Act 82 Working Meeting
July 25, 2017
WSOC – Cherry Conference Room
8:30 – 4:30

Link to PowerPoint Presentation:
http://mentalhealth.vermont.gov/sites/dmh/files/documents/news/Act82_Working_Meeting_2017-07-25.pdf

Link to DMH System of Care Adult Beds by type and location:
https://public.tableau.com/profile/emma.harrigan2032#!/vizhome/DMHMentalHealthSystemofCare-BedsbyTypeandLocation/Dashboard

Introduction of Act 82 (S.133) *Slide 3*

Current Data Collection *Slides 4-7*

Comments/Questions

It was noted that there are also Satisfaction Surveys that are sent to Parents as well as Children.

Q – Does DMH collect Involuntary data on inpatient status of Pediatric stays

A – Not currently as our AGs do not manage the court process for Children, but we are examining ways to get the data.

Q – DMH collects the data for patients who meet EE criteria, do you have any mechanisms to collect data for people who meet EE criteria but agree to voluntary?

A – This is the data we are currently working with VAHHS to obtain as voluntary are not in the care and custody of the Commissioner. There are different legal and legislative perspectives on this information.

Q – It sounds like you collect the LOS data for all of the traditional hospitals, what about the IRR's?

A – Yes, the IRR's report to a monthly service report, with crisis beds, the data is there but it is challenging as it requires a lot more finesse to pull the data.

Q – Is there any forecasting data happening, looking ahead at what we would be needing for capacity?

A – We are looking at demographics but not the capacity, we don't have the expertise do that accurately.

DMH has a variety of data, but we don't have the entire picture.

Data Needed *Slide 8*

Comments/Questions

Q – Does DMH breakdown the data you receive for geriatric, dementia, etc. that are stuck in the ED?

A – There are data points but each case you would have to go deeper to find the sticking point. Dr. Isabelle Desjardin did dig deeper into the in-patient information and will present that later today.

Comment: Designated Agencies (DA's) collect data and they are not good with quality control. How crisis response can be better, doesn't think they are asking the right questions – for example, when First Call responds, we don't have a children's crisis response, there is no mobile crisis in Chittenden County, which is a problem. In terms of data, they are not looking at who is calling, they are looking at response time but they don't look at where the kids go, do they have a developmental disability? Mental health complex needs? How old the child is? What are the services they are getting? How did they get to a hospital? Were the Police involved? Was street outreach involved or available? There are no follow-up services.

Comment: You (directed at DAs) are not servicing the kids well as you have the same person calling over and over; it is not working.

Comment: Quantity versus a quality number – each DA does collect the required data. Each DA is looking at how do we responds to the services we are providing. There needs to be some work done on the definition of crisis diversion. How do you measure that when each DA is different?

Comment: The issue of homelessness is an issue which is not fully tracked and it has a huge impact.

Comment: Interested in data around the prescribing practices in the DAs and hospitals. The best standard is low to no meds for most people.

Comment: DMH is not collecting data around EIPs in the EDs. That seems like important data to collect.

Response: This is something else we are working with VAHHS on as well

Comment: The grievance and complaint process through the DAs and DMH. People are generally feeling that the process is not useful. You have to wait 90 days to get a response. They are not being collated or reviewed with upper management. Quality issues need to be identified.

Comment: The Criminal Justice Core Team did create data for every county and jurisdiction in the state about what mental health services are available there. The Supreme Court has that data, and it shows the gaps.

Comment: Should collect data on the requests for emergency response services to the field by law enforcement and what was the outcome? What is the demand? What is the capacity? With the Crisis response unit, what is the outcome of this? Is there the ability, if not, do we have the adequate resources to meet the demand? Could they do the responses that was requested with law enforcement?

Comment: The mental health crisis is something that the hospitals have had to respond to, it is growing a new service line with hiring new FTEs, sitters, maintenance. I think it would be interesting to know how growing a new service line across the Vermont hospitals, have had to grow because of this service line. Interested to know how it affects the hospitals bottom line.

