Vermont Department of Mental Health

ACT 82 WORKING MEETING

Proposed Agenda

DATA OVERVIEW – 2 HOURS

BARRIERS AND GAPS/STAFFING – 1 HOUR

LUNCH ON YOUR OWN – 1 HOUR

CARE COORDINATION – 1 HOUR

CRISIS DIVERSION OPTIONS AND MODELS – 1 HOUR

MH PARITY/GERIATRIC/FORENSIC – 2 HOURS

QUESTIONS AND COMMENTS – 30 MIN

Introduction

Act 82 (S.133)

An act relating to examining mental health care and coordination

(Sec 1, 17) Before moving ahead with changes to improve mental health care and to achieve its integration with comprehensive health care reform, an analysis is necessary to take stock of how it is functioning and what resources are necessary for evidence-based or best practice and cost-efficient improvements that best meet the mental health needs of Vermont children, adolescents, and adults in their recovery.

(Sec 1, 18) It is essential to the development of both short- and long-term improvements to mental health care for Vermonters that a common vision be established regarding how integrated, recovery- and resiliency-oriented services will emerge as part of a comprehensive and holistic health care system.

Current Data Collection – 15 min

WHERE DOES DATA COME FROM?

- Established data applications
- Back-end data capture
- Spreadsheet data entry
- Surveys
- Data-sharing with other departments

Current Data Collection

WHAT TYPE OF DATA DOES DMH HAVE?

- Inpatient stays
  - Involuntary psychiatric inpatient hospitalizations for adults
  - Psychiatric inpatient hospitalizations (pilot)
  - All Medicaid-paid inpatient hospitalizations◆
  - All CRT inpatient hospitalizations
  - All VPCH hospitalizations
- Community services
  - Monthly service reporting
  - Satisfaction with services
  - Youth residential placements
  - Medicaid paid claims✱
  - VHCURES✱

Current Data Collection

WHAT TYPE OF DATA DOES DMH HAVE? (CONT'D)

- Event-specific
  - ED wait times for involuntary hospitalization holds
  - Emergency Involuntary Procedures on psychiatric hospital units
  - Involuntary transports to and from inpatient hospitalization
  - Electronic bed board census
- External data sources
  - DOC Custody file
  - General Hospital Discharge Dataset
  - DCF Custody file
  - Suicide deaths file
  - DOL quarterly match

Current Data Collection

WHAT TYPE OF DATA DOES DMH HAVE? (CONT'D)

- Event-specific
  - CRT Perception of Care
  - CYFS Perception of Care
- Relevant External data sources
  - DOC Custody file
  - General Hospital Discharge Dataset
  - DCF Custody file
  - Suicide deaths file
  - DOL matching

Current Data Collection

HOW ARE DATA USED?

- DMH RBA Scorecard
- DMH Statistical Report
- DMH Act 79 Report
- Grant application and management
- Monitoring
- Performance Management

www.mentalhealth.vermont.gov/reports

Data Needed – 30 min

(Sec 3, B) Identify data that are not currently gathered, and that are necessary for current and future planning, long-term evaluation of the system, and for quality measurements, including identification of any data requiring legislation to ensure their availability.

What long-term data should the department track?

What gaps in data collection do you see?

Why do you think we need this data?

What is needed to evaluate the quality of the mental health system?

Referrals – 15 min

(Sec 3, C) Identify causes underlying increased referrals and self-referrals to emergency departments.

Why are people being referred?

What affects lengths of waits in the Emergency Room?

What affects the rate at which people brought to the Emergency Room for Emergency Exam are found to need inpatient?

Accessibility and Gaps in Service – 15 min

(Sec 3,D) determine the availability, regional accessibility, and gaps in services that are barriers to efficient, medically necessary, recovery- and resiliency-oriented patient care at levels of support that are least restrictive and most integrated with regard to voluntary and involuntary hospital admissions, emergency departments, intensive residential recovery facilities, secure residential recovery facilities, crisis beds, and other diversion capacities; crisis intervention services; peer respite and support services; intensive and other outpatient services; services for transition age youths; and stable housing.

