Department of Mental Health
FY 21 Budget Submission
Narrative Talking Points

Salary and Fringe Increases

Gross: $672,100 GF: $225,985

Annualization of the FY20 salary and related fringe changes (salary, FICA, life, retirement, health, dental, EAP, LTD).

Retirement Cost Increases

Gross: $121,666 GF: $56,024

Annualization of the FY20 retirement plan increases

Forensic Evaluation Cost Increases (BAA Item)

Gross: $55,000 GF: $25,086

The cost of psychiatric forensic evaluations has increased significantly since FY 18. DMH is statutorily required to provide Forensic evaluations as ordered by the court and the volume of these requests has increased over the past year by 24%.

Increase in Medicare Revenue (BAA Item)

Gross: ($0) GF: ($228,050)

VPCH has several funding sources. One of those sources is Medicare and other insurance billings. These funds are accounted for in a special fund that is not specifically Medicaid, Federal or General Fund. In FY 19, DMH was able to recognize a significantly higher amount than originally projected.

DMH Contract Savings

Gross: ($122,740) GF: ($59,685)

The Department of Mental Health has several contracts that provide critical services to ensure the day to day operations of Central office, the Vermont Psychiatric Care Hospital and the Middlesex Therapeutic Community Residence as well as support the system of care. To obtain savings, DMH has identified contracts that may be reduced or eliminated. For contracts related to direct services DMH has identified alternative funding sources.

One of the contracts scheduled for elimination is our children's psychiatric consultation to primary care in the northeast kingdom area. DMH will continue to fund these services through our Mental Health Block Grant (MHBG).

In addition, DMH is proposing to significantly reduce the use of two other contracts to evaluate performance of institutions and staff in implementing Act 114. DMH and an independent contractor report annually on the implementation of Act 114. This reduction should not significantly impact the

information available through this dual reporting requirement; but will target efficiently the work of the contractor on this report. In addition, DMH has a contract for project management. We will reduce or eliminate this contract in order to manage within the confines of our budget.

Eliminate Position 840056

Gross: ($71,542) GF: ($36,900)

This position was responsible for receiving, tracking pre-authorizing and coding all the adult special service funding requests that came in from the Designated Agencies CRT program. In addition, this position worked with the Care Management Director and the Business Office to process invoices for transport/supervision of persons on involuntary status with the Designated Hospitals, as well as ensuring that the information is entered into the database for Research and Statistics. The duties of this position have been distributed to other administrative staff in the department.

Workers Comp Increases

Gross: $319,062 GF: $147,019

Increased cost for Workers Compensation.

Internal Service Fund Increases

Gross: $225,335 GF: $106,489

Increased cost for Insurance, VISION, Human Resources, ADS, Fee for Space and Desktop Cloud.

ADS Service Level Agreement

Gross: $38,379 GF: $18,831

Increased cost for ADS Service Agreement

Children's Residential (BAA Item)

Gross: $477,808 GF: $228,914

DMH has an ongoing pressure in PNMI (private non-medical institutions – residential treatment for children). This pressure is due to many factors, but primarily DMH has seen an increase in the acuity of clinical need for children and youth. The increased challenges within family environments (including adverse family experiences such as opioid use, parental mental health challenges, and difficulty managing a child/youth's challenging behaviors) coupled with decreased access to community-based services due to staffing challenges, and decreased risk tolerance in communities due to threats of violence or self-harm has increased the demand for residential services. When the community-based array of clinical and support services has not been able to adequately address the clinical needs, children may wait in EDs, crisis beds or inpatient units while being referred for residential treatment. Additionally, Vermont has seen a decrease in its number of available in-state residential beds and have had to send more children out-of-state (OOS) for residential treatment. However, DMH continues to prioritize the use of effective in-state programs and, as beds have decreased, the daily rates for many instate programs has increased due to the opposite impact of economy of scale.

Our children's clinical care management team uses clear procedures and guidelines with clinical criteria to determine medical necessity for residential treatment and provides technical assistance with expecting schools, communities, families and Designated Agencies (DAs) to work together to explore options to meet the needs of the child in the community. When children or youth are determined to meet the medical necessity criteria for residential treatment, the DMH is required to provide that level of care under the federal Early and Periodic Screening, Diagnostic and Treatment (EPSDT) mandate. Determinations adverse to the request of the family are sometimes met with appeals. In order to fulfill the EPSDT mandate to provide medically necessary services to address or ameliorate a child/youth's identified mental health needs, we fund the necessary residential treatment for children in programs in-state and out-of-state. As of 10/24/19, DMH had funded 64 children and youth in residential treatment since the beginning of the fiscal year. This number will increase in the remaining 3 quarters as youth are transitioned in and out of residential treatment.