A – Green Mountain Care Board could possibly know that answer.

Q – What is the percentage of people who present to the EDs known or unknown to the DAs?

A – Pretty often there is a 50/50 split but there are a lot of people that DAs have not encountered in the past. Possibly AITs could speak to this.

Q – If they are known, can we tell if they have shorter stays than those that are not known?

A – We can look at who is in the care and custody of the Commissioner, there are a variety of significant data (arrived, paperwork, LOS). We would need a solid definition of what known means and figure out parameters.

Q – Developing service lines i.e. FQHC – Federal Qualified Health Centers prescribing psychiatric medication– Is DMH communicating with them? How much does it impact the system?

A – DMH does not have a role in overseeing FQHCs, but could possibly look at Medicaid claim data, but that won't tell the whole story.

Q – ED LOS – as we try to move forward to come up with solutions, I am assuming the data existed for LOS before Tropical Storm Irene and it was shorter?

A – DMH has not come up with data on ED waits before Tropical Storm Irene. The data collection started with Act 79.

Comment – it would be important to compare before and after.

Comment – This has become a National issue for ED wait time all across the Country. Other states are experiencing an increase, according to NASMPHD.

Comment – I don't think that this is accurate, our factors are not the same.

Comment – UVMMC's ED – before Tropical Storm Irene it was unheard of to spend a lot of time in the ED. The prolonged wait time and decrease in Emergency medicine capacity does not add value and certainly does not add value to other members accessing care in the EDs. We have had a significant decrease in Emergency medicine capacity for our failure to provide appropriate, effective settings for our mental health patients. They are not receiving the right care at the right time.

Comment – Do we know for sure that we have created the appropriate level of care for all populations? Do we have a gap where we have not created an appropriate level of care in the community? Where have we defined what we have and what we need to fund?

Comment – One way to collect data would be standardizing the language we use when patients are refused at a facility. There are many different options people use (too acute, not taking medications, this is a female and we only have a male bed) – we need to categorize those a bit and find ways to get better at it. There are different reasons at each hospital whey they can't take a patient.

Comment – I have four points

1. We desperately need more psychiatrists in the state.

2. My proposal is fairly simple: create an appeals or review panel consisting of a psychiatrist, some psychopharmacologists, a psychotherapist and an internist to travel from agency to agency throughout the state to meet with patients who feel their diagnosis or treatment is incorrect, hear them and review their histories and help the agency find accommodations for unique situations. The members of this panel would not be tied to any of the county agencies and would be professionals of the highest standards and broadest interests having knowledge of the newest models for working with the chronically mentally ill. Perhaps some of the faculty of the medical school would find it rewarding to participate in a program that would take them out to the various and diverse communities around the state that lack both the sophistication and resources of Chittenden county. And although there might well be situations where the diagnosis is deemed correct, the original treatment plan might be outdated and could be revised to take into account advances in both the pharmaceutical and therapeutic fields, and the patient/client would benefit by feeling that his/her voice was heard.

3. In our 24/7 economy/world it seems that we should be able to meet clients' needs on the week-ends and evenings without their needs being labelled "crisis." Also, during holidays there should be counselors available (i.e. the agency should not be closed for a four day week-end over Thanksgiving, a time that is particularly stressful for many whom they serve.) If small issues can be resolved quickly they might not fester and become large issues.

4. A message to all of us: "Don't mail out bad or stressful news on a Friday!" It is tempting to clear our desks before the week-end but receiving disturbing mail on a Saturday when there is no chance to address the issue with the sender can be very stressful and can be "the straw to break the camel's back." Mail out "bad new" on Monday……

Comment: What can be done to support hospitals for kids who are deemed too acute for admission so it doesn't result in a child going out of state? Most of them are not VT Medicaid providers so it can further exacerbate the wait.

