

Act 82 Working Meeting
August 17, 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_2017-08-17_FINAL.pdf

Introduction of Act 82 (S.133)

Slide 3

Current Data Collection

Slides 4 – 8

Comments/Questions

Q – Is data collected on voluntary individuals?

A – We currently don't have a lot of information on these individuals. There is a pilot program where two hospitals are working with VAHHS to collect that data. They are currently looking into the privacy concerns related to obtaining/sharing that information.

Q – Do you track kids wait time in the ED?

A – Yes, this is tracked as well.

Comment: Across the state, FQHC's have about 77k behavioral health visits.

Comment: We send a daily census of patients in the EDs that are voluntary and involuntary. Voluntary patients that are boarding also plays a big role and should be shared.

Comment: It is important to collect the voluntary data. It is very relevant.

Q – Do you currently track the wait list for psychiatric (some are long lists) and outpatient services?

A – Only if it is submitted by the DA's, which it is currently not. There is some information about the gaps in those types of services through the Vermont Department of Health. OPR also tracks some data as well. The first report just came out regarding resources and gaps in age groups that therapists serve.

Comment: Kids stuck in the ED is a huge problem. That is not the right environment for that.

Q – Do you track when people are discharged and the frequency of readmissions?

A – We track the disposition for people in the custody and care of the Commissioner, and reoccurring ED visits. We track readmission to inpatient care and are starting to look at the frequency of the ED usage.

Comment: Readmission, this is a really crucial point. We have people at the Retreat who come back and it is hard to find out what the missing pieces are in the community.

Comment: Kids in the EDs, here is a point of information, Vermont is the only state in the country where a child as young as 5-6 has to agree to go into a hospital if they are in crisis. They have to sign in. This can also impact the wait times in the ED while this gets sorted out.

Q – Do you get statistics for people who get help outside of the state of Vermont?

A – We don't necessarily get notified of that. If it is a CRT enrolled client, that information would get back to us.

Q – When a person is d/c'ing and the case manager is helping the, I thought Vital was supposed to allow for coordination of care so they can reach out for what the care plan is?

A – Not sure who successful Vital is, but could find out some more information. The implementation so far is that it doesn't exist.

Q – For kids, there are currently 48 beds with 6 more coming. I think there is enough beds, but I think with ED waits, there is no inpatient place to go. If BR is clogged, do we have the data on why they have longer stays than 7-10 days?

A – BR: we do have a subset of children and adolescence who do stay longer than necessary and there are any number of reasons i.e. they are touch by multiple agencies (DMH, DCF, DVHA). How do you coordinate all of this along with finances and get an integrated plan?

Comment: Data can be over collected. I think the State failed with the size of the hospital. I don't think it is big enough.

Referrals

Slide 10

Q – Under what circumstance do you, when you receive a call, decide and suggested that the fact to face is going to happen at the ED as opposed to another place in the community?

A – A lot of times, if we don't have crisis staff available to go to a home, for a lack of other options, we go to ED. With kids, in order to get them in the hospital, we have to have them screened at the ED.

Comment: If you call a private therapist in the community, their voicemail tells you to go the ED. There is a cultural shift where you just go to the ED.

Comment: We keep talking about the ED's but what alternative do people have? Police have no alternative. The only voluntary place is the ED. There should be a place instead of the ED, possibly to the DA and get screened. When we call crisis, they don't have the staffing to come see them in the community.

Comment: More opportunities to integrate and imbed is a great thing. If the crisis team is available 24/7, is there a place to bring them? Could that person go to the Station and then meet with crisis? We need more people to be able to go mobile (more resources).

Comment: When people are d/c'd, in the d/c paperwork it states that the first thing to do is call the ED, it should be to call the Peer Support Line.

Comment: The imbedded model – this does cut down a lot on the immediate need to call crisis.

Comment: Some of the problems I see with the ED when I bring my loved ones is seeing a resident who does not have the expertise. We need to get to the person who has the expertise. If a place list Assist was in every county like Howard Center, that is what I want as a parent. That is where they can be empowered to make that decision of what level of care that person needs is. I really like the mobile units because they know that client.

