Family Service
OF RHODE ISLAND

4/10/2025

The Honorable Susan R. Donovan
Chair, House Committee on Health and Human Services
State of Rhode Island General Assembly
82 Smith Street, Providence, RI 02903

Re: Support for H6118

Chair Donovan and Members of the Committee

I am writing in strong support **of H6188, which requires private insurers to cover mental health crisis mobile response and stabilization services.** This bill would ensure that *all* children and youth have access to mobile response and stabilizations services, a proven model for diverting children and youth from emergency departments, law enforcement involvement, and or psychiatric hospitalization.

FSRI is a behavioral health and social service organization that has been serving Rhode Islanders for decades, including programming to support healthy child development, provide essential behavioral health services, and coordinate crisis intervention programs that help children and families thrive. FSRI is also one of Rhode Island's eight Certified Community Behavioral Health Clinics (CCBHCs).

FSRI has been providing children's mobile response and stabilization services (MRSS) in Rhode Island since November 2022. MRSS is a crisis intervention model of care that is considered best practice in our field in responding to children and youth who are experiencing a behavioral health crisis. We offer face-to-face crisis assessments in the home, community, school, or wherever the family is comfortable, 24/7/365. The MRSS model is designed to deploy both a clinician as well as a case manager or peer specialist in an effort to ensure the child and family receive as much support as possible during and after the crisis.

What is unique about the MRSS model is that in addition to the crisis assessment, all children and families who access our program are offered up to 30 days of follow-up clinical services. These follow-up services act as a bridge for the youth until they can be enrolled in an appropriate clinical service. As you can imagine, with the current crisis we are experiencing in children's behavioral health, this service has been a lifeline for many children and families who have not been able to access care when they need it most.

MRSS is an evidence-based practice, and as such, services must adhere to the model. This includes following the fidelity tool developed by The Center for Innovative Practices (CIP) and Child and Adolescent Behavioral Health Center of Excellence at Case Western Reserve University's Mandel School of Applied Social Sciences (see attached) for effectiveness.

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So far, under the model, over 90% of Rhode Island children and youth referred to MRSS have been deferred from emergency departments and more restrictive and costly higher levels of care. This model is working! *Of those we serve, close to 30% are children and youth covered under commercial insurance.* It is vital these youth continue to be able to access this proven model of care, as this bill proposes.

We currently have one contract with commercial plans for MRSS through Blue Cross Blue Shield of Rhode Island (BCBSRI). We appreciate BCBSRI's acknowledgement of this critical service, and it has been a pleasure to work with them as they have prioritized this proven behavioral health intervention for children.

We urge you to pass H6118 to provide all Rhode Island children and youth with equal access to MRSS, and ensure the health and wellbeing of our state.

Thank you,

Margaret Holland McDuff, CEO

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MRSS Fidelity Tool Version 11/2023
Child and Adolescent Behavioral Health Center of Excellence/Center for Innovative Practices

MRSS Benchmark Components							
Rating	**0**	**1**	**2**	**3**	**4**	**5**	**6**
Benchmark 1 Initial Visit: Face-to-face in the home or community **90% Benchmark**	**Benchmark data:** 0-64% of the cases had a face-to-face visit in the community.	**Benchmark Data:** 65-69% of the cases had a face-to-face visit in the community.	**Benchmark data:** 70-74% of the cases had a face-to-face visit in the community	**Benchmark Data:** 75-79% of episodes had a face-to-face visit in the community.	**Benchmark data:** 80-84% of the episodes had a face-to-face visit in the community.	**Benchmark data:** 85-89% of the episodes had a face-to-face visit in the community.	**Benchmark data:** 90-100% of the episodes had a face-to-face visit in the community.
Benchmark 2 MRSS Services: Safety planning **90% Benchmark**	**Benchmark Data:** 0-64% of the time a safety plan was done at first contact with the youth.	**Benchmark Data:** 65-69% of the time a safety plan was done at first contact with the youth.	**Benchmark Data:** 70-74% of the time a safety plan was done at first contact with the youth	**Benchmark Data:** 75-79% of the time a safety plan was done at first contact with the youth.	**Benchmark Data:** 80-84% of the time a safety plan was done at first contact with the youth.	**Benchmark Data:** 85-89% of the time a safety plan was done at first contact with the youth.	**Benchmark Data:** 90-100% of the time a safety plan was done at first contact with the youth.
Rating	**0**	**1**	**2**	**3**	**4**	**5**	**6**
Benchmark 3 Response Time: Immediate: 60 Minutes **80% for Triage Decision Only**	**Benchmark data:** 0-59% or below of the immediate episodes of care receive face-to-face services in the community within 60 minutes.	**Benchmark Data:** 60-64% of the Immediate episodes of care receive face-to-face services in the community within 60 minutes.	**Benchmark data:** 65-69% of the Immediate episodes of care receive face-to-face services in the community within 60 minutes.	**Benchmark data:** 70-74% of the Immediate episodes of care receive face-to-face services in the community within 60 minutes.	**Benchmark data:** 75-79% of the Immediate episodes of care receive face-to-face services in the community within 60 minutes.	**Benchmark data:** 80-100% of the immediate episodes of care receive face-to-face services in the community within 60 minutes.	