Comment: What are the reasons people are going to the EDs in the first place and what resources could prevent some of those admissions in the first place. Is it around housing, around safety in the home? It seems like the ED has become a revolving door – either they get sent away, or they get hospitalized. Once discharged, they still might not have what they are looking for. Are providers sharing peer support information?

Comment: It looks like we are really talking about decreased capacity in the hospitals. I want to look at how this effects the Police. Is there any way to track that? Have you contacted your DA? Are crisis lines putting calls to the Police?

Comment: There needs to be education and building awareness of resources in the community. People believe the ED is the place to go. They need to be able to get the care when they need it and know where to go.

Referrals *Slide 9*

Comment: With people not knowing what resources are available, the ED is the logical step.

Q – How many people are brought to the ED on an EE versus when they show up the get EE'd?

A – most people are not brought to the ED EE'd, but after they get there it happens.

Comment: People go to the ED for various reasons, some of the reasons don't get discussed. I think the EDs are a lot like schools, societal problems, we blame a lot on our teachers but problems show up there, same with the EDs. People go to the ED because they don't know where else to go, just a safety net, to get away from a spouse, even a bad living situation, homelessness. They also might think people are withholding care from them so they go to the ED to get it.

Comment: There are barriers for information sharing between the DAs and EDs. The EDs don't always know who are clients coming through the door. One of the barriers is how many people are coming to the ED, transition for data and information is very hampered and manual, case by case. I feel like there is no speaking from EMR to EMR.

Comment: If I don't have natural supports, there aren't sufficient alternative resources to talk to, so the resource is crisis. If it is in the evening, weekend or weekday, the only time they are willing to have that conversation is in the ED.

Comment: With the complexity of cases, there is not a lot of capacity for geriatric, etc. It can extend the time for many days.

Comment – DRVT goes out annually to the public and gets input from folks who qualify for our services. It comes up that when people go to the ED and they have a psych history, it overrides their physical complaints and this gets set to the side. There is a danger of looking too far in the other direction. Physical issues get deemed to be somatic. It is a problem that is real.

Comment – The concept of the right to refuse admission. If someone comes into the ED with chest pain, they have to get admitted. A DH can refuse people. That can affect the length of wait. This is a very unique situation that happens with mental health.

Comment: It is okay that they come to the ED as long as we have the resources to provide to the folks. We want people to come to us. level 1 beds (people who are deemed to be disruptive in the therapeutic milieu); I think we have to own the fact that we need to provide capacity for these people and they are disruptive to the milieu of the ED. We need to have the capacity with no right of refusal for the people who are in the greatest distress in our society.

Comment: Families are being told to go to the ED because if you document lots of visits to the EDs, that is how you access more care. This is what the DAs are making people do, same with the Police – this is not okay. Families do not want to bring kids to the ED. First Call is now telling people assessments are only done in the ED. When a kid has to be brought to the ED in physical restraints by the Police, they are screaming and need to be taken through the entire ED area, it is embarrassing and stressful.

Comment: We all approach the problem from the vantage point we have – peer secrecies wonder if there was more of that in the community, it would keep people from the ED. The DA's not accepting someone who might not meet the criteria, would also look at UVMC level 1 that came in. We need to have a frank conversation about regulations, the risks involved; why people are worried about the risks. We have driven the system on the hypothesis that we don't need a state hospital. That was developed before Irene as a hypothesis. We need to examine this and admit where we might be wrong – I don't get why we have such a back-up. There is a group studying where we go into the home in and interview ways to avoid isolation in the home. We are not going to solve the problem but it might help to support the really stressed crisis service and Police.

Comment: There have been some issues when someone was accepted on a secure unit, but they couldn't get transported in time. A couple of weeks ago a Sheriff from Lamoille had to come to BR, 4-5-hour total trip which escalated the patient waiting.

Response to Comment: DMH has contracts with two Sheriffs. We have put RFP's out to get transportation services from others but there were no other responses and it is a struggle to get Sheriff's at times.

Comment: Some people would rather be homeless that have a mental health label.

