Act 82, Sections 3, 4 & 5 Legislative Report

DEPARTMENT OF MENTAL HEALTH JANUARY 19TH, 2018

Table of Contents

1. Summary of Report Expectations
2. Process
3. Long-term Vision
4. Data
5. Emergency Department Referrals + Inpatient
6. Gaps in Service
7. Demographic Trends
8. Care Coordination
9. Crisis Diversion Evaluation and Diversion Models
10. Mental Health Access Parity
11. Emergency Services
12. Involuntary Treatment and Medication Review
13. Next Steps

Process

Perspectives gathered from across the system of care

Two day-long working meetings

- July 25th
- August 17th

Many other meetings of subcommittees (data group, 23 hour group, living room model group, etc.)

Meetings with individual stakeholders and organizations.

Long-term Vision

DMH is striving to build a holistic system of **prevention, treatment, recovery, and support services** to promote resilience for all Vermonters affected by mental illness, to prevent mental illness and build mental health. For this system to be effective, DMH is focused on the following vital strategies:

1. Integration across service sectors, including medical, substance abuse, justice and other human services.
2. A “whole health in all policies” framework that recognizes social determinants of health.
3. Strong leadership, active partnerships.
4. A strengths-based approach to empower individuals, families, and communities
5. Use of evidence based and promising practices.
6. Results Based Accountability
7. Innovation and flexibility in funding and program development

Data

Data collection and its use are limited by resources of staff and technology available.

Most data collection efforts include matching data to other sources to develop measures.

Due to a lack of technological resources, most data efforts are captured using spreadsheets. Other data collection efforts are captured using data warehouses, such as for the Monthly Service Report (MSR).

There are several hindrances to effective analysis at DMH:

- data quality
- data scope
- analytical resources

Data Recommendations

Obtain additional data:

- All psychiatric inpatient hospitalizations, regardless of legal status or insurer.
- All residential placements in mental health programs. (DMH currently receives service hits in MSR, but not enough information to evaluate system health.)

Information Technology:

- Procure IT resources to develop more robust systems to capture data.
  - As part of the Agency of Human Services, DMH is working with the Agency of Digital Services (ADS) to ensure that IT resources are strategically deployed.
- Examine other IT-related solutions to ease the strain on analytical resources.
  - DMH is working with ADS to pilot business analytics software to create dashboards designed to visually display frequently asked basic data questions.

Emergency Department Referrals & Inpatient Care

Decentralized System of Inpatient Care

Psychiatric Bed Capacity

The “No Refusal System”

Inpatient Hospitalization for Children

Children and Families in Crisis

ED Wait times: Stakeholder Surveys

Quality Metrics on ED Wait Times

Decentralized System of Inpatient Care

- People in need of hospitalization are provided treatment at either the state-run inpatient facility or one of five other Designated Hospitals throughout the state.
- Designated Hospitals provide treatment to both voluntary and involuntary patients.

Definitions:

- Level 1 Involuntary– involuntary hospitalization stays paid at-cost to contracted and state providers for people who are the most acutely distressed who require additional resources
- Non-Level 1 Involuntary – involuntary hospitalization stays for individuals who do not require additional resources
- Voluntary – voluntary hospitalization stays

