Advisory

Department of Mental Health

March 22, 2017

FROM MY PERSPECTIVE

As I assumed the role of Commissioner at the beginning of the new Administration, immediate concerns were identified. They were largely operational issues all too familiar in the mental health community. They regard Emergency Department stays that continue to be long for some individuals. This must be an immediate focus, requiring efforts by DMH and many others to achieve success in addressing these concerns. My longer view and priorities concern how the Department of Mental Health can develop and implement strategies that will yield positive outcomes for Vermonters, including individuals, children and families. Research findings have conclusively demonstrated a strong correlation between adverse childhood experiences (ACEs) and adverse family experiences (AFEs) that show us how reducing mental health issues later in life may be accomplished through preventive interventions for children and families and building resiliency. The evidence is very persuasive that a child's trajectory in life is influenced by such adverse childhood experiences as family income hardship, divorced/separated parents, parents experiencing alcohol/drug problems, and/or a parent experiencing severe depression, mental illness or suicide. These are the four most common AFEs among Vermont children. Including this focus on the underlying causes of mental health problems is an opportunity to intervene before poor health outcomes play out. Learn more from our testimony to Senate Health and Welfare at

http://legislature.vermont.gov/assets/Documents/2018/WorkGroups/Senate%20Health%20and%20Welfare/Bills/S.90/S.90~Melissa%20Bailey~Adverse%20Family%20Experience%20-%20The%20Vermont%20Story~3-17-2017.pdf

in collaboration with Vermont Care Partners.

~ Commissioner Melissa Bailey

HEALTH CARE AND WELLNESS

What is Population Health?

The Advisory partners with the Vermont Department of Health to enlarge public understanding of the integral relationship of mental health to health, seeking to bring pertinent articles on health care and wellness that serve the DMH goal of mental health and health care integration, benefit the mental health community, and provide us all with valuable information. This month, we thank Robin Edelman, MS, RD, CDE Health Systems Program Administrator, Vermont Department of Health / Division of Health Promotion and Disease Prevention, for this story. This is first in a series on population health and the impact of social determinants of health in 2017.

"Population health" is a term coined in the late 1990's and is commonly used today by people working in policy, public health, business, and healthcare settings. Population health was defined in 2003 as "the

health outcomes of a group of individuals, including the distribution of such outcomes within the group". (1) These outcomes could include vital statistics, clinical laboratory values indicative of disease risk, survey data about demographic and anthropometric measures, and self-reported perceived health status.

More recently, we hear the term population health used while discussing an organization's quality performance measurement such as the data collected by hospitals engaged in quality improvement work.

Approximately ten years ago, the Institute for Healthcare Improvement (IHI) developed a framework called the Triple Aim that recommends the integration of three key outcomes in healthcare design:

Improve the health of the population

Enhance the individual patient's satisfaction with quality, access and reliability.

Reduce or control the per capita cost of care.

IHI has popularized Population Health by using this term in their educational and promotional efforts to help healthcare organizations achieve the outcomes of the Triple Aim. (2)

Triple-Aim-Triangle

The "population" of population health refers to specified small or large groups of individuals that have something in common such as the neighborhood or state in which they live, the medical practice they use for primary care, or the designated agency where they receive mental health care. Populations might also reference a worksite's employees, an ethnic group, or another group that shares similar characteristics – such as people who have a diagnosis of high blood pressure or depression.

Many factors determine the health of any given population, including socioeconomic status, education, access to healthy food, safe places to walk, and protection from secondhand smoke. Mental health and medical health advocates in clinical and public health settings are all recognizing the importance of addressing the social determinants of health to improving a population's health. Vermont Care Partners is hosting a conference on health care equity and the promotion of population health on March 27-28, 2017 in Burlington: https://www.eventbrite.com/e/stepping-forward-together-advancing-equity-and-cultural-competency-to-improve-population-health-tickets-31292556880

Clinicians and public health workers may sometimes define populations differently. For example, a clinician may be thinking about only the patients using a community clinic (also called the panel of patients), while a public health data analyst may be thinking about all the people living within a short distance from that clinic regardless of whether they are current patients. It is important to define who comprises the population that is being addressed by any specific intervention or initiative.