Lastly, while our request is in response to the increased need for residential assessment and treatment, PNMI also funds the short-term children's crisis stabilization beds at Howard Center; however, these are accessed by local crisis teams following specific protocol. DMH does not approve the initial placement; crisis teams are authorized to approve admission for these settings. This represents around $1M of the DMH PNMI spending. As this program has been used less for DCF-funded children, DMH has been increasingly responsible for the costs. Each of the last three fiscal years, Howard Center has also requested extraordinary financial relief which DMH is unable to budget for in advance. This is also an issue with other residential PNMI providers. In the past 2 years, multiple residential providers have also asked for EFR and others have recently indicated they will be submitting requests

Room & Board Phase Down

Gross: $0 GF: $612,717

CMS is requiring the State of Vermont to phase down our payments toward room and board beginning on January 1, 2019 by 1/3 of the total each calendar year through 2021. This amount represents 1/3 for six months and 2/3 for the remaining six months of the fiscal year.

UVMMC Fellowship Grant Savings (BAA Item)

Gross: ($45,000) GF: ($20,525)

DMH grants funding to support an innovative training program in child psychiatry administered by the Vermont Center for Children, Youth and Families of the University of Vermont's College of Medicine and The University of Vermont Medical Center. DMH has been working with Dr. Hudziak around how UVMMC can assist in supporting this effort, and that work has resulted in the University agreeing to increase its ongoing funding of the program by $45,000.

Inpatient – Level 1 Cost Increases (BAA Item)

Gross: $1,175,302 GF: $536,055

RRMC: $799,206
BR: $376,096

Act 79 requires "reasonable actual" reimbursement of costs for the Level I hospitals. There have been inflationary factors such as contracted Doctors and Nurses which have significantly impacted the daily cost of the Level 1 units at both Brattleboro Retreat and Rutland Regional Medical Center. This does reflect the revised Level 1 rates based on previous cost settlements.

Inpatient – CRT Rate Cost Increases (BAA Item)

Gross: $1,032,450 GF: $470,900

DMH is responsible to ensure the payment and inpatient care for those individuals who are identified and eligible for Community Rehabilitation Treatment (CRT) services. This funding reflects a rate increase to align with other adult inpatient rates paid though DVHA. The DVHA rates were increased in FY19, however the CRT Inpatient Rates were not increased.

Annualization of New Level 1 Beds at Brattleboro Retreat

Gross: $3,942,032 GF: $1,797,961

In FY 20, Legislature appropriated $1,084,281for 12 new Level 1 beds at Brattleboro Retreat to open in the fourth quarter of FY 20. The amount is being updated to account for the annualization of the beds as well as the actual expenditures as cost settled in their calendar year ending December 31, 2018. Renovations are in process and additional bed capacity is expected to be on-line in late spring - early summer 2020.

The 12 new Level 1 beds will provide essential inpatient capacity to serve the most clinically acute individuals seeking mental health care and treatment. This additional inpatient capacity will contribute to substantially decreasing Emergency Department wait times and ensure timely access to quality mental health care and treatment thus improving outcomes.

CHIP FMAP Change

Gross: $0 GF: $74,380

This is due to the change in the Federal participation rate for the children's CHIP program.

AHS/AOA changes:

Suicide Prevention

Gross: $575,000 GF: $575,000

Vermont continues to grapple with the impact of suicide in our state. Vermont's suicide death rates are higher than US rates and increasing by faster that US rates in recent years. Suicide is the 2nd leading cause of death in Vermont for ages 15-34. The VT Youth Risk Behavior Survey indicates a growing sense of hopelessness and despair for young people -1 in 4 feeling sad or hopeless. The results are even more alarming for LGBTQ youth (58% feeling sad or hopeless) and the growing rate of suicide deaths for adults in Vermont suggest that this sense of increasing hopelessness translates to them as well. The rate of suicide for Vermonters aged 70 to 74 is 26 per 100,000 people, compared to the national rate for that age group of 15 per 100,000 people. We also understand how the loss of life has incredible ripple effects throughout families and communities increasing the risk for all of those touched by the loss. Vermont needs a strategic and comprehensive approach to suicide prevention in Vermont.