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Benchmark 4 Service Outcome: Stabilization Services Received **70% Benchmark**	**Benchmark data**: 0-49% or less of youth received stabilization services (4 days or more)	**Benchmark Data** 50-54% of youth received stabilization services (4 days or more)	**Benchmark data**: 55-59% of youth received stabilization services (4 days or more)	**Benchmark data**: 60-64% of youth received stabilization services (4 days or more)	**Benchmark data**: 65-69% of youth received stabilization services (4 days or more)	**Benchmark data**: 70-100% of youth received stabilization services (4 days or more)	
Benchmark 5 MRSS Services: Family Defined Problem **90% Benchmark**	**Benchmark Data:** 0-69% of time the family defined the problem.	**Benchmark Data:** 70-74% of time the family defined the problem.	**Benchmark Data:** 75-79% of time the family defined the problem.	**Benchmark Data**: 80-84% of time the family defined the problem.	**Benchmark Data**: 85-89% of time the family defined the problem.	**Benchmark Data:** 90-100% of time the family defined the problem.	
Benchmark 6 Referrals and linkages **80% Benchmark**	**Benchmark data**: 0-59% of the clients were referred to services or supports that were indicated prior to MRSS discharge.	**Benchmark data**: 60-64% of the clients were referred to services or supports that were indicated prior to MRSS discharge.	**Benchmark data**: 65-69% of the clients were referred to services or supports that were indicated prior to MRSS discharge.	**Benchmark data**: 70-74% of the clients were referred to services or supports that were indicated prior to MRSS discharge.	**Benchmark data**: 75-79% of the clients were referred to services or supports that were indicated prior to MRSS discharge.	**Benchmark Data:** 80-100% of the youth/families were referred to services or supports that were indicated prior to MRSS discharge.	

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Rating	**0**	**1**	**2**	**3**	**4**	**5**	**6**
Benchmark 7 MRSS Service Availability		**Benchmark data:** MRSS is only available for immediate Mobile Response during weekday business hours evidenced by weekly staffing schedule.	**Benchmark data:** MRSS Services available for immediate Mobile Response during extended business hours (at least 8 pm weekdays) AND/OR on weekends evidenced by weekly staffing schedule.	**Benchmark data:** MRSS Services available for immediate Mobile Response during extended business hours (at least 10 pm weekdays) AND on weekends evidenced by weekly staffing schedule.	**Benchmark data:** MRSS services available 24/7 for an immediate Mobile Response evidenced by weekly staffing schedule.		

Incentive/Bonus Points

Rating	**1**	**2**
MRSS Services: Youth and/or Family Peer Support Services **2 Potential Incentive Points**	25 – 49% Youth and/or caregiver received youth and/or family peer support services.	50 – 100% Youth and/or caregiver received youth and/or family peer support services.

