DRAFT -- Department of Mental Health budget recommendations

The House Health Care Committee believes that there is an urgent need to renew Vermont's commitment to parity of mental health services and to the recognition that mental health is an essential part of health. We need to persist in building an integrated and holistic health care system.

The persistent emergency room crisis is a symptom of the failure to address mental health in the same way our system would address other health conditions. If we were addressing mental health on a par, our hospitals would be leaping to resolve the lack of access to inpatient care, and not turning to the state to intervene. If we were addressing mental health as a full partner in health care, our core providers would see their budgets and reimbursements addressed within health spending growth as a whole, rather than being capped by the state's budget. If we believed in parity, employees in agencies that addressed state-financed functions would receive salaries in line with those received by state employees performing the same job descriptions.

In order to revitalize that commitment and press for progress, the Health Care Committee expects to move several bills that include articulation of that priority throughout the health care system, including renewing specific directives not fulfilled under Act 82 of 2017.

A recognition of the state's commitment to parity has the following implications for this year's proposed mental health budget and the recommendations of the Health Care Committee:

Designated Community Mental Health Providers

The health care system should not be divided into two classes of providers, and recipients of mental health care should not be treated as second class citizens in their access to providers. In order to continue the incremental steps towards parity and to increase access to mental health care by reducing levels of vacancies and turnover within the statutorily Designated Community Mental Health Providers, Vermont's largest provider of mental health services (cite statute), <u>the Health Care Committee urges that the budget include the second phase of salary equity for designated agency staff as expressed in legislative intent in the fy 2018 budget</u>:

> Sec. E.314.2 FISCAL YEAR 2019 BUDGETING FOR DESIGNATED AND SPECIALIZED SERVICE AGENCIES
> (a) The Secretary of Human Services, in consultation with the Departments of Mental Health and of Disabilities, Aging, and Independent Living, shall estimate the levels of funding necessary to sustain the designated and specialized service agencies' workforce, including increases in the hourly wages of workers to $15, and to increase the salaries for clinical employees and other personnel in a manner that advances the goal of achieving competitive compensation to regionally equivalent State, health care, or school-based positions of equal skills, credentials, and lengths of employment; enable the designated and specialized service agencies to meet their statutorily mandated responsibilities and required outcomes; identify the required outcomes; and <u>establish recommended levels of increased funding for inclusion in the fiscal year 2019 budge</u>t. (Emphasis added)

Even the addition of this appropriation would not place these providers on an equitable basis with either state employees or the allocation of health care resources as a whole, because it does not incorporate them into a system that maintains reasonable,ongoing reimbursement increases or sustainable rates. That needs to change. However, in the interim, this appropriation does make

another incremental step towards recognition that providers of mental health and addiction services need to be treated equitably, if access to services is to become equitable.

Budget line item: $5.74 million General Fund

Budget Proposal for Outreach Services

The House Health Care Committee recommends that the budget include, as a minimum, the funds that the Department of Mental Health has requested for an outreach program in four geographic centers in the state. Given the extent of the barriers to access to care – which are evidenced both by the lack of community resources to divert unnecessary emergency room use and the lack of community resources to support timely discharges from inpatient care – the Committee is concerned that the amount of this investment may be too limited.

Efforts by DMH over the past several years to reverse this crisis have not been successful. There is a further need for additional funding in this year's budget in light of the continuation of a "return-the-money-to-the-bottom line" BAA cut of $300,000 in unexpended crisis services funding from the first half of fy 2018, which will be necessary and expended if crisis services are fully staffed. DMH proposals for capital projects in response to the crisis are unlikely to be in place prior to fy 2020, and those proposals rely on institutional responses rather than community-based care. It is essential that there be improved access to care prior to 2020. The Committee therefore requests that an additional $500,000 be appropriated for hospital diversion, as outlined below.

At the same time, the Committee has concerns that the current outreach proposal is not yet fully articulated, and it thus cannot be fully assessed for how likely it will meet its critical goal of diverting people in crisis from unnecessary ED use and/or preventing crises from occurring. The Committee notes that a key component of the proposal is direct engagement of local communities, but that for the three new targeted areas, there are no such commitments yet in place. The commitment to matching funds from municipalities and hospitals are essential in order to create ownership of the outreach initiatives and to foster greater recognition that the services described are ultimately the responsibility of the health care system and communities – just as with other first responder and health emergency services – not that of the state. Furthermore, the program proposal itself is primarily based on engagement by DMH with one stakeholder group – the designated agencies – rather than consistent with our longstanding state commitment to engaging all stakeholders, most particularly the persons directly affected by services.

