MRSS

Mobile Response & Stabilization Services

Mobile Response and Stabilization Services

Practice Standards

Version 3.2- September 2026

Department of Behavioral Health

Center for Innovative Practices
Child & Adolescent Behavioral Health Center of Excellence

Table of Contents

Overview Page 3
MRSS Within the System of Care Page 3
MRSS Definition Page 4
MRSS Goals & Objectives Page 5
Intersystem Collaboration Page 6
Parameters of Operation Page 6
Target Population Page 7
Family/Caller Defined Crisis Page 7
Services Availability & Initiation Page 8
Service Location Page 9
Intersection with EDs Page 9
Intersection with Facility Based Care Page 10
Consent Page 11
Length of Stay & Intensity Page 11
Family Engagement Page 12
Cultural & Linguistic Competency Page 12
Trauma-Informed Care Page 13
MRSS Staffing Page 13
RMP Key Personnel Page 13
MRSS Team Composition Page 14
Integration of Peer Supporters Page 18
Psychiatric Consultants Page 18
Staffing Levels Page 19
Staff Competencies Page 19
MRSS Service Delivery Page 21
Screening/Triage Page 22
Mobile Response Page 23
Initial Mobile Response Page 24
Additional Mobile Response Activities Page 25
Ongoing Stabilization Page 27
Regional Service Delivery Page 27
Additional Service Standards Page 29
Individualized Safety & MRSS Plans Page 29
Linking to Ongoing Services & Supports Page 31
Transition from MRSS Page 31
Additional Situations/Readmissions Page 32
Provider Certification Page 33
Consultation & Fidelity Reviews Page 33
Marketing Page 34
Data Management Page 34
Quality of Care & Quality Improvement Page 35

Overview

The Mobile Response and Stabilization Services (MRSS) Practice Standards are authorized by the Ohio Department of Behavioral Health and serve as the basis for process improvement and expansion of MRSS to advance behavioral health services for the state's young people. The intent of these standards is to establish expectations for operational components and to guide implementation, while allowing ample flexibility to accommodate county/regional needs and practice innovation. The standards outline the goals, guiding principles, eligibility criteria, service components, implementation of model best practices, roles and responsibilities, data collection and quality assurance initiatives and resources recommended for MRSS. The Practice Standards have been developed through a collaborative process including Ohio Department of Behavioral Health staff, Board Authorities, Case Western Reserve University's Child and Adolescent Behavioral Health Center of Excellence (CABH COE), service providers, peer supporters, parents, youth, and national experts in children's mobile crisis and stabilization services. The Ohio MRSS model incorporates national best and promising practices for youth mobile crisis and is informed by statewide or highly established MRSS programs in Connecticut, New Jersey, Oklahoma and Nevada.

MRSS Within the System of Care

Ohio's MRSS was initially developed and implemented in several counties on a pilot basis in 2018. It was fully implemented in July of 2022 as one component of the OhioRISE (Resilience through Integrated Systems and Excellence) service array. MRSS is integrated as an essential service within Ohio's system of care (SOC) to fill a gap for youth and families needing an urgent behavioral health response to a situation that is defined as a crisis by the youth or family. MRSS is available to young people aged 20 and under, and their families in counties where MRSS is available. MRSS is designed to avert unnecessary emergency department (ED) visits, inpatient admissions, out-of-home placements, and placement disruptions, and juvenile justice involvement. Operating within a high quality, culturally and linguistically competent children's crisis continuum, MRSS works to keep a child, youth, or young adult safe at home, in the community, and in school whenever possible. MRSS is a cost-saving viable alternative to acute care and has demonstrated improved outcomes and high levels of family satisfaction.

Note: Behavioral health treatment services within the overall system of care are not always immediately available to youth and families. MRSS is a brief intervention and stabilization program, and it is important that referents remain mindful of the purpose and scope of the program. Youth and families should be encouraged to access MRSS to address urgent situations. A family should not be referred to MRSS for the sole reason of providing support until other services become available.

Note: As part of the effort to launch the next generation of its managed care program, the Ohio Department of Medicaid (ODM) implemented OhioRISE in 2022. OhioRISE is a specialized managed care program for youth with complex behavioral health and multi-system needs. Its services include MRSS, moderate and intensive care coordination, Intensive Home-Based Treatment (IHBT), Psychiatric Residential Treatment Facilities (PRTF), and behavioral health respite.

MRSS Within a Crisis Continuum of Care

MRSS is an essential part of Ohio's crisis continuum of care and is intended to supplement, rather than replace, other crisis-related programming for youth who present to emergency departments and/or specialized interventions for specific youth populations. Examples of other such programming include telephone-based crisis support lines and walk-in crisis services and screenings. Providers of such services are encouraged to refer families to MRSS (with the family's permission).

MRSS Definition

MRSS is a structured community-based, in-person intervention and stabilization service for youth and families, provided by certified MRSS teams. While effective in serving youth in acute crisis, MRSS is also an early intervention emergency program that often serves as a gateway to other services across the system of care.

MRSS is designed to promptly address situations in which young people are experiencing emotional symptoms, behaviors, trauma reactions and concerns that compromise or impact their ability to function within their family, living situation, school, or community. MRSS is informed by the unique strengths, needs, and culture of each youth and family served.

Rationale

Because options for assistance can be limited when young people experience a behavioral health crisis, families often utilize the options available to them (e.g., law enforcement, hospital emergency departments and inpatient treatment) for help. Primary goals of MRSS include reducing: 1) unnecessary use of emergency departments or acute care services; 2) out-of-home placements and/or disruptions from current living situations; and 3) involvement in the child welfare or juvenile justice systems. MRSS services are initiated proactively in response to young people who are experiencing significant emotional and behavioral distress due to trauma, conflict within the family, social challenges (e.g., bullying/ cyberbullying), and other situations. MRSS provides an effective and accessible alternative to more restrictive services for youth and families. A hallmark of MRSS is that youth, families, and other referrers define the crisis.

MRSS is designed to be a rapid intervention at the time and place the youth or family needs help and is not designed to be an office-based or telephonic service. Services are provided where the crisis occurs or at a community location requested by the family or other referrer. The MRSS team works closely with the youth and family to de-escalate and better understand the current crisis and create a safety plan. With the goal of helping families to better manage and prevent future crises, the team assists the family to enhance protective and resiliency factors, develop new skills and link to resources and supports. MRSS provides up to six weeks of stabilization from the date of the initial mobile response. Ready access to a psychiatrist or certified nurse practitioner or clinical nurse specialist for consultation purposes is available as needed.

MRSS Goals and Objectives

A. MRSS Goals

a. Mitigate risk and increase safety
b. Improve the abilities of families to manage behavior and prevent or effectively manage future crises
c. Provide immediate intervention and supports to assist young people, families/caregivers and other youth-serving entities in de-escalating and stabilizing behaviors, emotional symptoms and/or dynamics impacting the young person's life functioning
d. Assess, plan, and deliver appropriate interventions to stabilize the current crisis and prevent future crises
e. Enhance the resiliency and protective factors of families
f. Provide timely community-based interventions, skill building and resource development
g. Prevent/reduce the need for care in a more restrictive settings, such as inpatient psychiatric units, congregate care, and detention centers
h. Support the young person to live and function in the least restrictive home, school, and community settings
i. Facilitate the young person and caregiver's transition to identified supports, resources, and services (e.g., OhioRISE and other care coordination, evidence-based and promising community-based treatment services; community-based supports; and natural resources)

B. MRSS Objectives

MRSS services are guided by twelve objectives in three areas:

Young Person & Family Objectives

1. Stabilize the presenting crisis
2. Decrease risk and increase safety
3. Promote/enhance emotional and behavioral functioning
4. Empower young people and families to monitor, manage, and cope with situations to decrease the intensity and impact of future destabilizing events

Provider Objectives

5. Provide behavioral health stabilization services that are delivered in the home, school, and community, and that are responsive to youth and family need
6. Provide appropriate screening, early identification, and assessment of risk and safety concerns that minimally include suicide risk, non-suicidal self-injury, abuse and neglect, exposure to violence and/or other types of trauma, human trafficking risk, fire setting cyberbullying, substance use, risk of runaway, and other clinical presentations that pose an immediate or ongoing risk or safety issue
7. Incorporate system of care values and principles into all aspects of service delivery
8. Coordinate with existing providers and supports or facilitate linkage and transfer to appropriate level of services and support

System Objectives

9. Ensure that young people and their families have access to MRSS in their community
10. Whenever safe and possible, maintain youth in their homes and communities and reduce placement in costly, non-medically necessary and restrictive settings (e.g., emergency departments, congregate care, inpatient hospitalization, and incarceration).
11. Ensure MRSS is embedded in the youth behavioral health system of care
12. Increase community awareness of MRSS by providing education and outreach to families, schools, and communities

Intersystem Collaboration

An overarching goal of Systems of Care (SOCs) is for youth and families to receive the necessary array of services and supports to increase the likelihood of youth with complex behavioral challenges remaining at home and in their local communities. To achieve these aims, local SOCs, including care management and coordination entities, child-serving systems and programs, and formal and informal support networks share responsibility for prevention and intervention with youth and families experiencing high levels of distress. MRSS is embedded in the SOC and is an essential part of the crisis continuum of care. As part of a local SOC, MRSS develops collaborative partnerships to assure that services, supports, planning, and linkages are coordinated.

