280 State Drive – Center Building
Waterbury, VT 05671-1000

OFFICE OF THE SECRETARY
TEL: (802) 241-0440
FAX: (802) 241-0450

JENNEY SAMUELSON
SECRETARY

TODD W. DALOZ
DEPUTY SECRETARY

STATE OF VERMONT
AGENCY OF HUMAN SERVICES

MEMORANDUM

TO: Chair Houghton, House Committee on Health Care

Chair Wood, House Committee on Human Services

FROM: Monica Ogelby, Medicaid Director, Agency of Human Services

DATE: 3/21/24

SUBJECT: Follow up to 3/12/24 testimony on Psychiatric Residential Treatment Facility (PRTF)

DMH

1. *What are the top 3 or 4 diagnoses for PRTF youth?*

The most common diagnoses of youth who are currently at PRTFs in other states include: Severe Anxiety, Severe Depression, Other Mood Disorders, Disruptive Mood Dysregulation Disorder (DMDD), Oppositional Defiant Disorder (ODD), Obsessive Compulsive Disorder (OCD), Reactive Attachment Disorder, and Psychotic Disorder or Features. It is critical to understand that a singular diagnosis does not equate to complexity nor severity, and nearly every youth has coexisting diagnosis that require nuanced and multidisciplinary treatment. Many youth have a combination of mental health and developmental diagnoses and/or medical conditions. Additionally, while not all youth meet the official criteria for Post-Traumatic Stress Disorder (PTSD), almost all of these youth have experienced trauma. The most common developmental diagnoses are Autism Spectrum Disorder and Intellectual Disability.

Common profiles:

- Youth with internalizing behaviors, such as a combination of anxiety or depression, may have other developmental or medical needs, and have suicidal ideation, suicidal gestures, and/or intensive self-injurious behaviors, are not safe to themselves, and experience high family system distress.
- Youth with externalizing behaviors may have a combination of Disruptive Mood Dysregulation Disorder, ODD, underlying depression/anxiety, often with delayed

processing skills and lack of executive functioning skills, and engage in externalizing behaviors like aggression/violence towards others; often high family system distress.

For this VT PRTF, the youth will need to have verbal communication skills and a level of cognitive functioning to be able to benefit from the treatment modalities offered. Youth with more severe developmental disabilities or who are nonverbal may need to be referred to a residential treatment program or an PRTF out-of-state that specializes in severe developmental disabilities.

Please note that while all of these are diagnoses that can be treated in the community or at lower levels of care, it is the acuity of the symptoms and the behaviors that these youth engage in that indicates the need for a PRTF level of care. Lethality and/or significant risk of harm are priority areas of concern for most of these youth. Most have not been able to safely engage in treatment in the community, have therefore experienced multiple or long-term placements in crisis or inpatient settings, and may have even tried and been unsuccessfully discharged from lower levels of residential treatment.

2. *Will there be involuntary medication used at the PRTF?*

PRTF programs operate under the direction of a physician/psychiatrist. Like a hospital setting, they have the ability to administer involuntary medication to a youth, should it be required. This is not common practice, and when it occurs it is done as a last resort, and always under the direction of the physician. Should this occur, the referring agency (DCF, DMH, DAIL) is immediately notified and these data are tracked.

3. *Were updates on this facility included on the DMH Quarterly Update Reports?*

The quarterly residential reports do not include information about developing an in-state PRTF, but do include data about youth in out-of-state PRTFs. That data is combined with other out-of-state data.

4. *Why is VDH/DSU not in the room at testimony, considering potential substance use challenges some youth may present with?*

DSU is a standing member of the State Interagency Team which meets monthly and where we have discussed the need for different levels of care and the PRTF. The need and additional data about the children's system of care can be found in the annual System of Care Report. A representative from DSU also participates on the Case Review Committee (CRC) and is available to offer advice and consultation on any youth situation where there are co-occurring substance use concerns (either for the youth or the family).

DAIL/DCF

5. *Are these justice-involved youth? Can you discuss youth with intellectual disability and*

developmental disability waiting for placement?

