Department of Mental Health (DMH)

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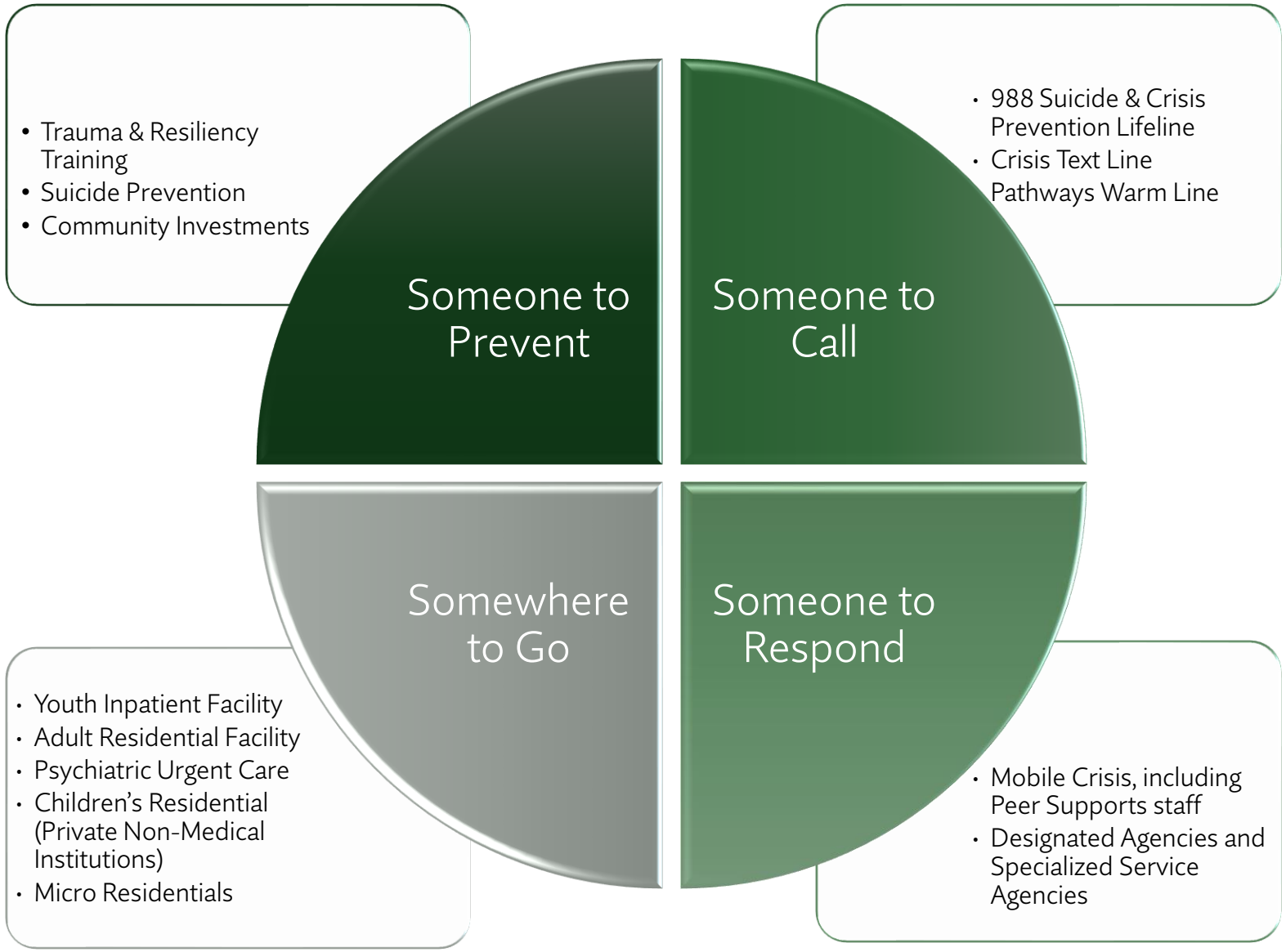
Today's Updates

1. Mental Health Urgent Care Programming
    - The Living Room Model
    - Psychiatric Urgent Care for Kids (PUCK)
    - Psychiatric Urgent Care (PUC)
    - Burlington CARES Team
2. Mobile Crisis
3. Certified Community Behavioral Health Clinics
4. Southwestern Vermont Medical Center Feasibility Study


