • Implement trainings that may be adopted and adapted across specialized populations • Develop robust trainings for bachelor's level mobile response team staff • Enhance peer support raining • Require harm reduction training • Train providers on the use of standardized and validated screening and assessment tools • 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 & formats • Train providers on core clinical competencies to serve the following special populations: a. Individuals with intellectual and developmental disabilities c. Culturally and linguistically diverse populations d. Older adults e. Veterans f. Homeless individuals g. LGBTQIA2+

Mobile Crisis Services Elements	Recommendations
Mobile Crisis Response Systems & Evidence-Based Best Practice	• MCT contract requirements should explicitly state service must be available 24/7 in community settings • Revise Emergency Service Standards and Mental Health Provider Manual to include substance use in populations served • Incorporate the unique needs of youth and families into the model building off of the successes of the MRSS and the wraparound process • Use of standardized assessment tool should be required • 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 mobile crisis teams • 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 • 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
Technology	In alignment with other state technology planning, the state should develop a crisis system services technology plan that: • Aligns and integrates with other Vermont technology initiatives • Identifies sources for funding technology • Develops an implementation plan with a specific implementation date • Utilizes crisis system technology best practices that support integration across crisis services including: ○ Electronic health records that are customized for crisis calls (document crisis events and has decision support tools that are guided by risk scoring), have an electronic dispatch of mobile teams that include sharing of clinical information and auto collects time stamp of activity with the press of a button ○ GPS-enabled mobile dispatch in which a call center hub and community mobile service providers electronically communicate, while enabling the call center to see a visual representation of the availability and location of mobile teams in the community ○ Electronic devices for mobile teams (e.g., tablets) to receive dispatch, allowing for access to critical information about the individual or family they are deployed to go see (e.g. features that allow for easy recording of time stamps as well as receiving and sending information regarding the crisis need and intervention)

Mobile Crisis Services Elements	Recommendations
	○ Technology tools to support mobile teams in electronically setting up appointments with community-based providers ○ Integrates with the Vermont bed-registry already operating ○ Real-time and static dashboards to know the current state and performance of the crisis system overall (calls, mobile teams, crisis walk-in) ○ Text and chat technology • Utilize the use of the CMS enhanced administrative claiming maximizing all that is allowable for implementing crisis technology including call centers capabilities that interact with mobile crisis • Promote use of telehealth to improve access to rural areas and expand access to underserved populations
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 needed by the community to ensure that there is a sufficient mobile crisis response available per the CMS' staffing guidance and within the timeframes that Vermont establishes. The state should consider if the capabilities are within a state agency or through vendor services • The state should develop a short- and long-term approach for using data within a workforce prediction model to determine mobile crisis staffing availability requirements. Short-term approach should use the best available and publicly available data to establish initial mobile crisis staffing availability requirements. A longer-term strategy must include collection of critical data points to use moving forward with adjusting the mobile crisis staffing availability requirements per need
Mobile Crisis Contracting	Given that crisis response is a specialty service within the continuum of mental health and the oversight of crisis services requires particular skills, 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 the is proper oversight. Options for the state include: • Consider procuring mobile crisis services directly apart from DA contracts. This option would require the state to build internal infrastructure to procure and monitor the contracts • Contracts should include all the CMS requirements and crisis care and operational best practices such as use of technology for recording of crisis care interventions, electronic dispatch, data collection, analytics, and information sharing, and dashboards supporting transparency with the community. The contracts should also include reporting requirements and meeting performance metrics

Mobile Crisis Services Elements	Recommendations

Quality Performance Measure Tracking	• Develop provider and system level metrics are designed to monitor effectiveness and ensure quality. These quality assurance strategies, when implemented together, will also strengthen relationships across the crisis continuum to better serve those in need and assist with long-term quality improvement efforts
	• AHS should determine targets for performance on each of the quality metrics**.** At minimum, quality metrics for the mobile crisis teams should include:
	  ○ Average response time
	  ○ Disposition of the case
	  ○ Location of intervention (community mental health center, home/work, ED etc.)
	  ○ Percentage of individuals who receive follow-up care within 48 hours
	• 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 a community mental health center/"office-based" setting
	• Modify MSR data elements collected by MCTs to include time elements, location of service, disposition and follow-up care by MCTs (inclusive of modality – in-person or telehealth)

Quality Oversight	• Identify a single entity should be accountable for oversight of performance of the crisis system and ensure services are delivered in alignment with best practice. Quality oversight functions include but are not limited to:
	  ▪ Provider Contracting
	  ▪ Network Management
	  ▪ Training (either directly or oversight of service provider's own staff training)
	  ▪ Leverage technology infrastructure for data collection and reporting of quality measures
	  ▪ Provider Payments
	• AHS should consider contracting with a behavioral health administrative service organization (BH ASO) to administratively manage community-based mobile crisis services. The contract should also include all CMS requirements and requirements to facilitate crisis care collaboration with system partners, and other activities to advance crisis care intervention and continuously improve outcomes for individuals and families accessing or in need of crisis care

Mobile Crisis Services Elements	Recommendations
Funding and Multi-Payer Reimbursement Strategies	Potential policy and financing options for developing a multi-payer strategy that may include: ▪ Adding mobile crisis services to the essential health benefit (EHB) benchmark plan ▪ Enforcing the federal Mental Health Parity and Addiction Equity Act (MHPAEA) that would require mobile crisis services to be included under parity through legislation ▪ Enacting legislation to require fully insured and large groups and state employee health plans to provide mobile crisis services