MRSS providers are encouraged to establish formal Memorandums of Understanding (MOUs) throughout the SOC. Examples include, but are not limited to:

- Local school district(s) to deploy MRSS when a young person is in distress and/or when they are at risk of 911 intervention.
- Children's Protective Services to deploy MRSS when children are experiencing a crisis related to a disruption in the living environment or entering custody
- Local law enforcement to access MRSS as an alternative to an arrest or bringing the youth to an emergency department.

Parameters of Operation

Ohio MRSS Statewide Infrastructure Landscape:

As a strategy to support statewide access to MRSS, Ohio created a regional MRSS provider structure that leverages regional and local resources to accelerate the expansion and sustainability of MRSS services. This regional approach to develop a statewide system includes both in-person MRSS services and telephonic support through two main components:

1. **Regional MRSS providers (RMP)**: The Regional MRSS Provider (RMP) is responsible for the delivery of high quality in-person MRSS services as defined in rule and practice standards for the entire regional catchment that they are assigned to. RMPs are the only entity eligible to receive reimbursement from Medicaid for MRSS services and are the only entity that will receive calls from the call center designated by the state. The RMP assumes responsibility to

provide the following functions for the entire coverage area assigned:

a. Provide Mobile Response and Stabilization Services (MRSS) responses to the entire coverage region for all calls that come during the minimum mobile response hours currently 8am-8pm Monday-Friday, including holidays
b. Ensure that all MRSS referrals received are responded to for the entire coverage region
c. If not 24/7, receive calls outside of minimum operating hours and provide telephonic intervention and support, develop a plan to address callers needs including but not limited to scheduling a next day in-person mobile response, and/or connecting to a more immediate safety net service like an emergency department or behavioral health urgent care center when the needs of the youth and family warrant immediate care
d. Engage in capacity building to work towards establishing regional operational hours of 24/7 mobile response coverage within three years from the effective date of the revised rule
e. Engage in regional quality monitoring, quality oversight and performance improvement of MRSS services. The RMP will accomplish this through data collection using the State's Data Management System (DMS), benchmark monitoring and engagement in fidelity monitoring processes established through the COE

2. **Call center designated by the state:** The call center designated by the state will be available 24/7 and is the primary point of entry for initiation of the MRSS service. The call center designated by the state will provide rapid screening and triage to initiate the deployment of MRSS services based on the results of the screening/triage. The screening and triage process holds a "just go" philosophy to deploy "immediate" in person MRSS services, except when the screening/triage process indicates an urgent and imminent need for 911, a caller requests a later response, beyond 60 minutes but within 48 hours, or when the triage indicates a need only for education regarding resources. The call center designated by the state will connect the youth and family caller directly to the assigned MRSS RMP through a seamless warm hand-off via direct call transfer.

A. Target Population

MRSS is delivered to any young person age 20 and under who is experiencing escalating emotional symptoms, behaviors, or traumatic circumstances that have impacted their ability to function within their family, living situation, school, or community. MRSS is available to all youth and families (birth, kinship, foster, guardianship, and adoptive). Youth need not have had previous behavioral health treatment and current involvement with a specific service or system is not necessary to access MRSS.

B. Family/Caller Defined Crisis

A hallmark of MRSS is that the young person and family and/or another referrer define what constitutes a crisis and their definitions of crises may vary from clinical practitioners. MRSS operates with a "just go" approach to all calls for service. These calls arise from situations, events, and/or circumstances that cannot be resolved with typical resources and coping skills,

or that jeopardize the youth's ability to use adaptive socio-emotional skills and strengths critical for healthy life functioning.

For those who have not yet transitioned to 24/7 operating hours, MRSS will continue to operate with a "just go" approach to all calls for service during the currently required minimum operating hours 8am-8pm Monday-Friday, including holidays.

C. Service Availability

MRSS-trained staff must be immediately and directly available to receive calls for service, including speaking with families and other referrers via a warm transfer process, and to respond to the location where the young person is experiencing the crisis or at another community location preferred by the family within 60 minutes during minimum mobile response hours. Beginning three years from the effective date of the revised rule, all MRSS providers will operate twenty-four hours a day, seven days a week, including holidays.

For any call received outside of minimum mobile response operating hours, either directly to the RMP or from the call center designated by the state, the RMP will provide telephonic support inclusive of triage, de-escalation, crisis intervention and support and will develop a monitoring plan, including check-in calls between the telephonic support team and the youth/family, until an in-person response is available at the next fully operational day of business.

At the outset of their next mobile response operating period, the RMP will review the calls that occurred during the non-response period, determine the outcome of the calls, the type of telephonic support provided, review the recommendations determined by the MRSS staff and family for next day support and provide the necessary outreach and follow up MRSS services. It is expected that MRSS staff be prepared to provide an initial mobile response at 8:00 am next business day for calls received outside of the 8am-8pm responding timeframe.

D. Service Initiation

MRSS may be initiated through direct connection with the RMP or call center designated by the state. In accordance with a "no wrong door" policy, MRSS may also be initiated by hotlines or warmlines.

MRSS referrals can be initiated by the young person, family members and caregivers, school staff, other youth serving providers, emergency departments and law enforcement and others. As described in OAC 5122-29-14 (N), under the emergency care doctrine recognized in Ohio, a minor of any age may receive emergency medical treatment to preserve life and prevent serious impairment without the consent of a parent or guardian. Because it may be difficult to determine whether an emergency situation exists until the risk assessment that occurs during the initial mobile response is completed, the MRSS phases of screening/triage

and mobile response are not to be delayed or denied to a minor due to inability to receive parental or guardian consent. Continuous efforts should be made to reach parents or guardians throughout the initial intervention and the MRSS team is responsible for communicating any pertinent safety-related information to them. The RMP needs to take into consideration the importance of meaningful inclusion of a parent or guardian in the development of a viable safety and supervision plan as part of the initial intervention. In the event a guardian declines, the intervention ends after immediate high-risk safety concerns are addressed. A brief screening and triage will take place at the time of referral to rule out the need for a 911 response and to otherwise recommend the appropriate MRSS response. Mobile responses will take place immediately (within 60 minutes) or, if specifically requested by the family or referrer, no later than 48 hours after the request for service.

E. Service Location

Youth and families in crisis are best served in their homes and local communities. MRSS is not an office-based or primarily telephonic service. MRSS services are to be provided at the location of the young person in distress or at a community location preferred by the youth, family, or another referrer. The best practice is for the mobile response and ongoing stabilization services to be provided face to face in person and in the community, unless extenuating circumstances (e.g., public health emergency, natural disasters, inclement weather, geographic distance, or other factors) prevent in-person interaction with the young person or family. When such instances occur, MRSS services can be provided via telehealth, as defined in rule 5122-29-31 of the Ohio Administrative Code, and providers must have the ability to provide telehealth services when necessary.

For those RMPs that are not yet 24/7 operational, RMPs may receive calls outside of the minimum mobile response operating hours from the call center designated by the state or directly from youth and families but may not have a mobile response available. In such circumstances, the RMP will provide telephonic support including; triage, de-escalation, crisis-intervention and support as part of developing a plan for access to necessary in person care, which often will include a next business day face-to-face MRSS response. All subsequent mobile response activities should be completed within the 72-hours from the initiation of the call to be in alignment with the parameters outlined in OAC 5122-29-14. During the after-hours telephonic response, the RMP will determine if an immediate connection to urgent behavioral health services is warranted (i.e. 911 or Emergency Departments).

F. Intersection with Emergency Departments

Youth in Emergency Department: When a youth is seen in an emergency department for behavioral health reasons, and subsequently stabilizes or is otherwise determined by emergency department staff to not need a higher level of care, as part of developing a viable community support plan, MRSS may be initiated to provide safety planning, crisis de- escalation

and stabilization support in accordance with the family's preferences. In these instances, the MRSS mobile response may take place at the emergency department, or families may prefer a non- immediate response after the youth's discharge from the emergency department. In such instances, emergency department staff should consult with families to make sure they agree with MRSS being part of the discharge/follow-up plan from the emergency department.

Occasionally, during an initial MRSS response or follow up response an MRSS provider may refer a youth to an emergency department for further evaluation and consideration as to whether the young person requires a higher level of care. In such instances, the MRSS team should communicate pertinent information to emergency department staff including any known risks and the rationale for the emergency department referral. Additionally, the MRSS team should follow-up with the family and the emergency department regarding the status of the youth. If the emergency department staff determines that the youth will be discharged home or has already been discharged, the MRSS team should continue efforts to further de-escalate and stabilize the youth, as warranted and according to the family's preferences.