Someone to Prevent
Someone to Call
Somewhere to Go
Someone to Respond
• Trauma & Resiliency Training
• Suicide Prevention
• Community Investments
• 988 Suicide & Crisis Prevention Lifeline
• Crisis Text Line
Pathways Warm Line
• Youth Inpatient Facility
• Adult Residential Facility
• Psychiatric Urgent Care
• Children's Residential (Private Non-Medical Institutions)
• Micro Residentials
• Mobile Crisis, including Peer Supports staff
• Designated Agencies and Specialized Service Agencies

3 Essential Elements of Crisis System of Care

Someone to talk to	Someone to respond	Somewhere to go
Regional or statewide crisis call centers	Crisis Mobile Team response	Crisis receiving and stabilization facilities

Crisis Now - Transforming Crisis Services
national-guidelines-for-behavioral-health-crisis-care-02242020.pdf (samhsa.gov)

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Mental Health Urgent Care: Program Goals

- Create an alternative space for individuals experiencing a mental health crisis to receive support services.
- Divert individuals from the hospital emergency departments whenever possible.
- Limit police involvement whenever possible to avoid criminal justice involvement, which can have long-term collateral consequences for youth and adults.

Mental Health Urgent Care: Program Types

- The Living Room Model
- Psychiatric Urgent Care (PUC)
- Psychiatric Urgent Care for Kids (PUCK)
- Crisis Assistance Health Out On The Streets (CAHOOTS)

The Living Room Model

The model is designed to feel like a warm, welcoming living room where guests feel safe and not overwhelmed. The model uses a multidisciplinary teams, including peer support workers.

- Provides a safe space for those experiencing a mental health crisis.
- Limits avoidable visits to the Emergency Department
- Helps to alleviate systems pressures
- Better meets the needs of individuals, by focusing on autonomy, respect, hope, empowerment, and social inclusion.

Funding Awardees:

- Counseling Service of Addison County (CSAC)
- Washington County Mental Health Services (WCMHS)

Psychiatric Urgent Care (PUC) or Psychiatric Urgent Care for Kids (PUCK)

The model provides a space for individuals (and their family members) experiencing a mental health crisis that needs an urgent response to meet with mental health clinical staff. Individuals can stay onsite for as long as they need during weekday daytime hours and even return the following days if they can be safe at home overnight.

Each urgent care site can provide:

- Crisis de-escalation
- Safety planning
- Clinical assessment
- Psychiatric consultation
- Sensory tools
- Peer and respite supports

Funding Awardees:

- Health Care and Rehabilitation Services (HCRS)
- Lamoille County Mental Health Services (LCMHS)
- United Counseling Services of Bennington County (UCS)
- The Howard Center (HC

Burlington CARES Team (CAHOOTS model)

Burlington CARES is designed to be a multidisciplinary mobile response team of mental health and emergency medical services. The CARES team will do welfare checks in lieu of police intervention when someone is in crisis.

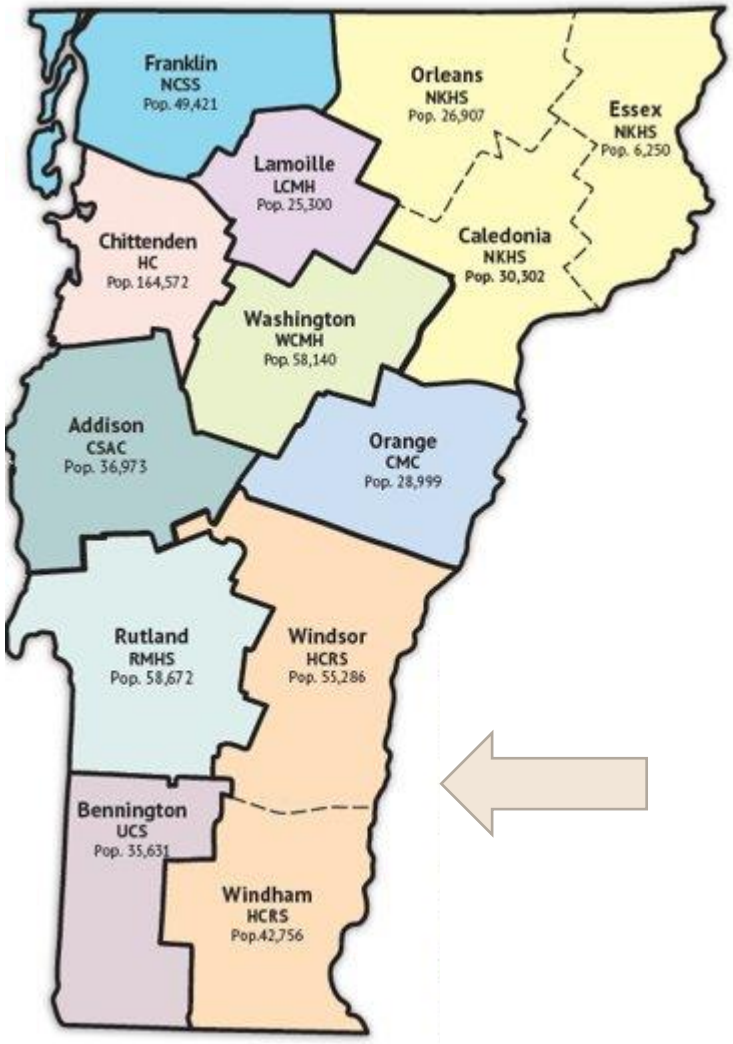
The CARES team will provide:

- Trauma-informed de-escalation
- Screening
- Assessment
- Referrals and service coordination

Funding Awardees:
The City of Burlington &
The Burlington Police Department (BPD)

Mobile Crisis Response: Providers

- Contract was awarded to Health Care & Rehabilitation Services (HCRS).
- HCRS will serve as lead agency, subcontracting with all 9 additional Designated Agencies to provide unified statewide community mobile crisis.
- The kickoff meeting occurred on Friday, March 24th, and the team will be meeting weekly to support implementation.
- The Department is currently working with HCRS to finalize the contract.



Mobile Crisis Response: Program Overview

Vermont's Mobile Crisis Program will:

- Be 24/7 and 365 days a year
- Arrive on site in the community within 60 minutes (with exceptions for some rural locations that include travel time in excess of 45 minutes)
- Respond to people experiencing a mental health, substance use or co-occurring.
- Serving Vermonters of all ages (children, youth, and adults)
- Be available to everyone, regardless of insurance status.
- Be delivered by a multidisciplinary two-person team in the community, including a peer or other paraprofessional.
- Connect individuals to other forms us care as needed, through warm hand-offs and coordination of transportation.
- Be able to provide follow up care up to 3 days for adults and up to 7 days for youth

Mobile Crisis Response: Training

HCRS will develop and implement training at all other designated agencies on standardized response protocols, including:

- transportation,
- dispatch of clinical versus non-clinical staff, and
- short-staffing.

At minimum, all mobile teams must be trained on core curriculum, including:

- J-IDEA (Justice, Inclusion, Diversity, Equity, and Accessibility)
- American Society of Addiction Medicine criteria
- Mental Health
- De-Escalation Skills
- Trauma-Informed Care
- Harm Reduction
- Community Safety

Mobile Crisis Response: Quality & Reporting

Quality Measure	Target
Average response time *From time of readiness	60 minutes
Response Time - percent within 60 Minutes	85% of all interventions achieve a response time within 60 minutes
Location of intervention	Adult: 80% community-based/20% MCT office based
	Youth: 85% community-based/15% MCT office based
Follow up Services by MCT - Percent of individuals that receive follow up services by MCT who are not admitted to 24-hour level of care	75%
Disposition	Adult: 70% Diversionary service/30% inpatient (or referred for IP screening by DA ES)
	Youth: 80% Diversionary service/20% inpatient screening (or referred for IP screening by DA ES)

Reporting to include key mobile crisis metrics, such as:

- Average response time
- Disposition of the case
- Location of intervention – e.g., homes, workplace, parks, community mental health center, etc.
- Percentage of individuals who receive follow-up care within 48 hours
  Client demographics
- Compliance with Medicaid documentation requirements.

Estimated Timeline & Next Steps

Action Item	Start Date	End Date
Release Notice of Intent to Procure for mobile crisis services in VT	8/1/2022	
Letters of Intent received from prospective bidders		8/31/2022
Revise mobile crisis RFP as needed based on bidder interest	9/15/2022	9/15/2022
Mobile crisis RFP released	11/1/2022	
Finalize oversight model, including identification of quality metrics and data collection/reporting needs.	11/1/2022	6/1/2023
Mobile crisis RFP responses due		12/30/2022
Hold requirements meetings for updates to state information systems; complete system work	1/1/2023	8/31/2023
Mobile crisis RFP and start-up funding awarded	2/2023	
Provider contracting process	2/2023	6/1/2023
Provider readiness assessments	6/1/2023	8/31/2023
State Plan Amendment submitted to CMS	6/1/2023	6/1/2023
Public notice posting	7/1/2023	7/30/2023
Response to public comment	8/1/2023	8/30/2023
Go-Live	9/1/2023	

What is a Certified Community Behavioral Health Clinics (CCBHC)?

A Certified Community Behavioral Health Clinic (CCBHC) provides a comprehensive range of mental health and substance use services. CCBHCs serve anyone who walks through the door, regardless of their diagnosis or insurance status.