An idea that has come up several times is an urgent care model for mental health, an intermediate level of the ED, what do folks think?

- Mobile idea is very important
- There are some models that exist in California and I do think there is value
- I could not think of a single negative for urgency care
- Risk – could turn into another place of wait
- It is simply relocating the problem. One of the bottlenecks in the system are transfers. You would be forcing longer waits.

Comment: As far as being a parent for minor children, we are hearing more of dysregulations in the school setting, it becomes a safety issue. Parents are wanting skills themselves to deescalate, but there are not enough resources to teach that.

Comment: #1 concern – some screeners or mental health professionals put in the crisis plan itself to call the Police.

Comment: When people are waiting in the ED's, one of the biggest complaints is why aren't you doing more for people while they are waiting in the ED? Why aren't there therapists that can go in and sit with that person?

Comment: For kids waiting, why aren't there video games in the ED? This could potentially deescalate them while in the ED.

Comment: ED's are ill equipped to handle these patients waiting. What is causing the delay for beds? Is it the number of beds? We have to identify the right place and the right care.

Emergency Department Wait Times

Slide 12

Link to Presentation:

http://mentalhealth.vermont.gov/sites/dmh/files/documents/news/Literature_Review_of_ED_Waits_Presented_Aug_17_2017.pdf

Q – Are there other measurements to look at, like physicians, in terms of the amount of time they devote per case?

A – One study in MA that was of perspective and it looked at the intervals of who moved through the hospitals; those waits were not significant and didn't really differ between psychiatric and non-psychiatric. If was after they decided on a disposition was the wait.

Comment: I think that is a huge point as the squeaky wheel gets the oil. If I go to the ED and I have an advocate, I am pretty sure I would get treated faster than someone waiting without one.

Comment: One of things that strikes me, it goes beyond people waiting in the ED, particularly for kids, they have been required to wait in the community – we have seen far more adolescents waiting in the community.

Comment: Peer support in the ED, this can help to deescalate the situation. Peer program has been very successful in helping with support before even going to the ED.

Comment: Echo the comment about peer support and the importance of this. It has changed his son's life.

Q – Is there any data where peer support was present, and did it drop wait times or help move out of the ED faster?

A – I found no peer review journals that talked about this.

Comment: What about the sitters? They were not involved at all. Any data about what makes a difference for the sitters/security guard? The sitters can sometimes cause problems as they are untrained, unsympathetic.

Comment: I can't stress enough it is critically important to have a training for the sitters. There is no formal curriculum. What could we do better to enhance that patients waiting?

Barriers and Gaps/Workforce Development Slide 16

Link to Presentation: <http://mentalhealth.vermont.gov/sites/dmh/files/documents/news/S 133-Act 82 Presentation 8-17-17.pdf>

Q – The increase in gap between DA/SSA staff and similar state positions, what is this saying?

A – Vermont Care Partners did an analysis of a certain number of positions and the gap in those dollar amounts paid as compared to state positions and DA/SSA. That is the gap to get DA/SSA staff equal to state positions. It is hard to compare as apples to apples, but there is a \$40M salary gap. What are we going to do about it?

Comment: In the Bill that was recently passed which got money for DA's, there is still a big gap compared to a DA position at \$26K and a state position at the State making \$36K.

Comment: 3% of DMH's budget is staff salary and the rest is to run services.

Comment: This person had recently written a letter to Burlington (Mayor, City, Police) regarding an individual that they see every day who has stuttered steps, hair matted down, bruises on face, etc. I spoke with the police chief who stated to make a records request. This individual had 860 different police interactions since 2011. If we had a just, compassionate and caring society, there would be a place for this individual. It would also probably involve involuntary commitment. My opinion is

that it needs to be come at times for the good of the person and for the good of society. This person has been through every community based setting. I am begging this committee to look at this issue.

Q – In all of the health care settings (PCP, Blue Print, ED) the solution is we need social workers to right size the team. Are we looking at this pipeline?

A – Yes, there are 4 work groups looking at healthcare in general and also one specifically or mental health and substance abuse. The Opiate taskforce is also looking at credentials and loan forgiveness.