Striving to improve "population health" requires the understanding that a population consists of unique individuals situated in the context of shared characteristics and health outcomes. Effective health management can only happen if providers identify the individuals within the population that have common needs, then use evidence-based strategies to provide care, and evaluate the results of care to see if the three Triple Aim outcomes are achieved.

We plan to address additional topics related to population health in upcoming issues of the Department of Mental Health Advisory newsletter.

References:

(1) http://healthaffairs.org/blog/2015/04/06/what-are-we-talking-about-when-we-talk-about-population-health/

(2) http://www.ihi.org/Topics/TripleAim/Pages/default.aspx

DEPARTMENT OF MENTAL HEALTH

Staff Announcements

Deputy Commissioner Mourning Fox, LCMHC

DMH Commissioner Melissa Bailey announced that Mourning Fox will serve as Deputy Commissioner. Fox has over twenty years of experience in the mental health field. He began his career with the Howard Center working as a crisis clinician and eventually running their crisis bed program, ASSIST. Fox later developed the counseling program at his alma matter, Earlham College. He was director of the maximum security psychiatric units at Bridgewater State Hospital in Massachusetts for many years. Fox's work with law enforcement started with training with the FBI as a hostage negotiator to being a part of developing Vermont's Team Two training program. Fox returned to Vermont in 2012 as the Behavioral Health Director of Lamoille County Mental Health. The Department of Mental Health recognized the breadth and depth of his experience four years ago, hiring him as Care Management Director and utilizing his talents in the positions of Director of Operations and, most recently, as the Mental Health Services Director. In each position, DMH staff has enjoyed working together with him to continue supporting mental health as the cornerstone of health in Vermont.

Interim CEO – Vermont Psychiatric Care Hospital – Frank Reed, LICSW

Frank Reed, Director of Operations, Planning and Development, is serving as interim CEO for VPCH during the current period of leadership transition for the hospital. For the next few months while the Scott Administration recruits for a hospital executive director, Deputy Commissioner Mourning Fox and Interim CEO Frank Reed will be providing leadership and management support for VPCH. Reed will provide day-to-day support and work on site at the facility for a dedicated portion of his time. As Commissioner's designee for policy and planning activities, human resources, and other matters, Fox will act as the Commissioner's designee, supporting Reed, including on-site as his attendance is required. General Counsel Karen Barber, Esq., will continue to provide legal services and support on behalf of the Commissioner. This transition plan has come about with the departure of the hospital's first CEO, Jeff Rothenberg, who was not reappointed.

Care Manager Alexandra (Allie) Nerenberg

The Care Management team welcomed our newest team member Alexandra Nerenberg (Allie) who joined over the last year. Allie has developed a strong clinical skill set hailing from Crossroads, an Intensive Outpatient Program and partial hospital based on the theory of Dialectical Behavior Therapy and as the Social Worker at Middlesex Therapeutic Community Residence. Allie is a licensed mental

health counselor and has vast experience and practice of clinical interventions and is knowledgeable about state resources. She has been a positive addition to the team. We are fortunate to have her insight as we support our hospitals and community partners.

The 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. Cindy Olsen is the lead for admissions work. Her focus is collaborating with DA screeners and ED staff as well as the inpatient admissions staff to facilitate and triage an admission for someone who is on involuntary status and waiting for placement. She is also available to support folks who are voluntary as needed. Anne Rich and Allie Nerenberg meet weekly with the hospital inpatient units to assist in facilitating discharges to the next appropriate level of care. They work in collaboration with several state and community partners to problem solve and provide clinical consultation with a primary focus on those individuals who have been admitted through an emergency examination. Anne and Allie have a bird's eye view on available resources and potential resources and can "cue" up potential next admissions to decrease discharge wait times. They are typically managing a combined caseload of approximately 65 individuals on a weekly basis. Kristy McLaughlin works in collaboration with Designated Agencies and DMH legal to support the work our partners are providing to those folks who are under the care and custody of the Commissioner and reside in the community. She also works directly with Department of Corrections staff to support reentry efforts for individuals who have been designated SFI (Severe Functional Impairment) in corrections.

