DMH Act 200 Listening Tour
Visioning Timeline Table – INTEGRATION AND STRUCTURE
2019

Send follow-up comments/questions to: Jennifer.rowell@vermont.gov

Short-Term	Mid-Term	Long-Term	End State

Strategy:
 	
• Consider formalizing peer workforce expectations and supports to expand peer supports statewide.
• Reconceptualize how to define "we"; everyone should see themselves as a member of the team supporting an individual in the ED.
• If someone is going to VPCH or Retreat, the conversation begins in the ED--here is the medication or support we would start with, will that work?
• Buy-in from the broader health care system
 	
Population impact
☒Children
☒Adults
☒Seniors/Elders
☒Other:_Families/Caregivers
☒Providers
Steps:
	Strategy:
	
	• Articulate the policy direction the state wants to go regarding supporting peer supports (funding mechanism, workforce support).
	
	• Have embedded people in EDs with a mental health background who meet with person right away.
	
	• Have spaces in the ED that are low stimulation and sensitive to the person's needs for being there.
	
	Population impact
	☒Children
	☒Adults
	☒Seniors/Elders
	☒Other: Families/Caregivers__
	☒Providers
	
	Steps:
		Strategy:
		• All ED staff are trained about mental health and how to provide trauma-informed care.
		  ○ To increase their level of confidence.
		
		• Embedded team to address and triage conditions as needed, create clinical pathways as guidance
		  ○ Includes training for coaching, consult those around their decisions and choice.
		
		Population impact
		☒Children
		☒Adults
		☒Seniors/Elders
		☐Other: Families/Caregivers
		☒Providers
		
		Steps:
			1. **People of any age, seeking out assistance in the Emergency Department experience the same care and support provided to those seeking treatment for any other health condition** *(this is based on the assumption this is the level of care needed)*
			
			Population impact
			☒Children
			☒Adults
			☒Seniors/Elders
			☒Other:__ Families/Caregivers_
			☒Providers
			
			Steps:

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Strategy:
• Explore how to identify what kind of workforce is needed to support an individual's transition to the community
  ○ Utilize workflow and an algorithm
  ○ E.g. "Doula"
• Determine the appropriate level for accountability
 	
Population impact
☒Children
☒Adults
☒Seniors/Elders
☒Other: Families/Caregivers
☒Providers
 	
Steps:
	Strategy:
	• Determine funding source for such support
	• Ensure the outpatient and post acute facilities are resourced to handle patients post admission to reduce chances of bottleneck
	
	Population impact
	☒Children
	☒Adults
	☒Seniors/Elders
	☒Other: Families/Caregivers
	☒Providers
	
	Steps:
		Strategy:
		• Deploy supports in a pilot scenario and study the impact
		
		Population impact
		☒Children
		☒Adults
		☒Seniors/Elders
		☒Other: Families/Caregivers
		☒Providers
		
		Steps:
			End State:
			2. When an individual has the need for an inpatient level of care, their transition back to the community begins immediately and includes warm, connected transitions to services and supports.
			
			Population impact
			☒Children
			☒Adults
			☒Seniors/Elders
			☒Other: Families/Caregivers
			☒Providers
			
			Steps:

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Strategy:	**Strategy:**	**Strategy:**	**End State:**

• Identify the types and resources to address the "urgent" level of care needed in Vermont.
  ○ 2 bed peer respite programs
  ○ Utilize the existing crisis bed system in our state
• Educate/Inform triage resources how to help patients navigate the systems
 	
Population impact
☒Children
☒Adults
☒Seniors/Elders
☒Other: Families/Caregivers
☒Providers
 	
Steps:
	• Improve communication and sharing of information to minimize the need for the individual "to tell their story" multiple times to different providers.
	• Interoperability and data sharing
	
	Population impact
	☒Children
	☒Adults
	☒Seniors/Elders
	☒Other: Families/Caregivers
	☒Providers
	
	Steps:
		• Bi-directional education and support occurs
		
		Population impact
		☒Children
		☒Adults
		☒Seniors/Elders
		☒Other: Families/Caregivers
		☒Providers
		
		Steps:
			3. People who need an urgent level of care, have the information and capacity to receive the appropriate level of support and care they need, decreasing the use of the ED when it is not the necessary or appropriate setting.
			
			Population impact
			☒Children
			☒Adults
			☒Seniors/Elders
			☒Other: Families/Caregivers
			☒Providers
			
			Steps:

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Strategy:	**Strategy:**	**Strategy:**	**End State:**
• Add inpatient beds to integrated settings • Consider IMD issue • Analyze the data available to determine where we need beds			**Inpatient services and care are integrated within general hospitals and delivered in the broader health system as close to a person's home community as is clinically appropriate.**
Population impact ☒Children ☒Adults ☒Seniors/Elders ☒Other: Families/Caregivers ☒Providers	Population impact ☒Children ☒Adults ☒Seniors/Elders ☒Other: Families/Caregivers ☒Providers	Population impact ☒Children ☒Adults ☒Seniors/Elders ☒Other: Families/Caregivers ☒Providers	Population impact ☒Children ☒Adults ☒Seniors/Elders ☒Other: Families/Caregivers ☒Providers
Steps:	Steps:	Steps:	Steps:

Commented [WC1]: Comment from Anne Donahue: Re: "within general hospitals" -- I'm not sure "integrated" makes clear this means as a part of a general hospital.

Re: "within home community" -- I don't recall us having much/any? discussion about inpatient care being within a person's home community, though I know there were references to potentially expanding inpatient psychiatry to within most community hospitals in the DMH report, and coming from another subgroup. I think there are reasons this is not an appropriate outcome goal.