MRSS Program Components					
Rating	**0**	**1**	**2**	**3**	**4**
8. Duration of Services: 42 Days	MRSS episode of care exceeds 42 days more than 40% of MRSS cases.	MRSS episode of care exceeds 42 days in 31 to 40% of the cases served.	MRSS episode of care exceeds 42 days in 21 to 30% of the cases served.	MRSS episode of care exceeds 42 days in 11 - 20% of the cases served.	MRSS episode of care exceeds 42 days in less than 10% of the cases served.
9. Safety plan content	Comprehensive safety planning includes one or less of five criteria (a)	Comprehensive safety planning includes two out of five criteria (a–b).	Comprehensive safety planning includes three out of five criteria (a–c).	Comprehensive safety planning is present in 100% of stabilization charts reviewed and includes four out of five criteria (a–d).	Comprehensive safety plans are present in 100% of charts reviewed and include the following: **a)** Assessment of safety concerns, risk behaviors, escalation patterns, and crisis triggers. **b)** Safety plans have actionable crisis stabilization steps created in collaboration with youth and family with strategies that are easily understood. **c)** Risk mitigation and safety promotion steps were identified, implemented, monitored, and updated as needed. **d)** Safety plans incorporate natural supports & do not rely exclusively on professional resources. **e)** Individualized safety plans, signed by youth and caretaker. Documentation of plan being provided to the family.
10. Stabilization Services	MRSS program routinely provide 3 or less out of 7 services listed (a-g)	MRSS program routinely provide 4 of 7 services listed (a-g)	MRSS program routinely provide 5 of 7 services listed (a-g)	MRSS program routinely provides 6 of 7 services listed (a-f)	**Trauma-informed stabilization services and supports are provided as evidenced by:** a) MRSS Comprehensive Crisis Assessment b) MRSS Plan **c)** Ongoing crisis stabilization **d)** System navigation, advocacy, continuity of care, and collaborative treatment and discharge planning **e)** Skill building with youth (communication, problem solving, regulation and coping skills) **f)** Skill building with parents/caretakers: Behavior management skills **g)** Individual and family support network development

11. System of Care Perspective	MRSS is implemented utilizing system of care principles as evidenced by meeting 2 or less of the 6 criteria (a-f).	MRSS is implemented utilizing system of care principles as evidenced by meeting 3 out of the 6 criteria (a-f).	MRSS is implemented utilizing system of care principles as evidenced by meeting 4 out of the 6 criteria (a-f).	MRSS is implemented utilizing system of care principles as evidenced by meeting 5 out of the 6 criteria (a-f).	**MRSS is implemented utilizing System of Care principles including:** **a)** Culturally and linguistically appropriate **b)** Trauma-informed **c)** Resiliency–focused and developmentally appropriate **d)** Strength-based **e)** Youth guided, family-driven **f)** Individualized to the unique needs and strengths of the youth and family
12. Clinical Supervisory Management, Support, and Availability	Supervisory support as evidenced by one or fewer criteria met (a-c).	Supervisory support as evidenced by 2 out of 5 criteria (a-c).	Supervisory support as evidenced by3 out of 5 criteria (a-c).	Supervisory support as evidenced by 4 out of 5 criteria (a-d).	**Best practice criteria:** **a)** Staff receive individual supervision, that is appropriate for the staff person's role, scope, and expertise. **b)** Weekly group supervision conducted by a clinical supervisor or alternate clinical supervisor. **c)** Supervisory support is available 24/7 to MRSS staff for emergency consultation and supervision. **d)** Clinical Supervisor or alternate clinical supervisor is available for on-call back up for MRSS families. **e)** Triaging and monitoring of level of acuity for every youth and family served is conducted by the clinical supervisor or clinical alternate supervisor who also assists staff in tailoring the service intensity to the stabilization needs of each youth and family.
13. Professional training and development	Professional training and development as evidenced by one of the five criteria (a-c).	Professional training and development as evidenced by 2 out of 5 criteria (a-c).	Professional training and development as evidenced by 3 out of 5 criteria (a-c).	Professional training and development as evidenced by 4 out of 5 criteria (a-d).	**Best practice criteria:** **a)** Every MRSS staff member, including the supervisor and peer supervisor complete the MRSS Core Training within 60 days of employment start date. **b)** Each MRSS staff including supervisor, peer supervisor and after-hours coverage staff have an individualized training plan based on an assessment of his or her specific training needs. **c)** Each MRSS supervisor receives training specific to the clinical & administrative supervision of MRSS.