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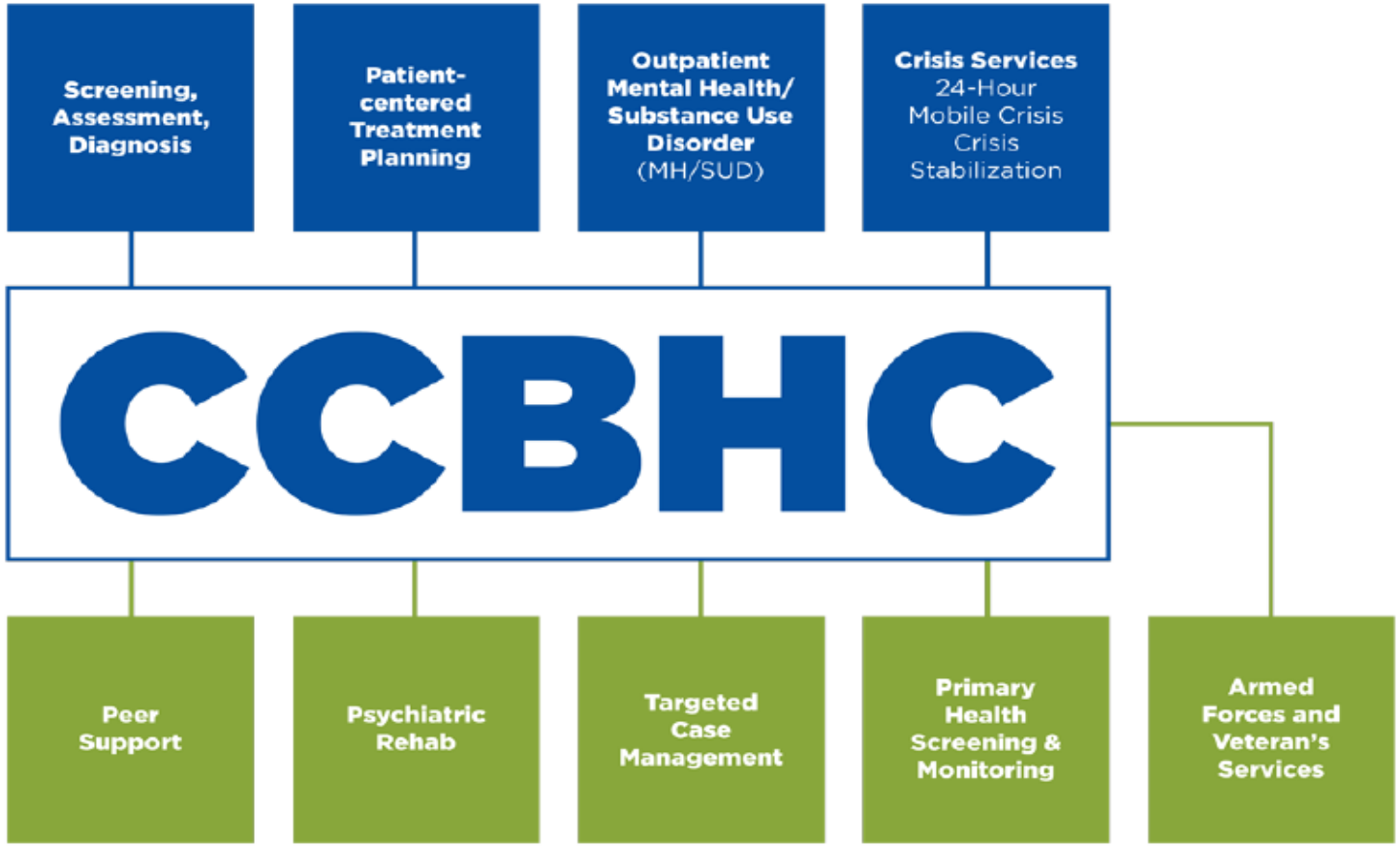
What are the requirements to be a CCBHC?

Provide access to integrated, evidence-based substance use and mental health services, including 24/7 crisis response and medication-assisted treatment (MAT).

Meet stringent criteria regarding timeline of access, quality reporting, staffing and coordination with social services, criminal justice and education systems.