Where are there gaps in bed locations?

Where are there gaps in bed types?

What are the barriers to getting different levels of care (including community care)?

Emergency Department Wait Times – 15 min

(Sec 3, E) Incorporate existing information from research and from established quality metrics regarding emergency department wait times

Presentation, Discussion, and Questions

Presenter: Wilda White

Trends – 15 min

(Sec 3, F) Incorporate anticipated demographic trends, the impact of the opiate crisis and data that indicate short and long-term trends

Overall VT population is static but slowly decreasing

Less youth under age 18, more adults over age 65

% of VT adults with any mental illness is 20%, higher than national avg. (2015)

% of youth with serious emotional disturbance is 6%, consistent with national avg. (2015)

% of VT adults getting treatment is 58%, also higher than national avg. (2015)

What demographic trends should we pay attention to?

Additional Materials: ADAP Handouts

Opiate Data – 1

Number of Medicaid Beneficiaries treated in spokes over time

Region	Sep 2013	Dec 2013	Mar 2014	Jun 2014	Sep 2014	Dec 2014	Mar 2015	Jun 2015	Sep 2015	Dec 2015	Mar 2016	Jun 2016	Sep 2016	Dec 2016	Mar 2017
Bennington	131	151	164	173	185	219	229	246	233	240	259	238	236	229	239
St. Albans	236	249	269	262	284	326	376	363	363	339	383	385	390	382	402
Rutland	206	242	251	253	234	244	245	256	259	267	274	300	223	253	282
Chittenden	352	408	314	357	382	402	400	420	434	474	528	514	553	596	573
Brattleboro	237	238	208	230	220	208	176	170	146	141	153	144	138	145	150
Springfield	41	54	57	41	55	50	52	52	67	57	77	77	55	53	73
Windsor	56	62	73	82	93	122	121	130	146	158	175	206	197	161	229
Randolph	78	91	103	110	112	99	95	100	93	83	83	107	130	145	97
Barre	198	201	210	212	234	245	254	251	231	302	317	301	268	273	263
Lamoille	117	125	134	135	127	134	137	139	147	154	155	157	145	151	217
Newport & St. Johnsbury	98	98	97	100	100	89	86	87	94	98	98	97	90	95	97
Addison			8	17	25	32	49	64	66	71	75	87	77	74	60
Upper Valley						9	5	6	6	5	7	8	34	13	12
Total	1,750	1,919	1,888	1,972	2,051	2,179	2,225	2,284	2,285	2,389	2,584	2,621	2,535	2,572	2,694

Vermont Department of Health

Source: DVHA/Blueprint for Health

Opiate Data – 2

Number of Spoke Prescribers Over Time

Region	Sep 2014	Dec 2014	Mar 2015	Jun 2015	Sep 2015	Dec 2015	Mar 2016	Jun 2016	Sep 2016	Dec 2016	Mar 2017
Bennington	7	9	9	11	10	10	11	10	11	9	10
St. Albans	11	12	12	12	10	13	16	15	15	15	13
Rutland	9	10	8	9	10	10	13	13	12	12	16
Chittenden	30	27	27	30	30	31	38	53	71	70	78
Brattleboro	16	18	18	18	13	13	12	11	10	10	13
Springfield	5	4	5	6	2	2	2	3	4	4	3
Windsor	3	5	5	7	7	7	8	7	9	6	8
Randolph	8	6	4	4	7	4	6	5	6	7	7
Barre	19	17	14	14	18	17	15	20	21	19	19
Lamoille	7	8	7	6	7	6	7	9	10	9	12
Newport & St. Johnsbury	9	9	8	8	8	8	8	10	11	14	15
Addison	4	5	4	5	6	6	5	4	5	5	4
Upper Valley		3	2	4	2	3	3	4	5	4	4
Total	128	133	123	131*	126*	126*	140*	160*	187*	180*	196*

