VERMONT

State of Vermont
Department of Mental Health
280 State Drive, NOB 2 North
Waterbury, VT 05671-2010
http://mentalhealth.vermont.gov/

Agency of Human Services

[phone] 802-241-0090
[fax] 802-241-0100
[tty] 800-253-0191

To: House Committees on Health Care and on Human Services, Senate Committee on Health and Welfare
From: Melissa Bailey, Commissioner
Date: September 19, 2017
Subject: Corrections to 2017 Act 82 Status Report

The Department of Mental Health recently discovered and rectified the following errors in the Act 82 Status Report.

- On page 6:
  - It was reported that: **NAMI** presented their ideas on creating different types of crisis beds or alternatives to emergency departments.
  - This should be: **The work group that studied alternatives to the ED** presented their ideas on creating different types of crisis beds or alternatives to emergency departments.

- On page 7:
  - It was reported that:

    • The two outstanding components of Act 79 include expanding the peer warm line to 24/7 and building up to 16 bed capacity of an adult secure residential program. During our Public Workgroups, it was clear peer supports are key to our system of care including peer warm line, peer run crisis supports and peer support in emergency departments and inpatient settings.

    • We have submitted several reports within Act 79 reports and separately related to the need of expanded and permanent secure residential programming. The last report is below: http://mentalhealth.vermont.gov/sites/dmh/files/documents/reports/SRR_Plan_for_Siting_and_Design2-22-16.pdf.

    • Additionally, we received three proposals although only one was secured via locked facility and the other two proposals were staff secured. The outstanding question of Medicaid participation may influence the type of secure and numbers needed.

- This should be:

  - The two outstanding components of Act 79 that remain are the expansion of the peer warm line to 24/7 and the addition of 8 intensive residential recovery beds. Full appropriation by the legislature has been unavailable to support these components. During our Public Workgroups, it was clear that:

    - peer supports continue to be key to our system of care including peer warm line, peer run crisis supports and peer support in emergency departments and inpatient settings; and
    - more secure bed capacity for individuals who no longer require hospitalization, but remain high risk to themselves or others preventing discharge, would improve access for individuals needing hospitalization.

  - We have submitted several reports within Act 79 reports and separate examination reports seeking expanded and permanent secure residential program capacity by the addition and repurposing of the 8 unfunded residential beds. An adult secure residential program capacity, up to 16 beds, would serve this transitionary, and more complex population need. The last DMH report is below: http://mentalhealth.vermont.gov/sites/dmh/files/documents/reports/SRR_Plan_for_Siting_and_Design2-22-16.pdf.

  - Additionally, we received three proposals: one secure (locked) facility and two staff secure facilities. The outstanding question of Medicaid participation may influence the type and size of a facility or facilities that may be funded.

VERMONT2017

Reforming Vermont's Mental Health System

Report to the Legislature on the Implementation of Act 82

September 1, 2017

VERMONT
Department of Mental Health
AGENCY OF HUMAN SERVICES
280 State Drive, NOB-2 North
Waterbury, VT 05671
www.mentalhealth.vermont.gov

Table of Contents

Summary of Report Expectations: The Mental Health System of Care

On or before September 1, 2017, the Secretary shall submit a status report to the Senate Committee on Health and Welfare and to the House Committees on Health Care and on Human Services describing the progress made in completing the analysis required pursuant to this subsection and producing a corresponding action plan. The status report shall include any immediate action steps that the Agency was able to take to address the emergency department crisis that did not require additional resources or legislation.

Actions to Date

On July 25, 2017 and August 17, 2017, the Department of Mental Health held all day public working meetings to gather input and ideas regarding the analysis required pursuant to this subsection and for producing a corresponding action plan. There was an open invitation to participate and the two days included, but were not limited to, representatives from the Department of Mental Health Leadership and Staff, the Designated Agencies Leadership and Staff, Hospital Leadership and Medical personnel, Vermont Association of Hospitals and Health Services, Vermont Chapter of the National Alliance of Mental Illness, Vermont Care Partners, Disability Rights Vermont, Vermont Psychiatric Survivors, Consumers and Families, and Legislators. For more information including PowerPoints from DMH, presentations by participants, meeting notes, written comments and other information please visit:

http://mentalhealth.vermont.gov/news/act-82-working-meeting
http://mentalhealth.vermont.gov/sites/dmh/files/documents/news/Act82_Working_Meeting_2017-08-17_FINAL.pdf

Additionally, we continue to work towards system improvements and meet regularly with hospital staff and leadership, designated and specialized service agencies and advocates. We know the next steps require more in-depth planning on what is needed to improve access to care for individuals with mental health needs as well as potential changes to statute or rule and funding needs. This is on the forefront of our day to day work and we will present a well-developed plan by January 2018.