Comment: Happy that children were mentioned. I am seeing schools calling crisis during the day and then transporting them. I would like to see some data on this. Kids who have dangerous behavior or dangerous patterns, I am hearing more and more that crisis was not helpful, not the right match, and that when the crisis plan is developed, the language in it is to call the Police. Calling the Police is not part of a mental health crisis plan, they should be calling someone else.

Accessibility and Gaps in Service *Slide 10*

Comment: Bed types – people that are not taking medications that are being prescribed in the ED, nobody will take that patient.

Comment: Windham - in the past, we could prearrange treatment planning with the State Hospital. They would agree to take the patient if they became unmanageable. We can't do that anymore. We can't take the risk if people are at a dangerous level.

Comment – NFI will have 6 more beds opening for kids in November.

Emergency Department Wait Times *Slide 11*

Link to Presentation

Comment: Police bring mental health patients to the ED instead of arresting them, the ED says to arrest them. This is a big problem.

Comment: The ED wait time is a National phenomenon and is increasing. It is relevant to Vermont, but as you can tell from the research, there is many factors that go into this.

Comment/Q – It is disconcerting to hear about this all over the county. Do you have any information on other countries system of care?

A – There is some literature on this and there are some interesting things that Finland is doing.

Barriers and Gaps in Service/Staffing *Slide 15*

Link to presentation:
http://mentalhealth.vermont.gov/sites/dmh/files/documents/news/VCP_Presentation_for_July_25_2017.pdf

Comments from the presenters:

- Adult Outpatient Programs (AOP) are very important and chronically have been an area where we don't get enough resources.
- Licensing and credentialing gets higher and higher, hard to take a job at a DA for low pay when you come out of college with $30K in debt. We need to find a way to loosen restrictions.
- It is very encouraging from Legislature to raise the pay to $14 an hour. It is a great step but too soon to know what it will look like state-wide. Some crisis based services and residential homes have started this and it looks good.
- Act 82 is really good, bringing us together to dialogue.
- We need to go back and do some more analysis of workforce payment levels to figure out where we should be. Look at things like Blueprint dollar investments to get going.
- The DAs have been doing a lot of work that is not fully funded for, not in the contracts but necessary. How do we make sure we have the funding to do the things we need to do?

Comments: We are hearing from the community that the turnover in case management is a problem and also feel that they get help from their case manager but access to a higher level of therapies has gotten thinner and thinner.

Comment: Feedback from the community is that the case manager and therapist sometimes wears the same hat, with many negative comments that it just does not work for them. They don't look to their case manager for therapy. There is a high need for psychotherapy.

Comment: I am not in favor of loosening the licensing restriction standards (OPR) and will fight against that.

Comment: I spent a lot of money on a good education and got a Master's. Coming from another state, I can't get licensed in Vermont because the system is not built to look at what I got for credits. It feels as someone coming from an outside state, it is not very welcoming to people.

Comment: It is an important part of recruitment and retention at the DA level is how their practices are supported. I think it is important that these providers have the resources so we can assure that all of the general health concerns of the patients are addressed. We need to have collaborative care with the PCP, the ability to gather records, facilitate referrals, help with assuring labs are followed up, routine phone calls with patients and families.

Comment: Other states have seen for the past 5-6 years a psychiatrist shortage and the Northeast is just starting to see the same issues here.

Comment: Different models of care – implementing this month is Tele-psych with both Dartmouth and the Retreat. We don't get reimbursed for this but it is worth it if so people don't languish in the EDs.

Comment: One gap is the support for reducing the use of psychiatric drugs overall. We need to make sure we are able to do that.

Regional Care Coordination *Slide 17*

Link to presentation:
http://mentalhealth.vermont.gov/sites/dmh/files/documents/news/VCP_Presentation_on_Regional_Navigation_Regional_Care_Coordination.pdf

http://mentalhealth.vermont.gov/sites/dmh/files/documents/news/Collaborative_and_Hub.pdf

Q – Have you had a peer or survivor sit at these meetings?