*Some providers prescribe in more than one region

Note: Prior to 9/14, spokes were tracked by number of providers rather than number of prescribers so are excluded from this report

Vermont Department of Health
Source: DVHA/Blueprint for Health

Barriers and Gaps in Service/Staffing – 1 hour

(Sec 3, G) Identify the levels of resources necessary to attract and retain qualified staff to meet identified outcomes required of DAs and SSAs and specify a timeline for achieving those levels of support.

What level of staffing is needed?

What are the different training levels needed?

Where do we need to put emphasis on staffing and training?

Presenters: Julie Tessler, Heidi Hall, and Jena Trombley
Georgia Maheras

Lunch – 1 hour

Please enjoy lunch on your own and
be prepared to resume the meeting at 12:30.

Regional Care Coordination – 30 min

(Sec 4, 1) The potential benefits and costs of developing regional navigation and resource centers for referrals from primary care, hospital emergency departments, inpatient psychiatric units, correctional facilities, and community providers, including the designated and specialized service agencies, private counseling services, and peer-run services.

Are you aware of care coordination models and initiatives in progress in Vermont?

Presenters: Mary Moulton and Simone Rueschemeyer

DMH Care Coordination

(Sec 4, 2) The effectiveness of the Department's care coordination team in providing access to and adequate accountability for coordination and collaboration among hospitals and community partners for transition and ongoing care, including the judicial and corrections systems. An assessment of accountability shall include an evaluation of potential discrimination in hospital admissions at different levels of care and the extent to which individuals are served by their medical homes.

Department of Mental Health	~265 Staff
VPCH/MTCR	~200
Business office, Quality, Research Policy, Administrative, Commissioner	~53
Utilization Review Care Management	~12

DMH Adult Care Coordination – 10 min

(Sec 4, 2) The effectiveness of the Department's care coordination team in providing access to and adequate accountability for coordination and collaboration among hospitals and community partners for transition and ongoing care, including the judicial and corrections systems. An assessment of accountability shall include an evaluation of potential discrimination in hospital admissions at different levels of care and the extent to which individuals are served by their medical homes.

The Adult Care Management team is currently comprised of four care managers with the specific focus of supporting the movement of consumers through the different systemic levels of care.

This current care management structure has evolved as we meet the needs of the state system of care to provide direct DMH support to DA's and other community partners for individuals who are accessing all the levels of mental health care the state offers.

Presenters: Emily Hawes, Cindy Olsen, Anne Rich, Allie Nerenberg, and Kristy McLaughlin

Current Adult Care Management Roles

Care Manager	Role
Cindy Olsen	Admissions
Anne Rich	Discharges
Allie Nerenberg	Discharges
Kristy McLaughlin	ONHs Inmates designated SFI