Outside of RMP minimum mobile response operating hours: When an RMP receives a request for MRSS services outside of the minimum mobile response operating hours, the RMP will provide telephonic after-hours support that includes triage, telephonic de-escalation, crisis intervention and support while developing a plan for access to necessary care, which often will include a next day face-to-face MRSS response. There may be circumstances outside the minimum operating hours wherein the RMP determines that the youth and family require access to urgent behavioral health services and may refer them to 911, a local emergency department or other safety net after hours service.

Note: If a youth is enrolled in OhioRISE, the MRSS staff should contact the assigned Care Management Entity (CME) or Care Coordinator to notify them of the youth's emergency room involvement. The OhioRISE Care Coordinator's contact information can be found using the CANS IT Portal when MRSS staff are accessing the portal to determine if a CANS assessment is needed or MRSS staff can email ohiorisecarecoordination@aetna.com to inquire about contact information.

G. Intersection with Facility-Based Care

Youth in Facility-Based Care: If a youth is in a facility-based care setting (e.g., intermediate care facilities, juvenile detention centers, crisis stabilization units, residential centers, etc.) and it is determined that they will be discharged back into the community, MRSS may be an appropriate intervention at their time of discharge as part of a viable community support plan to provide safety planning, crisis de-escalation, and stabilization support in accordance with the family's preferences. MRSS should not be initiated prior to 48 hours from the date of the young person's discharge from the facility-based care setting.

Admissions into Facility-Based Care: If a youth is admitted into a facility-based care setting (e.g., intermediate care facilities, juvenile detention centers, crisis stabilization units, residential

centers, etc.) during either the mobile response phase or stabilization phase of services, and it is clear the youth will not return home, then the episode of care typically ends. If the youth is admitted into a facility-based care setting during either the mobile response phase (with the necessary admission requirements for the stabilization phase completed) or the stabilization phase of services, and the anticipated length- of- stay will be brief, the MRSS episode of care may remain open. In such instances, the MRSS team would continue to support the family as they prepare for the youth to return to the community. It is also important to note that if the MRSS episode of care remains open while the young person is in a facility-based care setting, the days while admitted still count towards the length-of-stay in MRSS of up to 6 weeks or 42 days from the initial mobile response.

H. Consent

While minors usually need the consent of a parent or guardian before receiving medical care, including behavioral health care, a minor may receive emergency medical treatment to preserve life and prevent serious impairment without the consent of a parent or guardian under the emergency care doctrine recognized in Ohio as described in OAC 5122-29-14 (N). In accordance with OAC 5122-29- 14 (M), a young person who is at least 18 years of age or an emancipated minor is to consent to their receipt of MRSS. A young person who is at least 14, but less than 18 years of age, may consent to their receive of MRSS subject to the limitations in ORC 5122-04 (https://codes.ohio.gov/ohio-revised-code/section-5122.04). Continuous efforts should be made to reach parents or guardians throughout the initial intervention and the MRSS team is responsible for communicating any pertinent safety-related information to them. The RMP needs to take into consideration the importance of meaningful inclusion of a parent or guardian in the development of a viable safety and supervision plan as part of the initial intervention.

The MRSS team collects data for quality assurance and improvement (QA/QI) purposes. Per Ohio Department of Behavioral Health, consent to collect and enter data into the MRSS DMS is not specifically needed. However, the Ohio Department of Behavioral Health issued the following guidance language for providers to incorporate into consent for treatment: “As a part of my/my child’s treatment, I consent to data related to the Mobile Response and Stabilization Services I/my child receives to be shared with the State of Ohio Department of Behavioral Health for quality assurance and program evaluation purposes.” Families should be assured that data used for QA/QI purposes will be de-identified.

I. Length of Stay

An episode of MRSS care should last no more than 6 weeks or 42 days from the date of the initial mobile response and is informed by the youth and family’s unique needs and MRSS goals.

J. Intensity

MRSS services are provided through:

- Face-to-face contacts with the youth and/or family
- Telehealth (within established parameters)
- Telephone contacts with the family following the initial mobile response
- Telephonic or face-to-face collateral contacts

On average, young people and their families involved in MRSS initial response and stabilization phases will receive two face-to-face contacts for every seven days of service. The frequency of the response is based on current assessment, acuity and/or complexity of youth and family needs, the goals for the intervention and agreement with the family. For these reasons, some families will receive more than two visits while others will receive less.

K. Family Engagement

Young people and their families are full partners in all aspects of the planning and delivery of their MRSS services. MRSS ensures the voice and choice of the youth and family in the referral and selection of services and supports available in their community. These can include traditional and non-traditional services, as well as informal and natural supports. The young person and family will participate in decision making regarding all aspects of the services received through MRSS, including, but not limited to:

- Safety planning
- Identifying needs and preferences for MRSS service delivery and ongoing support
- Convening and participating in all planning meetings, including having voice and choice on which team members they would like to attend meetings
- Goal setting
- Identifying skill-building opportunities
- Determining service intensity
- Determining location of services
- Identifying referrals to resources post MRSS involvement

L. Cultural and Linguistic Competency

The MRSS provider must offer culturally and linguistically appropriate services to all young people and families. Agency expectations include:

- Hiring of bilingual or multilingual MRSS staff members as well as, hiring staff that reflect the demographics of the population being served
- Provision of written materials, including MRSS Plans, safety plans and consent forms that are understandable to families, written at an appropriate reading level and, when possible, in the language of the youth and family
- Assessment and incorporation of the cultural needs and preferences of the young person and family into plans, services provided and linkages to community supports

- Ensuring that staff have knowledge of unique cultures in their service areas and culture- specific values and practices which may impact service delivery
- Using current information related to disparities in access and outcomes of MRSS services to develop strategies for program improvement
- Using professional translation services when staff members are unable to accommodate families' language needs, including providing services in the primary language spoken in the home

M. Trauma-Informed Care Service Delivery

MRSS ensures that every part of the program incorporates the impact of trauma on the individuals they serve and adopts a culture that considers and addresses this impact. Many youth seeking MRSS have experienced significant trauma, and, in turn, many behavioral health crises are rooted in trauma. While at times necessary, MRSS works to divert children from environments and interventions which may introduce unintentional harm to youth and families (e.g., loss of freedom and separation from loved ones; noisy and crowded environments; exposure to others' crises; and/or the use of restraints), such as what might be experienced or witnessed in emergency departments, inpatient units or detention centers. These situations can traumatize/ re-traumatize individuals, exacerbate symptoms, escalate the current crisis, and may contribute to reluctance to seek help in the future. Trauma-informed care is an essential element of MRSS. MRSS providers must ensure that the following guiding principles, (established by SAMHSA in 2014) are integrated into service delivery:

- Safety
- Trustworthiness and transparency
- Peer support and mutual self-help
- Collaboration and mutuality
- Empowerment, voice and choice, and
- Ensuring that cultural, historical and gender considerations inform the care provided

Developing and maintaining a healthy environment of care also requires support for staff who may have experienced trauma themselves and/or who may be exposed to traumatic experiences when providing MRSS services.

MRSS Staffing

A. Staff Composition

Regional MRSS Provider (RMP) Key Personnel:

1. Regional Clinical Director: The regional clinical director is responsible for oversight of the clinical and operational aspects of MRSS services for the entire assigned region. The regional clinical director will provide clinical and operational leadership to all of the MRSS teams that make up the region's network of MRSS service providers. The clinical director will be responsible

for activities that include, but are not limited to; provision of clinical and administrative supervision to the MRSS team supervisors' across the region, oversee clinical quality assurance processes, develop and monitor a regional MRSS workforce development strategy aligned with regional capacity needs, develop community partnerships, convene community partners and stakeholders across the entire region and serve as a conduit for communication between Ohio Department of Behavioral Health, the COE and the call center designated by the state. The regional clinical director will provide real-time clinical consultation, supervision and support to MRSS staff throughout the entire region as needed.

2. Regional Quality Assurance Personnel: Each RMP is responsible for designing an organizational plan for Regional MRSS quality assurance monitoring and oversight. As part of the RMPs commitment to quality, the RMP will have personnel dedicated to quality assurance activities. Quality assurance activities will include but are not limited to; ensuring the region is compliant with data collection parameters, compliance status with training, supervision, minimum credentialing, and certification parameters, compliance with the established Ohio Department of Behavioral Health and ODM rules, monitoring the overall MRSS service implementation through program benchmarks, identifying areas for improvement, identifying system trends, gaps and needs and to track overall progress towards achieving benchmarks and fidelity metrics. The regional quality personnel will work in concert with the Regional Clinical Director, MRSS supervisors, State personnel, COE and community stakeholders to track progress towards achieving the regional milestones that will result in operationalization of a high fidelity MRSS program.