Youth referred into this program may be justice involved, but the nature of their justice involvement is not a condition of the referral. They are referred and, if appropriate, placed due to the nature of their mental health needs. This program will not serve youth solely for the purposes of placement based on their justice status. Similarly, youth with presenting intellectual or developmental needs, also must be presenting co-occurring mental health needs in order to justify this level of care. As mentioned above, ID/DD youth accepted into this program must have a level of cognition that would allow them to benefit from the program's treatment modalities.

6. *Can you advise whether it is an issue to mix justice-involved youth and youth with developmental disabilities?*

Residential programs struggle to provide positive outcomes to youth when serving mixed populations in a milieu setting. This can be seen especially within crisis stabilization programs, and especially when there are insufficient alternative residential resources, requiring extended placements in a crisis stabilization level of care. The difference with this PRTF level of care is that all of the youth placed there are placed due to the acuity of their mental health needs. While those individual needs will certainly vary from youth to youth, the overall acuity of mental health needs will reflect a relatively consistent standard.

Joint agency

7. *What type of assessment did the State and partners do regarding the path that youth currently take through each DMH, DCF, and DAIL in getting to this level of care? With the understanding that this facility/level of care is not currently in existence and will not always be a direct referral from ED or the Retreat, were "diversions" to this level of care explored? For example, what else was done to reduce the need for out of state placement of youth with these clinical needs? Or, what alternatives are we doing on the community end to prepare these families who will age out of this care soon?*

It's through the experience over several decades of helping youth and families access the right level of care that the State determined this gap in our system of care. This level of care is currently in existence in other states and is currently used by Vermont. It is one of the levels of care that are considered when seeking to secure the right level of treatment for Vermont youth. It does not currently exist within Vermont. There has never been a situation where a youth was referred directly from an ED to a PRTF. More typically, the youth is referred to a PRTF from an inpatient setting, from another non-PRTF residential program or from a community-based wrap due to indications of not being able to meet the youth's acute/complex needs in those settings. The State continues to support other efforts to create and/or stabilize diversion programs that divert from EDs, inpatient, residential, such as hospital diversion, urgent care programs, intensive outpatient programs (IOPs), and intensive community-based homes with wrapped supports.

<u>General path:</u>

For any youth who has needs for AHS services and educational supports, the family or providers may request to have a Coordinated Services Plan (CSP) meeting to review needs, strengths, long-term goals, current services and supports, and to identify gaps and potential additional supports/services. The family is offered the opportunity to connect with a local parent representative for support and advocacy during this process. The CSP form has additional sections to request referral to the Local Interagency Team for additional brainstorming of resources to meet the identified needs, and a section to request referral to the Case Review Committee (CRC) for residential assessment or treatment. During these local discussions at the CSP meeting, the team and family explore all options to meet the needs, including increasing community-based supports. Often the local providers consult with the State on the range of options. The team and family sign off on the CSP to indicate their agreement/disagreement with referral to CRC for residential level of care. The lead State department reviews the referral packet (CSP, clinical documentation, educational documentation, placement history, etc.) to determine medical necessity for residential level of care, communicates with the local lead entity about the referral, and discusses the request with the Case Review Committee to determine what programming would be best able to meet the needs of the youth and family. Often, several programs are identified to allow teams and families to explore appropriate fit and availability.

Related guidance:
Case Review Committee Guidelines and Procedures (2024)
Act 264/ Coordinated Services Plan information
DMH Out of Home Placement Procedural Guidelines (February 2018)

Exploration of options other than PRTF:

The State CRC representatives look to identify programs that are in the least restrictive setting appropriate to the youth and family needs and that are within or close to their own communities. When referrals are made to an in-state program(s) and the referral is declined by the program, the State may then refer to programs in nearby states. For the complex situations that we are talking about, referrals to non-PRTF programs are often declined by the program due to their determined inability to meet the clinical needs of the youth in their setting. The CRC representative then pursues PRTF programs based on the clinical presentation of the youth (e.g. some PRTF programs have specialty focus on youth with Autism or youth with significant suicidal or self-injurious behaviors). The typical pathway for a youth referred to a PRTF is:

- a history of intensive community-based supports that are no longer adequate to meet the needs;
- a history of multiple or lengthy stays in an inpatient psychiatric setting;
- referral to and denial from multiple non-PRTF residential programs; and/or
- admission to a non-PRTF residential program and the program determines that they are not able to make clinical progress and recommends discharge to a more intensive specialty level of care.