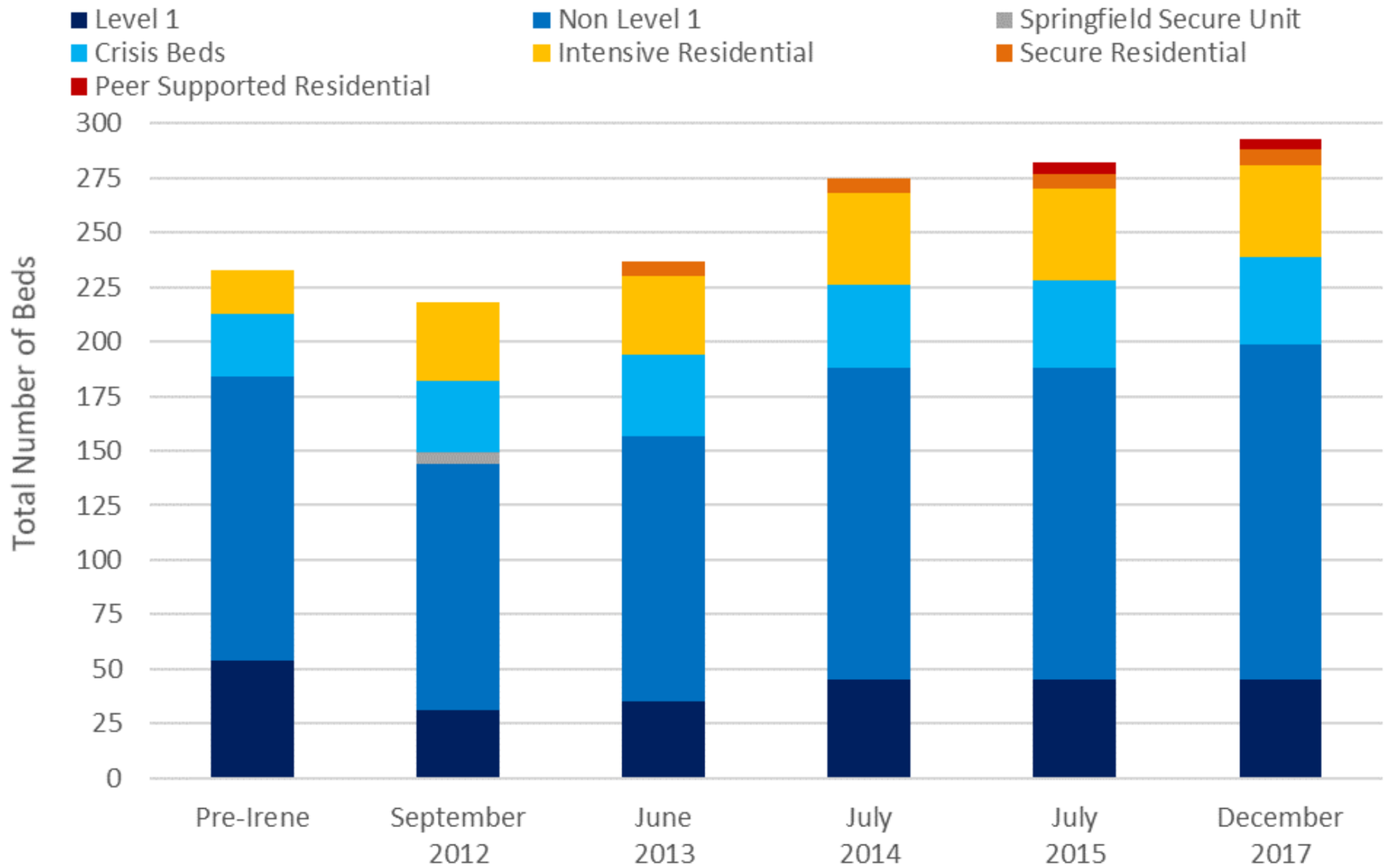
Decentralized System of Inpatient Care

Inpatient Hospitalization: Adults at Risk of Harm to Self or Others			
Hospitals	Level I Beds	Non-Level 1 Voluntary AND Involuntary Beds	Total
• Vermont Psychiatric Care Hospital	25	25*	25
• Brattleboro Retreat	14	75	89
• University of Vermont Medical Center		28	28
• Rutland Regional Medical Center	6	17	23
• Central Vermont Medical Center		14	14
• Windham Center at Springfield Hospital		10	10
• White River Junction VA Medical Center		10**	10
TOTAL	45		199

** VPCH Beds are primarily used for Level 1 stays but may also be used for non-level 1 involuntary patients if there is no other willing or available placement.*

***The VA Medical Center has 10 beds total for Veteran's psychiatric inpatient care. A subset of these beds (2-3) are allocated for involuntary care at the discretion of the Medical Center.*

Adult Psychiatric Beds



The No Refusal System

The Commissioner does not have the authority to compel a hospital, including VPCH, to admit a patient. This is because federal law prohibits non-medical professionals from making determinations around hospital admissions and discharges.

All hospitals and facilities in the “no-refusal system” have at times refused admissions due to their assessment that they cannot serve the person safely or maintain the safety of other patients.