MRSS Team Composition:

MRSS Team: It is essential that the RMP have developed an adequate number of MRSS teams to ensure its capacity to provide high quality mobile response services at the time and place it is needed across the regional catchment area. An MRSS team includes an MRSS-trained independently licensed clinical supervisor (see below), a licensed clinical staff member and any combination of peer supporter and/or Qualified Behavioral Health Specialist (QBHS). The team must also have ready access to a medical prescriber like a psychiatrist, certified nurse practitioner or clinical nurse specialist for consultation purposes when needed. It is likely that there will be more than one supervisor/staff "team" serving within one regional catchment area in order to provide adequate coverage to the entire region.

Note: Many of the responsibilities below are not mutually exclusive to a particular role. For example, while only independently licensed clinicians or licensed clinicians working under the supervision of an independently licensed clinician can diagnose a youth, they may carry out most responsibilities noted for certified peer supporters and QBHS staff. Similarly, any staff, including certified peer supporters and QBHS staff, who have been certified to administer the Ohio Children's Initiative CANS may do so. Each of the identified staff persons making up the MRSS team are required to stay within the bounds of their professionally defined scope of practice and only perform activities that are within their professional scope of practice.

1. Supervisor:

MRSS requires both clinical and administrative oversight, which can be carried out by one or more individuals designated as MRSS supervisor and who have appropriate qualifications and licensure for the responsibilities performed. The number or allocation of supervisors for the program must be sufficient to oversee or carry out all supervisory responsibilities and may be informed by the geographical reach in the identified regional catchment area, the total number of staff and/or volume of families served. When more than one supervisor is responsible for oversight of MRSS staff throughout the region, the RMP will ensure that supervisor duties are carried out in a coordinated manner.

Licensure:

The Regional Clinical Director must be an independently licensed behavioral health professional licensed by the State of Ohio. While it is preferred that MRSS team supervisors are independently licensed behavioral health professionals in the State of Ohio, the minimum requirement for an MRSS team supervisor providing the administrative supervision responsibilities as outlined below is to hold an Ohio issued dependent license in a behavioral health field. Every RMP and their respective subcontractors, if applicable, must have an adequate number of supervisors that are independently licensed behavioral health professionals licensed by the State of Ohio to support the clinical oversight and functions of the MRSS teams.

Primary Responsibilities of MRSS Supervisors:

Clinical Supervision

- The RMP needs to ensure that each MRSS team in the region has an assigned clinical supervisor to provide supervision to the MRSS staff, including MRSS peer support, whether hired by the provider or contracted from another agency.
- MRSS peer supporters must have a supervisor at the RMP who meets the supervisor requirements outlined in the OAC found here: https://mha.ohio.gov/static/CommunityPartners/PeerSupporters/Ohio-Administrative-Code-Adult-Family-and-Youth-certified-Peer-Supporter.pdf
- Provide clinical consultation and oversight of the care of enrolled youth and families and associated documentation
- Have 24/7 availability for telephonic consultation and/or mobile deployment in the event back up coverage is needed
- Oversee the service delivery quality, in accordance with state established quality parameters and in concert with the RMP Clinical Director and Quality Assurance Personnel
- Provide a mobile response when other MRSS staff are not available
- Convene regular team meetings, using an efficient, consistent process, to review progress of high acuity and/or complex youth and make intervention decisions to ensure families meet their identified goals

Administrative Supervision

- Assure that staff are trained in the Ohio MRSS model
- Ensure the model is being implemented with fidelity and in accordance with applicable rules and regulations
- Oversee timely data collection, data input and utilization of data for performance monitoring, improvement, and planning
- Oversee and/or provide community education and outreach to child-serving systems and agencies across the service region, directed by the Regional Clinical Director
- Ensure materials are culturally appropriate and in language of origin of young person and family

2. Licensed Behavioral Health Staff

The MRSS licensed behavioral health staff is an individual, as identified in rule 5122-29-30 of the Ohio Administrative Code, who can either independently diagnose behavioral health disorders or can diagnose behavioral health disorders under the supervision of an independently licensed staff. The licensed staff holds a valid and unrestricted certification or license or works under the supervision of an independently licensed individual who can diagnose. This staff provider must also demonstrate and maintain competency in the under 21 years of age population.

Primary Responsibilities of Licensed Behavioral Health Staff:

- Provide initial and ongoing mobile responses, inclusive of risk assessments for a young person in crisis
- Attend to safety and clinical concerns that require additional consultation, clinical intervention or assessment
- De-escalate the presenting crisis during the initial mobile response and subsequent crises during MRSS care
- Co-create and update safety and MRSS Plans with the young person and family
- Participate in the initial mobile response via telehealth if unable to present in-person as a deployment option described in OAC 5122-29-14
- Conduct necessary assessments to determine young person and family needs, strengths, and protective factors, including the use of the Ohio Children's Initiative Brief CANS when appropriate as identified in rule 5122-29-14.
- For those instances when the initial mobile response team consists of unlicensed staff, the licensed staff will coordinate with the unlicensed team to conduct the remaining elements of the initial mobile response phase (i.e. crisis assessment, MSE, lethality assessment etc.)
- Work with the youth and family to establish and achieve family defined goals; develop skills to prevent future crises; and determine what other types of services and supports are needed
- Secure appropriate approvals on plans and plan revisions
- Co-develop and initiate a transition plan to clinical and natural supports
- Collaborate with the MRSS peer supporters and paraprofessionals to define and achieve family goals

3. Certified Peer Supporters and Qualified Behavioral Health Specialists (QBHS)

Peer Support Certification

The MRSS Family or Youth Peer Supporter must have a valid and unrestricted certification in accordance with Ohio Administrative Code 5122-29-15.1. The peer supporter must be a parent, caregiver or young adult peer and demonstrate competency in the care and services of individuals aged 20 and under and has scope of practice for persons aged 20 and under with mental health disorders and/or substance use disorders.

QBHS Certification

The QBHS must meet the requirements of Ohio Administrative Code 5122-29-30. This QBHS demonstrates competency in the care and services of individuals aged 20 and under and has scope of practice for persons aged 20 and under with mental health disorders and/or substance use disorders.

Peer Supporter or QBHS Responsibilities:

- Use lived experience to assist young person and family (peer supporters)
- Provide initial responses as part of a response team with licensed behavioral health staff or as part of an unlicensed response team outlined in OAC 5122-29-14
- Provide follow-up responses within their scope of practice
- Follow the MRSS Plan regarding the type and frequency of interventions
- Inform licensed behavioral health staff of new or increased observations of risks and observations of change in young people's presentations during the MRSS episode of care
- Support the family including providing or assisting the family to access additional supports
- Collaborate with the youth and family and other MRSS team members to define family goals and to ensure that the MRSS Plan is representative of the family's values, preferences and needs
- Engage in and support crisis response and de-escalation within their scope
- Provide interventions including skill building, psychoeducation, role modeling, and advocacy
- Administer various screening tools to help inform care planning
- Identify and connect the young person and family to natural and other resources, including resources to meet basic needs
- Work with the young person and family to access and utilize cultural supports
- Consult with licensed behavioral health staff regarding the necessity, type and frequency of interventions and safety planning components

Integration of Peer Supporters

A transformative element of MRSS is to fully engage family and/or youth peer supporters with lived experience as core members of the MRSS team and the team's service delivery. Peer supporters are an integral part of the MRSS team and should be included in all aspects of care. They foster a collaborative partnership with the young person, family and service system and support families in exploring options that may be beneficial to returning to emotional and physical wellness after a crisis. Peer supporters share their personal journey with purpose and intent and use their lived experience to coach young people and their families to advocate for their needs. Peer supporters can help break down barriers of experience and understanding, as well as power dynamics that may get in the way of working with clinicians and other service providers. Through the unique power of bonding over common experiences, while adding the benefits peer modeling, stabilization and future crisis aversion are possible.

To ensure the inclusion of peer Supporters as an equal part of the team, MRSS providers will when applicable to their team:

- Commit to incorporating peer supporters in all aspects of the MRSS program
- Hire certified family and/or youth peer supporters with lived experience that reflect the characteristics of the community served as much as possible
- Develop support and supervision practices that align with the needs of the peer supporters engaged in the MRSS team whether the peer supporters are staff members of the MRSS provider or contracted through another agency
- Include peer supporters as a vital part of the MRSS team to emphasize engagement as a fundamental pillar of care, including:
    - Co-training peer supporters and clinicians supporting the team model
    - Having peer supporters serve as one of two team members during the mobile response, when possible
    - Integrating peer supporters into ongoing assessment, planning and intervention with the young person and family, in a manner consistent with their training and scope of practice
    - Including peer supporters in MRSS team meetings

4. Psychiatric Consultant/Provider Responsibilities and Certifications

The MRSS team must have timely access to a psychiatrist or certified nurse practitioner or clinical nurse specialist for consultation purposes. This provider may be a staff of the provider agency or may be contracted to provide consultation. The psychiatrist or certified nurse practitioner or clinical nurse specialist must hold a valid and unrestricted license to practice in Ohio and be familiar with the operations and aims of the MRSS program (e.g., diverting from ED and inpatient care). It is preferable that these providers have expertise and training

in delivering behavioral health and medication management services to children and adolescents. Of note MRSS provider agencies are encouraged to establish a means for youth to be directly assessed by a psychiatric provider on an emergency basis. At times, the provider may provide transition care for youth until their care can be transitioned to an ongoing provider. The RMP will have documentation that each medical prescriber, Psychiatrist, CNP, or CNS providing consultation and/or psychiatric care within the MRSS program has been provided internal training regarding the MRSS model and will have an internal mechanism to update the Psychiatric Consult team on MRSS operations and outcomes etc.