1. **Strategy 1: Expand ZERO SUICIDE statewide in Vermont -** ***Funding: $400,000***

Zero Suicide is a system-wide approach to improve outcomes and close gaps in suicide prevention. This includes **workforce training** to ensure that mental health and health care providers feel confident in their ability to provide care and effective assistance to patients with suicide risk and the also the **utilization of evidence based practices** including; screening and suicide risk assessment, suicide-focused care, intervention and collaborative safety planning, treating suicide risk, and care coordination and follow-up. Expanding ZERO SUICIDE statewide is a strategy that supports Suicide Prevention for Veterans. The VA's Gatekeeper Program (SAVE) is part of the ZERO SUICIDE Framework and Training. Vermont has piloted Zero Suicide in limited regions of the state and requires additional resources to scale up statewide. DMH will administer funding to the Vermont Suicide Prevention Center, a program of the Center for Health and Learning (CHL) to scale up ZERO SUICIDE statewide. This funding will also establish a 1FTE position shared by DMH and VDH to coordinate statewide suicide prevention efforts and to work in coordination with the VA.

There is significant data to support the expansion of Zero Suicide statewide:

- Zero Suicide has made a significant impact in other states that have engaged in statewide implementation, such as Missouri and Tennessee where suicide rates decreased between 35-65% post implementation.
- Avera Health System, a large network serving four states in the mid-west experienced outcomes such as a 32% reduction in Emergency Department admissions for suicide care, and a 45% decrease in re-hospitalization (emergency department or inpatient setting) among patients with suicidal ideation. These outcomes are attributed to patients receiving timely and effective community-based interventions developed through their Zero Suicide initiative, and timely follow up post inpatient care for suicidality.
- Vermont clinicians from the Zero Suicide pilot regions trained in CAMS have significantly stronger clinical skills for treating suicidality
- Vermont clinicians from the Zero Suicide pilot regions trained in CAMS are better able to identify suicidality with their clients
- Vermont clinicians from the Zero Suicide pilot regions trained in CAMS are better able to assess their client's suicide risk

2. Strategy 2: Expand Vermont's National Suicide Prevention Lifeline – *Funding: $125,000*

The National Suicide Prevention Life is a national network of local crisis centers that provides free and confidential emotional support to people in suicidal crisis or emotional distress 24 hours a day, 7 days a week. The National Suicide Prevention Lifeline includes specific referral and supports for Veterans. The National Suicide Prevention Lifeline is dependent on local in state call response infrastructure. Vermont currently ranks at the very bottom of in-state response for National Lifeline calls, at 0% response rate. Currently Vermont callers are routed out of state resulting in potential delays and barriers to appropriate referrals. DMH will administer funding to three of Vermont's local crisis call centers (Pathways, NCSS, 211) to expand capacity increasing to a 70% in state call response by 2021; which would equate to approximately 1,672 calls.

There is significant data to support the expansion of the National Suicide Prevention Lifeline:

- In 2019 there were 2,345 calls from Vermonters to the National Lifeline. Of those around 5% were answered in state (by NCSS who just started answering calls in September 2019, and only during business hours when someone is there is to answer the phone.)
- An independent research evaluation of nearly 1,100 National Lifeline conversations found that callers' intent to die had significantly decreased by the end of the call, as had their feelings of hopelessness and psychological pain. (Gould, Kalafat, HarrisMunfakh, & Kleinman, **2007**).
- There is also evidence that suicidal callers can experience some recurrence of suicidality (ideation, plan, or attempt) in the weeks following their crisis call (43% of callers in this study). This is why it is so important the calls be answered in-state, by people who know Vermont resources and referral options. Follow up is a major piece and one the Zero Suicide framework focuses on intently.
- Further as noted in an article in the Atlantic: The Lifeline can act like "air-traffic control for people in crisis, not only averting the immediate danger, but also connecting them to resources in their area that could put them on a more permanent path to safety." https://www.theatlantic.com/health/archive/2019/09/suicide-prevention-hotline-988/598588/

3. Strategy 3: Expand programs and supports for older Vermonters and Veterans

Suicide risk is often coupled with social isolation and lack of meaningful relationships. Older Vermonters and Veterans have the highest rate of suicide and the highest risk of social isolation. As an upstream suicide prevention strategy Vermont will explore the expansion of the **Elder Care Clinician Program** and/or the "**Vet to Vet," a visitor program** conducted by Senior Solutions in Southeastern Vermont in collaboration with the American Legion in Brattleboro that pairs older veterans and younger veterans together, creating an upstream suicide prevention program for both generations of veterans. This funding will be administered by the Department for Aging and Independent Living (DAIL). https://www.seniorsolutionsvt.org/volunteering/vet-to-vet-vermont-visitor-program/. **Budget:$50,000**

Total Budget: $575,000 Base Funding

Adjustment to DA Increase – Move Funds to DAIL (BAA Item)

Gross: ($239,994) GF: ($109,461)

In FY 20, Legislature appropriated funds to increase payments to the Designated Agencies and Specialized Service Agencies. This increase was provided with a 50%/50% split between DAIL and DMH with the intention of allocating the funds proportionally to each department. This is to redistribute the funds appropriately.