In the context of the above considerations, the Committee makes these recommendations:

1. Continue the funding of the Chittenden County area outreach program, which was fully articulated for purposes of the BAA and which has already received commitments of matching community funds.
2. Support the DMH recommendation for additional outreach projects, conditioned on development of those projects in the manner described below such that there is confirmation of a project start of July 1, 2018, to a maximum of the remainder of the $400,000 allocation. The criteria should include:

a. Structure of the projects as pilots to ensure that outcomes can be measured in terms of successful reduction of unnecessary emergency room visits.

b. Demonstrated engagement of all stakeholders in defining community-specific articulated needs and how to respond to them, including representatives of peer organizations, family representatives, community first responders, local town officials, and hospitals. The intent of the proposed projects has been identified as needing to be flexible in responding to local needs, and therefore should not presume a traditional "outreach" model or pre-determined staffing constructs, rather than inclusion of other, more direct, investments in services or involvement of other service agencies.

c. Incorporation of a peer services component and a housing support component in each project location.

d. Assurance that the communities involved have a continuing stake in the project and its outcomes, including an ongoing funding match commitment.

3. Any appropriations of the $400,000 requested by DMH that are not committed to projects that are able to begin by July 1, 2018, should be used to augment an additional recommended appropriation of $500,000 for the following evidence-based, existing initiatives demonstrated to prevent the need for hospitalization or enable timely discharges:

a. Completion of the funding commitment made in Act 79 of 2012 for reaching a full 24/7 capacity of the statewide peer support line. *(see, Sec 6(1) of Act 79 of 2012)* <u>*XXX $$ (this would be an amount equal to what was added last year, but I couldn't find that line item from last year's budget bill.)*</u>

b. Increased funding of the Housing First program as recommended by the House in its Appropriations bill of FY 2018, as passed in the House:

> Sec. E.314.3 APPROPRIATION; HOUSING FIRST
> (a) Of the funds appropriated to the Department of Mental Health the sum of $400,000 in Global Commitment funds, or less depending on the extent to which services are eligible for federal matching funds, is for the purpose of funding ten additional Pathways for Housing-funded slots for patients being discharged from an inpatient psychiatric hospital unit.

c. <u>*XXX [and/or further committee designation after receiving DMH recommendations on Tuesday]*</u>

Budget line item: $900,000

Long Term Planning: Secure Residential Expansion

<u>The House Health Care Committee believes that the essential replacement of the Middlesex secure residential program should include the proposed expansion in capacity from 7 to 16 beds</u>, and that budget planning thus will need to take into account those future additional operating expenses. This facility should be planned with the flexibility for potential future reconfiguration in line with the Committee's recommendations for long-term inpatient capacity planning, below. The Committee will prepare further recommendations regarding the operational parameters of a secure residential program and potential means to expedite the project.

Long Term Planning: Additional Inpatient Capacity/ Forensic Unit Proposal

<u>The House Health Care Committee believes that there is a demonstrated need for additional psychiatric inpatient capacity in Vermont at this specific point in time</u>.

However, in reviewing the DMH proposal to address this need through creation of a psychiatric inpatient unit within a correctional facility for forensic patients (those entering inpatient care through the criminal justice system) the Committee believes there are key concerns that would require full evaluation before such a facility should be considered. These include: the significant policy shift involved in separating patients based exclusively on legal status rather than clinical presentation; the ability to provide high quality care and appropriate clinical staffing for a new, segregated forensic inpatient unit at a new location; the possibility that added community resources and expanded secure residential capacity will mitigate the need for additional inpatient capacity over the longer term; and the need to address future operating cost issues presented by loss of federal matching funds for the majority of the state's current Level 1 beds and a significant proportion of all inpatient psychiatric capacity in the state.

In the longer term, additional concerns which require addressing include the need to ensure that the state's hospital system, including community hospitals and the academic medical center, increasingly takes responsibility for access to inpatient care regardless of whether that care is for psychiatric or other inpatient care needs; and the importance of integrating inpatient psychiatric care within an inpatient medical center.

Based on these issues, and additional practical concerns re: the unwise expenditure of significant state dollars for a *temporary* facility, and the likelihood that the temporary facility would not be available until 2020, the Committee does not support the recommendation to begin immediate development of a temporary 12-bed forensic unit within a DOC facility.

The Committee, however, recognizes the need for an immediate start for response to the current inpatient capacity shortage, and recommends that DMH identify an alternative plan for temporary expanded capacity at an existing inpatient facility, with particular consideration of options that might be achieved more expeditiously and at less expense than the proposed temporary forensic unit. Any temporary unit should be concomitant with development of a plan for reconfiguration of existing psychiatric care facilities in light of the considerations articulated above, within a time frame to ensure opening of any needed new capacities prior to the termination of use of the temporary facility described above, which should not have a projected use exceeding 3 years.