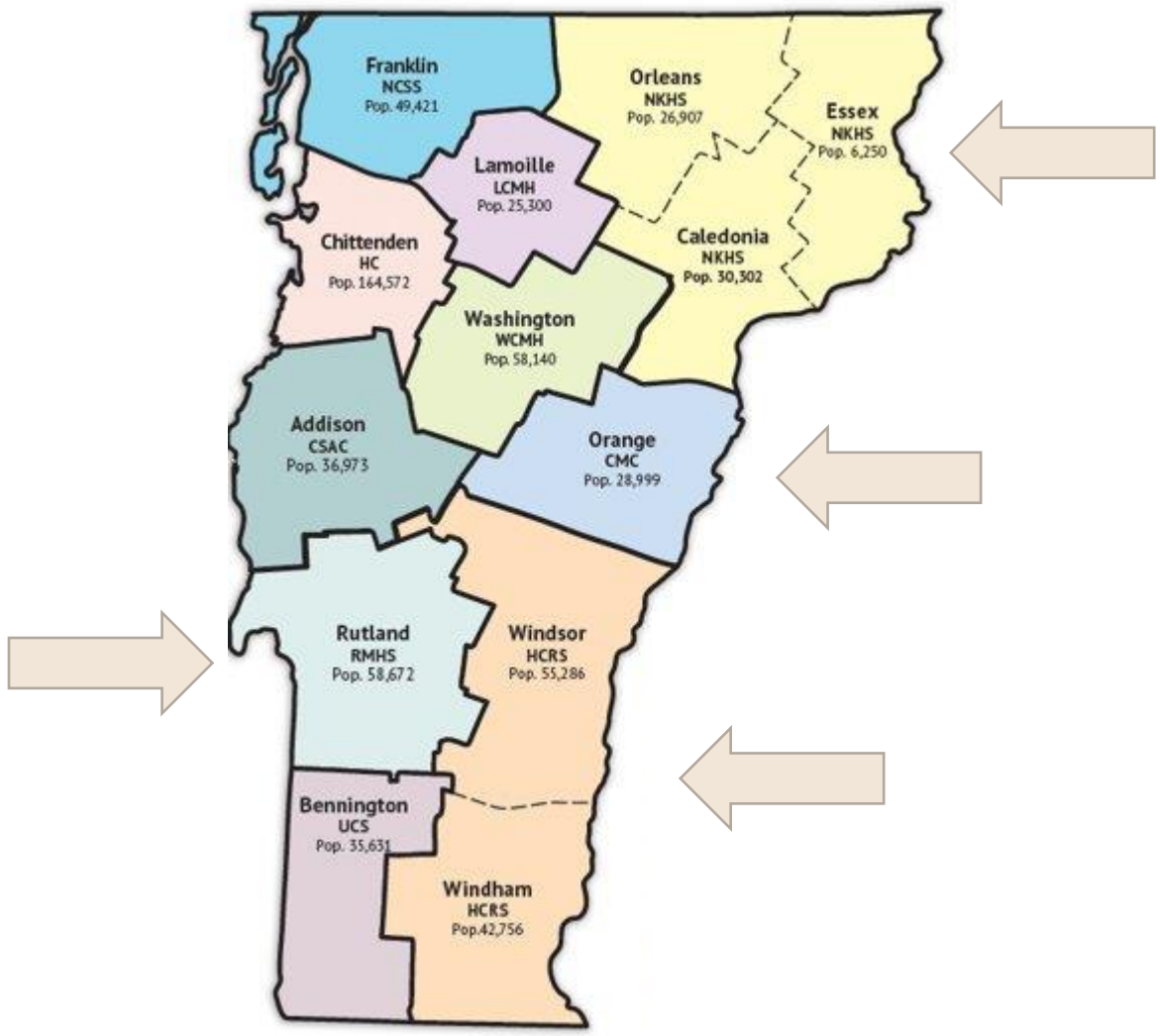
Receive cost-related reimbursement funding designed to support the true costs of services. The funding has built-in transparency and accountability that allows state leaders to make more deliberate decisions to meet the needs of the populations.

CCBHC Scope of Services



- Must be delivered directly by a CCBHC
- Delivered by a CCBHC or a Designated Collaborating Organization (DCO)

New changes to federal regulations, allow the statewide mobile crisis to comply with the criteria. This changes to the regulation opens opportunities for many more provider types to become CCBHCs.



Planning Grants to Designated Agencies

- 4 of the 10 Designated Agencies were awarded approximately $1 million per year for four years by the Substance Abuse and Mental Health Services Administration (SAMHSA). They are:
  - Clara Martin Center
  - Health Care Rehabilitation Services
  - Northeast Kingdom Human Services
  - Rutland Mental Health Services
- Grants will help agencies prepare to become a CCBHC.
- All remaining six agencies are currently in the process of applying for grants in the next round.