Related specifically to youth with intellectual/developmental disabilities, the State works closely with community partners (e.g., Designated Agency/Specialized Service Agency—DA/SSA) to confirm all available resources have been explored and exhausted. This includes such supports as:

- Vermont Crisis Intervention Network (VCIN) consultation;

- Dartmouth Hitchcock Medical Center clinical consultation;
- Department of Vermont Health Access resources for children;
- Department of Mental Health resources for children;
- Department of Aging, Independent Living/Developmental Disabilities Services, including Home- and Community-Based Services;
- School-based resources; and
- Natural supports.

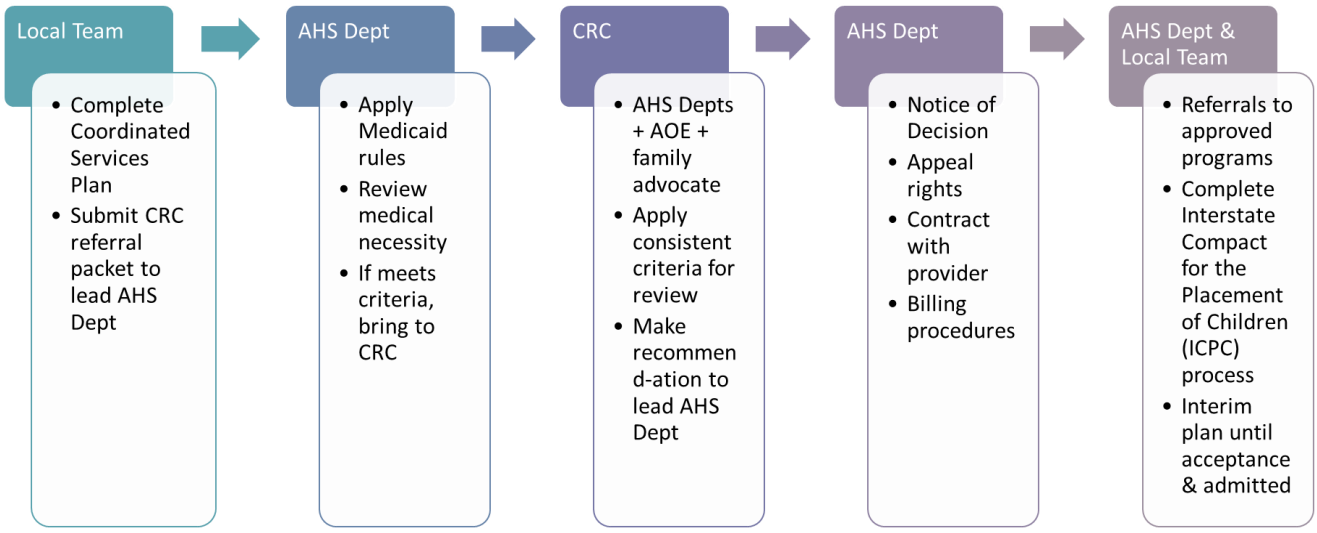
This is also confirmed through the Coordinated Services Plan (CSP) and Case Review Committee (CRC).

8. *Provide a document that outlines categories of care, what qualifies youth and the flow of where they go. Clarify how all department are involved.*

Under Early Periodic Screening, Diagnosis and Treatment (EPSDT) federal law, AHS is mandated to provide the level of care that can "correct or ameliorate" a child's needs based on their medical necessity. The AHS value is to use the least restrictive setting. If the determined level of care is not available, the team and State must determine whether the youth can safely remain at a lower level of care or whether ethically they need to be at a higher level for their safety until the right level is available.