September 1, 2017
Act 82. An act relating to examining mental health care and care coordination.

Objective	Summary of Information Presented at Public Meetings
Submit a status report to the Senate Committee on Health and Welfare and to the House Committees on Health Care and on Human Services	Completed on 9/1/17
Gather information re: current environment; information; ideas	Two all day public working meetings July 25 and August 17, 2017
Data Collection *(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.*	• DMH provided a list of datasets and how the data is used – see PowerPoint for more detail • There are some differing opinions about what is needed in addition to current data collected. • There is mostly agreement to collect voluntary data, reasons for ED admission and reasons regarding discharge, there is not yet common definitions for this data. • DMH is working with Vermont Association of Hospitals and Health Systems (VAHHS) to get data on voluntary individuals in the emergency department (ED). It is currently in pilot phase and will be expanded once the data definition and process is worked out.
Referrals *(Sec 3, C) Identify causes underlying increased referrals and self-referrals to emergency departments*.	• Wilda White, Executive Director, Vermont Psychiatric Survivors provided extensive information from national data and research which can be found here: http://mentalhealth.vermont.gov/sites/dmh/files/documents/news/Literature_Review_of_Emergency Department (ED)_Waits_Presented_Aug_17_2017.pdf • Most agreed the research presented mirrored their experience with a few exceptions. • There was a lot of discussion about the need for increase mobile crisis and that having access to mobile crisis could help appropriately divert individuals from EDs. • There was concern from the EDs regarding medical clearance if people are diverted. The EDs just want to assure there is a place to move a person to once medically cleared.
Accessibility and Gaps in Service *(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*	• DMH provided a map showing where resources are located and the number of beds available. See map here: https://public.tableau.com/profile/emma.harrigan2032#!/vizhome/DMHMentalHealthSystemofCare-BedsbyTypeandLocation/Dashboard • Dr. Desjardin at UVMMC did a review of all people who were admitted inpatient from 10/1/14-to3/31/17. Her report highlighted the following: o 181 inpatient psychiatric patients had stays of 30 days or more over a 30-month period o 61% represented voluntary status patients; 39% were involuntary o 38% of long stay patients had no barriers to discharge.

support services; intensive and other outpatient services; services for transition age youths; and stable housing.	o 62% of long stay patients experience a barrier to discharge resulting in an extended stay of some length. o The number of long stay patients has increased significantly since FY 2015. Long stay patients grew by 20% in FY 2016 and may increase by 15% in FY 2017. o Supportive housing was a key factor to delayed discharges http://mentalhealth.vermont.gov/sites/dmh/files/documents/news/Inpatient_Psychiatry_Barrier_Days_Analysis.pdf • NAMI presented their ideas on creating different types of crisis bed capacity. See PowerPoint here: http://mentalhealth.vermont.gov/sites/dmh/files/documents/news/Aternatives_to_ED_Living_Room_and_Immediate_Access_Beds.pptx
Emergency Department Wait Times *(Sec 3, E) Incorporate existing information from research and from established quality metrics regarding emergency department wait times*	• Wilda White, Executive Director, Vermont Psychiatric Survivors provided extensive information from national data and research which can be found here: http://mentalhealth.vermont.gov/sites/dmh/files/documents/news/Literature_Review_of_ED_Waits_Presented_Aug_17_2017.pdf • Additionally VAHHS and DMH are working together to better track reasons hospitals refuse admission of a person so we can better understand the themes regarding why someone waits for a bed. • The Designated Agencies provided these comments related to individuals requiring some level of crisis response. http://mentalhealth.vermont.gov/sites/dmh/files/documents/news/Overview_of_Designated_Agency_Services.pdf
Trends *(Sec 3, F) Incorporate anticipated demographic trends, the impact of the opiate crisis and data that indicate short and long-term trends*	• We have collected and reviewed demographic trends. • We also reviewed the data being gathered and reviewed by the Opioid Counsel. http://mentalhealth.vermont.gov/sites/dmh/files/documents/news/Opiod_Handout.pdf • We will incorporate this information into the other workgroups to info and provide information on trends. It is important to continue to note the aging population as well as the population of 25-45year old individuals who are leaving the state. It is contributing to a workforce issue.
Gaps in Service/Staffing *(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.*	• There are several current workforce workgroups taking place. We will provide a summary of that work and recommendations in the December 15, 2017 report. • Across the system, including DAs/SSAs, hospitals and children's residential hiring and maintaining the necessary staff is becoming increasingly difficult. Staffing issues are not just related to salary and population demographics also play a role state-wide and even more intensely in some regions. • The DAs/SSAs presented their information pertaining to hiring challenges: http://mentalhealth.vermont.gov/sites/dmh/files/documents/news/VCP_Presentation_for_July_25_2017.pdf