Vermont Awarded a State Planning Grant

In March, Vermont was one of 15 states to received a one-year $1,000,000 Planning Grant dollars to accomplish the following:

- Solicit stakeholder input
- Create and finalize application processes and review procedures for clinics to be certified.
- Assist clinics with meeting certification standards.
- Certify an initial set of clinics.
- Establish a bundled payment.
- Develop or enhance statewide data collection and reporting capacity.
- Submit a proposal to participate in the CCBHC Demonstration Program no later than March 20, 2024.

CCBHC: Enhanced Federal Medical Assistance Percentage (FMAP)

Since 2014, only 10 states have been eligible to be "Demonstration" States. Demonstration states are eligible for enhanced FMAP. As one of the 15 states awarded a planning grant, Vermont is eligible to apply to become one of the next 10 Demonstration states.

SFY 2024 RATES*	STATE SHARE		GROSS
Federal Medical Assistance Percentage (FMAP) o 56.52% Federal / 43.48% State o *Applied to the majority Medicaid expenditures*	$1.00 	=	$2.30 
Certified Community Behavioral Health Clinic Demonstration State Percentage** o 69.57% Federal / 30.44% State	$1.00 	=	$3.29 

** The State fiscal year is different than the federal fiscal year. As such, the state uses a blended match rate to calculate SFY FMAP rates*
*** The CCBHC FMAP is equal to the state's Children's Health Insurance Plan (CHIP) rate.*

Southwestern Vermont Medical Center: Feasibility Study

Southwestern Vermont Medical Center (SVMC) and TaraVista HealthPartners completed a feasibility study for the Bennington campus of SVMC. The unit would treat adolescents (age 12-17) experiencing mental health conditions that require inpatient care and would be capable of managing medically-stable co-occurring medical conditions.

The demand analysis suggests the need for more than 12 new inpatient adolescent mental health beds in addition to the Brattleboro Retreat.
Two primary data sources to determine the state-wide need for the unit, include:

- VAHHS' wait time report that tracks the number of adolescents in VT emergency departments waiting for a mental health inpatient admission, and
- DMH's FY2021 statistical report which conveys the magnitude and pattern of inpatient admissions

SVMC Feasibility Study: Facility Location

The space on SVMC's Bennington campus that best met the criteria was the former medical records space that currently supports hospital operations.

Decades ago, this area served as a medical inpatient unit, which means it will require fewer renovations to meet the new need.

SVMC Feasibility Study: Budget Projections

- $9.2 million in renovation and furnishing costs
- $1 million in year 1 operational support to supplement reimbursement for care
- Scaling reimbursement of approximately $2,000 per patient per day from Vermont Medicaid

	Year				
	1	2	3	4	5
Medicaid rate different from other payers (rate per patient day)					
Medicaid rate	$ 1,875	$ 1,950	$ 2,026	$ 2,106	$ 2,189
Anticiapted commercial payer rate	$ 1,200	$ 1,236	$ 1,273	$ 1,311	$ 1,351
All payers pay the same rate (rate per patient day)	$ 1,710	$ 1,777	$ 1,847	$ 1,920	$ 1,996