Intrastate Transfers

- Vermont established the decentralized system of inpatient psychiatric beds with the understanding and belief that individuals who need inpatient care should receive treatment in or near their home community.
- Over the last year RRMC and VPCH have had success in using intrastate transfers from high acuity beds to general units either in a person's home community if appropriate or to the general unit of the current hospital.
- This creates flow within the system. It allows patients to step down to a general unit from the highest acuity unit and then discharge when appropriate.
- This approach seeks to align inpatient mental health treatment with inpatient medical treatment.

Inpatient Hospitalization for Children

DMH recommends a change to state statute to allow parents and guardians to consent to inpatient treatment for children under age of 12. Under current law, young children are required to provide consent to voluntary inpatient psychiatric treatment.

Changing this statute would achieve the following:

- **Create more parity between standards for general health care and mental health care**
- Avoid unnecessary use of Emergency Exams, staff time, and resources for involuntary hospital admission for children who do not consent to hospitalization.

Children and Families in Crisis

Based on the increases in the number of children both 0-3 and 6-11 coming into DCF custody, there are more children in crisis in Vermont.

Addressing the challenge:

- Funding- the legislature has infused additional resources into the child protection system and into the Designated Agency System.
- AHS programming- DMH and the Family Services Division of the Department for Children and Families have worked together to implement three new initiatives:
  - Parent-child interaction therapy
  - Child-Parent Psychotherapy (CPP)
  - Building Flourishing Communities

ED WAIT TIMES: SURVEYS

DMH worked with partners outside of state government, NAMI and VAHHS, to gather information regarding the perceived causes of increased Emergency Department wait times.

Information collected from NAMI and VAHHS agreed on the shortage of resources, but recommended different solutions.

QUALITY METRICS ON ED WAIT TIMES

Vermont Psychiatric Survivors (VPS) did a literature review of national Emergency Department Wait Times:

http://mentalhealth.vermont.gov/sites/dmh/files/documents/news/Literature_Review_of_ED_Waits_Presented_Aug_17_2017.pdf

Key Findings:

- Wait times for all levels of response are longer for people seeking psychiatric care.
- Prolonged ED waits driven also by characteristics of patients, rather than solely lack of in-patient beds

Gaps in Service

Resource Availability and Regional Accessibility

Utilization Trends – Use of Crisis Bed Resources

Supportive Housing

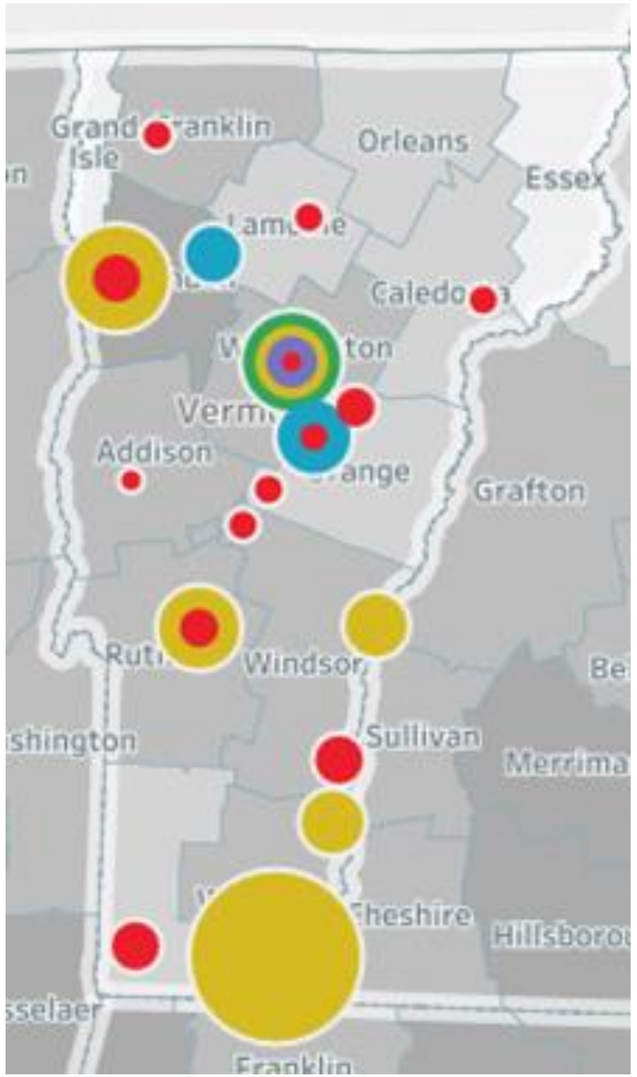
Peer Supports

Mental Health Treatment Court

Staffing Resources

Mental Health Profession Data

Resource Availability and Regional Accessibility



DMH maintains an electronic map of mental health beds available in the system of care, including type, location and number.