Regional Care Coordination *(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.*	• Washington County Mental Health and Vermont Care Partners presented their work to date on regional care coordination. It is still a work in progress and we will learn more about what would work in this region by December 15, 2017 http://mentalhealth.vermont.gov/sites/dmh/files/documents/news/Naviagation_and_Resource.pptx http://mentalhealth.vermont.gov/sites/dmh/files/documents/news/VCP_Presentation_on_Regional_Navigation_Regional_Care_Coordination.pdf
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.*	• The Adult Care Management Team and the Children's Care Management Team explained their different roles in relation to the larger system of care including inpatient care. On pages 19-21 of the main PowerPoint is a description of the Adult Care Management Team and on pages 22-30 there is a description of the Children's Care Management Team. http://mentalhealth.vermont.gov/sites/dmh/files/documents/news/Act82_Working_Meeting_2017-08-17_FINAL.pdf. The effectiveness of these two teams will be somewhat dependent on the functioning of the entire system and we will explore that throughout the next several months • We are exploring different ways to better communicate with all hospitals. Ideas such as daily conference calls to added additional information to the electronic bed board which tracks bed availability is being explored.
Crisis Diversion Evaluation *(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.*	• The work group that studied alternatives to the ED presented their ideas on creating different types of crisis beds or alternatives to emergency departments. See PowerPoint here: http://mentalhealth.vermont.gov/sites/dmh/files/documents/news/Aternatives_to_ED_Living_Room_and_Immediate_Access_Beds.pptxCurrent capacity and utilization is tracked for all crisis beds. At different times due to acuity or staffing levels beds are closed. Without having more consistent flow of inpatient and community based resources it will be challenging to determine if the current crisis bed capacity is sufficient.
Diversion Models *(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.*	This section included discussion about: • Involuntary holds and the different opinions on both sides of this treatment and legal process. • What some emergency departments have done to address individuals with mental health needs in their ED. • The use of more peer support in the ED. • Clearly there is a need for additional and enhanced services and that will be explored further for the final report.
Implementation of Act79 *(Sec4, 4) The analysis, action plan, and long-term vision evaluation, in coordination with the work completed by the Department of Mental Health for its annual report pursuant to*	• The two outstanding components of Act 79 that remain are the expansion of the peer warm line to 24/7 and the addition of 8 intensive residential recovery beds. Full appropriation by the legislature has been unavailable to support these components. During our Public Workgroups, it was clear that:

18 V.S.A. § 7504, shall address whether those components of the system envisioned in 2012 Acts and Resolves No. 79 that have not been fully implemented remain necessary and whether those components that have been implemented are adequate to meet the needs identified in the preliminary analysis. Priority shall be given to determining whether there is a need to fund fully the 24-hour warm line and eight unutilized intensive residential recovery facility beds and whether other models of supported housing are necessary. If implementation or expansion of these components are deemed necessary in the analysis, the action plan shall identify the initial steps needed to plan, design, and fund the recommended implementation or expansion.	o peer supports continue to be key to our system of care including peer warm line, peer run crisis supports and peer support in emergency departments and inpatient settings; and o more secure bed capacity for individuals who no longer require hospitalization, but remain high risk to themselves or others preventing discharge, would improve access for individuals needing hospitalization. • We have submitted several reports within Act 79 reports and separate examination reports seeking expanded and permanent secure residential program capacity by the addition and repurposing of the 8 unfunded residential beds. An adult secure residential program capacity, up to 16 beds, would serve this transitionary, and more complex population need. The last DMH report is below: http://mentalhealth.vermont.gov/sites/dmh/files/documents/reports/SRR_Plan_for_Siting_and_Design2-22-16.pdf. • Additionally, we received three proposals: one secure (locked) facility and two staff secure facilities. The outstanding question of Medicaid participation may influence the type and size of a facility or facilities that may be funded.
MH Parity *Sec4, 5) The analysis, action plan, and long-term vision evaluation shall evaluate opportunities for and remove barriers to implementing parity in the manner that individuals presenting at hospitals are received, regardless of whether for a psychiatric or other health care condition. The evaluation shall examine: existing processes to screen and triage health emergencies; transfer and disposition planning; stabilization and admission; and criteria for transfer to specialized or long-term care services.*	• Barriers that exist include hospitals' concerns with mix of patients, admitting forensic patients, safety of staff and the need to have a true "no refusal" system. • Hospitals described that at times they cannot admit an individual because of the acuity of their unit, staff shortage which are sometimes related to staff injury and because of damage done to a room that needs to be repaired before the next person can be admitted. • EDs triage as they see appropriate and some have reached out for additional psychiatric supports. When possible DMH will use VPCH psychiatrist to provide tele-psych and DA psychiatrist will also consult on individuals that are part of their agency.
Geriatric Support *(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*	• We explored the most current option which includes negotiations with Center for Living and Rehabilitation (CLR) a Nursing Facility in Bennington. They have a potential 12 bed capacity and are working on providing a staffing model and budget. We hope to have this option finalized soon. • There was discussion regarding the concerns nursing facilities have in taking individuals on psychotropic medication or individuals that have any violence in their history. It could put their license and CMS accreditation at risk. • Expanding the use of Choices for Care was discussed. The staffing needed for some community based plans continues to be a challenge.