A – Not yet, have had two meetings and are looking at patient satisfaction surveys.

Q – Regionally, would there be a central point that all of you are talking to each other? For instance, families who have loved ones who need Level 1 care, how does the family get informed?

A – We have not talked about the involvement for people who are already in the ED, this is more of an upstream access (earlier in the game).

Q – For adolescents, what is the experience in your region statewide, the degree and barriers to collaboration between mental health and substance abuse?

A – The initial conversation hasn't brought in the children's population and is a question on how much we can bite off at once.

Comment: Communication is so hard, speaking from in the trenches in a clinical position. It is a bigger system, more Dr.'s, more clinics, just being able to keep up communication is difficult.

Comment: We often hear there is too much care coordination and then on the other hand we hear there is not enough (depends on region/individual).

Comment: When you are dealing with Children, multiple agencies can touch them i.e. DMH, DCF, DVHA, School, DA – how does all of that get coordinated so that we are not making multiple phone calls? When we identify a high-risk child, there are regular, predictable calls that happen with all of the agencies to talk about their piece.

Comment: In BR peer coordination is great for those who have access, the most disenfranchised are the homeless. We created a Nurse (through a Grant) who is at the homeless shelter to help them interface with either ED or PCP. When we start looking at people who are seeking care in the ED due to mental health issues, a significant amount are homeless. The next piece will be to create a respite bed in the shelter.

Q – Are you collecting data on this?

A – Yes, for the grant foundation.

Comment: Our experience is there are two phases of care coordination/discharge planning, first is the effort to get all of the people together, second is it an effective meeting? It involves personal accountability and quick deadlines. We need a systematic model with the discharge planning groups.

DMH Adult Care Coordination *Slides 18 – 20*

Q – What do the care managers see as the major challenges that we face in terms of successful d/c planning?

A – Community partners to have the resources that can meet that person's level of need. We could use more IRR programs, housing can be an issue with no adequate supports. Difficult getting older individuals who are discharging – they may be resolved or stable but nursing homes may feel ill equipped or have some hesitation taking someone from with a mental health history.

Q – If you could have a wish list, what would it be?

A – My pad in every county, a forever placement where there is not a defined d/c date.

Q – The language in Act 82: How do we do that? Is it reasonable to judge on the effectiveness of waiting?

Comment: I would suggest that this is the only way. You can't judge how well without looking to see if you are getting them to the right place at the right time.

Comment: When DAs or nursing homes say they can't take this person, generally, the conversation will stop there. We have to be asking why won't they take them? If they don't have the right resources, what can we do to augment your resources? The state doesn't push it. There needs to be reasonable accommodations and the facility or DA still says no, that is when you run into discriminatory problems.

Q – Person centered care planning – what percentage of the time does the medical and team goals align with the persons goals and desired outcome? Are we meeting a person's goals when they come in?

A – There needs to be person centered panning – they are absolutely a part of the discharge process.

Q – Would it be more helpful if not only the team go together, but the larger team got together, or some sort of communication that went on, on a regular basis that included the people in the trenches. It seems to be so disconnected - mix of communication – should get all together on a regular basis.

Comment: The system as a whole doesn't understand the pressures or the areas where there may be potential resources. Each individual ED feels they only have a little bit of the information. There is an opportunity to have a view of the bigger picture in the system (not everyone talking to each other).

DMH Child/Youth Care Coordination *Slides 21 – 29*

There was a discussion about focus groups with both Vermont residential programs, family service, mental health workers, a family voice, partnering with state entities. One issue is to prevent admission or bringing kids back from admissions. We are having to hire and get staff when there is a new situation. There has been an effort around how we build and fund that capacity. There is a pilot program in St. Albans that is looking at the impact of that, how can we shift the funding mechanisms to be able to make that capacity known?

Q – What does the pilot actually look like in terms of enhancing wraparound?