https://public.tableau.com/profile/emma.harrigan2032#!/vizhome/DMHMentalHealthSystemofCare-BedsbyTypeandLocation/Dashboard

Utilization Trends – Use of Crisis Beds

Current capacity of 40 statewide crisis beds

Programs ranging in size from 1 bed to 6 beds

Decline in overall utilization for each of the past four fiscal years*:

- Average statewide utilization in FY 14 of 80-82% occupancy
- Average statewide utilization in FY 17 of 70 -74% occupancy

There are a number of issues that may be contributing to this lower utilization over time.

**First quarter FY 18 shows a higher utilization, but quarterly trends have fluctuated in the same manner in previous fiscal years.*

Supportive Housing

Supportive housing combines and links permanent affordable housing with flexible and voluntary support services.

Support Services are designed to help the individual stay housed and build the necessary skills to live as independently as possible.

Different types of supported housing offer different levels of support

Supportive Housing is currently challenged by several factors:

- High acuity individuals who utilize substantially more service and supports
- Many high cost and homeless users of DA resources may not be eligible for CRT program services in the absence of a severe and persistent illness diagnosis

Current efforts include three Designated Agencies: Clara Martin Center, and Lamoille County Mental Health and Washington County Mental health. They all have projects aimed at increasing the number of housing units.

These units are part of the DMH coordinated response to reduce cost and increase opportunity for persons prone to emergent care when homeless, and for those caught in a sub-acute care status unable to exit a needed bed, due to lack of affordable housing in the community.

Peer Supports

Peer support includes: self-help and mutual support groups, peer crisis respite, warm lines, inpatient peer services, wellness planning and skill development, peer-driven housing supports, peer drop-in and community centers. Peer support has been shown to be effective in supporting recovery.

It is the goal of the Department of Mental Health to make a variety of peer supports available to anyone in the state struggling with mental health and other co-occurring issues.

DMH focus: improving and refining Vermont's expanded array of peer services-community outreach, support groups, local peer-run initiatives, education, advocacy, transition support between hospital and community treatment settings, hospital diversion and step-down, crisis respite, and pre-crisis telephone-based support, referral and emotional support.

Mental Health Treatment Court

Research indicates that mental health court defendants have lower rates of recidivism, improved mental health treatment engagement and fewer days of incarceration. **Vermont's outcomes mirror these findings.**

Stakeholders recommend, and DMH supports, an expansion of mental health courts that are part of a coordinated effort to reduce the number of individuals with mental health challenges needlessly entering the criminal justice system. Planning and implementing an additional MHC program requires the commitment and involvement of:

- A local court judge, judicial staff and non-judicial court staff, including technology and security staff
- Input from key community stakeholders, such as the State's Attorney's office, the Defender General's Office, law enforcement, local service providers
- The Department of Corrections, the Department of Mental Health
- Local municipal partners
- Approval of the Vermont Supreme Court

An alternative to mental health courts in a rural state like Vermont may be increased community mental health services that focus on employment and education, strengthen the relationship between local law enforcement and mental health programs, and the design of a diversion model that utilizes regular statutory hearings in conjunction with existing specialty dockets.

Staffing Resources

Two reports were produced in 2016 that discuss the DA and SSA workforce, compensation and impacts on the system of care:

- Vermont Care Partners white paper brief: https://vermontcarepartners.org/pdf/files/139_VCP%20workforce%20white%20paper020516s%20(2).pdf
- Act 113, Section 11 Report: http://legislature.vermont.gov/assets/Legislative-Reports/Act-113-Sec-11-Medicaid-Pathway-Report-12-30-16.pdf

Information provided by Vermont Care Partners for the Act 113, Section 11 report estimated that "raising the DA and SSA direct care workers compensation up to the level of state employee compensation would require an investment of over $43 million to the $385 million system of care."