B. Staffing Levels

Staffing levels will be established as necessary to achieve the benchmarks, including providing home and community-based mobile responses and stabilization services within established parameters and based on family needs. There should be capacity to respond timely to multiple calls for MRSS services at the same time

C. Staff Competencies

To be successful, the MRSS team must be skilled in child-focused crisis response and ongoing crisis support and interventions. MRSS team members must be able to work with young people and families in collaboration with other team members. Successful MRSS team members are innovative in their approach to meeting the needs of the young person and family and can integrate non-traditional and natural supports into care plans. MRSS team members must have the capacity to be flexible and adapt to the changing circumstances of youth and families. Collectively, MRSS teams and provider agencies must possess the following competencies.

Overarching Competencies

- Cultural competency
- Trauma-informed care
- Care management, linkage, and referral
- Family engagement

Crisis Assessment, Stabilization and Safety Planning Competencies

- Conduct various indicated screening tools (e.g. Columbia Suicide Severity Rating Scale C-SSRS)
- Conduct crisis assessments, including mental status, diagnostic and lethality assessments
- De-escalate and stabilize youth and/or family crises
- Develop actionable safety plans (inclusive of means reduction strategies) and MRSS Plans in partnership with youth and family
- Continuous assessment and monitoring of youth and family safety and well-being, including changes that may warrant increased intervention
- Effectively engage with youth and family

Additional Assessment Competencies

- Conduct Ohio Children's Initiative Brief CANS assessment, with appropriate certification
- Assess individual, family, community, and school risk and protective factors
- Assess the triggers, crisis cycle patterns and interactions that may impact the presence or resolution of a youth and family crisis and otherwise serve as a basis for the MRSS Plan to achieve stabilization and prevent future crises
- Assess current and needed skill sets/coping strategies

Crisis Prevention Competencies

- Ability to teach parents and caregivers to identify early warning signs and develop strategies for preventing further escalation and future crises
- Ability to implement a youth and family MRSS plan
- Ability to design and implement strategic accommodations based on functional needs

Skill Building Competencies to Teach/Practice/Generalize Skills with the Youth and Family:

- Social problem solving and decision-making
- Coping skills
- Youth and family communication skills
- Parenting skills
- Collaborative problem solving
- Emotional regulation and distress tolerance skills
- Family co-regulation skills
- Family remediation following a crisis

Transition Competencies

- Ability to develop effective transition plans (linkages, supports, services)
- Cross-system collaboration skills

D. Staff Development and Training

The Child and Adolescent Behavioral Health Center of Excellence (CABH COE), Ohio Department of Behavioral Health's state- designated training center, will develop and coordinate the delivery of all required training for MRSS staff, administrators, and community partners. The MRSS provider will ensure that all members of their team complete the required trainings. Training will include core training modules, role-specific training and additional training modules delivered at various times and locations throughout the year. Ohio MRSS

training is for all MRSS staff including those employed to provide MRSS services as well as any per diem contract staff and any staff employed to provide coverage during times outside of RMPs' scheduled operating hours.

The following describes training requirements: Licensed MRSS team members and MRSS supervisors who oversee MRSS as part of their day-to-day activities, are required to complete the Ohio MRSS RMP Overview Training and 3-day MRSS Core Training Series within 60 days of hire or within 60 days of MRSS program start-up, followed by additional competency and practice-based supplemental trainings within reasonable designated timeframes as established by the Center of Excellence. Licensed per diem or PRN staff employed to provide coverage are required to complete the Ohio MRSS RMP Overview Training and the 3-day MRSS Core Training Series within 90 days of hire.

Non-Licensed MRSS team members, (QBHS and/or Family or Youth Peer Supporters) are required to complete the Ohio MRSS RMP Overview Training and 3-day MRSS Core Training Series prior to the provision of the MRSS service as outlined in 5122-29-14. Non-licensed MRSS team members will complete additional competency and or practice-based supplemental trainings within reasonable designated timeframes as established by the Center of Excellence.

- The Ohio MRSS RMP Overview Training is a prerequisite to the 3-day MRSS Core Training Series.
- MRSS supervisors must also complete a four-hour MRSS Supervisor training within 90 days of hire or within 90 days of MRSS program start-up.
- The state designated call center staff must complete at minimum the MRSS Overview training designated by Ohio Department of Behavioral Health. The state designated call center staff may also be required to receive additional training on topics deemed necessary by Ohio Department of Behavioral Health and the CABH COE.

Note: MRSS providers must incorporate Ohio Department of Behavioral Health approved trauma-informed care training, and training on cultural humility and responsiveness into MRSS employee orientation, with booster sessions delivered as needed: https://occrra.org/ohio-professional-registry/trauma-informed-care. Ohio Department of Behavioral Health may also offer additional supplemental trainings for MRSS providers. When these training offerings are available, details on enrolling will be posted on the MRSS.ohio.gov website.

Note: Staff members of entities providing MRSS triage and referral functions (e.g., 988, local hotlines and warmlines), should be familiar with the MRSS model and its underlying premises, including that families define the crisis, youth and families are best served face-to-face in the homes and local communities and that mobile responses should be provided for virtually all youth related calls. Staff members from such entities should watch an MRSS Overview training as it is made available.

MRSS Service Delivery

MRSS services are strengths-based, youth and family centered and driven, trauma-informed and responsive to the youth and family's cultural and linguistic needs and preferences. Evidence-based, evidence-supported, evidence-informed strategies and nationally established best practices for providing crisis intervention to youth and families are implemented in all phases of the MRSS model. MRSS is time-limited (up to six weeks from the time of initial face-to-face intervention). Goals and interventions should be achievable during this timeframe. As MRSS is a brief program, linkages and referrals should be initiated early in the episode of care.

MRSS consists of three phases: Screening and Triage, Mobile Response, and Ongoing Stabilization. Some young people and families will complete screening/triage and the mobile response but may not need, or choose, to move on to the stabilization phases.

A. Screening/Triage

Screening and triage processes should pass a parent defined "litmus test." They should be:

Consistent Calls are answered, questions and disposition standards are uniform; virtually all requests for help result in a mobile response.

Rapid Calls are answered rapidly, questions are minimal, a call record system is used to save the family from having to repeat their "story" each time they call, resulting in a quick warm transfer to local MRSS provider. All calls are answered by a live person and do not go into a queue.

Compassionate Staff are warm, non-judgmental, empathetic. They are well-trained in MRSS and typical presentations of youth in crisis and understand that crises are defined by the family and not based on adult standards.

Successful Call results in an MRSS team arriving at the location of the youth within 60 minutes of the call for immediate help.

To best achieve these aims and to be consistent with national MRSS best practices, Ohio:

- Has trained staff to conduct the screening and triage functions in accordance with the standards above through the call center designated by the state
- Implemented the MRSS Data Management System (DMS) to be used, in part, as the call record system

When a call for MRSS is received by the call center designated by the state or the RMP, the entity receiving the initial call will conduct a brief triage to rule out the need for a 911 or urgent medical response and to otherwise determine the appropriate MRSS response. When the triage process results in a determination of imminent risk to health and safety for the young person or other involved party, the triage outcome is identified as "**Emergency**." The caller is transferred to 911 and/or other appropriate emergency services unless the caller prefers to make the call themselves and it is safe to do so. If the call center designated by the

state receives a call that is identified as **“Emergency”**, a referral should still be sent to the RMP for follow-up.

For calls that are initiated through the call center designated by the state, after ruling out imminent risk concerns, call center staff will gather pertinent information (e.g., nature of the request, findings of the triage assessment, key contact information, address for mobile response), communicate the information to the RMP by phone and then connect callers to the local RMP via direct call warm transfer to finalize details for the MRSS intervention, these responses are identified as “**immediate**” unless specifically requested by the family or referrer to be scheduled out within 48 hours. In those circumstances, the call would be considered **“non-immediate”**.

When calls are initiated directly through the RMP, the RMP will conduct the same brief triage process to rule out the need for 911 or urgent medical responses and will otherwise determine the appropriate MRSS response (**“Immediate”, “Non-Immediate” or “Information and Referral**”).