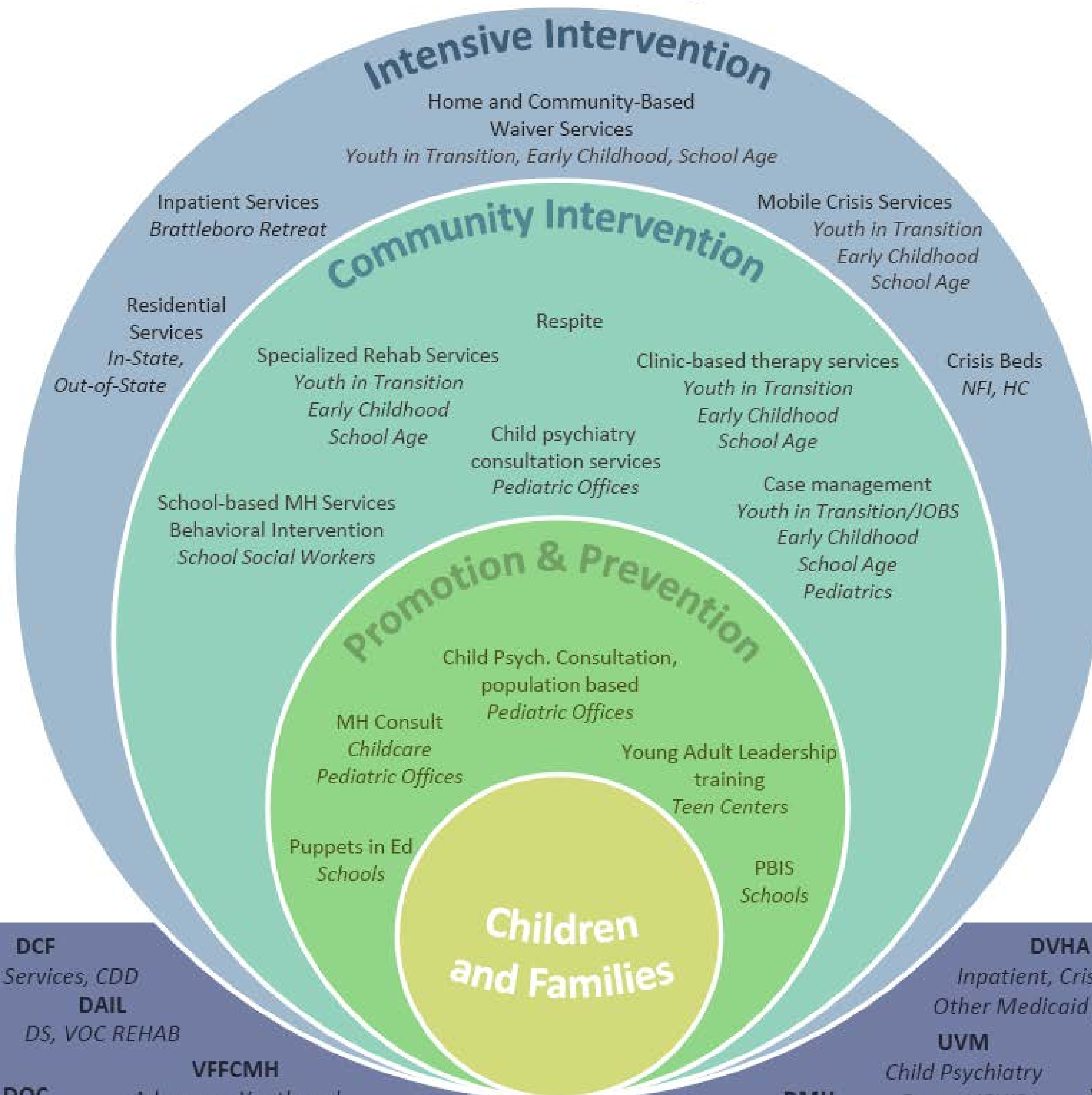
DMH Child/Youth Care Coordination – 10 min

(Sec 4, 2) The effectiveness of the Department's care coordination team in providing access to and adequate accountability for coordination and collaboration among hospitals and community partners for transition and ongoing care, including the judicial and corrections systems. An assessment of accountability shall include an evaluation of potential discrimination in hospital admissions at different levels of care and the extent to which individuals are served by their medical homes.