Additionally, Vermont Care Partners describes in its white paper that adding to the recruitment problem is the lack of availability of prospective employees. The lack of candidates for DA job openings forces Agencies to compete to hire people who are already working elsewhere at higher compensation levels.

These issues are complex. The total available workforce is not sufficient. A basic increase in wages to staff of DAs and SSAs, while desirable, may not equate to increased access to care for Vermonters across the entire system of care if the size of the total available workforce does not increase

Mental Health Profession Data

There are two recent studies regarding health care workforce.

2016 Vermont Health Care Innovation Project Health Care Workforce Work Group commissioned the information services firm IHS Markit to develop projections of current and future demand for health workers and to help monitor changes in demand over time:
http://healthcareinnovation.vermont.gov/sites/vhcip/files/documents/Vermont%20Health%20Care%20Demand%20Modeling%20Final%20Report%206-16-17%20FINAL.pdf

VDH Surveys: Mental Health Counselors (2017), Clinical Social Workers (2016), Master's- and Doctoral-Level Psychologists (2016), Psychiatrists (2014), Advance Practice Registered Nurses (2015). Detailed reports on each profession can be found at http://www.healthvermont.gov/health-statistics-vital-records/health-care-systems-reporting/health-care-workforce.

Mental Health Profession Data

	Mental Health Counselors 2017	Clinical Social Workers (2016)	Psychologists (2016)	Psychiatrists (2014)	Advance Practice Registered Nurses (2015)
Total Licenses	725	1020	591		
Total Inactive	101	220	104	179	64
Total Active	618	794	486		
Total Active FTE	423.4	635.5	355.9	116.6	41.5
% Response Rate	99.2%	99.40%	99.8%		

There are some noticeable trends that emerge when examining the availability of Psychologists, Mental Health Counselors, Clinical Social Workers, and Psychiatrists across Vermont.

- The geographical areas served by Northeast Kingdom Human Services (NKHS) and Northwestern Counseling and Support Services (NCSS) have the lowest rates of FTEs per capita for Clinical Social Workers, Psychiatrists, and Master's- or Doctoral-Level Psychologists. The NKHS geographical does have more advance practice registered nurses that other parts of the state, but not enough to make up for the absence of psychiatrists.
- The geographical areas served by Howard Center (HC), Health Care and Rehabilitation Services of Vermont (HCRS), and Washington County Mental Health Services (WCMH) have the highest rates of FTEs per capita for mental health counselors, clinical social workers, psychologists, and psychiatrists.
- The geographical area served by Rutland Mental Health Services (RMHS) has the highest rate of FTEs per capita for psychiatric advance practice registered nurses.

Demographic Trends

- Overall VT population is static but slowly decreasing
- Less youth under age 18, more adults over age 65
- % of all VT adults with any mental illness is 21%, which is higher than national avg of 18.7%. (2016)
- % of all VT youth with serious emotional disturbance is 6%, which is consistent with national avg. (2015)
- % of all VT adults getting treatment is 58%, which is also higher than national avg. (2015)

Between 1990 and 2014, the median age of Vermonters has risen to 42.4 years in sharp contrast to the median age in the U.S. of 37.5 years.

Adults served through the Department of Mental Health are also Aging:

- Community Rehabilitation and Treatment : 69% of active clients 35-64 years old
- Vermont Psychiatric Care Hospital (VPCH): 68% of all patient days are for clients 35-64 years old
- Age and longest lengths of stay for VPCH patients correlates with those 50 years and over with mean stays of 7-9 months.

Demographic Trends

DMH/Department of Disabilities, Aging and Independent Living (DAIL) Collaboration:

- Augmentation of in-home services and supports and facility-based rehabilitation services for individuals unable to manage in their own homes or requiring transition planning supports while longer-term living situations are developed.
- Working with existing long-term care providers, determining the mental health support services needed to support facility providers, and determining a financing model to sustain appropriate and quality services
- Resource intensive

Aging and long-term psychotropic medication use

- People who experience significant mental illness experience greater morbidity and live 10-25 years shorter than the general population.
- This is attributed to a number of variables:
  - social consequences of the illness
  - lifestyle factors
  - side effects of antipsychotic medication use

Suicide Deaths
Vermont has a disproportionate rate of suicide, placing it as the 8th leading cause of death in Vermont at 14.3 per 100,000 and an average age of 46 Veterans are overly represented in the suicide death rate for the 18 – 34-year age range at 57.7 per 100,000
Efforts such as the “zero suicide” initiative, the Crisis Text Line, and the GunShop Project in Vermont require ongoing support to bend the curve on this public health crisis.