It's important to understand that while there are recognized levels of care, each youth has unique individual needs and context that must be considered. The process to determine who needs what level of care is based on a combination of clinical presentation, educational needs, family choice, urgency of need and availability of an opening, and current milieu within the program and their determination of ability to serve this specific youth within that milieu.

Regarding how departments are involved, please refer to the Act 264 and Case Review Committee links above. Below is a visual of the process.



9. *Are we responding to people's needs and balancing the appropriate holistic, integrated upstream investments?*

   The State shares the interest in helping youth attain their highest level of independence, health, wellness, and community engagement. We must simultaneously invest in upstream, preventative, and early intervention systems while also meeting the current presenting needs of youth. As is inherent in the public health model, the youth who have identified needs (the intensive level at the top of the pyramid) must also have access to supports and opportunities for health and wellness (the universal level at the bottom of the pyramid) and we expect the intensive service programming, whether in the community or in a PRTF, to incorporate activities and services towards that end.

10. *At the case review committee (CRC) level, how are parents involved?*

    One of the standing members of the Case Review Committee (CRC) is a parent representative from the VT Federation of Families for Children's Mental Health (see CRC Guidelines and Procedures linked above). She shares information she has about the parents' perspective from Coordinated Services Planning (CSP) meetings she has participated in or from conversations she's had from other parent representatives who participated in CSP's from other counties. She also offers phone consultations to any parents who are interested. The parent reps are generally not involved in the CSP's for youth in DCF custody, but they participate in any other CSP's where a parent requests parent support.

11. How are we supporting families with equal investments so youth can restore in community with family?

    Thus far:

    - 2021 Legislative Session: 3% Medicaid rate increase for DA/SSA mental health and developmental disability staff. This represents an increase of $4,121,421 for DMH and $8,434,847 for DAIL.
    - November 2021: $1.5M distributed to DA/SSAs to support tuition reimbursement and loan repayment.
    - December 2021: AHS Secretary's office identified $2M for immediate distribution to network for workforce retention.
    - 2022 Legislative session: 8% Medicaid rate increase for DA/SSA. This represents an increase of $10,990,456 for DMH and $22,493,138 for DAIL.
    - 2022: AHS Premium Pay to DA/SSA: $14,116,000
    - 2022-2024: $4M distributed to DA/SSA programs to increase ADA accessibility at group homes, crisis beds, buildings to improve the experience of clients and staff.
    - 2023 Legislative Session: 5% Medicaid rate increase. This represents an increase of $6,803,695 for DMH and $14,117,120 for DAIL.
    - 2023: $6.9M distributed to DA/SSA for tuition reimbursement and loan repayment

12. *How do we track Social Drivers of Health (SDoH) that lead to higher levels of care? What are the barriers from people getting support in community (housing, staffing, etc.)? What leads people to higher levels of care? What policies can we implement to prevent that?*

    The CSP process includes gathering the strengths and needs of the family. This is often when concerns related to housing, food insecurity, other economic needs, education, community functioning, caregiver mental health or substance use concerns and/or ability to provide the level of supervision and care necessary, etc. are gathered and the team discusses potential solutions and resources to address those needs. Additionally, for youth served through the DA/SSA mental health system, the Child and Adolescent Needs and Strengths tool is used which pulls this information together to provide a comprehensive lens into the areas of need to address and strengths to build upon. When these referrals are discussed at CRC, there may be recommendations for specific concrete supports for the SDoH needs.

13. Why didn't the Committee know a PRTF is needed in Vermont before now?

    For the past few years, AHS has been looking critically at what is needed for children and youth at all levels of care. We have not needed funding prior to now to achieve this goal. We have been utilizing out of state options and just secured a possible provider late last summer to provide a PRTF in Vermont. The identification of the PRTF as a necessary resource needed here in Vermont has been the product of collaboration across AHS and in partnership with our DA/SSA colleagues.