Child, Adolescent & Family Care Management

Presenter: Laurel Omland

Children's Mental Health System of Care



Acronyms

Providers
DA – Designated Agency
DH – Designated Hospital
HC – HowardCenter
NFI – Northeastern Family Institute
SSA – Specialized Service Agency

State Government
AOE – Agency of Education
DAIL – Dept. of Disabilities, Aging, and Independent Living
DCF – Dept. for Children and Families
DMH – Dept. of Mental Health
DOC – Dept. of Corrections
VDH – Dept. of Health
ADAP – Alcohol Drug Abuse Programs at VDH
EPI – Epidemiology at DMH/VDH
MCH – Maternal Child Health at VDH

Partners and Programs
PBIS – Positive Behavioral Intervention and Supports
UVM – University of Vermont
VCHIP – Vermont Child Improvement Project
VFFCMH – Vermont Federation of Families for Children's Mental Health

Children Served by Public Mental Health System over Time

Number Served by FY

12,000
10,000
8,000
6,000
4,000
2,000
0

1985 1986 1987 1988 1989 1990 1991 1992 1993 1994 1995 1996 1997 1998 1999 2000 2001 2002 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2014 2015 2016

DMH Children’s Care Managers

3 primary roles:

- Care Management for intensive, non-hospital care
- System of Care development
- Quality of DA/SSA services

Authorize access and Medicaid funding of these children's MH services:

- Intensive Home and Community Based Services (aka Enhanced Family Treatment)
- Intensive residential assessment & treatment; and
- Extended stay reviews for Hospital Diversion and Crisis Stabilization

Provide feedback and technical assistance for local providers as to the most appropriate course of action on complex family needs.

Extensive case coordination with system of care partners:

- Families
- DCF Family Services
- DAIL Developmental Services
- Agency of Education and local schools
- Dept of VT Health Access (inpatient cases)
- VT Federation of Families for Children's Mental Health

Vermont's Act 264, established in 1988, defined the system of care for children and families

- Established values for the system of care
- Decision making and service delivery is more coordinated and involves parent voice at all levels
- Created local and state interagency teams
- Created ability to think and act like a system: common purpose; reasons to act together as allies; develop strategies for continuous quality improvement
- Created a Governor appointed advisory board
- Expanded in 2005 under the Interagency Agreement with Education to include all disabilities under Special Education
- Guides our daily work

Current focus:

- Early Childhood Mental Health consultation and treatment
- School-based Mental Health
- Development of Hospital Diversion Program in southern part of Vermont
- Transferring resources used for residential care into the community
- Working with the Agency of Education to reinvigorate Act 264
- Health Care Reform
- Addressing adverse childhood & family experiences (ACEs/AFEs)
- Suicide Prevention
- Integrating developmental and mental health services for children & families at the DAs

DA/SSA Service Delivery

Policy & procedure development

- Review quality of DA/SSA child, youth & family services
- Adherence to standards of care
- Review patterns of performance by service providers and provide feedback in collaboration with DMH quality team
- Promote best practice approaches for promotion, prevention, intervention & treatment

Child & Adolescent Inpatient

Department of Vermont Health Access (DVHA) authorizes inpatient stays beyond the initial admission for children & adolescents

Inpatient unit and DA have primary roles in aftercare planning

DMH-CAFU coordinates with DVHA, inpatient unit and DA when aftercare plans are complex

DMH-CAFU reviews quality processes of inpatient unit for children and adolescents

Children waiting in ED

Initial contact is DMH Adult Care Management

DMH-CAFU is brought in for prolonged stays and complex situations

Children’s Care Managers are involved primarily by providing information about cases they are currently actively following

DMH Care Coordination – 10 min

(Sec 4, 2) The effectiveness of the Department's care coordination team in providing access to and adequate accountability for coordination and collaboration among hospitals and community partners for transition and ongoing care, including the judicial and corrections systems. An assessment of accountability shall include an evaluation of potential discrimination in hospital admissions at different levels of care and the extent to which individuals are served by their medical homes.

Group Discussion

Crisis Diversion Evaluation – 30 min

(Sec 4,3Ai) Existing and potential new models, including the 23-hour bed model, that prevent or divert individuals from the need to access an emergency department; (ii) models for children, adolescents, and adults; and (iii) whether existing programs need to be expanded, enhanced, or reconfigured, and whether additional capacity is needed.

Can existing programs be expanded, enhanced or reconfigured?