Co-occurring substance abuse and opioid use compound mental health treatment needs and there is increased demand for inpatient psychiatric beds, residential substance abuse treatment beds, and varying levels of outpatient treatment expertise.

Care Coordination

Regional resource and referral "hub"" for mental health and substance abuse treatment
Central Vermont is examining a model for a regional resource and referral "hub"" in order to help alleviate consequences of inadequate mental health follow up care.
Currently examining resources needed and subsequent costs to expand the current navigation system to include evaluation of psychiatric needs, schedulers for private counselors, and provision of urgent brief treatment, as needed.
http://mentalhealth.vermont.gov/sites/dmh/files/documents/news/Collaborative_and_Hub.pdf
http://mentalhealth.vermont.gov/sites/dmh/files/documents/news/VCP_Presentation_on_Regional_Navigation_Regional_Care_Coordination.pdf

DMH Care Coordination Accountability
DMH Adult Care Management team: 4 care managers
Purpose: supporting the movement of consumers through levels of care
How: Direct support to hospitals, Designated Agencies and other community partners for individuals who are accessing all levels of care. Care managers help facilitate timely admissions and discharges to and from hospitals. Care managers do not have the ability to admit or discharge any individual. This final decision lies solely with the medical director of the unit or hospital.

Scope: Statewide. 2100 involuntary admissions and 2000 discharges over the past four years
Effectiveness- data is inconclusive
Historically, there has not been the ability to track and document when a hospital declines a referral for admission.
DMH is working with hospitals under DMH contract (Level One facilities) to provide written documentation outlining the "refusal" in order to have a better understanding of the specific challenges.

Crisis Diversion Evaluation and Diversion Models

DMH worked with stakeholders to explore different options related to crisis bed or crisis response. Stakeholders recommended that more options to access support and treatment be made available for people in psychiatric distress, outside of the hospital setting, including:

- Psychiatric Urgent Care Walk In clinics
- Psychiatric Emergency rooms
- Dedicated "Emergency Evaluations Beds" within existing psychiatric inpatient units

The group also explored the following:

- A "*23 hr bed*" that would provide an alternate site from a hospital for involuntary assessments.
- A "*Living Room*" model which is a peer support program providing an alternative structured staffed setting with immediate access, time limited stay and a "hub" for connecting people with services. This would not be a step down from inpatient hospitalization as it is viewed that existing crisis programs fill that role. It could provide a place for persons to go after emergency treatment and stabilization in a hospital emergency department.

The group determined that data currently unavailable is required to identify the specific problem of why people are waiting in Eds, who they are, and to develop relevant solutions. The following data was recommended for analysis before implementation of new programs:

- Number of voluntary boarders. Current data gathered by DMH is for involuntary only.
- Number of unique persons related to total bed days. For example: do 3 people account for 15 bed days at 5 days per person, or do 15 people account for 1 bed day apiece?
- Reason people are not being admitted into a hospital bed
- Number of High Users of Services: number of people who board in ED multiple episodes (not the same as multiple days)

Crisis Diversion Evaluation and Diversion Models

My Pad
Howard Center has implemented an effective stabilization and recovery team (START) that compliments existing emergency services with a modified Assertive Community Treatment team model. This approach extends service hours and uses peer support providers to better meet the needs of individuals who require more intensive service support to remain stable and independent in the community.

- DMH is working with Howard Center to replicate and pilot an additional “MyPad version 2.0”.
- This approach requires benchmarking success and improved outcomes for persons served in order to better demonstrate overall cost effectiveness.