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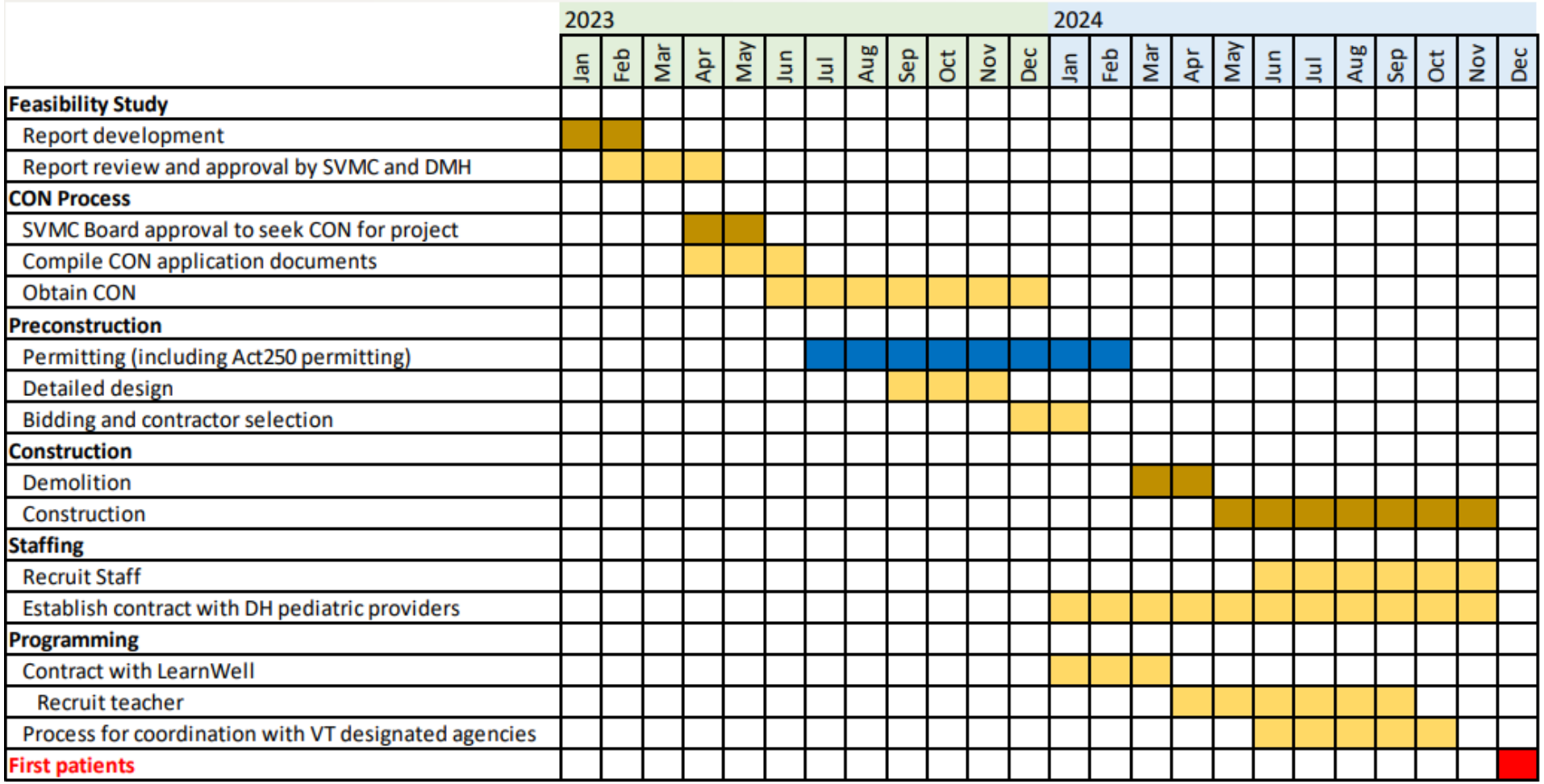
Timeline to Launch- First patients, winter 2024



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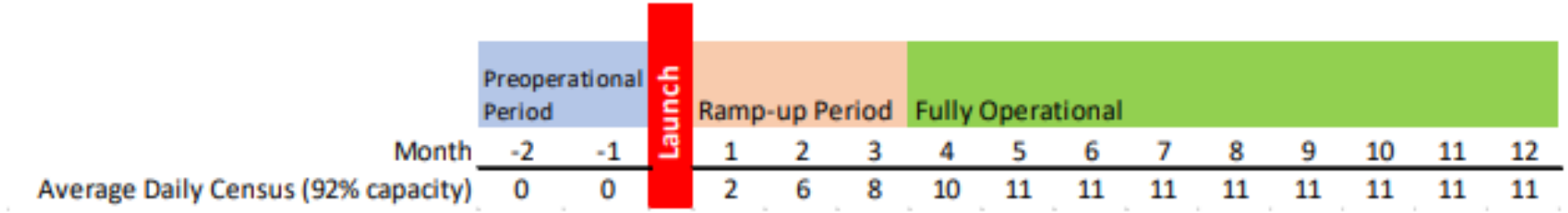
SVMC Feasibility Study: Timeline & Ramp-Up

The inpatient mental health unit, the team will be brought together for 2 months prior to launch in order to:

- establish protocols and process,
- smooth operations,
- coordinate with referring agencies and hospitals,
- create connections between education services and VT school districts, and
- develop timely systems for discharge of patients to independent counselors and designated mental health agencies across the state.

Launch would be followed by a three-month ramp-up period. Once fully operational, the 12-bed unit is projected to have 92% occupancy or an average daily census of 11. The projected occupancy allows 14 hours between patients for coordination of transportation, room preparation, and communication with referring counselors and institutions thereby ensuring the best start for the patient.

Anticipated census adolescent mental health inpatient unit



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Thank you!