MRSS uses a “just go” approach regardless of the provider's perceived acuity. As such, the expectation is for youth and families not requiring an emergency response, to receive an “immediate” response (arrival of the MRSS team to the site of the child within 60 minutes). If a family or other referrer specifically requests for an MRSS mobile response outside of the 60-minute time period, the MRSS team will provide a “non-immediate” response. In such instances, the mobile response should occur within 8-24 hours and must occur no later than 48 hours after the initial call for help. The “time clock” for the mobile response begins at the end of the initial call and linkage to the RMP or if the call for MRSS is made to the RMP directly, the “time clock” begins at the conclusion of the initial call for help.

MRSS providers are expected to be immediately available to receive all referral calls during minimum mobile response operating hours and during non-mobile response operating hours for those who have not yet transitioned to 24/7 mobile response availability. For those providers who are not operating 24/7, when an RMP receives a call outside the minimum operating hours, the RMP will provide telephonic crisis intervention, support, and develop a viable plan for safety while scheduling the caller for a next business day in-person MRSS response.

The RMP must provide the call center designated by the state with one direct number via the Data Management System (DMS) to ensure that families/referrers are directly connected to the RMP when the call center is connecting a caller. There should not be instances where the call center is unable to reach the RMP, transferred to a voicemail, or awaiting a call back from the RMP. The single number listed in the DMS for the RMP must be answered 24/7 for mobile responses during operational hours and telephonic support afterhours.

Note: When requests for MRSS services exceed 48 hours by family request, families should typically be referred to a more appropriate service.

B. Mobile Response

The Mobile Response phase lasts for up to 72 hours from the end of the initial call requesting MRSS response. MRSS may respond in teams of two staff members. When there is more than one MRSS team member present at the initial response, team composition must be in accordance with the OAC 5122-29-14. A licensed behavioral health provider must conduct clinical portions of the MRSS Crisis assessment. (e.g., mental status, lethality/risk assessment, determination of provisional diagnoses). During the 72-hour mobile response phase, the following activities occur: an initial mobile response is provided, and additional mobile response follow-up activities may be provided.

A key aim of MRSS is to provide an alternative to the use of law enforcement as a response to youth and families in crisis. Additionally, MRSS is a trauma-informed service and recognizes that many youth and families may experience fear or trauma in the presence of law enforcement. As such, the MRSS staff members should respond without law enforcement unless it is essential for safety reasons. If law enforcement is included in the response, the family must be included in the decision to do so, and the MRSS team must ensure that the family is aware that law enforcement will be responding prior to their arrival.

Initial Mobile Response

The mobile response team member(s) will arrive at the location of the behavioral health crisis, or a location specified by the family immediately (within 60 minutes) and no later than 48 hours in circumstances when the family or other referrer specifically requests a non-immediate response. A primary focus of the initial response is to restore calm and safety when situations are escalated or potentially unsafe. During the initial mobile response, the MRSS team, within each individual staff person's scope will:

- Assess precipitating events and responses; mental status; potential lethality to self or others; other safety and risk factors; past and current trauma; past and current substance use; contributing medical/ physical factors; and cultural considerations and preferences for care (within the team member's scope of practice)
- Utilize initial information, inclusive of strengths and protective factors, to determine a disposition about safety and to inform the safety plan
- Co-develop a safety plan with the youth and family, to be provided to the youth and family by the end of the first face-to-face contact
- Provide crisis intervention and de-escalation strategies

All mobile response activities for both immediate and non-immediate responses will be completed within 72 hours from the termination of the initial call with family/youth requesting the help.

As described in OAC 5122-29-14, the RMP may choose to deploy a two-person team that consists of a combination of at least one QBHS and either another QBHS or a certified family peer supporter or certified youth peer supporter. If a licensed behavioral health staff is unable

to be present in person at the location of the youth, the non-licensed staff is to contact the MRSS team's licensed behavioral health staff prior to leaving the site of the response so that they can participate in the initial mobile response by telehealth. If a telehealth connection cannot be made and sustained at the site of the response, the licensed behavioral health staff is to be available for telephone consultation or is to go to the site of the response. If the licensed behavioral health staff is only available via telephone consultation due to telehealth connectivity issues, the consultation will include a determination about how and when the remaining clinical elements will be provided to the youth/family. The licensed behavioral health staff will determine if immediate clinical intervention (i.e. completion of the MRSS crisis assessment, etc.) is necessary through deploying the licensed behavioral health staff in real time to the location of the youth or if a safety plan and follow-up activities are sufficient. The non-licensed staff will conduct only those activities that are within their scope of practice, which include, but are not limited to: de-escalation, crisis intervention, additional screening, safety planning and linkage.

Immediate clinical interventions could include completion of the initial MRSS crisis assessment, lethality assessment, imminent risk assessment, conducting a mental status exam, or enhanced safety planning to address specific risk.

In those circumstances where there are telehealth connectivity issues and licensed behavioral health staff are only available via telephone consultation, the RMP will ensure that the disposition and safety plan are clinically appropriate given current risk and protective factors and will make arrangements for the youth and family to complete the remaining clinical elements of the initial mobile response in one of the following ways: be immediately seen by a licensed behavioral health staff face-to-face or be seen by a licensed behavioral health staff within 24 hours of the initial mobile response. RMPs may consider developing an internal decision support mechanism that helps guide how decisions are made regarding the deployment of initial first responders (i.e. clinician vs. 2-person non-licensed teams) that incorporates factors such as the known clinical acuity at the time of the initial call requesting help.

The RMP is responsible for meeting all time-based response parameters outlined in OAC 5122-29-14 for each phase of the MRSS program, even during those times when a call comes outside of the minimum operating hours (i.e. a call received on a Thursday at 9:00pm, the RMP will need a plan to complete all the mobile response phase activities prior to Sunday).

Additional Mobile Response Activities

Beginning with the initial mobile response and throughout the Mobile Response 72-hour period, activities include:

- Ongoing risk assessment and safety planning
- Engaging the family to determine priority goals and considerations for the MRSS stabilization phase and their interest in receiving ongoing stabilization services. (Families may choose not to enter the stabilization phase of MRSS.)
- Initial exploration of the young person's and family's strengths, needs, resilience and protective factors, coping skills, and social support network

- Follow-up visits and contact based on acuity, the complexity of the family's needs and family preference
- Youth and family peer support
- Intervention and de-escalation, using strategies appropriate to meet the unique needs of the youth and family
- Initial use of MRSS tools (e.g., the crisis cycle, safety mapping and the contextual functional analysis)
- Identification of early cues and triggers to current crisis
- Identification of coping and de-escalation strategies to restore calm
- Seeking psychiatric consultation when indicated
- Consultation and coordination with the school, primary care physician, existing providers/services, and other care coordination programs
- If a youth is a member of OhioRISE an attempt to reach out to the CME/Care Coordinator within the first 72 hours is expected for continuity of care.
- If a youth is receiving care coordination through FCFC an attempt to reach out to the FCFC/Service Coordinator within the first 72 hours is expected for continuity of care.
- Initiation of referrals/ linkages to formal, informal, and natural supports
- Administration of the Ohio Brief Child and Adolescent Needs and Strengths (CANS) assessment by a qualified CANS assessor if one of the following is met: (1) The youth is not yet enrolled in OhioRISE OR (2) A CANS assessment has not been administered in the last 90 days OR (3) There has been any significant change in youth's circumstances as determined by the licensed behavioral health staff
- Initiate an individualized MRSS plan, prior to the stabilization phase, which is inclusive of the safety plan. (An individualized MRSS plan is valid for up to forty-two days from the date of the initial mobile response or until the end of the MRSS episode of care. If the MRSS episode ends before then and should be updated or modified as indicated during this time period.)

Note: While QBHS, certified youth peer supporter and certified family peer supporter staff may inquire about needs, risks, preferences and priority foci for MRSS services and may carry out activities within their scope of practice in both the MRSS Response and Stabilization phases, they must: 1) consult with licensed behavioral health staff regarding the necessity, type and frequency of interventions, 2) inform licensed behavioral health staff of new or increased risks and changes in clinical presentations during the MRSS episode of care and 3) follow steps, recommendations or directives provided to them by the licensed staff. Further, they may not make independent determinations about initial or modified safety plans or MRSS Plans.

Note: Providers of intensive home-based treatment, as designated in OAC 5122-29-28, are on-call 24/7 for crisis response to families they serve (with the exception of Functional Family Therapy). If MRSS is called to respond to a young person or family currently receiving intensive home-based treatment, the MRSS team should assess and de-escalate the presenting crisis and immediately reconnect the family to the existing IHBT program.

Note: When IHBT services are involved, MRSS stabilization phase services are not eligible for Medicaid reimbursement.