Alternatives to Emergency Department for Children - Crisis Diversion Beds
Regions in the Southern part of the state have high rates of child psychiatric hospitalization per capita (.0093 as opposed to .0030 for the rest of the state).
Northeastern Family Institute has created a new program in the southern region that will use their current successful model to:

- Allow children and youth to have access to a hospital diversion program versus having to be hospitalized in a psychiatric facility, and
- Provide a step down from hospitalization when needed

Mental Health Access Parity

Vermont has defined expectations for mental health service parity.

There is little to no agreement across a diverse constituency of stakeholders in how or what achieves true parity.

Discussions with health care providers regarding when and how individuals experience barriers have made little progress and this component of the report remains under-developed.

The majority of individuals presenting with primary physical health care needs are served emergently, desire or need services, and have capacity to provide the necessary consents.
Conversely, mental health patients do not always want what is recommended or actively resist what is recommended.

While controversial and a point of contention within hospitals with both emergency departments and inpatient psychiatric units, it may be reasonable to consider that parity must include some level of access and no refusal of inpatient psychiatric admission at these hospitals.

Emergency Services

Emergency services includes screening, assessment, support, referral, and crisis beds.

Funding: Emergency services are funded as a separate service and as part of CRT. Funding for emergency services includes Global Commitment Investment capacity payments (70%) and fee-for-service payments (30%) (varies slightly depending on DA) and DAs can bill DMH or DVHA for this state plan service depending on the individual being served.

Challenge: the majority of current DMH funding for this service is provided through a capacity payment and the state has little flexibility to increase funds in that category. The DAs also report challenges with third party billing.

Solutions:

- DMH is currently developing payment reforms with the DAs and is brainstorming how emergency services may be addressed.
- DMH is also working with some specific regions to increase these resources. The models will vary depending on regional need but will be either Street Outreach Workers, additional crisis staff in communities or additional crisis staff/screeners at the emergency departments.
  - We are just beginning the work and at this point have shared funding commitment from Chittenden Co. leadership.

Involuntary Treatment and Medication Review : Treatment modalities available to address the needs of patients in psychiatric crises

There are several non-medication alternatives that have been shown to address the needs of individuals in psychiatric crisis:

- Crisis Services
- Soteria
- Six Core Strategies for the Reduction of Seclusion and Restraint
- Sensory Modulation
- Collaborative Networks Approach

Causes of prolonged stays in hospital EDs and inpatient psychiatric units

Recommendations:

1. Piloting a city or county with buy-in of one assigned Judge and the local Designated Mental Health Agency in the tenets of the AOT Model.
2. Exclusion of individuals under ONH by Criminal Court.
3. Involvement of Court in the ONH process and monitoring of progress.
4. Dedicated inpatient beds if individuals require hospitalization.
5. Recognition that status as “a patient in need of further treatment” is retained throughout the period of ONH.
6. Data collection and evaluation of outcomes of changes.

Rights of staff, patients' rights, and the use of involuntary treatment and medication

Given the complexities of this question, DMH felt the best way to answer this would be to seek input directly from direct care staff members.

DMH solicited input from the VSEA's VPCH chapter, the Vermont Association of Hospitals and Healthcare Systems (VAHHS), the Vermont Medical Society, and Vermont Care Partners.

All input that was received is included, verbatim, in the report.

By far, the biggest concern was for the welfare of their patients.

Next Steps

- Data identification and analytics
- Data Collection
- ED Options
- Regional Navigation
- Mobil Crisis, Supportive housing and other Community Based Services:
- Involuntary Treatment

Next Steps

Next steps identified for the intensive level system of care described below. This is not an exhaustive list nor in priority order:

- Further examination of licensing and rules regarding emergency involuntary procedures (EIP).
- Further exploration of intensive residential programs treating and maintaining individuals with aggressive behavior.
- Fully utilize crisis beds and continue to explore alternatives that people may be more willing to access.
- Continue to expand mobile crisis outreach (including street outreach workers) to appropriately address crisis in community so individuals can be diverted, when appropriate, from the ED.
- Address the strong conflicting opinions of involuntary treatment. Is there a middle ground to be found?
- Provide supportive housing that can adequately support people coming out of inpatient or prevent some individuals needing inpatient or crisis services.
- Add more resources to assure training in evidence based practices. DMH works with VT Cooperative for Practice Improvement and Innovation to expand access to training in evidence based practices and grants to support training.
- Sustain and expand peer services.
- Expand mental health treatment court capacity.