Comment: WCMHS has 700+ and HC has over 1000 people, does Legislators know you have this many people you are trying to deal with?

Summary of the morning session – other questions/comments

Comment: Themes of long waits – the quality of care that some people are receiving is not the best practices.

Comment: I am in favor of the DA's receiving more money. I am concerned about some of the things DA's do. One of these is a problem that might be contributing to is when case management (cm) and therapist are the same person. This is a disaster. There are so many examples where the cm/therapist, that person is not getting the therapy they need. They would rather go to the ED.

Comment: At WCMHS we try to keep that separate. Sometimes therapists do case management services as there aren't resources on the Outpatient side. It may work in some areas but for best practices, agree that they should be separate.

Comment: Crisis workers are awesome who work through the DA's but for the crisis beds, these folks are entry level with very little knowledge. The same goes with the ED's. The average length of stay at Alyssum is 7 days. I would encourage people to look at a more holistic, peer support, open dialogue kind of model.

Comment: Endorse the therapist and case manager piece, from the standpoint we hardly can get enough therapists so they don't do any case management, but I think in the spirit of what is being said, to me, our ability is challenged sometimes by not having enough of those kinds of services on the adult side outside of CRT; and we are hard-pressed to be able to have that. Some folks that are a hair short of being CRT, they lack having a good therapist, and we don't have the outpatient system developed that well for those folks. There is a sense if we are much more able to adapt to get to the folks earlier that we would be able to affect that number of people that go do the ED's. AOP was cut heavily in the 80's 90's and we need to look at that component, it needs better analysis of are we doing it the best way and adding input from folks outside of DMH and DA to come up with a model that meets the needs of folks needing services.

Trends

Slide 13

Comment: The demographic trends not recognized on this slide is that medications cause metabolic problems. I think we might want to look at medical problems with psych issues that we need to plan for.

Regional Care Coordination

Slide 18

Link to Presentation:

[http://mentalhealth.vermont.gov/sites/dmh/files/documents/news/Naviagation and Resource.pptx](http://mentalhealth.vermont.gov/sites/dmh/files/documents/news/Naviagation%20and%20Resource.pptx)

Comment: This info includes substance abuse numbers as well

Comment: I would think that peer support would be important here to be built into the referral system and point of contact in the hospital.

Q – Brief treatment case management, are you also considering brief targeted therapy?

A – That is something we could consider – the idea is, if someone is referred and you can't get them in right away, we would need another person to help immediately.

Comment: Copley Hospital is doing a small piece of this with wonderful success with implementation of a social worker in the ED. We work closely with the DA's and community health center.

Q – Are you pulling data from the CVMC system and how are they coding that? We find that docs are putting in different reasons in the system for a visit.

A – We are just getting to look at this data.

Comment: One of the challenges we are finding is as we continue to do this, we have absorbed all of the possible people we can refer folks to. One of the challenges is it generates more referrals, and if the rest of the service system doesn't grow at the same time, it is a challenge.

Q – The screening and assessment done at the PCP, have you figured out how to bill for that?

A – No, and that is a problem.

Comment: Burlington Community Health Center has a great model to look at with a reasonable enhancement in their fee schedule.

Q – What are you using for a formal assessment tool?

A – In the doc's office I don't know – we haven't pulled out all of our tools yet. In the learning collaborative we have Camden, eagle mapping, chart reviews.

DMH Care Coordination

Slides 19 – 21

Comment: There is an underscore of things that DMH does, speaking from the Retreat, the coordination of conference calls, we can't tell you what help that provides. Thank you!

Comment: All of the phone calls DMH care team makes, the work they do is awesome and they are not thanked enough for their hard work.

Q – Is there something that crisis teams can look at for bed availability?

A – Yes, the electronic bed board. That shows where there may be bed availability (not necessarily totally live or accurate] for the crisis teams to look at. Part of the mandate is that the crisis team will call all of the hospitals to check-in with them regarding beds. It is a guide for the Screeners to use.

Q – Are hospitals allowed to refuse?

A – Yes. Hospitals will make the final decision on who gets admitted to their hospitals.