C. Ongoing Stabilization

Stabilization services are provided by the MRSS team as documented in the initial or updated MRSS Plan and focus on building the skills and support necessary to help the family avoid or effectively manage future crises. The stabilization phase may last from 4 days to no more than 42 days after the initial call for help. The MRSS Plan, including the safety plan, should be monitored, and updated by a licensed team member, as warranted throughout the stabilization phase. Updates should incorporate newly identified risks, safety needs, safety prevention and coping strategies, resources, and supports. The MRSS Plan should be collaboratively established and be driven by the family's needs and preferences.

Stabilization interventions are provided face-to-face and, in the home whenever possible. They will vary in focus, intensity, duration, and type based on the acuity and/or complexity of the youth and family's presenting concerns.

Stabilization services and activities will include:

- Continuation of Mobile Response activities
- Continued monitoring, updating, coordination, and implementation of the individualized MRSS plan, inclusive of the safety plan
- Identification, psychoeducation, and enhancement of the young person's and family's coping, behavior management, problem solving and effective communication skills.
- Youth and family peer support
- Referral for psychiatric consultation and medication management, if indicated
- Advocacy and networking by the provider to establish linkages and referrals to appropriate community-based services and natural supports
- Coordination of services to address the needs of the young person or family.
- Linkage to the natural and clinical supports and services to sustain the young person's or their family's stabilization post MRSS involvement
- Coordination with OhioRISE care coordination and/or Family and Children First service coordination
- Participation in Child and Family Team meetings
- Transition planning

D. Regional Service Delivery

Within A Region

The Regional MRSS Provider (RMP) is responsible for the delivery of high quality in-person MRSS services for their entire assigned regional catchment area. To ensure capacity to provide adequate services, it is likely that there will be multiple teams serving from different dispatch

locations throughout a regional catchment area. MRSS teams may be deployed to any youth experiencing a family/caller defined crisis throughout their region making it possible for team members from different dispatch locations to provide services to the same young person during an MRSS episode of care.

RMPs should establish processes, protocols and the necessary infrastructure to ensure all services throughout a youth's MRSS episode of care are provided in a coordinated, informed and responsive manner, regardless of the assigned team or staff member with the region. The RMP should have knowledge of served youth throughout their region, have ready access to pertinent information and/or documentation for each youth and confirm that assigned staff throughout the region have timely access to the same. Such information and/or documentation may include but is not limited to:

- Contact information
- Precipitating events and responses
- Crisis assessment
- Mental status
- Potential lethality to self and others
- Other safety and risk factors
- Safety plan
- MRSS plan
- Linkage/referral recommendations

Cross-Regional

RMPs are expected to deploy their staff to respond to all calls for youth located in their assigned regions. An RMP may receive a call and respond to a youth who is temporarily in their regional catchment area. RMPs should have processes and protocols that support cross-regional collaboration to assist in determining the appropriate RMP to provide ongoing MRSS services to those youth. Factors that should be considered are the preferences of the youth and family, the non-residential RMP's ability to provide mobile response follow-up and stabilization services that are aligned with the youth's and family's frequency and intensity of need, and the non-residential RMP's knowledge of resources and system of care supports available in the youth's community of origin.

In instances where an episode of care transfer may be necessary, the RMP team that provided the initial mobile response should conduct a warm handoff to the receiving RMP to ensure the seamless continuation of mobile response phase activities. The warm handoff process should include a real-time introduction between the youth and/or their family and the receiving RMP, either face-to-face or by direct phone contact, at the initial mobile response or as soon as the need for transfer is identified. The receiving RMP should have timely access to information necessary to support the continuity of care that was gathered during the initial mobile response including, but not limited to:

- Contact information

- Precipitating events and responses
- Crisis assessment
- Mental status
- Potential lethality to self and others
- Other safety and risk factors
- Safety plan

Through the warm handoff process, the receiving RMP should schedule an in-person follow-up service with the youth and/or family during the mobile response phase when possible. If the referring RMP is unable to complete the warm handoff as described, they remain responsible for following up with both the youth and/or family and the receiving RMP until the connection is successfully established. Once the referral is completed, the receiving RMP should notify the referring RMP of the scheduled follow-up service with the youth and/or family and confirm receipt of the necessary information to support ongoing service delivery.

Note: A youth cannot receive stabilization phase services from multiple RMPs at the same time.

E. Additional Service Standards

Use of Evidence- Based Practices

It is expected that MRSS staff will provide services that are within their professional scope of practice and will include evidence-supported and evidence-based practices (EBPs) and strategies to ensure young people and their families efficiently and effectively achieve their stated goals. Due to the multiplicity of presenting concerns of the youth and families served in MRSS, the MRSS team should have the capability to provide an array of such practices and strategies.

Visit the following EBP websites for information on additional evidence-based practices:

- The California Evidence-Based Clearinghouse for Child Welfare: https://www.cebc4cw.org/
- Office of Juvenile Justice and Delinquency Prevention Model Program Guide: https://www.ojjdp.gov/mpg
- The National Child Traumatic Stress Network: https://www.nctsn.org/treatments-and- practices/trauma-treatments
- SAMHSA EBP Resource Center: https://www.samhsa.gov/ebp-resource-center

Note: When implementing EBPs, specialized training and certification in these areas may be required.

Individualized Safety Plans and MRSS Plans

Individualized Safety Plan

A safety plan developed with the youth and family must be completed prior to leaving the

first face-to-face visit. While not required, it is recommended that MRSS staff utilize the safety plan and safety precautions/means reduction templates found on pages 68 and 69 of the MRSS Tool Kit: https://wraparoundohio.org/wp-content/uploads/2022/04/MRSS-Tool-Kit-V1.0.pdf. A copy of the safety plan should be provided to the family at the time of its development or be immediately accessible to the family after its completion. Safety plans are to be reviewed and modified as needed throughout the entire MRSS service and will become a component of the MRSS Plan. If a safety plan is updated, then the latest version needs to be provided to or made available to the family immediately. Safety plans should include:

- Emergency contacts
- Informal supports
- Safety concerns
- Crisis prediction and prevention strategies
- Signs of distress
- Individual coping strategies
- Stabilization and support strategies
- Safety and means reduction precautions

The RMP will ensure that all safety plans developed by non-licensed staff are reviewed and approved by licensed clinical staff throughout the complete course of MRSS care (initial mobile response, mobile response follow-up, stabilization, transition)

Individualized MRSS Plan

MRSS requires the development of an individualized MRSS Plan. The plan should focus on strategies that will assist the family in preventing further crises or to make them more manageable should they occur. Plan development must be initiated prior to the youth's transition to the MRSS stabilization phase; incorporate the safety plan; be developed with the young person and family; and be informed by their priorities. The plan should be enhanced or modified as necessary throughout the stabilization phase and should include a limited and achievable number of youth/family identified goals and objectives that are designed to:

- Restore and promote safety
- Further de-escalate and stabilize the crisis
- Build youth and family skills, including distress tolerance, coping, self-regulation, and self-care skills, to better manage and/or avert future crises
- Identify, refer, link and coordinate with existing or new longer-term supports, services and systems as family need indicates
- Enhance protective and resiliency factors

The individualized MRSS Plan should be informed by priorities, needs, strengths, protective factors and cultural considerations of the youth and family and include:

- The safety plan

- Young person and family identified MRSS goals. It is best practice that MRSS plans include goals and objectives written in youth/family language.
- MRSS interventions to assist in goal achievement
- Plans to link to necessary formal, informal, and natural supports to help ensure sustainability post MRSS involvement

The RMP will ensure that in instances when a non-licensed staff person facilitates gathering information for the MRSS Plan, a licensed clinician is consulted, formulates treatment goals based on youth and family identified needs, and approves the MRSS Plan.

Linking Young Person and Family to Ongoing Services and Supports

Throughout the MRSS service, the MRSS team will support the youth and family in the identification of and linkage to services, supports, and resources. Because of the limited timeframe for MRSS, linkage to ongoing support and services should be initiated as early as possible during MRSS involvement. There may be times when a family has met goals for MRSS involvement prior to additional services being initiated. In such instances, it may be appropriate to end the current episode of care after adequate transition planning and after encouraging the family to access MRSS if need be before the next service begins.

Facilitated Youth and Family Planning Meetings

MRSS providers actively engage families in family team planning meetings, which often includes cross-system partners for the purpose of developing linkages for on-going services and support. This may include a meeting convened by the MRSS team, an OhioRISE care coordinator or by another cross-system partner. The meetings must include additional system/agency partners, in addition to the MRSS staff and the family, to be considered a cross-system planning meeting. All meetings should include family members and family members should have voice and choice about meeting attendees.

Transition from MRSS

Transition out of MRSS includes reviewing newly formed coping skills and how future crises can be effectively managed. Emphasis should be placed on what the family did for themselves to bring about change. The MRSS team will work with the family to transition the safety plan, as well as the responsibility for regularly reviewing it. Additionally, the team will have a transition meeting with the youth, family, and ongoing provider(s) and any other pertinent parties identified by the family. The transition activities the team will address may include but are not limited to:

- Sharing a list of all upcoming appointments and activities including the type of services/ activities, locations, times, and contact information (i.e., name, phone numbers)
- Recommended follow-up actions for the family, care coordinators, and providers
- The most recent MRSS Plan, including the safety plan

In instances where a transition meeting is not possible, the MRSS team will initiate transition planning activities with the above noted parties to ensure a seamless transition to ongoing services and support.