					d) Each agency has a written description of the skills and competencies required to provide MRSS service. **e)** The agency's training plan includes provisions for quarterly trainings specific to the identified training needs of the staff.
14. Quality Management and Practice improvement	Quality and practice improvement strategies utilized as evidenced by 1 or less of 5 (a).	Quality and practice improvement strategies utilized as evidenced by 2 out of 5 (a & c).	Quality management and practice improvement as evidenced by 3 of the 5 criteria (a-c).	Quality management and practice improvement as evidenced by 4 (a-d) of the 5 criteria.	**Best practice criteria:** a) Family Satisfaction with services data (report from BG or paper copies) is collected and utilized for quality improvement. **b)** External expert clinical consultant utilized. c) Benchmarks are regularly tracked and reviewed (i.e., response time for initial call etc.) and utilized in program quality improvement. d) Utilizes daily service-load tracking to implement real-time staffing adjustments. **e)** Additional agency specific outcomes utilized.
15. Worker Safety	Worker safety protocols are evidenced by 2 out of 6 criteria (a-f).	Worker safety protocols are evidenced by 3 out of 6 criteria (a-f).	Worker safety protocols are evidenced by 4 out of 6 criteria (a-f).	Worker safety protocols are evidenced by 5 out of 6 criteria (a-f).	**Worker Safety includes the following criteria:** **a)** Program has written protocols and policies for worker safety. **b)** Supervisor and/or team leader as well as administrative supervisor have access to staff schedules. **c)** Program has a protocol for staff check-ins when appointments are finished. **d)** Program establishes and maintains positive working relationships with local CIT officers. **e)** Safety screening protocol for first visit is utilized **f)** Staff are issued agency cell phones and hot spot technology (or are reimbursed for these).

16. MRSS Staffing and Capacity	**Team Composition and Program Capacity**: **a)** Clinical Supervisor Less than 24% dedicated. **b)** BA level or higher MH licensed staff; and **c)** QBHS; OR a certified family or young adult peer support. **d)** No access to psychiatrist or certified nurse practitioner or clinical nurse specialist. **e)** MRSS provider operates in isolation – No QMHS or youth/family peer supporter.	**Team Composition and Program Capacity**: **a)** Clinical Supervisor 25 - 49% dedicated. **b)** BA level or higher MH licensed staff; and **c)** QBHS; OR a certified family or young adult peer support. **d)** Limited or no access to psychiatrist or certified nurse practitioner or clinical nurse specialist. **e)** MRSS Services are available for an immediate mobile response only during weekday business hours.	**Team Composition and Program Capacity**: **a)** Clinical Supervisor (50-74% dedicated); and **b)** BA level or higher MH licensed staff; and **c)** QBHS; OR a certified family or young adult peer support. **d)** Limited access to a psychiatrist or certified nurse practitioner or clinical nurse specialist for consultation purposes. **e)** MRSS services available for an immediate response during extended business hours until 8 pm weekdays and/or on weekends evidenced by weekly staffing schedule. **f)** During periods of high-call volume, staff have to reschedule stabilization phase appointments.	**Team Composition and Program Capacity**: **a)** Clinical Supervisor (75-99% dedicated); and **b)** BA level or higher MH licensed staff; and **c)** QBHS; OR a certified family or young adult peer support. **d)** Access to a psychiatrist or certified nurse practitioner or clinical nurse specialist for consultation purposes. **e)** MRSS services. available during extended business hours at least to 10 pm weekdays AND on weekends evidenced by weekly staffing schedule. **f)** Sufficient staff are available during periods of high-call volume - staff do not need to reschedule stabilization.	**Team Composition and Program Capacity**: **a)** Clinical Supervisor(s) (100% dedicated); and **b)** BA level or higher MH licensed staff; and **c)** QBHS; OR a certified family or youth peer supporter. **d)** Access to a psychiatrist or certified nurse practitioner or clinical nurse specialist for consultation purposes. **e)** Mobile services are available for an immediate full 24/7 response evidenced by weekly staffing schedule. **f)** Sufficient staff are available during periods of high-call volume - staff do not need to reschedule stabilization.