Comment: I don't agree. I have looked at some of the laws and we need to stop those refusals.

Q – Second spring, do they have to take anybody or can they refuse?

A – It is a no refusal system overall but Second Spring has been able to staff up recently and have been taking referrals. They are taking very high acuity. DMH also looks at all the IRR's to see what would be a good match.

Comment: If DMH were to start collecting all the information about voluntary patients, do we have the resources to do justice to this?

Comment: Discrimination – how do you go about assessing and evaluating this? How are you thinking about doing this? Are you thinking of surveying how are we doing? DA vs DMH – how do you view us; how do we view you?

Q – Does housing needs impact the wait time?

A – Yes it does.

Comment: To provide a counterbalance perspective on what it might look like discrimination from hospitals not taking patients. I don't want people leaving with the impression that there is any lack of attention or negligence on the parts of the hospitals. It is a balancing view.

Comment: Would like to add when individual hospitals or stepdown programs get stuck, we all have our reasons for it. We look at the Department to get on the phone to see what would it take to move someone around, etc.

Q – Howard Center is the DA for Chittenden County – does UVM have same status that 15 beds pays them for?

A – Some are Medicaid, some are DVHA, some have private insurance. They are not the same relationship as the DA has with DMH.

Q – Care managers are basic front-line workers and your personal experience is valuable. If you could have a wish list, what does the system need?

A –

- The ability to have some of those folks on involuntary status, when it is appropriate, consider passes to visit the stepdown facilities. One of the repeated issues is most of the hospitals don't typically offer that and at times it creates a risk of discharging someone a bit prematurely without giving them a chance to test the waters somewhere else.

- A huge benefit is public loan student forgiveness – important for greater pay for front line staff.
- We need forever placements. In every county (My Pad).

Comment: There is an incredible pressure CMS places on psychiatric care that is treated on the same level of physical care. It is unheard of at the Federal level. It is complexified when you can't take some of the risks of letting people have some degree of failure. It is hard for hospitals to have that failure as it would create an investigation by CMS.

Comment: Voluntary folks – if we don't track those people, we are just creating another class of folks who don't have a voice. Would like to do more with non-hospital care.

Comment: Med changes – when we get people who step down from hospitals, sometimes their meds have been really changed and they wind up going right back to the hospital.

Q – Do you have a list of every bed in the state?

A – Yes – we know inpatient, crisis, IRR.

Alternative to the ED

Link to Presentations:

<http://mentalhealth.vermont.gov/sites/dmh/files/documents/news/Alternatives to ED Living Room and Immediate Access Beds.pptx>

<http://mentalhealth.vermont.gov/sites/dmh/files/documents/news/Overview of Designated Agency Services.pdf>

Q – In regard to the living room, a humane way to treat people who are in crisis, how much does it cost?

A – I am guessing it is as expensive or less as the current crisis beds.

Q – What is the current median length of stay for crisis bed?

A – 10 days for mead, 8 days for median.

Comment: How much does it save?

Comment: It would need to have a high level of core competency as it would be a higher level of acuity, and a lot of training with this model.

Q – What would be the plan to assure appropriate medical evaluation?

A – This wouldn't be a 23-hour bed – we aren't recommending that. There would be a psych nurse on staff 24/7 to do assessments.

Comment: There are cases where individuals are in a very intensive IRR and may have a brief period of decompensations, they just need time away from the other IRR patients. Will they take the person back at the IRR?

Comment: I could have written this model – exactly what we are looking for.

UVMMC Inpatient Psychiatry Barrier Days Analysis

Slide 34

Link to Presentation:

[http://mentalhealth.vermont.gov/sites/dmh/files/documents/news/Inpatient Psychiatry Barrier Days Analysis.pdf](http://mentalhealth.vermont.gov/sites/dmh/files/documents/news/Inpatient_Psychiatry_Barrier_Days_Analysis.pdf)

Comment: The reason for 30 days – these are folks who are using a lot of the bed resources and what is the cause? One important take away – 38% were there for a long time were very ill and this doesn't represent a failing in the system, it is a failing in cures available for complex illnesses. The remaining 2/3rds (2 beds) you look at the glass half full/half empty. There is a strong argument for improving flow overall – the glass half empty is we only get those two beds if we do everything really well (you need housing, geri psych support, transportation). We have to do a lot of things really well to get those two beds.