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.	
Forensic Support *(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.*	• As of 8/8/17 13 of the 25 patients at VPCH are forensic. • There are different definitions of forensics that we will clarify. • The need for a forensic facility including type, location and number of beds will be further developed during the next several months as part of this report and Act 78.
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.*	• We will explore in consultation with BGS any facility that may be appropriate. • At this point the VNA Hospice facility identified during the legislative process is under contract • All feasible options will be explored once needs regarding facilities is fully developed.
Emergency Services *(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.*	• DMH explained to Public Workgroup the different payment methods for Emergency Services including crisis outreach and crisis beds. • The funding methods include fee-for-service, capacity payments and private insurance. • DMH has begun payment reform work to better how to match funding methodology with service type including emergency services • Many participants expressed the need to expand mobile/crisis outreach maybe even as much as doubling the size of the current system. • We will also explore the pros and cons of a more centralized system which has come up several times.

Key Elements:

The discussion regarding the growing pressures on the mental health system of care from inpatient to community based have continued to evolve over the last several years. The most recent pressures on inpatient flow and the needs of individuals requiring that level of care and intensive community based plans has been and continues to be a focal point. Some of the key themes continue to be:

- Best engagement strategies and access to care
- Peer supports
- Medicaid funding vs general funds
- Court involvement including voluntary vs. involuntary treatment
- Licensing requirements and restrictions that present as barriers

Several actions or resources continue to be identified as needed components to support intensive levels of care and include:

1. Increase the secure residential capacity to at least 16
2. Examining licensing and rules regarding emergency involuntary procedures
3. Create a forensic unit which could be in a corrections facility, a stand-alone facility or a new hospital.
4. Additional level 1 or VPCH type beds – assuring a "no refusal" system
5. Intensive residential programs treating and maintaining individuals with aggressive behavior
6. Assuring crisis beds are fully utilized and exploring some alternatives that people are more willing to access.
7. Expanding mobile crisis outreach to assure community outreach and appropriately address crisis in community so individuals can be diverted, when appropriate from the ED
8. Continue to explore or build geriatric psychiatric capacity starting with CLR in southern VT
9. Address the conflicting opinions of involuntary treatment. Is there a middle ground to be found? There are strong opinions on both sides
10. Supportive housing that can adequately support people coming out of inpatient or prevent some individuals needing inpatient or crisis services
11. Adding resources to assure training in evidence based practices
12. Peer services to be expanded and supported
13. Expand mental health treatment court

For any of the items listed above we will need to develop a budget, identify any law or regulation changes, the location the services can be provided including community and the providers.

Next Steps:

1. Use the ***ED Data subgroup*** to expand what data is needed from the EDs as well as other data elements that will help provide a full picture of current ED, inpatient and other flow related issues.
2. Use ***ED Data subgroup*** to further understand reasons for referrals to EDs
3. VAHHS and DMH to implement ***prospective collecting of data*** as it relates to reasons for referral to EDs, need for inpatient and barriers to discharge including gaps in services (and in connect to ED Data subgroup)
4. ***ED Data subgroup*** will work with hospitals to complete current data survey.
5. Use ***ED subgroup*** to explore ***alternatives to ED options***, develop budget and identify statute or regulation changes needed
6. ***Summarize Workforce Workgroup findings*** and recommendations for final report
7. Work with other ***facilities report*** requirements to ***finalize recommendations*** on forensic, potentially more inpatient, crisis alternatives (using information from above mentioned subgroup), and secure residential
8. Use the ***current work*** in Washington Co. on ***regional navigation*** to further develop framework for regional navigation, budget and plan needed to implement state-wide and if that will have any impact or identify changes needed from DMH Care Management Teams
9. Create workgroup to further explore ***expanding mobile crisis, supportive housing needs and other community based services needed***
10. Use work and ***information from Section 5*** of Act 82 report regarding ***involuntary treatment***
11. Continue to ***develop nursing facilities' options*** and explore what other options are needed in relation to services for geriatric individuals