What currently exists per county?

What alternative options are there?

What are the pros, cons, benefits and challenges of those systems?

Diversion Models – 30 min

(Sec 4, B) Diversion models used for patient assessment and stabilization, involuntary holds, diversion from ED and holds while appropriate d/c plans are determined shall be considered, including the extent to which they address psychiatric oversight, nursing oversight and coordination, peer support, security and geographic access. If preliminary analysis shows need for or benefits of additional, enhanced, expanded or reconfigured models, the action plan should include steps including licensing needs, implementation and ongoing costs.

What gaps in services, including community based through inpatient, are needed or missing in the SOC?

What specific areas of the state are missing these services?

UVMMC Inpatient Psychiatry Barrier Days Analysis – 30 min

Presentation, discussion, and questions

Presenter: Isabelle Desjardins, MD

Geriatric Psychiatric Support – 30 min

(Sec 4, 6) Geriatric psychiatric support services, residential care, or skilled nursing unit or facility. The analysis, action plan, and long-term vision evaluation shall evaluate the extent to which additional support services are needed for geriatric patients in order to prevent hospital admissions or to facilitate discharges from inpatient settings, including community-based services, enhanced residential care services, enhanced supports within skilled nursing units or facilities, or new units or facilities. If the analysis concludes that the situation warrants more home- and community-based services, a geriatric nursing home unit or facility, or any combination thereof, the action plan shall include a proposal for the initial funding phases and, if appropriate, siting and design, for one or more units or facilities with a focus on the clinical best practices for these patient populations. The action plan and preliminary analysis shall also include means for improving coordination and shared care management between Choices for Care and the DAs and SSAs.

What are the challenges for all levels of care to discharge to a lower level of care?

Presenters: Monica Hutt and Camille George

Forensic Psychiatric Support – 30 min

(Sec 4,7) Forensic psychiatric support services or residential care. The analysis, action plan, and long-term vision evaluation shall assess the extent to which additional services or facilities are needed for forensic patients in order to enable appropriate access to inpatient care, prevent hospital admissions, or facilitate discharges from inpatient settings. These services may include community-based services or enhanced residential care services. The analysis and action plan shall be completed in coordination with other relevant assessments regarding access to mental health care for persons in the custody of the Commissioner of Corrections.

What services and facilities currently exist forforensic patients?

What services and facilities are needed for forensic patients?

What are the barriers to access of services for forensic patients?

Units or Facilities

(Sec 4, 8) Units or facilities for use as nursing or residential homes or supportive housing. To the extent that the analysis indicates a need for additional units or facilities, it shall require consultation with the Commissioner of Buildings and General Services to determine whether there are any units or facilities that the State could utilize for a geriatric skilled nursing or forensic psychiatric facility, an additional intensive residential recovery facility, an expanded secure residential recovery facility, or supportive housing.

Are there any potential facilities we should be looking at?

Are there other spaces that are already built that would need reconfiguration?

Emergency Services – 30 min

(Sec 4, 9) How designated and specialized service agencies fund emergency services for the purpose of ensuring emergency services achieve maximum efficiency and are available to all individuals within a specific designated or specialized service agency's catchment area and shall identify any funding gaps, including methodologies of payment, capacity of payment, third-party payers, and unfunded services. "Emergency services" means crisis response teams and crisis bed programs.

Emergency Services

Emergency services includes screening, assessment, support, referral, and crisis beds

Emergency services are funded separately, funded within the IFS bundle and also as part of CRT

MCO investment capacity (70%) and fee-for-service (30%)

- Percentages vary by DA

Little additional funding over time (Act 79 capacity payment FY13)

Challenges with third party billing

Trends in Crisis Bed Utilization

Questions/Comments – 30 min

Contact Information

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*Please send any additional thoughts or information to Melissa with a CC to Jen Rowell (Jennifer.Rowell@vermont.gov)