Comment: Going forward, we have been talking about the data pilot project the hospitals are doing to collect involuntary/voluntary data. We are hoping to collect data from the DH to do an analysis going forward – that is in process. The DH's have just started to collect that data.

Comment: Crisis beds have been asked to collect data due to homelessness.

Geriatric Psychiatric Support

Slide 35

Comment: Nursing homes are not required to accept patients.

Comment: There are empty nursing home beds throughout the state – is that the right placement for this person? Would it be safe for the other residents? There are different rates for geriatric psych patients and one so far has been placed.

Comment: Because of licensing requirements, nursing homes have to be concerned with the same issues as DH's. CLR has been in talk with Frank about piloting something.

Comment: There are 13K Vermonters with a Alzheimer's or related diagnosis.

Comment: Other support services is Choices for Care. This has been very successful in serving in the home and community based settings. 50/50 mark now we have many more options for people to stay in their homes. Another choice is the adult family homes. Do we have enough people do this work?

Q – What are we doing with all of these people now?

A – We are working on individuals on a case by case basis. It is collaborative work to put together a plan, collaborates with DMH/DAIL/DA.

Comment: It has been so helpful for care management to coordinate with DAIL.

Q – What is an Adult family home?

A – They are much smaller settings where an agency DA/SSA work and identify a private individual, couple, or family and they are willing to open their home for people on Choices for Care.

Forensic Psychiatric Support

Slide 36

Comment: VPCH 54% are involved with forensics.

Comment: I think pre-Irene it has been a population that has been there. The experience pre-Irene days was often comments from Dr. Pierattini and Dr. Simpatico i.e. there is not a lot of difference on who could be seen as forensic patient. It wasn't what people expected to hear. If you had a 15 bed, given CMS rule, the concept of doing that could take any of the folks who are in the current beds and transfer them there and try to have some expertise with working with forensic patients. One of fears is forensic hospitals can become pretty dark places. They are not really Medicaid and there is a lot of things that can cause resources to dry up.

Comment: My concern with my son is how does he continue his medication and/or who will give him medication and how do they know it is the right medication.

Comment: We posted bail for my son, he had a tendency to walk 30 miles at a time, turns out it was because of the medicine, we posted bail and we would go for lunch before we pick him up and he was gone. When you post bail, they are immediately free to leave.

Comment: Disruption of care is a quality care issue when in corrections.

Comment: DOC has a mental health provider and if they are aware someone is taking medication, they would be in contact with those individuals about the medicine.

Comment: Another concern is with involuntary medication – how do we know it is the right medication? What test, what blood work is done to know? Body chemistry testing should be done.

Comment: Timeline – if the psychiatric and mental health teams in DOC determine they need inpatient hospitalization, if voluntary, they still remain in DOC care and custody so they reach out to secure an admission – if the inmate is not willing and they meet the legal criteria for that – they would do the paperwork within 24 hours for a telepsychiatry to do 2nd cert at VPCH, then if 2nd certified, it is the DMH care management team to facilitate admission.

Q – What if they go before a judge? Anyone at that point, if there is a concern about competency issue, the judge can order an inpatient evaluation. The judge issues the order, next step is they would be seen by a psychiatrist to see if they meet hospital level of care.

Comment: Educate judges together with the DH's.

Emergency Services

Slide 38

Comment: Not enough mobile crisis

Comment: It would be great if this service was a part of any discussion on value based. One of the areas that hurt us is the services provided in hospitals are not billable. We cover people who are

CRT and children screening for hospitalization – we go way outside of that realm. It feels like the reality is these services are covering a lot of things we are just starting to keep account of.

Comment: It is worth noting the shortage of providers in Vermont. There are no psych nurse programs in Vermont. We don't have that pipeline.

Comment: Part of the piece that needs to be removed is people in crisis feel immobilized – street outreach is part of this picture.

Comment: Another funding piece of the puzzle is looking at public safety, a way to start looking at broader payment systems.