February 16, 2017

Good evening. My name is Mary Moulton and I am the Executive Director at WCMHS. I do not need to tell you about the plight of the designated agencies. I am truly honored to be the Executive Director of an excellent non-profit organization, with a great track record, incredibly dedicated staff --- talented, creative, professional. We balance our budget and we have not reduced services substantially, which means that we have balanced that budget on the back of our employees and this cannot continue.

First, this is a system that has a core set of services, but as needs grew we worked to bridge gaps and we worked beyond the core. Core services are the CRT population; the DS population; Children with SED; Emergency Services for the core. In moving beyond the core we have developed housing, vocational supports, substance use treatment, out patient services, emergency services to all, integrated health projects – counselors in offices, and much more.

Recently, as part of the solutions conversation, we have been asked, **"What is our value to the system of care?"**

- We respond to ERs, which are crowded, diverting 65% of the people who arrive on their door step back out to community services
- 2889 hospital bed days in 2006 to 1600 hospital bed days in 2016
- 89% of CRT clients seen for a community service within 1 week of hospital discharge, thus keeping readmission rates down; our hospital LOS statewide is also considerably lower than the national average.
- Group Homes – 145 people moved through our group homes since 2007 with the majority of people discharged moved into housing that required less supports and services
- Therapists/counselors in doctor's offices with no support through any funding source other than FFS
- A fully integrated DS population living in homes, independently or with staff supports – no institution
- Emergency Services Response to all people in the community, beyond the core; unfunded Disaster Response Teams
- CYFS – a full range of services from Early Childhood Therapeutic Day Care to school-based services, education through therapeutic schools for children who cannot function in their school system; case management support for families with mental health and substance use issues; skills groups; individual therapy and more
- Public safety and support provisions through wraparound services for sex offenders with developmental disabilities

This is a small microcosm of what we offer yet our system is stressed with 90 openings, which leads to quality and access issues for our community members and our referring health care providers. We need to ask what we value as a system and what we are willing to pay as designated agency Board and senior management teams get ready to make very difficult decisions about what we can and cannot do in order to pay our staff to stay with WCMHS and not go to higher paying jobs in health care, schools, and state departments.

What is the Solution?

Some ideas for solutions in funding so that we can shore up needed services to increase patient flow, enhance pre-crisis response to prevent hospitalization; and maintain vital supports for those most vulnerable are:

- System is fully funded and rates are increased – thus enabling us to meet the need and develop with entire health care system the plan for addressing problems and filling gaps; OR
- Rates are increased and services decreased in order to pay staff competitively. Less services would be provided.
- A 3-year plan developed to pay staff of DAs in parity with state employees --- gap to bridge the divide on graded positions shall be determined and closed within 3 years.
- State of Vermont shall offer its health insurance plan to all Designated Agencies for its sub-contracted employees
- Another potential funding stream: Green Mountain Care Board is given authority to instruct a certain percentage of hospital budgets to be diverted to the mental health system based on mutually identified needs, with at least a focus on placement of mental health/substance abuse clinicians in ERs
- Consistent application of Blueprint payments to counselor supports in primary care practices
- DMH Acute Care Team duties or positions shifting to Regional Referral Resource Centers for Mental Health and Substance Abuse (shifting of approximately $250,000-$300,000 in positions being redeployed to communities. Referral Resource Centers very drafty model attached, but is a product which we should market to the ACOs
- Revision of paperwork requirements (50% of FTE time utilization in certain programs) to free up time for the direct service work needs
- AHS Funding sources for IT equipment and EHR similar to that committed to Health organizations (investment is in the millions and continuing to change; DAs are seeking a single platform to create efficiencies)
- Consideration of piloting global budgets with the goal of breaking down the silos that exist within the bundles so that true integration among services can happen, increasing rates to pay staff at market rate, with tracking of opportunities for economizing

These are just a few suggestions and I welcome the opportunity to continue the conversation.