Testimony to House Health Committee February 15, 2018

Good morning. I am Mary Moulton, Executive Director, Washington County Mental Health Services and President of the Vermont Council of Vermont Care Partners.

I've been invited to speak to you this morning, as I understand it, regarding the DMH budget. Why should we be concerned about a budget that is holding the line on mental health spending? I could cite many reasons, and share a few here:

- Mental health is health and there is an issue of parity that we have not achieved in service delivery, hospital access and worker salaries. You have heard testimony from Julie Tessler regarding the continued disparity in salaries between the state workforce and the contracted community workforce. There is reference specifically to this disparity below, but I'd like to concentrate on how a stabilized workforce can make a difference in service delivery.

  - While we can offer a crisis service in the immediate, we need to have sufficient therapists and case managers available in a timely fashion, requiring a fairly paid work force. The effect of care coordination, brought to bear by case managers and therapists, is making a difference in individuals needing higher levels of care. I'd like to refer to a few power point slides prepared by Anna Noonan, President and COO of CVMC, to demonstrate what we would like to see across the board for all of our clients. We would not have been able to accomplish this without our Community Services Program case management workforce stabilizing. Prior to the increase, which we implemented early in early 2017, we had experienced a 70% turnover rate in this program – in other words, all but 30% of case managers turned over.

  - The $14.00/hour helped to stabilize our residential programs. We dropped overtime significantly by bringing our pay rate up to $14.00. In our Developmental Services workforce, we were experiencing a high of 1000 hours of OT per pay period in residential/supported apartment programs in Oct-Dec 2016. We were able to drop that overtime to less than 500 hours per pay period starting in July 2017. This pay increase allowed us to make business practice adjustments that reduced our salary expense significantly and prevented service reductions last year.

  - While we can access a hospital bed eventually, for both children and adults, there can still be a wait. We need to identify the barriers to discharge and see if there are alternatives to building more beds. We are making progress in reducing emergency room utilization through care coordination and also according to most recent CVMC ER data. Designated agencies throughout the state are working on care coordination and tracking data. I have not seen recent data on emergency room wait times, however.

Additional points to support the second stage of a salary increase that will continue to bolster population health and our health care system

- DAs/SSAs have had increasing numbers overall of people coming in their doors for several years now. You will see this in the Act 79 Report, and is reflected in DS numbers, as well. Suicide rates continue to be high and promising prevention models are rolling out (unfortunately, with very little supporting funding)

- Substance abuse, particularly the opiate crisis, has exacerbated the need for services, including services for affected children and families who are experiencing trauma as a result

- DAs/SSAs have sophisticated processes: determination of eligibility criteria to receive these specialized services; follow up to people in crisis; intake processes; nursing oversight and assistance with medication through delivery; networking with other providers

- We have professional and well-trained support staff with standards of care for specialized populations and needs

- We have made incredible progress towards integration in areas where health care will have us across the DA system

- We're a really good "buy". Ex: If we were to move our WCMHS out-patient services division under the health care umbrella it would cost nearly $1,000,000 in salary increases. Buy – don't build!

- We are sewn to integration efforts. We are not siloing. Investment in our workforce brings results. We are welcoming payment reform. There are some of us that would welcome payment reform that allowed us a trend rate, such as that built into the ACO risk bearing bundles. There are some of us who are in risk bearing communities and are willing to negotiate on risk. So as we go forward to sort out what programs will be in payment reform bundles, we understand that we will be doing that without any increase in rates unless so deemed by the Legislature

- We are facing significant pressures to have sophisticated electronic systems to better analyze data through interoperability capacity. Data will lead us to the right answers for developing the system of care. We know this because we don't have a single center of truth currently for mental health systems, voluntary and involuntary. Our DA systems are also outdated and licensing for most of us is ending. We are working on a Unified Electronic Medical Record.

The one area we do understand has consistent unquestionable pressure is in the area of forensic referrals and the consideration of building additional beds seems prudent while carefully reviewing the forensic referral procedure, siting, and workforce issues.

- While recognizing that there is a focus on dollars for new positions for emergency services, we must recognize that emergency services is the response to crisis that could be averted through a solid foundation of prevention and support through: case managers, support staff, therapists, psychiatrists, nurses, residential specialists, children's interventionists, psychologists, early childcare specialists, care coordinators, vocational and housing specialists. Therefore, our organizations are requesting the increase described in Appendix 1.

Finally, we recognize that dollars are tight and that such things as DVHA transferring workloads to ACOs has not yet resulted in the anticipated workforce reduction on the state side. We recognize that hospitals who redirected funds to DAs now direct more funds to ACOs and likely will not be able to repeat that financial shift again. We also know, however, the many places our contribution generates savings in the system overall, and we hope that when some of these other systems settle and stabilize, we will be the beneficiary of investments. Until that time, we hope you will consider the investment in this 90% Medicaid funded system as worthy of consideration to champion.

Thank you so much for your time and consideration.

Workforce Investment Initiative – Appendix 1

THANK YOU!

A bit about us;

- **We have a dedicated workforce statewide, passionate and committed to making a difference and improving the quality of life of those we support.**
- **Quality Initiatives;**
  - **95%** of CSP and **100%** of DS folks get into follow-up appointments within 1-5 days of hospital discharge.
  - WCMHS was proud to receive the first *Center of Excellence* certification in the state.
- **Act 85 enabled designated & specialized services agencies to implement a $14 minimum wage The results are already evident.**
- FY17 statewide staff turnover rate decreased from **26.3%** to **23.8%** with the promise of new funding
- Turnover rates in FY'18 are continuing to show a trend of improvement
  - WCMHS, an early adopter, saw turnover decrease from **18.65%** to **16.60%** (FY16 to FY17)
  - Our vacancy rate went from close to 100 to just over 50 (**50% decrease**)
- 2,000 staff received pay raises and now earn a minimum of $28,000 per year

Act 82

Addressed how designated agencies fund emergency services to ensure emergency services achieve maximum efficiency and are available to all individuals within a specific designated agency's catchment area.

- **Funded increased wages for crisis staff with the $8.37 million/2% funding increase in FY'18.**
- **This has allowed us to begin stabilizing the workforce and filling job openings in this core area.**

After implementing Stage 1

- **We have seen market factors lead to difficulty recruiting staff at higher pay levels.**
- Analysis conducted in FY18 by Vermont Care Partners identified significant pay gaps between our staff and state employees with similar credentials and responsibilities:
- Bachelors level staff earned salaries **$21,344** below state employees for equivalent work and length of employment
- Masters level clinicians earned salaries **$12,830** below state employees for equivalent work and length of employment
- Licensed clinicians earned salaries **$18,768** below state employees for equivalent work and length of employment
- Each community has unique needs, cost of living variance and labor market fluctuations.
- Additionally, the cost of health benefit packages can vary significantly based on utilization patterns for agencies that are self-insured.

- **In FY18 Designated and Specialized Service Agencies experienced challenges in pay equity for staff receiving salaries just above the new minimum wage, because there were insufficient funds to address the compression of salary levels of staff**.
    - This led to some staff having the same or similar pay regardless of seniority, supervisory relationships, credentials, etc. which impacted morale.

Given these variables, flexibility in implementing future compensation increases will maximize the value of the investment to Vermonters served by the designated agency system.

We therefore request Stage 2 of the workforce investment initiative - $5.74 million in general funds to

- **conceptually achieve $15 minimum wage for DA/SSA staff**
- **with the flexibility for agencies to target compensation increases to the most critical positions to meet local needs, labor market dynamics, and fund health benefit costs.**