A – It is a funding to the Agency for 8 kids that will be rotated as the needs of the children decrease and they can go through other services in the Agency. There is intensive WRAP in home, crisis supports, process by which they can more rapidly have children admitted into the program. Are the needs met? Can they transition to a lower level of support? This has been in place since January. The way that we analyze the data is very rudimentary due to the databases not talking. We are trying to do data definitions. We are getting to the point where we can give information for the regions shortly.

Q – In the spirit of Act 82 of creating a long-term vision of long term care, it is my observation that inpatient services regionally is about as opposite as it could be. We are far removed geographically. Is anyone talking about acting on that?

A – NFI is creating new beds. We are talking with UVMC about a hospital across the lake. Part of this goal is not only inpatient capacity but not sending kids out of state. We need to keep them in their community. We are working closely with child welfare and with DAIL.

Comment: NAMI wanted to give member feedback. These people had a young son, there is only two beds in Vermont that can accommodate them at BR. They were having to go out of state when having to go to crisis. They are moving out of state to get the care they need.

Comment: There is a lack of inpatient crisis beds with a low stimulation environment for people that need that. There are ongoing conversations about this.

Comment: IFS is supposed to be the mechanism for Act 264. IFS has nothing concrete to show. In the meantime, there are kids out of state being separated from their families. We are spending an enormous amount of money upstream. Is there anything being done to share any info from the pilot program, not waiting until it is perfect?

UVMMC Inpatient Psychiatry – Barrier Day Analysis *Slide 33*

Link to presentation:

Q – What were your assumptions?

A – I thought the majority was involuntary patients – did not even think about the homelessness, limited support system was a total blind spot.

Q – Why has the frequency and severity of pathology increased?

A – I do not know.

Q – What are your thoughts about homeless? What can be done to address that?

A – The availability of shelters becomes very limited, only certain people can go, if they fit criteria. If there was a shift in that culture or additional support for individuals in crisis in the shelter system.

Q – The bulk was voluntary patients. What percentage of patients that start out are involuntary?

A – We looked at the legal status at discharge. We don't have the exact data.

Comment: Once the person has gone through the involuntary process, for the state to not provide the resources after step-down is a real problem.

Q – From the data you have uncovered, with your perspective at UVMC and VPCH, where is the State of Vermont to put its resources to get the most benefit?

A – Inpatient care and housing. We anticipate it will continue to increase by 15-20% per year of barrier days.

Comment: An asset that Burlington has is Safe Haven. This would target people who you are talking about. Now that there is new funding besides HUD for that program, it will allow them to take people who were just released from the hospital. There are 7 beds there. You should get in touch with Elaine Soto at Howard Center as this is a valuable asset. The department has funded. They don't have the restrictions to the shelters that were covered under HUD.

Comment: Safe Haven in terms of study – it has been a resource with a shift – we have been piecemealing the funds, for next year and we will face a gap in the program. These make a difference for communities.
Comment: VPCH is 30% capacity coming from the DOC community. They have more of nursing home barrier days and then really only operate 12-13 bed unit – the rest is forensic.

Comment: I think it is dangerous with this research as it is only looking at barrier system for inpatient – it is not looking at what is driving this – I would hate for the state to accept this. I would like to understand why are they arriving with such higher level of needs? There is a danger in drawing too many conclusions and not what is happening before the hospitalization.

A – I think they need to be parallel and I would agree with you – I think that looking at the interventions we can do from a public health perspective is necessary but I don't think it matched the urgency of the problem we have now. There is an urgency – it is not fun to be in those EDs.

Comment: Safe Haven – what we are seeing is those individuals who are just on the verge of losing their job, have gainful employment, do not meet criteria for EE, they have families, they have some type of core that is very fragile and they are fighting to make it, then they get a crisis from a psychiatric stand point – they see all the blocks falling apart – we are holding them longer in the hospital.

Crisis Diversion Evaluation

Comment: The 23-hour bed approach, I am against it. I think you are basically moving the problem from the ED to another area i.e. relocating your problem. That might make people in the ED happy but further perpetuates the mental health stigma. Also, it is not that practical in VT. Why create another facility that we can't staff? California claims to have no waits and that they have resolved this – what that means is that they have a standalone psych facility where they take everybody, in a huge room, patients are lying on the floor chemically restrained.