If the youth is eligible for OhioRISE and/or local care coordination and has an assigned care coordinator, the care coordinator is typically responsible for facilitating all needed transition to community-based services and supports and for monitoring the safety plan with the family after the family transitions from MRSS care. As MRSS is a brief service, the connection between MRSS team and the care coordinator should occur as soon as possible during or following the MRSS initial mobile response. When a timely connection is not made, the MRSS team may provide transition support to ensure the youth may be discharged in a timely manner.

Additional Crisis Situations/Re-Admissions to MRSS

At any time during the MRSS service, a youth and/or their family may experience episodic crisis situations. During these times, MRSS team member(s) should respond as clinically indicated to de-escalate the crisis, increase safety, and revise the MRSS plan as needed.

Families cannot be admitted, discharged, and re-admitted to MRSS within 72 hours of the initial intake, as any needs and services during this time are part of the Mobile Response phase. Otherwise, families who have been discharged from MRSS services can initiate another episode of MRSS service at any time. Each episode of care begins with screening and triage followed by a mobile response. Families who are re-admitted to MRSS must complete screening and triage and mobile response prior to entering stabilization. It is important to note that a re-admission cannot be initiated until a discharge date from the previous episode of care is documented in the MRSS DMS.

Emergency Department and Behavioral Health Inpatient Admissions

If a youth becomes a patient of an emergency department or an inpatient behavioral health service during the mobile response phase and: 1) it is clear the youth will not return home during the phase and, 2) the necessary admission requirements for the stabilization phase have not been completed, the episode of care typically ends. If the youth is admitted to either placement during the stabilization phase and the anticipated length-of-stay will be brief, the MRSS episode of care may remain open, with the MRSS team continuing to support the family as they prepare for the youth to return home. In other instances, and in consideration of family preference, the provider may discharge the young person from MRSS and re-admit the young person to MRSS, if needed and desired by the family, when the child returns home.

Administration

Selected RMPs should begin to build organizational capacity to start a new best practice service, strategically manage growth to accommodate the service from start-up to full service,

understand how MRSS is different than other crisis services, coordinate with other crisis services to ensure that families are seamlessly served, and be willing to champion the service both within the organization and externally across community partners.

Provider Certification

A provider must submit an application for interim certification to Ohio Department of Behavioral Health's Office of Licensing and Certification to add MRSS as a new service via the Licensure and Certification Tracking System (LACTS) and provide verification of policies/procedures and a staffing plan. Additionally, a provider will need to meet the requirements outlined in the Ohio Department of Behavioral Health Rule 5122-29-14, (E). Upon approval, the Department shall issue an interim initial six-month certificate.

Providers can remain in interim status up to 18 months (1st interim certificate is for six months and can be extended for up to two additional six-month periods). An onsite survey is scheduled based on when the provider has enough clinical charts to review for MRSS and the five required services. The provider stays in interim status up to 18 months until the onsite survey and any subsequent findings from an onsite survey have been corrected.

A. Practice Implementation Consultation and Fidelity Reviews

Practice Implementation Consultation: To support the development of a statewide high-quality MRSS system, ongoing program and organizational level consultation is available through the CABCH COE to each of the Regional MRSS Providers (RMPs) in conjunction with any of their subcontractors. Practice and Implementation consultation will focus on and support key elements of organizational program design, administration, supervisory structures, best-practices for clinically complex cases, integration of system of care and program quality improvement, all of which are anchored in MRSS model fidelity and benchmarks.

Fidelity Reviews: Fidelity reviews will be conducted by Case Western Reserve University's CABH COE, delivered through the Center for Innovative Practices at the Begun Center for Violence Prevention, Research and Education.

The RMP will:

- Obtain an initial fidelity review within 12 months of the RMP launch date
- Be operational for at least three months prior to requesting a fidelity review
- Have provided at least ten episodes of MRSS care beyond the Screening and Triage phase, of which at least five must include episodes with both the Mobile Response and Ongoing Stabilization services
- Each individual MRSS team within the RMPs network will be reviewed during the RMP's initial and annual fidelity review
- Have regular repeat fidelity reviews, no more than twelve months from the report

date of the previous fidelity review

MRSS providers will work with the Case Western CABH COE to determine readiness for their fidelity review, in collaboration with the Center of Assessment and Evaluation Services at Bowling Green State University (BGSU). Once ready, a fidelity review will be scheduled through the CABH COE.

Fidelity reviews will include the assessment of the Ohio Department of Behavioral Health's approved set of benchmarks and fidelity measures. Benchmarks and fidelity measures may be updated as necessary to address network trends or new areas of focus. When such changes occur, fidelity reviews will be based on measures in place at least six months prior to the review. The MRSS Fidelity Tool can be found at: https://mrssohio.org. If there is an RMP and/or individual MRSS team that has benchmarks reflecting concerns with model implementation, Ohio Department of Behavioral Health can request a fidelity review of an RMP and/or individual team at any time.

B. Marketing

MRSS fills a gap in the continuum of crisis services for young people and their families. Informing the public of this service requires intentional marketing and communication planning to disseminate materials across community systems and groups, through mass communication channels and one-on-one or group meetings. Examples of community systems and group outreach opportunities include kinship navigator support meetings, local school district staff and parent meetings, law enforcement roll calls, children's services team meetings, hospitals, Board of Developmental Disabilities team meetings, among others.

All marketing should include the Ohio Department of Behavioral Health approved MRSS logo and the number of the call center designated by the state.

C. Data Management

All MRSS referral, intake and discharge data must be entered into the MRSS Data Management System (DMS). Referrals should be entered in real-time, upon receiving a call from a referral source, and both intake and discharge data must be entered within 10 business days. Such data will be utilized to monitor overall service delivery, identify areas for improvement, track progress towards achieving benchmarks and monitor many of the MRSS fidelity measures. Additionally, data can be used: 1) by providers to inform and strengthen program operations and to generate site or county specific reports; 2) by Ohio Department of Behavioral Health and other state partners to identify system trends, gaps and needs; and 3) by Case Western Reserve University's CABH COE to identify and oversee training needs and other quality improvement activities.

Once a provider agency has received an interim certification to provide MRSS, a lead agency administrator should request access to the MRSS DMS from Ohio Department of Behavioral Health. Ohio Department of Behavioral Health will connect providers with BGSU, who conducts all DMS trainings. After BGSU confirms the provider has been trained, Ohio Department of Behavioral Health will grant provider-level access, and the lead administrator will then be responsible for enrolling and granting access to the DMS for their MRSS staff or other agency staff, as appropriate. The agency MRSS lead must also ensure that all staff receive DMS training before granting them access to the DMS.

The RMP and any applicable sub-contractors are responsible for ensuring that all team members are trained in the statewide data management system, understand the importance of accurate, timely and thorough data entry, and demonstrate proficiency in using the system. Recorded trainings on the MRSS Data Management System are available via the Ohio MRSS website (https://mrssohio.org). Additional MRSS Data Management System training, support and technical assistance is provided by BGSU and may be requested by contacting Ohio Department of Behavioral Health. Ohio Department of Behavioral Health, as referenced above, can be contacted at OhioMRSS@dbh.ohio.gov.

RMPs that choose to utilize individual subcontractors to provide MRSS services within their region, will need to ensure that the primary RMP and sub-contractors have the IT infrastructure to support bi-directional access to real-time client level data (outside of the data in the statewide DMS system) in order to allow the RMP to provide adequate clinical oversight, clinical consultation and support, deployment of necessary services to youth and families, and to manage quality related issues that may arise throughout the episode of MRSS care within their entire assigned region.

D. Quality of Care and Quality Improvement

National best practices for high-quality MRSS services include quality assurance and improvement processes and activities, frequently administered by a "lead quality entity." The CABH COE, in conjunction and at the request of Ohio Department of Behavioral Health, will be responsible for coordinating and overseeing such activities for the statewide network of providers. While each RMP will have their own specific regional goals and milestones, those regionally specific goals will not supersede or replace state identified goals as it relates to quality benchmarks and quality improvement.

Note: Additional MRSS resources and upcoming trainings/events can be found by visiting the MRSS Ohio website at https://mrssohio.org or by contacting Ohio Department of Behavioral Health at OhioMRSS@dbh.ohio.gov

Note: Please reference the Ohio Medicaid Behavioral Health State Plan Services Provider Requirements and Reimbursement Manual for guidance on billing Medicaid for MRSS services: https://bh.medicaid.ohio.gov/Portals/0/BH%20Manual%20v%201_25.pdf