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Appendix

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DEPARTMENT OF MENTAL HEALTH

MENTAL HEALTH SYSTEM OF CARE

Key to Provider Symbols
- BLUE: ADULTS SYSTEM OF CARE
- GREEN: CHILD, YOUTH & FAMILY SYSTEM OF CARE
- ORANGE: SERVICES IN BOTH YOUTH & ADULTS

Inpatient Hospitalization
229 total beds

- Children & Adolescent — 1 Facility | 30 Beds
- General Inpatient (Adult) — 7 Facilities | 142 Beds
- Level One Inpatient (Adult) — 3 Facilities | 57 Beds

Secure Residential
16 total beds

- MTCR → River Valley — 1 Facility | 7 Beds → 16 Beds

Intensive Residential & Treatment Programs
92 total beds

- Youth Residential (PNMI) — 5 Residences | 45 Beds
- Intensive Recovery Residential — 5 Residences | 42 Beds
- Peer-run Residential — 1 Residence | 5 Beds

Crisis Supports & Response
56 total beds

- Children's Crisis Stabilization Program — 1 Facility | 6 Beds
- Youth Hospital Diversion Program — 2 Facilities | 12 Beds
- Psychiatric Urgent Care for Kids (PUCK)
- Mobile Response Support Services — Rutland Pilot
- Adult Crisis Beds — 12 Facilities | 38 Beds
- Crisis Assessment, Support & Referral — Continuing Education & Advocacy
- 988 Crisis Lifeline Centers — Call | Chat | Text

Community Mental Health
174 total beds/109 vouchers

- Micro-residential (HCBS) — 3 Homes | 9 Beds
- Youth Group Homes (PNMI) — 4 Homes | 13 Beds
- Group Residential Homes — 19 Homes | 152 Beds
- Shelter & Care Vouchers — DMH Housing Vouchers
- Individual, family, and group therapy
- Clinical assessment
- Medical consultation and medication
- Service planning and coordination
- Community supports & employment services
- Schools/PCP/Early care & learning ctrs (youth only)
- Peer programming (adults only)
- Prevention work (youth only)

- Peer-run Services & Residential Care
- Department of Mental Health
- Designated and Specialized Services Agencies
- Private Providers

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Mobile Crisis: Stakeholder Engagement Process

Interviews, focus groups, and meetings were held with consumers, families, community members, providers, community-based organizations, schools, law enforcement, state agencies, and more.
The State specifically took care to gather input from community partners and diverse populations, such as:

- Transitional age youth, families, adults, and elders most impacted by the crisis service system
- Service providers and community stakeholders
- First responders including law enforcement and Emergency Services
- Refugees and immigrant communities
- Hospitals
- State leaders
- Schools
- People with intellectual and developmental disabilities
- LGBTQI+

Townhall

On March 22, 2022, public administrators conducted a virtual “town hall” as the first step to understanding how to best meet the needs of Vermonters.

Mobile Crisis: Stakeholder Feedback on Current Crisis System of Care

- 54 percent of consumers reported that **not knowing where or who to call** has been the hardest thing about getting crisis services.
- For consumers and families that have accessed crisis services, **64% reported receiving services in hospital emergency departments "most of the time"** although 65 percent of consumers and families indicated they would like to receive crisis care in the community.
- Half of the 15 hospital/ED respondents indicated that 50-75 percent of individuals that present to the ED for a mental health or substance use related crisis **could have been evaluated in the community** (i.e., did not warrant medical screening). *This presents significant savings potential for Vermont Medicaid and other payers.*
- In response to particular groups that are not well served by the current mobile crisis system, the top responses (in rank order) were **individuals who were unhoused**, individuals with **intellectual or developmental disabilities**, individuals with **substance use disorder** and **children and youth.**

Needs Assessment Findings

	Key Federal Requirements	Needs Assessment Key Findings
Key Services	Community based mobile crisis services must be available 24/7/365. Follow-up care delivered by mobile crisis teams is eligible for enhanced funding.	Mobile crisis services are not consistently available in the community and 24/7. Follow-up services are not consistently provided.
Mobile Team Composition	Services must be delivered by a multi-disciplinary team that includes at least one behavioral health care professional qualified to provide an assessment within their authorized scope of practice under state law and should also include other professionals or paraprofessionals with expertise in behavioral health or mental health crisis intervention.	In most instances, services are delivered by a single person. Best practices include incorporating trained peers who have lived experience, and use of peers is not currently required of Emergency Services teams. H. 740 describes future peer workforce requirements for mobile crisis teams.
Quality and Performance Measurement	States should develop a systemic process to continuously analyze data for performance evaluation. State must establish timeliness standards.	Current oversight of mobile crisis services does not exist in a meaningful way. Timeliness standards are explicitly stated in the Designated Agency Emergency Service Standards, but there is no data collection and monitoring.

Using a federal planning grant, AHS partnered with Health Management Associates (HMA) to conduct a statewide needs assessment to identify gaps and opportunities of the current crisis system.