Comment: I caution about the concept of diversion from the EDs. The thinking that the EDs just want to get rid of all these people is not true. My fear is that you have a population of people with mental health issues, and not getting a medical analysis; these go together (the mental health and physical health piece). You need every piece of the evaluation done first.

Comment: The ED is not a psychiatric place to wait. It is chaos, lights on all the time. It is not a healing environment. People need somewhere else to go, with therapy, etc.

Comment: Another model to look into is the living room model. This is an enhanced capacity for crisis assessment that involves peers, gets you food, a place to be. I don't think that would address all of the problems, but a good psychiatric assessment can take a while.

Comment: Peer respite – A place like Alyssum seems like a logical thing to add in for greater capacity.

Comment: Assuming things that we have failed to get the data on, the data needs to come first. When they are in the ED and don't need inpatient care, if there was something they could go to or be diverted from, until we know who is showing up and why. We need to be more data driven, not anecdotal, it doesn't make sense to talk about models. There is no data on the voluntary patients.

Comment: There was one version of a 23-hour bed model version you can go back and look at on the 2003-2004 health resource allocation plan that suggested a requirement that every ED have a 24-hour psych bed. It required a calm environment, a place where they can just sleep, calm down, then that person might be someone who could be diverted.

Comment: Another constraint is the issue on transferring people in VT. The literature review statistic talked about how often psychiatric patients are hospitalized, significantly more than medical issue presentations. Rutland opened up 5 beds in a separate area, with patients staying around 2-4 days and then able to be sent home.

Comment: That could potentially be useful if there are certain people who have a lot of treatment and could be fully on board. The question is where does that person go from there. The facility may have some validations about the effect of actions to others. We need to have a plan for what happens for someone who struggles with a horrific illness and is prone to have a bad day which is worse than anyone else's day.

Comment: Are there more therapeutic models? Could I see something like this be tried? This could merit consideration.

Comment: I look at it as accessibility of care. If you are not able to go to your counselor, what is available after hours? The ED, that is it!! It could be a crisis bed and expanding the services there; could be expanding things or even letting people know about the support line, the text line, a drop-in center.

Comment: We all think about diversion differently, regardless as a parent or a hospital. we are looking for assessment, de-escalation, a safe place to wait until they can get through what they are going through.

A hospital bed is not an ideal place for a child to be in for 3 days. There is something wrong with that. What could we do to divert a kid from the hospital? We need respite. The DA will not help with respite care.

Comment: Possibly an open dialogue model for an alternative to responding to crisis. I liked to hear the comment that was made about the EDs not wanting to get rid of us.

Q – The existing crisis system, are people who are now known to the DAs, not CRT about to access them?

A – Yes.

Geriatric Psychiatric Support *Slide 34*

We have a partnership with DMH and the DAs for elder care clinicians in the DA's across the state. Skilled nursing homes are reluctant to take patients who have a mental health issue. They are not required to take anyone as they are private entities. We cannot mandate who they accept. We have been working with CLR in Bennington on what will it take to create a unit that has enhanced staffing and an environment that is conducive for more complex needs, more than the average, but not diagnosed based and coming from a level 1 bed. It has been a year and a half, we are finally talking about money, what the rates would be, etc.

Q – How many people need this support?

A – We don't have a good number.

Q – How many people need nursing home level of care currently?

A – Probably around 5-7 that we are aware of on inpatient units.

Comment: CVMC on average 1-2 patients at any given time who are stuck who are older Vermonters. We need a menu of options for what is best for them. What is the least restrictive environment? I wish there was a greater urgency from the state level on this issue. There needs to be urgency.

Comment: 20 years ago, in the Childrens world, there was an effort to work with child care centers across Vermont to infuse these child care centers with therapist supports – partnering with DA's and other community agencies to really infuse those centers with more expertise. Is there something to learn from that with the nursing homes? Strategies to engage community partners?