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Strategy: • Remove payer barriers related to credentials of providers and related to trainee status to maximize reimbursement opportunities Population impact ☒Children ☒Adults ☒Seniors/Elders ☐Other:_____ ☒Providers Steps:	**Strategy:** • Evaluate the system for services that are in support of mental wellness and population health, but universally not reimbursed by payers and develop other funding streams for those (DMH, grants etc) Population impact ☒Children ☒Adults ☒Seniors/Elders ☐Other:_____ ☒Providers Steps:	**Strategy:** • Develop an incentive for smaller providers of health care to invest in services that are not break even when they are not necessarily seeing the downstream impact. Population impact ☒Children ☒Adults ☒Seniors/Elders ☐Other:_____ ☒Providers Steps:	**End State:** **4. Align payers to ensure all funding contributions occur in an equitable manner.** ○ **DMH** ○ **Medicaid** ○ **Medicare** ○ **Commercial** Population impact ☒Children ☒Adults ☒Seniors/Elders ☐Other:_____ Steps:

Anne Donahue Notes:

Comments on draft strategies:

- We did not get a chance to discuss a few in the "sample" draft, and I would need to understand what is meant by the short term strategy referencing treatment starting in ED for Retreat and VPCH referrals, before endorsing it.
- The others look good, but for potential further word-smithing and perhaps adding a few details or further strategies.
- A couple of potential additions/examples:
- Urgent care settings do not necessarily all require a "bed" (the examples we discussed -- peer respite and existing crisis bed system, both are overnight and longer); list of urgent care options to be explored could include 24/7 access to emergency clinician (mobile crisis team capacity to do counselling, not just screening?); expanding peer warmline to the intended 24/7; walk-in crisis centers -- similar to existing hospital "express care" -- that can triage for rapid outpatient follow-up, crisis/respite bed, ED/inpatient, etc.

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- ED clinical pathways should have potential option -- especially when EMTLA or clinical judgment may not allow for discharge to an "urgent care" alternative -- for an "observation" status in the ED for situations where a delayed admission may be appropriate for a person to get past an immediate crisis, resulting in a later discharge (possibly for urgent care follow-up) and an avoided admission.
- Regarding inpatient care, we discussed the geographic access issue regarding children, and we perhaps should add a strategy to evaluate the potential for development of a child/adolescent inpatient care in the northern part of the state.

Follow up discussion notes regarding inpatient integration in a general hospital:

Given time constraints, the final conversation on whether, in a post-stigma world, a freestanding "center of excellence" inpatient psychiatric hospital would be viable, only had time for brief response. My answer is still yes, but only hypothetically, because the other consideration is whether the scale would ever allow for sustaining the array of specialty services to address the significant co-morbidities in psychiatric inpatient settings. It was a key reason the UVM Dept of Psychiatry was so strenuously opposed to the initial plan for inpatient psychiatry to be on the Colchester campus: it was already like pulling teeth to get consulting physicians to come from several wings over to see a patient in psych; getting them in a car to go to Colchester would be a far greater hurdle.

So the scale would need to be able to sustain a wide array of on-staff specialists (not just primary care medical services.) I would imagine that Sloan Kettering has consulting cross-specialties on site, and I don't imagine a freestanding cancer specialty hospital could be sustained in Vermont; nor could a an appropriately staffed freestanding psychiatric specialty hospital be sustained on a practical level without direct connection to a general hospital. (Note that the Windham Center -- like the Retreat and VPCH -- also fails in this regard, even though "a part of" a hospital.)

So while philosophical objections would not be the same if there were not issues with segregation and stigma, the practical issues would remain.

On the philosophical level, the key reminder is that we learned a long time ago that in overcoming discrimination, there is no such thing as separate but equal.

Follow up discussion notes on concept of inpatient psychiatric care being available "within a person's home community."

One comment on one of the other groups' theme summaries (which was also referenced in the DMH report), was regarding some level of inpatient psychiatric capacity across all community hospitals. This discussion significantly lacks the clinical input of inpatient psychiatry among our overall membership. (The largest membership perspective is the DA system.) Inpatient psychiatric care relies significantly on "milieu therapy." Unlike other inpatient care, patients are not confined to bed, and patient interactions and group therapy are key components. You cannot run a 2-bed or 4-bed inpatient psychiatric unit; you need an average of at least six, meaning an 8-bed unit. The last time I drilled down

the numbers, there was no other hospital in Vermont (not already a DH) who has a sufficient average number of psychiatric inpatients receiving care elsewhere to sustain an inpatient psychiatric unit. Bennington was closest but not there; historically, they had one years ago but it closed for that reason. That was at a time that it was possible to get numbers from the DMH Inpatient Data Book from all hospital psych units about the number of patient days they had from each geographic/hospital catchment area. With some increased overall volume, it might be different today, but likely only to the extent of adding one further site capacity, not across multiple additional sites. (Of course, achieving this would have to address the fact that psychiatry is a money-loser requiring cost shifts from other types of care; these rate disparities, in theory, will eventually be addressed by the All Payer model.)

Note that these issues are hugely exacerbated if reference to this level of access includes children's inpatient care, where the statewide numbers are significantly lower; on the other hand, the current geographic access disparity is massively greater and is urgently in need of attention.

The same applies when discussing higher levels of inpatient care ("Level 1") -- which in my own opinion we already extended too widely, geographically. The higher a level of care, the more expertise is necessary and economies of scale increase in necessity. There is a reason we don't have any burn units in Vermont. (Some clinicians have told me they believe that on-site psychiatry is essential for Level 1 care, and this was provided at VSH and is at VPCH. However, neither Rutland nor the Retreat have this capacity, and the state – which pays full cost for Level 1 care – cannot meet the cost to achieve this at 3 sites, even if there was an ability to recruit for it. The Retreat does not even have an MD on site 24/7.)