One Time Funds:

Implement Mobile Response (MRSS)

Implementation in 1 Region of Vermont:
Gross: $600,000 GF: $600,000

Implement a Mobile Response team as a pilot in Rutland, Vermont. This would include the core components of Mobile Response including face-to face mobile response to the children's home, school or other location; on-site/in home de-escalation, assessment, planning and resource referral; follow-up stabilization services and case management; and data tracking and performance measurement reporting. Managing the social and fiscal impacts of the utilization of higher levels of care is important. Current data that looks at the utilization and total cost of care for Vermont children and youth with mental health needs indicates that Rutland has the highest average ED's visits for children and youth with mental health needs across the state (see chart below).

Mobile Response and Stabilization Services (MRSS) differ from traditional crisis services in that MRSS provides more upstream services. A mobile face-to-face response is provided to a *family-defined crisis* to provide support and intervention for a child/youth and their family, *before* emotional and behavioral difficulties escalate. MRSS has been shown in other states to be responsive to child, youth and family needs, clinically and cost effective in "averting unnecessary" higher levels of care in settings such as emergency departments, inpatient psychiatric care, residential treatment or other placement disruptions, and is often the first point of contact with families (NASMHPD 2018).

In Vermont we have the following challenges:

- ✓ Increases in children/youth (0-17) who go to Emergency Departments with a mental health crisis and then wait, sometimes for days, for a plan to be put into place (inpatient, crisis alternative program, or community-based).
- ✓ Designated Agencies' emergency services are expected to provide "Mobile outreach capability and crisis stabilization services *as feasible within existing resources* to help prevent need for higher level of care" (emphasis added). There is a gap between the current resourced capacity of the DA emergency services teams and the current demand for these services.
- ✓ The DA emergency services teams manage this gap between resource and demand by determining what constitutes a crisis and prioritizing crisis screening for inpatient admissions.
- ✓ Families and providers see a need for responsive, in-home community supports beyond screening.
- ✓ For additional information on mobile response see Making the Case for Mobile Response in Vermont.

States which have effectively implemented MRS have shown the following savings and outcomes:

- Connecticut: A study showed a 25% reduction in ED visits among children/youth who used MRSS compared to youth who didn't access MRSS *(Child Health & Development Institute, 2018).*
- Washington State: The Seattle, WA MRSS reported diverting 91-94% of hospital admissions and "estimated that it saved $3.8 to 7.5 million in hospital costs and $2.8M in out-of-home placement costs" (*NASMHPD 2018).*
- Arizona: Arizona's MRSS reportedly "saved 8,800 hours of law enforcement time, the equivalent of four full-time officers".

- New Jersey: Data showed that 46/46 children who entered foster care and who had a mobile response were able to remain in their first placement.

Vermont strives to get upstream as a system, but due to many factors including funding levels, much of our system supports are available only in reaction to an identified problem. We want to shift from being reactive to responsive. When supports and stabilization are offered earlier for families in their chosen setting (home or community), we can shift the trajectory for children and their families, heading off the need for more intensive, expensive and/or longer-term services down the road. Without new investment in MRSS, these trends will continue. MRSS is recognized as an effective component of a comprehensive crisis continuum.

Emergency Department Use by "High Utilizer" Children/Youth by Health Service Area

Member HSA	# Members	# ED MH Visits	Avg ED Visits/Member
Burlington	1056	631	0.60
Barre	644	481	0.75
St Albans	577	230	0.40
Rutland	505	626	1.24
Bennington	470	411	0.87
White River Jct	447	252	0.56
Brattleboro	290	292	1.01
St Johnsbury	277	152	0.55
Springfield	269	243	0.90
Newport	268	126	0.47
Morrisville	264	80	0.30
Randolph	200	80	0.40
Middlebury	124	77	0.62
Grand Total	**5391**	**3681**	**0.68**

Project of Depts of Vermont Health Access (DVHA), Mental Health (DMH), and Onpoint Health Data consultant

DMH FY 21 Summary of Request:

	Gross	**GF Equivalent**
General Fund (GF):	$1,777,360	$1,777,350
Special Funds:	$501,769	$0
Federal Fund:	$80,116	$0
Medicaid GC and Investment Funds:	$5,795,613	$2,643,379
Total DMH Request	**$8,154,858**	**$4,420,739**