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.

Mental Health Analyst David Horton

David Horton recently joined the Research and Statistics team as a Mental Health Analyst III. Dave comes to us from the Vermont Department of Health, where he served as the senior data analyst for Vermont's Prescription Monitoring Program. His ability to design, create, and maintain datasets, perform statistical analysis, and produce comprehensive written reports makes Dave an asset to the R&S team of five individuals.

Administrative Assistant B Cara Bogaczyk

Cara Bogaczyk recently joined the Administrative Support Team as a part-time Administrative Assistant. Cara comes to us from the Office of Child Support, where she oversaw two units that maintained records and performed administrative actions to collect funds owed on unpaid child support cases. Cara has been working for the State for 6 years, and previously worked for the Howard Center doing direct service work in residential homes and in classrooms throughout Chittenden County. She is excited to be returning to the mental health field, and is delighted that she was able to find a job share position so that she could spend more time with her 8-month old son, Brayden.

LEGISLATIVE AND REGULATORY

Legislative Overview

The Department of Mental Health is working with lawmakers this session in response to the need for orientation of new members; reassignment of mental health jurisdiction to the House Committee on Health Care; active monitoring of mental health integration with health care reform; discussion of the annual report on Act 79; requests for comment on a variety of bills; and coordination with other Agency of Human Services' departments and mental health stakeholders. Of special interest is a committee bill developed by Senate Health and Welfare (S.133). Unlike member-sponsored bills, a committee bill is sponsored by a committee and then introduced into its chamber of origin. At that point, the bill could be assigned to another committee to assess budget, legal or other matters; it could be placed on the calendar for consideration as is; or it could be requested back by the sponsoring committee for further review. Finally, there is the appropriations process that culminates in what is called the Big Bill – the operating budget for state government in the fiscal year beginning July 1, 2017.

Senate Health & Welfare Committee Bill – S.133

The hallmark of this bill is its intent to examine how parts of the mental health system of care, specifically the adult system, work as envisioned in the 2012 mental health bill enacted after Tropical Storm Irene. Taken together, these parts created a new policy framework and an extensive array of therapeutic, recovery-oriented, alternative, and secure levels of care supported by programs and facilities in a dispersed environment. There are still some challenges. The committee bill begins with findings of fact to identify them: hospital flow; lack of health care parity; shortage of psychiatric care professionals; inadequacy of current funding levels to meet demand for services; lack of a therapeutic environment in emergency departments; and the fundamental, increasingly understood link between the social determinants of health (housing, employment, food security, education and more) and the trajectory that requires addressing the needs of children and adolescents in the context of their family.

The committee bill calls for an action plan from the Secretary of Human Services with recommendations and proposed legislation for each of seven areas of study and analysis by September 1, 2017. These are system operations, care coordination, involuntary treatment and medication, psychiatric access parity, geriatric and forensic skilled nursing unit or facility, repurposing existing state facilities for geriatric or forensic psychiatric skilled nursing or residential home or supportive housing; and 23-hour bed evaluation. A workforce development study committee would be created to examine and report, also by September 1st of this year, with legislative proposals aimed at attracting more health care providers to Vermont. Greater interstate mobility and licensing reciprocity of mental health professionals would be studied by the Director of Professional Regulation in the Secretary of State's office with legislative recommendations due by September 1st. Rates of payment to designated and specialized service agencies would also be tackled by the Secretary of Human Services, a large, complex area of study to be completed January 1, 2018, at the beginning of the second half of this biennial session when lawmakers want to be ready to act upon a very broad range of issues that bear upon psychiatric services for child, adult, geriatric, and forensic patients; all levels in the continuum of mental health care; system affordability and sustainability; and integration with the whole health care system as it is evolving in Vermont.

To stay current on S.133 An act relating to examining mental health care and care coordination, the Senate Health and Welfare's committee bill, use this link.

http://legislature.vermont.gov/committee/sponsored/2018/27