Comment: There is an issue with recruiting psychiatrists.

Comment: Co-occurring in mental health particular in elder people – fall issues, dementia, I think it would be helpful.

Comment: Noticing we have the same challenges – not only we are hearing workforce challenges, licensure issues, the same exact issues with nursing homes, when we talk about the C4C, the tipping point where people want to get all of those services at home. There is lack of adequate staffing. C4C there is a lot of elders that are homeless, they can't go back home, it was taken away from them.

Q – What is the history of the PASRR reviews? How much state dollars are we spending on that?

A – PASRR is a federal mandate

Forensic Psychiatric Support *Slide 35*

There was an MOU signed with the Department of Corrections (DOC) for July 1st. We have coordination of services for folks within DOC as well as looking at the access/building of a forensic psychiatric unit.

Q – What is the MOU that is in place?

A – It speaks to how DMH will coordinate with DOC for folks who are under the care of Corrections i.e. awaiting trial, or someone who is adjudicated or serving time. The MOU lays out the process of how we will coordinate working with them, working with providers to adjust treatment plans, or to temporarily adjust the treatment plan for someone if they have been identified to have higher level of care then DOC can provide.

Comment: When we have a judge that makes a decision, evaluation determined there is a competency of sanity issues, the judge can decide they be ordered hospitalized. Now there is no ability to return to corrections and a lot of those cases we are not a party to.

Comment: Some coordination has to be done about if a patient is required to be sent to an ED, some coordination of what we are supposed to do in the ED. Who is doing what? We clearly needed law enforcement and it felt like a hot potato.

Comment: What needs to do they have for a separate facility? Example – people incarcerated or currently in DOC, there are facilities that will say we are not going to take that person, they are too much of a risk. People from DOC, their depression, anxiety, schizophrenia is no different than people out in the community, the difference is they are incarcerated. There needs are not different, just from DOC.

Comment: Prisoners are not a protected class, you can discriminate. There were mental health illness litigations against the State. Inmates only once in a while allowed to see a mental health therapist, people being locked in cells by themselves. The problem has gotten better. What is unfair is prisoner who is mentally ill and dangerous will get put in isolation. There has been a huge, drastic improvement in Springfield over the last two years. My concern that improvement has been brought about by staffing. There is a need, no different than the general need, it is much worse for prisoners, it is a lot worse to be on an Alpha unit.

Comment: Do we have a tracking data of what that percentage of the inpatient bed, the bed days between forensic? There are four distinct subcategories of forensic. People who need inpatient care with competency, 2. not competent to stand trial, people who are in DOC and have an acute episode, and people found not guilty for reasons of insanity. There was a study done in other states she can provide.

Units of Facilities *Slide 36*

Comment: Look at other options for different building that are available.

Emergency Services *Slides 37 - 38*

Comment: We often see people who are on a wait list, can't access services other than outpatient, or group therapy, who are needing home services (child), and are only able to access crisis or hospital level of care for outpatient therapy.

Comment: I am a big fan of crisis services, just not the name. There is, with the exception of WCMHS, DAs who feel they are not up to the capacity of the mobile crisis unit. They really think a mobile crisis would work for people around the state.

Comment: We need a more robust mobile crisis system. We don't have enough of them.

Comment: There as increased funding services for crisis service, the language did not say you could hire more staff but to work with that you have. Community disaster response is part of the mission, and we feel we need to do it as the community needs it. We need the adequate resources for this.

Comment: Street outreach with Howard Center has helped dramatically. Anything we can do to help with the capacity to expand that model as there are incredible outcomes from that.

Comment: The themes we hear from crisis bed managers – there are seeming more individuals with serious medical needs, needing help with activities of daily living, wound care, real increase in crisis beds and it is impacting staffing. Homelessness, having to be in crisis beds for weeks or months, who are in beds that would otherwise be filled by other individuals. Difficulty of retaining staff.