14. Can we use the money saved from out-of-state placements to fund this in-state?

    We anticipate that the funds AHS is currently spending for many of the children who are in PRTFs out of state will transition to fund children in the VT PRTF. We will continue to need to use a small number of PRTF programs out of state to meet the specialty needs of individual youth who would not be best served in the VT PRTF.

15. How much are we spending now on out-of-state PRTF?

    In State Fiscal Year 2024, DAIL estimates that it will spend over $450,000 in Global Commitment Investment dollars for room and board payments and for residential programs and approximately $779,000 of Global Commitment dollars for Medicaid claims for youth to receive support from out of state residential supports through Private Non-Medical Intuitions (PNMI) and PRFTs.

    In State Fiscal Year 2024 (SFY24), DMH estimates that it will spend $291,000 in global commitment dollars on Medicaid claims for youth in out-of-state PRTF facilities. For context, DMH has placed three children in a PRTF in SFY24. The monthly PRTF budget ranges from $17,632/month to $65,813/month. For comparison, in State Fiscal Year 2023 (SFY23), DMH placed seven children in PRTF and spent $795K in global commitment dollars on PRTF Medicaid claims for youth. The monthly budget ranged from $35,190/month to $92,424/month in SFY23.

    DCF currently has contracts with 16 PRTF programs out of state; however, the department does not have placements in all of them. In SFY23, DCF spent $2,851,801.49 placing youth in said programs. In SFY24, DCF has expended $1,910,249.92 to date on PRTFs.

16. Describe the care youth are receiving OOS (and how does it compare to what we could provide in VT)?

    Children who are out of state through AHS are in residential treatment programs and PRTFs due to their individualized needs not being able to be met by VT programs, due to clinical need (complexity/acuity) and/or timeliness of available openings. Some programs specialize in certain clinical areas of need that are not available in Vermont.

17. What is the timing for the PRTF?

    We are on track to execute the contract for the VT PRTF for July 1, 2024. We expect programming to begin at a pace that assures youth safety and staff readiness, thus the PRTF likely will not be at full capacity for months, or even a year.

18. Is it one-time money or base dollars that is being requested?

    There are 3.6 million global commitment dollars in the base budget for FY25. The PRTF will not open until we are assured appropriate staffing and program readiness, and most certainly at a thoughtful pace, reflected in the budget. Future budget needs will be based on caseload as are other Medicaid services.

    Savings from bringing youth home or moving youth through the higher levels of care more effectively and efficiently may be realized in subsequent years, however, like most prevention efforts, AHS cannot account for that in the same budget year. Future budget needs will be based on caseload and utilization.

19. What is the turnover on beds (days, weeks, or months)?

    Youth are typically in a PRTF for several months to a year. It is individualized with no pre-determined expected length of stay. Length of stay is driven by the goals for treatment, progress towards goals, and readiness of the next level of care for transition out of the current level of care.

20. What services are available at PRTFs?

    Psychiatry, outings in the community to work on social skills, groups for therapeutic intervention, individual therapy, ways to manage anger, anxiety, depression, work with families to support them.

21. Why is PRTF better than community care?

    PRTF supports are part of the continuum of care for Vermont's children. They are not "better" than community care but rather the appropriate level of support for youth at the time when it is needed. Attempting to provide community-based services to youth who meet medical necessity

for higher levels of care is dangerous and risks causing harm to children. The creation of a proposal of a PRTF in Vermont is expected to provide youth greater access to their families, community partners and improve the transition and discharge process. Referral for treatment at a PRTF is based on medical necessity. It is always a priority to keep children and youth in their communities, unified with trusted family and caregivers, and receiving the lowest level of care which can appropriately meet their needs.

22. Which Agency/Department oversees the PRTF?

    The Agency of Human Services, specifically the Medicaid Director, Monica Ogelby, is the primary point of contact. All decisions related to programming and service delivery model are made through cross-Departmental collaborative process and based on best-practice and CMS guidance. DVHA holds the contract and acts as the payor which is squarely within their area of expertise.